

Health Systems in Transition

Template for authors

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with invaluable inputs from the National Lead Institutions network, the staff of the WHO Regional Office for Europe and the Partners of the European Observatory on Health Systems and Policies

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The Health Systems in Transition (HiT) profiles are country-based reports that provide detailed descriptions of health systems and policy initiatives using a standard format. HiTs are produced by country experts in collaboration with Observatory staff. They are building blocks that can be used to:

- examine different approaches to the organization, financing and delivery of health services, and the role of key health system actors;
- describe the institutional framework for and the process, content and implementation of health policy;
- highlight challenges and areas requiring more detailed analysis;
- provide a tool for disseminating information on health systems;
- facilitate the exchange of reform experiences across countries;
- establish a baseline for assessing the impact of reforms; and
- inform comparative analysis.

This template is designed to guide the writing of HiTs by setting out key questions, definitions and examples needed to compile a country profile. It is intended to be used flexibly. The template is revised periodically and this iteration has been developed specifically to make HiTs easier to write and read. Authors and editors are encouraged to adapt the template to a particular national context and to deliver an accessible and clear profile rather than an encyclopaedic review of a health system.

Comments and suggestions for developing and improving the HiTs are most welcome and can be sent to info@obs.euro.who.int.

This edition of the template is a revised version of the template from 2007 which was in turn based on the original template of 1996. It incorporates many useful comments and suggestions from users and contributors.

The initial HiT template was developed by Josep Figueras and Ellie Tragakes as part of the work of the WHO Regional Office for Europe for the WHO Conference on European Health Care Reforms, Ljubljana, Slovenia in 1996.

The 2007 revision was edited by Elias Mossialos, Sara Allin and Josep Figueras and written by Sara Allin, Reinhard Busse, Anna Dixon, Josep Figueras, David McDaid, Elias Mossialos, Ellen Nolte, Ana Rico, Annette Riesberg and Sarah Thomson with Jennifer Cain, Hans Dubois, Susanne Grosse-Tebbe, Nadia Jemai, Suszy Lessof, Martin McKee, Laura MacLehose, Anna Maresso, Monique Mrazek, Richard Saltman, Ellie Tragakes and Wendy Wisbaum.

The current iteration was written by (in alphabetical order) Bernd Rechel, Sarah Thomson and Ewout van Ginneken with support from Reinhard Busse, Josep Figueras, Matthew Gaskins, Cristina Hernández-Quevedo, Suszy Lessof, Anna Maresso, David McDaid, Martin McKee, Sherry Merkur, Philipa Mladovsky, Elias Mossialos, Gabriele Pastorino, Erica Richardson, Richard Saltman, Peter Smith and Matthias Wismar.

Invaluable inputs to the current iteration of the template were made by the National Lead Institutions (NLI) network (see Box I). Thanks are due to the individuals who reviewed and

Box I National Lead Institutions

The Observatory has established a network of National Lead Institutions. Each NLI co-owns its national HiT and monitors health reform trends, shares news between updates and authors successive iterations of the HiT. NLI are selected on the strength of their health systems expertise and their access to local networks. The network is made up of the following institutions:

- Gesundheit Österreich GmbH (Austria)
- KCE, Belgian Health Care Knowledge Centre (Belgium)
- THL, National Institute for Health and Welfare (Finland)
- URC Eco IDF Université de Paris Val de Marne (France)
- Semmelweis University (Hungary)
- CERGIS, Bocconi University and the Institute of Hygiene, Catholic University of Rome (Italy)
- Myers-JDC-Brookdale Institute (Israel)
- NIVEL, Netherlands Institute for Health Services Research (Netherlands)
- NOKC, Norwegian Knowledge Centre for the Health Services (Norway)
- Universidade Nova de Lisboa (Portugal)
- SESPAS, Spanish Society of Public Health and Health Management (Spain)
- The King's Fund (United Kingdom)

contributed to the revised HiT template at the NLI meeting in London in November 2009. They are (in alphabetical order): Tit Albrecht, Geir Bukholm, Karine Chevreul, Marton Csere, Anton Giulio de Belvis, Walter Deville, Ana Dias, Andrea Donatini, Giovanni Fattore, Péter Gaál, Sandra Garcia Armesto, Sophie Gerkens, Maria Hofmarcher, Ilmo Keskimaki, Christian Léonard, Anne Karin Lindahl, Sara Ribeirinho Machado, Richard Meyers, Bruce Rosen and Lauri Vuorenkoski.

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Finally, special thanks go to the publications team. We are particularly grateful to Sarah Moncrieff for her work on designing the new template, Jonathan North for coordinating production and copy-editing, and Caroline White for administrative and production support.

Box 2 The European Observatory on Health Systems and Policies

The European Observatory on Health Systems and Policies supports and promotes evidence-based health policy-making through comprehensive and rigorous analysis of the dynamics of health systems in Europe.

The Observatory is a partnership between the World Health Organization Regional Office for Europe, the Governments of Belgium, Finland, Ireland, the Netherlands, Norway, Slovenia, Spain, Sweden and the Veneto Region of Italy, the European Commission, the European Investment Bank, the World Bank, UNCAM (French National Union of Health Insurance Funds), the London School of Economics and Political Science, and the London School of Hygiene & Tropical Medicine.

The Observatory's core functions are country monitoring, analysis, dissemination and performance assessment. The Observatory staff are based in Brussels, London and Berlin.

Writing HiTs is complex and Observatory editors will support authors throughout the process.

The role of the editors

The Observatory assigns editors to work with authors on each HiT. Their role is to:

- provide authors with documents to supplement the template, including:
 - Guidelines for authors and editors*
 - WHO EURO style guide* for advice on the house style including standard spelling
 - a standard set of tables
 - some sample HiTs that give a sense of what a typical profile is like
- brief authors at the beginning of the project
- set up timelines, deadlines and agreements about how authors will share work
- manage the various iterations and edit drafts
- manage the review process and incorporate feedback
- ensure quality including following internal clearance procedures.

The role of the authors

The lead author will select a team of co-authors and be responsible for liaising with the editor. Authors should follow the structure and main headings of the template. However, they are not expected to provide information on all areas. Discussion with the editor will determine which areas should be covered. In addition, authors are encouraged to:

- discuss tables and figures with the editor, including who will produce them and at what stage in the drafting process, and to state explicitly if data are not available or reliable;
- cite reports on implementation of reforms and comment on what is actually taking place;
- cross-reference between sections to avoid repetition; and
- ensure HiTs are not overly long (very long HiTs are hard to read and less accessible); word-count suggestions for each section are not provided in the template, but limits should be agreed with the editor.

Authorship policy

The Observatory's policy on authorship is in line with academic norms (see the International Committee of Medical Journal Editors' Uniform Requirements for Manuscripts Submitted to Biomedical Journals; www.ICMJE.org). Its policy on authorship is intended to give credit to all those who have made a substantive contribution by writing or rewriting parts of the text.

Unless there are particular circumstances, first authorship will be held by the lead national author, followed by other national authors who have written parts of the HiT and by the editors, who should be listed last. Ideally, no more than six authors should be named to allow all of them to be included on the cover and in standard format databases. Where more than six authors have been involved, they will all be listed in the inside cover of the published HiTs, but the cover will only show the name of the first author and the editors.

ALOS	Average length of stay
ANAES	National Agency for Accreditation and Evaluation in Health
CAM	Complementary and alternative medicine
CARK	Central Asian Republics and Kazakhstan
CHF	Congestive heart failure
CIS	Commonwealth of Independent States
COPD	Chronic obstructive pulmonary disease
CT	Computed tomography
DALE	Disability-adjusted life expectancy
DDD	Defined daily dose
DMFT	Decayed, missing or filled teeth
DRG	Diagnosis-related group
DTP	Diphtheria, tetanus and pertussis
EEA	European Economic Area
EFTA	European Free Trade Association
EU	European Union
EU12	12 countries that joined the EU in 2004 and 2007
EU15	15 EU Member States before May 2004
EU27	All 27 EU Member States as of 2010
GATS	General Agreement on Trade in Services
GDP	Gross domestic product
GP	General practitioner
HALE	Health-adjusted life expectancy
HLY	Healthy life years
HTA	Health technology assessment
IT	Information technology
MRI	Magnetic resonance imaging
NATO	North Atlantic Treaty Organization
NGO	Nongovernmental organization
NHS	National Health Service
NICE	National Institute for Health and Clinical Excellence
NLI	National Lead Institution
OECD	Organisation for Economic Co-operation and Development
OOP	Out-of-pocket (payment)
OTC	Over-the-counter
PET	Positron emission tomography
PHC	Primary health care
PPP	Purchasing power parity
PROM	Patient-reported outcome measure
SHI	Social health insurance
VHI	Voluntary health insurance
WTO	World Trade Organization

This new edition is designed to simplify the HiT authorship process. Navigation of the template has been clarified by separating the various elements that make up the template and introducing a number of visual indicators which are described below.

Separating content instructions from explanatory text

Content instructions and questions are positioned on the left hand side of the page.

Explanatory text, examples and helpful notes are positioned on the right hand side of the page.

Differentiating between essential and discretionary sections



Indicator for an 'essential' section.

These sections should be covered.



Indicator for a 'discretionary' section.

The decision to include/exclude a section should be made in conjunction with the editor.

Authors are not expected to answer all questions and provide information for all sections.

Discretionary sections should only be covered if they are of genuine national or international relevance, and reliable information is available.

Tables and figures

Table 1.1

Indicator for a Table or Figure.

Some figures will be supplied by Observatory staff. These will be indicated by a note in the explanatory text.

You should discuss the data in the text in detail, especially if you are concerned about discrepancies between the data presented in the figures and what you know from your own experience.

Include a comparative dimension in your discussions, drawing on comparators suitable for the specific country, such as averages for the Member States of the European Union (EU) in 2010 (EU27), before 2004 (EU15) and new states joining in 2004 to present (EU12); Commonwealth of Independent States (CIS); or Central Asian Republics and Kazakhstan (CARK).

Please supply data for figures in an Excel spreadsheet.

When comparing a number of countries, especially when using a line chart, please limit the number of countries to no more than five or six.

Remember to include your data sources.

Data from WHO's European Health for All database are updated twice a year, and therefore it may be necessary to review your text as new data become available. The standard Health for All data have been officially approved by national governments.

Glossary

If you are unclear about any of the terms used in the instructions, please consult the Glossary (available from the editor) for the latest information on definitions.

Some definitions provided in the Glossary may be different from those used in your country. If this is the case, please state this explicitly in the text.

Bibliographical references

Please use the Harvard (also known as the author–date) system.

Citations are made within the text in parentheses, e.g. (Taylor, 1996) or (Taylor, 1996; Connor, 2002).

Full references should be listed alphabetically in the References section of Chapter 9 *Appendices*. Some examples are shown on the right.

Please consult the *WHO EURO Style Guide* for further information (available from the editor).

Book

Kunst A, Mackenbach JP (2004). *Measuring socioeconomic inequalities in health*. Copenhagen, WHO Regional Office for Europe.

Chapter in a book

Dahl E et al. (2006). Welfare state regimes and health inequalities. In: Siegrist J, Marmot M, eds. *Social inequalities in health*. Oxford, Oxford University Press: 193–222.

Journal article

Nolte E, McKee M (2008). Measuring the health of nations: updating an earlier analysis. *Health Affairs*, 27(1):58–71.

Web site

ASSR (2010) [web site]. Rome, Agency for Regional Health Care Services (<http://www.assr.it>, accessed 20 May 2010).

Unpublished data

Unpublished data should be referenced in the text only and should not appear in the reference list at the end unless it is available to readers.

Style

Please follow the conventions listed in the *WHO EURO Style Guide* (available from the editor).


WHO has its own house style: a particular way of using language and design chosen to meet its particular needs. Use of a house style makes its publications consistent and professional, increasing WHO's credibility and strengthening its reputation as a leading source of reliable health information.

Preface

This is the standard introductory section common to all HiT profiles.

The text will be supplied by Observatory staff when the HiT is finalized.

Acknowledgements

 This is the standard acknowledgements page. Please adapt it to reflect the input of particular individuals and organizations and acknowledge sponsorship.

The Box provides a typical example.

The Health Systems in Transition (HiT) profile on xxxxxxxx was written by xxxxxxxx (affiliation) and xxxxxxxx (affiliation). It was edited by xxxxxxxx (affiliation). Research Director for the xxxxxxxx HiT was xxxxxxxx.

The basis for this edition was the previous HiT xxxxxxxx, which was published in 0000, written by xxxxxxxx and edited by xxxxxxxx.

The European Observatory on Health Systems and Policies is grateful to xxxxxxxx for reviewing the report.


The authors are grateful to everyone at the Ministry of xxxxxxxx and its agencies (xxxxxxx) for their assistance in providing information and for their invaluable comments on previous drafts of the manuscript and suggestions about plans and current policy options in the xxxxxxxx health system. The authors are particularly indebted to xxxxxxxx, who contributed by sharing his/her notes on health services organization and providing national statistics; to xxxxxxxx from WHO, for sharing the overview of pharmaceutical sector reforms; and to xxxxxxxx, representatives of private insurance companies, who shared their valuable knowledge on the latest voluntary health insurance (VHI) developments in xxxxxxxx.

The current series of HiT profiles has been prepared by the staff of the European Observatory on Health Systems and Policies. The European Observatory on Health Systems and Policies is a partnership between xxxxxxxx. The Observatory team working on the HiT profiles is led by Josep Figueras, Director, and Elias Mossialos, Co-Director and heads of the Research Hubs, Martin McKee, Reinhard Busse and Richard Saltman.


The production and copy-editing process was coordinated by xxxxxxxx, with the support of xxxxxxxx.

Special thanks are extended to the WHO Regional Office for Europe Health for All database, from which data on health and health services were extracted; to the European Commission for Eurostat data on EU Member States; to the OECD for the data on health services in western Europe; and to the World Bank for the data on health expenditure in central and eastern European countries. Thanks are also due to national statistical offices that have provided data. The HiT reflects data available in Month 0000.

List of abbreviations

-  Please provide a list of the abbreviations and terms in full used in the profile.

List of tables, figures and boxes

-  Please provide a list of all the tables, figures and boxes as they appear in the text.

Abstract


-  The abstract should provide a summary of the HiT in no more than 250 words.

Table I.1 Trends in population/ demographic indicators, selected years

Table I.2 Macroeconomic indicators, selected years


and so on.

The Box provides an example from the Estonia HiT.

Estonia has vigorously and quite successfully reformed its health system over the last decades. Whereas incremental changes are observed in the last five years, larger scale legislative reforms had been implemented since the early 1990s and at the beginning of this century. The current system is built on solidarity-based health financing; a modern provider network based on family-medicine-centred primary health care (PHC); modern hospital services; and more attention to public health. This has resulted in a steadily increasing life expectancy and continuously high population satisfaction rates with access and quality.

However, as in any health system, a number of challenges remain. They include reducing inequities in health status and health behaviour; improving control of and responding to the consequences of the high rates of HIV and related conditions; improving regulation of providers to ensure better public accountability; and sustaining health expenditures and human resources on a level that ensures timely access and high quality of care. The last challenge is particularly important in the face of rising patient expectations and increased costs and volume of health care services. If solidarity and equity are to be maintained and guaranteed for the future, additional resources need to be found from public sources of revenue.


