

# Health Care Systems in Transition

## *Production Template and Questionnaire*



WORLD HEALTH ORGANIZATION  
REGIONAL OFFICE FOR EUROPE  
COPENHAGEN

# **Health Care Systems in Transition**

Production template and  
questionnaire



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The HiT template and questionnaire have been developed by Josep Figueras and Ellie Tragakes.

# Introduction

The Health Care Systems in Transition (HiT) profiles are country-based documents that provide an analytical description of the health care system and of any reform programmes under development. HiTs form the basis of the information system on health systems and reforms at the World Health Organization Regional Office for Europe (WHO/EURO).

The aim of the HiT initiative is to provide relevant comparative information to support the development of health care systems and reforms in countries in the European Region of WHO. This initiative has four main objectives:

- to learn about different approaches to financing, organization and delivery of health care services in the European Region of WHO;
- to describe the process and content of health care reform programmes and to monitor their implementation;
- to highlight common challenges and areas that require more in-depth analysis and which could benefit in particular from cooperation and exchange of experiences between countries;
- to provide a tool for dissemination and exchange of information on health systems and reform strategies between different countries in the WHO European Region.

The HiT profiles are produced by country experts in collaboration with staff in WHO/EURO's Health Systems Analysis Programme. In order to maximize comparability between countries, a template and a questionnaire have been developed. These provide detailed guidelines and specific questions, definitions and examples to assist in the process of developing the HiT profile. Quantitative data on health services are based on the *WHO health for all database*, *OECD health data* and *World Bank data*.

The realization of the HiT profiles faces a number of methodological problems. In many countries, there is relatively little information available on their health systems and on the impact of health reforms. Most information contained in the HiTs is based on information gathered from individual experts in the respective countries. As a result, some statements and judgements may be coloured by personal interpretation. In addition, the wide diversity of systems in the WHO European Region means that there are inevitably large differences in understanding and terminology. As far as possible, these have been addressed by the development of a set of definitions but some differences may remain. These caveats, however, are not limited to the HiT profiles, but apply to most attempts to study health systems.

In addition, HiTs are a source of descriptive, up-to-date and comparative information on health systems, which should enable policy-makers to identify key experiences relevant to their own national situation. They constitute a comprehensive source of information which can form the basis for more in-depth comparative analysis of reforms. The current series of HiT profiles includes over half of the countries in the Region. This is an ongoing initiative with plans to extend coverage to all countries in the Region and to update the material at regular intervals and to monitor reforms over the longer term.

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Health Systems Unit

# Advice to authors

Authors are asked to follow the attached template and questionnaire for writing the HiT. The *template* is divided into three parts. Part I provides an introductory overview and a brief historical background of the health system. Part II provides an analytical description of the health system, as it exists today, highlighting recent changes, problems encountered and plans for reform. Part III is concerned with the overall reforms and the process of change. The focus here is to place reforms, which may have been discussed in Part II, within the overall reform programme and in chronological order, describing any legislative or other measures which prompted the reforms, as well as issues relating to progress made with implementation of change and plans for future reform. Finally, a concluding section outlines the main challenges, future prospects and lessons.

Please use the *questionnaire* for filling in the template. It contains specific questions, definitions and examples to assist in the process of writing the HiT profile. Each section of the template is explored in depth in the questionnaire.

Please note that you are not required to provide an answer to all questions or to follow the order indicated in the questionnaire. You are asked to write a seamless text on the health system and reforms in your country following the main sections indicated in the template. The questionnaire has been designed only as a guide to the topic to be explored, to ensure that key areas are covered and that authors follow similar approaches, terminology and definitions; thus maximising comparability between countries.

The diversity of systems within the European region means that there will inevitably be some overlap between different questions, that it is not possible to find answers to all questions in all countries and that several questions will be irrelevant to your own country. We have tried to phrase the questions in such a way as to overcome problems of terminology and we have provided definitions and examples for the most important concepts. But we recognize that this may not always be successful. Please do not hesitate to contact us to discuss any areas of concern.

Finally, please note that the questionnaire does not deal directly with the achievement of key policy objectives such as equity, cost containment or patient choice. But questions throughout the questionnaire examine these areas indirectly. These policy objectives are not concerned with one dimension of the health system such as finance or delivery but with all of them. Thus, the section on conclusions will review the lessons from the health system and reforms against the achievement of these objectives.

# Production template

## Part I: Introduction and historical background

1. Introductory overview
2. Historical background

## Part II: The health care system in country

3. Organizational structure and management
  - 3.1 Organizational structure of the health care system
  - 3.2 Planning, regulation and management
    - 3.2.1 Decentralisation of the health care system
4. Health care finance and expenditure
  - 4.1 Main system of finance and coverage
  - 4.2 Health care benefits and rationing
  - 4.3 Complementary sources of finance
    - 4.3.1 Out-of-pocket payments
    - 4.3.2 Voluntary health insurance
    - 4.3.3 External sources of funding
  - 4.4 Health Care expenditure
    - 4.4.1 Structure of health care expenditures
5. Health care delivery system
  - 5.1 Primary health care and public health services
    - 5.1.1 Public health services
  - 5.2 Secondary and tertiary care
  - 5.3 Social care
  - 5.4 Human resources and training
  - 5.5 Pharmaceuticals and health care technology assessment

## 6. Financial resource allocation

6.1 Third party budget setting and resource allocation

6.2 Payment of hospitals

6.3 Payment of physicians

## **Part III: Health care reforms in country**

7. Determinants and objectives

8. Content of reforms and legislation

8.1 Health for all policy

9. Reform implementation

10. Conclusions

## **References**

# Questionnaire

## ***Part I Introduction and historical background***

### **1. Introductory overview**

To be completed in collaboration with WHO, once the other sections have been completed.

### **2. Historical background**

Give a brief account of the key factors influencing the evolution of the health care system in your country in the twentieth century. Emphasis should be placed on major structural reforms as well as any major developments in the last decade that paved or are paving the way towards health care reforms.

## ***Part II The health care system in the country***

This part describes the health care system, as it exists today, following four main dimensions:

- health care finance and expenditure;
- organizational structure and management;
- health care delivery system; and
- financial resource allocation.

This part constitutes a cross-sectional view of the health system together with a view of recent, on-going and planned changes and the problems encountered. Thus, for each topic, it should include the following:

- If changes have occurred in recent years, explain what these changes have entailed.
- If changes are taking place at present, explain them.
- If changes are being planned for the future, explain what these are expected to be.
- Give an account of the main problems associated with particular aspects of the health care system, as well as problems associated with the implementation of change.

Particular emphasis should be placed on making a distinction between planned reforms and reforms that have or are taking place.

### **3. Organizational structure and management**

#### ***3.1 Organizational structure of the health care system***

##### **Chart 1. Organizational chart of health care system**

Please provide an organizational chart depicting the administrative structure of the statutory health system. It should include the main body or bodies responsible for financing, planning,

administration, regulation and provision of the statutory health services. Describe the main geographical/administrative tiers within the statutory system, e.g. national health system, national insurance, sickness funds, etc.

Discussion of Chart 1.

The organization of a health care system can be defined as “the systematic arrangement of various resources, with designated responsibilities and special channels of communication and authority, intended to attain certain objectives. The ultimate objective of organizations in a health care system is to promote or protect people's health, but this ultimate goal is approached through the intermediary role of many agencies with more focused objectives”. These agencies may be involved with financing, planning, administration, regulation, provision or any other health-related function. Consider the following:

- Ministry of Health;
- other ministries (e.g. Ministry of Finance, as well as ministries providing health care services for their employees and families) and government agencies;
- insurance organizations;
- statutory bodies;
- regional/local governments;
- public enterprises;
- private sector;
- professional groups (e.g. physicians' associations, nurses' associations); and
- voluntary organizations.

Describe the current organizational structure of the health care system including key bodies and their interrelationships. Give a brief indication of their functions (e.g. financing, planning, regulation, provision, etc.). Consider the following points:

- main functions of the ministry (e.g. Ministry of Health with main responsibility for health care);
- any other ministries with competence in health services (e.g. Ministry of Labour, Ministry of Defence, etc.);
- insurance organizations (public, quasi-public and private) at national, regional and local level;
- regional and local government;
- main voluntary bodies with responsibilities in the health sector;
- brief indication of the nature of health care providers (public, private) and their interrelationship with third-party payers (e.g. national insurance, sickness funds, etc.)<sup>1</sup>.

To what extent does the organizational structure described above represent a departure from what prevailed a few years ago? Consider the following:

- Have there been any major changes in organization?
- Have any new bodies (e.g. insurance organizations, professional groups) been established or are in the process of being established? What is their role and/or relative importance in the new structure?

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<sup>1</sup> Note that the nature of providers and their interrelationship with the third party is explored in more depth in the following sections under management and delivery.

