

**EUROPEAN HEALTH CARE REFORMS:  
ANALYSIS OF CURRENT STRATEGIES  
Summary**

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**Foreword**

Many governments in the WHO European Region are reviewing their health care systems and the suitability of their existing approaches to financing, organizing and delivering health care services. Yet health care reform is inherently a normative as well as an economic and organizational activity. Pressures to achieve better expenditure control and/or greater productivity and efficiency need to be balanced against deeply rooted moral imperatives to maintain universal access to necessary care, and to improve the equity with which services are distributed across social classes. Reform measures will be judged not only by short-term savings to public budgets, but also by their ability to promote health and to generate health gain for the entire population in line with WHO's health for all strategy. These normative dimensions are equally as important in the restructured health systems of central and eastern Europe (CEE) and the Commonwealth of Independent States (CIS) as in the widening health reform activities in western Europe.

Since the early 1990s, the WHO Regional Office for Europe has conducted an extensive programme of activities in support of reform development and implementation, including establishing a knowledge base and information system on reforms, developing networks to exchange experiences and support decision-makers, and providing direct advisory support on policy and competence building in individual countries.

The Regional Office has commissioned a study on recent experience in health care reform in the European Region. The study has been structured as an analysis of critical challenges that confront national health policy decision-makers in the second half of the 1990s. It is conceptual as well as empirical in approach, combining epidemiological, economic, organizational and managerial perspectives on the current status of health systems in both the eastern and western parts of the Region. The study's findings are based on over 30 background papers written by an extensive team of scholars and practitioners from all parts of Europe, as well as from Canada and the World Bank.

This document summarizes key conclusions from the study, the full results of which will become available in a separate Regional Office publication entitled *European health care reforms: analysis of current strategies*. Readers are referred to this forthcoming publication for a more detailed review of the issues and of the relevant evidence, together with a complete list of references. In addition, the full set of background papers provided by the project team will be available in two further publications to become available in 1997.

The aim of the book and this summary is to provide an introduction to a range of health and health sector challenges faced by policy-makers in the European Region, and to review the available evidence on the impact of a series of reform strategies. The approach adopted is to present a concise yet substantive perspective on those selected areas. Readers will thus benefit from the extensive research that has been

conducted on each topic of discussion. It should be noted that this summary is not intended to provide policy-makers with a set of specific recommendations. Rather, it is designed to synthesize the background evidence, which can help provide a foundation for further national health policy development. The draft of the book and this summary will serve as a basis for detailed discussions and recommendations at the WHO Conference on European Health Care Reforms in Ljubljana, Slovenia, in June 1996.

The Ljubljana Conference sets the stage for an intensified initiative by the Regional Office in the area of health reforms that could be of major importance for health providers, citizens, patients and scholars alike. It is hoped that this new initiative will assist policy-makers in surmounting the challenges they face as European health care systems prepare themselves for the next generation of service to their citizens.

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### **INTRODUCTION**

Health policy in Europe over the last two decades has been increasingly bedevilled by the growing cost of care. The aging of the population associated with higher levels of chronic diseases and disability, the increased availability of new

treatments and technologies, and rising public expectations have exerted an upward pressure on overall health-related expenditure.

Most European countries have responded with a series of measures to control these cost pressures. Organizational arrangements that had originally been conceived to improve equity, access and ultimately health status have increasingly been constrained by the concern for effective cost containment. In western Europe, successful control of expenditure at the macro system level in the early 1980s has, in the 1990s, given way to additional efforts to restrain growth in expenditure at the micro institutional level. In the CEE and CIS countries, the Soviet system of cost constraint based on macro level health budgeting on a "residual basis" has given way to efforts to increase funding in a time of economic transition, and a parallel concern about using scarce resources efficiently at the micro institutional level has also emerged.

This clash between, on the one hand, the moral imperative of maintaining solidarity and the social good character of health care and, on the other, the fiscal imperative of pursuing cost control has been the driving force behind much of the health policy debate across Europe in the 1990s. Arguments about the impact of specific cost containment measures on equity and health status have been raised in a number of countries. Indeed, a substantial portion of the present health reform discussion revolves around the connection between solidarity and cost containment. Must cost containment inherently and necessarily damage solidarity, defined in terms of health status and equity of access, as some public health professionals believe? Alternatively, is increased efficiency and effectiveness in the use of insufficient health sector resources essential to preserving solidarity, as some economists believe?

The depth of this debate can be seen in the degree to which even the definitions of key health sector activities have become vague and imprecise. The term "decentralization" has been applied to a wide variety of quite different organizational changes, and in the CEE and CIS countries has sometimes become synonymous with "privatization". Terms like "quality of care" have come to cover a wide variety of often disparate activities. Most disorienting of all, terms related to the introduction of coordinated health services like "managed care" have become entangled with concepts that stipulate a market-related role in the financing of health services such as "managed competition" or "regulated competition". This terminological confusion can be seen as one indication of the current level of policy flux and uncertainty.

Similarly, there is substantial inconsistency in the use of the term "reform" itself. In spite of the wide use of this concept, there is no universally accepted definition of what constitutes health sector reform. Different policy-makers and analysts place different connotations on this concept. For the purposes of the WHO study on European health care reforms, reform has been defined as a purposive, dynamic and sustained process that results in systematic structural change.

The impact of this reform debate on health policy can now be seen across Europe. Many western European countries are reviewing their health care systems in search of alternative strategies to finance and deliver services more efficiently and equitably. In some cases, such as in Germany and the United Kingdom, countries have formally adopted comprehensive reform programmes. In other instances they have introduced limited reform strategies to deal with specific problems of the health system. In the eastern part of the Region, the reform phenomenon has been

triggered by the political changes following the fall of the former Soviet system in the late 1980s. Some reform models and ideas have been transferred across national boundaries. For instance, the reform of the National Health Service in the United Kingdom, based on a notion of competitive contracting imported from the United States, has in turn had considerable influence on the content of health care reforms in several countries in both the western and the eastern parts of Europe. To date, there is little empirical evidence of the actual effectiveness of many reform policies, not just in those countries on the receiving end but also in countries championing such policies. In certain instances, the debate has been driven by ideology and rhetoric more than by evidence that substantiates anticipated benefits. Although many of these limitations are likely to persist, the current reform trend can be expected to continue in the second half of the 1990s, with additional western European countries introducing reform programmes and a continuation of the recently initiated reform process in the eastern part of the Region.

Taken as a whole, the evidence presented in the papers commissioned for the WHO study, presented in the forthcoming Regional Office publication, suggests three key dimensions for analysing health sector reform: the *pressures* for reform, the *strategies* for policy intervention, and the process of *implementation*. The main conclusions of the study in each of these dimensions are reviewed in the following sections.

## **PRESSURES FOR REFORM**

### **The context for health reform**

Two types of pressure from outside the health sector – the centrality of values and the reality of macroeconomics – determine the basic framework within which health-related policies must be formulated.

#### ***The centrality of values***

Health systems are strongly influenced by the underlying norms and values of the broader society within which they function. Health care services, like other human service systems, are mirrors that reflect the deeply rooted social and cultural expectations of the citizenry as a whole. These fundamental values, while generated outside the formal structure of the health system, often define the system's overall character and capacity.

A key indicator of a society's normative values is the very nature of health care itself. In some societies it is viewed as a predominantly social or collective good, in which all citizens benefit when an individual receives needed curative as well as preventive care. A related value is that of solidarity, in which the cost of care is intentionally cross-subsidized from the young to the old, from the rich to the poor and from the healthy to the sick, to ensure that all members of society receive needed care. In other societies, influenced by the radical market-orientated thinking of the 1980s, health care is increasingly perceived as a commodity to be bought and sold on the open market. This position emphasizes the technical and dynamic efficiency that market incentives can instil into the provision of health services, and the contributions these incentives are believed to make towards restraining future growth in health care expenditure. However, the concept of health services as a market commodity, while having been discussed in some policy-making circles, has not been adopted in any European country.

### ***The reality of macroeconomics***

A second, equally powerful factor for health reform is the structure and status of the overall national economy. In western Europe, macroeconomic policy increasingly reflects intense concern about national competitiveness in a period of regionalization and globalization of industrial production and trade. For the member states of the European Union, the Maastricht criteria for admission to the forthcoming European Monetary Union are also having a powerful effect on macroeconomic policy. Both concerns have led economic policy-makers to call for sharp reductions in public sector spending, particularly for human services such as health care.

In the CEE countries, although several years of negative economic growth have now been replaced by improvements in overall gross domestic product (GDP), only in Poland have current levels of production returned to their 1989 levels (Table 1). In the CIS countries, economic productivity in 1996 is estimated to be barely more than half what it was in 1989. These reduced levels of GDP reflect the painful economic restructuring that is under way, and help explain the sharp fall in state revenue available for the health sector.

### **The reform predicament**

In addition to external factors, national health policy-makers are also confronted with a variety of specifically health and health sector dilemmas that have encouraged them to consider major structural reforms.

### ***Health challenges***

The European Region faces continuing and, in some areas, growing challenges to the health of its population. The most significant health trend in the Region is the growing disparity in life expectancy and mortality between countries in the eastern and western parts (Fig. 1). This east–west gap has widened further in the 1990s, due mainly to a sharp deterioration in health in most of the CIS and some CEE countries. In 1993, life expectancy was 76.9 years in western Europe, 70.4 years in the CEE countries and 66.9 years in the CIS countries. While these aggregate figures conceal considerable national diversity, they indicate a trend that requires urgent attention by policy-makers and international organizations alike.

Cardiovascular diseases (CVD) continue to be the leading cause of death in the Region. They cause half of all deaths and one third of permanent disability, and are responsible for a large proportion of health care costs. Mortality from CVD is increasing in most of the CEE and CIS countries, and is responsible for approximately half of the east–west gap. Cancer is the second leading cause of death in the Region, accounting for 20% of the total. Many types of cancer are related to lifestyle and are thus, to varying degrees, preventable. External causes, such as accidents, homicide and suicide, are the third largest cause of death in the Region and are the second greatest contributor to the gap in life expectancy at birth between the eastern and western parts of the Region. These affect particularly adults in their thirties and forties, and thus have a disproportionate effect on families and on industrial productivity. Although mortality from infectious diseases is less significant compared with that from noncommunicable diseases, the emergence of new infectious diseases such as HIV infection and AIDS and the

resurgence of others such as tuberculosis, diphtheria and cholera is particularly notable.

