



WHO

REGIONAL OFFICE FOR EUROPE

42615
EUR/ICP/PHC 210(B)
3405g
ENGLISH ONLY
UNEDITED

HEALTH CARE IN TRANSITION

Report on the First Meeting
of the WHO Working Party on
Health Care Reforms in Europe

Madrid
23-24 June 1992

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1992

EUR/HFA TARGET 27

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.^a

TARGET 27

HEALTH SERVICE RESOURCES AND MANAGEMENT

By the year 2000, health service systems in all Member States should be managed cost-effectively, with resources being distributed according to need.

Keywords

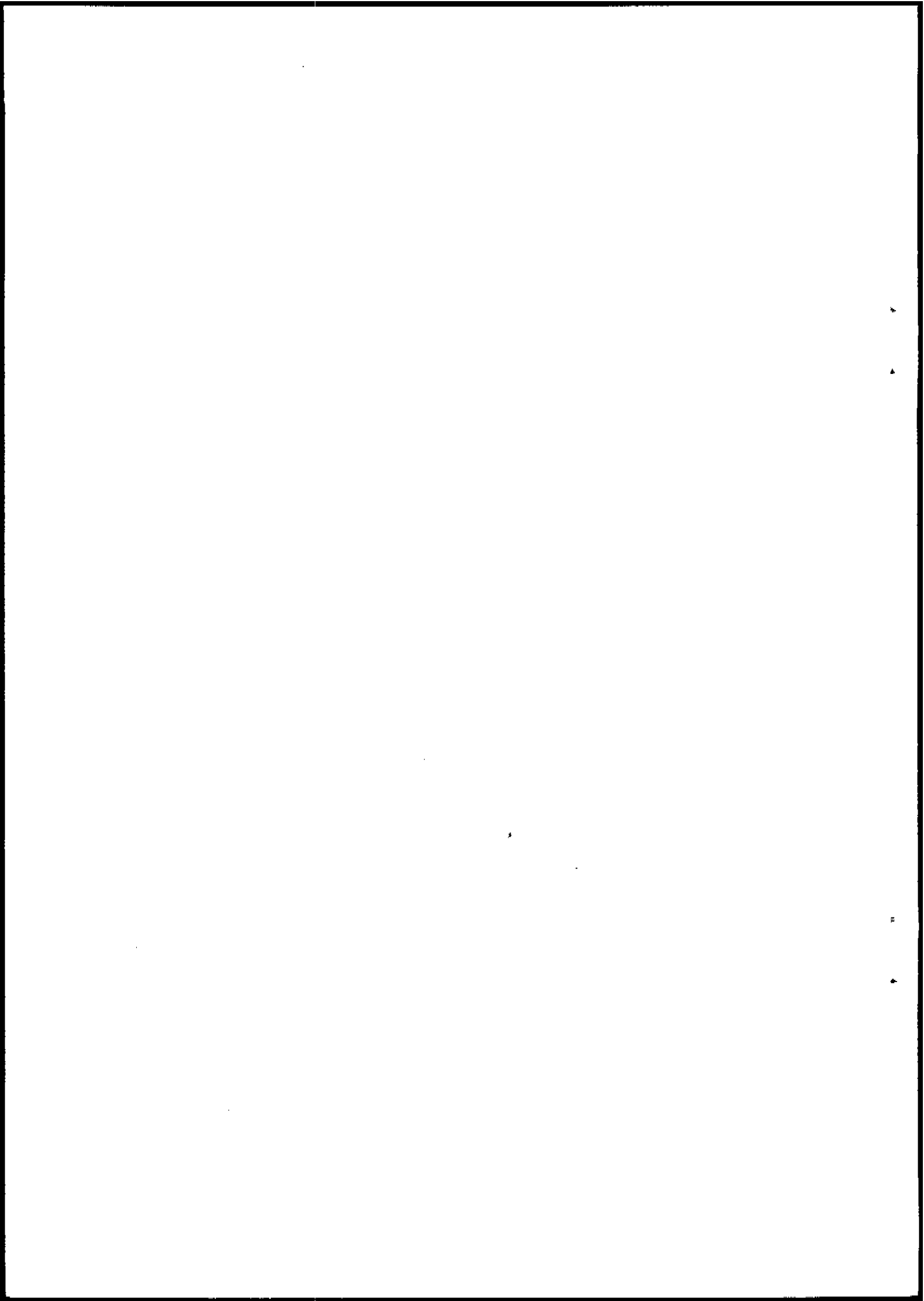
PRIMARY HEALTH CARE – trends
HEALTH POLICY
DELIVERY OF HEALTH CARE – trends
HEALTH FOR ALL
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^a Updating of the European HFA targets. Copenhagen, WHO Regional Office Europe, 1991 (document EUR/RC41/Inf.Doc./1 Rev.1).

