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Health Targets and Policy Making in CEE.
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Discussion Paper

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Introduction

The purpose of this paper is to explore the possibility of using the concept of health targets for helping construct a coherent health policy in Romania. The Romanian health system is undergoing a deep change. A series of structural reforms are implementing. The introduction of social insurance has increased the resources available to the system. However, the initial hardship brought by the start of transition has allowed the health statistics to deteriorate. The health system is facing high demands, and has proven prone to periodic crisis.

Health targets represent management by objective: a change of focus from the process of health delivery to the health outcome. It is conceivable that such an approach would be instrumental in establishing priorities and rationing health care delivery in Romania. This paper is not about setting the right health targets for Romania, but about how to go about setting them. In order to assess this, I shall look at the experience of Hungary: a similar post-communist health system, but with a considerable experience in employing health targets. Of special interest is the case of the Hungarian region of Szabolcs-Szatmar, largely acknowledged as the most successful employment of health targets in Hungary.

The first part of the paper will deal with the concept of health targets, its origin, and the most relevant international experience in employing them. Then I shall look at the Romanian health system: I shall present the path of change, and the main challenges faced by the system. Of special interest are the motivation structure and the policy-making and resource allocation mechanisms. In dealing with the Hungarian health system, a rather similar one to the before described Romanian one, I shall focus mainly on the relevant differences. Then I shall dwell on the experience with implementing health targets in Hungary. Finally, I shall speculate on the possible implementation of health targets in Romania.

The conclusion of the study is that health targets are a tempting instrument for health policy. They offer the chance of overcoming a serious lacking of the system design, both in Hungary and in Romania: a lack of incentives for payers (social insurance funds) to put pressures on providers to deliver in the public interest. However, for this to come true there is need of political will – elected officials taking the initiative to serve their constituents. The experience in Szabolcs-Szatmar has shown that the implementation of health targets require a large coalition of stakeholders (both governmental and society actors). But this coalition is unlikely to operate on voluntary basis alone, and this creates limits on what can be achieved in a regional setting alone. While different targets can be employed in different regions, the institutional framework has to be set from the national level. The actor best suited for leading the process of health targets setting and implementation is the Ministry of Health and Family, that posses both the expertise and the institutional authority for leading the process as well as having a vested interest in such a scheme.

Setting health targets. Theoretical Framework

For the beginning I shall provide a short definition of health targets (*Definition of health targets*). For a better understanding of what health targets mean, I consider necessary to look back at the first efforts to bring on the agenda this new model for addressing health policy (*When and how we start: short history for setting targets for health & The global background for health targets*). An overview on how things were dealt with at a regional level is provided by the approach in the WHO Europe region (*The European approach*). Finally, I present a theoretical model of “the health policy cycle” and the role of health targets (*Methodological*

background for health targets: a model for problem-solving – the health policy cycle). In addition, I include a dictionary that explains the professional jargon (*Short glossary*).

Definition of health targets

“Health targets are specific, quantifiable, and measurable objectives to improve health as a part of a comprehensive health care strategy on a national level¹”. The fundamental purpose is to improve people’s health through setting clear objectives to be reached within a certain period of time. The basic principle is that the governments should assume dual accountability, not only for the resources they invest in health care and the manner these resources are allocated, but also for the improvement gained in the health status of the population².

When and how we start: short history for setting targets for health

In 1979, a global strategy now known as *Health for all by the year 2000* (HFA) was launched by a resolution of the World Health Assembly endorsing a declaration from a conference on primary health care, which was organized in Alma Ata. This declaration invited World Health Organization (WHO) member states “to act individually in formulating national policies, strategies and plans of action for attaining this goal, and collectively in formulating regional and global strategies”³.

Twelve global targets were set and a system for monitoring progress towards their achievement was agreed upon. It was clarified from the start that this was not a separate WHO strategy, but rather an expression of individual and collective national responsibility, fully supported by WHO. Setting global targets for health was nothing new: targets had been set, for example, for the eradication of certain communicable diseases. It was however the first time a comprehensive approach was taken⁴.

The global background for health targets

The global strategy HFA reflects a broader concern in the United Nations family for a stronger focus on equity and inter-sectoral action⁵. The benefits of economic growth were not reaching all society’s sectors, and with mixed consequences. The United Nations General Assembly launched an international development decade in 1974, stating that “the ultimate objective of development must be to bring about sustained improvement in the well-being of the individual and bestow benefits on all. If undue privileges, extremes of wealth and social injustice persist, then development fails in its essentials purpose”⁶.

¹ Australia Department for Human Services and Health, “Better health outcomes for Australians: national goals, targets, and strategies for better health outcomes into the next century”, Canberra: Commonwealth of Australia, 1994, in Croatian Medical Journal, 39 (3): 332-338, 1998, quoted in “Health Targets as an Instrument for Improving the Rational Framework of Healthcare Decisions”, Dorange, Chantal T., Haim-Nemerson, Muriel;

²Dorange, Chantal T., Haim-Nemerson, Muriel, “Health Targets as an Instrument for Improving the Rational Framework of Healthcare Decisions”, in Croatian Medical Journal, 39 (3): 332-338, 1998, page 333;

³ World Health Organisation, “Global strategy for health for all by the year 2000”, Geneva, WHO, 1981 in European Journal of Public Health, volume 10 no. 4 December 2000 supplement quoted in Ritsakis, Anna, “Experience in setting targets for health in Europe”;

⁴ Ritsakis, Anna, “Experience in setting targets for health in Europe”, in European Journal of Public Health, volume 10 no. 4 December 2000 supplement page 7;

⁵ see Ritsakis A. “Using the Health for All framework to explore health policy development in the WHO European Region” in Ritsakis A., Barnes R., Dekker E., Harrington P., Kokko S., editors, “Exploring health: policy development in Europe”. Copenhagen: WHO Regional Office for Europe, 1999, pages 1-24;

⁶ Resolution 1494 (XLVIII) of the Economic and Social Council of the UN and resolution 2681 (XXV) of the General Assembly, in Ritsakis, “Experience in setting targets for health in Europe”;

The shifts in policy focus reflected efforts for integrated approaches to development planning and more appropriate indicators of social development in the member states of the UN. If we look at the health field, the rapid growth and technological advances of the 1960s had allowed increased spending on health care and optimism that many of the main challenges to public health could be brought under control. By the 1970s there was growing concern that, despite these advances, people's health was not as good as it could be⁷.

The European approach

Starting from the global strategy HFA, the European states had developed in the early 1980s a list of 38 health targets to be achieved by the year 2000 or earlier. These targets were unanimously adopted in 1984. 12 targets aimed to reduce mortality and the incidence of a number of diseases (chronic and infectious diseases, cardiovascular diseases, cancer, accidents, mental disorder and suicide), improve the health of certain groups (the handicapped, the elderly, children and women), reduce differences in health between groups and enhance the quality of life. In addition, there were targets aimed at the promotion of healthy life style (5 targets), a healthy environment (8 targets), the provision of good and accessible health care (6 targets), and the development of national Health for All policies (7 targets)⁸. These targets are enumerated in Annexes 1.

