SURVEY REPORT 2014

Harmonizing Prevention and Other Measures for COPD Patients Across Europe

European Federation of Allergy and Airways Diseases Patients Associations

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- Healthcare systems' organization
- Prevention and early diagnosis
- Pulmonary Rehabilitation
- Smoking cessation programmes

EFA
European Federation of
Allergy and Airways Diseases
Patients Associations

Acknowledgements

EFA is grateful to International Primary Care Respiratory Group (IPRG) members, and in particular to Sian Williams, for their valuable feedback and comments.

Project manager: Daniela Finizio, Scientific Communication srl, Naples, Italy

The questionnaire was designed by Daniela Finizio, the report was compiled by Daniela Finizio and Jean Ann Gilder.

All figures, except otherwise stated, are taken from the Health in Transition Reports of the WHO European Observatory on Health Systems and Policies.

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Foreword by Breda Flood, EFA President

Since the publication of our last book on COPD in 2013, "Minimum Standards of Care for COPD Patients in Europe", we have brought our priorities for COPD to the forefront of the European debate on chronic diseases and healthy ageing. As EFA President, I am satisfied that today there is a common understanding among the medical, scientific and political community that COPD needs more attention and resources.

The reality is that the quality of life of COPD patients is deteriorating. In addition, deaths in Europe will increase due to inaction on COPD care and prevention. In the European Union, COPD costs 142 billion Euro annually. To relieve this burden, we need urgent changes at national level on the three main areas studied in this report: prevention, coordinated care and rehabilitation. We, as patients, are going to do our part.

This survey report is an action tool that will help us achieve those changes. Given the complexity of the European health system, EFA has enquired about the functioning and status of healthcare policies in 19 countries in order to have a clear picture of what are the decision processes at national level and where the three main minimum standards for COPD stand.

COPD is a dormant disease, far too often underdiagnosed. **Early diagnosis remains today the top priority** to improve and save lives from COPD, but the practice of spirometry is not yet compulsory. I was shocked to discover that in many of the surveyed countries spirometer tests to assess if a person has COPD are not easily available even for those at risk, like smokers. National health authorities can dramatically reduce COPD deaths and costs by including spirometry as a compulsory test in regular health check-ups. By determining which healthcare level will be doing the spirometry tests and paying the medical professionals accordingly, European countries can make COPD prevention a reality.

Thanks to EFA's network of expert patients and specialists, this book encourages the establishment of **a multidisciplinary approach** for COPD management. Throughout my mandate as EFA President, I have had the opportunity to witness many inconsistencies on the follow-up and coordination by all the healthcare services involved in COPD care. With this survey, I hope the national leaders will take action to avoid duplication and increase efficiency of COPD management to better empower and guide COPD patients through their care.

Last but not least, this book reflects the continuous differences in COPD **rehabilitation** policies in Europe. The inequalities we mapped greatly concern me because COPD patients may be hindered from living active and meaningful lives due to the policies operating in the countries where they live. Rehabilitation might not be available or accessible for COPD patients that do not work or have limited resources to afford it in a given country, adding to the health inequalities gap already existing within the European Union. Scientists have demonstrated that employed patients experience less COPD symptoms due to their active lives compared to those that do not perform any paid activities. I believe all EU countries should encourage and support COPD patients willing to work and that any smoker willing to quit should have free access to smoking cessation programmes.

I really hope this report will enable COPD patients to get a better grasp of who decides how and what care they receive. What is more, I hope that this survey, together with the "Minimum Standards of Care for COPD Patients in Europe" will encourage healthcare professionals, insurers, and policy makers to take decisions to improve the situation at national level and to harmonise their practice at European level. I warmly thank all the COPD patients, EFA Members, professionals and staff working in European national health systems for their contribution to this survey. By mobilizing patients and partners for healthcare change at national level in several European countries, I am sure we will achieve policy change at European level.

Foreword by Michael Wilken, COPD patient and EFA COPD Working Group Chair

In 2013 EFA published the results of the European survey "EFA Book on Minimum Standards of care for COPD Patients in Europe". The book collected several recommendations aiming at increasing prevention and improving the care COPD patients receive in Europe.

Among the elements highlighted in the book, EFA asked for the reinforcement of COPD prevention through the inclusion of spirometry tests in general health checks, the promotion of (ambulant) rehabilitation programmes and the support of smoking cessation programmes.

Healthcare is a sovereign competency of EU Member States. As Chair of the EFA COPD Working Group, I felt the need to know more about how healthcare fragmentation in Europe was impacting COPD care, so we decided to collect information about healthcare systems. Our aim was to better understand how healthcare is organised in each Member State and especially to map the existing health policies to promote prevention, decide on treatment and authorise support actions such as pulmonary rehabilitation programmes for COPD patients.

This EFA survey confirmed the picture the book on minimum standards of care revealed. The fact is that there is a wide range of healthcare systems in Europe and in order to be able to shape them to better serve patients' needs, we need to know in detail the national procedures for health and the national practices for COPD. As a COPD patient myself, I am certain that only with the information that we have collected, we will be successful to develop national campaigns to advance on COPD care.

This report presents the results of the information EFA was able to collect, from 19 different European countries. All the countries EFA focused on have health policies in place, where virtually the entire population is covered by the national healthcare system. However, the health coverage and treatment that COPD patients receive differs from one country to another. Astonishingly, we found out that in countries like Italy and Finland, COPD has not been yet officially recognised as a chronic disease, a situation that poses real burden for COPD patients that might be paying higher for their care just because of this recognition.

I am happy that we have published this report. The number of different approaches and mechanisms that European countries use to decide on healthcare is remarkable. Some use the regional level to structure healthcare, others decide everything at national level. We still need to analyse to what extent such a variety of decision-making cultures influences equality at EU level and which could be the best recognised approach for COPD care in Europe. At the moment, we just witness that healthcare in Europe is far from uniform, especially if we analyse variables such as COPD severity or prevention, treatment and rehabilitation resources.

I wish to express my gratitude to the members of the International Primary Care Respiratory Group, especially Ms. Sian Williams; the pulmonary experts that agreed to be interviewed; Andrea & Daniele Finizio and Jean Gilder from Scientific Communications srl; and EFA's Project Manager Antje-H Fink-Wagner. Without the engagement and knowledge of these individuals, the present report would have never been published. Thank you all and be assured that EFA and its network of patients' associations will continue working for the effective implementation of these minimum standards at national level.

Rationale

This survey report aims to fill the data gaps EFA encountered in our previous analyses on the situation and coverage of chronic obstructive pulmonary disease (COPD) in Europe.

COPD is a progressive disease that results in changes in different parts of the respiratory system and lungs at the same time. It causes inflammation in the lungs, damages lung tissue and narrows the airways. Breathing becomes progressively worse. COPD affects approximately 4-10% of all adults in European countries.

In 2013, EFA issued a publication identifying eight minimum standards to guarantee quality care for COPD in Europe[1]. Those standards are reflected in Box 1.

To achieve tangible and positive changes towards the realization of those standards, EFA circulated a new survey among COPD patients, healthcare professionals and institutions. This survey served to retrieve information on how European national health systems are addressing the three priority standards identified by COPD patients: (i) prevention, (ii) early diagnosis and (iii) support measures and therapies such as pulmonary rehabilitation.

The results of the survey are the focus of the present report and aim to facilitate the understanding of decision processes at national level as well as to identify the relevant decision makers in the surveyed countries.

We strongly encourage individual patients, EFA Members, healthcare professionals and national policy-makers to use this report as a tool to develop advocacy campaigns at national level, tailored to the reality of each country and healthcare system, to tackle the gaps in prevention and ensure a concrete change on the impact of COPD in Europe.

1. EFA Book On Minimum Standards of Care for COPD Patients in Europe

Box 1. EFA's 8 Minimum Standards of Care for COPD Patients in Europe

	EFA Minimum Standard of Care	Result of implementation
1	Standardise the use of spirometry testing during frequent health checks-ups for current and ex-smokers as well as passive smokers older than 35 years old.	Earlier diagnosis of undiagnosed COPD patients and preservation of the best quality of life possible for COPD patients.
2	Enducate General Practitioners (GPs) to administer spirometry testing to their patients at risk for COPD, train them to interpret the results and reimburse them for the service.	Adequate system for earlier and accurate COPD diagnosis and prevention of existing disease risks built on incentives.
3	Improve means for collaboration between all levels of care and different medical professionals caring for COPD patients.	Improved quality of life for patients, more effective use of time for medical professionals and more efficient use of healthcare system resources by COPD patients, who are better informed on how to cope with their disease independently.
4	Provide access to smoking cessation services and pulmonary rehabilitation to patients who are still smoking regardless of their employment status.	Equal opportunities and access to COPD care services and improved quality of life for COPD patients.
5	Improve the availability and distribution of centers for COPD care and rehabilitation to help empower patients towards self-management.	Increasing services and roles of COPD care centers with consistent follow-ups and assistance for patients.
6	Endorse a multidisciplinary approach towards pulmonary rehabilitation for COPD patients.	Better strategies to address comorbidities and more personalised approaches to increase the likelihood of patients succeeding in improving their quality of life.
7	Embed the involvement of patients in any government measures and activities which could result in changes to COPD patient care.	Patient needs are considered, understood and included ensuring future healthcare system developments provide better care.
8	Make available Alpha-1 Antitrypsin Deficiency (AATD) testing for infants and pregnant women at risk and augmentation therapy (AT).	Disease progression is addressed and pre-emptively on pregnant women with a family history of risk factors and children under 1 are tested.

Executive Summary

Aim

The aim of this survey was to collect information about healthcare policies, particularly policies related to prevention, early diagnosis, support measures and therapies such as pulmonary rehabilitation for COPD patients. The results will help to understand the decision-making processes related to prevention, early diagnosis and rehabilitation, and also to identify the decision makers in the countries surveyed. The ultimate goal is to use this information to tailor advocacy campaigns, at national level, targeted to national decision makers in order to tackle the gaps in prevention and care in each country, and thus bring about a concrete improvement of COPD policies in Europe as well as harmonizing healthcare for COPD patients throughout the continent.

Methods

The data were collected during the summer 2014 via telephone interviews (or via email) with national healthcare professionals who are expert in COPD using a structured questionnaire during the summer 2014 with open reply options (Appendix 1). The questions were aimed at obtaining qualitative data. A selection of possible reply options was provided to assist respondents. Missing or complementary data were obtained from the European Observatory on Health Systems and Policies reports and from other official sources. These sources are indicated at the beginning of the section dedicated to each country. EFA members were invited to add patient focused information.

Results

We collected information on 19 countries: telephone interviews were conducted with experts in most countries, whereas the Czech Republic and Portugal provided written replies. The information is reported per country.

AUSTRIA

Expert contacted: Prof. Sylvia Hartl, Ludwig Boltzmann Institute for COPD and Respiratory Epidemiology, Vienna, Austria
Patient expert: Otto Spranger, Lungenunion
Other source: Austrian Federal Ministry of Health, 2010

Healthcare system organization

The Austrian Federal Ministry of Health prepares laws, is responsible for the protection of public health as well as for overall health policy. It also functions as facilitator between the different players (see Figure) in the healthcare system, and as decision maker and supervisory authority.

Provincial and local authorities are in charge of ensuring hospital care for their inhabitants as well as offering health promotion and prevention services. Local governments are in charge of social welfare benefits and services.

Healthcare coverage is based on mandatory public insurance for the whole population (99% of the population is protected). There are various insurance funds but apart from a few exceptions, it is not possible for an insured person to choose their social security institution. There is no competition between these institutions.

Access to healthcare is free. Take-up of selected healthcare services may be linked to special conditions or prerequisites such as age or type of illness or may also involve co-payments. These may be fixed rates (e.g., a prescription fee for medicines, €5.40 in 2014) or percentages (e.g., a 20% co-payment for persons insured with certain health insurance funds).

