

Audit Compendium

| Public health

Audit reports published between 2014 and 2019

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Opening words

Dear reader,

The Contact Committee of the European Union supreme audit institutions (SAIs) provides a forum to discuss and address matters of common interest relating to public audit in the EU and its Member States. By strengthening dialogue and cooperation between its members, the Contact Committee contributes to effective external audit of EU policies and programmes. This also helps to enhance accountability in the EU and its Member States, and to improve EU financial management and good governance for the benefit of EU citizens.

In 2017, we decided at our annual meeting in Luxembourg to make additional efforts to raise general awareness of recent audit work performed by EU SAIs. One year later, in 2018, we published a first audit compendium, setting out in a single document the work of EU SAIs on youth employment and the integration of young people into the labour market. In view of the success of this first edition, the Contact Committee decided to pursue the activity and address additional topics of general interest. We are therefore proud to present the second edition of the audit compendium, focusing on our recent audits of public health and related issues.

Over the last few decades, the health systems in EU Member States have faced numerous challenges, such as ever rising costs and ageing populations, and patients as well as healthcare professionals are becoming more and more mobile across Member States. Therefore, public health requires coordinated efforts by the EU and all Member States and the topic will undoubtedly continue to demand a prominent place on the political agenda for generations to come.

In the European Union, public health is largely the responsibility of the Member States. The EU mainly supports efforts undertaken at national level, with a specific focus on complementing or coordinating actions of the Member States in the area of public health. Consequently, public health, seen from an EU-wide perspective, is a complex area to audit.

This edition of the compendium offers a general introduction to public health and the role of the EU and its Member States in this policy field, and provides an overview of selected audit work by EU SAIs since 2014, including a summary of their work. For more information about these audits, please contact the SAIs concerned.

We hope you will find the audit compendium a useful source of information.



Klaus-Heiner Lehne

President of the European Court of Auditors
Chair of the Contact Committee & Leader of the project

Executive summary

I Public health is the science of preventing disease and prolonging lives. It affects people's lives every day and in every part of the world. It is therefore on the political agenda of every modern society and will be for generations to come.

II In the EU, public health is mainly the responsibility of the EU Member States. Therefore, health systems vary considerably across EU Member States. The European Union supports efforts at national level, with a specific focus on complementing or coordinating the Member States' actions in the area of public health.

III Consequently, public health, seen from an EU-wide perspective, is a complex area to audit. However, due to the importance of public health, the EU Supreme Audit Institutions have performed many audits on related issues.

IV The first part of this audit compendium gives a general overview of public health in the EU, its legal basis, main objectives and related responsibilities. It also illustrates the main challenges currently faced both by the EU and its Member States in the area of public health.

V The second part of this audit compendium summarises the results of selected audits carried out by 23 contributing Member State SAIs (Austria, Belgium, Bulgaria, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, Poland, Portugal, Romania, Slovakia, Slovenia and Spain) and the European Court of Auditors over the past five years. These selected audits addressed important aspects of public health, namely preventive action, access to health services and the quality of those services, the use of new technologies and the fiscal sustainability of public health services.

VI The third part of this audit compendium contains detailed fact sheets for selected audits carried out by the 23 Member State SAIs and the European Court of Auditors.

PART I – Public health in the EU

Public health – adding more years to life and more life to the years

- 1** Health plays an important role not only in every modern society as a whole, but also for each of us individually. It is an important, if not the most important, determining factor for quality of life.
- 2** Public health, as defined by the World Health Organization (WHO), is “**the science of preventing disease, prolonging life and promoting health through the organized efforts of society**”¹. It includes all activities aiming at maintaining or improving peoples’ health.
- 3** Besides being of value in itself, health is also an important economic factor. In Europe, as in almost all developed economies, public health is one of the largest and fastest growing areas of spending. Health and care workers represent around 8 % of the total workforce within the EU².
- 4** Over the last few decades, European health systems have faced a number of challenges. Ageing populations have led to a growing demand for health services and a stronger focus on long-term care. Providing innovative, and more effective, health technology and treatments has helped to improve health conditions in many areas but in some cases, it has also contributed to rising costs in the health sector. At the same time, financial resources are limited.
- 5** Public health systems must therefore not only be financially sustainable, but also resilient: they need to adapt effectively to an ever faster changing environment whilst taking advantage of the possibilities offered by modern technology.
- 6** In the EU, national health systems increasingly interact with each other, and patients as well as healthcare professionals are becoming more and more mobile across Member States. The future of public health will therefore require coordinated efforts by the EU and all Member States with the common objective of adding more years to life and more life to the years.

¹ Acheson, 1988; WHO.

² OECD/EU (2018), Health at a Glance: Europe 2018: State of Health in the EU Cycle, OECD Publishing, Paris/EU, Brussels, https://doi.org/10.1787/health_glance_eur-2018-en

EU health policy

Legal basis and responsibilities

7 The **Treaty of Maastricht** put health on the European Agenda, stating: “The Community shall contribute towards ensuring a high level of human health protection by encouraging cooperation between the Member States and, if necessary, lending support to their action”³. It paved the way for better healthcare support to the Member States in areas such as:

- improving the health of EU citizens;
- modernising health infrastructure;
- enhancing the efficiency of health systems.

8 The **Treaty on the Functioning of the European Union (TFEU)** further stressed the importance of health policy, stating in Article 168 that “[...] a high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities”.

9 In line with the TFEU, **primary responsibility** for health protection and, in particular, healthcare systems **lies with the Member States**, and EU actions should “[...] respect the responsibilities of the Member States for the definition of their health policy and for the organization and delivery of health services and medical care”.

10 The main **role of the EU** is therefore to support, complement or coordinate the Member States’ action in the area of public health. This action should particularly be “[...] directed towards improving public health, preventing physical and mental illness and diseases, and obviating sources of danger to physical and mental health”⁴.

³ Treaty of Maastricht (1992), Article 129.

⁴ Article 168(1) under Title XIV of the TFEU.

11 Within the European Commission, **DG SANTE** is responsible for the overall coordination and implementation of the health strategy. It supports the actions of the Member States through:

- proposing legislation;
- providing financial support;
- coordinating and facilitating the exchange of best practice between EU countries and health experts;
- health promotion activities.

Policy objectives

12 The **strategic objectives of EU health policy** as defined in the 2014-2020 health programme⁵ are to:

- **promote health, prevent disease and foster healthy lifestyles** through “health in all policies”;
- protect EU citizens from serious **cross-border health threats**;
- contribute to innovative, efficient and sustainable **health systems**; and
- facilitate access to **high quality, safe healthcare** for EU citizens.

13 The Commission’s **specific priorities for 2016-2020** in the area of public health are, among others, to achieve greater cost effectiveness, tackle emerging global threats such as antimicrobial resistance, address risk factors for non-communicable diseases and promote vaccination.

14 Under the **next Multiannual Financial Framework**, covering the period 2021-2027, the EU Health Programme will be covered by the European Social Fund Plus (ESF+). The current proposal suggests the following broad objectives: crisis preparedness, empowering health

⁵ Regulation (EU) No 282/2014 of the European Parliament and of the Council of 11 March 2014 on the establishment of a third Programme for the Union's action in the field of health (2014-2020) and repealing Decision No 1350/2007/EC.

systems, supporting EU health legislation and integrated work on European Reference Networks (ERNs), Health Technology Assessment, and the implementation of best practice and innovation in public health.

Funding

15 EU health policy can be funded under different instruments. The main instrument exclusively dedicated to health is the **EU health programme**, with a budget of around €450 million for the period 2014-2020. It finances initiatives in the area of health promotion, health security and health information.

16 Other instruments which may also fund health-related activities are:

- the **Horizon 2020** research programme, which supports projects in areas such as biotechnology and medical technologies;
- **EU cohesion policy**, which supports investments in health in EU countries and regions;
- the **European Fund for Strategic Investments**.

Public health in the EU Member States

17 Although based on common values – in particular, equality, universal access to good quality care and solidarity⁶ – the health systems in EU Member States vary considerably.

18 Basic differences exist between the health systems in terms of the way they are funded and provided. Three different funding method models can be distinguished within the EU⁷:

- the “**Beveridge model**” is a public tax-financed system which usually provides universal coverage and depends on residency or citizenship;

⁶ Council Conclusions on Common values and principles in European Union Health Systems, OJ C 146, 22.6.2006.

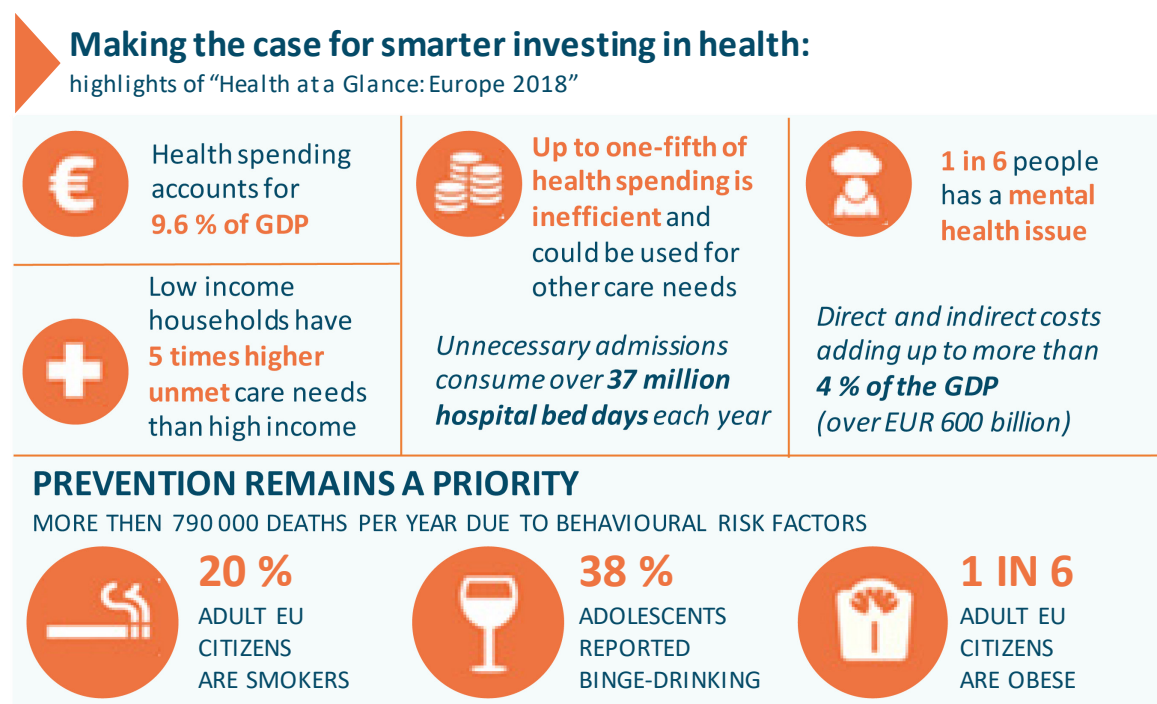
⁷ European Committee of the Regions: The Management of health systems in the EU Member States.

- in the “**Social Health Insurance System**”, or “Bismarck model”, healthcare is funded through compulsory social security contributions, usually by employers and employees;
- the “**mixed model**” is based on private funding from voluntary insurance schemes or out-of-pocket payments.

19 In 2016 the Commission launched, in cooperation with the OECD, the “State of Health in the EU” initiative, which aims at assisting the Member States to improve the performance of their health systems. Under this initiative, the Commission published the “**Health at a Glance**” analysis in 2018, which compares data from all Member States in relation to the performance of their respective health systems.

20 The analysis focuses on issues like preventive action, access to health systems and their effectiveness, as well as fiscal sustainability. The main conclusions of the report are summarised in *Figure 1*:

Figure 1 – Making the case for smarter investing in health



Source: European Commission, State of Health in the EU, Factsheet on the report Health at a Glance: Europe 2018 (OECD, European Commission).

Prevention and protection

21 Disease prevention involves interventions aiming to minimise the burden of diseases and their associated risk factors⁸.

22 It can be categorised as follows:

- primary prevention aims to avert diseases before they occur;
- secondary prevention is the early detection of a disease;
- tertiary prevention aims to reduce the impact of a disease.

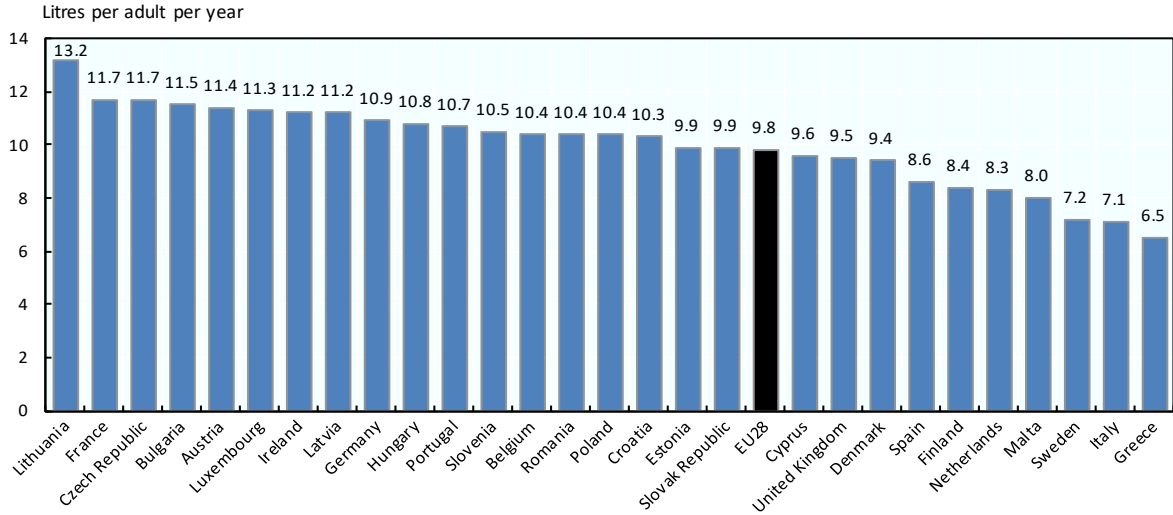
23 In 2016 an estimated **790 000 people in the EU died prematurely** because of smoking, alcohol consumption, unhealthy diets and a lack of physical activity⁹ – lives which could have potentially been saved by a stronger focus on health promotion and prevention.

24 In particular, non-communicable diseases (e.g. cardiovascular diseases, cancer, Alzheimer’s or diabetes) account for a high proportion of premature deaths and lead to higher health expenditure. Such deaths can often be prevented by simply cutting the main risk factors causing them (e.g. pollution, smoking, a lack of physical activity or alcohol consumption) (see *Figures 2, 3 and 4*). This is particularly true of the EU, as it is still the region with the highest alcohol consumption in the world. Europeans drink approximately 10 litres of alcohol per year. Further, around 20 % of adults in the EU smoke daily.

⁸ WHO, 2017.

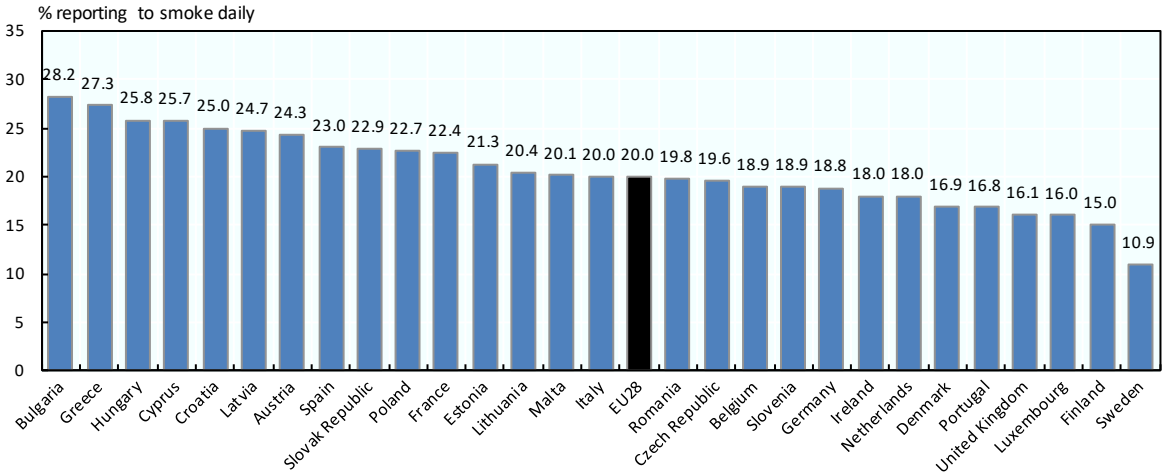
⁹ OECD/EU (2018), Health at a Glance: Europe 2018: State of Health in the EU Cycle, OECD Publishing, Paris/EU, Brussels, https://doi.org/10.1787/health_glance_eur-2018-en

Figure 2 – Overall alcohol consumption among adults (2016 or latest available year)



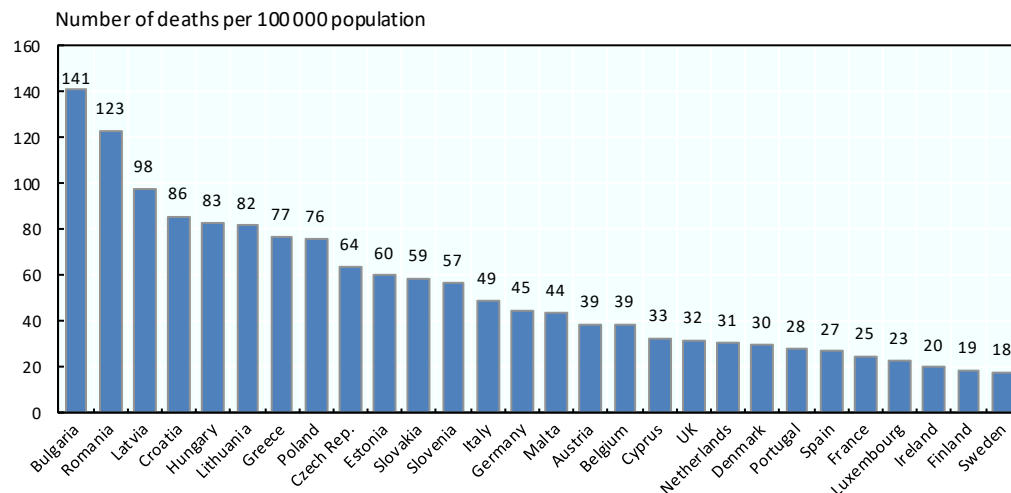
Source: OECD Health Statistics.

Figure 3 – Daily Smoking Rates among adults (2016 or latest available year)



Source: OECD Health Statistics.

Figure 4 – Mortality attributable to joint effects of household and ambient air pollution (per 100 000 population, 2016)



Source: World Health Statistics (WHO).

25 Although prevention plays a key role in saving not only lives but also **money**, at least in the long-term, it currently **only accounts for about 3 %** of the total health spending¹⁰.

26 Prevention is also an area characterised by **significant inequalities** in most if not all Member States. The probability of benefiting from health prevention measures is strongly correlated with education and/or socioeconomic status, for example:

- twenty percent of adults with a lower level of education are obese compared with twelve percent of those with a higher-level education;
- adults with a lower income are less likely to achieve the recommended 150 minutes physical activity per week and are more likely to be regular smokers.

27 In order to lower the number of premature deaths and to enable people to live longer whilst remaining in good health, the emphasis needs to **shift from curing diseases to preventing them**.

28 The EU has therefore launched several initiatives with a specific focus on prevention in recent years (see [Box 1](#)).

¹⁰ OECD/EU (2018), Health at a Glance: Europe 2018: State of Health in the EU Cycle, OECD Publishing, Paris/EU, Brussels, https://doi.org/10.1787/health_glance_eur-2018-en

Box 1

EU initiatives in the area of health prevention

Prevention through information

The main objective of EU action in relation to health prevention is to provide sufficient relevant information to allow consumers to make well-informed decisions.

To address **obesity**, the European Commission adopted a “Strategy on nutrition, overweight and obesity-related health issues” in 2007 and launched a number of specific initiatives in the same area. One of these initiatives was setting the legal framework for nutrition and health claims (e.g. “low fat” or “calcium for healthy bones and teeth”). In practice, it prohibited any nutrition or health claims on food labels or in food advertisements which were not clear, accurate or based on scientific evidence (EC regulation 1924/2006¹¹).

Additionally, the Commission published an Action Plan on Childhood Obesity¹², which proposes main areas for action and a possible toolbox to address excess weight and obesity in children and young people by 2020.

The 2014 EU Tobacco Products Directive¹³ made a health warning on **tobacco** and its related products compulsory, and prohibited all promotional or misleading elements on packaging.

29 On a more general level, in 2018 the European Commission established a Steering Group on Health Promotion, Disease Prevention and Management of Non-Communicable Diseases to support countries aiming to reach the health targets of the Sustainable Development Goals, in particular goal three “good health and well-being”. The Steering

¹¹ Regulation (EC) No 1924/2006 of the European Parliament and of the Council of 20 December 2006 on nutrition and health claims made on foods.

¹² EU Action Plan on Childhood Obesity 2014-2020 24 February 2014 [updated 12 March and 28 July 2014].

¹³ Directive 2014/40/EU of 3 April 2014 of the European Parliament and of the Council on the approximation of the laws, regulations and administrative provisions of the Member States concerning the manufacture, presentation and sale of tobacco and related products and repealing Directive 2001/37/EC.

Group provides advice and expertise to the Commission in the area of health promotion and prevention.

30 Member States have taken various actions to address the main risk factors to health:

- to reduce **smoking**, these measures have included awareness campaigns, taxes to increase prices, smoke-free environment legislation and advertising restrictions;
- to reduce the risks related to **alcohol consumption**, many Member States have limited adolescents' access to alcoholic products, increased prices and introduced stricter advertising regulations. All EU countries have set maximum levels of blood alcohol concentration for drivers;
- **obesity** – a growing number of Member States have taken measures to promote a healthy lifestyle and thereby prevent or reduce **obesity** among their citizens. One of these measures was to provide better information on nutrition to allow citizens to make healthy choices, e.g. food labelling or advertising restrictions on food targeting children;
- most Member States also engage in measures to reduce **air pollution** as annual casualties due to polluted air still amount to 400 000 each year in the EU.¹⁴

Access to healthcare

31 Universal access to healthcare is defined as the **availability of health services at the right time, place and price**. It is one of the most important preconditions for health equality.

32 The right of access to good quality healthcare is enshrined in the EU Charter of Fundamental Rights (Article 35) and is consequently one of the guiding principles of health systems in the EU. In addition, it is one of the UN's sustainable development goals (goal three).

33 Accessibility to healthcare is generally measured using the “number of persons declaring unmet healthcare needs” indicator. Healthcare needs are not met if the requested services are not available on time, at the right place or, in the case of at least partly privately funded health systems, at an affordable price.

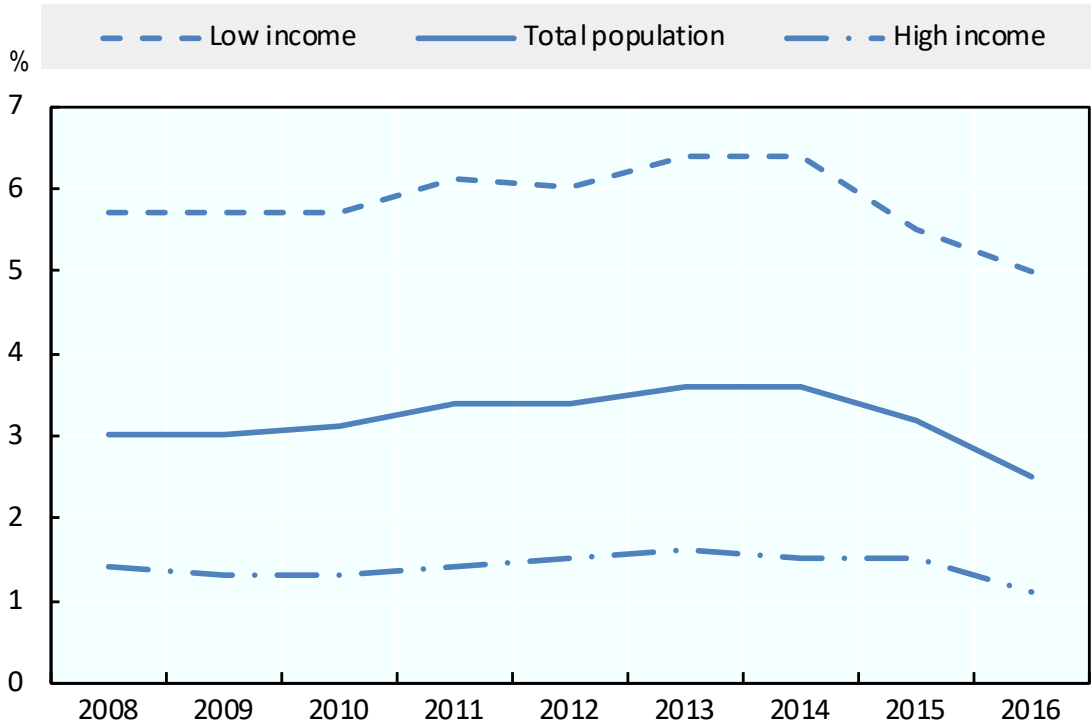
¹⁴ See ECA [special report 23/2018](#): Air pollution: Our health still insufficiently protected.

34 Overall, access to healthcare is ensured in the EU. In most Member States, the vast majority of citizens (well above 90 %) have no unmet healthcare needs to report, and the proportion of people reporting any such unmet needs has declined further over the last decade (see *Figures 5 and 6*).

