

Health Systems in Transition: Template for analysis

Edited by

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Keywords:

DELIVERY OF HEALTH CARE

EVALUATION STUDIES

FINANCING, HEALTH

HEALTH CARE REFORM

HEALTH SYSTEM PLANS – organization and administration

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Printed in the United Kingdom by The Cromwell Press, Stourbridge, Wilts.

Suggested citation:

Mossialos E, Allin S, Figueras J (2007). *Health Systems in Transition: Template for analysis*. Copenhagen, WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies.

ISSN 1817-6127 Vol. 9 Special issue

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Preface



The Health Systems in Transition (HiT) profiles are country-based reports that provide a detailed description of a health system and of policy initiatives in progress or under development. They are produced by country experts in collaboration with the Observatory staff. The profiles are based on a template which, revised periodically, provides detailed guidelines and specific questions, definitions and examples needed to compile HiTs. However, there might be cases where certain information may not be available in a specific country, or where the template may be too restrictive in terms of how the information and analysis are presented. It is important to highlight that this template is intended to be used in a flexible way to allow authors and editors to adapt it to their particular national context.

This edition of the template and questionnaire is a more comprehensive version of the 1999 template and incorporates the many useful comments and suggestions from users and contributors.

The HiTs are building blocks that can be used to:

- examine different approaches to the organization, financing and delivery of health services and the role of the main actors in health systems;
- describe the institutional framework, process, content and implementation of health and health care policies;
- highlight challenges and areas that require more in-depth analysis;
- provide a tool for the dissemination of information on health systems and the exchange of experiences of reform strategies between policy-makers and analysts in different countries;

- assist other researchers in more in-depth country-based and comparative health policy analysis.

Compiling the HiT profiles poses a number of methodological problems. In many countries, there is relatively little information available on the health system and the impact of policies and reforms. Owing to the lack of a uniform data source, quantitative data on health services are based on a number of different sources, including Eurostat, the World Health Organization (WHO) European Health for All database, the World Bank, national statistical offices, Organisation for Economic Co-operation and Development (OECD) Health Data, International Monetary Fund, and any other relevant sources considered useful by the authors. We acknowledge that data collection methods and definitions vary, but authors are encouraged to identify differences and report them.

A standardized profile has certain disadvantages because the institutional framework, and the financing and delivery of health care differ across countries. However, it also offers advantages, because it raises similar issues and questions. If the template is used in a flexible way, it is likely that some differences will be seen across country profiles in content and comprehensiveness.

Unfortunately we have not been able to accommodate some suggestions to revise the template; there are always trade-offs between comprehensiveness and what can be covered in an already-detailed template. We understand that this type of exercise in which we try to address several aspects of the health system has many limitations. While the HiTs may not always be up to date, other Observatory publications, *Eurohealth*, *Euro Observer*, and reports by other organizations are available on our web site (www.euro.who.int/observatory) under “country information”. We hope to update the template periodically to reflect changes in the health system environment.

Comments and suggestions for the further development and improvement of the HiTs are most welcome and can be sent to info@obs.euro.who.int. HiTs and HiTs in brief are available on the Observatory’s web site. A glossary of terms used in the HiTs can be found at: www.euro.who.int/observatory/glossary/toppage.

Acknowledgements

The authors and editors are grateful to the following individuals for comments made on previous drafts of this template: Nina Schwalbe, Noah Simmons and Karen Plafker (Open Society Institute, New York), Monica Ciupagea and Kasia Malinowska-Sempruch (International Harm Reduction Development, Open Society Institute, New York), Charles Shaw, Peter van Son (EUCOMP),

Stephen Wright (European Investment Bank), Peter Achterberg (National Institute for Public Health and Environment, the Netherlands), Besim Nuri (World Bank), Ceri Thompson (European Commission) and Mila Garcia-Barbero (WHO).

The authors and editors would also like to thank the two external reviewers of this template, Professor Peter Smith (University of York, UK) and Professor Karsten Vrangbaek (University of Copenhagen, Denmark), for their constructive contributions.

Special thanks are also extended to Shirley and Johannes Frederiksen for their support of Observatory staff in production of the HiTs.

Finally, the authors and editors would like to thank all the Observatory partners, institutions and individuals that have contributed to work on country monitoring.

Any errors in this template are solely those of the authors and editors.

Elias Mossialos

Sara Allin

Josep Figueras

An introductory note

The HiT template starts with Chapter 1, an introduction into the societal context and major health challenges. This is followed by a description, in Chapter 2, of the organizational structure and the main actors in the health system. The next chapters cover the financing system, including expenditure, coverage and benefits (Chapter 3), regulation and planning (Chapter 4), physical and human resources (Chapter 5), provision of services (Chapter 6), and principal health care reforms (Chapter 7). Finally a brief assessment of health system performance and conclusions are provided in Chapters 8 and 9.

Please note that this template offers detailed guidelines on writing a HiT. However, authors are not expected to answer all questions and provide information on all subjects. Some information may not be available or may not be relevant to the individual country. It is advised that authors follow the structure of the template, using the main headings and layout; however, the detailed questions that are outlined in each section are meant to provide an indication of what information should be included if time, resources and availability of data permit. It is also likely that authors might wish to add points or headings on issues that might not be included in the template. Authors should consult the editor allocated to them by the Observatory with their proposed changes.

General guidelines

- Omit sections and/or questions that do not apply to the health system under consideration. State if data are not available or are not reliable.
- Cross-reference to sections where appropriate to avoid repetition.
- If you are unclear about any of the questions raised or definitions used, please consult the Glossary on pages 115–124; if further discussion or clarification is needed, please contact the editor.
- Some definitions provided in the Glossary may be different from those used in the country under consideration. If this is the case, please state this explicitly in the relevant sections.
- Bibliographical references should be presented in the Harvard (also known as “author-date”) system, whereby citations are made within the text in parentheses (e.g. Taylor 1996) and the references are listed in full and alphabetically in the References section in the Appendix.
- Please follow the conventions listed in the WHO EURO style guide and the Guidelines for authors and editors (available from the editors).
- Word-count suggestions for each section are not provided; however, these should be agreed with the editors, depending on the material and information available.

Throughout the review it is important for the author to consider the distinction between political rhetoric and reality. While it is useful to look into the political agenda and priorities in health care, it is also necessary to look beyond political rhetoric and legislation to what is actually implemented. Reports on what is actually taking place in terms of implementation should be included where possible, and comments should be made on the extent to which these reports can be considered impartial.

Quantitative data and standard figures

The Observatory provides quantitative data in the form of a set of standard comparative figures, drawing on the European Health for All (HFA) database, as well as data from the Organisation for Economic Co-operation and Development (OECD) and the World Bank.

The HFA database contains more than 600 indicators defined by the World Health Organization (WHO) Regional Office for Europe for the purpose of monitoring health for all policies in Europe. It is updated for distribution twice a year from various sources, relying largely upon official figures provided

by governments, as well as health statistics collected by the technical units of the WHO Regional Office for Europe. The standard Health for All data have been officially approved by national governments but still do not always meet HiT authors' expectations. You should discuss the data in the text in detail, especially if you are concerned about discrepancies between the data presented in the figures and what you know from your own experiences. OECD Health Data contain over 1200 indicators for the 30 OECD countries. Data are drawn from information collected by national statistical bureaus and health ministries. The World Bank provides World Development Indicators, which also rely on official sources.

The set of standard figures

Each HiT includes a set of standard figures drawn from the HFA database that give information at a given point in time and compare the country concerned with others in the WHO European Region. A set of country-specific figures is also drawn up for each country, identifying trends in health expenditure as a percentage of gross domestic product (GDP), numbers of hospital beds, numbers of physicians and nurses, and comparing these with three to five other relevant countries and/or average figures for groups of countries to be decided with the HiT editor(s). When you are creating figures from the HFA database, be very cautious about using data prior to 1990. Data from 1980 to 1990 often reveal sharp (and often misleading) health and human resource changes as a result of new definitions, changes in registration procedures and gaps in data collection. Whenever possible, avoid figures and tables using data from the 1980s. If you must demonstrate longer time trends, include a comment in the text or a footnote explaining the reasons for sharp changes in trends.

With its summer 2004 edition, the HFA database started to take account of the enlarged European Union (EU) of 25 Member States. It is the Observatory's aim to acknowledge this political change; for technical reasons, however, we have decided to retain the geographical groupings of western Europe, central and eastern Europe (CCEE) and the Commonwealth of Independent States (CIS). Moreover, for the differentiated discussion of health trends in the text, we believe that some reference to the 15 EU Member States prior to May 2004 as well as the 10 new EU member states from May 2004 is useful.

Authorship

The Observatory normally gives credit for authorship of HiTs to all those who have made a significant or substantive contribution to its development and

analysis by writing or rewriting parts of the text. Unless there are particular circumstances (which will be discussed with the country author team and the Observatory research and management team), first authorship will be held by the leading national author, followed by other national authors who have contributed by writing parts of the HiTs. The main Observatory editors will be listed last, provided of course that they too have contributed by writing or rewriting/editing parts of the text.

Ideally, not more than six authors should be named to allow all of them to be included in standard format databases and citations. In cases when more than six authors have been involved, they will all be listed in the published HiTs but the standard citation will show the first three authors only, followed by “et al.”

The standard citation we suggest therefore is as follows:

National Author, National Author, National Author, National Author, and Contributing Editor. Country: Health system review. *Health Systems in Transition*, Year of publication; volume number (issue number): page range.

For any queries and information do not hesitate to contact the editor of the HiT.

The HiT production process

Producing a HiT is a complex process. It involves:

- writing and editing the report, often in multiple iterations;
- its external review by (inter)national experts and Ministry of Health (MoH)*;
- finalization of the profile including the stages copy-editing and typesetting;
- dissemination (hard copies, electronic publication, translations and HiT launches).

The editor will support the authors throughout the production process and, in close consultation with the authors, will ensure that the dissemination activities are taken forward as effectively as possible.

* The authors are supposed to consider comments provided by the MoH, but not necessarily include them in the final version.

Preliminary pages in HiTs

Preface

This is the standard introductory section common to all HiT profiles. An example is provided below in Box 1. It will be included by Observatory staff when the HiT is finally ready for the production process, leading to layout and printing.

Acknowledgements

This is the standard Acknowledgements page included in all the HiTs, adapted to reflect the input of particular individuals and organizations or to acknowledge sponsorship. Box 2 (overleaf) provides an example taken from the HiT on Canada.

Box 1

The Health Systems in Transition profiles are country-based reports that provide a detailed description of a health system and of reform and policy initiatives in progress or under development in a specific country. Each profile is produced by country experts in collaboration with the Observatory's staff. In order to facilitate comparisons between countries, the profiles are based on a template, which is revised periodically. The template provides detailed guidelines and specific questions, definitions and examples needed to compile a profile.

(cont.)

Box 1 (cont.)

Health Systems in Transition profiles seek to provide relevant information to support policy-makers and analysts in the development of health systems in Europe. They are building blocks that can be used:

- to learn in detail about different approaches to the organization, financing and delivery of health services and the role of the main actors in health systems;
- to describe the institutional framework, the process, content and implementation of health care reform programmes;
- to highlight challenges and areas that require more in-depth analysis;
- to provide a tool for the dissemination of information on health systems and the exchange of experiences of reform strategies between policy-makers and analysts in different countries;
- to assist other researchers in more in-depth comparative health policy analysis.

Compiling the profiles poses a number of methodological problems. In many countries, there is relatively little information available on the health system and the impact of reforms. Due to the lack of a uniform data source, quantitative data on health services are based on a number of different sources, including the European Health for All database, national statistical offices, Eurostat, the Organisation for Economic Co-operation and Development (OECD) Health Data, the International Monetary Fund (IMF), the World Bank, and any other relevant sources considered useful by the authors. Data collection methods and definitions sometimes vary, but typically are consistent within each separate series.

A standardized profile has certain disadvantages because the financing and delivery of health care differs across countries. However, it also offers advantages, because it raises similar issues and questions. The Health Systems in Transition profiles can be used to inform policy-makers about experiences in other countries that may be relevant to their own national situation. They can also be used to inform comparative analysis of health systems. This series is an ongoing initiative and material is updated at regular intervals. Comments and suggestions for the further development and improvement of the Health Systems in Transition series are most welcome and can be sent to info@obs.euro.who.int.

Health Systems in Transition profiles and Health Systems in Transition summaries are available on the Observatory's web site at www.euro.who.int/observatory. A glossary of terms used in the profiles can be found at the following web site: www.euro.who.int/observatory/glossary/toppage.

Box 2

The Canadian HiT was written by Gregory Marchildon (University of Regina). It was edited by Sara Allin (European Observatory on Health Systems and Policies) and Elias Mossialos (European Observatory on Health Systems and Policies). The Research Director for the Canadian Health System profile was Elias Mossialos. The European Observatory on Health Systems and Policies is especially grateful to Robert Evans, Armine Yalnizyan and Gary Catlin for reviewing the report and for their important contributions.

The author would like to thank the many individuals who have helped in the preparation of this report. The author greatly benefited from the detailed comments, suggestions and information provided by Geoff Ballinger (Canadian Institute for Health Information), Tim Caulfield (University of Alberta), Tony Culyer (Institute for Work and Health and University of York), Donna Magnusson (Saskatchewan Health), Tom McIntosh (Canadian Policy Research Networks), John Richards (Simon Fraser University and C.D. Howe Institute), James Smythe (University of Alberta) and Laurie Thompson (independent health consultant). The author was particularly appreciative of the extensive commentary provided by Robert Evans, Professor of Economics at the University of British Columbia, and the review provided by Pierre-Gerlier Forest, the G.D.W. Cameron Chair and Acting Chief Scientist at Health Canada. They both went far beyond the call of duty in terms of time and effort. In accordance with Observatory protocol, the manuscript was reviewed by Health Canada and the author benefited greatly from the review provided by the Health Policy Branch (Meena Ballantyne, Mary Gregory, and David Lee, assisted by Demetrios Angelis, Jamil Aouiti, Jennifer Cavasin, Roger Guillemette, Paul Kasimatis, Stephen Leclair, Brenda Lipsett, Georgia Livadiotakis, Steven Schwendt, Aruna Sehgal, and Barbara Woodward), the First Nations and Inuit Health Branch (Ian McGrath) and the Corporate Services Branch (Colleen Bolger and Ross Hodgins) of Health Canada as well as the Public Health Agency of Canada. None of these individuals or organizations is responsible for the author's interpretation or any remaining errors.

From the beginning, Kevin O'Fee's statistical research has been invaluable as well as his assistance as a liaison with Statistics Canada and the Canadian Institutes of Health Research. Nathan Schalm provided valuable research assistance in the first stage of this project. The author also learned much from his graduate students in healthy policy courses at the University of Regina and Queen's University in Kingston in which an earlier version of this profile was given a test run. Sections of this profile were also critiqued through public presentations at the University of Ottawa and Simon Fraser University.

The current series of Health Systems in Transition profiles has been prepared by the research directors and staff of the European Observatory on Health Systems and Policies. The European Observatory on Health Systems and Policies is a partnership

(cont.)

Box 2 (cont.)

between the WHO Regional Office for Europe, the Governments of Belgium, Finland, Greece, Norway, Spain and Sweden, the Veneto Region of Italy, the European Investment Bank, the Open Society Institute, the World Bank, CRP-Santé Luxembourg, the London School of Economics and Political Science and the London School of Hygiene & Tropical Medicine.

The Observatory team working on the Health Systems in Transition profiles is led by Josep Figueras, Director, and Elias Mossialos, Co-director, and by Martin McKee, Richard Saltman and Reinhard Busse, heads of research hubs. Technical coordination is led by Susanne Grosse-Tebbe. Giovanna Ceroni managed the production and copy-editing, with help from Nicole Satterley and with the support of Shirley and Johannes Frederiksen (layout).

Special thanks are extended to the OECD for the data on health services.

Thanks are also due to national statistical offices that have provided data.

The report reflects data available in May 2006.

List of abbreviations

Please provide a list of the abbreviations used in the profile.

Please take care to list all national institutions and institutes frequently referred to in the HiT in the original language as well as their official English translation.

List of tables, figures and boxes

Please list all the tables and figures as they appear in the text. The figures marked with an asterisk (*) constitute the set of standard figures that will be provided by Observatory staff.

NB: Note that not all data are available for CCEE and CIS prior to 1990 and that some tables may not be appropriate for some countries.

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Abstract

The abstract should identify a minimum of five key findings for the HiT and also include a standard paragraph, as shown in Box 3.

Box 3

The Health Systems in Transition (HiT) profiles are country-based reports that provide a detailed description of a health system and of policy initiatives in progress or under development. HiTs examine different approaches to the organization, financing and delivery of health services and the role of the main actors in health systems; describe the institutional framework, process, content and implementation of health and health care policies; and highlight challenges and areas that require more in-depth analysis.

Executive summary

The executive summary should provide an outline of the content of the HiT (no more than three pages), following the key headings included in the profile, focusing on the assessment of the health system, the main challenges and major conclusions (Chapters 8 and 9).

The executive summary should also include a description of the key features of the health system, and the most important recent policy developments.

What follows reflects the main structure of a HiT profile. It consists of 10 chapters, including:

- 1 Introduction
- 2 Organizational structure
- 3 Financing
- 4 Regulation and planning
- 5 Physical and human resources
- 6 Provision of services
- 7 Principal health care reforms
- 8 Assessment of the health system
- 9 Conclusions
- 10 Appendices (such as References, Useful web sites, Legislation)

Chapter 1

Introduction

This chapter explores the contextual background of the health system. Unless otherwise stated, data for these sections should be provided for the latest year available.

1.1 Geography and sociodemography

Give a brief outline of the country's geography, including:

- location of country (neighbouring countries)
- terrain (1 sentence)
- climate (1 sentence).

This section, as well as others where relevant, should also include information on dependent territories (e.g. Crown dependencies such as the Channel Islands, Gibraltar and the Caribbean Islands, in the case of the United Kingdom; Départements/Territoires d'Outre-Mer in the case of France; Greenland/Faroes in the case of Denmark), as well as a brief note about disputed frontiers or territories not fully under control of the national Government. Your editor will discuss with you how to present these issues sensitively.

Please provide a map of the country that shows dependent territories, where appropriate, and internal boundaries, where relevant (e.g. in federal countries).

Figure 1.1 *Map of the country*

Normally a United Nations map (source: United Nations Cartographic section (<http://www.un.org/Depts/Cartographic/english/htmain.htm>)) will be used and inserted by Observatory staff. If no United Nations map is available authors are welcome to propose a neutral source. Map clearance will be dealt with by the editor.

Provide a table with trends in demographic indicators.

Table 1.1 *Population/demographic indicators, 1970, 1980, 1990, 2000, 2005, latest available year*

Suggested database: <http://publications.worldbank.org/WDI/indicators>

- Total population
- Population, female (% of total)
- Population ages 0–14 (% of total)
- Population ages 65 and above (% of total)
- Population ages 80 and above (% of total)
- Population growth (average annual growth rate)
- Population density (people per sq km)
- Fertility rate, total (births per woman)
- Birth rate, crude (per 1000 people)
- Death rate, crude (per 1000 people)
- Age dependency ratio (population 0–14 & 65+: population 15–64 years)
- Distribution of population (rural/urban, etc.)
- Proportion of single-person households
- Educational level (e.g. proportion of the population with more than 9 and 12 years' schooling, or literacy rate)

Describe the following: ethnic composition of population, including any specific implications for health and health care; language(s), religion and other characteristics possibly impacting on health; and any major population movements (e.g. war, refugees, internal displacements).

1.2 Economic context

Provide a general overview of the country's current economic situation and any major events leading to the current status.

Provide a table with macroeconomic indicators.

Table 1.2 *Macroeconomic indicators, latest available year*

Include latest available year for all indicators except GDP average annual growth rate (%).

- GDP
- GDP, PPP (current international \$ or Euro)
- GDP per capita
- GDP per capita, PPP (current international \$ or Euro)
- GDP average annual growth rate (%) (for the last 10 years)
- Income or wealth inequality (Gini coefficient or other measure) (latest available year). Also report earlier data if available
- Short-term debt outstanding (current US\$ or Euro)
- Value added in industry (% of GDP)
- Value added in agriculture (% of GDP)
- Value added in services (% of GDP)
- Overall budget balance, including grants (% of GDP)
- Labour force (total)
- Unemployment, total (% of labour force)
- Official exchange rate (US\$ or Euro)
- Real interest rate
- Poverty rate (please define how poverty is measured in your country)

Suggested databases:

<http://publications.worldbank.org/WDI/indicators>

Eurostat

1.3 Political context

Consider the following questions. What type of governmental system does the country have (e.g. parliamentary or presidential democracy)? Is there separation of powers (executive, legislative, judiciary)? Consider to what extent the actions of the Head of State/Government are constrained by the Parliament or the courts? What are the main political parties and what, approximately, is the share of the main parties in the national Parliament? Please provide the date and, if possible, a link to a web site that may have up-to-date information on the political situation available. Have there been any major political changes in the last 20 years?

¹ For definitions of the economic indicators, please consult the World Bank web site.

- Is the political system federal or does it contain significant mesolevel governments (regional or local), and what are the competencies of the different levels of government?
- Are important laws related to health care enacted mainly by primary legislation (i.e. after discussion in Parliament) or secondary legislation (i.e. presidential or ministerial decree)?
- In federal systems or where mesolevel governments operate, do states or regional/local governments have legislative or tax-raising powers? Or do they have to operate within a national framework?
- What is the party configuration of the present Government and how long has it been in power?
- Are there any major political developments leading to the current political context (e.g. wars, independence, joining of a regional grouping)?
- To what extent are organized interest groups (e.g. employers/employees) formally and informally integrated in health policy-making? Name the most relevant organized interest groups for health policy-making and their channels for influencing health policy (e.g. negotiations over wage and work conditions, participation in annual coordination meetings, providing input to the policy process, collaborating on policy development, investing in health facilities).
- What international organizations does the country belong to (that are relevant for health) (e.g. United Nations, EU, EEA, WTO, NATO, EFTA, Council of Europe)?
- Has the country signed up to any major international treaties that have an impact on health (e.g. GATS, Convention on the Rights of the Child, European Human Rights Convention, International Bill of Human Rights)?

