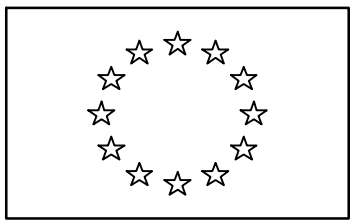
# EUCOMP

*Towards Comparable Health Care Data in the European Union*

*Part 5: Country profiles in tabular format*
*Volume A*



**EUROPEAN COMMISSION**

North Eastern Health Board
Bord Slainte An Oir Thuaiscirt

# *Contents*

## *Volume A*



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July 2000

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|---|---|
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| ***Code*** | 17.5 |
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# Country profile: Austria

| | | | |
|---|---|---|---|
| **Code** | 1 | | |
| **Description** | Introduction and historical background | | |
| **Contents** | | | |
| **Source** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. | **Year** | 1998 |

| | | | |
|---|---|---|---|
| **Code** | 1.1 | | |
| **Description** | Introductory overview | | |
| **Contents** | | | |
| **Source** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. | **Year** | 1998 |

| | | | |
|---|---|---|---|
| **Code** | 1.2 | | |
| **Description** | Historical background | | |
| **Contents** | | | |
| **Source** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. | **Year** | 1998 |

| | | | |
|---|---|---|---|
| **Code** | 2 | | |
| **Description** | Main functions of key bodies in the organizational structure and management of health care administration | | |
| **Contents** | | | |
| **Source** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. | **Year** | 1998 |

| | | | |
|---|---|---|---|
| **Code** | 2.1 | | |
| **Description** | (Con-)Federal/National government, Ministry with main responsibility for health care and other ministries with health care competence | | |
| **Contents** | Main responsibility for health care is borne by the Federal Ministry for Labour, Health and Social Affairs. This responsibility implies general health policy, health education, public hygiene and vaccination, contagious diseases control, radiation protection, health resorts, university hospitals, drug abuse, pharmacy and pharmaceutical policy. The Ministry for Science and Transports shares responsibility for the university hospitals. | | |
| **Source** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. | **Year** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 2.2 | | |
| ***Description*** | Regional government | | |
| ***Contents*** | Provinces and municipalities carry out general health administration. Health Department in each province is headed by a Provincial Sanitary Doctor. | | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 2.3 | | |
| ***Description*** | Local government | | |
| ***Contents*** | Provinces and municipalities carry out general health administration. | | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 2.4 | | |
| ***Description*** | Insurance organisations | | |
| ***Contents*** | The Association of Austrian Social Insurance Institutions co-ordinates 28 social insurance and health funds. These provide some or all of social health insurance, social accident insurance and retirement insurance. These are self-governing bodies. | | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 2.5 | | |
| ***Description*** | Professional groups | | |
| ***Contents*** | Physicians, dentists and pharmacists are organised in own associations: -The Austrian Medical Associations with nine provincial chambers; -The Austrian Association of Dental Practitioners; -The Austrian Chamber of Pharmacists. The membership of the Austrian Medical Association is compulsory for all doctors. | | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 2.6 | | |
| ***Description*** | Providers | | |
| ***Contents*** | | | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 2.7 | | |
| ***Description*** | Voluntary bodies | | |
| ***Contents*** | Voluntary welfare organisations provide emergency medical care, transport and social services (e.g. Red Cross). Furthermore self-help groups are active. | | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 3 | | |
| ***Description*** | Planning, regulation and management | | |
| ***Contents*** | Provincial health departments are not subordinate to the Federal Ministry of Health. Hospital planning exists at a supraregional base. Since 1997 the Austrian hospital plan covers also certain medico-technical equipment. Until 1997 new hospital buildings and annexes were needed approval by the Hospital Co-operation Fund (KRAZAF) funded by health insurance institutions, federal government, provinces and municipalities. This fund is now replaced by nine provincial funds. | | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 3.1 | | |
| ***Description*** | Extent of system decentralisation (deconcentration, devolution, delegation, privatisation) | | |
| ***Contents*** | | | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 3.2 | | |
| ***Description*** | Existence of national health planning agency/plan | | |
| ***Contents*** | | | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 3.3 | | |
| ***Description*** | Supervision of the health services | | |
| ***Contents*** | | | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. | ***Year*** | 1998 |

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|---|---|
| ***Code*** | 3.4 |
| ***Description*** | Financial resource allocation |
| ***Contents*** | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. |
| ***Year*** | 1998 |

| | |
|---|---|
| ***Code*** | 3.4.1 |
| ***Description*** | Third party budget setting and resource allocation |
| ***Contents*** | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. |
| ***Year*** | 1998 |

| | |
|---|---|
| ***Code*** | 3.4.2 |
| ***Description*** | Determination of overall health budget |
| ***Contents*** | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. |
| ***Year*** | 1998 |

| | |
|---|---|
| ***Code*** | 3.4.3 |
| ***Description*** | Determination of programme allocations |
| ***Contents*** | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. |
| ***Year*** | 1998 |

| | |
|---|---|
| ***Code*** | 3.4.4 |
| ***Description*** | Determination of geographical allocations |
| ***Contents*** | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. |
| ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 3.4.5 | | |
| ***Description*** | Health care budget decision-making at national/regional/local level | | |
| ***Contents*** | | | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 3.4.6 | | |
| ***Description*** | Approach to capital planning | | |
| ***Contents*** | | | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 3.4.7 | | |
| ***Description*** | Capital investment funding | | |
| ***Contents*** | | | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 3.4.8 | | |
| ***Description*** | Recent changes in resource allocation system | | |
| ***Contents*** | | | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 4 | | |
| ***Description*** | General characteristics of the organizational structure | | |
| ***Contents*** | | | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. | ***Year*** | 1998 |

| | |
|---|---|
| ***Code*** | 4.1 |
| ***Description*** | Integrated or contract model |
| ***Contents*** | There is a mixture of integrated and contracted systems. |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. |
| ***Year*** | 1998 |

| | |
|---|---|
| ***Code*** | 4.2 |
| ***Description*** | Organisational relationship between third party payers and providers |
| ***Contents*** | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. |
| ***Year*** | 1998 |

| | |
|---|---|
| ***Code*** | 4.3 |
| ***Description*** | Ownership: public, private, mix |
| ***Contents*** | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. |
| ***Year*** | 1998 |

| | |
|---|---|
| ***Code*** | 4.4 |
| ***Description*** | Freedom of choice |
| ***Contents*** | Patients are free to choose their own GP who refers to specialists and hospitals. Patients are free to choose practitioner/institution provided there is a contract with an insurer. |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. |
| ***Year*** | 1998 |

| | |
|---|---|
| ***Code*** | 4.5 |
| ***Description*** | Referral system |
| ***Contents*** | GP's provide primary medical care and should be the first contact, although insured patients will often go to specialists/hospitals directly. Policy is for referral from a GP, but patients are increasingly accessing hospitals/specialists directly. It is policy, that general practitioners should refer for more specialised treatment which implies a certain level of co-operation. |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. |
| ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 5 | | |
| ***Description*** | Out-patient care | | |
| ***Contents*** | Primary and non-inpatient secondary care is provided by 5400 general practitioners and 9000 specialist, including dentists. | | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 5.1 | | |
| ***Description*** | Medical care | | |
| ***Contents*** | Primary and non-inpatient secondary care is provided by 5400 general practitioners and 9000 specialist, including dentists. | | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 5.1.1 | | |
| ***Description*** | General practitioner (solo-, group practices) | | |
| ***Contents*** | Primary and non-inpatient secondary care is provided by 5400 general practitioners and 9000 specialist, including dentists. Most general practitioners are self-employed working in single practices. They may share consulting rooms and equipment. Draft for a Group Practice Act is presented some time ago, but acting jointly in relation to Health Board is not currently permitted. There are on average 2000 inhabitants per GP and 3800 contacts per GP. | | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 5.1.2 | | |
| ***Description*** | Medical specialist with own premises | | |
| ***Contents*** | Primary and non-inpatient secondary care is provided by 5400 general practitioners and 9000 specialist, including dentists. | | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. | ***Year*** | 1998 |

| | |
|---|---|
| ***Code*** | 5.1.3 |
| ***Description*** | Out-patient department |
| ***Contents*** | Outpatient wards in hospital provide emergency and specialised diagnostic services. The number of patients, attending outpatient wards as an alternative to physicians in private practice, is increasing: is this just for emergency care or is it substituting for services supplied by general practitioners? 800 outpatient clinics (e.g. dentistry, physical therapy, medical laboratories, health resorts). Outpatient wards in hospitals provide emergency care and specialised diagnostics and outpatient aftercare. (the latter increasingly attended as an alternative to GP's). Ambulatory services are offered both by privately practising physicians and in hospitals. (9000 specialists, 800 outpatient clinics, 1500 outpatient wards in hospitals). |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. |
| ***Year*** | 1998 |

| | |
|---|---|
| ***Code*** | 5.1.4 |
| ***Description*** | Combined services: health centres |
| ***Contents*** | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. |
| ***Year*** | 1998 |

| | |
|---|---|
| ***Code*** | 5.2 |
| ***Description*** | Dental care |
| ***Contents*** | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. |
| ***Year*** | 1998 |

| | |
|---|---|
| ***Code*** | 5.2.1 |
| ***Description*** | General dentist |
| ***Contents*** | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. |
| ***Year*** | 1998 |

| | |
|---|---|
| ***Code*** | 5.2.2 |
| ***Description*** | Dental specialist |
| ***Contents*** | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. |
| ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 5.3 | | |
| ***Description*** | Pharmacists | | |
| ***Contents*** | | | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 5.4 | | |
| ***Description*** | Midwifery | | |
| ***Contents*** | | | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 5.5 | | |
| ***Description*** | Paramedical care | | |
| ***Contents*** | | | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 5.6 | | |
| ***Description*** | Home nursing and home care (maternity home care included) | | |
| ***Contents*** | | | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 5.7 | | |
| ***Description*** | Out-patient mental health care services | | |
| ***Contents*** | | | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 5.8 | | |
| ***Description*** | Ambulance services and patient transport | | |
| ***Contents*** | | | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 5.9 | | |
| ***Description*** | Medical laboratories | | |
| ***Contents*** | | | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 6 | | |
| ***Description*** | In-patient care | | |
| ***Contents*** | There are 315 hospitals with 68000 beds. | | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 6.1 | | |
| ***Description*** | Hospital categories | | |
| ***Contents*** | In hospital are 68000 beds, of which more than 50% provided by provinces and 80% are located in public hospitals. | | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 6.2 | | |
| ***Description*** | Other in-patient provisions | | |
| ***Contents*** | | | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 7 | | |
| ***Description*** | Relationship between primary and secondary care | | |
| ***Contents*** | | | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 7.1 | | |
| ***Description*** | Planned or actual substitution policies for inpatient care | | |
| ***Contents*** | | | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 7.2 | | |
| ***Description*** | Degree of co-operation between primary and secondary health care providers | | |
| ***Contents*** | | | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 7.3 | | |
| ***Description*** | Imbalance between primary and secondary care | | |
| ***Contents*** | The health care system is very hospital-oriented. Projects to redress this imbalance are in place. Current policy aim: to determine access criteria for specific services in order to reduce high rates of hospital treatment. The current Health Care Plan addresses the need to improve integration of inpatient and outpatient care. | | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 8 | | |
| ***Description*** | Prevention and public health services | | |
| ***Contents*** | | | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 8.1 | | |
| ***Description*** | Maternal and child health: family planning and counselling | | |
| ***Contents*** | | | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 8.2 | | |
| ***Description*** | School health services | | |
| ***Contents*** | | | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 8.3 | | |
| ***Description*** | Prevention of communicable diseases | | |
| ***Contents*** | Public health offices are responsible for vaccinations and contagious diseases control. | | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 8.4 | | |
| ***Description*** | Prevention of non-communicable diseases | | |
| ***Contents*** | | | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 8.5 | | |
| ***Description*** | Occupational health care | | |
| ***Contents*** | | | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. | ***Year*** | 1998 |

| | |
|---|---|
| ***Code*** | 8.6 |
| ***Description*** | All other miscellaneous public health services |
| ***Contents*** | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. |
| ***Year*** | 1998 |

| | |
|---|---|
| ***Code*** | 9 |
| ***Description*** | Social care related to health care |
| ***Contents*** | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. |
| ***Year*** | 1998 |

| | |
|---|---|
| ***Code*** | 9.1 |
| ***Description*** | Organisation and financing of social care |
| ***Contents*** | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. |
| ***Year*** | 1998 |

| | |
|---|---|
| ***Code*** | 9.2 |
| ***Description*** | Role of central/regional/local government |
| ***Contents*** | Federal and local government is responsible for long-term care benefit legislation. Where no relatives with legal responsibility survive the Länder are responsible for granting social service benefits and providing supplementary benefit where persons' income is insufficient |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. |
| ***Year*** | 1998 |

| | |
|---|---|
| ***Code*** | 9.3 |
| ***Description*** | Role of other organisations |
| ***Contents*** | Ambulatory social care is mainly provided by not-for-profit organisations. Institutional long-term care is provided by local authorities, for-profit and not-for-profit organisations. |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. |
| ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 9.4 | | |
| ***Description*** | Responsibility of family members | | |
| ***Contents*** | Spouse, children or parents are legally obliged to provide assistance. | | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 9.5 | | |
| ***Description*** | Financing of social care | | |
| ***Contents*** | Long-term care benefits are funded directly from federal budget. Any additional cost paid out of pocket by beneficiary and those relatives who are obliged to provide support. | | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 9.6 | | |
| ***Description*** | Explicit health/social care policy | | |
| ***Contents*** | | | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 10 | | |
| ***Description*** | Medical goods and health care technology assessment | | |
| ***Contents*** | | | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 10.1 | | |
| ***Description*** | Pharmaceuticals | | |
| ***Contents*** | | | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. | ***Year*** | 1998 |

| | |
|---|---|
| ***Code*** | 10.2 |
| ***Description*** | Therapeutic appliances |
| ***Contents*** | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. |
| ***Year*** | 1998 |

| | |
|---|---|
| ***Code*** | 10.3 |
| ***Description*** | Health care technology assessment |
| ***Contents*** | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. |
| ***Year*** | 1998 |

| | |
|---|---|
| ***Code*** | 11 |
| ***Description*** | Other services |
| ***Contents*** | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. |
| ***Year*** | 1998 |

| | |
|---|---|
| ***Code*** | 11.1 |
| ***Description*** | Education and training of personnel |
| ***Contents*** | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. |
| ***Year*** | 1998 |

| | |
|---|---|
| ***Code*** | 11.2 |
| ***Description*** | Research and development in health |
| ***Contents*** | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. |
| ***Year*** | 1998 |

| | |
|---|---|
| ***Code*** | 11.3 |
| ***Description*** | Environmental health and control of drinking water |
| ***Contents*** | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. |
| ***Year*** | 1998 |

| | |
|---|---|
| ***Code*** | 11.4 |
| ***Description*** | Health programme administration and health insurance |
| ***Contents*** | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. |
| ***Year*** | 1998 |

| | |
|---|---|
| ***Code*** | 11.5 |
| ***Description*** | Administration and provision of cash benefits |
| ***Contents*** | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. |
| ***Year*** | 1998 |

| | |
|---|---|
| ***Code*** | 12 |
| ***Description*** | Manpower in health care |
| ***Contents*** | Health Board contracts are issued according to an employment plan determining number of physicians to be contracted for each region. Health Boards (provincial level) specify number of physicians to be contracted with the social insurance scheme for each region. This plan is drawn up in accordance with medical chambers. |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. |
| ***Year*** | 1998 |

| | |
|---|---|
| ***Code*** | 13 |
| ***Description*** | Fees, rates and salary structure |
| ***Contents*** | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. |
| ***Year*** | 1998 |

| | |
|---|---|
| ***Code*** | 13.1 |
| ***Description*** | Methods of payment to (specialist) physicians |
| ***Contents*** | Physicians working in public hospitals are paid under provincial law (basic salaries and extra payments and civil servant status with regard to retirement pensions etc.) Payments to other physicians working in hospitals is regulated under private law by contracts between physicians and legal entity in charge of the hospital. Most physicians in private practice have a contract with one or more Health Boards: 70% of GP's, 50% of specialists. Payments to private physicians working in public hospitals are regulated under private law by contracts between physicians and legal entity in charge of the hospital. Some specialised ambulatory services are contracted and some are integrated. |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. |
| ***Year*** | 1998 |

| | |
|---|---|
| ***Code*** | 13.1.1 |
| ***Description*** | Integrated or contracted |
| ***Contents*** | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. |
| ***Year*** | 1998 |

| | |
|---|---|
| ***Code*** | 13.1.2 |
| ***Description*** | Type of payment |
| ***Contents*** | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. |
| ***Year*** | 1998 |

| | |
|---|---|
| ***Code*** | 13.1.3 |
| ***Description*** | Method for deciding fees/salaries |
| ***Contents*** | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. |
| ***Year*** | 1998 |

| | |
|---|---|
| ***Code*** | 13.2 |
| ***Description*** | Methods of hospital payment |
| ***Contents*** | Hospitals are for 50 % financed by social security contributions and 50 % by taxes. Statutory hospital services are provided integrated. There is a nation-wide performance oriented hospital-financing scheme. As of 1997 payment of running costs is moving towards a nation-wide performance-oriented financing scheme (LKF). Funds are given by KRAZAF (Hospital Co-operation Fund) to be distributed to hospitals based on the shortfall between costs and insurance premiums, with about 50% of the hospitals eligible for these. Flat rate case (per patient and term) LKF points paid out of the provincial fund (Landesfonds). Social insurance carriers, federal government and provincial government finance this fund. Daily flat rate system (pre-1997) still applies to private and accident hospitals. Outpatient services are financed by provincial health boards on a flat rate per case basis. Most boards have a fixed flat rate covering all cases except for specified individual expensive procedures. Decision on rates is taken as results of contract negotiation between hospitals and provincial health boards to establish a budget for each hospital. Plans are deployed for the development of a performance-oriented hospital financing system for private hospitals. |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. |
| ***Year*** | 1998 |

| | |
|---|---|
| ***Code*** | 13.2.1 |
| ***Description*** | Method of payment |
| ***Contents*** | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. |
| ***Year*** | 1998 |

| | |
|---|---|
| ***Code*** | 13.2.2 |
| ***Description*** | Method for deciding rates |
| ***Contents*** | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. |
| ***Year*** | 1998 |

| | |
|---|---|
| ***Code*** | 13.2.3 |
| ***Description*** | Recent changes in payment method |
| ***Contents*** | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. |
| ***Year*** | 1998 |

| | |
|---|---|
| ***Code*** | 14 |
| ***Description*** | Main system of financing and coverage (tax based, insurance based, mixture) |
| ***Contents*** | The health sector is financed from public and private sources. Public sources are taxation by regional authorities (18%) and social insurance (59%), The remaining 23% stems from private sources. |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. |
| ***Year*** | 1998 |

| | |
|---|---|
| ***Code*** | 14.1 |
| ***Description*** | Main features of tax based systems |
| ***Contents*** | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. |
| ***Year*** | 1998 |

| | |
|---|---|
| ***Code*** | 14.1.1 |
| ***Description*** | Main body(ies) responsible for providing health care cover to beneficiaries |
| ***Contents*** | The Main Association of Austrian Social Insurance Institutions co-ordinates self-governing funds: 19 social health insurance funds and 9 insurance corporations, covering some or all of social health, social accident and retirement insurance. |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. |
| ***Year*** | 1998 |

| | |
|---|---|
| ***Code*** | 14.1.2 |
| ***Description*** | Extent of population coverage (excluded groups) |
| ***Contents*** | The social insurance system covers 99% of the population |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. |
| ***Year*** | 1998 |

| | |
|---|---|
| ***Code*** | 14.2 |
| ***Description*** | Main features of social health insurance |
| ***Contents*** | The contribution system is income-based with specific regulations for the retired and the unemployed. |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. |
| ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.2.1 | | |
| ***Description*** | Organisation of main body responsible for insuring/providing coverage | | |
| ***Contents*** | | | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.2.2 | | |
| ***Description*** | Extent of population coverage | | |
| ***Contents*** | 99% of the population are members of the social insurance system, | | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.2.3 | | |
| ***Description*** | Stipulations in premium contribution | | |
| ***Contents*** | | | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.2.4 | | |
| ***Description*** | Competition between insurance schemes | | |
| ***Contents*** | Between insurance schemes no competition exists. Contributions are compulsory and linked to gainful employment. | | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.2.5 | | |
| ***Description*** | Provision for risk adjustment | | |
| ***Contents*** | | | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.3 | | |
| ***Description*** | Health care benefits and rationing; recent reductions in benefits package and variations in extent between different insurance plans | | |
| ***Contents*** | Services covered by social insurance include health prevention (in hospital outpatient units and from GP's) and health promotion. The following services are not covered by social health insurance: -Long term care; -In vitro fertilisation; -Abortion; -Plastic surgery; -Some dental services; -Alternative medicine; -Some types of homeopathy | | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.4 | | |
| ***Description*** | Complementary sources of finance | | |
| ***Contents*** | | | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.4.1 | | |
| ***Description*** | Voluntary health insurance | | |
| ***Contents*** | 2,7 million Austrians pay also premiums to private supplementary insurance | | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.4.1.1 | | |
| ***Description*** | Organisation of voluntary health insurance: public, quasi public, private, not for profit | | |
| ***Contents*** | | | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.4.1.2 | | |
| ***Description*** | Type and nature of services covered | | |
| ***Contents*** | Benefits are e.g. single rooms in hospital accommodation and coverage of costs of treatment by physician of choice; in some cases costs of treatment by physicians in private practice and special dental services are covered. | | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. | ***Year*** | 1998 |

| | |
|---|---|
| ***Code*** | 14.4.1.3 |
| ***Description*** | Proportion of population covered |
| ***Contents*** | Private companies serve 2,7 million people (33%). |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. |
| ***Year*** | 1998 |

| | |
|---|---|
| ***Code*** | 14.4.2 |
| ***Description*** | Out-of-pocket payments: main cost sharing measure (partial reimbursement, co-payment) by care category: ambulatory, inpatient, drugs, medical aids and prostheses |
| ***Contents*** | Co-payments have been introduced or increased. Ambulatory sector: For physician and outpatient visits: ATS 50 per visit. Cost sharing for certain services provided by dentists and dental technicians and therapists such as psychotherapists, physiotherapists and others not under contract with the health boards. Inpatient sector: There are two fee classes, general and special. In the general class insured patients pay ATS 69 per day on average for max 28 days per year, although some categories of persons are exempt. In the special class health board pays a nursing fee specific to each hospital with all other services paid by patient or private supplementary insurance. Drugs: One third of all pharmaceuticals registered in Austria may be freely prescribed by physicians. Co-payments by patient of ATS 42. Exemption possible for those on low income. Medical aids and prostheses: Copayment of 10% for prostheses, with an upper limit on payment by insurer of 256 ATS in 1995. |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. |
| ***Year*** | 1998 |

| | |
|---|---|
| ***Code*** | 14.4.3 |
| ***Description*** | External sources of funding: employers, fund raisers etc. |
| ***Contents*** | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. |
| ***Year*** | 1998 |

| | |
|---|---|
| ***Code*** | 15 |
| ***Description*** | Health care expenditure |
| ***Contents*** | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. |
| ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 15.1 | | |
| ***Description*** | Structure of health care expenditures | | |
| ***Contents*** | | | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 15.2 | | |
| ***Description*** | Total and public health expenditure as % GDP | | |
| ***Contents*** | In 1985 total health care expenditure was 6.7% of GDP. Ten years later, 1995, this percentage increased to 8.0%. In that year public health expenditure accounted for 73.3% of total health care. In terms of GDP 5.8%. (Source: OECD Health Data 1998) | | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 15.3 | | |
| ***Description*** | Health care expenditure by category (%) of total expenditure on health care | | |
| ***Contents*** | In the period 1980-1995 73.3% of total health care expenditure was public expenditure. In 1995 20.5% of total health care expenditures concerned in-patient care and 14.1% concerned pharmaceuticals. Investment expenditures were 3% of total health care (Source: OECD Health Data 1998) | | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 16 | | |
| ***Description*** | Import and Export | | |
| ***Contents*** | | | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 16.1 | | |
| ***Description*** | Import | | |
| ***Contents*** | | | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. | ***Year*** | 1998 |

| | |
|---|---|
| ***Code*** | 16.2 |
| ***Description*** | Export |
| ***Contents*** | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. |
| ***Year*** | 1998 |

| | |
|---|---|
| ***Code*** | 17 |
| ***Description*** | Health care reforms |
| ***Contents*** | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. |
| ***Year*** | 1998 |

| | |
|---|---|
| ***Code*** | 17.1 |
| ***Description*** | Determinants and objectives |
| ***Contents*** | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. |
| ***Year*** | 1998 |

| | |
|---|---|
| ***Code*** | 17.2 |
| ***Description*** | Content of reforms and legislation |
| ***Contents*** | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. |
| ***Year*** | 1998 |

| | |
|---|---|
| ***Code*** | 17.2.1 |
| ***Description*** | future development of planning: move to be integrated/move to contract based |
| ***Contents*** | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. |
| ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 17.2.2 | | |
| ***Description*** | tax based system: change in population coverage; opting out permitted/encouraged | | |
| ***Contents*** | | | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 17.2.3 | | |
| ***Description*** | insurance based system: development of the degree of benefit coverage in the future | | |
| ***Contents*** | | | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 17.2.4 | | |
| ***Description*** | voluntary health insurance: changes in uptake; plans for change | | |
| ***Contents*** | | | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 17.3 | | |
| ***Description*** | Health for all policy | | |
| ***Contents*** | | | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 17.4 | | |
| ***Description*** | Reform implementation | | |
| ***Contents*** | | | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 17.5 | | |
| ***Description*** | Conclusions | | |
| ***Contents*** | | | |
| ***Source*** | EUROSTAT Project Health Care Resources Statistics, Report Part II, Description of Country Health Systems, IGSS, Luxembourg. | ***Year*** | 1998 |