The aging of the European population is also believed by many policy-makers to have a significant impact on the health needs of the population and on the patterns of disease contributing to it, owing to higher levels of chronic disease and disability. The percentage of the population over 65 years of age is increasing in all parts of Europe, with the increases likely to be particularly large in the next several decades in southern and western Europe.

Substantial health inequalities can readily be found within the European Region. There is considerable variation in health status between countries and, within them, between social classes, occupational groups, the sexes, ethnic groups and regions.

In the present context, these health challenges have two major implications for health sector reform. The first is the recognition that, while health services are fundamentally concerned with improving health, they only have a relatively limited impact. Overall health status is determined predominantly by behavioural and lifestyle factors, socioeconomic status and environmental conditions. Recent research has suggested that an individual's position in employment and social hierarchies may also help explain susceptibility to stress and illness. A wider intersectoral approach is required to address the main health determinants, as well as a strengthening of the public health function within the health services. This is discussed below under the main reform themes. The second major implication is the need to push health services to respond to these health challenges by shifting funds from curative to preventive care, and from secondary and tertiary care to primary care. Similarly, the configuration of health services themselves should be modified to respond to changes in the pattern of diseases due to demographic change, the rising level of chronic diseases, and the growth of new and re-emerging infections. Existing structures and incentives require rethinking if they are satisfactorily to address this changing disease pattern.

### ***Pressure on health expenditure***

During recent decades, several factors have combined to exert upward pressure on health care expenditure. As discussed above the aging of the population, with an increase in chronic diseases and disability, has created new pressures on health services. The pace of technology development has quickened over the past decade, generating new diagnostic techniques and treatments for conditions for which there was previously no treatment, or replacing or supplementing existing treatments. Health care providers typically face professional as well as clinical pressures to adopt the latest available medical techniques. The expectations of patients regarding the range of treatments and quality of services available have also increased in many European countries.

There are substantial differences in the levels of health care expenditure, both in per capita terms and as a percentage of GDP, between the countries of western Europe and those of the CEE and CIS (Fig. 2). In 1993 Switzerland, France and Austria had the highest levels of expenditure in western Europe with, respectively, 9.9%, 9.7% and 9.3% of GDP devoted to health care compared with the western European average of 8%. At the other end of the spectrum, Turkey and Greece spent 2.6 and 5.7% of GDP, respectively. After rapid increases in the 1970s, the rate of increase slowed in most countries between 1980 and 1990, reflecting successful macro system level efforts to contain expenditure. In the early 1990s,

however, there appears to have been a slight upturn in expenditure in several countries.

In 1994, the share of GDP devoted to health in the CEE countries ranged from 1.5% in The Former Yugoslav Republic of Macedonia to 9% in Croatia (Fig. 2). Although these levels are on average lower than in western European countries, some CEE countries have long spent a greater share of national income on health care than would be predicted given their income level, a proportion that has increased during the transition to an open economy. Despite the severe contraction (followed by moderate expansion in the best of cases) in real growth in GDP over the 1987–1994 period, real health expenditure either grew faster or contracted slower than did GDP. Two groups of countries can be identified. Those with the highest proportion of GDP devoted to health seem to be those that have historically relied on, or recently adopted, a national health insurance system financed by payroll taxation, such as Croatia, the Czech Republic and Hungary. A second group of countries comprises those, such as Poland and Romania, still relying predominantly on general revenue to finance health care; these are spending a lower percentage of GDP on health care. Although there are no comparative data available for CIS countries on current expenditure levels and trends, there has been a precipitous decline in publicly funded health sector spending both in real terms and as a share of GDP, corresponding to a severe contraction of the economy.

### ***Health sector challenges***

Beyond health concerns and increasing costs, there are also structural and organizational challenges in how countries in the Region finance and deliver health services. First, there are growing inequalities in health services – in terms of access to and quality of care – even in countries where health system structures provide universal access to services. Second, a growing body of research evidence has raised questions about the appropriateness and/or cost–effectiveness of various clinical procedures, suggesting that up to 30% of all delivered clinical services may be ineffective. Third, there are concerns about inefficient performance at the microinstitutional level. Some of the problems include poor coordination among providers and across subsectors, lack of incentives for efficient service provision, lack of adequate information about the costs and quality of services, inadequate management of capital resources, and insufficient or inappropriate management at the institution level. Fourth, the growing focus on micro level institutional activities has generated increasing concern about the quality of services delivered. Researchers have found wide variation in the utilization of particular procedures and in the outcomes achieved. Quality has also been a growing issue, as reflected in surveys of patient satisfaction. Finally, patients in both the eastern and western parts of the Region are no longer willing to be the passive objects of the service delivery system; rather they are calling for a greater say in choosing their physician and treatment facilities, as well as more participation in clinical and policy decision-making.

## **REFORM STRATEGIES**

In response to contextual changes and health and health sector challenges, countries have developed a wide variety of strategies for policy intervention at different levels of the health system. Underlying these different strategies and mechanisms, it is possible to identify a number of broad themes that affect all levels of the health system. For purposes of analysis, these policy responses can be

brought together into two groupings. The first can be summarized in terms of four integrating themes which can be observed across Europe as national policy-makers have sought to achieve their objectives. The four are: the changing roles of state and market in health care; decentralization to lower levels in the public sector and to the private sector; greater choice for and empowerment of the citizen; and the evolving role of public health. The second grouping classifies specific interventions in terms of the outcomes achieved, assessing the types of intervention that have worked well and those that appear to have been less successful. Taken together, these two groupings provide a broad review of both general trends and specific interventions in current European health reforms. Each is discussed in turn.

## **Integrating themes**

### ***The changing roles of state and market in health care***

Starting in the late 1980s, many European governments have begun to re-examine the structure of governance within their health systems. In countries in which the state has been the central actor in the health sector the presumption of public primacy, and with it a strong state role in nearly every dimension of health sector activity, is being reassessed. National policy-makers in northern, Mediterranean, central and eastern Europe have felt compelled by a combination of economic, social, demographic, managerial, technological and ideological forces to review existing authority relationships and structures. In countries where the state has played a less central role in the health sector, acting mainly to lay ground rules and to referee between quasi-public, statutory and/or private insurers and providers, a similar process of reassessment is under way, although from a different starting point.

While the pressure for change has been felt unevenly across the different parts of Europe, there appears to be a set of parallel trends regarding governance. Some state functions have been decentralized within the public sector to regional and/or municipal authorities. Other functions have been given over to private ownership. Conversely, in some countries where the state plays a less central role, there has been an increase in regulatory intervention in certain subsectors of the health care system.

The greatest pressure for change has been in the relative role of the private sector in the operation and, in some countries, the financing of health care services. While the popular media and some political figures have simplified this issue into "state versus market", in practice the issues are substantially more complicated. There is not a single, simple concept of the market that can be adopted for use within a health system. Rather, market-style mechanisms include a number of different specific instruments such as consumer sovereignty (patient choice), negotiated contracts and open bidding. These can be adopted within markets that are organized according to different principles: price, quality and market share. Markets can, in turn, be introduced within different sectors of the health system: in the financing of health care, in one or more subsets of the production of health services (among and/or between hospitals, nursing homes, physicians and social service personnel) and/or in the allocation instruments that distribute financing to service providers. Competitive incentives can be brought to bear on the behaviour of doctors, nurses, support personnel or home care personnel. In practice, then, there is not one but a series of decisions to make. Rather than a monolithic commitment to one of two abstractions – state or market – health systems in both the western and eastern parts of the European Region confront a range of smaller decisions.

The decision-making process must be not only strategic but also practical in nature, and as a result typically involves a multitude of approximations if not compromises.

In some instances, the decision has been to combine elements of both models – to mix an increased use of market-style incentives with continued ownership and operation of facilities by the public sector. This hybrid approach has been given a number of different names: internal market, public competition, provider market and quasi-market. The design and implementation of this type of planned market has played an important role in health reform in Finland, Italy, Spain, Sweden and the United Kingdom, as well as in various CEE and CIS countries.

The application of market-style mechanisms to the health sector is fraught with both conceptual and practical dilemmas. Conceptually, health care is considered by many academics to be a social good, in which the provision of service to each individual is also valuable to the community as a whole. This view has, in turn, been part of the traditional consensus within most European societies about the importance of solidarity and universal coverage in the design of health care financing systems. Market-style incentives, however, are by their nature based on the assumption that every service is a commodity, suitable for sale on the open market. Further, the classical concept of a market requires a clear distinction between the demand side (the buyer) and the supply side (the seller). Yet modern health care comprises a four-part relationship involving patient, physician, provider institution and payer. Thus, the application of market incentives to health care will by necessity focus on one or other of these submarkets rather than being comprehensive in character. Two additional dilemmas should be mentioned concerning the application of market theory to health care. First, physicians simultaneously supply services to patients and determine their demand for other services, which adds another layer of complication to simple market-oriented assumptions. Second, neoclassical economic theory assumes that cross-subsidies between different categories of payer and client are inefficient and unfair, yet the social function of a responsible health care system requires substantial cross-subsidies: from the young to the old, from the rich to the poor, and from the healthy to the sick.

A parallel set of changes is occurring in how national policy-makers approach the subject of state regulation. State intervention has expanded beyond traditional “command and control” measures to incorporate new market-derived incentive-based arrangements as well. Here, it is important to note that the contribution of both regulatory and competitive measures depends on how they are configured and introduced. Regulatory measures have demonstrated their effectiveness in a number of areas, most recently in the control of pharmaceutical expenditure. However, regulation is a valuable idea only when, first, it can reasonably be expected to achieve its intended objective and, second, when it can do so without creating major economic and financial distortions in the structure and quality of the services delivered. To achieve these goals regulation should be flexible, and should accommodate the multiple differences (technical, geographical and demographic) that often exist across a democratic society, within the limitations imposed by national law. Most importantly, effective regulation should be concerned with monitoring and evaluating *outcomes*, not with stipulating *inputs*.

Competitive measures, similarly, need to be carefully designed to achieve their intended objective. As most economists recognize, there is no room for unrestrained market activity in the provision of a social good like health care. Hence, the reliance of policy-makers on market mechanisms has been successful

where it has incorporated tight monitoring and evaluation as well as clear standards for market participants. Indeed, the decision to adopt a more incentive-oriented framework in one or other subsector of a health system requires not *less* governmental activity, only *different* activity. Some researchers have concluded that governments have to be *more* competent to supervise contracting and other market-style arrangements than to run services directly.

### ***Reorganizing the system: decentralization, recentralization and privatization***

Decentralization is a central tenet of health sector reform in many European countries. It is seen as an effective means to stimulate improvements in the delivery of services, to secure better allocation of resources according to needs, to involve the community in decisions about priorities, and to facilitate the reduction of inequities in health.