35 Access to healthcare is, however, not evenly distributed and **inequalities persist** between different countries but also between regions and between different income groups within countries:

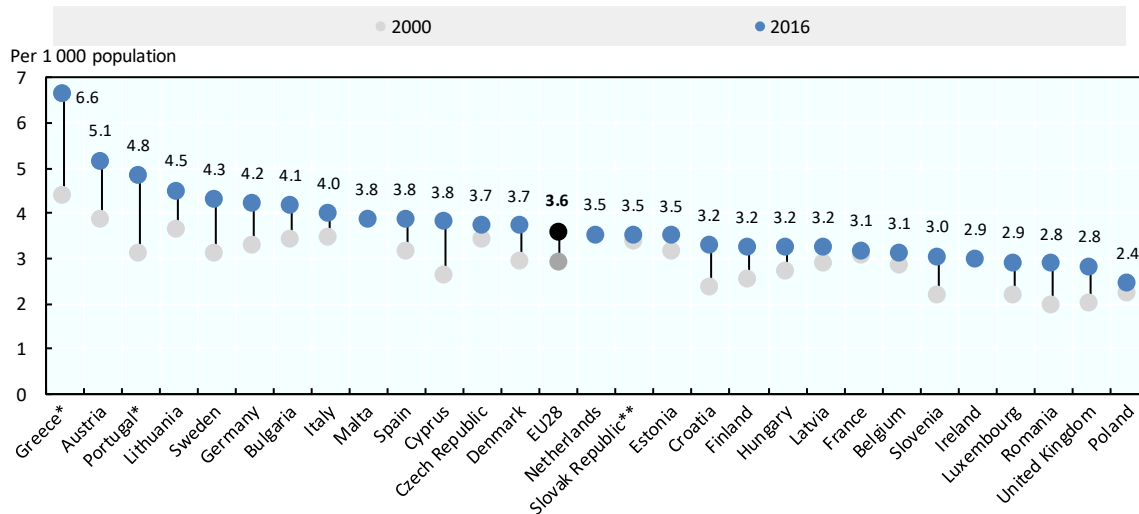
- unmet healthcare needs are still an issue in Estonia and Greece, where more than 10 % of citizens reported an unmet healthcare need in 2016;
- the probability of unmet healthcare needs is five times higher for low-income households;
- rural and remote areas are often characterised by a shortage of general practitioners, and waiting times for non-emergency surgery has increased in many EU Member States in recent years.

Figure 5 – Unmet medical needs by socioeconomic status, all EU Member States (2008-2016)



Source: Eurostat Database.

Figure 6 – Practising doctors per 1 000 citizens



* Data refer to all doctors licensed to practice, resulting in a large over-estimation of the number of practising doctors (e.g. of around 30 % in Portugal).

** Data include not only doctors providing direct care to patients, but also those working in the health sector as managers, educators, researchers, etc. (adding another 5-10 % of doctors).

Source: Health at a Glance: Europe 2018 (OECD, European Commission).

36 At EU level, data on the accessibility of health services is monitored regularly. The Commission established an expert group on accessibility, among other issues, in 2016.

37 Improving access to healthcare, however, falls primarily within the **responsibility of the Member States**. They have taken a number of measures to improve access to healthcare, such as ¹⁵:

- strengthening primary care, including better coordination between primary and specialised care;
- increased coverage of health services, thereby reducing out-of-pocket payments;
- higher wages for employees in the health sector;
- financial benefits to doctors in areas without sufficient cover, namely remote and rural areas.

¹⁵ European Semester Thematic Factsheet: Health Systems.

38 Specific measures have also been taken to ensure access to healthcare in another EU Member State (see [Box 2](#)).

Box 2

EU cross-border healthcare

Cross-border healthcare – what are the benefits for EU citizens?

The EU Cross-Border Healthcare Directive, adopted in 2011, sets out the legal framework for EU citizens seeking healthcare in an EU Member State other than the one where they are resident.

It grants EU citizens wishing to seek healthcare abroad access to safe and high-quality healthcare in another EU Member State, whilst being reimbursed by the same amount as they would receive if they were treated in their country of residence.

In addition, National Contact Points have been created throughout the EU, in order to provide information on healthcare available in the different EU Member States and the conditions under which the services are reimbursed.

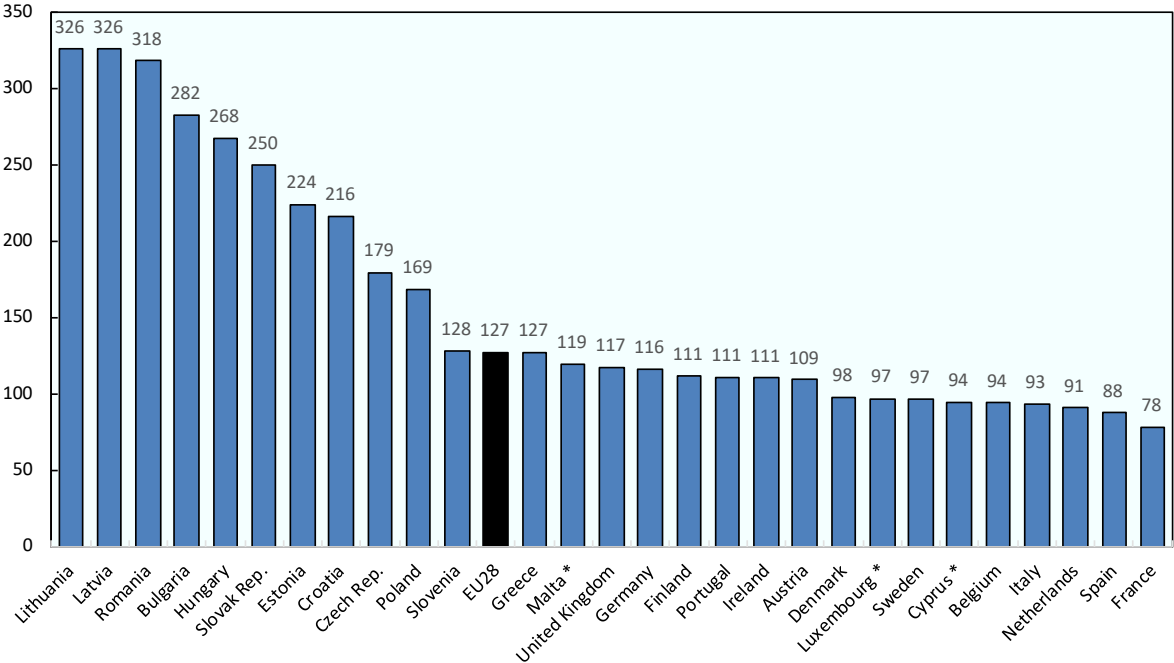
Although patients' mobility remains strongly influenced by cultural and geographical proximity, cooperation in cross border healthcare represents an important step in broadening European cooperation in the area of health.

The quality of health services

39 Quality health systems achieve their ultimate objective of maintaining or improving citizens' health effectively. The effectiveness of health systems is often measured based on amenable mortality rates (deaths that could have been avoided through timely and quality health interventions). Alternative indicators are life expectancy or "softer indicators" like patient experience or quality of life after recovery from an illness or injury.

40 The concept of amenable mortality rates is closely linked to the concept of preventable mortality (deaths that could be avoided through public health and prevention). Preventable and amenable mortality together make up avoidable mortality rates. In 2015, over 1.2 million people died prematurely (before the age of 75) due to a lack of effective public health policies, preventive measures and healthcare. More than 570 000 of these deaths were considered amenable (see [Figure 7](#) for amenable mortality rates by country).

Figure 7 – Amenable mortality rates (2015)



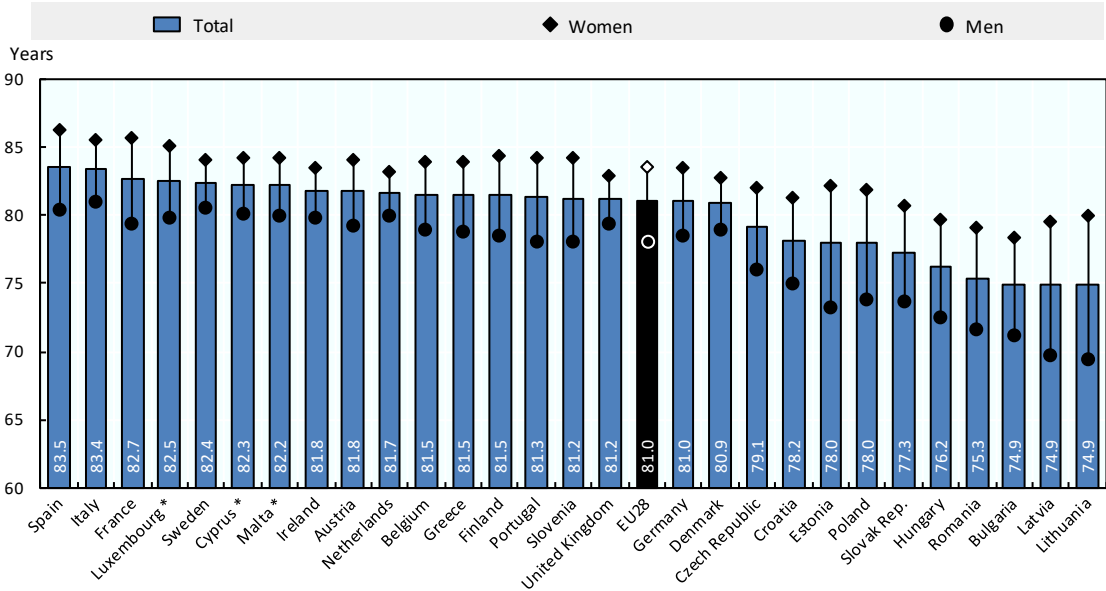
* Three-year average (2013-15).
Source: OECD Health Statistics 2018.

41 Over the last decade, the **quality of acute care** for life-threatening conditions has improved considerably across the EU. Between 2005 and 2015 the number of people dying following a hospital admission decreased by 30 % for those suffering acute myocardial infarctions and by 20 % for strokes. However, inequalities persist between countries as well as between different hospitals in the same country.

42 Considerable progress has also been made across the EU in relation to **cancer survival rates**, mainly through the implementation of screening programmes in combination with more effective and timely care.

43 **Average life expectancy** in the EU is currently 81 years (see [Figure 8](#)). Although life expectancy is still rising, the gains, in particular in Western Europe, have slowed in recent years. The main causes of death across the EU remain circulatory diseases and cancer, together accounting for over 60 % of all deaths.

Figure 8 – Life expectancy at birth by gender (2016)



* Three-year average (2014-16).

Source: Health at a Glance: Europe 2018 (OECD, European Commission).

44 Life expectancy also varies considerably, according to not only gender but also socioeconomic status. The life expectancy of people with a low level of education is eight years lower for men and four years lower for women than that of people with a high level of education.

45 The quality of care and the effectiveness of health systems are **strongly related to other areas of public health**, in particular access to health services and prevention. Measures to improve the quality of care therefore require a holistic approach.

46 Some of the measures taken at Member State level to increase the quality of care are the use of new technology, organisational changes in health services provision and, in general, a focus on more integrated and individual care.

47 Evaluating the results of these measures, however, remains complex. Although efforts have been made to collect data on the effectiveness of health systems, information on more qualitative indicators like patient experience or quality of life continues to be limited.

48 The European Commission has supported the development of European Core Health Indicators (ECHI), which are a set of indicators to monitor the health status of EU citizens and the performance of EU health systems. It has also launched the “Health at a glance” series in cooperation with the OECD.

49 In addition, the Commission set up an Expert Group on Health Systems Performance Assessment to provide EU countries with a forum for exchanging experiences in this field and to support national policymakers by developing health system performance assessment tools and methodologies in close cooperation with international organisations such as the WHO and the OECD.

New technologies and eHealth

50 EHealth, or digital health, can be defined as **all tools and services that use information and communication technologies** to improve the prevention, diagnosis, treatment, monitoring or management of health.

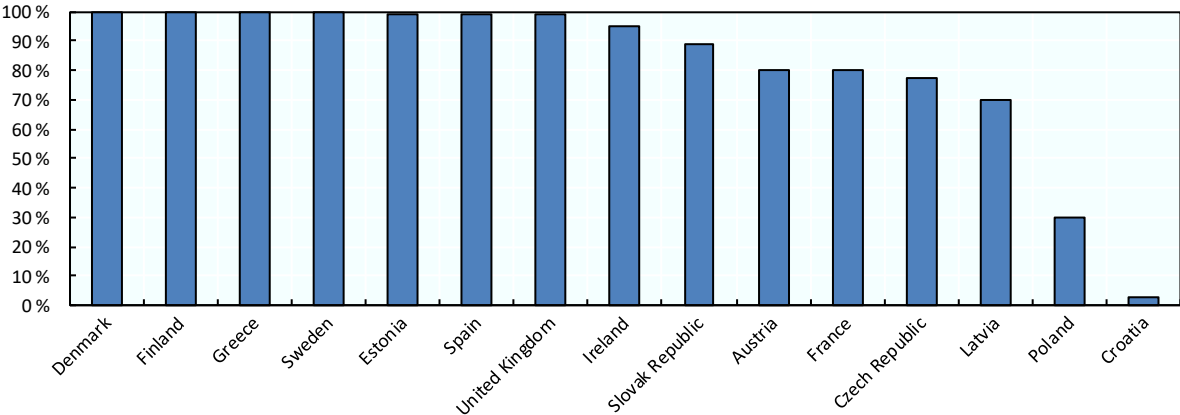
51 New technologies offer enormous potential gains in terms of efficiency and the quality of prevention and healthcare services. The main uses of new technologies in the area of health are currently:

- electronic medical records: computerised medical records created by and ideally shared between different health service providers;
- ePrescribing: computer-based generation, transmission and filing of medical prescriptions;
- online health information;
- getting access to health services (e.g. making appointments) through the internet.

52 Although the use of new technologies in public health is increasing across the EU, disparities still exist by age and socioeconomic group.

53 Electronic medical records have been promoted in many Member States and their use is increasing across the EU. A survey conducted in 15 Member States shows that on average 80 % of primary care physicians in these countries used electronic medical records in 2016 (see [Figure 9](#)). In most of these countries, patients have access to their own medical records and, in some, patients can also add or modify the information they contain.

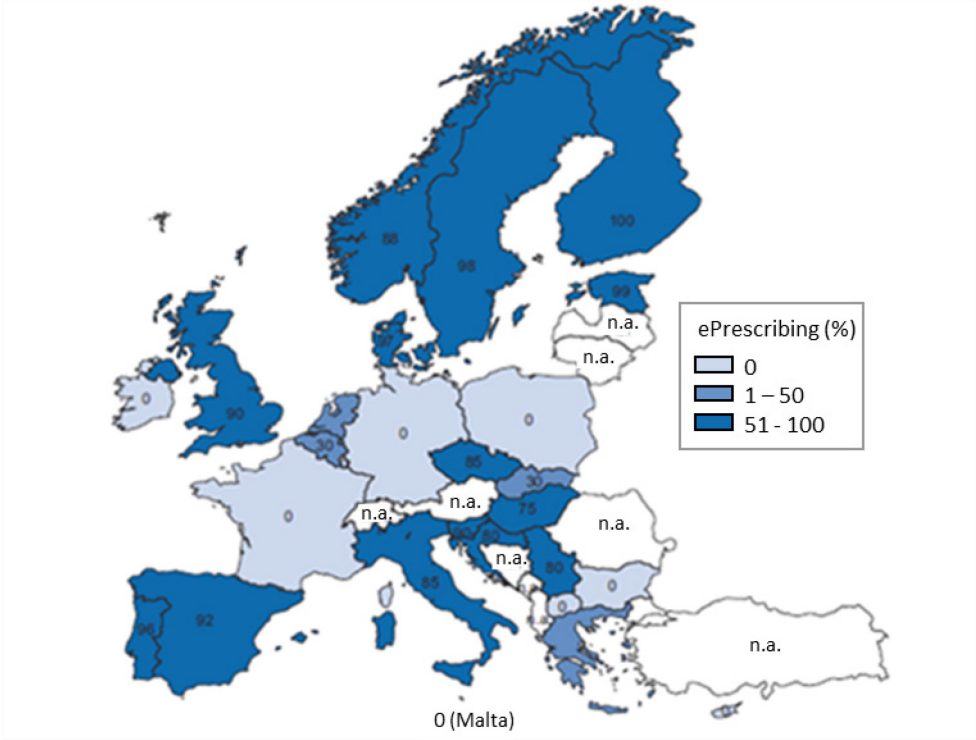
Figure 9 – Percentage of primary care physicians using electronic medical records (2016)



Source: OECD Survey of Electronic Health Record System Development and Use.

54 The picture for **e-prescription** is more varied, with an almost 100 % e-prescription rate in some countries like Finland, Sweden, Denmark, Portugal and Spain, versus e-prescription not having been implemented in other countries like France or Germany (see [Figure 10](#)). However, e-prescriptions should gain in importance with 22 EU Member States expected to exchange patient summaries and/or e-prescriptions by the end of 2021.

Figure 10 – Percentage of e-prescriptions in community pharmacies (2018)



Source: Pharmaceutical Group of the European Union (PGEU).

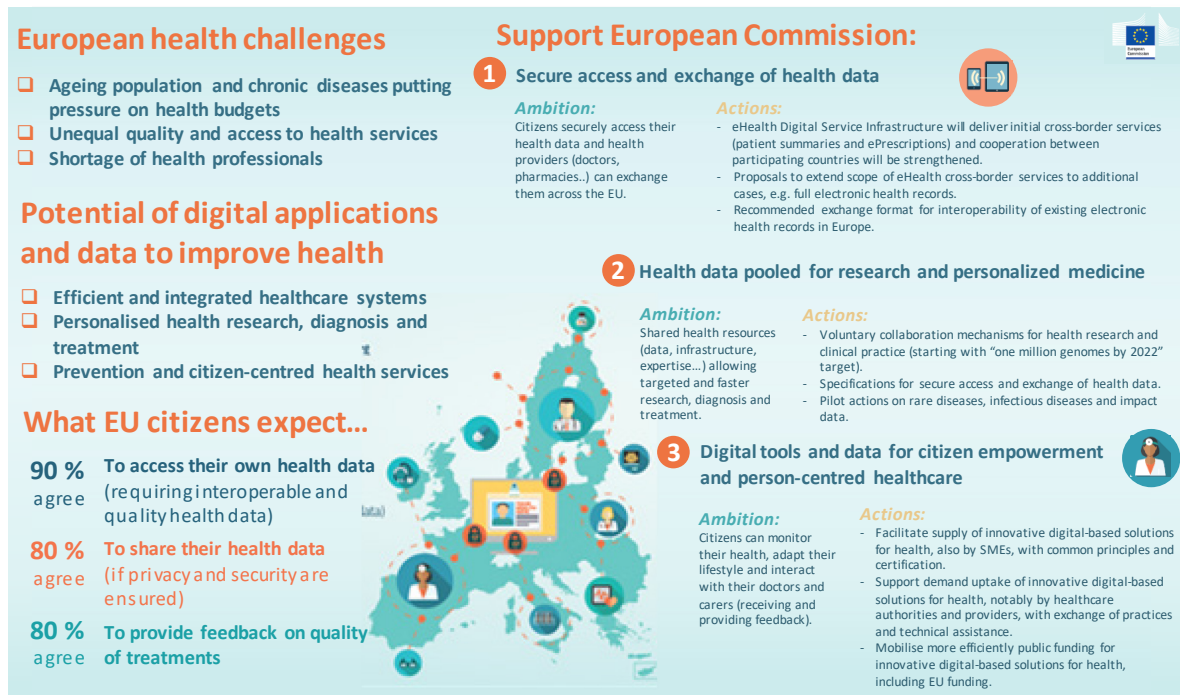
55 With the adoption of the **Digital Single Market Strategy in 2015**, the European Commission has made greater use of digital technology in all areas, including the health sector, one of its main priorities.

Figure 11 – Digital health

Digital Health and Care



TRANSFORMATION OF HEALTH AND CARE IN THE DIGITAL SINGLE MARKET - Harnessing the potential of data to empower citizens and build a healthier society



Source: European Commission.

56 In April 2018 the Commission issued a [communication on enabling the digital transformation of health and care](#), which identifies three different focus areas (see [Figure 11](#)):

- **Secure data access and sharing.** To facilitate greater cross-border healthcare access, the Commission is building an eHealth digital service infrastructure, which will allow [e-prescriptions and patient summaries to be exchanged](#) between healthcare providers. The first cross-border exchanges started in 2019. In the longer term, the Commission is working towards a European electronic health record exchange format accessible to all EU citizens.
- **Connecting and sharing health data** for research, faster diagnosis and improved health. The decentralised European digital health infrastructure is planned to facilitate tailored diagnosis and treatment, help health services to be better prepared to respond to cross-border health threats, and improve the development and surveillance of medical products.

- **Strengthening citizen empowerment** and individual care through digital services. Digital services can improve the prevention and management of chronic conditions, and allow patients to provide feedback to healthcare providers.

57 In addition, the Commission plays an important role in supporting Member States in using modern technology in health and in coordinating national efforts (see [Box 3](#)).

Box 3

EHealth initiatives

In February 2019, the Commission presented a set of recommendations for the creation of a secure system that will enable citizens to access their electronic health files across the EU.

This new system would build on existing initiatives to exchange health records by including the exchange of laboratory tests, medical discharge reports and imaging reports.

The benefits for EU citizens are, among others:

- immediate access to their medical records whilst abroad, including in emergency situations;
- increased quality and continuity of care for citizens moving abroad;
- new research opportunities through the sharing of health data (subject to patient's consent);
- efficiency gains by avoiding repetition of laboratory or radiology tests.

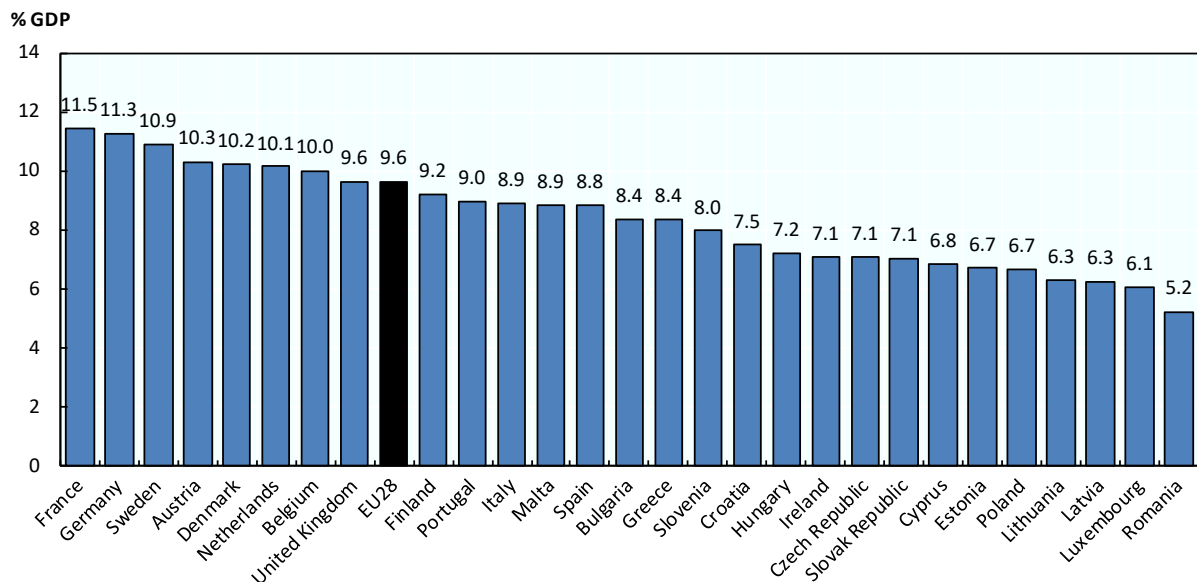
Fiscal sustainability and other financial aspects

58 Fiscal sustainability is one of the main public health challenges that the Member States are facing. Costing around €1.5 trillion (2016), health is one of the largest and fastest growing items of public spending in the EU¹⁶.

¹⁶ European Semester Factsheet: Health systems.

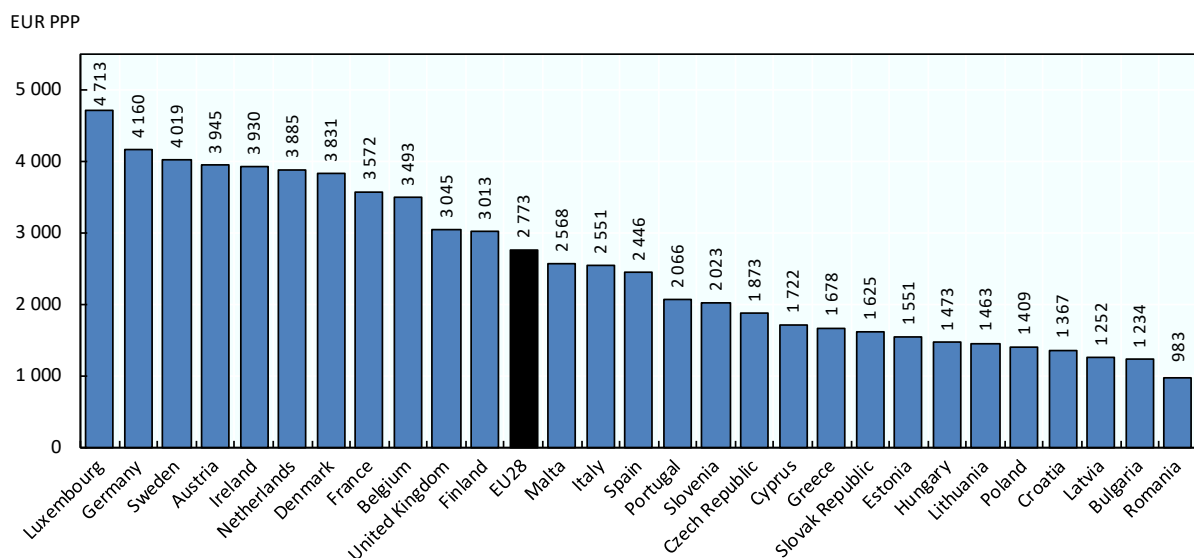
59 In 2017 health spending accounted for 9.6 % of EU GDP, compared to 8.8 % in 2008, and health expenditure per capita was €2 773 in 2017 (see *Figures 12 and 13*).

Figure 12 – Health expenditure as a share of GDP (2017)



Source: OECD Health Statistics 2018.