# Country profile: Belgium

| | | | |
|---|---|---|---|
| **Code** | 1 | | |
| **Description** | Introduction and historical background | | |
| **Contents** | | | |
| **Source** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | **Year** | 1996 |

| | | | |
|---|---|---|---|
| **Code** | 1.1 | | |
| **Description** | Introductory overview | | |
| **Contents** | | | |
| **Source** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | **Year** | 1996 |

| | | | |
|---|---|---|---|
| **Code** | 1.2 | | |
| **Description** | Historical background | | |
| **Contents** | | | |
| **Source** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | **Year** | 1996 |

| | | | |
|---|---|---|---|
| **Code** | 2 | | |
| **Description** | Main functions of key bodies in the organizational structure and management of health care administration | | |
| **Contents** | | | |
| **Source** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | **Year** | 1996 |

| | | | |
|---|---|---|---|
| **Code** | 2.1 | | |
| **Description** | (Con-)Federal/National government, Ministry with main responsibility for health care and other ministries with health care competence | | |
| **Contents** | Federal government is responsible for legislation, financing and insurance, hospital programming and hospital quality norms, prices of medicines, the acces to the health professions (legal requirements to exercise the profession) and the practice of health professionals. | | |
| **Source** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | **Year** | 1996 |

| | |
|---|---|
| ***Code*** | 2.2 |
| ***Description*** | Regional government |
| ***Contents*** | In the context of the development of a federal governmental structure in Belgium certain responsibilities for health care have been delegated from federal government to the authorities of the Flemish, French and German Communities. Regional, provincial and local authorities take responsibilities in organising prevention, but also ambulatory curative care: outpatient perinatal health care, outpatient mental health care, medical services for schools, medical services for industry and care for the handicapped. |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| ***Year*** | 1996 |

| | |
|---|---|
| ***Code*** | 2.3 |
| ***Description*** | Local government |
| ***Contents*** | Regional, provincial and local authorities take responsibilities in organising prevention, but also ambulatory curative care: outpatient perinatal health care, outpatient mental health care, medical services for schools, medical services for industry and care for the handicapped. |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| ***Year*** | 1996 |

| | |
|---|---|
| ***Code*** | 2.4 |
| ***Description*** | Insurance organisations |
| ***Contents*** | The sickness funds are grouped into five national associations. Three of them are organised according to the backgrounds of political parties: the National Alliance of Christian Mutual Funds, the National Union of Socialist Mutual Funds and the National League of Liberal Mutualist Federations. Another bears a neutral signature and the last is based on professional backgrounds. Apart from these sickness funds the government has created an assistance fund for sickness and disability (CAAMI). This fund is for those who refuse to join a sickness fund or who neglect to do so. Sickness funds receive their financial resources from the national Office of Social Security, where premiums from employers, employees and self-employed are brought together with governmental subsidies for care for the unemployed, the aged and the poor. INAMI/RIZIV and the national associations of mutualities play a role in the distribution of these resources. |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| ***Year*** | 1996 |

| | |
|---|---|
| ***Code*** | 2.5 |
| ***Description*** | Professional groups |
| ***Contents*** | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 2.6 | | |
| ***Description*** | Providers | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 2.7 | | |
| ***Description*** | Voluntary bodies | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 3 | | |
| ***Description*** | Planning, regulation and management | | |
| ***Contents*** | In the context of the development of a federal governmental structure in Belgium certain responsibilities for health care have been delegated from federal government to the authorities of the Flemish, French and German Communities. Regional, provincial and local authorities take responsibilities in organising prevention, but also ambulatory curative care: outpatient perinatal health care, outpatient mental health care, medical services for schools, medical services for industry and care for the handicapped. | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 3.1 | | |
| ***Description*** | Extent of system decentralisation (deconcentration, devolution, delegation, privatisation) | | |
| ***Contents*** | The health care system in Belgium is built up of private and public elements: it is mainly privately organised and publicly financed. Legislation and public financing offer the general context in which all these elements cooperate. | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 3.2 | | |
| ***Description*** | Existence of national health planning agency/plan | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1996 |

| | |
|---|---|
| ***Code*** | 3.4.6 |
| ***Description*** | Approach to capital planning |
| ***Contents*** | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| ***Year*** | 1996 |

| | |
|---|---|
| ***Code*** | 3.3 |
| ***Description*** | Supervision of the health services |
| ***Contents*** | With regard to hospitals technical control is exercised by the Communities and financial control by the Federal Ministry of Public Health. Hospitals must meet requirements for appropriate structural, architectural, functional and organisational standards and must be compatible with national and regional hospital plans. |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| ***Year*** | 1996 |

| | |
|---|---|
| ***Code*** | 3.4 |
| ***Description*** | Financial resource allocation |
| ***Contents*** | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| ***Year*** | 1996 |

| | |
|---|---|
| ***Code*** | 3.4.1 |
| ***Description*** | Third party budget setting and resource allocation |
| ***Contents*** | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| ***Year*** | 1996 |

| | |
|---|---|
| ***Code*** | 3.4.2 |
| ***Description*** | Determination of overall health budget |
| ***Contents*** | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| ***Year*** | 1996 |

| | |
|---|---|
| ***Code*** | 3.4.3 |
| ***Description*** | Determination of programme allocations |
| ***Contents*** | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 3.4.4 | | |
| ***Description*** | Determination of geographical allocations | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 3.4.5 | | |
| ***Description*** | Health care budget decision-making at national/regional/local level | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 3.4.7 | | |
| ***Description*** | Capital investment funding | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 3.4.8 | | |
| ***Description*** | Recent changes in resource allocation system | | |
| ***Contents*** | In 1990 a new bill on the financing of health care was introduced, of which the main elements are: -the fixing of a global budget for health care expenditure and several separate budgets for each sector; - the obligation to implement correction mechanisms when the global or partial budgets are exceeded: - the creation of a budget control commission entrusted with the supervision of the achievement of budgetary targets and with the task of proposing adjustments to them; - powers for the Minister to intervene when the care providers and the sickness funds do not succeed in meeting their budgetary targets. | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 4 | | |
| ***Description*** | General characteristics of the organizational structure | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 4.1 | | |
| ***Description*** | Integrated or contract model | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 4.2 | | |
| ***Description*** | Organisational relationship between third party payers and providers | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 4.3 | | |
| ***Description*** | Ownership: public, private, mix | | |
| ***Contents*** | Many private organisations (non-governmental and non-profit) as well as self-employed medical doctors play an important role in the supply of health care services. On the one hand this concerns individual self-employed professionals like general practitioners, specialists, dentists, pharmacists, physiotherapists and others. On the other hand many private non-profit organisations are active in extramural as well as in intramural care. Home nursing is delivered by organisations like the White and Yellow Cross or independent nurses. In the field of intramural care 226 hospitals out of a total of 366 are run by private non-profit organisations in 1993. Private hospitals outnumber public hospitals. This dominance is even stronger for psychiatric hospitals, where 58 of a total of 72 hospitals are in private hands. | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 4.4 | | |
| ***Description*** | Freedom of choice | | |
| ***Contents*** | Citizens in Belgium enjoy freedom of choice for health care. They can consult general practitioners of their choice or, without interference, they can consult medical specialists or visit hospital outpatient departments. They can even directly request to be admitted to hospital, in which case the hospital doctor decides whether admission is necessary or not. There is also freedom of choice with regard to sickness funds. After a certain period the insured can change rather easily from one sickness fund to another. | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 4.5 | | |
| ***Description*** | Referral system | | |
| ***Contents*** | The general practitioner is not the "gatekeeper" of the health care system, as the patient is entitled to visit specialists and hospitals without his interference. Nevertheless for non-medical services referral by medical practitioners is needed: clinical biology, röntgendiagnostics, physiotherapy, nursing care, opticians, acoustic prostheses, bandagist and orthopaedist. | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1996 |

| | |
|---|---|
| ***Code*** | 5 |
| ***Description*** | Out-patient care |
| ***Contents*** | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| ***Year*** | 1996 |

| | |
|---|---|
| ***Code*** | 5.1 |
| ***Description*** | Medical care |
| ***Contents*** | Out-patient medical care is provided by self-employed general practitioners and specialists. No division of tasks exists between these two categories. This, together with a high "doctor density" in Belgium, causes much competition between these categories. |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| ***Year*** | 1996 |

| | |
|---|---|
| ***Code*** | 5.1.1 |
| ***Description*** | General practitioner (solo-, group practices) |
| ***Contents*** | Out-patient medical care is provided by self-employed general practitioners and specialists. No division of tasks exists between these two categories. This, together with a high "doctor density" in Belgium, causes much competition between these categories. General practitioners therefore make many house calls, over 50% of their patient contacts, even if patients are very well capable of coming to the doctor's office. The average number of patient contacts is 11 per day , according to data published by NIVEL in 1993. GPs just starting out have fewer consultations. For younger GPs in particular, sideline jobs are indispensable to make a living. The solo-practice is the most common form, though there is a change of the attitude among younger general practitioners to join associations (which are mostly still solo's). Group practices occur rarely. |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| ***Year*** | 1996 |

| | |
|---|---|
| ***Code*** | 5.1.2 |
| ***Description*** | Medical specialist with own premises |
| ***Contents*** | Out-patient medical care is provided by self-employed general practitioners and specialists. No division of tasks exists between these two categories. For reasons of cost control, Mutualities have created a kind of polyclinics, in which some specialist services are concentrated. |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| ***Year*** | 1996 |

| | |
|---|---|
| ***Code*** | 5.1.3 |
| ***Description*** | Out-patient department |
| ***Contents*** | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 5.1.4 | | |
| ***Description*** | Combined services: health centres | | |
| ***Contents*** | For reasons of cost control, Mutualities have created a kind of polyclinics, in which some specialist services are concentrated. | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 5.2 | | |
| ***Description*** | Dental care | | |
| ***Contents*** | Dentists are in general self-employed. | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 5.2.1 | | |
| ***Description*** | General dentist | | |
| ***Contents*** | Dentists are in general self-employed. | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 5.2.2 | | |
| ***Description*** | Dental specialist | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 5.3 | | |
| ***Description*** | Pharmacists | | |
| ***Contents*** | Pharmacists are in general self-employed. | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 5.4 | | |
| ***Description*** | Midwifery | | |
| ***Contents*** | Midwives can either be as independent professionals as well as employees of health care institutions. | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 5.5 | | |
| ***Description*** | Paramedical care | | |
| ***Contents*** | Physiotherapists, speech therapists and midwives can either be as independent professionals as well as employees of health care institutions. Within these health care institutions also other paramedical professionals are employed. | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1996 |

| | |
|---|---|
| ***Code*** | 5.6 |
| ***Description*** | Home nursing and home care (maternity home care included) |
| ***Contents*** | There is a strong political tendency to give priority to home care. Generally, home nursing and home help services are separately organised. Only a few organisations provide both kinds of home care. However, in the actual provision of care co-operation between home nurses and home helps is increasing. Home helps sometimes assist home nurses in the daily care of the patient (especially with hygienic tasks) and occasionally signal problems, which they discuss together. Home nursing services are mainly provided by organisations, which work on a non-profit basis and an increasing number of independent nurses working in private practices. It is estimated that in 1995 about 35% of the market is covered by independent nurses (se literature 17). The largest organisation is the White/Yellow cross which covers the whole country and performs about 50% of all nursing activities. The White/Yellow Cross is divided into three main organisational levels. The actual provision of care is organised at the local level. There are 180 local departments consisting of 20-40 nurses and lead by a head nurse. These departments are controlled and supported by the nine Provincial Cross Associations which determine the number of nurses per region and contract the home nurses. The National Federation of White/Yellow Cross Associations is an umbrella organisation which supports the provincial cross associations, develops policy in co-operation with the provincial cross associations and represents these in contacts with ministries, social associations and professional organisations. Furthermore there are a number of smaller organisations like Solidariteit voor het Gezin (Solidarity for the Family). This organisation provides both home nursing and home help services, mainly in Eastern Flanders. Its catchment area is divided into nursing regions, which further are divided into sectors in which about 20 nurses and one social nurse are employed. In Walloon an equivalent organisation exists namely the C.D.S. (Centre des Soins à Domicile). When a person is in need of home nursing, he/she can contact a home nursing organisation or an independent nurse directly. Theoretically, patients have a free choice as to which home nursing organisation they approach, but this choice is often restricted by the limited availability of different organisations in the region. However, recently the opportunity to choose between home care delivered by formal organisations and home care by private nurses has increased enormously. Most patients have a prescription from their physician because a formal authorisation is required for all technical nursing activities such as injections, otherwise the health insurance associations do not reimburse these costs. Only general nursing activities, such as ADL-support, are freely accessible for heavily dependent patients. After the first contact, a nurse from the home-nursing organisation will visit the patient to assess the patient's level of care dependency. A standardised screening form is used. All nurses who provide home care are also able to fill out the screening forms. Accordingly, the assessment of needs, the actual provision of care and the evaluation of the care provided are mostly the responsibility of the same person. The actual nursing care provided includes hygiene and other personal care, routine technical nursing procedures (injections, stoma care, bladder washouts), more complicated nursing activities (epidural anaesthesia, handling respirator, catheterisation), patient education, and the encouragement of informal care. ADL-assistance, injections and wound dressing are the activities most frequently performed by Belgian home nurses during home visits. Home nurses from the White/Yellow Cross work in teams co-ordinated by the local departments. In daily practice, most of them operate from their own homes because each nurse takes care of her own specific area. In general, the organisation of home help services, mainly help with housework, is strictly separated from home nursing activities. Some exceptions are already mentioned, that is Solidariteit voor het Gezin in Eastern Flanders and the Centre des Soins à Domicile in the Walloon region which provide both home nursing and home help services. An important distinction must be made between public and private organisations. Although 76% of the home help services organisations are part of the public and 24% to the private sector, the latter accounts for almost 80% of the hours worked. Each municipality should have its own PCSW, which is in charge of social services in general and services for home help in the family and for the elderly in particular. The municipalities have the authority to control the budget of the centres. There are 589 Public Centres for Social Welfare (PCSW's) in Belgium. These centres own hospitals, old people's homes, and alternative housing units. They organise home help services, cleaning services, job services, service centres and meal distribution. One of the main social functions is to grant the elderly with an insufficient income a benefit equal to the subsistence level and, if necessary, to contribute to the accommodation expenses in the institutions. The principal professional home help organisations started about 40 years ago, having been based on charity and voluntary work. Private home help organisations are still associated or linked with broader social organisations (e.g. the Christian Workers movement, Socialist movement) and organisations for more specific groups such as the Catholic Pensioners Union, other religious groups, and Health Insurance funds (mutualities). They are also organised at a local level and their catchment area is restricted. Examples of these kinds or organisations are Familiehulp, Familiezorg en Solidariteit voor het Gezin. Theoretically all clients are free to choose the organisation for home help themselves. However in some regions there are only one or two professional organisations able to provide home help |

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|---|---|
| | services. No formal referral is needed. So potential clients can contact the home help organisations themselves. The needs of the potential client are assessed through a so-called social investigation performed by a social worker (or social nurse) who is responsible for the first contact with the client, the work schedule of the home helps and the follow-up. The next step is the actual provision of home help services by home helps employed by the organisations. All home helps and cleaners operate from their own homes; not from central working units like health centres, hospitals or old people's homes. The work of cleaners is limited to the cleaning of the house. Home helps provide a larger range of care, i.e. housework (preparing meals, washing dishes, washing and ironing, and cleaning), hygienic and other personal care (bathing, ADL-help), moral support (counselling and advice), general and family support (shopping, going for a walk, administrative support), and occasionally encouraging help from family members, neighbours or friends. In practice, the same organisations will provide cleaning as well as home help to the same client. Home helps provide an average of 11 hours help per week per family, generally the help is spread over two days. The cleaning services deliver help, an average of four hours a week per family. The majority of patients receive help one day per week, but there is a considerable group who only receives cleaning help once in 14 days. This is probably due to the fact that travel costs are not subsidised and therefore need to be kept to a minimum. |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| ***Year*** | 1996 |

| | |
|---|---|
| ***Code*** | 5.7 |
| ***Description*** | Out-patient mental health care services |
| ***Contents*** | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| ***Year*** | 1996 |

| | |
|---|---|
| ***Code*** | 5.8 |
| ***Description*** | Ambulance services and patient transport |
| ***Contents*** | There are 16 emergency centres in Belgium. These are all run with financial support from the Ministries of the Interior and Health. Messages are passed on to the fire brigade, who in turn call the nearest ambulance. These can either belong to a private company, "cross"-organisation (e.g. the Red Cross), the fire brigade itself or a hospital. The ambulance is normally manned with three persons inclusding a nurse. The patient is transported to the nearest hospital. Of the approx. 250 hospitals in Belgium, 180 of these have an emergency service, coupled to an emergency call network. Some hospitals are connected to a "Mobiele Urgentie Groep" or Mobile Urgency Group (MUG), which means that a doctor forms part of the ambulance team. The emergency services are partially financed through the hospital's daily bed fees. Other ambulance services are dependent on planned transport of patients. The patient pays a rate per kilometre. The compulsory insurance only covers certain cases, for example in the case of serious illnesses, such as with dialysis and cancer patients requiring radiation treatment. Besides the compulsory insurance, most insurance companies provide supplementary insurance, which includes the coverage of the transport of patients. The extent of coverage differs depending on the insurance. There are no data on how much contribution clients have to pay. A further item of information with respect to the transport of patients in Belgium, is the existence of the "Minder Mobielen Centrales" (about a hundred in Flanders), who work with volunteers and are partially financed by local authorities. The patients pay a rate per kilometre. This service is normally called in, for instance, to transport patients from and to a hospital or rehabilitation centre. |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 5.9 | | |
| ***Description*** | Medical laboratories | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 6 | | |
| ***Description*** | In-patient care | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 6.1 | | |
| ***Description*** | Hospital categories | | |
| ***Contents*** | The number of hospitals in Belgium is rather high. Most hospitals (62% in 1993) are in private or semi-private facilities. These are operated by bodies such as sickness funds, religious communities etc. Public hospitals are usually organised by Public Welfare Centres of Municipalities. In 1993 the country counted 366 general hospitals, of which 226 were privately owned and 140 publicly. Characteristic for both the private and the public sector in Belgium is their small units. In 1985 a policy was adopted aimed at rationalisation by quantitative and qualitative adaptation of the hospital sector. Goals of this policy were the reduction of overall hospital capacity, concentration in hospitals with minimal 150 beds and a well-balanced distribution, taking into account the particular situation of the Brussels Region, where three medical faculties (VUB, ULB, UCL) are established. The results are, that all hospitals have more than 150 beds and that fewer beds are available per 1000 inhabitants. Since 1986 beds for the chronically ill have been removed from hospitals to Rest and Nursing Homes (Rust- en verzorgingstehuis, RVT). These are no longer considered as hospitals, but constitute necessary links in the range of extramural and intramural facilities for the elderly, of which also geriatric beds in hospitals form a part. The number of beds in general hospitals decreased by 14% in the period 1982-1992. Bed occupancy rates became higher, but the average length of stay in hospitals dropped. The number of beds in psychiatric hospitals decreased gradually by 27% in the period 1979-1992. In 1990 a reorganisation plan for the psychiatric sector was accepted with less beds, more care facilities and greater collaboration between intra- and extramural care. | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 6.2 | | |
| ***Description*** | Other in-patient provisions | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 7 | | |
| ***Description*** | Relationship between primary and secondary care | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 7.1 | | |
| ***Description*** | Planned or actual substitution policies for inpatient care | | |
| ***Contents*** | There is a strong political tendency to give priority to home care. | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 7.2 | | |
| ***Description*** | Degree of co-operation between primary and secondary health care providers | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 7.3 | | |
| ***Description*** | Imbalance between primary and secondary care | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 8 | | |
| ***Description*** | Prevention and public health services | | |
| ***Contents*** | Preventive health care services are generally organised and financed by public authorities (Communities, provincial and local government, sickness funds), but also private non-profit organisations fulfil tasks in this field. Important areas of activities are outpatient perinatal care, outpatient mental health, medical services for schools, medical services for industry, sport medicine and care for the handicapped. A parastatal organisation, called "Kind en Gezin" (Child and Family), is specialised in preventive health care for children under the age of five years. | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 8.1 | | |
| ***Description*** | Maternal and child health: family planning and counselling | | |
| ***Contents*** | A parastatal organisation, called "Kind en Gezin" (Child and Family), is specialised in preventive health care for children under the age of five years. | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 8.2 | | |
| ***Description*** | School health services | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 8.3 | | |
| ***Description*** | Prevention of communicable diseases | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 8.4 | | |
| ***Description*** | Prevention of non-communicable diseases | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 8.5 | | |
| ***Description*** | Occupational health care | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 8.6 | | |
| ***Description*** | All other miscellaneous public health services | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 9 | | |
| ***Description*** | Social care related to health care | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 9.1 | | |
| ***Description*** | Organisation and financing of social care | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 9.2 | | |
| ***Description*** | Role of central/regional/local government | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 9.3 | | |
| ***Description*** | Role of other organisations | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 9.4 | | |
| ***Description*** | Responsibility of family members | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 9.5 | | |
| ***Description*** | Financing of social care | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1996 |

| | |
|---|---|
| ***Code*** | 9.6 |
| ***Description*** | Explicit health/social care policy |
| ***Contents*** | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| ***Year*** | 1996 |

| | |
|---|---|
| ***Code*** | 10 |
| ***Description*** | Medical goods and health care technology assessment |
| ***Contents*** | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| ***Year*** | 1996 |

| | |
|---|---|
| ***Code*** | 10.1 |
| ***Description*** | Pharmaceuticals |
| ***Contents*** | Costs of medicines are reimbursed according to their therapeutic significance. Only four urgent types of medicines are fully reimbursed (antibiotics against TBC and medicines for epileptics and diabetics and chemotherapy for cancer patients). For other medicines co-payments are requested at a rate of 25-75% depending on their therapeutic classification. |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| ***Year*** | 1996 |

| | |
|---|---|
| ***Code*** | 10.2 |
| ***Description*** | Therapeutic appliances |
| ***Contents*** | In Belgium all therapeutic appliances are accounted for in the health accounts. However the out of pocket expenditures are not included. |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| ***Year*** | 1996 |

| | |
|---|---|
| ***Code*** | 10.3 |
| ***Description*** | Health care technology assessment |
| ***Contents*** | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| ***Year*** | 1996 |

| | |
|---|---|
| ***Code*** | 11 |
| ***Description*** | Other services |
| ***Contents*** | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 11.1 | | |
| ***Description*** | Education and training of personnel | | |
| ***Contents*** | The expenditures of non-university education is included as well. | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 11.2 | | |
| ***Description*** | Research and development in health | | |
| ***Contents*** | Health research expenditures are only partially included. | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 11.3 | | |
| ***Description*** | Environmental health and control of drinking water | | |
| ***Contents*** | In the field of health protection and environmental health the regions, provinces and the "Institute for Hygiene and Environmental Health" play important roles. | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 11.4 | | |
| ***Description*** | Health programme administration and health insurance | | |
| ***Contents*** | All administrative expenditures are part of the health accounts in Belgium. | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 11.5 | | |
| ***Description*** | Administration and provision of cash benefits | | |
| ***Contents*** | In Belgium the income compensation and specific financial support in case of illness or disability is part of the health accounts. | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 12 | | |
| ***Description*** | Manpower in health care | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 13 | | |
| ***Description*** | Fees, rates and salary structure | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 13.1 | | |
| ***Description*** | Methods of payment to (specialist) physicians | | |
| ***Contents*** | General practitioners and specialists are paid by fee for service. The fee structure is regulated at national level by the National Institute for Sickness and Invalidity Insurance (INAMI/RIZIV). Fees are the results of negotiations between syndicates of medical doctors and sickness funds, followed by negotiations between doctors and hospitals. Agreement between medical doctors and sickness funds must be approved by central government. If no agreement is reached government is entitled by law to fix fees. If an agreement has been reached medical doctors are obliged to bill according to the fee schedule. Some medical doctors, however, do not accept the negotiated fees and in certain circumstances they are free to charge extra. These doctors must announce their non-affiliation to the agreed schedule. Patients making use of their services, are reimbursed according to the agreed fees. | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 13.1.1 | | |
| ***Description*** | Integrated or contracted | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 13.1.2 | | |
| ***Description*** | Type of payment | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 13.1.3 | | |
| ***Description*** | Method for deciding fees/salaries | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 13.2 | | |
| ***Description*** | Methods of hospital payment | | |
| ***Contents*** | Within the yearly budget of every hospital the Ministry of Health calculates a standard cost price per day, basedon historical factors and including more and more so-called production profiles. Factors involved in this calculation are types of medical service, diagnoses, nursing activities and age structure of patients. Other costs are budgetted, taking into account types of medical services, number of beds and age of buildings. Patients pay a small part of the standard cost price. The Ministry pays 25% of the standard cost price and the remainder is paid by the sickness fund. Medical specialists pay part of their income to the hospital for the use of facilities. For nursing staff a uniform salary system has been developed for the whole country. | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 13.2.1 | | |
| ***Description*** | Method of payment | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 13.2.2 | | |
| ***Description*** | Method for deciding rates | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 13.2.3 | | |
| ***Description*** | Recent changes in payment method | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 14 | | |
| ***Description*** | Main system of financing and coverage (tax based, insurance based, mixture) | | |
| ***Contents*** | Sickness fund premiums are relatively low in Belgium. High government contributions and a large number of co-payments supplement them. Government contributions are used to pay for the health care of the elderly, the disabled, pensioners, widows and orphans. Investments in hospitals (buildings and expensive equipment) are paid for by the government up to 60 to 100%. Moreover government bears the costs of prevention, like school health care and occupational health care, and some forms of curative care like perinatal care outside hospitals, ambulatory mental care and care for the disabled. | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1996 |

| | |
|---|---|
| ***Code*** | 14.1 |
| ***Description*** | Main features of tax based systems |
| ***Contents*** | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| ***Year*** | 1996 |

| | |
|---|---|
| ***Code*** | 14.1.1 |
| ***Description*** | Main body(ies) responsible for providing health care cover to beneficiaries |
| ***Contents*** | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| ***Year*** | 1996 |

| | |
|---|---|
| ***Code*** | 14.1.2 |
| ***Description*** | Extent of population coverage (excluded groups) |
| ***Contents*** | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| ***Year*** | 1996 |

| | |
|---|---|
| ***Code*** | 14.2 |
| ***Description*** | Main features of social health insurance |
| ***Contents*** | Health care in Belgium is guaranteed by a system of sickness fund schemes as part of the social security system. Originally only employees and their dependants were covered. By gradual extensions of legislation this system has been made compulsory for almost the whole population (99%). |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| ***Year*** | 1996 |

| | |
|---|---|
| ***Code*** | 14.2.1 |
| ***Description*** | Organisation of main body responsible for insuring/providing coverage |
| ***Contents*** | The sickness funds are grouped into five national associations. Three of them are organised according to the backgrounds of political parties: the National Alliance of Christian Mutual Funds, the National Union of Socialist Mutual Funds and the National League of Liberal Mutualist Federations. Another bears a neutral signature and the last is based on professional backgrounds. Apart from these sickness funds the government has created an assistance fund for sickness and disability (CAAMI). This fund is for those who refuse to join a sickness fund or who neglect to do so. Sickness funds receive their financial resources from the national Office of Social Security, where premiums from employers, employees and self-employed are brought together with governmental subsidies for care for the unemployed, the aged and the poor. INAMI/RIZIV and the national associations of mutualities play a role in the distribution of these resources. |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.2.2 | | |
| ***Description*** | Extent of population coverage | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.2.3 | | |
| ***Description*** | Stipulations in premium contribution | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.2.4 | | |
| ***Description*** | Competition between insurance schemes | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.2.5 | | |
| ***Description*** | Provision for risk adjustment | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1996 |

| | |
|---|---|
| ***Code*** | 14.3 |
| ***Description*** | Health care benefits and rationing; recent reductions in benefits package and variations in extent between different insurance plans |
| ***Contents*** | The law on sickness and disability insurance contains a limitative enumeration of the health care services accepted for reimbursements. This enumeration includes all kinds of preventive and curative care. Four main categories are distinguished: general medical care, specialist care, hospital-nursing care and medicines and medical appliances. As already indicated benefit packages vary according to employment status. Rights to be derived from this legislation are different for various groups. Employees and civil servants enjoy complete coverage of risks, but under the compulsory system self-employed people only are insured against high risks like hospitalisation. Persons who do not fall under the compulsory system are offered the possibility to join the social sickness funds voluntarily. The compulsorily insured are obliged to enlist in order to become a member of one of the 129 non-governmental and non-profit sickness funds. Employees and civil servants are entitled to a broad coverage, including so-called small and high risks. The self-employed are insured against high risks only (e.g. hospitalisation). About 70% of them sign up with a sickness fund or private/profit company for voluntary insurance to cover small risks. The sickness funds offer their members a broad package of supplementary advantages. Examples are savings schemes before marriage, benefits at marriage and birth, funeral insurance, family help and help for the aged, open air cures and holiday resorts, and recently also legal aid concerning patient rights. For each of these activities a separate bookkeeping is required by law. Reimbursement is the leading principle in the social sickness funds insurance in Belgium. This reimbursement is supplied after certification of delivered care. In 1986, however, a "third payer regulation" was introduced creating the possibility of immediate payments by the sickness funds to providers of care. This regulation is obligatory for admission to hospitals and all medical care provided in hospitals. |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| ***Year*** | 1996 |

| | |
|---|---|
| ***Code*** | 14.4 |
| ***Description*** | Complementary sources of finance |
| ***Contents*** | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| ***Year*** | 1996 |

| | |
|---|---|
| ***Code*** | 14.4.1 |
| ***Description*** | Voluntary health insurance |
| ***Contents*** | Due to the almost nation-wide coverage of the social sickness insurance scheme few opportunities are left for private insurance. They have only a supplementary function in the field of minor risks for persons insured under the scheme for the self-employed, in the field of own contributions (extra costs of hospitalisation, drugs etc.) and in the field of expenditures not covered by the sickness funds e.g. certain patient transport costs. |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| ***Year*** | 1996 |

| | |
|---|---|
| ***Code*** | 14.4.1.1 |
| ***Description*** | Organisation of voluntary health insurance: public, quasi public, private, not for profit |
| ***Contents*** | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| ***Year*** | 1996 |

| | |
|---|---|
| ***Code*** | 14.4.1.2 |
| ***Description*** | Type and nature of services covered |
| ***Contents*** | The self-employed are insured against high risks only (e.g. hospitalisation). About 70% of them sign up with a sickness fund or private/profit company for voluntary insurance to cover small risks. |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| ***Year*** | 1996 |

| | |
|---|---|
| ***Code*** | 14.4.1.3 |
| ***Description*** | Proportion of population covered |
| ***Contents*** | The self-employed are insured against high risks only (e.g. hospitalisation). About 70% of them sign up with a sickness fund or private/profit company for voluntary insurance to cover small risks. |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| ***Year*** | 1996 |

| | |
|---|---|
| ***Code*** | 14.4.2 |
| ***Description*** | Out-of-pocket payments: main cost sharing measure (partial reimbursement, co-payment) by care category: ambulatory, inpatient, drugs, medical aids and prostheses |
| ***Contents*** | Co-payments by patients using health care services are a widespread phenomenon in Belgium. Extramural services must be paid by the patient, and are reimbursed by the sickness fund at a rate of generally 75%. Costs of medicines are reimbursed according to their therapeutic significance. Only four urgent types of medicines are fully reimbursed (antibiotics against TBC and medicines for epileptics and diabetics and chemotherapy for cancer patients). For other medicines co-payments are requested at a rate of 25-75% depending on their therapeutic classification. In hospitals a fixed amount per day is obliged for boarding costs. Co-payments for physician costs, excluding surgery and gynaecology, are 25%. For the medicines used in hospitals 25 Bfr. have to be paid by the patient. Specific categories of patients - widows, the disabled, pensioners and orphans - are subject to a less strict scheme. In the case of industrial accidents and recognised industry-related diseases the patient is entitled to complete reimbursement of payments for medical treatment, medicines and nursing care. |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| ***Year*** | 1996 |

| | |
|---|---|
| ***Code*** | 14.4.3 |
| ***Description*** | External sources of funding: employers, fund raisers etc. |
| ***Contents*** | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 15 | | |
| ***Description*** | Health care expenditure | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 15.1 | | |
| ***Description*** | Structure of health care expenditures | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 15.2 | | |
| ***Description*** | Total and public health expenditure as % GDP | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 15.3 | | |
| ***Description*** | Health care expenditure by category (%) of total expenditure on health care | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1996 |

