

Health Systems in Transition

Template for authors 2019

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PREFACE

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 the 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 contact@obs.who.int.

ACKNOWLEDGEMENTS

This edition of the template is a revised version of the template from 2010, which was based on previous templates of 2007 and 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 2010 revision was written by (in alphabetical order) Bernd Rechel, Sarah Thomson

and Ewout van Ginneken with contributions 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.

The current iteration was written by Bernd Rechel, Anna Maresso and Ewout van Ginneken, with contributions from Reinhard Busse, Jon Cylus, Josep Figueras, Cristina Hernández-Quevedo, Marina Karanikolos, Suszy Lessof, Martin McKee, Sherry Merkur, Elias Mossialos, Ellen Nolte, Willy Palm, Dimitra Panteli, Gabriele Pastorino, Wilm Quentin, Erica Richardson, Anna Sagan, Richard Saltman and Matthias Wismar.

Invaluable inputs to the current iteration of the template were made by members of the Health Systems and Policies Monitor network (HSPM) and the Partners of the European Observatory on Health Systems and Policies.

THE HSPM NETWORK

The HSPM is an international network that works with the Observatory on country monitoring. It is made up of national counterparts that are highly regarded at national and international

level and have particular strengths in the areas of health systems, health services, public health and health management research.

ABBREVIATIONS

These are the abbreviations used in this template. The list of abbreviations in HiTs should be based on the abbreviations they use.

A&E	accident and emergency
CARK	Central Asian Republics and Kazakhstan
CIS	Commonwealth of Independent States
CT	computed tomography
DRG	diagnosis-related group
EU/EEA	European Union, European Economic Area
EU-SILC	EU Statistics on Income and Living Conditions
FFS	fee-for-service
GDP	gross domestic product
GP	general practitioner
HAQ	Health Assessment Questionnaire
HiT	Health Systems in Transition
HSPM	Health Systems and Policies Monitor network
HTA	health technology assessment
IT	information technology
LSE	London School of Economics and Political Science
LSHTM	London School of Hygiene & Tropical Medicine
MRI	magnetic resonance imaging
NGO	nongovernmental organization
OECD	Organisation for Economic Co-operation and Development
OOP	out-of-pocket
OTC	over-the-counter
P4P	pay for performance
P4Q	pay for quality
PPP	purchasing power parity
PREM	patient-reported experience measures
SDR	standardized death rate
SHI	social health insurance
UNCAM	French National Union of Health Insurance Funds
VHI	voluntary health insurance
WHO	World Health Organization
WTO	World Trade Organization

NOTES FOR AUTHORS

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:
 - a standard set of figures/graphs that are to be used and discussed in some of the chapters
 - some sample HiTs that give a sense of what a typical profile looks 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
- help the authors to make the text concise, engaging and accessible
- encourage the authors to use innovative graphs and figures
- make sure the text stays within permitted word limits
- manage the external 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 limits for each section are provided in the template, but authors are encouraged to stay well below them.

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 databases.

This 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 to 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.

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

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

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

Standard figures

Every HiT in the series contains some standard graphs (figures), which will be prepared and provided by the editor unless otherwise stated. These are listed in the table opposite and discussed in the relevant chapter of the Template.

figures and other figures are provided on the Observatory website: <http://www.euro.who.int/en/about-us/partners/observatory/publications/health-system-reviews-hits/about-the-hits-series>

Other figures

In addition to the standard figures, figures or tables specific to a country can be used to illustrate important points. We will need the underlying data in Excel files for the production process. Examples of standard

Assessment boxes

This template lists a number of boxes that should be used in various chapters to provide a brief assessment/evaluation of an issue. A number of questions are posed to guide authors in writing these "Assessment Boxes", which will be a uniform colour within the final published HiT, so that they are easily identified by readers.

CHAPTER	STANDARD GRAPHS
CHAPTER 1 INTRODUCTION	
Section 1.1 Geography and sociodemography	Fig. 1.1 Map of the country
Section 1.4 Health status	Fig. 1.2 Risk factors affecting health status, latest available year
CHAPTER 2 ORGANIZATION AND GOVERNANCE	
Section 2.2 Organization	Fig. 2.1 Overview of the health system (This template provides an example, which you should adapt to fit your country)
CHAPTER 3 FINANCING	
Section 3.1 Health expenditure	Fig. 3.1 Current health expenditure as a share (%) of GDP in the WHO European Region, latest available year Fig. 3.2 Trends in current health expenditure as a share (%) of GDP in country and selected countries, 2000 to latest available year Fig. 3.3 Current health expenditure in US\$ PPP per capita in the WHO European Region, latest available year Fig. 3.4 Public expenditure on health as a share (%) of current health expenditure in the WHO European Region, latest available year Fig. 3.5 Public expenditure on health as a share (%) of general government expenditure in the WHO European Region, latest available year
Section 3.2 Sources of revenue and financial flows	Fig. 3.6 Financial flows (This template provides an example, which you should adapt to fit your country)
CHAPTER 4 PHYSICAL AND HUMAN RESOURCES	
Section 4.1.1 Infrastructure, capital stock and investments	Fig. 4.1 Beds in acute hospitals per 100 000 population in country and selected countries, 1990 to latest available year
Section 4.2.2 Trends in the health workforce	Fig. 4.2 Practising nurses and physicians per 100 000 population, latest available year Fig. 4.3 Number of physicians per 100 000 population in country and selected countries, 1990 to latest available year Fig. 4.4 Number of nurses per 100 000 population in country and selected countries, 1990 to latest available year
CHAPTER 5 PROVISION OF SERVICES	
Section 5.2 Patient pathways	Fig. 5.1 Patient pathway (This template provides an example, which you should adapt to fit your country)
CHAPTER 7 ASSESSMENT OF THE HEALTH SYSTEM	
Section 7.2 Accessibility	Fig. 7.1 Unmet needs for a medical examination (due to cost, waiting time, or travel distance), by income quintile, EU/EEA countries, latest available year
Section 7.3 Financial protection	Fig. 7.2 Share of households that experienced catastrophic health expenditure, latest year for all countries with data available
Section 7.4 Health care quality	Fig. 7.3 Avoidable hospital admission rates for asthma, chronic obstructive pulmonary disease, congestive heart failure, hypertension and diabetes-related complications, country and selected countries Fig. 7.4 In-hospital mortality rates (deaths within 30 days of admission) for admissions following acute myocardial infarction, haemorrhagic stroke and ischaemic stroke, country and selected countries Fig. 7.5 Cancer survival rates for colon cancer, breast cancer (among women), and leukaemia (among children)
Section 7.5 Health system outcomes	If data are available for the country: Fig. 7.6 Preventable and amenable mortality in country and selected countries, 2000 and latest available year Fig. 7.7 Main causes of amenable mortality in country, 2000 and latest available year
Section 7.6.2 Technical efficiency	If amenable mortality data are available for the country: Fig. 7.8 Amenable mortality per 100 000 population versus health expenditure per capita, country and selected other countries

Note: The standard figures in this table should be renumbered if additional figures are included in the HiT. All tables and figures appearing in a chapter should be numbered sequentially.

Other boxes

Authors can use other boxes containing the following kinds of information:

- Specific details that are not absolutely essential to the text but that readers may find useful to know, for example, listing the broad content of a health benefits package; and
- Short asides that might help readers to understand the policy context or history of a specific issue but which might disrupt the narrative flow if it remains within the main text.

Discuss with your editor what may be appropriate. These boxes will be distinguished by a different colour to the 'Assessment Boxes'.

Word count

There are word limits for each of the chapters and for the HiT profile overall, which authors are expected to adhere to. Please do not exceed these limits when drafting the chapters, as cutting down overly long drafts is a time-consuming process.

	Word limit
Chapter 1 – Introduction	2 500
Chapter 2 – Organization and governance	6 000
Chapter 3 – Financing	7 000
Chapter 4 – Physical and human resources	3 000
Chapter 5 – Provision of services	8 000
Chapter 6 – Principal health reforms	2 000
Chapter 7 – Assessment of the health system	6 000
Chapter 8 – Conclusion	500
Total number of words allowed	35 000


Preliminary pages in HiTs

■ 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.

Example of an acknowledgement section

The Health Systems in Transition (HiT) profile on xxxxxxxx was co-produced by the European Observatory on Health Systems and Policies and XXX, which is a member of the Health Systems and Policy Monitor (HSPM) network.

The HSPM is an international network that works with the Observatory on Country Monitoring. It is made up of national counterparts that are highly regarded at national and international level and have particular strengths in the areas of health systems, health services, public health and health management research. They draw on their own extensive networks in the health field and their track record of successful collaboration with the Observatory to develop and update the HiT.

This edition was written by XXX. It was edited by XXX. 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.

Thanks are also extended to the WHO Regional Office for Europe for their European Health for All database from which data on health services were extracted; to the OECD for the data on health services in western Europe; to the World Bank for the data on health expenditure in central and eastern European countries, and to the European Commission for the Eurostat database.


The HiT uses data available on xxxxxx, unless otherwise indicated. The HiT reflects the organization of the health system and the data availability, unless otherwise indicated, as it was in xxxxxx.

The Observatory is a partnership that includes the Governments of Austria, Belgium, Finland, Ireland, Norway, Slovenia, Sweden, Switzerland and the United Kingdom; the Veneto Region of Italy; the French National Union of Health Insurance Funds (UNCAM); the WHO; the European Commission; the World Bank; the London School of Economics and Political Science (LSE); and the London School of Hygiene & Tropical Medicine (LSHTM). The partnership is hosted by the WHO Regional Office for Europe. The Observatory is composed of a Steering Committee, core management team, research policy group and staff. Its Secretariat is based in Brussels and has offices in London at LSE, LSHTM and the Technical University of Berlin. The Observatory team working on HiTs is led by Josep Figueras, Director; Elias Mossialos, Martin McKee, Reinhard Busse (Co-directors); Richard Saltman, Ewout van Ginneken and Suszy Lessof. The Country Monitoring Programme of the Observatory and the HiT series are coordinated by Anna Maresso. The production and copy-editing process was coordinated by xxxxxxxx, with the support of xxxxxxxx.

■ 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 300 words.

Table 1.1 Trends in population/ demographic indicators, selected years


Table 1.2 Macroeconomic indicators, selected years and so on.

The Box on the next page provides an example from the 2017 Malta HiT.

Example of an abstract – Malta HiT 2017

Maltese life expectancy is high, and Maltese people spend on average close to 90% of their lifespan in good health, longer than in any other EU country. Malta has recently increased the proportion of GDP spent on health to above the EU average, though the private part of that remains higher than in many EU countries. The total number of doctors and GPs per capita is at the EU average, but the number of specialists remains relatively low; education and training are being further strengthened in order to retain more specialist skills in Malta. The health care system offers universal coverage to a comprehensive set of services that are free at the point of use for people entitled to statutory provision. The historical pattern of integrated financing and provision is shifting towards a more pluralist approach; people already often choose to visit private primary care providers, and in 2016 a new public–private partnership contract for three existing hospitals was agreed. Important priorities for the coming years include further strengthening of the primary and mental health sectors, as well as strengthening the health information system in order to support improved monitoring and evaluation. The priorities of Malta during its Presidency of the Council of the EU in 2017 include childhood obesity, and Structured Cooperation to enhance access to highly specialized and innovative services, medicines and technologies. Overall, the Maltese health system has made remarkable progress, with improvements in avoidable mortality and low levels of unmet need. The main outstanding challenges include: adapting the health system to an increasingly diverse population; increasing capacity to cope with a growing population; redistributing resources and activity from hospitals to primary care; ensuring access to expensive new medicines while still making efficiency improvements; and addressing medium-term financial sustainability challenges from demographic ageing.

