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**ORGANIZATION AND FINANCING
OF HEALTH CARE REFORM
IN COUNTRIES OF
CENTRAL AND EASTERN EUROPE**

*Report of a Meeting
held at the World Health Organization
Geneva, 22 - 26 April 1991*

**WHO Task Force on Health Development
for Countries of Central and Eastern Europe**

HEALTH CARE FINANCING AND ORGANIZATION
IN COUNTRIES OF CENTRAL AND EASTERN EUROPE

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CONTENTS

	<u>Page</u>
Executive Summary	
Introduction.....	1
Health System Reform: Two General Overviews	2
THEME 1: A.-P. Contandriopoulos: "Regulation and Performance of Health Systems".....	9
Country Experiences	
Bulgaria.....	11
Spain.....	12
Czech Republic	13
Sweden.....	14
THEME 2: Richard Saltman: "Managing Change in the Public Private Mix".....	15
Country Experiences	
Romania.....	17
Germany.....	17
Yugoslavia.....	18
THEME 3: Professor Beatrice Majnoni d'Intignano: "Provider Payment Systems".....	19
Country Experiences	
USSR.....	21
Canada.....	22
Poland.....	23

	<u>Page</u>
THEME 4: Professor Jurgen Wasem: "Social Insurance Systems".....	25
1. Coverage.....	25
2. Financing.....	26
3. Organization.....	27
4. Provider payment systems.....	27
Country Experiences	
Hungary.....	28
Netherlands.....	29
Turkey.....	31
Slovak Republic	31
 Health System Reform: The Process of Change.....	 33
 ANNEX 1: Agenda of the Meeting.....	 35
 ANNEX 2: List of Participants.....	 38
 ANNEX 3: Figures 4 and 5.....	 43-44

Executive Summary

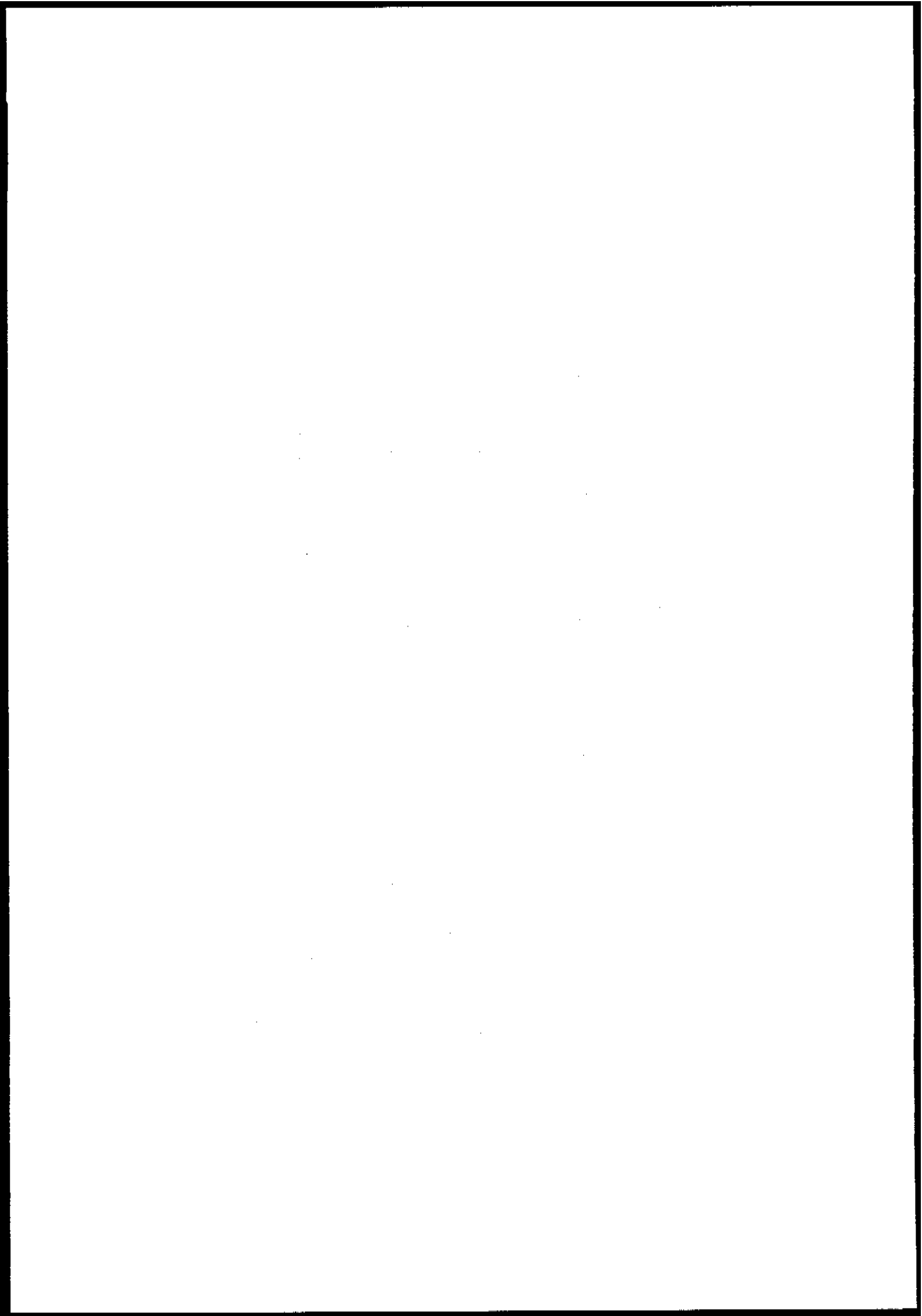
Extensive restructuring of the health system is in progress in the countries of central and eastern Europe. These changes are part of the transition which countries are making from centrally-planned and directed economies and societies to pluralistic, democratic systems. Political and economic factors make reforms both urgent and difficult.

Health systems in other industrialized countries are also changing, under pressures to contain costs, to keep abreast with demographic and technological change, and to improve performance.

This meeting brought together decision-makers and health policy analysts from some twenty countries. The objective was a structured exchange of experiences relating to organizational and financial reform in the health sector. A small number of themes was selected as a focus for discussion. These were: changing paradigms in health policy; public and private sector roles and responsibilities; alternative types of payment systems for health care providers; and social insurance models of health financing. In addition, general overviews of health policy and health financing were given, and country-specific commentaries made.

The report begins with comparative overviews of reform experience in Western Europe. These are followed by invited "theme papers" on the above topics. Each theme is then followed by country-specific illustrations of reform achievements and intentions.

This meeting was part of WHO's continuing programme of technical support activities in central and eastern Europe. It was organized through the Global Task Force on Health Development for Countries in Central and Eastern Europe, in collaboration with the WHO Regional Office for Europe. Financial support towards the costs of the meeting was provided by the German Government.



Introduction

Health systems, and their degree of success in achieving health objectives, are being re-examined throughout Europe and North America. In western Europe the review and reform process is driven by pressures to control health service expenditures in the face of rapidly increasing costs, and by the need for health systems to be more responsive to their users. In countries of central and eastern Europe (CCEE), health systems reform is taking place against a background of rapid general social and political change, designed to build and reinforce democratic structures. Political and ideological pressures for a fundamental change from the previous systems must be accommodated. Comparatively poor health outcomes in central and eastern Europe signal an urgent need to improve both the funding and the effectiveness of health care. But in all parts of the developed world, there is a concern about the relationship between increasing health system costs and diminishing returns in terms of health outcomes.

Whether "reform" means incremental fine-tuning or fundamental restructuring, the process of change in the health sector requires a realistic assessment of past and present conditions, clear long-term goals and medium-term objectives. A set of policy instruments for the short-term is also needed: these must both help to define the "next steps", and establish consistency between short-term changes and long-term goals.

These concerns were the background to the meeting on "Health care financing and organization in countries of central and eastern Europe", held in Geneva, 22-26 April 1991. The meeting featured invited theme papers on selected issues in financing reform. It also considered country-specific perspectives, drawn from both western and eastern experiences of health system reform. The agenda of the meeting, and the list of participants are contained in Annexes 1 and 2.

In his opening remarks, Dr Hiroshi Nakajima, Director-General of the World Health Organization, spoke of the paradoxical relationship between health and the economy. On the one hand, there exists a clear, positive relationship between countries' levels of economic development and levels of health status. On the other hand, at any given economic level, wide variations among countries in health indicators such as life expectancy or infant mortality, can be observed. Thus, whilst the state of the economy is always an important underlying influence on health, there remains substantial scope for health and social policy in influencing actual health outcomes. Dr Nakajima went on to emphasize the need for a new health paradigm, in which economic realities and changing social structures were incorporated. This point was further developed during the discussions of the meeting.

The country-specific material briefly summarized in this report reflects a diversity of history, experience and structures. Because of the nature and speed of the reform process in central and eastern Europe, some of this material necessarily has a short life. It represents thinking about health sector reform as at April 1991. Despite this, information about intentions and experiences will be of continuing interest as philosophies change, and new health systems are defined and consolidated in central and eastern Europe.

Health system reform: two general overviews

The first two presentations focused on some general features of health system financing and organization, and on the links between health care financing mechanisms and overall health system performance.