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|---|---|---|---|
| ***Code*** | 16 | | |
| ***Description*** | Import and Export | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 16.1 | | |
| ***Description*** | Import | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 16.2 | | |
| ***Description*** | Export | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 17 | | |
| ***Description*** | Health care reforms | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 17.1 | | |
| ***Description*** | Determinants and objectives | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 17.2 | | |
| ***Description*** | Content of reforms and legislation | | |
| ***Contents*** | In recent years several cost containment measures have been introduced in Belgium: - reimbursement of hospital costs by the Ministry of Health (except medical activities and activities under the RIZIV-nomenclature, reimbursed by the National Institute for Sickness and Invalidity Insu rance, RIZIV/INAMI) will be based on several factors but increasingly on case-mix (pathology grouping of patients), nursing care profiles and specific organisational features of particular services. At present, payment for hospital care is based on a functional budget (main structural characteristics of a hospital) and a supplementary budget (related to the nature and amount of medical and nursing activities, which of course are dependent on the case-mix of a hospital; - increase of co-payments by patients (especially for drugs) resulting in growing significance of supplementary insurance by sickness funds and private for-profit insurance companies; - decrease of government subsidies; - regulation of specific sectors, e.g. prices of medicines and laboratory tests; - reduction of beds in acute care and psychiatric care in favour of nursing beds for the aged and chronically ill. | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 17.2.1 | | |
| ***Description*** | future development of planning: move to be integrated/move to contract based | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 17.2.2 | | |
| ***Description*** | tax based system: change in population coverage; opting out permitted/encouraged | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 17.2.3 | | |
| ***Description*** | insurance based system: development of the degree of benefit coverage in the future | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 17.2.4 | | |
| ***Description*** | voluntary health insurance: changes in uptake; plans for change | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 17.3 | | |
| ***Description*** | Health for all policy | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 17.4 | | |
| ***Description*** | Reform implementation | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 17.5 | | |
| ***Description*** | Conclusions | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1996 |

# Country profile: Finland

| | | | |
|---|---|---|---|
| **Code** | 1 | | |
| **Description** | Introduction and historical background | | |
| **Contents** | | | |
| **Source** | European Observatory on Health Care Systems | **Year** | 1999 |

| | | | |
|---|---|---|---|
| **Code** | 1.1 | | |
| **Description** | Introductory overview | | |
| **Contents** | Finland is an independent republic located to the north east of the Baltic Sea. It is bordered by Norway in the north, the Gulf of Finland in the south, Sweden and the Baltic Sea in the west and Russian Federation along the entire eastern border. The land area is about 337 000 km2 and the population is about 5.0 million. The bulk of the population is concentrated in the south of the country and much of Finland is forested and sparsely populated. About 62% of the population live in urban areas. There are two official languages in Finland, Finnish and Swedish – about 6% of the population are Swedish-speaking. In addition there are small numbers of Saame-speakers in Lapland, the north of the country.<br>Finland has a high level of economic and human development: four fifths of 25- to 29-year olds complete secondary schooling and in 1994 women accounted for 49% of the workforce. The economy is based on services and industry. Following the global economic recession and the collapse of the Soviet Union, and for other reasons, Finland experienced a marked economic recession between 1990 and 1993: the economy shrank by 15% and unemployment rose from 3.5% to 19%. Since 1994 there have been signs that the economy is recovering, with the level of unemployment falling slightly. Real GDP per capita (adjusted for purchasing power) was US $16 300 in 1992, compared with an average of US $17 800 for the European Union.<br>Having been under Swedish and then Russian rule for centuries, Finland became an independent republic with its own constitution in 1917. The head of state is the President, who is directly elected for a six-year term of office. Parliament has a single chamber of 200 representatives, elected for a four-year term. Finland is divided into 11 administrative provinces and the Åland Islands, which have an autonomous status. Many responsibilities, including those for health services, education, social assistance and planning, are devolved to the level of municipalities. There are 455 of these throughout the country. Municipal councils are elected for a four-year term and may raise revenue through a proportional income tax. In addition they receive a subsidy from central government. Municipalities account for 40% of public spending. The tradition of devolving responsibility to municipalities is a long one in Finland, dating back several centuries to the time when the country was under Swedish rule.<br>Some of Finland's health status indicators are better than average for Europe: the infant mortality rate at 4.4 per 1000 live births is the lowest in Europe. Nevertheless, cardiovascular diseases remain well above the EU average, and deaths from suicides are among the highest in Europe. These contribute to a life expectancy, particularly for males, which is below the EU average. | | |
| **Source** | European Observatory on Health Care Systems | **Year** | 1999 |

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| ***Code*** | 1.2 |
| ***Description*** | Historical background |

***Contents***

In Finland, the organization and financing of health care has long been considered a public responsibility; a tax-financed health care system has developed gradually.

Finnish municipalities have long been the basic units for making health care arrangements. Before the Second World War, they concentrated mainly on the treatment of tuberculosis, other communicable diseases and mental diseases. They began to organize health services by employing general practitioners and public health nurses. Municipalities usually provided these general practitioners with facilities and personnel, but a considerable part of general practitioners' income came from direct payments by patients. As the overall number of doctors and nurses was small, they had to handle a wide variety of health problems.

In the 1940s, maternity and child care centres began to be built throughout the country. The right to maternal and child health care was laid down by law for every mother and child irrespective of residence and financial situation.

The provision of hospital care was fairly modest in the first half of the twentieth century. Treatment for tuberculosis was provided at specific tuberculosis hospitals. In the 1940s municipalities formed federations, so-called tuberculosis districts, which were responsible for the treatment and prevention of that disease.

The development of the hospital system was given a push in the 1950s. A new law stated that secondary care was to be provided by about 20 central hospitals, which were built in larger towns, with separate psychiatric hospitals. The bulk of state-owned hospitals passed into the possession of municipalities. Later in the 1960s, regional hospitals were built in smaller towns. As tuberculosis became of less concern, the treatment of tuberculosis was shifted into central hospitals and the tuberculosis hospitals were gradually reoriented towards treating other diseases.

In spite of all the progress in organizing health services, medical care and drugs were expensive and people's income during illness was precarious. A state sickness insurance scheme was therefore introduced in the 1960s. Part of the costs for medical care, drugs and some other services were reimbursed through this scheme.

In the beginning of the 1970s, there were still striking differences in the availability of health services. Most of the services were concentrated in urban areas. There was also an imbalance between primary and secondary health care. A network of high-standard specialized hospitals existed, but the supply of outpatient services and primary health care was insufficient. Almost 90% of total health care expenditure was spent on hospital care and only 10% on primary care. Different primary care services (for example, general medical care by general practitioners and mother and child care by nurses), were poorly coordinated with each other.

These issues were the reasons for the introduction of the Primary Health Care Act in 1972. A national plan for primary health care was also introduced then. The 1972 Primary Health Care Act obliged municipalities to provide primary and public health care to their inhabitants. This care was to be provided in health centres. All primary and public health care, which had until then been provided in a fragmented way, was brought together under the administration of health centres. This meant that the health centres began to provide primary medical care, various kinds of preventive services, home nursing, occupational health care and many other services. As health centres did not exist before the introduction of the law, the 1970s saw a comprehensive build-up of health centres in the country.

Other cornerstones in the history of Finnish health care are the inclusion of hospital care in national planning in 1974 and the introduction of the Occupational Health Act in 1979. The latter obliges employers to provide occupational health services to their employees. In 1984, new legislation brought social services (for example, children's day care and homes for the elderly) into the same planning and financing system as health care. Since then, collaboration between social and health care services has been stressed at both local and national levels. A marked feature of the 1980s was the continuous decrease in state regulation.

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| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1999 |

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| ***Code*** | 2 |
| ***Description*** | Main functions of key bodies in the organizational structure and management of health care administration |
| ***Contents*** | |
| ***Source*** | European Observatory on Health Care Systems |
| ***Year*** | 1999 |

| | |
|---|---|
| ***Code*** | 2.1 |
| ***Description*** | (Con-)Federal/National government, Ministry with main responsibility for health care and other ministries with health care competence |
| ***Contents*** | The Ministry of Social Affairs and Health directs and manages social and health services at national level. It defines general social and health policy lines, prepares major reforms and directs and monitors their implementation, and assists the government in decision-making. Attached to the Ministry of Social Affairs and Health is the Basic Security Council. On the initiative of the Ministry, the council may investigate any deficiencies observed in the provision of municipal health services. The council may then make recommendations on how and when the deficiencies should be eliminated. There are several authorities and institutes subordinated to the Ministry of Social Affairs and Health which are responsible for various issues related to social and health care (some of them are described in more detail below).<br>The government decides on general priorities and prepares bills to be discussed by parliament. The Ministry of Education is responsible for planning and partly for financing the education of health personnel. |
| ***Source*** | European Observatory on Health Care Systems |
| ***Year*** | 1999 |

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| ***Code*** | 2.2 |
| ***Description*** | Regional government |
| ***Contents*** | The main levels in the administrative organization of health care are the central government and the municipalities. The level between these two (the provincial boards) is not very strong in the administrative hierarchy. Finland is divided into 11 provinces. In addition, the Åland Islands have autonomous status. Each of them has its own provincial board. The provincial boards are state agencies and their members are appointed civil servants. The boards are responsible for directing and monitoring social and health services in their own provinces; in practice, their main health care responsibility is for the approval of capital investments plans. |
| ***Source*** | European Observatory on Health Care Systems |
| ***Year*** | 1999 |

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|---|---|
| ***Code*** | 2.3 |
| ***Description*** | Local government |
| ***Contents*** | In Finland, the organization and financing of health care has long been considered a public responsibility; a tax-financed health care system has developed gradually.<br><br>Finnish municipalities have long been the basic units for making health care arrangements. Before the Second World War, they concentrated mainly on the treatment of tuberculosis, other communicable diseases and mental diseases. They began to organize health services by employing general practitioners and public health nurses. Municipalities usually provided these general practitioners with facilities and personnel, but a considerable part of general practitioners' income came from direct payments by patients. As the overall number of doctors and nurses was small, they had to handle a wide variety of health problems.<br><br>In the 1940s, maternity and child care centres began to be built throughout the country. The right to maternal and child health care was laid down by law for every mother and child irrespective of residence and financial situation.<br><br>The provision of hospital care was fairly modest in the first half of the twentieth century. Treatment for tuberculosis was provided at specific tuberculosis hospitals. In the 1940s municipalities formed federations, so-called tuberculosis districts, which were responsible for the treatment and prevention of that disease.<br><br>The development of the hospital system was given a push in the 1950s. A new law stated that secondary care was to be provided by about 20 central hospitals, which were built in larger towns, with separate psychiatric hospitals. The bulk of state-owned hospitals passed into the possession of municipalities. Later in the 1960s, regional hospitals were built in smaller towns. As tuberculosis became of less concern, the treatment of tuberculosis was shifted into central hospitals and the tuberculosis hospitals were gradually reoriented towards treating other diseases.<br><br>In spite of all the progress in organizing health services, medical care and drugs were expensive and people's income during illness was precarious. A state sickness insurance scheme was therefore introduced in the 1960s. Part of the costs for medical care, drugs and some other services were reimbursed through this scheme.<br><br>In the beginning of the 1970s, there were still striking differences in the availability of health services. Most of the services were concentrated in urban areas. There was also an imbalance between primary and secondary health care. A network of high-standard specialized hospitals existed, but the supply of outpatient services and primary health care was insufficient. Almost 90% of total health care expenditure was spent on hospital care and only 10% on primary care. Different primary care services (for example, general medical care by general practitioners and mother and child care by nurses), were poorly coordinated with each other.<br><br>These issues were the reasons for the introduction of the Primary Health Care Act in 1972. A national plan for primary health care was also introduced then. The 1972 Primary Health Care Act obliged municipalities to provide primary and public health care to their inhabitants. This care was to be provided in health centres. All primary and public health care, which had until then been provided in a fragmented way, was brought together under the administration of health centres. This meant that the health centres began to provide primary medical care, various kinds of preventive services, home nursing, occupational health care and many other services. As health centres did not exist before the introduction of the law, the 1970s saw a comprehensive build-up of health centres in the country.<br><br>Other cornerstones in the history of Finnish health care are the inclusion of hospital care in national planning in 1974 and the introduction of the Occupational Health Act in 1979. The latter obliges employers to provide occupational health services to their employees. In 1984, new legislation brought social services (for example, children's day care and homes for the elderly) into the same planning and financing system as health care. Since then, collaboration between social and health care services has been stressed at both local and national levels. A marked feature of the 1980s was the continuous decrease in state regulation.<br>The 1972 Primary Health Care Act obliges municipalities to provide health counselling, medical care, rehabilitation (when it is not provided by the NSSI) and dental care for children and young adults. It also obliges municipalities to provide school, student and occupational health care, screening (for cervical and breast cancer), mental health care appropriate to a health centre and patient transportation. The statutory services are to be provided in health centres, either the municipality's own or together with other municipalities. They can also buy these obligatory services from the private sector. |

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| | Municipalities are also obliged by law to arrange specialized medical care for their citizens. The 1991 Hospital Health Care Act and the 1991 Mental Health Act regulate the organization of these services. There is also separate legislation concerning some vulnerable groups of the population, for example the disabled and chronic alcohol abusers. The law on social and health care planning and state subsidies also regulates the services provided by municipalities. In general, the legislation does not regulate in great detail the range and method of providing services. Where the legislation does not lay down detailed provisions, it is at the municipality's discretion to decide about the range and method of providing services.<br><br>In practice, there are differences in the organization of services due to local circumstances and population's needs. For example, the age structure, local policy targets, the social environment or the geographical location of a municipality may influence the way in which services are organized and provided |
| ***Source*** | European Observatory on Health Care Systems ***Year*** 1999 |
| ***Code*** | 2.4 |
| ***Description*** | Insurance organisations |
| ***Contents*** | Within the health care system there is a statutory state sickness insurance scheme, the National State Sickness Insurance (NSSI). The scheme is run by the Social Insurance Institute, with about 400 local offices all over the country. The Social Insurance Institute is under the authority of Parliament; it is not attached to the Ministry of Social Affairs and Health. The amount of benefits and services offered by the NSSI have been markedly extended since its establishment in the 1960s. At present, it is used to provide partial reimbursement for prescribed medication, transportation costs (municipalities are responsible for the transportation of a patient, but in specified cases the NSSI reimburses part of the costs for transportation), private medical care (i.e. private doctors' and dentists' fees, as well as examinations and treatment ordered by them), occupational health care, student health care and rehabilitation in some cases specified by law. The NSSI scheme also pays for income lost during illness, pregnancy and childbirth, and compensates for income loss incurred by parents of a sick child during treatment and rehabilitation of the child. |
| ***Source*** | European Observatory on Health Care Systems ***Year*** 1999 |
| ***Code*** | 2.5 |
| ***Description*** | Professional groups |
| ***Contents*** | |
| ***Source*** | European Observatory on Health Care Systems ***Year*** 1999 |

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|---|---|
| ***Code*** | 2.6 |
| ***Description*** | Providers |
| ***Contents*** | In addition to the health care services provided by municipalities (which is the main system), there are also private and occupational health care services. Private health care in Finland mainly comprises ambulatory care provided in large cities in the south of the country. The majority of physicians working in the private health sector are specialists who have a full-time job in a public hospital or health centre. The number of private hospitals is very small. The law on private health care regulates the provision of private health services.<br><br>The 1979 Occupational Health Care Act obliges employers to provide occupational health care for their employees. This Act defines obligatory occupational health care as those health services which are necessary to prevent health risks caused by work. Employers have to provide sufficient information on the health risks related to work and to advise their employees on how to avoid those risks. They are obliged to arrange physical examinations and first aid for their employees at the workplace. Employers also have to investigate an employee's health condition when a job might endanger his or her health. It should be noted that, besides the Occupational Health Care Act, employers must also take into account legislation concerning safety at work. In addition to this obligatory occupational health care, employers can voluntarily provide other health care and medical treatment for their employees.<br><br>Employers can arrange occupational health care in different ways. They may, for example, set up their own health centres. Large firms tend to have a health centre of their own with one or more doctors and nurses working there. Employers may also form a health centre together with other employers, or they may arrange occupational services at a health centre owned by a municipality. One common way of providing occupational services is to buy the services of a private provider – usually a private group practice.<br><br>In most cases, the National State Sickness Insurance reimburses employers with 50% of the (necessary and appropriate) costs of providing occupational health care. Users of occupational health care are not charged anything. About 1.6 million people (90% of all employees) are offered occupational health care by their employers. While occupational health care is meant to be preventive, in fact it is more often oriented towards treating various medical problems.<br><br>The private and the public sector services are neither coordinated with each other nor real competitors. The same is also true of occupational health services. The parallel private and occupational health care systems, alongside the public health care system, offer more choice for patients than just one sector could, but at the same time they also create problems. More details of the problems relating to these parallel systems are given in the section on health care finance and expenditure. |
| ***Source*** | European Observatory on Health Care Systems |
| ***Year*** | 1999 |

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| ***Code*** | 2.7 |
| ***Description*** | Voluntary bodies |
| ***Contents*** | Citizens participate in the health care system by voting every four years in both municipal and parliamentary elections. There are also various patients' associations which may influence decision-makers on issues concerning the planning and management of public health care.<br><br>In 1987, a law to compensate patients for injuries came into force. According to this law, a patient has the right to compensation for unforeseeable injury which occurred as a result of treatment or diagnosis. Notable in this law is the fact that health care personnel need not be shown to be legally responsible for the injury. For a patient to receive compensation, it is sufficient that unforeseeable injury occurred.<br><br>In 1993, a new law on patient's rights came into force. This mainly concerns patients' rights to information, to see any medical documents concerning them and to autonomy. A medical ombudsperson was also introduced under this. |
| ***Source*** | European Observatory on Health Care Systems |
| ***Year*** | 1999 |

| | | | |
|---|---|---|---|
| ***Code*** | 3 | | |
| ***Description*** | Planning, regulation and management | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1999 |

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|---|---|
| ***Code*** | 3.1 |
| ***Description*** | Extent of system decentralisation (deconcentration, devolution, delegation, privatisation) |
| ***Contents*** | The 21 hospital districts were formed in 1991. Before 1991, there were many more districts and their administration was different. The main problems with the organization of secondary care were its fragmented administration and poor coordination between the different units and districts. The present 21 hospital districts are responsible for providing hospital services and coordinating public hospital care within a defined area. Each municipality must be a member of a hospital district. A hospital district usually contains 1–3 acute (non-psychiatric) hospitals and 1–2 psychiatric hospitals. Both in-patient and outpatient care are provided in these hospitals.<br><br>Municipalities usually purchase services from hospitals within the hospital district they belong to, although they may purchase services from outside their own district or from a private provider. The reasons why municipalities do not purchase from outside their own district may be geographical (distance) or the fact that service prices are higher for members of another hospital district. As prices and services are defined in very different ways, it is impossible to compare different producers and choose the most cost-effective one. Hospital districts can also bill municipalities retrospectively when the hospitals' revenues are not sufficient to cover all expenditure (some districts have abandoned retrospective billing and some, although not all, are planning to do so).<br><br>Municipalities do not negotiate a formal contract with hospitals; instead they make agreements with some hospitals for the provision of certain specialized services. Hospital districts must have an equalization mechanism to spread the risks of very high costs. If an individual patient's treatment costs more than a specified threshold (agreed within the hospital district), all the municipalities that are members of the same district will pay all or part of the excess. This threshold varies from FM 100 000 to FM 300 000. Most hospital districts have set the threshold at FM 200 000. There are some variations in how the right to equalization is defined: most hospital districts allow for equalization for one illness period; one specifies that costs should be incurred in one hospital; while others apply the equalization threshold to all hospital care costs in any one year.<br><br>Owing to the small size of municipalities, the equalization mechanism is very important: without it, the risk of municipalities having to meet catastrophic costs would be too high. As can be imagined, the budget of a municipality which has a population of 2 000 or 10 000 inhabitants cannot cover expensive treatments such as organ transplantation or certain cancer treatments.<br><br>In general, it is thought that the equalization mechanism works reasonably well and that it is an important way of compensating municipalities for costly hospital treatment. The administration costs related to the equalization mechanism are minimal.<br><br>Despite the fact that the legislation clearly defines the role of hospital districts (to arrange specialized medical care within their areas), in practice their role is unclear. Some districts seem to act as representatives of the hospitals in their area, i.e. as providers. Others seem to be representatives of the municipalities which form the district (purchasers). Hospital districts are a kind of local monopoly: they cannot be described as one of the parties in the "classic" model of a purchaser-provider split. It is thought that the role of hospital districts needs clarification, but no specific plans have yet been made to do this.<br><br>Hospital districts seem to be in a strong position in terms of organizing and providing specialized medical care. This is because municipalities appear to be fairly powerless and cannot influence the provision and costs of hospital care. There is clearly an imbalance in the situation of a municipality of 2000 or even 10 000 inhabitants whose officials and political leaders are trying to negotiate with a large professionalized hospital. In most cases, municipalities also lack the medical, economic and other skills required to arrange services in the most efficient way. However, the purchasing of hospital services by municipalities is not contract-based (the method of paying for hospital care is described below).<br><br>At present discussions are being held about the municipalities' position in relation to specialized care, how it might be strengthened and what the role of hospital districts should be. The obligation for a municipality to be a member of a hospital district has also been under discussion. However, if this were abolished, the equalization mechanism would have to be modified. Yet, as mentioned above, an equalization mechanism is essential because of the size of municipalities. Since the whole of public administration in Finland is currently being discussed, there may be changes in public sector administration which will also influence hospital districts and other health sector bodies.<br>The Finnish health care system is very decentralized, following a devolved model. As described above, 455 elected municipalities are responsible for arranging health care and have |

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| | great freedom in doing this. The 1993 state subsidy reform gave even greater responsibility and decision-making power to the municipalities. There has not been much opposition to decentralization. In Finland, the population is dispersed and local decision-making has always been regarded as important.<br><br>Decentralization has highlighted significant variations, both in clinical practice and in the delivery of health services. For example, the number of in-patient cases and surgical procedures varies markedly from region to region, and the variations cannot be explained by different morbidity patterns or age and sex structures. These variations already existed before the 1993 state subsidy reform. There are also wide differences between municipalities in per capita expenditure on health care.<br><br>Municipalities have often a very small population: 75% have less than 10 000 inhabitants and 20% have less than 2000 inhabitants. This creates problems with handling risk: one costly treatment can be unbearable to the economy of a small- or medium-sized municipality. However, the equalization mechanism within hospital districts described above helps with the problem by pooling risk.<br><br>Another problem arising from decentralization to such small units is that municipalities may lack skills and negotiating power. This has already been discussed above |
| ***Source*** | European Observatory on Health Care Systems ***Year*** 1999 |

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|---|---|
| ***Code*** | 3.2 |
| ***Description*** | Existence of national health planning agency/plan |
| ***Contents*** | Until 1993, the state regulation of health service provision was rather strict and detailed. There was legislation and a national five-year plan for social and health care. The Ministry of Social Affairs and Health prepared this plan each year and it was approved by the Government along with the proposed state budget.<br><br>Implementation of the state subsidy reform in 1993 reduced regulation by the state. The main objective of the reform was to cut down on central administration and to increase decision-making power and responsibility at the local level. However, the reform did not change the fundamental principle of the Finnish health care system, that municipalities are responsible for providing health services. Municipalities were given an even more active role in arranging services and the power to decide more freely about administration, personnel and user charges. They also obtained the right to purchase services from any provider they choose and to contract services out to the private sector.<br><br>At the same time as the state subsidy reform was implemented, the national plan was changed from a five-year to a four-year basis. Its role also became less significant. Four-year plans now mainly contain general guidelines on activities in social and health care and information about the amount of state financing for running costs and capital investments.<br>There are additional problems with the organizational structure of health care in Finland. These include poor coordination of operating costs, capital investments and human resources planning. The Ministry of Education partly plans and finances the education of health personnel, but neither municipalities (which are responsible for employing such personnel), nor the Ministry of Social Affairs and Health participate in manpower planning. |
| ***Source*** | European Observatory on Health Care Systems ***Year*** 1999 |

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|---|---|
| ***Code*** | 3.3 |
| ***Description*** | Supervision of the health services |
| ***Contents*** | The National Board of Medico-legal Affairs, subordinate to the Ministry of Social Affairs and Health, is responsible for licensing, registration and monitoring of health care personnel. It also undertakes disciplinary procedures concerning health care personnel. |
| ***Source*** | European Observatory on Health Care Systems ***Year*** 1999 |

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|---|---|
| ***Code*** | 3.4 |
| ***Description*** | Financial resource allocation |
| ***Contents*** | |
| ***Source*** | European Observatory on Health Care Systems |
| ***Year*** | 1999 |

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|---|---|
| ***Code*** | 3.4.1 |
| ***Description*** | Third party budget setting and resource allocation |
| ***Contents*** | The Government submits the state's annual budget proposal to Parliament, and Parliament makes the final decision on how much state resources will be allocated to the health care sector. The health board of each municipality prepares the municipality's budget for health care. The municipal council approves the total municipal budget and, within this budget, the resources allocated for health. The council of each hospital district determines the budget for hospital care within its area.<br><br>Up to 1993, state subsidies were allocated retrospectively according to actual costs. These were adjusted for the wealth of the municipality: the richer a municipality, the smaller the subsidy it received, and vice versa. If municipalities provided services which did not follow the national five-year plan, they did not get a state subsidy for those services. The state subsidy was also earmarked and could only be spent on health care. This system helped achieve equal access and good quality services throughout the country, but because the state paid part of the hospitals, actual costs retrospectively, there were no incentives for efficiency.<br><br>In 1993, the state subsidy system was reformed. The reform was intended to achieve cost-containment and to improve efficiency within municipal health services. It was also aimed at giving more power to the municipalities and reducing state regulation. Under the new system, all state subsidies are calculated according to demographic criteria. In health care, the criteria for state subsidies (for running costs) are the population's age structure, mortality, population density and land area. The subsidy is automatically paid in advance to the municipality and it is not earmarked.<br><br>There was not much opposition to the state subsidy reform. The reform was designed at a time when the country's economic situation was good and there were no clear signs of a crisis. Municipalities appreciated the new freedom and decision-making power that they were being given. Agreements for a transitional period were made, so that changes in the amount of state subsidies would not be too radical.<br><br>It was estimated that those municipalities which organized their health care reasonably and efficiently would "gain" from the reform and those which were not doing as well would suffer. However, it is difficult to assess the impact of the reform because it came into force at the same time as a sharp economic decline – which started in 1990.<br><br>The criteria for determining the amount of state subsidies are to be changed in 1997, but it is not yet clear in what way the system will change. At the moment, research is being done on which criteria would best describe the need for health care services. However, it is not felt that there is a great need to change the present subsidy system. It may be that there will be some adjustments to the demographic criteria for calculating the subsidy for health care. |
| ***Source*** | European Observatory on Health Care Systems |
| ***Year*** | 1999 |

| | |
|---|---|
| ***Code*** | 3.4.2 |
| ***Description*** | Determination of overall health budget |
| ***Contents*** | |
| ***Source*** | European Observatory on Health Care Systems |
| ***Year*** | 1999 |

| | | | |
|---|---|---|---|
| ***Code*** | 3.4.3 | | |
| ***Description*** | Determination of programme allocations | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1999 |

| | | | |
|---|---|---|---|
| ***Code*** | 3.4.4 | | |
| ***Description*** | Determination of geographical allocations | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1999 |

| | | | |
|---|---|---|---|
| ***Code*** | 3.4.5 | | |
| ***Description*** | Health care budget decision-making at national/regional/local level | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1999 |

| | | | |
|---|---|---|---|
| ***Code*** | 3.4.6 | | |
| ***Description*** | Approach to capital planning | | |
| ***Contents*** | The state subsidy reform did not significantly change the financing of capital investments. Capital investments are financed in different ways depending on their size. Medium-sized (FM 2–25 million) and major (over FM 25 million) capital investments are subsidised by the state. The state subsidy varies from 25% to 50% of the capital investment costs, depending on the municipality's per capita income. Municipalities submit their plans for capital investments to the provincial boards which are state authorities. Medium-sized investments may be approved by the provincial boards, but major capital investments require approval by the Government. The Ministry of Social Affairs and Health allocates state funding for medium-sized capital investments to the provincial boards.<br>Capital investments can also be financed without the state's financial contribution, for example by municipalities, contributions from private sources and patient associations. Municipalities are allowed to borrow money to finance capital investments (or for other purposes). The Finnish Slot Machine Association has markedly increased its share of all capital investments in health services, at present accounting for about 30% of all capital investments in health care. It should be noted that this association supports only private providers, i.e. it does not give money towards municipal capital investments.<br><br>After the 1993 reform of the state subsidy system, which places more financial responsibility and risk on the municipalities, the problems related to the small size of Finnish municipalities have become even more obvious. | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1999 |

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|---|---|---|---|
| ***Code*** | 3.4.7 | | |
| ***Description*** | Capital investment funding | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1999 |

