EXPERT NETWORK ON HEALTH CARE REFORM STRATEGIES IN SOUTHERN EUROPE (SOUTHNET)

Report on a WHO Meeting

Jerusalem, Israel
8–11 November 1999
EUROPEAN HEALTH21 TARGET 15
AN INTEGRATED HEALTH SECTOR

By the year 2010, people in the Region should have much better access to family- and community-oriented primary health care, supported by a flexible and responsive hospital system

(Adopted by the WHO Regional Committee for Europe at its forty-eighth session, Copenhagen, September 1998)

ABSTRACT

The objectives for the third meeting of the Expert Network on Health Care Reform Strategies in Southern Europe (SOUTHNET), convened by the WHO Regional Office for Europe, were to discuss problems related to a shift in the balance of resource allocation towards primary health care (PHC), to share information about health reform strategies adopted in the participants’ countries and to learn about the progress of reform in the host country, Israel. Participants from 12 countries attended. In the discussion, participants identified obstacles to shifting the balance of resource allocation in favour of PHC: weak links between hospital and PHC staff, lack of trained staff in PHC, pressure from the equipment and pharmaceuticals industries, and the lack of standards for quality assurance, guidelines for accreditation and evidence-based treatment, and public information and education. The participants made five recommendations focusing on eliminating these obstacles. Country presentations and an in-depth analysis of the reform process in Israel gave the participants valuable insights on current developments in health services in SOUTHNET countries.

Keywords

HEALTH CARE REFORM
STRATEGIC PLANNING
COST ALLOCATION
HEALTH CARE RATIONING
PRIMARY HEALTH CARE
EUROPE, SOUTHERN
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Introduction

The Third Meeting of the Expert Network on Health Care Reform Strategies in Southern Europe (SOUTHNET) was held in Jerusalem, Israel, from 8 to 11 November 1999. The participants thanked the Israeli Ministry of Health for the excellent hospitality and the opportunity for an in-depth exchange of views.

Dr Herbert F.K. Zöllner, Regional Adviser for Health Economics, opened the meeting on behalf of Dr J.E. Asvall, WHO Regional Director for Europe, Copenhagen.

Eighteen participants from eleven countries attended the meeting, together with an international speaker, two representatives from international organizations and three staff from the WHO Regional Office for Europe (Annex 4). The following nominations were accepted:

Chairperson: Dr Michael Dor, Israel
Vice-Chairperson: Dr George Gotsadze, Georgia
Rapporteur: Dr Bodossakis Merkouris, Greece
Secretary: Dr Mårten Kvist, WHO

Dr Zöllner then presented the WHO health for all policy, illustrating the HEALTH21 framework and focusing on Target 15 (Annex 1), dealing with the integration of the health sector.

Dr Mårten Kvist, Technical Adviser for Primary Health Care, reviewed the previous meetings and referred to Target 17 (Annex 1) about the resource allocation mechanisms for health care system.

Shifting the balance in resource allocation

Mr Glenn Warren, Coordinator of Tipping the Balance towards Primary Health Care Network (United Kingdom), spoke on the overall theme of the Meeting: resource allocation in primary health care (PHC) – shifting the balance.

He analysed the PHC concept, either as multisectoral community health development (as promulgated at Alma-Ata) or as a set of essential medical care services provided to local communities, which are also referred to as PHC. Many countries have made a commitment to PHC, but they do not all structure the functions of detailed policy-making, the coordination of activities and measures, and the allocation of resources in such a way as to realize that idea. It is one thing to acknowledge the necessity for this intellectually, quite another to use it as the basis of health policy development.

The quality of policy analysis counts for little when the choice is not to spend more but to spend differently. To admit that it may be necessary to stop providing one thing in order to provide another is generally regarded as an act of political suicide. Politicians need a new mind set as well as new ways of engaging with the public in order to restore their credibility as public servants. The managers of public health services need strategies to guide politicians towards a new appreciation of their leadership and responsibilities.

With the increasing use of technology, societies have grown more complex. People have learned to adopt a passive role as consumers of specialist professional services. With hindsight, it can be seen
how the professions grew and became more hierarchical and protective of their positions as they competed for status, for the ear of political decision-makers, for resources – in short for power.

There are also difficulties in marketing PHC. If a long waiting time for an appointment or admission for, say, cardiac surgery, is said to be entirely a consequence of inadequate resource allocation, the manager may have to explain the need for making a counterbalance with small investments in community-based health promotion or protection intervention. The truth about PHC is thus elusive and complex.

The motivation for and understanding of the task of building PHC must, therefore, come from people themselves. They must feel that PHC is not another set of services, but a holistic philosophy of action which takes many forms.

A better strategy than to speak about moving resources from secondary health care to primary health care would be to stress the strand of the Alma-Ata philosophy that talks of the support given by secondary care to PHC. The issue is then no longer the level of resources going to secondary care, but how those resources are used.

Mr Warren concluded his presentation by stressing the principles of democracy and holism. All resources need to be mobilized, not to shift the accountant’s balance, but to realize fully the vision in the Alma-Ata declaration.

