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Financing

In general, organized primary care institutions in the countries of the European Region are financed on the same principles as solo practitioners, and primary care as a whole is subject to the financing policy that applies to all personal health services. In both respects, however, there are exceptions. In some of the countries with pluralistic systems, health centres may be operated under public or quasi-public auspices whereas other general practitioners, solo or in groups, are in the private sector. Also, there may be predominantly public or private non-profit ownership of hospitals, whereas ambulatory care is provided by private, independent practitioners. Discussion of all these aspects of financing policies and methods would go beyond the scope of this chapter which, therefore, will be confined to describing financing mechanisms mentioned as significant by either individual primary care institutions or the ministries concerned.

The emphasis will be on the methods of financing rather than on costs and amounts, since the latter would have little meaning in a cross-national review without establishing comparability and equivalence. Important distinctions are found in some countries between capital and revenue financing, as well as between the way a primary care facility receives its revenues and the method by which it remunerates its personnel. For example, patients or insurance carriers may pay on a fee-for-service basis, while doctors and other staff receive fixed salaries; alternatively, patients may pay fixed premiums but medical staff may be remunerated for each item of service.

Such variations reflect the respective roles of the public and the private sectors where both coexist; they are affected by priorities among the primary and other levels of care and, in the public sector, they will be determined by the degree of centralization or decentralization and the extent of local responsibility for the provision of primary health care. In reviewing the primary care situation in Europe in the context of the Alma-Ata Conference, the WHO Regional Director for Europe found it important to note "that the ideal of PHC as an integral part of the wider health care system can be effectively ended if health personnel are paid independently of that system. At the same time, much cooperation

is possible, and several countries have achieved a high degree of integration in spite of their *laissez-faire* payment systems" (*1*). An illustration of an attempt to achieve equity, if not equality, in remunerating the various members of the primary care team is the change made in Finland from item-of-service to salary payment for health centre doctors when the new Public Health Act of 1972 was implemented. There were several reasons for that change, but among them was the consideration that all members of the team should be paid on the same basis.

New approaches to primary care in the aftermath of Alma-Ata, and in the light of the re-ordering of priorities as a means of cost containment, inevitably have implications also for the financing of primary care services. Since the trend is towards a strengthening of this sector of the health services, the objective can be achieved only by organizing primary care resources sufficiently rationally so that multiple resources can be used in an optimal way. In those countries of the Region where the health centre concept, the idea of a multidisciplinary team, and a policy of outreach are as yet little developed, the typical hospital has about 25 other personnel per physician (about 15 if housekeeping and other ancillary staff are excluded), whereas there are only one or two others per primary care physician. There is good reason, of course, for some of this apparent imbalance: the hospital needs housekeeping staff and technical personnel to operate its sophisticated equipment, all of which accounts for a corresponding demand on administrative resources. However, with rising expectations of the functions of primary care and care in the community—an unfortunate term because it leaves the impression of the hospital being something apart from the community—we must expect an expansion of the team to provide the required outreach, to handle more diagnostic and treatment equipment at the primary level, and to make more of the remedial services available on an ambulatory or domiciliary basis. Where beds are attached to a health centre, they have to be staffed. Institutions such as day care (including day surgery) and hospital home care will tend to blur the dividing lines between primary and other levels of care, and make the hospital more clearly part of the community. The resulting shifts in the financing of the health services are strengthening the trend away from the solo general practice to the various forms of organized health care facility that have emerged in the European Region to enable primary care to perform its new functions and to meet the new demands made on it.

On the other hand, it may be the system of financing prevailing in a country that presents an obstacle to the development of new organizational forms of primary care. This is the case in countries that have a system of health insurance rather than a national health service and where insurance carriers, owing either to legal restrictions or to established practice, can have accounts only with individual practitioners and not with groups, centres or clinics. This used to be the case, for instance, in the Federal Republic of Germany.

A report prepared for the Council of Europe (*2*) on the organization of medical practice in Europe distinguishes two broad types of such organization: (*a*) medical partnerships with doctors practising independently or in a group, and owning their own equipment; and (*b*) practices where equipment and premises may belong to a public body or a private institution (usually a health insurance fund) which places them at the disposal of the team practising in those premises. A number of financial arrangements are possible. Doctors may pay rent to the owners of the premises and practise independently as described under (*a*) above. Alternatively, the doctors may become agents of the owner organization to which they will be administratively subordinate; in this case the owner (which may be a public body such as a municipality, or a semi-public body such as an insurance fund or similar) will retain the fees received and pay practitioners on the basis of services rendered. As a third alternative, doctors and other staff may be employed by the owner and receive a fixed income similar to the way in which hospital doctors are remunerated.

The method of financing can substantially influence the cost of primary care services. Because of the labour intensity of the services, implicit or explicit incentives and disincentives will affect the cost of operation. Maximal use of lesser trained and lower paid personnel will reduce the payroll, which normally constitutes about three quarters or more of the operating cost of a health centre (*3*). In comprehensive prepaid group practice plans in the United States, it has been demonstrated that certain pay structures with built-in incentives are associated with less use of hospital inpatient services and a lowering of the overall costs of health services.