Professor Martin Pfaff presented a typology of health care systems based on the type of financing (amount of public finance in total) and the type of production (amount of public production in total). Hypotheses regarding the relative costliness of predominantly private (in financing and production) health care systems, and on the role of co-payment in limiting excessive consumption of health goods were presented and discussed. The empirical evidence suggested that the most significant cause of differences in total costs (as measured by health expenditure per capita, or expenditure on health as a percentage of national income) is to be found in the dominant mode of financing. Predominantly public systems achieve lower overall costs than predominantly private systems because privately funded systems offer less countervailing power to providers' ability to create demand. Within the publicly-funded category, no significant differences in cost was found between those systems which are tax-based and those which are funded through contributory insurance. Health authorities in such systems may acquire a quasi-monopsony position vis-à-vis provider organizations.

Professor Pfaff went on to analyze the effects of different cost-sharing approaches. Cost-sharing models can either be constructed so as to provide significant additional financial support to the social health insurance funds, or alternatively, in a way so as to be more compatible with the aims of a social health-insurance system. In the first case, their distributive effects are likely to be regressive, in the latter, their effects in reducing fiscal burdens are likely to be minimal.

Similar conclusions apply to the introduction of a regime of risk-related premiums. This would lead to a lower average contribution per member for the large group of statutory members taken as a whole, but the contribution rates would increase for low-income groups, especially for the old, for women and for families with many children.

A second general overview on reforms of financing and organization of health services was presented by Mr. Jeremy Hurst, based on a recent study by the OECD¹.

Three models of predominantly public financed health systems were presented:

i. Public reimbursement

In this system patients are reimbursed by a public insurance fund. Providers are independent, and there is no connection between them and the third party payer (the insurance fund). Co-payments are significant (typically 25% in France), and there is no statutory limit on expenditure. This model still plays a residual role in France and Belgium, for ambulatory care.

ii. Public contract model

In this system, a sickness fund or public authority pays providers directly, by fee-for-service or capitation. The level of cost-sharing is low, and providers are usually independent. This model is followed in Germany, the Netherlands and the United Kingdom (for general practitioners), and in Canada.

iii. Integrated model

"Integration" here refers to the integration of providers and payers: public providers are paid from public resources. This is the predominant model in CEE countries, and also in hospitals in Spain, the United Kingdom and the Republic of Ireland.

The connection between the dominant system of payment and the achievement of health system goals was explored. All three models are found to fulfil the objectives of adequacy, equity and income protection (see Table 1). With public reimbursement models, however, there are difficulties with cost containment because of the open-ended nature of

¹ The Reform of Health Care Systems: A comparative Analysis of Seven Countries. To be published in late 1991 by OECD, 2 rue André-Pascal, 75775 Paris Cedex 16.

expenditure commitments. Where "money does not follow the patient", as in the integrated model, there are problems of consumer satisfaction because there is no systematic financial incentive to serve patients' needs.

TABLE 1: Connection between health system objectives and the three models

	Public Reimbursement (i)	Integrated Contract (ii)	Model (iii)
Adequacy, equity	Y	Y	Y
Income protection	Y	Y	Y
Macro efficiency	N	Y	Y
Health outcomes	?	?	?
Patient satisfaction	Y	Y	?
Cost minimization	Y	Y	?
Consumer choice	Y	Y	?
Provider autonomy	Y	Y	N

The result of these systemic deficiencies appears to be a convergence in western Europe on the "public contract" model.

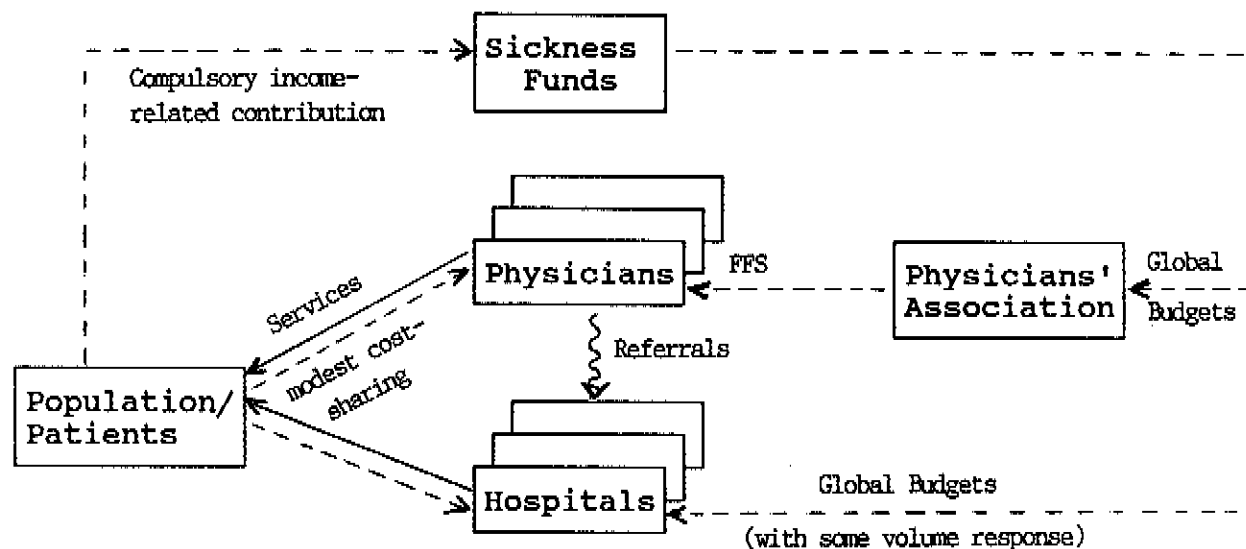
Variants of the "public contract" model have a number of features. Firstly, there is a trend towards universal and comprehensive coverage, that is, an increasing role for the public sector. In the Netherlands, although there has traditionally been public insurance for chronic care, approximately 35% of the population has relied upon private insurance for acute care. The Dekker reform programme will extend insurance coverage to include both chronic and acute care. Similarly, in Spain the universalization of public insurance has been recently completed.

A second common area in reform has been the use of global budgets in hospitals. This measure has particularly been adopted in those countries with more open-ended expenditure systems, such as Canada, Belgium, France, Germany and the Netherlands, in order to contain costs. Global budgets are an alternative to open-ended "fee-per-day" type of payment systems. They provide an overall limit on expenditure by a facility, and since this is stipulated in advance such mechanisms are also known as "prospective reimbursement" methods.

A third common area in which significant changes have been made is in introducing managed competition for providers. The principles of managed competition can be illustrated using the examples of recent reforms in three countries: Germany, the United Kingdom, and the Netherlands.

i. Germany

Figure 1



Source: OECD, The Reform of Health Care Systems, forthcoming.

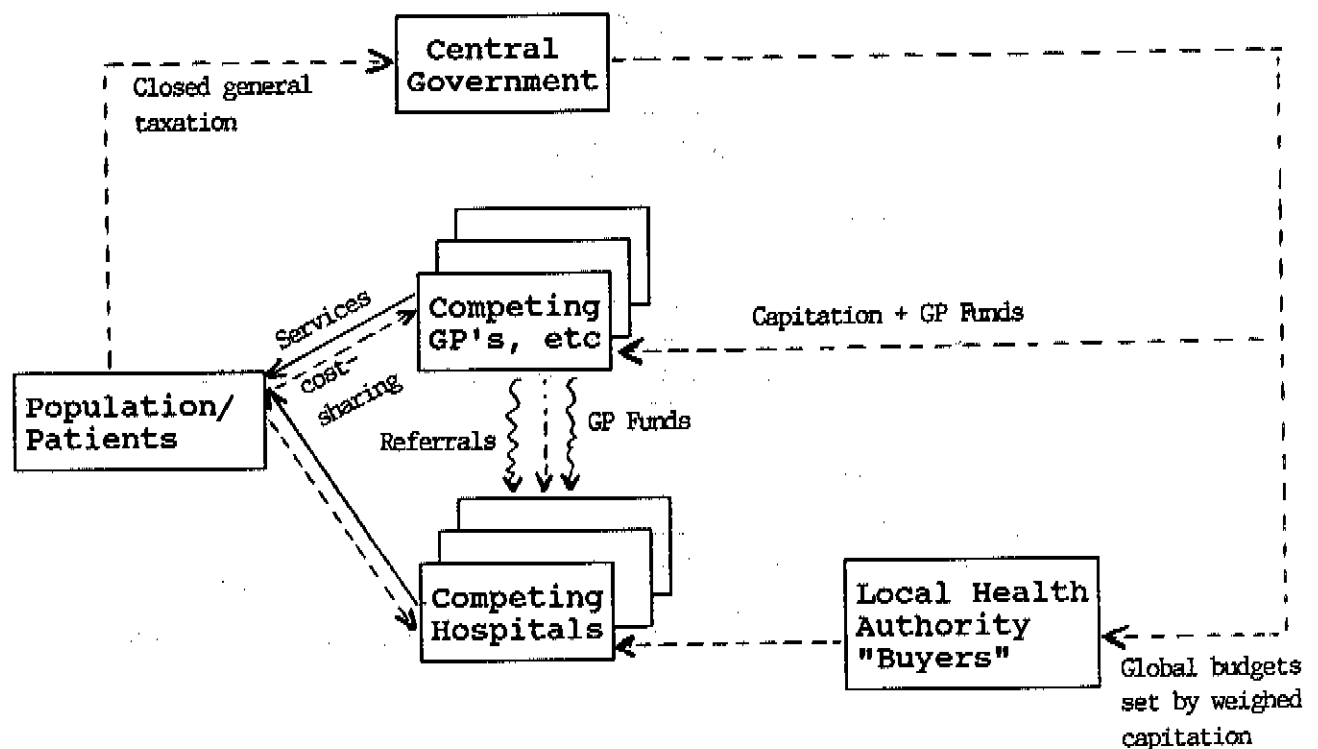
Recent reforms in Germany have resulted in the adoption of global budgets for primary care which are paid by the sickness funds to physicians. The regional association of physicians, in turn, pays physicians on a fee-for-service

basis. The combination of choice of physician for the patient and fee-for-service payment ("money follows the patient") creates an environment of competition among physicians and encourages sensitivity towards patient needs. Reforms in the hospital sector, giving sickness funds the right to cancel contracts with hospitals, provide a similar environment of competition among hospitals for the public money coming from sickness funds.

ii. United Kingdom

The United Kingdom reform experience illustrates the move from an integrated system to a form of the contract model for hospitals.