Figure 13 – Health expenditure per capita (2017)



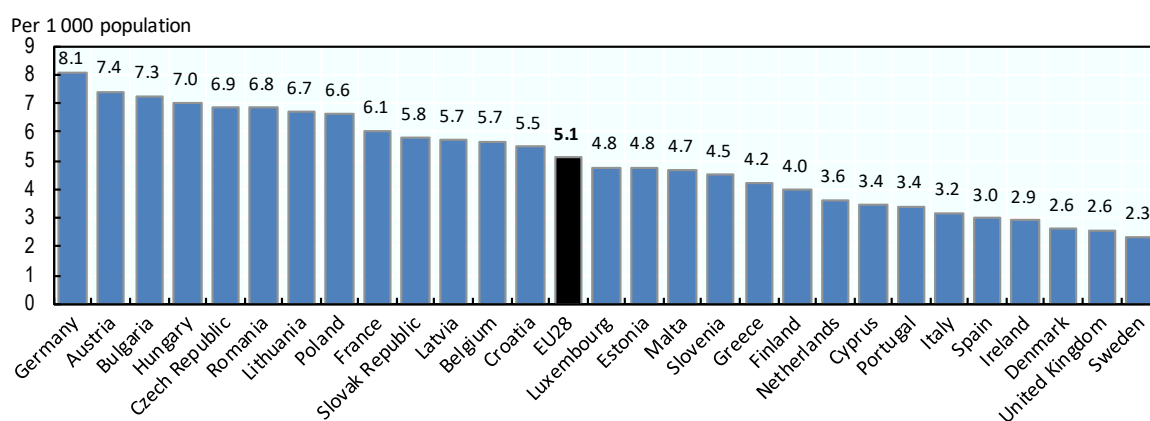
Source: OECD health statistics.

60 Health expenditure is forecast to increase further, largely due to **demographic changes** in combination with **higher costs** for new technologies in medicine and care.

61 At the same time, health spending is increasingly scrutinised due to limited financial resources. Given that in two thirds of Member States **more than 70 % of the health expenditure is publicly funded**, the sustainability of a health system is closely linked to the economic situation of the Member State and the EU as a whole.

62 Financially sustainable health systems also require potential savings to be identified. Currently, up to **one fifth of health spending is estimated to be avoidable** and could thus be better used elsewhere¹⁷. Two of the areas often associated with potential savings are hospitals (in particular the number of hospital beds (see [Figure 14](#)) or avoidable hospital stays) and pharmaceuticals (e.g. suboptimal selection, procurement and pricing).

Figure 14 – Hospital beds per 1 000 inhabitants (2016)



Source: OECD health statistics.

63 Closely related to the financial sustainability of health systems is the question of their resilience, defined as their capacity to react appropriately to changes. In particular, the demographic changes in modern society will not only require an increase in the health services offered, but also a transformation as hospital-based acute healthcare gives way to longer-term more people-centred care in the community.

64 The European Commission has continuously stressed the **need to reform public health systems** to ensure sustainability whilst maintaining universal access to good quality care. It supports the Member States in this work by providing analyses, guidelines and monitoring or evaluation tools, and recommending reforms in the context of the European Semester.

¹⁷ OECD; Tackling Wasteful Spending on Health; January 2017.

65 In addition, the Commission set up a panel of independent experts to provide advice on investing in health and introduced a number of initiatives to strengthen the effectiveness and resilience of national health systems, thereby increasing their sustainability. One such initiative is the Health Technology Assessment, a scientific approach to evaluating the effectiveness of health technologies. Member States cooperate through a network¹⁸ to reduce duplication of work at national level.

66 More specifically, the Commission also supports the Member States' efforts to coordinate their initiatives in the area of research and eHealth in order to increase efficiency and save costs. This is supported by EU funding mainly under the Horizon 2020 programme and subsequent research programmes.

67 Throughout the EU, the Member States have made a **continuous effort to reform** their health systems to make them not only more effective but also financially sustainable and resilient.

68 Whilst progress has already been made in some areas, such as savings in relation to hospitals, this process will be the focus of public health for years to come.

¹⁸ Directive 2011/24/EU of the European Parliament and of the Council of 9 March 2011 on the application of patients' rights in cross-border healthcare.

PART II – Overview of work done by the SAIs

Introduction

69 This part of the audit compendium summarises the results of selected audits carried out by the 23 contributing Member State SAIs¹⁹ and the European Court of Auditors.

Audit methodology

70 SAIs carry out their audits in accordance with the International Standards of Supreme Audit Institutions and relevant implementing standards developed at national level to ensure the quality of audit work and reports.

71 The audit methodology and procedures were selected and applied to ensure that the audit tasks were performed as effectively as possible.

72 Audit evidence was gathered through document and (statistical) data analysis, as well as through interviews with national and regional authorities or beneficiaries. Where relevant, this was complemented by surveys to obtain opinions from a larger and/or wider pool of respondents. Other methods used were direct testing, case studies and benchmarking.

Audited period

73 The effects of structural measures and the impact of programmes are often difficult to audit at an early stage. Audits covered in this compendium focused on multiannual programmes implemented between 2011 and 2019.

74 *Table 1* presents an overview of the main focus areas of the audit work of the SAIs.

¹⁹ Austria, Belgium, Bulgaria, Czech Republic, Denmark, Estonia, Germany, Greece, Finland, France, Hungary, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, Poland, Portugal, Romania, Slovakia, Slovenia, Spain.

Table 1 – Overview of EU SAIs' audit work reflected in this audit compendium

SAI	Audit title	Main focus area				
		Prevention and protection	Access to health services	Quality of health services	New technologies and eHealth	Fiscal sustainability and other financial aspects
Austria	Quality assurance for independent health practitioners			✓		
Belgium	Flemish preventive health policy – assessment of policy performance	✓				
Bulgaria	EHealth				✓	
Czech Republic	Funds spent by selected hospitals for the reimbursement of costs					✓
Denmark	Differences in the quality of care across Danish hospitals			✓		
Estonia	State activities in implementing the eHealth system				✓	
Finland	Trend projection for social security expenditure					✓
France	Preventing healthcare-related infections	✓				
Germany	Health research needed to study the value of orthodontic treatment		✓			
Greece	Audit on the State's arrears regarding hospitals and the National Healthcare Institution					✓
Hungary	Summary analysis of audits of hospitals					✓
Ireland	Managing elective day surgery			✓		
Italy	The implementation of the extraordinary programme for building renovation and the technological modernisation of the real estate properties of public health institutions					✓
Latvia	Is the "eHealth in Latvia" project a step in the right direction?				✓	
Lithuania	The accessibility of healthcare services and patient orientation		✓			
Luxembourg	Financing hospital investments					✓
Malta	The general practitioner function – the core of primary healthcare		✓			

SAI	Audit title	Main focus area				
		Prevention and protection	Access to health services	Quality of health services	New technologies and eHealth	Fiscal sustainability and other financial aspects
Poland	The prevention and treatment of type 2 diabetes	✓				
Portugal	Citizen's access to healthcare in Portugal's National Health Service		✓			
Romania	Performance audit on health infrastructure development at national, regional and local level to increase accessibility to health services		✓			
Slovakia	Public finances and property of healthcare facilities					✓
Slovenia	Tackling child obesity	✓				
Spain	The management and control of pharmaceutical benefits by the General Spanish Civil Service Mutual Insurance Company (MUFACE)					✓
European Court of Auditors	EU actions for cross-border healthcare: significant ambitions but improved management required		✓			

Prevention and protection

Audit objectives

75 Four of the audits included in this compendium focused primarily on the prevention of disease and protection of health. These audits cover a broad area of subjects, ranging from the general disease prevention policy in Belgium, to specific issues like the prevention of diabetes (Poland), child obesity (Slovenia) and healthcare-related infections (France).

76 The general objective of these audits was to assess whether the various policies and subsequent measures had been well designed and effective. Some audits paid particular attention to population groups at risk of deprivation.

Main audit observations

77 All audits noted weaknesses in terms of health prevention or protection. For example, the Belgian audit concluded that actual implementation of the health policy differed considerably depending on the health objectives in question. The implementing organisations were generally not very results-oriented and the reporting often lacked relevant information to assess the impact of the interventions funded. Finally, many campaigns and interventions were not sufficiently tailored to disadvantaged population groups.

78 The report from the Polish SAI stated that, in spite of the high and ever-increasing number of people suffering from diabetes in Poland, no national strategy had yet been formulated to prevent or treat the disease.

79 The Slovenian audit concluded that the Ministries and the Institute concerned were indeed contributing to tackling obesity in children. One of the weaknesses noted was, however, that the measures and activities funded did not always reach all children and thus did not ensure equal treatment. Overall, the systemic approach of promoting a healthy lifestyle in general was assessed as being more efficient than implementing specific projects.

80 The French SAI assessed the implementation of the policy to prevent healthcare-related infections in France as still insufficient. The prevalence of infections has not decreased further since 2006 and external reporting on these infections is not comprehensive. However, recent developments like the establishment of healthcare-related infection control centres are considered a step in the right direction. New initiatives to expand this policy to all segments of healthcare activities and to fully consider the threat of antibiotic resistance must now be taken.

Access to health services

Audit objectives

81 Six audits in this compendium assessed access to health services. Three of them (Lithuania, Portugal and Romania) looked at access to health services in general, one (Germany) focused on orthodontic treatment and one (Malta) looked at the general practitioner's role in ensuring access to health services. Finally, the European Court of

Auditors examined whether EU actions in cross-border healthcare deliver benefits for patients.

82 In addition to focusing on the prevention of type 2 diabetes, the Polish SAI assessed whether diabetic patients had access to specialist services and latest-generation medicines.

83 The main objectives of the audits carried out were to assess whether access to health services and specialist consultations were ensured, and whether measures implemented to improve access to health services had been effective.

84 The two more specific audits aimed, respectively, to obtain an overview of the costs and procedures for orthodontic treatments (Germany) and to ascertain the extent to which general practitioners facilitated access to health services (Malta).

Main audit observations

85 Overall, the audits concluded that health services were not always available at the right time and place or at affordable costs.

86 The Lithuanian audit noted weaknesses related to managing and reducing waiting lists for health services, as well as planning of demand for healthcare specialists.

87 This was also noted by the Portuguese SAI's audit, which concluded that there had in fact been increases in waiting times for specialist consultations, and in the number of patients on waiting lists for surgery, in the three years from 2014 to 2016.

88 The Romanian SAI concluded that the infrastructure investments in the health sector had only partly achieved the objective of increasing access to health services. The main weaknesses described in the report related to prioritisation of funds, coordination, follow-up of investments, and procurement procedures.

89 The German SAI's audit report found that the benefits of orthodontic treatments were not scientifically proven and that the patients themselves often had to pay for additional orthodontic services and treatments.

90 The Maltese audit report was more positive, in that it assessed the general practitioner function as operating in line with the strategic measures defined in the National Health

System Strategy. It noted, however, that further expansion of the general practitioner function to make it more patient-centric would require a shift in the distribution of funding.

91 The European Court of Auditors found that the Commission had supported the Member States in improving information on patients' rights to cross-border healthcare well, although some gaps remained.

92 The Polish SAI concluded that access to specialist treatment for diabetes (type 2) was not available at the right time and place. Waiting times for specialist consultations were lengthening and large regional disparities were found in access to health services.

The quality of health services

Audit objectives

93 Three of the audits included in this compendium – performed by the SAIs of Austria, Denmark, and Ireland – deal with the quality of health services.

94 Two of these audits focused on specific quality aspects in hospitals: the Danish SAI assessed the quality of care in Danish hospitals and analysed any quality differences between hospitals. The Irish SAI looked at how elective day surgery was managed. It analysed the reasons for variations between hospitals, to identify possible ways of increasing day surgery rates as well as any barriers in that respect. It also analysed information-sharing and the extent to which it facilitates the promotion of good practice ideas.

95 The SAI of Austria assessed the organisation, selected subjects and the transparency of the Federal Government's quality assurance for independent health practitioners.

96 In its audit on 'Preventing healthcare-related infections', the French SAI additionally analysed the scale and costs of healthcare-related infections, and the role played by hygiene rules and the correct prescription of antibiotics.

Main audit observations

97 The audits concluded that the quality of health services varied and showed room for improvement in certain areas.

98 The report on the quality of care in Danish hospitals noted weaknesses in the treatment of patients and a lack of consistency in the quality of care. The differences in care affected the patient's risk of readmission and death. However, the reasons for many of the differences could be traced to factors beyond the hospitals' control.

99 The Irish report on elective day surgery came to similar conclusions: in spite of the general effort to increase the proportion of day surgery as opposed to inpatient treatment, there were significant variations between hospitals. Possible reasons were the absence of written protocols and checklists for the selection of patients for day surgery and a lack of monitoring or review by senior management of the number of patients suitable for day surgery.

100 The Austrian report on quality assurance for independent health practitioners noted weaknesses concerning the validity of quality guidelines, output quality measures, standardised diagnosis and performance documentation. In addition, it suggested evaluating the options for raising the number of validity checks on the physicians' self-assessment through inspections in surgeries.

101 The French SAI found that the prevalence of infections related to inpatient care stopped decreasing in 2006. Proper enforcement of hygiene rules and the correct prescription of antibiotics are essential in this regard. Moreover, more active management of infectious risk also calls for better account to be taken of quality indicators when regulating the provision of healthcare.

New technologies and eHealth

Audit objectives

102 Three reports in this compendium (Bulgaria, Estonia and Latvia) focus on eHealth and the use of new technologies in the health area. The three reports look at whether the preconditions for the introduction and further development of eHealth were met and whether it was implemented effectively. The Latvian SAI additionally assessed whether eHealth had achieved its objective of promoting more efficient healthcare.

Main audit observations

103 All three reports noted that although eHealth was considered a national health priority, implementation fell below expectations and only partly achieved its objectives.

104 This result arose for a number of different reasons. The Bulgarian report noted the absence of the necessary preconditions for effective implementation of eHealth, namely the existence of a regulatory framework, a comprehensive definition of the responsibilities, and an effective system of coordination and harmonisation between the different actors. Therefore, the implementation of eHealth in Bulgaria faced delays and the actions taken were only partly effective.

105 The audit of the Estonian SAI also concluded that eHealth had not achieved its objectives, with digital prescription the only technical solution that was actively used at the time of the audit. Use of the Electronic Health Record and image reference had been modest, and Digital Registration (an e-booking system for appointments) had not been implemented. Further weaknesses were noted in the strategic planning and management of eHealth and, aside from being delayed, implementation was considerably more expensive than initially planned.

106 The report from the Latvian SAI came to a similar assessment as it also noted weaknesses in the implementation of eHealth, mainly concerning a lack of involvement of key stakeholders, as well as issues in project management and supervision. Consequently, the Latvian audit also assessed the objective of eHealth as only partly achieved.

Fiscal sustainability and other financial aspects

Audit objectives

107 Eight of the audits in this compendium analysed sustainability or other fiscal aspects of public health. Four of these audits (Czech Republic, Greece, Hungary and Slovakia) looked at compliance issues, whereas the other four (Finland, Italy, Luxembourg and Spain) delved into more general aspects of fiscal sustainability and financial management.

108 The areas covered by the four latter audits ranged from trend projection for social security expenditure (Finland) to public investments in the health sector (Italy and Luxembourg), and the sound financial management of payments to pharmaceuticals (Spain).

Main audit observations

109 The most common issues noted in the compliance audits were weaknesses in procurement procedures as well as in internal controls, financial management and the management of overdue liabilities.

110 The Finnish audit on trend projections for social security expenditure identified scope for developing the model used and improving methodology documentation, and saw that the results of the projections were not published regularly.

111 The audit of the Luxembourg SAI discovered shortcomings regarding the authorisation, coordination, reporting and follow-up of larger investments.

112 Similar issues were noted by the Italian SAI, which concluded that the reporting in place was not adequate to monitor the implementation of projects. In addition, it assessed that the public-private partnership was not being used efficiently.

113 The Spanish report concluded that payments of pharmaceutical benefits to pharmacies and hospitals had only partly been made in accordance with the relevant regulations and the principles of sound financial management.

Follow-up of audits

114 All SAIs, as a matter of principle and good practice, follow up on their recommendations. The approach depends on the internal rules of each SAI. Follow-up may be carried out by tracking the implementation of each recommendation or as part of another audit task.

115 Follow-up was typically carried out one to three years after the deadline for implementing the recommendations, in line with the SAIs' internal rules. Some SAIs follow up their audits without committing to any particular timeline.

PART III – SAI reports at a glance

PART III – SAI reports at a glance

44

Prevention and protection



Belgium

Rekenhof / Cour des comptes / Rechnungshof

Flemish preventive health policy – assessment of policy performance

Overview

116 The audit of the Belgian SAI assessed the performance of the Flemish preventive health policy in the period 2014 to early 2015.

117 The use of prevention in order to contribute to health gains and a higher degree of well-being among the population is one of the objectives in the policy memorandum of the Flemish Minister for Public Health. The Flemish preventive health policy had been formulated in the form of several health objectives and implemented by a number of organisations subsidised under it.

How the audit was conducted

118 The assessment was based on the following questions:

- Is the implementation of the preventive health policy well designed and organised?
- Is the implementation of the intended preventive policy of a high quality?
- To what extent does the implementation pay special attention to disadvantaged population groups?

119 The main auditees were the Flemish Minister for Welfare, Public Health and Family and the Flemish Agency for Care and Health. The assessment was mainly based on document analysis and interviews.

Main observations

120 In practice, the implementation landscape was found to differ considerably per health objective and organisation of the fieldwork can be improved.

- Some health objectives involved a lot of implementing organisations, but the delimitation of tasks was not always clear, requiring extensive consultation and agreement.
- For other health objectives, hardly any organisations were present “in the field”, so support was inadequate.
- The allocation of funds between health objectives and the implementing organisations was not sufficiently justified and was based on the allocation in the past.

121 The selection of implementing organisations through a call procedure led to a lack of knowledge-exchange and sparked tensions between the organisations involved.

122 Implementing organisations were not very results-oriented in the area of methodology development. Their reporting contained too little information to evaluate the impact of their work.

123 Finally, not enough attention was paid to disadvantaged population groups.

Recommendations

124 Implementation landscape

- The implementation structure for suicide prevention should be streamlined, tobacco, alcohol and drug prevention assignments should be based on clear agreements, and as for diabetes prevention more should be done on the ground.
- Awareness-raising tools for cancer screening programmes should be better coordinated and geared to insufficiently reached target groups.

- Accident prevention should focus more on stimulating multidisciplinary consultation, by establishing a clear working method, the division of tasks and cooperation agreements between the various actors.
- A long-term vision should be developed in relation to physical activity. It should be ensured that the implementation of the methodologies for the nutrition and exercise health objective is supported on the ground.
- The distribution of funds between the various health objectives or prevention themes should be clearly justified.

125 Implementation of preventive health policy

- The government must continue to weigh up the pros and cons of the call procedure.
- The output of partner organisations regarding methodology development deserves better planning and monitoring and should be linked to a budget.
- The Flemish Minister for Public Health should work on greater involvement in prevention work at the local and provincial level.
- The conclusion of management agreements should be aligned as much as possible with the action plans for the health objectives.
- The Flemish Agency for Care and Health should ensure that actual implementation can be reconciled with the initiatives proposed in the annual plan.
- The role of the pupil guidance centres in achieving the Flemish health objectives should be better developed.

126 Logos (local health networks)

- The relationship between the Flemish Agency for Care and Health, the Flemish Institute for Health Promotion and Disease Prevention and the Logos should be clarified and optimised.
- The role of the Logos in methodology development should be reviewed and improved.
- The consistency and quality of the information in the registration system should be improved.

127 Projects

- The Flemish Government should demonstrate the added value of subsidies to a (partner) organisation for prevention projects.
- Projects that have been running for several years should be evaluated with a view to their integration in the regular operation of the implementing organisation.

128 Disadvantaged groups

- The Flemish Government should invest more in the development of methods and materials that efficiently motivate people in poverty to maintain healthy behaviour, including building knowledge within the implementing organisations in this regard.

Publication and follow-up

129 The report was published electronically on the website of the Belgian Court of Audit on 23 February 2016 and presented to the Commission for Welfare, Public Health and Family of the Flemish Parliament on 8 March 2016. The follow-up for each recommendation is generally set out in the Minister's annual policy letters.

Expected impact

130 During the implementation of the audit, changes were made to the legislation in force and a number of initiatives were taken that remedied some of the bottlenecks (e.g. a guideline for developing and assessing prevention methods).

A new overall health objective regarding healthy eating, sedentary behaviour, physical activity, tobacco, alcohol and drugs was adopted in September 2017.



France

Cour des comptes

Preventing healthcare-related infections:
the next steps

Overview

131 The audit of the French SAI assessed the prevention of healthcare-related infections in the period 2010-2018.

132 An infection is said to be healthcare-related if it occurs during the treatment of a patient by a health professional, in ambulatory care, in a social healthcare institution or health institution (in the latter case, it is qualified as nosocomial). It does not necessarily coincide with the treatment itself: it may occur from 48 hours to one year thereafter.

133 Over the past 30 years, France has implemented a structured public policy to prevent healthcare-related infections, mainly in hospitals, and to compensate patients. Patient associations have played a decisive role in driving this policy forward, following the media coverage of grouped cases of infections in some health institutions.

134 The actions implemented have reduced and then stabilised the prevalence of infected patients in hospitals at about 5 % of patients (i.e. about 470 000 infected patients per year). While healthcare-related infections most often result in transient discomfort, they can have far more serious consequences. However, the prevalence of infected patients in ambulatory care is not known and its measurement is still at an early stage in the social healthcare sector.

How the audit was conducted

135 The assessment was based on the following questions:

- Main audit question: What are the stakes of the policy for the prevention of healthcare-related infections?

- With the following sub-questions:
 - What are the scale and cost of healthcare-related diseases?
 - Which results have the policies implemented by the Ministry for Solidarity and Health and its various bodies achieved?
 - How can we take into account the issues related to the patient's journey outside hospitals and antibiotic resistance?
 - At what levels of risk management should the restructuring of public action be managed?
 - How can the various actors be held accountable?

136 The main auditees involved were the French Ministry for Solidarity and Health, the various bodies that enforce its policies, at both national and regional level, and public hospitals.

137 The assessment was based on interviews and questionnaires sent to all relevant authorities.

Main observations

138 The *Cour des comptes* has made the following observations:

- Over the past thirty years, public authorities, health institutions and professionals have implemented a public policy for the prevention of nosocomial infections. Its results are still inadequate. The prevalence of infections related to inpatient care stopped decreasing as of 2006 and the external reporting of nosocomial infections is not comprehensive. A further step must now be taken to expand this policy to all segments of healthcare activities and to fully consider the threat of antibiotic resistance.
- The recent establishment of healthcare-related infection control centres in all regions should make it possible to develop action with professionals in the fields of ambulatory and social healthcare and to better coordinate with regional health agencies. Under this new structure, the Ministry for Solidarity and Health, via the Public Health Agency, must take its rightful place in the steering and coordination of public action.

- To face these new challenges, it is also essential to better empower all stakeholders in the proper enforcement of hygiene rules and the correct prescription of antibiotic medicines. More active management of infectious risk also calls for better account to be taken of quality indicators in regulating the provision of healthcare and for compensation schemes to be revised to foster responsibility.

Recommendations

139 The *Cour des comptes* has issued the following recommendations:

- conduct a national survey of the prevalence of healthcare-related infections in ambulatory care, with an adapted methodology if necessary, in order to target risk sectors and actions to be developed;
- explicitly entrust the Public Health Agency (*Santé Publique France*), a public institution under the supervision of the Ministry for Solidarity and Health, with the coordination of missions and means of action of the healthcare-related infection control centres;
- implement a range of measures aimed at reducing the consumption of antibiotic medicines and adjust the remuneration based on public health objectives that is allocated to private practice physicians, in order to ensure their effectiveness;
- regional health agencies should prioritise the inspection and control of health facilities and draw all operational conclusions, including suspension of activity;
- review the criteria for determining the size and composition of the operational hygiene teams in health institutions according to the activity of the latter and international recommendations. In public hospitals, these teams should be pooled within the framework of the territorial hospital groups (*groupements hospitaliers de territoire*);
- reverse the suspension of the obligation for health professionals to vaccinate against influenza (repeated recommendation).

Publication and follow-up

140 The First President of the *Cour des comptes* submitted the 2019 Annual Public Report to the President of the French Republic on 4 February 2019. It was subsequently presented to the media and published electronically on the website of the *Cour des comptes* on

6 February 2019. It was also presented to the National Assembly on 6 April 2019 and then to the Senate on 7 April 2019.

141 The *Cour des comptes* devotes particular attention to the follow-up of its recommendations. Three years after the publication of its reports, it examines the extent to which its recommendations have been implemented and the actual effects of those implemented. A monitoring report may be included in the annual public report.

Expected impact

142 Policies to prevent healthcare-related infections are a necessity. In view of the number of patients affected, efficient measures have to be implemented in order to provide treatment in the safest possible environment.



Poland

Najwyższa Izba Kontroli (NIK)

The prevention and treatment of type-2 diabetes

Overview

143 The audit of the Polish SAI assessed the prevention and treatment of type 2 diabetes in the period 2013-2017 for outpatient healthcare and 2015-2017 for inpatient healthcare.

144 Estimates indicate that one in eleven people in Poland may suffer from diabetes (type 1 and 2) and the number of patients suffering from the disease is growing by 2.5 % each year. Left untreated, diabetes leads to a number of negative consequences such as strokes, high blood pressure and amputated limbs (as a complication of what is known as diabetic foot syndrome), and hence to an increase in the number of people no longer able to work and therefore receiving social benefits.

How the audit was conducted

145 The assessment was based on the following main audit question:

- Does the healthcare system ensure that people suffering from or at risk of type 2 diabetes are detected early and that the effective methods of treatment for this disease are implemented?

146 Specific questions:

- Has the Ministry of Health formulated a national healthcare policy to prevent diabetes and improve the health of people suffering from the disease?
- Has the National Health Fund ensured the availability of diabetes services and resources for the treatment of diabetes and its complications?

- Have healthcare providers taken action in the field of prevention, early detection and treatment of type 2 diabetes?
- Have they provided type 2 diabetic patients with access to specialist services?
- Have they implemented the methods of treatment for type 2 diabetes using latest-generation medicines?

