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Note

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Introduction

The meeting was convened by the WHO Regional Office for Europe and organized in collaboration with the Nuffield Institute for Health Services Studies, University of Leeds. It was attended by 27 participants from 14 countries in eastern, central and western Europe, the Director of the European Healthcare Management Association and three WHO staff members. The participants were welcomed by Dr D. Hunter, Director of the Nuffield Institute and by Dr J.R. Bengoa on behalf of the WHO Regional Director for Europe. They represented a range of disciplines including health policy, planning and management, health economics, sociology, political science, social administration, medicine and public health.

Eight background papers commissioned for this meeting provided the framework for discussions. The papers reviewed the situation in countries which are either undergoing system-wide reforms or exploring new arrangements for health care organization and management. These papers - from Hungary, Israel, the Netherlands, Poland, Spain, Sweden, the USSR and the United Kingdom - plus an additional paper from the Federal Republic of Germany, will be published later in a joint WHO/Nuffield Institute publication.

Background

Despite manifest differences in European health care systems with respect to funding and organization, policy-makers in a number of countries have shown an increasing interest in the application of market principles to health care problems. This interest has been stimulated by a perpetual concern with issues of cost containment and managerial efficiency, by a desire to be more responsive to consumer preferences, and by the need to improve the overall standard and quality of

services. Existing organizational patterns are often considered to be unnecessarily bureaucratic and insensitive to the patients served.

Some European health systems already have separate purchasing and provider arrangements. Others are either starting to move in this direction or are contemplating doing so. Given the degree of structural ferment in European health care systems, there is a considerable potential for comparative evaluation and for learning from other countries' policies.

Movement towards a mixed or market-oriented system of health care may have major implications in terms of the range, comprehensiveness and standard of services and the equity with which they are distributed. While existing publicly operated health care systems inevitably exhibit inefficiencies and other problems, it is important to understand the source of these problems before launching into new departures in an effort to solve them.

The purpose of the meeting was to examine these new developments in management and organization and to assess their relevance to particular health policies and strategies being pursued or considered by selected countries. The intention was not to dwell on detailed changes in individual countries, but to develop a set of issues and themes common to - or at least shared in large measure by - all.

Efforts to establish new arrangements for the delivery of health care are under way in several countries. Other countries are watching these developments with great interest and have either embarked on small-scale experiments or are contemplating doing so.

A number of key issues related to the management, organization and financing of health care merit

understanding and analysis. The following are four examples.

First, proposed or potential changes typically involve the introduction of market principles, either wholly in the public sector (i.e. public competition) or among a public-private mix of service providers. What are the likely advantages and/or disadvantages of these different approaches?

Second, proposed or potential changes all aim at management processes with the stated purpose of improving performance and efficiency. They are therefore intended to be a means to an end rather than an end in themselves. To what extent, however, will these changes affect health outcomes? To what degree can notions of the marketplace fit with notions of health planning and strategy as currently conceived?

Third, the three principal sectors of health care systems - primary care, hospital care and community care - often have difficulty in providing properly integrated and coordinated patient care. Will proposed or potential changes encourage a more integrated approach to health service delivery?

Fourth, despite obvious differences among European health care services, there may be a growing convergence of ideas on the solutions to seemingly intractable problems. If various market-related developments now in progress are to inform thinking and policy analysis in other countries which may be considering similar reforms, it is essential that lessons be learned from them as early as possible.

Discussion

Setting the agenda

Mr D. Nichol, Chief Executive, National Health Service Management Executive in England, gave the opening speech. He stressed the "quiet revolution" which is occurring in health care systems throughout Europe. This revolution, he said, has its roots in a set of common concerns: rising health care costs; growing user dissatisfaction; insensitivity to issues of effectiveness and efficiency; and growing concern about outcomes and the quality of care being delivered. These factors have driven health care policy-makers and managers to seek a better way of meeting health care needs.

The agenda of change facing the countries of Europe, despite differences in the organization and financing of their health care systems, is also similar from one country to another, focusing on issues such as quality of care; improved resource use; consumerism; better linkages between primary, secondary and tertiary care; and more effective ways of auditing services.

There is a tendency for countries that are in the process of reorganizing their health care systems, continued the speaker, to look inward and concentrate their energies on immediate implementation of the changes. This is understandable; however, insularity can cause difficulties, in that past mistakes may well be replicated. Therefore, international meetings such as this one are a valuable opportunity to reflect on and learn from the experiences of others.