Executive summary

-  The executive summary should provide an outline of the HiT (in no more than 3000 words), following the key headings included in the profile, with a particular focus on the assessment of the health system, the main challenges and the major conclusions (Chapters 7 and 8).

The executive summary should make use of the summary paragraphs provided in each chapter.

This chapter sets the whole HiT in context and gives readers a sense of the geographic, economic and political setting in which the health system operates. It also covers health status in some detail so that readers can understand the health challenges the system faces.

Chapter summary

-  Please provide a summary of the whole chapter (maximum 300 words).

1.1 Geography and sociodemography



-  Briefly outline the country's geography, including information on:
 - neighbouring countries
 - terrain/climate, if relevant (one sentence)

Fig. 1.1

Map of the country

Where available, a United Nations map will be inserted by Observatory staff. Authors are welcome to propose an alternative from another neutral source.

-  Comment on the data in Table 1.1 (see overleaf) including, where relevant, the implications for health and health care of:
 - age and ageing of the population
 - rural/urban distribution of the population
 - migration and citizenship requirements
 - ethnic composition of the population
 - language
 - educational attainment
 - religion
 - family structure
 - any major population movements
 - any other characteristics that affect health

This will also be used in the executive summary.

Please identify where there are disputed frontiers or territories not fully under control of the national government. The editor will discuss with you how to present these issues sensitively. Also note any dependent territories where the national government has responsibility for the health system.

Source: United Nations Cartographic Section (<http://www.un.org/Depts/Cartographic/english/htmain.htm>).

Data on age structure of the population, gender balance, growth, birth, death and fertility rates will be drawn from the World Bank World Development Indicators database (<http://publications.worldbank.org/WDI/indicators>).

e.g. as a result of war; refugees, internal displacements


Table 1.1

Trends in population/demographic indicators, selected years


	1980	1990	1995	2000	2005	Latest available year
Total population						
Population, female (% of total)						
Population ages 0–14 (% of total)						
Population ages 65 and above (% of total)						
Population ages 80 and above (% of total)						
Population growth (average annual growth rate)						
Population density (people per sq km)						
Fertility rate, total (births per woman)						
Birth rate, crude (per 1000 people)						
Death rate, crude (per 1000 people)						
Age dependency ratio (population 0–14 & 65+: population 15–64 years)						
Distribution of population (rural/urban)						
Proportion of single-person households						
Educational level						

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

1.2 Economic context

 Give a general overview of the country's current economic situation and its implications for health and the health system including, if relevant:

- employment/unemployment
- social and living conditions, including occupational/employment mix
- distribution of wealth
- economic crisis
- any other major events leading to the current status

 Comment on the data in Table 1.2, focusing on implications for health and health care.

Suggested databases for EU Member States:

<http://epp.eurostat.ec.europa.eu/portal/page/portal/eurostat/home>

http://ec.europa.eu/economy_finance/research/index_en.htm

Table 1.2

Macroeconomic indicators, selected years

	1980	1990	1995	2000	2005	Latest available year
GDP						
GDP, PPP (current international US\$ or Euro)						
GDP per capita						
GDP per capita, PPP (current international US\$ or Euro)						
GDP average annual growth rate for the last 10 years (%)						
Public expenditure (% of GDP)						
Cash surplus/deficit (% of GDP)						
Tax burden (% of GDP)						
Public debt (% of GDP)						
Value added in industry (% of GDP)						
Value added in agriculture (% of GDP)						
Value added in services (% of GDP)						
Labour force (total)						
Unemployment, total (% of labour force)						
Poverty rate (please define how poverty is measured in your country)						
Income or wealth inequality (Gini coefficient or other measure)						
Real interest rate						
Official exchange rate (US\$ or Euro)						

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

Notes: e.g. any abbreviations not given in the List of abbreviations, or any clarification of data


1.3 Political context

 Give a brief overview of the country's system of government. Please consider:

- where power is concentrated
- how centralized/decentralized the system is and what authority each level of government has
- the main political parties and their relative share of the vote
- governance indicators
- major changes in recent years

It may be helpful to clarify if the country is a parliamentary or presidential democracy; to mention the relative strengths of the executive, legislative and judiciary if these affect health; and to indicate whether there is a system of checks and balances for parliament and the courts.

e.g. ranking from Transparency International <http://www.transparency.org/>


-  Discuss broadly how policy decisions are taken and responsibilities shared. Please consider:
 - the role of organized interest groups (such as trade unions or employer federations) in health policy-making, including civil society
 - membership of international organizations that affect health
 - major international treaties that have an impact on health

e.g. United Nations, EU, EEA, WTO, NATO, EFTA, Council of Europe

e.g. GATS, Convention on the Rights of the Child, European Human Rights Convention

1.4 Health status

Throughout this section, please check and comment on data quality, coverage and completeness.

-  Comment, as far as data permit, on changes in health indicators. Explain briefly any artefacts or political manipulation of data.

Where relevant, please draw on health interviews or health examination survey data and hospital activity/episodes data.

Please discuss with the editor which data to include, which data sources to use and any contested or sensitive issues.

Table 1.3

Mortality and health indicators, selected years

	1980	1990	1995	2000	2005	Latest available year
Life expectancy at birth, total						
Life expectancy at birth, male						
Life expectancy at birth, female						
Total mortality rate, adult, male						
Total mortality rate, adult, female						


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

Table 1.4


Main causes of death, selected years

Causes of death (ICD-10 classification)	1980	1990	1995	2000	2005	Latest available year
Communicable diseases						
All infectious and parasitic diseases (A00-B99)						
Tuberculosis (A15-A19)						
Sexually transmitted infections (A50-A64)						
HIV/AIDS (B20-B24)						
Noncommunicable diseases						
Circulatory diseases (I00-I99)						
Malignant neoplasms (C00-C97)						
Colon cancer (C18)						
Cancer of larynx, trachea, bronchus and lung (C32-C34)						
Breast cancer (C50)						
Cervical cancer (C53)						
Diabetes (E10-E14)						
Mental and behavioural disorders (F00-F99)						
Ischaemic heart diseases (I20-I25)						
Cerebrovascular diseases (I60-I69)						
Chronic respiratory diseases (J00-J99)						
Digestive diseases (K00-K93)						
External causes						
Transport accidents (V01-V99)						
Suicide (X60-X84)						
Ill-defined and unknown causes of mortality (R95-R99)						

Suggested data sources: <http://www.who.int/healthinfo/morttables/en/>; Eurostat for EU Member States; national mortality data

 Briefly outline the three main causes of mortality. Discuss, where relevant, any differences in Tables 1.3 and 1.4:

- between women and men
- by socioeconomic or ethnic group and level of education
- across regions (by age)
- over time (by age)

 Discuss how policy efforts have affected causes of death over time. Please consider:

- intersectoral policies on determinants of health
- health promotion and primary prevention
- screening policies (e.g. for colon cancer, breast cancer, cervical cancer)

Table 1.5

DALE, HALE and HLY, selected years

Suggested data sources:

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

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

<http://epp.eurostat.ec.europa.eu/tgm/table.do?tab=table&init=1&plugin=0&language=en&pcode=tsien180>

Table 1.6

Morbidity and factors affecting health status, selected years

Suggested data sources:

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

<http://www.iotf.org/database/index.asp>

<https://webgate.ec.europa.eu/idbpa/>

<http://www.emcdda.europa.eu/publications/country-overviews>

http://ec.europa.eu/health/index_en.htm

Cross-reference to

Section 2.6 *Intersectorality*,
Section 5.1 *Public health*, and
Chapter 7 *Assessment of the health system*.

Sources of information could include:
European Partnership for Action Against
Cancer

http://ec.europa.eu/health/major_chronic_diseases/diseases/cancer/index_en.htm#fragment0

DALE (disability-adjusted life expectancy)

HALE (health-adjusted life expectancy)


HLY (healthy life years)

Include the following factors if possible:

National data on morbidity by age and gender (e.g. prevalence/incidence of diabetes, cancer, myocardial infarction, stroke).

Major factors influencing health status (e.g. smoking, alcohol consumption, diet, physical activity, housing, poverty, education).

Report information either as a table (if data are available) or in the text.

 Comment on maternal, child and adolescent health indicators, including trends over recent years. Please consider:

- screening
- health education
- quality of health care provision
- contraceptive use and prevalence

Sources of information could include:
<http://www.europeristat.com/>





Table 1.7

Maternal, child and adolescent health indicators, selected years

	1980	1990	1995	2000	2005	Latest available year
Adolescent pregnancy rate (15–19 years)						
Adolescent birth rate						
Termination of pregnancy (abortion) rate*						
Perinatal and neonatal mortality rate						
Postneonatal mortality rate						
Infant mortality rate						
Under-five mortality rate						
Maternal mortality rate						
Syphilis incidence rate						
Gonococcal infection incidence rate						

* discuss legal issues where appropriate


Suggested data source for mortality indicators: <http://publications.worldbank.org/WDI/indicators>

-  **Comment on the country's dental health status.**
-  **Summarize and comment on immunization in general, including coverage of children from all socioeconomic, ethnic and regional groups. Indicate whether immunization figures are reliable.**
-  **Discuss any major health problems of policy significance that have occurred in the last decade.**
-  **Outline major health challenges facing the population as a whole and certain sub-populations (such as ethnic minorities or socioeconomic groups). Include information on the proportion of the population with access to safe water and air pollution (if relevant and data are available).**

Include information on decayed, missing or filled teeth (DMFT) if data are available.

e.g. major outbreaks or epidemics

Provide information as a table (if data are available) or in the text.

 Comment on the country's health status relative to other countries and European averages.

Please note that comparison across countries of mortality and morbidity data should be made with extreme caution because of potentially significant methodological variation in data collection and differences in definitions.

This chapter provides an overview of how the health system is organized, governed, planned and regulated; its main actors and their decision-making powers; and patient empowerment. It forms the basis for all the following chapters.

Chapter summary

- Please provide a summary of the whole chapter (maximum 500 words).

This will also be used in the executive summary.

2.1 Overview of the health system

- Briefly outline how the whole health system is organized. Please consider:
 - the overall legal framework
 - whether there is one or several statutory systems operating in parallel (e.g. at regional or local level); if there are several, describe the relationship between them
 - the main actors in the system and the roles and responsibilities they fulfil in the overall governance/management structure
 - the main actors' decision-making powers
 - the main links to other sectors

Health systems are understood in line with the *World Health Report 2000* as combining three elements:

- the delivery of health services (both personal and population based)
- activities to enable the delivery of health services (specifically finance, resource generation and governance)
- governance activities that aim to influence other sectors where they affect health.

This approach emphasizes the scope of health systems beyond health care.

The extent of decentralization should be discussed in Section 2.4

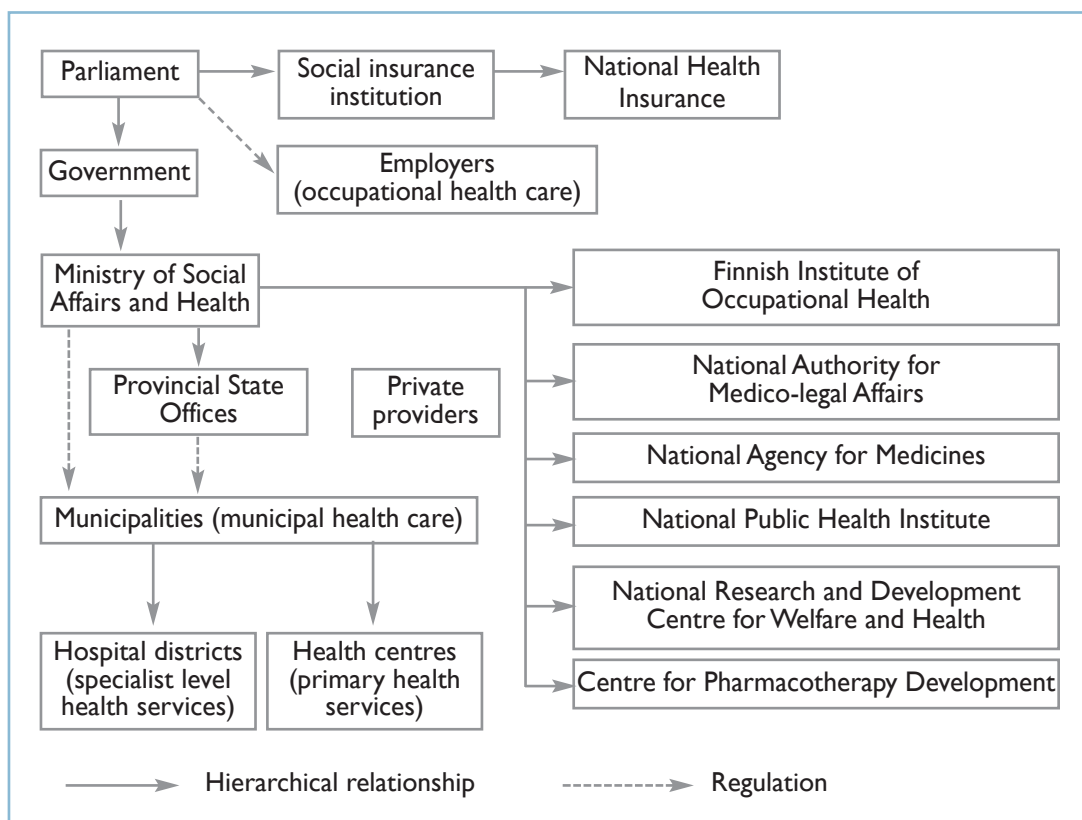
Fig. 2.1

Overview of the health system
(see example on p. 14.)


This diagram should give a simplified overview of the health system as a whole (e.g. financing mechanisms and service delivery by different providers), including the public health system, the private sector and (where relevant) the social care system.

It should clearly show the basic financing and organizational principles of the main system and, possibly, of important complementary subsystems.

Example of Fig. 2.1 Organization of the health system in Finland, 2008.



2.2 Historical background


 Give a brief account of the evolution of the health system to set the context for the current system. Please consider:

- political developments (e.g. changes in constitution or government), socioeconomic factors and sociocultural developments (e.g. citizens' preferences)
- the (changing) relationship between health and social care
- the (changing) relationship between health and other sectors


Go back as far as necessary to frame the current configuration of the country's health system (e.g. the historical establishment of social health insurance).
 Emphasis should be placed on major structural reforms in the 20th and early 21st century.
 Please focus on reforms which have been implemented.

Details of policy-making and implementation of reforms (especially during the last decade) should be discussed in Chapter 6 *Principal health reforms*.