The main payer is the Austrian Federal Government. Decisions on what will be covered by public healthcare are taken by the main payer together with the other stakeholders involved (insurance bodies, healthcare professional organizations and patients' organizations).

Prevention and early diagnosis

The national healthcare system foresees free yearly preventive check-ups (since 1974) for the Austrian adult population (18 years and older). The aim of these check-ups is to obtain a detailed case history, detect illness at an early stage, promote a healthy lifestyle and provide individual counselling. However, spirometry is not included in yearly check-ups, not even for the at-risk population (e.g., smokers). Despite requests from pulmonologists and patients organizations, insurance companies are not willing to pay for spirometry as a preventive measure and for early diagnosis of COPD.

Pulmonary Rehabilitation

Pulmonary rehabilitation is currently not included in the therapeutic programme for patients with COPD. Thus, patients generally pay for pulmonary rehabilitation.

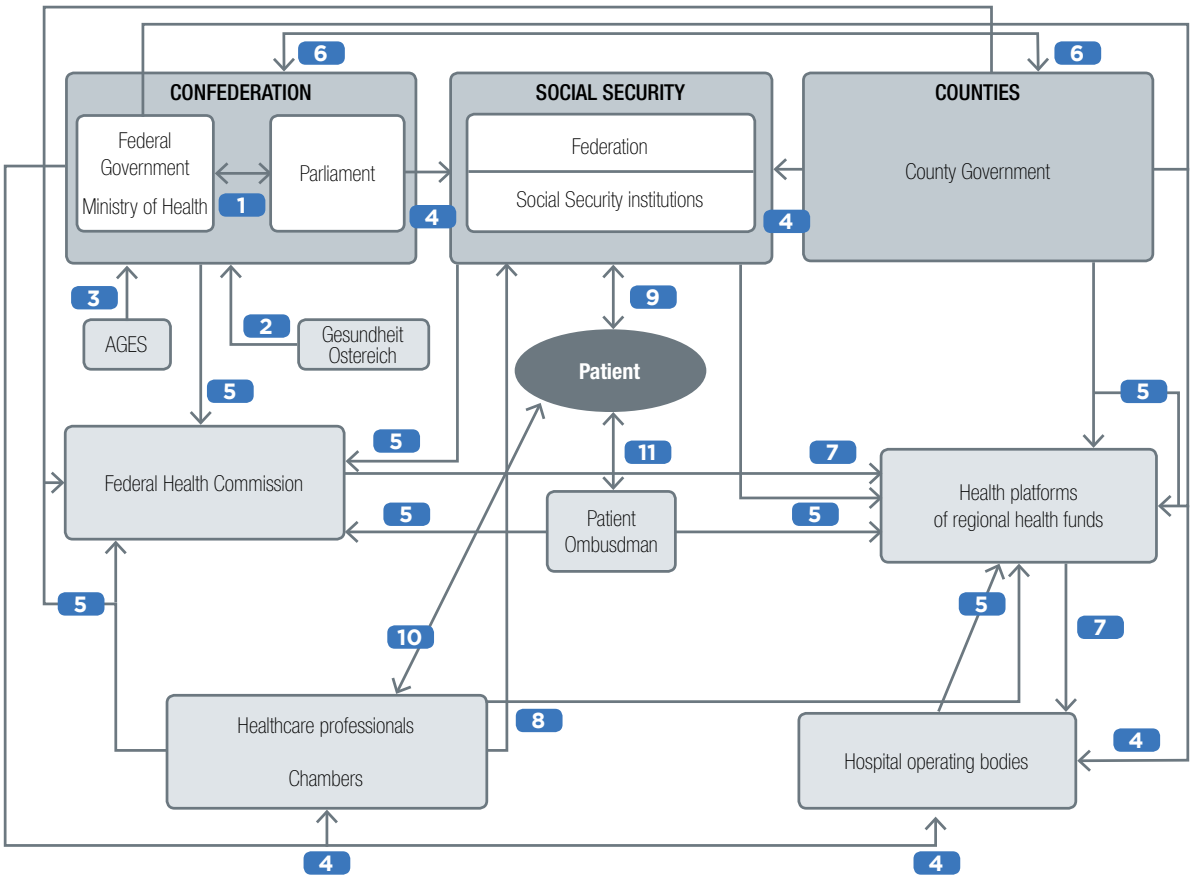
The responsibility for rehabilitation in general lies with regional and local authorities, therefore some differences may occur in the reimbursement policies at regional level. For instance in some regions, only ambulant patients are entitled to free access to rehabilitation. Healthcare professionals are advocating the Federal Government to include pulmonary rehabilitation in the therapeutic programme for patients. The discussion is ongoing and the Ministry is revising the programme.

Smoking cessation

Smoking cessation aid is free for patients with COPD. This includes counselling, and reimbursement of nicotine replacement therapy.

Overview of the Austrian healthcare system (2012)

Source: Ministry of Health



1 (a) Draft legislation by the federal government (minister responsible) to Parliament, or by the County government (minister responsible at County level) to the County Government. (b) Agreement of federal law by Parliament, or County law by the Counties.

2 Support to the Federal Ministry of Health.

3 Support to the Federal Ministry of Health, particularly in the context of licensing medication (AGES = Agency for Food and Health Safety).

4 Health administration:
(a) at federal level (e.g. health-care policing, sanitary supervision of hospitals, monitoring of social security institutions and legal bodies representing interest groups);
(b) at County level (e.g. concerning permits to build and run hospitals, licensing processes for outpatient clinics and group practices, implementation of planning in the region, investment finance).

5 Appointment of members of the Federal Health Commission or regional health platforms.

6 Consultation mechanism between the federal level and local and regional authorities with regard to legislative measures (laws and regulations) which require additional expenditure.

7 (a) Sanction mechanism: the Federal Health Agency (Federal Health Commission) can withhold financial resources from a regional health fund (health platform) if it contravenes compulsory plans and guidelines regarding quality and documentation.
(b) Regional health funds (health platforms) can designate a corresponding sanction mechanism for hospitals.

8 Negotiations on market entry, services and tariff charges (collective and individual contracts).

9 Legal membership of social security institutions (compulsory insurance).

10 (a) Fundamental freedom of choice for patients over hospitals and independently practising members of the health-care professions.
(b) Obligation to treat, which exists for public and private non-profit-making hospitals and contracted independently practising members health-care professionals.

11 Legal representation of patients in every County.

BELGIUM

Expert contacted: Prof. Eric Derom, Ghent University Hospital, Ghent, Belgium
Other sources: European Observatory on Health Systems and Policies, 2010 and Belgian National Institute for disease-handicap insurance (INAMI)

Healthcare system organization

The Belgian healthcare system is mainly organized on two levels:

- Federal government:
  In charge of compulsory healthcare insurance, financing of hospitals and heavy medical care units, registration of pharmaceuticals and their price control etc.

- Federated entities:
  In charge of health promotion, preventive medicine, various aspects of elderly care, and financing of hospitals.

Coverage is universal, via Health Insurance Funds (*Mutualités*). These Funds collectively negotiate prices, fees and reimbursable treatments and medicines. The procedures and medicines covered are negotiated with a National Joint Commission that includes healthcare professionals, hospital managements and the National Government.

Standard procedure is reimbursement *a posteriori*. All insured persons are entitled to reimbursement, but patients may pay a small amount particularly for medicines (approximately 95% of the cost is reimbursed). However, patients are entitled to a refund every year. The amount of the refund is based on the patient's income.

Prevention and early diagnosis of COPD

Periodic check-ups are not foreseen. The General Practitioner (GP) decides if a patient needs a check-up. In some cases screening programmes (e.g., for colon cancer and breast cancer) are implemented for the at-risk population.

Early diagnosis should be improved. Patients at-risk for COPD are generally seen by their GP, who usually fails to recognize stage 2 COPD. Pulmonary specialists see patients only in case of exacerbation, at which time patients may be diagnosed with COPD. After diagnosis, GPs are well trained to manage patients with stage 3-4 COPD.

Pulmonary Rehabilitation

Pulmonary rehabilitation is included in the therapeutic programme for COPD patients in Belgium. There are only three centres specialized in pulmonary rehabilitation. They offer a free full rehabilitation programme (60 sessions for 6 months) to outpatients. These centres are directed by a pulmonologist, and also offer psychological support and other support services, such as access to a dietician, etc.

There are other pulmonary rehabilitation centres, but they are not well-financed, and offer only a 40-session rehabilitation programme. The main issue is that policy makers (the National Government) tend not to recognize the importance of financing a full pulmonary rehabilitation programme.

There is a university course in physiotherapy, which foresees a specialization in internal medicine (i.e., cardio-pulmonary rehabilitation). Each year in Flanders, approximately 20-30 students graduate with a specialization in internal medicine.

Smoking cessation

Smoking cessation programmes (6-7 sessions) are supported by the Government. Nicotine replacement therapy is over-the-counter; it may be reimbursed for specific categories (e.g., pregnant women and patients with vascular diseases).

There is a 7-week university course to train healthcare professionals (nurses, psychologists, MDs, etc) in smoking cessation. At the end of training, they are awarded a diploma in "Tobaccology".

Also insurance companies organize smoking cessation programmes.

BULGARIA

Source: European Observatory on Health Systems and Policies, 2012

Healthcare system organization

The Ministry of Health is responsible for national health policy and the overall organization and functioning of the health system, and coordinates all ministries involved in public health. The Health Insurance Act of 1998 reformed the Bulgarian health system into a mixed health insurance system with compulsory and voluntary health insurance. Healthcare is financed by compulsory health insurance contributions, taxes, out-of-pocket payments, voluntary health insurance premiums, corporate payments, donations, and external funding.

The State owns all university hospitals, national centres and specialized hospitals, as well as 51% of the capital's regional hospitals. Other healthcare centres are privately owned. Access to healthcare in private centres is covered by insurance.

Prevention and early diagnosis

No information about the prevention and early diagnosis of COPD was identified.

Pulmonary Rehabilitation

Pulmonary rehabilitation is not usually covered by health insurance.

Smoking cessation

One of the most important risk factors in Bulgaria for COPD is smoking. The average death rate for smoking-related causes in 2008 was twice as high in Bulgaria compared to the EU-15. The government launched a smoking cessation programme (2007-2010) but it did not foresee smoking cessation services and it was targeted mainly to young people.

The law defines user fees for each outpatient visit, laboratory tests and hospital stays covered by social health insurance. User fees apply to all patients with a few notable exceptions: children, pregnant women, individuals with an income below a certain threshold, chronically sick patients and some other groups. Up to 2011, pensioners paid reduced fees.

Categories of insured individuals and their contributions

Source: WHO

Category of insured individual	Contribution*	Assessment base
Employed individuals	8%, shared between employer and employee in a 60:40 ratio	Size of the remuneration up to BGN 2,000 (€1,026, the maximal insurance income for 2011)
Self-employed individuals, registered farmers and tobacco growers	8% paid by the insured person	Declared income between the minimal (BGN 420, €215 for 2011) and maximal insurance income (BGN 2,000, €1,026 for 2011)
Pensioners	8% paid through the state budget	Size of the pension
Children up to 18 years of age and youths up to 26 years of age if they are full-time students	8% paid through the state budget	Minimal insurance income
Unemployed individual entitled to compensation for unemployment	8% paid through the state budget	Size of the compensation between the minimal and maximal insurance income
Individuals with disabilities entitled to social support	8% paid through the state budget	Minimal insurance income
Veterans; spouses of soldiers participating in international operations and missions; injured while performing their duties as employees of the Ministry of Interior and civil servants; parents, adoptive parents or spouses who take care of disabled people in constant need of help; refugees, detainees and prisoners	8% paid through the state budget	Minimal insurance income
Unemployed individuals who are not entitled to compensation for unemployment or social support	8% paid by the insured person	Chosen income no less than half of the minimal insurance income

* Of the minimun or maximum insurance income.