Figure 2



Source: OECD, The Reform of Health Care Systems, forthcoming.

In the primary care sector, general practitioners are paid mostly through capitation, which, because there is some choice of doctor, allows for competition among general practitioners. The current reforms involve measures to make it easier for the patient to move from one physician and

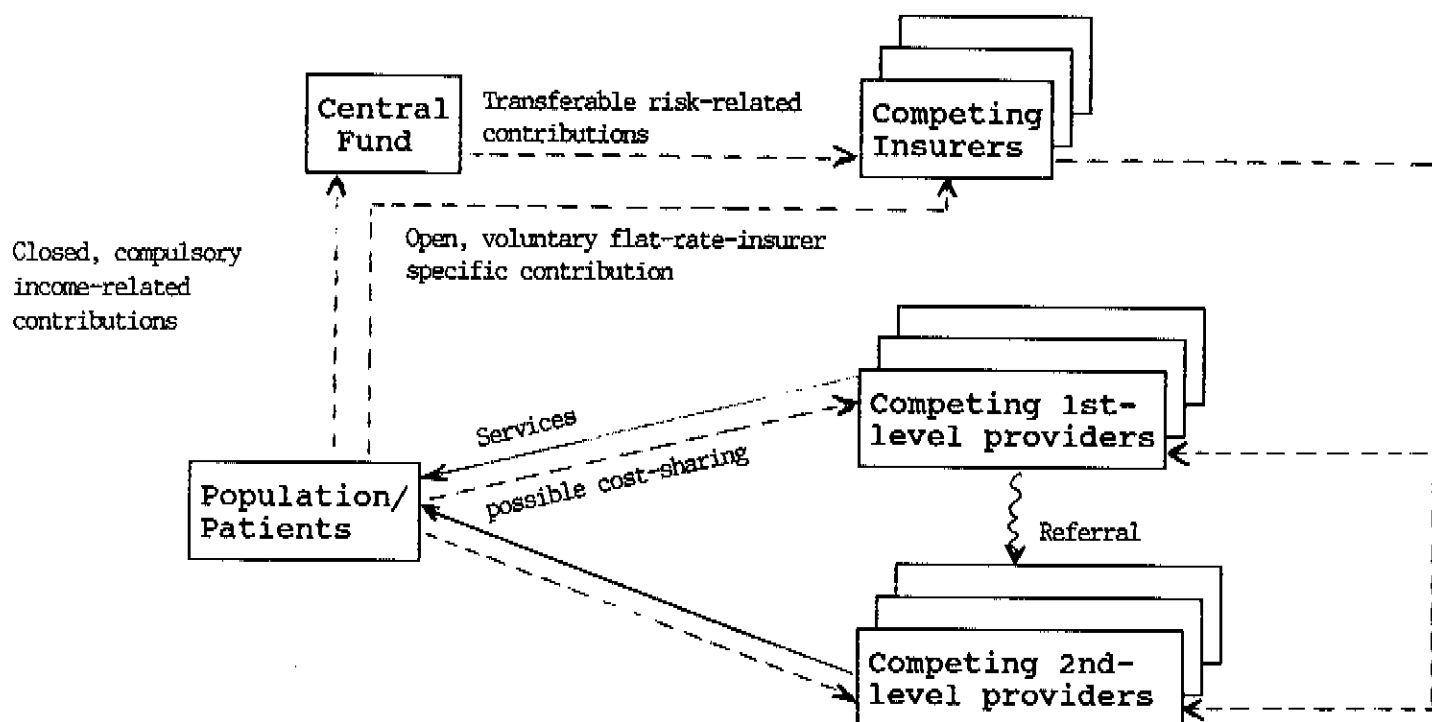
register with another if they are not satisfied with the service they receive. General practitioners can also choose to become "fundholders", receiving funds from which they buy hospital care for patients. They can then negotiate contracts with hospitals for certain elective services for their patients.

A second element of reform in the United Kingdom is at the district authority level, involving the separation of buyers from providers of services, by removing the previously existing direct management links between District Health Authority buyers and hospitals. This is intended to encourage hospitals to compete for health authority contracts, creating an "internal market" within the public system.

iii. Netherlands

The Dekker Reforms in the Netherlands are directed towards encouraging competition both among insurers and among providers.

Figure 3



Source: OECD, The Reform of Health Care Systems, Forthcoming.

A central fund will receive income-related contributions from the population, and pay risk-related premiums to the insurers (both public and private). This is a major shift in financing practice, further details of which are contained in the presentation on the Netherlands in pages 29-30 below. This will give insurers an incentive not to select against high risk patients. Free choice of insurer creates competition among insurers. In addition, a 15% direct contribution to the insurer is designed to ensure cost-conscious choice by consumers, and provide an incentive for insurers to reduce costs.

On the provider side, current legislation proposes to remove the right of every provider to contract with every insurer. This will allow insurers to select providers on cost-effectiveness grounds.

In summary, several European countries with tax-based systems are experimenting with a variety of new health instruments aimed at increasing consumer choice in health care. There is generally a greater reliance on active, informed purchasers of services, and on competition among providers and insurers. New types of payment systems, directed towards both achieving expenditure control and creating incentives for performance, are being used. Within an environment of control on total health spending, there is potentially more autonomy for providers, and more reliance upon self-regulation.

These first two presentations, and the discussion which followed, set the broad technical context for discussion of reform in central and eastern Europe. Subsequent discussion followed four invited theme papers.

Theme 1: A.-P. Contandriopoulos "Regulation and performance of health systems"

This paper's initial premise was that the ability of existing health care systems to support the attainment of health objectives is being challenged, and that a new paradigm must be sought. Taking an historical perspective, the transition between different models of intervention was traced. An evolution in the "dominant system of beliefs" about health, and the factors which contribute to its improvement and its deterioration, was illustrated.

Three major stages were sketched in recent thinking about health and its determinants. The first is the period of implementation of public health insurance systems during the first half of the twentieth century. This period was particularly associated with the view that medicine has a solution for all health problems, and that to operationalize the principle of the right to health, the State must ensure that all services are accessible to all in need. At the same time, the existence of the modern state became legitimized by its capacity to protect and promote life. This conjunction between the role of the State and the development of health knowledge justified the introduction, during the first half of the twentieth century, of health insurance and social security systems. Their common objective was: universal access to services regardless of ability to pay. The dominant conception of health at this time was the "absence of illness." Little emphasis was given to prevention.

Medical science was directed towards the understanding of the normal functioning of organisms and at determining the most rational way to correct malfunctions. Professionals enjoyed a high level of autonomy: in economic terms, physicians were seen as perfect agents for their patients, able to take all decisions regarding treatment. The regulatory structure was aimed at ensuring sufficient resources, and at making services available to all. Patients had a limited role in the system, and financed only a small part of costs. In this sense, the health system was intended to respond to health problems by offering health services. It was a period of belief in "triumphant medicine", when it was thought probable that medicine could solve all health problems. Use of health services would correct the health problem and improve the health status of the population. The more services available, the more disparities in health status would disappear. Professional ethics guaranteed that all required services, and only those, would be provided. Control was completely decentralized, resting on these professional ethics, and it was implicitly assumed that the behaviour of a medical professional would not be influenced by elements of the organizational framework, such as the provider payment system.

This system of beliefs dominated the organization of health systems until the end of the 1960's, when increasingly there was an awareness of rapidly increasing health costs without significant improvements in health status, and without significant reduction of disparities.

By the end of the 1970's, a broader concept was developing, both of health and of its determinants. This definition of health left health problems at the centre of analysis, but recognized explicitly that health problems originate in environment, lifestyle and biological factors. Different interventions and prevention policies were implied. The principles of health systems changed, from maximizing the availability of services to increasing the health of the population at least cost. A positive view of health was made operational, through, among other influences, the WHO advocacy of Health for All by the Year 2000. It was recognized that "health" is defined by the judgement of people, even if physicians define illness.