■ Executive summary

 The executive summary should provide an analytical overview of the HiT (in no more than 3 000 words). The editor is responsible for writing the first draft of the Executive Summary and s/he will then share it with the authors for their inputs.

Each section of the Executive Summary should be titled with message-led headings rather than descriptive titles. For example:

The health system is highly centralized and regulated (rather than “Organization and Regulation”)

Health financing is shaped by significant fiscal constraints (rather than “Financing”)

A weak primary care system is a major challenge for the delivery of services (rather than “Provision”)

Particular focus should be given to the findings in the assessment of the health system (Chapter 7) but for each chapter a standard list of elements should be covered in all HiTs, as outlined in the Table below.

Elements to cover within the Executive Summary

The information should be taken directly from the HiT. Where relevant, please include comparisons with EU (or other regional/comparator country) averages.

This list is not comprehensive – it only outlines the elements that should be covered as standard in all Executive Summaries. Authors should add any other relevant factors to the Summary.


CHAPTER	ELEMENTS TO INCLUDE
Chapter 1 Introduction	<ul style="list-style-type: none"> ▪ Population of the country and any demographic challenges (for example, ageing population, falling birth rates) ▪ The focus should be on the health status of the population: trends in life expectancy, two or three major causes of mortality and morbidity, the main health challenges, including risk factors (smoking, alcohol consumption)
Chapter 2 Organization and governance	<ul style="list-style-type: none"> ▪ The type of health system (for example, a national health service or a predominantly social health insurance requiring contributions) and main actors in provision (for example, public services and contracted private providers) ▪ Indicate the main actors responsible for stewardship, planning, regulation and delivery ▪ Indicate the degree of centralization or decentralization of the health system
Chapter 3 Financing	<ul style="list-style-type: none"> ▪ The main sources of health financing (tax, SHI, private insurance/VHI, private spending) ▪ Health expenditure as a % of GDP and per capita ▪ Public expenditure on health as % of GDP and as a % of current health expenditure ▪ Private spending as % of current health expenditure ▪ Main components of out-of-pocket spending, including co-payments and the presence (or absence) of informal payments ▪ Whether population coverage is universal; and any gaps/population groups excluded from coverage ▪ Whether the benefits package is extensive; any major exclusions ▪ Main payment methods for providers – and any associated issues (perverse incentives, etc.)
Chapter 4 Physical and human resources	<ul style="list-style-type: none"> ▪ A general statement on the distribution of physical and human resources across the country ▪ Trends in hospital infrastructure: hospital stock and acute beds per 100 000 population ▪ Numbers of expensive medical technology (CT, MRI scanners) and distribution ▪ Health workforce numbers, particularly practicing physicians and nurses per 1 000 population; any issues with distribution, over-supply, shortages, etc.
Chapter 5 Provision of services	<ul style="list-style-type: none"> ▪ Whether public health services are extensive or not and whether or not they focus on prevention and health promotion ▪ A brief description of the delivery of primary care/ambulatory care services, including whether gate-keeping is in place; any major issues, strengths or weaknesses ▪ A brief description of the hospital system, including any policies to substitute acute care with day care, etc. ▪ A brief description of pharmaceutical policy and how medicines are accessed by patients ▪ A brief statement on rehabilitative, long-term, mental health or palliative care, if any of these are of particular relevance or have been the focus of recent changes ▪ A brief statement on the provision of dental care, particularly the extent of private provision
Chapter 6 Principal health reforms	<ul style="list-style-type: none"> ▪ Briefly outline the three or four major reforms that have shaped the health system over the last 10–15 years ▪ Mention the major reforms on the policy agenda/currently being pursued
Chapter 7 Assessment of the health system	<ul style="list-style-type: none"> ▪ Mention any major issues highlighted in Chapter 7 concerning health system governance ▪ Mention whether any health system performance monitoring occurs and if so, the main findings, results of the most recent exercise ▪ Outline the main findings in Chapter 7 concerning accessibility and financial protection measures; mention the main results of the latest unmet need for medical care survey ▪ Outline the main findings in Chapter 7 concerning the impact of the health system on health outcomes ▪ Outline the main findings in Chapter 7 concerning health system efficiency
Chapter 8 Conclusion	<ul style="list-style-type: none"> ▪ Briefly summarize the main conclusions, including the health system's main strengths and future prospects and challenges

Introduction

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.

The maximum word length for this chapter is 2500 words (including tables and boxes).

■ Chapter summary

-  Please provide the key messages of the chapter in the form of five or six bullet points (maximum 300 words).


■ 1.1 Geography and sociodemography

 Briefly outline the country's geography, including information on:

- location in Europe and (where applicable) 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

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>.


- migration and citizenship requirements
- ethnic composition of the population
- language
- religion
- any major population movements
- any other characteristics that have a major impact on health

- *for example, as a result of war, refugees, internal displacements*

TABLE 1.1 Trends in population/demographic indicators, selected years

	1995	2000	2005	2010	2015	LATEST AVAIL-ABLE YEAR
Total population						
Population aged 0–14 (% of total)						
Population aged 65 and above (% of total)						
Population density (people per km ²)						
Population growth (average annual growth rate)						
Fertility rate, total (births per woman)						
Distribution of population (rural/urban)						

■ 1.2 Economic context

 Give a general overview of the country's current economic situation (including with regard to EU averages) and its implications for health and the health system including, if relevant:

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

Suggested data source: *Eurostat or World Development Indicators*

[<http://databank.worldbank.org/data/reports.aspx?source=world-development-indicators>].

Suggested databases for EU Member States:

<https://ec.europa.eu/eurostat/data/database>

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



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


TABLE 1.2 Macroeconomic indicators, selected years

	1995	2000	2005	2010	2015	LATEST AVAIL- LABLE YEAR
GDP per capita (current US\$)						
GDP per capita, purchasing power parity (current international US\$)						
GDP annual growth rate						
Public expenditure (Government expenditure as % of GDP)						
Government deficit/surplus (% of GDP)						
General government gross debt (% of GDP)						
Unemployment, total (% of labour force)						
Poverty rate (People at risk of poverty or social exclusion by age and sex as % total population)						
Income inequality (Gini coefficient of disposable income)						

■ 1.3 Political context

 Give a brief overview of the country's system of government. Relevant issues might include:

- where power is concentrated
- how centralized/decentralized the system is and what authority each level of government has
- the main political parties and government coalitions
- major changes in recent years

 Discuss broadly how policy decisions are taken and responsibilities shared. Relevant issues might include:

- membership of international organizations that affect health (only where particularly relevant)

Suggested data source: *Eurostat or World Development Indicators* [<http://databank.worldbank.org/data/reports.aspx?source=world-development-indicators>].

Notes: for example, any abbreviations not given in the List of abbreviations, or any clarification of data.


- *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.*

- *for example, EU, EEA, WTO, Council of Europe*

- major international treaties that have an impact on health (only where particularly relevant)

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 (including with regard to EU averages or other regional comparators). 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.


- *for example, Framework Convention on Tobacco Control*

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

	1995	2000	2005	2010	2015	LATEST AVAILABLE YEAR
LIFE EXPECTANCY (YEARS)						
Life expectancy at birth, total						
Life expectancy at birth, male						
Life expectancy at birth, female						
Life expectancy at 65 years, male						
Life expectancy at 65 years, female						
MORTALITY						
Mortality, SDR per 100 000 population						
Circulatory diseases						
Malignant neoplasms						
Communicable diseases						
External causes of death						
All causes						
Infant mortality rate						
Maternal mortality rate						


Suggested data source: *Eurostat or World Development Indicators*
 [<http://databank.worldbank.org/data/reports.aspx?source=world-development-indicators>].

 Discuss how health indicators differ across population groups. Relevant issues might include:

- socioeconomic groups
- geographical regions
- gender differences
- ethnic minorities (for example, the Roma) and migrants

Please discuss the main challenges in terms of mortality and morbidity, including the five leading causes of death.

FIG. 1.2 Risk factors affecting health status, latest available year

 Discuss any major health problems of policy significance.


 Outline major health challenges facing the population as a whole and certain subpopulations (such as ethnic minorities or socioeconomic groups).

Figure to be supplied by Observatory staff.

- *for example, levels of overweight and obesity, major outbreaks or epidemics*


2

Organization and governance


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

The maximum word length for this chapter is 6 000 words (including tables and boxes).

■ Chapter summary


-  Please provide the key messages of the chapter in the form of five or six bullet points (maximum 300 words).

■ 2.1 Historical background

 Give a brief (400 words maximum) account of the evolution of the health system to set the context for the current system. Readers can be referred to earlier HiTs for more information.

Details of recent policies and reforms should be discussed in Chapter 6

■ 2.2 Organization

 Describe how the health system is organized. Relevant issues might include:

- the overall legal framework
- whether there is one or several statutory systems operating in parallel (for example, 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 that they fulfil in the overall governance/management structure (with reference to Fig. 2.1)

- the main actors' decision-making powers
- the main geographical/administrative tiers within the statutory system
- the nature of the relationships between them
- the main links to other sectors

FIG. 2.1 Overview of the health system

Lines showing hierarchical relationships could have a small sign next to it, clarifying the nature of the relationship, for example, (a) delegation.

EXAMPLE OF FIG. 2.1 Overview of the health system:

Germany

Source: Germany HiT 2014.

- for example, national health service, national insurance system, system based on competing health insurance funds
- for example, hierarchical, contractual – details should be covered in Section 2.7 Regulation

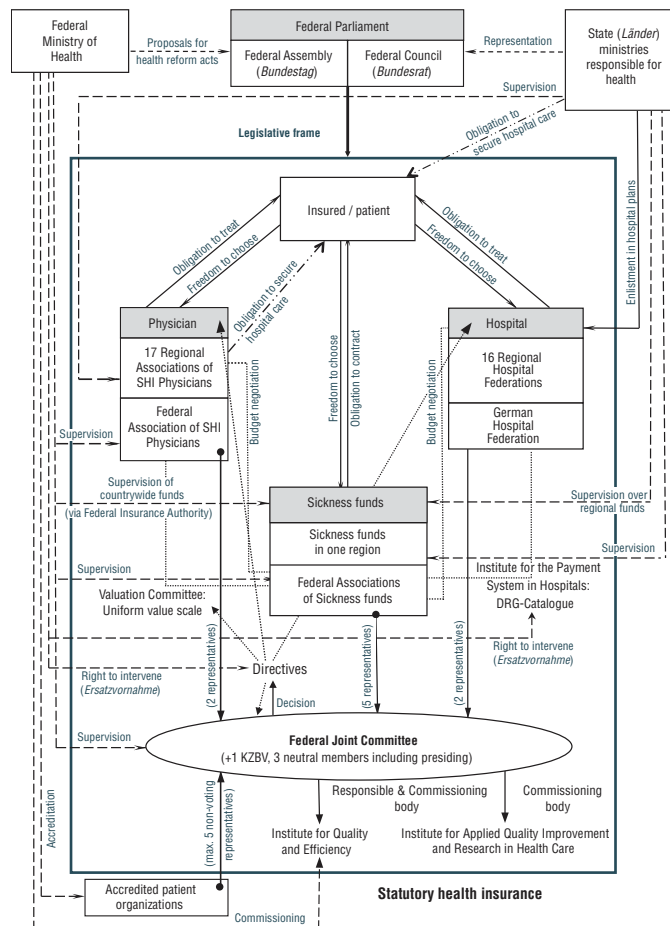
The extent of decentralization should be discussed in Section 2.3

This diagram should give a simplified overview of the health system as a whole, including the public and private sector and (where relevant) the social care system. It should distinguish between national, regional and local levels.