Please include brief references to objective external assessments of corruption and human rights (e.g. Human Rights Watch, Amnesty International, Transparency International, monitoring reports on compliance with the United Nations Convention on Rights of the Child).

1.4 Health status

Please include up to seven tables (or figures, if appropriate) showing the development of the indicators on mortality and health described below since 2005, 2000, 1990 plus 1980, 1970 and earlier if available.

Comment on data quality (including comparisons with other sources where relevant – for infants, children under 5 and maternal mortality this should include WHO Health for All, World Bank, and UNICEF estimates where relevant). To the extent that data availability permits, please comment on any changes in health indicators over time. Consider the extent to which any changes may be artefacts of the data: are health data subject to political manipulation? Are collectors of data independent from Government, or are they controlled by Government (and therefore data may not be reliable)? Please discuss with your editor any contested/sensitive issues.

What are the three main causes of mortality and morbidity? Are they different in women and men? Please compare the country's health status to other countries and the WHO European Regional average.² Consider presenting data differentiated by age or gender where striking differences exist. Comment on any regional variations.

Table 1.3 *Mortality and health indicators, 1970, 1980, 1990, 2000, 2005, latest available year*

- Life expectancy at birth, female (years)
- Life expectancy at birth, male (years)
- Life expectancy at birth, total (years)
- Mortality rate, adult, female (per 1000 female adults)
- Under 65 mortality rate, adult female (per 1000 female adults under age 65)
- Mortality rate, adult, male (per 1000 male adults)
- Under 65 mortality rate, adult male (per 1000 male adults under age 65)
- Mortality rate, infant (per 1000 live births)
- Mortality rate, children under 5 (per 1000 live births)

Suggested databases:

<http://www3.who.int/whosis/menu.cfm>

<http://www.euro.who.int/hfadb>

<http://publications.worldbank.org/WDI/indicators>

² Please note that comparison across countries of mortality and morbidity data should be done with extreme caution due to potentially significant methodological variation in data collection, and differences in definitions across countries.

Table 1.4 *Main causes of death, 1990 to latest available year*

Main causes of death (ICD-10 Classification):

I. Communicable diseases:

- Infectious and parasitic diseases (A00-B99)
- Tuberculosis (A17-A19)

II. Noncommunicable conditions:

- Circulatory diseases (I00-I99)
- Malignant neoplasms (C00-C97)
- Trachea/bronchus/lung cancers (C33-C34)
- Mental and behavioural disorders (F00-F99)
- Respiratory diseases (J00-J99)
- Digestive diseases (K00-K93)

III. External causes (V01-Y89)

- Transport accidents (V01-V99)

Table 1.5 *DALE and HALE, 1990 to latest available year*

Include data on disability-adjusted life expectancy (DALE) and health-adjusted life expectancy (HALE) (available from WHO at <http://www3.who.int/whosis/>). Comment on the reliability of DALE and HALE estimates.

Table 1.6 *Factors affecting health status, 1990 to latest available year*

Include national data on morbidity (e.g. prevalence/incidence of diabetes, cancer, myocardial infarction, stroke)³ and major factors influencing health status (e.g. smoking, alcohol consumption, diet, physical activity, housing, poverty). Either report available data in a table or text format.

Table 1.7 *Access to safe water, latest available year*

Include data on the proportion of the population with access to safe water either in a table or in text format.

³Potential sources for internationally comparable data could include the WHO Atlas of Heart Disease and Stroke and the Diabetes Atlas by the International Diabetes Foundation (note that data are approximate estimates only).

http://www.who.int/cardiovascular_diseases/resources/atlas/en/index.html

<http://www.idf.org/home/index.cfm?unode=8B24A731-BBF8-4B0A-8F0B-B588A438CCE5>

Table 1.8 *DMFT at age 12 years (mean value), 1990 to latest available year*

“DMFT” refers to decayed, missing or filled teeth.

Figure 1.2 *Levels of immunization for measles in the WHO European Region, latest available year*

Figure to be inserted by Observatory staff.

Summarize or visualize also other WHO Health for All immunization categories (e.g. polio, rubella, hepatitis, neonatal tetanus, diphtheria, pertussis, yellow fever, meningitis C, *Haemophilus influenzae* type B) (percentage of children under 3 years).

Discuss whether immunization figures are reliable.

Include data on the health status of ethnic minority groups (e.g. Roma populations, other ethnic minorities) and migrants. If data on significant minorities do not exist, please note that this is the case.

Include data on health inequalities, for example, between socioeconomic groups (by education, occupation, income) and geographical areas over the last 20 years, if data are available.

Have any major health problems of policy significance occurred in the last decade (e.g. major outbreaks)?

Table 1.9 *Maternal and child health indicators*

Maternal and child health indicators may reflect health system performance such as screening, health education and the quality of health care provision. Use ICD-10 classification, if available. Among these indicators, it is useful to make a table to analyse the following indicators over a 20-year trend (if possible).

- Adolescent pregnancy rates, as an indicator of health education/health promotion.
- Neonatal and postneonatal mortality.
- Perinatal conditions.
- Maternal death, as an indicator of health system quality. This indicator is difficult to use in countries with small populations (e.g. the Baltic states) and will require adjustment for population size.
- Sexually transmitted infections (STIs), as an indicator of health education and primary care quality.
- Infertility, as an indicator of screening and treatment quality (e.g. poor treatment of *Chlamydia* and gonorrhoea).

Please outline major health challenges that the population as a whole or certain subpopulations (i.e. migrants, ethnic minorities, people with disabilities) are facing.

As with the previous health indicators, comment on any changes over time and the extent to which these changes may be artefacts of the data or unreliable owing to political manipulation.

Chapter 2

Organizational structure



2.1 Overview of the health system

This chapter aims to provide an overview of how the health system in a country is organized and it outlines the main actors and their decision-making powers. It forms the basis for all the following chapters.

The aim is to inform the reader on the following points.

- How the health system is organized, especially whether there is actually *one* statutory system or whether there are several systems operating in parallel (e.g. at regional or local level); if this is the case, the relationship between them should be described.
- The main actors in the system(s) and what roles and responsibilities they fulfil in the overall governance/management structure.
- The main actors' decision-making powers. *Note:* Please emphasize who actually performs governance/management functions versus formally assigned powers – what each actor/part of the system actually does, rather than what it is meant to do.

Figure 2.1 *Overview chart on health system*

This diagram should give a simplified overview of the health system as a whole (e.g. patient flow, financing mechanisms, providers, service delivery, access), including the public health system, private sector and the social care system. The diagram should enable the reader to get an overview of the system especially if it is separated into subsystems; therefore, the exact composition will depend on the specific circumstances of the country. The diagram should clearly show the basic financing and organizational principles of the main system (e.g. national health service, social health insurance) and, possibly, of important complementary subsystems (see the example opposite from the 2004 HiT on Hungary).

2.2 Historical background

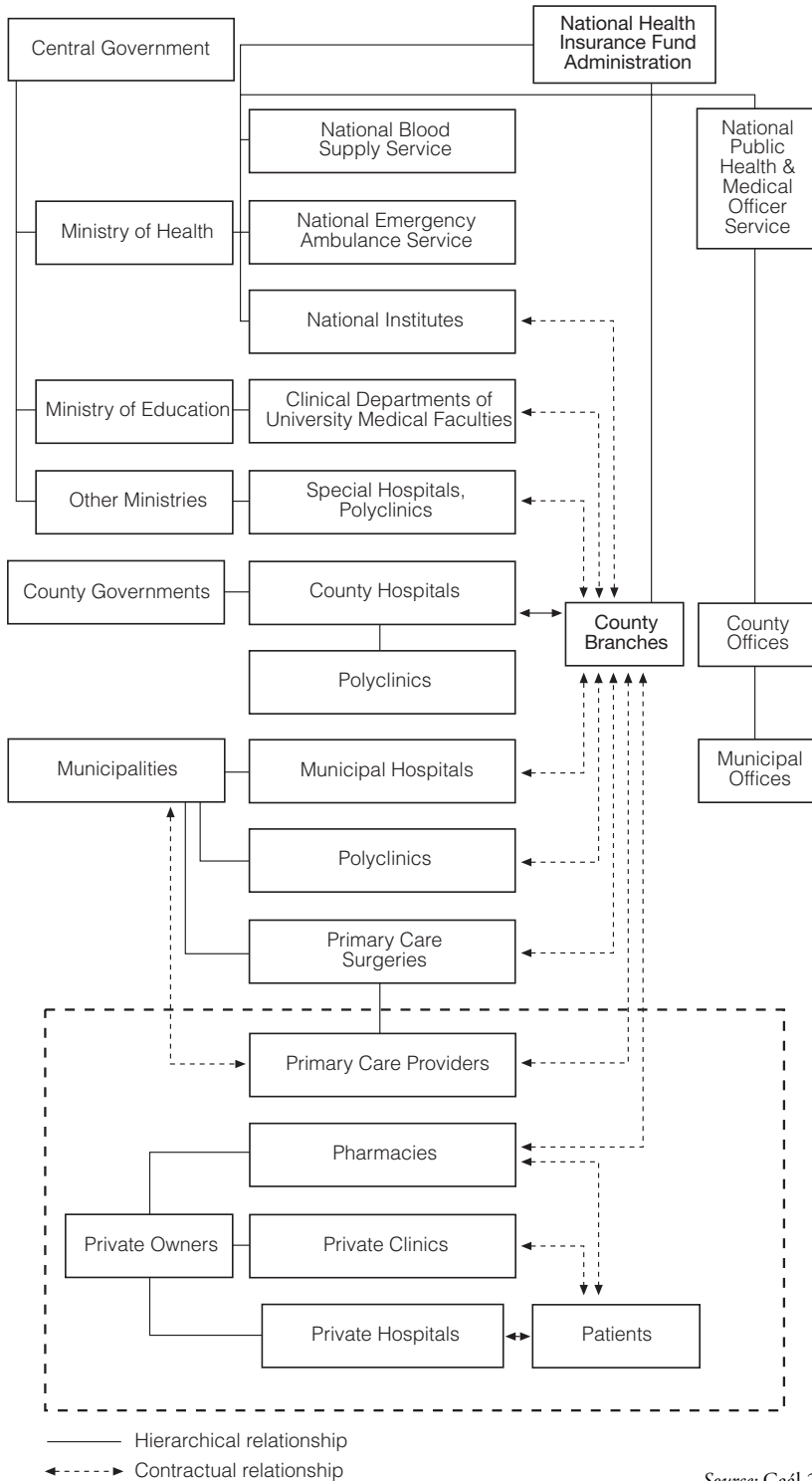
Give a brief account of the evolution of the health system in order to set the context for the current system. Go back as far as necessary to frame the current configuration of the country's health system (e.g. the historical establishment of social health insurance). Emphasis should be placed on major structural reforms in the 20th and early 21st century. Also give an overview of major developments in the last decade that shaped the current health system. Please focus on reforms which have been implemented. (Reform plans and reforms which failed or were legislated but were never implemented should be dealt with in Chapter 7 "Principal health care reforms").

- Refer to political developments (e.g. changes in constitution or government), socioeconomic factors and sociocultural developments (e.g. citizens' preferences) as much as necessary to understand changes, especially if they are contradictory to previous developments.
- Please clarify the (changing) relationship between health and social care. If shifts have taken place, please discuss their relevance for the health system, for funding and delivery.
- If relevant and available, please insert a table on the historical background of health care (chronologies of coverage, provider–population relations or important reforms).

Note: Details of policy-making and implementation of reforms (especially during the last 10–20 years) should be discussed in Chapter 7.

2.3 Organizational overview

Describe the administrative structure of the statutory health system in this



Source: Gaál 2004

Figure 2.1 Overview chart of health system

section. Besides medical care, consider also major structures of public health, mental health, long-term care and emergency care. Describe the main geographical/administrative tiers within the statutory system (e.g. national health system, national insurance system, system based on competing sickness funds). Please also characterize the type of relationships between them (e.g. hierarchical, contractual – details should be covered under Section 4.1 “Regulation”). An overview of the broader health system is shown in Figure 2.1.

Describe and analyse the institutional settings relating to the financing, planning, administration, regulation, provision or any other health-related function. These could include the MoH and other provider organizations and actors who influence the health system, as shown here.

- MoH. Please note that in addition to the MoH, several other ministries and authorities are usually involved in running the health system and relationships may not be strictly hierarchical. Previous organizational charts of some countries, depicting the MoH at the vertex of a pyramid-like structure may need to be reconsidered to more accurately reflect organizational interactions and authority flows.
- Other ministries (e.g. Ministry of Finance, as well as ministries providing health care services for their employees and families such as the Ministry of Defence) and government agencies.
- Regional/local governments (health authorities).
- Other public agencies at national and regional level (e.g. National Institute of Health and Clinical Excellence (NICE) in the United Kingdom and the National Agency for Accreditation and Evaluation in Health (ANAES) in France).
- Political parties and trade unions.
- Insurance organizations (e.g. insurance funds as well as their associations).
- Provider organizations and professional groups/associations (e.g. physicians’ associations, nurses’ associations, chambers, trade unions, dentists, pharmacists).
- Private sector (e.g. providers, insurers, manufacturers, distributors, stakeholder lobbyists).
- Voluntary/nongovernmental organizations (NGOs) or civil society associations.
- Patient/consumer groups.
- Research organizations.

- Media.
- International organizations.
- Any other important and relevant organization.

Describe these main actors and their main function(s) briefly (e.g. financing, planning, regulation, provision). Differentiate between formal functions (what they are meant to do) and informal roles (what they really do).

To what extent does the organizational structure described above represent a departure from what prevailed in the last 10 years? Consider the following questions:

- Have there been any major changes in organization?
- Have any new bodies (e.g. insurance organizations, professional groups) been established or are in the process of being established? What is their role and/or relative importance in the new structure?
- Has the role of any institutions (e.g. Ministry of Finance, Ministry of Labour) changed in connection with health care?

Please outline the main features of the policy formulation process:

- Who sets the policy agenda?
- How is the policy agenda influenced and by whom (stakeholders)?
- Which ministry is responsible for implementation of financial collection and resource allocation, delivery of health services and planning of health care?
- Have there been any reports on implementation? If so, were they produced by independent bodies, government/insurers, or international organizations?
- Have any reports on performance been produced? If so, which organization produced them?
- Which organization, if any, is responsible for assessing policy outputs? What are the assessment criteria? Are reports publicly available? Are they independent from political interference?

2.4 Decentralization and centralization

After a brief summary of the relationship between tiers of government (e.g. centralized, federal, confederation), characterize the organization of the health system in your country according to the state of decentralization. Four major types of decentralization can be distinguished: deconcentration, devolution, delegation, privatization (see the Glossary on pages 115–124).

Are governance mechanisms decentralized in your country? To what extent? Which powers and financial responsibilities are transferred to decentralized governance actors? (For example, transfer of full or partial responsibility for regulation, provision and financing.)

Describe policies of decentralization and centralization that are being implemented in your country. How far, if at all, has the implementation of recent policies proceeded?

Which context factors currently support or hinder efficient decentralized decision-making (e.g. coordination among centres of authority, administrative/financial capability of responsible actors, regulatory framework for privatization)?

Note: The specific problems that have been encountered with recent policy measures should be discussed in Chapter 7.

Cross-reference to Chapter 4 “Regulation and planning” (and in particular Tables 4.1 and 4.2) for a more detailed analysis of the degree of centralization or decentralization in regulatory functions.

2.5 Patient empowerment

This section aims to describe the extent to which patients are empowered in the health system. You should explore the following issues: information for patients, patient rights, patient choice, patient safety and compensation, complaints procedures, and patient participation and satisfaction.

2.5.1 Patient information

What level of information is available to patients when making decisions about the purchasing of health services (e.g. range of services covered, costs, quality, type of provider contracted)? By whom is this information made available? How is it distributed? Are documents also targeted at ethnic minorities and translated into minority languages? Is there evidence of which population groups use the information available and whether they find it useful?

What mechanisms are in place to guide patients around the health system (e.g. health counsellors)?

Do patients have access to information about the quality of health services?

What legislation is in place to govern the freedom of information? What implications does this have for the rights of patients and professionals to access and share information? (See also Section 4.2.2 “Information systems”.)

What mechanisms are in place to ensure access to those who might otherwise be excluded (e.g. Braille for blind people, leaflets in community languages or link workers for ethnic minorities)?

2.5.2 Patient rights

In 1994 WHO launched the Declaration of Patients' Rights in Europe (WHO 1994), which lays out principles of human rights in health care, freedom of health and health care information, consent in health care procedures and disclosure of information, protection of confidentiality and privacy, and patient choice in care and treatment.

What has been done at national or local level to implement this framework?

Implementation or adoption of the principles of the Declaration has taken on many dimensions in Europe. For example, implementation could be local or national legislation, charters for patient rights, entitlements, national reviews, institutional or clinical guidelines. In addition, it could be included in general consumer protection, citizens' empowerment or civil society movements. In some countries this could also include legislation or directives to protect children, older populations, minorities or coverage and care for internally displaced, refugee or stateless populations.

Please explain what has been done since 1994 to improve patient rights in your country.

Are patient rights clearly defined (e.g. through a charter, special patient legislation and/or subsumed sections in social, civil, penal code relevant to patient safety/autonomy)? How are they enforceable and are they actually enforced? What legal rights do patients have? Are they respected? For example, if a person is denied access to health care coverage or certain benefits, how can they claim their rights?

2.5.3 Patient choice

Choice is a complex issue. Some argue that choice has intrinsic value, while others value its instrumental potential (for example, to increase responsiveness, to encourage competition between providers, to increase quality and to empower people). In addition, acceptable levels of choice for individuals are likely to vary between countries and between different groups within a country. Individual choice may be associated with costs and benefits (Thomson and Dixon 2006). Please refer briefly to the following questions:

Is there any evidence to suggest whether/how/which individuals exercise choice?

Are levels of information adequate to facilitate choice?

Are there plans to increase choice for individuals in future? (NB: define for which service.)

Is there any evidence to suggest how the current level of individual choice affects equity and efficiency in the health system?

Do individuals have choice of insurer (third-party payer/sickness fund)? (Cross-reference to Section 3.2 “Population coverage and basis for entitlement”, if appropriate.)

Do individuals have choice of individual provider (e.g. general practitioner (GP)/specialist/hospital doctor)? Do individuals have choice of institutional provider (e.g. hospital)? Do individuals have choice of treatment, that is, what is the extent of evidence regarding patients being informed about treatment choice or having the opportunity to opt for a second opinion? (Cross-reference to Chapter 6 “Provision of services”, if appropriate.)

Can patients choose the organization that purchases services on their behalf? Is there competition between purchaser organizations for consumers/insurees (versus clearly defined catchment areas)? Do patients have opportunities to change the organization/sickness fund that purchases services on their behalf? How do these changes take place? How often is this possible? Is there any evidence of risk selection? Is there a risk-adjustment scheme in place? (Cross-reference to Section 3.4.1 “Pooling agencies and allocation” and Section 3.4.2 “Mechanisms for allocating funds among pooling/purchasing agencies”).

Is there any official or legal basis through which public, private payers and/or providers can decline patients? If so, on what grounds?

2.5.4 Patients and cross-border health care

To what extent is patient mobility an issue in your health system?

If data are available, provide information on the following questions.

Who is going abroad for treatment (tourists, retirees, inhabitants of border regions sharing cultural or linguistic links, migrant workers, individuals aiming to benefit from perceived higher quality in health care, people sent by health system to overcome capacity restrictions)?

Who is coming from abroad to receive treatment (tourists, retirees, inhabitants of border regions sharing cultural or linguistic links, migrant workers, individuals aiming to benefit from perceived higher quality in health care, people sent by health system to overcome capacity restrictions)?

Are there national criteria defining who is entitled to receive treatment abroad?
Is this restricted to countries within the EU?

2.5.5 Complaints procedures (mediation, claims)

What mechanisms are in place for patient complaints? How often are they used?

Do provider institutions and other health care actors have a duty to offer (evaluate and proceed) complaints procedures?

Are patient/user advocates employed within institutions (e.g. psychiatric hospitals, acute hospitals)? If so, do they work on a voluntary or salaried basis? Are they considered neutral? Do they operate as mediators? Are patient advocates organized? What “arrangements” are made for vulnerable populations (e.g. people with mental illness, ethnic minorities, disabled people)?

2.5.6 Patient safety and compensation

Are there specific regulations or initiatives for preventing health care-related harm? (For more details of quality supervision and quality management refer to Section 4.1.2 “Regulation and governance of providers”.)

Are individual/institutional health care providers legally obliged to have liability insurance?

How is compensation for health care-related harm organized (e.g. on a (public) fund basis, by private liability insurance)?

In legal cases, do patients have to prove that their harm was caused by the accused provider (e.g. neglectfully)? Are there conditions when the burden of proof may be reversed?

Are there any patient safety agencies? Is there a national strategy to improve public safety?

Are medical errors recorded or publicized? By whom?

With regard to adverse drug reactions, are professionals (doctors or pharmacists) responsible for reporting these, or can the public do so directly? To whom?

Is direct-to-consumer advertising of drugs, medical devices or doctors’ services permitted? (Cross-reference to Section 6.6 “Pharmaceutical care”.)

2.5.7 Patient participation/involvement

Are there any mechanisms in place by which patients can influence the purchasing decision by political or administrative means, either collectively (e.g. representation in decision-making bodies; elect the board of purchaser organizations; participate in surveys on public views) and/or individually (e.g. appealing to court)?

Are satisfaction surveys on providers' services carried out? By whom? How often?

What do results of surveys on patient or citizen satisfaction show? If possible provide an indication of patient satisfaction with services (e.g. based on citizen or patient satisfaction surveys). Also, report how satisfaction may have changed in recent years, if this information is readily available.

Table 2.1 *Patient or citizen satisfaction with health care and the health system, latest available year*

Emphasis should be on statistics regarding satisfaction with health care and the health system, and if data are available, with clinical services.

Potential source: Eurobarometer

(http://ec.europa.eu/public_opinion/archives/eb_special_en.htm)

If available, insert a table with results from satisfaction surveys in the country.

2.5.8 Physical access

What arrangements are made to enable access to health facilities for disabled people (e.g. with physical disabilities, in wheelchairs, with visual or hearing impairment)? Are these arrangements voluntary or governed by law? If by law, how is the law enforced? (Cross-reference to the relevant sections of the service delivery section in Chapter 6.)

