



# WHO

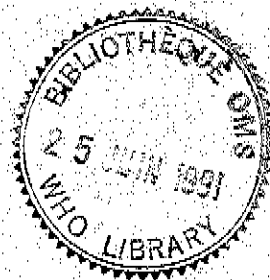
REGIONAL OFFICE FOR EUROPE

---

55860cf  
EUR/ICP/HSC 417  
1401n  
ENGLISH ONLY  
UNEDITED

## *POLICIES AND DEVELOPMENT OF HEALTH SERVICES IN A HEALTH FOR ALL FRAMEWORK IN COUNTRIES WITH PLURALISTIC HEALTH SYSTEMS*

Report on a WHO Working Group



Lugano  
18-19 October 1990

SCHERFIGSVEJ 8  
DK-2100 COPENHAGEN Ø  
DENMARK

TEL.: (45) 31 29 01 11  
TELEFAX: (45) 31 18 11 20  
TELEX: 15348

1991

EUR/HFA TARGET 33

This activity was organized by the WHO Regional Office for Europe to promote work aimed at achieving the following target in the health for all strategy.<sup>a</sup>

## TARGET 33

### POLICIES FOR HEALTH FOR ALL

#### Index terms

HEALTH FOR ALL  
HEALTH POLICY  
HEALTH PLANNING  
HEALTH SERVICES  
INSURANCE, HEALTH  
AUSTRIA  
BELGIUM  
FRANCE  
GERMANY, FEDERAL REPUBLIC OF  
NETHERLANDS  
SWITZERLAND

All rights in this document are reserved by the WHO Regional Office for Europe. The document may nevertheless be freely reviewed, abstracted, reproduced or translated, but not for sale in conjunction with commercial purposes. Any views expressed by named authors are solely the responsibility of those authors. The Regional Office would appreciate receiving one copy of any translation.

<sup>a</sup> *Targets for health for all*. Copenhagen, WHO Regional Office Europe, 1985 (European Health for All Series, No. 1).

CONTENTS

	<u>Page</u>
Introduction	3
Background	3
Task Force for Health for All Management in Countries with Pluralistic Health Systems	3
Recent development and new challenges	4
Scope and Purpose	4
Organization of the Conference	5
 Presentation of papers and discussions	 5
Problems to be solved and opportunities to be used for better health	5
Health for all policy: progress and new challenges	6
Health policy and strategies in countries with pluralistic systems	6
The impact of information on the health market	8
Patterns of organization of primary health care: present situation and new solutions	8
Hospitals in support of primary health care: pressures and opportunities	8
Collaborating and networking activities of AIDS service organizations	9
Instruction and training of multi-disciplinary teams in gerontology: programme contents and experiences	9
Communication and information networks of the health services: applications of advanced telecommunication and information technology to improve the quality, effectiveness and efficiency of care	9
Future health systems: scenarios for the future	10
Indicators for the HFA monitoring process	10
Cost containment and financing policies	11
Planning and managerial processes and mechanisms in countries with pluralistic systems	11

Discussion relating to the roles of the partners	11
Conclusions and recommendations	12
General conclusions	12
Recommendations to Member States	14
Recommendations to care providers	16
Recommendations to health insurance organizations	18
Recommendations to WHO	18
Annex 1. Participants	20

## 1. Introduction

### Background

The Thirtieth World Health Assembly resolved in May 1977 that "the main social targets of governments and WHO in the coming decades should be the attainment by all citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life" (resolution WHA30.43). The urgency of this goal for the European Region is underlined by two basic facts:

- despite the financial resources devoted to the health sector and the development of new drugs and medical techniques in the past 30 years, people's level of health is lower than it could be;
- despite the overall level of development in the European Region and the scientific, economic and educational level of most countries, the challenge of inequalities in health still has to be met.

It is within this framework that the representatives of Member States of the WHO European Region, on the occasion of the thirtieth session of the Regional Committee at Fez in 1980, approved their first common health policy, the European strategy for attaining health for all.

Four years later, the European conference on planning and management for health, convened by the WHO Regional Office for Europe in collaboration with the government of the Netherlands in The Hague, agreed that the notion of health planning and management should be enlarged to encompass the full range of forward-looking approaches for promoting health and improving the effectiveness, efficiency and quality of health systems. Member States were encouraged to select the approach that was most appropriate to them on the basis of their particular objectives and their circumstances, which necessarily differ from country to country and change over time. They were to develop appropriate policies and managerial processes to implement the strategy for Health for All, tailored to the actual situation in their own country.

### Task Force for Health for All Management in Countries with Pluralistic Health Systems

A number of Western European countries (Austria, Belgium, Federal Republic of Germany, France, The Netherlands and Switzerland) recognized the similarities in their problems with respect to the development of a health for all policy, and established a task force for health for all management in countries with pluralist health systems in 1985. Other countries, operating in a comparable environment, were invited to join this group. Their terms of reference were to review the present managerial processes for health for all, to identify the approaches that are most suitable for countries with pluralist health systems, to evaluate the implementation of selected approaches and mechanisms, and to exchange experience.

The task force held five discussion sessions: Düsseldorf (January 1985), Vienna (June 1986), Brussels (September 1987), Bad Honnef (September 1988), and Paris (November 1989). In addition, planning meetings were also held in Brussels (October 1985), Luxembourg (December 1987) and Geneva (February 1989).