- Have any bodies (e.g. other ministries, such as Finance or Labour) been phased out and/or are in the process of being phased out (in connection with health care)?
- What major problems were associated with the organizational aspects of the health care system of earlier years (e.g. excessive centralisation and bureaucracy, inefficient management and administration or any other problems)?
- What old problems persist, and what new problems, if any, have developed in the event that processes of change in organizational structures and functions have already been set into motion (e.g. absence of coordination among centres of authority, such as Ministry of Health and other bodies; absence of centres of authority, absence of sound management, inefficient administration, etc.)?

What plans/expectations exist at present concerning future developments in the organizational structure of the health care system?

### **3.2 Planning, regulation and management**

This section deals with the process of policy development, establishing goals and priorities, and translating them into action, i.e. the provision of health care services. In particular, it explores three main functions of the statutory health care system: planning, regulation and management of providers.

Often the boundaries between planning and regulation functions, and between planning and management functions are not clear-cut. Also the nature, characteristics and relative significance of these functions will differ among countries.

In particular, these functions will vary depending on the nature (public, quasi-public or private) of the providers and their organizational relationship with the third-party payers (e.g. national health service, sickness funds, etc.). Two principal models can be distinguished:

- *integrated model* – health care providers are directly employed (or “owned”) by the third-party payers;
- *contract model* – health care providers are independent and are contracted by the third-party payers. There is a separation between purchaser and provider functions.

The content and organization of this section will need to be particularly tailored to the specific organizational characteristics of each health care system. The order of questions presented here is purely arbitrary (i.e. planning, regulation, management and decentralisation). The template does not necessarily follow this order and will be adapted to each country.

Relate the discussion on planning, management and regulation to the organizational chart provided above.

Describe and discuss the organizational relationship between third-party payers and providers.

Describe the current approach to planning. Consider the following:

- Is there a national health planning agency either for health or health services? Is there a national health plan for either health or health services?
- Give a brief account of the approach to capital planning (e.g. number and type of facilities, beds, etc.) and human resources planning (e.g. number of doctors, nurses, etc.).
- Are there health plans at other levels (regional, district, local government, insurance funds, etc.) and, if so, how do they relate to the national plan, if any?
- Describe the process of policy development/priority setting by different tiers in the system (local government, health authorities, individual sickness funds, etc.).

How effective is the planning system in implementing change (i.e. in translating priorities into action)?

Regulation involves “the stipulation of various standards and their enforcement. Regulation is often regarded as applying government surveillance to private activities”. However there are other types of regulation and they can be classified in many ways.

Regulatory functions may include the following:

- pharmaceuticals (e.g. setting drug prices, number of pharmacies, etc.);
- provision of high technology (e.g. number of scanners, lithotripters, etc.);
- registration and licensure of health personnel;
- establishing standards for both public and private hospitals (e.g. physical structures, accreditation, etc.);
- control over sickness funds (e.g. scope of benefits, levels of contribution, etc.);
- control over supply/training of health personnel;
- control over financing mechanisms (e.g. hospital budgets, payment rates, levels of income of physicians, etc.).

Most of these regulatory functions are explored in other sections of the questionnaire. This section aims at providing an overview of main regulatory bodies and, in particular, explores regulation of health care providers.

Indicate main bodies and levels (national, regional and/or local) with responsibilities for regulation.

Discuss existing mechanisms to regulate health care providers.

Have any problems emerged as a result of the introduction of changes in the health care system in the absence of a parallel development of an appropriate planning or/and regulatory system? What plans are there, if any, for the future development of planning and regulation of the health care system?

What is the prevailing thinking on the future development of planning for health and health care?

- In *integrated systems*, in which health care providers are directly employed (or “owned”) by the third party, health care providers are managerially accountable to a series of governing bodies.
- What are the bodies responsible for management of primary health care, public health, secondary and tertiary providers at different levels of the health system (national, regional and local)? How do these management bodies relate to the planning function?
- In *contract-based systems*, in which there is a separation between purchaser and provider functions, providers are “managed” through contracts by third-party payers or purchasers and through regulation by statutory (governmental or non-governmental) bodies. The nature of the contracting process is explored in the next section on delivery and resource allocation. This section focuses on the purchasing function.
- Discuss the planning role of third-party payers/purchasers. How are purchasing decisions made? How are priorities identified and how are they translated into purchasing strategies, if at all?

What are the mechanisms, if any, for citizens’ participation in the planning and/or management of the statutory system?

### 3.2.1 Decentralization of the health care system

"Decentralization" is here defined as changing relations within and between a variety of organizational structures/bodies, resulting in the transfer of the authority to plan, make decisions or manage public functions from the national level to any organization or agency at the sub-national level. Decentralization can take various forms:

- *Deconcentration* involves passing some administrative authority from central government offices to the local offices of central government ministries. For a Ministry of Health, this would typically involve sub-national (district/regional/local) level administrative units of the Ministry of Health taking over administrative duties previously performed at central level, while remaining subordinate to the national government (e.g. health authorities at provincial or district level, health management boards, etc.).
- *Devolution* involves passing responsibility and a degree of independence to regional or local government, with or without financial responsibility (i.e. the ability to raise and spend revenues). Unlike deconcentration, these bodies are generally independent of the national government with respect to their functions and responsibilities.
- *Delegation* involves passing responsibilities to local offices or organizations outside the structure of the central government such as quasi-public (non-governmental) organizations, but with central government retaining indirect control.
- *Privatization* involves the transfer of ownership and government functions from public to private bodies, which may consist of voluntary organizations and for-profit and not-for-profit private organizations. The degree of government regulation is variable.

Characterise the organization of the health system in your country according to the above typology.

Consider each of the above cases of decentralization to characterise the organization of the health system in your country. Describe any such policies that are being implemented in your country.

How far, if at all, has the implementation of decentralization policies proceeded? Describe the present situation with regard to the extent of implementation of the decentralization policy in question.

Discuss main problems that have been encountered in the process of decentralisation. Consider for example:

- absence of centres of authority;
- lack of coordination among centres of authority;
- decentralization to levels lacking in administrative/financial capability;
- absence of a regulatory framework for privatization; and
- absence of the necessary funds for privatization.

Describe current plans, if any, that exist at present for future decentralization policies to be pursued. Are these currently at a proposal, legislation or early implementation phase?

## 4. Health care finance and expenditure

### 4.1 Main system of finance and coverage

Most countries have a mix of compulsory (or statutory) and voluntary systems of finance. This section looks at the organization and characteristics of the prevailing system (or systems) of

finance and at the population coverage. The next section looks at the package of benefits offered. This is followed by a section on the complementary sources of finance including out-of-pocket payments, voluntary insurance and external sources of funding.

For *compulsory (or statutory) systems* use the following classification:

- tax-based;
- national, regional, local;
- income, wealth, VAT;
- earmarked “sin” taxes;
- statutory health insurance;
- voluntary systems;
- voluntary insurance, provided by private, public, or quasi-public insurers; and
- direct, out-of-pocket payments for services.

*Compulsory systems* of finance are those under an obligatory public scheme. They may be based on tax sources of various kinds or on statutory health insurance. Statutory health insurance (also termed “social” or “public” health insurance) refers to health insurance funded by compulsory payment of (usually) income-related contributions by employers and employees. Compulsory systems are usually administered by public bodies or quasi-public bodies, although there are some cases in which statutory insurance may be administered by private insurers.

*Voluntary systems* are those in which finance is left to the discretion of the individuals, either through direct, out-of-pocket payments or through voluntary purchase of insurance, sometimes by employers on behalf of the individual. Voluntary insurance is usually purchased from private insurance organizations, although in some cases it may also be purchased from public or quasi-public bodies.

For most countries in the European Region, taxation, statutory health insurance or a combination of the two, form the main sources of finance.

Describe the main system (or systems) of finance, following the classification described above. If health care is financed primarily out of taxation, consider:

- Main body or bodies responsible for providing health care coverage to beneficiaries (e.g. Ministry of Health, local authorities, etc.);
- Extent of population coverage. What criteria constitute the basis of entitlement: citizenship, residence, any other?
- Are there any excluded groups? If so, what are they? How are they covered, if at all?
- Are there any changes in population coverage that have recently taken place, are presently taking place, or are expected to take place?
- Is opting-out permitted? Is it encouraged through financial incentives such as tax rebates?
- Problems or challenges with respect to any of the above issues;
- Future plans, if any.

Describe the organization of the main body (or bodies) responsible for insuring/providing health care coverage to the population (e.g. third-party insurers).

- Are these public bodies, quasi-public bodies or private (for profit or not-for-profit bodies) bodies?

- Is there a single scheme or are there several schemes?
- Is there freedom of choice of insurance scheme?

Describe the extent of population coverage.

- What criteria constitute the basis of entitlement (i.e. membership of insurance schemes) for occupational groups, residence in specific geographical areas, insurance contributions, etc.?
- Is membership of an insurance scheme compulsory? Are there any excluded groups, if so, what are they (e.g. unemployed, indigent)?
- Are there any groups or conditions in which some groups or individuals can join voluntarily (i.e. is opting out permitted)?
- Are there any income limits above which groups or individuals are not permitted to join the health insurance scheme(s)?
- What provisions are made for non-contributing portions of the population (poor, unemployed, elderly, etc.)? Does the government contribute for these individuals, in part or in full? Are there special tax-funded programmes to finance health services for these groups?
- Comment on any changes in population coverage that have taken place in recent years, or are in the process of taking place, or are expected to take place. What is the rationale behind these changes (e.g. result of implementing health insurance legislation, decreases in funds available for health care, other factors)?