Chapter 3

Financing

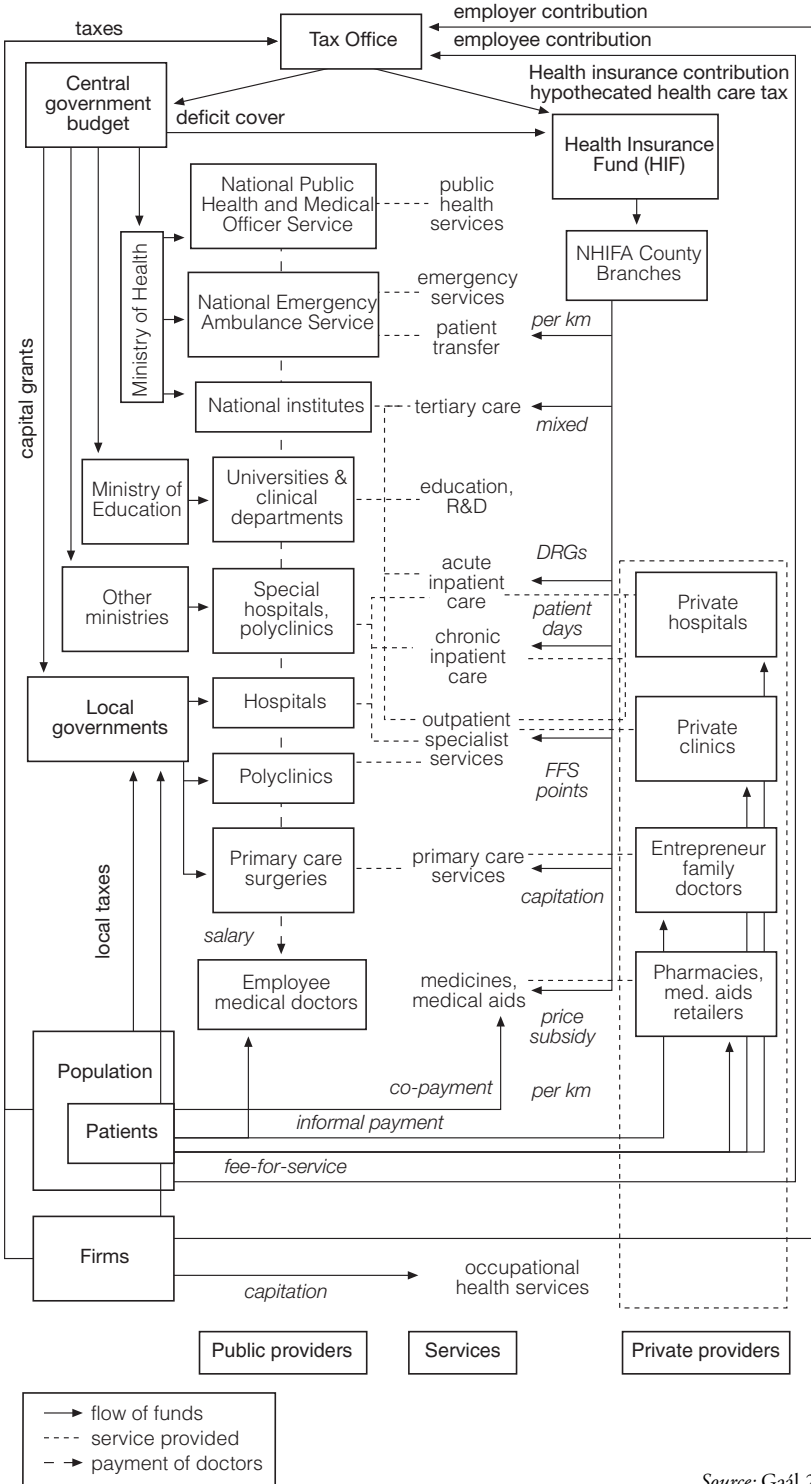
This chapter starts by considering the question, “How much money is spent, and on what?” The next section should address the following questions: “Who is covered and what are the benefits?”; “Where does the health system’s money come from (e.g. payroll taxes, voluntary health insurance, general taxation, out-of-pocket payments)?”; “How is money allocated (i.e. pooling and allocation to regions, purchasers)?”; “Who spends the money?”; and finally, “How are services paid for (provider payment methods)?”.

You should write one initial brief summary of the entire financing section, including a description of the level of expenditure, who is covered, what benefits are covered, the sources of health care finances, how they are pooled and allocated, the main areas of expenditure, and how providers are paid.

Figure 3.1 *Financial flows*

Please provide a chart that can not only serve as an introductory “snapshot” but also includes details which will be explained in the following sections. An example figure is provided below outlining the financial flows of the Hungarian health system, including payment methods in 2004.⁴

⁴ Figure 3.1 looks quite complicated and your editor will help you complete it.



Source: Gaál 2004

Figure 3.1 Financial flows

3.1 Health expenditure

This section looks at both how much money is spent on health care and where the money is spent in terms of the distribution of health expenditure between sectors and regions.

Please explain the basis of data used for reporting on health expenditures. Are the national health accounts based on and comparable with the WHO/OECD HQ approach to health accounts? If not, what type of expenditures/functions are included/not included (e.g. investments, cash benefits)? Particularly, are services and/or cash benefits for specific sectors such as mental health, long-term care, social care, palliative care, public health, etc. represented in health accounts?

Provide a table showing trends in health expenditure.

Table 3.1 *Trends in health expenditure in country, 1990 to latest available year (selected years)*

The table should include the following indicators for the years 1990, 1995, 2000, 2005, latest available year.

- Total health expenditure in EUR PPP per capita (1995 prices) (if not available in EUR, use US\$ PPP)
- Total health expenditure as a percentage of GDP
- Public expenditure on health as a percentage of total expenditure on health
- Private expenditure on health as a percentage of total expenditure on health (NB: Disaggregate private expenditure, if feasible, into the following categories: formal user charges, informal payments, out-of-pocket payments, private insurance.)

And for the periods 1990–1995, 1995–2000, 2000–2005 (or latest available year):

- Mean annual real growth rate in total health expenditure⁵
- Mean annual real growth rate in GDP
- Total government spending as a percentage of GDP (see also Section 1.2 “Economic context”)
- Government health spending as a percentage of total government spending
- Government health spending as a percentage of GDP
- Out-of-pocket payments as a percentage of total expenditure on health

Figure 3.2 *Health expenditure as a share (%) of GDP in the WHO European Region, latest available year*

Figure to be inserted by Observatory staff.

⁵ Calculated as the mean of the annual growth rates in national currency units at 1995 GDP prices.

Figure 3.3 *Trends in health expenditure as a share (%) of GDP in country and selected countries and averages,* 1990 to latest available year*

* *Note:* The other countries selected for this figure should be the same as in the later figures on hospital beds, physicians and nurses.

Should include weighted average for the EU, CCEE and CIS (as appropriate).

Figure 3.4 *Health expenditure in US\$ PPP per capita in the WHO European Region, latest available year*

Figure to be inserted by Observatory staff.

Figure 3.5 *Health expenditure from public sources as percentage of total health expenditure in the WHO European Region, latest available year*

Figure to be inserted by Observatory staff

Table 3.2 *Government health expenditure by service programme (percentage of total public health expenditure), 1990 to latest available year**

Where possible, this table should include data on the following:

- Total expenditure on X** as a percentage of total expenditure on health
- Public expenditure on X** as a percentage of total public expenditure on health

** "X" should represent:

- Health administration and insurance
- Education and training
- Health R&D
- Investment in medical facilities (land, fabric, equipment) at primary, secondary, tertiary, intermediate, social care levels
- Public health and prevention
- Medicines
- Medical devices (if available)
- Medical services:
 - inpatient care
 - outpatient/ambulatory physician services
 - outpatient/ambulatory dental services
 - ancillary services
 - home or domiciliary health care services
 - mental health (if funds are specifically allocated/recorded)

Note: Some of the above categories may overlap. If this is the case, please make a note of it in the text.

* If the data needed for this table are not available, include one table with information on spending by service category and service input.

Table 3.3 *Government health expenditure by service input (percentage of total public health expenditure), 1990 to latest available year**

Where possible, this table should include data on the following:

- Total expenditure on X** as a percentage of total expenditure on health
 - Public expenditure on X** as a percentage of total public expenditure on health
- **X' should represent:
- Personnel
 - Utilities
 - Investment in medical facilities (land, fabric, equipment) at primary, secondary, tertiary, intermediate, social care levels
 - Medicines
 - Medical devices (if available)

* If the data needed for this table are not available, include one table with information on spending by service category and service input.

Include data on mean annual growth rate in expenditure on different areas, calculated as the mean of the annual growth rates in national currency units at 1995 or 2000 GDP prices.

Discuss all the above tables and figures, highlighting the main trends over time, the position of the country in comparison to regional averages and other selected countries. Give any reasons for the changes/position.

3.2 Population coverage and basis for entitlement

Population coverage

The first part of this section deals with the question “Who is covered to have access to health care?”, while the next part will address the question “What benefits are covered?”

Describe the extent of population coverage based on the following questions:

- What criteria constitute the basis of entitlement (e.g. residence, nationality, membership of an insurance scheme, residence in specific geographical areas, insurance contributions)?
- Is the whole population covered to have access to health care? If yes, how is this defined (e.g. through Constitution, law)? Are foreigners and illegal immigrants included? Are there practical hurdles preventing some population groups from accessing health care even though they are entitled to it (e.g. because it is necessary to apply for a health insurance card)?

- Are there insured people who do not benefit from services? Are there uninsured people who benefit from services? Briefly, is the health insurance law enforced properly?
- Are there any population groups or conditions in which some people can join voluntarily (“opting-in”) or voluntarily leave (or are compulsorily excluded from) the statutory system in favour of private arrangements (“opting-out”)? Which groups? What conditions? How many exercise this choice between public/private/no coverage?
- Is membership of an insurance scheme compulsory? If yes, for whom and on what criteria (e.g. occupation, residence)? Are benefits, access terms, and contributions for people with compulsory insurance equal? Are there any excluded groups; if so, what are they (e.g. unemployed, indigent)?
- Is the non-employed part of the population (i.e. unemployed or pensioners) covered as well, and how is this achieved (e.g. membership as dependants of contributing members, tax-financed contributions, free membership)?
- Are there any conditions (e.g. income limits, status as self-employed) under which groups or individuals are not permitted to join the health insurance scheme?
- Does part of the population have choice of insurer? How often can they exercise this choice? What data are available on who actually exercises choice?

What percentage of the population has voluntary health insurance (VHI)? Of what type? Is this proportion increasing? If so, since when? (See the Glossary on pages 115–124 for a definition of VHI.) (Cross-reference to Section 3.3.2 “Voluntary health insurance”.)

- Have there been any changes in the uptake of VHI? If changes have occurred, discuss the factors behind these changes.
- Who has VHI coverage? Describe distribution according to gender, socio-economic status, regional distribution, etc. Have there been any changes? Explain.

Comment on any changes in population coverage that have taken place in the last 10 years, or are in the process of taking place, or are expected to take place. What is the rationale behind these changes (e.g. result of implementing health insurance legislation, decreases in funds available for health care, other factors)? Have there been increases or reductions in population coverage? If so, which groups are affected?

Definition of benefits

Most health systems have some form of a uniform/standard/minimum package of benefits to which the persons covered are entitled. This can be explicit, i.e. a list that states all the benefits available under the statutory system (or separate lists that exist for various sectors); or it can be implicit, i.e. based on traditions and routine.

When defining the benefits packages, the Government may also determine co-payments. What is the depth of coverage? For example, the Government may only cover 70% of some pharmaceutical costs, therefore establishing a 30% co-payment (see Section 3.3.3 “Out-of-pocket payments”).

Does your country have an explicitly defined uniform/standard/minimum package of care? How is it established? Who is involved in the decision-making process? Are the decisions made based on explicit criteria and/or following health technology assessments (HTA). (Cross-reference to Section 4.2.1 “Health technology assessment”, if appropriate.)

Please also mention the obligations of the insured to avail themselves of the entitlements. Similarly, please comment on the level of detail in which the package is specified. Is the population likely to be fully aware of benefits/rights and obligations?

In addition to a positive list stating benefits under the statutory system, countries use “negative lists” of services which are explicitly excluded (not available at all, available following full payment by the patient, available with co-payment). Does your country have a “negative list” of excluded services? What rationale/criteria are being applied, if any?

Are volumes of care specified as well?

What services and products are covered by the main public source of health care coverage and financing (e.g. diagnosis, treatment, prevention, health promotion, spa treatment, rehabilitation, long-term nursing care, long-term care for older people and people with mental health problems, palliative care, occupational health care and prevention, accident-related care, transport, after hours care, pre-hospital emergency care, patient information). Consider examples of benefits covered or excluded – for example, alternative therapy or complementary medicine; optician services (e.g. sight tests, glasses); pharmaceuticals (e.g. compliance with WHO essential drug list and beyond such as antiretroviral treatment, opioid analgesics); dental care (e.g. dental inspections, fillings and extractions, dentures); and specific interventions (e.g. renal dialysis, cosmetic surgery, abortion, contraception, in vitro fertilization,

organ transplantations). (Cross-reference to Section 3.3.3 “Out-of-pocket payments” if relevant.)

What cash benefits are available to eligible persons under the main (or public) sources of financing? Consider, for example, sick pay, benefits in case of maternity, disability, invalidity, cash payments for users of long-term care services, funeral benefits, cash benefits for family members caring for acute or chronically ill people. Are any cash benefits available for those with mental health disorders and people living with HIV/AIDS (e.g. disability, food supplements)?

Have there been any reductions or expansions in the benefits package in recent years? What services have been excluded or added?

Are there variations in the extent of entitlements/benefits between different purchaser organizations (e.g. in countries with social health insurance systems, for different occupational groups), and/or between different population groups (e.g. sickness fund members versus their dependants)? If so, what are they?

Can public insurance bodies offer additional benefits over and above the established package of care, for instance through complementary or supplementary insurance arrangements?

Are the entitlements the same for foreign nationals, tourists and other short-term visitors, asylum seekers and refugees? Is there separate coverage for prisoners? If not, in what respects do they differ?

If no explicit benefits package exists, how are decisions about benefits made? Who makes them? Do entitlements to health care services exist in the absence of a defined benefits package? Can patients appeal against rationing decisions? Are there any initiatives (proposals, policy documents, legislation) towards setting a basic package of health care benefits?

- What services are covered by VHI?
- How is the degree of benefit coverage of the population expected to develop in the future in response to changes that may be taking place or are expected to take place in the health system, such as cost-containment policies?
- Who decides whether they should be included in the benefits package (coverage decision)? Which methods and criteria are used?
- What is the role of HTA in decisions about inclusion or exclusion with regard to the benefits catalogue? (Please describe the process and details of HTA). What technologies are/have been subject to evaluation? (Cross-reference to Section 4.2.1 “Health technology assessment”).

Are there regulations/controls on the deployment of new technologies? Do these cover the public and private sectors? Are there measures to steer the appropriate usage of technologies (e.g. financial incentives, utilization review)? Comment using examples, if possible, on how effective these measures are.

What arrangements are in place for citizens getting treatment abroad? What are the benefits available to tourists, retirees, inhabitants of border regions sharing cultural or linguistic links, migrant workers, individuals aiming to benefit from perceived higher quality in health care, people sent by the health system to overcome capacity restrictions? (Cross-reference to Section 2.5.4 “Patients and cross-border health care”.)

3.3 Revenue collection/sources of funds

In the following sections, distinguish clearly between sources, pooling arrangements and purchasing methods.

Most countries have a mix of compulsory (or statutory) and voluntary systems of financing, but usually have a dominant source of funding, either payroll taxes destined for social health insurance (SHI) funds, or general taxation. Depending on the country, this source should be dealt with first, followed by other public sources of financing, i.e. taxes (in countries with SHI funds) or social insurance contributions (in countries whose health systems are funded principally from general tax revenues).

Provide a brief overview of the historical evolution of private expenditure on health care. If possible, distinguish between the following types of private expenditure: out-of-pocket payments for services (including direct payments, cost-sharing schemes and informal payments), voluntary (or private) health insurance, and external sources (including charitable funds, loans and technical assistance).

Where systems of pre-payment have collapsed and out-of-pocket payments constitute the main source of revenue, this section should precede both tax and SHI. The following sections should then concentrate on why revenue has not been easy to generate through taxation/SHI.

It may be helpful to consider these issues in the following sequence:

- 1) general revenues (mix of unearmarked taxes)
- 2) payroll taxes
- 3) voluntary prepayment (VHI)
- 4) out-of-pocket payment.⁶

⁶ If personal/medical saving accounts are used, add a section and discuss with HiT editor(s).

Please comment on the availability and reliability of data. If possible indicate whether figures presented here are likely to be an overestimate or underestimate of actual financing volumes.

Discuss the relative size of each category of financing and any changes that may have occurred in recent years as well as the factors behind these changes.

Figure 3.6 *Percentage of total expenditure on health according to source of revenue, latest available year*

Note: If these data are incomplete, you may consider moving Figure 3.6 and Table 3.4 to the previous section on expenditure patterns and use of national data.

Provide a pie chart showing the proportion of total health expenditure from different sources in the latest available year. (Payroll taxes (collected by SHI funds, local or central government), Taxation (TAX), Out-of-Pocket Payments (OPP), Voluntary Health Insurance (VHI), Other sources (OTHER)) from OECD Health Data, Eurostat, and national sources (if possible using national health accounts to reflect revenue income, rather than consumption data.)

Table 3.4 *Sources of revenue as a percentage of total expenditure on health, 1990 to latest available year*

Include years 1990 – latest available year

If possible, fill in the table with the percentages for each source of financing showing a trend over time. If figures are not available, give an indication of the relative importance of each category of financing, and the direction in which each is moving (increasing, decreasing, stable).

3.3.1 Compulsory sources of financing

Discuss either taxes or SHI contributions (payroll taxes). See relevant questions below.

What is the main body responsible for collecting compulsory funds for health care (including payroll taxes, general income tax, other taxes)? Is it a separate body from those collecting other legally mandated taxes or contributions? Are there local branches?

Questions for section on taxation

Describe the main sources of taxation (for example, income tax, VAT, public enterprise revenues, export taxes) and their contribution to health care financing. If possible, indicate the breakdown of percentage of local/

regional/national taxation where these contribute. Indicate the taxes on personal income, corporate income, sales (VAT) and other sources. Is the overall burden of taxation progressive (a higher share is taken from the rich) or regressive (a higher share is taken from the poor)? Where possible, use household survey data.

- What is the main body responsible for collecting taxes? How efficient is it? Is compliance high/low?
- At what level(s) are taxes collected (central/regional/local)? At what level(s) are taxes administered (if this differs from the level of collection)?
- Who is responsible for setting tax rates? What are the rates of taxation? Can local authorities raise taxes beyond the level defined by central Government?
- How progressive are taxes? Are there floors or ceilings for income taxes?
- On what sources of income are the taxes levied (e.g. wages/income/property)?
- Are any taxes earmarked for health care? If so, describe. Comment on the extent to which the hypothecation is real, or if the funds may be used for purposes other than health care.
- Are there any tax expenditure subsidies (e.g. tax credits or tax relief)? For example, are out-of-pocket payments or private health insurance premiums tax-deductible? What limits, if any, are placed on the level of tax relief? Are data available on the value of these tax expenditure subsidies?
- Describe any problems or challenges with respect to any of the above issues and whether there have been any recent changes or there are plans for change.

Questions for section on payroll taxes

Payroll taxes may be collected by SHI funds, local government and central Government, depending on the country context. If possible, give a breakdown of how much is collected from employer/employee contributions and how much from other sources. Please specify the size of these transfers if known, and from what sources. Information on management of SHI funds is provided in Section 4.1.1 “Regulation and governance of third-party payers”.

- Who is responsible for setting contribution rates? Are there differences in contribution rates across funds? What level are the contribution rates? If possible give the average contribution rate, range of contribution rates, describe whether rates are differentiated by funds or type of subscriber. Are there special rates for certain categories such as older people, self-employed, farmers, public employees, unemployed? Are there certain social groups that do not contribute?

- Are SHI contributions tax-deductible?
- How progressive are payroll taxes? Are there upper and lower thresholds on contributions?
- On what sources of income are the contributions levied (i.e. gross/net wage, gross/net income)?
- To what extent are contributions collected from self-employed people, farmers and the informal sector workers? What is the basis for contributions from these groups? Is there evidence of under-reporting of income?
- Does the State contribute to SHI funds? For whom and what amounts?
- Is there a tax subsidy to include excluded population groups in the SHI system? How is the amount transferred calculated? Please describe whether the expected transfers have actually been made.
- Who makes the contributions for pensioners? What percentage comes from pensions? What percentage comes from previous employers? Who continues to pay the contributions if previous employers go bankrupt?
- Are social insurance revenues earmarked for health care, or are they mixed with other sectors, such as pensions?

Additional contributions

Is there any additional contribution (e.g. flat-rate per-capita premium or additional taxes) allocated to SHI funds? See also Section 3.4 “Pooling of funds”.

3.3.2 Voluntary health insurance

VHI is health insurance that is taken up and paid for at the discretion of individuals or employers on behalf of individuals. VHI can be offered by public or quasi-public bodies and by for-profit (commercial) and non-profit-making private organizations. Describe the contribution of VHI to total expenditure on health.

In the European context, VHI can be classified in three different ways.

- *Substitutive VHI*: this provides cover that would otherwise be available from the State; it is usually purchased by those who are excluded from participating in some or all aspects of the statutory health insurance scheme, or by those who have voluntarily or involuntarily opted out of the statutory health insurance scheme and are therefore exempt from contributing to it.

- *Complementary VHI*: this provides cover for services excluded or not fully covered by the State (e.g. dental care), including cover for co-payments imposed by the statutory health system.
- *Supplementary VHI*: this provides cover for faster access and increased consumer choice.

Describe which of the three types above is available and their relative importance.

- How is eligibility for substitutive VHI determined: by income (e.g. those who have earnings or incomes above a certain threshold); by employment status (e.g. self-employed people); by occupation (e.g. civil servants)?
- What proportion of the population is covered by each type of VHI? What are the characteristics of those covered by different types of VHI?
- Do insurers offer open enrolment or can they reject applications?
- Does VHI provide annual or lifetime cover?