Each European country was supposed to elaborate these targets in its own way. The WHO/EURO had proposed a large number of indicators for monitoring the progress. On every three years the member states should report the progress in achieving the 38 targets.

A few years earlier, in 1982, the European states members of the WHO/EURO agreed on some conditions that the health target should accomplish:

- Directed at a significant health problem
- Reliable (expressing a reduction in the identified problem)
- Realistic
- Simply and clearly expressed
- Quantified as far as possible (making progress measurable)
- Relevant to the regional strategy for HFA
- Politically acceptable
- Meaningful and attractive to the public, politicians, administrators and professionals

The HFA strategy of the WHO/Euro influenced the thinking of many policy-makers in the field of health. However, many experts have expressed critics on the targets, arguing that they were too ambitious and based too much on political desirability and not enough on scientific (especially epidemiological) considerations⁹.

As a result, in May 1998 the World Health Assembly adopted "Health for All in the 21st century", a new global strategy with 10 targets and focusing on the developing world. In September 1998 the WHO/Euro approved a renewed HFA, called "21 targets for the 21st century: A public guide to the Health for All policy for the European region"¹⁰.

⁷ Ibid. Ritsakis page 7;

⁸ P.A. van de Water, Harry, M. van Herten, Loes, "Health Policies on Target? Review of Health Target and Priority-Setting in 18 European Countries", TNO Prevention and Health, Public Health Division, Leiden, 1998, page 40;

⁹ Ibid. Van de Water, van Herten, page 40;

¹⁰ Ibid. Van de Water, van Herten, page 40;

The 21 targets are as they follows:

1. European solidarity for health
2. Equity in health
3. Reducing non-communicable diseases
4. Reducing communicable diseases
5. Healthy aging
6. A healthy start in life
7. Health of young people
8. Reducing injury from violence and accidents
9. Improving mental health
10. Settings for health
11. Healthier living
12. Reducing harm from tobacco, alcohol, drugs
13. A healthy and safe physical environment
14. Multi-sectoral responsibility for health
15. An integrated health sector
16. Funding health care and allocating resources
17. Managing quality of care
18. Research and knowledge for health
19. Policies and strategies for Health for All
20. Developing human resources for health
21. Mobilizing partners for health

Source: WHO/Euro, 1998;

Van de Water, and Van Hertem have studied the implementation of health targets in 18 European countries. The data were collected until July 1998. The focus of the study were the influence of the WHO's Health for All strategy on the acceptance of the health targets idea at a national level, the practical use of health targets at a national level (in terms of goals, objectives and qualitative or quantitative targets) and the support provided by existing health information systems for a health target approach. A summary of the findings of the study is presented in the table below, and more details are provided in Annexes 2.

Country	Inspired by the WHO	Use of health targets	Information system
Austria	Yes	Yes	Existing system
Czech Republic	Initially yes	Not really	Expanded system
Denmark	Not really ^a	Not really	Expanded system
Finland	Initially yes ^a	Yes	Existing system
France	Yes	Yes	Expanded system
Germany	Yes	Yes	Expanded system
Hungary	Yes	Yes	Expansion planned ^b
Ireland	Yes	Yes	Expanded system
Italy	Yes, late	Yes	Existing system
The Netherlands	Yes	Not really	Expanded system
Norway	Initially yes	Yes	Existing system
Poland	Yes	Not really	Expansion planned ^b
Portugal	Yes, late	Not really	Expansion planned ^b
Romania	Yes	Yes	Expansion planned ^b
Spain	Yes	Yes	Expanded system
Sweden	Yes	Yes	Expanded system

Switzerland	Yes	Yes	Expanded system
UK	Yes	Yes	Expanded system
A: The Health for all strategy confirmed existing principles			
B: 'Expansion planned' may vary from being aware of inadequacies in the system to concrete plans for improvement			

The study of the two authors concluded that in most of the countries studied, health policy was inspired by the *Health for All by the Year 2000* strategy, but this does not mean that these countries have fully developed health targets in their health policy. Most countries use health targets as a political tool and only a few countries, such as UK and Spain, have elaborated the health target approach beyond the policy to the practical level. In most other European countries, the idea of health targets has gained political support, which is an important condition for further development.

Methodological background for health targets: a model for problem-solving – the health policy cycle

We can represent the health policy development as a four-step problem-solving process:

1. Understanding the problem: analyze developments in the health of population
2. Solving the problem: decrease future burden of disease and cope with existing burden of disease
3. Implementing solutions: organization and finance
4. Evaluating effectiveness and efficiency

The health status of a population depends on a number of determinants, and the causal relationships are all but clear. In 1974 the Canadian Ministry of Health presented a new outlook on health when it issued "A New Perspective on the Health of Canadians: A Working Document". According to this new concept, there are five categories of factors that can influence public health¹¹:

- a. Biological factors, e.g. hereditary (genetic) properties of individuals
- b. The physical environment, including air, water and soil, but also temperature, sound, radiation and microorganisms
- c. The social environment, i.e. the influence of family and society on the (mental) health of the individual
- d. Lifestyle factors, such as smoking, nutrition, physical exercise, use of alcohol and drugs
- e. The health care services

This approach has left traces in the strategies concerning public health that were later to be adopted.

We can identify six additional crucial questions that have to be taken into consideration when setting health targets¹²:

1. What is the present state of population health?
2. How can we decrease the future burden of disease?
3. How can we cope with the existing burden of disease?

¹¹ In van de Water, van Hertten, pages 34-35;

¹² Cf. to van de Water, van Hertten, pages 34-35;

4. What are the necessary organizational changes?
5. How should the activities needed to achieve the health targets be financed?
6. How should the policy be evaluated?

Finally, I shall attempt to clarify the jargon used, and especially to delimitate the concept of target from other policy tools.

Short glossary¹³

I use the term *policy* as an agreement or consensus on issues to be addressed in order to achieve a desired result or change.

A *goal* refers to the long-range aims of society and is usually expressed in rather general terms. In many national policy documents it is frequently used interchangeably with the term *objective* that is rather more specific than a goal and is an aim that can be partly achieved during the planning period.

A *target* is an intermediate result towards the achievement of goals and objectives; it is more specific and has a time horizon. A target needs to be specific, measurable, accurate, and realistic and time bound (SMART). Sometimes targets and indicators are confused. An indicator describes a given situation, but if there is a decision taken to change that situation, by changing the ratio of the specific indicator in a certain period of time, then we deal with a quantified target.