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

Fig. 2.1

Organizational relationships of the key actors in the German health care system, 2014



Source: Based on Busse & Riesberg, 2004.
Note: KZBV: Federal Association of SHI Dentists.

 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. Relevant actors might include:

- the ministry of health
 - other ministries and government agencies
 - regional/local governments (or health authorities)
 - other public agencies at national and regional level
 - third-party payers (public or private)
 - the private sector
 - patient/consumer groups
 - provider organizations and professional groups/associations
 - any other important and relevant organizations
- *for example, ministry of finance, as well as ministries providing health care for their employees and families, such as the ministry of defence*
 - *for example, National Institute for Health and Clinical Excellence (NICE) in England and the Haute Autorité de Santé (HAS) in France*
 - *for example, providers, manufacturers, distributors, stakeholder lobbyists*
 - *for example, physicians' associations, nurses' associations and trades unions*

■ 2.3 Decentralization and centralization


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 (that is, 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 or non-profit-making private organizations.

 Comment on the extent of decentralization and (re)centralization in the health system. Relevant issues might include:

- shifts in decentralization and centralization
 - decentralization of governance mechanisms
 - decentralization of powers and financial responsibilities
 - contextual factors supporting or hindering decentralized decision-making
- *for example, transfer of full or partial responsibility for regulation, provision and financing*
 - *for example, coordination among centres of authority, administrative/financial capability of responsible actors, regulatory framework for privatization*

■ 2.4 Planning

The discussion of planning should refer back to the organization chart in Section 2.2.


 Describe and assess the current approach to planning in the health system. Relevant issues might include:

- national health plans
- whether planning is based on health needs or inputs
- national health planning agencies for health or health services
- health plans at other levels (regional, district, local government, health insurance funds, etc.)
- whether plans are put into practice

Provide a box on capacity for policy development and implementation, using no more than 200 words.

BOX 1.1 Is there sufficient capacity for policy development and implementation?

- Assess whether there is sufficient capacity for health policy development and implementation.
- Consider capacity at the national and regional agencies or bodies in charge.

 Describe and assess the stated objectives of the health system. Relevant issues might include:

- 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

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


- *Cross-reference to Section 7.1 on Health system governance.*

- *Examples of objectives might include:*
 - *ensuring equal access for equal need*
 - *improving access to health care*
 - *improving population health*

■ 2.5 Intersectorality


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.

 Describe how health is taken into account by other ministries and agencies, at all tiers of government. Relevant issues might include:

- health in all policies
- mechanisms for intersectoral or cross-sectoral planning and implementation
- 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
- procedures and mechanisms for intersectoral working
- engagement with nongovernmental organizations (NGOs) and civil society
- engagement with the private (non-health) sector

■ 2.6 Health information systems

 Discuss health information systems

 Describe the health information systems in place for collecting, reporting and analysing data on activity, service and quality. Relevant issues might include:


- data collection, analysis and dissemination

- *Mechanisms for intersectoral working include:*
 - *intersectoral targets*
 - *horizontal public health committees or intersectoral structures*
 - *intersectoral programmes*
 - *public health reporting*
 - *formal consultation with other sectors*
 - *partnerships*

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

- *Cross-reference to Section 4.1.4 Information technology and eHealth.*


- sources of data (for example, vital statistics, disease registries, surveys)
- data quality
- linkages to financing
- requirements for providers (both public and private) to report data

 Discuss systems for monitoring health system performance

Discuss efforts undertaken to set up systems for health system performance assessment. Relevant issues might include:

- how health system performance is monitored and evaluated
- how the health system creates capacity for performance monitoring
- which agencies are responsible for performance monitoring and how far they live up to these responsibilities


■ 2.7 Regulation

 Describe to what extent the government plays a regulatory role at national, regional and district levels. Relevant issues might include:

- organizations at each level that carry out a regulatory function (for example, ministry of finance, ministry of health, parliament)
- national health plans for health or health services
- national policy statements
- the regulatory role of the EU (where applicable)


■ 2.7.1 *Regulation and governance of third-party payers*

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.


 Describe how the government regulates third-party payers. Relevant issues might include:

- 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


■ 2.7.2 Regulation and governance of provision

 Organization: describe how the government plays a regulatory role in relation to providers at national and subnational levels (such as through setting strategic direction, regulation, standards, guidelines). Relevant issues might include:

- 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. Specify which indicators are used. Relevant issues might include:

- quality assurance systems at national/regional level
- incentives for participation in quality improvement activities, professional development and the implementation of clinical guidelines

 Please provide an overview of the regulation of providers (Table 2.1).

- *for example, ministry of finance, ministry of health, parliament*

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

- *for example, ministry of finance, ministry of health, parliament*

- *An example from Switzerland is provided on the next page.*


TABLE 2.1 Overview of the regulation of providers

	LEGISLATION	PLANNING	LICENSING/ ACCREDITATION	PRICING/ TARIFF SETTING	QUALITY ASSURANCE	PURCHASING/ FINANCING
Public health services	KVG/LAMaL, Epidemics Law (EpG/LEp), cantonal implementing legislation	Confederation/ Cantons	Cantons	?	FOPH/Cantons	MHI, cantons
Ambulatory care (primary and secondary care)	KVG/LAMaL, cantonal implementing legislation	None (but cantons may limit number of new licenses since 2002)	Cantons	Corporatist TARMED eG for the national tariff framework / MHI companies, FMH and hospitals for the cantonal price level	FMH, cantons	MHI (santésuisse)
Inpatient care	KVG/LAMaL, cantonal implementing legislation	Cantons	Cantons compile annual cantonal list contracting individual hospitals for certain services	Corporatist SwissDRG SA for the national tariff framework / MHI companies and hospitals for the cantonal price level	ANQ (voluntary), Cantons	Cantons, MHI
Dental care	KVG/LAMAL KLV	None (but cantons may ban new licences)	Cantons	SSO + MTK/CTM, MHI companies	SSO, cantons	Households, VHI, SUVA, IV
Pharmaceuticals (ambulatory)	KVG/LAMaL, details regulated by HMG/LPTh	n/a	Swissmedic	FOPH by positive lists	Swissmedic	MHI
Long-term care	KVG/ LAMAI and KLV	Cantons	Cantons	?	Cantons	Households, cantons, MHI, AHV-IV
University education of personnel	MedBG/LPMéd	Confederation in consultation with Cantons	Confederation	n/a	FOPH + OAQ	Cantons, confederation

Source: Authors' own elaboration.

■ 2.7.3 Regulation of services and goods

Basic benefit package

 Describe the process of deciding which goods and services are to be included in/excluded from the statutory benefits package (with reference to Section 3.3.1). Relevant issues might include:

- who is responsible for/involved in the decision-making process
- the criteria used as a basis for decision-making
- *for example, safety, efficacy, effectiveness, cost-effectiveness*

Health technology assessment

☞ Describe the system for health technology assessment (HTA). Relevant issues might include:

- organizations involved
- principal activities
- methods used
- number of evaluations
- links to the policy-making process

☞ If no HTA agencies exist in your country, describe if or how evaluations produced by NGOs, external agencies or other countries are being used.

■ 2.7.4 Regulation and governance of pharmaceuticals

☞ Describe the regulation of pharmaceutical products. Relevant issues might include:

- responsible regulatory bodies
- market authorization
- quality of medicines (locally manufactured and imported)
- pharmacovigilance
- patent protection
- advertising

☞ Discuss the regulation of wholesalers and pharmacies. Relevant issues might include:

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


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/>


- *for example, a single medicines agency (or several bodies with executive regulatory responsibilities), ministry of health*

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.

 Describe the system for pricing prescription pharmaceuticals and how often it is revised. Relevant issues might include:

- profit-control scheme, reference pricing scheme (internal or external), value-based pricing, direct price controls
- composition of prices of medicines, that is, ex-factory/manufacturer price, wholesaler (profit) margin, pharmacy margin (or profit), and any taxes (for example, VAT)
- regulation of over-the-counter products

 Discuss any system for public reimbursement of pharmaceuticals. Relevant issues might include:

- 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

■ **2.7.5 Regulation of medical devices and aids**

Describe the regulation of medical devices and aids. Relevant issues might include:


- the process of purchasing/procurement
- controls on acquisition
- public and private sectors

▪ *Cross-reference to Chapter 3 Financing.*

▪ *Cross-reference to Chapter 3 Financing.*

■ 2.8 Person-centred care

■ 2.8.1 Patient information

 Describe and assess the level of information available to patients when making decisions about accessing health services. Using the information you provide in Table 2.2, focus on such issues as:


- sources and dissemination of information
- mechanisms in place to guide patients around the health system
- 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

- *for example, range of services covered, costs, quality, type of provider contracted*

TABLE 2.2 Patient information

TYPE OF INFORMATION	IS IT EASILY AVAILABLE?	COMMENTS
Information about statutory benefits		
Information on hospital clinical outcomes		
Information on hospital waiting times		
Comparative information about the quality of other providers (for example, GPs)		
Patient access to own medical record		
Interactive web or 24/7 telephone information		
Information on patient satisfaction collected (systematically or occasionally)		
Information on medical errors		

■ 2.8.2 Patient choice

 Briefly outline the extent of patient choice. Relevant issues might include:

- the different types of choice available to patients, such as choice of insurer, provider, treatment (including shared decision-making), etc.
- competition between purchaser organizations for consumers/insurees
- evidence on whether/how/which individuals exercise choice
- evidence on whether levels of information facilitate choice
- evidence on how the current level of individual choice affects equity and efficiency

Choice is a complex issue. Some argue that choice has intrinsic value, while others value its instrumental potential (for example, 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.

TABLE 2.3 Patient choice

TYPE OF CHOICE	IS IT AVAILABLE?	DO PEOPLE EXERCISE CHOICE? ARE THERE ANY CONSTRAINTS (E.G. CHOICE IN THE REGION BUT NOT COUNTRY-WIDE)? OTHER COMMENTS?
CHOICES AROUND COVERAGE		
Choice of being covered or not		
Choice of public or private coverage		
Choice of purchasing organization		
CHOICES OF PROVIDER		
Choice of primary care practitioner		
Direct access to specialists		
Choice of hospital		
Choice to have treatment abroad		
CHOICES OF TREATMENT		
Participation in treatment decisions		
Right to informed consent		
Right to request a second opinion		
Right to information about alternative treatment options		


■ 2.8.3 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 Directive on patients' rights in cross-border health care.