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|---|---|---|---|
| ***Code*** | 3.4.8 | | |
| ***Description*** | Recent changes in resource allocation system | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1999 |

| | | | |
|---|---|---|---|
| ***Code*** | 4 | | |
| ***Description*** | General characteristics of the organizational structure | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1999 |

| | | | |
|---|---|---|---|
| ***Code*** | 4.1 | | |
| ***Description*** | Integrated or contract model | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1999 |

| | | | |
|---|---|---|---|
| ***Code*** | 4.2 | | |
| ***Description*** | Organisational relationship between third party payers and providers | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1999 |

| | | | |
|---|---|---|---|
| ***Code*** | 4.3 | | |
| ***Description*** | Ownership: public, private, mix | | |
| ***Contents*** | Both primary health care physicians and hospital specialists may work in the private sector, in addition to their work in the public sector. Almost one third of all doctors (both general practitioners and specialists) have some kind of private practice. In 1995, only 7% of all doctors worked full time in private practice. There are no restrictions on the entry of doctors into the NSSI scheme; this means that any patients who are treated by any licensed medical doctor are partly reimbursed by the NSSI.<br>Hospital assets are owned by hospital districts which are, in turn, formed by municipalities. Hospitals are non-profit making organizations. There are variations in how much the hospital districts influence the functioning of a single hospital. Hospital districts are allowed to borrow money. | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1999 |

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|---|---|
| ***Code*** | 4.4 |
| ***Description*** | Freedom of choice |
| ***Contents*** | If a patient wishes to see a health centre doctor, he/she is usually assigned to the doctor who is responsible for his/her population area (division into responsibility areas is explained below). This means that patients do not have much choice of general practitioner. However, if a patient wishes to change his/her doctor within the health centre, this is usually allowed. According to patient surveys, the vast majority of patients are satisfied with their assigned doctor.<br>In general, patients cannot choose the hospital where they will be treated. Health centres have instructions where to send patients with certain symptoms and diagnoses. So far as possible, however, hospitals do try to allow patients to choose their hospital doctor.<br><br>The suggestion that patients should have more freedom to choose their doctor and hospital is under discussion, as is the question of whether patients should be allowed to see a health centre doctor outside their own municipality while financing responsibility remains with their own residential municipality. As yet, however, no decisions have been made on these issues. |
| ***Source*** | European Observatory on Health Care Systems — ***Year*** 1999 |

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|---|---|
| ***Code*** | 4.5 |
| ***Description*** | Referral system |
| ***Contents*** | In the public sector, patients need a referral from their general practitioner in order to have access to a specialist, i.e. to outpatient and in-patient care in a hospital. In practice, many patients go directly to hospital emergency units in order to bypass the referral process. In the private sector, there is direct access to private specialists, and either private general practitioners or specialists can refer to public hospital specialists. |
| ***Source*** | European Observatory on Health Care Systems — ***Year*** 1999 |

| | |
|---|---|
| ***Code*** | 5 |
| ***Description*** | Out-patient care |
| ***Contents*** | After the 1972 Primary Health Care Act came into force, government financing was allocated first to building health centres in remote and rural areas. These areas were poorer than the urban areas and also had less private health services; as a result, the development of municipal health centres was more rapid in rural areas than in the larger cities.<br><br>By the 1980s, although an increasing amount of resources had been allocated to primary care, there were problems with access to health centre doctors and with continuity of care. These problems particularly concerned the larger cities. Waiting times to see a health centre doctor were often 2–6 weeks for non-urgent cases, although there was always the possibility of seeing the doctor on call. But the on-call workload was often heavy and only the most acute problems could be dealt with, so patients had to come again during usual appointment times or for another on-call visit. Health centre doctors did not feel real personal responsibility for patients' care and continuity of care was poor, since patients would usually see another doctor on their next consultation.<br><br>To overcome these problems, a number of projects were launched in the 1980s. One was the introduction of the personal doctor system in some parts of Finland. In this system a person or a family is always assigned to the same health centre doctor. In 1988–1993, a project was carried out in which some private doctors in large cities acted as personal doctors.<br><br>In the personal doctor system, doctors are more or less free to organize their practice as they wish but on condition that patients can see their doctor within three days. The method of payment of doctors has also been altered, to relate better (than a fixed monthly salary) to the expertise and experience of the doctor and the population structure he or she is responsible for (payment of personal doctors is explained below).<br>The results of the personal doctor system projects have been encouraging. Access to general practitioners has improved and waiting times have been clearly reduced. Both doctors and patients seem to appreciate the system. In the 1990s, about one third of the population has been assigned to a personal doctor.<br><br>Recently, the personal doctor system has been further developed into a model which is called "vaestovastuu" in Finnish ("population responsibility"). Under this arrangement, collaboration between different health care personnel has been encouraged: doctors and nurses form a team which is responsible for a geographically defined area covering 1500–5000 persons. Most health centres are now moving towards the principle of population responsibility. Where it has not yet been introduced, the size of the population covered is so small that the principle of population responsibility is already being applied in practice.<br><br>The number of physician contacts per person in Finland is among the lowest in western Europe. This may be due to the fact that Finnish doctors do not ask patients to come for a check-up as often as doctors in other countries do. In part, this in turn may be due to different medical traditions, but it is likely that the fee-for-service payment arrangements in insurance-financed systems is also an important factor. The extensive role played by nurses, and by public health nurses, is probably also a reason for the low number of physician contacts in Finland. Nurses in Finland may carry out tasks which their colleagues in other countries may not do. |
| ***Source*** | European Observatory on Health Care Systems — ***Year*** 1999 |

| | |
|---|---|
| ***Code*** | 5.1 |
| ***Description*** | Medical care |
| ***Contents*** | |
| ***Source*** | European Observatory on Health Care Systems — ***Year*** 1999 |

| | | | |
|---|---|---|---|
| ***Code*** | 5.1.1 | | |
| ***Description*** | General practitioner (solo-, group practices) | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1999 |

| | | | |
|---|---|---|---|
| ***Code*** | 5.1.2 | | |
| ***Description*** | Medical specialist with own premises | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1999 |

| | | | |
|---|---|---|---|
| ***Code*** | 5.1.3 | | |
| ***Description*** | Out-patient department | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1999 |

| | |
|---|---|
| ***Code*** | 5.1.4 |
| ***Description*** | Combined services: health centres |

***Contents***

Primary health care is provided mainly in health centres. A health centre can be defined as a functional unit or an organization which provides primary and public health care to its population. It is not necessarily a single building or a single location where care is provided. Health centre activities are often organized at several locations: for example, maternal and child health care might be provided at a separate location from the general practitioner's practice. Large cities usually have health centre activities organized at several places. Health centres are owned by one or more municipalities; since they do not have independent status, they are non-profit making organizations and cannot borrow money on their own behalf. Municipalities, on the other hand, are allowed to borrow money and may do so on behalf of their health facilities.

In 1995 there were about 250 health centres in the country. In sparsely populated areas like Lapland, the distance to the nearest health centre is much greater than in the more densely populated south. The size of a health centre varies, depending on the number of people it serves. When health centres were first set up, it was recommended that they should serve a population of at least 10 000 inhabitants. However, there is no obligatory rule about this at present.

The number and type of personnel in each health centre depends on its size and location and on local circumstances. The personnel include general practitioners, sometimes medical specialists, nurses, public health nurses, social workers, dentists, physiotherapists, psychologists and administrative personnel. All are employed by the municipalities. The number of patients per health centre doctor varies: on average it is about 2000.

Health centres offer a wide variety of services: outpatient medical care, in-patient care, preventive care, dental care, maternal and child health care, school care, care for the elderly, family planning, physiotherapy and occupational health care. The minimum services to be provided by health centres are laid down by law, but the legislation does not generally define in great detail the range of services. In most cases it is left to the discretion of the municipality to decide what should be provided.

Usually health centres are well equipped. In addition to the doctors' and nurses' consulting rooms, there are usually X-ray facilities, a small clinical laboratory, facilities for minor surgery, an electrocardiogram and sometimes ultrasound equipment and facilities for endoscopy.

The doctors working in health centres are mainly general practitioners. About one fourth of all GPs working in health centres have specialized in general medicine. However, it is not obligatory to be a specialist in general medicine to work as a general practitioner in a health centre.

The main work of health centre doctors is to provide office-based general medical care to patients of all ages. They are often involved in other kind of activities as well. These include maternal and child health care, occupational care, family planning, work in the in-patient department of the health centre, home nursing (home visits by general practitioners are not very common; these are more often done by nurses), consultations at municipal homes for the elderly, etc. The tasks are often divided between the health centre doctors according to the circumstances in the health centre and the experience or interests of the doctors.

There are also an increasing number of specialists working in health centres. For example, an internist might be given responsibility for the elderly and the in-patient department, and a radiologist for X-ray examinations. Some health centres also have arranged for specialists to come once a week for consultations – for example, a radiologist from a nearby hospital to interpret X-rays.

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|---|---|---|---|
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1999 |

| | |
|---|---|
| ***Code*** | 5.2 |
| ***Description*** | Dental care |
| ***Contents*** | Dental care provided at health centres covers all children and young people under 19, veterans of the Second World War and usually also the disabled and some other vulnerable groups. However, there are variations in the provision of dental care by health centres: some municipalities manage to offer dental care to the whole population, while others offer only the obligatory services. |
| ***Source*** | European Observatory on Health Care Systems |
| ***Year*** | 1999 |

| | |
|---|---|
| ***Code*** | 5.2.1 |
| ***Description*** | General dentist |
| ***Contents*** | |
| ***Source*** | European Observatory on Health Care Systems |
| ***Year*** | 1999 |

| | |
|---|---|
| ***Code*** | 5.2.2 |
| ***Description*** | Dental specialist |
| ***Contents*** | |
| ***Source*** | European Observatory on Health Care Systems |
| ***Year*** | 1999 |

| | |
|---|---|
| ***Code*** | 5.3 |
| ***Description*** | Pharmacists |
| ***Contents*** | Pharmacists work in some large health centres. However, health centres do not have a pharmacy for the sale of prescription drugs to patients, although they do hold a stock of pharmaceuticals of their own for emergency cases: for minor surgery, acute cases at night when pharmacies are closed, use by in-patient departments and some other purposes. Patients are given drugs as part of their in-patient care, and these are included in the charge for in-patient care.<br><br>Health centres are of different sizes, and municipalities are free to decide on the organization of health services. Usually, the head of a health centre is the chief physician. However, in large and medium-sized health centres, the management often includes several leading persons. Often there are several chief physicians (who might be accountable to one medical director), one or several chief nurses and directors of finance and/or administration.<br><br>The services and facilities are of a high standard. As with the range of services, the quality of services has generally not been defined in detail. Various types of projects concerning quality assurance in both primary and specialized care have generated growing enthusiasm. National guidelines on quality assurance in social and health care were drawn up at the end of 1995. |
| ***Source*** | European Observatory on Health Care Systems |
| ***Year*** | 1999 |

| | | | |
|---|---|---|---|
| ***Code*** | 5.4 | | |
| ***Description*** | Midwifery | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1999 |

| | | | |
|---|---|---|---|
| ***Code*** | 5.5 | | |
| ***Description*** | Paramedical care | | |
| ***Contents*** | Physiotherapy and rehabilitation is offered mainly by physiotherapists. They not only treat individual patients but also give guidance and arrange physical exercise for groups of patients suffering from the same disorder. The health centre physiotherapy department is usually the place which also provides patients with medical aids and prostheses. | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1999 |

| | | | |
|---|---|---|---|
| ***Code*** | 5.6 | | |
| ***Description*** | Home nursing and home care (maternity home care included) | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1999 |

| | | | |
|---|---|---|---|
| ***Code*** | 5.7 | | |
| ***Description*** | Out-patient mental health care services | | |
| ***Contents*** | Sometimes health centres employ psychologists. Their work varies from advising on consultations done by other health centre workers to working with children and schools. However, ambulatory psychiatric care is normally organized at the outpatient departments of psychiatric hospitals and at separate clinics, so-called mental health centres (explained in more detail below). | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1999 |

| | | | |
|---|---|---|---|
| ***Code*** | 5.8 | | |
| ***Description*** | Ambulance services and patient transport | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1999 |

| | | | |
|---|---|---|---|
| ***Code*** | 5.9 | | |
| ***Description*** | Medical laboratories | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1999 |

| | |
|---|---|
| ***Code*** | 6 |
| ***Description*** | In-patient care |

***Contents***

Secondary and tertiary care are provided in hospitals, through outpatient and in-patient departments.
Hospital personnel are salaried employees. The management structure of hospitals is similar to that of hospital districts. The management board usually consists of a chief physician, a chief nurse and a director of finance (and/or administration), but there are variations, with larger hospitals having a more complex management structure. Hospital managers are accountable to the council of the hospital district.
The number of patients and the number of episodes treated in the in-patient departments of hospitals have increased in recent years, alongside a decline in the mean length of stay. For acute non-psychiatric care, this has dropped from 7.0 days in 1988 to 5.1 days in 1993. Similar reductions have occurred in all medical specialties. The number of patients treated at acute non-psychiatric hospitals increased by 4.2% in the same years. The bed occupancy rate has been fairly constant in the past few years, varying from about 80% to 85%.

About 80% of all treatment episodes take place in acute non-psychiatric hospitals, but only 36% of total bed days in all institutions are spent in such hospitals.

The reduction in the length of stay has been partly the result of more efficient medical treatment, for example the use of day surgery. It has also led to reduced waiting times for surgical procedures. However, there are still considerable local variations in waiting times for specific surgical procedures.

Psychiatric care has traditionally been fairly institutionalized in Finland. Efforts have recently been made to reduce the number of beds in psychiatric hospitals. There were 4.1 such beds per 1000 inhabitants in 1982, compared with 1.9 per 1000 inhabitants ten years later in 1992. At the same time, resources have been shifted from in-patient to ambulatory care, although not to the same extent as beds have been reduced. Some municipalities have reported deficiencies in the supply of mental health services. Attention is now being paid to this issue.

Primary and secondary care are not always very well coordinated. General practitioners often complain that they do not get sufficient information about the further treatment of patients they have referred to a hospital. It has been suggested that one person, for example the personal doctor, should have an overall view of patients when they are treated at different levels of the health system.
There is much excess capacity in the hospital sector. Departments or even whole hospitals have been closed. Some have been put up for sale. At present, there are no plans to build hospitals.

Table 4: The number of patients treated in in-patient departments has risen steadily. At the same time, the average length of stay has almost halved from what it was in 1970. In other words, more patients are treated in a much shorter time. The reasons for this are the growth in health care resources and in the number of health care personnel. The development of more efficient medical treatments, new medical technology and the introduction of day surgery have also played an important role here.

The number of hospital beds per 1000 population in Finland is above the average for western Europe (Fig. 9). Until the beginning of the 1990s, the health care delivery system was one of the most institutionalized in western Europe. Not only were patients treated too much in institutions, some of them were not treated in the most appropriate place.

Compared to some other western European countries, the number of hospital beds has always been rather high in Finland (Fig. 10). The number has fallen recently due to an active campaign to reduce institutionalized care, particularly chronic institutionalized care, and to improve the supply of various kinds of ambulatory care. As the number of hospital beds in other countries has also declined, however, the figure for Finland is still among the highest in western Europe. The number of hospital beds is expected to continue falling.

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|---|---|---|---|
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1999 |

| | | | |
|---|---|---|---|
| ***Code*** | 6.1 | | |
| ***Description*** | Hospital categories | | |
| ***Contents*** | The range of specialized care varies according to the type of hospital. There are 5 university hospitals, 17 central hospitals and over 30 other less specialized hospitals. There are only a few private hospitals. | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1999 |

| | | | |
|---|---|---|---|
| ***Code*** | 6.2 | | |
| ***Description*** | Other in-patient provisions | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1999 |

| | | | |
|---|---|---|---|
| ***Code*** | 7 | | |
| ***Description*** | Relationship between primary and secondary care | | |
| ***Contents*** | The in-patient department of a health centre works in much the same way as a hospital department. A typical health centre has 30 to 60 beds. The number of in-patient departments within a health centre varies. Larger health centres tend to have at least 2–3 departments. The majority of their patients are elderly and chronically ill. | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1999 |

| | | | |
|---|---|---|---|
| ***Code*** | 7.1 | | |
| ***Description*** | Planned or actual substitution policies for inpatient care | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1999 |

| | | | |
|---|---|---|---|
| ***Code*** | 7.2 | | |
| ***Description*** | Degree of co-operation between primary and secondary health care providers | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1999 |

| | | | |
|---|---|---|---|
| ***Code*** | 7.3 | | |
| ***Description*** | Imbalance between primary and secondary care | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1999 |

| | |
|---|---|
| ***Code*** | 8 |
| ***Description*** | Prevention and public health services |
| ***Contents*** | Nurses play an essential role in Finnish health centres. In addition to assisting general practitioners, nurses with a general nursing education have their own consulting hours for giving injections, removing sutures, measuring blood pressure and so on. Maternal and child health care are important parts of nurses' work. These activities are largely carried out by public health nurses (i.e. nurses specialized in preventive work). They are also involved in family planning, school care, occupational health services, home nursing and sometimes other kinds of consulting related to health.<br>At national level, the Ministry of Social Affairs and Health is concerned with the protection and promotion of public health. The Department for Health Promotion and Disease Prevention within the Ministry directs and develops preventive social and health care. It is responsible for health protection, environmental health and chemical affairs, and products (tobacco and alcohol) control. Several offices and institutes subordinate to the Ministry of Social Affairs and Health carry out some of these tasks. One of them is the National Public Health Institute. It conducts research into the causes of common national diseases and how to prevent them. It also collects data on communicable diseases, on health behaviour and on the effects of health promotion. As well as this, it must ensure the availability of vaccines in the country. |
| ***Source*** | European Observatory on Health Care Systems — ***Year*** 1999 |

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|---|---|
| ***Code*** | 8.1 |
| ***Description*** | Maternal and child health: family planning and counselling |
| ***Contents*** | Finnish health centres have an important role to play in providing public health services at local level. Maternal and child care and school care provided by health centres are central to preventive health services. Maternal and child care has a strong tradition in Finland. It is largely thanks to the comprehensive network of maternal and child care services and the great emphasis placed on these services that infant mortality in Finland is one of the lowest in the world.<br>Family planning and dental care for children in the Finnish public health care system deserve particular mention. The abortion rates in Finland have fallen constantly from a peak in 1973, despite a liberal abortion law. The reason is the comprehensive family planning services provided by health centres and health education directed at young people. |
| ***Source*** | European Observatory on Health Care Systems — ***Year*** 1999 |

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|---|---|
| ***Code*** | 8.2 |
| ***Description*** | School health services |
| ***Contents*** | Another success story in public health care is systematic dental care for children, which has yielded very good outcomes. |
| ***Source*** | European Observatory on Health Care Systems — ***Year*** 1999 |

| | |
|---|---|
| ***Code*** | 8.3 |
| ***Description*** | Prevention of communicable diseases |
| ***Contents*** | The general immunization programme in Finland covers the whole population. It starts with child care in health centres and is continued in schools. High immunization coverage rates have been achieved for tuberculosis, poliomyelitis, tetanus, diphtheria, measles, mumps, German measles and Haemophilus influenzae.<br>The control and follow-up of communicable diseases is defined by legislation and other regulations of the Ministry of Social Affairs and Health. The National Public Health Institute has issued recommendations concerning the follow-up and prevention of communicable diseases. The Institute also reports on communicable diseases to health authorities, health care providers and the mass media.<br><br>The National Public Health Institute and the hospital districts maintain communicable disease registers. Doctors are obliged to report those communicable diseases defined by law. Those diseases which have been chosen to be followed up are either quarantine diseases or diseases where prevention of epidemics is a concern (for example, sexually transmitted diseases – STDs – and salmonellosis).<br><br>The prevention of STDs is based on the detection of all those infected and easy access to treatment: treatment is therefore free of charge. All those possibly infected must be traced and directed to a health centre or another place to receive treatment. The largest cities have separate STD clinics, but otherwise the treatment of STDs is provided as part of the other health care services.<br>Finland has the highest level of immunization against measles in western Europe, with almost 100% of children immunized. The same is true of childhood immunization against most other viral infections. This is clearly thanks to the highly advanced child care system and the comprehensive network of child care centres within health centres. |
| ***Source*** | European Observatory on Health Care Systems |
| ***Year*** | 1999 |

| | |
|---|---|
| ***Code*** | 8.4 |
| ***Description*** | Prevention of non-communicable diseases |
| ***Contents*** | Municipalities are obliged by law to provide mammography screening for all women between the ages of 50 and 59 and cervical screening for 30–60-year old women. Municipalities often buy these services from a private provider. The vast majority of Finnish women participate in these screening programmes. Other screening programmes are not routinely carried out at national level.<br>Finnish public health policy has been particularly successful in some areas. Efforts have been made to reduce mortality and risk factors related to cardiovascular diseases, which are a major national problem. More efficient treatment and early diagnosis of coronary heart disease and other cardiovascular diseases have also reduced mortality. Active campaigns and education on nutrition and lifestyle factors have been carried out by health professionals, health authorities and voluntary organizations.<br><br>The prevalence of cardiovascular diseases among men in the eastern parts of Finland has been higher than in other parts of the country and is one of the highest in the world. In 1972 the North Karelia project was launched in the eastern province of North Karelia in response to a local petition to reduce the high levels of heart disease. The planning was done by Finnish experts, but also involved representatives from North Karelia and experts from the World Health Organization. The project was integrated as far as possible into the local service system and social organization. Various methods were used in the project: provision of general information and health education (through materials, mass media, meetings, campaigns etc.), development of referral and screening procedures in health services, encouragement of environmental changes (such as smoking restrictions, promoting vegetable-growing, collaborating with food manufacturers), preventive work directed at children and young people, training and education of health personnel and monitoring of results. Most of the practical work was carried out by various bodies in the community itself.<br><br>The original project period lasted from 1972 to 1977, but the project has continued operating beyond this period and activities have been expanded elsewhere in the country. Since the very beginning, the project has undergone careful scientific evaluation. The monitoring systems originally developed for the North Karelia project have been adopted over the years as a national monitoring system.<br><br>The project has been successful in changing people's lifestyles and reducing other risk factors. The changes over 20 years have been considerable: average serum cholesterol and average blood pressure levels have declined in both the male and the female population. Especially in men, smoking has been markedly reduced. The reduction in risk factors has also resulted in a fall in death rates from cardiovascular diseases. At the beginning of the 1990s, male mortality from coronary heart disease was almost 60% lower than at the beginning of the project. Mortality from other cardiovascular diseases has also declined.<br><br>It must be noted that the project has not been restricted to North Karelia only. Similar efforts to reduce the prevalence of and mortality due to cardiovascular diseases have been made elsewhere in the country. Trends in risk factors and mortality elsewhere in the country have paralleled those in North Karelia. |
| ***Source*** | European Observatory on Health Care Systems — ***Year*** 1999 |

| | |
|---|---|
| ***Code*** | 8.5 |
| ***Description*** | Occupational health care |
| ***Contents*** | The occupational health care available at health centres is offered to those employees whose employers have elected to arrange occupational health care in this way. Occupational health care is provided by one of the health centre general practitioners, together with one or several nurses. |
| ***Source*** | European Observatory on Health Care Systems — ***Year*** 1999 |

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|---|---|
| ***Code*** | 8.6 |
| ***Description*** | All other miscellaneous public health services |
| ***Contents*** | Health education is carried out by establishments in the health care system, by schools and by various voluntary organizations which represent different patient groups. Central issues in health education are smoking, nutrition, physical exercise and reproductive health. The Ministry of Social Affairs and Health also carries out health education and allocates a specific grant for this purpose.<br><br>Efforts have been made to reduce the consumption of harmful products. This has partly been achieved by taxation, which has kept the prices on alcohol and tobacco at high levels. As in most other Scandinavian countries, alcohol has been a state monopoly. This has made it possible to regulate pricing and sales. Total consumption of alcohol is about the same as 20 years ago, on the average for western European countries. Consumption is not evenly distributed throughout the population: a small proportion of the population consumes most of the total. There is a general trend towards less strong drinks such as medium-strength beer. This has been achieved partly by pricing policy. However, as Finland is now a member of the European Union, pricing and licences to sell alcohol can no longer be used as means to regulate alcohol consumption.<br><br>The prevalence of smoking in the adult population has declined, especially among men, although men still smoke more than women. Campaigns, pricing and legislation have been used to reduce smoking. In 1995, a strict law on smoking came into force, aimed at preventing passive smoking by prohibiting smoking in almost all public places. It also is intended to reducing smoking among children and young adults. Selling tobacco to children under 18 has therefore been prohibited. Drugs are not a large problem in Finland, although data indicate that their use is increasing.<br><br>The dietary habits of Finns have improved considerably during the last few decades. This has been due partly to health education and partly to other measures. The food industry has taken recommendations on healthy nutrition into account in its product development. For example, the range of milk products with a low percentage of animal fat has been broadened and the use of vegetable oil has increased. Healthy nutrition has also been supported by legislation. In 1993, a statute came into force defining the salt content of the most important foodstuffs. Those exceeding the defined salt content must be marked "strongly salted" and those containing less than the defined content can be marked "slightly salted". |
| ***Source*** | European Observatory on Health Care Systems |
| ***Year*** | 1999 |

| | |
|---|---|
| ***Code*** | 9 |
| ***Description*** | Social care related to health care |
| ***Contents*** | The provision of social services is the responsibility of municipalities. Like health care, social services are financed from municipal taxes, state subsidies and user charges. The state subsidies for social services are paid to municipalities according to certain criteria: number of inhabitants, age structure and unemployment rate within the municipality.<br><br>The majority of patients receiving long-term care are elderly (almost 90% are over 65 years old). Long-term care of the elderly is provided in the in-patient departments of health centres. There are also many homes for the elderly: the majority are owned by municipalities, but a number are private homes. Health centres often work closely with homes for the elderly by, for example, sending a health centre doctor for consultations once or twice a week.<br><br>Other long-term services for elderly include home help services, home nursing, day hospitals and other day care centres, part-day nursing and so-called service housing. This is where the elderly live in their own apartments but are offered different kinds of services such as nursing and other help needed for daily life. The national plans for social and health care have stressed support for the elderly living in their own homes, and this is the preferred alternative of older people themselves. As a result, considerable efforts have been made to improve the supply of supportive services offered to the elderly in their homes.<br><br>The disabled are also offered special homes and other services by the municipalities. Legislation requires that disability services must be provided according to the need in a municipality.<br><br>Institutionalized long-term psychiatric care is usually provided in psychiatric hospitals, but there are considerable regional variations in how long-term care is organized. A variety of services exist to support ambulatory and semi-institutionalized care for long-term psychiatric patients. These comprise residential homes, rehabilitation homes, shared apartments, day hospitals and day care centres, sheltered housing and so on. The organization providing these services varies from region to region; sometimes it is the municipal social and health service system, sometimes the private sector and sometimes specialized psychiatric hospitals.<br><br>A common way of providing ambulatory psychiatric care is through so-called mental health centres, where both acute and long-term patients can seek help. These units work under the management of psychiatric hospitals and are staffed by psychiatrists, psychologists, psychiatric nurses and social workers, among others. At present, some of the smallest mental health centres are being transferred to the administration of health centres, since the staff of the smallest centres are often only couple of nurses and they cannot therefore be regarded as specialized outpatient clinics.<br><br>As explained above, institutionalized psychiatric care has been cut back more than ambulatory services have been increased. The supply of supportive and intermediate services has not been sufficient. This issue is now regarded as needing more attention. |
| ***Source*** | European Observatory on Health Care Systems |
| ***Year*** | 1999 |

| | |
|---|---|
| ***Code*** | 9.1 |
| ***Description*** | Organisation and financing of social care |
| ***Contents*** | Health centres often employ social workers to deal with various problems related to illness, such as helping patients to apply for benefits or arranging home help and other services needed by patients discharged from in-patient care. |
| ***Source*** | European Observatory on Health Care Systems |
| ***Year*** | 1999 |

| | | | |
|---|---|---|---|
| ***Code*** | 9.2 | | |
| ***Description*** | Role of central/regional/local government | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1999 |

| | | | |
|---|---|---|---|
| ***Code*** | 9.3 | | |
| ***Description*** | Role of other organisations | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1999 |

| | | | |
|---|---|---|---|
| ***Code*** | 9.4 | | |
| ***Description*** | Responsibility of family members | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1999 |

| | | | |
|---|---|---|---|
| ***Code*** | 9.5 | | |
| ***Description*** | Financing of social care | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1999 |

| | | | |
|---|---|---|---|
| ***Code*** | 9.6 | | |
| ***Description*** | Explicit health/social care policy | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1999 |

| | | | |
|---|---|---|---|
| ***Code*** | 10 | | |
| ***Description*** | Medical goods and health care technology assessment | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1999 |