Describe the stipulations on premium contribution:

- Are these payroll-related?
- Progressive or fixed rates?
- Are there special rates for certain categories such as the elderly?
- Employer and/or employee contributions?
- How are contribution rates calculated (e.g. risk related, income related, community rating, etc.)? Who determines them? What is the role of the government in this process?

Is there competition between insurance schemes?

What, if any, provisions are there for risk-adjustment between different insurance funds (e.g. establishment of a national fund, etc.)?

Discuss any problems with respect to any of the above issues and plans for reform.

In many European countries, particularly in southern Europe and the CCEE, there are/have been parallel health care systems providing services for employees and officials of certain national enterprises and ministries, such as the Ministries of Defence, Transportation and others. Discuss any such enterprises or ministries with respect to their financing role.

What problems or challenges have these presented?

What is their present status, and what plans are there for the future of these systems?

Some European countries have mixed systems, in which substantial funding comes from both taxation and social insurance. In certain cases this may be due to an, as yet, incomplete transition from tax-based to social insurance financing or vice-versa. If health care financing

has in recent years switched or is in the process of switching to a social insurance system, give a brief account of the following:

- Reasons prompting this change – what problems were encountered in the previous system of financing?
- State of transition – what actions have been taken to date towards the establishment of the system?
- How far has implementation proceeded?
- What problems/obstacles have emerged in the course of implementation (e.g. insufficient funding through contributions, lack of necessary managerial/technical skills, lack of necessary information systems, etc.)?
- Are statutory health insurance sources of financing intended to replace or supplement taxation sources? What has been happening in practice (e.g. if social insurance has been intended to supplement taxation, has this actually occurred)?

If health care financing has in recent years switched or is in the process of switching to a tax-based system, give a brief account of the following:

- Reasons prompting this change: what problems were encountered in the previous system of financing?
- State of transition – what actions have been taken to date towards the establishment of the system?
- How far has implementation proceeded?
- What problems/obstacles have emerged in the course of implementation?
- Are tax-based sources of financing intended to replace or supplement social insurance sources? What has been happening in practice?

What plans, if any, are there at present for the future development/reform of the financing system? Have any concrete proposals or legislation been developed?

#### **4.2 Health care benefits and rationing**

Are services explicitly excluded from the statutory health system (not available at all, available following full payment by patient, available with copayment)? Which ones? Why? What rationale/criteria are being applied, if any?

Examples might include: alternative therapy or complementary medicine (e.g. spa treatment, homeopathy, osteopathy); long-term care for the elderly and mentally ill; optician services (e.g. sight tests, glasses); pharmaceuticals; dental care (e.g. dental inspections, fillings and extractions, dentures); and specific interventions (e.g. dialysis, cosmetic surgery, in-vitro fertilisation, organ transplantation).

- Have there been any reductions in the benefits package in recent years? What services have been excluded?
- Are there variations in the extent of benefits coverage (e.g. pharmaceuticals, high technology) between different social insurance plans (such as those for different occupational groups)? If so, what are they?
- Are there any initiatives (proposals, policy document, legislation) towards setting a basic package of health care benefits?
- How is the degree of benefit coverage of the population expected to develop in the future in response to changes that may be taking place or are expected to take place in the health care system, such as cost containment policies?

### 4.3 Complementary sources of finance

The health care systems in most European countries are funded either through social insurance and/or taxation. Hence this section presupposes that direct out-of-pocket payments for services (including cost-sharing schemes), voluntary (or private) insurance, and external sources are complementary sources of funding. These are roughly equivalent to private funding.

The main sources of finance appear in the table below. If possible fill in the table with the percentages for each source of finance. If figures are not available, give an indication of the relative importance of each category of financing, and the direction in which each is moving (increasing, decreasing, constant).

**Table 1. Percentage of main sources of finance in .....**

Source of Finance	1980	1990	Present
Public			
• Taxes			
• Statutory			
Private			
• Out-of-pocket			
• Private insurance			
Other			
• External sources			

Source:

Discuss the relative size of each category of financing and any changes that may have occurred in recent years as well as the factors behind these changes.

#### 4.3.1 Out-of-pocket payments

Out-of-pocket payments are payments made directly by a patient for the purchase of a medical service received, and include all payments made without the benefit of insurance.

Many out-of-pocket payments take the form of cost-sharing, which includes the following:

- *co-insurance* – the patient pays a certain fixed proportion of the cost of a service, with the third-party paying the remaining proportion;
- *co-payment* – the patient pays a certain fixed amount of the cost of a service with the third-party payer paying the balance of that amount;
- *deductible* – the patient pays a certain amount of the cost of a service prior to payment of the benefits by the third party.

In addition, out-of-pocket payments include all other payments that may be made by a patient for the purchase of a service (e.g. payments to physicians, hospitals, other medical providers for any services) that are not covered by a statutory body, all under-the-table or envelop payments for services.

Describe the main cost-sharing measures, as well as other forms of out-of-pocket payments, by different categories of care:

- ambulatory care
- hospital care
- drugs
- medical aids and prostheses.

In recent years, have there been any changes (decrease or increase) in the level of out-of-pocket payments? In what areas?

If out-of-pocket payments are increasing, why are they (e.g. cuts in the benefits package following the implementation of social health insurance; declining ability of the public health care system to meet the demand for health care; a growing private market for health care; increasing black market or under-the-table payments to providers, etc.)?

Describe the system of under-the-table or envelop payments. Are there any estimates regarding their prevalence and size relative to official payments? Have there been any attempts to estimate them? What services are they mostly used for? Are any efforts being directed towards reducing the importance of these payments?

Discuss any problems or challenges encountered, and any plans or expectations with respect to future developments in this field.

#### *4.3.2 Voluntary health insurance*

How is voluntary (or private) insurance organized? Is it offered by public, quasi-public or private (for profit, not-for-profit bodies) bodies?

Give an indication of the type and nature of services covered by voluntary insurance. Do private insurance schemes offer full coverage or are they mainly oriented towards complementary services not covered by the statutory system?

What proportion of the population takes out voluntary health insurance? Is this proportion increasing? If so, since when? Is voluntary insurance taken out mainly by individuals or by employers for groups of employees or both?

Have there been any changes in the uptake of voluntary insurance? If changes have occurred, discuss the factors behind these changes.

If voluntary health insurance until recently is or has been non-existent, what, if any, steps have been taken toward its establishment? What are or will be the bodies offering voluntary insurance – private insurance organizations (for profit or not-for-profit), public or quasi-public organizations?

Discuss the expectations and/or plans regarding future developments in this area.

#### *4.3.3 External sources of funding*

External sources of funding refer to external financial assistance for the health sector which may take the form of loans or grants from bilateral or multilateral organizations.

Comment on the evolution of external sources of financing, if any. Consider bilateral and multilateral assistance programmes. How are such external funds being used within the health care system (i.e. for what purpose)?

### **4.4 Health care expenditure**

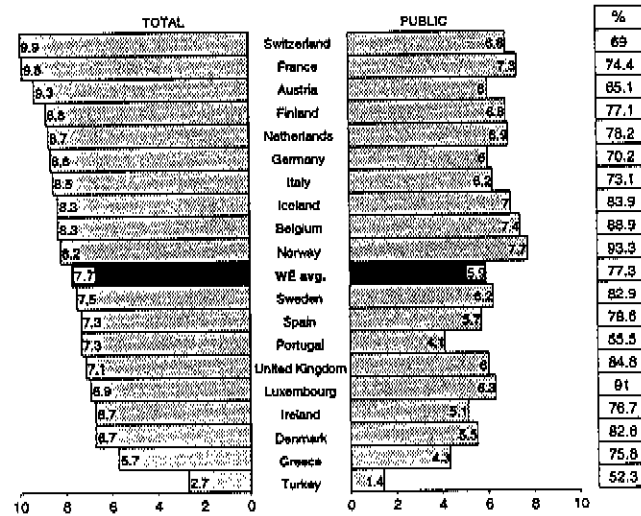
**Table 2. Trends in health care expenditure in ....., 1980–1994**

<b>Total Expenditure on Health Care</b>	<b>1980</b>	<b>1985</b>	<b>1990</b>	<b>1991</b>	<b>1992</b>	<b>1993</b>	<b>1994</b>
Value in current prices							
Share of GDP (%)							
Public share of total expenditure on health care (%)							

Source:

Discussion of Table 2.