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Part I

WHO's Response to Health Care Reforms

1. EUROCARE

Many European countries are reforming their health care systems. The impetus comes from a recognition that better health and health services can increase equity and improve the quality of life of their citizens. Spurred by widening citizen interest and participation in health care, the health authorities want to ensure that health services are of high quality, efficient and effective. Alarmed by the rising costs of health care, they stress cost containment.

Intent to support the health system reforms in the European Member States, the Regional Office for Europe of the World Health Organization has closely followed their progress. It has paid particular attention to the developments in the countries of central and eastern Europe. In consultation with the Member States, the Regional Office has set up a project called *EUROCARE*.

The project has three main parts:

- *Health care policy development*: reviews of health care policies and reforms in Europe and analysis of their development from an Health for All perspective;
- *Strategies for change*: identification and analysis of, and support to, local initiatives in health services development; and
- *Tools for health services development*: identification and development of tools that can be used in health care reforms (e.g., regulation, management, organization, human resources development, financing and information systems);

and support activities:

- *information base*: a data base on literature related to health care reforms and country specific health services profiles;
- *training programmes*: training of policy makers, health care providers and consumers on health care policies and organization of health services; and
- *research*: initiation of, and support to, health services research projects that establish a knowledge base for health care reforms.

2. Working Party on Health Care Reforms in Europe

The European health care reforms are the product of the socio-cultural, political and economic environment of the countries carrying out the reforms. To ensure the relevance of the EURO CARE project for such a wide variety of approaches and influences, the Regional Office has decided to establish a *Working Party on Health Care Reforms in Europe*. Its members are top decision-makers and leaders of health care reforms in Europe. The Regional Office will invite also other international, intergovernmental organizations and agencies with a stake in health care reform to participate. The Working Party aims at:

- establishing a working relationship and a forum for the sharing of experiences between European health care leaders,
- creating a knowledge base on health care reforms in Europe for those involved in the development of European health care systems, and
- analyzing ongoing developments in health care systems within a 'Health for All' framework.

The expected outcomes of the Working Party are:

- accurate and timely reviews of ongoing health care reforms, including country specific health care reform profiles;
- identification and analysis of "models of good practice" in health care reform;
- distribution of information on health to, and sharing it with, a wide audience of national and local decision-makers, consumers, health care providers, health care managers and researchers.

The annual meetings of the Working Party will lead in 1995 to a European Conference on Health Care Reform. The Working Party will have a permanent secretariat at the Regional Office.

Part II

Report on the First Meeting of the Working Party on Health Care Reform

1. Introduction

The first meeting of the Working Party on Health Care Reforms in Europe took place in Madrid, Spain, 23-24 June 1992 hosted by the Spanish Ministry of Health and Consumer Affairs. It was attended by 25 participants from 14 countries. Representatives from the European Commission, Organization for Economic Cooperation and Development and the European Bank for Reconstruction and Development also participated.

The report of the meeting is in four sections. Section 1 outlines the scope and purpose of the Working Party and of the Madrid meeting. Section 2 summarizes the principal issues and themes to emerge from the meeting. Section 3 proposes a set of guiding principles for health system reform. Section 4 sets out the recommendations and proposals for future activities of the Working Party.