| | |
|---|---|
| ***Code*** | 10.1 |
| ***Description*** | Pharmaceuticals |
| ***Contents*** | Pharmaceutical products may be sold only by permission of the Medicines Control Agency, which is subordinate to the Ministry of Social Affairs and Health. Until 1994, a reasonable price was one prerequisite for obtaining permission to market a drug. At the beginning of 1994, pricing matters were transferred from the Medicines Control Agency to the National Board for Drug Reimbursement, which is also attached to the Ministry of Social Affairs and Health.<br><br>In order to be licensed as a reimbursable drug, the wholesale price of a pharmaceutical – as determined by the National Board for Drug Reimbursement – must be reasonable. Several criteria are used to decide whether a price is reasonable or not. These include the total costs of treatment, the benefits of the pharmaceutical, the price when compared to similar preparations, the price in other countries, and the development and manufacturing costs of the pharmaceutical. Other matters related to reimbursement of drugs are handled by the Social Insurance Institute. The retail price is determined on the basis of the wholesale price as decided by the government.<br><br>The majority of drugs that have been authorized for sale in Finland also are licensed as reimbursable. Only some mild analgesics that are sold in very small packages or pharmaceuticals whose manufacturer has not asked for a reimbursement licence are excluded. In these cases, the manufacturer itself decides the price of the pharmaceutical. This is often done in the case of preparations used in hospitals (anaesthetics and radiological contrast mediums). The hospital and the producer negotiate a contract on the amount and price of such products.<br><br>Pharmaceuticals can be sold only by pharmacies. Prescription drugs are sold by order of a medical doctor, a dentist or a veterinary surgeon. Pharmacies are privately owned but require a permit from the Medicines Control Agency. The number and location of pharmacies are therefore controlled.<br><br>Efforts have been made to reduce the costs arising from prescribed pharmaceuticals and to encourage medical doctors to prescribe the cheapest preparations. In 1993, doctors were given permission to write the letter "G" next to the brand name of the product on their prescription. By doing this they allow pharmacies to choose the cheapest generic preparation. However, this kind of prescribing has not been very popular among doctors, and only a very small number of all prescriptions are marked with the letter "G".<br><br>A new law on generic prescribing was introduced in March 1996. According to the new law, doctors can write the generic name of the pharmaceutical on the prescription instead of the brand name as is obligatory now. Pharmacies are obliged to dispense the cheapest preparation or a preparation whose price differs only slightly from the cheapest one. The new law also allows prescribing in electronic form. This means that drugs can be prescribed by fax or electronic mail if the sender and the recipient can be identified. |
| ***Source*** | European Observatory on Health Care Systems — ***Year*** 1999 |

| | |
|---|---|
| ***Code*** | 10.2 |
| ***Description*** | Therapeutic appliances |
| ***Contents*** | |
| ***Source*** | European Observatory on Health Care Systems — ***Year*** 1999 |

| | | | |
|---|---|---|---|
| ***Code*** | 10.3 | | |
| ***Description*** | Health care technology assessment | | |
| ***Contents*** | In 1995, a centre for health care technology assessment, called FINOHTA, was established in Finland. The main activities of the centre are encouraging and financing health care technology assessment and providing information on the results of such assessments, i.e. to function as a "clearing-house". Two full-time and two part-time workers are employed in the centre. The centre has started supporting some health care technology assessment projects and publishes its own leaflet. The activities of the centre are expected to be extended in the near future. | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1999 |

| | | | |
|---|---|---|---|
| ***Code*** | 11 | | |
| ***Description*** | Other services | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1999 |

| | |
|---|---|
| ***Code*** | 11.1 |
| ***Description*** | Education and training of personnel |
| ***Contents*** | The Ministry of Education is responsible for the education and training for health personnel in Finland. Medical doctors are trained at five universities, and basic medical training lasts six years. To obtain a licence to practice independently, two years of practical work in both hospitals and health centres are required. Part of this training may be completed in the private health care sector or by doing research. After being licensed, doctors can continue working at health centres, specialize in one of the numerous medical specialties or establish a private practice.<br><br>Specialization starts with a doctor working at a central or regional hospital under the supervision of an experienced physician. After that, at least two years' work at a university hospital is required for most medical specialties. Doctors must register with a faculty of medicine for the relevant specialist training programme. Specialization lasts 4–6 years, depending on the specialty. To obtain a specialist diploma, a specified amount of theoretical training is required and a national examination has to be passed.<br><br>The theoretical training during specialization and other complementary training is organized by the medical faculties, hospitals, the various medical associations, pharmaceutical companies and other organizations.<br><br>Specialization in general medicine takes four years of training after licensing as a medical doctor. This includes two years working in a hospital, another two in a health centre, a specified number of theoretical courses and successful completion of a national examination.<br><br>The Ministry of Education estimates the need for general physicians and specialists. It makes proposals concerning the number of students to be admitted to medical faculties. In theory, universities are free to decide on the number of students to be taken in, but in practice the authorities and the universities jointly agree on the number of doctors to be trained.<br><br>The training of nurses and other health care personnel such as physiotherapists and laboratory personnel takes place at nursing colleges.<br><br>Until the end of the 1980s, nurse education began with a general programme, followed by specialization. Nowadays, the general and specialization programmes have been combined. When entering training, students have an opportunity to choose from a number of specialties:(i) nursing for surgery and internal medicine; (ii) paediatric nursing; (iii) anaesthetic and operating theatre nursing; and (iv) psychiatric nursing. Training in each of these specialties takes three and a half years. The training programme for public health nurses also lasts three and a half years, while that for midwifes takes four and a half years. Assistant nurses used to be trained in a one-year programme, but this programme has been abolished. Instead, a new two and a half-year programme has been launched to give qualifications for various tasks in both the health and the social services.<br><br>The Ministry of Education also estimates the need for nurses. The nursing colleges make suggestions about the number of students to be admitted for training. Agreement is then reached with the authorities on the number of students to be admitted. |
| ***Source*** | European Observatory on Health Care Systems |
| ***Year*** | 1999 |

| | |
|---|---|
| ***Code*** | 11.2 |
| ***Description*** | Research and development in health |
| ***Contents*** | |
| ***Source*** | European Observatory on Health Care Systems |
| ***Year*** | 1999 |

| | | | |
|---|---|---|---|
| ***Code*** | 11.3 | | |
| ***Description*** | Environmental health and control of drinking water | | |
| ***Contents*** | At national level the Ministry of Social Affairs and Health is responsible for matters related to environmental health. At local level, the municipalities are responsible for tasks concerning proper water supply, waste management and other environmental matters. | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1999 |

| | | | |
|---|---|---|---|
| ***Code*** | 11.4 | | |
| ***Description*** | Health programme administration and health insurance | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1999 |

| | | | |
|---|---|---|---|
| ***Code*** | 11.5 | | |
| ***Description*** | Administration and provision of cash benefits | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1999 |

| | | | |
|---|---|---|---|
| ***Code*** | 12 | | |
| ***Description*** | Manpower in health care | | |
| ***Contents*** | Unemployment among health care personnel is a recent phenomenon. Until the 1990s, unemployment among medical doctors and nurses was practically non-existent. The recent economic crisis has led to unemployment among doctors, nurses and other personnel: about 9% of all clinical personnel are currently unemployed. The number of students entering training has therefore been reduced.<br>The number of physicians has increased steadily, as it has in other European countries, although the number per capita is still below the average for western Europe.<br>The number of nurses per capita in Finland is higher than in other western European countries. There may be a number of reasons for this: in the past, there were very few doctors and therefore more nurses were needed for various tasks; in addition, a large number of public health nurses are needed for the various roles in public health care, especially maternal and child care. | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1999 |

| | | | |
|---|---|---|---|
| ***Code*** | 13 | | |
| ***Description*** | Fees, rates and salary structure | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1999 |

| | |
|---|---|
| ***Code*** | 13.1 |
| ***Description*** | Methods of payment to (specialist) physicians |
| ***Contents*** | |
| ***Source*** | European Observatory on Health Care Systems |
| ***Year*** | 1999 |

| | |
|---|---|
| ***Code*** | 13.1.1 |
| ***Description*** | Integrated or contracted |
| ***Contents*** | Physicians in hospitals are salaried employees, with the basic monthly salary depending on the physician's post and length of career. Various bonuses can be paid, for example, for increased responsibility. There is additional remuneration for being on call (this can also be "paid" as time off). Physicians can charge fees for certificates of health status or statements for other authorities. The payment of general practitioners in public health care centres varies. Most are salaried employees with the same conditions as hospital physician's concerning additional extra remuneration. In those health centres where the personal doctor system has been introduced the doctors are paid a combination of a basic salary (approximately 60%), capitation payment (20%), fee-for-service payment (15%) and local allowances (5%). The personal doctor payment is thought to give better incentives for cost-efficiency than the monthly salary payment. In the private sector, physicians are paid on a fee-for-service basis, with patients being partly reimbursed by the National State Sickness Insurance. |
| ***Source*** | European Observatory on Health Care Systems |
| ***Year*** | 1999 |

| | |
|---|---|
| ***Code*** | 13.1.2 |
| ***Description*** | Type of payment |
| ***Contents*** | |
| ***Source*** | European Observatory on Health Care Systems |
| ***Year*** | 1999 |

| | |
|---|---|
| ***Code*** | 13.1.3 |
| ***Description*** | Method for deciding fees/salaries |
| ***Contents*** | Health personnel's wages, salaries or fees are negotiated between the Association of Municipalities and the labour unions. The relevant ministries do not participate in these negotiations.<br>The physicians' labour union negotiates with the Association of the municipalities over physicians' salaries. The government does not have any influence over this procedure. The average income of medical doctors is above the general average income in Finland.<br>Specialists who work in private practice (in addition to their work in public hospitals) and personal doctors who see a lot of patients and do a lot of on-call work usually have a somewhat higher income than other doctors. |
| ***Source*** | European Observatory on Health Care Systems |
| ***Year*** | 1999 |

| | |
|---|---|
| ***Code*** | 13.2 |
| ***Description*** | Methods of hospital payment |

***Contents***

The financing of hospitals was changed at the same time as the state subsidy reform was implemented in 1993. Before 1993, hospitals received about half of their revenue from the state via the provincial boards. The other half of hospital revenues came from municipalities, but as the actual costs were reimbursed through state subsidies, the risk of high costs was largely borne by the state rather than the municipality. This system did not encourage hospital productivity: hospital revenues, being allocated largely on historical grounds, were fairly automatic from year to year and municipalities did not actively control costs. When the state subsidy system changed, the risks and incentives facing municipalities also changed. With prospectively fixed budgets, the risks of overspending are borne by municipalities – as are the advantages of making savings.

Since 1993 hospitals have been paid per item of service. Hospitals determine prices for their services without national guidelines. Much effort has been made within hospitals to define services and to calculate a price for each service. Services are defined and prices calculated in very different ways: there is not even uniformity within a single hospital district. The most common method of pricing is based on a bed-day. Bed-day prices are often divided into categories or groups according to the range and level of care needed by the patient. Service package prices for in-patient care have also become fairly common. A service package includes certain services (the diagnosis or type of treatment, for example, childbirth or cholecystectomy) for a specified length of stay. The prices for outpatient care also vary. Normally, the price is set per visit and often according to the range and level of treatment.

There are variations in how hospitals bill municipalities; usually they send a monthly bill to the health centre which then passes it on to the municipality. The municipality pays the bill directly to the hospital's account. Municipalities do not usually negotiate on prices, which means that they accept the prices announced by hospitals. However, very recently, municipalities have become more reluctant to accept prices without question.

Billing and pricing by hospitals are in a continuous process of change. At present, it is extremely difficult to compare services and prices between different hospitals and hospital districts because, as has been said, they are defined in different ways and the prices can be changed during the course of the year.

Probably the biggest problem associated with the Finnish hospital payment system is that the municipalities (who finance hospitals) do not have very much power. As a result, they are unable to influence prices or the level of services and they are not able to negotiate on them. Setting service priorities and prices is very much producer-centred. Some experiments have started, however, in which municipalities and hospitals make a contract in advance on the basis of predicted levels and prices of services.

Even though the billing often occurs on a bed-day basis, there is little evidence that hospitals are prolonging lengths of stay. Hospitals want to appear efficient and are motivated to discharge patients as quickly as possible in order to increase productivity. On the other hand, hospitals are not reluctant to admit patients to hospital for new treatment episodes.

In addition to their revenues from municipalities, the five university hospitals in Finland receive a special state subsidy to compensate additional costs arising from teaching and research. This special subsidy is granted according to the number of medical doctors and specialists graduating from the university (and university hospital) and the number of scientific publications which are produced by researchers in the university hospital. Each doctor or specialist graduating and each publication count for a specified number of points. A point is worth a specified amount of money (determined annually by the Ministry of Social Affairs and Health). Studies which are published in prestigious medical journals receive more points (and therefore more money) than those published in less esteemed medical journals. In 1995, the total state subsidy paid to university hospitals was about FM 650 million (around 12% of their running costs).

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|---|---|---|---|
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1999 |

| | | | |
|---|---|---|---|
| ***Code*** | 13.2.1 | | |
| ***Description*** | Method of payment | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1999 |

| | | | |
|---|---|---|---|
| ***Code*** | 13.2.2 | | |
| ***Description*** | Method for deciding rates | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1999 |

| | | | |
|---|---|---|---|
| ***Code*** | 13.2.3 | | |
| ***Description*** | Recent changes in payment method | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1999 |

| | | | |
|---|---|---|---|
| ***Code*** | 14 | | |
| ***Description*** | Main system of financing and coverage (tax based, insurance based, mixture) | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1999 |

| | |
|---|---|
| ***Code*** | 14.1 |
| ***Description*** | Main features of tax based systems |

***Contents***

The Finnish health care system provides universal coverage based on residence. Everyone permanently residing in Finland has the right to make use of the health service.

The health care system in Finland is mainly tax-financed. Both the state and the municipalities have the right to levy taxes. In 1994 about 33% of total health care costs were financed by municipal income tax, about 29% by the state, 13% by the compulsory National State Sickness Insurance (NSSI) Scheme and about 25% by private sources. About two thirds of total health care expenditure is on health services provided by municipalities. Most of the remaining one third is spent on medicines and other pharmaceutical products, private health care, medical aids and prostheses and occupational health care. This third is largely financed by NSSI, out-of-pocket payments and employers.

The state's revenues come mainly from a progressive income tax and indirect state taxes. After the economic crisis broke in 1990, the state had to finance public sector activities by taking out growing amounts of loans. Combined spending on health, welfare and social security accounts for about 30% of annual state expenditure: health care takes about 9%, social services some 7% and social security transfers about 14%. State financing for health care largely takes the form of state subsidies, which are allocated by the Ministry of Social Affairs and Health to every municipality. (The state also allocates subsidies for education and social services.) The allocation of state subsidies is explained in more detail below.

Municipal income tax is set as a fixed proportion of a person's income but varies from municipality to municipality: on average it is 17% of income. Municipal tax revenues are used not only for health care but also for other services such as education and welfare. On average some 35% of municipalities' budgets are spent on social and health services, with about 19% spent on health care alone.

NSSI revenues come from insurees and employers, returns on assets held and a state contribution. The contribution paid by wage- and salary-earners and pensioners is a specified percentage of their income, while that paid by employers is a specified percentage of their employees' earnings. The state pays a share of the total costs of sickness, parenthood and special care allowances (about 13%, or some FM 733 million in the year 1994). In 1995 and 1996, according to a provisional regulation, this state contribution was not paid to the NSSI. NSSI revenues in a given year must be approximately equal to expenditure in that year. The state guarantees the solvency of the NSSI.

The existence of several sources of public funding creates some problems. As explained above, municipal health care is financed by state and municipal taxes (with a small proportion of costs met by user charges). The other public funding source is the NSSI which is used to finance private health care, occupational health care and many other services. NSSI reimbursements do not affect the amount of the municipalities' state subsidy, even though a considerable proportion of a municipality's population may use private and occupational health services. The NSSI is financed by all citizens throughout Finland, but the majority of private health and occupational health care is provided in the largest cities in the south of the country. The utilization of private and occupational services is therefore supported by citizens who do not themselves use these services. This is, of course, not equitable.
Another problem with the existence of several public funding sources is that financing often determines how services are provided. For example, municipalities are responsible for financing institutional and ambulatory care, but the NSSI reimburses some ambulatory care costs (medication, transport, rehabilitation etc.). When it is not clear whether a treatment is ambulatory or institutional, both parties try to shift responsibility and costs to the other. This often leads to perverse incentives and inefficient use of services. In addition, the parallel systems are said to have created overlapping capacity (in terms of facilities and equipment).

It is believed that health care in Finland will remain tax-financed in the future. Nevertheless, there seems to be a need to clarify and simplify the public financing system. At present, there are no plans to change the funding basis, even though the marked economic recession has created – and still is creating – difficulties in the public sector economy.

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|---|---|---|---|
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1999 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.1.1 | | |
| ***Description*** | Main body(ies) responsible for providing health care cover to beneficiaries | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1999 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.1.2 | | |
| ***Description*** | Extent of population coverage (excluded groups) | | |
| ***Contents*** | Everyone in Finland has the right to health services regardless of ability to pay or place of residence. | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1999 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.2 | | |
| ***Description*** | Main features of social health insurance | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1999 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.2.1 | | |
| ***Description*** | Organisation of main body responsible for insuring/providing coverage | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1999 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.2.2 | | |
| ***Description*** | Extent of population coverage | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1999 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.2.3 | | |
| ***Description*** | Stipulations in premium contribution | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1999 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.2.4 | | |
| ***Description*** | Competition between insurance schemes | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1999 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.2.5 | | |
| ***Description*** | Provision for risk adjustment | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1999 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.3 | | |
| ***Description*** | Health care benefits and rationing; recent reductions in benefits package and variations in extent between different insurance plans | | |
| ***Contents*** | Some services are excluded from the statutory health system: these include some dental care, spectacles and sight tests.<br><br>Dental care for adults born before 1956 is not publicly funded. However, those adults with certain specified illnesses and veterans of the Second World War are reimbursed by the NSSI for dental care. It was planned to extend the reimbursement of dental care to cover the whole population, but these plans have been shelved owing to the economic recession and pressure on public expenditure.<br><br>Sight tests and spectacles are generally not financed by the public system, nor are alternative therapy or complementary medicine. Cosmetic surgery is publicly financed when it is necessary following a disease, burns or tumours, for example, but not for solely cosmetic reasons. In vitro fertilization and surgery for varicose veins are not excluded from the public system.<br><br>Employers are obliged to provide occupational health services for their employees, but because many employers arrange additional health care services, there are differences in the services available to employees. All employees, however, have access to public sector services.<br><br>There are no plans for an explicitly stated basic package of benefits. However, there have been discussions about setting priorities. A priorities task force published its report in the autumn of 1994. The report did not contain any specific recommendations, only very general principles and guidelines. It did, however, emphasize transparency in decision-making, stating that the main principles for decisions in this area should be human rights, self-determination, equality and justice. In setting priorities, a distinction should be made between priority-setting at the political or administrative level and at the clinical level. For the time being, benefits coverage is expected to remain about the same. | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1999 |

| | |
|---|---|
| ***Code*** | 14.4 |
| ***Description*** | Complementary sources of finance |
| ***Contents*** | Finland's Slot Machine Association has become an important financer of capital investments. (The Slot Machine Association operates slot machines, amusement machines and casino games. Its revenues are distributed to support the work of voluntary health and welfare organizations in areas such as the provision of service housing for the aged and disabled, assistance for individuals and families in difficulties, youth work and care for substance abusers.) In 1994, the Slot Machine Association financed around one third of all capital investments in the health sector. This has resulted in a greater need to coordinate investment activities. However, the Association does not finance any public health services (e.g. municipal health services).<br>The share of private financing has been increasing. This is due to increased out-of-pocket payments by patients. The charges for municipal services have been increased during the past 3–4 years. In addition, there have been reductions in the reimbursement of pharmaceuticals by the NSSI. Finally, the tax-deductible status of drug and other medical treatment costs was removed in 1992. |
| ***Source*** | European Observatory on Health Care Systems ***Year*** 1999 |

| | |
|---|---|
| ***Code*** | 14.4.1 |
| ***Description*** | Voluntary health insurance |
| ***Contents*** | Voluntary or private insurance is not significant in Finland. It accounts for about 2% of total health care financing. Private insurance mainly includes health care costs met under life and accident insurance schemes. No major changes are expected in this area. |
| ***Source*** | European Observatory on Health Care Systems ***Year*** 1999 |

| | |
|---|---|
| ***Code*** | 14.4.1.1 |
| ***Description*** | Organisation of voluntary health insurance: public, quasi public, private, not for profit |
| ***Contents*** | |
| ***Source*** | European Observatory on Health Care Systems ***Year*** 1999 |

| | |
|---|---|
| ***Code*** | 14.4.1.2 |
| ***Description*** | Type and nature of services covered |
| ***Contents*** | |
| ***Source*** | European Observatory on Health Care Systems ***Year*** 1999 |

| | |
|---|---|
| ***Code*** | 14.4.1.3 |
| ***Description*** | Proportion of population covered |
| ***Contents*** | |
| ***Source*** | European Observatory on Health Care Systems ***Year*** 1999 |

| | |
|---|---|
| ***Code*** | 14.4.2 |
| ***Description*** | Out-of-pocket payments: main cost sharing measure (partial reimbursement, co-payment) by care category: ambulatory, inpatient, drugs, medical aids and prostheses |

***Contents***

Those services which are free of charge are defined by law. A maximum out-of-pocket payment is defined by statute for those services where a fee is allowed.
Ambulatory care
The following services are free of charge: preventive health care (for example, maternity and child care); ambulatory psychiatric care; immunization (in most cases); the examination and treatment of some communicable diseases specified in law (sexually transmitted diseases, tuberculosis, hepatitis and some others); treatment of respiratory arrest patients; medical aids and prostheses; transportation from one health care unit to another when ordered by a medical doctor; and treatment of under 18-year olds in hospital if it lasts for more than 7 days in any calendar year.

Municipalities are free to decide if they want to charge patients, but they are not allowed to exceed the maximum limits set by statute.

Municipalities may choose from two alternative ways of charging for a visit to a health centre doctor: FM 100 to cover all visits during the following 12 months (if the patient does not want to pay the annual FM 100, he is charged FM 50 per visit); or a FM 50 payment per visit which is paid for the first three visits, with all further visits during one calendar year being free. Children under 15 years are not charged anything. Laboratory and X-ray examinations are included in the fees. Dental care is charged depending on the type of care: for example, preventive dental care is charged at FM 0–100 and dental treatment at FM 25–200 (all dental care is free of charge for under 19-year olds).

Fees for private sector doctors and dentists are reimbursed by the NSSI up to 60% of the established basic tariff. However, the actual fees charged by private doctors are normally higher than the basic tariff. Treatment and examination by a private doctor are reimbursed at 75% in excess of FM 70 of the established basic tariff. In 1993, the NSSI covered 36% of actual patient fees to private doctors, on average.

Dentists' fees are reimbursed by NSSI for patients born in or after 1956. Patients suffering from some chronic diseases and veterans of the Second World War are also partly reimbursed for dental treatment. In such cases the reimbursement rate for examination, preventive care and dental treatment is 60% of the basic tariff.
Hospital care
The maximum fee for an outpatient visit to a specialist at a hospital is FM 100 per visit and for in-patient care FM 125 per day. Hospitals are allowed to set lower prices. Charges for long-term care (provided, for example, in the in-patient departments of health centres) are determined according to a person's income.
Drugs
Patients receive 50% reimbursement of all pharmaceutical costs in excess of a fixed limit per single purchase (in 1996 this is FM 50) from the NSSI. Patients with certain chronic conditions are reimbursed at 75% or 100% in excess of FM 25. There is a maximum limit of costs to be met by a patient per year. In 1996 this limit was FM 3158. All drug costs exceeding this limit are met by the NSSI.
Medical aids and prostheses
Medical aids and prostheses are generally free of charge by law. The main responsibility for providing and financing medical aids and prostheses lies with the municipal health services, i.e. they are supplied either by health centres or by hospitals. Other bodies such as the social services authorities, the Social Insurance Institute and private insurance companies also provide or finance medical aids for their clients if the legislation concerned obliges them to do so.
Others
The NSSI also reimburses transportation costs if these exceed FM 45 per journey. If transportation paid for by patients exceeds FM 900 per year, the NSSI reimburses all transportation costs in excess of this limit.
Changes in out-of-pocket payments
The share of out-of-pocket-payments in total health care financing has been increasing. The deep economic recession, which started in 1990 and has created a growing public debt, has forced a reduction in public spending. The relative share of out-of-pocket payments has therefore increased.

Out-of-pocket payments have also increased in absolute terms. User charges for health centres were introduced in 1993. Before 1993, visits to health centre doctors were free of charge. In addition to this, the NSSI has reduced its compensation for numerous services, e.g. drugs. Charges for hospital care have also increased in recent years.

Compared to other countries, out-of-pocket payments are already rather high in Finland. It is thought that out-pocket-payments cannot be increased any more. If health care requires further funding, other sources of financing will have to be found.

In a similar way to the annual limit for prescribed pharmaceuticals, an annual maximum limit for costs arising from medical care other than drugs has been planned. This would mean that patients would not have to pay anything for medical care when costs exceeded the limit set. However, it is still uncertain whether this measure will be introduced.

***Source*** European Observatory on Health Care Systems ***Year*** 1999

***Code*** 14.4.3

***Description*** External sources of funding: employers, fund raisers etc.

***Contents***

***Source*** European Observatory on Health Care Systems ***Year*** 1999

***Code*** 15

***Description*** Health care expenditure

***Contents***

***Source*** European Observatory on Health Care Systems ***Year*** 1999

***Code*** 15.1

***Description*** Structure of health care expenditures

***Contents***

Health care expenditure, as measured as a share of GDP in Finland, is above the western European average (8.8% to 7,7%). The public share is about the same level as the average in western Europe (6.8% to 5.9%. The public share consists of the contribution paid by the municipalities and the state as well as the NSSI. The remainder is mainly financed by households.

In the 1970s and the 1980s, Finland's health care expenditure compared to other countries was about or below average. However, in the beginning of the 1990s the share of GDP was one of the highest in western European countries. As explained above, this was due not to growth in health care expenditure but to the dramatic decline in GDP. The share has reduced since 1992.
Total expenditure on health care rose constantly from the 1970s until the beginning of the 1990s. The value of health care expenditure in constant prices grew by 3.5% annually until 1990, but then in only three years (from 1991 to 1993) it declined by 9.5%. The declining trend was due to cuts in public expenditure on health care as a result of the marked economic recession of the early 1990s. Health care expenditure as a share of GDP has risen constantly during the past decades. In 1991 and 1992 it was exceptionally high due to the dramatic decline in total GDP. Health care expenditure has declined in real terms since 1991. The health care expenditure share of GDP has declined since 1992 as GDP has been growing again and expenditure on health care has been cut.
The table shows general trends in the health service delivery system in recent years. In-patient care accounts for almost half of health care expenditure. The share of total expenditure which goes on pharmaceuticals has grown to 10%. This is due both to the decline in total health expenditure and to an increase in costs of pharmaceuticals which, in turn, has been caused by an increase in the number of users and the use of new expensive drugs. A large number of new health care facilities were built in the 1970s. Since then, there has not been as much need for building new hospitals and health centres. This has resulted in a reduction of public investment. At present, there is considerable excess capacity, especially in hospitals.

***Source*** European Observatory on Health Care Systems ***Year*** 1999

| | | | |
|---|---|---|---|
| ***Code*** | 15.2 | | |
| ***Description*** | Total and public health expenditure as % GDP | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1999 |

| | | | |
|---|---|---|---|
| ***Code*** | 15.3 | | |
| ***Description*** | Health care expenditure by category (%) of total expenditure on health care | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1999 |

| | | | |
|---|---|---|---|
| ***Code*** | 16 | | |
| ***Description*** | Import and Export | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1999 |

| | | | |
|---|---|---|---|
| ***Code*** | 16.1 | | |
| ***Description*** | Import | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1999 |

| | | | |
|---|---|---|---|
| ***Code*** | 16.2 | | |
| ***Description*** | Export | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1999 |

| | | | |
|---|---|---|---|
| ***Code*** | 17 | | |
| ***Description*** | Health care reforms | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1999 |

| | |
|---|---|
| ***Code*** | 17.1 |
| ***Description*** | Determinants and objectives |
| ***Contents*** | While there has been no major reform of the health care system in Finland, there have been a number of changes to deal with specific problems. When waiting times to see a primary care doctor increased to unacceptable levels and problems with the continuity of care were noted in the 1980s, a personal doctor system was introduced. Because the number of patients per capita treated as in-patients is much higher than in many other countries, one important aim of Finnish health policy has been to reduce hospital and other kinds of institutional care and to develop outpatient and home care services. The growing number of elderly people and financial pressures have also influenced this emphasis on ambulatory care. In order to improve efficiency and to contain costs, the system of state subsidies to municipalities was reformed in 1993. |
| ***Source*** | European Observatory on Health Care Systems |
| ***Year*** | 1999 |

| | |
|---|---|
| ***Code*** | 17.2 |
| ***Description*** | Content of reforms and legislation |

***Contents***

Several minor reforms have been undertaken in Finland in recent years.

An action programme to reduce institutional care was drawn up in 1991–92. The main objective of the programme is to develop those forms of services which will enable elderly and other people to live in their homes as long as possible. More specifically, by the year 2000 no more than 10–12% of those over 75 years are to be in institutional care.

There are striking variations (up to 2.5 fold in some cases) between municipalities, in terms of health care expenditure per capita. The variations can only be explained to a small extent by "need factors" such as age structure, mortality and very low population density. Variables which can be decided by municipal policy-makers (for example, the amount of in-patient facilities) are stronger determinants of the variations. This means there is scope for reducing health care costs and increasing productivity and efficiency.

