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Volume IV Health Care Reforms for Health Gain

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Target 33

HEALTH FOR ALL POLICY DEVELOPMENT

*By the year 2000, all Member States should have developed, and be implementing,
policies in line with the concepts and principles of the European health for all policy, balancing lifestyle, environment and health service concerns*

Keywords

HEALTH POLICY
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HEALTH ECONOMICS
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EUROPE
UNITED KINGDOM
FINLAND
POLAND
ITALY
NETHERLANDS

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FOREWORD

The European Health Policy Conference: Opportunities for the Future covered issues related to the three pillars of the WHO regional policy for health for all: lifestyles, the environment and health care. This volume deals with the third of those.

It was not intended during a meeting of this broad scope to examine in great depth the issues related to changes taking place in health care. Rather, the intention was to flag some of the emerging challenges, and provoke thought and discussion on how they can best be met.

The Conference set the scene, placing health care reforms within a broader framework of intersectoral policies for health. Many of the issues dealt with will be taken forward to a European ministerial-level conference focusing specifically on health care reforms, to take place in Ljubljana in June 1996.

Reform measures must be judged not only by short-term economic savings to public budgets but also by their ability to promote health and to generate health gain for the entire population, in line with the WHO health for all policy. These normative dimensions are equally important in the restructured health systems of the countries of central and eastern Europe and newly independent states of the former USSR as in widening health care reform activities in western Europe.

J.E. Asvall
WHO Regional Director for Europe

PREFACE

This is volume IV of a report on the third European Health Policy Conference held in Copenhagen, 5–9 December 1994. Volume IV reports on that part of the conference which explored some of the main changes in health care in terms of their contribution to health gain. It gives a detailed account of the plenary session (Plenary D on the Conference Programme) dealing with these issues, and of the five related discussion groups. The full texts of papers presented or prepared as background documentation are included.

The other four volumes report in a similar manner on the plenary sessions and of the work in their related discussion groups. The full texts of the papers presented are also given.

Vol. I gives an overview of the Conference and reports in detail on the plenary sessions related to the politicians' viewpoint and to the role of the intergovernmental organizations in supporting health policy development. It also reports on the outcome, including the Copenhagen Declaration, and briefly on the follow-up since the Conference.

Vol. II deals with intersectoral action for health.

Vol. III examines the process of health policy developments at national, regional, and city level.

Vol. V highlights issues of particular importance to countries of central and eastern Europe and the newly independent states.

1. INTRODUCTION

Health gain is defined as *the result of a systematic process of approving for a specific population, a range of measures that are based on the length of life and the quality of life, and then providing and planning health resources that increase the average length of improved life enjoyed by that population* (WHO European Health Policy Conference glossary, 1994).

Although this may appear to be a fundamental objective of all health care systems, until now health gain has received surprisingly little attention as a goal of health care reform. Hitherto, so-called reforms have largely been directed toward achieving cost containment or other organizational, technical, and financial goals. Issues such as cost-efficiency, market competition, purchaser/provider systems, contracting of services, and health care management have dominated the national health care debates.

In some countries, monitoring and evaluation have been carried out quite extensively to assess the performance of health care reforms. However, the assessment of success is only relative to what is being measured, and until now health gain has received relatively little attention, while cost containment and meeting efficiency objectives have largely been the critical basis for evaluating health care reform as a success or failure. Such analysis reveals little about the impact of health care reforms on health gain.

There are many instances where reforms have not affected the health status of the population as intended, or may even have had a negative impact. In some cases indiscriminate cost cutting has hit sectors with proven health gain such as preventive services first, while highly technical and expensive curative services are somehow protected.

In many countries, the possible impact of changes on equity in health and their ethical implications, have not received the type of open discussion they deserve.

Gradually, this is changing, and reforms are coming in for criticism because they have focused too much on technical issues, and too little on overall health policy development and health gain. The situation is particularly acute in eastern Europe where in many countries it was thought that adopting western models would be sufficient to ensure

essential funding, a western level of technology, and better health status. This has proved to be an illusion and slowly countries are beginning to realize that dismantling the old systems does not necessarily ensure the rapid development they expected.

Achieving improvements in the financing, organization, and allocation of health care can lead to substantial improvements in the health status of the population, for instance, when waste is eliminated and essential resources are freed to assist those patients who are most in need. Re-orienting health services towards primary health care, increasing equity and accessibility to health services, and improving quality of treatment are just some of the many ways that patients can benefit from health care reforms.