Annex 1 lists the working papers and background material for the meeting. Annex 2 contains the list of participants, including officers of the meeting.

2. Scope and Purpose

The first meeting of the Working Party discussed two main themes:

- public versus individual responsibility for health care; and
- financing, purchasing, contracting and the provision of health care in Europe.

The meeting aimed at giving the participants an opportunity to: take stock of the current situation in the countries represented at the meeting; discuss themes of common interest; share views on European health care reforms; take the first step towards analyzing the developments in a 'Health for All' perspective; and to agree on the Working Party's objectives, expected outcomes, organization and programme of work.

3. Main Issues and Themes

3.1 Policy development - the art of making choices

As no health system organization is perfect, national governments will always have to make choices about the objectives their health care systems are to reach. In the financing and delivery of care, trade-offs are necessary among competing objectives. They include comprehensive coverage of services, freedom of choice for individual users of services, control of costs and equity. Different countries have reached, or are pursuing, their particular accommodations among these goals. Governments appear intent not upon creating the perfect health system but in reducing where feasible the degree of ineffective or inefficient provision of health care services.

The health care reforms have many common features, although significant differences also exist. No country appears satisfied that it has found the answer to issues such as how to ensure high quality services; the provision of health care which enhances health gain; the appropriate regulation of providers of care; the securement of equity; the optimal balance between public and private inputs into the financing and organization of health care; or the involvement of the consumers and citizens in the development of health care and ensuring that collective interests are not compromised. In the reform process, the countries are 'learning by doing'. Most reforms are dynamic, with continuing experimentation as a central feature.

Although the core concerns of the health reforms are similar, different groups of countries are coping with these issues in different ways. They have a different mix of influences reflecting their national, economic, political, social and cultural contexts. For example, while most countries agree in principle that equity is an important goal, it takes on different meanings within different systems. While some country policies focus on equity of access or of available resources, others are more concerned to achieve equity of outcome.

The responses to common policy dilemmas can be summarized as follows.

Many countries in northern (e.g., Sweden), northwestern (e.g., United Kingdom) and southern Europe (e.g., Portugal and Spain) want to move from health care systems operated through input budgeting to output financing and from "top-down control and command" administration to a separation between the financing and the provision of health care. The goals of the transition are:

- focus on health care outcomes;
- more autonomous resource management in health care delivery; and
- fewer constraints on patient choice of providers.

These countries are likely to retain predominantly tax-based health care financing and a large share of public provision of health. In many countries, accumulated public deficits and macro-economic pressures to contain public expenditures may become important constraints in the reform process.

While the goals are common, these countries differ. In the Nordic countries, with a tradition of decentralized government, change strategies reflect the interests of the

different groups involved. The United Kingdom reform, although more centrally driven, has also benefited by "learning by doing" from local initiatives. In southern Europe, some countries have adopted new health care policies but not yet carried them out (e.g. Greece, Portugal), while others actively debate the proposed reforms (e.g., Italy and Spain).

Insurance-based systems in continental European countries have aimed at ensuring a tailor-made response to the health care demands of the individuals while containing health care costs. The degree of individual satisfaction with health care and the interaction of many interests in policy development help to stabilize these systems. Improvements in the health care regulation in Germany and the Netherlands stress the importance of the principle of subsidiarity. The Dutch health care reform also changes the structure of health care financing. In France and Germany, initiatives to introduce more effective cost containment strategies are under way.

In *Turkey* the main aim of the current health care reform is the implementation of a comprehensive health insurance scheme to correct the present fragmentation in health care financing.

In the *countries of central and eastern Europe*, health care reforms are part of a deep political, economic and social change. The goal is to move rapidly from a tax-based, state-owned, centrally-administered system to one based on contributory financing and pluralistic delivery. The establishment of health insurance is a key element in this policy. The general priority given to privatization also influences policies concerning ownership in health care delivery.

3.2 Models of health care systems

The reform approaches reflect different points along a conceptual continuum.