The term *strategy* refers to the broad line of action for achieving the goals and objectives¹⁴. This would include identifying suitable points of intervention and ways of involving other sectors, considering the range of political, social, economic, managerial and technical factors that can affect the strategy and defining the possible constraints and ways of dealing with them¹⁵.

Reforming the Romanian Health Sector

Health Status

Central Eastern European countries had better health statistics than their GDP would have predicted (Chellaraj, 1996). Romania is the exception from this point of view. Romanian health expenditure at about 3% of GDP was lower than in its neighbours. Life expectancy was also lower and infant mortality higher. Due to the natalist policies of the Ceausescu regime, abortions were all but illegal, what resulted in horrific mother mortality rates. Based on anecdotal evidence, in the late 1980s malnutrition cases were reappearing. Morbidity of communicable diseases was also higher - especially hepatitis (A and B) and tuberculosis. The main AIDS population were children, as result of infections through the medical act. However, cardiovascular diseases and cancer represent the main mortality cause. (BASYS, 1997). Unlike other CEE countries, like the Czech Republic, the Romanian health statistics did not improve over the 1990s. In some respects, the transition has negatively affected the health status of the population.

Pre-reform Health Structure

¹³ World Health Organisation, "Terminology for the European Health Policy Conference: a glossary with equivalents in French, German and Russian, Copenhagen: WHO Regional Office for Europe, 1994;

¹⁴ World Health Organisation, "Global strategy for health for all by the year 2000", Geneva, WHO, 1981;

¹⁵ Ibid. Ritsakis, page 8;

The structure of the health care system was typical for the soviet model. The organisation of the healthcare was regulated mainly by Law 3/1978 on the providing healthcare to the population, further amended by other laws and decrees. The health system had a centralised, hierarchical structure, in accordance with the whole political system. It was, and still is, almost entirely public, delivering 'free' medical care, except for the pharmaceutical sector. The finance was provided by national taxes, through the budget. The public healthcare system was paid and managed by the Ministry of Health and its local structures, with three exceptions. The first exception was the existence of parallel systems operated by the Ministries of Transport, Interior, Defence and Labour, and by the secret service (after 1990 - Romanian Intelligence Service, SRI) and the State Secretariat for the Disabled. The second exception was a small number of facilities - especially dispensaries - operated and paid by enterprises. The third exception was that the patients were faced with official and unofficial co-payments that represent an important part of the income of facilities and staff. (BASYS, 1997)

The Ministry of Health was responsible for the management of the main healthcare network, as well as for devising health policy (including public health) and for medical education. The ministry carried out its functions through its specialised directorates. The basic administrative unit in the organisation of the health services was the county (judet). It was led by the Director of the County Health Authorities, appointed by the Minister of Health (after 1990 with the agreement of the prefect - the local representative of the central government). The district was divided into territorial units having at least a territorial hospital, a polyclinic and a general practice network (territorial and school dispensaries). In every district there were also infant shelters. Some districts have sanatoria and preventoria. A certain number of over-specialised or single speciality hospitals, medical institutes and centres, institutions for the continuous training of doctors and nurses were directly subordinated to the Ministry of Health.

Problems in the post-socialist health care system

Table 1 presents a summary of the shortcomings of the Romanian health system. The lack of adequate funding will be analysed later and the health status has been discussed above. While some of the prevention programmes were performing well, e.g. children immunisation, others were not effective enough, especially health education and contraceptives provision. This last failure was important because some poor health statistics are mainly explained by life-style factors (smoking, lack of physical exercise, unbalanced nutrition, risky sexual behaviour). Parallel health networks undermined the consistency of the health policy. Remote villages experienced worse access to health services, and the situation was made worse from this point of view by waiving the requirement for fresh graduates to spend a three year period in rural areas.

Table 1. Bottlenecks and problems in Romanian healthcare

*insufficient funding ⇒ especially low incentives for professionals *poor health indicators *inefficiencies:
⇒ emphasis on specialist care ⇒ high hospitalisation rates (but average length of stay) ⇒ surplus of hospital beds and low occupancy rates (but no staff surplus)

- * insufficient quality assurance
- * poor performance of some prevention programmes
- * existence of parallel health care systems
- * decreased access in rural areas
- * unclear ownership of facilities

source: BASYS, 1997

Objectives of reform

The main objective of reforms was to improve the health status through increasing the financial resources of the system, and reward the health personnel, improve efficiency, bring more flexibility and responsiveness to patient needs, develop primary care and public health and prevention measures. (BASYS, 1997)

Evolution after 1989

Changes in the health sector advanced in Romania at a much slower path than in other CEE countries. The consequence is that there was not much change in the fundamentals of the health status. The good part of this immobilism is that the situation did not deteriorate as in other countries of the region.

Starting from 2.37% in 1989, resources dedicated to health fluctuated between 2.82 - 4.04% of GDP (Chellaraj, 1997). While the relative fluctuation seems high, it was on the background of a mainly negative economic context. The rise in share of the national wealth dedicated to health partly compensated the drop in output during the so-called 'period of transition'. According to the World Bank estimates, between 1990-1993, the expenditure on health declined 15% in real terms, compared with an over 20% decrease in GDP (Chellaraj, 1996). This trend of conserving real expenditure on health continued after 1993. The impact on health services of the drop in real expenditure was even lower because, against expectations, the share of wages in total health expenditure declined (Chellaraj, 1996) - with the result that the average wage in the health sector dropped substantially below the national average wage.

The conservation in health services was also matched by constancy of important health statistics, like life expectancy. The major positive change is the substantial drop in mother mortality following the liberalisation of abortions in 1990 - from 170 death/100,000 live birth in 1989 to 60 in 1993. The reverse of the coin, is the upshot of (registered) abortions from 500/1000 live birth in 1989 to over 3000 in 1993 - Chellaraj, 1996. In addition to the huge increase in abortions, another negative phenomenon from a public health point of view was the substantial increase in smoking (trend matched over the whole region).

The institutional change did not go very far. The private sector was not very developed. Only (most of) dentistry and pharmaceutical services have been privatised.

Introduction of social insurance

Legal basis

The basic right to health care is guaranteed by article 33 of the 1991 constitution. After a lengthy passage through the bi-cameral Parliament, the Law of Social Health Insurance (LHSI) was promulgated by the president in July 1997 and came into effect on the 1st of January 1998. The system created by the new law was implemented over a transition period,

and started to work fully by 1st January 1999. Separate laws for the re-organisation of the hospital sector and for public health services were passed by Parliament at a later date.