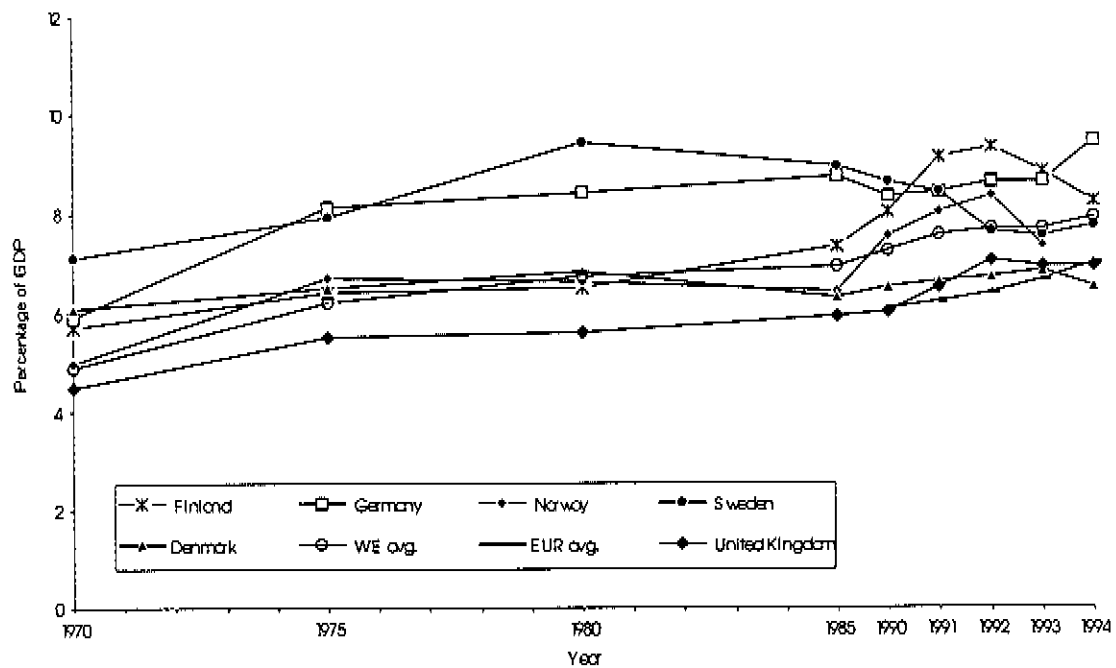
Figure 1. Total and public health care expenditure as a share of GDP (%) in western Europe, 1993



Source: WHO Regional Office for Europe, health for all database.

Discussion of Figure 1.

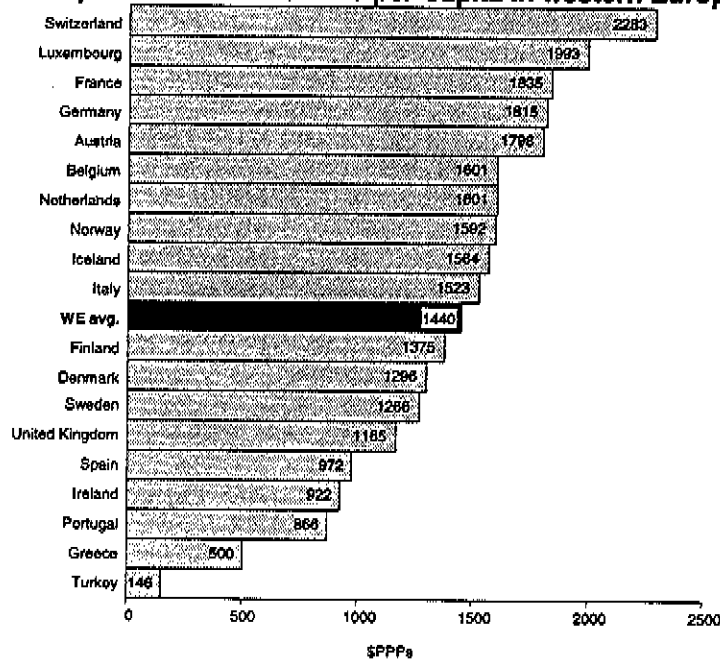
Figure 2. Trends in health care expenditure as a share of GDP (%) in ..... and selected western European countries, years 1970-1993



Source: WHO Regional Office for Europe, health for all database.

Discussion of Figure 2.

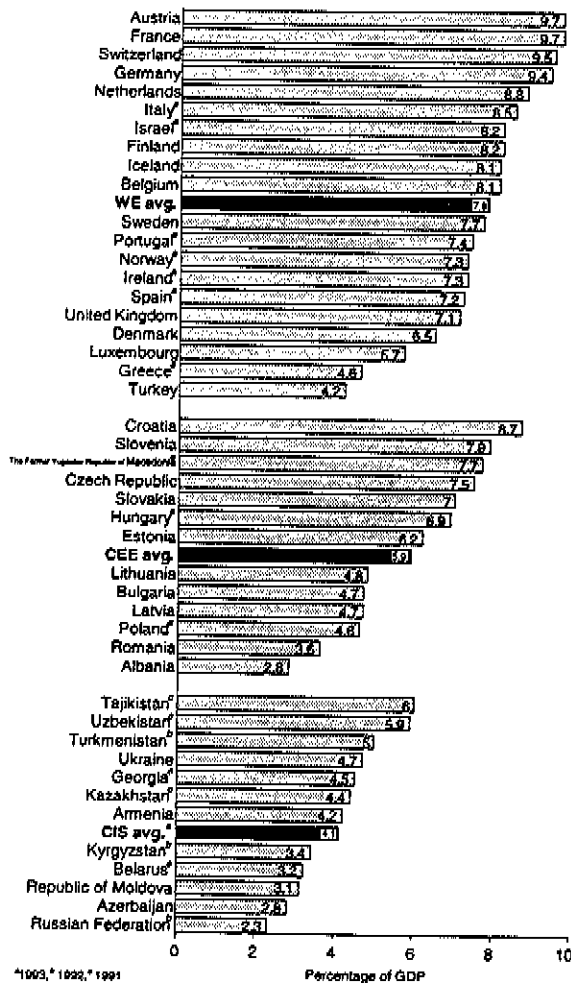
Figure 3. Health care expenditure in US \$PPPs per Capita in western Europe



Source: WHO Regional Office for Europe, health for all database.

Discussion of Figure 3.

Figure 4. Total expenditure on health as a percentage of GDP in WHO European Region, 1994



\*1993, \*\*1992, \*\*\*1991

Source: OECD health data, 1996; World Bank; WHO Regional Office for Europe, health for all database.

#### 4.4.1 Structure of health care expenditures

**Table 3. Health care expenditure by category, (%) of total expenditure on health care, 1970–1995**

Total expenditure on: as share of total expenditure on health care	1980	1985	1990	1991	1992	1993	1994
Public (%)							
In-Patient Care (%)							
Pharmaceuticals (%)							
Investment (%)							

Source: WHO Regional Office for Europe, health for all database.

Discussion of Table 3.

## 5. Health care delivery system

This section deals with the health care delivery system and includes:

- primary health care and public health services
- secondary and tertiary care
- community care
- human resources
- pharmaceuticals.

Also, under each of the sections it includes provision of facilities and human resources and utilization of services.

### 5.1 Primary health care and public health services

Here primary health care refers to the first point of contact of the health system with the individual consumer and includes general medical care for common conditions and injuries. Health promotion and disease prevention activities, also part of primary health care, are described under public health services.

How are primary health care services organized? Describe the model of provision of primary health care services including settings, nature of providers and functions. Consider:

- Settings and models of provision – independent/single-handed practices, group practice, health centre, hospitals;
- Are primary health care providers directly employed or contracted?
- Public-private ownership mix;
- Health care personnel involved (e.g. general practitioners, family physicians, specialists, nurses, fieldshers, paediatricians, social workers, dentists, pharmacists, midwives).
- Give a brief indication of the roles and functions of each category of health care personnel.
- If available, give the average number of patients per general medical practitioner.
- Provide an indication of the range of services provided. Consider the following categories: general medical care (including the adult population and elderly), care of children, minor surgery, rehabilitation, family planning, obstetric care, perinatal care, first aid, dispensing of

pharmaceutical prescriptions, certification, 24-hour availability, home visits, preventive services (e.g. immunization, screening), health promotion services (e.g. health education).

Is there freedom of choice of primary health care physicians (e.g. general practitioners)? What restrictions are there, if any, with respect to changing physician?

Access to secondary care:

- Is there direct access to specialist (ambulatory and hospital) services?
- Is there a GP gatekeeping role?
- Discuss the referral process, if any. Can patients choose hospital and/or physician.
- Comment on the geographical distribution of primary health care facilities/practitioners. How do rural areas compare with urban ones? If possible, provide figures illustrating geographical differences.

What restrictions, if any, are there on the entry of primary health care physicians into insurance practice or into the national health service?