A new view of the interaction between the individual and the health professional emerged. The demand for health care was seen to be expressed through the process of consulting a physician: it is the professional ability of a physician, and the uncertainty of the individual as to the cause and cure of his/her health problem, which provides the physician with his/her central role in the system.

Uncertainty in diagnosis and treatment, as well as the role entrusted to the medical professional in deciding upon the most appropriate course of treatment, means that incentives are important influences on the choice of treatment. The implications of these factors have resulted in the implementation of a number of policies designed to control the growth of expenditure.

Despite these new principles, however, costs have continued to rise, while at the same time greater levels of dissatisfaction are being expressed. Scientific discovery is contributing to a change in the dominant set of beliefs.

Enormous progress was made in the 1980's in the fields of genetics, immunology and neurophysiology. The human body seems infinitely more complex and possesses a considerable ability to adapt. In addition, the separation between essentially curative and preventive medicine no longer seems justified. The social environment can have an important curative role, and the health care system can exercise a preventive function by creating confidence in the population. At the same time, the interaction between health and economic development is known, even if the magnitude of the relationship is not.

It is at this current phase of transition between dominant sets of beliefs which we find ourselves today. The former paradigm of triumphant medicine is being challenged, and the process of determining a new one is underway.

The new paradigm of intervention is not simply that of market-based liberalism nor one based on a model of technocratic control. Its principles centre on a decentralization of responsibility, a new accountability for health outcomes, and a reconsidered role for the medical professions.

Country experiences

Bulgaria

Pressures for change in the financing and organization of the health sector are coming from all parts of Bulgarian society: citizens, health professionals and trade unions. Significantly, the pressures are concentrated more on the pace than the content of the reform.

The overall strategy envisaged at this time is the introduction of a system of social insurance. Current controversies revolve around how to implement this change. A way forward currently being entertained is the separation of health sector resources from the general budget, creating an insurance "fund". This would allow a change in the way those resources are used, without immediately changing the revenue base. This year the health budget has been decentralized to local authority level: municipality-owned facilities are responsible for the implementation of their own activities with the resources they receive from the state budget. Currently a process of determining prices for dental services is underway; other proposals include introducing new measures for a set of 100 health facilities, or changing expenditure rules for a particular medical activity, such as treatment of cardiovascular diseases.

Public health legislation in Bulgaria has been updated to allow for private practice, and management guidelines are being drawn up for public and private institutions. The need to introduce a cadre of trained managers in health facilities is recognized, although insufficient numbers of managers exist at present.

Attention is required in the area of public relations: the Bulgarian population is uninformed about the scope and nature of the planned changes to the health sector, creating a profound mistrust of the reforms. At the same time, the reformers know very little about the attitudes and needs of the users.

Spain

The Spanish experience is of particular significance in the discussion of health care reform in CCEE because of the recent history of political change in Spain. From 1976 Spain was faced with a political transition on a scale comparable to that of CCEE - from 40 years of dictatorship to a democratic system. Previously centralized structures were decentralized. Economic conditions were precarious in the transition period, and social and political life were radicalized. In the period which has followed, however, Spain has achieved a rate of economic growth which is one of the highest in the world, became a member of the EEC in 1986, and has been the fastest growing economy in Europe for three consecutive years.

The health sector in 1976 was a highly fragmented system in which doctors worked on different schedules, in different settings, treating different patients, paid by different institutions along different schemes and rules. Investment in the private sector was declining. The social security health care network (INSALUD) dominated the provision of health services, and operated under a substantial deficit. The Ministry of Health was created in 1978, although the social security budget remained under the Ministry of Labour.

In 1982 the first Socialist government was elected. Changes to the health sector were believed to be necessary due to the impact of the operating deficit of INSALUD on industrial competitiveness, the need for rationalization of the health care system, and an ideological imperative: equity, universal coverage, and a role for the regions were all part of the dominant reformist ideology. The strategy adopted was to move the system from fragmentation to unity, and to allow diversity within the system, with some role for local self-determination in the implementation of health policy.

The 1986 General Law for Health (produced after no less than 14 drafts) created a national health system. The new system is primarily publicly funded, predominantly from the state budget, and is run by the regions. The central structure and 17 regional services are coordinated through the Interterritorial Council.

There are shortcomings in the existing system: it has been difficult to overcome the historical absence of adequate budgeting and accounting mechanisms; the evolving political environment has made the process of transferring INSALUD from the centre to the regions complex (with respect to the amount of expenditure to be transferred, the timing and procedures for transfer, and mechanisms for compensation); accountability is poor due to chronic sliding of deficits; conflicts and inconsistencies exist in health care policies due to a combination of multiple actors with different objectives and a "noisy" political environment. There has

also been some naive "fetishization" of organizational and legal forms: management without information and without managers. Some problems with personnel and operational rigidities persist.

Despite these shortcomings there have been significant achievements in the health sector. The principle of equity appears to be consolidated; there is an explicit and practical determination to decentralize; the quality of hospital care has been maintained, quality in PHC has improved and many new services have been created. Training and research are being improved at all levels; public funding has been substantially consolidated and improved; finally, the basis now exists for building a qualitatively better system: the information system has been upgraded and infrastructure improved.

The most recent step in consolidating the health care system has been the appointment by the Interterritorial Council of the "Commission for Analyzing, Evaluating and Making Proposals for Improving the National Health System." Ways to increase the flexibility and efficiency of the system are being considered, as well as the possibility of allowing public firms to enter into health care delivery, and how to improve relationships with the private sector.

Czech Republic

The health sector in the Czech Republic receives a significant percentage of the government budget (up to 8.3% depending on the method of calculation) - suggesting a focus on the absence of health policy as a more significant factor in the health sector than absence of resources.

Since earlier this year health policy has been placed at the top of the government agenda. A feature which has contributed to this strengthening of the position of Ministry of Health has been their ability to put forward a conceptual framework and concrete plan of action. The framework, along with key principles and scenarios for implementation, is contained in the Draft of a New System of Health Care, presented to parliament in December 1990.

The principles guiding the design of the new health care system have been established, and focus is now upon setting out a realistic plan and schedule for implementing the required changes. Increasing the efficiency of the system, and allowing financing from multiple sources through more transparent mechanisms, are included in these objectives. The deadline of January 1992 for implementation has been extended in recognition of the need to change the system of taxation before fundamental financing reforms can take place.

The main steps in reform over the next years will involve the establishing of new bodies and entities to participate in policy making. Professional chambers and societies have been created and are adopting new roles. The structure and organization of health services is being changed through decentralization and the creation of a health insurance company. New patterns of ownership are being considered and the education of health professionals is being reviewed.

Sweden

As with many other western European health systems, the Swedish health system is predominantly publicly financed (90%). The system is organized on a regional basis, and each region is responsible for raising its own resources from a combination of municipal and county taxes. Up to 1982 there had been a continuous growth in the percentage of GNP devoted to health: in 1982 this was 9.7%; presently the amount is 9.1%.

Along with expenditure concerns, a number of other problems face the Swedish health system. They include an aging population, a low level of consumer satisfaction, and limited resources (with levels of taxation now capped at the municipal and county levels). There are also problems with personnel, distribution of resources, coordination, quality, and support to family caregivers.

For this reason a change of paradigm has been sought, and markets and competition introduced in the public sector (see Theme Paper 2 for detail).

The need to define units of service for the purpose of output measurement and payment mechanisms is being dealt with through the introduction of costings based on diagnosis related groups (DRGs). In order to avoid some of the difficulties experienced with the use of DRG's as a payment mechanism in the USA, a different approach has been taken in Sweden. The introduction of DRG's has been primarily physician-driven, and has been accompanied by training to support their use.

A current project for the introduction of DRG's involves 50% of hospitals, working by specialty. It is anticipated that by January 1992 DRG's will be used for a number of specialities.

Theme 2: Richard Saltman "Managing change in the public private mix"

This theme is concerned with issues of public-private mix and ways to introduce private sector mechanisms to "revitalize" the public sector. The central argument is that issues of competition should not be confused with those of privatization. Competition is a method of allocating available resources among multiple participants, where some win, some lose; while privatization refers to the transfer of ownership of capital resources.

If the notion of competitive mechanisms is separated from that of private ownership, a wide range of possible market mechanisms exist which can be designed to improve allocative efficiency but which require little or no private capital. In Finland, Sweden, and the United Kingdom, reform has focused on the design and introduction of various competitive mechanisms inside what remain publicly owned and operated health systems.

Planned markets

Perceived inadequacies in both command-and-control planning models and neoclassical market models have led to the development of hybrid models, or "planned markets". These involve the intentional combination by politicians and public officials of a mix of market and planning mechanisms in order to achieve a specific set of political and managerial objectives.

Planned markets occupy an intermediate position in the continuum that lies between traditional planning notions and standard neoclassical economic models. At its broadest, the design of planned markets can be considered to involve attempts to answer the following questions:

1. In which sector(s) or sub-sectors of the health system will competitive incentives be introduced?
2. On which specific incentives will competition be constructed?
3. For which actors will market-style incentives be introduced?
4. What innovative forms of market-oriented behaviour could create effective competition within "natural monopolies" in the health sector?
5. Where will integration and cooperation be emphasized rather than competition?