2.3 Organization

 Outline the administrative structure of the statutory health system (the broader health system is shown in Fig. 2.1). Please consider:

- major structures of public health and health service provision
- the main geographical/administrative tiers within the statutory system
- the nature of the relationships between them

 Briefly describe the role of the main actors responsible for the financing, planning, administration, regulation and provision of health care. These should include the actors depicted in Fig. 2.1. Please consider:

- the ministry of health
- other ministries and government agencies
- regional/local governments (or health authorities)
- other public agencies at national and regional level
- the private sector
- patient/consumer groups
- provider organizations and professional groups/associations
- any other important and relevant organizations

Major structures of public health include intersectoral planning mechanisms (details should be covered in Section 2.6), as well as infrastructure for primary prevention and public health service delivery (details should be covered in Section 5.1).

e.g. national health service, national insurance system, system based on competing health insurance funds


e.g. hierarchical, contractual – details should be covered in Section 2.8
Regulation

e.g. ministry of finance, as well as ministries providing health care for their employees and families such as the ministry of defence


e.g. National Institute for Health and Clinical Excellence (NICE) in England and the National Agency for Accreditation and Evaluation in Health (ANAES) in France

e.g. providers, insurers, manufacturers, distributors, stakeholder lobbyists

e.g. physicians' associations, nurses' associations and trade unions


 When describing the main actors, refer briefly to the main organizational changes in the last 10 years. Please consider:

- major changes in organization
- new bodies that have been established or are in the process of being established
- changes in role of any institutions in connection with health care

 Briefly outline the main features of the process of policy formulation, implementation and evaluation. Please consider:

- setting the policy agenda
- implementation
- assessment and evaluation

2.4 Decentralization and centralization

 Comment on the extent of decentralization in the health system. Please consider:

- shifts in decentralization and centralization
- decentralization of governance mechanisms
- decentralization of powers and financial responsibilities
- context factors currently supporting or hindering decentralized decision-making

Discuss principal health reforms in Chapter 6.

e.g. insurance organizations, professional groups

e.g. ministry of finance, ministry of labour

Four major types of decentralization can be distinguished:

Deconcentration: passing some administrative authority from central government offices to the local offices of central government ministries.

Devolution: passing responsibility and a degree of independence to regional or local government, with or without financial responsibility (i.e. the ability to raise and spend revenues).


Delegation: passing responsibilities to local offices or organizations outside the structure of central government such as quasi-public (nongovernmental) organizations, but with central government retaining indirect control.

Privatization: transfer of ownership and government functions from public to private bodies, such as voluntary organizations and profit-making and non-profit-making private organizations.

e.g. transfer of full or partial responsibility for regulation, provision and financing

e.g. coordination among centres of authority, administrative/financial capability of responsible actors, regulatory framework for privatization. Specific problems encountered with recent policy measures should be discussed in Chapter 6.

2.5 Planning

 Describe the current approach to planning in the health system. Please consider:

- whether it is based on health needs or inputs
- national health planning agencies for health or health services
- human resources planning
- infrastructure/capital planning
- health plans at other levels (regional, district, local government, health insurance funds, etc.)
- policy development/priority setting by different tiers in the system
- evidence regarding the effectiveness of the planning system in implementing change
- cross-border mobility of patients and health workers
- involvement of the health sector in multisectoral disaster risk management and preparedness, including humanitarian assistance
- health sector preparedness for all types of hazard, including through implementation of international health regulations
- management and coordination of health-related international development assistance

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


Discussion of planning, management and regulation should refer back to the organization chart in Section 2.1.

e.g. number of doctors, nurses


e.g. number; type and location of facilities, beds and expensive equipment – is their planning based on certain norms or on the demographic or epidemiological characteristics of given populations?

[Cross-reference](#) to Chapter 6 *Principal health reforms*.

2.6 Intersectorality

 Describe how health is taken into account by other ministries and agencies, at all tiers of government. Please consider:

- health in all policies
- mechanisms for intersectoral or cross-sectoral planning and implementation
- procedures and mechanisms for health impact assessment
- food safety
- agriculture
- policies on workplace safety and working conditions
- emergency planning (environmental threats, terrorism, war, natural disasters)
- policies on taxation, marketing and sales regulation of tobacco, alcohol and food
- environmental policies
- transport policies, including road safety
- engagement with nongovernmental organizations (NGOs) and civil society
- engagement with the private (non-health) sector

 Describe any national or regional initiatives/targets to identify and reduce inequalities in health. Please consider:

- programmes to reduce the impact of poverty on health
- how health hazards other than poverty are identified and addressed

The determinants of health are factors that affect the health of a population. They are influenced by policy decisions in a wide range of sectors, from agriculture and nutrition to education, employment, housing and transport.

So-called “health in all policies” emphasize intersectorality and aim to engage with other sectors to identify the impact of their policies on health determinants and health.

Health impact assessment considers the potential health effects of policy decisions in different sectors and feeds the results back into the decision-making process.

Mechanisms for health impact assessment include:

- intersectoral targets
- horizontal public health committees or intersectoral structures
- intersectoral programmes
- public health reporting
- formal consultation with other sectors
- partnerships

e.g. industrial hazards, housing, water supply


- investment in initiatives outside the health sector intended to promote public health
- the main problems and challenges as well as any future reform plans

e.g. traffic safety, food safety, school-based interventions

Cross-reference to Chapter 6 *Principal health reforms*.

2.7 Health information management

2.7.1 Information systems

 Describe the information systems in place for collecting, reporting and analysing data on activity, service and quality. Please consider:


- data collection, analysis and dissemination
- data quality
- linkages to financing
- requirements for providers (both public and private) to report data
- legislation on freedom of information
- health-related research and development
- meaningful involvement of patients, health professionals and the wider public
- whether information systems reflect various levels of care (such as primary or hospital care), different population groups (such as adolescents or people living with HIV) or are gender sensitive

This subsection should discuss the use of information for the purposes of management, including information on health services activity, service levels (e.g. waiting times or patient satisfaction) and quality (e.g. health status/health outcomes, adverse effects/errors).

Cross-reference to Section 4.1.4 *Information technology*.

Cross-reference to Section 2.9.5 *Public participation*.

2.7.2 Health technology assessment

 Describe the system for health technology assessment (HTA). Please consider:

- organizations involved
- principal activities

HTA is the systematic evaluation of the effectiveness, costs and impact of health care technology with the aim of informing health policy-making.

Potential data source:
<http://www.eunetha.net/>

- methods used
- number of evaluations
- links to the policy-making process

☞ If no HTA agencies exist in your country, describe any evaluations produced by NGOs or external agencies.

2.8 Regulation

📎 Describe to what extent the government plays a regulatory role at national, regional and district levels. Please consider:

- organizations at each level that carry out a regulatory function (e.g. ministry of finance, ministry of health, parliament)
- national health plans for health or health services
- national policy statements

To summarize the different regulatory functions in the health system, you may wish to consider to what extent regulatory functions are centralized (e.g. at ministry of health, ministry of finance level) or decentralized (e.g. to regulatory agencies, health authorities or private organizations).

An example from England is provided in the Table on p. 21.

The regulatory role of the EU

The EU's legislative power can be expressed through two main tools:

Regulations – become law in all Member States the moment they come into force, without the requirement for any implementing measures. Regulations automatically override conflicting national law.

Directives – set a certain result or objective, while leaving discretion as to how to achieve it. The details of how directives are to be implemented are thus left to Member States.


In addition, the European Commission can express its view on a specific topic by issuing a *Communication*. Despite not having legal binding power for Member States, these can present a political position or some policy options.

The Council may also adopt *Recommendations* following a proposal from the Commission. These are also legal acts; although there are no legal sanctions for not applying them, they represent a shared commitment of EU Member States and have proved an effective focus for action (such as in the case of the Council Recommendation on cancer screening).

Decentralization of regulatory functions and institutions in England

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

2.8.1 Regulation and governance of third-party payers

 Describe how the government plays a regulatory role in relation to public and private purchasers and how it steers policy by setting strategic direction and regulation. Please consider:

- definition of the statutory benefits package
- whether purchasing organizations reflect public health priorities in their purchasing plans
- the organizations at different levels that carry out a regulatory function
- decentralization of purchaser organizations and regulation by local/regional/national government
- mechanisms of accountability
- private insurers
- regulatory arrangements relating to cross-border health care purchasing and provision


The financing mechanisms in place for third-party payers should be discussed in depth in Section 3.5.

There are three principal models of the organizational relationship between purchasers and providers: integrated, contract and direct payment to providers (see Section 3.4). The model used will usually also determine the regulatory framework.


e.g. ministry of finance, ministry of health, parliament

[Cross-reference](#) to Section 3.5 *Voluntary health insurance*.

2.8.2 Regulation and governance of providers

 **Organization:** describe how the government plays a regulatory role in relation to providers at national, regional and district levels (such as through setting strategic direction, regulation, standards, guidelines). Please consider:

- ownership, governance and management arrangements for providers
- organizations that carry out a regulatory function
- licensing/accreditation/registration mechanisms
- statutory mechanisms to ensure that professional staff or provider organizations achieve minimum standards of competence; function-specific inspectorates for public health and safety

 **Quality:** describe the mechanisms in place to ensure and monitor the quality of care provided. Please consider:

- systems at national/regional level
- quality of training of health workers (e.g. continuing professional development, public and private sector)
- incentives for participation in quality improvement activities and professional development
- legislation for medical negligence
- plans to develop/accommodate European centres of reference (health care for patients with rare diseases)
- attempts to establish integrated care pathways

Cross-reference to Chapter 5 *Provision of services*, if appropriate.

e.g. ministry of finance, ministry of health, parliament


Cross-reference to Section 4.2.3 *Training of health workers*.

Where relevant, **cross-reference** to Section 7.4.2 *Health service outcomes and quality of care*.


A European portal for rare diseases and orphan drugs can be accessed at: www.orpha.net/consor/cgi-bin/index.php

Integrated care pathways are multi-disciplinary outlines of anticipated care for patients with specific conditions.

2.8.3 Registration and planning of human resources

-  Describe any system of registering and licensing health professionals. Please consider:
- organizations registering qualified practitioners, such as general practitioners (GPs) or specialists (voluntary or statutory)
 - systems of re-accreditation (periodic re-licensing)
 - EU standards for mutual recognition as applied to the country


e.g. training, registration, certification and revalidation

-  Describe the mechanisms (if any) for planning human resources. Please consider:
- limits to the number of training places
 - areas of training
 - training facilities
 - retraining

EU Directive 2005/36/EC provides for the mutual recognition of professional qualifications in EU Member States, with the aim of facilitating the provision of cross-border services in the EU, including in the health sector.

[Cross-reference](#) to Section 2.5 *Planning*.

2.8.4 Regulation and governance of pharmaceuticals

-  Describe the regulation of pharmaceutical products. Please consider:
- responsible regulatory bodies
 - market authorization
 - quality of medicines (locally manufactured and imported)
 - pharmacovigilance
 - patent protection
 - classification of pharmaceuticals


e.g. a single medicines agency (or do several bodies have executive regulatory responsibilities), role of ministry of health

Medicines of good quality are an important access criterion.


Chapter 2

Organization and governance


- categories of over-the-counter (OTC) pharmaceuticals
- advertising

 Discuss the regulation of wholesalers and pharmacies. Please consider:

- entry requirements for new pharmacies
- generic substitution
- mail-order/Internet pharmacies
- regulation of counterfeit drugs
- any clawback systems

 Discuss policies to improve cost-effective use of pharmaceuticals. Please consider:

- measures aimed at influencing physician prescribing behaviour
- measures aimed at influencing pharmacists
- measures aimed at informing patients
- how these policies are monitored and any penalties applied (in theory and practice) by regulatory bodies (e.g. fines)

 Describe the system for pricing prescription pharmaceuticals. Please consider:

- profit-control scheme, reference pricing scheme or direct price controls
- composition of prices of medicines, i.e. ex-factory/manufacturer price, wholesaler (profit) margin, pharmacy margin (or profit) and any taxes
- regulation of OTC products

e.g. general sales list, pharmacy supervised


Generic substitution is the substitution of a product, whether marketed under a trade name or generic name, by an equivalent product that contains the same active ingredients and is usually cheaper.

Clawback is a process by which the relevant authority can recoup some of the profits made by pharmacies on their dispensing margins.


e.g. information, prescribing by active ingredient, prescribing budgets, prescribing guidelines, prescribing feedback

e.g. substitution by pharmacists, dispensing budgets, margins that encourage generic dispensing


[Cross-reference](#) to Chapter 3 *Financing*.

-  Discuss any system for public reimbursement of pharmaceuticals. Please consider:
- factors that determine whether a product will be reimbursed
 - a national essential drug list or reimbursement list (positive list, negative list)
 - use of cost–effectiveness criteria in addition to safety, efficacy and effectiveness

2.8.5 Regulation of medical devices and aids

-  Describe the regulation of medical devices and aids. Please consider:
- the process of purchasing/procurement
 - controls on acquisition
 - public and private sectors

2.8.6 Regulation of capital investment

-  Describe the regulation of capital investment. Please consider:
- systems to ensure equitable geographical distribution of capital and the right balance of investment across different levels of care
 - efforts to use capital investment to improve strategic and service delivery, and achieve health policy objectives
 - level of government responsible for regulation
 - public and private sectors


Cross-reference to Chapter 3 *Financing*.

e.g. land, buildings and major pieces of medical equipment

e.g. through standards on health infrastructure

2.9 Patient empowerment

2.9.1 Patient information


 Describe the level of information available to patients when making decisions about accessing health services. Please consider:

- sources and dissemination of information
- mechanisms in place to guide patients around the health system
- health literacy and patient education
- information on the quality of health services
- recording and publication of medical errors
- freedom of information legislation
- information for ethnic minorities and translations into minority languages
- age-appropriate information for adolescents and young people
- evidence of accessibility and usefulness of available information
- whether the population has (or is likely to have) a clear sense of the benefits to which they are entitled

e.g. range of services covered, costs, quality, type of provider contracted

[Cross-reference to Section 2.7.1 Information systems.](#)

2.9.2 Patient choice

 Briefly outline the extent of patient choice. Please consider:

- the different types of choice available to patients, such as choice of insurer, provider, treatment, etc.
- competition between purchaser organizations for consumers/insurees
- evidence on whether/how/which individuals exercise choice

Choice is a complex issue. Some argue that choice has intrinsic value, while others value its instrumental potential (e.g. to increase responsiveness, to facilitate competition, to improve quality and to empower people).

In addition, acceptable levels of choice for individuals are likely to vary between countries and between different groups within a country. Individual choice may be associated with costs and benefits.


- evidence on whether levels of information facilitate choice
- evidence on how the current level of individual choice affects equity and efficiency

2.9.3 Patient rights


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

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

The EU is also becoming increasingly active in this area. Among other initiatives, the European Commission has adopted a draft Directive on patients' rights in cross-border health care.

 Describe what has been done at national or local level to implement WHO's patient rights framework. Please consider:


- definition of patient rights
- legislation
- enforcement

 Briefly describe any arrangements to enable physical access to health facilities for disabled people

e.g. people with physical disabilities, using wheelchairs or with visual or hearing impairment

Cross-reference to the relevant sections of service delivery in Chapter 5 *Provision of services*.

2.9.4 Complaints procedures (mediation, claims)


 Describe any mechanisms in place for patient complaints and how often they are used. Please consider:

- complaints procedures for institutions and other health care actors
- patient/user advocates employed within institutions
- arrangements made for vulnerable populations
- compensation for health care-related harm
- burden of proof

e.g. psychiatric hospitals, acute hospitals

e.g. people with mental illness, ethnic minorities, disabled people


2.9.5 Public participation

 Provide a brief overview of public participation in your country. Include any mechanisms by which members of the public can influence purchasing decisions by political or administrative means:

- individually
- collectively

e.g. representation in decision-making bodies; electing the board of purchaser organizations; participating in surveys

e.g. appealing to court

 If surveys of user or public satisfaction with purchaser or provider services are carried out, please describe what their results show. If possible, supply a table with survey results.

