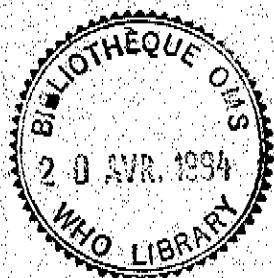


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EXPERT NETWORK ON HEALTH AND HEALTH CARE FINANCING STRATEGIES



WORLD HEALTH ORGANIZATION
Regional Office for Europe
COPENHAGEN

TARGET 27

HEALTH SERVICE RESOURCES AND MANAGEMENT

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

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EXPERT NETWORK ON HEALTH AND HEALTH CARE FINANCING STRATEGIES

Report on a WHO Meeting

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ABSTRACT

The Expert Network on Health and Health Financing Strategies was established with the active support and participation of the countries of central and eastern Europe in order to provide a specific forum for exchanging experiences and discussing issues of health care financing. The objective of the first meeting was to discuss problems in health care reform, finalize steps to set up the Network, and initiate its practical activities. A number of country presentations provided the opportunity to review and discuss the most pertinent experiences in key areas, to identify examples of good practice, to identify mistakes and formulate lessons arising from them and additionally to assess the completeness of information about health care reforms in participating countries. The opportunity to exchange and share experience was particularly relevant due to similarities of health care organization in the past and of present difficulties. The presentations revealed that, contrary to popular belief, progress has been made in reforming health care and that the misconception of stagnation can lead to reactions aimed at doing something, simply to demonstrate activity. Information presented within the forum of the Network should not be underestimated and its full value should be recognized. The establishment of a steering committee for the Network will enhance coordination which will strengthen the activities and outputs of the Network.

Keywords

- / HEALTH ECONOMICS *EC*
- / DELIVERY OF HEALTH CARE - trends
- CCEE

*Financing, Health
Comparison, 1980-1990
Comparison, 1980-1990*

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INTRODUCTION

The idea of establishing an Expert Network on Health and Health Care Financing Strategies was first conceived at a WHO meeting in Kiel in 1992. It was clear that many countries, especially countries of central and eastern Europe (CCEE), needed a more specific forum to exchange experiences and discuss issues related to health care financing. The WHO Working Party on Health Care Reform, which met in Madrid in June 1992, confirmed the need for such a Network and acknowledged that WHO would be in a position to offer the expertise and structure necessary to make it viable.

The First Meeting of the Expert Network on Health and Health Care Financing Strategies was organized by the WHO Regional Office for Europe in collaboration with the Ministry of Health and Social Welfare of Poland, which hosted the Meeting. It was attended by 29 participants from the Czech Republic, Hungary, Latvia, the Netherlands, Poland and Slovakia, as well as a representative from the World Bank, 3 observers from Germany, 2 from Lithuania and about 15 from Poland, including representatives from the Ministry of Labour and Ministry of Finance. The background material and participants are listed in Annexes 1 and 2, respectively.

Dr A. Wojtyla, Minister of Health and Social Welfare, opened the Meeting and Dr C. Sakellarides, Director, Health Services, welcomed the participants on behalf of the WHO Regional Director for Europe. Dr M. Miskiewicz was Chairperson and Dr J. Sabbat Rapporteur.

The aims of the Meeting were to:

- review and discuss the most pertinent issues of health care reform in central and eastern European countries;
- identify and recommend examples that could serve as suitable models for other countries;
- learn from the important experiences of other countries;
- discuss the running of the Network.

COUNTRY PRESENTATIONS

Hungary

General issues

The health care system in Hungary is characterized by a surplus in human resources, an overemphasis on hospital and specialist care, and a high rate of hospital admission. There are virtually no day-care services, and community facilities are underdeveloped, chiefly owing to inadequate resources. Over the past two decades investments were made primarily in high technology services, which have high operating costs. This has resulted in a geographic imbalance with regard to quality. A highly hierarchical health care system poses an additional obstacle to health care reform.

Several steps have been taken to reverse this trend, for example an autonomous social insurance institute was set up (1990), legislation focusing on prevention was passed (Public Health Act, 1991), social insurance was divided into a pension and a sickness fund, and capitation for general practitioners (GP) was introduced along with free choice of GP (1992), private practice was promoted through contracts with local government and sickness funds, and new regulations were introduced for financing specialist services (1993).