The level of health gain acts as a benchmark for comparing the health effects and effectiveness of health care policy initiatives. At a time when countries must strive even harder to promote equity and safeguard vulnerable groups, it is particularly crucial to ensure the development of comprehensive health policies which are clearly focused on health development, leading to improvements in the quality of life. It is within this broader framework of health objectives, that changes to health care systems must take place.

2. SETTING THE SCENE - HEALTH CARE REFORMS FOR HEALTH GAIN (PLENARY D)

Participants heard presentations from several speakers on the subject of health care reform for health gain. In the keynote speech, Dr Sakellarides WHO/EURO, first looked at public perceptions of health and health care institutions. He went on to describe the importance of developing partnerships for health, and outlined some of the pre-requisites for establishing such partnerships. Presentations, on specific national and regional strategies for health gain, were given by Dr Morton Warner (Wales), Dr Claes Örtendahl (Sweden), Dr Geert M. van Etten (the Netherlands), and Mr Ondrej Typolt (Czech Republic).

2.1 Health care reforms for health gain

Dr Constantino Sakellarides, Director, Health Services at WHO/EURO, opened the session, pointing out that the purpose of this plenary was to look at health care systems and health care reforms in terms of their contribution to health gain. He stressed that health and health care were not abstract concepts, and referred to the correlation between AIDS and drug abuse to show that health can be a tangible element. In his view, people's perception of health as something tangible is reinforced as they get older because of their increased vulnerability to ill health and disease.

Dr Sakellarides pointed out that throughout Europe people have very different perceptions of their level of health. He referred to a recent survey, which asked people aged 50 in several different European countries whether or not they thought they were in good health. There were quite substantial differences in the responses, with 90% of the Swiss reporting good health, 80% of the Italians, and 50% of the Finns. The poorest perceptions of health status came from the Czech Republic where just 30% of those aged 50 felt they were in good health.

Dr Sakellarides emphasized that people also have both positive and negative perceptions of health care institutions and these perceptions vary considerably between countries. He referred to a recent Eurobarometer survey which revealed that people from France, Germany, and Nordic countries have good perceptions of health care institutions, while

people from Italy, Portugal, and Greece have poor perceptions. Emphasizing the importance of maintaining people's trust in the health care institutions, he proposed that if health care institutions are to remain strong and effective, they must convey a positive message to the public.

Public entitlement to health care, minimum health service requirements, global budget, cost containment, regionalization, resource allocation, cost sharing, public/private mix, markets and fundholders, have recently emerged as issues in national health care debates. Dr Sakellarides pointed out that most health managers are familiar with these terms, however, for the vast majority of people, he felt these were abstract concepts. While many people experienced the consequences of decisions based on such concepts, very few understood them, even fewer could claim to have had any influence in making those decisions. Dr Sakellarides felt that an extensive "machinery" had grown between the patient/citizen and the health professionals, with many important decisions now being committed to that machinery.

He proposed that the "machinery" plays an important part in the social contract of contemporary developed societies, by assuring more appropriate and effective use of resources. However, problems arose when such structures became removed from reality, or decision-makers used a language people could not understand. This alienation meant that the "machinery" soon became incapable of solving the problems with which it was faced.

Emphasizing the importance of keeping "health" at the centre of the health care debate, Dr Sakellarides proposed that patients, managers, providers, and citizens should be able to come together in a new type of health care partnership. He felt there were a number of requirements for establishing such a partnership.

- Local actors should be permitted to define the scope and content of care.
- Priorities at the local level should be decided within a framework based on the rules of entitlement and availability of financial resources.
- Partners must share the common language of health care outcomes and effectiveness.
- Weaker partners must be informed about their rights.
- A multiplicity of institutions from the public, and the private sector must work together to act on the various problems of social protection systems.
- Health care institutions should be flexible, with substitution mechanisms that allow for transfer from tertiary care, to primary care, to community care accordingly, depending on where the best health care outcomes can be achieved.
- There must be a managerial mix between vertical management and horizontal contracting which allows different partners to move in the direction of better outcomes

- The organizational culture should not be solely focused on the core but also on the periphery in the way it interacts, counteracts, agrees, and negotiates, with other organizations.
- Partners should be aware that a sustained effort is required to build and maintain such a partnership.

Dr Sakellarides felt that it was important to change the configuration of actors in the partnership regularly, as allowing the same mix of partners to work together continuously will inevitably lead to domination by the stronger interests. Democracy, he felt was easily practised by gods, but people must work harder to achieve a fair and balanced society.