The search for solutions

The meeting considered that an alternative to looking inward for answers is to reject previous practice and search for a new or different solution. This approach can be equally problematic, in that tried methods (even if found wanting) may be discarded in favour of untried and in some cases untested ones. There is also a possibility that the "new" way forward will be characterized by unrestrained market forces determining the nature and type of health services available.

The rejection of mechanistic planning in favour of market-determined health care also can be questioned. Social justice and the importance of solving problems are being paid increasing attention by policy-makers. There is a danger of succumbing to "short-termism", that is satisfying present desires without regard to the long-term implications and/or consequences. The idea should be to find another, better way encapsulating the best of both worlds, so that the security hitherto afforded by state-organized health care is reframed but tempered by greater personal involvement and choice as regards the services available.

The rationale for reform

Health care systems established in the aftermath of the Second World War were intended to be stable structures. Over the years, however, this stability has led to rigidity and normative operating procedures which are often seen to be serving the objectives of providers and managers instead of increasing the welfare of the intended beneficiaries. Public dissatisfaction added to rising health care costs have induced governments to look for other ways and mechanisms for supplying health care.

Various participants made presentations concerning problems and proposed reforms in the health care systems of a broad spectrum of countries in eastern, central and western Europe. Although the background conditions varied, a number of common themes emerged.

Control/containment of expenditures

The rising cost of health care, whether funded centrally or through social insurance and sick funds, and the associated growing demand for care has become a major issue in all countries. A range of methods is under consideration to curb expenditure. One often mentioned is the introduction into the accounting system of a modified form of Diagnostic-Related Groups (DRGs), as a means of identifying where and how costs are incurred in treatment. The information obtained can be used as the basis for new policy.

Public expectations

A number of issues are bound up under this heading: first, growing dissatisfaction among patients with their lack of choice among the health services now available; second, growing concern over the lack of a direct patient contribution to health service decision-making; and third, high expectations on the part of patients concerning the curative health care system which, it is argued, are not always matched by a recognition that they must reciprocate by taking better care of their own personal health, and which create a misplaced dependence on curative health services. This reasoning is leading governments to seek ways of creating a "health care partnership" between the individual and the system, by using better mechanisms for disease prevention, health promotion and patient motivation.

Decentralization

A common feature of many changes or reforms is the desire to decentralize decision-making to the local level. This is in part a response to public pressure for health care providers to be more sensitive to their particular needs, which also means greater local accountability. It also is in part an attempt to strengthen intersectoral collaboration at the local level.

Market mechanisms

Many countries are considering various forms of market mechanisms in response to the twin pressures of rising costs and a growing demand for consumer choice in health care. The idea of competition in a market environment is attractive in that it is perceived as producing greater cost-efficiency, wider patient choice and better use of resources.

Quality of care

Improved quality was a stated objective of all the reforms under consideration. The concept of a "basket" or package of services was often mentioned favourably; however the consensus on what that package should include has still to emerge. It also was acknowledged that existing health care information systems were not sufficiently developed to measure quality of outcome. Most systems were good at measuring inputs but were unable to ascertain whether the services delivered had improved health status.

Staff training and development

Most reforms proposed would have an impact on staff. A number of personnel problems were identified which would need to be addressed simultaneously with the reform issues. These were questions about: staff

attitudes, especially towards patients; implications for the production and supply of staff; impact upon morale; staff shortages; and retraining of existing staff. These issues will present different challenges to the various health care systems represented at the meeting.

Proposed or potential reforms described in the presentations on the various countries highlighted a number of key factors whose implications have yet to be fully ascertained and assessed. The common theme was an overwhelming desire for change based on the belief that the existing infrastructure was no longer appropriate to the health care needs of the population. The need or basis for reform was thus clearly established. However, the likely consequences of the reforms proposed were less clear. This was the issue to which the meeting then turned.

A number of questions were drafted to focus discussion on how the new trends in policy-makers' thinking would bear on the established principles (as opposed to practice in countries) of health care provision as laid down in the Declaration of Alma-Ata, and on the European strategy and targets for health for all - especially those relating to equity, appropriate care and management systems.

The participants were divided into groups and the questions were put to them for discussion, as follows.

Core questions

(1) To what extent will the proposed reforms have an impact on current policies and programmes regarding particular populations, local areas and activities, notably:

- intersectoral activities undertaken in collaboration with the housing, education or other sectors and directed at various target groups;

- services provided for vulnerable populations (e.g the elderly and frail, children, the chronically ill and the poor);

- health promotion and education activities?