Potential data sources:

Eurobarometer
http://europa.eu.int/comm/public_opinion/archives/special.htm

Income, Social Inclusion and Living Conditions (EU-SILC)
http://epp.eurostat.ec.europa.eu/portal/page/portal/income_social_inclusion_living_conditions/introduction

European Health Interview Survey (EHIS)
http://ec.europa.eu/health/ph_information/dissemination/reporting/ehss_01_en.htm

2.9.6 Patients and cross-border health care


☞ If patient mobility is an issue in your health system and data are available, briefly describe the main cross-border care issues. Please consider:

- patients going abroad for treatment
- patients coming from abroad to receive treatment
- national criteria defining who is entitled to receive treatment abroad
- information on cross-border health care

Cross-border health care affects tourists, retirees, inhabitants of border regions sharing cultural or linguistic links, migrant workers, individuals aiming to benefit from perceived higher quality health care and people sent by the health system to overcome capacity restrictions.


This chapter considers how much is spent on health and the distribution of health spending across different service areas. It describes the different sources of revenue for health, focusing on how revenue is collected, pooled and used to purchase health services and pay providers. It also describes health coverage – for example, who is covered by compulsory prepayment, which services are covered by the statutory benefits package, the extent of user charges and other out-of-pocket (OOP) payments and the role played by voluntary health insurance (VHI).

Chapter summary

 Please provide a summary covering the whole chapter (maximum 500 words).

This will also be used in the executive summary. Please begin the summary by referring to the country's health financing policy framework or objectives and include a [cross-reference](#) to Chapter 7, which outlines the health system's stated objectives.

3.1 Health expenditure

 Please comment on the following tables and figures. Please consider:

- main trends over time
- reasons for changes/position in relation to other countries
- differences between national and international data sources
- the fiscal context

This section looks at how much money is spent on health and how it is distributed across services and population groups.

The *fiscal context* refers to the ability of the government to mobilize tax (including payroll taxes and compulsory health insurance contributions) and other public revenues, and the need for these to be balanced with total public spending. The fiscal context is important because the more money the government has, the more it can spend on health.

The following measures shed light on the fiscal context and are presented in Table 1.2:

- public expenditure (as % of GDP)
- cash surplus/deficit (as % of GDP)
- public debt (as % of GDP)

[Cross-reference](#) to Section 1.2 and Table 1.2.

Table 3.1 Trends in health expenditure in country, 1995 to latest available year

Expenditure	1995	2000	2005	Latest available year
Total health expenditure in € (or US\$) PPP per capita (1995 prices)				
Total health expenditure as % of GDP				
Mean annual real growth rate in total health expenditure*				
Mean annual real growth rate in GDP				
Public expenditure on health as % of total expenditure on health				
Private expenditure on health as % of total expenditure on health				
Government health spending as % of total government spending				
Government health spending as % of GDP				
OOP payments as % of total expenditure on health				
OOP payments as % of private expenditure on health				
VHI as % of total expenditure on health				
VHI as % of private expenditure on health				

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

Source: National Health Accounts data, available from <http://www.who.int/nha/en/>

Fig. 3.1

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

Figure to be supplied by Observatory staff using WHO estimates. These data are harmonized by WHO for international comparability; they are not necessarily the official statistics of WHO's Member States, which may use alternative methods.

Fig. 3.2

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

Fig. 3.3

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

Fig. 3.4

Public sector health expenditure as a share (%) of total health expenditure in the WHO European Region, latest available year

The other countries selected (up to three) should be chosen in discussion with the editor(s), have particular relevance for your country (neighbours, similar historical/socioeconomic background, etc.) and be the same as in the later figures on hospital beds, physicians and nurses. Weighted averages for EU27, EU15, EU12, CIS or CARK can also be included as appropriate.

Figures 3.2, 3.3 and 3.4 to be supplied by Observatory staff using WHO estimates (Health for All database).

Note: If the data needed for Tables 3.2 and 3.3 are not available, include one table with information on spending by service category and/or service input.

Table 3.2

Public health expenditure on health by service programme, latest available year

	% of public expenditure on health	% of total expenditure on health
Health administration and insurance		
Education and training		
Health research and development		
Public health and prevention		
Medical services:		
– inpatient care		
– outpatient/ambulatory physician services		
– outpatient/ambulatory dental services		
– ancillary services		
– home or domiciliary health services		
– mental health		

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

For outpatient care, please distinguish between primary and specialist care.

Source: national statistics


Table 3.3

Public health expenditure on health by service input, five latest available years (in %)

Service input					
Medicines					
Medical devices					
Investment in medical facilities (land, buildings, equipment) at primary, secondary, tertiary, intermediate and social care levels					
Human resources					
Utilities					

Source: national statistics

3.2 Sources of revenue and financial flows

 Please summarize the key elements of health financing in no more than 500 words. Include information about:

- the different sources of revenue for the health system and their relative share of total revenue
- coverage: who is covered (by the main system and by VHI), what is covered (by the publicly financed benefits package and the role VHI plays), how much of service cost is covered (the presence of user charges for services in the publicly financed benefits package)
- how compulsory sources of revenue are collected, pooled and used to purchase health services and to pay providers
- the composition of OOP payments
- the role played by VHI

This section is intended to provide the reader with an overview of the sources of revenue used to finance the health system, coverage breadth, scope and depth and how finances are collected, pooled and used to purchase health services and pay providers. It should cross-reference subsequent sections in which these elements are discussed in more detail.

e.g. general government budget, earmarked payroll taxes (social insurance contributions), OOP payments, VHI


e.g. formal user charges, direct payments for services not included in the benefits package, informal payments

Table 3.4

Sources of revenue as a percentage of total expenditure on health according to source of revenue, 1990, 1995, 2000, 2005 and last five available years

Source of revenue	% of total expenditure on health
General government expenditure	
Earmarked taxes or social insurance contributions	
OOP payments	
VHI	
Other (please specify)	

Source: national statistics or National Health Accounts data, available from <http://www.who.int/nha/en/>

 Discuss the relative size of each source of revenue. Please consider:

- any changes that may have occurred in recent years as well as the factors behind these changes
- the availability and reliability of data; if possible, indicate whether the figures presented here are likely to be an overestimate or underestimate of actual financing volumes

Fig. 3.5

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

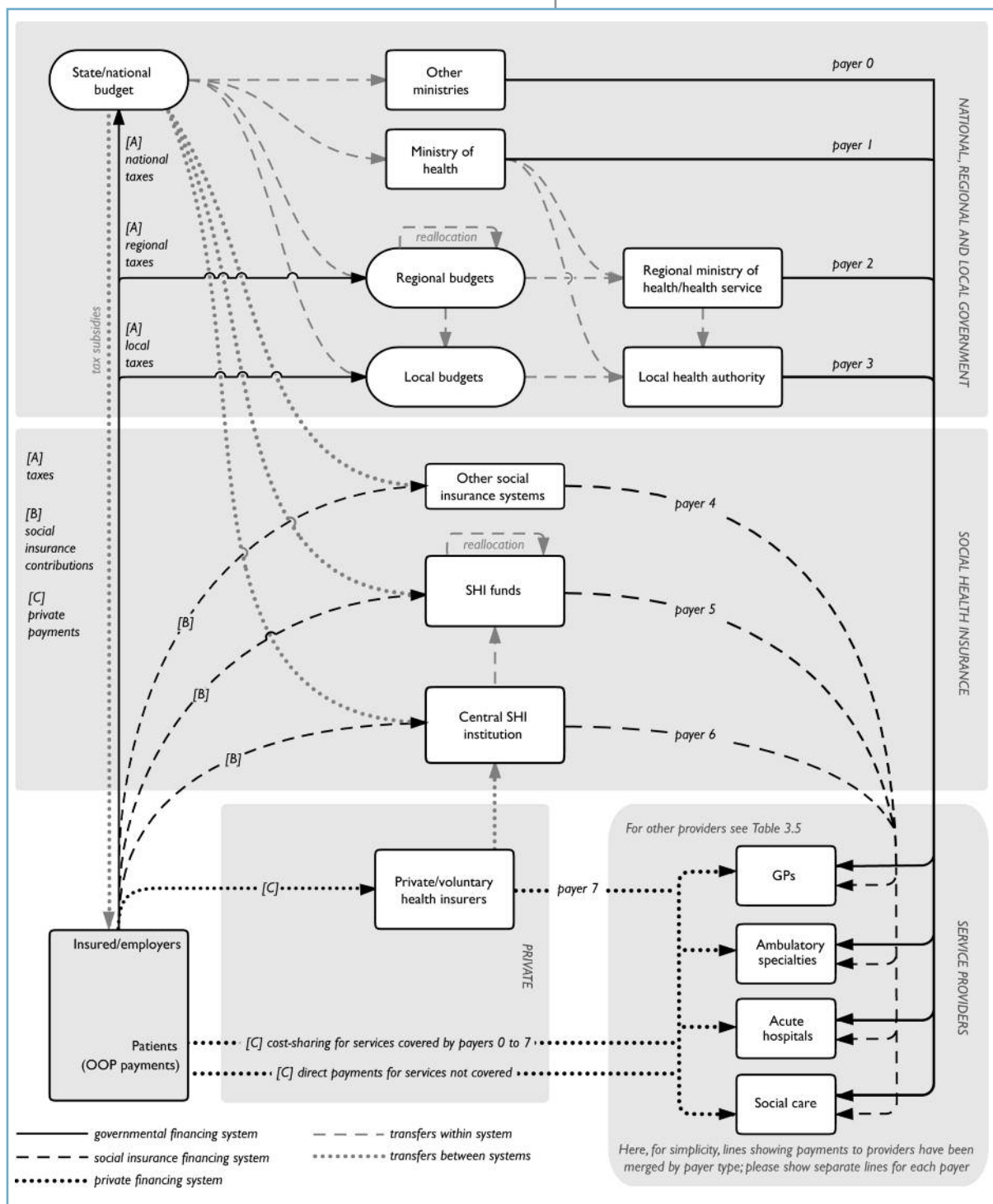
Please construct a pie chart (based on national statistics or National Health Accounts data from WHO) showing the proportion of total health expenditure from different sources in the latest available year.

Fig. 3.6

Financial flows

Please provide a diagram of financial flows using this figure.

The diagram should serve as an introductory snapshot but also include details which will be explained in the following sections.



Source: national statistics

3.3 Overview of the statutory financing system

Most countries have a mix of compulsory and voluntary systems of financing. This section focuses on the statutory health financing system (which is usually compulsory) and the way in which revenue from compulsory sources is collected, pooled and used to purchase health services and pay providers.

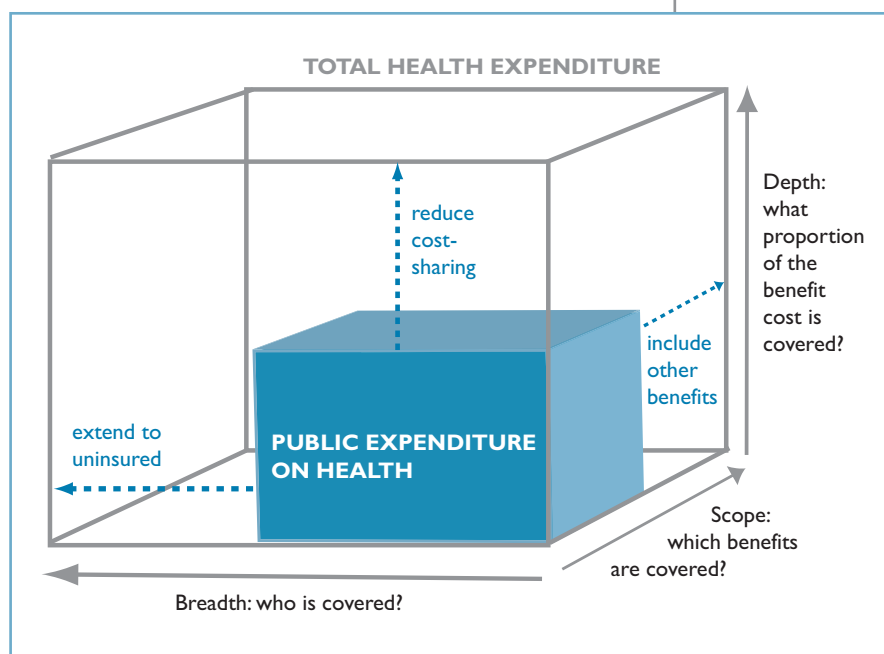
Compulsory sources of revenue usually include the following: allocations for health from the general government budget at national, regional or local level (including taxes earmarked for health that are part of the government budget); taxes (sometimes referred to as social insurance contributions) pooled by a separate entity (usually one or more statutory or social health insurance funds).

The section on VHI will discuss how voluntary prepayment is collected, pooled and used to purchase, and how private payment of providers differs from statutory payment.

The section on OOP payments will discuss the extent of formal cost-sharing (user charges) and other OOP payments (informal payments).

Note: statutory/compulsory prepayment will be discussed here even if OOP payments are the largest single source of finance. If OOP payments are the main source of finance, please say so.

3.3.1 Coverage




Coverage has three dimensions:

Breadth: the proportion of the population covered

Scope: the range of benefits covered

Depth: the proportion of the benefit cost covered


Breadth: who is covered?

 Describe the extent of population coverage and the basis for entitlement. Please consider:


This subsection should give the reader a clear picture of those covered by the statutory health system. It should also give the reader an idea of those who are not covered or choose alternative forms of coverage. Cross-references to the subsection on VHI may be necessary.

- the legal basis for entitlement
e.g. through the constitution, law
- criteria for entitlement
e.g. residence, employment status, membership of an insurance scheme, residence in specific geographical areas, insurance contributions
- whether membership of an insurance scheme is compulsory
- which groups are covered without having to make formal contributions
e.g. children, pensioners, unemployed, pregnant women
- any excluded groups
e.g. unemployed, foreigners, irregular immigrants
- practical barriers preventing some population groups from accessing health care even though they are entitled to it
e.g. because it is necessary to apply for a health insurance card or access requires a permanent address
- whether the health insurance law is properly enforced
e.g. are there insured people who do not benefit from services or uninsured people who benefit from services?
- whether some population groups can join voluntarily (“opting-in”) or voluntarily leave (or are compulsorily excluded from) the statutory system (“opting-out”)

Scope: what is covered?