 Referring to Table 2.4, briefly describe and assess what has been done at national or local level to implement WHO's patient rights framework. Relevant issues might include:

- definition of patient rights
- legislation
- enforcement

TABLE 2.4 Patient rights

	Y/N	COMMENTS
PROTECTION OF PATIENT RIGHTS		
Does a formal definition of patient rights exist at national level?		
Are patient rights included in legislation?		
Does the legislation conform with WHO's patient rights framework?		
PATIENT COMPLAINTS AVENUES		
Are hospitals required to have a designated desk responsible for collecting and resolving patient complaints?		
Is a health-specific Ombudsman responsible for investigating and resolving patient complaints about health services?		
Are there other complaint avenues?		
LIABILITY/COMPENSATION		
Is liability insurance required for physicians and/or other medical professionals?		
Can legal redress be sought through the courts in the case of medical error?		
Is there a basis for no-fault compensation?		
If a tort system exists, can patients obtain damage awards for economic and non-economic losses?		
Can class action suites be taken against health care providers, pharmaceutical companies, etc.?		

■ 2.8.4 *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 health care issues. Relevant issues might include:

- 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.


3

Financing


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).

The maximum word length for this chapter is 7 000 words (including tables and boxes).

■ Chapter summary

-  Please provide the key messages of the chapter in the form of five or six bullet points (maximum 300 words).

■ 3.1 Health expenditure

 Please comment on the following tables and figures. Relevant issues might include:

- main trends over time
- reasons for changes/position in relation to other countries
- differences between national and international data sources
- capital expenditure versus current expenditure

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

- *Cross-reference to Section 1.2 Economic context and Table 1.2.*

TABLE 3.1 Trends in health expenditure in country, 2000 to latest available year (selected years)

EXPENDITURE	2000	2005	2010	2015	LATEST AVAILABLE YEAR
Current health expenditure per capita in International US\$ (Purchasing Power Parity)					
Current health expenditure as % of GDP					
Public expenditure on health as % of total expenditure on health					
Public expenditure on health per capita in International US\$ (Purchasing Power Parity)					
Private expenditure on health as % of total expenditure on health					
Public expenditure on health as % of general government expenditure					
Government health spending as % of GDP					
OOP payments as % of total expenditure on health					
OOP payments as % of private expenditure on health					
Private insurance as % of private expenditure on health					

FIG. 3.1 Current health expenditure as a share (%) of GDP in the WHO European Region, latest available year

FIG. 3.2 Trends in current health expenditure as a share (%) of GDP in country and selected countries, 2000 to latest available year

FIG. 3.3 Current health expenditure in US\$ PPP per capita in the WHO European Region, latest available year

FIG. 3.4 Public expenditure on health as a share (%) of current health expenditure in the WHO European Region, latest available year

FIG. 3.5 Public expenditure on health as a share (%) of general government expenditure in the WHO European Region, latest available year

Source: *Global Health Expenditure Database* [<http://apps.who.int/nha/database/Select/Indicators/en>].

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.

The other countries selected 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 the EU, CIS or CARK can also be included as appropriate.

Figures 3.1, 3.2, 3.3, 3.4 and 3.5 to be supplied by Observatory staff using WHO estimates (European Health for All database).


TABLE 3.2 Expenditure on health (as % of current health expenditure) according to function and type of financing

	INPATIENT CARE	OUTPATIENT CARE	LONG-TERM CARE	PHARMA-CEUTICALS	PUBLIC HEALTH	ADMINIS-TRATION	OTHER SERVICES	TOTAL
General government								
Mandatory health insurance								
Private out-of-pocket								
Private insurance								
Other (for example, non-profit institutions serving households)								
Total expenditure								

Source: *OECD Health Data or national health statistics.*

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.

■ 3.2 Sources of revenue and financial flows

 Please summarize the key elements of health financing in no more than 500 words.

Relevant issues might include:

- 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
- whether there are different types of financing for different types of services (with reference to Table 3.2)

FIG. 3.6 Financial flows

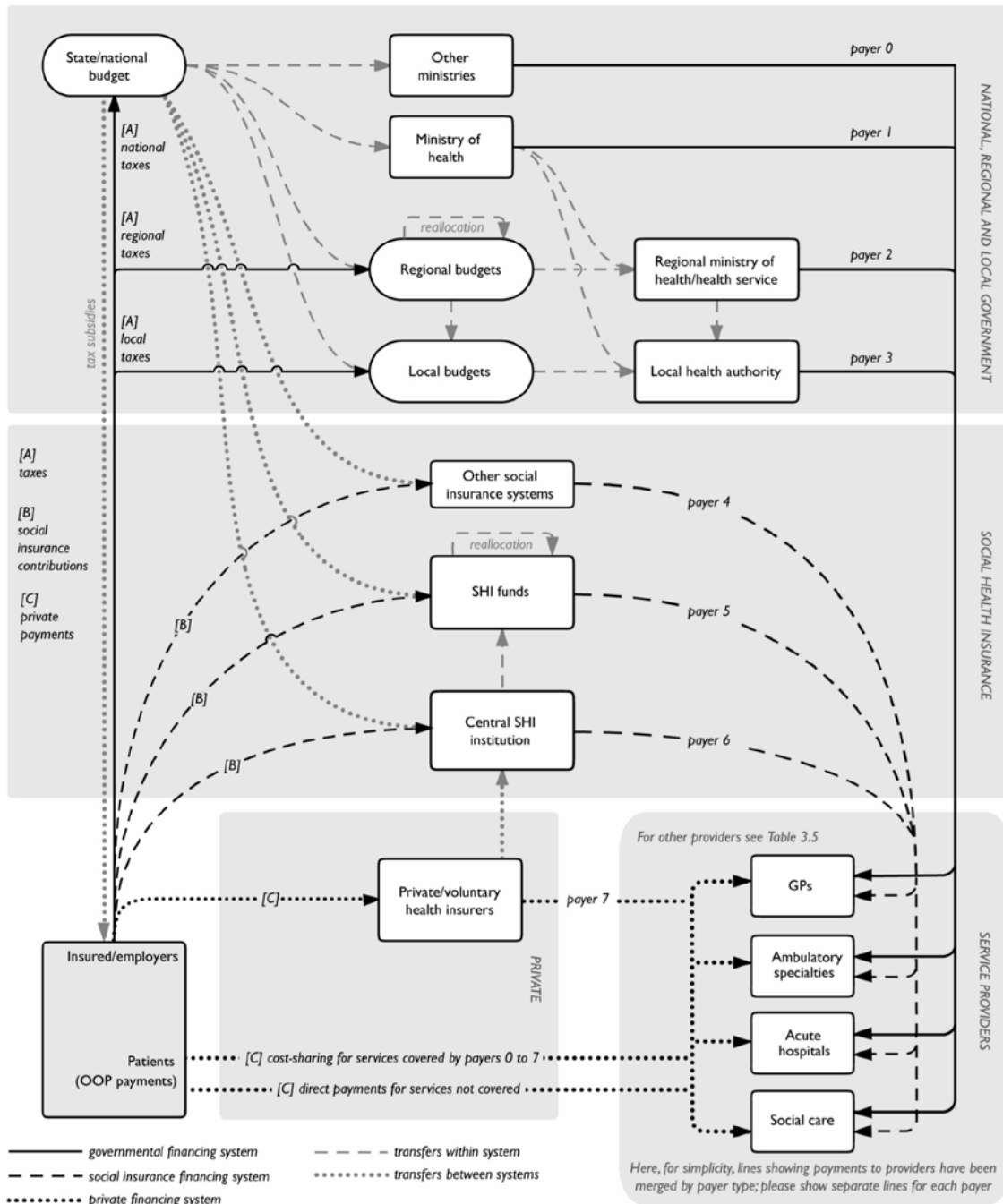
Please provide a diagram of financial flows using this figure.

The diagram should serve as an introductory snapshot but also include details which will be explained in the following sections. Make sure to refer to it in the text.

Consider marking collection, pooling and purchasing in this figure.

You could also add expenditure data for the latest available year to the figure. Delete elements in the Fig. 3.6 prototype that do not apply to your health system.

Source: national statistics



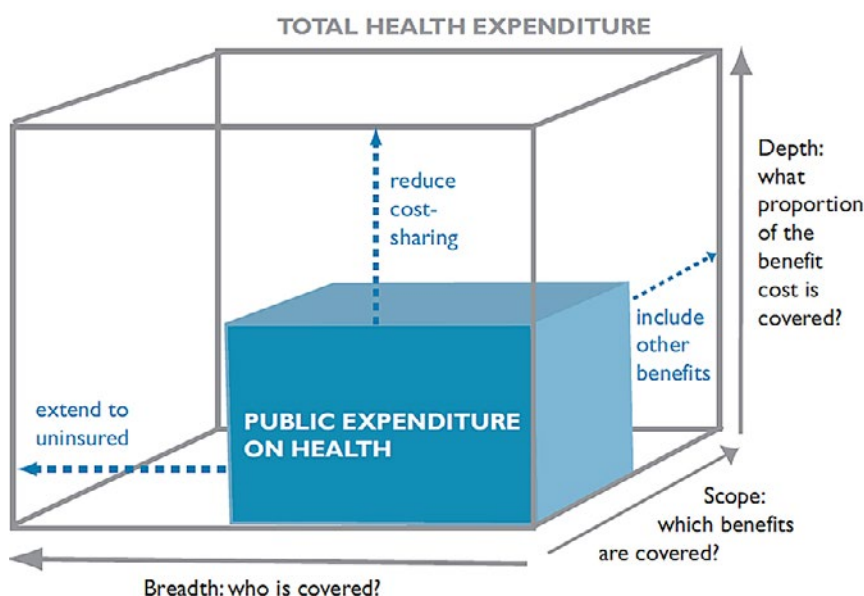
■ 3.3 Overview of the statutory financing system

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).

Note: VHI and OOP payments will be discussed in the following sections, but 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


Source: Busse R, Schreyögg J, Gericke CA (2007): *Analyzing Changes in Health Financing Arrangements in High-Income Countries: A Comprehensive Framework Approach*. Health, Nutrition and Population (HNP) Discussion Paper. Washington DC: World Bank

Breadth: who is covered?

 Describe the extent of population coverage and the basis for entitlement. Relevant issues might include:

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.

- the legal basis for entitlement
- criteria for entitlement
- whether membership of an insurance scheme is compulsory (exemptions for certain groups, for example, conscientious objectors)
- which groups are covered without having to make formal contributions
- any excluded groups

 Describe provisions to cover undocumented migrants

Scope: what is covered?

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

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

Relevant issues might include:

- whether the benefits package is uniform across the whole of the covered population
- the extent to which benefits are explicitly defined
- the extent to which formal benefits are available in practice
- the existence of a “positive list” of included goods or services
- any benefits explicitly excluded
- any cash benefits available
- the role of health technology assessment (HTA)

- *Cross-references to the subsections on VHI, 3.3.1 Coverage, and 2.4.3 Regulation of services and goods may be necessary.*

- *for example, through the constitution, law*
- *for example, residence, employment status, membership of an insurance scheme, residence in specific geographical areas, insurance contributions, income*


- *for example, children, pensioners, unemployed, pregnant women*

- *for example, unemployed, foreigners, undocumented migrants*

- *for example, sick pay, maternity benefits, disability, invalidity, cash payments for users of long-term care services, cash benefits for special groups (for example, those with mental disorders or living with HIV/AIDS)*

- *Cross-reference to Section 2.7.3 Regulation of services and goods – Health technology assessment.*

Depth: how much of benefit cost is covered?