2.2 Strategy for health gain in Wales

Dr Morton Warner, Executive Director of the Welsh Planning Forum described how the Welsh Planning Forum had developed a specific strategy for health gain in Wales, and its link to the new purchaser/provider system in the UK. It was very important he felt in the initial stages, to have a sense of destination, which he termed as the “strategic intent”. In this case the intent was to take the people of Wales into the next century with a level of health that could compare with the best in Europe. From the outset, it was made clear to the NHS that they would have to work with other partners in order to achieve that aim.

Dr Warner went on to suggest some lessons based on the Welsh experience. He began with the task of setting the goals or “destination”. For this, a yardstick was needed, and in order to get a true picture of the health situation, Wales was compared with European countries which were known to have achieved better health status.

Once the mileage to be covered had been established, the next step was to develop mechanisms to monitor progress over time. Later, the goals were more specifically defined, in terms of health gain and the HFA slogans: *adding years to life* and *adding life to years*. With these two slogans, the Welsh team managed to incorporate the main goal of health professionals, which is to provide effective care, and of patients by securing improvements in their quality of life.

On the problem of how to achieve a balance between the requirements of people who use and provide health services, and the effective use of resources, Dr Warner proposed that in order to be “resource effective”, the important consideration should not be money, but rather what money can buy. This related to questions such as: How resources are used? How much is allocated to preventive care and rehabilitation? How much goes to diagnostic and clinical interventions?

It was important to adopt a bottom-up approach to policy making. In the Welsh case, strategies to meet local needs were not dictated exclusively by the central level. Protocols were first developed for a number of specific areas of health gain and then linked to

community assessments of need. He felt that the clear link between policy and operational management provided for more effective assessment of need at the community level.

Dr Warner pointed out that health services are largely determined by forces of demand and supply. He stressed the importance of differentiating between *need* and *want* when allocating resources, and expressed concern that utilization and demand are increasingly being used as the basis for health care development decisions. On the supply side, he felt there was a strong tendency to focus on facilities and human resources, rather than care programmes. If the focus was to shift from resources to programmes, a radical shift in thinking was required.

Acknowledging the constraints posed by insufficient resources, Dr Warner proposed that decision-makers could improve their chances of achieving health gain by basing strategies on clinical effectiveness and intersectoral action. Carefully selected targets also helped to focus attention on the major issues, and Dr Warner felt that these should be sufficiently quantifiable to give some measure of achievement over time. He pointed out that it could be difficult to set quantifiable targets in some areas. Despite the difficulties, however, he urged countries to continue to work toward developing targets in qualitative areas.

Dr Warner emphasized that appropriate health gain and service targets were essential for linking policy, health gain, and operational management. He concluded that good planning and management practices were universally important, regardless of differences in the organization and financing of health care services between countries.

2.3 Strategy for health gain in the Czech Republic

Mr Ondrej Typolt, First Deputy Minister of Health from the Czech Republic opened with the famous quotation from Archimedes, "Give me a fixed point and I can move the universe". In the Czech Republic, the task at hand was to find the fixed point which would increase health gain while maintaining the balance between *quality*, *financing*, and *allocation* in health care services.

Mr Typolt pointed out that the health sector in the Czech Republic had undergone radical change during the transition to democracy. This process began in 1990 with some basic improvements in the quality of health care services. These included greater equity of access, free choice of physician, introduction of private health insurance, and decentralization of health services. These reforms were followed in 1991 by changes in health care financing and increases in out-patient health care. In 1992, compulsory health insurance was introduced, and 1993/1994 saw regulatory measures and the beginnings of a quality assurance system.

Future goals included establishing the quality assurance system and developing an accreditation process of health care providers. Mr Typolt stressed the importance of achieving a balance between effectiveness, equity, and quality of care. Of these, he considered that effectiveness and quality were the more critical issues, since accessibility to health care services is already guaranteed by the Czech constitution.

He saw reform in the finance and allocation of resources as part of the natural dynamics of the transformation process. If the reform strategy ensured that at least one of the cornerstones: *finance*, *allocation*, or *quality* remained fixed, then no more than two areas need undergo change at any one time.

Health is one of the few areas in the Czech Republic where there have been improvements, which would appear to indicate that there are some advantages to this approach. Current statistics show that over the last four years there have been substantial health improvements. Life expectancy at birth has increased both for women and men, mortality rates have decreased, meanwhile, in the spheres of specialized health care, such as kidney transplant and cardiosurgery, diagnostic and treatment activities are reaching European standards.