 Describe the range of benefits to which covered people are entitled. Please consider:

- whether the benefits package is standard across the whole of the covered population
- the extent to which benefits are explicitly defined
- the existence of a “positive list” of included goods or services or a national essential drug list
- any benefits explicitly excluded
- the existence of a “negative list” of excluded goods and services
- whether statutory insurance bodies can (and do) offer additional benefits over and above the established benefits package
- any cash benefits available

 Describe the process of deciding which goods and services are to be included in/excluded from the statutory benefits package. Please consider:

- who is responsible for/involved in the decision-making process
- the criteria used as a basis for decision making
- the role of HTA
- any reductions in or expansions of the benefits package in recent years (services that have been excluded or added)

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

The services and products that may or may not be covered include diagnosis, treatment, prevention, health promotion, spa treatment, rehabilitation, long-term nursing care, long-term care for older people and people with mental health problems, palliative care, occupational health care and prevention, accident-related care, transport, after hours care, pre-hospital emergency care, patient information, alternative therapy or complementary medicine, optician services (e.g. sight tests, glasses), pharmaceuticals (outpatient and inpatient), dental care, renal dialysis, cosmetic surgery, antenatal care, care during childbirth and postpartum, termination of pregnancy, contraception, in vitro fertilization, organ transplantations and treatment abroad.

e.g. through complementary or supplementary VHI

e.g. sick pay, maternity benefits, disability, invalidity, cash payments for users of long-term care services, funeral benefits, cash benefits for family members caring for acute or chronically ill people, cash benefits for special groups (e.g. those with mental disorders or living with HIV/AIDS)

e.g. safety, efficacy, effectiveness, cost-effectiveness

Cross-reference to Section 2.7.2 *Health technology assessment*.

- ⤿ If there is no explicitly defined benefits package, please discuss how decisions about benefits are made (and by whom).

Depth: how much of benefit cost is covered?

- ➡ Briefly describe the extent of user charges in place for accessing statutory benefits. Please consider:
 - the services for which people have to pay user charges, e.g. outpatient prescription drugs, GP visits, stays in hospital
 - whether any population groups are protected from user charges, e.g. through exemptions, reduced rates, VHI covering statutory user charges
 - formal user charges as a percentage of public and total expenditure on health
 - significant trends over time

3.3.2 Collection

General government budget


- ➡ Briefly describe:
 - the contribution to health financing of the government budget
 - the mix of taxes used to fund the government budget, indicating which (if any) are earmarked for health and noting any significant changes
 - the process/mechanism of tax collection (including responsible bodies, level of collection)

This section should give the reader a brief overview of statutory user charges and their role in the health system, but should not describe these charges in detail since this will be done in the subsection on cost-sharing.

Cross-reference to Section 3.4 *Out-of-pocket payments*.

e.g. the relative share of direct vs indirect taxes and income vs labour vs consumption taxes

e.g. national/regional/local, compliance issues, tax credits/relief


-  the breakdown of percentage of local/regional/national taxation where these contribute to health financing
- progressivity of the total tax burden and of different types of tax (where possible use household survey data)

Progressive: a higher share is taken from the rich

Proportionate: an equal share is taken from all income groups

Regressive: a higher share is taken from the poor

Taxes or contributions pooled by a separate entity

 Describe the nature of these taxes/social insurance contributions. Please consider:

- whether social insurance contributions are earmarked for health or whether they are mixed with other sectors, such as pensions
- on what they are levied, e.g. gross/net wages, other income
- who is responsible for collecting them
- who is responsible for setting contribution rates
- whether there are differences in contribution rates by funds or type of member
- whether there are certain social groups that do not contribute
- whether contributions are shared between employers and employees and if so, in what ratio
- whether there are upper or lower thresholds on contributions
- whether the state contributes and if so, for whom and how much
- breakdown of how much is collected from employers/employees and how much from other sources
- progressivity of social insurance revenue




This section focuses on taxes or social insurance contributions used to finance health care that are pooled by an entity that is separate from the general government budget. These are often payroll taxes earmarked for health. They may be collected by statutory health insurance funds, local government or central government, depending on the country context.

e.g. different rates for older people, self-employed, farmers, public employees, unemployed

e.g. transfers from the general government budget, flat-rate premiums

3.3.3 Pooling of funds

Allocation from collection agencies to pooling agencies

-  Discuss whether or not there is an overall budget for the health system and how the process of setting this budget works. Please consider:
 - whether decisions about the health care budget are made at different levels, e.g. national, regional, local
 - the process of determining the size and content of the overall health system budget
 - whether overspending has been a problem historically
-  Discuss the market structure of pooling. Please consider:
 - whether the same agency that collects funds also pools them
-  Discuss the process of transferring collected revenue to pooling agencies:
 - describe the nature of the agencies responsible for pooling compulsory sources of revenue
 - if revenue is pooled by one or more statutory health insurance funds, describe any flows in addition to earmarked contributions, and the allocation mechanisms used
 - if government agencies pool funds for health care, describe the process for determining the size of the budget held by each
 - if there are “parallel” government health systems, describe the process for determining the size of their budgets

This subsection focuses on any process by which financial resources flow from a collection agency to a pooling agency (e.g. from the ministry of finance to the ministry of health or from the tax agency or social security agency to a central statutory health insurance fund). In some cases, the revenue collection and pooling functions are integrated (e.g. where statutory health insurance funds collect their own contributions) and the resource allocation mechanism to poolers is therefore implicit.

Information on management of statutory health insurance funds is provided in Section 2.8.1 *Regulation and governance of third-party payers*.

In these cases, the contribution mechanism is also the allocation mechanism to the pool

e.g. ministry of finance, ministry of health, other government departments, local governments, health insurance funds, private insurance companies; these may or may not be the same agencies that purchase services from providers

e.g. how does the government decide how much should be allocated to the ministry of health?

e.g. ministry of defence, ministry of interior

- if there are territorial pools, describe the allocation process from central to territorial levels.

If these pooling agencies are also purchasers, please refer the reader to the following section and discuss this issue there

Allocating resources to purchasers

This subsection focuses on any process by which financial resources flow from a pooling agency or among agencies that pool funds to those that purchase services (e.g. from a central agency to statutory health insurance funds or geographically defined purchasers such as local governments).

In some cases the revenue collection, pooling and purchasing function are integrated and the resource allocation mechanism to purchasers is therefore implicit (e.g. where statutory health insurance funds collect their own contributions). Even in these situations, however, there may be some redistribution or reallocation of resources among purchasers, which should be described in this section.

Describe the market structure of purchasing. Please consider:

- the nature of the purchasers and the population for which they are responsible
- the number of purchasers
- whether people have choice of purchaser

e.g. entire population of territory, people that are members of the particular scheme managed by the purchaser

Cross-reference to Section 2.9.2 *Patient choice*.

Describe the method(s) used to allocate funds from pooling agencies to purchasers or to reallocate funds among pooling agencies/purchasers. Please consider:

- the basis for allocating resources
- whether the process is standardized across the country
- whether budgets are set for different sectors or programmes within the health system and if so, whether they are hard or soft budgets/risk-adjusted or not

e.g. full retrospective reimbursement for all expenditure incurred; reimbursement based on a fixed schedule of fees; prospective funding based on expected future expenditure, using fixed budgets; risk-adjusted capitation

- if a system of budgets is in place, please say how they are calculated

⊃ If risk-adjusted capitation is used to allocate (or reallocate) resources, please consider:

- the stated purpose of risk-adjusted capitation
- the percentage of total allocations to purchasers made through risk-adjusted capitation
- the resource allocation formula or risk adjustment mechanism, the process used to determine the formula/mechanism, and what the formula/mechanism involves

⊃ If relevant, please also consider:

- whether health resource allocations (e.g. from central to local government) are separate from allocations for other sectors, such as education and social services; if not, describe the mechanisms in place to define health allocations
- whether purchasers can vary their own resources (e.g. through cost-sharing, charging additional per capita premiums or raising local taxes)
- whether purchasers bear financial risk (i.e. can they carry over a deficit or a surplus or borrow money)

Budgets may be calculated in the following ways:

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

When describing a resource allocation formula or risk adjustment mechanism, please consider:

- risk factors or risk adjusters used
- weights applied to different factors
- how double counting is avoided
- whether there is adjustment for supply-side factors, such as the number or type of hospitals in a region
- whether adjustments account for “pure cost” factors that could affect the expected cost of service delivery and are part of the context (e.g. population density, remoteness) rather than something amenable to policy or efficiency improvement
- whether adjustments are made for socio-economic factors
- whether specific types of morbidity (e.g. psychiatric, HIV or tuberculosis prevalence, cardiovascular disease prevalence) are used as factors
- whether there are any retrospective adjustments made to the allocations, based on actual expenditure
- whether there is a safety net or additional pool to cover exceptionally expensive treatments

- ☞ If purchasers are responsible for collecting all or some revenue, there may be a system of reallocation between them (i.e. transfers of funds from one purchaser to another). If so, describe
 - whether there have been any recent changes to the system of resource allocation or any are being proposed. Discuss reasons for these changes and any implications.

3.3.4 Purchasing and purchaser–provider relations

- 👉 Describe the process through which purchasers and providers interact.

If providers are integrated, please consider:

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

If contracting is used, please consider:

- whether purchasers can contract selectively with individual providers (in theory and in practice)
- whether there is competition between providers for contracts from purchasers
- the main types of contract agreed between purchasers and providers
- the contracting process
- how contracts are monitored and enforced
- any cases where national competition authorities have intervened
- incentives to provide services to specific groups of people
- any examples and data/evidence available

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

Integrated: health care providers are directly employed (or “owned”) by the third-party payers.

Contract: health care providers are independent and are contracted by the third-party payers (be they public, private non-profit-making or private profit-making, regional monopolies or competing), i.e. there is a separation between purchaser and provider functions and contractual or contract-like relationships between them.

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

If direct payments from patients form an important part of provider reimbursement, please consider:

- whether the insurer or regulator intervenes (e.g. through price controls, OOP payments limits, reporting requirements)
- whether payers/purchasers control providers and patients (in theory and in practice)
- whether there are any mechanisms to counter supplier-induced demand and if so, how these are implemented

3.4 Out-of-pocket payments



Provide a brief overview of the historical evolution of private expenditure on health.

- if OOP payments constitute the main source of revenue, please explain why revenue has not been easy to generate through prepayment.



Describe the composition of OOP payments. Please consider:

- the relative contribution of direct payments, cost-sharing and informal payments
- whether informal payments are a feature of the health system and whether data on informal payments are included in calculations of private expenditure
- changes (decrease or increase) in the level of OOP payments and in which areas; explain why

OOP payments include:

Direct payments: payments for goods or services that are not covered by any form of third-party payment.

Cost-sharing (user charges): a provision of health insurance or third-party payment that requires the individual who is covered to pay part of the cost of health care received.

Informal payments: unofficial payments for goods or services that should be fully funded from pooled revenue.

- implications for financial protection and equity
- policy debates concerning user charges

Is there any research showing the distribution of OOP payments across the population, the structure of OOP payments (i.e. what services they are spent on) and their impact on catastrophic household spending and poverty levels?

Cross-reference to Section 3.7 *Payment mechanisms* and Section 7.2 *Financial protection and equity in financing* and Section 7.3.2 *Equity of access to health care*.

3.4.1 Cost-sharing (user charges)

Cost-sharing can be direct or indirect, as set out in the table below.


Direct methods of cost-sharing

Co-payment	A fixed amount (flat rate) charged for a service.
Co-insurance	The user pays a fixed proportion of the cost of a service, with the third party paying the remaining proportion.
Deductible	A fixed amount to be paid by the user before a third-party payer will begin to reimburse for services. It is usually an annual amount of all health care costs or costs for a particular service that is not covered by the insurance plan.

Indirect methods of cost-sharing

Extra billing	Charges by the provider that are higher than the maximum reimbursement levels set by the third-party payer, leaving users liable to pay the difference.
Reference pricing	The maximum price for a group of equal or similar products (mostly pharmaceuticals) the third-party payer is willing to reimburse. If the actual price exceeds the reference price, the price difference must be met by the user.
OOP payments maximum	A defined limit on the total amount of OOP payments for which an insured individual or household will be liable for a defined period, over and above which the third party pays all expenses.
Benefit maximum	A defined limit on the amount that will be reimbursed by the third-party payer for a defined period, over and above which the user is entirely liable for payment.

Source: adapted from the European Observatory on Health Systems and Policies Glossary (available from the editor)

 Complete Table 3.5 outlining which methods of direct or indirect cost-sharing are applied to each item or service and the mechanisms in place to protect specific groups of people.

Protection mechanisms may include reduced rates, exemptions for certain groups of people or for certain conditions, caps on patient OOP payments, generic or therapeutic substitution, complementary VHI covering statutory user charges.


Please delete irrelevant categories or discuss with the editor(s) where other categories would be more appropriate.

Table 3.5

User charges for health services

Health service	Type of user charge in place	Exemptions and/or reduced rates	Cap on OOP spending	Other protection mechanisms
GP visit				
Primary care				
Outpatient specialist visit				
Outpatient prescription drugs				
Inpatient stay				
Dental care				
Medical devices				
Other (please specify)				

Source: national statistics

 Provide an overview of the system of formal user charges in place. Please consider:

- whether user-charges policy has explicit objectives; if so, whether the stated objectives have been achieved
- who is responsible for making decisions about the level of cost-sharing and protection mechanisms
- changes in policy

e.g. raising revenue, cost-containment, reducing inappropriate demand

e.g. national/local government; statutory health insurance funds; are there regional variations in cost-sharing?

- Discuss whether complementary VHI covering statutory user charges is available, what proportion of the population is covered by this form of VHI and whether it has any distributional implications.

3.4.2 Direct payments

- Describe the extent of user payment at the point of use for goods or services that are not covered by statutory prepayment. Please consider:
 - the sorts of services for which people are most likely to make direct payments
 - any issues arising
 - any changes

3.4.3 Informal payments

- If informal payments exist, please consider:
 - the nature and magnitude of informal payments
 - their prevalence (historically if possible) and size relative to official payments
 - geographic variations in the prevalence of informal payments
 - efficiency and equity implications
 - problems or challenges encountered
 - plans or expectations with respect to future developments in this area

Cross-reference to Section 3.3.1 *Coverage*, the subsection on *Scope: what is covered?* and Section 3.5 *Voluntary health insurance*.

e.g. use of private providers, private elective surgery

Cross-reference to Section 7.2 *Financial protection and equity in financing*, Section 7.3.2 *Equity of access to health care*, and Section 3.7.2 *Paying health workers*.

3.5 Voluntary health insurance

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


It is useful to think of VHI in relation to statutory coverage since VHI markets are generally heavily shaped by the rules and arrangements of the statutory health system. VHI plays different roles in relation to statutory coverage. Understanding differences in market role (summarized below) is important for three reasons. First, the role VHI plays is often correlated with market size, particularly in terms of its contribution to health expenditure. Second, a market's role largely determines the way in which it is regulated. And third, as a result of its combined effect on market size and public policy towards VHI, market role may tell us a great deal about the likely impact of VHI on the attainment of health system goals, both within the market and in the health system as a whole.

VHI market roles


Market role	Driver of market development	Nature of cover	European examples
Substitutive	Statutory system inclusiveness: the proportion of the population eligible for statutory cover or permitted to opt out	Covers people excluded from or allowed to opt out of the statutory system	Germany
Complementary (services)	The scope of benefits covered by the statutory system	Covers benefits excluded from the statutory system, e.g. dental care, physiotherapy, etc.	Denmark Hungary the Netherlands
Complementary (user charges)	The depth of statutory coverage: the proportion of the benefit cost met by the statutory system	Covers user charges imposed in the statutory system	Belgium France Slovenia
Supplementary	Consumer satisfaction: perceptions about the quality of publicly financed care	Covers faster access to care and enhanced consumer choice of provider and amenities	Ireland Poland Romania Sweden United Kingdom

Source: adapted from Foubister T et al. (2006). *Private medical insurance in the United Kingdom*. Copenhagen, WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies; Mossialos E, Thomson S (2002). Voluntary health insurance in the European Union: a critical assessment. *International Journal of Health Services*, 32(1):19–88.