CROATIA

Source: European Observatory on Health Systems and Policies, 2014

Healthcare system organization

The healthcare system in Croatia is based on a public insurance system. The Croatian Health Insurance Fund (CHIF), established in 1993, is the sole insurer in the mandatory health insurance (MHI) system, which provides universal health insurance coverage to the whole population. As the main purchaser of health services, the CHIF plays a key role in the definition of basic health services covered under statutory insurance, the establishment of performance standards, and price setting for services covered under the MHI scheme.

The Ministry of Health is responsible for health policy, planning and evaluation, and public health programmes, as well as for the regulation of capital investments in healthcare providers in public ownership.

The majority of primary care physicians' practices have been privatized. The counties own secondary healthcare facilities, while the State owns tertiary healthcare facilities. In order to access secondary or tertiary hospital care services contracted for by the CHIF, patients need a referral from their primary care doctor, except for medical emergencies in which case no referral is needed.

Prevention and early diagnosis

No information about the prevention and early diagnosis of COPD was identified.

Pulmonary Rehabilitation

Rehabilitation services in Croatia cover three types of care:

- orthopaedics,
- balneology and
- physical medicine.

Croatia is in the process of updating all specialty training following EU Directive 2005/36/EC. This reorganization will include training in rehabilitation.

Smoking cessation

Since 2009, smoking is allowed in bars.

No information about smoking cessation for COPD patients was identified.

CZECH REPUBLIC

Expert contacted: Prof. Stanislav Kos, GOLD National consultant, Miros, Czech Republic
Other source: European Observatory on Health Systems and Policies, 2009

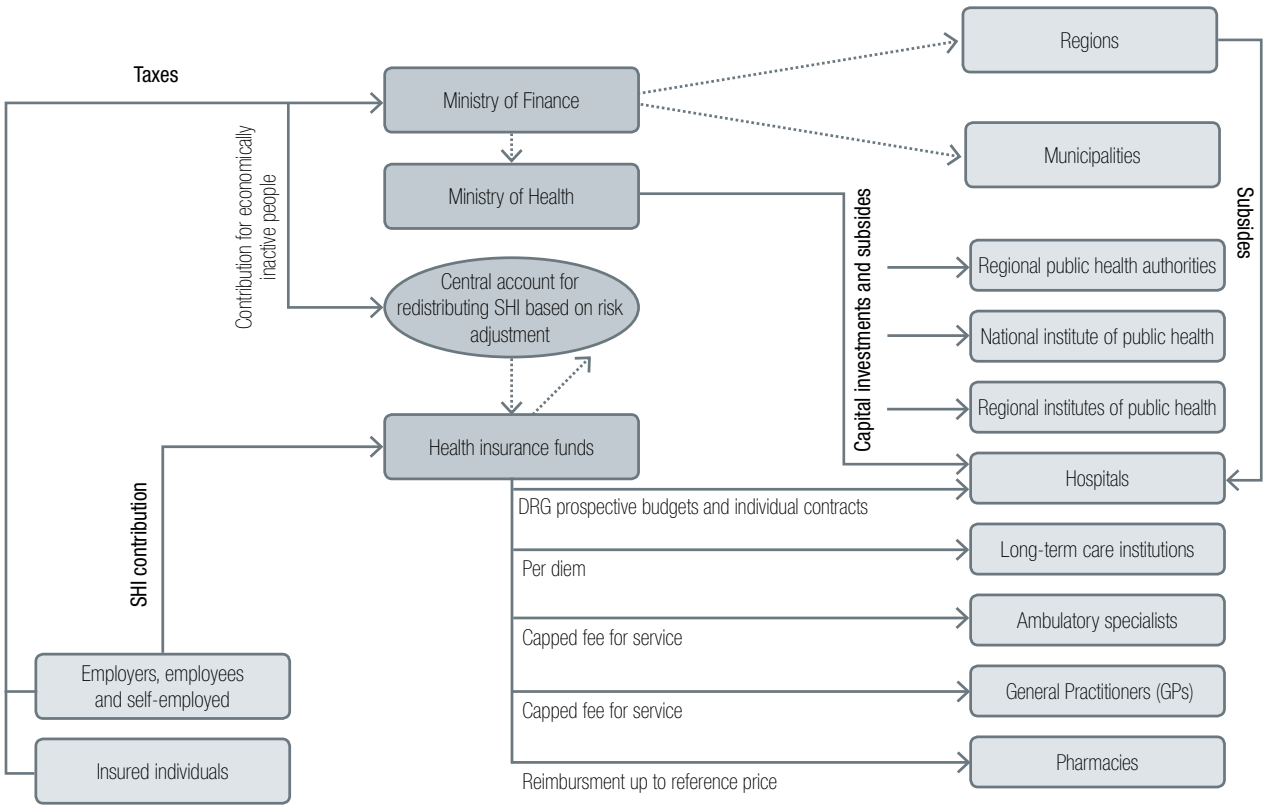
Healthcare system organization

The Czech Republic has a system of social health insurance based on compulsory membership of a health insurance fund. The funds are quasi-public, self-governing bodies that act as payers and purchasers of care.

The Ministry of Health's chief responsibilities include setting the healthcare policy agenda, supervising the health system and preparing health legislation.

The regional authorities and the health insurance funds play an important role in ensuring accessibility to healthcare, the former by registering healthcare providers, the latter by contracting them.

Overview of the financial flows in the Czech Republic health system



Prevention and early diagnosis

The healthcare system foresees periodic check-ups that are covered by public insurance. Spirometry is not included in check-ups. General Practitioners (GPs) generally do not provide spirometry testing.
Prevention policies are set-up by the Ministry of Health.

Pulmonary rehabilitation

Pulmonary rehabilitation is available and reimbursed only for ambulant patients. Moreover, access to rehabilitation may be limited by local availability. Pneumologists decide which patients are entitled to access rehabilitation. Non-ambulant patients must pay for pulmonary rehabilitation. The Ministry of Health is the decision-making authority regarding pulmonary rehabilitation.

DENMARK

Source: European Observatory on Health Systems and Policies, 2012

Healthcare system organization

The health system is fairly decentralized, with responsibility for primary and secondary care located at local level. The State carries out the overall regulatory and supervisory functions as well as fiscal functions, but is also increasingly taking responsibility for more specific planning activities, such as quality monitoring and planning of the distribution of medical specialties at hospital level. The five regions are, among other things, responsible for hospitals as well as for self-employed healthcare professionals. The municipalities are responsible for disease prevention and health promotion.

General Practitioners (GPs) play a key role as the first point of contact for patients and as gatekeepers to hospitals, specialists, physiotherapists and others. GPs derive their income from the regions according to a fee scale that is negotiated by the Organization of General Practitioners (*Praktiserende Lægers Organisation*) and the Danish Regions.

Prevention and early diagnosis

There are clear socioeconomic and geographical inequalities in the use of preventive services, but there are also differences in the use of some curative services because of co-payments and the geographical distribution of practicing specialists.

A national educational programme, Healthy Throughout Life (2002-2010), was targeted to patients with chronic diseases (including COPD). The programme focused on reducing major preventable diseases and disorders. It included counselling, support, rehabilitation and other patient-oriented measures.

The COPD standard in Denmark (*Resumé Af Anbefalinger For KOL. Sundhedsstyrelsen 2007*) recommends that people older than 35 years of age, receive spirometry tests if they are smokers or ex-smokers and have pulmonary symptoms. Patients older than 35 years of age in a risk-environment with pulmonary symptoms are also recommended spirometry.

Pulmonary rehabilitation

If rehabilitation in general or home care is prescribed by the General Practitioner (GP) or the hospital, it will be provided free of charge by the municipality. Rehabilitation in general is partly provided by public hospitals, which are the responsibility of the regions. Municipalities have the responsibility of providing training and rehabilitation that are not offered in connection with hospital treatment. Further coordination between the two actors is needed.

The regions and municipalities are developing specific programmes for COPD.

No specific data on COPD pulmonary rehabilitation identified.

Smoking cessation

Most community pharmacists provide smoking cessation counselling. Smoking cessation counselling is free for selected groups. Starting in 2009, pharmacies have agreements with municipalities concerning quit-smoking counselling.

FINLAND

Expert contacted: Dr. Tuula Vasankari, Secretary General, Finnish Lung Health Association (FILHA)
Other source: European Observatory on Health Systems and Policies, 2008

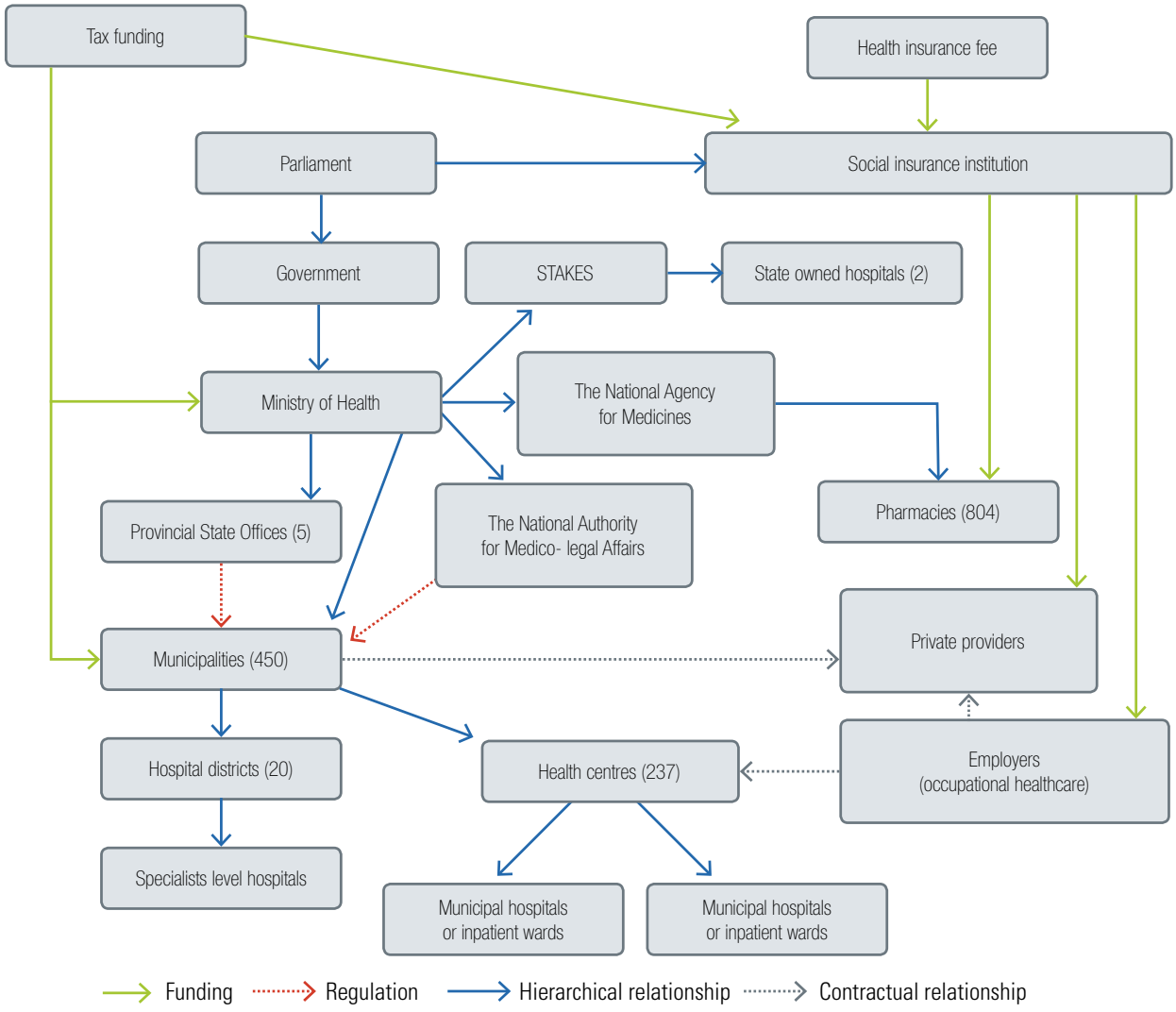
Healthcare system organization

The Finnish healthcare system is decentralized. Sixty-one per cent of funding comes from municipality taxation, and the remaining amount from National Health Insurance (Overview below).