Family medicine

As a first step towards family medicine and economic competition, legislation was passed in 1992 that provided for the free choice of primary health care physician. A provisional contractual system was also established in primary health care that regulated the relationship between family practitioners and the health insurance fund, and partially introduced outcome-centred health care financing at the primary health care level.

Family practices are based on a contractual agreement with the health insurance fund and are run by local governments, either individually or together with other local governments, private family

doctors or health enterprises that either contact the insurance fund directly or indirectly through local government, or occupational health service organizers and other health service institutions if the local government responsible guarantees to pay the appropriate contribution to the health insurance fund.

To establish a family practice the population to be served must be at least 1700, or in the case of paediatric services 800 children. In group practices peer review is conducted by an elected senior partner, who is given a small reimbursement. Family practitioners are encouraged to provide prevention and health promotion services.

Of the 7000 primary health care centres, only 100 have been privatized. Fear and lack of experience have slowed down the privatization process.

Family practices are financed through an output points system. Points are awarded on the basis of number and type of patient (for example, age group), years of experience, specialized training and number of communities cared for. The system was to be audited in July 1993.

Reimbursement on a fixed rate is regulated so that the greater the number of patients served the less the reimbursement. The fixed rate is higher for paediatric practices and lower for mixed adult and paediatric practices. Supplementary reimbursements are given depending on where the practice is located: the lowest amount is given for city practices, more for villages and most for scattered settlements. Additional funds have been put aside to fund out-of-hours services and care for non-list patients who require assistance. Those practices providing activity data on a diskette receive additional payments.

Practices are monitored by the Health Insurance Fund, and in cases of severe or repeated violations of the terms of agreement, the contract will be terminated.

Primary health care services that are not yet covered by the new system include public health nursing, oral health care, occupational health and adolescent and school health services.

The new family practice financing system is unduly complicated because of the double administrative work involved. A sophisticated and rapid information system is required to transform

the data provided by practices. Another problem is that the system allows contracting with doctors who have inadequate experience. Moreover, it neither promotes disease prevention and continuity of care nor care of good quality. In a system based on privatization, practitioners require managerial skills, experience and know-how, and local government needs to be sound to avoid bankruptcy of the system.

Specialist care

Outpatient services will be financed by 70% of the previous year's budget; the remaining 30% will be covered by fees for service. This is a transitional measure to avoid a sudden financial crisis. Fees for service will ultimately be the sole basis for the budget. However, this system has the disadvantage of penalizing those who practise good management. Later in 1993 a financing system similar to diagnosis-related groups (DRG) was to be introduced for acute inpatient care. During the transition period, reimbursement would be based on a points system derived from the WHO performance code list. The list was drawn up under time pressure and rather heated discussion among specialist groups, who were fighting for the highest ranking. The system would therefore have to be monitored regularly to make the required adjustments. Chronic inpatient care is financed on the basis of a daily rate. The long-term plan is to create a point system with ambulatory visit group categories based on a mixed system of input and output financing, incorporating quality assurance mechanisms.

The present point system is heterogeneous and requires continual assessment. Although it may appear complex none of the 200 trained managers using it have experienced difficulty, and the data collection is easy. The point system is identical throughout the country, although the value of the forint (during the transition phase) varies to encourage cost-effectiveness. Real competition is expected in the future between all forms of institution ownership. Because hospitals can abuse the system, specific DRG protocols should be drawn up. This is expected to take one to two years.

These financial tools will stimulate change but should not be seen as the final solution. Several problems still need to be addressed:

- the need for greater flexibility
- social disparity between the provider and the purchaser
- amortization
- promotion of community care
- clear priority setting – where to cut, what to support.

Evaluation criteria should include the length of hospital stay, admittance ratio, proportion of inpatient to outpatient care, and use of medical equipment.

Those who expect a full range "western" system immediately will be disappointed.

Health insurance

In 1992 the Act on Self-government of National Insurance Funds paved the way for separation of the one existing fund into two different funds, a pension fund and a health fund. Each fund is governed by a general assembly, which draws up its own rules and procedures, but the funds may establish common institutions.

Citizenship is no longer a condition for access to health services free of charge. The former system was replaced by one based on insurance which covers contributors and their families, pensioners (paid by the Pension Fund), unemployed people (paid by the Solidarity Fund) and people who need social support (sanctioned by the local government and paid under the annually approved state budget). Thus in principle, all Hungarian residents are covered.