#### Recent development and new challenges

In recent years, tremendous political, social and economic changes are taking place in Europe, in particular in the former communist countries of central and eastern Europe (CEEC). The health systems of these countries need to be reoriented and reorganized, and the pluralistic model is now being studied as a basis for future development. But also other European countries with highly organized health systems, like the United Kingdom and Sweden, are introducing changes which can be considered "pluralistic". It can be expected that the unification of the countries of the European Economic Community and the establishment of a large, open market in Europe will create greater interest in the efficiency of market mechanisms and pluriform decision making, also in the health sector. Under these circumstances, it is anticipated that the World Health Organization and its Task Force on Health for All Management in Countries with Pluralistic Systems will have to extend their efforts to explain and to demonstrate the effectiveness of the HFA framework for application in countries with pluralistic systems, with particular emphasis on the need to achieve equity in health, and the role and responsibility of the state vis-à-vis the many partners in a pluralistic system.

#### Scope and purpose

At the above-mentioned meetings, it was concluded, confirmed and re-confirmed that HFA offers a suitable framework for the analysis of policy and for policy development. The HFA concept focuses on health, shows interdependencies within the health sector and between sectors, and it offers a long-term perspective. Moreover, it provides a simple and flexible approach, which can be adapted to different requirements and settings. There was general agreement that HFA is of major relevance to countries with pluralistic systems in federal and decentralized administrative settings, since it can be applied to all levels, and by a multitude of potential partners in the health field.

It was, therefore, found useful to analyse regularly, in depth the achievements and the particularities inherent in establishing HFA policies in pluralist countries. For this reason, a conference was organized by the WHO Regional Office for Europe, with the support of the federal government of Switzerland and three cantons (Bern, Vaud and Ticino) to examine the development of health services, in relation to the underlying principles of HFA.

In countries with pluralistic health systems, health policies are influenced and determined by many different actors and agencies, i.e. by physicians and nurses, hospitals and other health institutes, sickness funds and private insurers, consumer organizations, employers, trade unions, and by governments at all levels of administration. In order to facilitate the

exchange of experiences concerning policy alternatives, particularly innovative approaches, the identification of possible mismatches in perceptions of priorities, and ways of resolving such differences, and to search for a consensus on ways of integrating health services policies in a HFA framework, representatives from the above groups met to undertake the following tasks:

1. to inform the major actors in the health field in countries with pluralistic systems about progress in the development of the HFA strategy in Europe;
2. to analyse the present and future challenges for health care systems in a HFA framework;
3. to review the role of different actors in reorienting health services in the implementation of the HFA 2000 strategy;
4. to anticipate the new roles, functions, activities and organization of future health services with particular reference to hospitals, taking into account the HFA policy framework as applied in pluralist countries;
5. to gain understanding of the various planning and managerial processes that are applied in different countries in this respect, with particular attention being paid to cost containment and financing strategies in a HFA framework;
6. to make recommendations with respect to the development of policies and strategies for change in health care systems in countries with pluralistic systems.

#### Organization of the Conference

The Conference was chaired by Mr R. Bervini, Cantonal Minister of Health in Tessin (first day) and Dr G. Liebeswar, Director General of Public Health, Austria. Dr E. Dekker and Professor A. van der Werff (The Netherlands) acted as rapporteurs.

## II. Presentation of papers and discussions

### Problems to be solved and opportunities to be used for better health

Mr Bervini, speaking on behalf of Tessin, pointed out in his welcoming address that the Canton of Tessin has now ten years of experience in implementing the HFA policy in particular by the realization of an extensive health promotion programme, continuing evaluation of the effectiveness of this programme and by the establishment of a comprehensive, critical information system. A legal basis for this entire activity has recently been provided by the adoption by the cantonal parliament of an act on health promotion and health coordination. Responsibility for health services in Switzerland is divided among the companies and beneficiaries. The responsibility of the

Confederation is restricted to activities involving international cooperation, matters that require a high degree of coordination and the protection of public health in relation to issues not contained within cantonal boundaries, such as AIDS. At cantonal level, health policy is essentially an integral part of overall policy. The cantons regard health as essentially their responsibility and are therefore prepared, as is in Tessin, to give health priority, particularly from the financial point of view. The countrywide, decentralized system of health services, which is based on the considerable autonomy enjoyed by the cantons and communes, has resulted in large-scale community involvement and in a multiplicity of services. The population has various ways of intervening directly at federal, cantonal and communal levels. As a result, health policy decisions are always taken, ultimately, by the population.

#### Health for all policy: progress and new challenges

Dr Anna Ritsatakis, speaking on behalf of the World Health Organization, responded to the question whether the health for all policy is still relevant when so much emphasis is given to cost containment and to achieving managerial efficiency, frequently through the introduction of market principles. She affirmed that it is at this time that the underlying principles of HFA (equity, participation, reorientation of health services, and intersectoral action) are particularly relevant. The HFA policy promotes long-term vision in times of crises and rapid turnover of governments. It provides the benchmark by which to measure new proposals and assesses the direction in which we are going. At the present time, the 38 targets are being updated. From the comments received from Member States, it is obvious that in the updated targets, much more emphasis will need to be given to health services, particularly to the quality of care, care for the elderly and chronic sick, and care for vulnerable groups. The work of the "pluralistic group" in this area is of particular importance, since what might be called the "pluralistic" model of health systems seems to be proving attractive to many countries which, until recently, had systems dominated by central government. The experience of the pluralistic countries will, therefore, be very relevant to the current debate on health care reform. Much of the experience of the task force for HFA management in countries with pluralistic health systems has been gathered for the World Health Organization by Dr E. Dekker and Professor A. van der Werff in a publication entitled, "Policies for Health in European Countries with Pluralistic Systems". However, the current trends toward deregulation and introducing competition and other market forces should not lead to greater inequities or relative neglect of vulnerable groups. According to Dr Ritsatakis the challenges for the future such as the problems of the limits of care, the growing health burden due to the aging of the population and the chronic sick, the advance of medical technology, and the relative shortage of human resources ask for a common strategy involving all relevant actors, on the basis of the identification of priority areas.