In practice, three healthcare systems receive public funding: municipal healthcare, private healthcare and occupational healthcare. There are significant differences between the systems, for example, in the scope of the services provided, user fees and waiting times.

Patients pay small fees to access healthcare services (approximately €20-30 for specialized visits, and €15 for the first three visits at the General Practitioner's (GPs) office ; subsequent visits are free). No specific reimbursement scheme is available for patients with COPD.

Organizational overview of the Finnish healthcare system



STAKE: National Research and Development Centre for Welfare and Health

Prevention and early diagnosis

Health promotion, including the prevention of diseases, has been the main focus of Finnish healthcare policy for decades. Check-ups are available for workers. In the case of workers at occupational risk of respiratory diseases, spirometry is included in the check-ups.

Most General Practitioners (GPs) have a spirometer in their office, but it is not used systematically. The Finnish Lung Health Association is campaigning to introduce micro-spirometers in all GP offices with the aim of increasing its use.

Pulmonary rehabilitation

Health centres and hospital districts provide medical rehabilitation in the form of counselling, tests to establish the individual's need for rehabilitation, treatment and course of rehabilitation to improve functional and working capacity, the provision of various technical aids, adaptation training and rehabilitation guidance.

National Clinical Practice Guidelines recommend pulmonary rehabilitation for the treatment of COPD. Unfortunately, patients are not systematically offered pulmonary rehabilitation. The main barrier is that it is not available in public healthcare, except in some specialized centres (inpatients). Inpatient rehabilitation is covered by social insurance, whereas outpatient rehabilitation is organized by the municipalities, and it may or may not be free.

Smoking cessation

Smoking cessation counselling is available for patients with COPD. Usually group counselling is offered to all newly diagnosed patients in order to help them improve their lifestyle. Nicotine replacement therapy is sold over-the-counter and is paid for by the patients. Other drugs may be partly reimbursed.

FRANCE

Expert contacted: Prof. Nicolas Roche, Department of Pulmonology and Intensive Care, Hôpital de l'Hôtel Dieu, Paris, France
Other source: European Observatory on Health Systems and Policies, 2010

Healthcare system organization

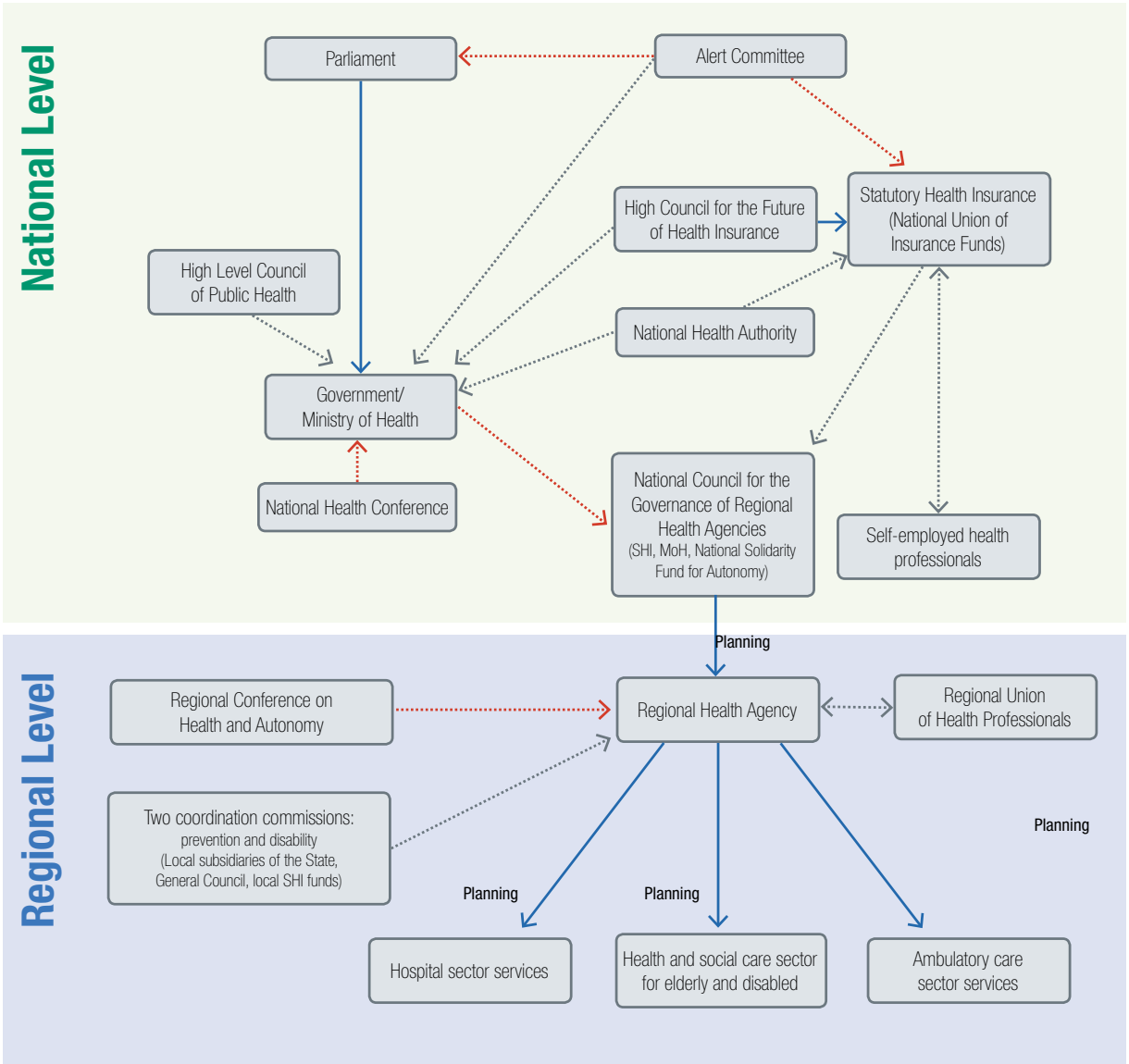
The French healthcare system can be described as a mixed model.

Jurisdiction in terms of health policy and regulation of the healthcare system is divided among:

- the state: parliament, the government and various ministries;
- State health insurance;
- to a lesser extent, local communities, particularly at regional level.

Seventy-five per cent of healthcare costs are covered by the National Health System (NHS) and may be topped up to 100% by health insurance. Chronically ill patients are entitled to 100% (NHS) reimbursement. Payment is usually *a posteriori* to healthcare providers, including pharmacists, so patients do not have to pay in advance. But some insurance bodies apply a reimbursement system.

Organization of the health system in France (2010)



Prevention and early diagnosis

The working population is entitled to yearly check-ups at specialized prevention centres. The cost for check-ups is covered by the NHS. But most people prefer to be examined by their General Practitioners (GPs).

Theoretically, spirometry would be part of the standard check-up in the above-mentioned prevention centres. However, in most cases it is performed only in the at-risk population (the elderly and heavy smokers).

Technicians and nurses working in the centres are not trained to perform spirometry correctly, nor to satisfactorily interpret the results. Furthermore, 95% of GPs do not perform spirometry.

Some private insurance companies are planning to organize periodic check-ups for their clients.

Pulmonary rehabilitation

Rehabilitation is free for chronic patients. Nevertheless, only a small percentage of patients actually access a rehabilitation programme (the percentage improves for patients managed in specialized centres). The low enrolment of patients in rehabilitation programmes is mainly due to two reasons:

- COPD patients are managed by GPs who may not be aware of rehabilitation, or are not aware of where and how a patient can enter such programmes, and
- patients themselves decide not to enrol in a rehabilitation programme since the rehab centres may be very far from their homes and difficult to reach.

Smoking cessation

COPD patients are entitled to free smoking cessation counselling. However, nicotine replacement therapy is reimbursed only up to €50 per year. Notably, some insurance companies are considering changing their policy to full reimbursement of nicotine replacement therapy.

GERMANY

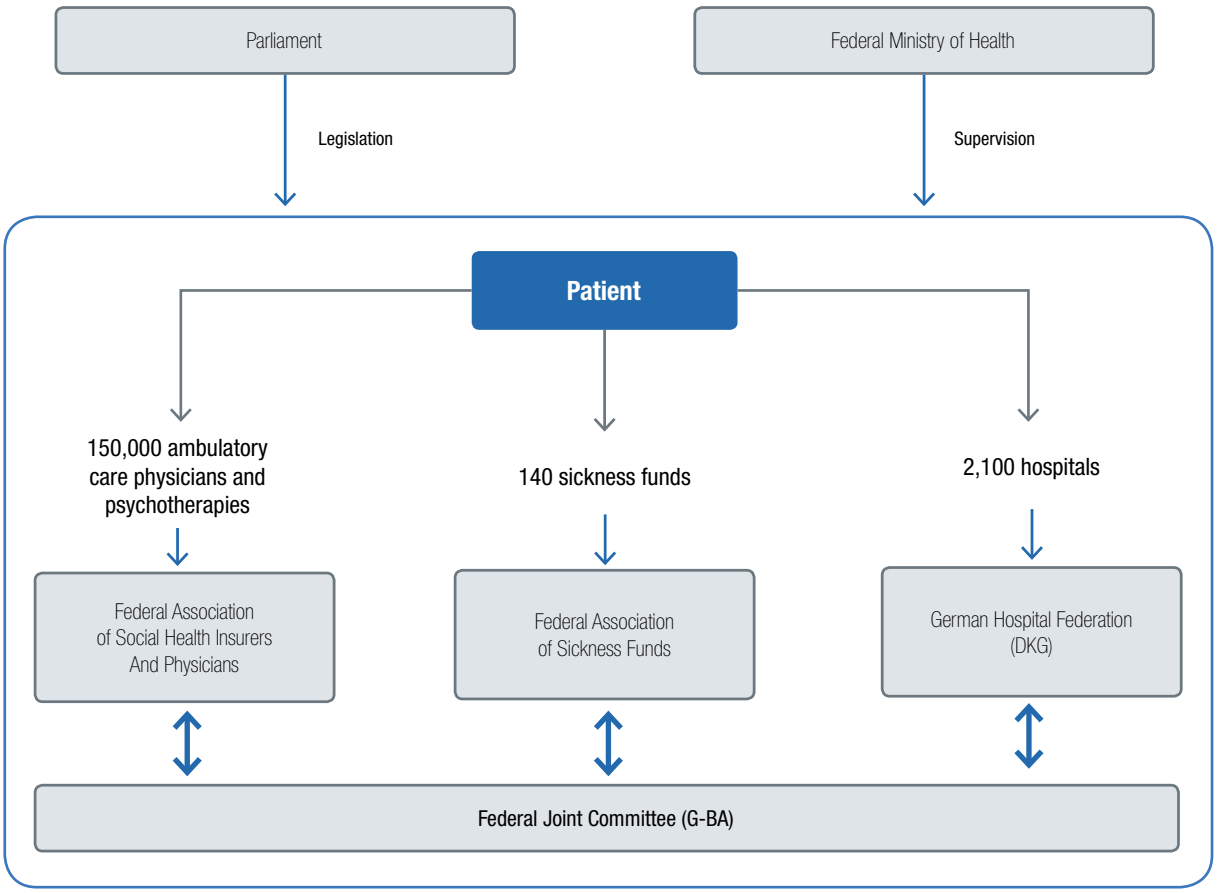
Experts contacted: Prof. Tobias Welte, Hannover Medical School (MHH), Hannover, Germany and Dr. Frank Kanniess, Practicioner and IPCRG representative, Schleswig-Holstein, Germany
Patient Expert: Michael Wilken, Patientenliga, Hanover, Germany
Other source: European Observatory on Health Systems and Policies, 2013

Healthcare system organization

The healthcare system in Germany is based on mandatory insurance. People can choose between public or private insurance funds (there are 131 sickness funds and 46 private insurers). Currently, 86% of the population is covered by public insurance and 10% by private insurance.