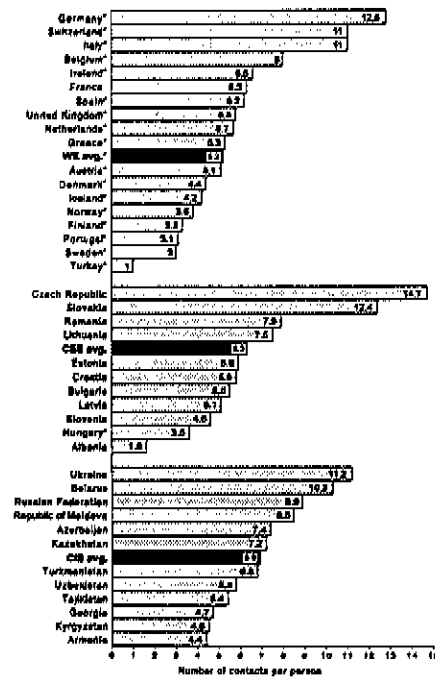
Comment on the quality of services and facilities. If available, include an indication of the level of patient satisfaction with services and facilities (e.g. based on consumer surveys).

Describe major changes that may have occurred in recent years in any of the above areas.

Discuss main problems or challenges associated with current practices relating to the above areas.

What expectations or reform plans, if any, are there regarding future developments?

Figure 5. Physicians contacts per person, western European countries, 1994



Source: WHO Regional Office for Europe, health for all database.

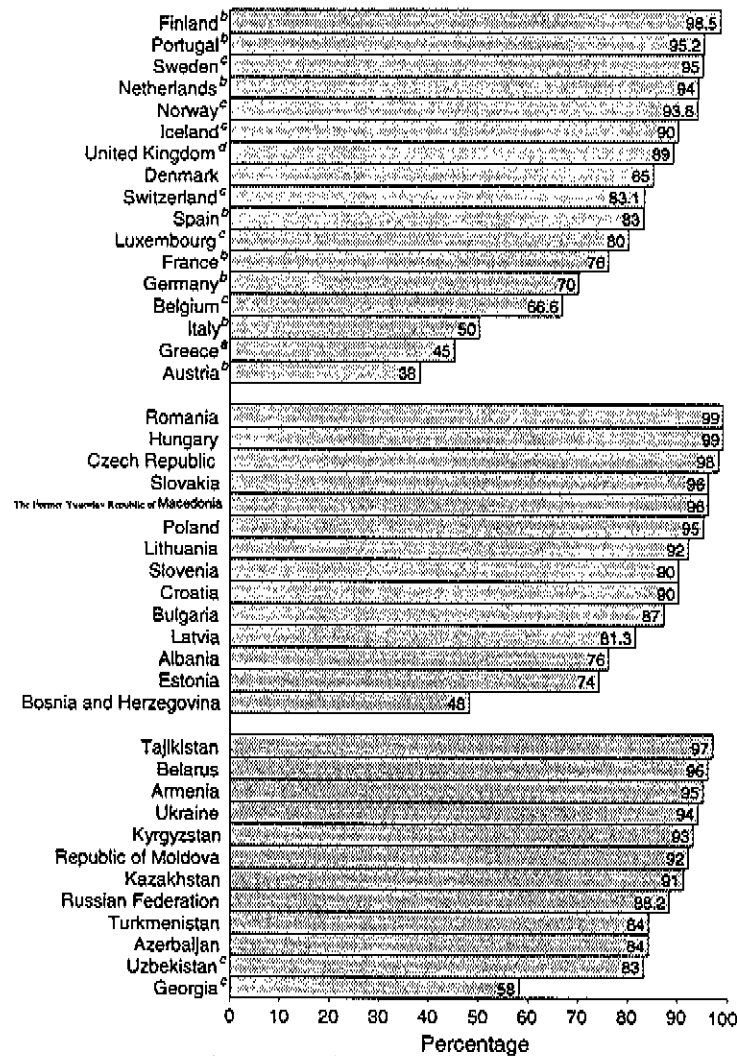
Discussion of Figure 4.

### 5.1.1 Public health services

What are the organizational forms and personnel primarily concerned with the protection and promotion of the public's health? Consider the following:

- How are environmental and communicable disease control functions carried out? What agencies and staff are involved, and by whom are the regulations enforced?
- Are there established programmes of health promotion and education? Who is responsible for executing these?
- How are preventive services organized? Consider immunisation services, family planning, ante-natal services, screening programmes. Who is responsible for providing these services?
- What main developments, if any, have taken place in recent years with respect to the above?
- Discuss the main problems or challenges faced regarding the above topics.
- What reform plans, if any, are there at present regarding the future development of public health services?

Figure 6. Levels of immunization against measles in WHO European Region, 1994



<sup>a</sup>1993, <sup>b</sup>1992, <sup>c</sup>1991, <sup>d</sup>1990

Source: WHO Regional Office for Europe, health for all database.

### Discussion of Figure 5

## **5.2 Secondary and tertiary care**

Here secondary care refers to specialized ambulatory medical services and commonplace hospital care (out-patient and in-patient services). It excludes general long-term care which will be dealt with in the next section on community care. Tertiary care refers to medical and related services of high complexity and usually high cost.

- How are secondary and tertiary care services organized?
- How are specialized ambulatory medical services provided: specialists working in their own practices, polyclinics of specialities, out-patient departments of hospitals, etc.?
- Method of providing specialized ambulatory services under the statutory system (i.e. excluding the voluntary system): are these provided according to the integrated (directly employed) or the contracted (indirect) method?
- Describe public/private ownership mix of specialized ambulatory services and hospital services: public, quasi-public, private for-profit and private not-for-profit.
- Describe the main categories of hospitals, functions and distribution (e.g. district general hospitals, teaching hospitals, “single speciality” hospitals (maternity, orthopaedics, etc.).
- Method of providing hospital services under the statutory system (i.e. excluding the voluntary system): are these provided according to the integrated (directly employed) or the contracted (indirect) method?
- Discuss public/private ownership mix of hospital services (public, quasi-public, private for-profit and private not-for-profit).

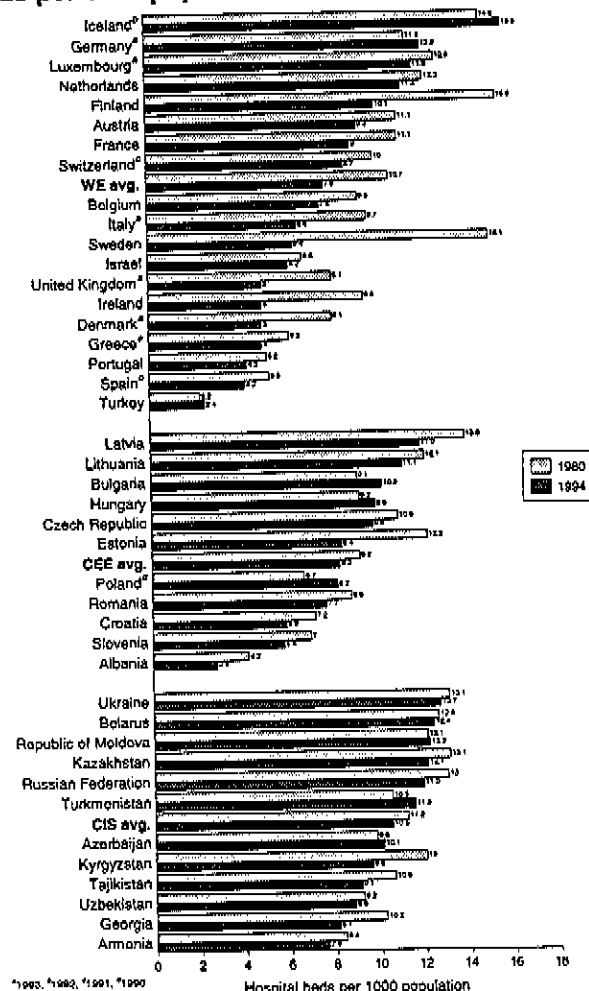
Discuss the geographical distribution of secondary and hospital care facilities. Provide an indication of the quality of hospital services. This may be related to the age, state of repair, and standards of equipment and facilities. If possible, provide an indication of patient satisfaction with services (e.g. based on consumer surveys).

Discuss the relationship between primary and secondary care. Consider:

- Substitution policies which have been, are currently, or are being planned for the future that involve the replacement of the relatively more expensive hospital (in-patient) care by the relatively less expensive out-patient care or home care.
- What is the degree of cooperation between primary health care and secondary care (out-patient and in-patient) providers?
- Possible imbalances that may be present between the importance of primary health care relative to hospital care.

Describe major changes that may have occurred in recent years in any of the above issues. With regard to all of the above issues, discuss the problems or challenges that have emerged. What reform plans and expectations for change, if any, are there at present in connection with the future development of all of the above areas?