147 The main auditee was the Ministry of Health, the headquarters of the National Health Fund as well as healthcare providers. The methodology used included the review of documents, surveys, clarifications from employees of auditees and other organisations.

Main observations

148 Diabetes is recognised as a “disease of civilisation” and combating the disease is one of the priorities of the Minister of Health, who is in charge of formulating national health policy. However, no national strategy has been formulated for the prevention of diabetes or for the treatment and care of people suffering from the disease.

149 The Minister of Health has not adequately identified the health needs or determined the number of diabetes specialists needed to care for the patients suffering from the disease. He has also failed in raising sufficient public awareness of diabetes.

150 Overall, Polish patients do not have access to innovative treatments for type 2 diabetes as none of the drugs with positive recommendations from the Agency for Health Technology Assessment and Tariffs, i.e. incretins and gliflozins, has been included in the list of reimbursable medications.

151 Although the National Health Fund took action to improve the treatment of patients with type 2 diabetes, the number of patients on waiting lists for specialist diabetes clinics and hospitalisation as well as the waiting time for services is increasing. At the same time, the number of service providers contracted to the National Health Fund is decreasing.

152 A lack of appropriate entries in medical records also suggests that, in many cases, doctors did not follow the principles set out in the recommendations by the Polish Diabetes Association (PTD) for treating people at risk of diabetes and patients with type 2 diabetes, or

that their record-keeping was unreliable. In some cases, patients did not follow the doctors' recommendations. Consequently, treatment results were not good enough and the cost of treating type 2 diabetes complications was high.

Recommendations

153 The NIK made the following recommendations.

- The Minister of Health should prepare a comprehensive nationwide programme of activities aimed at the prevention, early diagnosis and treatment of diabetes.
- The Minister of Health should take action to estimate the number of people who remain undiagnosed and so are unaware of suffering from diabetes, and develop methods to reach them with appropriate information on the symptoms and effects of the disease, as well as encourage them to undergo appropriate diagnosis and treatment.
- The Minister of Health should step up efforts to develop a medical staff-planning model.
- The President of the National Health Fund should take action to ensure nationwide access to services provided within the framework of comprehensive outpatient specialist care for diabetic patients and comprehensive treatment of chronic wounds.
- Healthcare providers should:
 - refer diabetes patients for diagnostic tests and specialist consultations as frequently as recommended by the Polish Diabetes Association;
 - refer patients for diabetes screening as per the Polish Diabetes Association's recommendations;
 - adhere to the Polish Diabetes Association's recommendations for preventing type 2 diabetes;
 - keep individual medical records in a way that ensures full and reliable information about the patient's diagnosis and treatment process.

154 Public authorities should also take joint, coordinated action with healthcare and patient organisations to promote healthy lifestyles, including exercise and diet, to help cut type 2 diabetes in Poland.

Publication and follow-up

155 The report was published on the website of the Polish SAI on 26 March 2018 and sent to the supreme and central national authorities. It attracted great media interest and was widely commented on by healthcare experts.

156 In response to the report, the Polish Minister of Health informed the SAI about action taken to implement the audit recommendations, including analysing needs and developing a plan for a new health programme as well as actions to improve the effectiveness of health education and disease prevention.

Expected impact

157 Strengthening the healthcare system by ensuring more effective monitoring of diabetes prevention and care, increasing the effectiveness of diabetes education, and coordinating action to reduce the occurrence of new diabetes cases.



Slovenia Računsko Sodišče Republike Slovenije

Tackling child obesity

Overview

158 The audit of the Slovenian SAI assessed whether the mechanisms for tackling obesity in children were effective and efficient. The audit covered the period 2015-2016.

159 The Court of Audit of the Republic of Slovenia decided to implement an audit on tackling child obesity due to alarming statistics on overweight and obese children.

160 In 1989, 12.5 % primary school children in the Republic of Slovenia were overweight and 2.35 % were obese. Although the share of overweight and obese primary school children has been decreasing since 2010, figures still stood 43.2 % and 193.6 % higher respectively in 2016 compared to 1989.

161 Issues with weight and obesity depend, to a large extent, on a family's socioeconomic status and the commitment of each individual. All the State can do is implement policies to promote healthy lifestyles.

How the audit was conducted

162 The assessment was based on the main audit question “Does the Republic of Slovenia appropriately tackle childhood obesity?” and the following sub questions:

- Are the objectives and measures for tackling obesity in children appropriately planned?
- Are the operations of the Ministry of Health, the Ministry of Education, Science and Sport and the National Institute of Public Health in implementing activities for tackling obesity in children efficient?

- Have the objectives for tackling obesity in children been achieved and is the share of overfed and obese children decreasing?

163 The main auditees were the Ministry of Health, the Ministry of Education, Science and Sport and the National Institute of Public Health. The audit methodology included the review of documents, websites, media reports and other public sources of information, interviews with auditees and other stakeholders, and data analysis.

Main observations

164 The SAI concluded that the State (Ministry of Health, Ministry of Education, Science and Sport and National Institute of Public Health) promoted a healthy lifestyle among children at the systemic level (by regulating healthy diets and physical activities) and additionally through selected projects.

165 Although the effects of State activities to tackle obesity in children are visible only over time and are not directly measurable, the Court of Audit assessed that the State to some extent contributed to tackling obesity in children, as could be indirectly seen in the change in the evolution in overfed and obese children ratios. Nevertheless, the State could improve its actions in tackling obesity in children by measures and activities that would reach all children, making their implementation more efficient.

166 The SAI specifically noted that:

- schools participate in several additional projects and programmes for promoting a healthy lifestyle. However, the implementation of projects is less efficient compared to the systemic approach. Projects are time-limited, do not always ensure equal treatment of children and cause an additional administrative burden and costs;
- the system for organising healthy school meals has been appropriately established and ensures equal treatment of all children;
- physical education in primary schools falls below 180 minutes per week recommended by the World Health Organization.

Recommendations

167 The Ministry of Health was recommended to:

- consider how it could improve compliance between organised school meals and nutrition guidelines;
- amend the regulations for issuing medical certificates justifying absences from sports classes or a special diet;
- review the needs and define procedures for early actions to tackle obesity in children as well as possible treatment of associated diseases.

168 The Ministry of Education, Science and Sport was recommended to:

- review requirements for entities organizing school meals, including ways to simplify and harmonise public procurement procedures for purchases of food for school meals; consider whether regular training courses in that respect should be organised and by whom;
- carry out analyses on the efficiency and effectiveness of individual sports programmes;
- develop cost-benefit analyses for projects related to awareness-raising and healthy eating and examine the options for incorporating the content of the projects and programmes in regular training and educational programmes;
- consider training courses on the importance of a healthy lifestyle for school staff, children and their parents;
- consider training teachers in the field of health promotion;
- conduct a detailed analysis of the staff and resources required to introduce 5 hours of physical education per week for all children.

Publication and follow-up

169 The report was presented to the auditees and published on the website of the Court of Audit of the Republic of Slovenia on 11 September 2018.

Expected impact

170 The main result of the implemented audit was that it informed the public about the current situation and the problems arising from overweight and obesity in children.

171 One possible effect of the audit could be, among others, to bring about changes and amendments to the regulations, in particular in relation to the recommended scope of physical education at school.

Access to health services



Germany
Bundesrechnungshof

Health research needed to study the value
of orthodontic treatment

Overview

172 The audit of the German SAI assessed the value of orthodontic treatment. The audit covered the period 2014-2016.

173 Statutory health insurance funds only reimburse orthodontic treatment (e.g. braces) if malpositioned teeth or jaws significantly impair, or threaten to impair, chewing, biting, speaking or breathing. The cost per pathologic case treated has approximately doubled in recent years. According to estimates, more than half of all children and adolescents in Germany receive orthodontic treatment. Against this backdrop, the Bundesrechnungshof, which has a mandate to audit Germany's statutory health insurance system, reviewed how the health insurance funds dealt with orthodontic services for their beneficiaries.

How the audit was conducted

174 The objective of the audit was to gain insight into the costs and procedures involved in the approval, implementation and billing of orthodontic treatment by the statutory health insurance funds.

175 In addition, the *Bundesrechnungshof* investigated whether and to what extent the Federal Ministry of Health ensured the efficiency of these services.

176 The main auditee was the Federal Ministry of Health, selected health insurance funds and the umbrella organisation of statutory health insurance funds.

177 The audit was mainly based on the review of documents provided by the Federal Ministry of Health and by health insurance funds, patient consultation bodies and

contracted dentists' self-governing bodies (orthodontic procedures, contracts, studies on orthodontics, etc.), and interviews with representatives of such bodies.

Main observations

Value of orthodontic treatment not supported by scientific research

178 The *Bundesrechnungshof* concluded that the Federal Ministry of Health and the health insurance funds did not have a comprehensive overview of the specific orthodontic services provided to patients. There was a lack of nationwide data, e.g. on the type, duration and success of treatment, the age groups treated, underlying diagnoses, the number of completed cases and treatments discontinued. Moreover, there was no assessment in place, based on such data, of the added value of orthodontic treatment. As a result, there is no information available on the health insurance funds' objectives in spending more than €1 billion annually on orthodontic treatment, or on the success of such treatment, if any.

Beneficiaries often pay extra for orthodontic treatment

179 In addition, the *Bundesrechnungshof* found that dentists often offered additional services, which beneficiaries had to pay for out of their own pocket. These self-pay services mainly involved other treatment methods, diagnostics and orthodontic appliances (e.g. braces).

180 According to a study by one health insurance fund, three quarters of those surveyed had arranged private self-pay services with the orthodontists treating them. Almost half of those surveyed had paid more than €1 000. For the most part, health insurance funds did not know the orthodontic treatment and self-pay services their beneficiaries had received. The health insurance funds only learned about the treatments and services received in exceptional cases, such as when the beneficiaries complained about their dentists. Here, it was also not clear how much success had been achieved.

Recommendations

181 The *Bundesrechnungshof* recommended surveying and collecting data on the orthodontic care situation and treatment needs and objectives, quality indicators and controls, including self-pay services. The Federal Ministry of Health should initiate

evaluations and, where necessary, work towards creating the necessary statutory conditions. The type of orthodontic services provided under statutory health insurance must be determined to reflect the results of such healthcare research. If self-pay services are preferable to the current services provided by health insurance funds, the relevant bodies should consider whether to include these in the care provided by the health insurance funds.

Publication and follow-up

182 The *Bundesrechnungshof* submitted its report to the Public Accounts Committee of the Budget Committee of the *Bundestag* as part of its annual report on the Federal Government's federal financial management.

183 The audit report was published on the *Bundesrechnungshof's* website in April 2018. Its publication was accompanied by a press release (see www.bundesrechnungshof.de/en/themen/health-health-insurers/health-health-insurers, third item in the list).

184 The *Bundesrechnungshof* intends to follow up on whether the Federal Ministry of Health is taking effective steps to help ensure the cost-effectiveness of health insurance benefits for orthodontic treatment.

Expected impact

185 In response to the *Bundesrechnungshof's* recommendation, the Federal Ministry of Health commissioned a scientific report to research, present and evaluate the current state of medical knowledge on the long-term effects of orthodontic treatment on oral health.

186 Together with the central associations of health insurance funds and of contracted dentists, the Ministry intends to evaluate the recommendations for action drawn up by the experts and discuss the next steps to take to enhance healthcare research and assessing the value of orthodontics.



Lithuania
Valstybės Kontrolė

The accessibility of healthcare services and patient orientation

Overview

187 The audit of the Lithuanian SAI assessed the accessibility of healthcare services and patient orientation. The audit covered the period 2014-2016. Data from 2017 and 2018 was also examined, if relevant to the changes that took place.

How the audit was conducted

188 The assessment focused on the following issues:

- management of waiting times for healthcare services;
- appropriateness of the planning for the required number of healthcare specialists;
- effectiveness of the use of expensive equipment owned by medical establishments;
- development of conditions necessary to ensure the accessibility of the latest medical technologies and review of technologies already in use;
- identification, assessment and management of patient expectations.

189 The main auditees were the Ministry of Health, the State Healthcare Accreditation Agency and the National Health Insurance Fund.

190 In addition, data and information were collected from public and private medical establishments, municipalities, professional organisations of healthcare specialists, patient organisations and scientific establishments.

191 The audit methodology included document review, benchmarking, surveys of medical establishments and municipalities, population surveys, interviews, data analysis and testing.

Main observations

The ineffectiveness of measures designed to reduce the waiting times for services

192 The Ministry of Health lacked objective information on waiting times, as well as the tendencies and the underlying factors which impaired planning of effective measures to reduce them. The Ministry also failed to analyse the impact of deployed measures on fluctuations in waiting times. The waiting time-reduction measures had failed to deliver the desired results because of the failure to address key issues related to patient flows, the functioning of the eHealth system, the imbalance of the structure of healthcare specialists, etc. As a way of addressing the service accessibility issue, 17 % of patients were using paid services (half of whom did so because of over-long queues), and 19 % were engaging in self-treatment.

The need to improve planning for the demand for healthcare specialists

193 When drawing up the request for the training of healthcare specialists for science and education establishments, the Ministry failed to assess the changes in the service structure, the demand for these services in the regions, specialists' workloads, doctors' resignations from the profession, and emigration forecasts. The Ministry only attempted to replace doctors going into retirement, but did not take into account the demand for nurses. The number of doctors exceeded the EU average, yet there was a lack of experts in specific areas, such as cardiology, ophthalmology and neurology, as well as of nurses, which affected the accessibility of services.

The ineffective use of expensive devices at medical establishments, and the lack of incentives for the assessment of new technologies

194 The intensity of the use of more than half (59 %) of expensive medical devices (costing over €29 000) was low and 7 % were not used at all. During the audited period, the Ministry commenced procedures for the procurement of new devices, yet failed to initiate the redistribution of expensive devices, thus leaving the issue of the ineffective use of available devices unsolved.

195 The initiation of the assessment of new technologies was sluggish (during the four-year period, medical establishments and private providers submitted only 11 technologies for assessment) because of the lack of funding for the use of new and approved healthcare technologies. When new technologies emerged, those available were often not assessed. This led to failure to ensure treatment with the latest technologies for all patients.

Patients not involved in the development of healthcare to meet their expectations

196 Both the Ministry and medical establishments failed to make use of patient surveys designed to determine their expectations. Although half of the audited municipalities collected data on medical establishments, they failed to make use of it when making decisions regarding the organisation of services. Patient representation was fragmented – patient representatives were only involved in 40 % of the working groups they considered important. Notification of patients concerning their rights and duties was incomplete, which contributed to approximately 20 % of patients missing their appointments, thereby further increasing waiting times.

Recommendations

197 In order to increase the accessibility of healthcare services, reduce waiting times, and use available resources more effectively, the SAI recommended:

- to regularly monitor and analyse the use and accessibility of services and patient flows, as well as the impact of measures to reduce waiting times, and to base the implementation of measures on the outcomes of this monitoring and analysis;
- to develop a system for the planning of demand for all healthcare specialists based on the analysis of data;
- to expand the annual assessment of establishments by including usage indicators for expensive medical devices;
- to specify the procedure for the funding of new assessed technologies, and to review and reassess healthcare technologies already in use.

198 In order to improve the patient orientation of the healthcare system, the SAI recommended the following:

- o expanding and/or revising the content of the patient outlook studies and surveys conducted by the Ministry and medical establishments to identify patient expectations, which could then be used to improve the organisation of healthcare;
- o expanding the content of information designed to encourage patients to fulfil their obligations and exercise their rights and the means of providing it;
- o setting criteria for the inclusion of patient organisations in decision-making by committees and working groups with regard to the improvement of healthcare.

Publication and follow-up

199 The audit report was presented to the auditees, the parliamentary committee on audit, medical establishments and the general public (at Signals 2018, an international conference organised by the SAI in 2018).

200 In line with the deadlines for the implementation of the recommendations agreed in the report, semi-annual reports are submitted to the parliamentary committees.

Expected impact

201 The audit is expected to result in organisational/procedural changes (in the fields of monitoring accessibility of services, planning the demand of healthcare specialists, assessment of medical device usage, identification of patient expectations and inclusion of patient organisations) and reconsideration of funding decisions (due to new technologies).



Malta
National Audit Office

The general practitioner (GP) function – The coreg
of primary healthcare

Overview

202 The audit of the Maltese SAI assessed the general practitioner function and its role in primary healthcare. The audit covered the period 2014-2016.

203 National and European Union documents acknowledge that, despite a significant extension of primary healthcare services over time, this sector was not appropriately placed at the forefront of health services in Malta.

204 The National Audit Office of Malta had already assessed the GP function within health centres in 2001 through the performance audit *Primary Healthcare – the General Practitioners Function within Health Centres*. The audit had highlighted very high satisfaction levels among users of GP services at the time. However, the report had raised concerns about various aspects of service delivery. The issues raised mainly related to continuity of care through a more personalised service, the uneven distribution of GPs within health centres, the non-utilisation of an appointment system and the cost efficiency of services.

How the audit was conducted

205 The audit aimed to determine the extent to which:

- operations related to the GP function render related services accessible and provide adequate quality in terms of attaining primary healthcare objectives;
- organisation and administrative structures facilitate service delivery;
- the services provided are cost-effective.

206 The main auditees were the Primary Healthcare Department (Malta), the Gozo General Hospital (Gozo) and the Mater Dei Hospital Accident and Emergency Department.

207 The audit methodology included documentation review, the conduct of semi-structured interviews and a survey, and costing exercises for the various services provided by GPs. The scope of this audit did not encompass non-GP services provided by various medical specialists in health centres.

Main observations

208 The audit provided strong indications that, generally, the GP function was operating according to the national strategic measures as defined in the National Health System Strategy for Malta and the services were being extended and broadened.

209 On the other hand, this review also raised certain issues. In its current set-up, further expansion of the GP function by making it more patient-centric would be unlikely to occur without a shift in the distribution of funding to reflect more realistically the long-term socio-economic advantages of investments in primary healthcare. Additionally, there was an opportunity to further exploit the interrelationship and potential synergies of private and public sector collaboration. Thus, through closer stakeholder collaboration, the public GP function could contribute more towards placing primary healthcare at the fulcrum of national health services.

Recommendations

210 The National Audit Office of Malta issued the following recommendations:

- The Primary Healthcare Department (PHCD) was encouraged to focus more on assessing the feasibility of broadening and extending the GP function through exploiting the complementarity of services provided by doctors in the public and private sectors – including through public-private partnerships and contracting out.
- Consideration should be given to shifting more budgetary allocations within the health sector in favour of primary healthcare.

- The PHCD was encouraged to upgrade the strategic measures listed in the National Health System Strategy for Malta for the period 2014-2020, and other documents, to implementable project plans. This would entail establishing the resources required and the implementation timeline.
- Efforts should be stepped up to introduce the Chronic Disease Management Clinic across all health centres. This would further promote continuity of care and patient-centric principles and, in the long-term, would improve the cost-efficiency of the GP function.
- The PHCD was encouraged to continue its efforts to shift the balance of its services from immediate care towards health promotion and disease prevention. There was an opportunity for the PHCD to build on current awareness campaigns by encouraging GPs to re-emphasise the messages of these campaigns during patient visits.
- Consideration should be given to increasing strategic, management and operational collaboration across health centres in Malta and Gozo. This would ensure a higher degree of service harmonisation and customisation as well as the sharing of experiences in service development.
- The accessibility of financial management information was to be improved – the Finance Section still needed to be supported through investment in the appropriate ICT infrastructure.
- The PHCD was encouraged to better utilise the ICT available, such as the Clinical Patient Administration System, to ensure accurate contact patient statistics. Such information would strengthen strategic planning and management control of PHCD operations.
- Efforts related to the enrolment of e-prescription facilities at Bereġ were to be increased. This was dependent on the appropriate investment in ICT.
- The PHCD was encouraged to improve coordination with Mater Dei Hospital's Accident and Emergency Department to minimise the incidence of patients seeking the latter's attention unnecessarily when they could receive the required care from GPs at health centre level.

Publication and follow-up

211 The report was presented to the Speaker of the House of Representatives on 27 June 2016, who submitted it to the House of Representatives. The report was also discussed in the Public Accounts Committee. Upon submission of the above report to Parliament, the National Audit Office of Malta published it on its website. A press release was also issued, containing a summary of the main and most crucial findings and conclusions in both Maltese and English. The SAI forwarded copies of the report to the media and other interested stakeholders.

212 The National Audit Office of Malta carried out a follow-up of the performance audit in 2018. Carrying out this follow-up mainly entailed conducting semi-structured interviews with key officials at the Primary Healthcare Department and a review of related documentation. The follow-up audit generally showed that the Primary Healthcare Department had actively embarked on implementing the report recommendations. To this effect, two recommendations of the original report had been fully implemented, while substantial work had already been undertaken with respect to the remaining eight.

Expected impact

213 The expected long-term impact of the report is that it will result in organisational and procedural changes, an increase in funding and human resources for the GP function, and the strengthening of IT infrastructure. It should also result in more patient-centric services with increased focus on continuity of care and the broadening of GP services. Other long-term impacts include reducing the demand for secondary care and the demands made on Mater Dei Hospital's Accident and Emergency Department. A further long-term impact could be that primary healthcare raises life-choices awareness thereby influencing the incidence of chronic diseases prevalent within the Maltese population.



Portugal
Tribunal de Contas

Citizens' access to healthcare in Portugal's National Health Service

Overview

214 The Audit of the Portuguese SAI assessed citizens' access to healthcare in Portugal's National Health Service in the period 2014-2016. Citizens' access to healthcare in the National Health Service, in particular specialist hospital consultations and surgery, is facing ongoing difficulties, particularly in terms of waiting times.

How the audit was conducted

215 The audit sought to establish whether:

- o the National Health Service is responding, in a clinically acceptable time, to citizens' needs in terms of access to initial specialist consultations and planned surgery;
- o the procedures for registering and moving waiting lists were carried out in accordance with the rules in force;
- o the measures the Ministry implemented to respond to access difficulties were effective.

216 The main auditees were certain services of the Ministry of Health and selected hospital units.

217 The National Health Service's performance as regards initial hospital consultation and surgery access indicators was assessed based on:

- o technical reports produced by the Ministry of Health, various Ministry of Health bodies and the Health Regulatory Authority;

- o analysis of data and information provided by the Health System Central Administration on the registration and movement of patients on waiting lists for consultations and surgery.

218 The quality of the calculated indicators and underlying records was assessed based on:

- o interviews with the Health System Central Administration, the Regional Health Administration of Lisbon and the Tagus Valley, and the sample of hospital units that were audited;
- o information and data collected from the hospital units that were audited, including walk-through tests of the control environment and of the procedures for registering and moving patients on waiting lists for consultations and surgery.

Main observations

219 The *Tribunal de Contas* concluded that patient access to specialist hospital consultations and planned surgery had deteriorated in the three-year period from 2014 to 2016, resulting in an increase in:

- o the average waiting time for an initial hospital specialist consultation from 115 to 121 days, and non-compliance with maximum guaranteed response times, from 25 % in 2014 to 29 % in 2016;
- o (i) the number of patients on waiting lists for surgery, by 27 000 users (+ 15 %);
(ii) the average waiting time until surgery, by 11 days (+ 13 %); and
(iii) non-compliance with the maximum guaranteed response times, from 7.4 % in 2014 to 10.9 % in 2016.

220 It also concluded that the centralised initiatives implemented by the Health System Central Administration in 2016 to validate and clean up waiting lists for first hospital specialist consultations in National Health Service hospitals included the administrative elimination of very old applications, which distorted the reported performance indicators.

221 Specifically in the area of surgery, the finding was that the failure to issue timely and regular surgical vouchers and transfer notes to patients on waiting lists, which would have

enabled them to be operated in other hospital units with response capacity, increased waiting times.

222 The *Tribunal de Contas* concluded that the information on waiting lists that was made publicly available by the Health System Central Administration was unreliable not only due to repeated flaws in incorporating hospital information into the centralised systems for managing access to hospital consultations and surgery, but also due to the centralised initiatives referred to above.

Recommendations

223 The *Tribunal de Contas* made several recommendations in light of its audit findings, including:

To the Minister of Health:

- o to create mechanisms for automatically issuing surgery vouchers within the statutory time limits whenever it is not possible to comply with the maximum guaranteed response times in National Health Service hospitals, so that the process of internalising surgical production in the National Health Service does not undermine a patient's right to receive treatment within a period regarded as clinically acceptable;
- o to have a body external to the Health System Central Administration carry out regular checks on the quality of the advertised access indicators for initial hospital consultations and planned surgery.

To the Governing Board of the Health System Central Administration:

- o not to adopt administrative procedures that result in artificial reductions in waiting lists and times;
- o to produce reports explaining the criteria adopted, and the methods and results obtained, whenever the centralised information system databases for managing access to hospital consultations and surgery are modified, to rectify errors.

Publication and follow-up

224 The report was sent to the audited bodies and the members of the Government responsible for them. It was also published on the *Tribunal de Contas'* website, together with a one-page summary, and notifications were provided to the media.

225 Following the publication, the President of the *Tribunal de Contas* and the Health Minister were heard at a parliamentary hearing before the National Assembly's Health Committee.

226 In order to comply with the report's final stipulations, the authorities to which the recommendations were addressed reported within three months on the action they had taken. Subsequent exchanges of information also took place. The action taken in light of the recommendations was analysed in September 2018, the conclusion being that 20 of the 47 recommendations made (43 %) had been implemented and 21 other recommendations (45 %) had been partially implemented. This included:

- o implementing procedures for qualifying data on access to initial consultations and planned surgery, the aim being to ensure that work to correct errors in the current information systems was standardised and made more transparent and easier to audit;
- o contracting out services to ensure that surgery vouchers are issued uninterruptedly and in a timely manner to patients on waiting lists.

Expected impact

227 Changes in operational and control procedures for managing waiting lists for consultations and surgery. Promotion of accountability as regards the efficient management of waiting lists, compliance with maximum response times and procedural transparency.



Romania Curtea de Conturi a României

Developing health infrastructure at national, regional and local level to increase access to health services

Overview

228 The Romanian SAI assessed the use of the funds allocated to the development of health infrastructure. The audit covered the period 2011-2015.

How the audit was conducted

229 The main auditee was the Ministry of Health.

230 The audit methodology included examining existing ministerial documents related to the audited subject, direct observations, questionnaires and interviews with the auditee's employees.