 Briefly describe the extent of user charges in place for accessing statutory benefits. Relevant issues might include:

- the services for which people have to pay user charges, for example, outpatient prescription drugs, GP visits, stays in hospital


Provide a box on key gaps in coverage, using no more than 200 words.

BOX 3.1 What are the key gaps in coverage?

Provide an overall assessment of what the key gaps are in the breadth, scope and depth of coverage of the statutory system.

- Consider the role of out-of-pocket payments (where applicable) and whether they indicate gaps in public coverage.
- Discuss the implications for financial protection, access and equity.

3.3.2 *Collection***General government budget**

 Briefly describe (with reference to Fig. 3.6):

- 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.*
- *Cross-reference to Section 7.2 Accessibility.*

for example, the relative share of direct versus indirect taxes and income versus labour versus consumption taxes

for example, national/regional/local, compliance issues, tax credits/relief

Taxes, contributions or premiums pooled by a separate agency

 Relevant issues might include:

- who is responsible for setting contribution rates
- whether there are differences in contribution rates by funds or type of member
- on what they are levied, for example, gross/net wages, other income
- who is responsible for collecting them
- 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

Provide a box on the fairness of health financing, using no more than 200 words.

BOX 3.2 Is health financing fair?

Provide an assessment of how fair health financing is. Consider issues of progressivity and equity. Discuss:


- 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

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, but community-rated premiums also exist in some countries. They may be collected by statutory health insurance funds, private insurers, local or central government, depending on country context.

- *for example, different rates for older people, self-employed, farmers, public employees, unemployed*

3.3.3 Pooling and allocation of funds

Allocation from collection agencies to pooling agencies


 Discuss the process of transferring collected revenue to pooling agencies:

- whether the same agency that collects funds also pools them
- 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 territorial pools, describe the allocation process from central to territorial levels.


This subsection (with reference to Fig. 3.6) focuses on any process by which financial resources flow from a collection agency to a pooling agency (for example, 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 (for example, where statutory health insurance funds collect their own contributions) and the resource allocation mechanism to poolers is therefore implicit.

- *In these cases, the contribution mechanism is also the allocation mechanism to the pool*
- *for example, 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*
- *for example, how does the government decide how much should be allocated to the ministry of health?*
- *If these pooling agencies are also purchasers, please refer the reader to the following section and discuss this issue there*

Allocating resources to purchasers

 Describe the market structure of purchasers. Relevant issues might include:

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

 Describe the method(s) used to allocate funds from pooling agencies to purchasers or to re-allocate funds among pooling agencies/purchasers. Relevant issues might include:

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

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 (for example, 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. Even in these situations, however, there may be some redistribution or reallocation of resources among purchasers, which should be described in this section.

- *for example, entire population of the territory, people that are members of the particular scheme managed by the purchaser*
- *Cross-reference to Section 2.8.2 Patient choice.*

- *for example, 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*

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 (that is, risk-adjusted capitation)

☞ If risk-adjusted capitation is used to allocate (or re-allocate) resources, relevant issues might include:

- 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

Provide a box on the health system's allocative efficiency, using no more than 200 words.

BOX 3.3 Are resources put where they are most effective?

Assess whether resources are put where they are most effective, that is, the health system's allocative efficiency. Issues that might be relevant include:


- the use and quality of risk-adjusted resource allocation formulas
- the allocation of resources between different types of providers or levels of care (for example, primary health care, hospital services, long-term care, administration)
- mechanisms for setting priorities and the use of evidence about effectiveness and cost-effectiveness
- whether there are systems in place to ensure the health system is doing the right things

When describing a resource allocation formula or risk adjustment mechanism, relevant issues might include:

- 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 (for example, population density, remoteness) rather than something amenable to policy or efficiency improvement
- whether adjustments are made for socioeconomic factors
- whether specific types of morbidity (for example, 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

- *Cross-reference to Section 7.6 Health system efficiency.*

■ 3.3.4 Purchasing and purchaser–provider relations

 Describe the process through which purchasers and providers interact (with reference to Fig. 3.6).

If providers are integrated, relevant issues might include:

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

If contracting is used, relevant issues might include:

- 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
- whether there are any mechanisms to counter supplier-induced demand and if so, how these are implemented
- incentives to provide services to specific groups of people

If direct payments from patients form an important part of provider reimbursement, relevant issues might include:

- whether the insurer or regulator intervenes (for example, through price controls, OOP payment limits, reporting requirements)
- whether payers/purchasers control providers and patients (in theory and in practice)


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), that is, 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.

■ 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. Relevant issues might include:

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

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.

- *Is there any research showing the distribution of OOP payments across the population, the structure of OOP payments (that is, what services they are spent on) and their impact on catastrophic household spending and poverty levels?*
- *Cross-reference to Box 3.2 Assessing coverage, Section 3.7 Payment mechanisms, Section 7.2 Accessibility and Section 7.3 Financial protection.*

■ 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) that 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.


 Complete Table 3.3 outlining which methods of direct or indirect cost sharing are applied to each good 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 3.3 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
Primary care				
Outpatient specialist visit				
Outpatient prescription drugs				
Inpatient stay				
Dental care				
Medical devices				
Other (please specify)				

 Provide an overview of the system of formal user charges in place. Relevant issues might include:


- whether the 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
- *for example, raising revenue, cost-containment, reducing inappropriate demand*
- *for example, national/local government; statutory health insurance funds; are there regional variations in cost-sharing?*

■ 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. Relevant issues might include:

- the sorts of services for which people are most likely to make direct payments
- *for example, use of private providers, private elective surgery*

■ 3.4.3 *Informal payments*

 If informal payments exist, relevant issues might include:

- 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
- plans or expectations with respect to future developments in this area
- *Cross-reference to Section 7.2 Accessibility, Section 7.3 Financial protection 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 because 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.

Functions of private health insurance in relation to public coverage schemes

		ELIGIBILITY TO PUBLIC HEALTH INSURANCE	
		INDIVIDUALS HAVE PUBLIC COVER	INDIVIDUALS DO NOT HAVE PUBLIC COVER
Health services covered by private health insurance	Private health insurance covers medically necessary curative services typically covered under the public system	Duplicate private health insurance	Primary private health insurance: <ul style="list-style-type: none"> • substitutive • principal
	Private health insurance covers cost-sharing applicable to public coverage systems	Complementary private health insurance	
	Private health insurance covers top-up health services not included in public systems or primary private health insurance	Supplementary private health insurance	

Source: OECD, 2004, *Proposal for a Taxonomy of Health Insurance*.

 Provide an overview of the market for VHI, if it plays an important role in your country. Relevant issues might include:

- 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 and which population groups buy VHI
- the factors that drive demand for VHI
- changes

☞ Provide an overview of public policy towards VHI. Relevant issues might include:

- 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

■ 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.

■ 3.6.2 *External sources of funds*

☞ Comment on the evolution and use of external sources of financing.

■ 3.6.3 *Other sources of financing*

☞ Briefly discuss the following, where they exist and are relevant:

- Occupational health services and other medical benefits to employees provided by corporations and private employers

- *for example, 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*

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

Cross-reference to any further details provided in Sections 3.3.3 *Pooling and allocation of funds* and 3.3.4 *Purchasing and purchaser-provider relations*.

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.

or provided to certain special groups (for example, soldiers, prisoners)

- Mental health and social care services where these are funded separately from general medical services.
- Long-term care financing where this is funded separately from general medical services.
- Non-profit-making institutions serving households (excluding social insurance)
- Voluntary and charitable financing in general

3.7 Payment mechanisms

See Box on next page for an explanation of the different types of payment methods

- *for example, NGOs, donor organizations or religious organizations*
- *for example, by a separate social insurance scheme, NGOs or donor organizations*
- *for example, the Red Cross, philanthropic and charitable institutions, religious orders, lay organizations*
- *for example, national and international donations in cash or in kind from NGOs*

This section should provide an overview of payment mechanisms used in the health system, with reference to Table 3.4 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.

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.

Different types of payment mechanisms

The three most important payment mechanisms for physicians (for example, GPs, ambulatory specialists) are:

Fee-for-service (FFS), which involves paying for each unit of service provided with the amount of the fee depending on the type of service. This generally incentivizes providers to provide as many reimbursable services as possible, creating the potential for inappropriate or unnecessary use of services and leading to escalating costs.

Capitation payment, which entails paying a fixed amount per patient (for example, per registered patient on a list), irrespective of the volume of services provided. A particular form is *contact capitation*, which involves a payment triggered by an initial visit (for example, per quarter). Capitation payments have incentives to provide as little care as possible to each patient, creating the potential for underprovision of services, increasing referrals and the adverse selection of low-risk patients.

Salary, which is a payment per time period that depends on the characteristics of the physician, for example, the years of experience or the position in a hierarchy. Salaries are administratively simple but provide limited incentives for activity.

The three most important hospital inpatient payment mechanisms are:

Global budgets, which are payments that are (at least in theory) independent of hospital activity and that are determined on the basis of the hospital's characteristics, such as the number of beds or the type of available equipment and staff. Global budgets are administratively simple and control

expenditure but discourage productivity and may lead to increasing waiting lists.

Case payments, such as diagnosis-related group (DRG) -based payments, pay hospitals a fixed amount of money per inpatient stay depending on the characteristics of the patient and the treatment provided. Case payments provide incentives to make efficient use of resources, when treating patients. However, they are administratively complex and provide incentives for increasing the number of inpatient stays.

Per diem fees are payments per day of inpatient stay, which provide incentives to increase the length of inpatient stay, while limiting the amount of services provided during each day of stay.

Fee-for-service payments (see above) also exist for inpatient care – but they are usually limited to particular services provided during an inpatient stay.

In addition, many countries have increased efforts to measure quality of care and to use this information to adjust payment of providers. This is often called *pay for performance (P4P)* although *pay for quality (P4Q)* is more precise.

In practice, most countries combine different payment mechanisms (blended payment) to limit the incentives related to each of these mechanisms. For example, primary care physicians often receive a capitation payment for general services, combined with FFS for certain selected services that purchasers want to incentivize. Similarly, hospitals often receive a budget that is partially determined on the basis of past activity (for example, measured in terms of DRGs or days).

TABLE 3.4 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
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 – for example, DRGs
- Pay for quality – P4Q
- Bundled payment – BP

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

Delete any irrelevant rows/columns.

■ 3.7.1 *Paying for health services*


 Referring to Table 3.3, please discuss how each of the following types of service are funded and cross-reference to the relevant sections in Chapter 5 *Provision of services*:

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

 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

■ 3.7.2 *Paying health workers*

 Describe how different categories of health workers are paid and who sets their remuneration. Relevant issues might include:

- 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:

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

- *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 – ex-factory price, wholesaler's (profit) margins, pharmacy margins (or profit), and any taxes*
 - *regulation of OTC products*

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

- *for example, negotiation, regulation*

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

- *for example, physiotherapists, alternative medicine*

⊖ If relevant, issues that might be included (for each group):

- any (non)financial incentives
- any problems


4

Physical and human resources

This chapter provides an overview and assessment 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 training and mobility.