These are matters coming under increasing scrutiny by systems analysis, operational research and modelling in health services management in most countries of the Region, regardless of the nature of the health care system. The application of these methods, however, is still fragmentary and generally too limited in scope to have a decisive effect on decision-making and resource allocation (*4*).

The methods of remunerating health service personnel, which are thought to affect the use and cost of health services, vary considerably among the countries of the European Region; in many cases, especially in countries with a pluralistic system, they also vary among the different categories of personnel. Whereas nurses, therapists, technicians and non-medical personnel are paid fixed salaries, doctors, dentists and pharmacists frequently receive a fee for each item of service, a capitation fee, or combinations of these. And, for these latter categories, the method of remuneration may also vary between those working in the hospital and those outside. The various methods as well as their effects (real or imputed) on the services provided have been extensively studied (*5, 6*). Each method has certain advantages and disadvantages, but there is no ready answer as to why certain groups of personnel, and the most highly trained at that, should require special stimulants of a monetary nature to exercise their profession in a manner optimal for their patients

and for the use of available resources. It should be recognized, however, that item-of-service billing by physicians provides useful statistical data not otherwise available for primary care services. Also, negotiating fee schedules for insurance payments makes it possible to build in incentives for certain procedures and disincentives for others, thus encouraging, for instance, preventive rather than curative procedures or discouraging unnecessary use of expensive equipment and materials.

Another aspect of the financing of primary as well as other levels of care, which in some countries of the Region has been receiving considerable attention, is the respective roles of the public and private sectors where a national health service exists, and to a lesser extent in countries with a universal health insurance system. Most countries of the Region, including some of the socialist countries, permit the private practice of medicine. In countries with a pluralistic system private practice is the rule, although most of a doctor's income may come from social or private insurance. In those socialist countries where private practice is tolerated, it is strictly regulated and its scope limited by law. In countries where private practice coexists with a national health service, it is, especially in times of economic pressure, seen as relieving the public system – a rather narrow policy because it merely means a transfer of the cost from one sector of the economy to another without reducing the total cost to society. Furthermore, it is argued that a competing private sector syphons off resources from the public services for the benefit only of those who can pay for it. These issues have occupied the political scene in the United Kingdom, as cuts in the public service lead more and more people to seek compensation in the private sector.

Financial incentives of some kind are used in various countries to attract doctors and other personnel to primary care practice in otherwise less desirable areas, traditionally the more remote rural areas but increasingly also the declining parts of inner cities. Higher pay alone does not seem sufficient to overcome the disadvantages of practising in such areas, but the provision of other amenities, including housing, practice premises and equipment, may be more effective. The establishment of health centres in otherwise medically deprived areas and the provision of accommodation in shopping facilities mentioned earlier may, together with financial inducements, be an effective means of correcting maldistribution of primary care resources. The methods in a particular system depend on its general policy on financing (*7*).

The discussion so far has concerned itself with general aspects of financing, which in some ways affect primary care and its organization in the countries of the European Region. The following sections describe specific features observed in selected countries within each of the three major types of health service system existing in the Region.

The socialist countries of eastern Europe

In the socialist countries the health services are part and parcel of societal activities, the financing of which fits into an overall plan.

Centrally promulgated norms and standards provide the framework within which local budgets are prepared, to be consolidated at the next higher level and ultimately to result in a comprehensive national plan. In countries with a federal constitution, such as the USSR and Yugoslavia, the constituent republics exercise a certain degree of autonomy, and this is extended in Yugoslavia—with appropriate checks and balances—to the individual self-governing health institutions. There is, therefore, a certain similarity among these countries in the budgeting process, although specific norms and standards vary according to the individual country's needs and available resources. Budgeting is simplified by the existence of accepted standards, and financing by the fact that facilities are publicly owned and all personnel are public employees with fixed salaries and wages.

The USSR exemplifies the basic pattern of budgeting for and financing health services in the socialist countries, although the procedures and underlying specific criteria vary from country to country in accordance with their different needs and institutions.

The distinction between norms and standards, as used in the USSR, is that the former represent scientifically established indices of health care requirements and utilization, whereas standards are indices relating to the resources needed to satisfy the norms (*8*). Examples of norms applicable to primary care are those relating to the need for immunization or epidemiological investigations, requirements for community medical care in outpatient facilities and dispensaries, hourly workloads of physicians, or the need for drugs, dressings or other treatment. Corresponding standards would relate to the establishment of primary care facilities, the number of medical and other personnel required, medical and other equipment required, furnishings and transport, and construction and maintenance requirements. Allowing for some flexibility to adapt to local situations, these are the guidelines for budgeting at the local level.

At the beginning of the fiscal year the local administrative level (*rayon*) is notified of its allocation for health. The finance officer is responsible for controlling its use, and auditors check periodically to ensure that proper allocations are made to individual institutions. The health budget amounts to about one third of the total local (*rayon* and *oblast*) budget; the percentage gradually decreases with higher administrative levels because of their wider responsibilities in other sectors. In addition to the funds allocated through the central planning mechanism, local services are also strengthened by financial support from major industries, as well as from state and collective farms for their employees. Trade unions, too, operate health institutions for their members and contribute to health promotion among them (*9*). A major role in monitoring the allocation and use of funds is assumed by the chief physician of the *rayon* (*10*).