How are premiums calculated? Are they community-rated, group-rated or risk-rated? If premiums are risk-rated, what risk factors are used (e.g. age, gender, health status)? Is genetic testing required as a condition of applying for VHI? Are there any controls on the price of premiums? Are pre-existing conditions covered? Are dependants automatically covered or do they need to purchase separate policies?

Are insurers free to set their own package of benefits or do they have to offer a minimum or standard package? Are benefits provided in cash (i.e. reimbursement) or kind? Is there cost sharing? If so, in what form (e.g. deductibles)?

What proportion of VHI policies are purchased by groups (usually employers), as opposed to individuals? Do group-purchased policies differ from individually purchased policies in terms of price, policy conditions, etc.?

- Is VHI subject to any other type of regulation (e.g. solvency controls)? If so, describe.
- Are there any cross-subsidies from VHI to statutory health insurance? If so, describe.
- What is the balance of non-profit-making (or mutual) insurers and for-profit (commercial) insurers. Are non-profit-making and for-profit insurers subject to the same regulatory framework?
- Can public insurance funds (i.e. sickness funds) offer complementary or supplementary VHI policies in addition to providing statutory health insurance?

Discuss any distributional implications, e.g. are particular socioeconomic groups more/less likely to be covered by VHI or more/less likely to have good-quality VHI cover?

Are there any tax subsidies for VHI? If so, and if data are available, what is the proportion of total health expenditure that this tax subsidy represents?

Discuss any potential changes or future developments in this area.

3.3.3 Out-of-pocket payments

Out-of-pocket payments (OOP) include:

- *direct payments*: payments for goods or services that are not covered by any form of insurance;
- *cost sharing*: a provision of health insurance or third-party payment that requires the individual who is covered to pay part of the cost of health care received; often referred to as formal cost sharing or user charges;
- *informal payments*: unofficial payments for goods or services that should be fully funded from pooled revenue.

Describe the composition of OOP. If possible, indicate the relative contribution of direct payments and cost sharing. Also indicate whether informal payments are a feature of the health system and whether data on informal payments are included in calculations of private expenditure on health.

In recent years, have there been any changes (decrease or increase) in the level of OOP? In what areas? Explain why there have been changes over time.

Cost sharing

Cost sharing can be direct or indirect, as set out in Box 4. (Cross-reference to Section 3.2 “Population coverage and basis for entitlement”.)

Do cost-sharing policies have explicit objectives? These might include:

- raising revenue for the health sector
- reducing inappropriate demand
- containing costs
- encouraging consumer responsibility.

Who is responsible for making decisions about the level of cost sharing and protection mechanisms (e.g. national/local government; sickness funds; are there regional variations in cost sharing)?

Box 4 Cost sharing – direct and indirect methods

Direct methods of cost sharing	
Co-payment	A fixed amount (flat rate) charged for a service.
Co-insurance	The user pays a fixed proportion of the cost of a service, with the third party paying the remaining proportion.
Deductible	A fixed amount that is required to be paid by a patient before a third-party payer will begin to reimburse for services. It is usually an annual amount of all health care costs or costs for a particular service that is not covered by the insurance plan.
Indirect methods of cost sharing	
Extra billing	Charges by the provider that are higher than the maximum reimbursement levels set by insurers, leaving users liable to pay the difference.
Reference pricing	The maximum price for a group of equal or similar products (mostly pharmaceuticals) the third-party payer is ready to reimburse. If the actual price exceeds the reference price, the price difference must be met by the user.
Out-of-pocket maximum	A defined limit on the total amount of out-of-pocket spending for which an insured individual or household will be liable for a defined period, over and above which the insurer pays all expenses.
Benefit maximum	A defined limit on the amount that will be reimbursed by the insurer for a defined period, over and above which the user is entirely liable for payment.

Sources: Adapted from the European Observatory on Health Systems and Policies' Health Care Systems Glossary (see www.euro.who.int/observatory/glossary/toppage).

Discuss any policy debates concerning cost sharing. Has cost sharing been a contentious issue? Has there been opposition to existing cost-sharing policies or to attempts to introduce cost-sharing policies? By whom? With what effect? Have stated objectives been achieved? How are they collected/is the collection efficient? Have there been any recent changes? Describe and explain the reasons for the changes.

For which goods or services is cost sharing required? These might include:

- ambulatory care (e.g. visits to a GP/specialist/direct access to a specialist);
- hospital care (e.g. inpatient stays);
- drugs;
- medical aids and prostheses (including hearing aids and corrective lenses);
- dental care;
- other.

Describe which methods of direct or indirect cost sharing are applied to each good or service (e.g. co-payment/co-insurance/deductible/reference pricing) and show their value in national currency units and euros.

Are differential charges applied to some types of good or service to encourage the use of another type of good or service? For example, charges may be applied to brand drugs to encourage the purchase of generic drugs⁷ or charges may be applied to visits to a specialist without a referral to encourage GP gatekeeping.

What mechanisms are in place to protect vulnerable groups of people? Protection mechanisms include:

- reduced rates
- exemptions
- ceilings (caps) on expenditure
- tax relief
- discounts for prepaid charges (vouchers)
- substitution of cheaper/generic drugs by pharmacists.

The availability of complementary VHI is another method of protecting people from cost sharing. Discuss whether this type of VHI is available, what

⁷ Generic drugs are identical in chemical composition to a brand name pharmaceutical preparation, but produced by competitors after the firm's patent expires.

proportion of the population purchases this type of VHI and whether it has any distributional implications (and cross-reference to Section 3.3.2 “Voluntary health insurance”).

Do protection mechanisms apply to:

- particular groups of people (e.g. children, those aged 60 and over, pregnant women, people with chronic illnesses, people with low incomes)?
- particular types of good or service (e.g. essential drugs or drugs for serious illnesses)?

How is eligibility for protection determined? Which criteria are used to decide whether certain illnesses or types of product should be exempt or not?

How extensive are protection mechanisms (e.g. what proportion of prescriptions or people requiring hospitalization are exempt from charges)?

How are protection mechanisms implemented (e.g. using special concession cards or other forms of identification)? Are there problems in implementing protection mechanisms?

Is there any evidence of fraud (e.g. illegal use of exemption systems)?

Are there any annual limits to out-of-pocket payments? How are these set and by whom? Once the limit is reached, are patients fully exempted from charges?

Informal payments

Describe whether informal payments exist, and the nature of these payments. If possible give estimates of their prevalence and size relative to official payments. Describe any geographic variations in the prevalence of informal payments.

- For which services are informal payments commonly made?
- What form do they take: cash or the provision of goods in kind?
- Are payments made *ex post* (after the service is received) or *ex ante* (before the service is received)?
- Are payments requested by health care professionals? Who retains the payments? How much do informal payments contribute to the income of particular health care professionals?
- For how long have informal payments been in place? What reasons can be given for their existence/persistence? Have there been or are there any efforts being made to reduce the importance of these payments?
- What evidence is there of how informal payments affect access to health care?

- Is there any evidence showing that informal payments contribute to poverty in the country?
- If possible, comment on people's/policy-makers'/providers' perceptions of informal payments.

Discuss any problems or challenges encountered, and any plans or expectations with respect to future developments in this area.

3.3.4 Parallel health systems

In some European countries, there are/have been parallel health systems providing services for employees and officials of certain national enterprises and ministries, such as the ministries of defence, transportation and others. Discuss any such enterprises or ministries with respect to their financing role.

- What problems or challenges have these presented?
- Do populations covered by parallel health system arrangements also have access to the main health system, i.e. is there double coverage?
- What is their present status, and what plans are there for the future of these systems?

(Cross-reference to any more details provided in Sections 3.4 “Pooling of funds” and 3.5 “Purchasing and purchaser–provider relations”).

3.3.5 External sources of funds

External sources of funds refer to financial assistance for the health sector which may take the form of loans or grants from bilateral or multilateral organizations. Comment on the evolution of external sources of financing, if any. Consider bilateral and multilateral assistance programmes.

How are such external funds being used within the health system (i.e. for what purpose)?

3.3.6 Other sources of financing⁸

This section might include a discussion of the following points where they exist.

- Occupational health services and other medical benefits to employees provided by corporations and private employers.
- Occupational health services and other medical benefits provided to special population groups (e.g. soldiers, prisoners, refugees).

⁸ Please omit this section if there are no other sources of financing or their importance is very limited.

- Non-profit-making institutions serving households (excluding social insurance) such as the Red Cross, philanthropic and charitable institutions, religious orders, lay organizations.
- Expenditures incurred by foreign or international bodies (i.e. through external sources of financing).
- Mental health and social care services where these are funded separately from general medical services.

Voluntary and charitable financing

Voluntary and charitable financing refers to national and international donations in cash or in kind from NGOs. Comment on the contribution of voluntary and charitable financing and the relative importance of national and international NGOs.

How are such funds being used within the health systems (i.e. for what purpose)?

Consider how health care for the particular area is financed. Please provide figures, if available, on the percentage of health care funding dedicated to it. Are the financing mechanisms for the particular area in any way different from general health care financing? If yes, please describe how it is financed. For instance, are some mental health care services excluded from standard coverage under general financing arrangements within the health system; if so, what services are excluded? How are they funded? This might be separately, for instance through a different insurance system or through local/national income tax.

Alternatively, some services may not be financed or provided within the health system. Please outline any key services not provided within the health system. For instance, these could include long-term institutional care; community care; sheltered or supported housing schemes. How are such services provided (e.g. in social care and housing)? Provide some brief examples of how they are financed. (Cross-reference to the relevant sections of Chapter 6 on service delivery.)

Mental health care financing

How is mental health care financed?

- What user charges are there for institutional and community-based mental health services?

- What exemption criteria, if any, are there?
- Do NGOs, donor organizations or religious organizations contribute significantly to the funding of mental health care services? If so, provide further information. (Cross-reference to Section 6.11 “Mental health care”.)

Long-term care financing

How is long-term care financed?

- Are some long-term care services excluded from insurance coverage, and if so, how are they financed?
- Do NGOs and donor organizations contribute to the funding of long-term care services?
- Are there any regional variations in approaches to funding long-term care?
- What user charges are there for institutional care and community-based care services? If there are exemption criteria, what are they?

(Cross-reference to Section 6.8 “Long-term care”.)

3.4 Pooling of funds

Please specify each of the two kinds of resource allocation: (1) allocation from collection of pooling (e.g. allocation from general budget to SHI fund or MoH/local government); (2) allocation among pools/purchasers (e.g. risk-adjusted capitation).

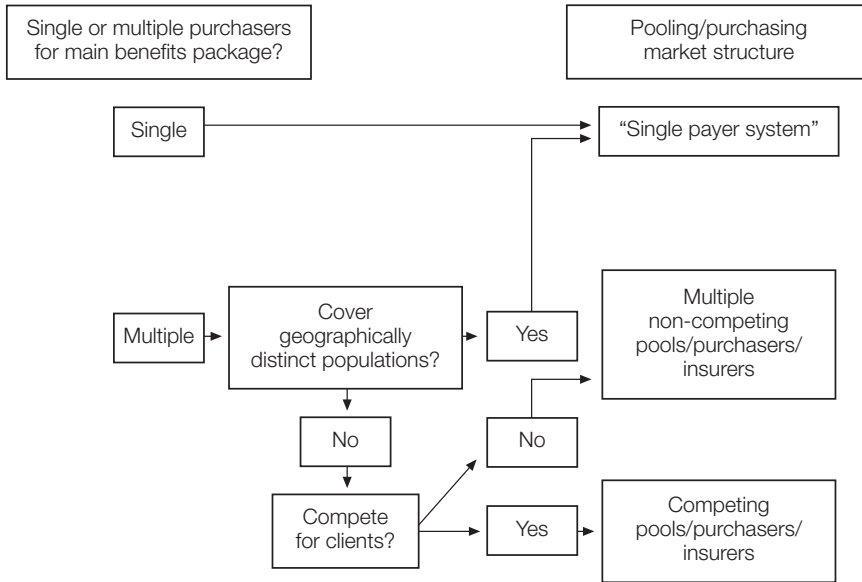
3.4.1 Pooling agencies and allocation

Describe who the “insurers” are, e.g. government agencies like the MoH or local governments, SHI funds, VHI funds. These can be any intermediary that accumulates prepaid funds for health; typically, but not always, these are agencies that also purchase services from providers.

Describe the market structural issues in the pooling agencies. For example, is choice allowed (cross-reference to Section 2.5.3 “Patient choice”)? The following flowchart can be useful for characterizing market structure.

Also, describe the flow of funds to the pooling agencies.

The aspect of financial resource allocation to be addressed in this subsection is any process by which financial resources flow from a collection agency to a pooling agency. In some financing arrangements, the revenue collection and pooling functions are integrated and hence the resource allocation mechanism to poolers is implicit.



Characterizing market structure of pooling (and purchasing)

Source: Adapted from Kutzin 2001.

- Does the same agency that collects funds also pool them (integrated system, as with an SHI fund that has its own revenue collection system, or with VHI funds)? In these cases, the contribution mechanism is also the allocation mechanism to the pool.
- In the context of compulsory SHI fund(s) as pooling entities:
 - describe the flow of funds to the SHI funds. Do they collect payroll taxes themselves, or is there a “multi-purpose” social tax collection agency that also collects for pensions, unemployment, etc.? If the latter, describe the flow from the multi-purpose fund to the SHI fund. Describe any flows from other sources (e.g. direct transfers from central or local budgets, from pension funds, etc.) to the SHI fund(s). Are there specific rules governing such transfers? How well are they enforced? Are there big differences between the rules governing the transfers (e.g. a fixed amount per capita or a certain percentage) and the actual practice of allocation? What are the allocation mechanisms used?
- Where other government agencies pool funds for health care:
 - what is the process for determining the size of the budget held by each? Where there are territorial pools, is there an allocation process from central to territorial levels? Is this done within the health sector (e.g.

MoH to territorial health purchasing agencies) or at the broader governmental level (e.g. central Government to local government, and then local government to local health purchaser)? This will help clarify the key responsibilities for resource allocation in the system.

- to the extent that there are “parallel” government health systems (e.g. Ministry of Defence, Ministry of Interior), what is the process for determining the size of their budgets?

3.4.2 Mechanisms for allocating funds among pooling/purchasing agencies

The aspect of financial resource allocation to be addressed in this section is any process by which financial resources flow from a pooling agency or among agencies that pool funds and/or purchase services (e.g. territorial resource allocation processes to geographically based purchasers, risk-adjusted capitation to SHI funds, local governments, local administrative boards, etc.). In some systems the revenue collection, pooling and purchasing functions are integrated and, as a consequence, the resource allocation mechanism to purchasers is implicit.

Contracting and payment of providers are dealt with in Section 3.5 “Purchasing and purchaser–provider relations” and Section 3.6 “Payment mechanisms”.

Is a global budget set for overall spending? If so, how frequently and by whom? What is the decision-making process to determine the magnitude and conditions for the overall health budget? How is this enforced? Is it a hard or soft budget (i.e. are there penalties for overspending)? Has overspending been a problem historically?

Are decisions about the health care budget made at different levels (e.g. national, regional, local)? If so, by whom?

Are budgets allocated to geographical regions? Are budgets (re-)allocated between funds? On what basis and/or resource allocation formula are they determined? Is there risk adjustment? By whom and how often?

Are budgets set for different sectors within the health system? If so, how frequently and by whom? How are these enforced? Are they hard or soft budgets? Is there risk adjustment? If so, describe the scheme.

In the case that resources are collected and pooled at local level, is there a mechanism for redistribution from the relatively wealthy regions or local authorities to the relatively less-wealthy ones?

In the case that there are multiple insurance funds, do patients have choice of fund? Is there a risk-adjustment scheme in place? (Cross-reference to Section 2.5.3 “Patient choice” and Section 4.1.1 “Regulation and governance of third-party payers”.)

Are there separate budgets for individual sectors such as mental health, long-term care, rehabilitation, palliative care, social care, public health, etc.?

Is there a specific budget for mental health care?

Is there a specific budget for human resource development?

Are budgets set for specific programmes or initiatives? Who, if anybody, decides how much is allocated to different programmes? How?

For countries with devolved purchasers, explain how allocations to devolved purchasers are made. The following questions are to guide you; please consider them in relation to the main system of resource allocation.

Identify the nature of the purchaser and the population (e.g. entire population of territory, people that are members of the particular scheme managed by the purchaser, etc.) for which they are responsible.

Are allocations to purchasers made on the basis of:

- full retrospective reimbursement for all expenditure incurred?
- reimbursement for all activity based on a fixed schedule of fees?
- prospective funding based on expected future expenditure, using fixed budgets?
- risk-adjusted capitation (describe the nature of the risk-adjustment formula)?

If a system of budgets is in place, are they calculated:

- according to the size of bids from purchasers?
- based on political negotiation?
- according to historical precedent?
- according to input-based budget process that is also used by individual health facilities, as part of an overall “bottom-up” budget construction process for the sector (one type of historical precedent)?
- based on some independent measure of health care need (i.e. risk-adjusted capitation)?

If budgets are allocated through risk-adjusted capitation:

- what is the stated purpose of risk-adjusted capitation?
- what percentage of total allocations to purchasers is made through risk-adjusted capitation?
- what factors are used to adjust the capitation? Is double-counting avoided?
- how is the associated expenditure calculated?
- what weights are given to the different factors?
- is any adjustment made to account for supply-side factors, such as the number or type of hospitals in a region?
- is psychiatric morbidity a factor?
- are there adjustments made to account for “pure cost” factors that are expected to affect the expected cost of service delivery and which are part of the context rather than something amenable to policy or efficiency improvement (e.g. population density, altitude, remoteness, etc.)?
- are there adjustments made for socioeconomic factors?
- are specific types of morbidity (e.g. psychiatric, HIV, TB prevalence, cardiovascular disease prevalence, etc.) used as factors?
- are any retrospective adjustments made to the allocations, based on actual expenditure?
- is there a safety net or additional pool to cover exceptionally expensive people or treatments?

Are health resource allocations (e.g. from central to local government) separate from allocations for other sectors, such as education and social services? If not, what mechanisms are in place to define health allocations? Have local governments, for example, full discretion over the use of allocated funds?

Are purchasers able to vary their own resources (e.g. through cost sharing, charging additional per-capita premiums or raising local taxes)?

Do purchasers bear financial risk (i.e. can they carry over a deficit or a surplus or borrow money)?

Where purchasers are responsible for collecting all or some revenue, there may be a system of reallocation between them (i.e. transfers of funds from one purchaser to another). Is there a system of reallocation between purchasers? If so:

- how does this operate?

- on what basis are reallocations calculated (consider some of the questions above)?
- who are the net winners and net losers in this reallocation process?

Have there been any recent changes to the system of resource allocation or are any being proposed? Discuss reasons for these changes and any implications.

3.5 Purchasing and purchaser-provider relations

The organizational relationship between purchasers and providers is based on two models: integrated or contract. (*Note:* health care providers can either be individuals or institutions.)

- *Integrated:* health care providers are directly employed (or “owned”) by the third-party payers.
- *Contract:* health care providers are independent and are contracted by the third-party payers (be they public, private not-for-profit or private for-profit, be they regional monopolies or competing), i.e. there is a separation between purchaser and provider functions and contractual or contract-like relationships between them.

In addition, direct payments by patients to providers play an important role in allocating resources to providers in many countries of the region.⁹

Is a global budget set for overall spending? If so, how frequently and by whom? What is the decision-making process to determine the magnitude and conditions for the overall health budget? How is this enforced? Is it a hard or soft budget (i.e. are there penalties for overspending)? Has overspending been a problem historically?

Are decisions about the health care budget made at different levels (e.g. national, regional, local)? If so, by whom? Describe the process of “budget formation” (the basis for determining the size and content of the health system budget).

Describe the process through which purchasers and providers interact.

If providers are **integrated**:

- how is their behaviour/activity controlled (e.g. through hierarchical management, norms, targets)?
- what happens when provider organizations deviate from agreed plans/targets?

⁹While this is not the prevalent situation in most of the countries of the European region, it does play an important role in many countries and should be identified at this early stage in the HiTs.

- are integrated purchaser–provider relations found in the public and the private sector?

If **contracting** is used:

- what are the main types of contracts agreed between purchaser organizations and provider organizations?
- how are contracts developed?
- how are contracts put into place?
- what is the duration of contracts?
- how do purchaser organizations monitor contracts?
- what happens if the provider organization deviates from the agreed contract or performance agreement?
- can purchasers contract selectively with individual provider organizations?
- do the same rules of contracting apply to public and private providers? If not, how do they differ?
- do purchasers have different contracts with providers?
- is there competition between provider organizations for contracts from purchasers?

Provide examples and any data/evidence available that you consider relevant.

Consider the following types of contractual arrangements:

- Case by case or spot contracts: payments linked directly to client; may be a fixed sum or dependent on costs; pricing structure may be determined prospectively.
- Block contracts: linked to facilities made available by the provider; units are bought at an agreed price, regardless of utilization.
- Cost and volume contracts: a combination of the above; initial block contract agreed; supplemented by individual case-by-case payments depending on level of utilization.

In addition, where direct payments from the patients form an important part of provider *reimbursement*:

- in what ways, if any, does the insurer or regulator intervene (e.g. price controls, OOP limits, reporting requirements, etc.)? How do payers/purchasers control providers and patients?

- are there any mechanisms to counter supplier-induced demand? How are these implemented?

Have there been any cases where competition authorities have intervened?

Is there the provision of block contracts with other countries for cross-border health care provision?

What are the financial implications for purchasing as regards the development of reference centres?

3.6 Payment mechanisms

This section should provide an overview of payment mechanisms used in the health system, with reference to the financing flow diagram shown in Figure 3.1. Discuss the transactions shown in the financial flow diagram and the incentives these transactions provide for providers. Highlight any recent changes in how providers are paid and whether any evaluation of their effect has been carried out. Where possible, distinguish between the method of paying health care personnel and the method of paying for services. Where payments amount both to reimbursement for services and to the income of the individual delivering the service, this should be clearly noted.

3.6.1 Paying for health services

Distinguish between retrospective and prospective payment mechanisms.

