



# WHO

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## *SECOND MEETING OF THE WHO ADVISORY GROUP ON HEALTH CARE REFORMS*

Report on a WHO Working Group

Rome  
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1996

EUR/HFA target 26

## TARGET 26

### HEALTH SERVICE POLICY

*By the year 2000, all Member States should have developed, and be implementing, policies that ensure universal access to health services of quality, based on primary care and supported by secondary and tertiary care.*

### ABSTRACT

The second meeting of the Advisory Group on Health Care Reforms (Rome, October 1994) concentrated on developments in the area of health sector reforms in anticipation of the Conference on Health Care Services in Transition to be held in Ljubljana (Slovenia) in 1996. The meeting reviewed WHO's preparatory activities for the Conference, discussed principles, goals and options for health care reforms and the nature of and responsibility for reforms (including the political dimension), and considered ways in which WHO can support the introduction of reforms in Member States, including detailed examination of a policy package and monitoring systems.

### Keywords

HEALTH CARE REFORM  
HEALTH FOR ALL  
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## 1. Introduction

### 1.1 Scope and purpose of the meeting

A central theme in the European health for all (HFA) policy is the balanced interaction of its main elements - health status and its development through healthier lifestyles and environment and appropriate care. Current developments in Europe, and in particular in the countries of central and eastern Europe (CCEE), call, with some urgency, for a WHO perspective on the development of the European health care system inspired by the HFA principles. In recent years, a number of European Member States have been looking to WHO for such a perspective.

The challenge is formidable: re-focusing the management and financing of health care towards health and health care outcomes; re-addressing the role of government, public, quasi-public and private organizations in health care policy, financing and the provision of services; re-analyzing the decision-making process that determines individual entitlements to health care (scope, nature, financing); evaluating the implications of emerging health care policies in human resources development and research; recognizing the practical implications of European diversity in adopting a health policy agenda, in managing the process of change, in focusing international cooperation and mobilizing European solidarity.

This task is challenging and difficult. The Department of Health Services, WHO Regional Office for Europe, has developed fora for structured discussion and dissemination of knowledge during the previous biennium. The *Working Party on Health Care Reforms in Europe*, and the *Expert Network on Health and Health Care Financing in The Countries of Central And Eastern Europe* have proven to be valuable tools in clarifying the issues and concepts. In addition the *Network for Health Care Management and Financing in the Central Asian Republics* has been established as a result of the Ministerial Consultation in Almaty in December 1993.

Special efforts have also been made to: focus on the citizens' views on health care reform; to strengthen the patients' rights movement (a consultation on patients' rights was held in March 1994); and to provide advisory support to countries currently reforming their health services. However, to fulfill its responsibilities to the unique comprehensive and Europe-wide mandate to contribute to the development of European health care systems, the Organization has decided to hold a *WHO Conference on European Health Care Systems in Transition* in two years' time, in 1996.

In order to respond to the needs of Member States and to be able to prepare WHO support in a way that reflects experience from the field, at the beginning of 1994 the Department of Health Services decided to establish an *Advisory Group for Health Care Reforms* under the auspices of the EURO CARE project. The group consists of outstanding policy makers from different parts of Europe participating in their personal capacity and representing Member States which have stood in the forefront of health care reforms. A small secretariat consisting of WHO staff members and selected experts will take care of the practical arrangements. The first term would end in 1996 at the WHO Conference on European Health Care Systems in Transition.

The group will meet about twice a year in short two-day meetings, during which constructive discussion, debate and advice on implementation of WHO activities will be carried out. From among the group members a chairperson and a rapporteur will be selected for each meeting.

The first meeting of the Advisory Group, hosted by the *Istituto Superiore di Studi Sanitari*, took place in Rome in March 1994. The second meeting of the Advisory Group will also take place in Rome, through the generous hospitality of the same Italian Institute.

The topics to be discussed will be:

Firstly, to clarify the **principles, goals and options** of health care reforms (investing in health; the implications for health care reforms in relation to health for all principles and public health action models; personal/social responsibility and future of welfare society; basic basket of services; the role of government and decentralization of decision making and the delivery of services; issues of ethics and equity under health care delivery). Under the mentioned six items the group will aim to elucidate the fundamental philosophy and objectives forming the foundation for the design of actual health care reform. At the end of the meeting we specifically aim to answer the questions: **What is the problem and whose problem is it?** The political dimension of reforms will be included in the answers.

Secondly, the group will focus on the **monitoring** of health care reforms - advising WHO on the draft designs for the health services knowledge base and monitoring systems. (Existing plans and designs will be presented at the meeting.)