Similar methods of budgeting based on sets of norms and standards are used in the other socialist countries, although the actual scope of these guidelines varies.

Thus, in Bulgaria the basis for budgeting is stated to be the amount of services rendered, with the financing of each outpatient institution channelled through the respective state organ (people's council) to which it is subordinate. There is a set of financial norms for the different types of polyclinic services. The head of the institution determines the expenditure of the funds allocated, in compliance with the plan and according to need.

In Czechoslovakia the funds required for the construction and operation of health facilities, including community health centres and polyclinics, form part of the budget of the District Institute of National Health. An exception is the capital expenditure for the construction of factory health facilities, which are financed by the firms concerned; the firms also contribute to the cost of such items as power supply, maintenance and cleaning. Equipment, drugs, sanitary materials and the salaries of health personnel are paid by the state health administration. Construction of rural health facilities, such as health centres, may exceptionally be financed by agricultural cooperatives, with self-help construction work contributed by the community.

Personnel of all first contact health facilities are paid by the District Institute of National Health from state funds. Salary levels vary with the category of health worker, length of service and possibly also with special difficulties inherent in a particular post. In addition to these fixed sums there is provision for various special payments relating to the quality of work and also possibly for personnel acting as locum tenentes. Extra payment is also made for certain emergency medical services, such as night and holiday duty, taken in turn by almost all first contact physicians.

To the patient, primary care is generally provided free of charge but there is a nominal fee for prescriptions, and patients are required to contribute to the cost of certain dental prosthetic appliances. When a patient is referred to a health facility outside his place of residence, for instance on being referred from a rural health centre to an urban polyclinic, he is entitled to claim reimbursement of his public transport fare from the state health administration (*11*).

The Institute for Social Hygiene and Organization of Health Protection of the German Democratic Republic shows (*12*) that expenditure in that country for health and social affairs has risen steadily since 1950 in line with national income, of which it has constituted in recent years a fairly steady 5–6%. There have been, however, remarkable shifts within the health and social budget: while expenditure for general hospitals increased about three-fold between 1955 and 1978, that for primary care facilities—polyclinics, outpatient clinics, doctors' offices and communal nursing stations—grew about fourteen-fold during the same period.

Treatment at primary care establishments in the German Democratic Republic is free. According to the Ministry of Public Health, expenditure for state outpatient establishments increased from 1.09 million marks in 1971 to 1.55 million in 1975. In the occupational health

services, personnel and materials are financed from the national budget. Prescribed drugs, preparations and medical appliances are paid for by social insurance, whereas all other operational and treatment costs are borne by the state owned enterprises.

In Hungary, as in all countries with a centrally planned economy, the financing of primary care services falls within the framework of the national budget. Each county has its own income from its industries and from local city councils, which contribute to the funds for county development. The national council contributes "target oriented funds", mostly for capital expenditure. While the national budget ensures uniform standards, each council finances its own services. The operating expenses of district health services are thus covered by the local council budgets. Voluntary labour sometimes contributes substantially to health centre construction and special contributions may be received from local industries; in one case, for example, a factory provided roofing material for the health centre at cost. Salaries for health personnel vary according to age, length of service and special circumstances such as work in mines or certain factories. Doctors and dentists may be permitted to enter private practice after working full-time in the national health service; permission from the local council, which also inspects the premises, is necessary.

In Yugoslavia operating expenses of health institutions are funded essentially from insurance funds. Capital for construction, extension or modernization of existing facilities is allocated on the basis of the social agreements or compacts in which health institutions participate with the local administration and other organizations such as local industries, which may co-finance programmes of particular concern to them.

Other European countries with a national health service

As with the socialist countries, there are differences among these countries in the way money is raised for the health services, including primary care, and the degree of local responsibility. It may be predominantly through general revenue, as in the United Kingdom, or by insurance premiums or earmarked taxes as in the Scandinavian countries. The latter countries are also characterized by the considerable degree of local responsibility for the provision of health services.

In 1967 the county councils in Sweden took over the system of district medical officers, who had previously been employed by the government. These officers also provide primary care. In that year, the councils also assumed responsibility for mental health care, leaving the county council with the main responsibility for health services, apart from privately practising physicians and dentists. The health services are financed mainly through local taxes levied by the counties, about 80% of whose expenditure goes on the health services. Part of this expenditure is reimbursed through the health insurance system, particularly for the cost of medicines. The central government uses an equalizing system to give greater financial support to counties with a

high percentage of elderly people and lower economic activity. Fees collected from patients, especially for pharmaceuticals and certain dental services, constitute a steadily diminishing share of the county councils' incomes. All physicians in the public sector are salaried (*13–16*).

In its argumentation leading to Finland's Public Health Act of 1972, the government expected to stimulate the use of general practitioner services by abolishing previously existing charges to the patient because "the effect of charges in delaying the seeking of care has been particularly great among patients of small means". The aim was to abolish charges by general practitioners and to extend free dental care to persons over 16 years of age.