6. How can new information systems be constructed to limit distortion of clinical treatment patterns and priorities?
7. How will "regulatory capture" and other forms of provider domination be forestalled?
8. How will a market-generated explosion of new managerial costs be prevented?
9. Where will accountability over capital decisions be located?
10. How will new competition designs be field tested? Will demonstration and pilot projects be properly evaluated before they are transformed into nationwide programmes?

Sweden is experimenting with planned markets. A public competition model, in which different publicly capitalized and operated providers compete for public market share is being partially implemented in Stockholm and Malmohus. An alternative, the "Dalamodel" adopts the mixed market framework, with both public and private providers competing against each other for public funds. The key differences between the two experiments are the character of the new market to be established and the relative decision-making balance between patients, and administrators and politicians.

There are a number of similarities, however. Both models are animated by market-style incentives, rather than planning targets; both take needs-based budgeting, tied to programs and clinics, as only the starting point rather than as the final basis for resource allocation; capital allocations in both models will have to be justified on patient-volume, revenue-generating criteria rather than traditional population-based mechanisms; primary health centres and clinics will act independently to establish new efficiency-oriented incentives, without waiting for planning department approval; and hiring, firing and components of salaries will be decided at the individual institutional or local district board level.

The conclusions from this discussion of planned markets were that:

1. Neither command and control planning nor pure neoclassical markets seem to be capable of achieving the broad mix of objectives of modern health systems;
2. There is no necessary connection between introducing competitive mechanisms and markets on the one hand, and private ownership on the other;

3. Fragmentation of health care financing among multiple, independent services, is not necessary to achieve macro or micro organizational efficiency.

Country experiences

Romania

Underlying health sector reform in Romania are the principles of equity, efficiency, quality, choice and participation, and a family physician orientation. A strong distrust of the state amongst Romanians has created and reinforced an impetus towards privatization. Private practitioners are licensed by the Ministry of Health, and can choose to work in the public sector on a part-time basis or to undertake only private practice. A device to help cope with overcapacity in some hospitals has been to allow private practitioners to rent beds. Similarly, public facilities can be rented for private practice out-of-hours or during holidays.

Decentralization is seen to be an important feature in health sector reform in Romania. Experiments are planned in this area, with current plans for decentralization in four districts. This may be reinforced by draft legislation which proposes that revenue collected by the Ministry of Health be retained at Ministry level. For the longer term, there are plans to implement a social insurance system.

Germany

The German system of social health insurance and the experience of unification of East and West German systems was presented.

Within the German system, insurance carriers are predominantly public (90%) although private and special insurance systems exist. Between an upper and a lower income limit insurance is compulsory. Certain groups are free to choose between insurers, although for others, based on trade or other affiliation, there is a single carrier. Premiums are income-related and collected by the insurer. Only "medically necessary" treatments are covered. Social insurance in Germany works under the principles of solidarity, subsidization and competition.

Unification of the East and West German systems became effective in January 1991. The deeply political nature of this was emphasized, as was the need for solidarity during times of profound political change. It is now assumed that the insurance system in the formerly East German territories will be "self-funding", that is, will not receive transfers from the Federal government. It is understood however, that the capital budget will require a significant external investment programme if the health infrastructure is to reach the standards of that in formerly West Germany.

Yugoslavia

As in some other central European countries, Yugoslavia had early experience with health insurance systems, having established a system after World War I along the lines of the German and Austro-Hungarian experiences.

After 1945, a national health insurance system was established at the federal level. It was financed from the federal budget and income-related contributions. Since then a number of reforms have taken place, first decentralizing then re-centralizing the system due to difficulties associated with inequalities between regions. Today there are problems of unemployment among health professionals and a deficit in the insurance funds.

There is a strong feeling today that the health system must be in line with prevailing economic conditions. Similarly, current political and economic crises point to persistent regional inequalities. Current reform proposals include the transformation of ownership and increasing the level of private ownership and the implementation of a compulsory insurance system in combination with private supplementary insurance.

Theme 3: Professor Beatrice Majnoni d'Intignano "Provider payment systems"

The way in which providers of health care are paid has a significant impact on both the overall level of expenditure, and the incentives facing the individual provider. These in turn are important determinants of the functioning of the health system as a whole, and will promote or detract from the achievement of overall health system objectives. Payment systems in OECD countries are evolving to fulfil the requirements both of cost containment and providing appropriate incentives. Existing systems include global fee-for-service payments, cash-limited budgets for hospitals, family doctors paid by capitation and filtering access to specialist treatment, pharmaceutical lists, control of health expenditure by parliament and joint management by health insurance funds and physicians.

An overview of provider payment systems, using a typology proposed by Professor Contandriopoulos, distinguished between i) the pricing process; ii) the payment mechanism; and iii) the method of payment. A number of alternatives exist for each of these three variables:

- The pricing process determines how prices are set: physicians can set fees themselves, fees may be negotiated between the provider and the payer, or they may be set by administrative decision.
- Possible payment mechanisms include payment directly by the patient, third party reimbursement, or payment to the organization which employs the physicians (Health Maintenance Organization (HMO), National Health Service, or hospital).
- Actual payment may be on the basis of fee-for-service, salary or capitation.

Any actual provider payment system combines an element from each of these categories. Figures 4 and 5 in Annex 3, illustrate.

Some of the incentives resulting from provider payment systems are well known. With fee-for-service payment methods, for example, a tendency towards cost inflation has been observed, due in part to the fact that even where fees can be controlled by the third-party payer (e.g. insurance company) there is an incentive for the physician to increase the number of services delivered. This is known as "supplier-induced demand". The inflationary impact of fee-for-service has been countered in some countries through the use of global budgeting or other upper limits on the level of reimbursement for physicians. In Germany, where physicians are paid on the basis of service "points" accumulated, the total sum available

is paid by the physicians' association to the physicians on the basis of the number of points accruing to each. This system combines the incentives of fee-for-service with overall control on expenditure.

Capitation is an alternative system for payment of GP's which has a number of advantages such as continuity of care, and responsiveness to patients needs, especially where patients are free to change their physician.

Similar considerations apply to payment of hospitals. "Fee per day" reimbursement is equivalent to fee-for-service, and has also been associated with cost escalation. Overall global budgets for hospitals have checked the increase in hospital expenditure, but have had the negative impact of creating inflexible structures. DRG's, used to finance hospitals on the basis of their medical activity, have been used in the USA since 1984. Payment by DRG encourages hospitals to choose the most effective method of treatment, reduce the length of stay, and maximize the use of non-physician medical professionals. There are negative effects, however, which include encouraging hospitals to refuse to treat unprofitable patients, and to transfer treatment from hospitals to non-hospital medicine.

The Health Maintenance Organization (HMO) is an organizational form which attempts to combine the producers and insurers of treatment, and in so doing to suppress supplier-induced demand. Payment is based on actuarially determined premiums, and can vary with type of services offered. A HMO then has an incentive to increase productivity, to eliminate overcapacity and to favour cost-effective care (including disease prevention and health promotion). At the same time, it must offer quality care to keep its subscribers. As a result, premiums for HMOs are lower than for health insurance funds which reimburse ex post.

A number of western European and other reforms have included modifications to the system of paying for health care. Competition between insurers has been pursued in the Netherlands, and between HMO's in the USA. Competition between providers is being encouraged by developing contractual relationships between payers (third party insurers in the USA; Regional Health Authorities in the United Kingdom) and providers of services (hospitals and physicians). In Germany, the Blum Reform is directed towards encouraging competition between pharmaceutical products by setting a ceiling on the level of reimbursement for each class of treatment. Patients, unwilling to pay the additional costs of more expensive treatment, have exerted sufficient pressure to cause a significant change in the prescribing practices of physicians, and on the level of drug prices themselves.

In France, physicians are allowed to set their own fees as an alternative to adhering to fee schedules negotiated with the insurance companies. Where fees have been freely-set patients are required to pay the co-payment and a surcharge. Very few general practitioners have opted for free choice of fees, and those who do have seen their level of activity fall, as well as their overall income. In the specialist sector, where demand is more inelastic, many more physicians set their own fees, with concomitant increases in their level of income.

The choice of payment system (the pricing process, the payment mechanism, and the method of payment) ultimately has major impact on the achievement of health policy objectives. Trade-offs must be made between equity, efficiency, provider autonomy and patient choice.

Country experiences

USSR

In line with recent economic reforms, the objectives of health system reform in the USSR are to change managerial structures, increase the autonomy of health care institutions, introduce new principles for the financing of health care, to allow free choice of physician and multiple forms of ownership of health facilities.

Although the majority of health care facilities will remain within the public sector, the possibility will exist for some institutions to be rented by collectives or be transferred to the private sector.

Basic medical services will remain free of charge, financed through contributory insurance, although it is understood that new management practices to increase the efficiency of resource use should be introduced before any change in the financing basis for health services. Lessons in economic management of health facilities from the Leningrad, Kemerovo and Samara experiments, and are being introduced in other republics with prices are being established for medical services and quality standards for treatment set.

Canada

The provider payment system in Canada has allowed costs to stabilize (in contrast to the USA, where costs have continued to rise), while maintaining health status and controlling administration costs. As was noted in earlier presentations, there is an expressed high level of satisfaction amongst users of the Canadian system.