Main observations

231 The Romanian SAI made the following observations:

- the Ministry of Health failed to adequately substantiate the resources needed to finance investments in the healthcare system;
- the Ministry of Health did not efficiently coordinate the implementation of the investments through the functional departments, which led to faulty management both at its level and at the level of the subordinated sanitary units, meaning that in 19 years, only two major investment objectives were finalised;
- installation of purchased medical equipment with a delay of 90 to 800 days;

- failure to establish a centralised record of the financing requests for investments submitted to the Ministry by public health units, including the reasons for not admitting financing of investments;
- non-observance of the principles of economy, efficiency and effectiveness. Healthcare units have purchased imaging services from outside providers while possessing equipment with which they could perform such services;
- allocation of investment funds predominantly takes place in the second semester of the budget year. Sometimes the procurement procedures were not finalized in the budgetary year, which led to the loss of financing;
- there is no centralised public procurement of medical equipment. Acquisitions were made in a decentralised way by each health unit, which led to different purchase prices;
- the Ministry of Health did not establish a set of physical and efficiency indicators to track the achievement of investments, the development of health infrastructure, the provision of medical equipment to healthcare facilities or the degree of fulfilment of established indicators. Regular analysis of physical and efficiency indicators has not been carried out;
- a lack of knowledge of the actual situation of sanitary facilities in terms of high performance medical devices (CT, MRI, angiographs, linear accelerators);
- the Ministry of Health did not plan and carry out controls verifying the use of funds allocated to the development of the health infrastructure.

Recommendations

232 The Romanian SAI issued the following recommendations:

- establish appropriate resources for the financing of capital expenditures/capital transfers, aimed at an efficient use of allocated resources;
- set up permanent monitoring of the use of financial resources by sanitary units, elaboration of procedures establishing a mandatory framework for subordinate units of timely reporting of unused amounts;

- ensure adequate financing of the approved investments and measures to provide specialised support to subordinate units;
- get involved in a sustained manner in the work carried out by the sanitary units with an emphasis on the timely realisation and commissioning of the investments in optimal terms;
- arrange periodic inspections on investment activity to assess the stage of realisation;
- establish a real record of the requests for financing investments from the sanitary units, for use as a source of information for the selection of the beneficiary units of funds and the prioritisation of investments based on objective criteria;
- analyse measures for centralised procurement at least for high performance equipment and develop measures to ensure the efficient use of public funds;
- establish a set of physical and efficiency indicators to monitor how health system infrastructure is being developed;
- analyse possible ways of finalising, implementing and operating the high-performance computer system and of capitalising the pre-feasibility and feasibility studies, architectural guides and the technical projects acquired and not used;
- coordinate and monitor sanitary units throughout the absorption process of non-reimbursable funds to boost the absorption rate;
- take all necessary measures to achieve the ex-ante conditionalities and release the non-reimbursable financing provided through Regional Operational Programme 2014-2020;
- take all necessary steps to access and efficiently use the funds made available by the EU through the Regional Operational Programme and the funds allocated through the loan agreement with the International Bank for Reconstruction and Development;
- implement the national health infrastructure database.

Publication and follow-up

233 The report was presented in the form of a synthesis to the Romanian Presidency, the Government, the Chamber of Deputies, the Senate, the Romanian Academy, the Academy of

Medical Sciences, the specialised committees of the Romanian Parliament, some ministries and National Health Insurance House. The report was published in July 2017 in the form of a summary on the Romanian Court of Accounts' website.

234 A follow-up report was drafted in October 2018, prompting the Ministry of Health to begin steps to implement the measures requested by the Court of Accounts.

Expected impact

235 Identifying the best results achieved following implementation of the requested measures and the causes that led to non-fulfilment of the proposed objectives.



European Union European Court of Auditors

EU actions for cross-border healthcare: significant ambitions but improved management required

Overview

236 The European Court of Auditors (ECA) assessed if EU actions for cross-border healthcare deliver the anticipated benefits for patients. The audit covered the period 2008-2018.

237 The EU Cross-Border Healthcare Directive, adopted in 2011, aims to ensure safe and high-quality medical care across borders in the EU, and to provide for reimbursement abroad under the same conditions as at home. It further seeks to facilitate closer cooperation on eHealth, cross-border exchanges of patients' data and access to healthcare for rare diseases through the development of the European Reference Networks (ERNs).

238 The auditors examined whether the European Commission has monitored the implementation of the EU Cross-Border Healthcare Directive and guided Member States in informing patients of their rights. In addition, they assessed the results achieved on exchanges of health data across borders and checked key EU actions on rare diseases.

How the audit was conducted

239 The main audit question was: "Do EU actions in cross-border healthcare deliver benefits for patients?"

240 The ECA further examined whether:

- the Commission had overseen the implementation of the EU Cross-Border Healthcare Directive in Member States well;
- the results achieved so far in terms of cross-border exchanges of health data were in line with expectations;

- EU actions on rare diseases had added value to Member States' efforts to facilitate patients' access to healthcare.

The main auditee was the European Commission.

241 The methodology included interviews with Commission representatives and five Member State authorities responsible for implementing the Directive (in Denmark, Italy, Lithuania, the Netherlands and Sweden). A survey was conducted among all Member States' representatives in the Cross-border Healthcare Expert Group and among representatives of the eHealth Network. Moreover, EU-funded projects were assessed and experts consulted.

Main observations

242 The ECA made the following observations:

Implementation of the EU Cross-Border Healthcare Directive

- The Commission monitored the transposition of the directive into national law and its implementation by the Member States well.
- It has also supported the Member States in improving information on patients' rights to cross-border healthcare, although some gaps remain.

Cross-border exchanges of health data

- The Commission did not properly assess either the potential number of users or the cost-effectiveness of exchanging cross-border health data.
- Forecasts of volumes of health data exchanges across borders have been overoptimistic. At the time of the audit – November 2018 – Member States were only about to start exchanging patient health data electronically.

The European Reference Networks

- The ERNs for rare diseases are an ambitious innovation, which is widely supported by doctors, healthcare providers and patients.
- However, the process of establishing the ERNs was marked by shortcomings, and they are facing significant challenges to their financial sustainability.

Recommendations

243 The ECA recommends that the Commission:

- provide more support for national contact points to improve information on patients' right to cross-border healthcare;
- better prepare for cross-border exchanges of health data;
- improve support for and management of ERNs to facilitate rare disease patients' access to healthcare.

Publication and follow-up

244 The ECA presents its special reports to the European Parliament and Council of the EU, as well as to other interested parties such as national parliaments, industry stakeholders and representatives of civil society.

245 The report was published on the ECA website in 23 EU languages together with a press release on 4 June 2019.

246 As a standard procedure, a follow-up of the report will be undertaken after three years of its publication by the ECA.

Expected impact

247 The ECA expects the following impact:

- clearer information to EU patients on their right to cross-border healthcare;
- provision of information about ERNs for rare diseases on National Contact Points websites;
- assessment of the practice and cost-effectiveness of exchanges of healthcare data across borders and whether they provide meaningful input to national healthcare systems;

- EU actions in the field of rare disease and cross-border healthcare facilitate access of rare disease patients to faster diagnosis and appropriate treatment;
- assessment of the results of the EU rare disease strategy;
- ensuring the sustainability of the ERNS, any future EU funding for the Networks will be managed under the simpler structure and thus reduce their administrative burden.

The quality of health services



Austria
Rechnungshof

Quality assurance for physicians

Overview

248 The audit of the Austrian SAI aimed to assess the organisation, selected subject matters and the transparency of the Federal Government’s quality assurance for physicians having their own practice. The audit covered the period 2013-2016.

How the audit was conducted

249 The assessment focused on the following elements:

- o legal and technical basis for quality assurance, including aims and benefits of quality assurance;
- o organisation of quality assurance, including players, structures and activities;
- o evaluation of the financial and human resources used for quality assurance;
- o evaluation of selected priorities of quality assurance – quality assurance procedures, quality management systems and quality measurement projects at the outpatient level;
- o quality assurance reporting.

250 The main auditees were the Ministry of Health and Women’s Affairs (at the time of the audit: Ministry of Health), the Austrian Medical Chamber and the Austrian Society for Quality Assurance and Quality Management in Medicine (ÖQMed).

251 The audit methodology included an assessment of Austrian and international studies, interviews with staff of the main auditees, and an analysis of the collected evidence, including whether and how the targets were implemented.

Main observations

252 Between 2005, when the Healthcare Quality Act became effective, and 2012, the Federal Ministry of Health published three sets of quality guidelines for physicians having their own practice. As they were valid for only a limited time and the Ministry did not provide follow-up regulations in time, at least two of them were no longer valid in 2017.

253 The 2013 healthcare reform included the decision to introduce output quality measurement for physicians having their own practice. Since then, however, standardised measurement of treatment quality has been neither developed nor implemented for the outpatient sector. Therefore, there is still no independent federal platform to provide patients with information on the treatment quality.

254 Furthermore, the Austrian SAI noted that the Federal Government, the provinces and the social security institutions had not introduced standardised diagnosis and performance documentation at the outpatient level, although this had already been agreed upon as part of the 2005 healthcare reform and a pilot project had confirmed its technical feasibility.

255 Although quality assurance tasks were of public interest, the Federal Government assigned these tasks to the Austrian Medical Chamber, the main purpose of which is to safeguard the professional, social and economic interests of physicians. Against this backdrop, in practice the ÖQMed carried out the quality assurance tasks on behalf of the Austrian Medical Chamber. However, as its subsidiary, the ÖQMed had close organisational and budgetary ties to the Chamber.

256 Pursuant to the Physicians' Act, physicians had to evaluate the quality of the services offered in their surgery every five years. To do so, they filled in self-assessment questionnaires provided by ÖQMed. Responses to the questions were limited to "yes", "no" or "not applicable". Their layout and content encouraged positive responses.

257 97 % of the practitioners filling in the questionnaire between 2012 and 2016 stated that they fully complied with the queried criteria. However, validity checks on the self-assessment conducted by ÖQMed through inspections of surgeries chosen via a random sample showed that about 18 % of the surgeries did not comply with at least one criterion. The chance of being reviewed by ÖQMed, however, was only 7 %; statistically, a surgery was only included in the sample every 70 years.

Recommendations

258 The Austrian SAI made the following observations:

To the Federal Ministry of Health:

- Develop quality standards with binding criteria and/or provisions as soon as possible and thus ensure implementation of the objective set in the Healthcare Quality Act by the legislative body.
- Draw up follow-up regulations for the invalid federal quality guidelines. In future, when publishing quality standards, it should be made clear whether they are binding or only recommended.
- Provide the outcome control commission with a resolution proposal for prioritising and implementing further nationwide care programs, which should be developed and implemented quickly.
- Strive to implement the output quality measurement at the outpatient level set in the Agreement on the Organisation and Financing of the Healthcare System pursuant to Article 15a of the Federal Constitutional Law; this should be based on the concept agreed upon within the outcome control period 2017 to 2021.
- Establish the outpatient diagnosis documentation on a legal basis as soon as possible.
- Develop scenarios to establish a financially and organisationally independent quality assurance institution.
- In future quality reports, the non-compliance rate of the self-assessment of physicians having their own practice and of the validity check of the institution responsible for quality assurance should be described separately and compared. Furthermore, deviations should be evaluated and measures (e.g. information and advisory services) taken to prevent false declarations in the self-assessment.

To the Federal Ministry of Health and the Austrian Medical Chamber:

- Make the response options in the self-assessment questionnaires neutral.
- Consider options to raise the number of validity checks. To guarantee the necessary quality of surgeries and as an advisory service for physicians setting up a new surgery,

the validity check could be made binding. The additional costs could be covered with a fee levied from those involved.

Publication and follow-up

259 The report was sent to the Austrian Parliament, the Minister of Health and the Austrian Chancellor in July 2018 and published on the ACA's website on the same day. It was presented to the Public Accounts Committee of the Austrian Parliament in November 2018 and discussed in the Austrian Parliament in January 2019. The Austrian Court of Audit intends to enquire about the state of implementation of the recommendations in 2019 and the results will be published on their website at the end of 2019. Depending on the results of this enquiry, a follow-up audit may be carried out with on-site audits and a separate report.

Expected impact

260 The audit is expected to contribute to output quality management by examining the activities that had been undertaken and assessing their effectiveness. From a timing point of view, the audit results could incentivise organisational and procedural changes and contribute to adequate targeting and prioritisation of funds and resources in times of budgetary constraint.



Denmark Rigsrevisionen

Report on differences in the quality of care across
Danish hospitals

Overview

261 The audit of the Danish SAI aimed to assess potential differences in the quality of care across Danish hospitals. The audit covered the period 2007-2016.

262 The Danish Health Act stipulates that all patients are to have easy and equal access to high-quality care. The Ministry of Health and the regions have focused on geographical differences in the quality of care through various initiatives. Since 2012, the Danish Clinical Registries (RKKP) has monitored data on the quality of care. The RKKP monitors whether the patients receive care that is consistent with the clinical practice guidelines. In doing so, the RKKP gathers knowledge on the quality of care provided in the regions and on any differences between the regions and hospitals.

How the audit was conducted

263 The audit focused on the quality of care and differences concerning four common diseases: heart failure, chronic obstructive pulmonary disease (COPD), stroke and hip fractures. These diseases were selected for the study because they affect a large number of patients and are treated in most hospitals in the country. It aimed to answer the following questions:

- Have the Ministry of Health and the regions established frameworks that adequately ensure that all patients have equal access to quality care in hospital and allow the regions and hospitals to identify the causes of any differences in the quality of care across hospitals and reduce unfounded differences?
- Are there unfounded differences in the extent to which the care provided in the hospitals to patients suffering from heart failure, COPD, a stroke or a hip fracture is consistent with all relevant process indicators (quality indicators for care)?

264 The main auditees were the Danish Ministry of Health and the five Danish Regions. (Health services are among the key tasks of the Danish regions.)

265 The audit was conducted drawing on document reviews, interviews and registry-based analysis.

Main observations

266 *Rigsrevisionen* made the following observations:

- The SAI's analysis showed that a significant number of patients suffering from heart failure, a stroke or a hip fracture did not receive the full programme of recommended care. Moreover, the analysis showed a lack of consistency in the quality of care in all four disease areas. The differences could not be explained by conscious professional decisions based on the circumstances or the patients' own needs and wishes.
- The analysis showed that differences in care affected the patients' subsequent risk of readmission or death. The registry-based analysis also indicated that most of the differences relating to readmission and death could be traced to factors beyond the hospitals' control.
- The registry-based analysis showed that the care provided to the patients with the worst prospects was less consistent with all relevant process indicators (quality indicators for care) than the care provided to the patients with the best prospects. This applied to all four disease areas.
- Thus, the registry-based analysis indicated that for patients with the worst prospects within three of the four diseases, quality differences in care might potentially have an effect on their subsequent risk of readmission or death.
- The study showed that the Ministry and regions followed up on regional differences in the quality of care provided in the hospitals and their causes. However, the quality assurance had not been organised and followed up with a specific focus on whether patients with similar needs for care, but different circumstances, had received the same high quality of care. This meant that the Ministry and the regions had no data on differences in the quality of care provided to patients in different circumstances, nor

did they know what effect a potential difference might have on the patients' risk of readmission or death.

Recommendations

267 *Rigsrevisionen* recommended that the Ministry of Health and the regions regularly assess whether failure to provide care in accordance with all relevant process indicators affected only patients with certain characteristics. This information could provide the basis for steps to improve the quality of care for these types of patient and thus support the objective of the Ministry and the regions of providing consistently high-quality care to all patients.

Publication and follow-up

268 The report was presented to the Public Accounts Committee, which then added its own remarks before requesting a response from the Minister of Health.

269 The report is freely available online, and the Public Accounts Committee was available for questions from journalists.

270 As the report is quite recent (January 2019), *Rigsrevisionen* is awaiting the Minister's statement and will continue to follow the report closely until satisfactory measures have been implemented.

Expected impact

271 It is too early to determine the impact of the report.



Ireland
**Office of the Comptroller
and Auditor General**

Managing elective day surgery

Overview

272 The audit of the Irish SAI assessed the progress in switching the delivery of treatment from an inpatient to a day-surgery basis. It aimed to identify any factors either facilitating or hampering the switch and to assess if there was scope for extending the use of day surgery. It covered day surgery activity in acute public hospitals in Ireland during the period 2006-2012.

How the audit was conducted

273 The audit focused on one main question: Is there potential to reduce inpatient cases by ensuring that, where medically appropriate, such cases are treated as day cases?

274 Under this main question, the audit considered whether:

- the Health Service Executive (HSE) had analysed the reasons for variations between hospitals to identify possible improvements;
- barriers to improving day surgery rates had been identified and addressed;
- hospitals/HSE processes facilitated information-sharing to gain good practice ideas.

The main auditees were the HSE and the Department of Health.

The assessment was mainly based on the collection of day surgery data, interviews conducted with key personnel and a survey issued to all acute public hospitals in the Health Service Executive. It was carried out in cooperation with two UK-based medical consultants (an anaesthetist and a neurological surgeon).

Main observations

275 The Irish SAI made the following observations:

- There was a steady increase in the proportion of reported elective surgery carried out as day cases between 2006 and 2012. The volume of elective surgical procedures carried out in acute public hospitals increased by 26 %, while the day-case rate for those procedures increased from 55 % to 69 % over the same period.
- There was significant variation in performance across hospitals, indicating that considerable scope remains for increasing the day-case rate in some hospitals.
- The volume of “non-target” elective day surgery cases carried out in acute hospitals increased between 2006 and 2012, without a corresponding change in the number of “non-target” procedures performed on an inpatient basis. This may mean that increasing numbers of minor surgical procedures are being carried out on a hospital admissions basis.
- The criteria applied when clinicians decide whether to list a patient for day surgery or inpatient treatment may not be clear or consistent due to the absence of written protocols and checklists. It may not be possible for management to assess why patients have been deemed unsuitable for day surgery.
- The absence of monitoring or review by senior management of the number of patients deemed unsuitable for day surgery makes it difficult for hospitals to identify where day surgery rates for individual clinicians or specialties are low and to investigate the causes of this.
- Pre-operative assessments are not routinely performed in a significant proportion of hospitals despite their importance in identifying factors that make day surgery inappropriate for individual patients. Less than half the hospitals surveyed monitor the cancellation rate of scheduled day surgery.
- Nurses are responsible for only around 50 % of discharges, although the use of appropriately trained nurses may relieve some of the burden on doctors. Little written information is given to day surgery patients at discharge.

Recommendations

276 The Irish SAI issued the following observations:

- The HSE should monitor the levels of day surgery by hospital, procedure and specialty to establish where the level of day cases is low for high-volume procedures, and focus efforts on improving performance in these instances. Hospitals should set specific targets for day surgery rates for each clinician. The review of clinicians' surgical performance assessments should include consideration of day surgery performance rates.
- To optimise rates of day surgery for elective procedures, the HSE should set separate appropriate targets for each surgical procedure. The overall day-case targets set for each procedure should be based on the performance at the top-performing hospitals while more ambitious targets could be set for those hospitals that are already among the top performers.
- To ensure that hospitals focus attention on increasing day surgery rates for all elective surgery, the HSE should increase the number of procedures for which it sets day-case rate targets.
- The HSE should monitor cases currently classified as day surgery cases with a view to ensuring that all hospitals direct surgical cases to the most appropriate and economical delivery settings.
- All hospitals should put in place locally agreed protocols and checklists clearly setting out the criteria for use by clinicians when selecting patients suitable for day surgery. The HSE should oversee this process to ensure consistency in approach across hospitals.
- In order to identify areas where day surgery rates are low, hospital management should monitor day surgery rates for individual clinicians and for each speciality. The HSE should seek confirmation from hospitals that low day surgery rates are routinely discussed with the relevant clinical teams.
- Hospitals should ensure that pre-operative assessment procedures are put in place to identify patients unsuitable for day surgery in advance.

- Hospitals should ensure that appropriate written information is made available to day patients at discharge. Written information should be clear, complete and available in relevant languages. The HSE should assist hospitals in providing this information.
- Assessing patients' suitability for discharge should ideally be carried out by nurses using set criteria.

Publication and follow-up

277 The report was presented to the Public Accounts Committee of Dáil Éireann (the Irish Parliament). It was published on the website of the Office of the Comptroller and Auditor General of Ireland on 19 August 2014. Publication was accompanied by a press release. The HSE has agreed to implement the audit recommendations. It remains to be seen what impact this will have on the efficiency and cost of elective surgery or on the quality of the service provided to patients.

Expected impact

278 Opportunities for HSE to create operational and cost efficiencies in the delivery of elective day surgery.

PART III – SAI reports at a glance

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New technologies and eHealth



Bulgaria Сметна палата на Република България eHealth

Overview

279 The audit of the Bulgarian SAI assessed whether eHealth had been developed effectively in Bulgaria. The audit covered the period 1 January 2012 to 30 June 2016.

280 Bulgaria began introducing eHealth in 2006 and it is referred to in the government’s strategies and plans as a priority. By 2016, an adequate health information system that (1) provided the information required for decision-making processes, and (2) allowed cross-border health data exchanges, had not yet been deployed.

How the audit was conducted

281 The main audit question was “Has eHealth been developed effectively in Bulgaria?”

282 Under this main question, the SAI examined two sub-questions:

- Have the prerequisites for the introduction and development of eHealth been established?
- Have the goals of building up and developing eHealth been achieved?

283 The main auditees involved were the Ministry of Health, the National Health Insurance Fund (NHIF) and the National Center of Public Health and Analysis (NCPHA).

284 Standard methods for data gathering and analysis were used to accomplish the audit’s objectives, such as document review, interviews with officials at the Ministry of Health, the NCPHA and NHIF, and case studies.

285 The accuracy and integrity of the electronic health records was assessed through the “mystery shopping” tool. The Bulgarian SAI took special measures to safeguard participants’ private data. Citizen satisfaction and awareness was measured through public opinion polls conducted by a specialised agency.

Main observations

286 The necessary preconditions for the effective implementation of eHealth had not been created:

- a regulatory framework for eHealth and its components was lacking;
- there were weaknesses in the operational planning and distribution of the strategic objectives, measures and activities at the level of the Ministry of Health, NCPHA and NHIF;
- eHealth was being built up in the context of very frequent structural and staff changes, both at senior management level and at the level of expert staff, which had a very negative impact on process traceability and the achievement of goals;
- the distribution of responsibilities for the introduction of eHealth was not sufficiently comprehensive or adequate;
- an effective system for coordinating and harmonising actions, projects and public procurement among institutions had not been established, leading to inefficient spending of public funds and for delays in the achievement of strategic priorities.

287 During the audited period, there was a delay in establishing eHealth in Bulgaria, and the actions of the institutions could be considered ineffective due to the following:

- There was no clear concept behind the construction of the system or plan for the necessary financial resources; duplication of functionalities and projects of other institutions, etc.
- As at 30 June 2016, there were no developed and approved national health information standards or medical documentation, which would allow electronic processing and exchanges of medical and health information.

- An adequate integrated health information system was not yet in place.
- Healthcare information systems and registers were not integrated and real-time data exchange among them had not been implemented.
- Almost 10 years after the need for electronic referrals, e-prescriptions, and other real-time data sharing software was declared to be a strategic priority, they had not been developed.
- As at 30 June 2016, no complete electronic health record had been created providing citizens and medical professionals with the necessary information to take adequate decisions in the process of diagnosis, treatment and rehabilitation.
- By the end of the audited period, there was no functioning national health portal to be used as a single point of access to electronic health services and providing important information on health prevention, health education, etc.
- The results of the national representative survey conducted confirmed that the actions to implement eHealth had been ineffective.

Recommendations

288 Twenty recommendations were made to the Minister of Health for the improvement of:

- the regulatory framework and the regulation of responsibilities;
- the overall organisation for planning and implementing the measures;
- the system for coordinating, monitoring and verifying implementation.

289 Seven recommendations were made to the manager of the NHIF in relation to automatic real-time data exchange and the improvement of the information systems.

Publication and follow-up

290 The report was presented to the Bulgarian Parliament’s Budget and Finance Committee and to the Healthcare Committee. The report was published electronically on the website of the SAI on 28 July 2017. Publication was accompanied by a press release.

291 The audit report also was widely presented via different Bulgarian media channels: newspapers, Bulgarian National Radio, Bulgarian National Television, information agencies and electronic media.

292 In accordance with the standard procedure, a follow-up of the report will be performed after the deadline for implementation of the recommendations.

Expected impact

293 The implementation of eHealth is a complex and expensive process. Taking this into account, the expected impact of the audit is:

- an improvement in the regulatory environment;
- the development of a clear concept for building up eHealth, with the involvement of all stakeholders;
- better coordination to eliminate the risks of inefficient spending of public funds;
- urgent actions by the relevant institutions to implement key public measures, such as eHealth records, e-prescriptions, e-referrals, a national health portal and a national health information system.



Estonia Riigikontroll

State activities in implementing the eHealth system

Overview

294 The audit of the Estonian SAI assessed the implementation of the nationwide eHealth information system.

295 The first plans for eHealth in Estonia were prepared in 2004. The Government approved the Estonian Health Information System Development Plan 2005-2008 in 2005. The Estonian eHealth Foundation was established in November 2005. Although the health information system should have been fully operational from 2013, the Electronic Health Record (the central health database) had been only partially implemented, healthcare providers (as the main users of eHealth services) were unsatisfied with the system, and more money was spent than originally planned.

296 The audited period was 2005 to 2012, covering all the activities carried out since the establishment of the Estonian eHealth Foundation.

How the audit was conducted

297 The main audit questions were:

- (1) Does the eHealth information system meet its objectives, and has it been implemented as planned? If not, what are the reasons for this?
- (2) Do the preconditions of the current eHealth system allow it to meet its objectives in the future?

298 The main auditees were the Ministry of Social Affairs, the Estonian eHealth Foundation, the Estonian Health Insurance Fund and the Republic of Estonia Information System Authority (ISA).

299 The audit methodology included the analysis of documents and reports, a survey among approximately 200 doctors, data analysis, observation of eHealth information systems (such as their functionality and user interface for doctors) in cooperation with health service providers and interviews with auditees and healthcare providers.