While in Finland the creation and operation of health centres according to the 1972 legislation is the responsibility of the commune or a federation of communes, the state contributes between 39% and 70% depending on the general solvency classification of the commune. Announced government policy in respect of these subsidies was that charges collected from patients at the health centre would be deducted from running costs for the purpose of determining the amount of state support; the same was to apply to reimbursements received by the centre for services provided under the sickness insurance act. The state was to pay monthly advances toward the running costs of centres, calculated as one twelfth of the total of the preceding year's support. Statutory provision may be made for health centres to make charges for transport, for materials or appliances used, and for the upkeep of a patient at a health centre. Doctors are salaried, with extra allowances for overtime work. Provisions for state assistance for capital expenditure, machinery and equipment, and specifications for eligible running costs are detailed in paragraphs 30–39 of the Act (*17*).

Like the German Democratic Republic, Finland is devoting increasing proportions of the health budget to primary care. Primary care grants were estimated to have grown by 687% between 1972 and 1979, compared to a 52% growth for hospital care and a total growth rate for the health sector of 106% during the same period (*18*).

In Denmark, following legislation introduced in 1973, the county councils have assumed functions similar to those in Sweden as regards raising taxes and the financing of health services. The remuneration of general practitioners, of whom an increasing proportion practise in groups, is based on an interesting distinction between the city of Copenhagen and the remaining parts of the country. In the former, practitioners are paid on a per capita basis, whereas elsewhere about half the remuneration is on a per capita basis—lower, of course, than that in Copenhagen—and the rest is based on a negotiated tariff of fees for specified services. This dual payment system, which has a long tradition in Denmark, is explained by findings that suggest the per capita method to be more appropriate in the city, where practise conditions are reasonably homogeneous and the workload more evenly spread, whereas equity among rural doctors is seen to be better achieved by the addition of a fee-for-service element (*19*). Under both systems of

remuneration, doctors are responsible for the running expenses of their practices and their own pension benefits.

In Iceland the capital cost of health centres, where more and more family physicians practise, is shared between the state (85 %) and the local authority (15 %). Doctors in health centres are employed by the state and, like other members of the team, are paid a salary. The local community is responsible for the running of the health centres, but physicians, nurses and midwives (nurse/midwives) are appointed by the Minister of Health and Social Security and remunerated by the state for preventive work. For their curative work, physicians are paid on a fee-for-service basis by the social security administration, which is a branch of the Ministry of Health and Social Security. All other staff (secretarial and clerical staff, laboratory and X-ray technicians, administrative and maintenance personnel, etc.) are paid by the local authority.

Under the British National Health Service the basic form of remuneration of general practitioners is the capitation fee, modified to an increasing extent by additional payments for specified purposes, relating both to the services rendered by the physician and the establishment of his practice. As distinct from the Nordic countries, health services in the United Kingdom are financed almost entirely (88 %) from general government taxation, the remainder coming from national insurance contributions (about 10 %) and direct charges to patients (2 %) for prescriptions and dental services, from which vulnerable population groups are exempted. There also is a private sector, amounting to the equivalent of about 4 % of National Health Service expenditure, largely in the area of specialist and hospital services.

The remuneration of general practitioners by a capitation fee maintains a tradition established in earlier insurance schemes in the country. Extra payments relate to incentives to attract doctors to underserved areas, to the greater demand by the elderly on a doctor's list, to newly assumed activities such as family planning, and to certain other activities accounting for increased demands. General practitioners in the United Kingdom are not employed by the government but are under contract to the National Health Service. They are in principle responsible for establishing and running their own practices, but here again they receive government support in a variety of forms. Group practice, for instance, is encouraged by weighting doctors' fees and allowances, and there are financial incentives to employ support staff and to improve the standard of premises. Thus, 70 % of the salaries of up to two full-time staff per practitioner, or the equivalent in part-time staff, are reimbursed by the health authority. This encourages the employment of trained personnel including nurses, health visitors, secretaries and receptionists. Alternatively, other members of the primary care team may be seconded to a practice by the relevant authority. Various government sponsored schemes provide funds for group practice premises, but some practitioners prefer private capital financing to preserve greater independence from the health authority.

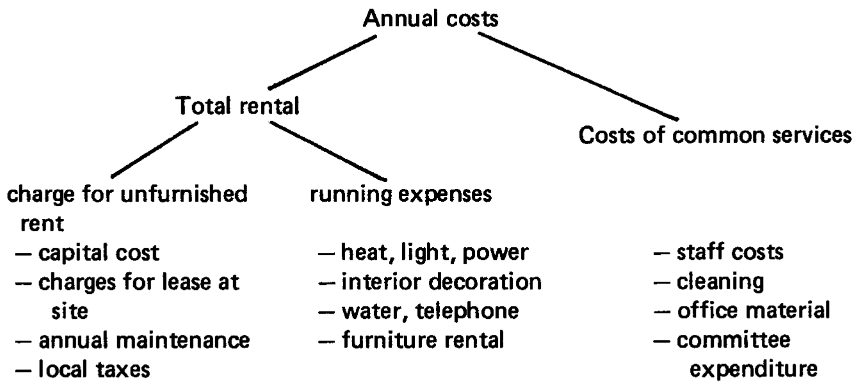
Practitioners are also directly reimbursed for actual or estimated rent and local taxes paid on their premises. In contrast to privately arranged group practices, formal health centres are provided by the Area Health Authority and running costs financed out of the Regional Health Authority's revenue allocation. Consulting rooms for general practitioners and shared rooms in a centre are available under licence, i.e. practitioners pay a charge for accommodation, which is fully reimbursed together with a service charge for heating, lighting, telephone, cleaning, decoration and repairs. This rather complicated arrangement, the Ministry explains, results from the profession's insistence that a practitioner shall not derive financial advantage over his group practice colleagues from working in a health centre. It reflects the fear on the part of some members of the profession of undue regimentation were they to practice in the more tightly controlled setting of a health centre. In addition, however, the various charges to doctors practising in a health centre may well be higher than corresponding charges in private—if poorer—premises, and doctors may have less control over such expenditure when practising in a centre. Some practitioners are also reported to prefer owning their practice to working in a health centre because ownership would enable them to preserve capital for their retirement.