**Group work**

The Meeting divided into groups to discuss and analyse the following subjects.

- How to understand the task of shifting the balance.
- Who are the partners and the opponents in shifting the balance towards primary care and what are their arguments?
- What measures should be taken which facilitate shifting the balance in resource allocation towards primary health care?
- What is meant by “adequate spending on health services, while corresponding to the health needs of the population?” (HEALTH21, Target 17.1)?
- How should resources be allocated “between health promotion and protection, treatment and care, taking account of health impact, cost-effectiveness and the available scientific evidence” (HEALTH21, Target 17.2)?
- What kind of funding system guarantees the best universal coverage, solidarity and sustainability (HEALTH21, Target 17.3)?

These discussions contributed a lot to the real understanding of shifting the balance. Participants analysed and examined the subject both from the top down and the bottom up. Some statistics for the SOUTHNET countries were presented (Annex 2). Shifting the balance could mean moving from paternalism to partnership: it is more cost–effective, it improves accessibility and continuity and supports coverage of larger portion of people. Thus it is essential to think differently about what health is, to learn how to use available resources and to take into account different cultures.
Participants identified the following groups and factors as partners or opponents in this endeavour: the public, health educators, general practitioners (GPs), politicians/government, health technology industries, specialists, hospitals, time, research community and media. Most of these move from partnership to opposition and vice versa, depending on how the system works. Thus the time gap has been identified as a main weakness of PHC, while the public, health education, PHC staff, GPs and politicians could as easily be partners as opponents.

Efforts are therefore needed to persuade specialists, hospitals, the research community, media, health technology and pharmaceutical industries, which form the main body of opponents, to become partners and join the process under certain necessary policies.

The following measures were suggested to facilitate shifting the balance:

- information for the public about success stories;
- health education directed at decision- and opinion-makers, people working in health and the population as a whole;
- well educated PHC staff – with an appropriate infrastructure – willing to approach the community, to affect and be affected: PHC settings should not be seen as just buildings but as reaching out to the whole catchment area;
- health care management education for PHC staff;
- intersectoral cooperation;
- community involvement;
- promotion of career development in PHC;
- measures to increase public confidence in PHC;
- the introduction of tools (not necessarily from inside the health sector) to develop partnerships and challenge the people.

Participants identified the following conditions as the main obstacles in shifting the balance towards PHC:

- the gaps between hospitals and primary care providers (weak links in the referral system and continuity of care);
- the lack of trained PHC providers (GPs, PHC, nurses, etc.);
- pressure from technology/the pharmaceutical industry;
- the absence of standards for quality assurance, accreditation and evidence-based guidelines of treatment;
- the lack of information and education.

**Plenary discussion**

All participants declared their countries’ willingness to changes to their systems that would definitely include moving the balance of their health resources in favour of PHC. Israel was a useful example, as the process of change there gave the opportunity to examine in detail a step by step procedure.
Many countries had already started to reform their health systems, with the following features as the main components:

• social security: funding, contracts, co-payments;
• family doctors: GP training and the use of other specialists such as paediatricians in the field of family medicine;
• family health nurses: a significant percentage of nurses in almost all the SOUTHNET countries are unemployed;
• remuneration: changes in remuneration systems can be reforms in themselves, for example, changes from salaries to capitation or fees-for-services, mixed systems;
• decentralization of health personnel, using incentives and strategic planning;
• decentralization of PHC authorities with, at the same time, creation of central services in ministries of health aiming to plan, evaluate and generally support PHC units.

Participants felt that it would be useful to:

• exchange information about health reform strategies adopted in their countries;
• look closely at the changes taking place right now in Israel;
• discuss the needs and prerequisites of the reform common to all countries;
• discover whether there is a conflict between primary and secondary health care in some countries and, if so, why and what can be done to bring about agreement, for example, the concept of shared care;
• take into account that shifting the balance of resources towards PHC is a major reform that would automatically ensure adequate resources for health education, disease prevention, etc., as well as improvement of conditions such as nutrition and housing.

Site visits

The Ministry of Health in Israel had arranged site visits to a number of health facilities.

Archie Sherman group practice, Jerusalem

The Archie Sherman group practice belongs to Kupat Holim Clalit, the biggest general sick fund in Israel (http://www.clalit.org.il). Dr Michael Rosenbluth acted as guide during this visit. The practice was built four years ago on a site where there were some old graves, which had been integrated into the architecture. The practice has a catchment area of about 380,000 people and contains GPs, dermatologists, ophthalmologists, orthopaedic surgeons, gynaecologists and otolaryngologists. An unusual feature is that special doctors and nurses are appointed to take care of home health services. Meeting participants were keenly interested in the DOS-based health information system used in a local network by all practitioners.

Hadassah Medical Centre, Emergency Department and Children’s Hospital, Jerusalem

The Hadassah Medical Centre (http://www.hadassah.org.il) is a private teaching hospital with several community outreach projects, including a mother and child health station, an adolescent unit and a health information library. The emergency department was well equipped and crowded with people seeking help for acute illnesses. The children’s hospital was in a new building and modern principles had been applied in the architecture to make the environment as
much as possible like a home and pleasant for the children. The participants were also shown the world-famous window paintings by Marc Chagall in a synagogue located in the hospital.