The law institutes the health social insurance, financed by compulsory payroll based contributions. The system is administered by a decentralised network of regional health insurance funds, which contract the providers in the limits set by a national frame contract. The law gives the right for establishment of supplementary, volunteer private insurance. It guarantees the right of the patient to choose the provider at all levels and the insurer fund, but the general practitioner has the role of gatekeeper. The yearly national frame contract also specifies the basic package of services that has to be provided by each health fund. (LHSI, 1997)

Governance

The health system is decentralised. The payer becomes the county health insurance house, which collect the social contributions from members. There are regional insurance houses (one for each of the 41 administrative counties, plus the insurance house of Bucharest, the capital, that accounts for 10% of the population). In addition to the regional health funds, there is the National Health Insurance House (NHIH) that administers the solidarity (i.e. redistribution) fund to which the county houses have to contribute. The administration council of the county health insurance house and of the National Health Insurance House were to have separately elected representatives of employees, self-employed, retired, housewives, unemployed, students (art. 74). However, similar to Hungary, this provision was amended by Government Ordinance, and the boards are built on a corporatist basis, with one third of members nominated each by government (county council in the case of regional health funds), employers and trade unions.

The National Health Insurance House and the National College of Physicians negotiate the frame contract, with the agreement of the Ministry of Health and Family (MoHF) (art. 11.2). The frame contract provides the basic package of services provided and the reimbursement of providers. Within the limits set by the frame contract, regional health funds contract the local providers (general practitioners, hospitals etc.). NHIH and the MoHF decide annually the list of reimbursed drugs, with the agreement of the College of Physicians and the College of Pharmacists (art. 24.1). The big equipment purchases are approved by a national commission created by NHIH, MoHF and the College of Physicians (art. 46.2). NHIH and the College of Physicians are in charge with controlling the quality of medical services (art. 83), and the accreditation of medical personnel (art. 38), and, together with others, in designing the preventive programmes (art. 16.3). The same two institutions create a paritary Commission of Arbitration, whose decisions are executory (art. 85 - 87). The areas of responsibility are summarised in table 2.

The ownership of facilities is a pending matter, part of them moving in the administration of local government, and part being effectively privatised – even if by long term lease, rather than out-right transfer of ownership: the case of GP practices. The new administration, that was swept to power in the 2000 elections, intends to extend privatization to hospital sections, that would co-exist with public sections.

Table 2. Responsibilities of institutions

Tasks	Ministry of Health and Family	National Insurance House	College of Physicians
Framework Contract	X	X	X

Drug List	X	X	X
Approval of High Tech Medical Equipment	X	X	X
Health Care Programmes	X	X	X
Commissions of Arbitrage Quality of Services Surveillance Accreditation		X	X
Medical and dentistry services		X	X

X = Responsibility

Source: BASYS, 1997

Reform of Finance

The sources of financing health services are payroll social insurance, the state budget and co-payments (LHSI, art. 51). The payroll contributions amount to 7% of the gross wage paid by the insured and a matching of 7% of the total wage bill paid by the employer. The social contribution is deducted from the income, respective profit tax (art. 52, 53). Pensioners and the recipients of unemployment benefit pay from their benefits (art. 54). The contribution for the recipients of social aid is paid by the budget of social insurance (art. 55). (N.B. social insurance is separate from health social insurance). Some particular categories of expenses, the most important being capital investments, are paid by the national budget (art. 56). Co-payments apply mainly to drugs (art. 58).

These funds are collected to the regional health insurance fund, and 25% of their monthly revenues are transferred to the National Health Insurance House to form a solidarity fund, available to support those regional funds in financial difficulty – initially this amount was only 7%, but was later amended to 25%, out of fear that regional discrepancies could not have been smoothed out with such a limited redistribution. It has to be mentioned that some of the 25% transferred to the national fund may be returned to the source, so the effective scope of redistribution is more difficult to gauge.

There are reports of difficulties for the health funds in collecting the payroll contributions, in conditions when the access to health services is still unrestricted (in spite of the implications of the law). However, the introduction of social insurance has increased the overall resources of the health system, even in the conditions when the Ministry of Finance did not release all the funds collected (as was the case both in 2000, and 2001).

Primary Care

General practitioners represent approximately 30% of all physicians. Through the reforms initiated, general practitioners, called family doctors, receive the role of gate-keeper (art. 21.1) controlling through referrals the access to secondary care: hospitals (in-patient care) and specialists (out-patient departments). They are contracted by the county health fund of the territory where they have the cabinet. In order to be eligible for contracting they have to be legally accredited and to be members of the College of Physicians. General practice receives a higher emphasis in the medical education, being up-graded to a speciality status - previously the general practitioners were the non-specialist medical doctors.

The patient has the right to choose the family doctor and to change this choice after three months (art. 14.3). Primary care is free at the point of delivery, and co-payments apply only to pharmaceutical products.

Concerning the payment, the law is vague: it mentions capitation and / or fee for service (art. 45a). The system actually employed is mixed: weighted capitation together with fee for service for a group of prophylactic measures. Local authorities have the possibility to offer special inducements for medical personnel in under-served areas. A family doctor has 1000 - 1200 patients. If the number of patients rises to 1500 - 2000, then the value of point declines.

The main problem in the primary care sector is the lack of trained personnel for preventive activities and home aid. In addition, there is not a uniform coverage of the territory with GPs, with villages suffering heavily.

Secondary and tertiary care

The reform process has been most present in the structure of financing, and in primary care. Effectively, the health reform did not enter into hospitals and ambulatory specialist care.

The specialist sector

One of the aims of the Romanian reforms is to shift the emphasis from the secondary to the primary care. Table 3 illustrates this shift. Concerning specialist care the reforms envisage the transformation of all specialist facilities in out-patient hospital departments, and changing the payment from salary to fee for service. These changes are still pending however. To prevent this payment system resulting in supplier induced demand, access to specialist care is restricted to referrals only and will incur a co-payment. It is also possible for the specialist to have to pay a fee to the hospital for using its equipment, in order to discourage over-referrals to hospitals (BASYS, 1997). In the opinion of the author, very much depends on the value of the co-payment, because referral system per se is not a deterrent against over-use of specialist care: under capitation the GP is under pressure to 'please' the patient and referrals (and prescriptions) are one way to achieve this, especially that it might save time to the GP.

Table 3 Financial allocation to health care services

Kind of health care	Pre-reform	Envisaged
1. Hospitals	50%	35%
2. Secondary care	30%	30%
3. Primary health care	20%	35%

Source: BASYS, 1997

Hospital care

As presented in table 3, hospital care consumed most resources in the pre-reform system. Romania entered the reforms with an over-bloated hospital sector – not unlike most EU and CEE countries however. The main indicators used to assess the efficiency of the hospital sectors are:

- number of beds,
- occupancy rate
- number of admissions, and
- length of stay

On the last data available, Romania figures are at the higher end, but within the expected range, on all these indicators. The rate of admissions (about 20 / 100 people), and the length of stay (about 10 days) are in the higher numbers in WHO Europe region as a whole, and average for CEE countries. In addition, as much as 20% admissions might be social rather than medical cases. There are also wide differences in occupancy ratios across the sector, territorywise and according to the type of medical department. The occupancy rate (about 75%) is in the lower half of the WHO region league table, while the number of beds (over 7 / 1000 population) is in the higher one.