The Ministry of Social Affairs and Health has directed and coordinated the process of transferring resources from institutional care to ambulatory services. From the very beginning, it was recognized that decisions should be made at the local level in the municipalities. The provincial boards have also been involved in this process, as has the Association of Finnish municipalities.

In general, the process has advanced at a good pace. The objectives have been widely accepted by municipalities and change is going in the right direction. However, the changes are occurring at different paces in different parts of the country. A number of municipalities have already successfully reshaped their service delivery system, while others are not as advanced.

In general, institutionalized care has been reduced throughout the country in recent years, mainly due to more efficient use of ambulatory services. The transfer of personnel from institutional care to other services has not occurred as was originally planned. During the process it has become obvious that if apartments and other housing services are not available it is impossible to reduce institutional care.

Enormous variations in treatment practices have also been revealed. These variations cannot be explained by demographic or other exogenous factors. During 1995, the Ministry of Social Affairs and Health submitted this question for discussion, so far mainly among national-level health care experts.

The state subsidy system, implemented in 1993, has changed somewhat since the beginning of 1996. Up to the end of 1995, municipalities were classified into different categories according to their financial capability (the classification was determined by the Ministry of the Interior). In the years 1993–1995, state subsidies for health care depended on the population's age structure, morbidity, population density, land area and the municipality's financial capability. The classification for financial capability has now been abolished.

At present, a comprehensive project is being carried out to investigate the functional and economic relationships between the state and the municipalities. Therefore the overall regional administration is being discussed. As stated above, research work is being carried out on new criteria for determining the state subsidy for health care. Some adjustments may be made to the present criteria for calculating the state subsidy, depending on the results of this research.

In addition to reforms concerning the whole country, some local projects are being carried out in Finland. Experiments with a waiting time guarantee (for elective procedures) are planned to begin in three hospital districts (South Karelia, Vaasa and Middle-Ostrobothnia) in the spring of 1996. The waiting times will concern both primary and specialized care, the objective being that a patient should have access to a primary care doctor within three days and to a hospital specialist within 1–2 weeks. In the projects that have been planned, the maximum waiting times for specific treatments have not yet been defined, but they will probably vary between districts. If the patient does not have access to care within the time limit specified, he/she will be offered treatment at another health centre or hospital.

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|---|---|---|---|
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1999 |

| | |
|---|---|
| ***Code*** | 17.2.1 |
| ***Description*** | future development of planning: move to be integrated/move to contract based |
| ***Contents*** | |
| ***Source*** | European Observatory on Health Care Systems |
| ***Year*** | 1999 |

| | |
|---|---|
| ***Code*** | 17.2.2 |
| ***Description*** | tax based system: change in population coverage; opting out permitted/encouraged |
| ***Contents*** | |
| ***Source*** | European Observatory on Health Care Systems |
| ***Year*** | 1999 |

| | |
|---|---|
| ***Code*** | 17.2.3 |
| ***Description*** | insurance based system: development of the degree of benefit coverage in the future |
| ***Contents*** | |
| ***Source*** | European Observatory on Health Care Systems |
| ***Year*** | 1999 |

| | |
|---|---|
| ***Code*** | 17.2.4 |
| ***Description*** | voluntary health insurance: changes in uptake; plans for change |
| ***Contents*** | |
| ***Source*** | European Observatory on Health Care Systems |
| ***Year*** | 1999 |

| | |
|---|---|
| ***Code*** | 17.3 |
| ***Description*** | Health for all policy |
| ***Contents*** | Finland published its own national health for all (HFA) programme in 1986. The main guidelines of the programme were the promotion of healthy lifestyles, the reduction of preventable health problems and appropriate development of the health care delivery system. Since its publication, the programme has formed the basis of Finnish health care policy.<br><br>The World Health Organization's Regional Office for Europe made an evaluation of the Finnish HFA programme and published a report about the evaluation in 1991. The evaluation showed the strong sides of the Finnish health care system but also the areas where Finland had not succeeded. One criticism was that HFA had been restricted to health professionals and health experts even though the programme should have been extended to other sectors, too. There was also insufficient local input, weak management practices and poor public and private sector coordination.<br><br>The programme was reviewed in the light of WHO's statements and recommendations. The revised HFA programme was approved by the Government in December 1992 as the basis for development of Finnish health policy. |
| ***Source*** | European Observatory on Health Care Systems |
| ***Year*** | 1999 |

| | |
|---|---|
| ***Code*** | 17.4 |
| ***Description*** | Reform implementation |
| ***Contents*** | |
| ***Source*** | European Observatory on Health Care Systems |
| ***Year*** | 1999 |

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|---|---|
| ***Code*** | 17.5 |
| ***Description*** | Conclusions |
| ***Contents*** | Any discussion of the health care system in Finland starts with the observation that it is in many ways a model of success. There is already a comprehensive primary care network covering the entire country. Health services are locally accountable through the municipalities, and the health care system has been changed and developed over a long period of time.<br><br>It is difficult to assess the impact of recent changes to the funding of municipal health services, in view of their introduction at a time of economic crisis. From the point of view of equity, the health care system in Finland provides care to the entire population. The financing of this care still contains a number of unusual features which undermine an otherwise equitable system of financing. The National State Sickness Insurance system in effect subsidises both private health care and occupational health care. Neither of these, but particularly the former, are accessible to the whole population. A second equity problem stems from the rising proportion of health spending coming from out-of-pocket payments: they are a regressive source of funding. That these have risen is more likely to be a function of economic constraints imposed by the recession than a consequence of recent changes in the health care system.<br><br>Efficiency is difficult to judge in Finland. Services are defined in different ways in different places, and data on prices are not readily comparable between hospitals. Lengths of stay for in-patient care have declined, but it is not clear whether there are incentives for hospitals to improve efficiency or whether hospital districts are in a position to force through efficiency improvements. There are also marked variations in expenditure and activity rates between different municipalities; and in international comparisons, Finland's health care system still has a relatively high number of hospital beds.<br><br>Consumer choice is another area where improvements could be made. Patients have little choice of either primary care doctor or hospital. In practice, however, Finland's geography and the relatively high rural population impose some constraints on this.<br><br>It is likely that targeting waiting times will result in improvements in this aspect of quality of care. The advent of the personal doctor system may also help improve continuity of care. If moves continue to be made towards increased social care in the community, this will help meet the needs and aspirations of a growing elderly population.<br><br>Despite the fact that the municipal system has served the country well, there are structural problems when responsibility is devolved to such a local level. The small size of municipalities is problematic; with their small population, they do not have the same know-how and negotiating power as professional producers, especially large secondary care hospitals. This creates an imbalance between the municipalities who pay for services and the producers of services. The role of hospital districts also needs to be clearly defined. Financing and provision are not generally sufficiently separated for hospital districts to act as third-party purchasers, nor are the districts sufficiently integrated with hospitals to exert strong managerial control.<br><br>Finland faces a number of challenges in the field of health and health care. The rates of heart disease and diseases of the circulation are still unacceptably high and the number of suicides is alarming. Perhaps the next big challenge will be to translate the successes of the health care system into improvements in health status. |
| ***Source*** | European Observatory on Health Care Systems |
| ***Year*** | 1999 |

# Country profile: Denmark

| | |
|---|---|
| **Code** | 1 |
| **Description** | Introduction and historical background |
| **Contents** | |
| **Source** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| **Year** | 1998 |

| | |
|---|---|
| **Code** | 1.1 |
| **Description** | Introductory overview |
| **Contents** | |
| **Source** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| **Year** | 1998 |

| | |
|---|---|
| **Code** | 1.2 |
| **Description** | Historical background |
| **Contents** | |
| **Source** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| **Year** | 1998 |

| | |
|---|---|
| **Code** | 2 |
| **Description** | Main functions of key bodies in the organizational structure and management of health care administration |
| **Contents** | |
| **Source** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| **Year** | 1998 |

| | |
|---|---|
| **Code** | 2.1 |
| **Description** | (Con-)Federal/National government, Ministry with main responsibility for health care and other ministries with health care competence |
| **Contents** | At national level the Ministry of Health is the main authority and is responsible for legislation on health care, personnel, hospitals and pharmacies, pharmaceutical products, nutrition, vaccination, maternity and child care, patient rights etc. The Ministry controls the health care system mainly by issuing general rules and guidelines. Its main advisor is the National Board of Health; this agency also fulfils advisory tasks for local authorities and health professionals. In addition to advisory tasks the National Board carries out the administration of health services, supervisory functions with regard to health professionals and is charged with regulation and planning of the education of health professionals. |
| **Source** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| **Year** | 1998 |

| | |
|---|---|
| ***Code*** | 2.2 |
| ***Description*** | Regional government |
| ***Contents*** | The 16 counties in Denmark play the most important role in the field of health care. They are responsible for hospital care and primary curative care as well as for health promotion activities. |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| ***Year*** | 1998 |

| | |
|---|---|
| ***Code*** | 2.3 |
| ***Description*** | Local government |
| ***Contents*** | At local level, the 275 municipalities are responsible for the care for the elderly, including both home nursing services and nursing homes, and a number of preventive programmes including public health nurses, school health and child dental services. |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| ***Year*** | 1998 |

| | |
|---|---|
| ***Code*** | 2.4 |
| ***Description*** | Insurance organisations |
| ***Contents*** | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| ***Year*** | 1998 |

| | |
|---|---|
| ***Code*** | 2.5 |
| ***Description*** | Professional groups |
| ***Contents*** | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| ***Year*** | 1998 |

| | |
|---|---|
| ***Code*** | 2.6 |
| ***Description*** | Providers |
| ***Contents*** | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| ***Year*** | 1998 |

| | |
|---|---|
| ***Code*** | 2.7 |
| ***Description*** | Voluntary bodies |
| ***Contents*** | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 3 | | |
| ***Description*** | Planning, regulation and management | | |
| ***Contents*** | The 16 counties in Denmark play the most important role in the field of health care. They are responsible for hospital care and primary curative care as well as for health promotion activities. At local level, the 275 municipalities are responsible for the care for the elderly, including both home nursing services and nursing homes, and a number of preventive programmes including public health nurses, school health and child dental services. | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 3.1 | | |
| ***Description*** | Extent of system decentralisation (deconcentration, devolution, delegation, privatisation) | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 3.2 | | |
| ***Description*** | Existence of national health planning agency/plan | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 3.3 | | |
| ***Description*** | Supervision of the health services | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 3.4 | | |
| ***Description*** | Financial resource allocation | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 3.4.1 | | |
| ***Description*** | Third party budget setting and resource allocation | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 3.4.2 | | |
| ***Description*** | Determination of overall health budget | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 3.4.3 | | |
| ***Description*** | Determination of programme allocations | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 3.4.4 | | |
| ***Description*** | Determination of geographical allocations | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 3.4.5 | | |
| ***Description*** | Health care budget decision-making at national/regional/local level | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 3.4.6 | | |
| ***Description*** | Approach to capital planning | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 3.4.7 | | |
| ***Description*** | Capital investment funding | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 3.4.8 | | |
| ***Description*** | Recent changes in resource allocation system | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 4 | | |
| ***Description*** | General characteristics of the organizational structure | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 4.1 | | |
| ***Description*** | Integrated or contract model | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 4.2 | | |
| ***Description*** | Organisational relationship between third party payers and providers | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 4.3 | | |
| ***Description*** | Ownership: public, private, mix | | |
| ***Contents*** | Intramural care is operated mainly by regional and local authorities. Private hospitals are rare: in 1991 there were six, of which two can be characterized as proper acute hospitals and the others as specialised clinics for rheumatism (two), diabetes (one) and epilepsy (one). Extramural care is provided by self-employed professionals (general practitioners, practising specialists, dentists, physiotherapists, pharmacists) and public domain services (municipal home nursing services). | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | |
|---|---|
| ***Code*** | 4.4 |
| ***Description*** | Freedom of choice |
| ***Contents*** | Everyone aged 16 or over may choose his or her own general practitioner. Families often keep the same family doctor for a number of years, which gives the doctor a thorough knowledge of the family's social and medical condition. |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| ***Year*** | 1998 |

| | |
|---|---|
| ***Code*** | 4.5 |
| ***Description*** | Referral system |
| ***Contents*** | The general practitioner (GP) is the "gatekeeper" in the Danish health care system. Every patient must contact his or her GP. If the GP considers it necessary, the patient will be referred for further examination or treatment, either to a self-employed practising specialist or to a hospital. The GP may also call on the services of physiotherapists, health visitors, home nurses and the community social services. There are only few deviations from the this system: -in the case of sudden serious injury or disease a patient may be treated at a hospital without any previous contact with the GP; -referral is not necessary for eye specialists and ear, nose and throat specialists; -in general referral is not necessary for "group 2" patients in the Health Care Reimbursement Scheme. |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| ***Year*** | 1998 |

| | |
|---|---|
| ***Code*** | 5 |
| ***Description*** | Out-patient care |
| ***Contents*** | Out-patient care is a central and integral part of the Danish health care system Out-patient care is provided by self-employed professionals (general practitioners, practising specialists, dentists, physiotherapists, pharmacists) and public domain services (municipal home nursing services). |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| ***Year*** | 1998 |

| | |
|---|---|
| ***Code*** | 5.1 |
| ***Description*** | Medical care |
| ***Contents*** | The pillar of the health care system is the so-called "family-doctor system". The general practitioner (GP) is the "gatekeeper" in the Danish health care system. Every patient must contact his or her GP in case of illness or injury. If the GP considers it necessary, the patient will be referred for further examination or treatment, either to a self-employed practising specialist or to a hospital. |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 5.1.1 | | |
| ***Description*** | General practitioner (solo-, group practices) | | |
| ***Contents*** | In principle the general practitioner runs a private practice alone or in collaboration with other general practitioners. | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 5.1.2 | | |
| ***Description*** | Medical specialist with own premises | | |
| ***Contents*** | Specialists examine and treat patients referred to them by general practitioners. There are about 800 full-time self-employed practising specialists in Denmark. A similar number have other positions, usually within the hospital services and have a private practice on a part-time basis. Hospital specialists (hospital consultants) may be allowed to do private outpatient care for up to three hours a week at hospitals; these specialists then pay rent for hospital facilities. Their services are usually paid for by the Health Care Reimbursement Scheme. | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 5.1.3 | | |
| ***Description*** | Out-patient department | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 5.1.4 | | |
| ***Description*** | Combined services: health centres | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 5.2 | | |
| ***Description*** | Dental care | | |
| ***Contents*** | Most dentists have private practices and patients are free to choose. | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 5.2.1 | | |
| ***Description*** | General dentist | | |
| ***Contents*** | Most dentists have private practices and patients are free to choose. | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 5.2.2 | | |
| ***Description*** | Dental specialist | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 5.3 | | |
| ***Description*** | Pharmacists | | |
| ***Contents*** | Pharmacists are independent entrepreneurs, but under considerable public control. The Ministry of Health determines the number and location of pharmacies and appoints new pharmacists. The Ministry of Health negotiates their total gross profit and a corresponding mark-up scale with the pharmacists association. | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 5.4 | | |
| ***Description*** | Midwifery | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 5.5 | | |
| ***Description*** | Paramedical care | | |
| ***Contents*** | GPs can refer patients for treatment by physiotherapists and chiropractors, which are permitted to establish private practices. Physiotherapists may also be employed by municipalities, for instance in nursing homes. The Health Care Reimbursement Scheme only partly reimburses treatment by a private practising physiotherapist, psychologist, chiropodist or chiropractor. | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | |
|---|---|
| ***Code*** | 5.6 |
| ***Description*** | Home nursing and home care (maternity home care included) |
| ***Contents*** | With the exception of acute hospital care, psychiatric institutions and general care (GP's), which are the county's responsibility, all remaining care for the elderly is organised by the municipality (Kommune). This implies that a broad range of facilities can be offered, while, according to priorities determined at community level, the emphasis can be on residential services, home care or other facilities. However, in general, absolute priority has been given to home care and sheltered housing. The Social Security Act of 1976 stresses the explicit obligation of the municipalities to organise home help services for the elderly. Nursing homes for elderly people are no longer built in Denmark. The building stop of nursing homes was introduced in the Social Security Act in 1988 in connection with a new act on housing for elderly people. In accordance with this act, from 1988 an increasing number of new sheltered dwellings for elderly people have been build. Several nursing home 'beds' were closed and replaced by sheltered housing. The sheltered housing is designed and produced in such a way, that the special needs of elderly and disabled people are taken into account. The elderly and disabled people are, in these settings, closely linked to staff and other service facilities. In Denmark home nursing is provided by the municipality in the same department as home help services. Home nursing services are provided by home nurses and assistant nurses. The demand for home nursing care is generally initiated by health professionals. The assessment procedures of home nursing needs can differ between the municipalities. Home nursing is granted on referral from a physician. Hospitals often use the services of a social counsellor for the estimation of the home care required and the contacts with the home care providers. In other cases there are fixed agreements, such as a nurse assessing home care needs on the same day or the day after discharge. In general, there is no formalised assessment: nurses assess the need for care and provide it themselves or have it provided by assistant nurses and/or home helps. As already mentioned, home help and home nursing are organised within the community. Essential for the organisation of health care and social security in Denmark is the supply of a comprehensive and integrated set of services ranging from institutional care (nursing homes) to home help and from specially adapted housing facilities to concrete adaptations in existing dwellings. Since the building stop for nursing homes in 1988, there is an increased emphasis on home care facilities like home nursing and home help. Home help, in its turn, belongs to an even wider range of services: neighbourhood work that includes services like gardening, snow clearance, meals-on-wheels and public transport for which modest co-payments are charged. The help is to be granted and planned in close co-operation with the beneficiary and shall support him or her in preserving or regaining a physical and mental functional level. The provisions in the Social Security Act on home help are: home help of temporary or permanent character, home help for occasional relief, partial grant costs for help arranged by the beneficiary. In the Social Security Act of 1976 the flowing home help activities have been described: - housework such as cleaning, cooking, bed making, washing and ironing; - assisting with going to the toilet, dressing, washing, bathing, hair combing and other aspects of personal hygiene; - shopping and outdoor walks. It is clear, that home help in Denmark involves substantially more, than just cleaning the house. Personal care such as dressing, washing, bathing re activities assigned to assistant nurses in most countries; while accompanying a disabled or frail person on outdoor walks and taking care of hopping is usually not included in home help activities in other countries that are ore strictly limited to cleaning activities. |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| ***Year*** | 1998 |

| | |
|---|---|
| ***Code*** | 5.7 |
| ***Description*** | Out-patient mental health care services |
| ***Contents*** | The district psychiatry scheme, which is organised on county level, is a service for mentally ill people, who do not need to be admitted into psychiatric hospital. The district psychiatry scheme provides medication and medical attention when needed. Practising psychologists are free enterprises. Patients can attend a private psychologist without referral, and cost are not reimbursed. Only in the case of shock treatment following traffic accidents or other traumatic incidents, patients can be referred to treatment at a practising psychologist with partial reimbursement. These costs are held at county level. Practising psychiatrists are office-based specialists and as such observe the same conditions as other specialists mentioned under 'medical care'. With regrd to alcohol and drugs addicts a large number of private institutions are functioning. These are to some degree supported financially by the state. On municipal level, also a few public institutions exist. These uphold primarily the function of hostels, however medical attention and treatment is offered as well. |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| ***Year*** | 1998 |

| | |
|---|---|
| ***Code*** | 5.8 |
| ***Description*** | Ambulance services and patient transport |
| ***Contents*** | The ambulance service is organised at county level. The service is entirely financed by the counties. Though the responsibility belongs to the counties, most counties have subcontracted this enterprise to the private organisation "Falck". Falck covers about 85 % of the population. The patient transport in counties or areas, not covered by Falck, is managed by the local fire brigade. All services are paid for from general taxation, and at no cost to the patient. There is also a regulation governing the transport of seated patients. Wheelchair patients are compensated for the use of wheelchair buses. Subject to income (e.g. in the case of pensioners) some patients are eligible for compensation for transport by taxi. Transport in own cars can be reimbursed under certain conditions. |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| ***Year*** | 1998 |

| | |
|---|---|
| ***Code*** | 5.9 |
| ***Description*** | Medical laboratories |
| ***Contents*** | In most counties the laboratories are situated and run by hospitals. However in Copenhagen the general practitioners own a laboratory, to which they can refer patients for tests. All laboratory services are free for the patients. |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| ***Year*** | 1998 |

| | |
|---|---|
| ***Code*** | 6 |
| ***Description*** | In-patient care |
| ***Contents*** | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| ***Year*** | 1998 |

| | |
|---|---|
| ***Code*** | 6.1 |
| ***Description*** | Hospital categories |
| ***Contents*** | The hospital services within a county consist of hospitals of different sizes and types. In general all major medical specialisms are offered by the hospital services of a given county. General hospitals with specialised departments constitute the largest group. Except for psychiatric hospitals, mono-specialised hospitals are almost non-existent. Nursing homes and institutions for the mentally handicapped are not considered to be part of health care services, but of the social welfare system at municipal level. Between 1980 and 1992 the total number of hospital beds decreased by 35%, from 41,500 to 27,000, and, counting only somatic beds, by 26%, from 32,500 to 24,000. The number of admissions increased by 15% in the same period; this was accompanied by a rapid decline of the average length of stay, which is now under seven days (excluding psychiatry), and a corresponding expansion of outpatient services. For hospital services that require larger catchment populations than one county an "inter-county market" has been established. From 1 January 1993 Danish citizens who need hospital treatment may choose from all public hospitals and a number of private clinics which co-operate with the public hospital services. This means that, after referral by his or her GP, the patient may choose the hospital without regard to geographical considerations. The county of residence will be obliged to pay for the treatment. Admission to highly specialised wards is granted only on medical grounds. The hospitals cover the whole spectrum of physical and mental illness, providing diagnosis, treatment and care. They also provide diagnostic assistance to general practitioners on a considerable scale through laboratory services and imaging diagnostic services. |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| ***Year*** | 1998 |

| | |
|---|---|
| ***Code*** | 6.2 |
| ***Description*** | Other in-patient provisions |
| ***Contents*** | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| ***Year*** | 1998 |

| | |
|---|---|
| ***Code*** | 7 |
| ***Description*** | Relationship between primary and secondary care |
| ***Contents*** | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| ***Year*** | 1998 |

| | |
|---|---|
| ***Code*** | 7.1 |
| ***Description*** | Planned or actual substitution policies for inpatient care |
| ***Contents*** | Over the past decade much has been done to redistribute services from hospitals to the extramural health care sector. Hospitals have increasingly extended outpatient treatment in order to relieve the pressure on the in-patient facilities. |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 7.2 | | |
| ***Description*** | Degree of co-operation between primary and secondary health care providers | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 7.3 | | |
| ***Description*** | Imbalance between primary and secondary care | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 8 | | |
| ***Description*** | Prevention and public health services | | |
| ***Contents*** | Denmark has several preventive health services, which are part of the established health care system and are free of charge. | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 8.1 | | |
| ***Description*** | Maternal and child health: family planning and counselling | | |
| ***Contents*** | Prenatal care and guidance can be obtained from the family doctor and from a midwife at a local midwifery centre and from hospitals. Several examinations are offered before and after delivery. During pregnancy prenatal diagnostic screening is offered to most women. The municipal health authorities are notified of all births and offer the mother and child health care from a visiting public health nurse. All children are visited several times during their first year, depending on the need of the individual child or family. The main focus of the public health nurse is monitoring the child's health, advising and supporting the parents and providing information about supplementary health services. All children are entitled to preventive health examinations by a doctor. The first is scheduled for five weeks after birth. | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 8.2 | | |
| ***Description*** | School health services | | |
| ***Contents*** | The municipalities are responsible for the medical examination of all school children. In addition, all school children are examined in their first and last school year by a doctor employed by the municipality. The doctor and the school nurse participate in health education together with the teaching staff. All children up to 18 years have access to free routine dental examinations and treatment. A preventive programme is carried out in day care institutions and schools. The dental care is provided by practising dentists or special services organised by the municipalities. | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 8.3 | | |
| ***Description*** | Prevention of communicable diseases | | |
| ***Contents*** | All children (age under 18) are offered free immunisation by the family doctor against diphtheria, polio, tetanus, whooping cough, measles, mumps and German measles. Immunisation against German measles is also offered to women past the age of 12, as well as immunisation against the infectious disease caused by "haemophilus influenza, type B (HIB)" is offered to children younger than 6 years. A small number of children are now immunised against tuberculosis. | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 8.4 | | |
| ***Description*** | Prevention of non-communicable diseases | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 8.5 | | |
| ***Description*** | Occupational health care | | |
| ***Contents*** | The occupational health services are separate from the ordinary health services. Their purpose is to prevent diseases and accidents at the workplace. Legislation sets certain standards for occupational safety and health facilities in factories and offices. | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

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|---|---|---|---|
| ***Code*** | 8.6 | | |
| ***Description*** | All other miscellaneous public health services | | |
| ***Contents*** | A wide range of other preventive measures have been established. Many of these were initiated by individual counties and municipalities and thus cover only the local area. National preventive measures include: - sex education in all schools, including advice on contraception and sexually transmitted diseases; - anonymous testing for human immunodeficiency virus (HIV) antibodies, free of charge. A health promotion programme was presented to parliament in 1989. This programme defines the targets and initiatives of the national authorities. One basic idea of the programme is that a significant part of the health promotion tasks should be initiated locally, in close co-operation with people in the community and the local authorities and associations. The Minister for Health has set up an independent Council on Health Promotion Policy. An independent Council on Alcohol has been set up under this council. Other national agencies for prevention and health promotion are: - the National Board of Health; - the Danish Council on Smoking; - the Danish Veterinary and Food Administration; - the Danish Institute for Clinical Epidemiology; - the State Serum Institute; - the Drugs Council | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 9 | | |
| ***Description*** | Social care related to health care | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 9.1 | | |
| ***Description*** | Organisation and financing of social care | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 9.2 | | |
| ***Description*** | Role of central/regional/local government | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 9.3 | | |
| ***Description*** | Role of other organisations | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 9.4 | | |
| ***Description*** | Responsibility of family members | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 9.5 | | |
| ***Description*** | Financing of social care | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | |
|---|---|
| ***Code*** | 9.6 |
| ***Description*** | Explicit health/social care policy |
| ***Contents*** | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| ***Year*** | 1998 |

| | |
|---|---|
| ***Code*** | 10 |
| ***Description*** | Medical goods and health care technology assessment |
| ***Contents*** | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| ***Year*** | 1998 |