- Retrospective payment (reimbursement) at “full cost”: third-party payers (purchasers) reimburse providers after services are delivered, either without any clear constraints on the price or quantity of health services provided or according to a specific fee schedule.
- Prospective payment: third party payers (purchasers) allocate revenues to providers before services are delivered (e.g. budget, capitation) or the total amount of payment to be received is fixed in advance.
- Mixed methods: payment methods that combine retrospective and prospective methods (e.g. fee schedule-based reimbursement subject to volume/budget caps).

Prospective payment methods may involve line-item budgets or global budgets. Key policy issues relate to the basis on which the budgets are determined (e.g. capitation).

Retrospective payment methods typically involve use of a fee schedule. Methods for fixing fee-for-service vary according to the way in which health care activity is measured (units of payment):

- individual fee-for-service or charge list: third-party payers pay hospitals according to a price list of separate services provided to patients (e.g. for the use of operating rooms, tests, drugs, medical supplies or doctors' fees);
- *per diem* fees or daily charge: third-party payers pay hospitals a daily charge; *per diem* fees cover all services and expenses per patient per day and do not vary according to treatment;
- case payment: third-party payers pay hospitals according to the cases treated rather than treatments provided or bed days; case payment can be based on a single flat rate per case, but in most cases it is based on a schedule of payment by diagnosis; the most widely known case classification (mix) approach is diagnosis-related groups (DRGs).

Prospective payment methods (e.g. global budgets, line-item budgets, capitation) involve the payment of a particular sum to cover the operating costs of the service provider over a given period of time. The budget may be calculated on the basis of:

- the actual costs of a particular provider unit (essentially a budget determined by retrospective payment);
- historical incrementalism (i.e. based on the previous year's allocation adjusted for inflation and budget growth);
- the provision of inputs (i.e. based on the number of beds and/or doctors involved);
- the population covered (i.e. per capita);
- the volume of bed days;
- the volume and mix of cases.

In practice, there are no pure payment methods. Hospitals are usually paid on the basis of a combination of some of the above. For example, individual fees for services are usually combined with a daily charge to cover basic services, such as nursing, food and overheads. In most payment methods there is a budget component to fund investment. Similarly, most systems can be supplemented by bonus payments as an incentive to providers to achieve certain objectives.

For each of the following areas discuss in detail how each type of service is funded (and cross-reference to the relevant part of Chapter 6):

- public health services
- primary/ambulatory care
- specialized ambulatory/inpatient care
- pharmaceutical care.

The following areas may also be included, depending on the level of data available:

- rehabilitation/intermediate care;
- long-term care;
- palliative care;
- mental health care;
- dental care;
- alternative/complementary medicine;
- health care for specific populations (e.g. prisoners, military personnel, illegal immigrants and asylum seekers. *Note:* if these groups are treated within the main health system then they should not be discussed here).

Are any specific services (e.g. medical or nonmedical services) outsourced? For example, diagnostic services provided by the private sector but paid out of the public budget, or catering services of hospitals outsourced to private companies.

Discuss whether there have been any recent changes in the methods used to pay providers. Indicate any problems or issues that triggered the changes. (Cross-reference to Chapter 7 “Principal health care reforms”, if appropriate.) If any new payment mechanisms have been introduced:

- how are rates decided and how often?
- how widespread has their use been to date?
- have there been any problems/difficulties with implementation?
- are there any reforms being planned?
- are there any differences in the way services provided to public/private patients are funded?
- are there differences in the way services provided by public/private providers are funded?

- comment on methods of deciding rates/prices (e.g. negotiation, rate regulation, payer dictation); what is the extent of government regulation in this process?
- do payment methods provide incentives to deliver any particular type of care (e.g. preventive or diagnostic services or institutional or community-based services)?
- in systems where doctors hold budgets, what financial incentives, if any, are provided to encourage specific patterns of treatment or prescription?
- what arrangements are in place to reimburse providers to treat foreigners/citizens who seek health care abroad?

3.6.2 Paying health care personnel

Health care personnel may be paid in the following ways:

- fee-for-service (officially from the third-party purchasers, officially from patients as co-payments, and unofficially as informal payments);
- salary;
- capitation;
- blended systems.

Some health care personnel may also generate income through extra billing.

How are different categories of health care professionals paid and who sets their fees? Consider the following groupings.

- Public health professionals: distinguish between specialists in public health (trained as doctors) and other public health professionals, but note whether a medical degree is needed to hold a senior public health position; exclude primary care physicians who may perform public health duties.
- Doctors: (a) primary care/ambulatory care doctors: distinguish between general medical practitioners and specialists in ambulatory settings and primary health care; (b) hospital-based doctors: distinguish between different medical specialties; (c) academic doctors (doctors engaged in teaching and research rather than clinical work).
- Nurses and midwives: distinguish between levels of nursing, including nursing assistants, and discuss relevant nursing specialties (e.g. psychiatric nursing, community nursing).
- Dentists and dental auxiliaries: distinguish between dental practitioners (primary care), specialist dentists (working in hospitals) and dental

auxiliaries; where fee-for-service is used, consider whether there is any evidence of supplier-induced demand leading to the provision of additional, inappropriate treatment.

- Other health care workers.
- Pharmacists: distinguish between hospital and community pharmacists.
- Professionals allied to medicine: physiotherapists, other therapists, clinicians and scientists who work in the health system.
- Complementary and alternative medicine practitioners: those involved in acupuncture, chiropractic, osteopathy, herbal medicine.
- Managerial staff.
- Social workers or care workers.

For each group consider:

- the incentives structures associated with the method of payment. Describe any additional financial or non-financial incentives provided (e.g. target payments for immunization and screening programmes or to undertake minor surgical and other procedures which would typically be performed within a secondary care setting);
- the problems associated with the present methods of payment (e.g. lack of regard for cost-effectiveness, low quality of services, low professional satisfaction, morale);
- how rates and methods of payment are determined (e.g. bilateral negotiation, rate regulation, payer dictation, etc.), and who takes part in negotiations. Also describe the extent of government regulation in this process and the mechanism for negotiating fees for publicly funded services purchased from the private sector;
- how terms and conditions are negotiated for different groups of professionals. Has there been industrial action by any group? If so, what were the reasons for this and how was the situation resolved?
- how the average income of health care professionals compares to that of other equivalent professionals/the average national income;
- whether any financial or non-financial incentives exist for health care professionals in secondary care institutions to attain specific objectives (e.g. increase activity, influence prescribing patterns, improve quality and health outcomes).

Chapter 4

Regulation and planning



This chapter deals with the process of policy development, establishing goals and priorities, and translating them into action, i.e. the provision of health care services.

Often the boundaries between planning and regulation functions, and between planning and management functions, are not clear-cut. Also the nature, characteristics and relative significance of these functions will differ among countries.

In particular, these functions will vary depending on the nature (public, quasi-public or private) of the providers and their organizational relationship with the third-party payers (e.g. national health service, sickness funds). Please state clearly if this is the case or not in the various sections that follow.

The content and organization of this chapter will need to be particularly tailored to the specific organizational characteristics of each health system.

The discussion on planning, management and regulation should refer back to the organizational chart provided in Section 2.1 “Overview of the health system”.

4.1 Regulation

This section deals with questions about relationships between institutional actors with specific emphasis on their role in regulation and what aspects are subject to regulation. The section also explains basic characteristics of

regulation methods, while more detailed information (e.g. on the purchasing process) is given in the sections on resources or provision.

Consider to what extent the Government plays a regulatory role at national, regional, district levels. Describe the specific organizations at each of these levels that carry out a regulatory function (e.g. Ministry of Finance, Ministry of Health, Parliament) and their organizational arrangements. Indicate main bodies at other organizational levels and their specific roles.

The different regulatory functions can be summarized in two tables (4.1 and 4.2) at the end of this section.

Is there a national health plan for either health or health services? Has a “health-for-all” policy or another “health targets” programme been developed? Has it led to a national policy statement by the Government? If not, describe any actions that are being taken towards developing one.

There are three principal models of the organizational relationship between purchasers and providers: integrated, contract, and direct payment to providers (see Section 3.5 “Purchasing and purchaser–provider relations”). The model used will usually also determine the regulatory framework. It refers to a complex network of relationships among several actors with purchasing being an important function, but not the only one.

4.1.1 Regulation and governance of third-party payers

See the Glossary (on pages 115–124) for a definition of third-party payers. (Cross-reference to Chapter 3 “Financing”, if appropriate.)

Organization: What organizations have the responsibility for purchasing health services (e.g. sickness funds, district/regional/national government agencies, private insurance companies, other private organizations, primary care organizations)? How many separate organizations are there within each category (e.g. in social insurance systems, how many individual sickness funds)?

Outline briefly the ownership, governance and management arrangements that apply to these organizations. Indicate whether these are public sector, private not-for-profit and/or private for-profit organizations.

- Have there been changes in the number of funds and/or the size of funds in recent years? If so describe the pattern and the reasons for it (e.g. mergers or bankruptcies).
- Are these public bodies, quasi-public bodies or private (for-profit or not-for-profit) bodies?

- How are they governed? Bipartite representation of employers and employees or tripartite with government representation?
- Is there a single scheme or are there several schemes?
- How is voluntary (or private) health insurance organized? (See the Glossary on pages 115–124 for a definition of VHI) Is it offered by public, quasi-public or private (for-profit, not-for-profit) bodies? Who provides VHI (e.g. for-profit, not-for-profit, mutuals)? (Cross-reference to Section 3.3.2 “Voluntary health insurance”.)
- How many companies are there in the market? How competitive is the market (e.g. market share, etc.)?

Finances for purchasers: How do purchasing organizations receive their budgets and on what basis (e.g. allocations from a central sickness fund on a capitation basis, direct premium payments from insurees, capitation payments)? Does this differ from operational costs of the system and capital responsibilities? (Cross-reference to Section 3.4 “Pooling of funds”.)

Does the Government undertake risk pooling or revenue sharing between purchasers? What are the risk-pooling arrangements? Is there any redistribution (risk-adjustment) formula between different pools?

To what extent does the Government play a regulatory role **in relation to purchasers** at national, regional, district levels (that is, does the Government steer policy through setting strategic direction and regulation?)?

Describe the specific organizations at each of these levels that carry out a regulatory function (e.g. Ministry of Finance, Ministry of Health, Parliament) and their organizational arrangements.

- Who defines the package of services to be purchased by the purchasing organization?
- Do purchasing organizations reflect public health priorities in their purchasing plans, how and at what level (e.g. community health priorities, national health priorities)?
- To what extent are purchaser organizations decentralized and regulated by the local/regional/national government?
- Please explain how this regulation takes place. To what extent are the purchasing organizations integrated with higher-level agencies?
- How do the higher-level agencies control the purchaser organizations? How are purchaser organizations held accountable by the local/regional/national government for their purchasing decisions (e.g. annual reports, audits)?

On what criteria are they held accountable (e.g. costs, volume of services purchased, quality of services purchased)?

- Does this apply equally to private insurers? If not, how does it differ?
- What are the regulatory arrangements in place to tackle cross-border health care purchasing and provision?

4.1.2 Regulation and governance of providers

(Cross-reference to Chapter 6 “Provision of services”, if appropriate.)

Organization: In brief, what kinds of organizations have the responsibility for providing health services (e.g. public agencies, office-based physicians, hospitals? Details will be covered in each case in Chapter 6 “Provision of services”).

Outline briefly the ownership, governance and management arrangements that apply. Please indicate whether these are public sector (both hierarchical as well as autonomous organizations), private not-for-profit and/or private for-profit organizations.

Have there been deliberate attempts at national or subnational level to change this (e.g. by transforming hospitals previously integrated in a “command-and-control”-type health system into autonomous organizations)? If yes, which decision-making powers do such organizations have over capital, staff (numbers, payment), types of services offered, prices charged, etc.?

To what extent does the Government play a regulatory role **in relation to providers** at national, regional, district levels (that is, does the Government steer policy through setting strategic direction, regulation, standards, guidelines)?

Describe the specific organizations at each of these levels that carry out a regulatory function (e.g. Ministry of Finance, Ministry of Health, Parliament) and their organizational arrangements.

- What kinds of licensing/accreditation/registration mechanisms are in place? (Cross-reference to Section 5.2.4 “Registration/licensing”).
- Describe statutory mechanisms that are in place to ensure that professional staff or provider organizations achieve minimum standards of competence (e.g. training, registration, certification and revalidation); also, describe function-specific inspectorates for public health and safety. Are the respective regulations, standards, assessments and results accessible to the public?

Mechanisms include:

- licensing of (public and/or private) health care facilities;
- licensing of doctors, dentists, nurses and allied practitioners;
- periodic relicensing of facilities/practitioners;
- licensing of medical equipment and drugs;
- certification of safety (radiation, fire, environmental and occupational hazards);
- voluntary external quality assessment and improvement programmes that are recognized by and consistent with statutory investigation and inspection. Do their standards, assessment processes and operations comply with international criteria (e.g. systematic, confidential national enquiries into the occurrence of adverse events and outcomes in health care)?

How are these policies monitored? Are these controls effective? What penalties are available to regulatory bodies (e.g. fines)? Have any therapies been subject to evaluation?

Who is responsible for them? Are providers held accountable by the local/regional/national government for their quality of care and, if yes, how is this done (e.g. annual reports, audits, publication of “league tables”)? What role, if any, do standards and guidelines play? Who is responsible for their design, implementation and evaluation?

Quality. To what extent are mechanisms in place to ensure and monitor the quality of care provided? Are medical errors reported to the public? How is the safety of the blood supply ensured and monitored? Is there any national legislation for medical negligence? (Where relevant, cross-reference to Section 2.5.5 “Patient safety and compensation”.)

Regarding quality of training of health care professionals, consider the following questions.

- What continuing professional development (CPD) is required for health professionals?
- Are there any incentives/opportunities for professional development available to health care personnel?
- Are there differences in the level of quality monitoring of medical staff in quasi-public, private for-profit and private not-for-profit institutions?

(Cross-reference to Section 5.2.3 “Training of health care personnel”.)

Are there plans to develop/accommodate European centres of reference?

4.1.3 Regulation and governance of the purchasing process

(Cross-reference to Section 3.5 “Purchasing and purchaser–provider relations”, if appropriate.)

Describe and discuss the organizational relationship between third-party payers and providers. What are the main mechanisms that purchaser organizations deploy for influencing providers (e.g. contracting or other arrangements)?

If contracting is used, what are the main types of contract agreed between purchaser organizations and provider organizations? Does contracting equally apply to public and private providers? If not, how does it differ? Do purchasers contract selectively with individual provider organizations (in theory and in practice)? Do purchasers have different contracts with providers? Is there competition between provider organizations for contracts from purchasers?

Describe the process through which purchasers and providers interact (e.g. if contracts are used, how they are developed and put into place and how purchaser organizations monitor these contracts). What happens in the case in which the provider organization deviates from the agreed contract or performance agreement (in theory and in practice)? How are deviations from contracts dealt with?

Please provide examples and any data/evidence available that you consider relevant.

Summary of section

To summarize the different regulatory functions in the health system, you may wish to consider to what extent regulatory functions are centralized (e.g. at Ministry of Health, Ministry of Finance level) or decentralized (e.g. to regulatory agencies, health authorities or private organizations). An example from England is provided below (Table 4.1). Definitions of the different types of decentralization can be found in the Glossary (on pages 115–124). In addition, you may want to incorporate the framework adapted from Baldwin and Cave (1999) on regulatory instruments and examples of health care regulations (Table 4.2).

4.1.4 Regulating quality of care

The aim of this section is to give readers some idea of overall attempts to ensure that the health system operates in a way that ensures high-quality care. For instance, are there any national or regional programmes to improve quality? How are quality programmes monitored? Are there any targets to improve quality?

Table 4.1 Decentralization of functions and regulatory institutions (in England)

Function	Type of decentralization	Regulatory institution
Standard setting	Centralization	Department of Health
	Delegation	National Institute for Clinical Excellence
Monitoring	Delegation	Healthcare Commission, National Clinical Assessment Authority, National Patient Safety Agency
	Deconcentration	Strategic health authorities, NHS trusts
	Devolution	Local government overview and scrutiny committees
Enforcement	Privatization	General Medical Council
	Delegation	Healthcare Commission
	Deconcentration	NHS trusts

Sources: Adapted from Baldwin and Cave, 1999; and European Observatory on Health Systems and Policies *Health Systems in Transition: The United Kingdom* (2007)

Comment on the quality of services and facilities. Please include, if available, indications from official quality assurance reports.

What incentives are available to providers to improve the quality of services (financial, non-financial)?

What incentives are available to providers for customer-oriented structures and attitudes/behaviours (opening hours, waiting times, barriers to access)? Are any incentives provided to non-contracted doctors?

How is national patient safety monitored? Provide any details on relevant information systems. Has there been any litigation?

4.2 Planning and health information management

This section deals with the approach to planning in the health system and describes how information is used. More detailed information on the subject of planning (e.g. physical resources) should be given in the following section.

Describe the current approach to planning. Consider the following points.

Table 4.2 *Regulatory instruments and examples of health care regulations*

Regulatory instrument	Examples of health care regulations
Legislation/command and control	Laws to sanction providers not meeting minimum standards Planning controls on location of facilities Duty to treat
Self-regulation and enforced self-regulation	Professional codes of practice Voluntary hospital accreditation schemes
Incentives	Extra pay to locate in underserved area Public subsidies for new market entrants Controls on borrowing rights and disposal of assets Subsidize teaching and research functions, unprofitable intensive care/emergency facilities
Market harnessing	Contracting for clinical and non-clinical services Franchising management of public hospitals to private sector Action to prevent price fixing, collusion, mergers and acquisitions, geographical monopolies
Disclosure	Mandatory reporting of quality information Quality guidelines for reference Public disclosure of price lists, qualifications, insurance status League tables of performance
Direct action	Public ownership of facilities in areas with access problems
Rights and liabilities	Patients' rights, litigation, criminal damages
Public compensation	No-fault compensation for medical negligence Compulsory health insurance for employers

Source: Adapted from Baldwin and Cave, 1999

- Is there a national health planning agency either for health or health services? If so, what has the output been (e.g. is there a national health plan for either health or health services)?
- Give a brief account of the approach to infrastructure/capital planning (e.g. number and type of facilities, beds, and norm-based versus epidemiology/demographic needs-based) and human resources planning (e.g. number of doctors, nurses). (Cross-reference to Section 5.2.2 “Planning of health care personnel”.) Comment on the implications of cross-border mobility (cross-reference to Section 5.2 “Human resources”).
- Are there health plans at other levels (regional, district, local government, insurance funds, etc.) and, if so, how do they relate to the national plan, if at all?
- Describe the process of policy development/priority setting by different tiers in the system (e.g. local government, health authorities, individual sickness funds).

Is there any evidence regarding the effectiveness of the planning system in implementing change? Please give examples of successful policies or failures. Evaluation criteria should be based on whether the stated goals have been met (these goals may not be the most appropriate, but a limited perspective needs to be taken).

What is the prevailing thinking on the future development of planning for health and health care?

- In *integrated systems*, in which health care providers are directly employed (or “owned”) by the third party, health care providers are managerially accountable to a series of governing bodies.

What are the bodies responsible for management of primary health care, public health, secondary and tertiary providers at different levels of the health system (national, regional and local)? How do these management bodies relate to the planning function?

- In *contract-based systems*, in which there is a separation between purchaser and provider functions, providers are “managed” through contracts by third-party payers or purchasers and through regulation by statutory (governmental or nongovernmental) bodies.

What is the planning role of third-party payers/purchasers? How are purchasing decisions made? How are priorities identified and how are they translated into purchasing strategies, if at all?

The nature of the contracting process is explored in Section 3.5 “Purchasing and purchaser–provider relations”. This section focuses on the purchasing function.

What arrangements are in place to assess any spare capacities to be shared across borders? Is planning of facilities and capacities negatively affected by cross-border health staff/patient mobility? (Cross-reference to Section 5.2.2 “Planning of health care personnel”.)

4.2.1 Health technology assessment

Please describe the system for HTA (see the Glossary on pages 115–124 for definition of HTA), if existing, other than formal regulatory procedures described in Section 4.1 “Regulation”. Does anyone else evaluate health technologies in order to inform the policy process? Provide a brief description of these organizations, in particular stating their formal status – for instance, are they governmental agencies, are they university-based groups or other independent groups? Do national or regional agencies exist?

(Cross-reference to Section 6.6 “Pharmaceutical care”, if appropriate.)

Briefly describe the principal activities of these HTA organizations and the methods they use (Drummond, 2006).

- What priority-setting mechanisms do they use to select topics for evaluation?
- What types of technologies are evaluated?
- Do HTA organizations evaluate existing as well as new technologies?
- What role do stakeholders play in the selection and assessment process (stakeholders can include manufacturers, professional organizations, health authorities, academic groups and patient organizations)?
- Is there a critical mass of skilled personnel?
- Are there efforts to improve the transparency of decision-makers?
- What methods of evaluation are used? For instance, do they concentrate on systematic reviews and meta-analysis of existing information, modelling studies, involvement in individual trials and/or other types of study?
- Do they undertake economic evaluation as standard in their evaluations? If so, what economic guidelines are used?
- What methods of dissemination do they use for their findings?
- Do they undertake organizational analysis in HTA (i.e. how does HTA work in specific organizations)?

Give an indication briefly of the number of evaluations undertaken in the last five years and the proportion of evaluations which examine pharmaceuticals, medical devices and technologies, or other types of intervention.

How are the findings of HTA groups linked to the policy-making process? What formal links are there? Are the results of HTA part of a formal regulatory process to determine reimbursement, formulary listing or approval for use within health systems? (See also Section 3.2 “Population coverage and basis for entitlement”.) Is there any appeal process against initial decisions?

Are there measures to steer the appropriate usage of technologies (e.g. financial incentives, utilization review, professional audit, controls on deployment of new devices or drugs)? Comment using examples, if possible, on the effectiveness of these measures.

At what level is HTA undertaken (local/organizational, regional, national)? If possible, note the distribution of HTA activities across the levels.

If no HTA agencies exist in your country, are any evaluations produced in other countries taken into account systematically when considering access to technologies? For example, are there any donor agencies that produce evaluation studies related to health services? To what extent are these studies used for decision-making purposes? (Cross-reference to Section 3.2 “Population coverage and basis for entitlement”.)

What mechanisms are in place for sharing evaluations across borders? Are there international links in place?