It is important that over the 1990s these indicators moved in the right direction. The number of beds declined sharply by about 20%, while the admission rate stayed practically the same. This boosted the occupancy rate. The length of stay declined by about 15%.

The over-use of hospital services is stimulated by the payment system. Currently, hospitals are financed by budgets. These are construed on historical basis, and the entire amount must be spent till the end of the respective financial year. The budgetary allocation has to deal mostly with the political ability of the manager, rather than with an objective need assessment. From this year is envisaged the move to the DRG system. Its impact remains to be seen.

The staff is paid by fixed salaries, but could make additional income for overtime and night shifts. However, on anecdotal basis, the largest share of doctors' income comes from patient payments.

Privatisation of laboratory and pharmaceutical services and 'hotel' facilities is under consideration, and there was some transfer of ownership of hospitals away from the central government (towards local authorities). However, key hospitals stay in state hands - they are defined as university hospitals and high performance central clinics.

In order to control the number of admissions strict referrals (from GPs and specialists) should be used for non-emergency services. These limits to access were introduced in 2001, but the implementation is still lax.

To date the stated objective of channelling resources away from the hospital sector, and into primary care has failed, as hospitals claim a growing share of system resources. This claim is substantiated in the table below. The table presents the actual break down of resource allocation inside the health sector. In parallel with the actual expenses, are presented the provisions of the frame contract (drafted at the start of the year), and of the summer budget – the mid-term correction of the budget.

Health expenditure: comparison between actual expenses and amounts provided by the National Frame Contract (NFC), and revised mid-term budget (MTB)

Tip serviciu	1998 Actual (%)	1999 NFC (%)	1999 MTB (%)	1999 Actual (%)	2000 NFC (%)	2000 MTB (%)	2000 Actual (%)	CoCa 2001 (%)
Primary care	9,01	15,5	9,48	9,05	14,5- 15	9,78	9,51	14,5-15
Out-patient (specialists)	5,85	11,75	6,62	6,11	8,75	7,85	7,23	8,75

Hospitals	67,25	40,00	61,24	64,18	59-61	63,99	65,48	50-53
Subsidised drugs	6,81	20,0	9,32	8,03	10-11	12,83	12,41	10
Dentistry	2,66	4,25	2,76	2,36	2,5-3	1,58	1,43	3
Rehabilitation services	0,82	1,00	1,17	1,11	1	0,63	0,65	1-1,2
Protesis	3,23	3,00	0,62	0,28	1	0,33	0,28	1
Ambulance services	4,32	4,50	3,80	3,67	3-4	3,00	3,00	3
Health programmes	0,06	0	4,99	5,20	0,1-1	0,00	0,00	8
Total	100	100	100	100	100	100	100	100

Source: Vladescu, 2000

Pharmaceuticals

There are a few elements worth noting about the pharmaceutical sector. First, it is the sector where privatisation went furthest. The retail sector is practically entirely private. Private capital made inroads in whole sales too, but the former state monopoly still has a strong market position. The privatisation of domestic manufacturers is pending. This higher proportion of private capital in the sector means that it is more sensible to market forces, and therefore the state has less scope for administrative decisions and more for using economic incentives.

A large share of the drugs is provided by international producers. The high proportion dedicated to the pharmaceutical expenditure, and the fact that much of it pays for imports, make this area of the health budget a priority target for cost-containment.

The lack of public funds leads to serious delays in reimbursing the pharmacist from the health budget for the price of 'compensated' drugs, what in turn lead to many pharmacies refusing to dispense drugs under the reimbursement scheme, and patients being forced to buy the drugs at the full price.

Since 1998, was introduced the reference price system. This system was encouraged by the World Bank and was in accordance with emulating the German experience – the assumed model for the Romanian health reform. Reference pricing is actually provided for by the Law on Social Health Insurance, but the wording is very vague. In addition to reference pricing, the law also states that pharmacists have the obligation to dispense the cheapest product when only the active substance is indicated, and to inform the patient of the replacement options (art. 48).

The government adopted the model one of reference pricing - grouping according to the active substance. The clusters include both generics and patented drugs - even if it means that some INN classes contain just one drug. The reimbursement level was established at 80% of the reference price. The main exceptions are children up to 16 years old and the war veterans. Reimbursement prices are supposed to be revised once a year, but this was not systematically observed in the past.

In addition to the reference price list, there is a separate list of fully reimbursed drugs. These are prescribed for very serious diseases (e.g. cancer, tuberculosis, diabetes, AIDS etc.). Prices for domestic producers are regulated by the Office of Competition (from the Ministry of

Finance) on a cost-plus basis, while foreign producers are allowed free pricing at entrance, but may not increase the price afterwards, and have to submit their prices in ten western countries for comparison. The hospital sector continues to fully reimburse the whole drug bill. Hospitals are supplied by tenders for INNs.

The system of paying the pharmacists was preserved on a regression basis. In addition to the cost-containment effects of reference prices, regional health authorities have the right to impose maximum prescribing monthly thresholds for physicians (both general practitioners and specialists) if they found it necessary for financial reasons.

Challenges or the reform process

Any evaluation of the Romanian health reforms has to take into account that it is still an open process. However, even on the elements that are certain alone, the changes in the Romanian health sector fulfil the criteria defining a reform process¹⁶. The replacement of the soviet style state integrated system with social insurance, based on purchaser provider separation, is an important change and has big institutional implications. Moreover, the changes has been introduced by a government with a clear democratic mandate, and follow in many respects the plans of the previous administration (that after 1996 formed the main opposition, and currently is back in government). Apart from the representatives of the electorate, the process involves the other main stakeholders of the health system, the health professionals, and therefore as far as can be predicted meets the political sustainability criterion too. There is not to be expected that the changes will prove financially unbearable either.

Once established that we deal with a genuine reform process, I shall further on evaluate its likely consequences and challenges, from the point of view of what is the interest of this paper: the governance of the system, the way health policy decisions are taken. I shall therefore focus on the overall funding of the system, the micro-economic incentives, and the accountability of the system. This fourth major criterion of health policy evaluation is equity, but the transition to social insurance is less problematic in this field.

Macro-efficiency

Unlike the established health systems of Western Europe and US, the challenge facing the Romanian healthcare is under-funding rather than spending too high a proportion of the national wealth. The health expenditure between 2.8 - 4% of GDP during the transition years, is less than half of what is spend in the developed world (around 9% in Germany - the model of Romanian reforms, or 13% in US). It is also less than in the neighbouring countries of Central and Eastern Europe, but according to the World Bank is consistent with what is to be expected at the current level of economic development of Romania (Chellaraj, 1996). However, behind the introduction of social insurance, in anything but name a hypothecated health tax, was the idea of solving the perceived under-funding of the sector.