Figure 7. Hospital beds per 1000 population in the WHO European Region, 1980 and 1994

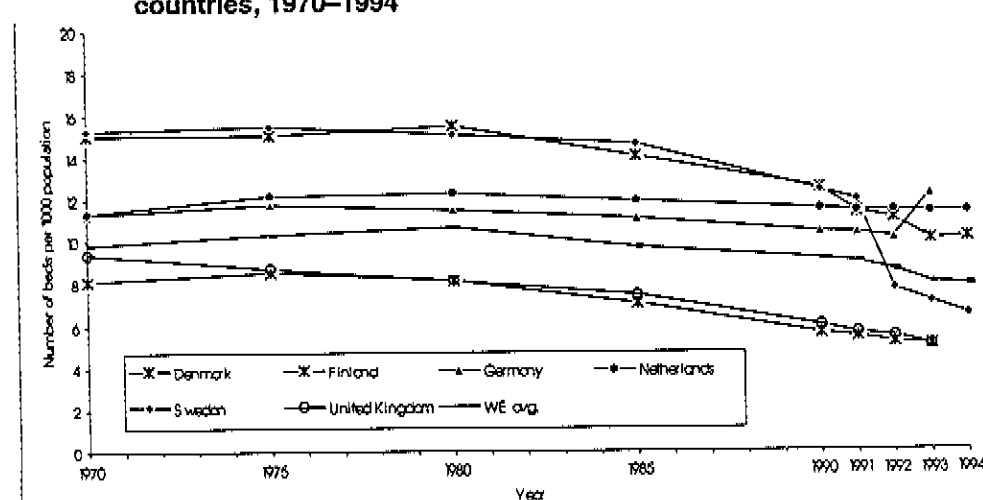


CIS – Commonwealth of Independent States

Source: OECD Health data 1996 (for western Europe); WHO Regional Office for Europe, health for all database (for CEE and CIS countries and for Israel, Norway and Switzerland).

Discussion of Figure 6.

Figure 8. Hospital beds per 1 000 population in ..... and selected western European countries, 1970–1994



Source: WHO Regional Office for Europe, health for all database.

Discussion of Figure 7.

**Table 4. In-patient utilization and performance, ....., 1980–1994**

In-Patient	1980	1985	1990	1991	1992	1993	1994
Hospital beds per 1000 population							
Admissions per 100 population							
Average length of stay in days							
Occupancy rate (%)							

Source: WHO Regional Office for Europe, health for all database.

Discussion of Table 4.

**Table 5. In-patient utilization and performance in the WHO European Region, 1994**

Country	Hospital beds per 1000 population	Admissions per 100 population	Average length of stay in days	Occupancy rate (%)
<b>western Europe</b>				
Austria	9.4	26.5	10.3	80
Belgium	7.6	19.7 <sup>a</sup>	12 <sup>a</sup>	83.5 <sup>a</sup>
Denmark	5.0 <sup>a</sup>	20.5 <sup>a</sup>	7.6 <sup>a</sup>	84.8 <sup>a</sup>
Finland	10.1	25.1	13.1	90.3
France	9	23.4 <sup>a</sup>	11.7 <sup>a</sup>	80.5 <sup>a</sup>
Germany	10.1 <sup>b</sup>	21.3 <sup>b</sup>	15.8 <sup>b</sup>	86.6 <sup>b</sup>
Greece	5.0 <sup>a</sup>	13.1 <sup>b</sup>	9.8 <sup>b</sup>	70 <sup>c</sup>
Iceland	15.8 <sup>b</sup>	28.2 <sup>c</sup>	17.8 <sup>c</sup>	84 <sup>c</sup>
Ireland	5.0 <sup>a</sup>	15.5 <sup>a</sup>	7.7 <sup>b</sup>	n/a
Italy	6.6	15.5 <sup>b</sup>	11.2 <sup>b</sup>	69.6 <sup>b</sup>
Luxembourg	11.8 <sup>a</sup>	20.3 <sup>b</sup>	16.5 <sup>b</sup>	81.4 <sup>b</sup>
Netherlands	11.3	11.2	32.8	88.6
Portugal	4.3	11.5	9.5	68.7
Spain	4.2 <sup>c</sup>	10 <sup>a</sup>	11.5 <sup>a</sup>	77 <sup>a</sup>
Sweden	6.4	19.5 <sup>a</sup>	9.4 <sup>a</sup>	83 <sup>a</sup>
Switzerland	8.7	14.6 <sup>b</sup>	n/a	82.6 <sup>c</sup>
Turkey	2.4	5.8 <sup>a</sup>	6.7 <sup>a</sup>	57.8
United Kingdom	5 <sup>a</sup>	21.6	10.2 <sup>a</sup>	n/a
<b>CCEE</b>				
Albania	2.8	8.07	8.98	71.8
Bulgaria	10.2	17.71	13.6	64.4
Croatia	5.9	12.78	13.78	81.6
Czech Republic	9.8	20.61	13.5	77.7
Estonia	8.4	17.82	14.2	83
Hungary	9.9	22.76	11.3	n/a
Latvia	11.9	20.14	16.4	78.7
Lithuania	11.1	20.6	15.9	79.1
Poland	8.2 <sup>d</sup>	n/a	n/a	n/a
Romania	7.7	21.1	10.3	77.4
Slovakia	7.9 <sup>a</sup>	17.8	12.74 <sup>a</sup>	76.6
Slovenia	5.8	15.8	10.6	79.4
The Former Yugoslav Republic of Macedonia	5.3 <sup>c</sup>	n/a	n/a	n/a
<b>CIS</b>				
Armenia	7.6	7.6	16.32	n/a
Azerbaijan	10.1	8.52	17.9	41.5
Belarus	12.4	24.65	15.3	83.2
Georgia	8.1	5.5	15.2	28.3
Kazakhstan	12.1	18.17	16.8	68.9
Kyrgyzstan	9.6	17.7	15.4	77.9
Republic of Moldova	12.2	22	17.3	n/a
Russian Federation	11.9	21.6	16.8	n/a
Tajikistan	9.1	16.44 <sup>b</sup>	14.5 <sup>b</sup>	58.3 <sup>b</sup>
Turkmenistan	11.5	17.01	15.1	66.6 <sup>a</sup>
Ukraine	12.7	n/a	16.91	n/a
Uzbekistan	8.8	19.3	14.3	n/a

<sup>a</sup> 1993, <sup>b</sup> 1992, <sup>c</sup> 1991, <sup>d</sup> 1990

Source: OECD, health data, 1996; WHO Regional Office for Europe, health for all database, Slovakian data from MOH.

### **5.3 Social care**

Community care services include long-term inpatient care, day care centres and social services for the chronically ill, the elderly and other groups with special needs such as the mentally ill, mentally handicapped and the physically handicapped.

Outline the availability and organization of community-care services including settings and nature of providers. Consider:

- Method of providing these services under the statutory system – are these provided according to the integrated (directly employed) or the contracted (indirect) method?
- Describe the public/private ownership mix of long-term in-patient facilities and day-care centres – public, quasi-public, private for-profit and private not-for-profit.

Comment on methods of access to long-term care facilities.

Provide an indication of the level of availability, adequacy and quality of services.

As for the previous sections, discuss any major changes that may have occurred in recent years, main problems and challenges faced and any reform plans for the development of community services.

### **5.4 Human resources and training**

Discuss the level of provision and quality of health care personnel, in particular physicians, qualified nurses, feldshers, dentists and pharmacists. Are the levels of provision appropriate? Have numbers of health care personnel shown a declining/increasing trend in recent years?

Outline the major issues regarding the training of medical doctors, nurses and managers. For example:

- What has been the position of general practice? What kind of training, if any, has been available for general practitioners?
- Availability of management skills and relevant training programmes;
- Is the geographical distribution of physicians and nurses appropriate?
- What major problems have emerged in connection with the training, management and quality of health care personnel?

Consider the following examples:

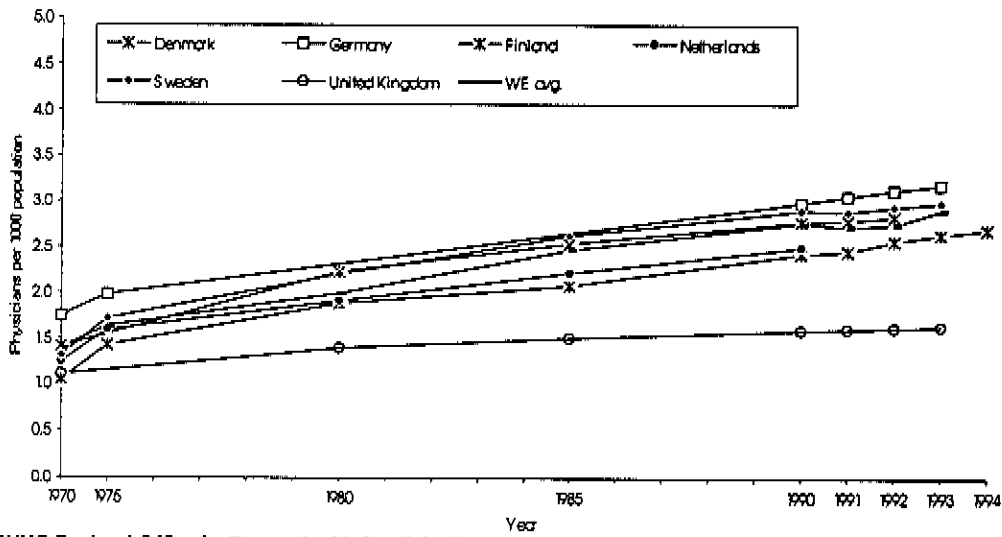
- excessive numbers of specialized physicians;
- medical unemployment;
- lack of managerial skills;
- low educational attainment;
- low status of health care profession;
- low productivity of health care personnel.