Decentralization is attractive because it is difficult for central administration to be close enough to the users of services to make appropriate and sensitive responses to expressed preferences. Disappointment with large, centralized and bureaucratic institutions is widespread throughout Europe. In almost every country the same drawbacks of centralized systems have been identified: poor efficiency, slow pace of change and innovation, and a lack of responsiveness to external changes that affect health and health care.

Decentralized institutions have a number of advantages. They can be more flexible than centralized institutions and can respond more rapidly to changing circumstances and needs. They can be more effective than centralized institutions, as the frontline workers are better able to identify problems and opportunities. They can be more innovative than centralized institutions in the types of solution they adopt. They can generate higher morale, more commitment and greater productivity from the workplace. Decentralized structures can also facilitate policy-making partnerships with citizens and local groups, thus increasing the democratic character of policy-making at the local level.

Successful decentralization, however, requires a specific social and cultural environment. One academic has identified the following: sufficient local administrative and managerial capacity, ideological certainty in implementation of tasks, and readiness to accept several interpretations of one problem. Decentralization can also have negative effects, including fragmented services, weakening of central health departments, inequity, political manipulation to favour particular interests or stakeholders, and a weakening of the position and status of the public sector. The experience of many countries in recent years demonstrates that there are certain areas where decision-making power should not be decentralized. Four such areas may be identified: the basic framework for health policy; strategic decisions on the development of health resources; regulation concerning public safety; and monitoring, assessing and analysing both the health of the population and health care provision.

Privatization is the ultimate form of decentralization in that it replaces direct public authority over decision-making with privately capitalized firms. The central benefits of privatization are seen to flow from the introduction of market incentives for greater efficiency and higher quality in the management of health care institutions. In addition, financially hard-pressed governments see privatization as a way to

entice private capital into the health sector, and thus to reduce demands on scarce public funds.

The disadvantages of privatization are, however, considerable. Private management and invested capital require financial returns consistent with those obtainable in markets in other sections of the economy. Pressures to achieve these returns can result in abandoning the social character of health services and intentionally discriminating against the sick and other vulnerable groups who require care. Recent experience with private competitive insurance in the Czech Republic, Israel, the Russian Federation and, to a lesser degree, the Netherlands has confirmed observations from the United States that private insurers have powerful financial incentives to engage in adverse selection of risks. If privatization is not to undermine broad health policy, national governments must accompany the decision to privatize with strengthened central regulation.

Whether the advantages of decentralization outweigh the disadvantages, notably fragmented and duplicated services and high transaction costs, is an issue that must be resolved on a case by case basis by national policy-makers. It is not uncommon to find that countries that engage in radical decentralization subsequently recentralize control over key elements of the system, typically health funding and the setting of medical standards. Privatization, however, has only rarely been viewed as a viable health policy strategy in western Europe, and has been pursued in CEE and CIS countries unevenly and with considerable trepidation.

### ***Citizens' rights, choice and participation***

In addition to the objectives of equity, effectiveness and efficiency, European policy-makers are also grappling with patient empowerment. In the health sector context, this refers to a growing chorus from patients that they be allowed a greater say in logistical matters (selecting their physician and hospital) and in clinical matters (such as participating in elective medical decision-making) and, increasingly, that they be allowed to participate in local policy-making when the state has made this possible through decentralization.

In varying mixes, countries in Europe allow patients to select their general practitioner, their specialist(s), their hospital and/or their hospital physician. In a limited number of countries subscribers may choose their insurer, although in western European sick fund countries this option has traditionally been only for people with a high income. Further, some patients in some countries with some (typically elective or chronic) conditions are able to influence the clinical decisions concerning their course of treatment.

Choice of specialist and/or hospital (for elective procedures) remains a controversial issue. There is no clear consensus among countries as to whether patients should be allowed to refer themselves to specialist care or whether, on the contrary, general practitioners should serve as gatekeepers and patients should be required to seek referral to a specialist.

Choice of insurer is also a controversial subject. Only one country in the European Region (Israel) currently has a universal system of insurance that requires subscribers to choose among competing private companies. In the Dutch experience, trying to introduce competition among insurers creates a severe challenge to the maintenance of solidarity and potentially insurmountable technical

difficulties. In some CEE and CIS countries, competitive insurance has proved to be expensive and to provide little benefit in terms of additional service.

Finally, there are currently only a limited number of instances of patients being able to influence clinical decisions. A few countries, for example, may consult elderly patients as to whether they wish to be placed in a nursing home or to remain in their own homes with home care services.

A related policy in a number of European countries has been the introduction of mechanisms for protecting patients' rights. While this does not necessarily involve public participation, it is an attempt to make health service provision more sensitive to patients' concerns about the accountability of providers and the confidentiality of information. The number of countries with active patients' rights movements can be expected to grow considerably in the next few years.

Countries with comprehensive approaches to patients' rights include Finland and the Netherlands. In the latter the Act on the Medical Contract, which took effect in April 1995, spells out clearly the principal rights of patients. The legislation treats the contract between patient and physician as a "special contract" in civil law. This gives the individual patient a direct claim on the doctor and the ability to enforce those rights through the courts, without relying on any further action by government.

Regarding participation in local policy-making, two key issues are the degree to which the citizen's voice is listened to by health care authorities, and how much authority and power citizens have in influencing decisions. In Finland, citizens have a formal influence through municipal health boards. The elected municipal council selects a health board consisting of a mix of local lay people representing citizens' views, which is supported by the chief physician from the municipal health centre. In the United Kingdom, local community health councils, also composed of appointed members, are set up specially to represent citizens' interests in health care. Unlike in Finland, these councils act only in an advisory and informative role.

In the CEE countries, there has been a rapid development of the voluntary sector, including a variety of patient support groups. One of the more successful reforms in Poland, for example, has been the establishment of local self-governing councils with health committees. Despite centralized financing and provision of health care, many local governments have taken over some health care responsibilities, typically concerning primary care.

### ***Evolving role for public health***

A fourth integrating theme is the growing importance of public health in current reforms. Public health is broadly defined as the promotion of health and prevention of disease through the organized efforts of society. It encompasses the promotion of health through intersectoral action, strengthening of preventive activities, and reorientation of the traditional public health services.

It is well recognized that key determinants of health lie outside the health sector, with social and economic factors being of particular importance. Policies in areas such as education, fiscal policy, transport and agriculture often have a greater impact on levels of health than those in the health sector. This recognition has underpinned many national programmes aimed at promoting health. Influenced by the WHO health for all strategy, these emphasize the importance of intersectoral

action. They draw on the five action areas suggested in the Ottawa Charter: building healthy public policies, creating supportive environments, strengthening community action, developing personal skills and reorienting health services. Related activities have been developed at local level, as exemplified by the WHO Healthy Cities network with some 500 healthy cities in Europe. These and other community-oriented programmes, such as the North Karelia Project that addressed the high level of heart disease in Finland, have been shown to be effective in bringing about change in behaviour and thereby improving health. Intersectoral programmes can be conducted through formal or informal means, involving public and private organizations, individuals acting alone or together, and bodies within and outside the health sector. In addition, many policies undertaken to achieve objectives not explicitly related to health, such as those encouraging community development or redistribution of wealth, may have important consequences for health.

Advanced public health skills are required to enable individuals to assess the health needs of populations and to then design, implement and evaluate appropriate interventions in response to those needs. Such skills are, however, relatively scarce in many European countries. Well trained personnel can play an important role throughout the health services and in other sectors, supporting the development of intersectoral policies as well as ensuring that health care policies remain focused on the improvement of health.

Evidence from countries in which public health services are well developed suggests that they can make an important contribution to the development of healthy public policies. In other countries, either because of scarcity of appropriate skills or organizational weaknesses, they are often unable to realize their potential. Experience suggests that public health services can be made most effective by reorientating their activities in certain areas. For example, in the fields of communicable disease and environmental health, this involves the use of up-to-date epidemiological methods to assess the impact of agents at the population level and the identification and control of underlying factors, rather than an obsolete laboratory-based approach to surveillance. In the field of health promotion, reorientation requires a move from policies based on education to those that help individuals to make healthy choices, whether by empowering them through advocacy or community development or by encouraging fiscal, regulatory or other means to increase the choices available. While such reorientation should not ignore health services, it should concentrate on the broader determinants of health. Public health services also have an important role in evaluating the effectiveness of health services, and in designing and implementing mechanisms to make services more appropriate, efficient, equitable and humane. This is substantially different from public health's traditional role of providing services for those who lie at the margins of society such as the poor and those with communicable diseases. Instead, it involves participating in planning or purchasing mainstream health care services. Indeed, in many countries the traditional public health role of providing services is disappearing as these are integrated into comprehensive primary care services.

Health sector reform offers a valuable opportunity to strengthen public health infrastructure across all sectors of society; to define national policy priorities linked not only to health care but to determinants of health and health gain; to improve health promotion and intersectoral strategies; and to reorient the public health service to support the health care services in pursuit of health gain.

### ***Strategies for policy intervention***

Reform strategies can be categorized according to a variety of analytical logics, including objectives (e.g. whether they are aimed at achieving equity, effectiveness or efficiency), health system components (e.g. whether they affect funding, allocation of finance or delivery of services), and health sector actors (e.g. whether they focus on the patient, third party insurer, third party purchaser or service provider). Strategies can also be categorized according to traditional economic parameters, such as by their impact on the demand for and supply of services. The approach adopted here classifies the evidence on the impact of different policy interventions according to four categories, drawing on a mix of these logics. The first group is formed by strategies that address resource scarcity, mainly by containing aggregate expenditures. The second group brings together strategies that affect health care funding, seeking to maintain universal access and financial sustainability by acting on third party insurers. The third group includes strategies aimed at achieving a more effective reallocation of financial resources from third party purchasers to service providers in accordance with health service objectives and priorities. The final group includes strategies that act directly on service providers to achieve more cost-effective and higher quality care.

### **Confronting resource scarcity**

The rise in health care costs in the face of constrained resources leaves countries with two basic and often complementary options. First, countries may increase the amount of resources for health care by shifting funds from other areas of public sector expenditure or by increasing taxation or social insurance contributions. The policy options include incremental funding according to additional health needs, linking health expenditure to growth in GDP, or using international comparisons. None of these approaches has been found to be completely satisfactory. Rather, the "right" level of funding depends on the value placed on health and health care in itself, and inevitably reflects political preference.