How much social insurance will meet this end is debatable. It collects 7% of the pre-tax wage of the employees and another 7% of the employer's wage bill, what together account for up to 14% of the pre-tax personal income of earners¹⁷. In addition, the pensioners pay 7% of their income and the budget (state or social insurance) pays for under-aged and the unemployed.

¹⁶ For a discussion about these criteria, see Mossialos (1993)

¹⁷ A correction is needed for self-employed whose 7% contribution is not matched by a contribution from an employer.

One problem however is how much of this due amount is actually collected. One of the vulnerable spots of social insurance is the collection of contributions from the self-employed - the other CEE countries had encountered this problem too, case documented for the Czech Republic (Mullen, 1998). In addition, there are social categories whose income is difficult to estimate in monetary terms - as is the case with farmers. While all this is true, it is also true that these social categories that do not pay enough for social insurance would not have paid their income taxes either, so overall the transition to social insurance does not mean less resources.

However, the funding situation in Romania remains serious. Romanian health funds had difficulties receiving contributions including from state companies. While the Romanian government has had difficulties in collecting taxes and this had repercussions on health funding - e.g. the lateness of drug reimbursements to pharmacists - matters might have been made worse by the change to social insurance. It is conceivable that economic agents consider less dangerous to delay payments to health funds, what bears as maximum consequence that their employees will no longer have health coverage, than do break the law by not paying taxes to the treasury, and thus risk fines and theoretically even prison. There is a similar problem concerning social contribution for pensions, and one option under consideration is to criminalise the non-paying of social contributions. In addition, as mentioned elsewhere, even from the funds collected not the whole amount was available for the health fund¹⁸.

The situation was made worse, from a financial perspective, by the fact that hospitals continued to provide 'free' care, without asking for evidence of payment of contributions. This situation is allegedly to be remedied this year. Coupled with the lack of effective budget constraints on the hospital sector, and their strong political position in the system, this situation lead to hospital costs spiralling out of control.

Micro-efficiency

The same tools that are useful for reducing the macro-efficiency risk, by reducing competition, might reduce micro-efficiency in the same time. Le Grand in Robinson (1994) developed the conditions that would allow quasi-markets to approximate the efficiency of competitive markets - these conditions refer to: market structure, information, transaction costs and uncertainty, motivation and cream-skimming. In an environment with little competition like that provided by the Romanian reforms, cream-skimming and transaction costs are not likely to create problems. The market structure is represented by two local monopolies: the health fund and the association of physicians. Opposing monopolies satisfy Le Grand's criterion for quasi-markets, but, for reasons to be detailed in the next section, the author does not expect the health funds to be motivated to behave like perfect agents of the patient community. The market structure is further vitiated by the high entry barriers (legal monopoly of the physician association) while forced exit (i.e. bankruptcy) is not a likely alternative. Finally, if the health funds are captured by the providers, this will also vitiate the price-setting process, and with this the market information.

Choice and responsiveness

In theory the Romanian system assures the cherished freedom of choice of both provider and insurer. But since the health funds are in practice regional monopolies, the choice of insurer does not exist, except perhaps in a restricted way for people leaving close to the neighbouring

¹⁸ In 2000, the amount collected went over what is provided for in the budget law. This happened on one hand because the collection rate was better than anticipated, but mainly because the higher than expected inflation inflated the payrolls, and thus the contributions.

county. With the restriction of insurer comes the restriction of provider to those contracted by the respective insurer. While the choice is relatively wide concerning primary care practitioners, it narrows considerably when dealing with specialised care, especially hospital care. Perhaps more important than this is the fact that providers have limited room to differentiate one from another. They cannot compete on either price or the range of services, because these are stipulated in the national frame contract. The only thing left is, the otherwise important, quality of care.

The mechanism left open to the patients for adapting the system to their (perceived) needs is the representative mechanism. But the most important features of the system are provided through the frame contract, decided nationally - this reduces very much the power of the individual patient. The representative mechanism is designed on corporatist basis, what diminishes its democratic character and makes it more obscure. It is therefore likely that the whole negotiation process will be captured by providers (i.e. medical doctors).

Conclusion

Romanian healthcare reforms follow the convergence track with the other Central East European countries. The soviet style health system is replaced with payroll based social insurance, capitation for GPs and prospective budgets for hospitals become the main payment schemes for providers, and the reimbursement of drugs is based on reference pricing. Within this track the less controversial alternatives are being chosen - e.g. type one of reference pricing for drugs. Crucial, the current reforms deal at arm length with market mechanisms: they shy away from competition in the insurance market, and the competition between providers is tightly regulated. These choices confirm the cautiousness that characterised the whole approach to reform and allow Romanians to avoid the worst mistakes made in neighbouring countries, as exemplified by the Czech Republic.

The current reforms represent an improvement over the previous institutional set-up. Social insurance will improve the under-funding of the system, therefore ameliorating the macro-efficiency parameter. The question mark in this respect is the ability of the health funds to enforce the collection of the social contributions on one hand, and to impose budget constraints, on the other. The paper did not find evidence to support the claim that the introduction of social insurance will damage the good record on equity inherited from the communist health system, by limiting the coverage of medical assistance. The danger is however that the regionalisation of healthcare will increase the geographic inequalities in the distribution of health services that already existed in the previous regime.

The cautious and market-sceptic approach that makes us expect a relatively good performance on the macro-efficiency and equity criteria, leads the system to fare worse on the other two objectives of health policy: micro-efficiency and choice. Without competition between the insurance funds, with no possibility for the providers to compete on either price or the type of services provided, the market structure is vitiated and the choice for patients drastically reduced. The compensatory mechanism envisaged by the designers of the system is to replace the freedom to chose in the market with the representative mechanism in the boards of the health funds. Given the inherent limitations of this process, augmented by a cumbersome corporatist mechanism, the author is sceptic over the efficiency of this tool. The likely outcome is that the health funds will be captured by the providers (i.e. health professionals) they are supposed to negotiate with, what will maintain the provider-focused and paternalist nature of the Romanian health system.

The relevant conclusion is that the social insurance system put in place by the reform process, while an improvement on many fronts, is unlikely to produce the rationing, to set the priorities that the lack of abundant resources require. Moreover, there is no mechanism in the set up of social insurance that would produce the all-encompassing public health strategy, that is needed for an improvement in health outcomes, as opposed to the mere optimisation of healthcare delivery.

Health targets in Hungary

Healthcare system

Hungary has been the first country to launch the reform of the health system. The structure of the health system put in place by Romania after 1997, borrows very much on the previous Hungarian experience. That is why I should not go into much length to describe the set-up of the Hungarian system. There are somehow certain differences. The most important is that while Romania adopted a model of social insurance based on regional health funds (albeit with a large inter-regional redistribution, and a tendency for centralisation), Hungary opted for a single, nation-wide health fund, with regional branches only. The accountability of this national health fund was a hotly disputed issue. Built initially (like later in Romania) as an autonomous organisation, with a corporatist basis (elected board members, coming from the government, employee organisations and trade unions), its management was later accountable to different central government branches (chronologically: the Ministry of Health, Ministry of Finance, and the Office of the Prime Minister).