The National Government makes decisions regarding laws, whereas decisions regarding reimbursements and access to healthcare services are made by the Federal Joint Committee, which is constituted by 13 voting members: 3 neutral members, 5 representatives of health funds and 5 healthcare providers, plus up to 5 representatives of patients (Chart below).

Decision-making system in the German healthcare system



Prevention and early diagnosis

The German system foresees periodical check-ups (every two years), but the type of check-up is subject to negotiation with the Federal Joint Committee. For instance, colon and breast cancer screening is foreseen. Some insurance companies offer yearly check-ups.

COPD could be diagnosed by General Practitioners (GPs), since approximately 70% of practices are equipped with a spirometer. However, GPs are not well trained in its use or in the interpretation of results. For instance, in 2014 in the state of Schleswig-Holstein spirometries were performed on 100 patients. The average patients per practice being 845. Reimbursement to physicians for spirometry by insurance funds is around € 6.

Pulmonary rehabilitation

Pulmonary rehabilitation is foreseen as part of the rehabilitation programme for COPD patients. However reimbursement of pulmonary rehabilitation is subject to approval by the insurance fund. Moreover, very few rehabilitation centres focus on pulmonary rehabilitation. Consequently, it is not easy for a patient to access qualified pulmonary rehabilitation. The German Respiratory Society organizes rehabilitation programmes for outpatients but only in cities not in rural areas.

Smoking cessation

Smoking cessation will be eventually included in the national Disease Management Programme for COPD. But there is a discussion ongoing about whether patients should pay for smoking cessation programmes. Currently this cost is covered only in some hospitals.

IRELAND

Expert contacted: Prof. Tim McDonnell, Consultant Respiratory Physician, St. Vincent's University Hospital, Dublin and St. Michael's Hospital, Dun Laoghaire, Co. Dublin, Ireland
Patient expert: Breda Flood, President at European Federation of Allergy & Airways Diseases Patients' Associations (EFA)
Other source: European Observatory on Health Systems and Policies, 2009

Healthcare system organization

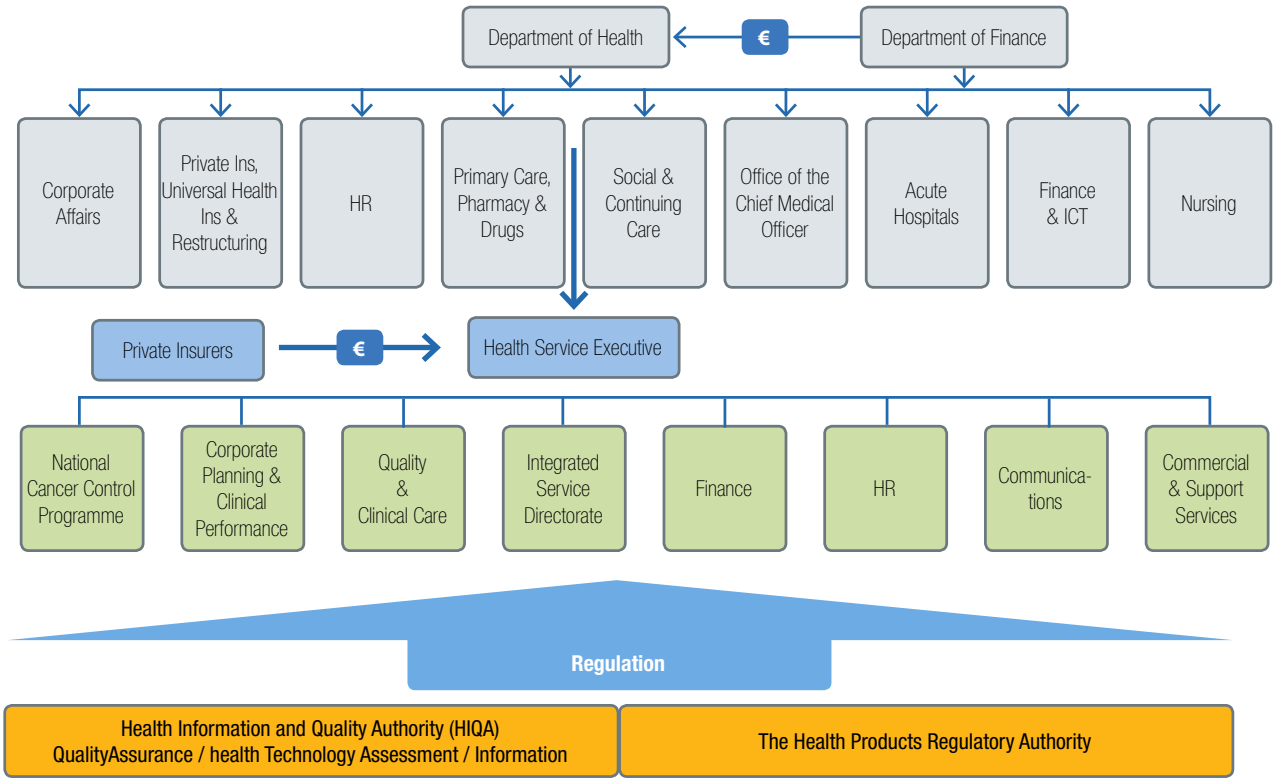
The Irish healthcare system has undergone many reorganizations in recent decades. Currently, the system consists of mixed public and private insurance (each covering around 50% of the population). General Practitioner (GP) visits are free to those awarded a Medical Card (approximately 39%) or GP visit card (approximately 2%), but there is a €1 prescription fee. Medical cards and GP visit cards are currently awarded on the basis of medical and financial need. In the case of other services, patients pay approximately 35% of the cost depending on income. The Central government makes the decisions concerning healthcare policies. Insurance companies are the payers in almost 50% of cases.

A scheme called the 'Long Term Illness Scheme' allows for free drugs for certain chronic illnesses. Unfortunately, COPD and asthma are not included in this scheme and thus patients are not entitled to free medication.

There are inequalities in the quality of care based on geographical area. For instance,certain drugs are only available in some regions, oxygen supply may be subject to restriction, and strollers may not be provided in some areas.

Irish healthcare system organization

(Source: Asthma Society of Ireland)



Prevention and early diagnosis

In general, check-ups should be part of the contract with the primary care physicians. This is subject to negotiation with payers. Currently, there is no screening for lung diseases. Only 50% of General Practitioners (GPs) have a spirometer, and only 15% of them are able to perform spirometry effectively. The main barriers to the use of spirometry in general practice are:

- the time required and money, in terms of reward and available staff resources; and
- a lack of appropriate training. Cuts in budget are also a barrier to improve prevention. There are no structured programmes in primary care for asthma or COPD.

Pulmonary rehabilitation

Budget cuts are the main barrier to the implementation of the recommendation that pulmonary rehabilitation should be included in the therapeutic programme for patients with COPD. Financial restrictions force decision-makers to establish priorities, and, unfortunately, the importance of pulmonary rehabilitation is largely neglected. Hospitals and day-care centres have difficulty in replacing physiotherapists when they retire. Thus, the service is not offered to patients, except in some hospitals where it is free of charge. There are no private pulmonary rehabilitation centres, and, in any event, insurance companies would not pay for it.

Smoking cessation

Like rehabilitation, also smoking cessation services exist and are free for patients. Due to cuts in expenditure, these services are being closed. Hence, it is difficult for patients to access smoking cessation services, or to enter a complete smoking cessation programme (for instance, a centre may have a doctor to prescribe medications, but not a psychologist for counselling).

ITALY

Sources: European Observatory on Health Systems and Policies, 2009, and the Global Alliance against Chronic Respiratory Diseases (GARD) Italy Report, 2011

Healthcare system organization

The Italian healthcare system is organized in three levels:

- At national level, the Ministry of Health and the National Government are responsible for ensuring the general objectives and fundamental principles of the national healthcare system *(Livelli essenziali di assistenza-LEA)*;
- the regional governments, through the regional health departments, are responsible for ensuring the delivery of a benefit package; and
- at local level, healthcare is dispensed by the *Aziende Sanitarie Locali (ASLs)* that coordinate the public healthcare providers (hospitals, outpatients and General Practitioners (GPs) in a certain area that is established by the Region.

The Regions decide how to spend their budget and establish healthcare priorities provided that the LEA are guaranteed. Moreover, each Region establishes the fees that people must pay to access some services.

Chronically ill patients are exempt from paying for visits and medicines. Respiratory insufficiency is included in the list of chronic diseases compiled by the Ministry of Health (code 024), hence COPD patients are entitled to some exemptions under this code, i.e., they have free access to some therapies. COPD patients' associations and pneumologists are advocating to have COPD recognized as a chronic disease.

Prevention and early diagnosis

Prevention policies are established by each Region. Consequently, there is a great variability in prevention policies, including screening and periodic check-ups. Most Regions have screening for patients at-risk of breast cancer and cervix cancer. A few Regions (e.g., Tuscany) are aware of the need for an early diagnosis of COPD, and promote spirometry campaigns. But these programmes vary from year to year (based on the budget).

Visits to the GP are free, but GPs do not offer spirometry testing to at-risk patients (they are not encouraged to do so by the payers). GPs refer patients to a pulmonary specialist for a diagnosis of COPD.