Conceptual Continuum of Health Reform Strategies

A	B	C	D
Command-and-Control	Planned/Managed	Regulated	Neo-classical

It ranges from the "*top-down command-and-control*" model of health systems (Point A) through to the "*neo-classical market*" model (Point D). Between these pure planning and market models, are hybrid strategies that combine elements of both models. The "*planned or managed market hybrid*" (Point B) seeks to inject particular market mechanisms into traditional planning structures, while the "*regulated market hybrid*" (Point C) uses selected planning instruments to guide and regulate various health care markets.

The end points of this continuum represent two different conceptual models. . While many European countries have experienced health systems based on "command-and-control" models, no industrialized country (not even the United States) has ever had a health system based on a pure "neo-classical market" model.

The countries with health system reforms are at different stages of general health system development. The countries of Central and Eastern Europe are engaged in massive economic and social reconstruction. Their macro reforms affect the whole socio-economic infrastructure. Since health care reform is lower on the policy agenda, it is inevitably caught up in the general reforms that seek to establish a social market-type economy. The health reform process is more incremental in other parts of Europe. Their reforms take place in a stable political and socio-economic situation. These countries also have stable health care systems and a tradition of negotiating and bargaining among the various stakeholders, particularly with the medical profession.

4. Guiding Principles of Health Care Reform

In undertaking health care reforms, some guiding principles are particularly important.

4.1 Policy framework

The reform process needs a policy framework. Clear final objectives of reform are particularly important. Some countries had placed 'nuts and bolts' concerns at the forefront of policy-making in stead of overall objectives and strategy. In such settings, strategies had emerged implicitly in the guise of seemingly technical or administrative issues. An explicit policy framework seeks to reach agreement on the desired balance between public collective responsibility, private corporate responsibility, and individual responsibility for health. This balance determines the boundary between collective and corporate interests on the one hand and the exercise of individual choice on the other.

A conflict of values may be inevitable in a situation of major reform. Political agreement on which values are to be priorities is necessary. For instance, there are tensions between efficiency and equity, just as there can be tensions between consumer choice and cost containment. Whose standard should prevail: that of the politician? the consumer? the manager or planner? the health professional? The variety of stakeholders is typical of all health care systems. It is important to establish their respective concerns and interests and to take them seriously. The commitment of the stakeholders to the reform is essential for effective implementation. Any health care reform strategy needs to recognize the importance of organizational politics since a particular reform will most likely advance certain interests at the expense of others.

4.2 Health vs. health care

The relationship between health and health care should be established. Is the goal of the reforms to improve the health status of people or are they designed to

improve the operation of existing arrangements? Underpinning health care reforms in some countries is a commitment to securing health gain for the population. This goal presumes an intersectoral approach embracing agencies and activities that extend beyond the conventional boundaries of health care services but influence health status.

4.3 Structural issues

An agreement on policy framework and on the desired relationship between health and health care influences the structural options available for the financing and organization of health services. The issues to be settled include the following:

- the public-private mix of finance and of suppliers of health services;
- various types of health care contracting;
- the role of regulation and evaluation;
- the type and degree of public accountability, both to national and subnational governments and to local communities;
- relationships between purchasers and providers in health care systems;
- the three dimensions of quality: quality of care, quality of management, and quality of life;
- the balancing of top-down and bottom-up forces making for change; the combination of collective direction in establishing the policy framework, with provider initiative and entrepreneurial independence;
- the assessment of transaction costs within a "contract culture", to minimize these costs and to maximize anticipated gains from such arrangements.

4.4 Management of the transition in health system reform

In central and eastern Europe, management of the actual transition is an urgent issue and the pressures on governments to act are intense. It entails giving attention to many issues:

- *infrastructure development and management strengthening*: This involves acquisition of appropriate skills by those managing and providing health services; the training of personnel; development of management and organization; changing the culture in organizations from an administered to a managed environment; and embedding change in the organization;
- *clarification of the roles* of national ministries and sub-national units (whether at a regional, district or facility level) in any move towards decentralization.
- *Creating intersectoral relationships* at national and sub-national levels, especially between health and social care and between disease prevention and health promotion.