The maximum word length for this chapter is 3 000 words (including tables and boxes).


■ Chapter summary

-  Please provide the key messages of the chapter in the form of five or six bullet points (maximum 300 words).

■ 4.1 Physical resources

■ 4.1.1 Infrastructure, capital stock and investments

Infrastructure

 Describe the distribution of infrastructure. Relevant issues might include:

- whether changes have been the result of explicit political decisions
- how trends for acute hospitals beds compare with those in other countries (Fig. 4.1)

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

Figure to be supplied by Observatory staff.

Provide a box on the distribution of health facilities, using no more than 200 words.


BOX 4.1

Are health facilities appropriately distributed? Comment on the distribution of health infrastructure across the country. Consider:

- differences across regions
- differences across urban and rural areas
- the reasons for any major differences
- do the differences impact on access to care?

FIG. 4.1 Beds in acute hospitals per 100 000 population in country and selected countries, 1990 to latest available year

Current capital stock

 Briefly describe the number, location, size and age of hospitals or other relevant health care infrastructure. Relevant issues might include:

- the main categories of hospitals and their function and distribution
- types of hospital management
- the public–private ownership mix of hospital services

 Also describe the condition of facilities. Relevant issues might include:


- property condition surveys available at various levels of care (primary, secondary, tertiary, intermediate, social care)
- whether appraisals of condition and performance feed into planning future strategies and investment

- *Cross-reference to Section 7.6 Health system efficiency.*

Figure to be supplied by Observatory staff using WHO data.


- *for example, district general hospitals, teaching hospitals, single-specialty hospitals (such as for maternity services or orthopaedics). Cross-reference to Fig. 4.1.*
- *for example, public, quasi-public, private profit-making and private non-profit-making*

Regulation of capital investment

 Describe the regulation of capital investment. Relevant issues might include:

- 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

Investment funding

 Describe how capital investments are funded. Relevant issues might include:

- whether investment funding is separate from or covered through reimbursement for service delivery
- whether capital investment reflects stated policy priorities
- money borrowed through public allocations and the criteria for public investment
- the nature of any private borrowing
- public–private partnerships for investment in capital facilities

- *for example, land, buildings and major pieces of medical equipment*
- *for example, through standards on health infrastructure*


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

- *for example, strengthening primary care*

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.

■ 4.1.2 *Medical equipment*

Equipment infrastructure

 Describe briefly how major pieces of medical equipment are funded. Relevant issues might include:

- whether basic equipment is available in sufficient quality and quantity
- differences between primary/ambulatory and inpatient care
- how the data in Table 4.1 (if available) compare with the EU average

TABLE 4.1 Items of functioning diagnostic imaging technologies (MRI units, CT scanners) per 1 000 population in latest available year

	COUNTRY	EU AVERAGE
MRI units		
CT scans		

■ 4.1.3 *Information technology and eHealth*

 Describe the use of IT in the health system and the eHealth maturity of the country. Relevant issues might include:

- 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
- plans or strategies for the development and use of IT systems within the health system
- electronic medical records or electronic health cards
- electronic appointment booking systems
- information on the number of people accessing the internet for health information


Sources: national statistics/Eurostat/OECD Health Data

This Section provides an assessment of the development of information technologies in the health sector and the eHealth maturity of the country.


- *for example, clinical decision support systems, prescribing systems, clinical information systems (audit and feedback).*
- *Cross-reference to Section 2.6.1 Patient information.*

■ 4.2 Human resources

■ 4.2.1 Planning and registration of human resources

 Describe the mechanisms (if any) for planning human resources. Relevant issues might include:

- limits to the number of training places
- areas of training
- training facilities
- retraining

 Describe any system of registering and licensing health professionals. Relevant issues might include:

- 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


- *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.*

■ 4.2.2 Trends in the health workforce

FIG. 4.2 Practising nurses and physicians per 100 000 population, latest available year


FIG. 4.3 Number of physicians per 100 000 population in country and selected countries, 1990 to latest available year

FIG. 4.4 Number of nurses per 100 000 population in country and selected countries, 1990 to latest available year

 Comment on trends for the professional groups shown in Figs 4.2–4.4. For each group, relevant issues might include numbers of full-time equivalent staff (where available), the adequacy of staffing levels and geographical distribution.

physicians: primary care/ambulatory care physicians (distinguish between general medical practitioners and specialists in ambulatory settings); hospital-based physicians (distinguish between different medical specialties); academic physicians

nurses and midwives: distinguish between the levels of nursing, including nurse practitioners and nursing assistants, and discuss nursing specialties available (for example, psychiatric, paediatric and community nursing)

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

dentists: distinguish between dental practitioners (primary care), specialist dentists (working in hospitals) and dental auxiliaries

pharmacists: distinguish between hospital and community pharmacists

public health professionals: distinguish between specialists in public health and other public health

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).

Figure to be supplied by Observatory staff.

Figure to be supplied by Observatory staff using WHO data.

Figure to be supplied by Observatory staff using WHO data.

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

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, such as physician assistants or medical assistants

managerial staff: discuss senior management and administrative posts within the health system

social workers or care workers

Provide a box on the distribution of health workers, using no more than 200 words.

BOX 4.2

Are health workers appropriately distributed?
Assess the geographic distribution of health workers across the country. Consider:

- differences across regions
- differences across urban and rural areas
- differences across specialties
- Is it a problem?
- What are the reasons for potential imbalances?

■ 4.2.3 *Professional mobility of health workers*



Briefly comment on professional mobility. Relevant issues might include:

- recruitment of staff 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

■ 4.2.4 *Training of health personnel*



Describe the basic training of health professionals. Relevant issues might include:


- requirements for specialization and further training, for example, length;

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

is there a probationary period (and how long?)


- whether continuing professional development is required, how often revalidation is needed, whether there is a peer-review process
- the bodies responsible for setting educational standards

■ **4.2.5** *Physicians' career paths*

 Describe the career paths of physicians, in both hospital and ambulatory settings. Relevant issues might include:

- how the promotion of physicians 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 there is much movement of physicians across hospitals, clinics or departments within hospitals, or countries

■ **4.2.6** *Other health workers' career paths*

 Describe the career paths of other health workers, for example, nurses, dentists and pharmacists. Relevant issues might include:

- mechanisms for career development
- who makes decisions on promotions


5

Provision of services


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.

The maximum word length for this chapter is 8 000 words (including tables and boxes).

■ Chapter summary

-  Please provide the key messages of the chapter in the form of five or six bullet points (maximum 300 words).

■ 5.1 Public health


 Describe the organization and provision of public health services, including settings, responsible organizations, nature of providers and functions. Relevant issues might include:

- organizational set-ups and the main institutions at national and local levels (include profit-making and non-profit-making organizations if relevant) and the scope of public health functions covered
- the organization of preventive services
- the general emphasis on public health interventions versus curative care
- public health interventions to address major risk factors (such as drinking, smoking, unhealthy diet and lack of exercise) either through regulation or health promotion and education
- 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 intervention, such as through regulation.

- *Cross-reference to Section 2.5*
Intersectorality.
- *for example, immunization services, family planning and antenatal services*
- *These are organized programmes ideally based on a population register with invitations to participate, integrated*

- environmental and communicable disease control functions
- mechanisms for notification and surveillance of disease outbreaks
- the organization of occupational health services

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

Provide a box on the effectiveness of public health interventions, using no more than 200 words.

BOX 5.1 Are public health interventions making a difference?

Assess the effectiveness of public health interventions. Please focus on interventions that address tobacco, alcohol and obesity. Where available, draw on evaluations of public health interventions.

■ 5.2 Patient pathways

 Provide a typical patient pathway in the form of a patient flow diagram. Relevant issues might include:

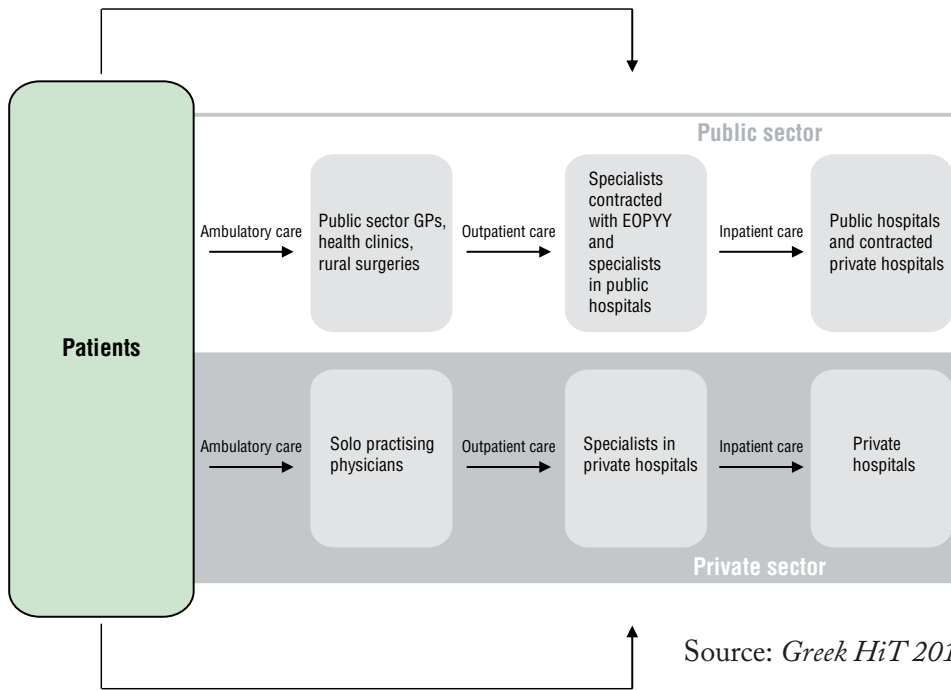
- whether such pathways differ significantly across the country
- recent changes

quality control and follow up. There may also be opportunistic screening (for example, a patient attending a physician for something else is offered a cervical smear or mammogram).

- *These may include first aid and curative, preventive and rehabilitative services.*
- *Refer to Section 1.4 Health status and relevant figures or tables.*
- *Cross-reference to Section 7.5 Health system outcomes.*


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, for example, consultations, diagnosis, treatment, medication, dietary advice, assessment, teaching and preparing for discharge from hospital.

FIG. 5.1 Patient pathway, example from Greece




Source: *Greek HiT 2017*.

5.3 Primary care

 Describe the organization and provision of primary care services, including settings, responsible organizations, nature of providers and functions. Relevant issues might include:

- 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. Relevant issues might include:

- freedom of choice of primary care physicians (for example, 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 gate-keeping role

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.

Primary care may include the following services: 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, nursing care for acute and chronic illnesses, palliative care, specific services for mental illness, preventive services (for example, immunization, screening) and health promotion services (for example, health education).

- the role of GPs in coordinating care
- 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.

Provide a box on the strengths and weaknesses of primary care, using no more than 200 words.


BOX 5.2 What are the key strengths and weaknesses of primary care?


Describe selected key strengths and weaknesses of primary care within the wider health system. Consider:

- structures, access, coordination, continuity and comprehensiveness
- the reputation of primary care and whether priority is given to primary care within the wider health system


 An assessment of the strength of primary care in Europe is for example given in: Kringos et al. (2013) Political, cultural and economic foundations of primary care in Europe, *Social Science & Medicine*, 99:9–17.