Thirdly, a tentative agenda towards the preparation of the Conference on Health Care Services in Transition will be drafted.

## **2. Review of progress towards conference of 'Health Care Systems in Transition' in 1996**

### **2.1 Location**

It was reported that contrary to the information we had last spring during the first advisory group meeting, the Conference would not be held in Vienna, and the new location would be announced soon. The strongest candidate for the time being is Ljubljana, Slovenia.

### **2.2 Activities 1992-1994**

There have been many activities in WHO which form part of the preparation for the 1996 Conference. Some of these were not initiated solely for the purpose of supporting the Conference, but do form an important part of the preparation. Examples of the preparatory activities are:

- **Working Party on Health Care Reform**
  - \* the first meeting held in Madrid in 1992 on issues of health care reforms
  - \* the second meeting held in Essen in 1993 on management of change and health insurance
  - \* the third meetin held in Leeds in 1994 on innovation in health care management
  
- **The Network on Health and Halth Care Financing Strategies**  
[1) Belarus, 2) the Czech Republic, 3) Germany (Land of Brandenburg), 4) Hungary, 5) Latvia, 6) Lithuania, 7) Poland, 8) Slovakia, and 9) Slovenia]  
A common theme in these activities is the role of the state in health care reform.
  
- **Consultation on Patients Rights (Amsterdam 1994) and the Network**

## on Citizens Views on Health Care

- **'CARNET' : Network of Health Care Management and Financing of the Central Asian Republics**
  - \* the first meeting held in Almaty in 1993
  - \* the second meeting to be held in Tashkent November 1994
- **European Health Policy Conference, Copenhagen 5-9 December, 1994** (components on 'health care reforms and health gain' and 'health care reforms in the CCEE/NIS')

There are also other important activities related with health care systems in transition e.g. in health care delivery (PHC and Hospitals) such as 'innovation in primary health care and hospital services', 'human resources for health', and 'public health management'. What is needed is a clear purpose and common denominator for these activities.

### 2.3 Planned activities

The core question is what should WHO be doing to support the health care reform process. The meetings of the Advisory Group (probably three more before the Conference) aim to clarify the important activities and developments.

In addition, one more meeting of the Working Group of Health Care Reforms is planned in 1995 as well as a technical meeting on issues of monitoring health care systems and health care reforms in Kiel (GER) Nov. 1994.

An **Office Task Force** (WHO-EURO) and an **Editorial Board** will be set up. The first meeting of the Editorial Board will be held in January-February 1995.

### 2.4 Purpose and expected outcomes of Conference on Health Care systems in Transition

The conference will have two main purposes:

- 1) To establish and reinforce important principles and goals in health care reforms as a political mechanism. The outcome may be in the form of a Charter or Declaration
- 2) To focus on activities which call for WHO action even without a Conference, but which will benefit from the added momentum.

The Conference should provide an overview and analysis of current patterns of health care reform. The main objectives of WHO are:

- 1) To ensure that health care reforms are guided by a Health for All (health gain) perspective

- 2) To assist the Member States to strive for balance of efficiency, income protection, equity, quality of care, choice and autonomy for patients, and sustainability.

WHO has a unique responsibility for this role, although it is important to work with other organisations with overlapping objectives.

An aim of WHO is to improve its policy advisory roles to member states, by developing tools, approaches, and information bases. Policy development in advanced pluralistic countries is increasingly difficult as governments attempt to accommodate perspectives of providers and users of services.

The challenge is to see if it is possible to agree on policy principles and goals inspired by Health for All, and to encourage monitoring the progress of reforms against these. This will require co-operation with Member States and other international agencies with interests in the health field.

### **3. Tools and packages for health sector reform**

A major focus of this meeting was to review the appropriate tools and packages to support health sector reform. Small groups considered in detail the content of the policy package, and the knowledge base.

#### **3.1 Policy package**

Consideration of the policy package started with a detailed look at what are the appropriate principles, goals and options in health sector reform. This process was assisted by the results of the questionnaire sent to the Advisory Group before the meeting. The results of the survey and the small group discussion showed considerable overlap between the principles and goals.

The aim of the group discussions was to move towards an early draft of the policy package. This requires the development of a clearer understanding of what should be the components of the package, and what should be the content of the package. A starting point for the discussion was the results of the questionnaire sent to delegates before the meeting. However, this was not to be taken as being more than a guide for the groups

The questionnaires showed that the principles fall into following main categories:

- philosophical / moral
- Health for All -related ('health gain')
- consumer rights (patients' rights, Citizen's views)
- financial control and efficiency.