#### Health policy and strategies in countries with pluralistic systems

Dr Stein (Federal Republic of Germany), speaking on behalf of the Task Force for Health for All Management in Countries with Pluralistic Systems, expressed his agreement with the point of view of the preceding speaker. He emphasized the timeliness of the Conference. Tremendous political, social and

economic changes are taking place in Europe at this moment. To say it in one sentence: Europe is going pluralistic. This will mean that the way and the extent to which they have been able to transform a political ideal into a day-to-day reality, will very much determine if and how HFA will have a perspective for the future. A shift from government planning and management to the pluralistic model with greater freedom for market forces and deregulation requires a shift in emphasis from organization issues to emphasis on support activities such as information, research, training and education, leaving the actual provision of health care to the providers. According to Dr Stein, even in the pluralistic setting, an overall strategy and concerted action will still be needed. Setting priorities, definition of outcome-oriented targets, formulation of long-term strategies, and the establishment of specific processes and mechanisms of debate, consultation and negotiation to achieve consensus are vitally important in countries with pluralistic systems. The improvement and extension of national health-oriented information systems are essential. These are some of the major principles upon which transfer of knowledge to the countries of central and eastern Europe could be provided.

### The impact of information on the health market

Dr Domenighetti (Tessin, Switzerland) made, in his paper, an attempt to set out the theoretical basis and empirical evidence, both from literature and experiments in Tessin and elsewhere, of the importance of information for modifying the behaviour of the "actors" in the health market. He reached the conclusion that, taking into account the differences in genetic make-up of people and the individual chances, especially with regard to unintentional or accidental injuries, health on one hand and information on the other are essentially equivalent. This concept may be of great importance for HFA, especially in industrialized countries with pluralistic health systems where the principle of free choice in health, when linked to the market economy, has a greater impact on the mechanisms of the health market and the behaviour of its actors than in countries with centralized or socialized health systems. Health related, critical information systems and professional dissemination of information through all relevant media are of paramount importance.

### Patterns of organization of primary health care: present situation and new solutions

Discussing patterns of organization of primary health care, Mr Hamilton referred to the differences that exist across Europe. Patterns of primary health care organization differ widely between countries. The Netherlands rely exclusively on general practice as a gatekeeper for specialized care and care. In most other countries, however, mixed systems exist in which general practitioners and specialists work next to each other. Also, the degree of organization is different across countries ranging from individual practices to large multidisciplinary teams operating in fully equipped health care centres. The general organization of health care systems traditionally has been characterized by a distinct division between an ambulatory and institutional level of care. This pattern is now also changing; mainly because of the fast growing demand for long-term care in the greying societies of Europe, new solutions are being initiated for home care, ambulatory and institutional care that support each other and offer services as close as possible to where people live and work. New forms of care and new types of organizations depend largely on the national financing systems. Although private practice and fee for service are the basic concepts for the organization of primary health care in countries with pluralistic systems, sickness funds, private insurers and public health authorities play vital roles as countervailing powers, both in quality control and in cost containment.

### Hospitals in support of primary health care: pressures and opportunities

Professor Prims (Belgium) analysed in his contribution the trends in primary health care and hospital care. Major factors were cost explosion, demographic evolution, progress in medicine and the demands of patients. Within this context, generally the following policies were adopted: reduction of bed capacity of acute general hospitals; creation of alternative forms of care and introduction of new financing methods and improvement of quality of care. Quality of care is a patient's right. This concept is of great importance in countries with pluralistic systems, and is embedded in legislation in an increasing number of countries. Quality of care is not restricted to scientific-technical quality but includes the hospital environment and the manner and behaviour of all professionals providing care to and communicating with patients as well. Partly because of competition

between hospitals and partly because of methods of financing, hospitals in countries with pluralistic systems offer in general a better quality of care than hospitals in "organized" systems. Like Mr Hamilton, Professor Prims said that as a result of the policies to strengthen primary health care and to restructure hospital care these two levels are now becoming one world, working not any longer in a spirit of competition, but in a spirit of complementary support. Major opportunities for further development are the improvement of the referral system and training (at all levels). A major opportunity in this respect is the improvement of the functions, reach, content and responsiveness of hospital information systems. The advancement of information and telecommunication technology can be extremely helpful, as is shown by the initiative of the Commission of European Communities to develop a standard European framework, known as RICHE (Réseau d'Information et de Communication Hospitalier Européen), upon which different solutions can be developed for the exchange of patient data within a hospital and between hospitals and their environment.