3.5.1 Market role and size

-  Provide an overview of the market for VHI. Please consider:
- the role VHI plays and its relative importance
 - the contribution of VHI to total expenditure on health and private expenditure on health
 - the proportion of the population covered by VHI
 - the factors that drive demand for VHI
 - changes

3.5.2 Market structure


-  Describe the market structure of VHI. Please consider:
- where relevant, who is eligible to buy VHI
 - the nature of those who buy VHI and, if possible, the relative market share of individuals and groups
 - the characteristics of those covered by different types of VHI
 - the nature, number and relative market share of the entities selling VHI
 - changes

e.g. individuals, groups (often employers, employees)

e.g. age, gender, socioeconomic status, education, area of residence

e.g. mutual associations, other non-profit-making insurers, commercial (profit-making) insurance companies

3.5.3 Market conduct

-  Provide an overview of the way in which VHI operates, noting any systematic differences in operation between types of insurer (e.g. profit-making versus non-profit-making). Please consider:
- how premiums are set
 - the scope (range) of benefits covered
 - whether benefits are provided in cash or in kind

e.g. risk rated (based on individual risk), community rated (the same premium for all members of a community or group) or experience rated (adjusted based on claims history)

- the depth of benefits
- the nature of policy conditions applied to those purchasing VHI
- the nature of insurer–provider relations
- how insurers pay providers and who sets the level of provider remuneration
- the nature of the institutions and professionals providing VHI-covered services
- the level of administrative costs incurred in the VHI market
- the profitability of the VHI market
- changes

e.g. the extent of cost-sharing for covered benefits and whether benefits are subject to ceilings (an upper limit)

e.g. age limits for purchasing VHI, whether annual versus lifetime contracts, cover of pre-existing conditions, waiting periods


e.g. whether insurers are integrated with providers, engage in selective contracting of providers or simply reimburse patients

e.g. are they private or public or do they operate in both sectors?

e.g. administrative costs as a proportion of total premium income

e.g. claims ratios: benefits paid as a proportion of total premium income


3.5.4 Public policy

 Provide an overview of public policy towards VHI. Please consider:

- who is responsible for regulating the market
- how the market is regulated
- tax incentives or disincentives to take up VHI, such as tax relief, taxes on premiums, taxes on the receipt of benefits in kind
- changes
- issues arising
- policy debates about VHI

e.g. the types of regulation in place; examples include solvency margins, open enrolment, lifetime cover, community-rated premiums, systematic prior notification of premiums and changes to premiums and policy conditions, premium caps, minimum or standard benefits, cover of pre-existing conditions, risk equalization, consumer information requirements

3.6 Other financing

 If there are no other sources of funding, or if they are very insignificant, please say so.

3.6.1 Parallel health systems

- ⌚ Discuss the role of parallel health systems with respect to their financing role, the challenges they represent and their future role.

In some European countries, there are parallel health systems providing services for employees and officials of certain national enterprises and ministries, such as the ministries of defence, transportation and others.

[Cross-reference](#) to any further details provided in Sections 3.3.3 and 3.3.4 on pooling and purchasing.

3.6.2 External sources of funds

- ⌚ Comment on the evolution and use of external sources of financing.

External sources of funds refer to financial assistance for the health sector, which may take the form of loans or grants from bilateral or multilateral organizations. EU structural funds may be an important external source in many European countries.

[Cross-reference](#) to Section 4.1.1 *Capital stock and investments* if relevant.

3.6.3 Other sources of financing

Discuss the following, where they exist:

- ⌚ Occupational health services and other medical benefits to employees provided by corporations and private employers or provided to certain special groups (e.g. soldiers, prisoners)
- ⌚ Non-profit-making institutions serving households (excluding social insurance)
- ⌚ Voluntary and charitable financing, e.g. national and international donations in cash or in kind from NGOs
- ⌚ Mental health and social care services where these are funded separately from general medical services. If relevant, please consider:
 - user charges for institutional and community-based mental health services
 - exemption criteria, if any, from user charges
 - whether NGOs, donor organizations or religious organizations contribute significantly to the financing of mental health services

e.g. the Red Cross, philanthropic and charitable institutions, religious orders, lay organizations

- ⤿ Long-term care financing where this is funded separately from general medical services. If relevant, please consider:
 - whether some long-term care services are excluded from insurance coverage
 - if so, how they are financed (e.g. by NGOs or donor organizations)

Cross-reference to Section 5.8 *Long-term care*.

3.7 Payment mechanisms

See Box on p. 55 for an explanation of the different types of payment methods.

3.7.1 Paying for health services

- 🔧 Please discuss how each of the following types of service are funded and cross-reference to the relevant sections in Chapter 5:
 - public health services
 - primary/ambulatory care
 - specialized ambulatory/inpatient care
 - pharmaceutical care

This section should provide an overview of payment mechanisms used in the health system, with reference to Table 3.6 and the financing flow diagram shown in Fig. 3.6.

Discuss the transactions shown in the financial flow diagram and the incentives these transactions provide for providers.

Highlight any recent changes in how providers are paid and whether any evaluation of their effect has been carried out.

Where possible, distinguish between the method of paying health workers and the method of paying for services.

Where payments amount both to reimbursement for services and to the income of the individual delivering the service, this should be clearly noted.

- ⤿ If robust data are available, please discuss any other relevant areas.

e.g. rehabilitation, dental care, mental health care, alternative medicine

- ⤿ If relevant, please also discuss:
 - any recent changes in the methods used to pay providers and their purpose
 - any problems or issues that triggered the changes

In discussing how prescription medicines are funded, authors may consider the following:

- profit-control schemes, reference-pricing schemes or direct price controls
- composition of prices of medicines, i.e. ex-factory price, wholesaler's (profit) margins, pharmacy margins (or profit), and any taxes
- regulation of OTC products

Different types of payment method

Retrospective payment (reimbursement) at “full cost”: third-party payers (purchasers) reimburse providers after services are delivered, either without any clear constraints on the price or quantity of health services provided or according to a specific fee schedule.

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

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

Prospective payment: purchasers allocate revenues to providers before services are delivered or the total amount of payment is fixed in advance. Key policy issues relate to the basis on which the budgets are determined (e.g. capitation).

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

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

Mixed methods: payment methods that combine retrospective and prospective methods (e.g. fee schedule-based reimbursement subject to volume/budget caps).

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

Table 3.6

Provider payment mechanisms

Payers \ Providers	Ministry of health	Other ministries	Regional ministry of health/ health service	Local health authority	Central SHI institution	SHI funds	Other SHI systems	Private/ voluntary health insurers	Cost-sharing	Direct payments
GPs										
Ambulatory specialists										
Other ambulatory provision										
Acute hospitals										
Other hospitals										
Hospital outpatient										
Dentists										
Pharmacies										
Public health services										
Social care										


Please complete the table by showing the different mechanisms by which payers pay providers, indicating whether payment is via:

- Fee-for-service – FFS
- Per diem – PD
- Salary – S
- Capitation – C
- Case payment – e.g. DRGs
- Performance-related pay – P4P

Where a provider is paid through a combination of methods, please indicate the relative share of each payment mechanism.

Delete any irrelevant rows/columns.

3.7.2 Paying health workers

 Describe how different categories of health workers are paid and who sets their remuneration. Please consider:

- how rates and methods are established
- recent changes in payment methods and any evaluation of the effect of changes
- how the average income of health professionals compares with that of other equivalent professionals/the average national income

 Consider the following groupings:

- doctors
- nurses and midwives
- dentists and dental auxiliaries
- pharmacists
- other health workers

 If relevant, please consider (for each group):

- any incentives, both financial and non-financial
- any problems

Health workers may be paid in the following ways:

- fee-for-service (officially, from the third-party purchaser or patients, and unofficially as informal payments)
- salary
- capitation
- blended systems


e.g. negotiation, regulation

Please distinguish between health professionals working in primary/ ambulatory care or community settings and those working in hospitals and academic settings.

e.g. physiotherapists, alternative medicine

This chapter provides an overview of physical and human resources in the health system. Physical resources encompass infrastructure, capital stock, medical equipment and information technology (IT). The section on human resources discusses health workforce issues, such as planning, training and mobility.

Chapter summary

-  Please provide a summary of the whole chapter (maximum 300 words).



This will also be used in the executive summary.

4.1 Physical resources

4.1.1 Capital stock and investments


Please note that Section 4.1.1 focuses on buildings, not equipment.

Current capital stock

-  Briefly describe the number, location, size and age of hospitals.
-  Also describe the condition of facilities. Please consider:
 - property condition surveys available at various levels of care (e.g. primary, secondary, tertiary, intermediate, social care)
 - whether appraisals of condition and performance feed into planning future strategies and investment

Cross-reference to Section 2.8.6 *Regulation of capital investment.*

Investment funding

-  Describe how capital investments are funded. Please consider:
 - whether investment funding is separate from or covered through reimbursement for service delivery
 - whether capital investment reflects stated public health priorities
 - money borrowed through public allocations and the criteria for public investment
 - the nature of any private borrowing

Distinguish here between capital investment funding and the ongoing funding of capital/life cycle/maintenance costs.

e.g. strengthening primary care

- public–private partnerships for investment in capital facilities
- investment funding through donation or sale/disposal of assets
- any differences between capital investment in hospitals, primary care facilities and intermediate, social, long-term, palliative or mental care facilities
- implications for capital investment funding of sharing facilities across borders

4.1.2 Infrastructure

 Describe the distribution of infrastructure. Please consider:

- the mix of beds in acute hospitals, psychiatric hospitals and long-term care institutions (Fig. 4.1)
- how trends in typical operating indicators compare with those in other countries (Fig. 4.2)
- how trends for acute hospitals (and other institutions) compare with those in other countries (Fig. 4.3)

Fig. 4.1

Mix of beds in acute hospitals, psychiatric hospitals and long-term care institutions in country, per 1000 population, 1990 to latest available year

Fig. 4.2

Operating indicators in country and selected countries, 1990 to latest available year

Fig. 4.3

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


Public–private partnerships are public sector programmes and services that are operated and funded with private sector participation. They should be distinguished from privatization if the rules for profit-making entities involved in public–private partnerships are set and enforced solely by government agencies.

e.g. average length of stay (ALOS), occupancy rates, day cases as percentage of total surgery

Figure to be supplied by Observatory staff based on the following sources: Eurostat, Health for All database, OECD Health Data.

Figure to be supplied by Observatory staff.

4.1.3 Medical equipment

-  Describe briefly how major pieces of medical equipment are funded. Please consider:
- how the data in Table 4.1 (if available) compare with those in other countries
 - whether basic equipment is available in sufficient quality and quantity
 - differences between primary/ambulatory and inpatient care

Cross-reference to Section 2.8.6 *Regulation of capital investment.*



Table 4.1

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

Item	Per 1000 population	% utilization
MRI units		
CT scanners		
PET		

Sources: national statistics/Eurostat/OECD Health Data

4.1.4 Information technology

-  Please provide data on Internet access and use (at home, school or work).
-  Describe the use of IT in the health system. Please consider:
- the current level of IT use in primary care/secondary care/the health system in general
 - the compatibility and coordination of IT systems in the health sector
 - the extent to which computers are integrated into primary care and the proportion of primary care settings with computers

The general context in which IT systems operate within a country is important. Access to the Internet will influence how IT can be used within the health system. This Section provides some background information.

Possible data sources: national census or other survey data, e.g Eurostat

e.g, clinical decision support systems, prescribing systems, clinical information systems (audit and feedback).
Cross-reference to Section 2.7.1 *Information systems*, as well as relevant delivery sections.

Please note that patient information should be discussed in Section 2.9.1.

- plans or strategies for the development and use of IT systems within the health system
- electronic medical records or electronic health cards or plans for introducing them
- electronic hospital (or other health care facility) appointment booking systems or plans for introducing them
- information on the number of people accessing the Internet for health information, if available

[Cross-reference](#) to Section 2.9.1 *Patient information*.

4.2 Human resources

4.2.1 Health workforce trends



- Comment on trends for the professional groups shown in Table 4.2 and Figures 4.4–4.8. For each group, please consider numbers of full-time equivalent staff, the adequacy of staffing levels and geographical distribution.
- *doctors*: primary care/ambulatory care doctors (distinguish between general medical practitioners and specialists in ambulatory settings); hospital-based doctors (distinguish between different medical specialties); academic doctors
 - *nurses and midwives*: distinguish between the levels of nursing, including nursing assistants, and discuss nursing specialties available (e.g. psychiatric, paediatric and community nursing)
 - *dentists and dental auxiliaries*: distinguish between dental practitioners (primary care), specialist dentists (working in hospitals) and dental auxiliaries
 - *pharmacists*: distinguish between hospital and community pharmacists

This section should describe the human resources available in the health system. Discuss the numbers of health workers (defined as “all people engaged in actions whose primary intent is to enhance health”). Where possible, compare trends with those in other countries.

How professionals are remunerated should not be discussed in this section (see Section 3.7.2 *Paying health workers*).

Please make clear whether your country statistics on midwives are collected separately or included in the total number of nurses.

Dental auxiliary: a member of the dentist's supporting team who helps in the provision of dental treatment.

☞ Also consider other health workers of particular relevance to your system, such as:

- *public health professionals*: distinguish between specialists in public health (trained as doctors) and other public health professionals (exclude primary care physicians who may perform public health duties)
- *professionals allied to medicine*: discuss other therapists, clinicians and scientists who work in the health system
- *complementary and alternative medical practitioners*: discuss providers of therapies outside orthodox medicine
- *managerial staff*: discuss senior management and administrative posts within the health system
- other particular roles/health workers
- medical technicians
- social workers or care workers
- outreach workers

e.g. acupuncture, chiropractic, osteopathy, herbal medicine

e.g. quality managers, IT specialists

e.g. radiology, laboratory, pathology

Table 4.2

Health workers in country per 1000 population, 1990 to latest available year

	1990	1995	2000	2005	Latest available year
Primary care doctors					
Specialist physicians					
Nurses					
Midwives					
Dentists					
Optometrists					
Pharmacists					
Psychologists					
Occupational therapists					
Radiographers					
etc.					

Sources: national statistics/WHO data

Fig. 4.4

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

Fig. 4.5

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

Fig. 4.6

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

Fig. 4.7

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

Fig. 4.8

Number of pharmacists per 1000 population in country and selected countries, latest available year

Figure to be supplied by Observatory staff using WHO data.


Figure to be supplied by Observatory staff using WHO data.

Figure to be supplied by Observatory staff using WHO data.

Figure to be supplied by Observatory staff using WHO data.

Figure to be supplied by Observatory staff using WHO data.