(2) The movement among institutions towards markets, marketing profitability and corporate strategic planning implies a shift in the locus of planning. What will be the consequences of this shift compared to existing and/or continuing approaches based on public sector planning?

(3) Given current trends in organization and funding, what appear to be the likely effects on:

- the existing relationship that binds professional provider and individual patient;

- relationships between health workers and their local communities?

Although the groups were expected to channel their main energies into discussing the core questions, they were also given some optional questions. Whereas the presentations and discussions so far had explored the projected benefits from the reforms being introduced or contemplated, these optimal questions were designed to address and test some of the objections raised.

Optional questions

(1) To what extent does a market-based delivery system encourage economic efficiency through short-term productivity, rather than longer-term social, political and cultural objectives?

(2) Different market-style reforms will generate different transaction costs. What will be the costs under different reform proposals of negotiating, monitoring, evaluating and where necessary going to court over contracts? Many such reforms will involve much greater and more frequent use of formal contracts between purchasers and providers.

(3) By creating competition between services, to what extent will the proposed reforms lead to duplication of services?

Results of group discussions

The core questions were designed to focus on the impact or implications of the proposed reforms. It became clear that there was little or no homogeneity, however, among the reforms under consideration or being implemented in the various countries. This lack of uniformity or similarity led to an attempt to categorize the reforms taking place, as follows:

- the addition of market mechanisms to tax-based public health care systems;

- the addition of market mechanisms to social-insurance-based health care systems;

- a shift from tax-based public health systems to social-insurance funding (with the possible addition of selected market mechanisms);

- a move from social-insurance-based health schemes to a tax-based public health system (with the possible addition of selected market mechanisms).

The influence of reforms

The term "market mechanisms" undoubtedly covers a wide range of measures, some of them more radical than others. It is particularly important to distinguish between measures designed to open the funding of health care to market pressure - for example, the introduction of, or an increase in, co-payments - and those aimed at stimulating competition or choice between public, voluntary or private providers. In general, it was felt that measures encouraging a greater element of private finance in health care would be a less desirable outcome in so far as they carried a risk of introducing new or greater inequities in the system, whereas measures which attempted to promote competition among providers while leaving untouched the existing and socially acceptable balance between public and private funding would be preferable. This conclusion reflected the prevailing view that the goals and objectives which the reforms seek to achieve could only be achieved through some form of public or open-access health care system, whatever the details and mechanisms might be in a given country.

The impact of reforms on intersectoral activities was rather difficult to assess. While different elements in the reform packages will have different effects, as a general statement there is no reason to presuppose that the reforms will necessarily lead to a down-turn in intersectoral activities. There are substantial problems of intersectoral collaboration and coordination in the present systems, and indeed the reforms have the potential to improve on the current track-record, provided they do not introduce any perverse incentives which might harm health care.

Certain aspects of the reforms such as decentralization and deregulation might increase intersectoral cooperation because of the emphasis on finding local solutions to common problems, which could make it easier for people to cooperate, especially where they share common goals. Decentralization of health care is perhaps most likely to encourage more intersectoral activities, especially if it results in an improvement in the nature and quality of community health surveillance and monitoring, identification of risk factors, control of exposure to the risk factors and follow-up programmes.

The effect of the "market" on intersectoral activities is more difficult to discern. Specification of needs for and standards of service and their enforcement in contracts may or may not help intersectoral coordination. The risk is that, as can occur with existing systems, each sector will seek to offload its problems on to the other. The outcome of this will depend on the arrangements adopted and the incentives in the system. However, it does suggest that some mechanism to monitor effects and to take, or at least to prompt, corrective action when required would be advantageous.

With respect to the impact on vulnerable populations, at least three categories of vulnerability were identified:

- social and intellectual vulnerability;
- financial vulnerability;
- health status vulnerability.

To increase individual choice is one of the aims of the reforms, and it is important to ensure that this choice is available to all, including the vulnerable categories. Opinions differed on how best to achieve this aim. Some argued that if providers had to compete they were bound to be influenced by the "short-termism"

of public opinion, with the result that the vulnerable would be the losers. Others believed that market mechanisms in a public-sector-funded health care system would improve efficiency and quality of care, which in turn would benefit the vulnerable, who had little or no voice in the current system.