#### Collaborating and networking activities of AIDS service organizations

Professor Marin (Austria) presented the first, international, comparative study being carried out on managing AIDS in an institutional, (inter-)organizational, health policy field. The main outcomes to be expected from this project will be: an AIDS Institutions Directory, providing a complete list of all major public and all voluntary AIDS institutions in countries, an Integrated AIDS Policy Management Information System, and regular expertise outputs. This enterprise may result in the establishment of a national and international network to provide a coordination mechanism in countries where "wildcat patchwork pluralism" dominates the health and social welfare area.

#### Instruction and training of multi-disciplinary teams in gerontology: programme contents and experiences

After this large scale project on AIDS, Ms Josée Thill (Luxembourg) presented a local pilot project on gerontology that is currently being carried out in the integrated care centre for the elderly in Bofferdingen. To enable old and very old people to live independently and secure, to provide them with appropriate care and allow them to die in dignity, an environment of the "new" gerontology needs to be created. Both in the homes and in the institutions, professionals and voluntary helpers should serve old and very old people in multidisciplinary teams on the basis of solidarity and humanity in order to achieve an optimal quality of life for the elderly. Basic education and further training are essential for reaching a sufficient level of motivation and new methods for education and training are required. In Bofferdingen, professional and voluntary care providers, administrative and technical personnel are trained together and the overall impact on care of the elderly is measured and evaluated.

#### Communication and information networks of the health services: applications of advanced telecommunication and information technology to improve the quality, effectiveness and efficiency of care

In addition to Professor Prims, Professor Le Beux (France) pointed out that the development of communication networks and, in particular, computer

networks, are now making it possible to build standardized and integrated communication networks in the health field. Today, a variety of networks is available ranging from microcomputer networks, local area networks to broadband (satellite) and ISDN networks. These technologies allow for interconnection of national and regional levels with local levels. At local level, these networks will enhance and enlarge the communication between the homes of the patients, physicians and other health care workers operating at primary, ambulatory care levels and hospitals. These networks will facilitate the development of "telemedicine" and will provide cost effective alternative solutions to substitute specialized hospital care. The evolution towards such integrated health communication and information networks will certainly improve effectiveness, efficiency and quality of care. Data protection requirements, based on legislation and current practice in European countries will have to be given proper attention.

#### Future health systems: scenarios for the future

Dr Cense and Dr Schreuder (The Netherlands) discussed health systems of the future. The Dutch Memorandum 2000 (1986) provided a landmark in a shift from emphasis on services to emphasis on overall, integrated view on all factors influencing health. A similar document was published and discussed, also in Parliament, in 1988, and a revised issue will be available in 1991. Future health scenarios are applied to overcome resistance towards planning, to provide a long-term orientation to all concerned actors, identification of alternative courses of action and minimization of risks. Application of this tool has proven to be of great value in countries with pluralistic systems. Driving forces for change of health systems are demographic and social factors, political and economical factors, technological development and changes in morbidity and mortality patterns. Dr Cense and Dr Schreuder also expect that home care, primary (ambulatory) care and hospital care will be linked and, by the application of new communication technologies, be merged into "true" systems. The hospital will get a more active role in supervising technical care outside hospitals, and in making specialized medical knowledge accessible to all components of the system. For the future "mixed model" health systems are expected, financed from a variety of sources. "Essential", generally accessible services may become equal in specification and levels of quality across countries and their financing be harmonized. Public control will be acceptable for these basic services, whereas "nonessential" services may be marketed freely. The speakers emphasized the need for a permanent dialogue between all actors involved.

#### Indicators for the HFA monitoring process

Professor Noack and Dr Weiss (Switzerland) presented the results and some of the experiences of the Swiss Inter-cantonal Health Indicators Project. The objectives of this project were to develop key elements of a suitable health information system and to gain experience by using it. Elements for success are: the existence of a conceptual model of the health system; consensus on health targets; appropriate data; professional staff; and excellent open collaboration between users and producers of information. The major challenge has been to build health information and health reporting systems that actually serve all users, i.e. all actors in the pluralistic health field. The paper was concluded by quoting Peters, c.q. Weber: "Develop simple systems that encourage participation and understanding by everyone and that support initiative. Measure what is important. What gets measured gets done!".

### Cost containment and financing policies

Dr Weber and Mr Brenner (Federal Republic of Germany) argued that health targets will have to be defined, discussed and measured within the context of financial policy. In health care, prices cannot be used as instruments of controlling health expenditures. The most effective way is control on the basis of budgets. However, in Europe only "sectoral" budgets are practised. Sectoral budgets are not specified in terms of health outputs and can therefore not serve as a basis for allocation of cost to the changing health needs of the consumers. For this reason, Weber and Brenner propose the introduction of a budgeting system expressed in terms of health outputs and related to specific health problems, respectively to particular diseases. The mechanisms of delegating responsibility have not yet been developed. An important contribution to such a development has been the study of the project group "Prioritäre Gesundheitsziele" (Priority Health Targets). This project group has published its findings in Weber et al. (Dringliche Gesundheitsprobleme der Bevölkerung in der Bundesrepublik Deutschland, Zahlen, Fakten, Perspektiven, Nomos Verlagsgesellschaft, Baden-Baden, 1990).