The somewhat ambivalent attitude towards health centres in the United Kingdom has two sources: the jealously guarded independence on the part of the practitioners and the financial constraints on the National Health Service. The latter is quite willing to assist with the capital funding of cheaper private premises rather than the building of new centres. Therefore, the government is also willing to provide funds for converting existing premises for use as health centres, for providing general practitioner premises in National Health Service buildings already accommodating district nurses and health visitors, or to accommodate nurses and other primary care services in proximity to existing general practitioner premises (*20*).

Scotland, with its smaller population, has always had a simpler organizational structure than the former district–area–region tiers in England. It has also been more emphatic in its health centre policy, and more specific information is available on the financial aspects of the operation of some of its health centres. The particular financial arrangements reported relate to the initial period of operation before the reorganization of the National Health Service in 1974, so that some of the agencies involved will have changed in the meantime; the basic principles of financing, however, will not have altered.

One of the centres described (*21*) is located in the city of Glasgow. An interim management committee was established prior to the opening of the centre and a number of subcommittees were set up. After the centre was occupied, a permanent management committee was formed. The health authority provided the capital for the building and equipment. The annual running costs to the occupiers of the centre are made up of the elements shown in Fig. 4.

Fig. 4. Annual costs of a Glasgow centre



The occupying doctors are fully reimbursed for the rent of unfurnished premises. It was agreed that the management committee should be regarded as the supplier of services, and certain rules were agreed on regarding the distribution of charges for these items to the practitioners in the centre. Clerical staff costs were to be divided in proportion to the staff time likely to be required by the practitioners. Cleaning of fully shared accommodation was to be charged on the basis of floor area, but for partially shared accommodation charges would be divided by the same formula as used for staff costs. Each quarter an analysis of expenditure was to be made and expenditure allocated on the agreed basis. An individual practitioner's share of the respective expenditures is calculated according to the number of patients on his list. The management committee also had to look for the most economical way of purchasing materials and equipment, and to establish priorities among competing demands from several subcommittees.

Methods of allocating shared expenditure among several agencies occupying a centre are described for another Scottish centre (*22*) where, furthermore, the then Regional Hospital Board assumed the cost of operating the centre's computer-assisted medical record system.

These arrangements are, as stated before, peculiar to the British National Health Service because of the special position held in that system by general practitioners. They have little relevance for other national health service systems, but have been described here in some detail because of possible applications in countries without a national health service, where the state may wish to create health centres to accommodate otherwise independent private practitioners.

In those areas of Turkey where health services are provided by the government, both the physical facilities and the staff of general and maternal and child health centres are government financed.

Pluralistic health care systems

In these countries the general pattern is one of predominantly private practice, with private responsibility for capital and running costs, the latter being largely derived from various sickness insurance arrangements. In addition, however, most such countries in the European Region have health centres or clinics established and operated by public, semi-public or private agencies, where the sponsoring agency assumes total financial responsibility.

Sickness insurance funds accrue, with relatively minor exceptions, to those physicians and dentists who are under contract to a sickness insurance carrier or, of course, those who are employed at one of the sponsored facilities mentioned above. In Austria, for instance, over 80% of physicians and dentists in "free practice" are under contract to sickness insurance bodies. In that country sickness insurance carriers operate their own health centres where, in 1969, services were provided by 1318 specialists, dental specialists and dentists (*23*). Outpatient departments of public hospitals in Austria are also available to the insured population. Some 25% of all sickness insurance payments in 1973 went for physicians' services, and 16% for dental care. Physicians' services were the fastest growing item of expenditure (*24*).

The financing of health care in general, and primary care in particular, in the Federal Republic of Germany is predominantly taken care of by compulsory "social insurance", a blend of insurance principles and considerations of necessary social adjustment. This system is supplemented by funding by the *Länder* of certain services where they share responsibility with the local authorities as, for instance, in regard to mental health and tuberculosis services. In addition, about 6–8% of the population have voluntary private insurance, and there are direct payments by patients in the private sector. Doctors in private practice who wish to participate in the insurance system, as practically all do, form an association that contracts with the social insurance funds. These doctors remain self-employed and provide their services as medical contractors with the insurance funds. The remuneration of doctors is based on negotiated tariffs and depends entirely on the service performed rather than on the doctor's status as general practitioner or specialist. Insurance covers the cost of all medical care considered necessary. It derives its funds from earnings-based contributions from employers and employees, with special arrangements for pensioners and other groups. Dependants are entitled to the same benefits as the insured. To receive care, the insured or his dependant obtains a certificate from the insurance carrier and presents it to a doctor of his choice who is registered with the insurance fund. Based on the service rendered, the doctor is reimbursed by his association of insurance doctors. About 10% of the doctors' work, and on average about 20% of his income, come from private services paid for directly or by voluntary insurance.