Main observations

300 The Estonian SAI found that eHealth objectives had not been achieved as:

- despite the initial plans, data in the eHealth system could not be used for national statistics, keeping registries or supervision, and it was not actively used by doctors for treatment purposes;
- Digital Prescription was the only e-solution created by the state that was actively used;
- use of the Electronic Health Record and image reference had been modest and Digital Registration (an e-booking system for appointments) had not taken off in the five years since its completion;
- eHealth did not have a strategic manager to pursue the interests of the state and this held back implementation;
- the creation and implementation of eHealth had cost considerably more than planned and it was unknown how much more money it would still require;
- eHealth did not help to save health insurance money or optimise the working time of doctors;
- the state's institutions were not yet benefiting from the data in the eHealth system, as a lot of data was missing or its quality was poor. Although health service providers must submit medical files to the eHealth system, this was not done systematically, and a lot of data was not submitted at all.

301 The SAI found that the reason behind the weak launch of eHealth was the aimless and random activity of the Ministry of Social Affairs as the strategic manager in charge of the development and implementation of eHealth. They concluded that the success of eHealth depended on strengthening the leading role of the Ministry of Social Affairs.

Recommendations

302 The Estonian SAI made a number of recommendations. The main recommendations are listed below.

- Determine the state's interests in the implementation of eHealth and thereafter set out the tasks of the Ministry of Social Affairs and the Estonian eHealth Foundation in the implementation of eHealth.
- Complete and implement eHealth projects that have already started (above all, Digital Registration and Electronic Health Record) before attempting to create new services.
- With immediate effect, health service providers should be obliged to start using the eHealth information system and, if necessary, tie payment for services to its use.
- Develop the user-friendliness of eHealth in cooperation with the Estonian eHealth Foundation.

Publication and follow-up

303 The report was presented to the auditees, the Social Affairs Committee and the State Budget Control Select Committee in Parliament.

304 The report was published on the website of the SAI. Publication was accompanied by a press release. One day before publication, a press briefing was held at the SAI.

305 On 10 February 2014, the State Budget Control Select Committee of the Parliament held an open meeting attended by the main stakeholders of the eHealth system and the SAI. The meeting was broadcast live on the website of the Parliament and by a major news portal. The SAI also wrote an article about the main audit observations, which was published in a leading daily newspaper.

306 A follow-up of the report was conducted from April to September 2019. It was found that significant advances have been made in the development of the e-health system over the last five years. In addition to the digital prescription, the digital image and the patient portal have been implemented. Also, the nationwide Digital Registration for medical appointments was launched in August 2019. However, several important bottlenecks

remain. For example, the user-friendliness of the Electronic Health Record has not been improved so far, so healthcare professionals do not have quick access to all of the information necessary for providing a timely and high-quality service to the patient. Also, the e-ambulance system requires enhancements in order to ensure that information moves efficiently between ambulances and hospitals so that patients can be given the quickest possible treatment. In addition, the statistics and analytics capacity within the eHealth system for evaluating the quality of health care services needs to be improved.

Expected impact

307 The audit was expected to encourage the Ministry of Social Affairs to fulfil its role as the strategic leader of the eHealth system and define the state's interests in the implementation of eHealth. It was important that the Ministry ensured that strategic and financial planning were integrated, because the audit showed that, at the time, there was no overview of how much completion and implementation of the eHealth projects would cost. Overall, the audit report was expected to contribute to the development of the eHealth system so that its potential for healthcare providers, patients and the state would be fully achieved.



Latvia Valsts Kontrole

Is the “eHealth in Latvia” project a step
in the right direction?

Overview

308 The audit of the Latvian SAI assessed whether the activities of the Ministry of Health and the National Health Service were effective, productive and focused on achieving the objectives of the introduction of eHealth and whether the investments in eHealth in Latvia have been used economically and productively. The audit covered the period between 1 January 2007 and 1 April 2015.

309 The deadline for the implementation of eHealth was the end of 2015. €14.5 million had been invested over nine years, but no eHealth services were available to users. Meanwhile, since 1 January 2016, the eHealth information system has been made mandatory for all healthcare service providers (for outpatient and inpatient treatment, electronic bookings, electronic referrals to examinations or treatment, electronic prescriptions and electronic sick leave certificates).

How the audit was conducted

310 The main audit question was: Has eHealth been implemented in such a way that it will achieve its objective of promoting more efficient healthcare?

311 Under this main question, the SAI examined whether:

- the eHealth system would be able to solve problems and achieve objectives;
- activities performed by the National Health Service for the introduction of eHealth were appropriate for the achievement of the objectives;
- the newly developed eHealth information system ensured information security and the protection of personal data;

- o efficient supervision and controls of “eHealth in Latvia” project had been set up.

312 The main auditees were the Ministry of Health and its subordinate institution – the National Health Service, which was responsible for the implementation of eHealth.

313 The audit methodology included analysis of external laws and regulations, evaluation of the policy implemented by the Ministry of Health, and assessment of eHealth compliance with the requirements of data safety and personal (patient) data protection, as well as surveys, a review of documents and interviews with officials from the Ministry of Health and the National Health Service.

Main observations

314 The project implemented by the Ministry of Health is a step in the right direction to improve the effectiveness of the provision of healthcare services. It will give patients greater control over their health by encouraging them to maintain a healthy lifestyle and will provide greater justification for decision-making, speed up services in the healthcare industry and ensure high-quality and accessible information.

315 Nevertheless, the policy prepared by the Ministry of Health in the area of eHealth had not been implemented in the planned scope and deadline; so the target of improving the effectiveness of healthcare services provision had only been partially achieved.

316 Substantial deficiencies (errors) emerged from the very beginning of implementation of the eHealth project, i.e. industry experts were not involved in the project, multiple changes in the institution implementing the project and ineffective project management were identified, and finally there had not been adequate supervision of the project.

- o Although the Ministry of Health had prepared a planning document for implementation of eHealth, over a nine-year period (from 2007), it had not been updated and did not reflect reality.
- o Although nine years had passed since the beginning of the eHealth project (from 2007) and the Ministry of Health had invested €14.5 million in the project, as at 1 April 2015, the health information system and planned e-services were not accessible to users.

- There was a risk that the eHealth system would not gain sufficient popularity among the population and healthcare service providers, because the system was not understandable and accessible to all potential users.
- As at 1 April 2015, the eHealth information system was not ready from a data security and personal data protection perspective.
- Supervision and controls of the implementation of eHealth, carried out by the Ministry of Health, were not sufficiently effective.

Recommendations

317 The State Audit Office of Latvia made a number of recommendations. The main one to the Ministry of Health was that it should amend the regulation concerning the start date for mandatory use of the eHealth information systems, by providing a time frame for resolving the deficiencies found, and define a reasonable period – at least six months – to allow stakeholders to join the eHealth information system on a voluntary basis.

318 In order to successfully launch the operation of the eHealth information system, the SAI recommended that the Ministry of Health do the following:

- repeatedly test all developed eHealth solutions, according to the requirements of the technical specifications, in order to gain assurance as to the system's operation, its capacity to work together with other systems and its semantic compatibility;
- rectify all deficiencies and imperfections related to data security and physical entities' data protection;
- develop a plan for undertakings involving all healthcare service providers using the eHealth information system, in order to improve the effectiveness of healthcare;
- after launching the eHealth information system and when healthcare service providers are able to freely join the eHealth information system, perform a targeted information campaign to promote it.

Publication and follow-up

319 The report was presented to the Public Expenditure and Audit Committee of the Parliament. The report was published on the website of the State Audit Office of Latvia on 8 September 2015. Publication was accompanied by a press conference and press release.

320 The Ministry of Health must update the State Audit Office of Latvia on implementation of recommendations according to the agreed reporting time frame. After receiving this information, the State Audit Office of Latvia evaluates the progress made by the Ministry of Health. By 2019, the Ministry of Health had implemented 70 % of all recommendations.

Expected impact

321 As the audit was performed at a time when the eHealth information system was not yet mandatory and was still in the implementation phase, all audit recommendations were expected to improve the eHealth implementation process and ultimately ensure successful use of the eHealth system by all stakeholders in order to improve the effectiveness of provision of healthcare services. Since 2016, the eHealth information system and e-services have gradually been made available to users. According to statistics, the most commonly used eHealth services are e-sick leave certificate and e-prescription: in 2018 1 million e-sick-leave certificates and 11.7 million e-prescriptions were issued.

PART III – SAI reports at a glance

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Fiscal sustainability and other financial aspects



Czech Republic Nejvyšší kontrolní úřad

Funds spent by selected hospitals for the reimbursement of costs

Overview

322 The audit of the Czech SAI assessed the compliance of university hospitals with legal regulations in their procurement of materials, goods and services and if the ministries, as the hospitals' founders, complied with the law's obligations. The audit covered the period 2014-2016.

323 The SAI audited purchases of medicines and medical devices in significant volumes. Furthermore, auditors examined the obligation of university hospitals to select suppliers through public procurement and assessed if the ministries complied with the obligations of the founder in accordance with the law.

How the audit was conducted

324 The main questions addressed by the audit were:

- Is the procurement of materials, goods and services (in particular medicinal products and medical devices) by university hospitals in line with legal regulations, and is it efficient and cost-effective?
- Are there significant unit purchase price differences between university hospitals?
- Do the Ministry of Health and Ministry of Defence fulfil their role as the founders of the university hospitals?

325 The main auditees were the founders of the university hospitals, i.e. the Ministry of Health (MoH), Ministry of Defence (MoD), as well as the university hospitals Brno University Hospital (BUH), Motol University Hospital (MUH) and the Central Military Hospital – Military University Hospital Prague (CMH).

326 The assessment was performed drawing on the analysis of collected evidence, document review, interviews and comparisons.

Main observations

327 The Czech SAI made the following observations:

- The procurement of materials and goods was expedient but not always cost-effective or in line with legislation. The purchasing of services was not always cost-effective or in line with legislation. The ministries in some cases failed to comply with their founder obligations in accordance with the law.
- University hospitals purchased pharmaceuticals either through procurement procedures or direct purchases from suppliers. Due to the wide portfolio of used pharmaceuticals and medical devices, efforts to ensure the vital functions of patients, the existence of a single manufacturer on the market or an unsuccessful tender procedure, it was not always possible for the university hospitals to select a supplier according to results of the tender procedure. The proportion of supplies acquired outside tender procedures was considerable, even though all the university hospitals provided reasons for purchasing pharmaceuticals and medical supplies (excluding the BUH) without a tender procedure.
- The criteria set for the evaluation of the bids was not uniform among the university hospitals.
- A comparison of unit purchase prices across the individual university hospitals on an audit sample of the same pharmaceuticals and medical devices revealed significant differences in both absolute values and percentage proportions.
- Among the university hospitals, the unit purchase prices of a selected sample of pharmaceuticals and medical devices differed significantly, often even in purchases from the same suppliers. These price differences were mainly due to discounts from suppliers, the existence of a single manufacturer, supplier shortages, acquisition without a tender procedure, direct distribution by a single supplier, changes in reimbursement, or the introduction of a generic to the market. The SAI sees room for lowering costs in these considerable price differences.

- The healthcare bonus system did not have clear rules for purchasing pharmaceuticals and medical devices. The concept of bonus was not defined by law but was just based on the terms of a specific contractual relationship between the university hospital and the supplier. The university hospitals did not follow a unified procedure when negotiating bonuses and using the bonus income. The university hospitals generally concluded bonus contracts separately from the main supply relationship. The university hospitals, with reference to trade secrets, did not disclose the bonus contracts in the register of contracts, nor the value of the contracted bonuses.
- The BUH had breached the budgetary discipline by unjustifiably using funds in the procurement of medical devices and waste disposal services.
- The CMH had used its assets inefficiently by not providing conclusive evidence for 15 invoices for the legal consultations provided.

Recommendations

328 The Czech SAI recommends that:

- the university hospitals acquire pharmaceuticals and medical devices on the basis of procurement procedures, which is a statutory obligation and a prerequisite for economical management of funds and transparent supplier selection;
- the MoH and the MoD clearly establish the rules for the receipt, reporting and handling of bonuses from healthcare suppliers;
- in procurement procedures, the university hospitals set as a criterion not only the price but also, given the nature and complexity of the object of the public contract, the bonus, if any is to be provided;
- the MoH deal with development strategies and prepare its own concept of the development of directly managed organisations;
- the MoH and the BUH examine the usefulness and merits of the BUH endowment fund and consider the reasons for its continued existence;
- the MoD deal with the identified risk in the provision of funds to the CMH.

Publication and follow-up

329 The report was presented to the government on 8 April 2019.

330 The report was published on the website of the SAI on 3 September 2018. The SAI published this audit conclusion in the SAI Bulletin No 4/2018. Publication was accompanied by a press release.

331 The report has not yet been followed up.

Expected impact

332 Changes to the university hospitals' procedures are expected, as are improvements by ministries in fulfilling their roles, especially in terms of adopting the rules for bonuses, procurement procedures and monitoring the practical and economic operation of university hospitals on a cost-effective basis.



Finland
Valtiontalouden Tarkastusvirasto

Trend projections for social security expenditure

Overview

333 The audit of the Finnish SAI (NAOF) assessed the reliability of trend projections for social security expenditure. These projections are used as a basis for policy decisions and economic sustainability estimates.

334 The audit focused on the use of the macroeconomic model for social security expenditure projections. The model was redefined during the years 2007-2009, and the audit concentrated mainly on the period after 2010. It covered the long-term trend projections for social security expenditure used as a basis for social and health policy decisions. Some of the trend projections were prepared in the Ministry of Social Affairs and Health with the social security expenditure analysis model (SOME model).

How the audit was conducted

335 The main audit question was: How reliable are the trend projections for social security expenditure, used as a basis for policy decisions and economic sustainability estimates?

336 Under this main question, the NAOF asked:

- (1) What kind of trend projections or forecasts for social security expenditure are compiled for decision-making?
 - (a) What are the key differences between them?
 - (b) How are they used in decision-making processes?

- (c) What is the role of the population forecast produced by Statistics Finland in these projections?
- (d) What kind of cooperation exists between the authorities compiling and using the projections?
- (2) Does the Ministry of Social Affairs and Health have the capability to develop the model according to demand?
 - (a) How flexible is the model with regard to its development?
 - (b) Does the Ministry have sufficient resources and expertise to develop the model?
- (3) Is policymaking based on open and transparent methods in terms of the trend projections for social security expenditure?
 - (a) How are the models and underlying assumptions documented?
 - (b) Are assumption-based sensitivity analyses systematically carried out and published?

337 The main auditees were the Ministry of Social Affairs and Health and the Ministry of Finance.

338 Evidence was obtained from an assessment of the transparency and methodology of the trend projections in the Ministry of Social Affairs and Health, from interviews of experts in the Ministry of Social Affairs and Health and in the Ministry of Finance, as well as in some other institutions producing trend projections (the Social Insurance Institution of Finland (Kela) and the Finnish Center for Pensions (ETK)), by benchmarking and analysing the SOME model methods used in the Ministry of Social Affairs and Health with the methods used for trend projections in Kela and ETK.

Main observations

339 The NAOF made the following observations:

- o The SOME model turned out to be the most comprehensive used in the production of long-term trend projections for social security expenditure. The accounting framework was clearly structured and provided a good basis for further development.

- The description of the model and the technical manual were comprehensive and detailed. However, the description had not been updated, even though a number of changes had been incorporated in the model since its introduction.
- There was a need for more advanced versions of the model. For example, the social and healthcare reform (SOTE reform) created a need for trend projections for social security expenditure in individual SOTE regions.
- The SOME model played a central role in the Ministry of Finance’s sustainability gap estimates, as it served as a basis for the estimates for age-related expenditure. Trend projections for age-related expenditure were jointly prepared by the Ministry of Social Affairs and Health and the Ministry of Finance on an unofficial basis. The division of responsibilities in this cooperation process remained unclear, even though ultimate responsibility for the sustainability gap estimate lay with the Ministry of Finance. The description of the methodology applied in the sustainability gap estimate for age-related expenditure was of a general nature and characterised by a lack of transparency.
- Scenarios or sensitivity analyses produced with the SOME model were not published on a regular basis. Systematic publication of the findings would provide a basis for a dialogue between experts, make social and health policymaking and the sustainability gap estimates produced by the Ministry of Finance more open and transparent, and make it easier to develop the model.
- The resources allocated to the SOME model were not necessarily adequate for developing it in accordance with demand and in a manner that would allow for systematic analysis of the findings.

Recommendations

340 The NAOF issued the following recommendations:

- The Ministry of Social Affairs and Health should ensure that the technical manual of the SOME model is updated. Reports on the scenario calculations produced with the SOME model and containing sensitivity analyses should also be published on a regular basis.
- When developing the SOME model, the Ministry of Social Affairs and Health should take into account the new information needs arising from the SOTE reform. The Ministry

should allocate adequate resources to the development work and regular analysis, and ensure sufficient expert-level cooperation with other organisations producing trend projections for social security expenditure and supplying information for them.

- Cooperation between the Ministry of Social Affairs and Health and the Ministry of Finance in the preparation of the sustainability gap estimate aimed at producing age-related expenditure should be described in a transparent manner. The Ministry of Finance should prepare a thorough and transparent description of methodology on the sustainability gap estimate and use sensitivity analysis in the regular reporting on the sustainability gap estimate, for example in relation to trends in social security expenditure.
- The analysis based on the model could also be used more extensively in short-term policy planning.

Publication and follow-up

341 The report was presented to the auditees and to the Audit Committee in the Parliament. The report was published on the website of the NAOF on 16 January 2017. Publication was accompanied by a press release.

342 The follow-up procedure was carried out as scheduled in autumn 2018. The follow-up was made by a questionnaire sent to the auditees. The follow-up report has been released on the NAOF's website.

Expected impact

343 It was expected that the Ministry of Social Affairs and Health, responsible for the SOME model, would put some effort into developing the model and into documenting the methodology and publishing the projection results systematically. It was also expected that the Ministry of Finance would improve the transparency of the economic sustainability estimates methodology and the usage of the SOME model in that context.



Greece

Ελεγκτικό Συνέδριο

Horizontal thematic audit on the State's arrears regarding hospitals, the National Organisation for Healthcare Services Provision (EOPYY) and a regional health directorate

Overview

344 The Greek SAI assessed the accumulation of State's arrears.

345 The audit covered the period from 31 December 2016 to 30 September 2017.

How the audit was conducted

346 The main audit questions were:

- Has the European Stability Mechanism funding for the clearance of arrears been used for the intended purpose?
- Why do arrears continue to accumulate?

347 The main auditees were six hospitals, the National Organisation for Healthcare Services Provision (EOPYY) and the First Attica Region Health Directorate.

348 Evidence was mainly obtained from interviews, clearing letters to third parties (suppliers), unannounced on-the-spot checks on deliveries of goods and services, document reviews, and verification of the legality and regularity of documents and procedures.

Main observations

Overdue Liabilities – Arrears

349 The audit revealed:

- irregularities in the ageing of arrears and incomplete supporting or payment documents regarding supplies and services;
- a lack of mechanisms monitoring the payment of interests and financial penalties and of records regarding the status of court cases;
- that a significant number of liabilities had not been registered or had been erroneously registered in the Commitment Register, or were not accounted for in the IT systems;
- that IT systems failed to export specific aggregate and analytical reports on offsetting.

Arrears Clearance Program

350 The Greek SAI found:

- cases of non-compliance with the FIFO rule and with the time limits for the settlement of liabilities, discrepancies among the reviewed documents and deficiencies in the payment procedure. The findings with respect to the data and reporting systems reliability mainly concerned the liabilities recording systems; and in addition
- discrepancies have been identified among the reporting systems.

351 The audit further focused on identifying sources of new arrears. The findings were as follows:

- A lack of liquidity attributed to unrealistic budgets, the imposition of expenditure ceilings by the European Stability Mechanism, delays in the application of rebate and clawback mechanisms, delays in revenue collection and a reduction in the relevant claims under specific arrangements.
- Due to the complexity (and in some cases vagueness) of the legislative framework governing procurement procedures, tender procedures were not always completed (as a result of red tape and the restrictiveness of the legislative framework which lead to

countless engagements and delays in repayments due to legality issues), and a large volume of supporting documents was required for the clearance of arrears.

- The assessment of the results of the arrears payment programme revealed that the programme was not mature enough and that, in some cases, the rule of self-financing – namely the payment of the entities’ own liabilities with their own resources – had not been respected.

Recommendations

352 The Greek SAI recommends to:

- upgrade the IT systems and their support for regular budgets;
- use these systems to extract all required reports automatically;
- update the Commitment Register automatically; make specific changes and improvements to it in order to ensure the legality and regularity of the recording and payment of liabilities and arrears;
- apply the “First-In-First-Out” method when paying liabilities; and reconcile payments with older invoices automatically;
- make the national central purchasing body for the public health sector fully operational;
- establish production protocols by medical procedure, internal controls on the administrative procurement and payment procedures, a unified codification and classification, uniform Technical Specifications, common barcodes and registers for consumables, materials and medical equipment;
- improve management of stock;
- accelerate the evaluation of tenders in contract award procedures;
- consolidate and adopt a common IT system in all hospitals;
- apply indicators, KPIs, benchmarks, cost accounting and an accrual-based accounting system;
- apply, in a timely manner, the clawback refund mechanism to care providers;

- develop realistic budgets;
- establish internal rules of procedure, internal controls per procedure and an internal audit manual;
- improve the risk analysis process in hospitals; improve staff adequacy and allocation;
- accelerate the clearing and payment procedures; and
- pay out government subsidies on a monthly basis.

Publication and follow-up

353 All eight reports were presented in Parliament at a joint meeting of the Parliamentary Standing Committees of Economic and Social Affairs in October 2018. The reports were published on the website of the Hellenic Court of Audit. The aforementioned presentation was broadcast on the Parliament’s television station.

354 The follow-up was scheduled to be performed within one year.

Expected impact

355 The horizontal audit aimed to identify the causes for the general government arrears and help the Government develop strategies to address this problem as well as to institutionalise the necessary reforms to prevent others from arising.



Hungary
Állami Számvevőszék

Summary analysis of experience gained
from audits of hospitals

Overview

356 The analysis of the State Audit Office of Hungary summarised the experience it had gained in auditing hospitals.

357 The analysis covered the period 2008-2016.

How the audit was conducted

358 The analysis focused on:

- the governing bodies' performance of tasks;
- the internal control system of the hospitals;
- the financial management of the hospitals;
- the asset management of the hospitals;
- the realisation of the integrity approach.

359 Among the main auditees were 21 hospitals, the Ministry of Human Capacities and the National Healthcare Service Centre.

360 The methodology included document reviews, benchmarking and (statistical) data analysis.

Main observations

361 The State Audit Office of Hungary made the following observations:

- The basic requirements for the management of hospitals were set by the governing bodies. Irregularities occurred linked to the middle governing body's activities during public procurement and the approval procedures. The controlling activities of the governing bodies, however, did not lead to the proper management of hospitals.
- Hospital leaders did not properly see to the establishment and operation of an appropriate internal control system.
- Irregularities occurring in the financial management of hospitals (linked to planning, appropriation management and public procurement) put the transparency and accountability of public funds at risk.
- Requirements concerning the lawful and transparent management of state assets were not met during either the purchase, installation, registration and depreciation of assets, or the stocktaking of assets and liabilities.
- The integrity approach in hospitals was strengthened; however, the integrity controls were not fully effective, resulting in irregularities in financial management.

Recommendations

362 A total of 441 recommendations were made: 16 to the Minister, 21 to the middle governing body and 404 to the leaders of hospitals.

363 Areas subject to recommendations are:

- the internal control system;
- financial management;
- asset management;
- the governing bodies' activity.

Publication and follow-up

364 The analysis was presented at a press conference in April 2019 and published on the website of the State Audit Office of Hungary.

Expected impact

365 An impact is expected due to the identification of risky areas. The analysis may lead to greater institutional consideration of legal compliance in management and assist other institutions in the sector with sound management and regular operation.



Italy
Corte dei conti

Implementation of the extraordinary programme for building renovation and technological modernisation of the real estate properties of public health institutions

Overview

366 The audit of the Italian SAI assessed the extraordinary programme of building renovation and technological modernisation of the public real estate properties of public health institutions.

367 The audit covered the period 2012-2016.

368 The Building Renovation and Technological Modernisation Programme was adopted with Law No 67/88 and the first phase was concluded in 1996. The *Corte dei conti* had already carried out an audit and presented a report in May 2011.

How the audit was conducted

369 The main audit question was:

- Is it possible to balance the national interest in the stability of the accounts with the priorities and needs of health and structure safety?

370 The main auditee was the Ministry of Health.

371 The assessment was made using evidence obtained from requests for information and documents to the Ministry of Health (the Directorate-General for Health Planning), which is responsible for the implementation of the infrastructure investment programme.

Main observations

372 The Italian SAI made the following observations:

- The Ministry of Health had not yet established the **Multiannual Planning Document** as laid down by the Legislative Decree No 228/2011.
- The so-called “Mexa” methodology did not permit a real evaluation of the effectiveness of the interventions.
- The annual report submitted by the regions to the Ministry of Health on the progress of works was deemed inadequate to monitor the implementation of projects. The document concerning the state of progress of the works sent by the regions once a year is not adequate, as it does not properly show the actual development.
- The public-private partnership has not been used in an efficient manner and private resources were scarce.

Recommendations

373 The Italian SAI issued the following recommendations:

- the Ministry of Health should adopt the Multiannual Planning Document as laid down by Legislative Decree No 228/2011;
- the “Mexa” methodology should allow for both strategic control and performance audit. The evaluation of public investments should be part of a management control system including both the setting of objectives and the assessment of results achieved.

374 In addition, a public-private partnership should be developed to allow:

- for interrelationships and connections between the public and private sector;
- greater visibility of the project in order to fully involve the private partner in the decision-making process; and
- more appropriate management of risks connected with projects.

375 Moreover, the Ministry should favour private undertakings oriented to long-term investments and able to fund projects in the initial phase.

376 It is fundamental to reorganise and improve the collection of administrative and accounting information on the management processes behind the implementation of the programme.

377 The Ministry of Health should be aware of any initiative undertaken by local entities concerning health infrastructures funded with national or European resources. Moreover, it should implement a database in order to gather the information necessary to improve the planning activities and optimise investments.