The five main principles identified by the Advisory Group as most pertinent for health care reforms were:

- 1) that the reforms should be based on Health for All -principles and targets,
- 2) that the reforms should be based on equity,
- 3) that health services should have universal access and that their financing should be based on solidarity,
- 4) that the reforms are acceptable to citizens, providers and payers, and
- 5) that the citizens share the view of responsibility for promoting their own health with organisations of health care financing and health care providers\* .

The goals in reform of health sector can be divided between high level goals concerned with overall objectives and characteristics ('development objectives'), and those concerned with achieving these (immediate objectives).

The main goal of health care reform is to assist in improving the health of the population, in the context of equity in access and respect and autonomy for the patient.

The achievement of this goal requires:

- solidarity in financing
- concern for quality of care, both in terms of outcomes and the quality of experience for patients
- control of cost and improved efficiency ('doing the right things instead of just doing the things right')
- sustainability
- educating people about health promoting life styles
- educating people about resource implications of their use of health services

There was particular concern that attention should be given in designing reforms to the need to ensure access to care for traditionally disadvantaged groups in the population, and to ensure geographical equity.

Although the goals may be seen as more operational than principles, it is clear that the underlying ideas are similar, and the lists represent similar approaches. It may be, however, that there is more divergence between principles (which may be seen as universal) and goals (which are more

pragmatic) in the context of reforms and planning reforms in a single country than when all countries in the Region are being considered.

Options are defined in this context as different ways of achieving goals of reforms and respecting principles. Options were identified in terms of a number of dimensions of choice:

1. Financing .....	↗ ↘	<ul style="list-style-type: none"> <li>• citizens</li> <li>• patients/ consumers</li> </ul>
2. Organization of health care system	↗ → ↘	<ul style="list-style-type: none"> <li>• free market</li> <li>• regulated market</li> <li>• planned system</li> </ul>
3. Provider payment .....	↗ ↘	<ul style="list-style-type: none"> <li>• prospective or retrospective</li> <li>• service related or not service related</li> </ul>
4. Ownership .....	↗ ↘	<ul style="list-style-type: none"> <li>• public</li> <li>• private</li> </ul>
5. Primary health care organization	↗ → ↘	<ul style="list-style-type: none"> <li>• geographical</li> <li>• by GP</li> <li>• not organized</li> </ul>
6. Decision making level .....	↗ ↘	<ul style="list-style-type: none"> <li>• decentralized</li> <li>• centralized</li> </ul>
7. Citizens' participation .....	↗ ↘	<ul style="list-style-type: none"> <li>• what source?</li> <li>• what level?</li> </ul>
		<ul style="list-style-type: none"> <li>• universal or sectoral</li> </ul>



10. Resource allocation.....	<ul style="list-style-type: none"> <li>↗</li> <li>→</li> <li>↘</li> </ul>	<ul style="list-style-type: none"> <li>• geographical</li> <li>• technological</li> <li>• using human resource management</li> </ul>
11. Information.....	<ul style="list-style-type: none"> <li>↗</li> <li>→</li> <li>↘</li> </ul>	<ul style="list-style-type: none"> <li>• patient</li> <li>• professional</li> <li>• management</li> </ul>
12. Patients' rights.....	<ul style="list-style-type: none"> <li>↗</li> <li>↘</li> </ul>	<ul style="list-style-type: none"> <li>• specified</li> <li>• non-specified</li> </ul>
13. Relations of health services with other components of health for all	<ul style="list-style-type: none"> <li>↗</li> <li>↘</li> </ul>	<ul style="list-style-type: none"> <li>• lifestyles</li> <li>• environment</li> </ul>

There was discussion about presenting these options as **sets of profiles** or packages rather than as separate dimensions of choice. This would make the pictures simpler and more realistic, but would risk encouraging unnecessary linking of dimensions, such as private provision and fee-for-service payment. The general preference was for a longer menu of choices, which can then be put together as alternative packages.

Further options were identified, including should reforms happen quickly or be gradual, and should they be comprehensive or incremental?

### 3.2 Monitoring health sector reform

Many existing activities of WHO are relevant to monitoring health care reforms although there are broader objectives. There are comparative data on different countries in the Region, some of which can be used to compare access to services, trends in health and important background information. The issue addressed was how far the existing and planned activities in gathering and analysing information meet the needs of monitoring reforms. The emphasis was on the knowledge base needed rather than on details of the indicators.