Acceptance of new forms of collective medical practice has been slow

in the Federal Republic of Germany. Since most doctors derive the major part of their income through their patients' insurance funds, the policy of these funds regarding group practice is important. While regulations, as they stood in 1977, do not recognize pooled medical practice (as distinct from common use of auxiliary personnel, equipment or facilities) (*25*), recommendations have been made to promote common and even multispecialty practice.

Certain innovative ways of organizing health and social care in the community in the Federal Republic of Germany require ad hoc arrangements for funding from a variety of sources. Examples are the *Sozialstationen*, which provide nursing and ancillary services on referral by a doctor in the community who, however, is not on the staff of the station and is remunerated in his own right. In part, these stations are subsidized by the *Länder*, whose policy is exemplified by the following guidelines from Rheinland-Pfalz (*26*). The *Land* provides subsidies to *Sozialstationen* for capital and running costs. Stations are required to charge for services and larger items of equipment, but not for mere consultations. Exceptions are made for indigents according to their means. Stations are expected to recover insurance benefits and to liaise with social service departments regarding their services. Capital subsidies may amount to 50%, with a maximum of DM 3000 per motor vehicle. Operating costs are subsidized in terms of fixed amounts for the various categories of personnel. Stations are required to follow prescribed reporting and licensing procedures. The remainder of the funds must be obtained from other sources, including the county and local authorities, the church, insurance bodies, membership contributions, and various fund raising activities (*27*).

The assumption by third parties, especially those under public auspices, of responsibility for the financing of health services inevitably implies some controls. And controls become more stringent in times of economic constraint. In the Federal Republic of Germany, as elsewhere in the European Region, there has been apprehension among the medical profession lest financial controls lead to an infringement of the physician's clinical freedom. Like insurance carriers in other countries, those in the Federal Republic compare accounts submitted by physicians against profiles based on general experience, and substantial deviations may be disallowed. A federal court (*Bundesozialgericht*) in a decision of 1st March 1979 declared that checks of that sort must not lead to a restriction of clinical freedom, within the need to maintain the economic operation of the system. In other words, deviation from the norm does not automatically preclude reimbursement but may be justified in individual cases (*28*). On a different plane, the medical profession complains that the schedule of fees reimbursed by insurance funds does not keep pace with the sharply increased running costs of medical practice (*29*).

Similar areas of conflict exist in France, as illustrated by a strike by doctors protesting against government control of prescribing practices. Doctors and dentists in independent practice are generally paid by the

patient who is then reimbursed by the insurance system, except for his co-payment of the *ticket modérateur* from which certain chronic conditions are exempt. Some population groups, such as public employees, take out private insurance cover for this co-payment through the *mutuelles*, which also operate their own health centres. Sickness insurance is compulsory and, for employees, financed jointly by employers and employees, with contributions by the state. Some health centres are sponsored by the social security system or a local commune. To give an example of one commune-sponsored centre in the vicinity of Paris, the payment for services is on a fee-for-service basis by insurance carriers. The *ticket modérateur*, with its exemptions, in this case amounts to 7%. Capital costs, equipment, instruments, etc. are financed by the commune, which also covers any deficit; staff, including doctors, are salaried. Maternal and child care services are paid for by the government. Crèche services are paid for on a day-fee basis with the deficit also borne by the commune.

It is essentially the sponsoring agency that assumes the capital cost of clinics or health centres in France, possibly aided by local public or private organizations. The operating costs are covered by insurance carriers, with contributions from patients. Any deficit may also be covered by the sponsoring organization. Because the fee schedules of the insurance carriers do not cover such activities as health education, epidemiological studies, case conferences and other preventive activities, these fields are poorly developed in primary care institutions. Dispensaries, devoted primarily to prevention and follow-up for certain disease categories, are publicly funded. In Paris half the funds for these institutions come from the city, the remainder being divided between the state and social security; the staff are employed by the prefecture.

Dental clinics in Paris operated by the social security administration also receive their payment on a fee-for-service basis, but all personnel are salaried. Social insurance pays for services according to the tariff, except for the *ticket modérateur*, which amounts to 20% in this case and, subject to a means test, is covered by social assistance. Because of the sharp rise in costs during recent years, there is a substantial deficit; this is covered by the sponsoring agency but it does put constraints on the services provided.

Maternal and child health centres are financed entirely through social security and are free.

General health centres in Paris operated by the social security system, where full-time staff are salaried and part-time specialists are paid by the hour, receive payment on a fee-for-service basis through social insurance, except for the 20% *ticket modérateur*.