### Planning and managerial processes and mechanisms in countries with pluralistic systems

Mr Marrot (France) summarized the reasons for the relative failure of planning in European countries with pluralistic health systems as follows: the characteristics of pluralistic systems, the predominance of a technological ideology, and the weaknesses of information systems. Under these circumstances, planning has essentially been a system of quantitative norms to limit the capacity of hospital care, and has not been planning for health. At this moment, all countries with pluralistic systems face a funding crisis and have adopted policies to control cost either on the supply side or on the demand side, or on both sides. Under these circumstances, it may be possible to make better use of planning that could be defined at central level, but should be implemented at local level. Information systems for one-off and priority checks, and the functions of ensuring the final output and of evaluation will be of vital importance.

### Discussion relating to the roles of the partners

During the discussions, a number of aspects of the roles of the main partners in pluralistic systems were highlighted:

Government: The role of the government will remain important although the decision-making power in countries with pluralistic health systems is not concentrated in its hands. An overall strategy and concerted action will still be needed, but in the pluralistic model the significance of formal government planning will be restricted. Emphasis will be on support activities such as research, education and training, as well as information. In particular, information systems were discussed and standardization recommended. Minimum data sets should be developed and the unification of data systems should be sought in order to allow for policy analysis and comparison on an equal basis across Europe. Present work initiated by the Commission of the European Communities (e.g. ESPRIT, RICHE and AIM) was recognized.

Care providers: Representatives of the health professionals again made it clear that the acceptance of the HFA policy will not easily lead to its implementation, without the full support of the health care providers. Some physicians have tended to reject HFA policy since they feel that too much emphasis is given to health promotion without sufficient scientific evidence of its effectiveness. Moreover, the relative growth of old and very old people is causing a strong increase in demand that cannot be met without large investments and increasing expenditure in curative care. Speakers recommended greater and more effective involvement of the collaboration with physicians.

Nurses are interested and, in general, they are willing to support the implementation of the HFA policy in spite of the related difficulties. Nurses can play important roles far beyond the application of medical technology. In the discussions, it appeared that nurses feel that their potential to contribute to HFA is underestimated and even somewhat neglected. Mr Favel (France) recommended concentrating on the following elements: education; the new meaning of the nursing profession; new technologies of nursing; professional commitment to social wellbeing of patients; and better, harmonious collaboration with physicians.

In the discussions, quality of care was raised as an issue of growing importance in countries with pluralistic systems. Both physicians and nurses, but also ambulatory services at primary care level and hospitals are interested in contributing to an improvement of quality of care. This interest is reflected in the creation of programmes of quality assurance on one hand, and in legislation and regulation on the other. Since the programmes of quality assurance usually are organized on a voluntary basis, government needs to take supporting measures.

Health insurance organizations In countries with pluralistic health systems, sickness funds share to a certain extent public responsibility for health with government bodies. They make contracts with the care providers comprising agreements on volume, price and quality of care and, in this way, they provide a countervailing power in the health market and help in directing the developments. Since social insurance is based on solidarity, like HFA, the sickness funds are generally supporting the implementation of this concept. The proposal made by Weber and Brenner to introduce an output oriented budget system related to specific health problems or particular diseases was highly appreciated.

### III. Conclusions and recommendations

#### General conclusions

"Europe is going pluralistic," was an expression by one of the speakers to underline that the pluralistic model seems more attractive than ever before in Europe. Not only do former communist countries in eastern Europe show interest in the pluralistic model, but also other European countries with highly organized health systems like the United Kingdom and Sweden are now introducing changes into their health systems which can be considered "pluralistic" (notably the decentralization of decision-making). This situation imposes a special responsibility on the countries with pluralistic health systems. Not only are they expected to share their knowledge and experience with the "new partners", but they have also to consider once again how HFA principles can be implemented in pluralistic systems.

All European countries are pluralistic to a certain extent; however, some are more so than others. Therefore, the following summary of features of pluralistic health systems is of interest:

- decision-making power is not predominantly concentrated in the hands of one person, group or authority;
- several of the actors are private;
- actual health policy is generally not decided by government alone, but rather through negotiation amongst interest groups;
- even government is not a single entity and its decision-making power may also be distributed amongst various administrative echelons;
- typically, the user is free to choose the care provider who is, likewise, free to accept or refuse patients;
- although financing is socialized, the relation of a care taker and a care provider is of the nature of a private contract (in terms of civil law); and
- there is a relatively strong belief in the efficiency of market mechanisms.

The essential components of HFA policy were, again, summarized:

- emphasis on equity and equal access to health services;
- health status orientation instead of health service orientation;
- strengthening of health promotion and disease prevention;
- intersectoral action;
- reorientation of health services according to developments in health status; and
- community participation.

It was then observed that, although HFA has been generally accepted at the political level, and in a number of pluralistic countries, interesting activities in the field of HFA have been undertaken, generally speaking the HFA policy does not yet formally have a sufficiently firm basis in most pluralistic countries. The recent developments in central and eastern Europe, the emphasis on cost containment and some of the recent health care reforms could imply that HFA principles are moving to the background of policy. Although the meeting recognized the validity of the underlying principles of HFA for the development and evaluation of health policies, they felt there was a need to continuously reassess the targets. Bringing together the actual practice in pluralistic countries and the essential elements of HFA, it was agreed that:

1. HFA offers a flexible framework for health policy which can be adopted in a variety of circumstances and in all federalistic or nonfederalistic states at national and subnational level.
2. Health services policy, including hospital services, should play a more central role in HFA than in recent years, i.e. by taking into account HFA components such as equity, equal access, health orientation and intersectoral action.
3. The observed intentions towards re-regulation, less government control and the introduction of competition and market forces should not lead, either directly or indirectly, to greater inequities or to the relative neglect of vulnerable groups, such as chronic patients, psychiatric patients and the handicapped.
4. The relative autonomy of care providers and health insurance organizations and the special position of the consumers in pluralistic systems offer ample opportunities to negotiate, to reach consensus and to enter into contracts, in which the main HFA components are present.
5. The health promotion and disease prevention approach should be assessed regarding its effectiveness and efficiency, by scientific methods similar to the assessment of curative technologies.