Since 1992, the financing of the health insurance system has been based on contributions made by employers and employees. The monthly health insurance subscription is proportional to monthly income and not related to service use. Contributions are 19.5% from the employer and 4% from the employee. Family dependants are also covered. Contributions for those without an income are paid by the relevant funds or the state.

Services provided under the health insurance scheme include health care (primary health care, specialist services, continuing care

and rehabilitation), maternity care, preventive screening and risk care, subsidies for medication and welfare payments (paid sick leave, invalidity pension and maternity allowance).

Access to services is based on the possession of a health insurance card, which costs US \$1.2 million to introduce. For the system to function effectively, the informatics structure needs to be developed; this will be done with the assistance of the World Bank and will cost US \$120 million.

The Health Fund is in a difficult situation due to growing unemployment and is on the verge of insolvency. This means that some areas might not be covered by insurance.

Public health

One of the first major steps towards health reform in Hungary was the introduction in 1991 of legislation on the national public health services and medical inspection. Prior to this, public health services functioned as a vertically integrated structure composed of public health and epidemiology stations at both country and municipal levels.

The present system is in the form of a public health network made up of three levels: the national public health centre together with the national public health institutes, county institutes and city institutes, all of which come under the auspices of the Ministry of Welfare.

The network functions as a health authority and has some administrative power. It supervises curative services and health care organizations, and licenses health care establishments. It also serves as the main link between the Ministry of Welfare and the health care services of the country. The new regulations have extended the scope of activities and responsibilities of the public health service to include health status monitoring, health promotion, disease prevention, hygiene and environment control and the control of nosocomial infections.

Considering the wide range of tasks and responsibilities of the public health services, the budget is low, an estimated 3% of the health care budget; this proportion should be increased.

Public health activities, in particular health promotion, microbiology services that undertake screening and primary health care, should be supported by the Health Insurance Fund, which is currently struggling with a deficit. The mobilization of resources is therefore essential. At local government level this may prove difficult if the public health unit is not perceived as a local responsibility. Resources are required in particular for health informatics and the reorientation, education and training of public health personnel.

Slovakia

As a result of the abolition of certain regional and district structures in 1991, the health care system became highly centralized, with the result that the introduction of a new management structure was blocked, the number of employees increased, effective control of the system diminished, and progress towards privatization was impeded. This further led to reduced productivity and efficiency of the system and to escalating costs. Important positive changes include the free choice of physicians, emphasizing the key role of primary health care, and the eventual transformation of the general practitioner to the family doctor.

As a step towards decentralization, governing boards were established in every hospital in 1993, in order to strengthen decision-making and improve effectiveness. Cooperation between governing bodies and managers is necessary for appropriate resource allocation.

In 1991 seven regional financial authorities were established whose main task is the allocation of resources to health care institutions. An Institute for the Introduction of Health Insurance was established in 1992. The Institute is responsible for funding the regional financing authorities and for designing and implementing the national insurance system, which consists of a coordination centre and 37 branch offices throughout the country. In 1993 the National Insurance Bureau was established with three independent funds: the Health Insurance Fund (health care), the Sickness Fund (reimbursement for sick leave) and the Pension Fund. Contributions are paid as a percentage of income by both employee and employer,

with the latter contributing about three to four times the amount contributed by employees. The contributions of those not employed are paid through the state budget. Contributions from those employed covered 96.5% of expected revenue. Since the Funds are unable to collect all the contributions due, and consequently secure a stable revenue base, the state subsidizes health care services. However, by mid-1993, it is expected that the Funds would become financially autonomous.

The major obstacles to the privatization process are insufficient financial resources, disproportionate increases in costs, the slow flow and allocation of funds, and a lack of codified health service indicators. Moreover, without a system of cost accounting, health care establishments cannot be assessed on the basis of objective data. Another impediment to the rapid implementation of a fee-for-service system is the lack of consensus.

The changes proposed require more legislative initiatives. To date, three health laws have been enacted that regulate insurance, resource allocation and health promotion. Further legislation must be passed in order to ensure implementation of reforms in the area of health care provision, national insurance, health promotion, disease prevention and pharmaceuticals. With respect to the last item, improvements in drug policy and financial control are expected to make savings equivalent to about one fifth of total health expenditure.