See also: <https://www.nivel.nl/en/dossier/country-information-primary-care>

 Comment on the nature of outpatient contacts and the reliability of data

 Comment on the accessibility, adequacy and quality of primary care. Relevant issues might include:

- 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 Section 7.4 Health care quality.*

- *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.*

- *for example, reports from the ministry of health or other bodies*

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


■ 5.4 Specialized care

Specialized care includes both specialized ambulatory care and inpatient care. Many countries distinguish further between secondary and tertiary care.


Secondary care refers to specialized ambulatory medical services and typical hospital services (outpatient and inpatient services). It excludes long-term care.

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


■ 5.4.1 *Specialized ambulatory care*

 Describe the organization and provision of specialized ambulatory care. Relevant issues might include:


- settings and models of provision
- the range of services available


 Comment on the accessibility, adequacy and quality of specialized ambulatory care. Relevant issues might include:

- the geographical distribution of facilities
- national programmes to improve quality
- any data from official quality assurance reports

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

■ 5.4.2 *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. Relevant issues might include:

- 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

- *for example, specialists working in their own practices, specialist polyclinics, outpatient departments of hospitals*

- *for example, reports from the ministry of health or other bodies*


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

- *for example, 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*


- *for example, in hospitals, ambulatory care or long-term care facilities*


- trends in day care provision in the last 10–20 years

■ 5.4.3 *Inpatient care*

 Describe the organization and provision of secondary and tertiary inpatient care, including settings, responsible organizations, nature of providers and functions. Relevant issues might include:

- the geographical distribution of facilities
- national programmes to improve quality
- any data from official quality assurance reports

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

 Discuss the relationship between primary and secondary care and other services such as social care. Relevant issues might include:

- 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)

- *for example, reports from the ministry of health or other bodies*

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


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

Provide a box on the integration of care, using no more than 200 words.

BOX 5.3 Are efforts to improve integration of care working?

Assess efforts (where existing) to improve the integration of care. Consider:

- attempts to establish integrated care pathways and disease management programmes
- integration between health services, social services and other care providers (horizontal integration)
- integration across primary, community, hospital and tertiary care services (vertical integration)
- the use of new technologies
- the use of incentives (for example, governance, guidance, funding)

 Comment on the accessibility, adequacy and quality of inpatient care. Relevant issues might include:

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

- *Cross-reference to Section 7.4 Health care quality.*

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


- *for example, reports from the ministry of health or other bodies*

Provide a box on patient evaluations of care, using no more than 200 words.


BOX 5.4 What do patients think of the care they receive?


Assess patient evaluations of the care (including both inpatient and outpatient care) they receive. Consider:

- the use of patient-reported experience measures (PREMs)
- user experience
- public satisfaction with the health system


 Discuss how trends in typical operating indicators compare with those in other countries (insert a figure if helpful).


■ 5.5 Urgent and emergency care

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

 Describe the organization and provision of urgent and emergency care, including settings, responsible organizations, nature of providers and functions. Relevant issues might include:

- organizations involved in transporting patients and deciding on the appropriate health care setting
- pre-hospital care (for example, administration of thrombolysis in ambulances) and (out-of-hours) primary care

 Comment on the accessibility, adequacy and quality of services.

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

PREMs are typically short, self-completed questionnaires, which measure the patients' experience of the care they received.

▪ *Cross-reference to Section 7.5 Health care quality.*


▪ *for example, average length of stay, occupancy rates, day cases as percentage of total surgery*

Data sources: Eurostat, Health for All database, OECD Health Data

▪ *for example, medical care provided to patients with life-threatening conditions who require urgent treatment*

▪ *for example, the national health service or specialized services such as the Red Cross*

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

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

Source: Malta HiT 2017.

Patient pathway in an emergency care episode

Most patients arrive at the Accident and Emergency (A&E) Department driven in a private car by a relative. Upon arrival, they are registered at reception and seen in the triage room by a triage nurse. Their onward pathway is determined by their triage assessment outcome.


In the community, in case of a severe emergency requiring external assistance, the patient (or someone on behalf of the patient) calls 112. All calls to 112 regarding acute illness or injury are directed to health professionals able to guide the patient or bystanders until an ambulance arrives. The ambulance service is provided by the Department for Health. An ambulance will be sent to the address provided. In the case of a life-threatening situation, ambulances are accompanied by a nurse, and, if need be, a doctor. In the case of emergencies at sea, a helicopter may be dispatched. During large public events, public ambulance services are often complemented by organizations such as the Red Cross or the St John's Ambulance Services staffed by trained volunteers.

Emergency care is initiated in the ambulance. First, the patient is stabilized and then, depending on how urgent the situation is, treatment may be started on site or within the ambulance during transfer. Thrombolysis is not given in ambulances. Primary percutaneous coronary intervention (angioplasty) is performed on site within the hospital.

Ambulances take patients to Mater Dei Hospital, Malta or the Gozo General Hospital A&E Department (depending on location), where the patient is triaged by a specialist nurse who assesses the urgency of the case.

Following assessment by an emergency physician, the patient will receive emergency care within the A&E Department and, if further inpatient care is required, will be admitted to hospital. Patients requiring follow-up ambulatory care are provided with a follow-up appointment, or referred for follow up with their family doctor. Minor emergencies are also handled by GPs at the primary care health centres.

■ 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. Relevant issues might include:

- 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


▪ *Some of the information in this section will have been provided in previous sections (for example, Section 2.5.2 Regulation and governance of pharmaceuticals). Instead of repeating it, please cross-reference where appropriate.*

▪ *for example, manufacturers, importers, parallel importers, wholesalers and pharmacies*


▪ *for example, through supermarkets*

 Discuss policies to improve cost-effective use of pharmaceuticals. Relevant issues might include:


- 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 (for example, fines)
- *for example, information, prescribing by active ingredient, prescribing budgets, prescribing guidelines, prescribing feedback*
 - *for example, substitution by pharmacists, dispensing budgets, margins that encourage generic dispensing*

 Comment on the accessibility, adequacy and quality of pharmaceuticals and pharmaceutical care. Relevant issues might include:

- whether pharmaceuticals are covered as part of the statutory system
- the location of pharmacies
- changes in the services provided by pharmacies

 Discuss levels of consumption of pharmaceuticals. Relevant issues might include:

- pharmaceutical expenditure per capita
- the retail price for the most common medications

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


Provide a box on waste in pharmaceutical spending, using no more than 200 words.


BOX 5.5 Is there waste in pharmaceutical spending?


Discuss the key issues in your country with regard to waste in pharmaceutical spending. Consider the following issues:

- Are there attempts to promote rational prescribing and the use of generics and, if yes, how successful are they?
- What is the impact of policies to increase the share of generic medicines as % of the market?
- What is known about adherence to cost-effectiveness guidelines?

■ 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.


- *Cross-reference to Section 7.6 Health system efficiency.*

Rehabilitation: care that aims to cure, improve or prevent a worsening of a condition, for example, 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.*


■ 5.8 Long-term care

 Describe the provision of long-term care services and the services available for informal carers. Relevant issues might include:

- 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
- 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.

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 Mental health care.

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


■ 5.9 Services for informal carers

 Describe the provision of informal care, and the services available for informal carers. Relevant issues might include:


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


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

■ 5.10 Palliative care

 Describe the organization and provision of palliative care services, including settings, responsible organizations, nature of providers and functions. Relevant issues might include:

- 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.

 Describe 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.

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 (for example, within hospitals, hospices, day care centres);
- palliative care offered in the home;
- bereavement support services for families.


- *for example, 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. Relevant issues might include:


- availability of specific services to deal with special problems that may be faced by certain groups of individuals
- 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. Relevant issues might include:

- availability of specialized mental health professionals
- location of care (e.g. primary health care, general hospitals, 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. Relevant issues might include:

- 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

- *for example, refugees, asylum seekers, internally displaced persons or military personnel*


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

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


- *Cross-reference to Fig. 4.1.*

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

- *for example, fluoridation, school education programmes*

 Comment on the accessibility, adequacy and quality of services and facilities. Relevant issues might include:

- 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.


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

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.


The maximum word length for this chapter is 2 000 words (including tables and boxes).

■ Chapter summary

-  Please provide the key messages of the chapter in the form of five or six bullet points (maximum 300 words).

■ 6.1 Analysis of recent reforms

TABLE 6.1 Major health reforms


 Please list major reforms and policy initiatives that have had a substantial impact on the health system in chronological order.

This section focuses on the reforms that have taken place since the last HiT or in the last 5–10 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 2.1 Historical background.

Relevant issues might include the distinction between rhetoric and reality. Although it is useful to look at the political agenda and priorities in health policy, it is also necessary to look at what is actually being 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.

 In the main text for each principal reform describe:


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

In doing so, 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


 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 briefly 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.

- *for example, geographical inequity in access, rising costs, poor perceived quality, inefficiency, excess/inappropriate capacity*

Obstacles to reform can include:

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

- *for example, forthcoming national and regional elections and the impact of EU legislation*

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

7

Assessment of the health system

This chapter provides an overall assessment of the health system and how well it achieves key health system goals. It draws on the material presented in the previous chapters and provides additional data and analysis.

The maximum word length for this chapter is 6 000 words (including tables and figures).


The assessment of the health system starts with exploring the overall governance of the health system. The following sections analyse the accessibility of health services and the degree of financial protection, which highlights how well people are protected against the financial consequences of illness. The next section explores the quality of health services provided, including primary health care, secondary and tertiary care, and an assessment of how well services are integrated. Health system outcomes are assessed in the following section. The final section on health system efficiency relates health outcomes to health system expenditure, assesses the allocation of resources to different types of health services and identifies areas of waste.

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, because these can illustrate developments in health system performance within a country
- discuss health system performance in your country in comparison with other (similar) 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


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

■ Chapter summary


-  Please provide the key messages of the chapter in the form of five or six bullet points (maximum 300 words).

■ 7.1 Health system governance


Assess the overall governance of the health system.

 Discuss how transparent the health system is. Relevant issues might include:

- health policy development and implementation
- the extent to which people are aware of the health benefits to which they are entitled
- issues around financing mechanisms (e.g. the existence of informal payments)
- the impact of reforms and initiatives to enhance transparency
- overall governance indicators (where relevant)

 Discuss how accountable the health system is. Relevant issues might include:

- how priorities are set for improving health system actions and standards
- 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
- the impact of reforms and initiatives to increase accountability

 Discuss population participation and involvement. Consider:


- patient involvement in treatment decisions
- the impact of reforms or initiatives to improve user experience

- *for example, the existence of informal payments and tax/contribution evasion*
- *for example, ranking from Transparency International [<http://www.transparency.org/>]*

- *for example, central targets, choice and competition, local democracy, performance reporting, etc.*


- *Cross-reference to Section 2.8 Person-centred care.*

- mechanisms by which patients can influence the purchasing decision by political or administrative means:
 - individually
 - collectively

 Discuss the capacity of the health system. Relevant issues might include:

- How well developed capacity is for the different stages of policies, including evidence review, problem identification, policy formulation, policy adoption, implementation, and monitoring and evaluation

■ 7.2 **Accessibility**

 In discussing access to health services, relevant issues might include:

- Population coverage
 - Who is covered by health care?
 - Who is excluded?
- Benefits package
 - scope of coverage, that is, what services are people entitled to
 - whether benefits are the same across the population
- Availability of services
 - factors or barriers that impact on the effective delivery of care: distance, opening hours, waiting time, choice, preferences.
 - waiting times for elective surgery
 - insufficient services in remote areas


- *for example, representation in decision-making bodies; electing the board of purchaser organizations; participating in surveys*
- *for example, appealing to court*

This section focuses on access to health services (for example, financial, geographical, cultural, supply-related). It should indicate the extent to which there are problems or barriers in access to health services, along three main categories: population coverage, benefits package and availability of services. The fourth category of accessibility – affordability – is covered separately in Section 7.3 on Financial Protection. Refer to published studies where possible.