Sheba Medical Centre, Magnetic Resonance Technology Department, Tel Hashomer, Tel Aviv
The participants were initially guided by Dr Poriya Shachaf, Deputy Director. The hospital, which has more than 2000 beds, was founded in 1948. In 1979 it introduced some community outreach programmes. Professor Ari Örenstein showed participants the innovations which are taking place in his department. It is one of the 15 leading centres in the world developing real-time magnetic resonance technology for use during operations. A whole industry has evolved in Israel inventing non-magnetic instruments and medical apparatus.

JDC-Brookdale Institute, Jerusalem
Dr Revital Gross, senior researcher at the Brookdale Institute, gave a comprehensive evaluation of the health reform in Israel. A new health insurance law had been adopted in 1995. The reform has been mainly successful, but issues that are still unresolved include the level of funding, the capitation formula, how to update the benefits package, what kind of supplementary insurance should be developed, and how psychiatric and geriatric services can be included in the responsibilities of the sick fund. In the following panel discussion with Professor Michael Weingarten, Dr Yonah Yaphe, Dr Michael Rosenbluth, Dr Amnon Lahad and Dr Michael Dor, the results were intensively discussed.

Summary of recommendations
The Meeting made the following recommendations:
1. quality assurance and accreditation mechanisms should be improved and developed;
2. guidelines should be developed for shared care;
3. the public, decision-makers, politicians and health personnel in general should be informed and educated;
4. knowledge should be developed about health impact, cost–effectiveness and equity in access;
5. additional funds/resources should be mobilized for PHC.

SOUTHNET member countries
The following countries are members of SOUTHNET: Albania, Armenia, Bosnia and Herzegovina, Bulgaria, Croatia, Georgia, Greece, Israel, Malta, Romania, Slovenia, the Former Yugoslav Republic of Macedonia and Turkey.

The Meeting discussed the interest expressed by two observers invited from Italy and Spain in their countries joining the network. Participants unanimously accepted the idea of including countries from the western Mediterranean represented by appropriate regions, and felt that Portugal could also be approached. A suggestion that Cyprus could also be invited was not pursued, because Cyprus does not belong to the European Region.
Next meeting

Participants welcomed the offer from the Ministry of Health in Armenia to hold the next meeting in Armenia in November 2000. The topic would be health information systems in PHC. The Meeting noted the suggestions made by participants from Bosnia and Herzegovina, Georgia and Italy (Sicily) to hold the 2001 network meeting in their countries.

Members were encouraged to disseminate the messages from this Meeting in their countries and to keep regular contact among themselves. In order to facilitate these contacts, WHO was willing to establish a list-server for e-mail exchange between the members of SOUTHNET.
Annex 1

TARGETS 15 AND 17

TARGET 15 – AN INTEGRATED HEALTH SECTOR

By the year 2010, people in the Region should have much better access to family- and community-oriented primary health care, supported by a flexible and responsive hospital system.

In particular:

15.1 at least 90% of countries should have comprehensive primary health care services, ensuring continuity of care through efficient and cost-effective systems of referral to, and feedback from, secondary and tertiary hospital services;

15.2 at least 90% of countries should have family health physicians and nurses working at the core of this integrated primary health care service, using multiprofessional teams from the health, social and other sectors and involving local communities;

15.3 at least 90% of countries should have health services that ensure individuals’ participation and recognizes and supports people as producers of health care.

TARGET 17 – FUNDING HEALTH SERVICES AND ALLOCATING RESOURCES

By the year 2010, Member States should have sustainable financing and resource allocation mechanisms for health care systems based on the principles of equal access, cost–effectiveness, solidarity, and optimum quality.

In particular:

17.1 spending on health services should be adequate, while corresponding to the health needs of the population;

17.2 resources should be allocated between health promotion and protection, treatment and care, taking account of health impact, cost–effectiveness and the available scientific evidence;

17.3 funding systems for health care guarantee universal coverage, solidarity and sustainability.
Annex 2

FACTS ABOUT SOUTHNET COUNTRIES

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<th>Population in 1998 millions</th>
<th>Population aged &gt;65 years (%)</th>
<th>GDP per capita (US $)</th>
<th>Health expenditure as % of GDP</th>
<th>Crude death rate per 1000 population</th>
<th>Infant mortality per 1000 live births</th>
<th>Life expectancy at birth (years)</th>
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Annex 3

**WORKING PAPERS AND BACKGROUND MATERIAL**

**Working papers**

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<td>Resource allocation in primary health care – shifting the balance.</td>
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<td>CARE 100202/7</td>
<td>Health reform in Israel – An updated overview of activities (1999).</td>
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**Background material**

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<tr>
<td>European Health for All Series No. 6</td>
<td>Target 15 – an integrated health sector (related to PHC). Extract from <em>HEALTH21, the health for all policy framework for the WHO European Region</em>.</td>
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Annex 4

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