The Canadian system is a decentralized one, with provinces allocated responsibility for, inter alia, the organization of social and health services. Four principles dictated by the Federal government circumscribe the organization of health services: health care must be universal, comprehensive, publicly administered, and "portable" (ie. between provinces). Within these constraints, each province organizes its health services separately.

In Quebec, tensions between equity, on the one hand, and freedom on the other, exist and are mediated by the State. Health insurance is universal, comprehensive, and financed through public funds. Evaluation and accountability are exercised at central level, although decision-making is decentralized. Virtually all physicians (99%) participate in the health insurance scheme, although they can choose to practice independently from the insurance system. There is free choice of physician and a high level of autonomy for the physicians who act as entrepreneurs. Payment is by fee-for-service, which is paid directly by the third party payer. Excess charges, direct charges and negotiation of fees are not accommodated by the system. The schedule of fees is negotiated between the physicians and the government: this includes both prices of individual services and the size of the global expenditure budget. Fees can be adjusted to accommodate total expenditure targets. The law provides the formal mechanisms for quality of care, although this responsibility is delegated to professional associations.

With respect to hospital care, global budgets for facilities are set by the Department of Social Affairs, with annual adjustments determined by past performance. Capital and equipment expenditure is authorized by regional authorities. Working conditions are negotiated at provincial level. Patients have free choice of hospital, and hospitals are autonomous legal entities, although the composition of the Board of Directors is set by law.

If the system of provider payments is described with respect to a) the pricing process, b) the payment mechanism, and c) the method of payment (see Figure 3), we can see that the Quebec system (negotiated fees, third party payer, payment by salary or fee-for-service) can be seen as highly successful in containing growth of expenditure, with low administrative costs (<4%). The relationship between physician payment

modalities and health system objectives of i) appropriate health services utilization; ii) cost control; iii) ease of administration; iv) productivity; v) accessibility; vi) quality; and vii) satisfaction is explored in Figure 4.

Poland

The Polish health care system follows the "integrated model", with global budgets decentralized to voivodship (district) level. The health budget is contained within the overall budget allocated to the region, and the Chief Medical Officer is accountable to the Governor of the voivodship.

Payment to physicians was by salary until 1959. In the 1960's supplements were paid for specialization, etc., in addition to salary. The 1972 ZOZ reform aimed to give more local control and flexibility, though it was criticized for its discretionary character. Although in general, "only the administrators were better off", this system did have some positive effects particularly in small counties. In the 1980's "relative value" salary scales were introduced, rating elements such as the complexity of a job, level of responsibility, working conditions, etc. Basic salary accounted for approximately 55% of total income.

Recently the relative value scale has been abandoned, and payment of health professionals is now indexed to industrial wages. Surplus funds resulting from vacancies can be used to increase salaries.

It is important to recall the political context of physician payment: the average salary in the health sector over the period 1960-1989 was approximately 70% of the national average wage. In this light, a rapid increase in incomes is seen by doctors to be a test of goodwill on the part of the authorities. In 1989 average health sector salary rose to 90% of national average, and this year (1991) it is 102.7%.

The reforms currently envisaged aim to reconcile the needs of the patient (protection), the provider (profit) and the payer (control). This requires a change from a paternalist system to one with greater autonomy; from administration to management; and from monopoly to pluralism. This will inevitably involve a trade-off between equity and efficiency; between security and freedom; and between privilege and entitlement.

The need to start and support the reform process with emergency efficiency measures was emphasized, given the longer term requirements for implementation of a contributory insurance system. There is a particular role for small "success stories" in providing encouragement in an environment of uncertainty and disillusionment.

Some small changes to the provider payment system are being contemplated. Given the high level of enthusiasm for a fee-for-service system, the use of fee-for-service with a total expenditure cap (along the lines of the German system) is being discussed. A new Bill proposes that part of any savings from the global budget could be used to increase income of health workers.

Theme 4: Professor Jurgen Wasem "Social insurance systems"

The financing of health services through social insurance (also called contributory health insurance) has been promoted as a "middle way" between financing through private insurance and tax-based National Health Service-type systems. Although social insurance systems are often held to be both more efficient and more effective than NHS-type systems, it is not possible to reach any general conclusions about the cost-efficiency of social insurance systems. This is due largely to the structural differences which exist between different social insurance systems.

A useful way of looking at social insurance systems is to conceive them as falling along a continuum between NHS-type systems and private insurance systems. Although as a general type social insurance can be regarded as situated between these two extremes, it is the structural features of the insurance system which determine its precise nature, and, obviously, how different health system objectives are achieved. The most important of these structural features are addressed below.

1. Coverage

The overall level of coverage of a social insurance system is determined by who is entitled to services. Generally all those who are employed are covered by a social insurance system, but special measures are required to ensure coverage for groups such as the unemployed, the rural population and those in upper-income groups.

European experience with levels of coverage of social insurance suggests two groupings of countries: firstly, those with almost comprehensive, compulsory insurance for employees and groups of unemployed persons, who achieve rates of coverage of between 95 and 100% (Belgium, France, Greece, Austria); and secondly, those countries without complete compulsory insurance: in this case there may be an upper income limit, above which insurance is not compulsory (Germany, Spain), or regional differences in regulations (Switzerland). Coverage in this group of countries ranges from 60 to almost 100%.

TABLE 3: Coverage by Social Health Insurance, Europe, 1988

Country	Coverage
Belgium	95-100%
Germany	89
France	95-100
Greece	95-100
Netherlands	60/100*
Austria	95-100
Switzerland	98
Spain	95

*100% coverage for insurance against specific "catastrophic" illnesses.

An important feature of a social insurance system is whether individuals are permitted to opt out of the system. Of particular concern in permitting opting out is the risk of "adverse selection", a feature which would undermine the pooling of risks on which social insurance is based. If private insurance is an alternative for those opting out of the social insurance system, further issues as to the regulation of the private carriers arise.

2. Financing

Although in principle the main difference between social insurance systems and general taxation-financed NHS systems is in how resources are collected, in reality the distinction is not so clear. Most social insurance systems receive some funding from the central government, whether in the form of premiums for the unemployed or disabled, or capital investment budgets.

The bulk of revenue, however, is collected through income-related premiums, usually jointly paid by the employee and the employer. Co-payment is used in some systems either as an additional source of resources or to deter "frivolous" use. Evidence suggests that low levels of co-payment do not generate much in the way of additional revenue, but that larger co-payments tend to deter use among low-income groups.

Premiums are generally collected through a payroll tax, although use of this mechanism means that any non-employment income is excluded. In some countries there is a limit beyond which additional income is non-contributory.

Whether a system is "open-ended" or "closed" describes whether additional funds can be brought into the system if costs exceed income in a given period, either by raising premiums or injecting central government resources. Systems in Spain and Germany are open-ended, whilst that in the Netherlands is closed.

3. Organization

Organizational features of a social insurance system include the degree of independence of the insurance system from government control, and whether the system is a centralized or a de-centralized one. In Germany the government exercises a relatively large level of control over the insurance system, due to the imperative to contain costs. Reforms in the Netherlands are at least partly directed towards limiting government control.

With respect to the second issue, there are two elements involved: whether there is a central institution with regional or local branches or whether local level insurers are autonomous entities; and whether the system comprises a number of standard regional insurance carriers or alternatively, regional funds co-exist with other funds which operate nationally catering for persons of specific profession or company. In the case of Germany, 50% of the insured can choose their carrier. In Belgium and Switzerland, nearly all the insured can choose.

4. Provider payment systems

The main provider payment arrangements used in European social insurance systems are third-party payment and reimbursement systems. These may be combined: in France and Belgium there is third party payment for hospital care, while the remaining costs are reimbursed.

As with other mechanisms for the financing of health care services, the relationship between social health insurance and overall health policy goals must be addressed. Of particular concern are whether the system allows for equitable access and redistribution (both between individuals and between geographical areas); and how tensions between cost-containment and equity are resolved.

Country experiences

Hungary

Political and social change in Hungary, towards a pluralist democracy, includes changes in the health care delivery system. An action plan has been produced, legislation passed, and other legislation is currently being discussed.

An important feature of the Hungarian reform process is the awareness or "taking stock" of the positive features of the existing system. Three features have been identified: access is a right of all citizens; the health services network is national in coverage, although regional inequalities do exist; and there is a large number of health personnel, although there is a problem of inappropriate distribution by medical specialty.

The structural framework for reform sets out the responsibilities of the State and local government. In 1990 the funds for the financing of social security activities were separated from the central budget, creating room for flexibility within the existing revenue collection system. Social security funds are presently used for payments in relation to the running costs of the health services, accident and disability benefits, pensions and other social welfare benefits. Plans exist for the division of the central fund into independent branches in 1992, allowing the separation of health funds from those for other social welfare activities.

In the medium term, the Government of Hungary plans to implement a compulsory social insurance system to cover basic health services. Private health insurance would be allowed to function for the coverage of supplementary services. In the long run there may be scope for competition among insurance funds.

Options for provider payment mechanisms are being discussed. For primary care both fee-for-service and capitation systems are feasible options. As regards inpatient services, the German-type system, an improved version of the present input system, or an output orientation with some measure of case-mix are all being considered.