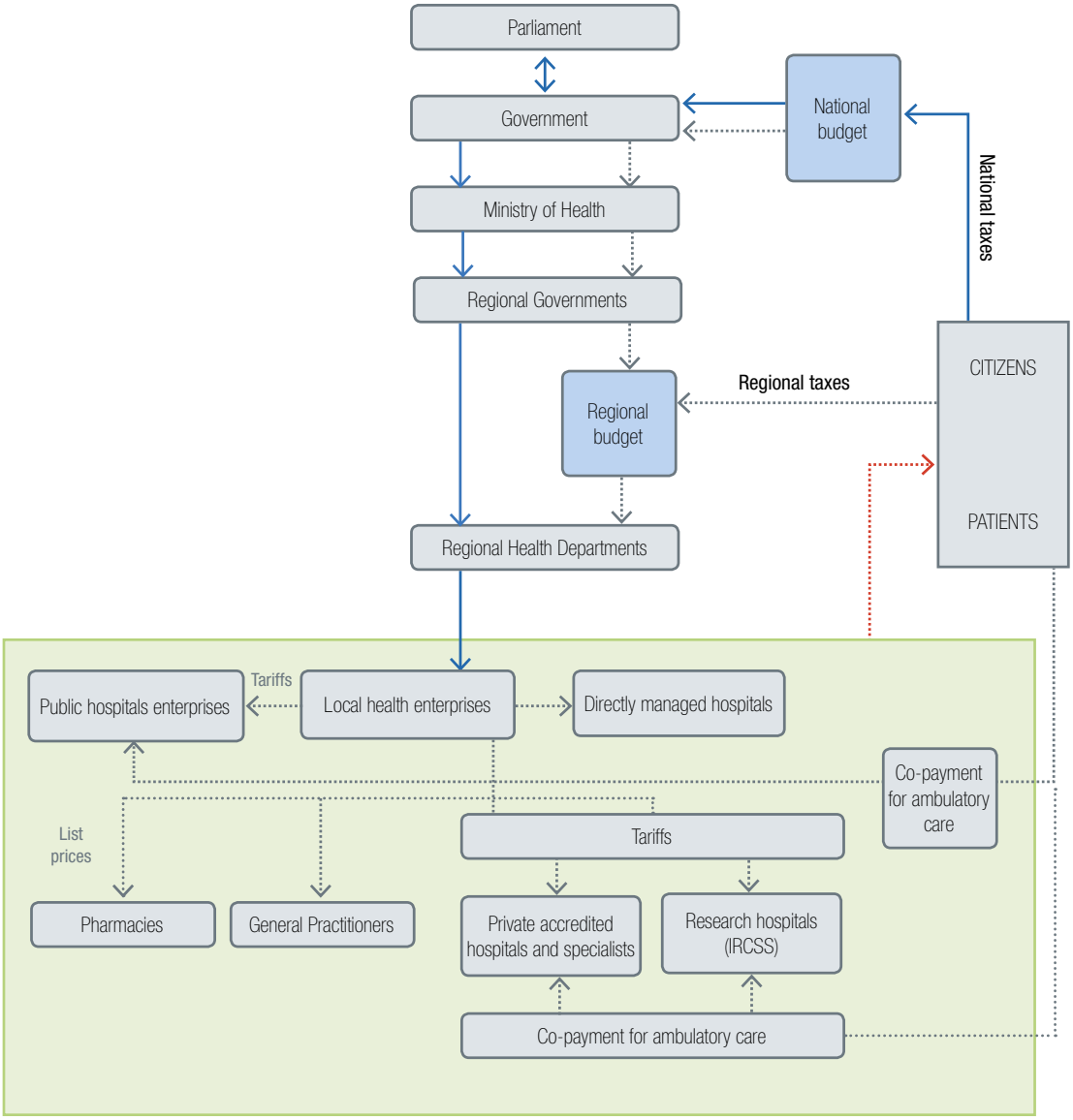
Pulmonary rehabilitation

Pulmonary rehabilitation is recognized by GARD Italy as part of the therapeutic programme for COPD patients, also those at an early stage. The organization of rehabilitation in general varies among Regions particularly in terms of the duration of outpatient rehabilitation, and the availability of rehabilitation centres for acutely ill patients in hospital. Due to budget restrictions, the tendency is to reduce the duration of rehabilitation, and to concentrate rehabilitation units in large hospitals. Nevertheless, some Regions (e.g., Basilicata and Friuli Venezia Giulia) are implementing rehabilitation programmes for COPD patients.

Smoking cessation

In Italy, access to smoking cessation is free for all patients, and counselling centres are available in all major hospitals and ASLs. Nicotine replacement therapy is available, but it is mainly sold over-the-counter.

Italian healthcare system organization



NORWAY

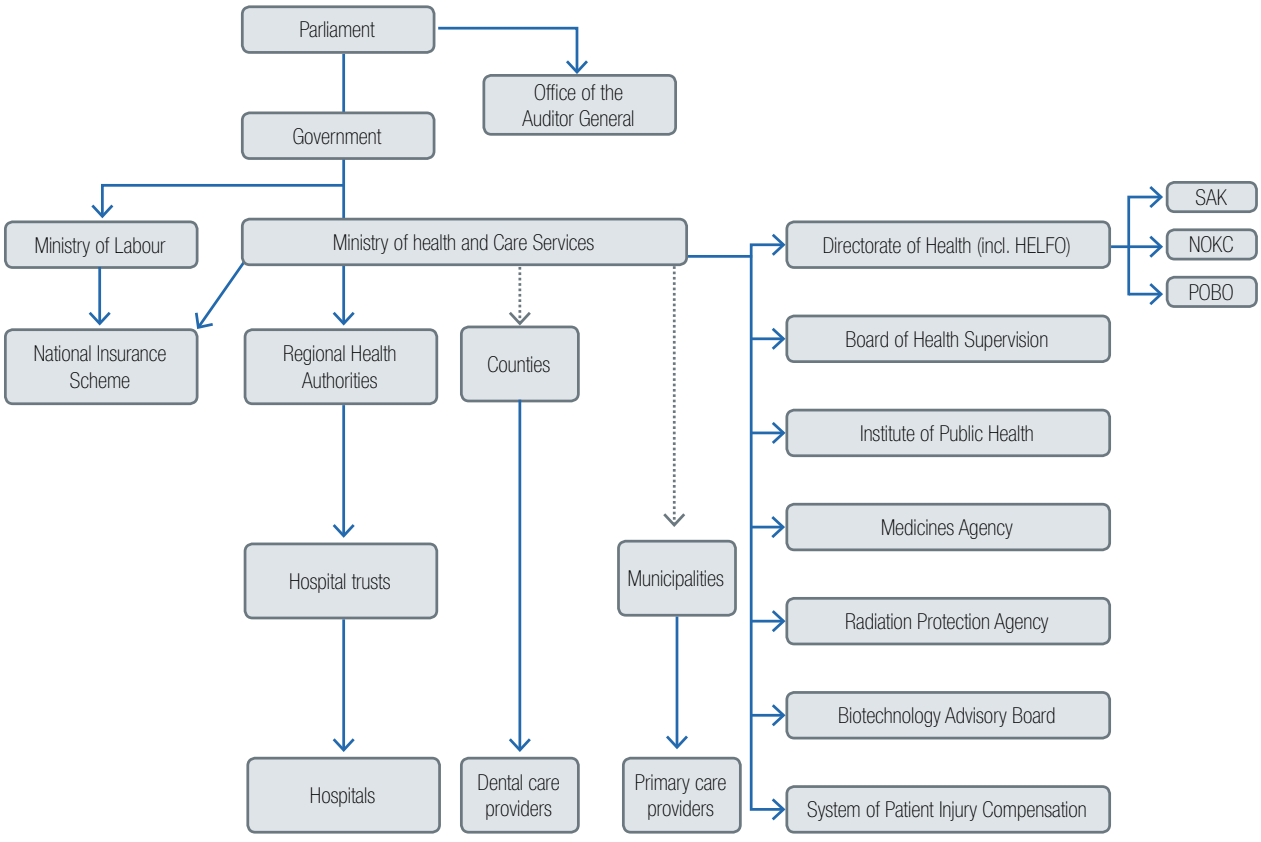
Expert contacted: Anders Østrem, IPCRG, Practitioner at Gransdalen Legesenter, Oslo, Norway
Source: European Observatory on Health Systems and Policies, 2013

Healthcare system organization

The Norwegian healthcare system can be characterized as "semi-decentralized". Since 2002, the State has been responsible for specialist care, administered by four Regional Health Authorities. Municipalities are responsible for primary care and enjoy a great deal of freedom in organizing health services (although counties provide dental care). The Ministry of Health is in charge of regulation and supervision of the system, but many of these tasks are delegated to various subordinate agencies, such as the Directorate of Health and the Norwegian Medicines Agency. Various types of health data are collected in compulsory national registers (15 in 2012), such as national registers on cancer and cardiovascular disease, as well as around 200 other medical registries. The overall supervision and monitoring of health services is provided by the National Board of Health Supervision.

The organizational structure of the Norwegian healthcare system is built on the principle of equal access to services for all inhabitants, regardless of their social or economic status and geographical location.

Overview of the Norwegian health system (2013)



Early diagnosis and prevention

Almost 99% of General Practitioner (GP) practices have a spirometer. It is used to some extent but knowledge regarding interpretation and appropriate use is lacking. In a study conducted in an area of Northern Norway, S. Johansen (*Primary Care Respiratory Journal*, 2007;16:112-114) found that there was a low access to spirometry in GP practices. Spirometry is reimbursed and GPs get € 25,- which is a good sum compared to other procedures.

Pulmonary rehabilitation

No information specifically related to pulmonary rehabilitation was identified.

In general, provision of rehabilitation care has a long tradition in Norway and the approach to rehabilitation has evolved over time from a narrow (medical) focus on restoring lost functions to a more comprehensive approach incorporating non-medical (e.g., social and economic) factors, and involving comprehensive cooperation between several sectors and areas of care. Rehabilitation is defined by the Ministry of Health as "planned processes with explicit ends and means, where several providers cooperate within a limited amount of time". Rehabilitation is provided at both the primary (physiotherapy, occupational therapy, etc.) and secondary (specialized rehabilitation) levels. Municipalities as well as the Regional Health Authorities are responsible for the coordination of rehabilitation services.

There are only three specialized hospitals with rehabilitation programmes of excellence for COPD patients, but the waiting lists are up to one year. Pulmonary rehabilitation is not offered in primary care, but some outpatient departments in hospitals have such programmes, but due to budget cuts since three years, the offer is rapidly declining.

Smoking cessation

Hospitals receive extra payment from the national health system for smoking cessation, and other secondary prevention services (but mainly for follow-up of cardiovascular patients). However, hospitals are few and are concentrated in urban areas.

In primary care, physicians can get reimbursed for a "structured programme" for smoking cessation but few in primary care (less than 15%) offer patients this.

Smoking cessation medications are not reimbursed.

POLAND

Expert contacted: Prof. Grazyna Bochenek, Jagiellonian University School of Medicine, Krakow, Poland
Other source: European Observatory on Health Systems and Policies, 2011

Healthcare system organization

The healthcare system in Poland is based on a mixed public and private insurance system. Approximately 98% of the population is covered by the system of compulsory health insurance, including family members of persons paying insurance contributions and some vulnerable groups whose contributions are financed by the State budget.

The Ministry of Health, together with the National Health Fund (NZF), is responsible for the management and financing of the healthcare system, including contracting health services with public and non-public service providers. Local authorities (territorial health authorities) are responsible for the identification of the health needs of their respective populations, for planning the delivery of health services, health promotion and the management of public health care institutions.

Prevention and early diagnosis

Spirometry is not part of regular check-ups, even for the at-risk population. Spirometry is performed by pneumologists. Prevention should be established by local governments, but they fail to organize them in a systematic and effective way.

The National Strategic Healthcare Programme (2007-2015) includes the reduction of morbidity and mortality due to chronic respiratory disease among its objectives.

Pulmonary rehabilitation

Pulmonary rehabilitation is not paid for by the NZF. Patients can access pulmonary rehabilitation only in specialized centres. This is a major issue for COPD patients in Poland. The NZF is responsible for contracting rehabilitation services. But it is not clear who is in charge of establishing the policies.

Smoking cessation

Smoking cessation services are available and free for patients. They are organized by local authorities. Reducing tobacco smoking is a target of the 2007-2015 National Strategic Healthcare Programme.

PORTUGAL

Experts contacted: Prof. Jaime Correia de Sousa, President Elect IPCRG
Patient experts: Isabel Saraiva and Luisa Soares Branco, RESPIRA Portuguese Association of COPD and Other Chronic Respiratory Diseases
Other source: European Observatory on Health Systems and Policies, 2011

Healthcare system organization

The Portuguese National Health Service is public and free for some categories depending on income, disability, age or disease. It is characterized by three overlapping systems: the universal national health system; special public and private insurance schemes for certain professions ("health subsystems"), covering about a quarter of the population; and private voluntary health insurance, with estimates of coverage ranging from 10% to 20% of the population.

Planning and regulation take place largely at central level in the Ministry of Health and its subsections (see Figure). The regional authorities are responsible for the organization and management of healthcare services in their area, as well as for contracting these services.

A National Program for Respiratory Diseases (2012-2016) has been established. The main objectives are: prevention; access to early diagnostics (spirometry); therapeutic guidelines; and reduction of the hospitalization rate by 10%, and the morbidity and mortality rate by 2%.

Prevention and early diagnosis

There is no structured prevention system for COPD. The planning of prevention policies is the responsibility of the Directorate-General of Health that is also responsible for public health programmes. Since the COPD guidelines were approved in 2012, there has been an increasing awareness of the need for an early diagnosis and family physicians and pulmonologists have been cooperating to improve diagnosis by targeting smokers over 40 years of age. A lot of educational sessions have been organised to provide primary care professionals with up-to-date guidelines for the diagnosis and treatment of COPD.