In the face of escalating costs and a worn-out infrastructure, emphasis must be put on cost containment. Efforts will be made to use health facilities in a more intensive manner, ensure state regulation of the network of health facilities, shift from inpatient to outpatient care and community care, introduce a fee-for-service system within the insurance system, provide effective management and ensure the sound application of knowledge.

Latvia

The main deficiencies of the present health care financing system are the dual source of financing (both state and municipal budgets), the lack of correlation between workload and expenditure or remuneration, and the lack of stimulation to develop initiatives in

the private sector. The budget deficit has resulted in the inability to meet required health care needs; this is compounded by poor data collection on cost estimates and the absence of regulations that promote cost-effective provision of health care, clinical services, drugs and health care products.

Transformation of the system is under way in which the principle of social solidarity must be observed. Patients, Latvian residents, will receive health care without entering into a direct financial relationship with service providers. The role of the state in health services provision must be clearly defined. It is hoped that the provision of a broad range of services can be maintained, with access for all rather than the provision of exclusive services for a narrow clientele. Another goal is improved cost-effectiveness, especially during this period of scarce resources.

The system will be oriented towards social health insurance (compulsory participation and state guarantees), possibly supplemented through voluntary schemes. During the transition period, municipal institutions will develop accounting offices that will receive funds to purchase health care, setting aside 10% for a reserve fund that will compensate for fluctuations in expenditure between different health institutions and forms of care. The remainder will finance emergency services, dental treatment, inpatient and outpatient services, support services and the administrative expenses of the accounting offices.

A point system has been devised to facilitate outpatient reimbursements and comprises salaries, complexity and risk of care, time taken, age of patient, working conditions, associated drug treatment, use of materials and technology and operating costs of the institution. Inpatient costs are assessed on the basis of average bed-days, also taking the above-mentioned factors into consideration. The bed-day value excludes capital construction and repair costs.

If a health institution cannot cover costs of services that are essential for the region, the municipal authorities are charged with the responsibility to ensure their provision.

Poland

Contracts

The Health Care Institution Act, which came into force in 1992, introduced a relationship between purchase and provision of health care aimed at stimulating competition between providers in order to rectify faults in the old system. However, no decision has been taken on how the financial resources should be collected – from general taxation through the state budget or through contributions. At present, the purchaser-provider relationship is characterized by two features: administrative integration, because it is the purchaser who has established the health facilities, and a monopoly of providers, because they all belong to the same organizational entity. This results in the much stronger relative position of providers. There are no registration criteria for health institutions and closing down one of them is very unusual. The private sector is too small and can have only a marginal effect on the dominant public sector. The position of patients is weak, and there is little incentive to be cost-effective or offer appropriate, good quality care. In the present system existing institutions are more likely to receive funds while contracting could provide opportunities for new providers.

Initially, the resource deficit acted as a stimulus for cost containment. Further efficiency can only be brought about through resource allocation mechanisms and contracting appears to be a suitable method for Poland. Implementation of a type of DRG mechanism directed at limiting costs, as introduced elsewhere, requires sophisticated information systems but contracting can overcome such a deficiency with the introduction of cost standards, particularly at local level.

New legislation on health care institutions allows the private sector to compete for public funds and contracts allow for equality of all sectors, which thus restricts the provider monopoly. Legislation is in place for private contracts but additional regulatory instruments, necessary for their operation, have not yet been formulated. Additionally, health care institutions may have an independent status rather like the British National Health Service.

The market should be strongly controlled and supervised. The real issue is cost. Frequently, only the recurrent costs are considered in contract prices. When contracts are made with public institutions capital costs can be covered from other resources, but when the provider can be either public or private, the price must reflect these costs. As yet, no solution to this problem has been found.

To introduce market mechanisms, health care needs must be identified and priorities set. Information systems must be improved and managerial capability strengthened. Instruments for resource allocation in the public sector and for auditing the quality of care must be devised. Managerial contracts should be introduced, and the status and influence of patients strengthened.

It is uncertain how contracting will be affected by the forthcoming reform of the state territorial administration and shift in responsibilities from central to local level. This will depend on the actual future role of the district. Currently, the *voivodship* is the funding agency for most health care institutions, and as such provides resources for their upkeep rather than for the purchase of their services, and this situation is incompatible with contracting.