Additionally, some countries proposed to replace their tax-based systems with social insurance schemes precisely in order to help the most vulnerable, who were put at a disadvantage by the lack of transparency in present arrangements. Provided the replacement social insurance scheme was redistributive, the greater resources could be beneficial to the most vulnerable in society. Whatever the reforms, the general view was that the state would be required increasingly to act as protector to the vulnerable to ensure that their needs were adequately met in the new health systems.

It would appear that health education and promotion activities are not conceived of as forming part of the reforms, and some anxiety was expressed that they would be overshadowed and might be vulnerable to competitive pressures, especially from the much more politically powerful professionals in the acute sector. This problem might even be exacerbated if the public in its perception of health care persisted in not attaching priority to health promotion, in view of the greater visibility of acute sector outcomes. Moreover, under competition, health care providers may be more likely to favour activities which offer short-term benefits rather than the longer-term benefits associated with health promotion.

However, although the participants were not confident that market mechanisms would of themselves promote greater efforts at health promotion, it was stressed that the form of the reforms and their objectives in no way ran counter to the possible use of market mechanisms outside the health sector to encourage

or promote health promotion. High taxes on tobacco and alcohol and lower insurance premiums for those with healthy lifestyles were cited as obvious examples of the possibilities.

The locus of planning

The locus of planning and the role of the planner will change but both will remain crucial to the overall functioning of health systems. It is likely that planning will increasingly be linked more directly to decision-making and to the resulting action. The emphasis will thus be on managed planning in a more market-oriented system.

The changes in planning are likely to include the following:

- a change in scope: planning will be limited in focus rather than comprehensive, but more manageable;

- a change in substance: the planning tasks of purchasers and providers will be different, although ultimately they will need to come to an understanding with each other;

- a change of level: plans will be "owned" by all levels of the system;

- a change of time-scale: time-scales are likely to be shorter, especially at local level;

- uncertainty: this will increasingly prevail, particularly where market mechanisms flourish.

As an important spin-off, where there is less government involvement in the actual delivery of health care, this should provide an opportunity for more long-term (strategic) planning, and it should also give planners the role of protecting the interests of those

who have no constituency (the vulnerable). A key issue is how far the planning activities of competing providers would or should be constrained by national objectives. If national objectives are to prevail, then the emphasis must be on managed competition.

Consequences for local relationships

Advocates of all four types of reform claim that they will be able to improve relationships between the public and health workers.

Health workers/local communities

It is impossible at the moment to predict what the effects of market mechanisms will be. Decentralization should increase the involvement of local communities in health care. The effect of this will depend considerably on the mechanisms chosen, including the character and membership of local governing bodies and forums for local public participation. Different patterns of involvement will follow if the key persons from the community are, say, local business people, newly elected politicians or representatives of community action groups. It was noted, however, that some of the proposed reforms aim to establish a more equal and less paternalistic relationship between the local community and health workers. At this level it will be very important to observe and try to understand how financial arrangements do affect behaviour, especially as many of the reforms will use financial mechanisms not only to pay for care but also to influence the behaviour of the provider.

Physicians/patients

The "health contract" between physician and patient may take various forms: professional, social or private/legal. These relationships are changing partly due to negative reactions to the paternalist medical model of care, the growth of self-help groups, and

interest in alternative forms of care. Greater choice and information about medical services should alter the relationship further. Some concern was expressed that introduction of a financial element into the relationship could have adverse consequences for the patient, and especially for the trust between patient and doctor. All the reforms would benefit from being accompanied by public information and education on the subject of medical uncertainty. Developments such as these must go hand in hand with mechanisms for dealing with consumer complaints or appeals.

In the event, the nature and the extent of the debate on the three core questions meant that the groups could not give serious consideration to the three optional questions. One of these concerned the likely transaction costs of different market-style reforms. It was accepted that there would be particular costs associated with negotiating, monitoring, evaluating, renegotiating and litigating contracts, but also that there would be substantial additional costs for installing and maintaining the information systems necessary to provide data about volumes and costs as the basis for systems of charges.

It was felt certain that the reforms would lead to additional costs, and the question therefore arose whether these costs could be offset by savings achieved through efficiency. There are three complicating factors:

- current calculations of present management costs are unreliable and potentially misleading;

- national guidelines and constraints will restrict the efficiency gains from market mechanisms;

- the health market will have both natural and artificial imperfections.