#### Recommendations

##### Recommendations to Member States

1. It was confirmed that HFA offers a useful framework for the analysis and development of health policy in pluralistic countries, where a variety of actors are responsible for the formulation and implementation of health policy. The HFA framework is target-oriented, comprehensive, directed towards the long-term future and adaptable to the differences in the health and political-administrative context of different European countries.

Governments in pluralistic countries have endorsed HFA principles. Therefore, their policies should facilitate that health services be developed in such a way as to give due attention to issues of equity and participation in decision-making; to facilitate health promotion and disease prevention; to ensure a balanced provision of health services; to facilitate intersectoral action for health through collaboration between the health services and other sectors; and to encourage international collaboration.

2. It was also recognized that in many European countries, and not only in the pluralistic ones, reform proposals which allow for greater autonomy and responsibility for the actors participating in health services, introduction of competition and market forces and re-regulation are presently being prepared or carried out. It was agreed that these developments could support HFA policy, since they allow for further flexibility in care policy, but that a careful assessment of these proposals should be made in the light of HFA principles with special attention to equity and equal access to services.

3. It was recognized that policy making and planning in pluralistic countries can best be done on the basis of consensus between all relevant actors, and the normative and top-down way of planning being of limited effectiveness. Although some participants doubted the possibility of getting agreement on a coherent policy in countries with pluralistic health systems at national level, they felt HFA might be valuable as a frame of reference to be applied by various actors in processes of negotiation to reach agreement.
4. The importance of adequate information systems for the development of health services was emphasized. It was felt that, given the wide variety of actors involved in pluralistic systems, all actors should share the responsibility for the creation of the necessary information services and for ensuring its accessibility, data protection and confidentiality. Above all, it was seen as essential to tailor information to users' needs. It was also recognized that the results of the evaluation of data obtained from this information system will have to be widely disseminated to the consumers, providers and policy makers in order to assure equity and adequacy of knowledge, practices, technologies, health services and politics in relation to the health needs of the population.
5. It was recommended that governments in pluralistic countries should present, on a regular basis, comprehensive reports of the health status of the population with special emphasis on possible future trends and the identification of priority areas, preferably in the form of concrete targets. It was also suggested that such health status reports could be usefully produced in different forms and widely be disseminated to meet the needs of different target groups at all levels.
6. If required, governments may play a leading role in the development of adequate information systems and on this basis, encourage and stimulate negotiations between actors to ensure health services development in accordance with HFA principles.
7. It was agreed that in pluralistic countries, on the basis of collaboration, governments should accept full responsibility for health promotion and disease prevention with special emphasis on the creation of the preconditions for health, identification of priority areas and ensurance of the proper balance between individual-oriented activities and social-oriented structural measures. It was concluded, therefore, that the health services would only be able to carry out their proper role in health promotion and disease prevention if central and local governments would create the necessary enabling environment.

Health messages can be communicated to all actors in the health sector. Special attention was paid to direct communications to the citizens and assessment of the impact of this information. Citizens are not only targets, i.e. receivers of information but should also become major suppliers of information. Locally organized projects in which the people are involved in producing information and have direct access to sources of information were mentioned as examples.

Finally, the recommendation was made to enlarge the volume and level of research in the field of disease prevention and health promotion to provide this activity with a solid scientific basis.

8. Although in pluralistic countries governments generally have limited responsibility for and authority over actual care provision, it was recognized that governments should encourage the use of health status reports for planning purposes and should promote client participation and stimulate health promotion and disease prevention to be strengthened within health service policy.
9. Since practical tools for HFA implementation are becoming more and more important, it was agreed that governments on the basis of consensus with the other actors have a particular responsibility of stimulating their development, i.e.:
  - developing budget procedures through consensus and according to priority areas and health targets;
  - promoting evaluation and technology assessment;
  - strengthening research for HFA with emphasis on future studies;
  - reorientation of training and education of health professionals with emphasis on public health and including HFA principles;
  - exploring innovative ways of making the health care professions more attractive to young people.
10. Future health scenarios cover all issues of the HFA policy framework, can be applied to overcome resistance towards planning, provide a long-term orientation, and a basis for detection of future problems, and are instrumental in identifying alternative courses of actions. Application of scenario development has been found an effective approach to reach consensus since it allows for participation of a wide variety of actors whereas no interference of governments is required.
11. It was recognized that many countries in central and eastern Europe are introducing "pluralistic elements" into their health systems and that the pluralistic countries of western Europe have a special responsibility towards these countries, for example, through organizing a network of experienced senior experts ready to give support and advice, particularly on issues like the role of government vis-à-vis the private sector, organization and management of health services, incentives, remuneration systems, budgeting, insurance and other financing methods, quality control, consumer participation and information systems.

#### Recommendations to care providers

1. Bearing in mind that in pluralistic countries care providers are generally privately operating, it was recommended that care providers should use to the full extent their power to ensure equity, equal access to and distribution of health services.