Second, countries can control health care expenditure by pursuing reform strategies that influence either the demand for or the supply of health care services. Reform strategies that act on demand include cost-sharing arrangements, priority setting to ration access to certain services funded by insurance, "no claim" bonuses in social insurance systems, incentives for private spending such as income tax concessions for those who use private services, and the right to opt out of the statutory system. In general, these measures seek to reduce demand by shifting a portion of health care costs to the individual, thus generating substantial equity problems. Two key demand strategies are discussed later in this section: cost sharing and priority setting.

Costs can also be contained by influencing the supply of health services. A wide range of reform strategies can be placed in this category. These include introducing competition between public insurers; reducing the production of doctors and the number of hospital beds; controlling the price of the manpower (e.g. salaries) or the supplies (e.g. pharmaceuticals) used to provide care; setting global expenditure ceilings or global budgets for providers; changing the methods of remunerating professionals; influencing the use of resources authorized by physicians; introducing market incentives; optimizing the use of technologies; and introducing more effective delivery patterns such as substitution of outpatient and primary care for more expensive inpatient services. These strategies have met with different degrees of success in containing costs. Overall, experience to date shows that

establishing budgets for the health system or for each main subsector, based on targets and manpower limits, appears to be the most effective means of containing costs.

Reform strategies, however, should not be evaluated exclusively in terms of their success in containing costs, but on a wider range of societal objectives. Moreover, success in containing costs does not necessarily imply greater efficiency. It is entirely possible for cost-containment initiatives to lower total costs while at the same time giving rise to greater inefficiency. Consequently, following the discussion of cost sharing and priority setting in this section, the review then takes a two-track analytical approach: it assesses health reform strategies in terms both of their focus on the funding, allocation or delivery of services, and of their impact on specific objectives including equity, efficiency and health gain.

### ***Appropriate role for cost sharing***

Cost sharing refers to any direct payment made by users of health services to the providers of those services. Economists are divided as to whether cost sharing can be an effective tool for improving efficiency and containing costs. There is, however, more general agreement that, unless accompanied by compensating measures for people on low incomes, cost sharing will be inequitable in terms of both the financing and the receipt of care. In countries that do not have a functioning universal health care system, the rationale for cost sharing may be less one of managing demand than of raising revenue for the purpose of sustaining services. For some of these countries, this may also reflect a history of informal payments ("grey market") for services and supplies.

Some researchers and policy analysts have argued that there is an inherent conflict in the use of a tool that raises revenues as a means of containing costs. This argument, put forcefully by Canadian health economists, rejects the use of cost sharing as a cost-containment measure. On the assumption that supplier-induced demand exists and that expenditures (of insurers and patients) are always equal to revenues (of providers), they assert that imposing or increasing cost sharing will not reduce costs but simply cause them to be shifted from those paying premiums (including taxpayers in a tax-based financing system) to those unfortunate enough to fall sick and require medical care. Further, these economists argue that in systems in which providers are reimbursed on a per-episode basis, providers respond to any generalized reduction in consumer-driven demand by increasing the volume and/or intensity of services, in order to maintain their income levels. From this perspective, if it is true that provider-driven utilization is a major cause of high health costs, then incentives and/or regulations affecting the supply side of the market are likely to be more effective in containing costs. These economists reason, moreover, that systems based on per-case reimbursement will always generate provider-led cost increases. They also note that cost sharing increases health sector costs by increasing the complexity of administering the financing system.

Cost sharing raises obvious concerns about equity with regard to both the financing and the receipt of care. It can cause inequity in financing because of the potential for the burden of cost sharing to fall on households with low incomes. It can cause inequity in the consumption of health care services by reducing access for the elderly, children and the chronically ill. This reflects the economic reality that price is more of a deterrent to the use of services when it consumes a greater percentage of a household's available funds. Reductions in utilization or delays in seeking treatment can lead to lower health status to the extent that use of health

services would have had beneficial health effects. Broadly-based exemptions from co-payment can alleviate much of this problem, but they do so by substantially reducing the amount of revenue raised.

The countries of the European Region employ a variety of approaches to cost sharing. The context for cost sharing, the objectives of these policies, and the way cost sharing is implemented in practice tend to differ in western Europe compared to the formerly socialist CEE and CIS countries.

Most western European countries place little emphasis on cost sharing as a tool for either raising revenue or containing costs for physician and hospital services. On the other hand, cost sharing for pharmaceuticals is widespread. Although the objectives of such policies are rarely stated explicitly, their main purpose appears to be to shift part of the cost of drugs to the user. About half of western European countries use some form of cost sharing for first contact care, and about half also apply cost sharing to inpatient and specialty outpatient care. In most countries the patient's co-payment tends to be nominal and is often accompanied by comprehensive exemption systems. Only a few countries rely on cost sharing as a significant source of health sector revenue. In these countries most patients typically purchase supplementary private insurance to defray out-of-pocket expenditure. In France, despite reliance on the *ticket modérateur*, 80% of their co-payments are reimbursed to patients by private insurers.

The most common forms of direct cost-sharing are co-payments and co-insurance; only in Switzerland is much use made of deductibles. Virtually all countries in western Europe use some form of out-of-pocket maximum to limit the liability of individuals or households for medical care costs, and none employs service or benefit maximums. Hence, income protection is a strong feature of these systems.

Raising revenue has been a principal concern of cost-sharing policies in most CEE and CIS countries. The falling levels of employment in most of these countries in recent years have reduced the scope for mandatory contributions to social insurance, since this is usually financed by the contributions of employers and employees. Similarly, there are limits to the amount of revenue that can be generated through general taxation. Thus many (though not all) of these countries are charging patients directly, primarily as a means of providing additional resources to sustain the health services. At the same time, the available evidence suggests that providers are increasingly reliant on informal "side payments" from patients.

Taking both theory and practice together, it appears that cost sharing does not provide a very powerful policy tool for improving efficiency or containing health sector costs. Given the reliance of patients on the providers for information that affects their demand for certain services, the theoretical basis for using cost sharing to reduce demand for services that are largely determined by the provider (such as referral services) is weak. Cost sharing may reduce the utilization of services initiated by the patient, but such reductions are not very effective for cost containment. This is because one of the main drivers of health care costs is service intensity, which is a provider rather than a demand driven characteristic.

### ***Setting priorities in health care***

Some academics have argued that rationing would not be necessary if additional funding were available and/or if resources were used more efficiently. Indeed, as

shown in the following sections, there is ample scope for achieving greater operating efficiencies by funding only those interventions that are appropriate and by adopting more cost-effective patterns of resource allocation and delivery. While the search for cost-effective patterns of care should be the first objective of policy-makers, it is not likely that it will avoid the need to set priorities in allocating limited funds among competing health sector needs. It may, however, forestall or reduce the need to ration the individual's access to necessary services.

Making choices about the allocation of resources between competing demands has always existed in health care systems. What is new is the public interest in the process and the demand for transparency. In recent years, several countries in the European Region and elsewhere have taken initiatives to examine priority setting on a more systematic and explicit basis. In western Europe these include the Netherlands, Norway, Spain and Sweden. However, there have been no substantial reductions in the coverage or the package of benefits offered by their health care systems. The situation is more acute in the CEE and CIS countries: in the midst of economic transition, these countries are under severe financial pressure to limit public sector spending by reducing benefits.

Setting priorities involves several levels of decision, ranging from the overall funding of health services to the treatment of individual patients. The evidence suggests that a strategic approach to priority setting is needed in order to coordinate decision-making at these different levels. This is illustrated by experience in the Netherlands, where national debate on the care package has been combined with investment in technology assessment, the development of practice guidelines, and the establishment of criteria to control waiting lists.

Priority setting at the macro level may involve rationing by exclusion, such as the approach in Oregon in the United States, or rationing by guidelines such as in New Zealand. These approaches may also be combined, as in the Netherlands. To date, only Oregon has defined in detail the core services that should be funded, with reductions in services applying only to poor women and children in the Medicaid programme. The Oregon experience illustrates both the technical and the equity-related difficulties that can accompany meaningful efforts to restrict access to clinically necessary services. Methodologies for involving the public in the process of priority setting are at various stages of development; a number of approaches have been used, and there is little apparent agreement as to which ones are most effective. There is, none the less, an increasing trend to engage the public in debate in countries of the Region, and this seems likely to continue in the future.

The key influences on the priority-setting process include government, providers, the public and patients, as well as evidence on health needs and on the cost and effectiveness of available interventions (Fig. 3). In seeking to set priorities in a more systematic and explicit fashion, some countries have emphasized methods that measure the need for services as well as the cost and effectiveness of available procedures. There is, however, an increasing recognition that priority setting cannot be reduced to a technical exercise. Technical analysis should be combined with a thorough public debate about the choices to be made.

Ultimately, priority setting is the responsibility of elected public officials, who must consider the options available and weight a range of objectives. Decision-making in this area inevitably involves tradeoffs between objectives as a balance is sought among universal coverage, comprehensiveness of services, equity, efficiency, cost containment and broader social values. As the Dunning Committee in the

Netherlands noted, choices in health care have to balance the aim of achieving basic care for all and the need to contain health care costs. In the Netherlands, the degree of comprehensiveness has been to some extent sacrificed in the pursuit of cost containment. Another important objective is equity. In the Netherlands and Sweden, equity or solidarity is explicitly mentioned as one of the key principles that should guide priority setting. In both countries, particular priority has been attached to care for vulnerable groups. In Sweden, for instance, the Parliamentary Priorities Commission has emphasized the need to ensure that cost-efficiency in the use of resources is not pursued at the expense of equity. All this illustrates the tradeoffs inherent in priority setting. While the aim of achieving greater efficiency in the use of resources is widely acknowledged, it is one objective among many and has to be weighed against other considerations.

### **Funding systems equitably**

Countries in the European Region can be divided into three groups according to the predominant method of funding their health system: the Beveridge model, mainly based on taxation; the Bismark model, chiefly based on social insurance; and the CEE and CIS countries, historically based on the Semashko model but now in transition to social insurance or mixed social insurance/taxation-based systems.

Beveridge countries in western Europe have taken a variety of paths to a predominately tax-funded health system. They include the Scandinavian countries, Ireland and the United Kingdom, and southern European countries (Greece, Italy, Portugal and Spain). Universal or near universal access to health care can be found in all these systems. None of these countries has expressed any intention to shift away from taxation as the main source of funding for health care. The role of the public sector as the main provider of funds, thus ensuring universal access to health care and equitable geographical distribution of resources, is widely accepted by their populations.