Pulmonary rehabilitation

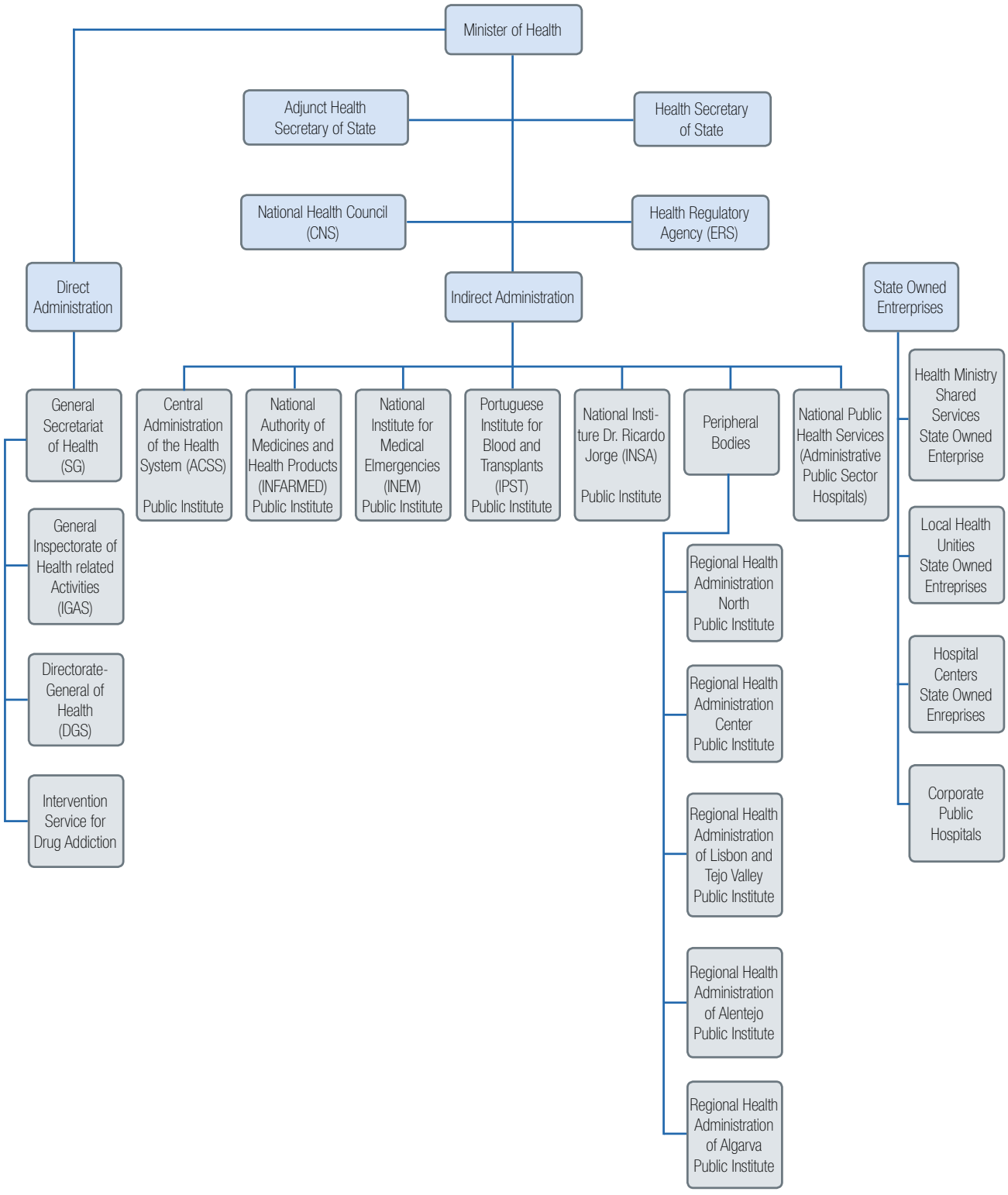
Pulmonary rehabilitation is mostly free under the national healthcare system (sometimes co-payment is required); different policies apply to patients under other funds. There are very few centres for pulmonary rehabilitation (approximately 12 within the national healthcare system). In addition, many private clinics deliver pulmonary rehabilitation services under contract with the national healthcare system.

Smoking cessation

Many health centres provide smoking cession counselling free-of-charge. Several hospitals also have smoking cessation clinics. Also many family physicians provide individual smoking cessation advice and medication.

Ministry of Health organization and subsections

(Source: Portuguese Ministry of Health, 2001)



SERBIA

Expert contacted: Prof. Branislava Milenkovic, Clinic for Pulmonary Diseases, Belgrade
Source: Healthcare System and Spending in Serbia From 2004-2008. Gajić-Stevanović M. et al.

Healthcare system organization

Serbia has a compulsory health insurance system (the Republic Health Insurance Fund). Access to healthcare is in principle free. However, because of the financial crisis and rising unemployment, people tend to stop paying their insurance, thereby reducing resources and causing problems in the delivery of healthcare. The final decision maker for healthcare policies is the Ministry of Health.

Prevention and early diagnosis

Periodic check-ups are foreseen only for certain categories (e.g., people at occupational risk). A lung function test is not usually included in check-ups.

Funds for the prevention of illnesses, special programmes and health protection measures for the whole population come from the Republican budget.

Pulmonary rehabilitation

Pulmonary rehabilitation is free for all patients with COPD. General Practitioners (GPs) are not aware of the importance of pulmonary rehabilitation and do not know how and where it can be accessed. Therefore, only patients managed by pulmonologists receive advice on rehabilitation.

Smoking cessation

Smoking cessation services, available in major cities, are free for COPD patients.

SPAIN

Source: European Observatory on Health Systems and Policies, 2010

Healthcare system organization

The statutory Spanish National Health System (SNS) is universal coverage-wise, and is almost fully funded from taxes and is predominantly within the public sector. Provision is free of charge at the point of delivery, except for pharmaceuticals prescribed for people under the age of 65 years, which entail co-payment of 40% of the retail price. Since 2002, all health competences are devolved to regional level. There are 17 regional ministries or departments of health. The national Ministry of Health and Social Policy has authority over legislation on pharmaceuticals and is the guarantor of the equitable functioning of health services across the country.

In general, primary health services (including family care, health promotion, prevention and rehabilitation) and specialized services (linked to hospitals) have two distinct managerial structures.

Under the umbrella of the National Government and with the approval of the Regions, national health strategies have been established. These are aimed at improving care for patients with diseases associated with a high social burden. The Interterritorial Council of the Spanish National Health Service has approved nine national strategies, and these are already in place (i.e., cancer, ischaemic diseases, diabetes, rare diseases, COPD, stroke, and specific services such as palliative care and mental health).

Distribution of competences in the SNS

State health administration (central government)	Basic legislation and general coordination of the SNS International health issues Pharmaceutical policy Management of INGESA*
17 regional health administrations (ACs)	Regional health legislation CINIS Health insurance Health services planning Health services management and provision Public health
Local authorities (provinces and municipalities)	Sanitation Collaboration in health services provision and direct management of "residual" public health and community services

*The body in charge of health care for the two autonomous cities in the north of Africa, Ceuta and Melilla.

Prevention and early diagnosis

No information specifically related to the prevention and early diagnosis of COPD was identified.

Pulmonary rehabilitation

Pulmonary rehabilitation services are delivered consequent to a doctor's prescription, either under an ambulatory regime or at home depending on the patient's physical limitations or access difficulties. They are provided by physiotherapists appointed to the primary healthcare team. Often all rehabilitation services are concentrated in a centre and accessible to patients from all primary healthcare teams in the health area. Rehabilitation services include respiratory physiotherapy.

Smoking cessation

In 2006, smoking counselling was included in the common health benefits basket.

SWEDEN

Source: European Observatory on Health Systems and Policies, 2012

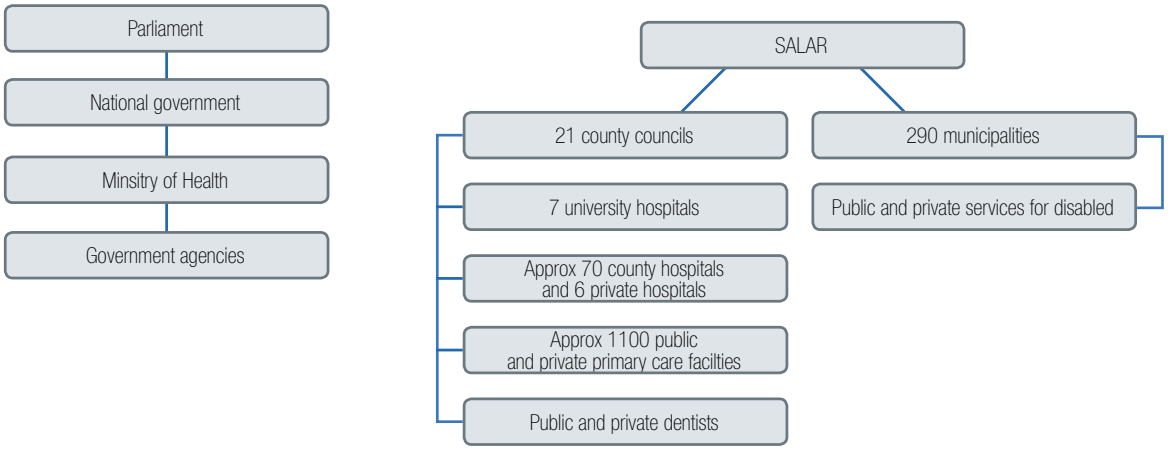
Healthcare system organization

The Swedish healthcare system is organized in three levels: national, regional and local. The State, through the Ministry of Health and Social Affairs (*Socialdepartementet*), is responsible for overall healthcare policies. The 17 county councils and four regional bodies are responsible for the funding and provision of healthcare services for their populations. Municipalities provide care and housing for older residents or people with disabilities.

Highly specialized care, requiring the most advanced technical equipment is concentrated in the seven regional/university hospitals. Counties are grouped into six medical care regions to facilitate cooperation regarding tertiary medical care. The Swedish Association of Local Authorities and Regions (*Sveriges Kommuner och Landsting,* or SALAR) is the decision-making body (Overview below).

The National Board of Health and Welfare is commissioned by the government to provide evidence-based guidelines for the care and treatment of patients affected by a serious chronic illness.

Overview of the healthcare system in Sweden



Prevention and early diagnosis

The importance of prevention in terms of supporting lifestyle changes (smoking, alcohol use, dietary habits and physical activity) across the population has emerged over the last decade. Efforts have been made at both national and regional levels to increase awareness across healthcare staff as to the importance of identifying patients belonging to certain risk groups and facilitating lifestyle changes. It is not clear if COPD is included in such prevention programmes.

Pulmonary rehabilitation

No information data specifically related to pulmonary rehabilitation was identified.

The municipalities are responsible for outpatient rehabilitation, whereas the counties are responsible for acute inpatient rehabilitation. The division of responsibilities between, on the one hand, medical treatment by the county councils and, on the other hand, nursing and rehabilitation by the municipalities, requires coordination of services.

Smoking cessation

No information related to smoking cessation in COPD was identified.