- *Cross-reference to Box 3.1 Key gaps in coverage.*

- *for example, cataract surgery, or hip or knee replacement (see data in OECD Health Statistics)*

- the distribution of health workers and facilities across the population
- cultural or language issues

 As a general indication of accessibility please discuss data on unmet need for medical and dental care (due to financial reasons, distance and waiting times)

Please also consider:

- any evidence to suggest that the use of health services is related to factors other than need
- survey data on the affordability of health care
- 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


FIG. 7.1 Unmet needs for a medical examination (due to cost, waiting time, or travel distance), by income quintile, EU/EEA countries, latest available year

- *Make allowances for an acceptable level of inequality; for example, highly specialized centres are likely to be concentrated in urban centres.*
- *Cross-reference to Boxes 4.1 and 4.2 on the Geographical distribution of health facilities and health workers.*
- *for example, data from the EU Statistics on Income and Living Conditions survey (EU-SILC), giving information on unmet medical and dental care (this information is also available by income quintiles (see Fig. 7.1)*
- *for example, income level or socioeconomic status*
- *for example, surveys asking people whether they have foregone care for financial reasons*
- *for example, lower socioeconomic groups, ethnic minorities, older people, (undocumented) migrants, unemployed people*

Figure to be supplied by Observatory staff using Eurostat data.

■ 7.3 Financial protection

FIG. 7.2 Share of households that experienced catastrophic health expenditure, latest year for all countries with data available

 Discuss the degree of financial protection the health system provides. Relevant issues might include:

- OOP household spending on health, its distribution across different groups of people and its structure (for example, which health services it is spent on)
- longitudinal data showing changes in the extent, distribution and structure of OOP household spending on health
- 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
- evidence of financial hardship due to using health services

Financial protection means ensuring people do not face financial hardship when they use health services. It 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, as well as by the quality and timeliness of service delivery.

Universal health coverage means all people are able to use needed health services (of sufficient quality to be effective) without experiencing financial hardship.

It is a way of framing the following health system goals:


- **equity in service use** – reducing the gap between need and use
- **quality** – ensuring services are effective enough to improve health
- **financial protection** – ensuring no one experiences financial hardship as a result of paying for services

Figure to be supplied by Observatory staff.

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

Financial hardship 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).

■ 7.4 Health care quality

 Discuss health care quality in primary and hospital care.

For primary care consider:

- quality of primary care for chronic conditions, for example, avoidable hospital admission rates for asthma, chronic obstructive pulmonary disease, congestive heart failure, hypertension, diabetes and diabetes-related complications (Fig. 5.3)
- quality of primary care in terms of antibiotic prescribing (overall prescribing volume and proportion of quinolones and cephalosporins among all antibiotics prescribed in primary care)

FIG. 7.3 Avoidable hospital admission rates for asthma, chronic obstructive pulmonary disease, congestive heart failure, hypertension and diabetes-related complications, country and selected countries

For hospital care consider:

- in-hospital mortality rates (deaths within 30 days of admission) for admissions following acute myocardial infarction, haemorrhagic stroke and ischaemic stroke, procedural or postoperative complications (Fig. 7.4)
- Cancer survival rates for selected cancers (Fig. 7.5)

FIG. 7.4 In-hospital mortality rates (deaths within 30 days of admission) for admissions following acute myocardial infarction, haemorrhagic stroke and ischaemic stroke, country and selected countries

FIG 7.5 Cancer survival rates for colon cancer, breast cancer (among women), and leukaemia (among children)

- *Cross-reference to Box 5.2 on the strengths and weaknesses of primary health care.*

Figure to be supplied by Observatory staff.


Figure to be supplied by Observatory staff.

Figure to be supplied by Observatory staff.

For overall quality of care consider:

- development and implementation of clinical guidelines
- integration of care between different providers and levels of care
- patient evaluations of the care they receive
- the impact of reforms and initiatives to improve health care quality and safety

■ 7.5 Health system outcomes

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

- mortality amenable to health care intervention (Figs 7.5 and 7.6)
- the factors that have contributed to changes in population health and whether these are related to health care/public health/health policy/lifestyle/other (for example, changes in tobacco and alcohol control policies)
- any studies showing whether health improvement occurred as a result of health policy or health care interventions

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

FIG. 7.6 Preventable and amenable mortality in country and selected countries, 2000 and latest available year

FIG. 7.7 Main causes of amenable mortality in country, 2000 and latest available year

If amenable mortality data are not available for your country, discuss instead how the country performs on the Healthcare Access and Quality Index (HAQI), its position relative to selected countries, changes over time, and main causes of index position and changes over time.

- *Cross-reference to Box 5.3 on integration of care*
- *Cross-reference to Box 5.4 on patient evaluations of the care they receive*

- *Cross-reference to the relevant sections in Chapter 1 Introduction.*

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 or wider public health policies.


Amenable mortality refers to deaths which should not occur if people have access to timely and effective health care.

Preventable mortality is broader and includes deaths which could have been avoided by public health interventions focusing on the wider determinants of public health, such as behaviour and lifestyle factors, socioeconomic status and environmental factors.

- *Cross-reference to Section 2.5 Intersectorality; Section 5.1 Public health; Box 5.1 on whether public health interventions made a difference*
- Figure to be supplied by Observatory staff.*

Figure to be supplied by Observatory staff.


Equity of outcomes

 Discuss how health and health service outcomes differ across different population groups. This might include:

- socioeconomic groups
- geographical regions
- the impact of reforms to address health inequities

■ 7.6 Health system efficiency

■ 7.6.1 *Allocative efficiency*

 In discussing allocative efficiency, relevant issues might include:


- whether the health system is providing an appropriate mix of services or interventions that maximize health improvements
- mechanisms for setting priorities and the use of evidence about effectiveness and cost-effectiveness
- the use and quality of risk-adjusted resource allocation formulae
- trends in the balance of allocation between different sectors
- the impact of reforms or initiatives to increase allocative efficiency

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

- *Cross-reference to Table 3.2*


- *Cross-reference to Box 3.3 on whether resources are put where they are most needed.*

■ 7.6.2 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:

- *hospital care*: trends in average length of inpatient stay, day case surgery rates, preoperative bed days, variation in surgical thresholds, variation in emergency admissions, variation in outpatient appointments
- *human resources*: the impact of policies to change the skill mix, staff turnover, sickness absence rates, agency costs, specialist productivity
- the impact of reforms or initiatives to increase technical efficiency
- the efficiency of pharmaceutical spending

FIG. 7.8 Amenable mortality per 100 000 population versus health expenditure per capita, country and selected other countries

 Discuss sources of waste and inefficiencies in the health system. Assess the success of policies to achieve cost control and improve the sustainability of the health system. Consider the issues depicted in the following table:

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.*
- *for example, to make greater use of nurses/ dental assistants in place of physicians/ dentists*
- *Cross-reference to Box 5.5 on whether there is waste in pharmaceutical spending*

Figure to be supplied by Observatory staff.

Fig. 7.8 should be used as an entry point for a more detailed discussion on how a country is using its resources. Amenable mortality is used here as a proxy indicator for how efficiently resources are being used.

Sources of technical inefficiency

SOURCE OF INEFFICIENCY	POSSIBLE REASONS FOR INEFFICIENCY
Health care workers: Inappropriate or costly staff mix	Conformity with predetermined HR policies and procedures; resistance by medical profession; fixed / inflexible contracts
Medicines: Under-use and overpricing of generic drugs	Inadequate cost controls on prescribers; lower perceived efficacy / safety of generic drugs; historical prescribing patterns
Medicines: Irrational use of drugs	Consumer demand / expectation; limited knowledge about lack of therapeutic effect; inadequate regulatory frameworks
Medicines: Sub-standard or counterfeit drugs	Weak drug regulatory structures; weak procurement mechanisms
Health care products: Over-use of procedures, investigations and equipment	Supplier-induced demand; fee for service; fear of litigation (“defensive medicine”); inadequate guidelines / review
Health care services: Sub-optimal quality of care and medical error	Insufficient guidelines, standards or protocols; poor coordination; inadequate supervision
Health care services: Inappropriate hospital size	Uneven historical development of hospitals; inadequate planning, coordination and control
Health care services: Inappropriate hospital admissions or length of stay	Lack of alternative care arrangements; insufficient incentives to discharge; limited knowledge of best practice
Health system leakages: Corruption and fraud	Corruption; unclear resource allocation guidance; poor accountability mechanisms
Administrative complexity: Inefficient or misguided rules	Lack of standardized forms, hidden administrative costs

Source: adapted from Chisholm and Evans (2010) Improving health system efficiency as a means of moving towards universal coverage, World Health Report (2010) Background Paper, 28; and Berwick and Hackbarth (2012) Eliminating Waste in US Health Care, *JAMA*, 307(14):1513–16.

8

Conclusions


The aim of this chapter is to:

- highlight the main lessons learned from recent health system changes and reforms in the country
- summarize remaining challenges and future prospects, in particular with regard to the (financial) sustainability and resilience of the health system.

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

Appendices

■ 9.1 References

 Include references to publications that were used as sources of information within the HiT. Use the following referencing style:

Book

Jordan P. *Schistosomiasis – The St Lucia project*, 2nd ed. Cambridge, Cambridge University Press, 1985.

Chapter in book

Pawlowski ZS. Control of ascariasis within primary health care. In: Crompton DWT et al., eds. *Ascariasis and its public health significance*. London, Taylor & Francis, 1985:245–252.

Journal article

Feldmeier H et al. Clinical experience with metrifonate. *Acta Tropica*, 1987, 44:357–368.

Electronic materials

GSÖ (2017). Themenbereich: Zahngesundheit für Volksschulen. Baden: Gesellschaft der Schulärztinnen und Schulärzte Österreichs. (<http://www.schulaerzte.at/unsere-themen/zahngesundheit.html>, accessed 26 July 2018).


Vernacular-language references

References can be given in any of four languages (English, French, German and Russian). References in other languages require translations of the title.

Jordon JR. Desarrollo psicomotor del niño [Psychomotor development of the child]. In: *Temas de pediatría [Aspects of pediatrics]*. Havana, Editora Universitaria, 1976.

Bibliographical references should be presented in the Harvard (also known as Author–date) system throughout the text and in the referencing style given here at the end of the document.

■ 9.2 Useful web sites


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

■ 9.3 HiT methodology and production process

 A standard text describing the HiT process

Text will be supplied by Observatory staff.

■ 9.4 About the authors

 Each HiT author should provide a short (two or three sentences) note on their background, current role and affiliation.



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