State guarantees

Uncertainty exists with regard to how health care should be financed and how the reformed health care system should be administered. The government health policy guarantees health care and is based on the principle that the state has a responsibility to provide essential and appropriate care of good quality, irrespective of the financial situation of the patient. However, the scope of health care provision needs to be defined because of financial constraints. Demographic pressure requires a rationalization of service provision and the elimination of the overconsumption still evident despite deficient resources. At present, there is a discrepancy between the constitutional entitlement to free health care and the ability of the state to meet health needs, including costs.

A range of publicly funded services and state-guaranteed access to them has been introduced to contain costs so that they can be covered by the state budget. Legislation has been drafted that will ensure equal access of all entitled to the services, emergency care

for all in need, and the introduction of mechanisms to rationalize procedures and enforce discipline. The legislation will also define principles of access and of patient participation in costs as nil, partial or full according to a fixed price list. Additionally, categories of patients eligible for exemption will be specified.

Following the principle of equity, most services will remain free of charge, including preventive care, and will be universally accessible, although there are certain restrictions, some made on the basis of referral and others on the basis of waiting lists. Health care is considered a human right and a public good, not a marketable commodity. Equity also has an economic rationale because improvements in services are made in deprived areas and for vulnerable population groups. Rationing is an important policy tool and the nature of essential health care must be defined. The patient must be considered the central element in health care, and patients' rights are an important part of the draft legislation.

Drug policy

The pharmaceutical sector is undergoing reform parallel with other socioeconomic sectors of the country, and is quite advanced. Little can be done to increase health resources and therefore reform efforts are aimed at making services cost-effective. Changes implemented in the pharmaceutical sector in 1991 were of particular significance.

Privatization of state-owned pharmacies was initiated as early as 1989. Concurrently, the privatization of drug distribution significantly improved product availability in pharmacies. Privatization was introduced rapidly and many mistakes were made. The procedure adopted for privatization did not allow for tendering for the purchase of equipment or leasing of pharmacy premises, and in some cases people became new pharmacy owners not because of their qualifications but because of personal connections. However, the advantages far outweighed the disadvantages, in particular the increased profitability of pharmacies, which before tended towards bankruptcy. Some 88% of pharmacies became private rather than state owned.

The introduction of the zloty as convertible currency and the lack of supervision contributed to escalating drug costs and

threatened to undermine the state budget. The system of payment for pharmaceuticals was amended and improved through legislation on drug payments, passed in 1991. The new law introduced a flat rate for most essential drugs, 30% contribution for supplementary drugs and full rate for other drugs. It resulted in a more rational use of drugs and improved provision of drugs to the population, and slowed down the pace of budgetary expenditure. In addition, benefits were introduced to assist patients with financial difficulties in buying drugs.

A major legislative initiative on pharmaceutical products, medical materials, pharmacies, warehouses and pharmaceutical supervision was passed in 1991, and a supervisory agency was established. *Voivodship* pharmaceutical inspectors are now directly answerable to the national pharmaceutical inspector, and have undergone extensive training in drug surveillance.

Although several issues have been resolved, others need further attention, for example the rationalization of pharmacotherapy. The reform process is thus still under way.

The Czech Republic

The heritage of half a century of totalitarian rule has left Czech citizens with a poor understanding of their own responsibility for health and of economic realities, and has deprived them of initiative. The privatization of the health sector is thus part of the enormous task of transferring ownership. The introduction of a contributory system of health care financing is based on legislative measures that will create conditions conducive to the provision of a quality service comparable to those of mature democracies. Further, the new tax system is expected to promote the development of regional structures that will affect the organization of health care provision. In 1992, the Government approved the National Programme of Health Restoration and Promotion, which is oriented towards healthy lifestyles.

The process of privatization has both stimulative and regulatory components. An example of the former is a credit policy that helps to overcome the lack of investment capital, and an example of the latter is the assurance that health care expenditure will not exceed

the budget. The basic principle governing privatization is the transformation of the former inefficient system to one founded on health insurance, and financing health facilities from various sources. By the end of 1992, 6000 project proposals had been submitted for privatization, 10 projects per health facility. These proposals are being evaluated by a special committee composed of representatives of the Ministry of Health Privatization and National Properties Administration, which will recommend action. Ownership can be transferred by public sale (auction), public competition, direct sale to an identified purchaser, or the formation of a limited liability company. Steps have been taken so that a network of facilities will be maintained to ensure a guaranteed health care system.