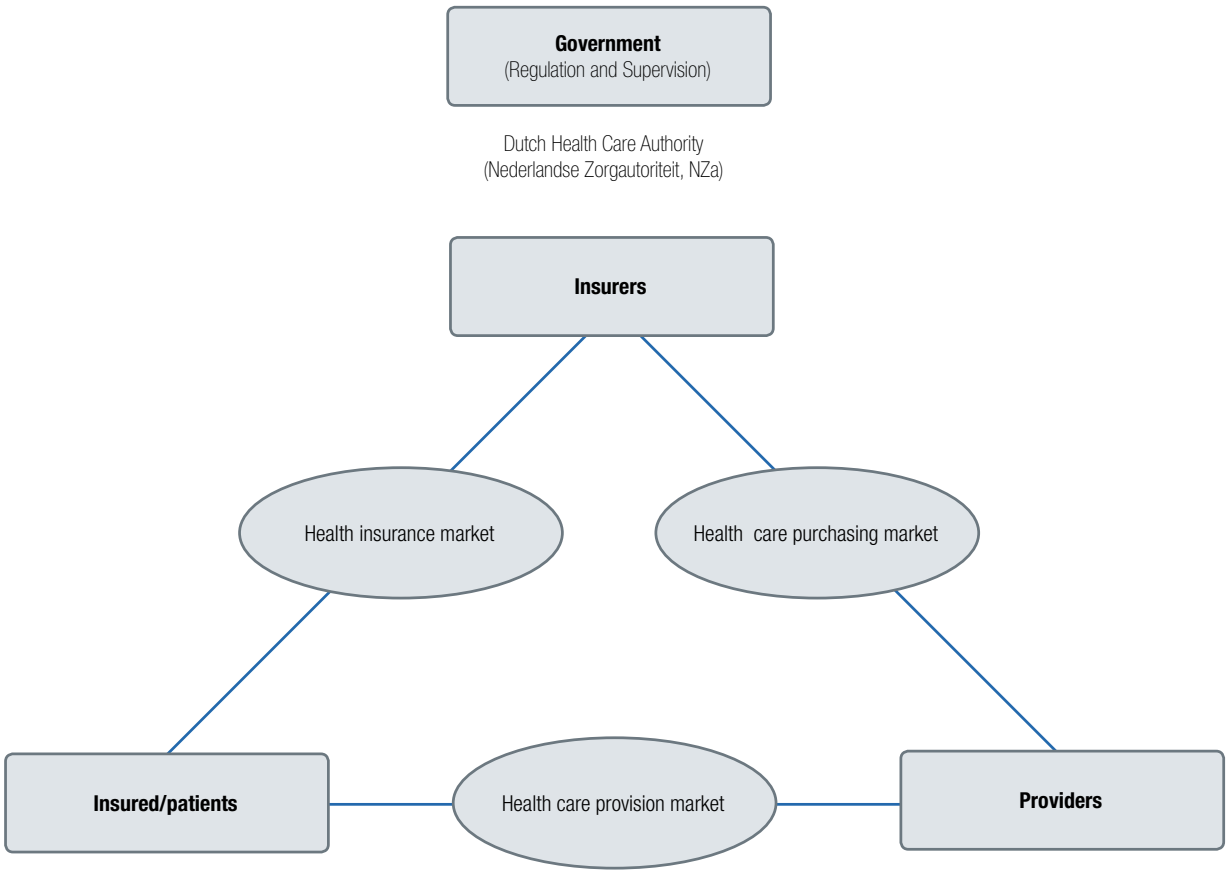
THE NETHERLANDS

Expert contacted: Dr. Lowie Vanfleteren, Centre of Expertise for Chronic Organ Failure, Horn, The Netherlands
Source: European Observatory on Health Systems and Policies, 2010

Healthcare system organization

In The Netherlands there is a mixed public/private insurance mandatory system with no distinction between public and private insurance. Only one insurer is for-profit (Achmea), the other three (UVIT, CZ and Menzis) are non-profit. Health Insurers Netherlands (*Zorgverzekeraars Nederland, ZN*) is the umbrella organization of Dutch health insurers. The working population usually has private insurance. The government has largely delegated the supervision and management of the system to independent bodies as shown in the Figure.

Actors and markets in the Dutch healthcare system



Overview of the payment system for healthcare services

Provider	Payment system
General Practitioners (GPs)	The remuneration is a combination of: • capitation fees • consultation fees • out-of-hours care: mainly per hour • extra income from innovation and substitution • prevention (influenza vaccination, cervical screening), medical examinations: fee-for-service • some GPs are in salaried service of a GP practice or primary care centre
Practice nurses	Same as above (except for out-of-hours care)
Other primary care providers (dentists, etc.)	Fee-for-service
Medical specialists	Independent professionals are paid via the DBC* system, and they receive a normative hourly fee for a normative time spent per DBC. A quarter of medical specialists are in salaried service of the hospital.
Nurses	Salary
Home helps	Salary

*DBC (Dutch: *Diagnosebehandelcombinatie*) can be defined as a predefined average care package, which is applied with a fixed price when a specific diagnosis occurs

Prevention and early diagnosis

Prevention and social support are mainly financed through general taxation. Organization of prevention falls under the responsibility of the municipalities through the municipality health centres (*Gemeentelijk Gezondheidsdiensten*). There is no screening for COPD. Patients at-risk are seen by their GP. Most GPs can provide lung function testing for at-risk patients.

Pulmonary rehabilitation

Pulmonary rehabilitation is included in the therapeutic programme for patients with COPD. It is free for all patients.

Smoking cessation

In The Netherlands, smoking cessation programmes are conducted by dedicated nurses. Counselling is free, but some medications may not be reimbursed by some insurance companies.

UNITED KINGDOM

Expert contacted: Prof. Peter M.A. Calverley, School of Ageing and Chronic Disease, University of Liverpool, Liverpool, UK and Dr. Bronwen Thompson, IPCRG
Other source: European Observatory on Health Systems and Policies reports (England, 2011; Scotland 2012, Northern Ireland, 2012; and Wales, 2012)

Healthcare system organization

In the UK, the National Healthcare System (NHS) grants free access to care for all. The Ministry of Health is responsible for publicly funded healthcare. The system recently changed towards increased decentralization. In England, the responsibility of establishing healthcare priorities lies with local commissioning groups (138 across the country). These commissions are also in charge of applying healthcare policies. In Northern Ireland, Scotland and Wales decisions are taken at Regional level.

As mentioned above, access to healthcare services is free, but there is a prescription fee for medications (around €8-9), but many patients, including patients suffering from chronic diseases, are exempt from this fee.

Prevention and early diagnosis

There is no obligatory check up programme, but General Practitioners (GPs) are encouraged to screen at-risk populations (for instance there are screening programmes for breast and bowel cancer).

GPs may provide lung function testing for at-risk patients. Although there is a free NHS health check programme to which all 40-75 year olds are invited, this focuses on cardiovascular and renal conditions, and stroke, dementia and diabetes, and there is no lung function test included.

Pulmonary rehabilitation

Pulmonary rehabilitation is part of the therapeutic programme for COPD patients, is free to patients, and features in national guidance about best practice management for COPD. Nevertheless, pulmonary rehabilitation is very unevenly distributed in the UK, with very different standards of delivery. Rehabilitation programmes are mainly for outpatients. Severely disabled patients are not usually offered rehabilitation. There is not universal provision of pulmonary rehabilitation across the country, as this is commissioned at a local level, so it may not be available in some areas, or patients may decline it because of the distance they may have to travel to access it.

Rehabilitation is decided mainly by pulmonary specialists, which is according to the guidelines of professional societies (e.g., the British Thoracic Society). Patients may also be referred to pulmonary rehabilitation programmes by clinicians in primary/community.

Smoking cessation

Patients who smoke can be referred to free specialist stop smoking services to provide them with the treatment and support they require to quit smoking. Specially trained stop smoking advisors run these services. Voluntary organisations play an important role in lobbying for government-led initiatives to discourage and ban smoking, such as smoking bans in indoor spaces, and in cars where children are present. The former have been shown to reduce the burden of smoking related disease.

Conclusions

The results of this survey revealed several tendencies in healthcare organization in Europe. For example, in all the 19 countries examined, virtually the whole population is covered by the national healthcare system, although there are some intercountry differences in the kind of services provided and in terms of reimbursement policies. In all countries patients must pay a small fee for some services, mainly for some tests and some medications. However, chronically and severely ill patients are often exempt from paying these fees. Unfortunately, in some countries like Italy and Finland, COPD is not recognized as a chronic disease, thus patients may have some limitations in accessing appropriate care free of charge.

Strikingly, in countries where periodical check-ups are promoted, spirometry is not included, not even for at-risk patients (with the exception of some categories of subjects at occupational risk). In most countries, COPD is diagnosed by pulmonary specialists. General Practioners (GPs) are mainly not aware of the importance of spirometry for early diagnosis of COPD, and they are not actively encouraged to use it, also because they do not receive extra payment for spirometry.

Another issue in most countries is the availability of pulmonary rehabilitation. Whereas national associations of healthcare professionals fully recognize rehabilitation as part of the therapeutic programme for COPD patients, often this is not recognized by the healthcare systems. Moreover, the organization of rehabilitation centres is often the responsibility of the local or regional authorities, and this causes disparities in access to pulmonary rehabilitation.

In summary, the results of this survey illustrate that we are still far from harmonization of preventive and other healthcare measures for COPD patients in Europe. Hopefully, the information reported herein will provide ammunition with which to fuel campaigns aimed at filling the gaps in some countries, and in eliminating inequalities in COPD prevention and care throughout Europe.

Appendix 1. Questionnaire harmonizing prevention and other measures for COPD patients accross Europe

The aim of this survey is to collect information about healthcare policies, in particular policies related to prevention, early diagnosis, support measures and therapies such as pulmonary rehabilitation for COPD patients.

The results will help to understand the decision-making processes concerning prevention, early diagnosis and rehabilitation as well as to identify the decision makers in the countries surveyed. The ultimate goal is to use such information to tailor advocacy campaigns at national level targeted to the national decision makers in order to tackle the gaps in prevention and care in each country, and thus bring about a concrete improvement of COPD policies in Europe.

The questionnaire is structured in items with open reply options. Nevertheless a list of possible reply options, which is not complete, is provided to assist in the replies.

This questionnaire is for guidance purposes only. We will contact responders for a telephone interview.

ITEMS:

Information on the national healthcare system
1. Which healthcare system is applied in your country? a. National Public healthcare is free for all patients b. Regional Public healthcare is free for all patients c. Mixed public/private insurance d. Mandatory private insurance e. Pension funds f. Other, please specify
2. Who makes decisions concerning healthcare policies in your country: a. National government i. Ministry of health? ii. Ministry of economics? iii. Other, please specify b. Regional government c. Both National and Regional (please provide details)
3. How is the national/regional healthcare system organized: a. Free b. Reimbursement via public system c. Reimbursement via insurance companies d. All patients pay a fee (indicate approximately the amount of fee _____) e. Some patients pay a fee (indicate approximately the amount of fee _____)
Prevention and early diagnosis

4. Does your healthcare system foresee periodical health check-ups?

5. Who covers the costs of check-ups?

a. Public insurance
b. Private insurance
c. National public healthcare system
d. Regional public healthcare system
e. Other (specify)

6. Is lung function testing (spirometry) included in the periodical check-up?

a. Yes for all patients
b. No
c. Only for patients at risk (specify)

7. If no periodical check up is foreseen, is spirometry included in regular visits to the General Practitioner (GP)?

a. Yes for all patients
b. No, Please explain why.
c. Only for patients at risk (specify)

8. Please identify the decision makers concerning prevention policies

a. Same as in question #2
b. Other. Please specify

Rehabilitation

9. Is pulmonary rehabilitation included in the therapeutic programme for patients with COPD?

a. Yes, for all patients
b. Yes, with some limitations
   i. Age
   ii. Working population only
   iii. Other specify
c. No. Please explain why.
d. It is not foreseen, patients must ask for rehabilitation

10. Is pulmonary rehabilitation free for patients?

a. Yes, for all patients
b. Yes, with some limitations
   i. Age
   ii. Working population only
   iii. Other specify
c. No, patients must pay a fee (amount_____)
d. No, patients must pay for rehabilitation

11. Please identify the decision makers concerning access to rehabilitation

a. Same as in question #2
b. Other. Please specify

Other healthcare measures

12. Are COPD patients assisted in

a. Smoking cessation
b. Appropriate diet
c. Other

13. If yes, such measures are:

a. Free for all patients
b. Free with some limitations
   i. Age
   ii. Working population only
   iii. Other specify
c. Patients must pay a fee (amount_____)
d. Patients must pay to access such services

14. Please identify the decision makers concerning access to other healthcare measures

a. Same as in question #2
b. Other. Please specify

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