5. Recommendations and Programme of Work

The Working Party should meet annually. It could focus on the implementation of policies, the market strategies for health and the progress of reforms. The discussion on market strategies should cover such aspects as: the role of different health care providers, both as organized professions and as providers of specific services (e.g., hospital services and care for the elderly); the role of pharmaceutical industry and high technology medicine; quality of care; patient satisfaction; and health outcomes.

A programme of work was agreed for the year ahead and for the next meeting of the Working Party in 1993. The main elements of this programme are as follows:

1. Reinforcing the Working Party network

WHO needs to establish a health care reform network of key contacts and focal points in all countries with ongoing reforms. This network could arrange meetings on particular issues such as contracting, regulation, and quality assurance.

2. Learning from local reform initiatives

The process of reform should be a continuous cycle involving policy-setting, implementation, review and, where necessary, modification. Such a cycle ensures that policy-makers discuss regularly with key implementors.

The main topic of the 1993 Working Party meeting should be *local initiatives in health care reform*, focusing on the need to close the gap between policy and practice. Implementation will fail without the commitment of those at "street level" who put policies into practice. Local initiatives can illustrate key aspects of the changes under way - such as mechanisms for contracting, models of decentralization, and ways of preparing professionals for the new tasks.

Such initiatives should be identified based on their commitment to the following criteria:

- assessing the effectiveness of policies and finding models of good practice;
- reviewing the progress of policy implementation;
- testing the reaction to controversial proposals and projects;
- winning support and local ownership for the reforms;
- providing pointers for implementation and distribution of results; and
- developing understanding of what to reform and how to carry out the reform process.

3. Developing a knowledge base on health care reform

- Publication by WHO of the background material and working papers in the autumn of 1992;
- Preparation by EURO of European health care system profiles and making them, if possible, available on disk;
- Preparation of background material for the 1993 Working Party meeting.

4. Focusing on the needs of countries in central and eastern Europe

A travelling seminar should be organized in central and eastern Europe involving key contacts from those countries. It would explore issues of particular concern such as the funding of health care through public and private insurance schemes, the improvement of primary health care, and the decentralization of health care management.

Annex 1

LIST OF WORKING PAPERS AND BACKGROUND MATERIAL

Working papers

ICP/PHC 210(B)/1	Provisional list of working papers and background material
ICP/PHC 210(B)/2	Scope and purpose
ICP/PHC 210(B)/3	Provisional agenda
ICP/PHC 210(B)/4	Provisional programme
ICP/PHC 210(B)/5	Provisional list of participants
ICP/PHC 210(B)/6	Working Party on Health Care Reforms in Europe
ICP/PHC 210(B)/7	Public versus individual responsibility for health care: A policy perspective
ICP/PHC 210(B)/8	Financing, purchasing, contracting and the provision of health care in Europe: current developments
ICP/PHC 210(B)/9	Contracting for health and health services: Issues for the UK

Background material

ICP/PHC 210(B)/BD1	Health care reforms in the Russian Federation
ICP/PHC 210(B)/BD2	Some aspects of health care reforms in the Nordic countries
ICP/PHC 210(B)/BD3	Reforms in the United Kingdom: Current and main developments
ICP/PHC 210(B)/BD4	Overview of health care reform in Spain
ICP/PHC 210(B)/BD5	New modalities for health care financing
ICP/PHC 210(B)/BD6	Health insurance: A review and compendium of arguments and evidence from Europe
ICP/PHC 210(B)/BD7	Public health functions in pluralistic systems
ICP/PHC 210(B)/BD8	Quality in health care
ICP/PHC 210(B)/BD9	The development and regulation of a public-private mix of health services
ICP/PHC 210(B)/BD10	Health care reform: the managerial challenge
ICP/PHC 210(B)/BD11	Health Care reforms in the Netherlands

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