Another important difference, but with less relevance for our discussion, is that Hungary is the first CEE country to introduce DRG for the funding of hospitals.

Health targets

The debate on priorities in health policy began after the WHO launched the Health for All initiative. As I mentioned earlier, the Hungarian law adopted practically all the main points of the strategy, and lists priorities in health policy with the accent on health care. Qualitative and quantitative targets for population health have been set for the year 2010 and pilot projects for practical implementation have been started. The health information system is to be modified to meet these requirements.

Actually, efforts to develop a public health policy started as early as 1989. They were in conjunction with the reform process of health care – described above. The progress appears to have been limited however.

The experience in Szabolcs – Szatmar region

The employment of health targets in the eastwards region of Szabolcs – Szatmar is acknowledged as the most advanced such experiment in the country. It is indicative of this situation that the people who galvanised the project in Szabolcs – Szatmar have now received leadership positions in the national programme.

The region of Szabolcs – Szatmar used to have health statistics worse than the rest of the country. Life expectation was shorter and male mortality was especially high. This was related to higher than average incidence of cancer and of cirrhosis (both for men and women). Another main cause of mortality, similar to the national trend, is cardiovascular disease.

The root causes of these ailments was found in behaviour patterns – especially the high consumption of alcohol and tobacco. These became the focus of health targets in the region.

What is characteristic for the implementation of health targets in Szabolcs – Szatmar is the pioneering role taken by the regional Public Health and Medical Officer Service. There is a national umbrella for these offices, and it has a quasi-independent status. The National Medical Officer is taking a leading role in shaping the national programme on health targets.

To tackle the setting and implementation of health targets, the approach taken has been inter-sectoral. The strategy followed at the regional level has been the construction of a wide coalition of all conceivable stakeholders. Both governmental and NGO actors have been involved, coming from social, health, education, and economic fields, plus the media. What is the most relevant aspect in the whole approach is the consensual approach. The initiator had to convince the other stakeholders to take part in the process and all stakeholders worked together to reach a consensus on establishing the health targets and their implementation. The stakeholders agreed to create a county health association, including representatives of hospitals, the medical chamber, the public health authority, local government, trade unions.

At the time of writing, the outcome of this endeavour is uncertain. There has been a decrease in the mortality rate due to cardiovascular disease, but there has been no progress concerning cancer and cirrhosis. However, it is too early to judge on the success of the project. What is more significant at the moment is the success of the approach taken. Practically, we are dealing with a large voluntary coalition, encompassing all relevant actors, both governmental and societal. It is interesting that the coalition comprises the important healthcare sector stakeholders, both payers (health funds) and providers. But the coalition has been put together by a somehow marginal and under-employed actor, that possessed the right expertise. I believe these were the right ingredients for success. There are however limits to what can be achieved by voluntary, consensual co-ordination. The key individuals involved themselves acknowledge the difficulties of reaching consensus. They also appear to have realised the need for institutionalisation, and they are now working to build at the national level on their regional experience.

A model for health targets management

In conclusion, I believe the Hungarian experience suggests that for the implementation of health targets to succeed what is needed is:

- a process encompassing all stakeholders
- initiated by an institution that possesses the right type of knowledge
- and that can acquire a vested interest in this process (e.g. is somehow marginal in the existing healthcare system)
- and finally, the process must be institutionalised – i.e. there must exist the authority to determine the stakeholders to reach agreement.

Conclusion: health targets in Romania

The Health for All strategy has not strongly influenced the health policy of the country, as I mentioned earlier in the study. Important targets (such as equity, communicable diseases, and women health) had been adopted, and there is more emphasis on health promotion. The health target approach is just starting to be developed. This is in spite of many years of existence of a desk dealing with health targets in the Institute of Public Health. Where it actually matters, at the level of decision makers, the concept is virtually unknown, as my interviews with leading

managers from the healthcare system, health academics, and professional leaders has proven. The major stakeholders in the system are mostly concerned with improving the process of healthcare delivery. An approach based on health outcomes is alien to them, and not very high on their agenda.

Stakeholders

The major stakeholders in the Romanian health field are, not unlike in Hungary, the providers and the professional association (the Medical Chamber), and the health fund – the payer – with the Ministry of Health retaining an important supervision role. There is no clear equivalent in Romania of the Hungarian Medical officer. The public health supervision is exercised at the regional – i.e. county – level by the decentralized organs of the ministry: the County Public Health directorates. They differ from the Hungarian counterparts in that they have more say in the management of health institutions – e.g. they nominate the hospital managers. This makes them pretty influential players. There is only at the national level that there is a purely public health institution – the Public Health Institute – but it is more a research institution.

Applying the model for health targets management

The Romanian health system, facing the challenges I have presented earlier in the study, is in bad need of rationing, of establishing priorities. I believe there is little question that the health targets approach would be beneficial to the Romanian health system. Following the Hungarian example, the question that has to be answered who is the actor that can initiate and institutionalise this process. From the main stakeholders discussed above, I believe this role can be fulfilled only by the Ministry of Health and Family. This is where the relevant knowledge is present. More important, health targets can offer the ministry a new *raison d'être*. It is true that the ministry handles important technology acquisitions and new investments, as well as managing the national health programmes, and over-viewing the health system. But the management of health targets would augment the natural strategic dimension of its activity.

The process of actually setting targets can best be handled at the regional level by a process initiated by the County Public Health directorates – the local arm of the ministry. The targets themselves would probably take into account the three most important causes of mortality: cardiovascular diseases, cancer, and accidents, but adjusting for the regional differences. This has been the path followed in Szabolcs – Szatmar.

The crucial point is building the local coalitions of stakeholders. This requires an institutional mechanism, by which governmental actors are required to take part and reach an agreement. This cannot be achieved at the regional level, on one hand because the de-centralised organs of the government ministries are not properly accountable at the regional level, and on the other hand because the support from local government elected officials is not very strong for such an initiative. Therefore, the setting up of the institutional structure has to take place at the national level. It is here where the locus of authority is. It is also from where political leadership can be exercised, to compensate for the otherwise unaccountability of the healthcare stakeholders. The Ministry of Health and Family must co-ordinate a health policy committee that would bring together all the relevant government agencies.