Bismark countries in western Europe (Austria, Belgium, France, Germany, Luxembourg and Switzerland) have long established statutory insurance-based systems. Though inspired by similar principles, however, the social insurance systems differ significantly. In nearly all cases they are subject to close regulation by government. There has been a noticeable increase in the level of government control and regulation, on grounds either of cost containment (by, for instance, putting a ceiling on premiums) or of equity and solidarity.

The third group comprises the CEE and CIS countries, most of which are moving towards health insurance funded largely through payroll taxation. These countries are at different degrees of transition. The republics of the former Yugoslavia already had such a health insurance system before transition, while Hungary and the Russian Federation (1991), the Czech Republic and Estonia (1992), Latvia and Slovakia (1993), Georgia (1995) and Kazakhstan (1996) all adopted such systems during the 1990s. Other countries such as Belarus, Bulgaria, Kyrgyzstan, Lithuania, Poland and Romania, which still rely principally on general revenue to finance health care, have national health insurance laws under consideration.

In the CEE and CIS countries a number of factors, including economic recession and the precipitate introduction of these schemes, have led to a series of problems in the shift to insurance-based funding. Among them are substantial increases in

expenditure, as well as structural deficits associated with insufficient transfer of funds and higher labour costs.

### ***Balancing solidarity and competition***

A core concern in countries engaged in transforming their funding system is balancing the principle of solidarity with pressures to establish competition among insurers. Solidarity has become synonymous with “risk pooling”, referring to all arrangements in which health care costs are not financed individually, and in which people who remain healthy through a given period financially support those who become sick and use health care services. The term “solidarity” is also reserved in Europe for health care systems designed to reduce health-related inequalities. According to this principle individual financial contributions are, at a minimum, not dependent on the individual’s health status – instead they are related to his or her ability to pay. However, services are not delivered according to ability to pay but according to need. As a consequence, a health care system is judged to achieve solidarity if it realizes a more equitable distribution between age groups, between income classes, between single people and families, and between good and bad health risks, than would be the case in the (fictive) situation of an unregulated private health care market.

Whether a society can base health care funding on competing insurers and, at the same time, maintain a high level of social solidarity is a challenging conundrum. In many countries, private health insurance schemes are operated in a manner that corrodes social solidarity. This is because the basis of payment by individual families to the health insurance company usually takes the form of risk adjusted premiums that reflect the health status of each individual. The opposite extreme is funding through one or other form of general taxation and solidarity, understood as risk pooling, is in general achieved through such a system. The amount of redistribution within such a system depends to a large degree on the progressiveness of the tax system. There is, however, no market competition over health care financing in such an arrangement, although there is political–budgetary competition between health and other areas of government expenditure that may have implications for solidarity. Moreover, solidarity will be affected by the level of private health care financing operating parallel to, and sometimes mixed with, public financing.

Social insurance usually involves government mandating purpose-specific taxes on employers and employees, as well as on the self-employed, pensioners and sometimes even the unemployed. Sometimes a specific proportion of social insurance taxes are designated for health, or there is a specific earmarking for health. Unfortunately, however, social insurance systems do not usually contribute to solidarity in financial terms. Most social insurance systems finance health care in a regressive fashion. This is due to the fact that contribution rates are usually a flat percentage of salaries or income, and there is often a ceiling on the amounts subject to tax. In such a situation those earning above the ceiling, for example, are paying an increasingly lower proportion of their income for social insurance and health care. Solidarity is also affected by rules governing who is included in or excluded from social insurance, or who may opt out of it. If those with high incomes are not included (or may opt out) they do not contribute to the system’s funding and make it more regressive.

If there is only one social insurance agency providing health care services, there is no competition. Competition is also absent if there are several such agencies but no

right of choice among them. Competition can be combined with social insurance schemes to the extent the insured may choose among those that have an interest in attracting members. As in systems relying on private health insurance, however, there will be a “natural” conflict between solidarity and competition, with social insurance schemes trying to compete for the good risks. Government regulation can try to set a framework for maintaining solidarity in such systems, and the extent to which solidarity will be eaten away by competition depends heavily on such regulation (but also on self-enforcement by statutory insurers and consumer education).

In most western European health systems, direct payments by patients at the point of service make up a limited portion of overall health care financing. In terms of solidarity, such payments represent the most regressive form of payment for health care, since they constitute a greater share of income for the poor (who are also higher consumers of medical care).

As already noted, a central trend in the reforms in the CEE and CIS countries has been a shift away from financing health care through general taxation towards a significant reliance on national health insurance funded through payroll taxation. While this trend is an expression of the countries’ will to decentralize and liberalize their health care systems, the impact on solidarity is ambiguous, since the shift in the source of financing is likely to be regressive. All CEE countries that have introduced national health insurance also continue to rely in considerable part on general budgetary revenue. In the CIS countries, budgetary revenues still provide the majority of health care funds.

There is, in addition, a growing informal sector. Since services in this sector are provided only for those who can afford it, ability to pay plays a more important role in health care than before. Therefore, although most CEE countries continue to offer a more or less comprehensive package of benefits through their publicly run health care systems, overall solidarity in health financing has been reduced. Additional problems created by the informal sector involve loss of control over total expenditure, as well as leakage of earnings by health professionals from the income tax system.

Although most western European health care systems still achieve a certain level of solidarity, the idea of a health care system based on solidarity evokes increasing scepticism. Although conditions and discussions vary in different countries, the basic reasons for this scepticism are similar. Rising health care costs conflict with financial pressures on governments not to increase taxes or social insurance premiums in a globally competitive environment. A strengthened libertarian and/or neoclassical philosophy argues that health should be much more a private good than a public interest. Rising health care costs are increasingly seen as a result of the collective, public organization of health systems – “moral hazard” and “supplier-induced demand” being prominent issues. Moreover, the shift in the age structure is expected to lead to an increase in per capita health care costs.

Nevertheless, European governments have been very cautious about introducing financial reforms that would directly damage solidarity. The eight-year history of health reform in the Netherlands reflects the trepidation of successive Dutch governments to embrace competitive financing if it would compromise solidarity. This tension can also be seen in the 1995 Health Insurance Law in Israel, and in reforms now under way in the German sick fund system.

Competition between health insurers (regardless of whether they are private or public) tends to erode solidarity in health care financing, since health insurers seek to select good risks. As a consequence, health politicians have had to seek innovative solutions to this problem. One common solution has been mandatory open enrollment. Another, closely linked to financing, has been the introduction of either individual or collective risk-adjustment schemes that redistribute the health insurance system's revenue among competing health insurers.

Maintaining solidarity in health care financing while introducing competition among insurers is an ambitious and difficult undertaking. Owing to the dynamic forces of competitive markets, implementing competition without damaging solidarity cannot be achieved solely through deregulation. The "safety-net" for solidarity has to be designed very carefully, and such an undertaking requires experienced supervision of health care markets. Moreover, several crucial questions have not yet been answered. Whether competition among insurers really leads to more efficient and more effective health care has yet to be demonstrated, as does the question of whether recently introduced mechanisms to combine solidarity with competition can succeed.

### **Allocating resources effectively**

A number of countries in both the eastern and western parts of the Region have begun to move from integrated models of provision to a separation of public or quasipublic third party payers from health service providers. As direct managerial relationships between these actors weaken, resource allocation mechanisms become increasingly central in enabling payers to achieve macro level control of expenditure as well as improved institutional efficiency. Key strategies for allocating resources more effectively include contracting mechanisms, payment systems for professionals and institutions, and purchasing mechanisms for pharmaceuticals.

### ***Buying better health: purchasing and contracting***

In an increasing number of countries in Europe contracting is seen as an instrument to implement health policy objectives. It is a coordinating mechanism that offers an alternative to traditional command-and-control models of health care management. An essential element of contracting is that it facilitates a more market-oriented form of institutional resource allocation, based on separating purchaser from provider. Contracting mechanisms bind third party payers and providers to explicit commitments, and generate the economic motivation to fulfil these commitments.

In social insurance-based health systems, contracts between third party payers and the suppliers of health services have existed for many years. In Germany and the Netherlands, for instance, complex institutional structures have developed to represent health insurers and physicians in negotiations over payment schedules. However, these contracting arrangements existed primarily to stabilize the relationship between insurer and provider. In current reforms, particularly in tax-based health systems, contracting has become a device for negotiations on prices and quality, as well as to ensure compliance by the provider.

Proponents of contracting present four major reasons for introducing contractual relationships into tax-based, command-and-control health systems: to encourage decentralization of management; to improve the performance of providers; to improve planning of health care development; and to improve management of care.

Contracts can support equity if, through needs assessment, they take explicit account of vulnerable and disadvantaged groups as well as underserved communities. From this perspective, purchasers represent the interests of their populations, allocating resources and purchasing services in accordance with their needs. However, contracting also carries dangers that can undermine equity. For example, some commentators have argued that services that are less profitable, as opposed to less efficient, may be underemphasized or phased out.

Community participation in contracting can lead to a process of democratization in health services, increase the accountability of governments and the medical profession, and make health policy more relevant to the needs and priorities of society. The process of contracting can be divided into three stages: pre-contracting, the actual contract or written agreement, and post-contracting. Community participation can take place in all three of these stages.

Intersectorality is not emphasized in contracting as currently practised, which focuses predominantly on primary, secondary and tertiary curative care. A few countries do incorporate community and social care into their contracting structures. However, numerous aspects of curative care are linked with other non-health sector activities such as education, labour affairs and social protection mechanisms. Contracting could therefore be used to integrate these activities into health care. In addition, contracting could be implemented in areas other than health care, such as the environmental health services.

In the Beveridge model the purchasing side is represented by the public health authorities. A recent innovation in some regions of Sweden and the Russian Federation and in the United Kingdom is that primary care providers act as purchasers of care as well. On the supply side are the providers. Contracts might deal not only with inpatient or outpatient care, but also public health, programmes for specific diseases, or community care. In the Bismarck model statutory insurers act as the purchasers of care. Contracting is between insurers and employers or individual subscribers, and also between insurers and providers of care. This might be supplemented by contracts between insurers and government for the provision of subsidies, and also between insurers and central insurance agencies.

Health care reforms that introduce contracting in the Beveridge group of countries seek to soften the command-and-control elements of this model. Contracting entails the introduction of a split within the public health sector between payers and providers. Of the countries in this group, three have directly introduced contracting: Finland, Sweden and the United Kingdom.

Contracting has been a part of the Bismarck-style social insurance-based health systems of continental Europe since their inception. Until recently, however, these contracts did not focus on price or efficiency, nor were they understood to be contestable. Since the late 1980s the Netherlands has sought to introduce a more price sensitive form of contracting, which would incorporate the individual's health insurance premium payments as well as contracts between the third party payers (sick funds) and provider institutions. Germany is scheduled to begin a similar process in 1996.