4.2.2 Professional mobility of health workers

 Briefly comment on professional mobility. Please consider:

- recruitment of health workers from abroad or the loss of staff to other countries
- the main countries involved
- reasons for health workers leaving/coming to the country
- any danger of so-called brain drain and, if so, any plans to remedy this trend


Health professional mobility is any change of country after graduation to deliver health-related services, including during training periods.

4.2.3 Training of health workers


-  Describe the basic training of health workers. Please consider:
- requirements for specialization and further training
 - whether continuing professional development is required
 - the bodies responsible for setting educational standards
 - the nature of any process of revalidation of qualifications to ensure medical competency

Cross-reference to Section 2.8.3 *Registration and planning of human resources.*

4.2.4 Doctors' career paths

-  Describe the career paths of doctors, in both hospital and ambulatory settings. Please consider:
- how the promotion of doctors to different grades within hospitals is organized
 - whether it is influenced by the directors of the clinic or department
 - whether the decision is local (within the hospital) or national
 - whether hospital management is involved in promoting staff
 - whether there is much movement of doctors across hospitals, clinics or departments within hospitals, or countries


4.2.5 Other health workers' career paths

 Describe the career paths of other health workers, e.g. nurses, dentists and pharmacists. Please consider:

- mechanisms for career development
- whether health workers are leaving the sector in significant numbers


This chapter concentrates on patient flows, organization and delivery of services. The respective subsections of this chapter primarily focus on the organization and provision of services, but should also comment on the accessibility, adequacy and quality of services, as well as current developments and future reform plans.

Chapter summary

-  Please provide a summary covering the whole chapter (maximum 500 words).

This will also be used in the executive summary.

5.1 Public health

-  Describe the organization and provision of public health services, including settings, responsible organizations, nature of providers and functions. Please consider:
 - environmental and communicable disease control functions
 - mechanisms for notification and surveillance of disease outbreaks
 - mechanisms for surveillance of the population's health and well-being
 - the organization of occupational health services
 - the organization of preventive services
 - any established programmes of health promotion and education (include profit-making and non-profit-making organizations if relevant)
 - national screening programmes for the whole or part of the population

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

[Cross-reference](#) to Section 2.6 *Intersectorality*.


e.g. surveys of health behaviour

These may include first aid and curative, preventive and rehabilitative services.

e.g. immunization services, family planning and antenatal services


e.g. programmes aimed at risk factors such as drinking, smoking, unhealthy diet and lack of exercise

These are organized programmes based on a population register with invitations to participate, integrated quality control and follow-up. There may also be opportunistic screening (e.g. a patient attending a physician for something else is offered a cervical smear or mammogram).

-  Please comment on the accessibility of public health services, as well as their adequacy and quality.

Refer to Section 1.4 *Health status* and relevant figures or tables.

5.2 Patient pathways

 Provide a typical patient pathway or patient flow diagram. See the Box below for an example. In the text, please consider:


- whether such pathways differ significantly across the country
- changes

A *patient pathway* is the route a patient takes from their first contact with the health system (such as their GP), through referral, to the completion of their treatment. It can be seen as a timeline which maps every event relating to treatment, e.g. consultations, diagnosis, treatment, medication, dietary advice, assessment, teaching and preparing for discharge from hospital.

In Denmark, a woman in need of a hip replacement because of arthritis would take the following steps:


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

5.3 Primary/ambulatory care


 Describe the organization and provision of primary care services, including settings, responsible organizations, nature of providers and functions.

Please consider:

- settings and models of provision: independent/single practices, group practice, health centres, medical laboratories, hospitals, polyclinics
- whether primary care providers are directly employed or contracted
- the range of services available

 Describe the level of choice and access to primary care. Please consider:

- freedom of choice of primary care physicians (e.g. GPs) and any restrictions with respect to changing physicians
- whether patients have direct access to specialist (ambulatory and hospital) services
- whether the GP has a gatekeeping role
- the referral process
- whether people have choice of hospital and specialist
- whether the GP has a role in health promotion/public health

 Comment on the geographical distribution of primary care facilities/practitioners.

Primary care refers to the individual's first point of contact with the health system and includes general medical care for common conditions and injuries. Health promotion and disease prevention activities, also a part of primary care, are described in Section 5.1 *Public health*.

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

Ambulatory care refers to health services provided to patients who are not confined to an institutional bed as inpatients during the time services are rendered.

They may include the following categories: general medical care, diagnostic services, minor surgery, rehabilitation, family planning, obstetric care, perinatal care, first aid, dispensing of pharmaceutical prescriptions, certification, 24-hour availability, home visits, ambulance services and patient transport, nursing care for acute and chronic illnesses, palliative care, specific services for mental illness, preventive services (e.g. immunization, screening) and health promotion services (e.g. health education).

Fig. 5.1

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




-  Comment on the nature of outpatient contacts and the reliability of data
-  Comment on the accessibility, adequacy and quality of primary/ambulatory care. Please consider:
 - national programmes to improve quality
 - any data from official quality assurance reports
-  Describe major changes in recent years, current problems/challenges and reform plans.


Figure to be inserted by Observatory staff using WHO data.

In many countries, outpatients are treated in hospitals. Please clarify whether data include outpatient visits in hospitals or whether they refer exclusively to outpatient contacts outside hospital.

e.g. reports from the ministry of health or other bodies

[Cross-reference](#) to Chapter 6 *Principal health reforms*.

5.4 Specialized ambulatory care/ inpatient care

-  Describe the organization and provision of secondary and tertiary health care services, including settings, responsible organizations, nature of providers and functions. Please consider:

Secondary care refers to specialized ambulatory medical services and typical hospital services (outpatient and inpatient services). It excludes general long-term care, which is dealt with separately.

Tertiary care refers to medical and related services of high complexity, usually of high cost and provided at university/tertiary/referral hospitals.

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

- how specialized ambulatory medical services are provided
 - e.g. specialists working in their own practices, specialist polyclinics, outpatient departments of hospitals
- the main categories of hospitals and their function and distribution
 - e.g. district general hospitals, teaching hospitals, single-specialty hospitals (such as for maternity services or orthopaedics).
 - [Cross-reference](#) to Fig. 4.1.
- types of hospital management
- discuss the public–private ownership mix of hospital services
 - e.g. public, quasi-public, private profit-making and private non-profit-making

➤ Discuss the relationship between primary and secondary care and other public sectors such as social care. Please consider:

- substitution policies (or plans) to replace inpatient care with less expensive outpatient or home care
- the degree of integration between primary and secondary care providers (outpatient and inpatient)

➤ Comment on the accessibility, adequacy and quality of specialized ambulatory/inpatient care. Please consider:

- the geographical distribution of inpatient facilities and facilities providing secondary care
- national programmes to improve quality
- any data from official quality assurance reports

➤ Describe major changes in recent years, current problems/challenges and reform plans.

5.4.1 Day care

➤ Please provide the definition of day care used in your country.

➤ Describe the organization and provision of day-care services, including settings, responsible organizations, nature of providers and functions. Please consider:

- the location of day care
- the proportion of care provided in special day-care settings
- the main medical services provided on a day-care basis
- trends in day-care provision in the last 10–20 years

Please note that long-term care options should not be discussed here, but in Section 5.8 *Long-term care*.

[Cross-reference](#) to Fig. 4.2.

e.g. reports from the ministry of health or other bodies


[Cross-reference](#) to Chapter 6 *Principal health reforms*.


e.g. medical and paramedical services delivered to patients who are formally admitted for diagnosis, treatment or other types of health care with the intention of discharging the patient the same day

e.g. in hospitals, ambulatory care or long-term care facilities


[Cross-reference](#) to data on day cases as a percentage of total surgery in Section 4.1.2.


5.5 Emergency care


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

 Describe the organization and provision of emergency care, including settings, responsible organizations, nature of providers and functions. Please consider:

- organizations involved in transporting patients and deciding on the appropriate health care setting

 Comment on the accessibility, adequacy and quality of services.

 Describe major changes in recent years, current problems/challenges and reform plans.

 Provide a patient pathway in an emergency care episode (see the Box for an example).

e.g. medical care provided to patients with life-threatening conditions who require urgent treatment

e.g. the national health service or specialized services such as the Red Cross


Cross-reference to Chapter 6 *Principal health reforms*.


In the Netherlands, a man with acute appendicitis on a Sunday morning would take the following steps:


- The man (or someone else) calls the GP out-of-hours service. His call will be answered by a triage assistant who decides, possibly after consulting the GP, that the patient can come for further investigation (note that the diagnosis is not made yet).
- The patient arrives at the GP-post. The GP diagnoses acute appendicitis and refers the patient to the emergency department.
- At the emergency department, a specialized nurse does the triage and estimates the urgency of the complaint. The waiting time depends on the level of urgency.
- A surgeon performs surgery on the patient.


Another possibility is that the man goes directly to the emergency department, without consulting the GP. Around 60% of emergency department patients come without referral.

5.6 Pharmaceutical care

-  Describe the organization, method of distribution, and provision of pharmaceuticals to the public, including settings, responsible organizations/bodies, nature of providers and functions. Please consider:
 - the pharmaceutical sector’s production capabilities, the number of firms, local production as a percentage of pharmaceutical expenditure
 - public and private bodies involved in manufacturing and distribution
 - report on the number of pharmacies
 - any innovative ways of providing access to pharmacies

-  Comment on the accessibility, adequacy and quality of services/pharmaceuticals. Please consider:
 - whether pharmaceuticals are covered as part of the statutory system
 - who has access to publicly subsidized pharmaceuticals
 - whether certain groups are exempt from pharmaceutical cost-sharing or pay reduced user charges

-  Discuss levels of consumption of pharmaceuticals. Please consider:
 - pharmaceutical expenditure per capita
 - types of prescription written
 - the defined daily dose (DDD) consumption rate if possible

-  Describe major changes in recent years, current problems/challenges and reform plans.




Some of the information in this section will have been provided in previous sections (e.g. Section 2.8.4 *Regulation and governance of pharmaceuticals*). Instead of repeating it, please cross-reference where appropriate.

e.g. manufacturers, importers, parallel importers, wholesalers and pharmacies



e.g. through supermarkets

DDD is the assumed average maintenance dose per day for a drug used for its main indication in adults.

5.7 Rehabilitation/intermediate care

-  Describe the organization and provision of rehabilitation/intermediate care services, including settings, responsible organizations, nature of providers and functions. Provide information on links between rehabilitative services and health/social care services.
-  Comment on the availability, accessibility, adequacy and quality of services.
-  Describe major changes in recent years, current problems/challenges and future reform plans if any.

5.8 Long-term care

-  Describe the organization and provision of long-term care services, including settings, responsible organizations, nature of providers and functions. Please consider:
 - the extent to which health and social services are integrated and any mechanisms to coordinate services
 - *community-based care*: services available and percentage of each client group receiving them
 - *residential care*: percentage of each client group in institutional care and types of residential care facility provided
-  Comment on the accessibility, adequacy and quality of services. Also consider:
 - whether there is a process for assessing eligibility and who carries it out

Rehabilitation: care that aims to cure, improve or prevent a worsening of a condition, e.g. physiotherapy after hip replacement surgery or occupational therapy to prevent carpal tunnel syndrome.


Intermediate care: short-term health and social care that aims to facilitate earlier discharge or prevent admission to hospital by providing support at a level between primary and secondary care.

[Cross-reference](#) to Chapter 6 *Principal health reforms*.

This section focuses on long-term care provision for older people, people with physical disabilities, people with chronic diseases and people with learning disabilities. Please distinguish between these four categories. Long-term care may be provided both within institutions (residential) and in the community (home care).


Care for acute and chronic mental health disorders should be discussed in Section 5.11.

- whether assessment is based exclusively on a patient's care needs or if it is also based on the availability of informal care
- national programmes to improve quality
- any data from official quality assurance reports

 Describe major changes in recent years, current problems/challenges and reform plans.

Cross-reference to Chapter 6 *Principal health reforms*.

5.9 Services for informal carers




 Describe the organization and provision of informal care, including settings, responsible organizations, nature of providers and functions. Please consider:

- policies (e.g. financial entitlements, training, facilities) that recognize the value of informal care, protect informal carers and provide them with access to support services
- if available, information on estimates of the number of individuals providing informal care
- the accessibility, adequacy and quality of services and facilities
- any major changes in recent years, current problems/challenges and reform plans

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

Cross-reference to Chapter 6 *Principal health reforms*.

5.10 Palliative care

-  Describe the organization and provision of palliative care services, including settings, responsible organizations, nature of providers and functions. Please consider:
 - the extent to which palliative care services are reliant on volunteers and what level of training/support is provided for these volunteers
 - whether patients and their families are explicitly involved in determining palliative care management plans
 - links between specialist palliative care services and other health professionals
-  Comment on the accessibility, adequacy and quality of services and facilities. Include any data available (e.g. from surveys) on the quality of palliative care.
-  Describe major changes in recent years, current problems/challenges and reform plans.

Palliative care is the continuing active total care of patients and their families at a time when cure is no longer expected. The goal of palliative care is the highest possible quality of life for both patient and family.


It may include the following services :

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

e.g. social workers, psychologists, physiotherapists, occupational therapists, complementary therapists, speech therapists, spiritual counselling


Cross-reference to Chapter 6 *Principal health reforms*.

5.11 Mental health care


-  Describe the organization and provision of mental health services, including settings, responsible organizations, nature of providers and functions. Please consider:
 - availability of specific services to deal with special problems that may be faced by certain groups of individuals

e.g. refugees, asylum seekers, internally displaced persons or military personnel


- programmes (national or local) and educational initiatives to tackle the discrimination and social exclusion/stigma that those with mental health problems may suffer from
- legal obligations, if any, that families have to provide care for people with mental health problems

 Comment on the accessibility, adequacy and quality of services and facilities. Please consider:

- availability of specialized mental health professionals
- the balance of psychiatric hospital beds and beds for acute, chronic and long-term care and the reliability of existing data
- indicate whether psychiatric beds are integrated into general hospitals or provided in special psychiatric hospitals

 Describe major changes in recent years, current problems/challenges and reform plans.

5.12 Dental care

 Describe the organization and provision of dental care, including settings, responsible organizations, nature of providers and functions. Please consider:

- any specific policy documents or national strategies on the provision of dental care
- any preventive dental care programmes or activities and their effects
- the public–private mix in financing and delivery


Cross-reference to Section 5.9 *Services for informal carers*.

e.g. psychiatrists (distinguish child and old-age psychiatrists), psychiatric nurses, psychologists, mental health social workers, neurologists, psychologists, psychiatric social workers and other specialist mental health staff.


Cross-reference to Fig. 4.1.

Cross-reference to Chapter 6 *Principal health reforms*.


e.g. fluoridation, school education programmes

 Comment on the accessibility, adequacy and quality of services and facilities. Please consider:

- fees, if any, for dental services, indicating whether prices are regulated and by whom
- whether the quality of dental services is monitored and by whom

 Describe major changes in recent years, current problems/challenges and reform plans.

5.13 Complementary and alternative medicine

 Describe the organization and provision of complementary and alternative medicine (CAM), including settings, responsible organizations, nature of providers and functions. Please consider:

- any regulations of the provision of CAM
- the extent to which CAM is accepted by the mainstream medical profession and provided within the mainstream health system
- the extent to which CAM is reimbursable by third-party payers
- any data on the use of CAM
- any licensing/certification procedures for CAM practitioners
- the accessibility, adequacy and quality of services and facilities
- any major changes in recent years, current problems/challenges and reform plans

Cross-reference to Chapter 6 *Principal health reforms*.