However, Mr Typolt stressed that the current system was not problem free. In particular, a practice of passive reimbursement for each service provided, had not promoted quality and effectiveness in services, and he felt that this was one of the principal reasons why health care costs were rising in the Czech Republic. Efficiency and effectiveness in meeting people's health care needs were in his view important parts of health care reform.

Mr Typolt pointed to the on-going conflicts between various interests in the health sector, in particular between payers who want to reduce expenditure on health care, and providers who want to increase expenditure. The government, in his view, had a major responsibility in regulating such conflicts. However, embarking on a path of radical health care reform was not always the ideal solution. Mr Typolt advised reformers to tread carefully, and pointed out that "an elephant in a china shop" could do a considerable amount of damage.

2.4 Strategy for health gain in the Netherlands

Dr Geert van Etten, Director-General of the International Health Policy Department in the Netherlands Ministry of Health, Welfare, and Sports pointed out that in the past, health gain has not been a declared goal of health care reform in most countries. Generally, issues, such as access to services, cost-efficiency objectives, and quality of care, have been given higher priority. Increasingly however, reforms in areas such as quality of care and consumer choice were providing important opportunities for linking health gain to the current change process.

Dr van Etten felt that greater efforts were needed to combine the health gain approach with health care reforms both at the national and the international level. He believed that this had been thwarted at the national level, because of the prevailing view of health care as a treatment industry. Politicians, he felt, were generally more concerned with treatment issues than public health and prevention. Even in the Netherlands - one of the first countries to introduce a national HFA policy - there had been virtually no attempt to link health gain with health care reform or HFA.

Health gain had also been held back at the international level, Dr van Etten felt. He believed that WHO had been strong in promoting HFA, but weak in addressing other aspects of health care reform.

It was possible to integrate health gain and health care reform in a common policy framework and he identified some examples of successful strategies. These included the Welsh case earlier described by Dr Warner, and the United States' strategy - *Healthy People 2000*. The latter had as one of its major goals, access to preventive services for all Americans, a goal which was to be achieved primarily through health care reform.

Dr van Etten described the World Bank's report, *Investment in Health* as a good example of combining the public health approach with health care reform. He felt that the above examples proved that health gain could be achieved through health care reform.

2.5 Strategy for health gain in Sweden

Dr Claes Örtendahl, Director General of the Swedish National Board of Health, described Sweden's strategy for health gain. To achieve health gain, Dr Örtendahl felt that two essential pre-requisites must be met:

- (i) there must be economic and social development and
- (ii) equity must be a goal of economic and social policies.

Sweden had initiated the process of linking health gain with health care reform during a period of economic decline. Evidence that the health effects of economic decline were more detrimental for low income women than for other population groups, had been the catalyst for the health gain strategy.

In particular, women working in the health sector had been the first to suffer dramatic cutbacks and increased unemployment and as a result their real income deteriorated. They developed higher levels of stress. Use of alcohol, drugs, and tobacco among women increased. Meanwhile costs of health services also increased, and studies revealed that women now tended to wait longer before seeking help from the health care system than they had previously. To improve the health status of women, Sweden embarked on its strategy for health gain, concentrating first on economic and social development.

Dr Örtendahl emphasized the importance of Sweden's hard-line legislation in alcohol, tobacco, accidents, and drugs, proposing that in order to have a successful strategy for health gain, a mix of interventions, such as legislation, health promotion, etc. must be applied simultaneously. He felt that it was important for legislation to have a popular basis, if mobilization is to be achieved at the local level.

Health care systems cannot be self-administering, and Dr Örtendahl stressed the importance of monitoring and evaluation. The invisible hand of the market would not achieve health gain alone. Without a pedal for the brakes and a steering wheel, market

interests would more than likely predominate. This situation would also more than likely favour suppliers and providers, rather than consumers and patients.

In developing strategies for health gain, Dr Örtendahl advised countries to consider carefully which groups they were targeting. Taking the elderly as an example, he pointed out that active therapy for senior citizens has traditionally not been part of the health gain concept. This had changed to some extent over the past five years, with age limits for active medical intervention being removed in many areas. However, he felt that, these limits, although invisible, were often still there. He also referred to immigrants, another vulnerable population group. He urged decision makers to take particular account of such groups when devising and developing their strategies for health gain.