| | |
|---|---|
| ***Code*** | 10.1 |
| ***Description*** | Pharmaceuticals |
| ***Contents*** | The wholesale profits are fixed through individual negotiations between each single manufacturer or importer and wholesaler and the profit level will be determined only by competition. Pharmacy retail prices are calculated on a regressive scale set by the Ministry of Health. The retail prices consist of the pharmacy purchase price (the recommended price for the wholesalers' resale) plus a fixed amount and a percentage profit. Reimbursement of the cost of medicinal products is administered by the county councils. At the pharmacy the patient only pays his share according to the reimbursement status of the product, and the pharmacy gets the reimbursement amount from the county. Citizens may take out an insurance with the private insurance company "danmark" and thus obtain further reimbursement on presenting the bill from the pharmacy. 100% reimbursement is granted for insulin preparations. In all other cases decision concerning the reimbursement status of a given product depends on a concrete assessment along the following lines: Generally a 49.8% reimbursement is granted for medicinal products which have a definite and valuable therapeutic effect, unless there is a risk of undesirable excess consumption. Generally a 74.7% reimbursement is granted for medicinal products which in addition to the above mentioned criteria are used for the treatment of well-defined and often life-threatening diseases; but only if the medicinal product in question may not be prescribed for less appropriate indications. Medicinal products which may be bought without prescription may be added to the list of reimbursement of medicinal products. In such cases the reimbursement of 49.8% or 74.7%, however, is granted only to pensioners and patients suffering from chronic disease and only if a prescription has been issued for the medicinal product in question. The Minister for Health may omit to grant reimbursement for a given medicinal product if the price of this product is not commensurate with its therapeutic value. As mentioned above the reimbursement granted varies and may amount to 100%, 74.7% or 49.8% of the pharmacy retail price of a given product. If, however, several products contain the same active substance, reimbursement is granted in the form of a fixed amount. This is calculated as 100%, 74.7% or 49.8% of the average of the price of the two cheapest products in the group under consideration - the reference price. The fixed amount may not exceed 100%, 74.7% or 49.8% respectively of the retail price of a given product. |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 10.2 | | |
| ***Description*** | Therapeutic appliances | | |
| ***Contents*** | Purchase of many therapeutic appliances are partly reimbursed, if the patient is elderly or poor, and if the appliance is prescribed by a doctor, dentist, hearing therapist etc. Glasses and dental appliances are also partly reimbursed by the private insurance scheme 'Danmark'. | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 10.3 | | |
| ***Description*** | Health care technology assessment | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 11 | | |
| ***Description*** | Other services | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 11.1 | | |
| ***Description*** | Education and training of personnel | | |
| ***Contents*** | In the Danish health accounts official government expenditures the expenditures concerning non-academic education of health care staff are included. | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 11.2 | | |
| ***Description*** | Research and development in health | | |
| ***Contents*** | In the Danish health accounts official government expenditures in the field of health research performed in universities are included. | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 11.3 | | |
| ***Description*** | Environmental health and control of drinking water | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 11.4 | | |
| ***Description*** | Health programme administration and health insurance | | |
| ***Contents*** | In the Danish health accounts official government expenditures in the administrative area are included. | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 11.5 | | |
| ***Description*** | Administration and provision of cash benefits | | |
| ***Contents*** | In the Danish health accounts official government expenditures in the administrative area are included | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 12 | | |
| ***Description*** | Manpower in health care | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 13 | | |
| ***Description*** | Fees, rates and salary structure | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 13.1 | | |
| ***Description*** | Methods of payment to (specialist) physicians | | |
| ***Contents*** | Office-based general practitioners and specialists run a private practice. The main part of their income comes from the Health Care Reimbursement Scheme. General practitioners are paid according to a combined capitation/fee-for-service scheme. Office-based specialists are paid on a pure fee-for-service basis. Fees are negotiated between providers, professional organisations and the Association of County Councils. The contracts specify prices for all services covered and imply that fees and capitation are paid by the counties in full or in part. In the latter case the remainder must be paid by the patients directly. No extra billing is allowed for services covered by the contracts. Doctors and other hospital staff are salaried employees. The salaries are negotiated centrally by the County Councils Association and the trade unions. Hospital specialists may be allowed to do private outpatient care for up to three hours a week at hospitals; these specialists then pay rent for hospital facilities. Their services are usually paid for by the Health Care Reimbursement Scheme. Costs of private hospitals are paid at the same rate as public hospitals. Extra bills must be paid by the patients themselves. | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 13.1.1 | | |
| ***Description*** | Integrated or contracted | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 13.1.2 | | |
| ***Description*** | Type of payment | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 13.1.3 | | |
| ***Description*** | Method for deciding fees/salaries | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 13.2 | | |
| ***Description*** | Methods of hospital payment | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 13.2.1 | | |
| ***Description*** | Method of payment | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 13.2.2 | | |
| ***Description*** | Method for deciding rates | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 13.2.3 | | |
| ***Description*** | Recent changes in payment method | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 14 | | |
| ***Description*** | Main system of financing and coverage (tax based, insurance based, mixture) | | |
| ***Contents*** | As most health care services are free of charge, the major part of health care spending, about 85%, is public expenditure, borne by general taxation (state, county, municipality). | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.1 | | |
| ***Description*** | Main features of tax based systems | | |
| ***Contents*** | As most health care services are free of charge, the major part of health care spending, about 85%, is public expenditure, borne by general taxation (state, county, municipality). The counties play the most important role in financing health care. Public spending on hospitals as wel as the Health Care Reimbursement Scheme are financed by the counties and account for 65% of total county spending. In order to distribute the burden of hospital and other costs more equally, "block grants" are paid by the national government to the counties, based on differences in income levels of the inhabitants and demographic characteristics. These grants represent about 25% of the health care spending by counties. Private expenditure amounts to about 15% of total health care expenditure. Co-payments and over the counter expenses constitute 92% of these private expenditures, private insurance the remaining 8%. Most health care services are provided by counties and municipalities as a public service free of charge. All hospital services (in-patient and out-patient) and municipal health care services are free at the point of use, as are curative services by general practitioners and specialists under the Health Care Reimbursement Scheme. | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.1.1 | | |
| ***Description*** | Main body(ies) responsible for providing health care cover to beneficiaries | | |
| ***Contents*** | Most health care services are provided by counties and municipalities as a public service free of charge. All hospital services (in-patient and out-patient) and municipal health care services are free at the point of use, as are curative services by general practitioners and specialists under the Health Care Reimbursement Scheme. | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.1.2 | | |
| ***Description*** | Extent of population coverage (excluded groups) | | |
| ***Contents*** | Under the Health Care Reimbursement Scheme citizens can choose between two types of arrangements, group 1 and group 2. The majority of the population (in 1991 96.4%) chose group 1. Group 1 patients are registered with one specific general practitioner, which they may consult free of charge. If group 1 patients need to see a practising specialist, a referral by their GP is necessary to get specialist treatment free of charge. Group 2 patients are free to visit any GP or practising specialist without previous referral. Group 2 patients receive reimbursement equivalent to the reimbursement given to group 1, but in this case doctors are free to charge extra. Also co-payments for medication and dental services are higher for group 2 patients. | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.2 | | |
| ***Description*** | Main features of social health insurance | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.2.1 | | |
| ***Description*** | Organisation of main body responsible for insuring/providing coverage | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.2.2 | | |
| ***Description*** | Extent of population coverage | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.2.3 | | |
| ***Description*** | Stipulations in premium contribution | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.2.4 | | |
| ***Description*** | Competition between insurance schemes | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.2.5 | | |
| ***Description*** | Provision for risk adjustment | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.3 | | |
| ***Description*** | Health care benefits and rationing; recent reductions in benefits package and variations in extent between different insurance plans | | |
| ***Contents*** | Most health care services are provided by counties and municipalities as a public service free of charge. All hospital services (in-patient and out-patient) and municipal health care services are free at the point of use, as are curative services by general practitioners and specialists under the Health Care Reimbursement Scheme. The Health Care Reimbursement Scheme also partly reimburses specific types of dental care, while other types of dental care are paid for entirely by the patients. Dental care for children and some elderly people is free of charge. | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.4 | | |
| ***Description*** | Complementary sources of finance | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.4.1 | | |
| ***Description*** | Voluntary health insurance | | |
| ***Contents*** | Private health insurance is mainly supplied by one non-profit insurance company called "Danmark". About 26% of the population is covered by "Danmark". | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.4.1.1 | | |
| ***Description*** | Organisation of voluntary health insurance: public, quasi public, private, not for profit | | |
| ***Contents*** | The private insurer "Danmark". | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.4.1.2 | | |
| ***Description*** | Type and nature of services covered | | |
| ***Contents*** | The private insurer "Danmark" offers three different degrees of protection. Two are meant as a supplement to group 1 in the Health Care Reimbursement Scheme. The other is a supplement to group 2 in the Health Care Reimbursement Scheme. Most of the reimbursements by "Danmark" are for medication and dental care, not fully covered by the Health Care Reimbursement Scheme. | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.4.1.3 | | |
| ***Description*** | Proportion of population covered | | |
| ***Contents*** | About 26% of the population is covered by "Danmark". | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.4.2 | | |
| ***Description*** | Out-of-pocket payments: main cost sharing measure (partial reimbursement, co-payment) by care category: ambulatory, inpatient, drugs, medical aids and prostheses | | |
| ***Contents*** | Co-payments exist for some services under the Health Care Reimbursement Scheme, particularly for medication (outside the hospital), dental services, physiotherapy etc. The Health Care Reimbursement Scheme partly reimburses expenditure on medication prescribed by physicians or dentists if included in two specific lists published by the Ministry of Health. For drugs included in the lists the reimbursement is 75% and 50% respectively. The scheme also partly reimburses specific types of dental care, while other types of dental care are paid for entirely by the patients. | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.4.3 | | |
| ***Description*** | External sources of funding: employers, fund raisers etc. | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 15 | | |
| ***Description*** | Health care expenditure | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 15.1 | | |
| ***Description*** | Structure of health care expenditures | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 15.2 | | |
| ***Description*** | Total and public health expenditure as % GDP | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 15.3 | | |
| ***Description*** | Health care expenditure by category (%) of total expenditure on health care | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 16 | | |
| ***Description*** | Import and Export | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 16.1 | | |
| ***Description*** | Import | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 16.2 | | |
| ***Description*** | Export | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 17 | | |
| ***Description*** | Health care reforms | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 17.1 | | |
| ***Description*** | Determinants and objectives | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | |
|---|---|
| ***Code*** | 17.2 |
| ***Description*** | Content of reforms and legislation |
| ***Contents*** | Cost containment policy is considered to have been successful in Denmark. One basic reason for this is the financing of health care by counties and municipalities, which have been under economic restraint by the national government. In the last decade many activities have also been initiated to improve the efficiency of health care services by developing information systems, modernising hospital administration and management and organising work and training programmes more effectively. Extra attention has been paid to general practitioners. Hospital facilities - such as consultancy and the use of laboratories - have been put at their disposal. Furthermore municipal home nursing services offer a twenty-four hour service so that referral to hospital can be prevented and patients can stay at home. In the near future further improvements are expected as consequences of the introduction of a competition element, more free choice for patients and market orientation. Concrete plans have been developed to reduce waiting lists, not only on the part of the hospital, but also on the part of the municipal home nursing service. Since 1993 Counties are allowed to charge municipalities for the costs of patients having to wait in hospital after treatment for the municipal home nursing service to take over. From January 1995 the hospitals of Copenhagen and Frederiksberg and the State University Hospital are joined in a company owned by the three parties together. This organisational reform, it is hoped, will pave the way for better resource utilisation in the Copenhagen area. As part of the negotiations on the budget of 1995 Parliament has decided to introduce a new payment system for two specific operations, "slipped disc surgery" and "knee-alloplastic surgery". Patients on a waiting list for one of these treatments will be guaranteed treatment within three months from the time of referral by their general practitioner. If they cannot be treated in one of the wards of the home county within this time limit, the County is obliged to pay for treatment outside the County, either in another County hospital or in a private hospital/clinic. The prices of treatment are set at national level and the payment will be directed to the hospital treating the patient. Until now payments between County hospitals were payments between County-level budgets. This experiment came into effect in the spring of 1995. Other market-like incentives will be studied in the near future: - development of a system of diagnosis related normal costs to facilitate comparisons of efficiency between hospitals and their departments and to support budgeting; - improvement and expansion of data collection on output, costs etc., including registration of activities of general practitioners; - investigation of the effects of contracting between Counties and hospitals, which already is taking place in some of the Counties; - development of quality measures and improved information to the public to support the free choice in the framework of hospital reform. |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| ***Year*** | 1998 |

| | |
|---|---|
| ***Code*** | 17.2.1 |
| ***Description*** | future development of planning: move to be integrated/move to contract based |
| ***Contents*** | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| ***Year*** | 1998 |

| | |
|---|---|
| ***Code*** | 17.2.2 |
| ***Description*** | tax based system: change in population coverage; opting out permitted/encouraged |
| ***Contents*** | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 17.2.3 | | |
| ***Description*** | insurance based system: development of the degree of benefit coverage in the future | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 17.2.4 | | |
| ***Description*** | voluntary health insurance: changes in uptake; plans for change | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 17.3 | | |
| ***Description*** | Health for all policy | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 17.4 | | |
| ***Description*** | Reform implementation | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

| | | | |
|---|---|---|---|
| ***Code*** | 17.5 | | |
| ***Description*** | Conclusions | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1998 |

# Country profile: France

| | | | |
|---|---|---|---|
| **Code** | 1 | | |
| **Description** | Introduction and historical background | | |
| **Contents** | | | |
| **Source** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | **Year** | 1997 |

| | | | |
|---|---|---|---|
| **Code** | 1.1 | | |
| **Description** | Introductory overview | | |
| **Contents** | In France the right to health care is laid down in the Constitution. The French health care system is sometimes characterized as a reconciliation of solidarity and liberalism by means of a combination of collective financing and a public and private sector for the delivery of care. On the one hand there are the social principles embodied in the national health insurance schemes, and on the other liberal principles resulting in the independent medical practice (la médecine libérale) and the large freedom of choice for patients. There is strong government influence in the intramural sector. Extramural care is predominantly operated privately. | | |
| **Source** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | **Year** | 1997 |

| | | | |
|---|---|---|---|
| **Code** | 1.2 | | |
| **Description** | Historical background | | |
| **Contents** | | | |
| **Source** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | **Year** | 1997 |

| | | | |
|---|---|---|---|
| **Code** | 2 | | |
| **Description** | Main functions of key bodies in the organizational structure and management of health care administration | | |
| **Contents** | | | |
| **Source** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | **Year** | 1997 |

| | | | |
|---|---|---|---|
| **Code** | 2.1 | | |
| **Description** | (Con-)Federal/National government, Ministry with main responsibility for health care and other ministries with health care competence | | |
| **Contents** | Within the centralised governmental system, health care belongs to the responsibilities of the Ministry of Social Affairs, Health and Cities. This Ministry executes control of the health insurance schemes, provides grants and approves the level of doctors' fees and the prices of pharmaceuticals. | | |
| **Source** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | **Year** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 2.2 | | |
| ***Description*** | Regional government | | |
| ***Contents*** | The 22 regions and 100 departments are all involved to a certain extent in financing and delivering health care. In the regions and departments a director of health and a medical inspector are responsible for the public health care system and the public hospitals. The main responsibility at regional level is to plan health care and social amenities through the imposition of annual budget controls or a revision of the "health care map", which establishes the number of hospital beds and sets standards for the distribution of expensive high-tech equipment. Departments are responsible for controlling public hospital facilities operating within the public sector. | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 2.3 | | |
| ***Description*** | Local government | | |
| ***Contents*** | Municipalities play a role in the field of health care in the context of social services. | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 2.4 | | |
| ***Description*** | Insurance organisations | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 2.5 | | |
| ***Description*** | Professional groups | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 2.6 | | |
| ***Description*** | Providers | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 2.7 | | |
| ***Description*** | Voluntary bodies | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 3 | | |
| ***Description*** | Planning, regulation and management | | |
| ***Contents*** | The 22 regions and 100 departments are all involved to a certain extent in financing and delivering health care. In the regions and departments a director of health and a medical inspector are responsible for the public health care system and the public hospitals. The main responsibility at regional level is to plan health care and social amenities through the imposition of annual budget controls or a revision of the "health care map", which establishes the number of hospital beds and sets standards for the distribution of expensive high-tech equipment. Departments are responsible for controlling public hospital facilities operating within the public sector. | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 3.1 | | |
| ***Description*** | Extent of system decentralisation (deconcentration, devolution, delegation, privatisation) | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 3.2 | | |
| ***Description*** | Existence of national health planning agency/plan | | |
| ***Contents*** | The planning of hospitals is operated at regional level with the "carte sanitaire" as planning instrument. | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 3.3 | | |
| ***Description*** | Supervision of the health services | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 3.4 | | |
| ***Description*** | Financial resource allocation | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 3.4.1 | | |
| ***Description*** | Third party budget setting and resource allocation | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 3.4.2 | | |
| ***Description*** | Determination of overall health budget | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 3.4.3 | | |
| ***Description*** | Determination of programme allocations | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 3.4.4 | | |
| ***Description*** | Determination of geographical allocations | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 3.4.5 | | |
| ***Description*** | Health care budget decision-making at national/regional/local level | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 3.4.6 | | |
| ***Description*** | Approach to capital planning | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 3.4.7 | | |
| ***Description*** | Capital investment funding | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 3.4.8 | | |
| ***Description*** | Recent changes in resource allocation system | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 4 | | |
| ***Description*** | General characteristics of the organizational structure | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 4.1 | | |
| ***Description*** | Integrated or contract model | | |
| ***Contents*** | Mixture of integrated and contract model | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 4.2 | | |
| ***Description*** | Organisational relationship between third party payers and providers | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 4.3 | | |
| ***Description*** | Ownership: public, private, mix | | |
| ***Contents*** | Despite the great influence of public authorities part of the health care is delivered by non-public hospitals (1/3 of hospital beds), self-employed general practitioners, specialists, home nurses and other professionals. Also in the field of sickness insurance private organisations (non-profit and for-profit) play a role in financing health care. | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 4.4 | | |
| ***Description*** | Freedom of choice | | |
| ***Contents*** | Patients are free to choose the medical doctor they want, whether he/she is a general practitioner or a specialist in his/her own cabinet, or a specialist at a hospital. Also in the case of hospital admission patients are free to choose the hospital. It is sometimes even attractive for patients to visit hospitals immediately, if costs for the care needed are almost entirely reimbursed. Patients are free to choose between public or private hospitals. The difference in the payment system has no consequences for patients. | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 4.5 | | |
| ***Description*** | Referral system | | |
| ***Contents*** | The general practitioner does not function as a "gatekeeper", and patients are not registered with a doctor | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 5 | | |
| ***Description*** | Out-patient care | | |
| ***Contents*** | Thermal cures and laboratory tests outside hospitals are also included under this category of care. | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 5.1 | | |
| ***Description*** | Medical care | | |
| ***Contents*** | Out-patient health care is provided both by general practitioners and independent specialists working from their own premises. Also many hospital specialists have private practices. The general practitioner does not function as a "gatekeeper", and patients are not registered with a doctor. In most cases the general practitioner is an independent doctor, practising alone. | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 5.1.1 | | |
| ***Description*** | General practitioner (solo-, group practices) | | |
| ***Contents*** | In most cases the general practitioner is an independent doctor, practising alone. | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 5.1.2 | | |
| ***Description*** | Medical specialist with own premises | | |
| ***Contents*** | Out-patient health care is provided both by general practitioners and independent specialists working from their own premises. Also many hospital specialists have private practices. | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 5.1.3 | | |
| ***Description*** | Out-patient department | | |
| ***Contents*** | Most hospitals have outpatient departments. | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 5.1.4 | | |
| ***Description*** | Combined services: health centres | | |
| ***Contents*** | A small number of general practitioners work in health centres, which are established by municipalities, voluntary societies and other organisations like local health insurance funds and labour unions. These health centres are generally recognised as part of the social security system. | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 5.2 | | |
| ***Description*** | Dental care | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 5.2.1 | | |
| ***Description*** | General dentist | | |
| ***Contents*** | Most dentists work as self-employed entrepreneurs, but dental assistance may also be sought in health centres and hospitals. | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 5.2.2 | | |
| ***Description*** | Dental specialist | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 5.3 | | |
| ***Description*** | Pharmacists | | |
| ***Contents*** | harmacists are self-employed entrepreneurs, but subject to many government regulations. | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 5.4 | | |
| ***Description*** | Midwifery | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 5.5 | | |
| ***Description*** | Paramedical care | | |
| ***Contents*** | Out-patient care is completed by the care of physiotherapists, orthoptists speech therapists, dieticians and psychologists. However, psychologists are not counted as health care professionals. | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | |
|---|---|
| ***Code*** | 5.6 |
| ***Description*** | Home nursing and home care (maternity home care included) |
| ***Contents*** | With regard to home care a distinction is made between home care of a medical kind (home nursing) and home care of a social kind (home help, meals-on wheels etc.). Only the medical kind is paid for by the sickness funds and, by consequence, included in the health accounts.Two organisations are active in the field of home nursing: SIAD (Soins infirmiers à domicile pour personnes âgées) and HAD (Hospitalisation à domicile).HAD-service can be viewed as a substitute for complete or partial hospitalisation with comparable nursing care. SIAD provides continuous, lighter care, especially for the elderly.In addition to these organisations with salaried workers, there are a large number of self-employed nurses, the "libérales". They can be hired by a patient, but also by home nursing organisations. In order to control the development of the "libérales" the government has set limits, beyond which activities are no longer remunerated. |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| ***Year*** | 1997 |

| | |
|---|---|
| ***Code*** | 5.7 |
| ***Description*** | Out-patient mental health care services |
| ***Contents*** | Ambulatory mental care is provided by the Centres Psychiatriques d'Orientation et d'Accueil, the consultation units of the Centres médico-psychologiques or by physicians and their assistants visiting their patients at home or in the homes for the elderly.Ambulatory mental health care is provided also by psychiatric specialists, practising from their own premises or connected to private clinics, or by psychologists and psychoanalysts, not being psychiatrists.In the health accounts only the costs of self employed physicians are presented under the entry "soins ambulatoires"."Centres d'hygiène alimentaire et d'alcoologie" exist since 1970. In 1987 there were 247 of these centres. They are easy accessible for the intake of patients, but also for crisis intervention and therefore open permanently. They are places for the treatment and re-education of excessive drinkers. Personnel are composed of physicians and social workers. Another task of these centres is prevention, especially by intervention at the working place and in schools, universities and hospitals. Treatment of alcohol patients is provided also by self employed physicians, generalists as well as specialists.Centres specialised in the care of drug addicts are predominantly financed by the central government. Drug addicts, treated in these centres don't pay for their treatment or aftercare, but only for their protected shelter, if they are lodged with the perspective of re-integration. The centres must fulfil at least the following functions: -medical and psychological treatment of the addict;-social care and education, directed to integration or re-integration;-relief and information for the drug addicts and their families;-withdrawal and its guidance, until realised in a hospital environment;-support of the family of the addict.The centres also can participate in preventive activities and in training and research in the field of drug addiction. They can be managed by private, non-profit organisations or by public health institutions. They also can be governed directly by State services. Therapeutic dwellings exist since 1993: In this system, adult addicts are treated by a medical staff and live in an independent way with the aim to re-integrate, not realisable in a collective lodging system. In the same perspective drug addicts can be placed in host families, under the responsibility of the addiction centre and under continued treatment. |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| ***Year*** | 1997 |

| | |
|---|---|
| ***Code*** | 5.8 |
| ***Description*** | Ambulance services and patient transport |
| ***Contents*** | The term transport of patients in France relates to the transport of patients (the sick, injured, pregnancies) by means of a form of transport specially equipped for that purpose, by land sea or air, in connection with medical care or diagnostics, by medical prescription or in event of emergency.There are 4 categories of land transport: -'ambulance de secours et soins d'urgence' (ambulances, equipped for rendering first aid and special care in emergency situations);-'voiture de secours d'urgence aux asphyxiés et blessés (VSAB) ' (ambulances, equipped for rendering first aid and transporting the injured and others in having difficulty in breathing);-ambulance (standard ambulance);-'véhicule sanitaire léger' (vehicle for transporting patients who are only slightly ill/injured). The companies involved require the approval of the prefect of the relevant department. The Ministry of Health is responsible for setting down the standards for the categories A, C and D. The Ministry of Home Affairs is the authority for category B, the VSAB's, which falls under the fire brigade. In France there is an organisational difference between the transporting of patients in vehicles with and without a doctor on board. Transport without a doctor is executed by a private enterprise, or by the fire brigade VSAB's. The private enterprise acts solely as directed on medical prescription. The (voluntary) fire brigade not only comes into action to fight fires, but also in cases of accidents on public roads. The fire brigade renders first aid to the injured and provides the necessary transport. Ambulance staff, both drivers and other staff, have all had special training. The same applies for the ambulance personnel of the fire brigade. The medical ambulance transport (with doctor on board) is done by the "Services mobiles d'urgence et de réanimation" (SMUR) or by certain fire brigade ambulances. A SMUR team is made up of at least one driver-stretcher-bearer, nurse and a doctor, qualified in treating road-accident victims and resuscitation. A SMUR ambulance has special apparatus and medicine on board for resuscitation and patient care (monitoring). The SMUR must have a permit from the Ministry of Health, that supervises compliance of the regulations. At hospitals with a regional function for receiving accident victims, there are landing areas for helicopters close by the first aid station. The sickness funds and medical insurance companies pay for cost relating to the transport of patients, even when the transport is done by a private car, taxi or train. |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| ***Year*** | 1997 |

| | |
|---|---|
| ***Code*** | 5.9 |
| ***Description*** | Medical laboratories |
| ***Contents*** | Medical laboratories outside hospitals are private laboratories. They numbered 4100 in 1995. Since 1988 anatomo-cyto-pathology can be exercised by self employed physicians practising this specialism from their own premises. Since then the medical laboratories are no longer the only to practice this specialism. |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| ***Year*** | 1997 |

| | |
|---|---|
| ***Code*** | 6 |
| ***Description*** | In-patient care |
| ***Contents*** | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| ***Year*** | 1997 |

| | |
|---|---|
| ***Code*** | 6.1 |
| ***Description*** | Hospital categories |
| ***Contents*** | Hospitals in France can be classified in several ways. A basic division takes length of stay as criterion: short stay, medium stay and long stay hospitals. According to Schneider et al. this classification has only statistical significance, as acute hospitals (short stay services) also have departments for medium and long stay. The distinction between public and private hospitals is more important. For public hospitals there is a kind of hierarchy: -regional hospital centres in the greater health regions; these regional hospitals are also teaching hospitals and therefore equipped with all specialisms and with research facilities. -hospital centres, which are general hospitals or specialised hospitals (other than psychiatric hospitals), established to cope with the basic health needs of the community. These hospitals have all basic specialisms of medicine, surgery and maternity care, but no "top-specialisms". -local hospitals, providing general medicine and care for the elderly. They have no emergency department. The care for the elderly is an important feature of hospitals in France. According to Van der Werff French public hospitals contain about 120,000 beds for the elderly. Private hospitals can be divided into non-profit hospitals and for-profit hospitals. Many non-profit, private hospitals take part in the public hospital service and are financed under the same budget system as public hospitals. Other private hospitals are paid at day prices with separate fee-for-service payments for physician services. For their investments they depend on loans from banks and other private sources like philanthropic grants. Public hospitals tend to be large, well equipped and under duty to deal with accidents and emergencies. They have limited dispensation to treat private patients. Private hospitals are smaller and specialise in elective surgery, obstetrics or medium and long term care. Military hospitals and prison hospitals are included in hospital statistics. |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| ***Year*** | 1997 |

| | |
|---|---|
| ***Code*** | 6.2 |
| ***Description*** | Other in-patient provisions |
| ***Contents*** | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| ***Year*** | 1997 |

| | |
|---|---|
| ***Code*** | 7 |
| ***Description*** | Relationship between primary and secondary care |
| ***Contents*** | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| ***Year*** | 1997 |

| | |
|---|---|
| ***Code*** | 7.1 |
| ***Description*** | Planned or actual substitution policies for inpatient care |
| ***Contents*** | Psychiatric care has shown a strong decrease of complete hospitalisation in favour of other modalities of care: partial hospitalisation or ambulatory care. In 1981 60% of adult patients in general psychiatry were admitted to complete intramural care, compared with 13% in 1993. |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 7.2 | | |
| ***Description*** | Degree of co-operation between primary and secondary health care providers | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 7.3 | | |
| ***Description*** | Imbalance between primary and secondary care | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 8 | | |
| ***Description*** | Prevention and public health services | | |
| ***Contents*** | Apart from preventive care intertwined with curative care preventive care services have been developed at individual and collective level. At individual level GP's, Mother & Child Protection centres and the Dispensaries ("dispensaires") play an important role. The "dispensaires" may be polyvalent or specialised: vaccination, TBC- abatement, sexually transmitted diseases, AIDS, family planning, food hygiene, abuse of alcohol, drugs and tobacco, sports medicine. At the level of collective prevention there are services for school health and industrial health. In the field of health protection services have been organised at national, departmental and municipal level. Their activities are especially directed to public hygiene, e.g. the surveillance of foodstuffs, drinking water and environmental hygiene. Distinct services have been created for the prevention of industrial | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 8.1 | | |
| ***Description*** | Maternal and child health: family planning and counselling | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 8.2 | | |
| ***Description*** | School health services | | |
| ***Contents*** | At the level of collective prevention there are services for school health. | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 8.3 | | |
| ***Description*** | Prevention of communicable diseases | | |
| ***Contents*** | Dispensaries ("dispensaires") play an important role. The "dispensaires" may be polyvalent or specialised: vaccination, TBC- abatement, sexually transmitted diseases, AIDS, family planning, food hygiene, abuse of alcohol, drugs and tobacco, sports medicine. | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 8.4 | | |
| ***Description*** | Prevention of non-communicable diseases | | |
| ***Contents*** | Dispensaries ("dispensaires") play an important role. The "dispensaires" may be polyvalent or specialised: vaccination, TBC- abatement, sexually transmitted diseases, AIDS, family planning, food hygiene, abuse of alcohol, drugs and tobacco, sports medicine. | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 8.5 | | |
| ***Description*** | Occupational health care | | |
| ***Contents*** | At the level of collective prevention there are services for industrial health | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 8.6 | | |
| ***Description*** | All other miscellaneous public health services | | |
| ***Contents*** | Dispensaries ("dispensaires") play an important role. The "dispensaires" may be polyvalent or specialised: vaccination, TBC- abatement, sexually transmitted diseases, AIDS, family planning, food hygiene, abuse of alcohol, drugs and tobacco, sports medicine. | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 9 | | |
| ***Description*** | Social care related to health care | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 9.1 | | |
| ***Description*** | Organisation and financing of social care | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 9.2 | | |
| ***Description*** | Role of central/regional/local government | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 9.3 | | |
| ***Description*** | Role of other organisations | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 9.4 | | |
| ***Description*** | Responsibility of family members | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 9.5 | | |
| ***Description*** | Financing of social care | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 9.6 | | |
| ***Description*** | Explicit health/social care policy | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 10 | | |
| ***Description*** | Medical goods and health care technology assessment | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 10.1 | | |
| ***Description*** | Pharmaceuticals | | |
| ***Contents*** | Pharmaceutical consumption is high. In order to control the costs of this a positive list has been introduced. The Medicines Directorate must approve pharmaceuticals for reimbursement. If a drug offers no therapeutic advantages over its rivals, it is only listed if its price is lower. With regard to pharmaceuticals there are differences as to the urgency. For patients suffering from chronic diseases, as listed on an official list of about 30 severe pathologies, drugs, prescribed with regard to these diseases, are reimbursed completely.Other drugs require co-payments of 35 or 65% or even 100 %. | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 10.2 | | |
| ***Description*** | Therapeutic appliances | | |
| ***Contents*** | In France a large package of therapeutic appliances is included in the health accounts. For dental prostheses, glasses, contact lenses, optical and acoustical aids partial reimbursement is possible after previous agreement with the sickness fund. Other therapeutic appliances are exempted from co-payments. | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 10.3 | | |
| ***Description*** | Health care technology assessment | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 11 | | |
| ***Description*** | Other services | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 11.1 | | |
| ***Description*** | Education and training of personnel | | |
| ***Contents*** | In France the education of health care personnel is included in the health account. | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 11.2 | | |
| ***Description*** | Research and development in health | | |
| ***Contents*** | In France the health care research. is included in the health account. | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 11.3 | | |
| ***Description*** | Environmental health and control of drinking water | | |
| ***Contents*** | In the field of health protection services have been organised at national, departmental and municipal level. Their activities are especially directed to public hygiene, e.g. the surveillance of foodstuffs, drinking water and environmental hygiene. | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 11.4 | | |
| ***Description*** | Health programme administration and health insurance | | |
| ***Contents*** | The expenditures of the health insurance funds are excluded from the expenditures in the administrative area. The expenditures of private insurance companies in the area of health insurance are partially included in the health accounts. | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 11.5 | | |
| ***Description*** | Administration and provision of cash benefits | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 12 | | |
| ***Description*** | Manpower in health care | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | |
|---|---|
| ***Code*** | 13 |
| ***Description*** | Fees, rates and salary structure |
| ***Contents*** | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| ***Year*** | 1997 |