In the CEE and CIS countries, health care systems have historically been based on the Semashko model, a rigorously hierarchical command-and-control system. A few are attempting to establish contracting between payers and providers in the context of newly established health insurance systems. Many of the issues surrounding the

contractual arrangements between insurers and providers have yet to be worked out. Countries that are attempting to implement contracting through one or other form of a purchaser–provider split include Bulgaria, the Czech Republic, Estonia, Georgia, Hungary, Romania and the Russian Federation.

In some countries in both the eastern and western parts of the European Region, the move to more sophisticated cost and volume and cost per case contracting models is limited by insufficient information for an effective purchasing policy. The minimum information requirements for effective contracting cover patient flow data, cost and utilization information across specialties or diagnostic groups, and demographic and risk groups. Large investments are needed in information systems, including the capacity to process individual patient's bills. It is also important to disseminate information to facilitate a rational choice of providers. Resistance of the health authorities and the medical profession to the collection and dissemination of health information, and also a tendency to manipulate the available information, must be overcome.

An associated issue is rising transaction costs, such as costs associated with the continuing interaction of purchasers and providers (needs assessment, performance analysis, negotiating, monitoring, etc.). A substantial increase in quality and efficiency is required to justify these additional costs. To lower transaction costs, some scholars encourage purchasers and providers to enter into long-term contractual relationships rather than to view their task as one of making spot market deals.

### ***Performance-tied payment systems for providers***

No single payment system for professionals – fee for service, salary or capitation – can meet all policy objectives. A major drawback of a retrospective open-ended (fee for service) system is supply-induced demand, which exerts significant upward pressure on costs. There is ample evidence that physicians use their discretionary power to increase the quantity and alter the mix of services, thereby maintaining their target income. In response, countries such as France and Germany have introduced a series of measures including price regulation by adjusting fee scales; controls on the quantity and mix of services through penalties for overutilization of procedures; target expenditure levels; and capping overall expenditure. These mechanisms have been relatively effective in controlling costs at the macro level, but little is known about their impact, in terms of equity and quality, at the micro level. Although prospective payment systems (capitation and salary) tend to give physicians incentives to practise preventive medicine and to control expenditure, and may lead to a better geographical distribution, these systems can also result in excessive referrals, overprescribing, reduced access for sicker patients and – particularly with salaried practitioners – less responsiveness to patients.

Overall, mixed payment systems (with a large prospective component) seem to be more successful in combining macro and micro efficiency objectives. However, tradeoffs between different combinations remain inevitable. Two major tradeoffs are the balance between individual and collective preferences and that between complex systems – involving a mix of incentives to achieve a variety of objectives – and less complex systems that achieve fewer objectives. However, payment systems are only one among several determinants of professional behaviour. Professional standards, access to education, peer review and professional expectations are also important factors. Ultimately, if doctors are paid less than

they think they deserve, they will be more likely to act opportunistically to maximize their income.

The acute hospital system constitutes the largest single component of health expenditure in most European countries. While the order of priorities may vary, the objectives most frequently cited for the reform of hospital payment mechanisms include cost containment, improvement of quality and community-wide access. The pursuit of these objectives is made more difficult by the dynamic nature of the hospital system; by its visibility and political significance involving issues such as waiting lists; and by pressures created by technological advancement and the expanding expectations of the consumer.

Several key issues concerning the payment of physicians also apply to the payment of hospitals. Like physicians, hospitals can be paid according to the volume of services they provide, based on a price list for services (fee for service), patient-days (per diem fees or daily charge) or cases treated (case-mix payment); they can also be paid prospectively via global budgets provided to the hospital for a given period of time. Budgets may be calculated according to actual costs, historical patterns of expenditure, provision of beds, population covered or volume of services to be provided (measured by number of bed-days or volume and mix of cases).

The most prevalent characteristic of prospective budgeting systems is that limits on expenditure for a defined period are determined in advance. Traditionally, prospective budgets based on historically incremental norms have been typical of tax-based systems. However, during the 1980s and 1990s several insurance-based systems in western Europe have adopted prospective global budget systems, incorporating some measures of hospital activity such as bed-days or cases. The prioritization of cost control is complemented by a concern for efficiency, with a growing number of countries applying some adjustment for activity/case mix within the budget framework. Improvements in the budget mechanism may also help enhance quality, autonomy and management flexibility. The implementation of any budgeting system must, however, address potential problems with quality of care and with the possible politicization of the resourcing process.

It is more difficult to generalize about hospital financing systems based on the volume of services provided, because by their very nature they operate at the micro rather than the macro level. While this approach is generally characterized by the association of resource use with service use at the patient level, the approaches used to put it into operation vary substantially. The most obvious disadvantage of the approaches within this category is their open-ended nature, which makes control of cost and utilization difficult to achieve. However, when this volume-oriented approach is combined with prospective pricing as well as contracting, payers can require hospitals to achieve specific objectives like cost control and effective utilization of resources. In turn, to achieve these objectives, hospitals need more flexibility in the organizational, manpower and financial aspects of service provision.

### ***Cost-effective provision of pharmaceuticals***

A third set of strategies towards more effective allocation of resources focuses on the provision and consumption of pharmaceuticals. The continuous rise in pharmaceutical costs has caused increased concern to governments. Pharmaceutical expenditure in western Europe represents between 10% and 20%

of total health care expenditure, a figure that has been increasing more rapidly than total health expenditure during the 1980s and the beginning of the 1990s. This has reflected the introduction of expensive new medicines and increases in volume rather than a general increase in prices. A related factor is that the proportion of prescription costs paid for by publicly financed schemes has been increasing steadily. There are also concerns about the quality of prescribing patterns and the effectiveness of many drugs, with some preparations having little or no proven therapeutic value.

In addition to the above concerns, CEE and CIS countries have also had to deal with structural problems in the former Soviet system for the provision and distribution of pharmaceuticals. Problems in the pharmaceutical sector in these countries have been heightened by the acute shortage of drugs, budget restrictions, lack of appropriate pricing systems and reimbursement mechanisms, and the absence of adequate legislation and regulation.

The characteristic three-tier demand system – the doctor prescribing the product, the patient consuming it and the insurer paying for it – generates imperfections in the market for pharmaceuticals and poses particular challenges for its regulation. European countries have adopted a wide range of measures to contain costs and increase the quality of drug prescription; these are summarized in Table 2 under three major categories. Strategies on the supply side are mainly aimed at influencing physicians' prescribing practices and making them more cost-conscious. These include expenditure ceilings such as indicative budgets or fixed budgets for family practitioners as well as a variety of methods for influencing their prescribing behaviour, including the introduction of a limited (positive or negative) list of drugs reimbursed by the statutory system, promoting the use of generic preparations and/or allowing them to be substituted for the prescribed brand, and a wide range of measures aimed at more effective medical practice such as the introduction of auditing, practice guidelines and the use of financial incentives. Measures on the demand side can include cost sharing and health education programmes. Finally, there are a set of strategies aimed at the market as a whole. These include direct control of pharmaceutical prices, controls on the profits of the pharmaceutical industry and, more recently, the introduction of reference pricing.

In several countries, strict price control systems have constituted the major cost containment measure in the last 20 years. But price controls, if not combined with other measures, may also lead to perverse incentives to the pharmaceutical industry, such as the introduction of duplicate or only slightly altered products that offer nothing new. Other types of action such as budget controls can be effective in containing costs, although less is known about their effect on quality. Cost sharing typically transfers costs to private household budgets, a form of "de-insurance" which, as noted earlier, may have economic as well as equity drawbacks.

At present, there is insufficient information about the long-term effects of more recently introduced measures such as reference pricing. This system operates by grouping similar products and fixing a price to be covered by the insurer, with any excess above this price to be paid by the patient. In the European Region, the reference price system was first introduced in Germany in 1989, followed later by other countries such as Denmark, the Netherlands, Norway and Sweden. Savings have been less significant than expected, as in some cases the industry made major efforts to promote drugs not covered by this system, and succeeded in increasing the market share for these products.

More countries might encourage generic prescribing and more might adopt positive lists, since both measures have a significant impact in increasing the quality of prescribing. However, it is notable that most countries that have not adopted limited lists are major drug exporters. This illustrates the conflicting policies, faced by many governments in the field of pharmaceuticals, between the need to contain pharmaceutical costs and the need to increase investment and exports.

Individual strategies concerning pharmaceutical expenditure tend to have an initial impact on containing costs, but are later bypassed by professionals or the industry through cost shifting to other areas or categories. A comprehensive drug policy is required that combines several different strategies in order to increase their overall effectiveness, for example by combining reference pricing with positive lists and/or expenditure ceilings.

The introduction of a market-oriented drug supply system has been accepted in most CEE and CIS countries as a necessary component of the general reform process, with only few countries leaving this sector in the hands of the state. While this has led to an increase in drug availability, in many cases rapid privatization combined with a lack of control and proper regulation has led to chaotic and unmanageable development. High prices, an overflow of imported drugs and excessive profit margins have led to problems of affordability.

In general, the reform of the pharmaceutical sector in the CEE and CIS countries faces a wide variety of challenges. These include the inappropriate use of drugs, insufficient legislation and control, the lack of a comprehensive sector strategy or national drug policy, and the need to develop mechanisms for drug pricing, drug reimbursement and privatization of distribution in the pharmaceutical wholesale and retail sectors.

### **Delivering services efficiently**

In the late 1980s and early 1990s, health care reforms in Europe have paid increased attention to the organization and behaviour of service providers at the micro-institutional level. These changes have concentrated on improving both managerial efficiency and health outcomes. The measures adopted have focused on developing quality of care programmes, restructuring the internal and external organization of hospitals, enhancing the capacities of primary health care and, where possible, substituting more appropriate for less appropriate forms of care. Related changes have also been introduced in the area of human resources. Each of these topics is discussed below.

### ***Improving outcomes and quality of care***

There is increasing recognition across Europe that health reform should include efforts to improve both the process and the outcome of the care provided. Former deference to medical judgement about how to deliver health care is giving way in the face of wide variations in how physicians actually provide care. Such variation has many causes, the most important being clinical uncertainty about the most appropriate treatment in any given circumstance. This has led to three related sets of concerns. First, there are sizeable gaps in knowledge about which treatments result in improved health outcomes, with only an estimated 20% of medical interventions having been evaluated in clinical trials. Second, many clinical interventions do not achieve the intended objectives, and sometimes result in poor health outcomes. Information is still fragmentary, but systematic reviews have

demonstrated that commonly used interventions in many areas are either definitely or probably ineffective. Finally, there are still large gaps in understanding how to change professional behaviour so as to ensure that the most effective, efficient and humane treatments are provided.