Publication and follow-up

Presentation of the report:

378 The report was presented to Parliament, the Ministry of Economy and Finance, the Ministry of Health, and the regions Veneto, Emilia Romagna and Calabria.

379 The report was published on the web site of the *Corte dei conti* on 9 April 2018.

Expected impact

380 The Italian SAI expects the following impact:

- Legislative changes to facilitate the building renovation and technological modernisation of the public health sector's immovable assets.
- Better evaluation of critical issues highlighted by the auditees in order to develop new solutions.
- A focus on the safety of buildings, in particular in connection with anti-seismic and fire-fighting materials.



Cour des comptes
Grand-Duché de Luxembourg

Luxembourg
Cour des comptes
Public financing of hospital investments

Overview

381 The Luxembourg SAI assessed the public financing of hospital investments in the period 2011-2017.

How the audit was conducted

382 The objective of the audit was to verify whether the requirements of the Grand-Ducal Regulation laying down detailed rules for the State's participation in hospital investments had been met. In addition, the SAI analysed the effectiveness and consistency of the inspection mechanisms in the Ministry of Health for validating the reimbursement requests submitted by hospitals.

383 The main auditees were the Ministry of Health and a sample of beneficiaries of state participation.

384 The audit methodology included interviews with the audited bodies and an analysis of the documents provided.

Main observations

State participation in financing the modernisation, refurbishment or construction of hospitals

385 The Ministry of Health did not provide a financial statement comparing the costs of the projects authorised by the law and the actual cost of investments, including justifications for any financial overruns in excess of the legal increases.

Legal and regulatory provisions

386 Although required by law, there was no agreement as regards the granting of aid for some of the hospital projects, e.g. the extension of one hospital and work on the central sterilisation facility of another. In addition, work on one project was carried out without prior formal authorisation from the Minister of Health.

387 The law also provides that a regulation must determine the detailed procedures for financial aid, e.g. as regards time limits and procedures for examining files, the supporting documents to be provided, and the requirement and scope for a needs and impact study. However, no such regulation had been adopted at the time of the audit.

Monitoring of construction and/or modernisation projects

388 For the four sampled projects, project managers regularly prepared progress reports, but did not systematically submit them to the Ministry, as required by the Regulation.

389 The auditors also found various inconsistencies between the multiannual programming of the Hospital Infrastructure Fund that had been drawn up as part of the State revenue and expenditure budget, and the monitoring tables for the subsidised projects that were drawn up for each hospital by the Ministry of Health.

390 As regards adjusting the budget for hospital investment projects to take into account changes in the construction price index, the auditors noted that the Ministry of Health did not have the means to determine, with precision, the available budget for a project in progress, or to check the hospitals' calculations.

Reimbursement requests

391 The auditors noted that (1) projects were authorised and subsidised by separate entities; (2) contact between these entities was lacking; and (3) a single official was responsible for checking reimbursement requests.

392 The law puts the Government's Hospital Commissioner in charge of scrutinising the allocation of public subsidies and reimbursement requests. Although his powers have been strengthened, the auditors concluded that he is not in a position to carry out his duties in full due to a lack of sufficient human resources.

393 In addition, according to the law, the State covers 80 % of the costs of the movable and immovable investments in hospitals that have been authorised by the Minister of Health. However, the auditors noted that the Minister of Health had departed from this rule on several occasions.

394 As regards areas that cannot be subsidised by the Ministry of Health, the Regulation specifies that for those parts of the project which cannot be separated, the costs of the non-subsidised parts will be calculated at the end of the work. However, for one project in the sample only the costs for the underground carpark were reassessed at the end of the project. For another project, the costs of the non-subsidised areas were indeed reassessed, but it remained unclear whether this separation was relevant, as various details had not been provided.

395 Although the Regulation stipulates that the Minister of Health may adopt uniform eligibility rules for all hospitals, this has not been done.

Recommendations

The State's participation in financing the modernisation, refurbishment and construction of hospitals

396 The Ministry of Health should:

- periodically update the Chamber of Deputies on progress with major public-funded hospital investment projects;
- follow procedures similar to those followed at the Chamber of Deputies for state-implemented infrastructure projects, i.e. any significant programme change must be reviewed, a new draft law must be tabled whenever a project's expenditure exceeds 5 % of the authorised amount, and a final breakdown of expenditure must be presented for each individual project authorised by a financing law.

Monitoring construction and/or modernisation projects

397 The Ministry of Health should:

- specify which information it requires and demand that the rapports are sent regularly;

- review the financial data for projects in detail and use a single monitoring instrument for this purpose;
- set up its own tool for calculating budget adjustments and regularly notify hospitals of the remaining budget.

Reimbursement requests

398 The tasks of authorising and financing modernisation and/or construction projects should be brought together within a new special unit, including experts from the Public Buildings Administration. The Ministry should draw up a list of investment costs that are not eligible for subsidies, set financial limits for certain types of expenditure and include the list in future financing agreements. All parts should be reassessed at the end of the project and a breakdown of the actual costs incurred provided.

Publication and follow-up

399 As part of the adversarial phase, the findings and recommendations were sent to the auditee on 15 November 2018. The special report was presented to the Chamber of Deputies on 29 April 2019 and subsequently published on the SAI's website together with a press release.

400 The Court of Auditors' special reports are followed up by the Chamber of Deputies' Budgetary Execution Committee, which draws up a report on the action taken by the authorities concerned in response to the Court's recommendations.

Expected impact

401 The expected impacts are to optimise the procedural process for subsidising hospital investments and to keep the Chamber of Deputies regularly informed of progress on major State-funded hospital investment projects.



Slovakia
Najvyšší kontrolný úrad
Slovenskej republiky
Public finances and property of healthcare facilities

Overview

402 The audit of the Slovak SAI assessed the compliance of public finances and property of healthcare facilities with legal regulations.

403 The audit covered the period 2011-2015. For an objective assessment of some of the audited facts, other years were also taken into consideration.

How the audit was conducted

404 The main audit questions were:

- Was the audited entity's budget realistic?
- Has the balanced budget principle been followed?
- How was the financial health of the individual medical facilities?
- Have the liabilities of the audited entities been paid?
- Has the audited entity invested in the purchase of new medical equipment and were investment plans drawn up?
- Was public procurement transparent and non-discriminatory, and were the principle of economy and efficiency observed?
- Are there differences in the types of healthcare facilities (from the perspective of ownership) in each of the audited areas?

405 The main auditees were hospitals and medical facilities, including 22 public ones (14 state and 8 self-governing entities), 10 that had been converted into other kind of entities (joint-stock companies, limited liability companies, non-profit organisations) and 6 private entities.

406 The audit methodology included document reviews, interviews, benchmarking and statistical data analysis.

Main observations

407 Many findings applied to all types of healthcare facilities (state, self-government, converted and private), but in some areas approaches to management were significantly different.

- The process of budgeting and approving budgets in state and self-governing facilities was not realistic since in previous years the economic result had been negative. The founders, who approve and control the budgets, also have a degree of responsibility for the insufficient quality of budgets. Better access to budget management and asset management has been found in transformed and especially in private facilities.
- There was a direct link between the level of management, the control of budgetary resources and the economic results achieved. The management of most of the converted healthcare facilities and private hospitals resulted in a profit (except for one converted and one private hospital).
- The costs of healthcare increased but were not covered by the proceeds. Audited entities reported significant amounts of unpaid healthcare. The SAI of Slovakia considers the non-payment of recognised healthcare by health insurance companies to be one of the main causes of hospital indebtedness.
- A year-on-year increase in commitments was recorded for up to one third of the audited period (2011-2015).
- Investments in the field of medical technology were low in public healthcare facilities, resulting in increased repair and maintenance costs. In addition, there was no investment plan.

- In the field of public procurement, deficiencies were found regarding the discrimination of tenderers, information advantage of some tenderers, linking procurement of medical equipment with construction work, suspected conspiracy and suspected overpricing. In private facilities, the price of medical equipment procured was significantly lower than in facilities with another form of ownership.
- Several disadvantageous service contracts were concluded in state and self-government healthcare facilities.
- The objectives of eHealth and diagnostic-related groups were not fully achieved.

Recommendations

408 The recommendations proposed by the SAI of Slovakia to remedy the identified shortcomings and improve the management of public finances and the assets of health facilities mainly concerned the management and audit of financial and material expenditure, the unification of reporting and recording to optimise parameters, and the option of purchasing medical equipment in a centralised way.

Publication and follow-up

409 The report was sent to the President of the Slovak Republic, the President of the National Council of the Slovak Republic, two parliamentary committees and the Prime Minister of the Slovak Republic. The results were also sent to the Antimonopoly Office of the Slovak Republic, the Office for the Supervision of Healthcare, the Office for Public Procurement, the Ministry of Health of the Slovak Republic, the General Prosecutor's Office of the Slovak Republic, and the National Criminal Agency. The audit results were presented to the press, radio and television media.

410 Pursuant to the Act on the SAI of Slovakia, the audited hospitals/healthcare facilities were obliged to take measures to remedy the detected deficiencies and to submit them to the SAI by a deadline. Audited entities have adopted a total of 168 measures, of which 122 were from public, 41 were from converted and 5 were from private health facilities.

411 In compliance with this Act, the audited entities submitted to the SAI of Slovakia written reports on the state of play in the implementation of the measures to remedy the

detected deficiencies. According the submitted reports, the SAI monitored implementation of the adopted measures and proposed further procedures (e.g. further monitoring of the implementation of measures, audit of the implementation of measures in a specific audited entity, etc.).

Expected impact

412 Audit results may bring about:

- o organisational/procedural changes in the Ministry of Health of the Slovak Republic for the management of subordinate organisations, and the establishment and approval of budgets of state healthcare facilities and their relation to health insurance companies;
- o a review of the decision to invest in a new medical devices;
- o procedures for ensuring the central procurement of medical equipment;
- o other systemic changes in health policy implementation.



Spain
Tribunal de Cuentas

The management and control of pharmaceutical benefits by the General Spanish Civil Service Mutual Insurance Company (MUFACE)

Overview

413 The audit of the Spanish SAI assessed the management and control of pharmaceutical benefits by the General Spanish Civil Service Mutual Insurance Company (MUFACE). The audited period was the fiscal year 2015.

414 MUFACE has many members entitled to pharmaceutical benefits, a high number and amount of payments and a high number of private companies participating in the procedure. In addition, deficiencies and overpayments were detected in pharmaceutical benefits financed by other similar bodies, whose management had been analysed previously.

How the audit was conducted

415 The main audit objective was to verify whether pharmaceutical benefits to pharmacies and hospitals had been invoiced and paid in accordance with the regulations in force and the principles of sound financial management.

416 The specific objectives were to analyse the procedures implemented by MUFACE to check the invoicing and payment of pharmaceutical benefits to pharmacies and hospitals in line with the above-mentioned regulations and principles. And to assess if the medical prescriptions were financed by MUFACE following the applicable regulation and the agreement signed with the General Council of Provincial Pharmacy Chambers in Spain.

417 The main auditee was MUFACE, an autonomous body under the Ministry of Territorial Policy and Civil Service.

418 The assessment was performed using a combination of document reviews, interviews, sampling and data analysis during the fieldwork. Databases and payment files of beneficiaries of pharmaceutical services were analysed, and checks and controls were performed on the computer application used for the management of pharmaceutical benefit files.

Main observations

419 The Spanish SAI made the following observations:

- Control limits on the consumption of psychotropic drugs set by MUFACE were common to all active substances, regardless of the maximum doses recommended for each type of medication by the Spanish Medicines and Health Products Agency.
- The system of alerts established to limit the delivery of prescription stubs to members exceeding the normal use of medicines had several deficiencies (lack of instructions, lack of alerts concerning members who had either already left MUFACE or had no or excessive use of medicines).
- The payment procedure for decentralised pharmaceutical benefits did not correspond to any of the three types specified by Spanish Budgetary Law No 47/2003, of 26 November 2003.
- Duplicated invoices were detected amounting to €55 998.
- The amount still pending to be discounted as at 31 December 2016, because the maximum expenditure limits for 2015 for certain medicines had been exceeded, amounted to €329 988.
- In the medication dossiers for the treatment of hepatitis C, financed by MUFACE, the corresponding price had been paid, but generally hospitals did not make the deduction of 7.5 % provided for in Article 9 of Spanish Royal Decree-Law 8/2010.

Recommendations

420 The Spanish SAI issued the following recommendations:

- Strengthening controls, making periodic comparisons between the databases of MUFACE and those of the Spanish Tax Agency (verification of income level) and of the National Social Security Institute (verification of correct membership).
- Promoting the implementation of the electronic medical prescription system, in order to allow greater control over doctors prescribing medicines and other validity and dispensation requirements for those medicines.
- Adopting appropriate measures for the correct management of the prescription stubs, their production and distribution, and checks on stocks.
- Adapting instructions on the pharmaceutical benefits regime to the real procedure for processing those benefits, fixing current deficiencies in the alert system for the consumption of medicines, improving and expanding the controls established for this purpose, setting consumption limits depending on the active substance in each medicine.
- Setting measures to recover the overpayments made to hospitals for the financing of the hepatitis C medication, and adopting appropriate measures so that hospitals could apply the 7.5 % deduction in the billing process for hospital-dispensed medicines.
- Modifying the payment management procedure for hospital-dispensed medicines that is carried out through MUFACE's bank accounts.

Publication and follow-up

421 The preliminary draft report was sent to MUFACE for comment. The final audit report was presented to the Parliamentary Committee on 16 November 2017.

422 The audit report has been available on the Spanish Court of Audit's website since 1 October 2017. A press release summarising the main conclusions and recommendations was published on 16 October 2017. The Resolution of the Parliamentary Committee, dated 23 November 2017, was published in the Official State Gazette on 26 February 2018.

423 A follow-up of the recommendations in the report will be carried out either by means of a specific follow-up report, or when new audit tasks related to that entity are carried out. No follow-up actions have been performed so far because only a short time has passed since the report was approved.

Expected impact

424 The General Director of MUFACE informed the Spanish Court of Audit about the implementation of several organisational, procedural and regulation amendments on 27 March 2018:

- modification of the healthcare agreement;
- modification of the resolution on delegation of tasks, dated 23 May 2012;
- modification of MUFACE-specific accounting rules related to expenses, payments, financial control and accounting;
- controls had been reinforced, regular cross-checks were being made across members' databases, in particular with regard to beneficiaries and holders;
- In 2018, a specific computer application for the management of medications payments would be implemented;
- measures to recover overpayments to hospitals for financing hepatitis C medication had been taken;
- implementation of an electronic prescription system, enhancement of detection and prevention controls in respect of over-consumption of medicines, adoption of appropriate measures for the correct management of prescription stubs.

List of participating EU SAIs' audit work related to public health since 2014

425 This list provides an overview of EU SAIs' audit work which has – in full or partially – touched upon public health. For more information about the relevant audit, please contact the SAI concerned.

Austria

- Qualitätssicherung für niedergelassene Ärztinnen und Ärzte [*Quality assurance for physicians*] - Bund 2018/37] (2018)

Belgium

- Vlaams preventief gezondheidsbeleid – Evaluatie van het uitvoeringslandschap [*Flemish preventive health policy – assessment of policy performance*]

Bulgaria

- Ефективност на системата на психиатричното обслужване (одитът да бъде завършен и публикуван през 2020) [*Effectiveness of the psychological care system, to be completed and published in 2020*]
- Електронно здравеопазване (2017) [*e-Health, published 2017*]
- Дейност на Центъра за асистирана репродукция (2017) [*Work of the Assisted Reproduction Centre, published 2017*]
- Одит за съответствие при финансовото управление на Изпълнителна агенция по лекарствата (2016) [*Financial management compliance audit of the Medicines Executive Agency, published 2016*]
- Одит за съответствие при финансовото управление на Министерството на здравеопазването (2016) [*Financial management compliance audit of the Ministry of Health, published 2016*]
- Ефективност на контрола върху дейностите по профилактика и диспансеризация на задължително здравноосигурените лица в РБ на възраст до 18 (2016)

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[Effectiveness of the monitoring of preventive health and medical follow-up under statutory health insurance for minors in Bulgaria, published 2016]

- Дейност по оказване на спешна медицинска помощ (2015) [*Work of the emergency care services, published 2015*]
- Механизъм за договаряне на изпълнението на болнична помощ (2014) [*Negotiation mechanism for the delivery of hospital care, published 2014*]
- Одит на изпълнението на проекти, реализирани от Министерството на здравеопазването по Оперативна програма „Развитие на човешките ресурси“ (2014) [*Performance audit of Ministry of Health projects under the “Human resources development” OP, published 2014*]

Czech Republic

- No 18/14 - Prostředky vybírané na základě zákona ve prospěch Vojenské zdravotní pojišťovny České republiky [*Funds collected under the Act for the benefit of the Military Health Insurance Company of the Czech Republic*]
- No 18/13 - Závěrečný účet kapitoly státního rozpočtu Ministerstvo zdravotnictví za rok 2017, účetní závěrka Ministerstva zdravotnictví za rok 2017 a údaje předkládané Ministerstvem zdravotnictví pro hodnocení plnění státního rozpočtu za rok 2017 [*Closing accounts of the chapters of the state budget concerning the Ministry of Health for 2017, financial statements of the Ministry of Health for 2017, and data submitted by the Ministry of Health for evaluation of the state budget fulfilment for 2017*]
- No 18/11 - Peněžní prostředky státu určené na podporu rozvoje a obnovy materiálně technické základny regionálního zdravotnictví [*State funds intended to support the development and renewal of the material-technical base of regional health care*]
- No 17/19 - Peněžní prostředky vynakládané vybranými fakultními nemocnicemi na úhradu nákladů z činnosti [*Funds spent by selected hospitals for the reimbursement of costs*]
- No 17/14 - Majetek a peněžní prostředky státu, se kterými je příslušná hospodařit příspěvková organizace Národní ústav duševního zdraví [*State property and funds under the management of the National Institute of Mental Health contributory organisation*]

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- No 17/13 - Majetek a peněžní prostředky státu, se kterými je příslušná hospodařit příspěvková organizace Státní zdravotní ústav [*State property and funds under the management of the National Health Institute contributory organisation*]
- No 17/03 - Zdravotnické informační systémy ve správě organizačních složek resortu zdravotnictví [*Health information systems in the administration of organisational units of the Ministry of Health*]
- No 16/28 - Peněžní prostředky vynakládané vybranými nemocnicemi na úhradu nákladů z činnosti [*Money spent by selected hospitals to cover the costs of their activities*]
- No 16/18 - Majetek a peněžní prostředky státu, se kterými je příslušný hospodařit Státní ústav pro kontrolu léčiv [*State property and funds managed by the State Institute for Drug Control*]

Denmark

- Beretning om lægemiddelanbefalinger (2019) [*Report on medication recommendations, published 2019*]
- Beretning om forskelle i behandlingskvaliteten på sygehusene (2019) [*Report on differences in the quality of care in Danish hospitals, published 2019*]
- Beretning om rettidigheden i indsatsen over for kræftpatienter (2018) [*Report on cancer patients' access to cancer services, published 2018*]
- Beretning om forløbet for flygtninge med traumer (2018) [*Report on pathways for refugees with trauma, published 2018*]
- Beretning om udredningsretten (2018) [*Report on patients' right to prompt investigation, published 2018*]
- Beretning om Sundhedsplatformen (2018) [*Report on health platforms, published 2018*]
- Beretning om salget af Statens Serum Instituts vaccineproduktion(2018) [*Report on the sale of the vaccine production of the state-owned Serum Institute, published 2018*]
- Beretning om forebyggelse af hospitalsinfektioner (2017) [*Report on prevention of hospital-acquired infections, published 2017*]

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- Beretning om 3 regioners beskyttelse af adgangen til it-systemer og sundhedsdata (2017) [*Report on the protection of IT systems and health data in three Danish regions, published 2017*]
- Beretning om Region Hovedstadens akuttefon 1813 (2017) [*Report on the medical helpline 1813 set up by the Capital Region of Denmark, published 2017*]
- Beretning om Beskæftigelsesministeriets data om ressourceforløb (2017) [*Report on the Ministry of Employment's data on resource programmes, published 2017*]
- Beretning om indsatsen over for patienter med hjerneskade (2016) [*Report on efforts directed at patients with acquired brain injury, published 2016*]
- Beretning om hospitalslægers bibeskæftigelse (2016) [*Report on hospital physicians' dual practice, published 2016*]
- Beretning om regionernes styring af ambulans behandling af voksne patienter med psykiske lidelser (2016) [*Report on the Danish regions' management of out-patient treatment of adult patients with mental illness, published 2016*]
- Beretning om Patientombuddets arbejde med utilsigtede hændelser (2015) [*Report on the Patient Ombudsman's work with patient safety incidents, published 2015*]
- Beretning om Fødevarerministeriets indsats mod husdyr-MRSA (2015) [*Report on the effort made by the Ministry of Food to combat LA-MRSA, published 2015*]
- Beretning om hospitalernes brug af personaleresurser (2015) [*Report on the use of staff resources at Danish hospitals, published 2015*]
- Beretning om forskningsmidler på hospitalerne (2015) [*Report on external research funds at Danish hospitals, published 2015*]
- Beretning om second opinion-ordningen (2014) [*Report on the second-opinion programme, published 2014*]
- Beretning om problemerne med at udvikle og implementere Fælles Medicinkort (2014) [*Report on the problems connected with the development and implementation of the digitally based Shared Medication Record, published 2014*]
- Beretning om indsatsen for at få sygemeldte tilbage i arbejde (2014) [*Report on the effort made to help people on sick leave return to work, published 2014*]

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- Beretning om kvindekrisecentre (2014) [*Report on women's shelters, published 2014*]
- Beretning om regionernes præhospitale indsats (2014) [*Report on the pre-hospital care provided by the regions, published 2014*]

Estonia

- E-tervise ülevaade (2019) [*E-Health Review, published 2019*]
- Erakorraline meditsiin (2018) [*Emergency Medicine, published 2018*]
- Riigi tegevus laste tervise hoidmisel ja ravimisel (2016) [*State action in the field of child health and medical treatment, published 2016*]
- Riigi tegevus tervishoiu järelevalve korraldamisel ja kvaliteedi hindamisel (lõppes märgukirjaga) (2015) [*State activities in the organisation of health surveillance and quality assessment (closed with a letter of formal notice), published 2015*]
- Riigi tegevus iseseisva õendusabi korraldamisel (2015) [*State action in organising independent nursing care, published 2015*]
- Riigi tegevus e-tervise rakendamisel (2014) [*State action on implementation of e-health, published 2014*]

Finland

- Ohjauksen vaikutus ensihoitopalvelun toimivuuteen [*Impact of steering on the functioning of emergency medical services*], performance audit 2019
- Asiakkaan lasten huomioiminen aikuisten mielenterveyspalveluissa [*Considering children of clients in mental health services for adults*], performance audit 2018
- Sosiaalimenojen kehitysarviot [*Trend projections for social security expenditure*], review 2017
- Lasten mielenterveysongelmien ehkäisy ja hyvinvoinnin tukeminen kouluterveydenhuollossa [*Preventing children's mental health problems and supporting their wellbeing through school health care services*], review 2017
- Paljon palveluja tarvitsevat ja käyttävät asiakkaat perusterveydenhuollossa [*Frequent users of basic health care services*], performance audit 2017

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- Työnjaon kehittäminen sosiaali- ja terveydenhuollossa [*Developing division of labour in social welfare and health care*], performance audit 2016
- Teknisten apuvälineiden hyödyntäminen kotiin annettavissa vanhuspalveluissa [*Using technical assistive devices in services for older persons provided at home*], performance audit 2015
- Pienhiukkasten terveyst- ja kustannusvaikutusten huomioonottaminen strategioiden valmistelussa [*Consideration of the health and cost impacts of fine particles in the preparation of strategies*], performance audit 2015

France

- Rapport sur l'application des lois de financement de la sécurité sociale (2019) [*Report on the implementation of the Social Security Finance Acts, published 2019*]
- La politique de prévention des infections associées aux soins: une nouvelle étape à franchir (2019) [*Policy to prevent healthcare-associated infections: a new step forward, published 2019*]
- La politique de prévention et de prise en charge du VIH en France depuis 2010 (2019) [*HIV prevention and treatment policy in France since 2010, published 2019*]
- Rapport sur l'application des lois de financement de la sécurité sociale, octobre 2018, chapitre VI – La lutte contre les maladies cardio-neurovasculaires: une priorité à donner à la prévention et à la qualité des soins (2018) [*Report on the implementation of the Social Security Finance Acts, October 2018, Chapter VI The fight against cardio-neurovascular diseases: priority should be given to prevention and to the quality of care, published 2018*]
- Rapport sur l'application des lois de financement de la sécurité sociale, octobre 2018, chapitre VII – Les soins visuels: une prise en charge à réorganiser (2018) [*Report on the implementation of the Social Security Finance Acts, October 2018, Chapter VII Eye care: restructuring needed, published 2018*]
- Le rôle des centres hospitaliers universitaires (CHU) dans le système de santé (2018) [*The role of university hospitals (CHU) in the French health service, published 2018*]
- L'avenir de l'assurance maladie (2017) [*The future of health insurance, published 2017*]

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- Les politiques de lutte contre les consommations nocives d'alcool (2016) [*Policies to tackle harmful alcohol use, published 2016*]