4.2.2 Information systems

This section should discuss the use of information for the purposes of management and include information on: health services activity; service, such as waiting times, patient satisfaction; and quality, such as health status/health outcomes or adverse effects/errors. (Cross-reference to Section 5.1.4 “Information technology”.)

- Are there information systems in place for the collection, reporting and analysis of data on activity, service and quality? Who collects data? How is information disseminated? Who has access to data? Are there linkages between data collection and financing?
- What requirements are there for providers to report data? Are providers in both the public and private sectors subject to the same requirements? These might include communicable diseases, adverse events or routine morbidity data.

- What legislation is in place to govern freedom of information? What implications does this have for the rights of patients and professionals to access and share information? (Cross-reference to Section 2.5.1 “Patient information”, if appropriate.)

4.2.3 Research and development

If appropriate, describe what type of health-related research is funded by governmental agencies, including those responsible for health. Are there specific research programmes? What are the main research priorities? How is the production of research knowledge utilized, if at all, by decision-makers?

What mechanisms are in place for sharing evaluations across borders?

Chapter 5

Physical and human resources

This chapter addresses the planning and distribution of physical resources, including hospitals, health care facilities and medical devices. It then deals with the human resource input into the health system, focusing on planning, training, licensing and career paths.

5.1 Physical resources

5.1.1 Infrastructure

This subsection deals with two main issues: the planning and distribution of infrastructure and the capital investments needed.

Planning and distribution of infrastructure

- Who is responsible for licensing hospitals and health care facilities and major medical technologies (in both public and private sectors)? (Cross-reference to Chapter 4 “Regulation and planning”.)
- Give data on the numbers of beds in acute hospitals, psychiatric hospitals and long-term care institutions per 1000 population over time and comment on whether any changes have been the result of explicit political decisions (Figure 5.1).
- Give data on typical operating indicators (average length of stay, hospital utilization rates, percentage of day cases).
- Compare the trends for acute care hospitals (and other institutions) to other countries (Figure 5.2).

Figure 5.1 *Mix between beds in acute care hospitals, psychiatric hospitals and long-term institutions in country, 1990 to latest available year*

Please indicate the percentage of day care versus inpatient care.

Figure 5.2 *Beds in acute hospitals per 1000 population in country and selected countries, 1990 to latest available year*

Figure to be inserted by Observatory staff.

5.1.2 Capital stock and investments

Current capital stock

Briefly describe the current capital stock (e.g. the number, location, size and age of hospitals).

Also describe the condition of facilities. Are any estate condition surveys available at various levels of care (primary, secondary, tertiary, intermediate, social care, etc.)? Do surveys or other information distinguish between physical condition, functional suitability, space utilization, energy efficiency, and fire and safety compliance? Are appraisals of condition and other indicators of estate performance undertaken at all or on a regular basis? How do they contribute to planning future strategies and investment? Is there typically a backlog maintenance problem and if so, to what extent, why and how does this contribute to capital investment decisions?

Note: This subsection focuses on buildings, and not equipment, but the latter is becoming increasingly important (e.g. major medical equipment inventories) (cross-reference to Section 5.1.3 “Medical equipment, devices and aids”).

Investment funding

How are capital investments funded? It is useful to distinguish here more explicitly capital investment funding from the ongoing funding of costs of capital/life-cycle/maintenance. Is this separated from reimbursement for service delivery (“dual” financing – for instance, because of direct transfers from Government) or does it have to be covered through the reimbursement for service delivery? If the latter, what allowance is made for depreciation, the cost of capital, etc.? If money is borrowed, is it through public allocations and/or borrowing, through private borrowing or both – and in what circumstances? If through allocations of public funds, on what criteria are investment resources allocated? Are there public–private partnerships for investment in capital facilities, and if so, of what nature? Is investment funded through donation and/or through sale/disposal of assets?

Capital investment controls

What controls are there on capital investment? At what level of government? Do these controls cover the public and private sectors? Are there any systems to ensure equitable geographical distribution of capital? Are there procedures for central/local “approval” for capital investment and, if so, what do these involve and who makes the approval decisions? Is capital investment used to deliver/trigger strategic and service delivery change/improvement, and if so, how?

What, if any, differences exist among capital investment in hospitals, primary care facilities, intermediate care, social, long-term, palliative and mental care facilities? Are there national standards for health infrastructure (e.g. building and nonmedical equipment)?

What issues (pros and cons) are raised by all this? Are capital revenue decisions made rationally/explicitly? Are capital versus labour decisions made rationally/explicitly?

What are the implications of sharing spare capacities across borders? What are the mechanisms put in place to develop European centres of reference? (Cross-reference to relevant sections in the regulation and planning, as well as the delivery chapters.)

5.1.3 Medical equipment, devices and aids

What is the process of purchasing/procuring medical aids and devices? (Cross-reference to Section 4.2.1 “Health technology assessment”, if appropriate.) Describe briefly the supply chain.

- How are major pieces of medical technologies for diagnostic imaging, clinical laboratory services and therapeutic interventions funded? Are there differences between ambulatory and inpatient care?
- What controls are there on the acquisition of “big-ticket technologies” (e.g. MRIs, CT scans, PET)? At what level of government? Do these controls cover both the public and private sector? Are there any systems in place to ensure equitable geographical distribution of equipment?
- Is there any regulation of technologies in the private sector?
- Compare the availability/distribution of big ticket technologies in primary care/ambulatory care and secondary care.
- Give data on the numbers per 1000 population of different items of equipment and comment on how these compare to other countries, if possible.

Table 5.1 *Items of functioning diagnostic imaging technologies (MRI units, CT scanners, PET) per 1000 population, latest available year*

Item	Per 1 000 population	% utilization
MRI units		
CT scanners		
PET		

- Is basic equipment available in sufficient quality and quantity in any health care delivery setting (geographic and level)?

5.1.4 Information technology

The general context in which information technology (IT) systems operate within a country is important. Access to the Internet will influence how IT can be used within the health system. It would be helpful to provide some background information on this, in particular providing data (where available) from any official statistics (e.g. National Census data) or surveys which report on:

- the number and proportion of households who have access to the Internet (at home, school, work?);
- the proportion of population who have never used the Internet.

Within the health system:

- What is the current level of IT use (define) in primary care/secondary care/ the health system in general?
- To what extent are computers integrated into primary care? If possible, give proportion of primary care settings with computers. Are there any available data on the number of GPs making use of IT?
- Is information kept at the institutional level or in a centralized database?
- What plans are there for the development and use of IT systems within the health system? Is there a national IT strategy for the health sector? Is there a strategy for using modern IT for health purposes (e.g. surveillance, referrals, telemedicine, prescriptions, billing)?
- What is the process of purchasing/procuring IT systems? Describe briefly how compatible and well coordinated IT systems in the health sector are.
- Is there already or are there plans for the introduction of electronic medical records or electronic health cards?

- Are there any electronic hospital (or other health care facility) appointment booking systems in place? If not, are there any plans for introducing them?
- Is any information available on the number of people accessing the Internet for health information? If so, briefly report on this.
- Are health staff well informed about the conditions under which they can seek work abroad?

(Cross-reference to Section 4.2.2 “Information systems”, Section 2.5.1 “Patient information”, as well as the relevant delivery chapters, if appropriate.)

5.2 Human resources

This section should describe the human resource input into the health system. Discuss the numbers of health professionals and their training. (*Note:* How professionals are remunerated should not be discussed in this section (see Section 3.6.2 “Paying health care personnel”).)

The following health care personnel should be discussed.

- Public health professionals: distinguish between specialists in public health (trained as doctors) and other public health professionals (exclude primary care physicians who may perform public health duties).
- Doctors: primary care/ambulatory care doctors (distinguish between general medical practitioners and specialists in ambulatory settings); hospital-based doctors (distinguish between different medical specialties); academic doctors.
- Nurses and midwives: distinguish between the levels of nursing, including nursing assistants, and discuss nursing specialties available (e.g. psychiatric nursing, community nursing).
- Dentists and dental auxiliaries: distinguish between dental practitioners (primary care), specialist dentists (working in hospitals) and dental auxiliaries.
- Pharmacists: distinguish between hospital and community pharmacists.
- Professionals allied to medicine: discuss other therapists, clinicians and scientists who work in the health system.
- Complementary and alternative medical practitioners: discuss therapies that are outside of orthodox medicine (e.g. acupuncture, chiropractic, osteopathy, herbal medicine).

- Managerial staff: discuss senior management and administrative posts within the health system.
- Other particular roles/health care workers.
- Medical technicians (radiology, laboratory, pathology, etc.).
- Social workers or care workers.
- Outreach workers.

For each type of health care profession or professional groups (e.g. health care providers, managerial staff, allied professionals) discuss the following:

- trends
- planning
- training
- registration.

Table 5.2 *Health care personnel in country per 1000 population, 1990 to latest available year*

Figure 5.3 *Number of physicians per 1000 population in country and selected countries, 1990 to latest available year*

Figure to be inserted by Observatory staff.

Figure 5.4 *Number of nurses per 1000 population in country and selected countries, 1990 to latest available year*

Figure to be inserted by Observatory staff.

Figure 5.5 *Number of physicians and nurses per 1000 population in the WHO European Region, latest available year*

Figure to be inserted by Observatory staff.

Figure 5.6 *Number of dentists per 1000 population in country and selected countries, latest available year*

Figure to be inserted by Observatory staff.

5.2.1 Trends in health care personnel

- Give data on the numbers of full-time equivalent staff. Have numbers of health care personnel shown a declining/increasing trend in recent years? Is there any evidence of significant geographical inequalities in the distribution of personnel?
- Give data on the numbers of doctors and nurses trained in other countries (e.g. in the EU/outside of the EU).
- Compare the trends in the numbers of doctors and nurses with those of other countries.

5.2.2 Planning of health care personnel

Are there particular shortages/oversupply in any professional groups or specialties?

Describe the mechanisms (if any) for planning workforce numbers (e.g. *numerus clausus* for medical specialties, restricted lists by insurance funds).

Are there limits on the number of training places available (for basic training/for specialist training/for clinical placement.)

Is professional mobility an issue for your country? Are you recruiting staff from abroad/are you losing staff to foreign countries?

5.2.3 Training of health care personnel

- What basic training must health care professionals complete? How many years of training? Where are these courses taught (type of educational institution – public/private, university/college/school – and number and location of institutions)?
- What requirements are there for specialization and further training? How many years of further training? Where are these courses taught (type of educational institution – public/private, university/college/school – and number and location of institutions)?
- What requirements are there to complete practical clinical experience before qualification?
- What CPD is required for health professionals? Who is responsible for CPD?
- Who sets educational standards?

- Are there differences in the training of medical staff being trained in or working in quasi-public, private for-profit and private not-for-profit institutions?

5.2.4 Registration/licensing

Who registers qualified practitioners? Is this body voluntary or statutory – that is, are its powers defined in law? Is there a system of re-accreditation or revalidation of qualifications to ensure medical competency (periodic relicensing)? If so, by which body? How often?

(Please cross-reference to Section 4.1.2 “Regulation and governance of providers”.)

Have there been any policies to change the mix of health care professionals in the health system to adapt to the needs of the population?

Does the training of health professionals conform with EU standards for mutual recognition? How has/will the free movement of professionals impact on training and numbers?

What major problems have emerged in connection with the training, management and quality of health care personnel? Consider the following examples: excessive numbers of specialized physicians; medical unemployment; lack of managerial skills; low educational attainment; low status of health care profession; low productivity of health care personnel.

What policies, if any, have been instituted towards health care personnel in recent years? Are there any plans for policy changes, such as:

- attempts to reduce or increase numbers of practising health care professionals? If so, how (e.g. through reductions/increases in numbers of medical students)?
- efforts to upgrade existing or establish new educational/training facilities for health care personnel? If so, in what areas – general practice, nursing, management, public health?
- retraining of existing specialists to work in other specialties (e.g. specialists to work in general practice or in public health)?

Discuss the relative importance of the different health care professionals. What is the relative public and professional standing of different professional groups in the health system? How can this be explained?

5.2.5 Doctors' career paths

Please describe the career paths of doctors, in both hospital and ambulatory settings.

Consider the following questions.

- How is the promotion of doctors to different grades within hospitals organized?
- Is it influenced by the directors of the clinic or department?
- Is the decision local (within the hospital) or national?
- Is hospital management involved in clinical staff promotions?
- Is there much movement of doctors across different hospitals, different clinics or departments within hospitals, or different health care facilities?
- Are medical doctors leaving the sector in any significant numbers owing to unattractive working conditions?

5.2.6 Other health staff career paths

Please describe the career paths of health staff other than medical doctors (e.g. nurses, technicians, managers). What mechanisms for career development are in place?

Are health staff leaving the sector in any significant numbers owing to unattractive working conditions or the like?

5.2.7 Pharmacists

Comment on the number of pharmacies and pharmacists in your country.

Who is entitled to own a pharmacy? Is this restricted to pharmacists?

Does a *numerus clausus* apply on the number of pharmacies for the country/regions?

Figure 5.7 *Number of pharmacists in country and selected countries, latest available year*

Figure to be inserted by Observatory staff.

Chapter 6

Provision of services

This chapter concentrates on patient flows, organization and delivery of services.

(Note: As with the template as a whole, some subsections within this section may vary depending on the country and not all may be applicable.)

Key areas

For each of the main areas of service provision (Sections 6.1–6.14), briefly comment on the following key aspects in the organization and delivery of different sectors of care.

- The method of service provision under the statutory system (where applicable): are these integrated directly within the mainstream health system, or are they contracted out?
- The public–private ownership mix of facilities: public, quasi-public, private for-profit and private not-for-profit.
- Availability and accessibility of services.
- Adequacy and quality of services.

Also discuss any major changes that may have occurred in recent years, problems experienced and challenges faced and any reform plans for continued development of these services.

(Cross-reference with Section 1.4 “Health status” and other sections of the report as appropriate.)

6.1 Public health

Public health is the science and art of promoting health, preventing disease and prolonging life through the organized efforts of society. Public health is a social and political concept aimed at improving health, prolonging life and improving the quality of life among whole populations through health promotion, disease prevention and other forms of health intervention.

What are the organizational forms and personnel (and their training and qualifications) primarily concerned with the protection and promotion of the public's health? Consider the following questions.

- How are environmental and communicable disease control functions carried out? How are responsibilities divided between national and local levels? What agencies and staff are involved? By whom are the regulations enforced?
- What means are there for notification and surveillance of disease outbreaks?
- Are there established programmes of health promotion and education? Who is responsible for executing these? Is there a national body responsible for health promotion and education? What types of initiatives are undertaken?
- Are there any major for-profit or not-for-profit organizations involved in health promotion and education services?
- How are preventive services organized? Consider immunization services (in particular, what are the obligatory immunizations that the population is expected to have?), family planning, antenatal services. Who is responsible for providing these services? Who is responsible for financing them?
- How are occupational health services organized? Do they include first aid, preventive, curative, rehabilitative services? Which type of providers deliver occupational health services? How are they financed? Are they based on company premises, at single surgeries, in public health offices?
- Screening programmes/opportunistic screening. Are there any national screening programmes for the whole or segments of the population (e.g. screening for breast and cervical cancer).¹⁰ How are these screening programmes financed? Are there any recommended screening programmes for high-risk populations? What are the mechanisms, if any, for evaluating or identifying effective screening programmes? Do any methods exist for monitoring screening programmes in terms of their clinical quality?

¹⁰ Screening programmes are those where there is an organized programme, based on a population register, invitations to participate, and integrated quality control and follow-up. Where a programme is absent, there may be opportunistic screening (e.g. where someone attending a doctor for something else is offered a cervical smear or mammogram).

- Have there been any initiatives to identify and tackle inequalities in health? If so, which organizations are responsible for implementing these initiatives? In particular, are there any programmes to reduce the impact of poverty on health? How are health hazards, other than poverty, identified and remedied (e.g. industrial hazards, housing, water supply)?
- Have any national or subnational targets been set, which include the aim to reduce inequalities in health (e.g. targets for reducing pre-school mortality rates, coronary mortality rates)? Is there evidence of success/failure?
- Has there been any investment in any initiatives outside the health care sector intended to promote public health (e.g. traffic safety, food safety, social housing interventions, social work, initiatives to tackle poverty, school-based interventions)? If so, who is responsible for these programmes and initiatives? What main developments, if any, have taken place in recent years with respect to the above?
- Discuss the main problems or challenges faced regarding the above topics.
- What reform plans, if any, are there at present regarding the future development of public health services? (Cross-reference to Chapter 7 “Principal health care reforms”, if appropriate.)

(Refer to Section 1.4 “Health status” and relevant figures or tables on immunization levels.)

6.2 Patient pathways

It may be helpful to insert a typical patient pathway or patient flow diagram at the start of this section. (See example in Box 5 from Dixon and Mossialos 2002).

Do such pathways differ significantly across the country?

6.3 Primary/ambulatory care

Here, “primary health care” refers to the first point of contact of the health system with the individual patient and includes general medical care for common conditions and injuries. Health promotion and disease prevention activities, also part of primary health care, are described under public health services (Section 6.1 “Public health”).

(*Note:* If secondary care specialists are mainly organized around a private-practice model (rather than in hospital), they may be included here under “ambulatory care”.)

Box 5 An example of a patient pathway

In Denmark, a woman in need of a hip replacement due to arthritis would take the following steps.

- During a free visit to the GP with whom she is registered, the GP refers her to a hospital orthopaedic department.
- She has free access to any public hospital in Denmark and her GP advises her which hospital to go to on the basis of information about waiting times (available on the Ministry of Health's web site), quality, her special needs, etc.
- If she does not want to wait at all, she can choose to go to a private hospital (although the number of private beds in Denmark is limited). She must pay for treatment in a private hospital either directly or through VHI. Currently, only a handful of patients would choose this option.
- Her GP prescribes any necessary medication.
- After referral the patient may have to wait for three months or more for an outpatient hospital appointment for examination by a specialist.
- After this she will have to wait for inpatient admission and surgery.
- Following surgery and primary rehabilitation at the hospital, the patient goes home, where she might need home care (home nurse and/or home assistance); if this is prescribed by the hospital or her GP, it will be provided by the municipality free of charge.
- The GP receives a discharge summary from the hospital and is responsible for further follow-up such as referral to a physiotherapist (to whom the patient will have to pay a small co-payment).
- A follow-up hospital visit is likely to take place to check the treatment's outcome.

How are primary health care services organized? Describe the model of provision of primary health care services, including settings, nature of providers and functions. Consider the following points.

- Settings and models of provision: independent/single-handed practices, group practice, health centre, medical laboratories, hospitals.
- Are primary health care providers directly employed or contracted?
- Public–private ownership mix.

- Give a brief indication of the roles and functions of each category of health care personnel.
- Provide an indication of the range of services available in ambulatory care. Consider the following categories: general medical care (including the adult population and older people), diagnostic services, care of children, minor surgery, rehabilitation, family planning, obstetric care, perinatal care, first aid, dispensing of pharmaceutical prescriptions, certification, 24-hour availability, home visits, ambulance services and patient transport, nursing care for acute and chronically ill, palliative care, specific services for the mentally ill, preventive services (e.g. immunization, screening), health promotion services (e.g. health education).

Is there freedom of choice of primary health care physicians (e.g. GPs or specialists)? Please describe how freedom of choice is exercised. What restrictions are there, if any, with respect to changing physician?

Figure 6.1 *Outpatient contacts per person in the WHO European Region, latest available year*

Figure to be inserted by Observatory staff.

Please comment on the reliability of data.¹¹

Give information about access to secondary care.

- Is there direct access to specialist (ambulatory and hospital) services?
- Is there a GP gatekeeping role?
- Discuss the referral process, if any. Can patients choose the hospital and/or doctor? Can primary care doctors refer patients directly to the hospital?
- Comment on the geographical distribution of primary health care facilities/practitioners. How do rural areas compare with urban ones? If possible, provide figures illustrating geographical differences.

Comment on the quality of services and facilities, and include, if available, indications from official quality-assurance reports. Is there any national programme to improve quality? How are quality programmes monitored? Are there any targets to improve quality?

Describe major changes that may have occurred in recent years in any of the above areas.

¹¹ In many countries, outpatients are treated in hospitals. Therefore, the authors should clarify whether these data include outpatient visits in hospitals or whether they are exclusively outpatients outside of hospitals.

Discuss main problems or challenges associated with current practices relating to the above areas.

What expectations or reform plans, if any, are there regarding future developments? (Cross-reference to Chapter 7 “Principal health care reforms”.)

6.4 Secondary care (specialized ambulatory care/inpatient care)

Here, “secondary care” refers to specialized ambulatory medical services and typical hospital services (outpatient and inpatient services). It excludes general long-term care, which is dealt with separately. “Tertiary care” refers to medical and related services of high complexity, usually of high cost and provided at university/tertiary/referral hospitals.

Note: If secondary care specialists are included in “ambulatory care” because they operate within a private-practice model, this section should be called “inpatient care”.

Consider the following points:

- How are secondary and tertiary care services organized?
- How are specialized ambulatory medical services provided (e.g. specialists working in their own practices, polyclinics of specialties, outpatient departments of hospitals)?
- Method of providing specialized ambulatory services under the statutory system (i.e. excluding the voluntary system). Are these provided according to the integrated (directly employed) or the contracted (indirect) method?
- Describe the public–private ownership mix of specialized ambulatory services and hospital services (public, quasi-public, private for-profit and private not-for-profit).
- Describe the main categories of hospitals, functions and distribution (e.g. district general hospitals, teaching hospitals, single-specialty hospitals (e.g. maternity, orthopaedics)).
- Describe types of hospital management (e.g. are hospitals autonomous or under government control?).
- What is the method of providing hospital services under the statutory system (i.e. excluding the voluntary system)? Are these provided according to the integrated (directly employed) or the contracted (indirect) method?

- Discuss the public–private ownership mix of hospital services (public, quasi-public, private for-profit and private not-for-profit).

Discuss the geographical distribution of hospital care facilities and facilities providing secondary care. Provide an indication of the quality of these facilities. This may be related to the age, state of repair and standards of equipment and facilities; if possible, use evidence from official reviews of services.

Discuss the relationship between primary and secondary care and other public sectors such as social care. Consider the points below.