The existence of this uncertainty has given rise to a wide range of activities that have gone under terms such as health care technology assessment, evidence-based medicine, outcomes research and quality assurance which, despite some differences in approach, have as a common aim the improvement of health outcomes. This "outcomes movement" in its most developed form encompasses systematic reviews of available evidence on selected topics, the dissemination of the evidence, the development of a research agenda to fill the gaps, and support to create a research infrastructure.

All of these activities are based on a multidisciplinary approach, with emphasis on timeliness, relevance to the needs of the users, and the importance of changes in policy and practice. Many countries have mechanisms to address some or all of these tasks. One example is the establishment of organizations for health technology assessment, which typically involves the early identification of emerging technologies, synthesis of available evidence and commissioning of needed research.

The synthesis and dissemination of research-based evidence is at the core of these approaches to assuring the quality of clinical care. It is, however, also necessary to establish mechanisms to ensure that the available evidence is used by practitioners. These constitute what are usually described as quality assurance activities although a range of other terms, such as continuous quality of care development and clinical audit, are also used in some countries.

Three concepts concerning quality assurance stand out. The first is that it is a continuous process, involving repeated cycles of standard setting, change and reassessment. The second is the need to separate different ways of measuring quality, for example structure (such as facilities and the availability of trained staff), process (adherence to agreed good practice) and outcome (the extent to which the objectives of treatment are achieved). The third is differentiating between internal and external approaches to quality assurance.

Most quality assurance activities have dealt more with the structure and process of care, and less with outcome. In general, however, there are difficulties in linking structure and process variables to desirable health outcomes. When process measures are used, these should be based on evidence that they correlate with a good outcome. One way to measure quality is in terms of structure. This is based on the assumption that high quality care cannot be provided in the absence of basic prerequisites, such as adequately trained staff. It is a necessary but not sufficient measure, and normally should be supplemented by measures of either process or outcome.

Internal as against external forms of quality assurance have different characteristics. In the former, the activity is conducted by those undertaking the clinical activities concerned, such as the physicians in a hospital. They are responsible for setting standards and implementing change. This has the advantage of fostering a sense of ownership and is less open to opportunistic manipulation of results. It does, however, require a culture in which it is accepted that clinical practice should be open to examination by one's peers. In some western European

countries, professional bodies have played a major role in promoting this internal approach.

The alternative is an external approach, in which a body outside the hospital or general practice examines measures of quality. This typically focuses on structure, largely because this is so much easier to measure than process or outcome. A typical example is hospital accreditation. Accreditation is especially important for countries seeking to establish a mix of private and public health services, as it offers a means of reassurance that all facilities meet an agreed minimum level of quality.

The production of clinical guidelines represents a way in which technology assessment and quality assurance have been linked. On the basis of a systematic review of evidence, supplemented where necessary by expert opinion, guidelines for the management of particular conditions are drawn up. There is now an extensive literature on both the most appropriate means of developing guidelines and how they should be used. Clinical practice guidelines are being viewed as highly promising tools for promoting cost-effective and appropriate care. However, a review of the evidence seems to show that the effect of guidelines is small when established on the basis of expert judgement only. The lesson appears to be that information alone cannot be expected to have a major effect on how physicians practise. Rather, such guidelines need to be reinforced by respected senior physicians at both hospital management and national medical association levels. Ultimately, if physicians are to adopt these guidelines, they need to be convinced that the proposed clinical protocols will improve how they practise medicine, and that the information collected for quality reviews will be treated confidentially.

A recent trend in the European Region has been the introduction of continuous quality of care development (QCD) programmes. This initiative takes a comprehensive, integrated and dynamic approach to quality development, acts at the various levels of health care systems, and involves different health care actors. QCD is based on the following principles: the identification of the best outcomes, explicit definition of goals, professional self-assessment and self-regulation, and patient involvement. Quality development compares outcome results between similar settings, identifies and disseminates the best practice, and encourages implementation. There is a need for a broad framework of enabling measures, including financial and professional incentives, information systems such as national databases on outcome indicators, clearing houses or clinical databases, and the introduction of telematics and legislation. In collaboration with the Regional Office several countries, including Belgium and Denmark, have developed national policies on quality of care with major results. At the international level, significant progress has already been made in identifying common quality indicators in fields such as perinatal and obstetric care, mental health, diabetes, hospital infections, usage of antibiotics and oral health care.

The various components of evidence-based medicine, from research through dissemination to implementation, are in place in only a few countries in the Region. In many countries the focus of health policy discussion often remains predominantly on issues of financing and organization. The difficulties confronting countries that seek to integrate evidence-based health care with health sector reform should not be underestimated. Some countries face substantial problems such as a lack of appropriate information systems and clinical research infrastructure. There is considerable scope for international cooperation. This is already well established through the Cochrane Collaboration, an international

grouping of researchers with centres in several European countries, which undertakes systematic reviews of available evidence in the literature, agrees standardized methods and disseminates information.

Linking policy and practice decisions to formal assessment is still a relatively new concept. Health care systems need to measure their performance directly, ensuring the collection of better data on health outcomes and involving the professions. In the long run, health care can only make a greater contribution to health outcomes if more is known about the value of health care interventions and if this information is used more systematically in decision-making. Furthermore, the evidence of both ineffective care and underprovision for those who can benefit means that failure to address these issues leads to wasted resources and missed opportunities.

### ***Decentralized provider management***

A notable reform trend across the Region is the decentralization of management functions to provider institutions, coupled with the development of more effective management within institutions through strengthening managerial expertise, introducing improved information systems and increasing financial autonomy. This reflects a general trend towards decentralization that includes, in some countries, the introduction of provider markets and the separation of the purchaser and provider functions. Increased managerial autonomy and reduced bureaucratic control is aimed at encouraging more innovative practices and increased responsiveness to the demands of the purchaser and patient.

In several publicly operated health systems in western Europe, the traditional hierarchy between health authorities – at regional, area or local level – and hospital providers is being replaced by more decentralized management arrangements. In some cases they take the form of quasi-autonomous nongovernmental organizations (quangos) or self-governing hospitals. These have been introduced in the United Kingdom, and similar arrangements are under consideration in several other countries. In social insurance systems, managerial autonomy in hospitals has been strengthened by the recent introduction of more market-oriented incentives in the relationship between the insurer/purchaser and provider. In several of the CEE and CIS countries, responsibility for hospitals has been decentralized to local public authorities and, in some cases, endowed with the ability to contract directly with insurers. However, self-governing schemes are still at an early stage of development in both the western and eastern parts of Europe. Key issues include public accountability, the representativeness of management boards, and legal liability.

In some health systems, hospital decentralization and more effective hospital management also include involving clinical staff in management. For decentralized structures and contractual arrangements to operate efficiently, hospital management and clinical providers need to cooperate closely. This cooperation has been encouraged in the United Kingdom and some Scandinavian countries through the development of new management structures, including clinical directorates and the devolution of budgetary responsibility to groups of clinicians at department or specialty level. In general, these experiences have encouraged more effective use of scarce resources.

### ***Restructuring hospitals***

Inpatient care typically consumes between 45% and 75% of resources dedicated to health care. There is an increasing perception that there are more cost-effective alternatives to the care currently provided in hospitals and that consequently there is scope for a further reduction in hospital services. Policy-makers thus face questions about the long-term role of the hospital, its future configuration and how changes in hospital systems can be implemented.

In almost all western European countries, the total number of hospital beds fell significantly between 1980 and 1993, accompanied in most cases by a shortening of length of stay (Fig. 4). These reductions probably result from a combination of cost-containment policies, changes in technologies or treatment, and an increased reliance on primary and social care.

In general, CEE and CIS countries have higher levels of bed provision (associated with higher levels of admission and longer lengths of stay) than in western Europe. This results in part from norm-based planning and reimbursement practices based on number of beds. It also reflects differences in the role of the hospitals and in public expectation, and a less well developed community care sector. In recent years, as a result of health reforms, there have been some reductions in the numbers of hospitals and beds, as well as in length of stay. Overall, however, there is still clear scope for further reduction and rationalization of hospital services in most CEE and CIS countries.

Policy strategies for restructuring hospitals aim at achieving a more appropriate use of hospital services, changing the shape of the hospital network towards a more efficient configuration, and improving the efficiency of service delivery. These measures are intended to reduce the need for beds and allow changes in the size, cost and configuration of the hospital system. To achieve these objectives, a combination of both market and planning mechanisms have been employed. Table 3 shows a number of these mechanisms according to whether they act on the demand or on the supply side of the hospital system. As discussed previously, the use of financial incentives such as a hospital reimbursement policy, evidence-based purchasing or provider markets are key elements in attempts to reform the hospital sector. Hospital substitution policies can affect demand by reducing the need for admission or by allowing early discharge. Another strategy to reduce demand is the use of utilization review, which has been shown to prevent inappropriate admissions and bed utilization.

Overall, a series of management strategies ranging from development of managerial capacity and information systems to specific performance management techniques (e.g. target setting for length of stay) have been shown to be effective. Many of these measures are complementary, challenging policy-makers to build a system that will achieve increased appropriateness and efficiency but that is still flexible enough to facilitate innovation.

Experience with efforts to close hospital beds leads to several observations. If closures are to be consistent with a broad health gain strategy, they cannot be left to market devices but require a planned approach that balances expenditure savings and access to care. Given the particular features of hospital costs, the closure of whole sites may be more effective in releasing significant resources than intra-institutional adjustments.

***Shifting borders: hospitals, primary health care and community care***

Patterns of health care organization and delivery across care settings (hospital, primary, community and home care) have been changing to reflect new circumstances, both on the demand and supply sides of services. Pressures to review current practices reflect growing pressures to contain overall system costs, as well as new demands for resources resulting from epidemiological changes related to demographic structure, policy shifts and the increased expectations of patients. New technologies have also been developed in fields such as genetics, imaging, miniaturization, pharmaceuticals and information that have had a substantial impact on preventive, diagnostic and treatment practices. In response, health sector staff, skills, equipment, information and facilities need to be reorganized to achieve better results. There has also been increased scepticism about earlier assumptions concerning the appropriate role of hospitals, given the growing possibilities of providing diagnostic and treatment procedures elsewhere.