Conclusion

In conclusion, I believe the health targets approach to be a useful tool for policy building in the Romanian public health field. The device and implementation of health targets related

measures would come to a large coalition of health stakeholders, including governmental and societal actors. The targets themselves can best be set regionally, taking advantage of the regional organisation of Romanian government, including the management of the health system. The targets will adjust for regional specificities, starting from the intuitive national priorities: reducing the mortality from cardiovascular disease, cancer, and accidents. The regional actor best placed to perform the task of initiating the process is the County Public Health Directorate – the local arm of the health Ministry – because it possesses both the relevant knowledge and the interest to run such a system. In order for the process of coalition building to be successful (all stakeholders to be involved, decisions to be taken, and resources to be allocated), health target setting must function within an institutional framework. This framework has to be national, must be co-ordinated by the Ministry of Health and Family, and must include the other relevant central government departments – at the very least: Ministry of Finance, Ministry of Education and Research, Ministry of Interior, Ministry of Environment, Ministry of Local Government, and the Ministry of Agriculture and Rural Development.

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Annexes 1

WHO Europe Health Targets

Here are the initial 38 health targets items as they appear in the *Health for All by the year 2000* strategy:

1. Equity in health
2. Health and quality of life
3. Better opportunities for people with disabilities
4. Reducing chronic diseases
5. Reducing communicable diseases
6. Healthy aging
7. Health of children and young people
8. Health of women
9. Reducing cardiovascular diseases
10. Controlling cancer
11. Accidents
12. Reducing mental disorder and suicide
13. Healthy public policy
14. Settings for health promotion
15. Health competence
16. Healthy living
17. Tobacco, alcohol and psychoactive drugs
18. Policy on environment and health
19. Environmental health management
20. Water quality
21. Air quality
22. Food quality and safety
23. Waste management and soil pollution
24. Human ecology and settlements
25. Health of people at work
26. Health service policy
27. Health service resources and management
28. Primary health care
29. Hospital care
30. Community services to meet special needs
31. Quality of care and appropriate technology
32. Health research and development
33. Health for All policy development
34. Managing Health for All development
35. Health information support
36. Developing human resources for health
37. Partners for health
38. Health and ethnics

Source: WHO/EURO, 1985;

Annexes 2

Health targets in 18 countries

Austria

Developments had been strongly influenced by the WHO Health for All strategy. Current Austrian health policy includes a number of targets for both health care and the health insurance system (concerning quality and accessibility), as well as several qualitative targets for health protection and promotion. Health data used to develop the policy were obtained from existing information systems.

Czech Republic

The need to restructure the health care system initially overshadowed involvement in the Health for All strategy. Health targets have not been formulated, but the country has a National Program of Health which includes priorities. This program has made use of existing health data system, but new forms of data collection (health interview survey) are currently being developed.

Denmark

The principles of HFA strategy were already important before the WHO presented its strategy. Formally speaking, there is no health target policy under this name, but priorities are formulated in the National Promotion Program. The country is developing a more comprehensive health information system to monitor developments in population health.

Finland

The principles and values of the Health for All strategy were already accepted before the WHO presented its report in 1984. Although the country was initially quite active in developing a national health policy, an economic setback dampened enthusiasm for this approach and prompted discussion of the rationing of health services. The country already has an extensive information system.

France

The WHO Health for All strategy has had a clear influence in France. The 1994 document *Health in France* laid the basis for recent health target-setting efforts, both at the national and regional levels and resulted in the organization of a National Health Conference to establish priorities. There has been some expansion of the existing health information system, i.e. annual national health reports.

Germany

After initial interest in the Health for All strategy, discussion on the setting of health targets faded followed by a later revival. Now, some regions already have or are in the process of formulating health targets. The health insurance sector appears to be interested in applying health targets as tools for quality assurance. Some Lander and the Federal Government are moving to develop better health monitoring systems.

*Hungary*¹⁹

¹⁹ For more details concerning both health care systems from Hungary and Romania, see the following pages of this study;

The debate on priorities in health policy began after the WHO Health for All initiative. A recent law, which adopted practically all the main the points of the strategy, lists priorities in health policy with the accent on healthcare. Qualitative and quantitative targets for population health have been set for the year 2010 and pilot projects for practical implementation have been started. The health information system will be modified to meet the requirements.

Ireland

Influenced by the WHO Health for All strategy, Ireland has revised its key values for health policy and has started to reorient its health services toward prevention and health promotion. The present health strategy includes several health targets at the national level, which are to be translated at the regional level by the recently installed regional health boards. Some initiatives have been taken to improve the existing health information structure.

Italy

Although the health target idea was not initially used, the recently published *National Health Care Plan* includes five national targets that are similar to those of Health for All strategy. The focus is on the healthcare system rather than on population health. Health data used to develop the policy were obtained from existing information systems.

The Netherlands

The Health for All strategy has been an important stimulus for the development of current national health policy. Although the Secretary of State for Health rejected the setting of quantitative health targets in 1992, the most recent policy sets three general goals. Monitoring of population health has been extended and improved through the introduction of four yearly health reports.

Norway

Although the Health for All strategy was well received, there is no clear relationship between the strategy and current policy documents. The report on population health includes concrete health targets, but the practical relevance of these targets is unclear. The data used to develop the policy came from existing databases on health and health care.

Poland

Since 1990 there has been a National Health Program, which is clearly based on the WHO Health for All strategy. The 1996 version of the program formulates 18 strategic goals. Policy realization, with emphasis on health promotion, is in an early phase. Improved regulations for health data systems have been issued and it is recognized that there is a need for a more extensive national health monitoring system.

Portugal

Given the similarities in the formulation of principles it is clear that the WHO HFA strategy had some influence. The country's national policy includes objectives and the acceptance of health targets lies somewhere between contemplation and development. Policy documents are based on information obtained from existing data sources.

Romania

The Health for All strategy has not strongly influenced the country's health policy, but important targets (such as equity, communicable diseases, and women's health) have been adopted, leading to more emphasis on health promotion. The health target approach is just

starting to be developed. The existing health monitoring and health data collection systems need to be improved.

Spain

The *Health for All's* principles were accepted. Since 1989, nearly all regions have approved regional health plans with approximately the same set of health targets, although practical approaches may differ. A special health data collection system was established to monitor progress in achieving the WHO health targets.

Sweden

Swedish policy documents frequently refer to the Health for All strategy. Health promotion and disease prevention are priorities areas associated with a number of national and regional targets. The country's extensive health information system has been improved to facilitate comparisons between regions.

Switzerland

The European Health for All strategy has had a fairly strong influence on health policy in this country. There is no national health target strategy, because the federal government does not have the authority to adopt such strategy. Switzerland has reorganized and improved its health information system to adapt to the Health for All program.

UK

The initiative of the WHO influenced health policy in all parts of the UK. England has implemented the most concrete follow-up to the HFA strategy. The 1998 strategy *Our Healthier Nation* and its predecessor *Health of the Nation* present a limited number of quantitative health targets for England that affect the practical organization and financing of public health and health care. A special unit at the Department of Health has been set up to monitor progress towards meeting health targets.