CAM refers to medical practices not typically considered to be orthodox therapies. These might include acupuncture, osteopathy, herbal medicine, spa treatment, electromagnetic therapy, massage therapy, music therapy and meditation.

Complementary medicine is used in combination with mainstream techniques.

Alternative medicine is used in place of conventional medicine.

Cross-reference to Chapter 6 *Principal health reforms*.

5.14 Health services for specific populations

 Describe the organization and provision of these services, including settings, responsible organizations, nature of providers and functions. Please consider:

- the accessibility, adequacy and quality of services and facilities
- any major changes in recent years, current problems/challenges and reform plans

The focus of this section is the delivery of health care to specific population groups who either do not have access to the mainstream health system or have special access to other health services.


These might include minority populations such as the Roma and social groups such as prisoners, military personnel, refugees, asylum seekers, irregular immigrants, homeless people, street children, intravenous drug users and sex workers.

Note: If these groups are treated within the main health system, they should not be discussed here.

[Cross-reference](#) to Chapter 6 *Principal health reforms*.


In this chapter, individual health reforms, policies and organizational changes, some of which may have been discussed earlier, are set within the context of the overall reform programme. The chapter considers major reforms already implemented as well as those which failed or were passed but never implemented. It also provides an overview of future developments.


Chapter summary

 Please provide a summary covering the whole chapter (maximum 500 words).

This will also be used in the executive summary.

6.1 Analysis of recent reforms

 Please provide a box (Box 6.1) listing major reforms and policy initiatives that have had a substantial impact on the health system in chronological order.

 For each principal reform describe:

- (1) aims and background
- (2) the policy process
- (3) content and implementation.

In doing so, please consider:

- key issues underlying the development of each reform
- how the content of the reforms was developed
- how far objectives have been achieved
- the role of key national actors, interest groups, European institutions, international agreements or pressures and pilot projects
- the impact of any evaluation
- any major obstacles (see the Box on the right)
- significant policy proposals and legislation from other fields that have had an impact on the health sector

This section focuses on the reforms that have taken place since the last HiT or in the last five to ten years, sets them in context and explains their impact on health and health service provision.

For more details on older reforms it may be useful to refer readers to the previous HiT profile or cross-reference to Section 2.2 *Historical background*.

Please consider the distinction between rhetoric and reality. While it is useful to look at the political agenda and priorities in health policy, it is also necessary to look at what is actually implemented.

Where possible, include reports on what is taking place in terms of implementation and comment on the extent to which these reports can be considered impartial.

e.g. geographical inequity in access, rising costs, poor perceived quality, inefficiency, excess/inappropriate capacity

Obstacles to reform can include:

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

- Please discuss major reforms that have failed to be implemented, noting reasons why they were not implemented, independent evaluations of the reforms and prospects for future implementation.

6.2 Future developments

- Outline any current political or policy debate around health and the health system.
- Note any recently announced reforms including, where appropriate:
 - current policy proposals
 - ongoing public debates
 - political party plans
- Include potential developments outside the health system that may have an impact on health policies.
- List plans/expectations concerning developments in relation to:
 - organizational structure or governance of the health system
 - financing
 - services and specific sectors such as mental health, long-term care, social care, palliative care

e.g. forthcoming national and regional elections and the impact of EU legislation

[Cross-reference](#) to the relevant sections in Chapter 5.

The approach to assessing health system performance adopted by the HiTs is based on that of WHO's *World Health Report 2000*.


Assessment should take into account all areas of the health system, including public health services, mental health care, social care and intersectoral approaches towards improving health determinants and health. The selection of appropriate indicators should be discussed with the editor.

Where appropriate and possible:

- discuss the quality of data and indicators used
- use longitudinal (time series) data, since these can usefully illustrate developments in health system performance within a country
- discuss health system performance in your country in comparison with other countries, where it is methodologically sound to do so
- refer to published studies, include findings from reports evaluating the health system and comment on the extent to which these reports can be considered to be impartial and of a high standard; for example, are they produced by reputable organizations independent from government?


If information and evidence are not available, please say so.

Chapter summary

-  Please provide a summary covering the whole chapter (maximum 500 words).

This will also be used in the executive summary.

7.1 Stated objectives of the health system

-  Discuss the stated objectives of the health system and specific reform initiatives. Please consider:
 - whether policies have been developed and implemented to meet these objectives
 - the extent to which major strategies and laws are actually being implemented
 - political commitment to intersectoral approaches and health in all policies

Examples of objectives might include:

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

Where there is lack of conclusive evidence on the effects of reforms please note this.

7.2 Financial protection and equity in financing

Financial protection measures the extent to which people are protected from the financial consequences of illness. The need for financial protection arises from three factors: uncertainty about the need for health care (timing and severity of ill health); the high costs of health care (both in absolute and relative terms; even low-cost health care may be expensive for poorer households); and the loss of earnings associated with ill health.

Financial protection is closely linked to health coverage and can be undermined by gaps in the breadth (universality), scope (range of benefits) and depth (user charges) of coverage.

7.2.1 Financial protection




Discuss the degree of financial protection the health system provides. Please consider:

- evidence of high OOP household spending on health, its distribution across different groups of people and its structure (e.g. which health services it is spent on)
- longitudinal data showing changes in the extent, distribution and structure of OOP household spending on health
- survey data on the affordability of health care
- whether high OOP health spending by households occurs due to gaps in coverage breadth (universality), scope (range of benefits) or depth (user charges)
- the impact of reforms or initiatives to strengthen financial protection

High OOP household spending on health is often measured as OOP payments above a certain percentage of household capacity to pay (so-called catastrophic expenditure) or as the percentage of households pushed below the poverty line by OOP payments (so-called impoverishing expenditure).

e.g. surveys asking people whether they have foregone care for financial reasons


7.2.2 Equity in financing

 In discussing this aspect of equity, please consider:

- whether individual sources of financing are regressive, proportional or progressive
- the progressivity of the financing system as a whole
- whether the financing system results in a redistribution of resources (from whom to whom?)
- changes in the distribution of financing
- the impact of reforms or initiatives to increase equity in financing

7.3 User experience and equity of access to health care

7.3.1 User experience

 Discuss different aspects of user experience of the health system. Please consider:


- data on what happened during people's actual contact with the health system
- public satisfaction with the health system
- efforts to ensure confidentiality of personal information
- patient involvement in treatment decisions
- waiting times
- the impact of reforms or initiatives to improve user experience

This section focuses on the distribution of the burden of financing the health system.

This section focuses on how well the health system meets people's legitimate expectations about how they should be treated, independently of any health outcomes – a notion often referred to as “responsiveness” (*World Health Report 2000*).

[Cross-reference](#) to section 2.9 *Patient empowerment*.

7.3.2 Equity of access to health care

 In discussing equity of access to health care, please consider:

- whether benefits are the same across the population
- the distribution of health workers and facilities across the population
- any evidence to suggest that the use of health services is related to factors other than need
- evidence of barriers to accessing health services
- the extent to which barriers to access affect some population groups more than others
- the impact of reforms or initiatives to increase equity of access to health care

This section focuses on equity in the provision and use of health care. It should indicate the extent to which there are problems or barriers in access to health care (e.g. financial, geographical, cultural, supply-related). Refer to published studies where possible.

Make allowances for an acceptable level of inequality; e.g. highly specialized centres are likely to be concentrated in urban centres.


e.g. income level or socioeconomic status

e.g. user charges (formal or informal), insufficient services in remote areas, cultural or language issues, long waiting times

e.g. lower socioeconomic groups, ethnic minorities, older people, (undocumented) migrants, unemployed people

7.4 Health outcomes, health service outcomes and quality of care


7.4.1 Population health

 Discuss trends in population health. Please consider:

- data on morbidity and mortality
- risk factors

Cross-reference to the relevant sections in Chapter 1, including Tables 1.4, 1.6 and 1.7.

e.g. rates of tobacco and alcohol use, obesity

 Discuss improvements in population health that may be attributed to the health system. Please consider:

- mortality amenable to medical intervention
- five-year cancer survival rates for breast, cervical and colorectal cancers
- the factors that have contributed to changes in population health
- whether these factors are related to health care/public health/health policy/lifestyle/other
- any studies showing whether health improvement occurred as a result of health policy or health care interventions

Although it is difficult to disentangle the contribution that health care makes to improving population health, it would be good to have an estimate of any improvement in health status that may be attributed to the health system (including intersectoral action and public health measures).


Amenable mortality refers to death from causes where death should not occur if people have access to timely and effective health care. It seeks to capture mortality that is (at least to some extent) within the control of the health system. Data for OECD countries are presented in Box 2 of Joumard I, André C, Nicq C (2010), *Health care systems: efficiency and institutions*, Paris, Organisation for Economic Co-operation and Development (OECD Economics Department Working Papers, No. 769). Available from <http://econpapers.repec.org/paper/oeccecoaaa/769-en.htm>

Data for OECD countries are available at: <http://www.oecd.org/health/hcqi>

7.4.2 Health service outcomes and quality of care

Direct indicators of health service outcomes are available in the form of health service quality measures, such as standardized hospital mortality rates, numerous disease-specific health outcome measures and patient-reported outcome measures. For the purposes of international comparison, the OECD quality indicators project is an important resource (see http://www.oecd.org/document/31/0,3343,en_2649_33929_2484127_1_1_1_1,00.html).

While such measures offer direct indicators of the performance of individual organizations (after suitable adjustment for case mix and other contextual circumstances), international comparison is complicated by different organizational settings and reporting conventions.

 Discuss quality in the delivery of health services. Please consider use of the following dimensions and indicators:

- quality of preventive care: rates of (child) vaccination for measles, and diphtheria, tetanus and pertussis (DTP) and rates of influenza vaccination for older people
- quality of care for chronic conditions: avoidable hospital admission rates for asthma, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), hypertension and diabetes-related complications
- quality of care for acute exacerbations of chronic conditions: in-hospital mortality rates (deaths within 30 days of admission) for admissions following acute myocardial infarction, haemorrhagic stroke and ischaemic stroke
- the use of patient-reported outcome measures (PROMs)


Although these are process rather than outcome indicators, they have the advantage of being readily available and may indicate areas for improvement.

High admission rates for these conditions may indicate poor quality because these admissions could be prevented by timely access to primary/ambulatory care.

These are regarded as good outcome measures of acute care quality.


PROMs are typically short, self-completed questionnaires, which measure the patient's health status or health-related quality of life at a single point in time – usually before and after certain elective health care interventions such as surgery to remove cataracts. After controlling for variation in patient characteristics and the influence of other factors, health status measured by PROMs can be attributed to the health care delivered to the patient.

- appropriateness of care
- the impact of reforms and initiatives to improve quality in health service delivery

 Comment on patient safety indicators such as:

- foreign body left in during surgical procedure
- catheter-related blood-stream infection
- post-operative pulmonary embolism or deep vein thrombosis
- post-operative sepsis
- accidental puncture or laceration
- obstetric trauma for vaginal delivery with or without instrument
- the impact of reforms and initiatives to prevent health care-related harm

7.4.3 Equity of outcomes

 Discuss how health and health service outcomes differ across different population groups. Please consider:


- socioeconomic groups
- geographical regions
- gender differences
- the impact of reforms or initiatives to address unacceptable variation in outcomes and health inequalities

e.g. evidence of under- or overprovision of care in comparison to evidence-based standards


Please see the OECD's report on patient safety indicators for more information: <http://www.oecd.org/dataoecd/56/31/44192992.pdf>

7.5 Health system efficiency

7.5.1 Allocative efficiency

-  In discussing allocative efficiency, please consider:
- whether there are systems in place to ensure the health system is doing the right things
 - mechanisms for setting priorities and the use of evidence about effectiveness and cost–effectiveness
 - the use and quality of risk-adjusted resource allocation formulas
 - trends in the balance of allocation between different sectors

7.5.2 Technical efficiency

-  Discuss the efficiency with which the health system's outputs are produced, commenting on whether they cost more than they should or could. Suitable indicators might include the following, but please consider any other indicators of wasteful use of resources in the system:
- *hospital care*: trends in average length of inpatient stay, day case surgery rates, pre-operative bed days, variation in surgical thresholds, variation in emergency admissions, variation in outpatient appointments
 - *pharmaceutical care*: impact of policies to increase take-up of generic pharmaceutical products, low-cost statin prescribing, adherence to cost-effectiveness guidelines
 - *human resources*: the impact of policies to change the skill mix, staff turnover, sickness absence rates, agency costs, specialist productivity

Allocative efficiency indicates the extent to which limited funds are directed towards purchasing an appropriate mix of health services.


Technical efficiency indicates the extent to which a health system is securing the minimum levels of inputs for a given output (or the maximum level of output in relation to its given inputs).

Note that these data do not necessarily indicate the efficiency of the sector concerned, but they may highlight priorities for reform.

[Cross-reference](#) to Fig. 4.2 and other parts of the HiT report where relevant.


e.g. to make greater use of nurses/dental assistants in place of doctors/dentists

7.6 Transparency and accountability

 Discuss how transparent the health system is. Please consider:

- health policy development and implementation
- public participation
- patient empowerment
- the extent to which people are aware of the health benefits to which they are entitled
- issues around financing mechanisms
- the impact of reforms and initiatives to enhance transparency

e.g. the existence of informal payments and tax/contribution evasion

 Discuss how accountable the health system is. Please consider:

- how priorities are set for improving health system actions and standards
- how health system performance is monitored
- approaches to ensuring accountability in the health system, their effectiveness and the extent to which they are aligned with the country's broader governance structures
- how the health system creates capacity for performance monitoring and strengthening accountability
- the impact of reforms and initiatives to increase accountability


e.g. central targets, choice and competition, local democracy, performance reporting, etc.

The aim of this chapter is to:

- identify a minimum of five key findings
- highlight the lessons learned from health system changes
- summarize remaining challenges and future prospects.


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

9.1 References


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

Bibliographical references should be presented in the Harvard (also known as author–date) system. See the Section *Bibliographical references* on p. 2.

9.2 Further reading

-  This can be provided after the References section, suggesting any other useful material that is not actually cited in the text of the profile.

9.3 Useful web sites


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

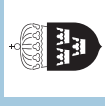
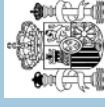
9.4 HiT methodology and production process

A standard text describing the HiT process

Text will be supplied by Observatory staff.

9.5 About the authors

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



The European Observatory on Health Systems and Policies is a partnership between the WHO Regional Office for Europe, the Governments of Belgium, Finland, Ireland, the Netherlands, Norway, Slovenia, Spain, Sweden and the Veneto Region of Italy, the European Commission, the European Investment Bank, the World Bank, UNCAM (French National Union of Health Insurance Funds), the London School of Economics and Political Science, and the London School of Hygiene & Tropical Medicine.

HiTs are in-depth profiles of health systems and policies, produced using a standardized approach that allows comparison across countries. They provide facts, figures and analysis and highlight reform initiatives in progress.