A system similar to that in France, based on the *ticket modérateur*, operates in Belgium; services are paid for by insurance in accordance with a tariff agreed on with the social security administration. As in France and other countries with insurance systems this tariff, confined as it is to curative activities and procedures, limits the ability of a primary care establishment to provide other services not contained in the tariff,

such as preventive measures, health education, etc. Health centres generally receive no other outside financial support, so that any additional activities are left entirely to the initiative of the doctors and other team members. Certain centres do receive occasional support for building costs, personnel and other items of expenditure from outside sources such as local or regional government, mutual societies and universities, but such support is limited in amount and duration.

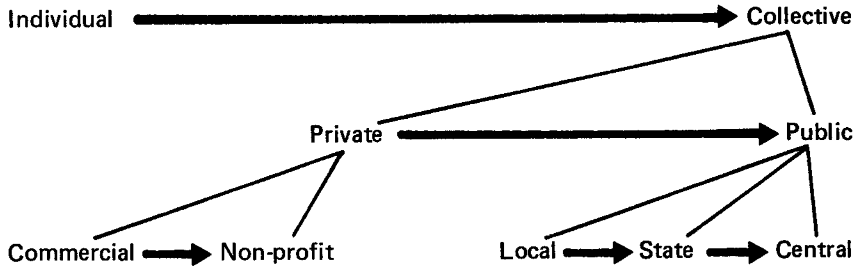
In the Republic of Ireland, the traditional system of general practice by independent practitioners goes hand in hand with the government's encouragement of the development of health centres. General practitioners are encouraged to provide their own practice premises with the aid of grants. Health boards offer practice premises in new health centres for general practitioners who are members of a group practice. Premises are also provided as a means of attracting doctors to underserved areas.

The Netherlands finances primary care largely through various nonprofit sick funds, general practitioners in independent practice being remunerated by a capitation fee. Special checks of prescribing practices are made by sickness funds, and some of the larger funds have special committees to deal with what they consider objectionable practices.

The range of financing mechanisms

At one end of the scale on which one may arrange the mechanisms for financing primary care in the countries of the European Region are the fully socialized health care systems, where all facilities are owned and operated and all personnel employed by the state. At the other end there are the systems under which the patient is responsible for paying for the services he receives, although he may be reimbursed under a variety of insurance arrangements. The distinction is partly between a national health service and some provision for paying for the services of independent practitioners. In countries that do not have a national health service there appears to be a definite trend in the methods of financing the health services. This trend is away from personal, individual arrangements towards collective forms of insurance with increasing participation of the public sector. Fig. 5 depicts these shifts. Recently, however, there have been instances of a slowing down or even reversal of that trend in some countries of the Region. An example is the United Kingdom where, as in other parts of the world, a conservative government, in order to reduce public spending, encourages private sector health care. Certain other countries are increasing the practice of user charges. The former approach is purely cosmetic, however, since it does not in itself reduce the total cost of health care to society. User, charges, on the other hand, are a very controversial tax on the sick and a potential deterrent to needed use of the service. Similar is the distinction between payment by the recipient for services received and indirect payment; the latter may be through charity, employment insurance, voluntary insurance, compulsory insurance, or government financing (7).

Fig. 5. Alternative channels for funding health care



From the review of the European scene it becomes clear that the existing systems do not fit neatly into any one category, but that most contain elements based on different principles and policies. If there is a trend towards greater involvement of the public sector in both the provision and the financing of primary care services, it may be due partly to the gradual acceptance of the principle of every citizen's right to health care, but partly also to the growing complexity and cost of health service which make it increasingly difficult for the individual to cope. The variety of arrangements existing in the Region, as well as within individual countries, illustrates the wide range of possible alternatives to suit any sociopolitical economic configuration. Differences in the philosophy on which health systems are built do not rule out international cooperation and there is ample room and opportunity for identifying common approaches to common needs (*4*). Models, aided by operational research and systems analysis, can help in identifying components of other systems that may merit adoption. "We are now on the threshold of a truly quantitative revolution in health care and the new numerical methods must be employed in modelling health care systems . . ." (*1*).

What then is the effect of different financing mechanisms on the care provided and its organization? These are issues not confined to the European Region or indeed to any one part of the world. In the United States, the promotion of the health centre concept in the form of the health maintenance organization is largely based on the finding that prepaid group practice organizations reduce the demand for costly hospital services without impairing the care provided to patients. In one of its more recent policy statements the American Public Health Association accordingly urged improvements in the organization of

ambulatory care because of its cost containment significance as an alternative to hospitalization (*30*). Individuals or groups may join such health maintenance organizations in the United States for the periodic payment of a fixed sum (often paid or contributed to by employers as a fringe benefit). In return the members receive the full range of services they need, both medical and hospital care. Costs are kept low because of various incentives and the strict budgets within which the organization operates.

A Canadian study inquiring into the economics of group practice in one of the provinces found that "complex multi-specialty clinics, and particularly consumer sponsored clinics, do have economies in clinic operation which result in higher investigative costs but lower hospitalization rates" (*31*). This is looking purely at the economic aspects without regard to the quality of care. And purely from the cost point of view, the study finds that the lower rates of hospitalization for investigative and non-surgical conditions are largely offset by the groups' higher investigative and consultative or referred costs. Nevertheless, the authors conclude with the comment on the present pluralistic system existing in Canada, that the country may have no alternative and "although the precise effect of group practice in general and community health centres in particular is not clear, the data of this study and other Canadian studies suggest to the authors that the incorporation of these centres into a rationalised Canadian health care system could produce greater returns than anticipated". It may be noted that Australia, under its Commonwealth Community Health Program, assists in the financing of health centres through commonwealth and state grants, the operating costs being met largely from patients' fees, rent paid by professionals using the centres, and donations (*32*). Japan is gradually changing the concept of health centres originally designed to provide preventive services of the traditional public health service type into facilities offering comprehensive primary care services (*33*).