2. It was also seen as essential that care providers:
  - improve all aspects of quality of care in a continuing effort and by all available methods;
  - cooperate with health information systems in order to build up a reliable database and develop health indicators also for the assessment of quality of health care;
  - use data on the health status of the population, including health scenarios, to plan and organize the health services;
  - consider how financing and resource allocation methods might be developed in accordance with health priority or health target based budgets;
  - consider how referral systems can be made to function more effectively and efficiently, and ways in which hospitals can support ambulatory and primary health care for the improvement of health status.
3. It was observed that a "silent cultural revolution" has taken place during the last decade by which clients become more involved and the traditional family support is not always available. As a consequence, health services should be more tailor-made, act in networks with coordination points, link with social services, use data on epidemiology and effects of service, and adapt training to a caring humanistic attitude. Multidisciplinary teamwork in health care, in particular for the elderly and very old people was considered of great importance, and education and training of these teamworkers should be promoted. In the light of the large degree of autonomy of care providers in pluralistic countries, it is essential that they recognize their power to promote client participation, with emphasis on quality control, patient information and staff training.
4. Much can still be developed by care providers to strengthen health promotion and disease prevention. They could particularly develop concrete methods for prevention (protocols to work with in curative practice) and strengthen tertiary prevention for chronic patients and vulnerable groups.
5. Care providers can play an important role in strengthening support for HFA. In the field of training and education, they should create conditions to meet the changing health problems caused by the aging of the population and the increase of chronic care. In many countries, this situation, together with a relative decrease in the number of young people, will pose serious problems of human resources in the next decade. Care providers could take steps to improve labour conditions and work environment and the public image of the caring professions.
6. The accelerated development of medical technology and, in particular, of information and telecommunication technology will have great impact on the organization and functioning of health services in the year 2000 and beyond. The application of open standard communication and integrated information networks will allow better collaboration with respect to

patient care between all professionals and institutions at primary and secondary care level, resulting in the improvement of quality of care, strengthening of primary care, greater coherence of services, and overall reduction of costs, without affecting the autonomy of the health care providers. With respect to individual patients, such networks can only be entered by authorized professionals, taking into account present legislation about data protection and confidentiality.

#### Recommendations to health insurance organizations

1. It was agreed that health insurance organizations play a pivotal role in pluralistic countries since they can, through negotiating and entering contracts with care providers, facilitate HFA implementation.
2. Particularly health insurance organizations can facilitate HFA implementation through:
  - guaranteeing equal access to and distribution of health services, bearing in mind that solidarity traditionally has been the hallmark of sickness funds;
  - financing health promotion and disease prevention as an integral part of health services and in collaboration with other actors;
  - promoting intersectoral action at regional and local level;
  - collaborating in the development of health information systems in order to build up a database for health policy and to develop health indicators;
  - using health status reports for the planning and organization of health services.
3. It was felt that health insurance organizations can play an important role in assisting central and eastern European countries to develop and organize their health finance systems. Therefore, the health insurance organizations were called upon to participate in the European network of experts to assist countries in central and eastern Europe mentioned earlier.

#### Recommendations to WHO

1. It was recommended that the Regional Office for Europe, if requested to do so, should play a stimulating and coordinating role in using the knowledge and experience of the pluralistic countries for its assistance to the countries of central and eastern Europe. In particular, it was suggested that the Regional Office take the initiative in establishing a network of experts to assist those countries.
2. The Task Force of HFA management in countries with pluralistic systems should be continued but concentrated more on the transfer of experience, technologies and information to other European countries, in particular to the countries of central and eastern Europe.

3. It was suggested that the Regional Office for Europe should take all possible steps to support countries in ensuring that the current care reform proposals being considered by many countries integrate the HFA principles as completely as possible, particularly with regard to equity and health orientation.

ANNEX I

LIST OF PARTICIPANTS

**TEMPORARY ADVISERS**

- Monsieur F. O. Baumann  
Président de la Société de Formation thérapeutique du Généraliste,  
Paris, France
- Monsieur R. Bervini  
Direttore Del Dipartimento Delle Opere Sociali, Bellinzona, Suisse
- Monsieur le Dr M.J.S. de Brabander  
Docteur en médecine, Anesthesiologiste, Clinique Maria Middelares  
Sint-Niklaas, Belgique
- Dr G. Brenner  
Geschäftsführer des Zentralinstituts, Zentralinstitut für die  
Kassenärztliche Versorgung, Köln 41, Federal Republic of Germany
- Dr Gerhard Bubik  
Generaldirektor-Stellvertreter, Hauptverband der Osterreichischen  
Sozialversicherungsträger, Vienna, Austria
- Dr J. Bultman  
Secretary, National Health Insurance Board, Amstelveen, The Netherlands
- Dr W. Cense  
Chairman, Royal Academy of Physicians, Utrecht, The Netherlands
- Monsieur le Dr P.J. Cousteix  
Médecin-conseil national adjoint, Caisse nationale de l'assurance maladie  
Paris, France
- Monsieur le Dr D. van Daele  
Secrétaire général, Ministère de la santé publique et de l'environnement  
Bruxelles, Belgique
- Dr E. Dekker  
Coordinator, Health Policy Development, Ministry of Welfare, Health and  
Cultural Affairs, Rijswijk, The Netherlands
- Monsieur le Dr G. Domenighetti  
Dipartimento Opere sociali, Sezione sanitaria, Bellinzona, Suisse
- Mr P. Dukarich  
Stellvertretender Leiter Krankenanstalten-Zusammenarbeitsfonds,  
Vienna, AustriaAustria