In order to ensure that the interests of both providers and users of the health system are being considered in the reform process, a number of associations have been established, including the Medical Chamber, and a variety of "self-help" groups and associations.

Netherlands

Currently in the Netherlands four types of health insurance operate. The Exceptional Medical Expenses Act (AWBZ) is statutory and covers the whole population resident in the Netherlands against "exceptional medical expenses", mostly long term care and catastrophic illness. Contributions are income related, and the Act is implemented by the sickness funds, private insurers and the agencies that operate the statutory insurance schemes for civil servants. The Sickness Fund is a statutory insurance scheme, with compulsory participation for all those with income less than a given ceiling. Contributions are income related, paid jointly by the employee and the employer. This scheme covers a broad spectrum of "ordinary" services: hospital admission, general and specialist medical treatment, dental care, pharmaceuticals, etc. Those with incomes greater than f50 000 can insure themselves through a private insurer, for which the contribution is a flat rate. Approximately 35% of the population are covered by private insurance. Civil servants are insured against normal medical expenses as part of their conditions of employment. Contributions are income related, and 5% of the population are covered.

A number of problems exist, however. Because of the four different schemes with different premiums, adverse selection in the private sector, and multiple structures, the system lacks transparency. There are few financial incentives for efficient behaviour. In the interest of cost control there is a high level of regulation with concomitant inflexibility. In addition, costs of health care are increasing as a result of demographic changes.

The 1986 Dekker report proposed fundamental changes in the health care system, focusing mainly on the insurance system. The solution to the problems of the existing system was to remove the barriers between the existing schemes and introduce a single scheme: the Basic Insurance Scheme. The Basic scheme will cover 95% of health expenditure, with the remaining 5% covering luxury services.

The Basic Insurance Scheme will be a compulsory basic insurance. It will cover the whole population for a broad package of benefits. Premiums will be income related, and collected by a central fund. This fund will distribute contributions among the insurance companies (both sickness funds and private insurers - now called "care insurance") using risk assessments of the insured. A nominal, flat-rate payment will be made by the insured directly to the insurance company. With the income from these two sources, the insurer will pay the costs of health care for its insured. Since the amount of money paid from the central fund is fixed, the remaining funds necessary must come from the flat rate

contributions from the insured, creating an incentive for the insurer to choose the most cost effective care for its insured. Contracts between insurers and providers will specify volume of services, price and quality. The co-payment by the insured is also the main mechanism for introducing competition among insurers. Each person is free to choose his/her insurer, and insurers will be obliged to accept all applicants and to charge the same fixed premium to each insured.

One of the objectives of the reform is to reduce the direct influence of the Government and thereby the volume of legislation in the health sector. It is hoped that this will be achieved through the introduction of market elements and increased self-regulation.

A number of problems have been faced in the implementation of these reforms. These include:

- i. How to incorporate private insurance companies into the compulsory insurance system. Since this runs against the current tide of privatization, it was necessary to be creative, and to denote the flat rate contributions from the insured as private rather than public. This has allowed the new flat rate contribution to be related to the previous private insurance premiums.
- ii. Opposition of the private insurance companies. Given the difference in interests between private insurers and health policy makers, the advice given was to avoid them. However, it is felt that the overall environment can contribute towards moderating the actions of private insurers.
- iii. Distribution of funds from the central fund to insurers. This issue has not yet been resolved. However, the proposals have caused a change in the behaviour of the sick funds.
- iv. Implementation. This is being done incrementally, with special implications for CCEE countries: if an insurance system is being created, it is best to start with one or two sectors of health care which are well-organized and priced.

Turkey

The total level of expenditure in the health sector in Turkey amounts to approximately 3% of GNP. Half of this is private expenditure, and of the public share of expenditure, only 35% is by the Ministry of Health. The MOH budget ranges from 2.3 to 4.0% of the total government budget.

Currently there are three different insurance systems: one for employees, one for civil servants and one for independent workers. Approximately 70% of the population is covered by one or the other of these systems.

Current discussions about reform concern the extension of insurance coverage to the entire population and the reorganization of health services along the lines of the "family practice" model. Concern exists, however, about the feasibility of extending insurance coverage given the existing level of resources available to the health sector. In particular, reform of the health sector will require the resolution of some of the current economic problems.

Slovak Republic

In the context of general economic reform in the Slovak Republic, and recognizing that indicators of health outcome such as average life expectancy reflect poor health status amongst the population, a decision was taken in November 1990 to undertake reform of the health system. Over the next 2-3 years a national programme of health promotion and prevention will be implemented, and strategies defined in light of an analysis of health status.

The main organizational change will be to replace the Regional National Health Committees with autonomous authorities at community level. Whilst previously the national budget, including resources for health care, was allocated by the Ministry of Interior Affairs to regional and then to district level, the Ministry of Health will now control the allocation of funds for health services. This initiative will help to alleviate the problems of lack of coordination between resource allocation and health sector strategy. New bodies, the Regional Health Financing Committees, will allocate resources directly to providers. This regionally-based system will form the basis of the planned health insurance system.

Because of the need to ensure that the provision of health services is not interrupted by the reform initiatives, it is understood that changes must be gradual. The present range and level of health services will be maintained during the initial phase of reform, whilst implementing measures to increase the efficiency and effectiveness of health service delivery.

Health system reform: the process of change

From the technical presentations and country experiences presented during the course of the discussions, it became clear that the process of health system reform in central and eastern Europe will be extremely complex, from both an organizational and a political perspective. The aspirations and needs of the population, and the pressures for rapid change which these needs impose must be accommodated. Although the models of health system reform presented during the course of the meeting were of interest and relevance for those countries undergoing fundamental health system reform, the specific characteristics and constraints of each country, both political and economic, are the factors which will determine both the shape of the system in the long run, and the pace of change.

The convergence of western European health systems upon a public contract or "managed market" model of financing and organization reflects a recognition that privatizing the provision of health care services will not, in itself, create a flexible and responsive environment. The public sector is being revitalized by creating a competitive internal environment, or through encouraging competition between public and private providers and insurers.

In order to move from the old organizational structures to a new health system, deliberate transitional steps are necessary. It is here that the distinction between a "normative" and a "developmental" process of policy development is useful. In contrast to a normative process, based on the development, usually over a period of years, of a comprehensive system of norms which circumscribe the functioning of the system, a developmental approach permits strategic use of a few well-placed transitional measures. The implementation and evaluation of these measures will permit policy to evolve along consensual lines, and can, if carefully designed, signal the overall direction of change in a way which will reassure the population that change is taking place and that some of the most immediate problems are being dealt with. This approach also allows policy-makers some flexibility and can help to ensure that longer term systemic objectives are not compromised by short-term political imperatives.

There are a number of areas in which these immediate, transitional measures can be taken. Funds for health care can be separated from the state budget, into an insurance "fund" allowing for measures to improve the efficiency of the use of these resources without requiring the fundamental reform of the tax system necessary for a full-fledged insurance system. Similarly, pressures for fee-for-service payment for physicians can be met by introducing fee-for-service payment within a global budget, in this way avoiding inflationary

pressures. More generally, an experimental approach, with new policies and combinations of mechanisms implemented on a small scale basis, can perform a strategic function, allowing for observation and evaluation of results, and can at the same time send appropriate political signals.

Macroeconomic circumstances will inevitably influence the amount of resources available to the health sector, regardless of whether the system is predominantly tax-based or insurance-based. Changes directed at making the financing system more transparent, such as switching from a tax-financed system to a contribution-based one, will not overcome overall resource constraints. Under conditions of economic restructuring, where resources available to the State will invariably be reduced, any decision to increase the resources available to the health sector will be a political one, since it will require reallocation of funds from another sector. A case for additional funds will be strengthened by proposals to use resources more efficiently. Similarly, a change in the financing system will not in itself change the way resources are allocated or improve efficiency: additional managerial and policy decisions are required.

Both provider payment systems and insurance-based financing are mechanisms rather than principles in themselves. Overall policy direction will be influenced by the priorities of the population, whilst financing and provider payment systems will determine whether these will be achieved. Where the issue of financing mechanisms becomes the subject of political debate, such as in the case of insurance-based financing and fee-for-service payment, care must be taken to ensure that overall health system objectives are not compromised.

Throughout Europe, health system reforms are aimed at achieving equity of access, efficiency (both at a macro and a micro level), improved health outcomes, patient satisfaction, consumer choice, and provider autonomy. Countries in central and eastern Europe are embarking upon a process of change which will take them from a centrally planned and financed health care system to one which is capable of achieving a better balance among these objectives. There is no unique set of policy choices and implementing mechanisms which will steer the reforms in the right direction. The challenge for policy-makers in central and eastern Europe is of choosing a strategy consistent with each country's history, sociocultural values and economic structures.