Germany

- Prüfung der Krankenhausabrechnungen durch die Krankenkassen der gesetzlichen Krankenversicherung - Bericht an den Rechnungsprüfungsausschuss des Haushaltsausschusses des Deutschen Bundestages nach § 88 Abs. 2 BHO (6. Mai 2019) [*Audit of billing for hospital treatment by statutory health insurance companies – Report to the Audit Committee of the Budget Committee of the German Bundestag pursuant to Article 88(2) of the German Federal Budget Code (6 May 2019)*]
- Einführung der elektronischen Gesundheitskarte und der Telematikinfrastruktur - Bericht an den Haushaltsausschuss des Deutschen Bundestages nach § 88 Abs. 2 BHO (18. Januar 2019) [*Introduction of eHealth card and telematics infrastructure – Report to the Budget Committee of the German Bundestag pursuant to Article 88(2) of the German Federal Budget Code (18 January 2019)*]
- Finanzierung der Versorgung mit Rettungsfahrten und Flugrettungstransporten - Bericht an den Haushaltsausschuss des Deutschen Bundestages nach § 88 Abs. 2 BHO (20. August 2018) [*Funding for provision of emergency vehicles and aircraft – Report to the Budget Committee of the German Bundestag pursuant to Article 88(2) of the German Federal Budget Code (20 August 2018)*]
- Krankenkassen und Krankenhäuser vereinbaren unzulässige pauschale Rechnungskürzungen in Millionenhöhe und umgehen Abrechnungsprüfungen - Bemerkungen 2018 [*Health insurance companies and hospitals agreeing millions in unlawful flat-rate invoice write-downs and avoiding billing audits – Observations 2018*]
- Steuervorteile für Tabakindustrie abschaffen - Bemerkungen 2017 [*Abolishing tax advantages for the tobacco industry – Observations 2017*]
- Nutzen kieferorthopädischer Behandlung muss endlich erforscht werden - Bemerkungen 2017 [*Benefits of orthodontic treatment must finally be researched – Observations 2017*]
- Haftpflichtversicherung für kassenärztliche Behandlungsfehler gesetzlich sicherstellen - Bemerkungen 2017 [*Making liability insurance against malpractice by doctors on statutory insurance schemes a legal requirement – Observations 2017*]

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- Hilfsmittelversorgung durch die Krankenkassen der Gesetzlichen Krankenversicherung - Bericht an den Haushaltsausschuss des Deutschen Bundestages nach § 88 Abs. 2 BHO (20. Juni 2016) [*Provision of medical aids by statutory health insurance companies – Report to the Budget Committee of the German Bundestag pursuant to Article 88(2) of the German Federal Budget Code (20 June 2016)*]
- Erstattung von Reiseschutzimpfungen: Rechtsgrundlage noch zeitgemäß? - Bemerkungen 2015 [*Reimbursement for travel vaccinations: does the legal framework need updating? – Observations 2015*]

Greece

- Οριζόντιος θεματικός έλεγχος στις ληξιπρόθεσμες υποχρεώσεις του Κράτους και ειδικότερα, μεταξύ άλλων, έξι νοσοκομείων, του Εθνικού Οργανισμού Παροχής Υπηρεσιών Υγείας (Ε.Ο.Π.Υ.Υ) και μίας περιφερειακής διοίκησης υγείας (1η Υγειονομική Περιφέρεια Αττικής). [*Horizontal thematic audit on the State's arrears regarding hospitals, the National Organisation for Healthcare Services Provision (EOPYY) and a regional health directorate*] (2018)

Hungary

- A kórházak ellenőrzési tapasztalatait összegző elemzés (2019) [*Summary analysis of experience gained from audits of hospitals, published 2019*]

Italy

- L'attuazione del programma straordinario di ristrutturazione edilizia e ammodernamento tecnologico del patrimonio sanitario pubblico [*Implementation of the extraordinary programme for building renovation and technological modernisation of the real estate properties of public health institutions*] (2018)

Ireland

- Managing elective day surgery (2014)

Latvia

- Cilvēkresursi veselības aprūpē (2019) [*Human resources in healthcare, published 2019*]

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- Vai rehabilitācija ir pilnvērtīga veselības aprūpes pakalpojumu sastāvdaļa? (2019) [*“Is rehabilitation a fully-fledged part of the healthcare services?” published 2019*]
- Vai ambulatorā veselības aprūpes sistēma Latvijā ir pilnveidojama? (2017) [*“Can the ambulatory health care system in Latvia be improved?” published 2017*]
- Vai ievēroti rezidentūras finansēšanas noteikumi? (2016) [*“Are the rules for financing hospital residency being observed?” published 2016*]
- Vai projekts “E-veselība Latvijā” ir solis pareizajā virzienā? (2015) [*“Is the “E-Health in Latvia” project a step in the right direction?” published 2015*]

Lithuania

- Kaip vykdoma onkologinė sveikatos priežiūra (2014) [*Health care in oncology, published 2014*]
- Visuomenės sveikatos stiprinimo organizavimas savivaldybėse (2015) [*Organisation of reinforcement of public health in municipalities, published 2015*]
- Ar užtikrinamas kompensuojamųjų generinių vaistų prieinamumas (2016) [*Ensuring the availability of compensatory generic medicines, published 2016*]
- Viešosios sveikatos priežiūros įstaigoms perduoto valstybės turto valdymas (2017) [*Management of possession of sovereign property transferred to public health establishments, published 2017*]
- Elektroninės sveikatos sistemos kūrimas (2017) [*Development of an electronic health system, published 2017*]
- Savižudybių prevencija ir postvencija (2017) [*Prevention of suicide and support for those bereaved by suicide, published 2017*]
- Asmens sveikatos priežiūros paslaugų kokybė: saugumas ir veiksmingumas (2018) [*Quality of personal healthcare services: safety and efficacy, published 2018*]
- Asmens sveikatos priežiūros paslaugų prieinamumas ir orientacija į pacientą (2018) [*The accessibility of healthcare services and patient orientation, published 2018*]
- Sveikatos priežiūros sistemos vertinimas (2019) [*Health care system assessment (landscape review), published 2019*]

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Luxembourg

- Rapport spécial sur le financement public des investissements hospitaliers [*Public financing of hospital investments*] (2019)

Malta

- Follow-up Audit: Follow-up Reports by the National Audit Office, 2018 – October 2018
 - General Practitioner Function – The Core of Primary Health Care (pages 46-52 of Report)
 - An Analysis of the Pharmacy of Your Choice Scheme (pages 71 to 81 of Report)
- Performance Audit: A Strategic Overview of Mount Carmel Hospital – July 2018
- An Investigation of the Mater Dei Hospital Project – May 2018
- Performance Audit: Outpatient Waiting at Mater Dei Hospital – November 2017
- Follow-up Audit: Follow-up Reports by the National Audit Office, 2017 – November 2017
 - The Management of Elective Surgery Waiting Lists (pages 69 to 77 of Report)
 - The Provision of Residential Long-Term Care for the Elderly through Contractual Arrangements with the Private Sector (pages 78 to 87 of Report)
- Performance Audit: Service Agreements between Government and Richmond Foundation Malta – September 2016
- Performance Audit: The General Practitioner Function – The core of primary health care – June 2016
- Information Technology Audit: Mater Dei Hospital – May 2016
- Performance Audit: Service Agreements between Government and INSPIRE Foundation – February 2016

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- Performance Audit: Provision of residential long-term care for the elderly through contractual arrangements with the private sector – April 2015

Poland

- System ochrony zdrowia w Polsce – stan obecny i pożądane kierunki zmian (megainformacja) [*Poland's healthcare system – where things stand and how they should change (synthesis report)*] (2019)
- Dostępność refundowanych wyrobów medycznych wydawanych na zlecenie i bezpieczeństwo ich stosowania [*Availability and safety of reimbursable medical devices on loan*] (2019)
- Funkcjonowanie systemu podstawowego szpitalnego zabezpieczenia świadczeń opieki zdrowotnej [*Functioning of primary hospital care*] (2019)
- Bezpieczeństwo pacjentów przy stosowaniu antybiotykoterapii w szpitalach [*Ensuring patient safety during antibiomatic treatment in hospitals*] (2019)
- Wsparcie osób z autyzmem i zespołem Aspergera w przygotowaniu do samodzielnego funkcjonowania [*Support for people with autism and Asperger syndrome preparing for independent living*] (2019)
- Zapewnienie opieki paliatywnej i hospicyjnej [*Provision of palliative and hospice care*] (2019)
- Pomoc państwa realizowana w formie środowiskowych domów samopomocy udzielana osobom z zaburzeniami psychicznymi [*State-funded community self-help centres for people with psychiatric disorders*] (2019)
- Wdrożenie przez podmioty lecznicze regulacji dotyczących ochrony danych osobowych [*Enforcement of data protection regulations by medical establishments*] (2019)
- Profilaktyka uzależnień od alkoholu i narkotyków [*Prevention of alcohol and drug addiction*] (2019)
- Dostępność leczenia psychiatrycznego dla dzieci i młodzieży [*Availability of psychiatric treatment for children and young people*] (2019)

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- o Działania podejmowane przez wojewodę wobec placówek udzielających całodobowej opieki bez wymaganego zezwolenia [*Action by the Provincial Governor against establishments providing 24-hour care without the necessary approval*] (2019)
- o Podlaski System Informacyjny e-Zdrowie [*Podlaskie Province's eHealth information system*] (2018)
- o Profilaktyka i leczenie cukrzycy typu 2 [*Prevention and treatment of type 2 diabetes*] (2018)
- o Tworzenie map potrzeb zdrowotnych [*Mapping health needs*] (2018)
- o Żywienie pacjentów w szpitalach [*Patient nutrition in hospitals*] (2018)
- o Funkcjonowanie aptek szpitalnych i działów farmacji szpitalnej [*Functioning of hospital pharmacies and hospital pharmacy units*] (2018)
- o Dostępność świadczeń ginekologiczno-położniczych finansowanych ze środków publicznych na terenach wiejskich [*Availability of publicly funded gynaecological and obstetric care in rural areas*] (2018)
- o Zapobieganie i leczenie depresji [*Prevention and treatment of depression*] (2018)
- o Opieka zdrowotna nad dziećmi i młodzieżą w wieku szkolnym [*Healthcare services for schoolchildren and adolescents*] (2018)
- o Zakażenia w podmiotach leczniczych [*Infections in medical establishments*] (2018)
- o Ochrona intymności i godności pacjentów w szpitalach [*Protection of patient privacy and dignity in hospitals*] (2018)
- o Bezpieczeństwo badań genetycznych [*Safety of genetic testing*] (2018)
- o Działalność organów państwa na rzecz zapewnienia dostępności produktów leczniczych [*Action by national authorities to ensure availability of medications*] (2018)
- o Realizacja strategicznego programu badań naukowych „Profilaktyka i leczenie chorób cywilizacyjnych” – STRATEGMED [*Implementation of the Strategic Research Programme “Prevention and treatment of ‘diseases of civilisation’” — STRATEGMED*] (2018)

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- Realizacja zadań Narodowego Funduszu Zdrowia w 2017 roku [*The National Health Fund's performance in 2017*] (2018)
- Pozasądowe dochodzenie roszczeń przez pacjentów [*Out-of-court settlements for patients*] (2018)
- Finansowanie i realizacja „Programu inwestycji rozwojowych i modernizacyjnych w szpitalach wojewódzkich na lata 2009-2016” w województwie kujawsko-pomorskim [*Financing and implementation of the 2009-2016 hospital development and modernisation investment programme in Kujawsko-Pomorskie Province*] (2018)
- Nadzór nad obrotem i stosowaniem produktów zawierających substancje anaboliczne, hormonalne, odurzające i psychotropowe w leczeniu zwierząt, w tym towarzyszących [*Monitoring of the marketing and use of products containing anabolic, hormonal, narcotic and psychotropic substances, and of associated products, in the treatment of animals*] (2018)
- Wykorzystywanie naturalnych surowców leczniczych w lecznictwie uzdrowiskowym [*Use of natural pharmaceutical raw materials in spa treatment*] (2018)
- Dostępność i efekty leczenia nowotworów [*Availability and results of cancer treatment*] (2017)
- Przeciwdziałanie sprzedaży dopalaczy [*Action to combat the sale of 'legal highs'*] (2017)
- Realizacja programów wczesnego wykrywania raka piersi oraz raka szyjki macicy w województwie lubelskim [*Implementation of programmes for early detection of breast and cervical cancer in Lublin Province*] (2017)
- Profilaktyka zdrowotna w systemie ochrony zdrowia [*Preventative treatment in the healthcare system*] (2017)
- Realizacja zadań Narodowego Programu Ochrony Zdrowia Psychicznego [*Performance of the National Programme for the Protection of Mental Health*] (2017)
- Dostępność i finansowanie diagnostyki laboratoryjnej [*Availability and funding of laboratory diagnostics*] (2017)
- Przygotowanie i wdrażanie pakietu onkologicznego [*Preparation and implementation of the oncology package*] (2017)

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- Opieka nad osobami chorymi na chorobę Alzheimera oraz wsparcie dla ich rodzin [*Care for Alzheimer's disease patients and support for their families*] (2017)
- Profilaktyka stomatologiczna dzieci i młodzieży w województwie lubelskim [*Preventative dental treatment for children and young people in Lublin Province*] (2017)
- Respektowanie praw pacjentów w transgranicznej opiece zdrowotnej [*Honouring of patients' rights in cross-border healthcare*] (2017)
- Dostępność terapii przeciwbólowej [*Availability of pain relief treatment*] (2017)
- Realizacja zadań Narodowego Funduszu Zdrowia w 2016 roku [*The National Health Fund's performance in 2016*] (2017)
- Realizacja zadań związanych z zapewnieniem pracownikom badań profilaktycznych [*Performance of tasks related to the provision of preventive medical check-ups to employees*] (2017)
- Realizacja świadczeń zdrowotnych z zakresu kardiologii przez publiczne i niepubliczne podmioty lecznicze [*Provision of cardiac care by public and private medical establishments*] (2016)
- Kształcenie i przygotowanie zawodowe kadr medycznych [*Training and professional development of medical staff*] (2016)
- Tworzenie i udostępnianie dokumentacji medycznej [*Creation and sharing of medical records*] (2016)
- Dostępność profilaktyki i leczenia chorób układu oddechowego [*Access to prevention and treatment of respiratory diseases*] (2016)
- Realizacja programów polityki zdrowotnej przez jednostki samorządu terytorialnego [*Implementation of health policy programmes by local government bodies*] (2016)
- Opieka okołoporodowa na oddziałach położniczych [*Perinatal care in maternity wards*] (2016)
- Korzystanie z usług zewnętrznych przez szpitale publiczne [*Use of external services by public hospitals*] (2016)

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- Przygotowanie szpitali do leczenia pacjentów z udarem mózgu [*Preparedness of hospitals for treating stroke patients*] (2016)
- Badania prenatalne w Polsce [*Prenatal examinations in Poland*] (2016)
- System szczepień ochronnych dzieci [*The system of childhood vaccinations*] (2016)
- Restrukturyzacja wybranych samodzielnych publicznych zakładów opieki zdrowotnej korzystających z pomocy ze środków publicznych [*Restructuring of selected independent publicly funded healthcare establishments*] (2016)
- Wykonywanie przez Państwową Inspekcję Farmaceutyczną zadań określonych w ustawie Prawo farmaceutyczne [*The National Pharmaceutical Inspectorate's performance of its statutory role under the Pharmaceuticals Act*] (2016)
- Realizacja zadań Narodowego Funduszu Zdrowia w 2015 r. [*The National Health Fund's performance in 2015*] (2016)

Portugal

- Auditoria orientada às dívidas ao Instituto Português do Sangue e da Transplantação, I.P. [*Targeting of debts to the Portuguese Institute of Blood and Transplantation, I.P.*] (2018)
- Auditoria às práticas de gestão no Centro Hospitalar Lisboa Norte, EPE, e no Centro Hospitalar de São João, EPE [*Audit of management practices in the CHLN, EPE and CHS João, EPE*] (2018)
- Auditoria à Conta Consolidada do Ministério da Saúde – Exercícios de 2015 e 2016 [*Audit of the consolidated Account of the Ministry of Health — Financial Year 2015 and 2016*] (2017)
- Auditoria orientada à situação financeira da SPMS - Serviços Partilhados do Ministério da Saúde, EPE [*Oriented Audit of the SPMS Financial Situation, EPE*] (2017)
- Auditoria ao Acesso a Cuidados de Saúde no Serviço Nacional de Saúde [*Audit on Access to Health Care in the National Health Service*] (2017)
- Auditoria aos acordos celebrados entre a Administração Regional de Saúde do Norte, IP, e a Santa Casa da Misericórdia do Porto [*Audit of the agreements concluded*]

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between the Regional Health Authority of North Health, I.P. and the Santa Casa da Misericórdia do Porto] (2017)

- Auditoria à prestação de contas por entidades do Ministério da Saúde [*Audit of the accountability of Ministry of Health entities*] (2017)
- Auditoria Financeira ao Centro Hospitalar Lisboa Norte, EPE – Exercício de 2014 [*Financial Audit at the CHLN, EPE — ex.2014*] (2017)
- Auditoria à execução do Contrato de Gestão do Hospital de Braga em Parceria Público-Privada (PPP). [*Audit of the execution of the Braga Hospital Management Contract in Public-Private Partnership*] (2016)
- Auditoria orientada a procedimentos de contratação pública das unidades de saúde do setor empresarial do Estado. [*Audit on the Public Procurement Procedures of the Health Units in the State Business Sector*] (2016)
- Auditoria de Seguimento de Recomendações Formuladas no Relatório de Auditoria ao Desempenho de Unidades Funcionais de Cuidados de Saúde Primários [*Follow-up audit of recommendations made in the audit report to the performance of primary health care units*] (2016)
- Auditoria de resultados ao Serviço de Urgência do Centro Hospitalar do Algarve, EPE [*Performance audit of the emergency service of the Hospital Centre of Algarve, EPE*] (2016)
- Auditoria de Seguimento das Recomendações formuladas no Relatório de Auditoria ao Sistema de Proteção Social aos Trabalhadores em Funções Públicas (Relatório n.º 12/2015 – 2ª Secção) [*Audit of the Follow-up to Recommendations made in the Audit Report for the Social Protection System for Workers in Public Functions (Report No 12/2015 — Section 2)*] (2016)

Romania

- Dezvoltarea infrastructurii de sănătate la nivel național, regional și local în vederea creșterii accesibilității la serviciile de sănătate [*Developing health infrastructure at national, regional and local level to increase access to health services*] (2017)

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Slovakia

- Verejné financie a majetok zdravotníckych zariadení [*Public finances and property of healthcare facilities*] (2017)

Slovenia

- Obvladovanje debelosti otrok [*Tackling child obesity*] (2018)

Spain

- 1231.- Fiscalización sobre la gestión y control de las prestaciones farmacéuticas a cargo de la Mutualidad General de Funcionarios Civiles del Estado, ejercicio 2015 (28/09/2017) [*Audit of the The management and control of pharmaceutical benefits by the General Spanish Civil Service Mutual Insurance Company (MUFACE), 2015 fiscal year, published 2017*]
- 1213.- Fiscalización sobre la gestión del buque sanitario y de apoyo logístico “Esperanza del Mar”, ejercicio 2015 (29/03/2017) [*Audit of the management of the Medical and Logistical Assistance Vessel "Esperanza del Mar", 2015 fiscal year, published 2017*]
- 1205.- Fiscalización sobre la gestión y control de las prestaciones farmacéuticas a cargo del Instituto Social de las Fuerzas Armadas, ejercicio 2015 (23/02/2017) [*Audit of the management and control of pharmaceutical supplies by the Social Insurance Institute of the Armed Forces, 2015 fiscal year, published 2017*]
- 1200.- Fiscalización de la Fundación Centro Nacional de Investigaciones Cardiovasculares Carlos III, ejercicio 2014 (26/01/2017) [*Audit of the National Centre for Cardiovascular Research Foundation Carlos III, 2014 fiscal year, published 2017*]
- 1199.- Fiscalización sobre la gestión del buque sanitario y de apoyo logístico “Juan de la Cosa”, ejercicio 2015 (26/01/2017) [*Audit of the management of the Medical and Logistical Assistance Vessel “Juan de la Cosa”, 2015 fiscal year, published 2017*]
- 1185.- Fiscalización de la actividad económica desarrollada por el Ministerio de Sanidad, Servicios Sociales e Igualdad en relación con el área farmacéutica, ejercicios 2014 y 2015 (19/12/2016) [*Audit of the economic activities of the Ministry of Health, Social Services and Equality in relation to medicines, 2014 and 2015 fiscal years, published 2016*]

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- 1167.- Fiscalización sobre la gestión y control de las prestaciones farmacéuticas a cargo de la Mutualidad General Judicial (22/07/2016) [*Audit of the management and control of pharmaceutical supplies by the General Mutual Insurance Scheme for the Judiciary, published 2016*]
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European Court of Auditors

- Special report 07/2019: EU actions for cross-border healthcare: significant ambitions but improved management required (2019)
- Special report 28/2016: Dealing with serious cross-border threats to health in the EU: important steps taken but more needs to be done (2016)

Acronyms and abbreviations

ACA: Austrian Court of Audit

ANSM: National Agency for the Safety of Drugs and Health Products (*Agence Nationale de Sécurité des Médicaments et des Produits de Santé*)

ARS: Regional Health agencies (*agences régionales de santé*)

ATC: Anatomical Therapeutic Chemical Classification System of Medicines

BNAO: Bulgarian National Audit Office

BUH: Brno University Hospital

CMH: Central Military Hospital

CNAM: National Health Insurance Fund (*Caisse nationale d'assurance maladie*)

COPD: Chronic Obstructive Pulmonary Disease

CPIAS: Healthcare related Infection Control Centres

CT: Computerized Tomography

DG SANTE: Directorate-General for Health and Food Safety

DRG: Diagnostic Related Groups

EC: European Commission

ECHI: European Core Health Indicators

EFSI: European Fund for Strategic Investments

EHF: Estonian eHealth Foundation

EOPYY: Greek National Healthcare Institution

ERN: European Reference Network

ESF+: European Social Fund Plus

ETK: Finnish Center for Pensions

GDP: Gross Domestic Product **GP:** General Practitioner

GP: General Practitioner

HAS: High Authority for Health (*Haute Autorité de santé*)

HSE: Health Service Executive (Ireland)

HTA: Health Technology Assessment

ICT: Information and Communication Technology

ISA: Information System Authority (Estonia)

ISSAI: International Audit Standard

KPI: Key Performance Indicator

MoD: Ministry of Defence

MoH: Ministry of Health

MRI: Magnetic Resonance Imaging

MUH: Motol University Hospital

MUFACE: Spanish Civil Service Mutual Insurance Company (*Mutualidad General de Funcionarios Civiles del Estado General*)

NAO: National Audit Office

NAOF: National Audit Office of Finland

NCPHA: National Center of Public Health and Analysis (Bulgaria)

NFZ: National Health Fund (Poland)

NHIF: National Health Insurance Fund (Bulgaria)

NIK: Polish Supreme Audit Office (*Najwyższa Izba Kontroli w Polsce*)

OECD: Organization for Economic Cooperation and Development

ÖQMed: Austrian Society for Quality Assurance and Quality Management in Medicine (*Österreichische Gesellschaft für Qualitätssicherung und Qualitätsmanagement in der Medizin*)

PGEU: Pharmaceutical Group of the European Union

PHCD: Primary Healthcare Department (Malta)

PPP: Public Private Partnership

PTD: Polish Diabetes Association

RKKP: Danish Clinical Registries

ROsP: Remuneration on public health objectives (*Rémunération sur Objectifs de Santé Publique*)

SAI: Supreme Audit Institution

SOME model: Social Security Expenditure Analysis model

SOTE reform: Social and Healthcare reform

TFEU: Treaty on the Functioning of the European Union

UN: United Nations

VAT: Value Added Tax

VRIND: Flemish Regional Indicators

WHO: World Health Organization

Glossary

Amenable mortality: Death could have been avoided through effective and timely healthcare.

Beveridge model: A public tax-financed health insurance system, which usually provides universal coverage and depends on residency or citizenship.

Digital Single Market: A market in which the free movement of persons, services and capital is ensured and where the individuals and businesses can seamlessly access and engage in online activities under conditions of fair competition, and a high level of consumer and personal data protection, irrespective of their nationality or place of residence.

eHealth: All tools and services that use information and communication technologies to improve prevention, diagnosis, treatment, monitoring or management of health.

ePrescribing: Computer-based generation, transmission and filing of medical prescriptions.

EU cohesion policy: The policy which aims at strengthening economic and social cohesion within the European Union, reducing the gap in the level of development between the regions of the EU.

EU Cross-Border Healthcare Directive: Directive that aims to ensure safe and high-quality medical care across borders in the EU, and to provide for reimbursement abroad under the same conditions as at home.

European Fund for Strategic Investments (EFSI): EFSI is an initiative launched jointly by the EIB Group – the European Investment Bank and European Investment Fund – and the European Commission to help overcome the current investment gap in the EU. EFSI is one of the three pillars of the Investment Plan for Europe that aims to revive investment in strategic projects around the continent to ensure that money reaches the real economy.

European Core Health Indicators (ECHI): A set of indicators to monitor the health status of EU citizen and the performance of health systems.

European Reference Networks (ERN): Virtual networks involving healthcare providers across Europe. They aim to facilitate discussion on complex or rare diseases and conditions that require highly specialised treatment, and concentrated knowledge and resources.

European Semester: Framework for the coordination of economic policies across the European Union. It allows EU countries to discuss their economic and budget plans and monitor progress at specific times throughout the year.

European Social Fund Plus (ESF+) / Structural Funds: EU funds composed of the European Regional Development Fund (ERDF) and the European Social Fund (ESF). Together with the Cohesion Fund, their activities for the 2007-2013 programming period is worth 308 billion euro (in 2004 prices) to support regional growth and stimulate job creation.

Healthcare related infection: An infection that occurs during the treatment of a patient by a health professional, in ambulatory care, in a social health care institution or in a health institution.

Health Technology Assessment (HTA): A scientific approach to evaluate the effectiveness of health technologies.

Horizon 2020: Financial instrument implementing the Innovation Union, a Europe 2020 flagship initiative aimed at securing Europe's global competitiveness.

Logos: Local health networks (Belgium)

Mixed health insurance model: A health insurance system based on private funding from voluntary insurance schemes or out-of-pocket payments.

Preventable mortality: Death could be avoided through public health and prevention.

Public Health: The science of preventing disease, prolonging life and promoting health through the organized efforts of society.

Social Health Insurance System (or Bismarck model): A health insurance system where healthcare is funded through compulsory social security contributions.

Sustainable development: According to the 1987 "Brundlandt report" for the General Assembly of the United Nations sustainable development is development that meets the needs of the present without compromising the ability of future generations to meet their own needs.

Universal access to healthcare: Availability of health services at the right time, place and price

VRIND (Flemish Regional Indicators): A monitoring instrument of the Flemish government.

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