Madame Annick Favel

Infirmière générale, Centre hospitalier général, Pau, France

Madame le Dr Nicole Florio

Secrétaire générale, Département de la prévoyance sociale et de la santé publique, Geneva, Suisse

Monsieur L. Geenen

Coordinateur, Organisation catholique des Infirmières flamandes, Bruxelles, Belgique

Mr G.J.A. Hamilton

Legal Adviser, Association of Dutch Health Insurers, Zeist, The Netherlands

Dr L.H.G. Hoornweg

Director, National Cross Organization, Gravenhage, The Netherlands

Monsieur C. Kleiber

Chef du Service de la santé publique et de la planification sanitaire, Lausanne, Suisse

Monsieur P. Le Beux

Professeur, Centre hospitalier et universitaire de Rennes Pontchaillou  
Département d'Information médicale, Rennes, France

Dr G. Liebeswar

Sektionschef, Leiter der Sektion Volksgesundheit im Bundeskanzleramt  
Bundesamtsgebäude, Vienna, Austria

Dr C. Maggini

Direttore Ente Ospedaliero Cantonale, Bellinzona, Suisse

Dr B. Marin

Professor, Director, European Centre for Social Welfare,  
Training and Research, Vienna, Austria

Monsieur B. Marrot

Directeur régional des Affaires sanitaires et sociales des  
Pays de la Loire, Nantes, France

Dr A.P.W.P. van Montfort

Professor and Director, National Hospital Institute  
Utrecht, The Netherlands

Dr H. Noack

Director, Health Research Institut für Sozial - und Präventivmedizin,  
Berne, Switzerland

Mr M. Nowak

Leiter der Abteilung Gesundheitsförderung und Gesundheitssicherung  
Behörde für Arbeit, Gesundheit und Soziales, Hamburg, Federal Republic  
of Germany

- Madame Luce Oleffe van Dierdonck  
Directeur de l'Association des Etablissements Publics de Soins,  
Bruxelles, Belgique
- Monsieur le Dr G. Peeters  
Secrétaire général, Nationaal Verbond van Socialistische Mutualiteiten  
(Union nationale des Mutualités socialistes), Bruxelles, Belgique
- Dr A.V. Prims  
Professor, Faculty of Medicine of the University of Leuven, School of  
Public Health, Leuven, Belgium
- Madame Annette Sabouraud  
Présidente Association Réseau français Villes Santé, Maire-adjoint  
délégué à la santé, Ville de Rennes, Rennes, France
- Dr Hadmar D. Sacher  
Obermedizinalrat, Präsidialreferent der Osterr. Ärztekammer für  
auswärtige Angelegenheiten und Beziehungen zu internationalen  
Organisationen, Klagenfurt, Austria
- Mr R. F. Schreuder  
Staff Bureau for Policy Development, Ministry of Welfare, Health  
and Cultural Affairs, Rijswijk, The Netherlands
- Dr B. Somaini  
Vizedirektor, Bundesamt für Gesundheitswesen, Hauptabteilung Medizin und  
Pharmazie, Liebefeld, Switzerland
- Mr G. Spanninger  
Abteilungsleiter, Sektion Volksgesundheit im Bundeskanzleramt  
Bundesamtsgebäude, Vienna, Austria
- Dr E. Standfest  
Referatsleiter für Gesundheitspolitik DGB - Deutscher Gewerkschaftsbund -  
Bundesvorstand, Düsseldorf, Federal Republic of Germany
- Dr H. Stein  
Health Policy Officer, Ministerialrat, Bonn, Federal Republic of Germany
- Dr J. Steinhausen  
Abteilungsleiter "Planung und Forschung" Verband der Angestellten-  
Krankenkassen, Siegburg, Federal Republic of Germany
- Madame Josée Thill  
Directeur, Centre intégré de l'Etat pour personnes âgées  
Bofferdange, Luxembourg
- Mr A. Weber  
Premier secrétaire, Direction d l'hygiène publique du Canton de Berne  
Berne, Switzerland

Dr I. Weber  
Project Leiter, Zentralinstitut für die Kassenärztliche  
Versorgung in der Bundesrepublik Deutschland, Köln,  
Federal Republic of Germany

Mr Dieter Wenty  
Österreichischer Arbeiterkammertag, Vienna, Austria

Professor A. van der Werff, Woubrugge, The Netherlands

Mr Franz Wyss  
Secrétaire central ODS, Conférence des directeurs cantonaux des affaires  
sanitaires, Berne, Switzerland

#### OBSERVERS

Dr Dominique Biedermann  
Département de la prévoyance sociale et de la santé publique  
Genève, Suisse

Ms Anni Strounza  
Direction de santé publique, Département de prévoyance sociale  
et de la santé publique, Genève, Suisse

#### WORLD HEALTH ORGANIZATION

##### Regional Office for Europe

Mrs Irène Henriksen  
Administrative Assistant, Health Policy

Dr S. Luculescu  
Director, Programme Management

Dr Anna Ritsatakis  
Regional Officer for Health Policies and Planning

Ms Nancy Stewart  
Secretary, Health Policies and Planning