What policies, if any, have been instituted towards health care personnel in recent years? Are there any plans for reform. For example:

- Attempts to reduce numbers of practising physicians. If so, how (e.g. through reductions in numbers of medical students)?

- Efforts to upgrade existing or establish new educational/training facilities for health care personnel. If so, in what areas – general practice, nursing, management, public health, etc.?
- Current policy on feldshers;
- Retraining of existing specialists to work in other specialities (e.g. specialists to work in general practice or in public health).

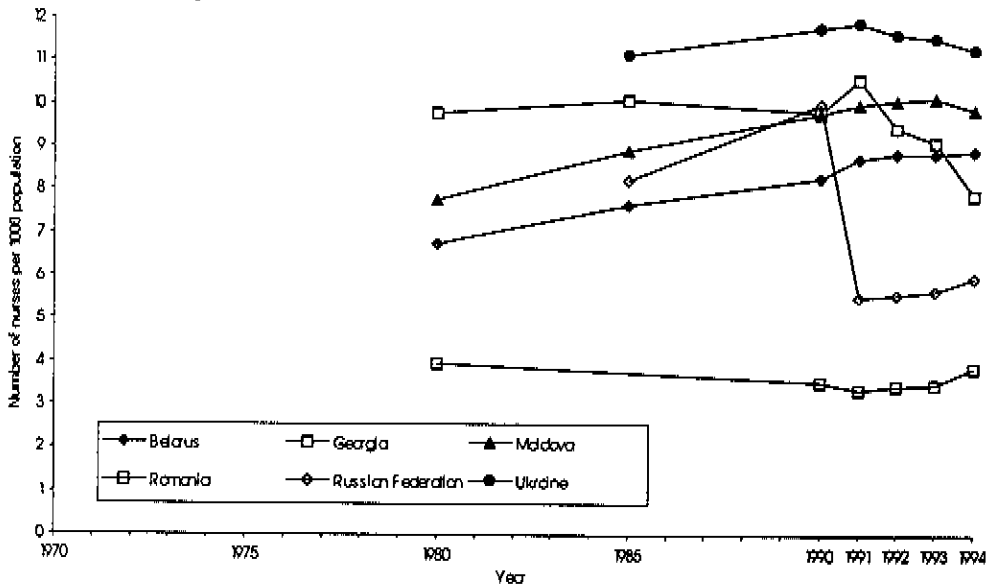
**Figure 9. Physicians per 1000 population, country and selected western European countries, 1970–1994**



Source: WHO Regional Office for Europe, health for all database.

Discussion of Figure 8.

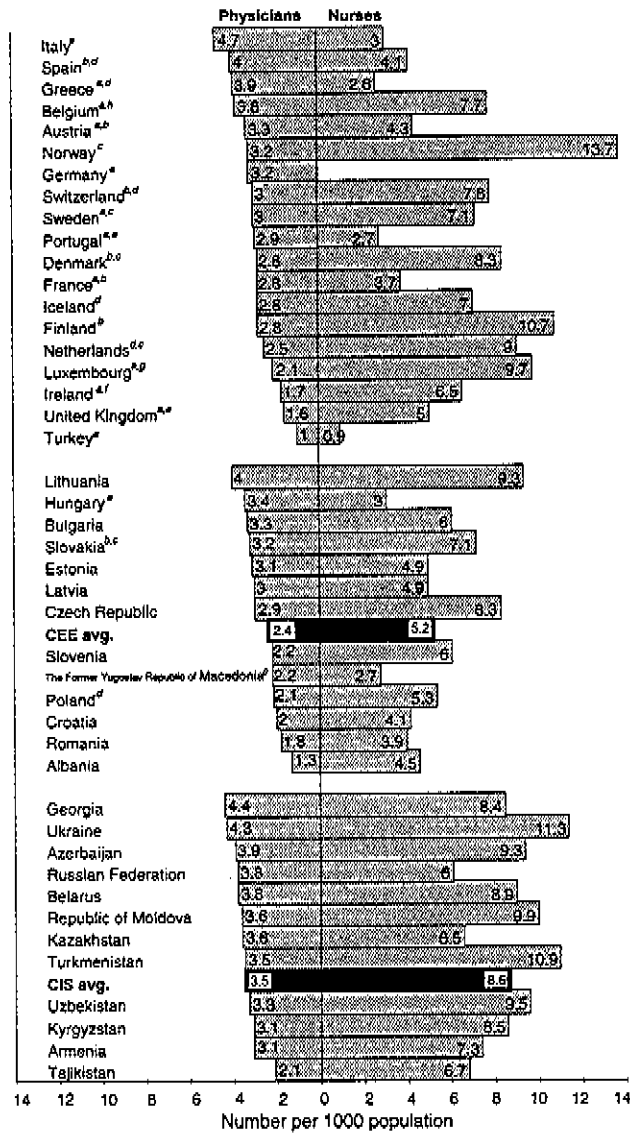
**Figure 10. Nurses per 1000 population, country and selected western European countries, years 1970–1994**



Source: WHO Regional Office for Europe, health for all database.

Discussion of Figure 9.

Figure 11. Number of physicians and nurses per 1000 population in western Europe, 1994



<sup>a</sup>1993, <sup>b</sup>1992, <sup>c</sup>1991, <sup>d</sup>1990, <sup>e</sup>1989, <sup>f</sup>1988, <sup>g</sup>1987, <sup>h</sup>1985

Source: WHO Regional Office for Europe, health for all database.

Table 6. Health care personnel, country, 1970-1995

Persons per 1000 population	1980	1985	1990	1991	1992	1993	1994
Active physicians							
Active dentists							
Certified nurses							
Midwives							
Active pharmacists							
Physicians graduating							
Nurses graduating							

Source: WHO Regional Office for Europe, health for all database.

**Table 7. Health care personnel entering the work force in western Europe per 100 000 population, latest available year**

This includes midwives, pharmacists; physicians and nurses graduating per 100 000 population.

	Physicians	Dentists	Pharmacists	Nurses	Midwives
Austria	16.11	0.02 f	0.3 h	33.43	n/a
Belgium	n/a	0.04 h	n/a	n/a	n/a
Denmark	9.62 b	2.18 d	2.54 b	37.15 b	0.54
Finland	10.39	2.16	6.43	62.75	4.72
France	9.38	1.88	3.83	21.56	1.05
Germany	13.68b	2.66 b	2.51 b	n/a	n/a
Greece	13.3b	3.89 b	2.49 b	19.09 b	1.56 b
Iceland	11.49	3.06	3.06	23.75	2.68
Italy	15.33	1.16	3.7	45.64 a	n/a
Luxembourg	n/a	n/a	n/a	24.91 e	0.27 e
Netherlands	8.86 b	0.59 b	0.97 b	51.6 b	0.43 c
Norway	6.59	1.94	0.7 g	47.71	n/a
Portugal	5.87 d	0.73 e	2.39 e	10.41 d	0.84 d
Spain	18.17 g	n/a	5.81 g	12.86 g	n/a
Sweden	9.94 b	1.96 b	0.71 d	39.17 b	3.03 b
Switzerland	10.06	1.61	2.84	44.67	1.28
United Kingdom	6.34	1.27	1.25	48.69 d	n/a

a 1993, b 1991, c 1990, d 1989, e 1988, f 1987, g 1986, h 1985

Source: WHO Regional Office for Europe, health for all database.

Discussion of Table 7.

### **5.5 Pharmaceuticals and health care technology assessment**

Discuss levels of consumption of pharmaceuticals.

Discuss the country's drug policies to improve cost-effective consumption of pharmaceuticals. In particular, consider:

- Is there a national essential drug list?
- Is the use of generics promoted?
- Is there a negative or positive list?
- Are there any efforts to influence physicians' prescription (e.g. by providing better information or using financial incentives such as "budget holding")?

Discuss level and adequacy of supplies.

Outline the organization of the pharmaceutical sector and the method of distribution of pharmaceuticals to the public. Consider public/private bodies involved in distribution and the extent of government regulation.

What reform plans or expectations are there at present with regard to future developments in this sector?

What controls (regulation, national plans, financial incentives to providers and consumers, etc.) are there on new technology? Do these controls cover the public and private sectors? Comment using examples, if possible, on how effective these controls are.

## 6. Financial resource allocation

Financial resource allocation is defined here as any process by which financial resources flow from a third-party payer (e.g. government, insurer, etc.) through the health care organization (e.g. geographical areas, programmes, provider units, etc.) to the individual clinical provider. This section focuses mainly on provider payment mechanisms. Obviously the method of payment adopted will be directly related to the organizational relationship between third-party payers and providers explored in previous sections.