The Health for All data base has useful epidemiological indicators, but relatively little on health services. There are country specific data on profiles

on nursing, primary health care and Health Care in Transition Profiles (HiT). Other international agencies hold useful data on health and health services. Data on health care reform need to be country based but should allow general lessons to be learned. They cannot be too comprehensive, but must contain the relevant information, in accessible and easy to use forms.

It is important to be clear about the ways in which the information is to assist member states. It should allow countries to draw on the experiences of others, and better to monitor their own progress.

It must be understood that there are times when countries will have good political reasons for not wanting to monitor progress since it can conflict with beliefs and long established policy. In addition it can be difficult for governments to be specific about priorities, especially if this involves specifying those who are not to obtain access to care.

The task for the Advisory Group was:

- to review components of WHO monitoring of health sector reform
- to advise on the overall content of the monitoring system
- to review the expected products of the knowledge base taking into account the following two main criteria:
  - \* WHO's role as the lead international agency in the field of health and health care, and
  - \* the need to improve WHO's capacity to provide advice to member states

The key points identified were:

- The starting point should be the demand for information and its use. Availability of information, whilst important, should not be the main criterion for inclusion of indicators in the data base.
- The knowledge base should provide a comprehensive analysis of health care reforms in the Region, linked to relevant data and analytical approaches from other organisations.
- There should be a comprehensive toolkit in a user friendly format to allow the knowledge base to be linked with daily practice.
- The indicators need to be based on good, reliable, comparable and well validated data .
- Information about the key topics in health care reform should be made available

- The knowledge base should provide a guide to obtaining literature on health care reforms.
- The knowledge base should aim to give good overall picture and to provide detailed guidance, but should avoid intermediate levels of detail.
- There is a general problem that health indicators are unlikely to be very useful in monitoring health services due to the weak association between health and health services. There is a stronger association between health services and quality of life.
- The indicators currently available and under development do not adequately cover quality of services (including the experience of patients) equity, choice and autonomy of patients and health related quality of life. There is a need to identify indicators, which can measure variations in access to health services by socio-economic status and geography. Solidarity can partly be characterized by data on population coverage. Health gain can be measured only at the insensitive aggregate level.
- There is also a need for problem oriented case studies on such topics as the effects of reforms on occupational and environmental health services, the experiences of introducing new mechanisms for collecting funds for health care finance, the effects of new rules on referring patients, or the consequences of primary health care reforms. WHO may be able to provide a common structure for such studies, and to add such studies to the resources provided. It could include sections on what went well (and from whose point of view). This in turn could help to get principles and goals more explicitly on the agenda. This approach may have the advantage to get below the surface, and to discover what really happened.

There were particular suggestions to collect data at national and operational levels from research centres. Some information is needed from the perspective of the citizen as well as health care professionals and providers. National health inquiries should be carried out with a mixture of open and closed questions. The analysis should aim to clarify and identify obstacles to change, and assist management of change.

There is little point in collecting data unless they will be useful and used. It is probably not enough to provide good information, but rather there is a need to be more active in sponsoring its use. However, there is a limit to how far it is possible to go in persuading countries to assist with and use information on reform.

#### **4 Preparation for the Conference on Health Care Systems in Transition**

The programme of work leading up to the Conference needs to develop the policy package and the plans for monitoring reforms. The materials need to be in a form in which only minor developments and amendments are expected during the Conference. This requires a staged programme of work to clarify the issues and develop the documents and other resources.

##### **4.1 Format of the Conference on Health Care Systems in Transition**

The Conference is a political event, with the objective of obtaining agreement to principles and goals in health care reform. This will probably be in the form of a charter or declaration, as the most effective tool in encouraging adoption of principles and goals for reform that are based on Health for All principles. It is desirable to have some serious discussion and learning at the meeting itself, but this must not have the effect of creating divisions and dissent.

It may or may not be useful to have a preliminary meeting before the main event. This could help if there is need for further building of consensus and to allow fuller discussion of some of the issues.

##### **4.2 Next meeting of the Advisory Group**

The next meeting of the Advisory Group should aim to move to the first proper draft of the **Policy Package**. It should also help to provide further clarification on the monitoring of reform.

Current data are poorly matched to problems. It may be useful to the Advisory Group to start with about five pages on outcomes, obstacles to achieving outcomes, avoidance of conflict etc. This would focus on why reforms are likely to succeed or fail, how to manage conflicting interests, and retain a focus on basic principles.

There should also be consideration of the principles and goals, and how these can be refined to useful and serious, but widely acceptable tools. These might then be tested on provider and patient interest groups prior to documents being prepared for the Conference.