- Substitution policies which have been, are currently, or are being planned for the future that involve the replacement of the generally relatively more expensive hospital (inpatient) care by the relatively less-expensive outpatient care or home care. (*Note:* Long-term care options should not be discussed here, but in Section 6.8 “Long-term care”.)
- What is the degree of cooperation between secondary care and social care providers?
- Possible imbalances that may be present in the importance of primary health care relative to hospital care.
- To what extent are primary and secondary care providers (outpatient and inpatient) integrated? For instance, are laboratory tests at GP level repeated at secondary level? Do medical records follow the patient to GP from secondary care, and vice versa? Is there communication between hospital-based doctors and GPs in terms of treatment approaches?

Describe major changes that may have occurred in recent years in any of the above issues. With regard to all of the above issues, discuss the problems or challenges that have emerged. What reform plans and expectations for change, if any, are there at present in connection with the future development of all of the above areas?

6.4.1 Day care

Please provide the definition of day care used in your country. Is day care provided in hospital or in an ambulatory-care setting?

What is the proportion of care provided in a day-care setting? What are the main areas covered? How is day care financed? Where is day care provided (e.g. in hospitals, long-term care facilities)? What has been the trend in day-care provision over the last 10–20 years?

6.5 Emergency care

Please provide the definition of “emergency care” used in your country.

In addition to key areas outlined at the beginning of the chapter, describe how emergency care is organized in your country.

Provide a patient pathway in an emergency care episode, outlining: who picks up the patient (e.g. the national health service or specialized services such as the Red Cross), and which organizations are involved in transporting the patient and deciding on the appropriate health care setting.

6.6 Pharmaceutical care

Outline the organization of the pharmaceutical sector and the method of distribution of pharmaceuticals to the public. Consider public and private bodies involved in the manufacture and distribution (i.e. manufacturers, importers, parallel importers, wholesalers and pharmacies) of pharmaceuticals and the extent of government regulation. Some of the information in this section will have been provided in previous sections (e.g. 4.2.1 “Health technology assessment”), instead of repeating it, please cross-reference when appropriate.

Describe the process of market authorization and patent protection. What regulations, if any, govern the availability of alternative/complementary medicines? Is direct-to-consumer advertising of prescription drugs permitted? Are mail-order/Internet pharmacies permitted? If so, what regulations govern their activities?

Are there price controls for prescription pharmaceuticals? How does the pricing system work? Is a profit control scheme in operation? Discuss the composition of consumer prices of medicines i.e. in terms of the ex-factory price, the wholesaler’s (profit) margin, pharmacy margin (or profit), and any taxes. Are there price controls for generics? Are prices of over-the-counter products regulated?

Discuss the regulation of wholesalers and pharmacies. Can pharmacists make generic substitutions? If so, can they do this without the physician’s approval? Are there incentives in place for generic substitution? Does a “clawback” system operate? (See the Glossary on pages 115–124 for definition of “clawback”.)

Discuss the system for public reimbursement of pharmaceuticals. What factors determine whether a product will be reimbursed and the price that is set (i.e. economic evaluation, reference prices, price controls)? What is the process of purchasing/ procuring pharmaceuticals?

What regulations govern the licensing of pharmaceuticals, market access and inclusion in the benefits catalogue? Are pharmaceuticals covered as part of the public system? Who has access to the subsidized pharmaceuticals of the public system? Are there exemptions to pharmaceutical co-payments or lower co-payments for certain vulnerable groups?

Include any information on fourth hurdles (the use of cost-effectiveness criteria in addition to safety, efficacy and effectiveness) (cross-reference to Section 4.2.1 “Health technology assessment”).

Discuss the patenting of pharmaceuticals and whether the country is “TRIPS compliant”. (See the Glossary on pages 115–124) for a definition of “TRIPS compliance”).

Also discuss whether there are provisions for compulsory licensing, parallel importing (exhaustion of rights), and data exclusivity within national legislation. Is there a “Bolar provision”? (See the Glossary on pages 115–124 for a definition of “Bolar provision”).

Discuss the country’s drug policies to improve cost-effective consumption of pharmaceuticals. In particular, consider the following questions.

- Is there a national essential drug list or reimbursement list (positive list, negative list)?
- Is there generic substitution (same substance or therapeutic substitution) by either doctors or pharmacists? Is the use of generics promoted; if so how? See the Glossary for definition of “generic drug” and “generic substitution”.
- Are there any efforts to influence physicians’ prescription (e.g. by providing better information or using financial incentives such as “budget holding”)?

Do these controls cover both the public and private sectors? How are these policies monitored? Are these controls effective? (Cross-reference to Section 4.1.2 “Regulation and governance of providers”).)?

Discuss levels of consumption of pharmaceuticals (e.g. pharmaceutical expenditure per capita, types of prescriptions written). If data are available, please provide figures on the defined daily dose (DDD) consumption rate. (See the Glossary for definition of “defined daily dose”).

Report on the number of pharmacies and pharmacists, and how competitive this market is. For instance, what are the entry requirements for establishing new pharmacies? Are there any innovative ways of providing access to pharmacies (e.g. through supermarkets)? (Cross-reference to Section 5.2.7 “Pharmacists”).

Discuss the pharmaceutical sector in terms of its production capabilities, number of firms, local production as percentage of pharmaceutical expenditure.

6.7 Rehabilitation/intermediate care

In addition to key areas outlined at the beginning of the chapter, consider also the following questions.

- When reporting on access and availability of rehabilitation services, are there any links between rehabilitative services and health/social care services (e.g. are there coordinated strategic frameworks in place for rehabilitation services)?
- In reporting on access and utilization of services, are there any typical and geographical variations in time to recovery/re-ablement, if available?

6.8 Long-term care

Here, we discuss long-term care provision for older people, people with physical disabilities, people with chronic diseases, and people with learning disabilities. In providing information, if possible, distinguish between these four categories. Long-term care may be provided both within institutions (residential) or in the community (home care). Individuals requiring care for acute and chronic mental health disorders should be discussed later in Section 6.11 “Mental health care”.

In addition to key areas outlined at the beginning of the chapter, consider also the following questions.

- To what extent are health and social services integrated or separated? If separated, what mechanisms exist to coordinate services?
- Access to services: assessment and entitlements. Is there a process of assessment? Who carries it out? Is the assessment based exclusively on need or is it also based on the availability of family care?
- Community-based care: what services are available and what percentage of each client group receives them?
- Residential care: what percentage of each client group is in institutional care, and what types of residential care facilities are provided?
- What reform plans or expectations are there at present with regard to future developments in the long-term care sector?
- How is long-term care financed? (Cross-reference to Section 3.3.6 “Other sources of financing”.)

6.9 Services for informal carers

Informal care refers to the provision of (formally) unpaid caregiving activities, typically by a family member to an individual who requires help with basic activities of daily living. Examples of individuals with such needs could be people with dementia, the physically disabled, those with learning disabilities, the terminally ill and those with mental health problems.

- What policies are in place to recognize the value of informal care, protect informal carers and provide them with access to support services?
- What legal obligations, if any, do families have to provide care?
- If available, provide information on estimates of the number of individuals providing informal care. For instance, how many/what proportion of specific client groups receive informal care, how many/what proportion of client group live alone, with spouse only, with children, or in other household types?
- What access do carers have to short-term respite care facilities? Examples of these would include day-care centres, short-term residential care centres (e.g. where individuals may stay for perhaps one or two weeks) or specially supported holiday breaks.
- What financial entitlements are available for informal carers and those that they provide care for? Do these differ depending on the client group?
- Is there any training provided for informal carers? Is there any organizational structure in place for informal carers?

6.10 Palliative care

In addition to key areas outlined at the beginning of the chapter, consider also the following points.

Determine if a national policy and/or guidelines on palliative care and/or pain relief have been put in place.

In reporting on the availability, access to and utilization of specialist palliative care services, consider whether the following types services might be provided:

- specialist palliative care teams, including individuals with recognized palliative care accreditation, specialist nurses and care attendants;
- specialist palliative care units, and their location (e.g. within hospitals, hospices, day-care centres);
- bereavement support services for families;

- palliative care offered in the home.

To what extent are patients with great palliative care needs able to access secondary care facilities rapidly? For instance, do hospital admission policies include specialist provision for such individuals?

What links are there between specialist palliative care services and other health care professionals that might be involved in delivering care (e.g. social workers, psychologists, physiotherapists, occupational therapists, complementary therapists, speech therapists, spiritual counselling)?

- To what extent are palliative care services reliant on volunteers to help provide services, and what level of training/support is provided for these volunteers?
- Are patients and/or their families explicitly involved in determining palliative care management plans?
- Is any information available on the quality of palliative care services? Are there any patient/family surveys available? Are there any performance indicators available?
- Are palliative care strategic programme plans, or local agreements, used to determine the level of service required?

What reforms have or will be implemented? For instance, have there been any moves to change the care delivery setting from hospitals to community-based locations (e.g. development of palliative care in the community-based policies)?

6.11 Mental health care

In addition to key areas outlined at the beginning of the chapter, consider also the following.

Determine if specific mental health policy and strategic plans/programmes have been established either at national or local level.

Identify whether legislation is in place to protect those with mental health problems and to ensure access to services. Report on provisions to safeguard against inappropriate compulsory treatment and/or detention. How recently was legislation passed? Does it address individuals residing in the community as well as in institutions? Has legislation been influenced at all by the 1991 United Nations principles on protecting the rights of those with mental health disorders? (Available online at <http://www.un.org/documents/ga/res/46/a46r119.htm> or from the European Convention on Human Rights.)

- What programmes/educational initiatives have been undertaken to tackle the discrimination/social exclusion/stigma that individuals with mental health disorders may suffer from?
- Are specific services provided to deal with special problems that might be faced by refugees and asylum seekers, notably post-traumatic stress disorder?
- What legal obligations, if any, do families have to provide care for people with mental health problems? (Cross-reference with Section 6.9 “Services for informal carers”.)

Report specifically on availability of specialist professionals involved in the delivery of mental health care services (e.g. numbers of psychiatrists (distinguish child and old-age psychiatrists), neurosurgeons, psychiatric nurses, psychologists, mental health social workers, neurologists, psychologists, psychiatric social workers, and any specialist mental health staff at work within the country).

Please comment on the balance of psychiatric hospital beds compared to beds for acute, chronic and long-term care and the reliability of existing data. Are psychiatric beds integrated into general hospitals or/and provided in special psychiatric hospitals?

What is the balance between provision of institutional and community care services? Is priority given to treatment of specific conditions (e.g. towards care of people with cognitive disorders rather than care of people with affective disorders)?

What reforms of the mental health system are under way? For instance, has there been a shift away from institutional to community care, or a change in the organizational structure of mental health care services, meaning that they are more or less integrated with other health and social care services?

If current reforms are shifting service provision to the community, are additional transitional funds being provided to cover periods when institutions will still need to be maintained? Are adequate community-based support structures being developed/in place to deal with the de-institutionalized population? Are funds for community-based services ring-fenced?

6.12 Dental care

In addition to key areas outlined at the beginning of the chapter, consider also the following points.

- Indicate the public–private mix in funding and delivery.
- Are there any specific policy documents or national strategies on the provision of dental services?
- Are dental prices regulated, and if so, by whom? If not, who defines them?
- Is the quality of dental services monitored by any organization?
- Refer to any preventative dental care programmes or activities (e.g. fluoridation, school education programmes) and their discernible effects.

(Cross-reference to Table 1.8.)

6.13 Complementary and alternative medicine

Here, we refer to complementary and alternative medical practices not typically considered to be orthodox therapies. (See the Glossary on pages 115–124 for definition of “Complementary and alternative medicine (CAM)”.) These might include acupuncture, osteopathy, herbal medicine, spa treatment, electromagnetic therapy, massage therapy, music therapy, meditation, etc.

In addition to key areas outlined at the beginning of the chapter, consider also the following questions.

- Are there any regulations regarding the provision of CAM? If so, what are these?
- To what extent is CAM accepted by the mainstream medical profession and to what extent is it provided within the mainstream health system?
- Are any data available on the utilization of different complementary therapies?
- To what extent are alternative therapies reimbursable within the health system by third-party payers?
- To what extent are alternative therapies reliant on out-of-pocket payments?
- What reform plans or expectations are there at present with regard to future developments in this sector? (This may include information on any proposed regulation of sector.)
- Is there any licensing/certification procedure for CAM practitioners?

6.14 Health care for specific populations

The focus of this section is the delivery of health care to specific populations.

Discuss key areas outlined at the beginning of Chapter 6 for any special population groups who either do not have access to the mainstream health system, or alternatively have special access to other health care services.

This section might include minority populations such as the Roma people and specific social groups such as prisoners, military personnel, refugees, asylum seekers, illegal immigrants, travellers, homeless people, street children, intravenous drug users, and commercial sex workers. With regard to minority populations and marginalized groups, do they have access to the health system? Discuss the quality of care provided. *Note:* If these groups are treated within the main health system, then they should not be discussed here.

Chapter 7

Principal health care reforms



In this chapter individual health care reforms, policies and organization changes, some of which may have been discussed earlier (e.g. historical background, decentralization, access to care, financing) can be set within the context of the overall reform programme. By reform we mean top-down changes of structure and/or practice institutionalized through authoritative legislation, administrative decree or binding agreements; these changes should affect the majority of the country or a significant subset of regions/localities. This should provide a better understanding of the relative significance and relationships between different reforms. The chapter shall consider major reforms already implemented as well as reforms which failed or were passed but were never implemented. Particular emphasis should be placed on the process of change and on plans for future reform.¹²

When investigating health care reforms, it is important to consider both the political rhetoric and legislation, and what is actually implemented. Include reports on what is actually taking place in terms of implementation, where possible, while commenting on the extent to which these reports can be considered impartial.

Topics that could be considered for this chapter when selecting and analysing health care reforms and plans for the future include:

- the stipulated aims and objectives of the Government;
- major changes in policies;
- the role of major stakeholders;

¹² Please note that the evaluation of reforms, and the issue of what else can be done to address major system problems, are discussed in Chapter 8.

- role of European institutions and international agreements;
- impact of reforms in other sectors of society on health and/or health care financing (e.g. pension reform) and provision (e.g. impact of drug legislation on HIV/AIDS prevention among intravenous drug users);
- recent policies on shifting of inpatient care to other types of care (e.g. day care, home care, ambulatory care, primary care);
- reforms of mental health care (e.g. shift from institutional to community-based care), long-term care, other social care, palliative care, rehabilitation, etc.;
- recent reforms in public health (e.g. legislation, national programmes).

7.1 Analysis of recent reforms

Please provide a box (Box 7.1) listing in chronological order major reforms and policy initiatives that have had a substantial impact on health care (and relationship with other sectors such as social care) over the last 10–20 years. Earlier reforms may be better located in Section 2.2 which discusses the historical background of the health system.

In addition to those topics already listed, reforms might include issues around cost-containment measures, financing arrangements, use of HTA, organization of services, regional devolution, and changes in entitlements and coverage. In some countries with a high degree of decentralization it may be appropriate to include some significant reforms within individual regions within this box.

Box 7.1 *Major health care reforms and policy measures*

A brief description of each principal reform should also be provided. Include key policy proposals and legislation from other fields that can have an impact on the health sector. This should focus on three dimensions: aims and background; reform contents; implementation and impact.

Aims and background to reform

Give a brief account of the main perceived issue underlying the development of a particular reform (e.g. geographical inequity in access, rising costs, poor perceived quality, inefficiency, excess/inappropriate capacity). What were the objectives of the reform? What claims did the Government make about their purpose? In particular, where relevant, what did the Government state would be the impact on entitlements, financing arrangements and access to services?

Reform content

Provide brief information on the key policy proposals and list legislation associated with each reform. To avoid unnecessary repetition, reform measures discussed here may be cross-referenced with earlier sections, wherever relevant.

Policy process and reform implementation

Please describe briefly the process of policy-making for major health care reforms. In particular, consider the following points.

- What is/has been the role of key national actors and interest groups in the process of agenda-setting (which issues receive government attention?), reform development (design of contents) and reform implementation (making changes effective)? What is/has been the role of civil society? What is/has been the role of European institutions, international agreements?
- Describe the extent to which each of the most important measures has been fully or partly implemented to date as well as the prospects for future implementation.
- Were there any contextual factors (e.g. pilot projects or evaluation exercises; national political debates; electoral shifts; political or health system scandals) which facilitated/hindered the launch of reforms?
- Which were the main obstacles/facilitating factors faced in the process of reform implementation?
- What policy measures have failed and why?
- Were there any reports produced from independent organizations on the process? What were the key findings?

Factors influencing reform and policy implementation can include:

- political resources (e.g. government stability, support of interest groups and/or the population);
- financial resources required to implement change and to run and sustain the new model;
- technical/managerial resources (e.g. administrative skills, information systems, expertise);
- the impact of sociocultural context on policy-making and implementation;
- the role of the media.

7.2 Future developments

Outline any potential and recently announced reforms and policy changes within the health system. This may be done on the basis of current policy proposals, ongoing debates, or political party plans.

Outline any potential developments outside the health system that may have an impact on health policy – for instance, forthcoming national and regional elections, and the impact of EU legislation.

If not already discussed, what plans/expectations exist at present concerning future developments in relation to:

- organizational structure of the health system;
- decentralization (political, administrative, managerial – see the Glossary on pages 115–124 for definitions);
- regulation and planning;
- specific sectors such as mental health, long-term care or social care?

Chapter 8

Assessment of the health system

There are several legitimate approaches to assessing health system performance. We adopt an approach similar to *The World Health Report 2000* (WHO 2000) and have chosen to use a set of headings that primarily address the dimensions of efficiency and equity. We realize this approach has its limitations, and additional items could be included. For instance, we have left out the criteria of responsiveness because of the difficulty in developing a comparable definition and measurement.¹³

Authors should interpret normative criteria on the basis of local definitions, where these differ from the definitions given in the Glossary (on pages 115–124). Reform measures should be assessed against a set of normative criteria and the stated objectives of the health system.

We do not expect authors to be able to address all points listed below. However, we would like authors to make some assessment of the following elements of the health system:

- the extent of population coverage (consider coverage in terms of both financial protection and access to care) (disaggregate by sociodemographic variables);
- the existence of barriers to access;
- the allocation of resources (e.g. between primary and secondary/tertiary care, and whether there are needs-based resource allocation mechanisms);

¹³ We acknowledge that valuation of public services is a very complex and challenging task, and several approaches could be taken (see for example Boyne et al. 2003).

- the relationship between efficiency indicators and access and quality indicators (e.g. simple reductions in the size of waiting lists do not, on their own, indicate efficiency);
- the impact of methods of paying providers on efficiency;
- quality of care;
- whether the health system contributes to health improvement.

The assessment should not only take into account the medical care system but also public health services, mental health care, social care and the private health care industry.

Your assessment should refer to information presented in earlier chapters and summarize evidence briefly if necessary.

When analysing these issues, please comment on the extent to which major strategies and laws are actually being implemented.

If possible, include findings from reports evaluating the health system and comment on the extent to which these reports can be considered impartial. For example, are the reports produced by organizations that are independent from the Government?

If information and/or evidence are not available, authors should say so. Where there is no evidence of the impact of reform measures, authors should assess their impact on the basis of theoretical assumptions. For example, is it reasonable to assume that increases in user charges are likely to deter access for some sectors of the population?

Please see the Glossary (on pages 115–124) for definitions of the terms and concepts mentioned below.

You may structure this chapter according to the following order, around concepts, or you may choose any other structure that seems appropriate to discuss the issues below.

8.1 The stated objectives of the health system

Authors should state the objectives of the health system and reform initiatives and critically evaluate whether any policies have been developed to meet these objectives. We understand that some of the objectives and stated reforms may not be possible to evaluate, therefore authors should state that this may not be possible, owing to a lack of conclusive evidence at present.

What are the stated objectives of the health system? Examples of stated objectives might include:

- ensuring equal access for equal need
- improving access to health care
- improving population health.

Use the following set of normative criteria to evaluate whether these objectives, or other stated objectives (whether explicit or implicit), are being met.

8.2 The distribution of the health system's costs and benefits across the population (equity in finance as well as in the distribution of services and resources for the population)

This section should indicate the extent to which there are problems or barriers in access to care (e.g. financial, geographical, cultural, supply-related).

Please base your assessment on information given in previous sections (e.g. on trends and inequalities in coverage, benefits and financing). Please also refer to published studies, if possible.

With respect to financing, the following questions may be important to consider.

- Are the different sources of funding progressive? Is the overall system of funding progressive (vertical equity)? Is the funding system horizontally equitable?¹⁴
- Does the funding system result in a redistribution of resources?
- To what extent do people experience catastrophic and/or impoverished levels of health expenditure?

With respect to the provision of benefits, consider the following questions.

- Is there an equitable distribution of personnel and facilities across the population? Authors should make allowances for an acceptable level of inequality; for example, highly specialized centres are likely to be concentrated in urban centres.

¹⁴ Horizontal equity is the principle that says that those who are in identical or similar circumstances should pay similar amounts in taxes (or contributions) and should receive similar amounts in benefits; vertical equity is the principle that says that those who are in different circumstances with respect to a characteristic of concern for equity should, correspondingly, be treated differently, e.g., those with greater economic capacity to pay more; those with greater need should receive more (see Observatory Glossary: <http://www.euro.who.int/observatory/Glossary/Toppage>).

- Is there any evidence to suggest that the utilization of health services is related to need rather than income level or socioeconomic status?
- Is there any evidence of barriers in accessing health care services? For example, user charges (formal or informal), insufficient services in remote areas, cultural or language issues, long waiting times and/or waiting lists? Please consider the extent to which these barriers to access may be affecting some population groups more than others (e.g. lower socioeconomic groups, ethnic minorities, older people, migrants, unemployed people).
- Are benefits the same across the population?

8.3 Efficiency of resource allocation in health care (across services, across inputs)

Allocative efficiency indicates that current allocations of resources for health care meet the needs of the population. The assessment should consider financial as well as human and physical resources. In health systems, given resource constraints, there are changing priorities and possibilities in different sectors (e.g. hospital and primary care, mental health, public health and medicines). How flexible are different systems in reallocating resources among sectors, and to what extent do their patterns of allocation match what is known about the potential effectiveness of interventions in different sectors (Evans 2002)?

Please base your assessment on information given in previous chapters (e.g. total and public spending, distribution of health personnel, capacities and equipment).

Evaluate trends in the balance of allocation to:

- tertiary, secondary and primary care
- prevention, long-term nursing care and curative care
- care for mentally ill and physically ill people.