### 6.1 Third-party budget setting and resource allocation

Comment on the following:

- How is the size of the overall health care budget determined?
- Who, if anybody, decides how much is allocated to different programmes (primary health care, hospitals, community services, etc.)? How?
- How is funding allocated to different geographical areas (regions, urban, rural areas)? Are there any prospective formulae for resource allocation?
- What decisions on the health care budget are made at each level (national, regional, local)? What body makes the decisions?
- How are capital investments funded? What controls are there on capital investment? At what level of government? Do these controls cover the public and private sectors? Are there any systems to ensure equitable geographical distribution of capital?
- Have there been any changes in the system of resource allocation in recent years? What are the main challenges faced?
- describe the prevailing thinking and/or plans for change in the system of allocating resources. What are the expected future developments?
- Construct a financing flow chart showing financing flows and service flows between consumer, third-party and providers. Discuss with WHO.

#### Chart 2. Financing flow chart

Financing flow chart showing financing flows and service flows between consumer, third-party and providers. To be completed in collaboration with WHO.

Discussion of Chart 2.

### 6.2 Payment of hospitals

Consider the following classification of payment methods:

*Retrospective payment* (reimbursement) at "full cost". Third-party payers reimburse providers for all expenses incurred in health care provision. There are no clear constraints on the price (P) or quantity (Q) of health care services provided.

*Prospective payment* methods.

- *Fixing price (P) with or without fixing quantity (Q) of services provided.* Third-party payers reimburse providers for all services provided at a prospectively fixed rate of payment (P).

Alternatively third-party payers can also fix the quantity of services provided. There are three main methods available according to the way health care activity is measured (or units of payment):

- *Fee-for-Service or charge list.* Third-party payers pay hospitals according to a price list of separate services provided to patients such as the use of operating room, tests, drugs, medical supplies, or physicians' fees.
- *Per diem fees or daily charge.* Third-party payers pay hospitals a daily charge. Per diem fees cover all services and expenses per patient per day and do not vary according to treatment.
- *Case payment.* Third-party payers pay hospitals according to the cases treated rather than treatments provided or bed days. Case payment can be based on a single flat rate per case, but in most cases is based on a schedule of payment by diagnosis. The most widely-known case classification (mix) approach is the Diagnostic Related Groups (DRGs). Other methods include the Patient Management Categories (PMCs) and Disease Staging.
- *Global budgets.* Payment of a particular sum to cover the operating costs of services provided by the hospital in a given period of time. The budget may be calculated on the basis of:
  - *Actual costs of a particular provider unit<sup>2</sup>;*
  - *Historical incrementalism,* based on previous year's allocation adjusted by inflation and budget growth;
  - *Provision of inputs* (i.e. based on the number of beds and/or doctors provided);
  - *Population covered* (i.e. per capita);
  - *Volume of bed days;*
  - *Volume and mix of cases.*

*Mixed formulae.* There are no pure payment methods. In most cases, hospitals are paid on the basis of a combination of some of the above. For instance fee-for-service systems are usually combined with a daily charge to cover basic services, such as nursing, food and overheads. In most payment methods there is a budget component to finance investment. Similarly, most systems can be supplemented by *bonus payments* as an incentive to health-care providers to achieve certain objectives.

Describe how hospitals (public, quasi-public, private-for-profit, and private not-for-profit) are being paid at present.

Comment on methods of deciding the rates (e.g. negotiation, rate regulation, payer dictation, etc.). What is the extent of government regulation in this process?

Have there recently been any changes in methods of payment? Indicate problems that triggered change.

What problems are associated with present forms of hospital payment (e.g. lack of regard for cost effectiveness, adverse selection, etc.)?

If new payment mechanisms have been introduced:

- How widespread has their use been to date?
- Have there been any problems/difficulties with implementation?

Are there any reforms being planned?

<sup>2</sup> This is essentially a retrospective system.

### 6.3 Payment of physicians

Consider the following payment methods:

- *Fee-for-service.* A specific amount is paid for each act/treatment provided. Physicians itemize services on an invoice after the completion of care whereupon the third-party payer reimburses the physician or the patient. This is common for self-employed doctors, both for ambulatory and in-patient services.
- *Capitation fee.* Every patient is on a list of general medical practitioners or specialists. The third-party pays the physician a fixed amount per year for each subscriber, regardless of the services provided.
- *Salary.* Physicians are paid a fixed amount for time at work. The physician is paid on a time basis regardless of the quantity/type of services provided or the number of patients treated. This system is mainly associated with direct employment by an organization.
- *Case payment.* Physicians are paid a fixed amount for providing all necessary care to each patient. This can be based on a single flat rate per case or on a schedule of payment by diagnosis.
- *Mixed formulae.* Often payment of professionals is based on a mix of methods (i.e. capitation plus fee-for-service for some services). Similarly, systems can be supplemented by bonus/target payments as an incentive for achieving certain objectives.

Describe how physicians are being paid at present. Distinguish between general medical practitioners and specialists (in ambulatory and in hospital settings).

Comment on methods of deciding the rates (e.g. negotiation, rate regulation, payer dictation, etc.) What is the extent of government regulation in this process?

Have there recently been any changes in methods of payment? Indicate problems that triggered change.

What problems are associated with the present forms of physician payment (e.g. lack of regard for cost effectiveness, low quality of services, low professional satisfaction, morale, etc.)?

Comment on the levels of income of physicians. How do these compare with the levels of income of other professionals?

If new payment mechanisms have been introduced:

- How widespread has their use been to date?
- Have there been any problems or difficulties with implementation (i.e. rapidly increasing physician remuneration leading to payment difficulties in view of resource constraints)?
- How extensive are black market (under-the-table or envelop) payments to physicians estimated to be?
- Are there any reforms on payment systems being planned? What is the prevalent thinking and expectations in this field?

## **Part III Health care reforms**

This part is concerned with the overall health care reform and with the process of change. The focus here is to place reform policies and changes, which have been discussed in part II, within the context of the overall reform programme. This should provide a better understanding of the nature and content of the reforms as well as of the relative significance and interrelationships between different reform policies. Also, particular emphasis is placed on the process of implementation and on plans for future reform.

Health care reform is a phenomenon that in some cases is difficult to characterize. For instance: when does incremental change become reform? When does reform begin or when does it end? Also the understanding and approach to health care reform differs markedly between countries. The contents of this section need to be discussed with WHO for each individual country case.

### **7. Determinants and objectives**

Give a brief account of the main reasons underlying the initiation of health care reforms (e.g. rising costs, poor health service performance, low consumer satisfaction, etc.).

What are the key aims of the reforms and what are they intended to achieve? What is the policy orientation?

### **8. Content of reforms and legislation**

This section is intended to provide a chronology of the process and content of reforms, indicating reform "packages" (if any) and when these appeared (i.e. what reform measures appeared together and at what particular time). As the questionnaire has already touched upon reforms in as much as there has been a discussion of both changes in recent years and plans for future change, the point here is not to repeat what has already been said, but rather to organize the process of change according to a chronology. To avoid unnecessary repetition, reform measures discussed here may be cross-referenced with earlier sections wherever relevant.

Provide a list of key policy proposals and legislation relating to the health care system and reforms. This list should be in chronological order.

For the most important of these measures, provide a brief account of the contents of the legislative measures or proposals.

#### **8.1 Health for all policy**

Has a health for all policy been developed? Has it led to a national policy statement by your Government? If not, describe any actions that are being taken towards developing one.

### **9. Reform implementation**

With reference to the items discussed under *Content of reforms and legislation* above, describe the extent to which each has been implemented to date. A clear distinction should be made between: changes that have already occurred and that have been fully implemented, changes which are under way and which have only partially been implemented, and changes which are expected to be implemented at some point in the future.

What is/has been the role played by key actors and interest groups in the process of reform development and implementation? Consider the following groups:

- health care providers, in particular the medical profession;
- government and major political parties;
- non-governmental organizations;
- research centres and organizations;
- financing organizations, in particular insurance organizations;
- population and consumer organizations.

What is/has been the role of international (multilateral and bilateral) organizations in the process of reform development and implementation?

Mention any other major events which may have a bearing on the process of change.

For example:

- the beginning of the implementation of a key piece of legislation, or alternatively, the non-implementation of another key piece of legislation;
- any pilot projects or evaluation exercises that may have been undertaken;
- national debates involving main social actors.

Discuss the main problems and obstacles faced in the implementation of the reforms. These may be due to structural problems that remain, difficulties in drafting or approving appropriate legislation or difficulties in implementing legislation that has been passed.

Are proposals not being passed into legislation (i.e. difficulties in drafting or approving legislation)?

Are certain legislative measures not being implemented (i.e. difficulties in implementing legislation that has been passed)?

What are the reasons? Consider the following types of resources required for reform implementation:

- political resources include autonomy and stability of the government, consensus among the elite, support of key stakeholders;
- financial resources required to implement change and more importantly to run and sustain the new model;
- managerial resources include managerial and administrative skills, information systems, financial systems, etc.;
- technical resources refer to the capacity for technical analysis to evaluate alternatives and policy change.

## 10. Conclusions

To be completed in collaboration with WHO once the other sections have been completed.

This part will conclude with lessons learned from the health care system and the reform policies against a series of policy goals: equity, health gain, efficiency, consumer choice and quality of care.

It also provides a summary of remaining challenges, future prospects and the way forward.

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Include key references.

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*Note: Some definitions and classifications adopted here are based on the following publications.*

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