Some health care facilities will never be privatized because of their importance to public health. Access to health care, irrespective of the ownership of facilities, will continue on the basis of compulsory health insurance contributions.

Germany (Brandenburg *Land*)

The health care system in the former German Democratic Republic was similar to that of other CCEE. Since the reunion of Germany, the five "new" *Länder* have adopted the federal health legislation, and health care reformers were not given the opportunity to choose alternative solutions.

Change was radical and characterized by a speed that both opponents and pessimists thought impossible. The period of reform has demonstrated that:

- the change from a budget-based to contribution-based financing can be made from one day to the next;
- the new system can be self-financing and economically feasible;
- the process of change can be economically and socially acceptable, even in a period of unemployment; and
- the process of change can produce improvements in many subsystems.

However, some problems remain. For example, there has been little improvement in the care of the chronically ill.

Transformation of the system was imposed and did not come about as the result of a democratic process of discussion. Western health professionals had greater influence than those from the east, although there was no evidence that the dispensary or polyclinic was a less effective form of health care.

Rough comparative data on health status in the two Germanys show a two-year difference in life expectancy in favour of western Germans, for both men and women, and lack of improvement at the same speed in neonatal mortality since the late 1970s. Further, in the east, there were considerably fewer trained medical personnel at the point of patient contact. In the former Federal Republic of Germany, 9% of the gross national product was spent on health while this figure was only 6% for the former German Democratic Republic.

Within the limits of federal legislation, Brandenburg was able to choose its own direction of reform. A single Sickness Fund has been established that covers two thirds of the population, while the remainder is covered by Funds regulated by the federal authorities. Under the unification treaty it was agreed that the existing health care system could run for another five years. It was expected that most health professionals would leave the system and choose private status. This assumption proved true in the other new *Länder*, but in Brandenburg the local budget was used to support about 40 polyclinics (now called health centres) through investment and adaptation so that these now function on an economically sound basis. This has resulted in a reconsideration of the role of health centres, and this system might be introduced elsewhere in Germany.

Brandenburg was also the first *Land* to enact public health legislation that gives health promotion and education an extensive role.

Managerial assistance was required from the west as the east has no suitable model of their own.

Brandenburg was not free to follow the options available to other countries undergoing reform; nonetheless, certain general lessons can be learned from its experience. There is no single ideal combination among the different solutions: centralization versus

decentralization; autonomous self-government versus state regulation; public versus private provision of health care services. The different solutions can be rationally combined in many ways in a given country. The other CCEE have a greater freedom of choice, and their current economic difficulties should have no influence on the selection of a financing system.

CONCLUSIONS AND RECOMMENDATIONS

1. The participants agreed that the central issues in health care reforms had to be reviewed and debated regularly. The opportunity to exchange and share experience in this field is especially relevant for CCEE as their health care services had been organized in a similar way.
2. The Meeting dispelled the common belief that little has been accomplished in health care reform. In fact, considerable progress has been made in many countries. However, the belief that no progress has been achieved can result in rash and ill informed decisions being made, just to demonstrate that something is being done. Therefore, the information gained at this Meeting should not be underestimated, and greater consideration should be given to this aspect at future meetings.
3. The activities and outputs of the Network should be further strengthened by enhanced coordination and focusing. This can be achieved by establishing a steering committee. The first meeting of the steering committee should be held as soon as possible.

*Annex 1***BACKGROUND MATERIAL^a**

ICP/PHC 512(1)/B1	The Network Charter
ICP/PHC 512(1)/B2	Terms of reference (organization, management and financing)
ICP/PHC 512(1)/B3	Operational plan of work
ICP/PHC 512(1)/B4	Health and health care finance - options for reform: assessment from a WHO perspective
EUR/ICP/PHC 210/B	Health care reforms in Europe (Proceedings of the First Meeting of the Working Party on Health Care Reforms in Europe, Madrid, 23-24 June 1992)
HIT Profiles	Unedited drafts of profiles on health care in transition (HITs) for Belarus, Hungary, Latvia and Poland

^a Copies can be obtained from the Health Economics unit, WHO Regional Office for Europe, Scherfigsvej 8, DK-2100 Copenhagen Ø, Denmark.

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