Research and development issues

The questions considered by the discussion groups could be called "metaproblems" because they are not only complex but also have compound implications. Not surprisingly, therefore, it was agreed that certain issues or elements of the questions needed further analysis and clarification. These may be summarized as follows:

(1) What is the optimum balance needed between centralization and decentralization in order to achieve improvements in health care and improvements in health status? How and why do the approaches differ between countries?

(2) What is the role of risk capital in providing health services and in improving health status?

(3) What is the real contribution made by health services to improvements in health and what is the methodology behind the calculation?

(4) What changes in process, under a mixed health care economy, are likely to affect patients who will need protection because providers need profits and payers need power?

(5) In many Member States the general practitioner is considered the gatekeeper to health services. How will this role change in the mixed economy and what will be the effects?

(6) Many health care systems seek to control costs by treating people non-institutionally. What are the limits to home care, and how is home care technology changing?

(7) What are the criteria for the hospitalization of patients, and how might they vary between disease conditions?

(8) Some of the proposed reforms advocate the substitution of staff or different mixes of skills. What will be the training and retraining requirements of health workers faced with health care systems in which the balance is shifting, wherever possible, towards non-institutional care?

(9) The importance of incentives as the key determinant requires investigation, with particular emphasis on the nature and consequences of various incentives, especially whether they have a sustained influence on behaviour.

Recommendations

1. It was generally agreed that the scale of the reforms taking place or about to take place in the health sector across eastern, central and western Europe are so fundamental and far-reaching that there would be merit in re-convening a group such as the participants brought together for this meeting from time to time, to review and evaluate the changes as they evolve.

2. Existing classifications of health systems are increasingly inappropriate in view of the changing situation with regard to health services. Clarification of the various elements of the changes and their consequences will make it easier to identify new system types. The Regional Office for Europe could play a leading role in this.

3. It is essential to break down the various elements in the reform packages being introduced throughout Europe in order to identify and measure their effects - economic

and otherwise - on the provision of health services. The Regional Office could encourage and facilitate this activity in cooperation with Member States.

4. There is a role for the Regional Office to play in monitoring the rapid changes and reforms taking place throughout Europe and feeding the analysis back to Member States as rapidly as possible.

5. The Regional Office should encourage the cross-fertilization of ideas between Member States, and could encourage new bilateral and multilateral initiatives in their early stages.

6. Member States should be encouraged to explore the status and role of health for all in the new reforms.

7. The management issues arising from a mixed health care economy will require careful assessment and evaluation. This may be a future task for a working group.

Annex 1

WORKING PAPERS AND BACKGROUND DOCUMENTS[a]

Working papers

ICP/MPN 039/5	New approaches to managing health care systems in the USSR, by I. Pustovoj
ICP/MPN 039/6	The new national health fund and the health care reform in Hungary, by A. Javor
ICP/MPN 039/7	New directions in Israeli health care, by M.A. Cohen and B. Rosen
ICP/MPN 039/9	Organization and financing of health services: the ideology of market mechanism, by W.J.A. van den Heuvel
ICP/MPN 039/10	Spain: current developments, by J.J. Artells Herrero, F. Rodriguez Artalejo, Dr Pinilla Palleja and H. Pascuai
ICP/MPN 039/11	New approaches to managing health services in Sweden, by W. Slunge
ICP/MPN 039/12	Provider markets in English health care: incentives and prospects, by S.R. Harrison
ICP/MPN 039/13	Reform of health service system in Poland, by P. Mierzewski

[a] Copies are available from the Health Policies and Planning unit, WHO Regional Office for Europe, 8, Scherfigsvej, DK-2100 Copenhagen Ø.

Background documents

ICP/MPN 039/BD/1 Barnard, K. Trends in health care: beyond market economics? A reflection on 40 years past and 10 years future. Copenhagen, WHO Regional Ofice for Europe, 1990 (unpublished document).

Changing health care in the Netherlands, and summaries of the Dekker report "Willingness to Change" and of the Government's reply "Change Assured". Rijswijk, Ministry of Welfare, Health and Cultural Affairs, 1988.

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Targets for health for all. Copenhagen, WHO Regional Office for Europe, 1985 (European Health for All Series, No. 1).

SSR/MPN 501 The Leningrad experiment in health care management 1988: report of a visit to the USSR. Copenhagen, WHO Regional Ofice for Europe, 1988 (unpublished document).

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Annex 2

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