ANNEX 1

AGENDA

Monday 22 April

- 14.00 - 14.30 Opening address
Dr H. Nakajima, Director-General, WHO
- 14.30 - 15.30 Health services in Europe: the challenge for
the 1990s - Dr C. Sakellarides, EURO/HQ
- 15.30 - 16.00 COFFEE BREAK
- 16.00 - 17.30 Financing Issues: Professor Martin Pfaff -
University of Augsburg
- 18.00 RECEPTION

Tuesday 23 April

- 09.00 - 10.45 Some Western European health care system reform
experiences: a critical appraisal - Mr Jeremy
Hurst, Department of Health, UK
- 10.45 - 11.00 COFFEE BREAK
- 11.00 - 12.45 Theme No. 1: Health policy, health care
financing and health system performance

Presenter: Dr A.-P. Contandriopoulos,
University of Montreal
- 12.30 - 14.00 LUNCH
- 14.00 - 15.30 Theme 1, continued - Some country perspectives:

Bulgaria
Spain
Czechoslovakia (Czech Republic)
Sweden
- 15.30 - 15.45 COFFEE BREAK
- 15.45 - 17.00 Discussion, continued

Wednesday 24 April

09.00 - 10.45 Theme No. 2: Managing change in the public-private mix

Presenter: Professor Richard Saltman,
University of Massachusetts

10.45 - 11.00 COFFEE BREAK

11.00 - 12.30 Theme 2, continued - Some country perspectives:

Romania
Germany - Mr Werner Gerlach
Yugoslavia

12.30 - 14.00 LUNCH

14.00 - 15.30 Discussion, continued

15.30 - 15.45 COFFEE BREAK

15.45 - 17.30 Theme No. 3: Provider payment systems

Presenter: Professor B. Majnoni D'Intignano,
University of Paris

Thursday 25 April

09.00 - 10.45 Theme 3, continued - Some country perspectives:

USSR
Canada: Professor Contandriopoulos
Poland

10.45 - 11.00 COFFEE BREAK

11.00 - 12.30 Theme No. 4: Health care financing through social insurance

Presenter: Professor Jurgen Wasem, University
of Cologne

12.30 - 14.00 LUNCH

- 14.00 - 15.45 Theme 4, continued - Some country perspectives:
Hungary
Netherlands
Czechoslovakia (Slovak Republic)
- 15.45 - 16.00 COFFEE BREAK
- 16.00 - 17.00 Overview and Summary - Mr Jeremy Hurst

Friday 26 April

- 09.00 - 10.00 Round table discussion: The health care reform process and WHO support activity - introduced and moderated by Professor W. Van Eimeren, Director, Institute for Medical Informatics and Systems Research
- 10.45 - 11.00 COFFEE BREAK
- 11.00 - 12.00 Round table discussion - concluded
- 12.00 - 12.30 Closing session - Dr J.-P. Jardel, Assistant Director-General

ANNEX 2

LIST OF PARTICIPANTS

BULGARIA

Mrs E. I. Delcheva, Research worker, Institute of Social Medicine, Sofia, Bulgaria

Dr S. Gladilov, Vice President of the Bulgarian Red Cross, Sofia, Bulgaria

Dr N. B. Vassilev, Deputy Minister, Ministry of Health, Sofia, Bulgaria

CANADA

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Mrs Ing. Z. Fontanova, Advisor of the Minister, Vice-Director of Health Policy Department, Ministry of Health Czech Republic, Praha, Czechoslovakia (Rapporteur)

Mr F. Weber, Director, District Institute of National Health, Tepuce, Czech Republic, Czechoslovakia

Mr M. Ihnat, Director, Foreign Relations Department, Ministry of Health of the Slovak Republic, Bratislava, Czechoslovakia

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Professor Dr. M. Pfaff, Professor of Economics, University
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ROMANIA

Dr G. Iacob, Secretary of State, Ministry of Health,
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Mrs E. Badea, Chief, Department of Health and Social
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Ms E. Erhan, Director, Department of Health Budget, Ministry
of Health, Bucharest, Romania

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Dr A. Duran, Advisor to the Regional Ministry of Health,
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Dr J. Hernandez, Chief Service of Health Economics, Office of
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SWEDEN

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Institute for Planning and Rationalization of Health Services,
Stockholm, Sweden

TURKEY

Dr M. Tokat, Maître des conférences de l'économie de la santé
à l'école supérieure de l'administration sanitaire de
l'Université of Hacettepe, Ankara, Turkey

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Mr J. W. Hurst, Senior Economic Adviser, Department of Health,
London, United Kingdom

Professor C. Normand, Professor of Health Policy, London
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Prof. R. B. Saltman, School of Public Health, University of
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USSR

Mr L. Kishenko, Chief Central Planning Economical Board,
Member of Collegium Ministry of Health, Moscow, USSR

Dr A. Moskvitchev, Deputy Minister of Health, Ministry of
Health, Moscow, USSR

Mrs J.S. Tchistjakova, Chief Department of Financial Health,
Ministry of Finance, Moscow, USSR

YUGOSLAVIA

Dr D. Bobarevic, Special Adviser to the Federal Secretary,
Federal Secretariat for Labour, Health, Veteran Affairs and
Social Policy, Novi Beograd, Yugoslavia (Co-chairperson)

Mrs Nada Gogic, Senior Adviser for Financing Matters, Federal
Secretariat for Labour, Health, Veteran Affairs and Social
Policy, Novi Beograd, Yugoslavia

Dr P. Todorovic, Secretary of Environment Secretariat,
Ministry of Health and Environment, Republic of Serbia,
Yugoslavia

REPRESENTATIVES OF OTHER ORGANIZATIONS AND INSTITUTIONS

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FIGURE 4

A TYPOLOGY OF PHYSICIAN PAYMENT MODALITIES

PRICING PROCESS	PAYMENT MECHANISM	METHOD OF PAYMENT	PAYMENT MODALITIES	OVERVIEW OF PAYMENT MODALITIES SELECTED COUNTRIES AND SETTINGS	REMARKS
The Physicians	Individual	Fee-for-service payment per case	1	United States Italy, United Kingdom	Ambulatory and hospital; specialists and GPs Specialists, (private visits)
			2	United States	Ambulatory and hospital; specialists and GPs
	Third Party Payer	Fee-for-service payment per case	3	France, Sweden, Switzerland, Norway, Norway, Australia New Zealand	Ambulatory and hospital; specialists and GPs Specialists and GPs Payment per case
Negotiation	Third Party Payer	Salary, Seasonal fees	4	Canada, Quebec	CLSC and CAIF; both specialists and GPs
			5	Canada, Quebec, West Germany The Netherlands Denmark Austria, New Zealand	Ambulatory and hospital; specialists and GPs Specialists Rural areas Fee-for-service and payment per case
	Organization	Capitation	6	Denmark The Netherlands	Urban areas GPs
Administrative facilities	Individual	Fee-for-service payment per case	7	United States	HMO's "staff model"
			8	United States	HMO's "group model"; only GPs
	Third Party Payer	Salary, Seasonal fees	9	?	—
Administrative facilities	Third Party Payer	Fee-for-service payment per case	10	West Germany France	Hospital sector Public sector; hospital; public health; occupational health between 1972-1976 (blending arbitration) Medicare, Part A (DRO)
			11	Quebec United States	—
	Organization	Capitation	12	?	—
Administrative facilities	Third Party Payer	Fee-for-service payment per case	13	United Kingdom, Italy Sweden, Norway Soviet Union United States	Only specialists Specialists and district medical officers (DMOs) All Physicians Some public and teaching hospitals
			14	United States	Some HMO's
	Organization	Capitation	15	United Kingdom, Italy Spain	Only GPs Both GPs and specialists

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GRIS, University of Montreal, September 1990.

FIGURE 5

PHYSICIAN PAYMENT MODALITIES AND OBJECTIVES OF THE HEALTH CARE SYSTEM

MODALITIES OF PAYMENT			OBJECTIVES										
Pricing process	Payment mechanism	Payment method	Appropriateness of services utilization	Cost control	Admissibility	Productivity	Regional	Accessibility	Comprehensiveness	Quality	Physicians	Satisfaction	
								Regional	Organizational	Comprehensiveness	Quality	Physicians	Public
Physician	Individual	Fee-for-service Case 1	-(Over)	-	-	++	-	-	+	-	-	++	-
Physician	Third party	Fee-for-service Case 2	-(Over)	-	-	++	-	-	+	-	-	++	0
Negotiation	Organization	Salary, Seasonal Fees Case 7	+	+	+	+	+	++	+	+	+	+	+
Negotiation	Organization	Capitation Case 8	+	++	+	+	+	+	+	+	+	+	+
Negotiation	Third party	Salary, Seasonal Fees Case 4	++	0	+	+	++	++	++	++	+	+	+
Negotiation	Third party	Fee-for-service Case 5	-(Over)	-	-	++	-	++	+	-	-	+	+
Negotiation	Third party	Capitation Case 6	-(Under)	+	0	-	++	++	+	0	++	+	+
Negotiation	Individual	Fee-for-service Case 3	-(Over)	-	-	++	-	0	+	-	-	+	0
Administration	Organization	Salary, Seasonal Fees Case 13	-(Under)	0	+	-	++	+	++	++	+	-	-
Administration	Organization	Capitation Case 15	-(Under)	++	+	-	+	++	+	++	++	0	+
Administration	Third party	Salary, Seasonal Fees Case 10	++	0 ¹	+	-	++	+	++	++	++	+	+
Administration	Third party	Fee-for-service Case 11	-(Over)	-	-	++	-	++	+	-	-	0	+

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