If the development of health centres and similar forms of primary care organization is widely promoted throughout the world, it is because of the need to marshall rationally the resources necessary to enable primary care to fulfil its functions. The prominent role primary care has to play in the provision of comprehensive and balanced services, and the need for teamwork, outreach and coordination with other community services, demand an effective organization to guarantee the quality of the services; cost saving is not the main consideration. When evaluating health centres in terms of their cost, including personnel and equipment, the range and volume of services must, of course, be taken into account. If health centres help to reduce the rate of hospitalization to a greater extent than, say, solo practice, there is likely to be a saving of costs; "however, to find out whether the more economical services provide lesser or greater benefits than those that cost more is a task requiring much further research" (*3*).

Another aspect of financing primary care, which in some countries of the European Region arouses considerable controversy, is the method of

remunerating physicians. The methods range from a fixed salary to capitation fees to strict payment for each item of service, whereby the fees to be paid may be negotiated with the government or an insurance carrier, or may be set at the discretion of the attending doctor. In reality, one finds that the prevailing methods of payment often modify these basic types quite considerably. The advantages and disadvantages of various payment methods have been studied and discussed (*5*, *6*). In many cases the prevailing method is that with a tradition in a particular country, its use often being maintained to make other changes in the system more palatable to the medical profession. It remains difficult to understand, however, why doctors, with all their training and concern with human wellbeing, should require incentives different from those provided to most other professionals and even to some of their colleagues who work in different settings.

Among the recommendations emanating from the Alma-Ata Conference in 1978, No. 17 deals with resources for primary care (*34*):

> The Conference,
> Recognizing that the implementation of primary health care requires the effective mobilization of resources bearing on health,
> RECOMMENDS that, as an expression of their political determination to promote the primary health care approach, governments, in progressively increasing the funds allocated for health, should give first priority to the extension of primary health care to underserved communities; encourage and support various ways of financing primary health care, including, where appropriate, such means as social insurance, cooperatives, and all available resources at the local level, through the active involvement and participation of communities; and take measures to maximize the efficiency and effectiveness of health-related activities in all sectors.

It is with some satisfaction that one notes priority being indeed given in many countries of the European Region to the strengthening of primary care. This chapter, it is hoped, will assist in assessing "various ways of financing primary health care".

On the road towards health for all by the year 2000, it is as well to bear in mind the principles and essential issues formulated by the WHO Regional Committee for Europe (*35*) and by the Executive Board of WHO (*36*) to serve as strategies towards the attainment of that goal. This may involve a reorientation of the existing health system, where it is particularly important to ensure "that primary health care and its support do not become a parallel system that is a 'poor relation' of the existing system. In ensuring adequate support to primary health care at all levels, governments will no doubt have to face the realities of the existing health system, whose functions and emphases may differ greatly from those required to implement the new policies, strategies and plans of action" (*37*).

The various aspects of financing—such as sources of funding, methods of remunerating staff, incentives, and the financial responsibilities of patients—are usually interdependent. Health centres in

the narrower sense, namely primary care facilities under public auspices, can be expected to be financed from public sources; their staff are usually salaried, and services are provided free of charge or possibly for a fixed fee.

Modifications do exist, however, in all these regards and especially in facilities not operated by governments. Funding, for instance, may come from general tax revenue or earmarked taxes; the rationale for the latter is usually that potential consumers are more aware of the cost of service, but it also keeps the health care budget clearly separate from other commitments of the central or local government. There is also a tendency to have primary care facilities wholly or partially financed by local rather than central government as a means of suiting the service to local needs and, again, of creating among the population served an awareness of the resources required.

As to the remuneration of the health centre staff, fixed amounts are the rule for most categories of personnel. Exceptions exist for doctors and dentists, but in publicly administered centres salary or sessional pay for part-time work is the most common form of remuneration, modified not infrequently by extra payments for special services such as house calls, night calls, etc. Special incentives may be instituted, for example to attract staff to remote or otherwise undesirable areas. In the less structured facilities, such as various forms of partnership particularly in the private sector, various other forms of remuneration exist, including fee-for-service payment. The Finnish example demonstrates one particular advantage of the salary method for all categories of staff, which puts all members of the primary care team on the same basis as far as the method of remuneration is concerned.

The method by which a centre receives its funding may be unrelated to the way the staff is remunerated. The centre may receive its payments on a fee-for-service basis from an insurance carrier or patients but the staff, including doctors, may be on a fixed income. Alternatively, the reverse may be the case, with the centre operating on a fixed budget while remunerating its medical or dental staff according to services provided.

How the necessary financial support can best be allocated to primary care and its institutions may well be a worthwhile subject for further study to enable both the WHO regional offices and WHO headquarters to provide Member States with the kind of guidance envisaged by the Executive Board.

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