In addition, evaluate trends in the balance of allocations to:

- fixed costs (personnel, utilities, etc.)
- medicines
- capital investment.

Did recent reforms have an impact on these trends? Which other factors contributed to these trends?

Are there needs-based resource allocation formulas?

8.4 Technical efficiency in the production of health care

The aim of this section is to assess whether the health system provides good value for money. Where data are not available, authors should express their own views on this issue.

Refer to the efficiency with which a health system's output is produced. Does it cost more than it needs to, should, or could? A system may be unnecessarily expensive either because it uses up too many resources for the output it produces, or because it pays the owners of those resources "too much" in fees, wages or profits (Evans 2002).

Please base your assessment on information given in previous sections (e.g. the role of HTA, generics, spending on administration).

- How is productivity in the health system as a whole and in different sectors (e.g. hospitals/primary care)?
- What is the impact of the way in which providers are paid on efficiency?
- Are there any substitution policies (e.g. generic pharmaceuticals/nurse care for doctor care/dental assistants for dentists)?

8.5 Quality of care

The aim of this section is to provide a summary of the evidence on quality of care in the health system. See Section 4.1.4 "Regulating quality of care".

8.6 The contribution of the health system to health improvement

Although it is difficult to disentangle the contribution that health care makes to improving health status, it would be good to have an estimate of any improvement in health status that may be attributed to the health system (including public health measures). Please base your assessment on information given in previous sections (e.g. on health trends, health inequalities). Include information and evidence on mortality amenable to medical intervention (Nolte and McKee 2003).

Also consider the following questions.

- What are the factors that have contributed to changes in health status?

- Are these factors related to health care/public health/health policy/lifestyle changes/other?
- Are there any studies showing whether health improvement occurred as a result of health policy or health care interventions?

Chapter 9

Conclusions



The aim of this chapter is to:

- highlight the lessons learned from health system changes
- summarize remaining challenges and future prospects.

It should be prepared in collaboration with the Observatory editors, once the other sections have been completed.

Chapter 10

Appendices



10.1 References

Include key references to relevant academic publications which were used as sources of information within the HiT.

Bibliographical references should be presented in the Harvard (also known as “author-date”) system, whereby citations are made within the text in parentheses (e.g. Taylor 1996) and the references are listed in full and alphabetically in this section.

Please follow the layout recommended in the WHO *Euro style guide*.

10.2 Further reading

A Further Reading list can also be provided after the References section, suggesting any other useful material that is not actually cited in the text of the profile.

10.3 Web sites

Provide a list of the most important web sites that were referred to in the report, or would provide further information for readers.

10.4 HiT methodology and production process

The Health Systems in Transition (HiT) profiles are produced by country

experts in collaboration with the Observatory's research directors and staff. The profiles are based on a template that, revised periodically, provides detailed guidelines and specific questions, definitions, suggestions for data sources, and examples needed to compile HiTs. While the template offers a comprehensive set of questions, it is intended to be used in a flexible way to allow authors and editors to adapt it to their particular national context. The most recent template is available online at: http://www.euro.who.int/observatory/Hits/20020525_1.

Authors draw on multiple data sources for the compilation of HiT profiles, ranging from national statistics, national and regional policy documents, and published literature. Furthermore, international data sources may be incorporated, such as those of the OECD and the World Bank. OECD Health Data contain over 1200 indicators for the 30 OECD countries. Data are drawn from information collected by national statistical bureaux and health ministries. The World Bank provides World Development Indicators, which also rely on official sources.

In addition to the information and data provided by the country experts, the Observatory supplies quantitative data in the form of a set of standard comparative figures for each country, drawing on the European HFA database. The HFA database contains more than 600 indicators defined by the World Health Organization (WHO) Regional Office for Europe for the purpose of monitoring Health for All policies in Europe. It is updated for distribution twice a year from various sources, relying largely upon official figures provided by governments, as well as health statistics collected by the technical units of the WHO Regional Office for Europe. The standard HFA data have been officially approved by national governments. With its summer 2004 edition, the HFA database started to take account of the enlarged European Union (EU) of 25 Member States.

HiT authors are encouraged to discuss the data in the text in detail, including the standard figures prepared by the Observatory staff, especially if there are concerns about discrepancies between the data available from different sources.

A typical HiT profile consists of 10 chapters.

- 1 Introduction:** outlines the broader context of the health system, including geography and sociodemography, economic and political context, and population health.
- 2 Organizational structure:** provides an overview of how the health system in the country is organized and outlines the main actors and their decision-making powers; discusses the historical background for the system; and

describes the level of patient empowerment in the areas of information, rights, choice, complaints procedures, safety and involvement.

- 3 **Financing:** provides information on the level of expenditure, who is covered, what benefits are covered, the sources of health care finance, how resources are pooled and allocated, the main areas of expenditure, and how providers are paid.
- 4 **Regulation and planning:** addresses the process of policy development, establishing goals and priorities; deals with questions about relationships between institutional actors, with specific emphasis on their role in regulation and what aspects are subject to regulation; and describes the process of HTA and research and development.
- 5 **Physical and human resources:** deals with the planning and distribution of infrastructure and capital stock; the context in which IT systems operate; and human resource input into the health system, including information on registration, training, trends and career paths.
- 6 **Provision of services:** concentrates on patient flows, organization and delivery of services, addressing public health, primary and secondary health care, emergency and day care, rehabilitation, pharmaceutical care, long-term care, services for informal carers, palliative care, mental health care, dental care, complementary and alternative medicine, and health care for specific populations.
- 7 **Principal health care reforms:** reviews reforms, policies and organizational changes that have had a substantial impact on health care.
- 8 **Assessment of the health system:** provides an assessment based on the stated objectives of the health system, the distribution of costs and benefits across the population, efficiency of resource allocation, technical efficiency in health care production, quality of care, and contribution of health care to health improvement.
- 9 **Conclusions:** highlights the lessons learned from health system changes; summarizes remaining challenges and future prospects.
- 10 **Appendices:** includes references, useful web sites, legislation.

Producing a HiT is a complex process. It involves:

- writing and editing the report, often in multiple iterations;
- external review by (inter)national experts and the country's Ministry of Health – the authors are supposed to consider comments provided by the Ministry of Health, but not necessarily include them in the final version;

- external review by the editors and international multidisciplinary editorial board;
- finalizing the profile, including the stages of copy-editing and typesetting;
- dissemination (hard copies, electronic publication, translations and launches).

The editor supports the authors throughout the production process and in close consultation with the authors ensures that all stages of the process are taken forward as effectively as possible.

10.5 About the authors

Each HiT author should provide a short (2–3 sentences) biography.

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Glossary of selected terms

This section gives definitions for selected terms commonly used in this template in addition to terms that might be used by the author when writing. For more information on these terms and for definitions of other terms and concepts, see the full version of the Glossary on the Observatory web site: www.euro.who.int/observatory/Glossary/Toppage.

Accreditation A self-assessment and external peer review process used by health care organizations to accurately assess their level of performance in relation to established standards and to implement ways to continuously improve.

Accountability The obligation to disclose periodically, in adequate detail and consistent form, to all directly and indirectly responsible or properly interested parties, the purposes, principles, procedures, relationships, results, incomes and expenditures involved in any activity, enterprise, or assignment so that they can be evaluated by the interested parties.¹

Appropriateness The degree to which service is consistent with a client's expressed requirements and is provided in accordance with current best practice.²

Audit A systematic independent examination and review to determine whether actual activities and results comply with planned arrangements.¹

Benchmarking Comparing the results of organizations' evaluations to the results of other interventions, programs, or organizations, and examining processes against those of others recognized as excellent, as a means of making improvements.¹

Bolar provision A “Bolar” provision provides exemptions to exclusive patent rights which permit the testing, using, making (not selling) of patented pharmaceuticals for the purpose of submitting information required for obtaining marketing approval prior to the date of patent expiration. Bolar exemptions facilitate the entry of generic competition because they allow generics manufacturers to submit their products for regulatory approval before the expiry of a patented invention. Without these exceptions, generic manufacturers can only submit their products for regulatory approval after the expiry of the patent term.

Choice A complex issue. Some argue that choice has intrinsic value, while others value its instrumental potential (for example, to increase responsiveness, to encourage competition between providers, to increase quality and to empower people). In addition, acceptable levels of choice for individuals are likely to vary between countries and between different groups within a country. Individual choice may be associated with costs and benefits.

Clawback Recapturing of excess pharmaceutical company profits by the Government.

Community care “Community care means providing the right level of intervention and support to enable people to achieve maximum independence and control over their own lives. Community care means that a wide range of services provided in a variety of settings need to be provided. It is not simply care provided by family members. These services range from domiciliary support provided to people in their own homes, strengthened by the availability of respite care and day care for those with more intensive care needs, through sheltered housing, group homes and hostels where increasing levels of care are available, to residential care and long-stay hospital care for those for whom other forms of care are no longer enough.”³

Competence Guarantee that an individual’s knowledge and skills are appropriate to the service provided and assurance that the knowledge and skill levels are regularly evaluated.¹

Complementary and alternative medicine (CAM) Sometimes referred to as “non-conventional” or “parallel” medicine, this term is used to refer to a broad set of health care practices that are not part of a country’s own tradition, or not integrated into its dominant health system.⁴ Complementary medicine is used together with conventional medicine. Alternative medicine is used in place of conventional medicine. While some scientific evidence exists regarding some CAM therapies, for most there are key questions that are yet to be answered through well-designed scientific studies – questions such as whether they are safe and whether they work for the diseases or medical conditions for which

they are used. The list of what is considered to be CAM changes continually, as those therapies that are proven to be safe and effective become adopted into conventional health care and as new approaches to health care emerge.⁵

Continuity The provision of coordinated services within and across programs and organizations, and over time.¹

Data exclusivity Data exclusivity provides a minimum term of protection for undisclosed information (test or other data), such as health registration data, used in the submission for the registration of a pharmaceutical product. Data exclusivity prevents a drug regulatory authority or any other national competent authority from relying on such data to assess further applications relating to the same drug until the expiry of exclusivity.

Decentralization Changing relations within and between a variety of organizational structures/bodies, resulting in the transfer of the authority to plan, make decisions or manage public functions from the national level to any organization or agency at the subnational level. Decentralization can take various forms.

- Deconcentration involves passing some administrative authority from central government offices to the local offices of central government ministries. For a Ministry of Health, this would typically involve subnational (regional/district/local)-level administrative units of the Ministry of Health taking over administrative duties previously performed at central level, while remaining subordinate to the national Government (e.g. health authorities at provincial or district level, health management boards, etc.). In the context of regulation, regulatory functions pass to an independent public agency
- Devolution involves passing responsibility and a degree of independence to regional or local government, with or without financial responsibility (i.e. the ability to raise and spend revenues). Unlike deconcentration, these bodies are generally independent of the national Government with respect to their functions and responsibilities. In the context of regulation, regulatory functions pass to a lower tier of government.
- Delegation involves passing responsibilities to local offices or organizations outside the structure of the central Government such as quasi-public (nongovernmental) organizations, but with central Government retaining indirect control. In the context of regulation, regulatory functions pass to a lower administrative tier.
- Privatization involves the transfer of ownership and government functions from public to private bodies, which may consist of voluntary organizations

and for-profit and not-for-profit private organizations. The degree of government regulation is variable. In the context of regulation, some or all of the regulatory functions are handed over from state to private organizations (self-regulation or co-regulation).

Defined daily dose (DDD) The assumed average maintenance dose per day for a drug used for its main indication in adults.

Effectiveness The degree to which services, interventions or actions are provided in accordance with current best practice in order to meet goals and achieve optimal results.¹

Efficiency Minimizing the opportunity cost of attaining a given output, or maximizing the output for a given opportunity cost. More specifically, technical efficiency is the state where more inputs are not used than are technically necessary to obtain a given output, and cost-efficiency is where a given output is produced using the least-cost, technically efficient combination of inputs (or conversely, where output is maximized for a given level of input).⁶

Equity The principle of being fair to all, with reference to a defined and recognized set of values. Equity in health implies that everyone should have a fair opportunity to attain their full health potential and, more pragmatically, that no one should be disadvantaged from achieving this potential. However while this is a definition of equity in health, in practice equity is typically measured not in terms of attaining equivalent health outcomes but rather in terms of the geographical and financial access of individuals to available resources in health care.^{7,8} Equity is thus to be differentiated from sameness.

In HiT reports, equity can be differentiated in two ways: vertical equity (preferential treatment for those with greater health needs), and horizontal equity (equal treatment for equivalent needs). In respect of financing mechanisms within health systems horizontal equity can be reflected if those in identical or similar circumstances pay similar amounts in taxes or insurance contributions and receive similar levels of benefits, while vertical equity would be reflected if those in different socioeconomic circumstances make contributions according to the capacity to pay (e.g. progressive income tax), and receive benefits according to need. As with equity there are also several definitions of “need”, but one commonly accepted assumption is that a need for an intervention exists if there is a capacity to benefit from that intervention.

Evidence Data and information used to make decisions. Evidence can be derived from research, experiential learning, indicator data, and evaluations. Evidence is used in a systematic way to evaluate options and make decisions.¹

Financial resource allocation Any process by which financial resources flow from a third-party payer (e.g. government, insurer, etc.) to a devolved health care purchaser/plan. This might be a local government, a local administrative board, a provider group or an SHI fund. Purchasers are charged with organizing specified types of health care for a designated population, whether defined by geography, employment type or voluntary enrolment, over a given time period. In some systems the revenue collection and purchasing functions are integrated and there is no resource allocation mechanism to purchasers.

Generic drug A pharmaceutical product usually intended to be interchangeable with the innovator product, which is usually manufactured without a licence from the innovator company and marketed after the expiry of a patent or other exclusivity rights. Generic drugs are marketed either under a nonproprietary or approved name rather than a proprietary or brand name.⁹

Generic substitution The practice of substituting a product, whether marketed under a trade name or generic name, by an equivalent product, usually a cheaper one, containing the same active ingredients.¹⁰

Governance The function of determining the organization's direction, setting objectives and developing policy to guide the organization in achieving its mission, and monitoring the achievement of those objectives and the implementation of policy.¹

Guidelines Principles guiding or directing action.¹

Health technology assessment (HTA) HTA can be defined as “the structured analysis of a health care technology, a set of related technologies, or a technology-related issue that is performed for the purpose of providing input to a policy decision”.¹¹ The analysis may take many forms and may consider safety, clinical efficacy and effectiveness only, but it can also include considerations such as cost–effectiveness analysis, organizational impact, legal, ethical and social considerations. Technology in this context is a broad term encompassing pharmaceuticals, all medical devices, procedures and the organizational and support systems by which health care is delivered. It does *not* look solely at new or expensive technologies. What distinguishes HTA from standard evaluation is the key requirement that data are generated to inform the policy-making process.

Indicator Performance measurement tool, screen or flag that is used as a guide to monitor, evaluate, and improve the quality of services. Indicators relate to structure, process, and outcomes.¹

Information systems Systems for planning, organizing, analysing and controlling data and information, including both computer-based and manual systems.¹

Licensure Process by which a government authority grants permission to an individual or health care organization to operate, or to an individual practitioner, to engage in an occupation or profession.²

Management Setting targets or goals for the future through planning and budgeting, establishing processes for achieving those targets and allocating resources to accomplish those plans. Ensuring that plans are achieved by organizing, staffing, controlling and problem-solving.¹

Moral hazard The possibility of consumers or providers exploiting a benefit system unduly to the detriment or disadvantage of other consumers, providers or the financing community as a whole, without having to bear the financial consequences of their behaviour in part or in full.

Organization (of a health system) The systematic arrangement of various resources, with designated responsibilities and special channels of communication and authority, intended to attain certain objectives. The ultimate objective of organizations in a health system is to promote or protect people's health, but this ultimate goal is approached through the intermediary role of many agencies with more focused objectives.

Out-of-pocket (OOP) payments These include:

- direct payments: payments for goods or services that are not covered by any form of insurance;
- cost sharing: a provision of health insurance or third-party payment that requires the individual who is covered to pay part of the cost of health care received; often referred to as formal cost sharing or user charges;
- informal payments: unofficial payments for goods or services that should be fully funded from pooled revenue.

Cost sharing can be direct or indirect, as described in Section 3.3.3.

Palliative care “The continuing active total care of patients and their families, at a time when the medical expectation is no longer cure. Palliative care responds to physical, psychological, social and spiritual needs, and extends to support in bereavement. The goal of palliative care is the highest possible quality of life for both patient and family.”¹²

Payment methods These can broadly be subdivided into:

- retrospective payment (reimbursement) at “full cost”: third-party payers reimburse providers for all expenses incurred in providing health services; there are no clear constraints on the price or quantity of health services provided;

- prospective payment: fixing the price with or without fixing the quantity of services provided; third-party payers can reimburse providers for all services provided at a prospectively fixed rate of payment; they can also fix the quantity of services provided.

Physical inputs (into the system) These include buildings, equipment, devices and drugs.

Public health Also known as collective health services, this has been defined as “the science and art of preventing disease, prolonging life and promoting health through the organized efforts of society”.¹³ An alternative definition is “Activities that society does collectively to assure the conditions in which people can be healthy. This includes organized efforts to prevent, identify, pre-empt and counter threats to the public’s health”.¹⁴

Purchasing Regarding the overall make-up, three principal models can be distinguished:

- integrated model – health care providers are directly employed (or “owned”) by the third-party payers;
- contract model – health care providers are independent and are contracted by the third-party payers (be they public, private not-for-profit or private for-profit, be they regional monopolies or competing), i.e. there is a separation between purchaser and provider functions and contractual or contract-like relationships between them;
- direct payments to providers model – typical for purely private arrangements where providers are paid more or less fully by patients. NB: While this is not the official model in any European country, it does play an important role in many countries and should be identified at this early stage in the HiT.

Here we use the term “purchasing” to indicate all processes between purchasers/third-party payers and providers about the provision (or non-provision) of health care services. In countries with integrated systems (i.e. without purchaser–provider split), this section should discuss how this is done within the integrated system.

Quality The degree of excellence, or extent to which an organization meets clients’ needs and exceeds their expectations.¹

Quality assessment Planned and systematic collection and analysis of data about a service, usually focused on service content and delivery specifications and client outcomes.¹

Quality control The monitoring of output to check if it conforms to specifications or requirements and action taken to rectify the output. It ensures safety, transfer of accurate information, accuracy of procedures and reproducibility.¹

Quality improvement Ongoing response to quality assessment data about a service in ways that improve the processes by which services are provided to clients.¹

Regulation A narrow view of regulation defines it as setting forth mandatory rules that are enforced by a state agency. A broader definition, which should be followed here, incorporates all efforts by state agencies to steer the economy. This considerably broader view is seen to include state ownership and contracting, as well as taxation and disclosure requirements. However, there are other types of regulation and they can be classified in many ways. Regulatory functions to be considered include the following:

- regulating quality and effectiveness: assessing cost–effectiveness of clinical interventions; training health professionals; accrediting providers;
- regulating patient access: gatekeeping; co-payments; GP lists; rules for subscriber choice among third-party payers; tax policy; tax subsidies;
- regulating provider behaviour: transforming hospitals into public firms; regulating capital borrowing by hospitals; rationalizing hospital and primary care/home care interactions;
- regulating payers: setting rules for contracting; constructing planned markets for hospital services; developing prices/budgets for public-sector health care services; introducing case-based provider payment systems; regulating reserve requirements and capital investment patterns of private insurance companies; retrospective risk-based adjustment of sickness fund revenues;
- regulating pharmaceuticals: generic substitution; reference prices; profit controls; catalogue-based pricing; positive and negative lists;
- regulating physicians: setting salary/reimbursement levels; licensing requirements; setting malpractice insurance coverage.

Rehabilitation “The primary objective of rehabilitation involves restoration (to a maximum degree possible) either of function (physical or mental) or role (within the family, social network or workforce)”.¹⁵ Rehabilitation services can help individuals either stay at or return home after hospital admission. They may also therefore reduce admissions to specialist residential nursing homes. Such services may be provided in the community, or in acute and specialist settings. Intensive rehabilitation usually requires specialist medical and nursing support

within a secondary care setting (e.g. stroke units). Intermediate care provides active rehabilitation services, with a focus on confidence building. It takes place in a specialist setting half way between home and hospital; it can be used either as part of therapy following discharge from hospital, or as part of a transition process from home to hospital.

Rights Something that can be claimed as justly, fairly, legally, or morally one's own. A formal description of the services that clients can expect and demand from an organization.¹

Third-party payer Any organization, public or private, that pays or insures health care expenses for beneficiaries at the time at which they are patients. Refers to situations where the first party (patient) does not pay directly for the activities of the second party (provider), but where this is done through a private insurer, sickness fund or government agency (third-party payer).¹⁶

TRIPS compliance The WTO Agreement is a treaty that creates international obligations among its members. Members must adhere to 18 specific agreements, one of which is the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS). To be TRIPS compliant the obligations of members include refraining from taking actions that are inconsistent with the agreement and implementing certain provisions via national legislation that embody certain specific standards.

Voluntary health insurance (VHI) Health insurance that is taken up and paid for at the discretion of individuals or employers on behalf of individuals. VHI can be offered by public or quasi-public bodies and by for-profit (commercial) and non-profit-making private organizations.

In the European context, VHI can be classified in three different ways.

- **Substitutive VHI** provides cover that would otherwise be available from the State; it is usually purchased by those who are excluded from participating in some or all aspects of the statutory health insurance scheme OR by those who have opted out of the statutory health insurance scheme and are therefore exempt from contributing to it.
- **Complementary VHI** provides cover for services excluded or not fully covered by the State (e.g. dental care), including cover for co-payments imposed by the statutory health system.
- **Supplementary VHI** provides cover for faster access and increased consumer choice.

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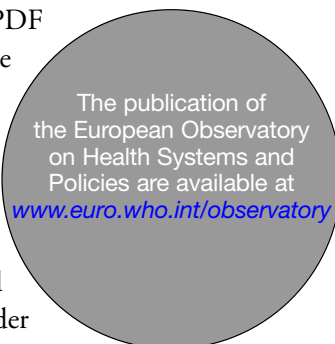
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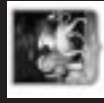
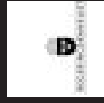
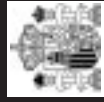
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