The adaptation of health systems to these pressures has occurred through a process of *substitution*, by which there has been a continual regrouping of resources across care settings to exploit the best available solutions. There are a multitude of shifts in treatments, procedures or organizational patterns that can be included under the category of substitution. A useful typology differentiates them according to three kinds of substitution: moving the location of care, introducing new technologies, and shifting the mix of staff and skills. Fig. 5 sets out a framework of care delivery, indicating the main health care settings and the types of substitution between them. Some examples include substituting *home care* for secondary hospital care (e.g. hospital at home schemes, enhancement of long-term care and renal dialysis) or for primary/community care (e.g. self-care programmes and diagnostic patches) and substituting *primary/community care* for secondary hospital care. This involves shifts in location (e.g. physiotherapy and open access diagnostics), in location and technology (e.g. desk-top laboratory) and in location and staff skills (e.g. nurse practitioners, shared care protocols, some minor surgery procedures and community-based mental illness services). Other opportunities for substitution are between specialist and secondary hospitals and between health and social care, where the potential for reduced costs and improved patient services is believed to be greatest.

Some western European countries such as the Netherlands and the United Kingdom have had considerable experience with various substitution schemes. The potential advantages of substitution policies include increased patient satisfaction, improved clinical outcomes, greater efficiency and more appropriate management of certain diseases. However, there are substantial differences between the various substitution schemes, and in many cases there is little evidence as to their impact on health service objectives.

The advantages of substitution may be reduced or lost if policy-makers adopt new schemes in an uncoordinated manner or without clear strategic objectives. Too often substitution involves simply changing the location, without an appropriate shift in skills and technology or without a reallocation of resources. Successful substitution relies on a comprehensive analysis of current service delivery patterns in each country, good information on the merits of individual substitution policies, and a detailed understanding of the changes required in resources and the mix of skills.

### ***A renewed role for primary health care***

The broad principles of primary health care (PHC), systematically defined in the Declaration of Alma-Ata in 1978, have helped develop a new health culture that transcends narrow biomedical determinism. Over the last two decades PHC has advanced considerably in taking on new roles and functions. Progress, however, has been patchy and anecdotal rather than conceptually-based and systematic. There also continues to be considerable debate about the most appropriate way to structure the delivery of PHC services.

This debate is illustrated by the variability of functions, structures and professionals involved in PHC in the European Region. While the principle that PHC should provide “promotive, preventive, curative and rehabilitative services” is widely accepted, the functions carried by PHC differ from one place to another. There is, however, a general trend in both publicly operated and social insurance based health systems to integrate certain preventive and health promotion functions, formerly carried out by vertical public health programmes, into PHC. This has been shown to be effective where there is a well developed PHC infrastructure, an appropriate incentives system, and good coordination and support by the public health services.

There are also substantial differences in the organization of PHC among European countries. There are arrangements based on solo general practice, on group general practice and on multidisciplinary health centres. One also finds different strategies for placing patients on a list, or for regulating access to specialists through gatekeeping. There appears to be a trend towards introducing the family or personal list system where it did not previously exist, probably reflecting the change from a salary or fee-for-service form of paying general practitioners to capitation-based systems, as well as the increased adoption of the gatekeeper role for general practitioners. The personal list system appears to address both the cost-containment problems generated by a free choice of physician reimbursed through fee-for-service on the one hand and, on the other, restrictions of choice imposed by a geographical catchment system in which consumers are assigned to a general practitioner based on place of residence. The patient list system also increases the likelihood of a personal relationship being established between physician and patient, and ensures good continuity of care. Although gatekeeping restricts direct access to specialist care, if it is accompanied by a patient list system, a well developed PHC infrastructure and appropriately trained professionals, gatekeeping has the potential to contain costs while maintaining or improving quality of care. PHC has had a rather fitful relationship with the continuing process of health reform in the European Region. On the one hand, reform programmes emphasize the development of PHC as a means of increasing the effectiveness of health care. On the other hand many reforms have focused predominantly on financing and organizational issues at the macro level and as a result PHC, like public health, is often viewed as a marginal player.

PHC may have its largest role to play in health reform in the growing number of countries that seek to give it control over part or all of other delivery sector budgets, including Finland, the United Kingdom, and some parts of the Russian Federation and Sweden. These efforts to give PHC more financial responsibility are not uncontroversial. While they enhance the position of PHC, increasing its power *vis-à-vis* specialist services, there are also concerns that budget-holding may lead to adverse selection and greater inequities in the delivery of services. Budget-holding is also a managerially complicated arrangement that requires substantial state regulation and supervision. Nevertheless, it is in this area that PHC may well be most actively involved in European health care reforms.

As noted above, changes in the environment in which health services operate, such as recent advances in medical science, the appearance of new technologies and concerns about the appropriate role of hospitals, pose new challenges for the development of PHC. In some instances, PHC is under pressure to take the place of existing providers without having a sufficient infrastructure or receiving additional resources.

In order to face the challenges that lie ahead, PHC should build on its unique strength as a provider of integrated services to and with the patient and the community. This role has three complementary aspects. The first is functional integration, which implies that the episodic management of disease should be superseded by an integrated approach to the health needs and problems of the individual, the family and the community. Community-oriented primary care has shown that it can achieve considerable improvements in health in an effective and efficient manner. The second aspect is organizational integration, which reinforces the multidisciplinary character of the health team within the health centre, and integration with other agencies providing services to the patient. This means that PHC should define clearly the limits of its mandate and work closely with clinical specialist, social welfare and public health services to improve the quality of services to patients. The third aspect is educational integration, which can generate the knowledge, skills and attitudes that are currently lacking in many training programmes for health professionals. Key initiatives here include undergraduate training in PHC, specialist training, and continuing education for general and family practitioners and other members of the PHC team.

### ***Developing human resources***

The largest proportion of recurrent expenditure in health care systems is typically the cost of staff, making human resources a critical factor to be addressed in any reform of the delivery of health care. Successful health reform requires careful consideration of key human resource implications, such as planning of staffing levels and mix of skills, educational training and accreditation, incentive policies and industrial relations.

Southern European countries and those of the CEE and CIS have health sectors that are overstaffed with physicians. For instance, in 1993 the ratio of physicians to the population in CIS countries such as the Russian Federation and Ukraine were well above the overall regional average. Whether the higher numbers of physicians observed in some countries are the result of long-standing traditions or a tendency to substitute staff for capital intensive approaches, this overcapacity needs to be addressed. Market factors and medical unemployment seem not to be reducing the supply of physicians at a sufficient rate, and some countries still report increases in the number of qualifying doctors. There is a need, therefore, to review recruitment to medical schools, in particular those in the private sector. There are also wide variations in the ratio of doctors to nurses and of nurses to the population in the Region. In western Europe in 1992, the number of registered nurses per 1000 population ranged from 3.0 in Portugal to 13.7 in Norway. In general, these rates reflect a north–south divide.

A related need is to review traditional definitions of medical roles as well as the division of responsibilities between different professionals, and to avoid the use of overqualified and expensive personnel by devolving certain less clinically demanding tasks to more appropriate staff. The distribution of staff is also critical, with a number of countries in the Region experiencing difficulties in staffing rural

areas. In several Member States the provision of family doctors and other primary health care staff is also a problem. Specialists continue to predominate numerically, in terms both of status and of their earning potential.

Reform programmes in European countries need to place more emphasis on establishing appropriate assessment and training policies for the numbers and mix of skills of staff required in reformed systems. There are examples of reform failure, which have resulted in part from the absence of trained staff with appropriate skills. Areas requiring particular development include public health, general and family practice, nursing and management training.

Two key professional groups in the health sector are nursing and general practice. As the single most numerous group of health care professionals in the Region, nurses play a significant role in the health system. In many countries and many settings nurses are the first, last and most consistent point of contact that patients have with the health care system. Despite wide differences in professional roles and functions among European countries, there are some common trends emerging. Nursing development is part of the more general trend to increase the cost-effectiveness of health care delivery. Efforts to audit and measure outcomes from nursing interventions are now taking place in several countries. Also, nursing is shifting its focus from hospital-based services to PHC, with an emphasis on disease prevention and health promotion. Changes in nursing practice inevitably bring a need for reform of nursing education and revision of curricula. Issues of low pay, poor working conditions and low status also need to be addressed through the introduction of career structures and appropriate financial incentives. These difficulties are most acute in the CEE and CIS countries, where nursing regressed under the previous disease-oriented systems, based heavily on medical specialization and hospital care.

In many European countries the role, status and training of the family practitioner has been neglected in favour of specialist medicine. Primary care reforms have emphasized the cost-effective role of the family physician as a gatekeeper and first point of contact with the system, providing continuous, person-centred care with a community-orientation.

Growing emphasis is being placed on training family physicians and general practitioners. In some countries, family or general practice is considered a specialty in its own right. Most western European countries have vocational training programmes for general practice. In the CEE countries, Estonia has rapidly developed a specialization and training programme for general practitioners with an up-to-date curriculum. In some CEE and CIS countries, slow progress has undermined the introduction of appropriate PHC-based reform.

## **THE PROCESS OF IMPLEMENTING REFORMS**

Health care reforms have been harder to implement than expected. Moreover, they have often had unintended consequences. Several countries have experienced difficulties that have had little to do with actual content that reflect inadequate planning for the process of implementation. Yet the reform debate has so far paid little attention to the problems of implementation and to strategies for managing change.

Implementation should be viewed as integral to the reform process. The same level of thought and effort that goes into developing policies should also go into developing a strategy for their implementation. However, implementation is not an exact science. There is no agreed set of strategies which, if followed faithfully, will ensure successful results. Further, reform circumstances vary greatly between countries. Nevertheless, a better understanding of the factors facilitating or impeding change and of the strategies that have been shown to be effective in particular country situations could assist policy-makers in achieving change. Fig. 6 suggests a framework that may help policy analysts reach a fuller understanding of factors facilitating or impeding change. Greater attention should be paid to the context in which reform policy is introduced, the process by which it is formulated, implemented and evaluated, and the actors who are affected by and influence its content, context and process. The development of health reform in a specific country is influenced by a wide range of *contextual factors*, including the macroeconomic situation, the sociopolitical environment and the mix of societal values. The *process* of implementation is directly affected by the system of government, particularly the distribution of authority between central and local levels. Although context and process are important, *actors* or stakeholders are often the key determinants of policy change. Four groups have a major bearing on implementation: citizens, professionals, policy elites and interest groups.

### ***Learning from experience***

Recent country experience with implementation suggests several factors that have played a key role in bringing about or creating obstacles to health sector change. Choosing the most appropriate *timing* for reform, such as when there are specific circumstances that favour change, is a key determinant of success. In times of political and social transformation, opportunities for radical adjustment can lead to quite dramatic reforms. *Financial sustainability* is also critical