| | |
|---|---|
| ***Code*** | 13.1 |
| ***Description*** | Methods of payment to (specialist) physicians |
| ***Contents*** | The national agency (CNAM) is responsible for the co-ordination between 16 regional and 123 local sickness funds and negotiates with professional syndicates in health care. General practitioners in independent practice and self-employed specialists receive fees for their service. In the sickness fund scheme there is a general regulation on fees, the so-called "nomenclature'. This "nomenclature" consists of three parts: 1:a list of over 4000 procedures grouped under about 50 alpha-numeric codes (or "key letters") ,2:a relative value scale for each procedure,3:a set of monetary multipliers for the alpha-numeric codes. The doctor charges for the number of points under each alphanumeric code, which contributes to medical secrecy. The list and the relative values are changed infrequently. Necessary adjustments to the specifications of this schedule are advised by a three-party committee. The monetary multipliers are re-negotiated annually between the sickness funds and unions of independent doctors, who try to reach national agreements ('convention nationale') on contracts and conditions. Individual doctors have the freedom to quit the convention (to be 'non conventionné'). In fact almost all doctors join the convention. Those who subscribe to the convention can be divided into two groups. The largest group (75%) bills according to the fee schedule, and their patients are reimbursed the full charge minus the co-payment rate. A second group consists of doctors designated by the sickness fund because of their academic position, experience or professional reputation. These doctors may charge higher fees (les dépassements). The patient, however, must pay the surplus amount. A third, very small group, only two percent of the doctors, does not conform to the convention and is free to fix fees themselves. Their patients are reimbursed at a very low rate. The sickness funds have little or no control over the volume of medical services or the location of the doctors. However, they do monitor the volume of each doctor's activity and feed back the results in the hope that this will influence the volume of activity. Excessive prescribing may be sanctioned. General practitioners in health centres and hospital-based physicians are salaried. |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| ***Year*** | 1997 |

| | |
|---|---|
| ***Code*** | 13.1.1 |
| ***Description*** | Integrated or contracted |
| ***Contents*** | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| ***Year*** | 1997 |

| | |
|---|---|
| ***Code*** | 13.1.2 |
| ***Description*** | Type of payment |
| ***Contents*** | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 13.1.3 | | |
| ***Description*** | Method for deciding fees/salaries | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 13.2 | | |
| ***Description*** | Methods of hospital payment | | |
| ***Contents*** | Public hospitals and private non-profit hospitals taking part in the public hospital service have had global, prospective budgets for operating expenses since 1984. These are shared by the local statutory insurers in proportion to the number of bed-days consumed in their catchment are. The budgets include depreciation and interest on capital and are based on historical levels of expenditure. A rate of increase for all global budgets is set centrally, with little scope for local deviation. The budgets are divided into 12 monthly allocations and distributed to the hospital through a local sickness fund referred to as the "caisse pivot". Most private hospitals are reimbursed on a per diem basis for in-patient care, with separate fee-for-service payments for physician services under the same convention, which applies to ambulatory care. The rates cover depreciation and interest on capital. They are negotiated between the hospitals and the statutory insurers under government guidelines about the permitted annual rate of price increases. The statutory health insurance system also plays an important part in financing long-term care, much of which is provided by the hospital system. | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 13.2.1 | | |
| ***Description*** | Method of payment | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 13.2.2 | | |
| ***Description*** | Method for deciding rates | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 13.2.3 | | |
| ***Description*** | Recent changes in payment method | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 14 | | |
| ***Description*** | Main system of financing and coverage (tax based, insurance based, mixture) | | |
| ***Contents*** | The Service des Statistiques, des Etudes et des Systèmes d'Information (SESI) in Paris observes a decreasing significance of government financing from 2.9% in 1980 to 0.9% in 1993. Also the percentual share of social security has diminished from 76.5% in 1980 to 73.9% in 1993. On the other hand individual payments and expenditures by the Mutuelles have risen substantially in the course of time. | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.1 | | |
| ***Description*** | Main features of tax based systems | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.1.1 | | |
| ***Description*** | Main body(ies) responsible for providing health care cover to beneficiaries | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.1.2 | | |
| ***Description*** | Extent of population coverage (excluded groups) | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.2 | | |
| ***Description*** | Main features of social health insurance | | |
| ***Contents*** | Social security is built on four pillars in France: "Régime général": -Assurance Maladie (sickness insurance);-Branche Famille (supplementary family benefits);-Assurance Vieillesse (old age benefits). and out of the "régime général: -Assurance Chômage (benefits for the unemployed); The sickness insurance fulfils two objectives:-to meet the medical and ancillary health care expenses incurred by the patient. -to provide the contributor with a replacement income in case of absence of work or sick-leave. | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.2.1 | | |
| ***Description*** | Organisation of main body responsible for insuring/providing coverage | | |
| ***Contents*** | The national agency (CNAM) is responsible for the co-ordination between 16 regional and 123 local sickness funds. | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.2.2 | | |
| ***Description*** | Extent of population coverage | | |
| ***Contents*** | Sickness insurance, covering 99% of the population, is divided into a number of "regimes". The "régime général" is the scheme for salaried people. About 80% of the French population is covered by this scheme. Other schemes include a regime for the self-employed and salaried farmers (9%) and one for the self-employed (6%). Benefits of these schemes are less comprehensive and there are higher rates of co-payment. The rest of the population is covered by one of about 15 special schemes, with minor advantages for specific sections of the labour force (civil servants etc.). | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.2.3 | | |
| ***Description*** | Stipulations in premium contribution | | |
| ***Contents*** | The social security system is funded by compulsory contributions related to income and shared between employers (70%) and employees (30%). A national central agency (Caisse Nationale d'Assurance Maladie, CNAM) gathers all the contributions collected at local level. Funds are then dispersed to local agencies according to risk.Premiums vary according to the sector in which people are employed and also relate to income. Government pays the insurance for the handicapped and special groups of unemployed. | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.2.4 | | |
| ***Description*** | Competition between insurance schemes | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.2.5 | | |
| ***Description*** | Provision for risk adjustment | | |
| ***Contents*** | In order to exercise his rights the insured person must have worked for a certain period and he must have paid sufficient contributions. Also he must be registered with the administrative organ concerned. In the case of loss of his position as insured a person is entitled to sickness fund benefits for a period of twelve months. | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.3 | | |
| ***Description*** | Health care benefits and rationing; recent reductions in benefits package and variations in extent between different insurance plans | | |
| ***Contents*** | In first instance cost of health care services are paid by the patient. These costs are reimbursed afterwards. Reimbursements will always be lower than the costs paid. In the case of industrial accidents or professional diseases the insurance will pay the providers of care directly. Reimbursements are paid for the services of the general practitioner, surgeon, dentist, pharmacist, hospital and nursing home. Costs for rehabilitation, transport and housing for the disabled are also reimbursed. | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.4 | | |
| ***Description*** | Complementary sources of finance | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.4.1 | | |
| ***Description*** | Voluntary health insurance | | |
| ***Contents*** | In addition to compulsory insurance 87% of the population take out optional supplementary insurance. Private insurance can be divided into profit and non-profit organisations. The latter, "mutuelles" play an important role in French health care. They cover compulsory co-payments and risks not included in the sickness funds. | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.4.1.1 | | |
| ***Description*** | Organisation of voluntary health insurance: public, quasi public, private, not for profit | | |
| ***Contents*** | Private insurance can be divided into profit and non-profit organisations. | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.4.1.2 | | |
| ***Description*** | Type and nature of services covered | | |
| ***Contents*** | The "mutuelles" play an important role in French health care. They cover compulsory co-payments and risks not included in the sickness funds. | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | |
|---|---|
| ***Code*** | 14.4.1.3 |
| ***Description*** | Proportion of population covered |
| ***Contents*** | In addition to compulsory insurance 87% of the population take out optional supplementary insurance. |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| ***Year*** | 1997 |

| | |
|---|---|
| ***Code*** | 14.4.2 |
| ***Description*** | Out-of-pocket payments: main cost sharing measure (partial reimbursement, co-payment) by care category: ambulatory, inpatient, drugs, medical aids and prostheses |
| ***Contents*** | Co-payments are very common in France. The government has fixed contributions for every kind of service (ticket modérateur). For the service by medical doctors patients pay a legally fixed 30%. The same applies to specialist outpatient treatment, laboratory tests (40%) and X-rays. For the first 30 days of stay in a hospital a forfeit of 55 FF per day has to be paid.With regard to pharmaceuticals there are differences as to the urgency. Essential drugs are reimbursed completely. Others require co-payments of 35 or 65% or even 100 %. Dental and ophthalmologic care are reimbursed as other medical treatments. Transport costs also are only partially (65%) reimbursed. For dental prostheses, glasses, contact lenses, optical and acoustical aids partial reimbursement is possible after previous agreement with the sickness fund. Other therapeutic appliances are exempted from co-payments. |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| ***Year*** | 1997 |

| | |
|---|---|
| ***Code*** | 14.4.3 |
| ***Description*** | External sources of funding: employers, fund raisers etc. |
| ***Contents*** | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| ***Year*** | 1997 |

| | |
|---|---|
| ***Code*** | 15 |
| ***Description*** | Health care expenditure |
| ***Contents*** | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| ***Year*** | 1997 |

| | |
|---|---|
| ***Code*** | 15.1 |
| ***Description*** | Structure of health care expenditures |
| ***Contents*** | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 15.2 | | |
| ***Description*** | Total and public health expenditure as % GDP | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 15.3 | | |
| ***Description*** | Health care expenditure by category (%) of total expenditure on health care | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 16 | | |
| ***Description*** | Import and Export | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 16.1 | | |
| ***Description*** | Import | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 16.2 | | |
| ***Description*** | Export | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 17 | | |
| ***Description*** | Health care reforms | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | |
|---|---|
| ***Code*** | 17.1 |
| ***Description*** | Determinants and objectives |
| ***Contents*** | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| ***Year*** | 1997 |

| | |
|---|---|
| ***Code*** | 17.2 |
| ***Description*** | Content of reforms and legislation |
| ***Contents*** | As in other countries cost containment is the most important issue in health care policy in France. In this respect the introduction of global hospital budgets is considered to be successful. Government policy is more oriented towards a sectoral evaluation of health care than towards the definition of an overall health policy. It continues to improve the performance of the health care system by a succession of more modest reforms. The Hospital Law (1991) centred on three major issues: - a desire to implement regional planning for the whole of the hospital system (public and private) thus improving the "health care map"; -a need to strengthen the autonomy of the public hospital system; -a wish to standardise regulations relating to establishments in the public and private sector. Measures proposed to reduce expenses have included the imposition of limits on medical fees and the removal of refunds for a growing list of non-essential pharmaceuticals. An experimental new form of regulation, based on "target contracts" which determine a maximum increase in expenditure at national and regional level for 1992, has been agreed between the government, the social security system and certain health care professionals. This has already been implemented for ambulance drivers, nurses, biologists and private clinics. Under the proposals, patients would register with a single family doctor and enjoy third party payment and an annual health statement. The doctor would receive a fixed amount from the sickness fund for each person on his list and the annual health statement would be used for epidemiological studies. In hospitals an attempt has been made to adapt the concept of diagnosis related groups (DRG's) to the French health care system. The development of medical information systems in both intramural and extramural care is envisaged in order to increase knowledge about medical activities per pathology. |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| ***Year*** | 1997 |

| | |
|---|---|
| ***Code*** | 17.2.1 |
| ***Description*** | future development of planning: move to be integrated/move to contract based |
| ***Contents*** | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| ***Year*** | 1997 |

| | |
|---|---|
| ***Code*** | 17.2.2 |
| ***Description*** | tax based system: change in population coverage; opting out permitted/encouraged |
| ***Contents*** | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 |
| ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 17.2.3 | | |
| ***Description*** | insurance based system: development of the degree of benefit coverage in the future | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 17.2.4 | | |
| ***Description*** | voluntary health insurance: changes in uptake; plans for change | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 17.3 | | |
| ***Description*** | Health for all policy | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 17.4 | | |
| ***Description*** | Reform implementation | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 17.5 | | |
| ***Description*** | Conclusions | | |
| ***Contents*** | | | |
| ***Source*** | International Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 | ***Year*** | 1997 |

# *Country profile: Germany*

| | | | |
|---|---|---|---|
| ***Code*** | 1 | | |
| ***Description*** | Introduction and historical background | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 2000 |

| | |
|---|---|
| ***Code*** | 1.1 |
| ***Description*** | Introductory overview |
| ***Contents*** | Political and economic background<br>The Federal Republic of Germany covers an area of about 356 978 km 2 . The longest distance from north to south is 876 km, from west to east 640 km. The total population is 82 million (40 million males and 42 million females). The density of the population is 230 inhabitants per km 2 (1998 figures). This includes over 7 million foreigners, of whom just over 2 million are Turkish. The population is unevenly distributed with far more people living in the western part of Germany. Of the 19 cities with more than 300 000 inhabitants only three (including Berlin) are in the eastern part of Germany. The largest city is Berlin with 3.5 million inhabitants. Other densely populated areas are the Rhine-Ruhr region with about 11 million people and the Rhine-Main area surrounding Frankfurt. Germany is a federal republic consisting of 16 states (known in Germany as Länder). Each of the states has a constitution which must be consistent with the republican, democratic and social principles embodied in the constitution (known as the Basic Law or Grundgesetz). The constitutionally defined bodies which have primarily legislative functions are the lower and upper chambers of parliament, namely the Federal Assembly (Bundestag) and the Federal Council (Bundesrat). The Federal Assembly is made up of 672 members who are elected every four years. Since 1998, the Social Democrats (SPD) and the Greens have held the parliamentary majority and have formed the government. The main functions of the Federal Assembly are to pass laws, to elect the Chancellor and to control the government. The Federal Council which represents the sixteen federal states does not consist of directly elected representatives but of three to six members – depending on population size – from each of the sixteen state governments or their representatives. The main function of the Federal Council is to approve laws which have been passed by the Federal Assembly. About half of all bills require the formal approval of the Federal Council, i.e. both the upper and lower chambers have to pass them, while in other cases the Assembly may overrule a negative vote by the Council. The requirement for being passed by both chambers applies especially to bills that are of vital interest to the states, such as those regarding financial affairs or their administrative powers. Passing laws that need the approval of both chambers is often difficult and requires a compromise since the political majority in each chamber is typically held by opposing parties or coalitions. The compromise is often found and formulated by the 32-member arbitration committee (sixteen from the Federal Assembly and one from each Land) before being passed by both chambers. The President (currently Johannes Rau) is elected for five years by an assembly consisting of the members of the parliament and an equal number of representatives from the states according to their population size. The president's major tasks are to approve new laws, formally appoint the chancellor and the federal ministers and to fulfil a representative function. Legislative authority lies principally with the Länder, except in areas for which this authority is explicitly given to the federal level. The Federation's legislative authority falls into three different categories: • exclusive • concurrent • framework. Areas of legislation which pertain exclusively to the Federation are foreign affairs, defence, monetary matters, air transport and some elements of taxation. In the case of concurrent legislation, the states may only pass laws on matters not covered by federal law. The Federation may only legislate in such cases where it is necessary to have a uniform law for the whole country. Where the states grant the federal level the right to enact framework legislation, they retain a considerable amount of legislative latitude. This applies, for instance, in the fields of higher education, nature conservation, landscape management, regional planning and water management. The states can fill in any gaps left by federal legislation or in areas not specified by the constitution. Thus they are responsible for education and culture almost in their entirety as a manifes-tation of their "cultural sovereignty". They are also responsible for legislation defining the powers of local government and the police. The real strength of the states lies in their participation in the legislative process at the federal level through the Federal Council. All internal admini-stration lies in their hands, and their bureaucracy implements most federal laws and regulations. Difficulties can arise due to the fact that the Federal Council is often dominated by states that are led by parties which are a minority in the lower chamber or Federal Assembly. The Federal Government's Cabinet consists of the Chancellor (since 1998 Gerhard Schröder) who is head of the government, and the federal ministers. The Chancellor chooses the ministers and proposes them to the President for appointment or dismissal. He also determines the number of ministers and their responsibilities. The Chancellor is in a strong position primarily due to the fact that he establishes the guidelines for government policy. The federal ministers run their departments independently but within the framework of these guidelines. Besides the legislature and the executive, the various separate court systems (e.g. administrative, constitutional and civil courts) represent a strong third pillar of decision-making. Germany is a member of the G7 group of leading industrial countries. In 1998 the gross domestic product amounted to a total of DM 3784 billion or DM 46 100 per capita. German industry is mainly export-oriented. The major economic problem is the high rate of unemployment. In the five states of the former German Democratic Republic employment declined by about 3.5 million to 6.3 million between 1989 and 1994 as a result of the crisis precipitated by the transition to the social market |

economy. Around 4.1 million people, on average, were without employment in 1999, a rate of 10.5%, with a rate of 17.6% in the eastern parts which is twice as high as that in the western parts of the country. Rates by districts vary much more: between 13.9% and 22.9% in the east and between 3.3% and 15.4% in the west.
Health status Valid morbidity data about the German population are not easy to obtain. The most important source for health data is the biennial report of the German Ministry of Health on the health system and the Basic Health Report which was published for the first time in 1998. This latter report will be updated regularly and will be supplemented by reports on specific aspects. Another source is the Hospital Diagnosis Statistics of the Federal Bureau of Statistics which provides data from 1993. Other morbidity data come from analyses of sickness fund statistics for hospitalized patients and medical certificates, pension fund data on rehabilitative measures, cancer registries, claims data for preventive measures and specific surveys. A national periodical survey, the micro-census, gathers subjective data on perceived health status of a small representative sample of the population. According to the 1995 micro-census, around 8.4 million people in Germany consider themselves to be ill and a further 0.7 million are injured by accidents. In total, 9.1 million (12.3%) of the total population are therefore classified as “not healthy”. In 1995, the Cancer Registry Act came into effect. According to this law, every federal state must establish a cancer registry by 1999. Until these registries are functioning, cancer incidence and prevalence can only be estimated (with the exception of children and registries in a few states). Mortality data are more reliable. These data are derived from the Cause of Death Statistics compiled by the statistical bureaux of the states and the Federal Bureau of Statistics. In 1998, 852 400 people died (while 785 000 children were born alive). The main causes of death were cardiovascular diseases (about 50% of all deaths) and malignant tumours (around 25%). For the purposes of international comparison, the health status of the German population can be illustrated using certain health indicators. Cardiovascular and non-malignant lung disease mortality rates in Germany are well above the European average. In 1991 unified Germany had a life expectancy, both at birth and at age 65, that was slightly below the EU-12 2 average at that time (The term EU-12 refers to the 12 members of the European Union that were members in 1991). (prior to this the Federal Republic of Germany had consistently been narrowing the gap towards the EU average). Infant and maternal mortality rates are lower than the European average. Death rates (standardized to the European population) were above the EU average for diseases of the circulatory system (74.1 versus 62.4 per 100 000 for persons under 65 years of age) and for suicide and self-inflicted injury (15.4 versus 11.7 for all ages). They were at or around the EU average for malignant neoplasms and all external causes of injury and poisoning. Standardized death rates for motor vehicle traffic accidents are below the EU average (12.9 versus 14.1 for all ages) but remain a problem in eastern parts of the country, especially among young males. The incidence of AIDS has been stable since the early 1990s and amongst the lowest in the EU (around 2.5 new cases per 100 000 per year in 1996); this may be due to a concerted strategy towards prevention. Dental diseases, on the other hand, remain a prob-lem with Germany having one of the highest DMFT (decayed, missing and filled teeth) index for 12-year olds of all EU countries. Germans consume more cigarettes and alcohol than the average European. This situation of the population’s health in Germany may also be analysed against the background of a 40-year political and geographical separation which provides a very interesting case-study for changes in health due to political, social and economic influences on an otherwise homogenous population. The most obvious indicator of a different pattern of the population’s health in the Federal Republic of Germany compared to the German Democratic Republic is life expectancy at birth. This initially increased faster in the east (from a slightly higher level) but by the late 1960s life expectancy at birth had stagnated. However, since the late 1960s this indicator shows continued improvement in the western part of the country. Between 1980 and 1990 the gap in life expectancy widened, especially for men. According to McKee et al. (1996), explanations for the widening gap pre-1990 include differences in diet, better living conditions, differences in access to high technology care, better health care at all levels and the selective migration of pensioners from the eastern to the western parts of the country. Since unification, the gap in life expectancy has rapidly narrowed, especially for women. It is not likely that any pre-1990 factors are responsible for this. Instead, the following post-1990 changes are likely factors that are (partly) responsible for this trend:
• the adoption of the Federal Republic of Germany social welfare system
• the adoption of the FRG health care
• greater personal freedom (but also higher unemployment)
• a cleaner environment. Current health concerns are mainly related to diseases associated with the age structure and demographic trends of the German population. Important demographic and health-related trends that are currently observed include an increase in the number of one-person households, an increase in long-term chronic-degenerative diseases, increasing public expectations with respect to medical and paramedical care as well as incentives for the excessive use of health care services. In addition, the share of elderly people in the population is increasing while the relative number of people of working-age decreases, leading to shrinking social security revenues. Future changes in the structure of the population will lead to a moderate increase in the elderly population’s need for therapy, rehabilitative care, and nursing care whereas the morbidity transition will result in less need for curative medical intervention. It is also expected that there will be an additional need for health services

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| | responding to obstructive lung diseases, diseases of the cardiovascular system, urogenital diseases and cancer diagnosis and therapy. A large preventive potential for coronary and circulatory diseases, respiratory diseases and accidents is also foreseen. |

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| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 2000 |

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| ***Code*** | 1.2 |
| ***Description*** | Historical background |
| ***Contents*** | The history of the modern German health care system can be best be described according to the major periods in German history: Industrialization and the introduction of mandatory health insurance (on a national level) in 1883, social conflicts and doctors' victories during the Empire and Weimar Republic 1883–1933, the national-socialist period 1933–1945, the post-war period 1945–1949 which resulted in two separate German states and a reunified Germany since 1990.<br>The rise, continuity and prominence of statutory health insurance (SHI)<br>The rise of Germany's modern health care system dates back to 1883 when the parliament made nationwide health insurance compulsory. Germany is recognized as the first country to have introduced a national social security system. In the following decades the principle of statutory social insurance, called the Bismarck system, was also applied to alleviate the risks of work-related accidents and invalidity (1884), old age and disability (1889), unemployment (1927) and the need for long-term nursing care (1994). The prominence and structural continuity of social insurance is one of the key features of the historical development of Germany's health care system to the present day. The origins of social insurance lie in the mutual-aid societies of guilds which emerged after the middle ages. During the nineteenth century, the rising class of industrial blue-collar workers adopted this principle by setting up occupa-tional self-help and regulation (voluntarism). Contributory funds were also set up by companies and local communities, thus relieving (and complementing) statutory support for the poor and charity. In 1849 Prussia – the largest of the German states – made health insurance compulsory for miners and allowed local communities to oblige employees and their employers to pay financial contributions. Multiple economic crises during rapid industrialization worsened already miserable living conditions, especially of the urban working class. The govern-ment responded to increasing workers' protests by prohibiting socialist and communist organizations in 1878 including trade unions, but increasingly it perceived political repression as an insufficient measure of maintaining the existing social order. In 1876, five years after the unification of the German states, the parliament enacted national standards for minimum contributions and benefits but opposed regulations for mandatory payments. The Emperor's charter of 1881 declared social welfare for the poor to be essential for national survival in a hostile world. Motivated by paternalism and by concerns about military and economic efficiency, Chancellor Bismarck suggested a national health service type of system in 1881. However, provincial governments as well as liberal members of parliament from business, agriculture and the church opposed tax-based financial provisions and the expansion of national govern-ment. The resulting legislation of 1883 reflected a compromise of these rival interests but was opposed by leftist-liberals and social democrats. They dismissed the "carrot and stick" strategy of the bill and instead called for political rights and workers' protection within the industrial process – demands which were only met gradually from the 1890s onwards. The law built upon existing local funds and occupation-based funds (miners, guilds and companies). Health insurance was made compulsory for workers of certain industries with hourly wages or up to a legally fixed income ceiling. They were to pay two thirds of the contributions while their employers were obliged to pay one third. Furthermore, the two opponents in the class conflict were entitled and forced to cooperate in elected assemblies and boards propor-tionate to their 2:1 contributions. Members were eligible to receive monetary benefits, i.e. sick pay equivalent to 50% of the customary local wage for 13 weeks, maternity pay and death compensation. In addition, a minimum set of primary health care services including medication was to be provided while hospital care was left to the decision of the funds on a case-by-case basis. The funds functioned on a non-profit basis. They were initially free to choose private suppliers of health care (physicians or any other health care professionals) and to determine the nature of contractual relationships with them. The role of the national parliament and government was limited to prescribing social policy and setting legal standards for the self-administrated funds which were to be supervised by provincial governments. For compulsory social insurance covering work-related accidents and invalidity, employers accepted the 100% contributions to self-administered accident funds as an alternative to third-party insurance schemes. Thus, they increasingly introduced and controlled preventive safety measures and rehabilitative care which were to precede financial compensation. The statutory insurance for old age, to which employers and workers paid equal contributions, also offered health care services according to the principle of "rehabilitation before compensation". Rehabilitative care, e.g. for tuberculosis patients, was delivered directly by most financing agencies, including sickness funds and local communities, in the form of inpatient treatment in the countryside. This led to the heterogeneous development of rehabilitative care and to the popular-ization of spa treatments which became an institutional niche, e.g. for natural treatments and remedies (often categorized as alternative medicine today). During the 1880s many workers boycotted the self-administered statutory funds and chose self-supporting funds as a legal alternative to statutory funds (known as substitute funds). These funds were self-governing and were run entirely by the workers. However when this choice became restricted in the early 1890s, statutory funds became the stronghold of the |

social democratic party. The national government interfered to separate the rising white-collar movements from the blue-collar by introducing a separate string of statutory health insurance for salaried employees in 1901. Since white-collar workers received greater rights to choose, the existing substitute funds catered almost exclusively for white-collar employees from that time onwards (until 1995). The substitute funds, although contributions were now shared with employers, maintained the historical pattern of representation; that is, 100% employees, which is still the case today. The 1911 Imperial Insurance Regulation introduced a common legal framework for social insurance; the regulations covering health insurance remained in force – with changes – until 1988. The regulations governing maternity benefits still remain in force today. The number of citizens with health insurance in 1883 had doubled when compared to 1880. Over the ensuing decades statutory health insurance was gradually extended from covering 10% of the population in 1883 to 88% (mandatory and voluntary) of the population of the Federal Republic of Germany in 1987 and to 100% of the population in the German Democratic Republic in 1949. The universal national health insurance system of the socialist German Democratic Republic (GDR) was abandoned after reunification in 1990 in favour of the liberal Federal Republic of Germany (FRG) insurance system. The extension of membership was achieved either by increasing the income ceiling of mandatory membership or by adding new occupational groups to the statutory fund system, i.e. white-collar workers from the transport and com-mercial sector (1901), domestic servants, agricultural and forestry workers (1914) or farmers (1972). Germany also managed to integrate certain social groups, which in many other European countries were financed and/or cared for by public agencies, e.g. the unemployed, family dependants, pensioners, students and disabled persons, into the statutory health insurance scheme. Contributions and expenditure increased substantially during the 116 years of statutory health insurance. This was the result of the extension of benefits – often following decisions by the civil courts – through state intervention but mainly by the self-administered funds themselves or by joint committees between funds and physicians. While initially the statutory health insurance scheme aimed primarily at preventing impoverishment by compensating income in cases of illness, sickness funds increasingly funded services and the pre-scriptions of specialized professionals. This is reflected in the falling ratio between monetary and service/product benefits. The trend was accelerated even further from 1969 when FRG employers became obliged to continue remuner-ating their employees during the first six weeks of sickness. When looking at rising expenditures it should not be overlooked that the pay-as-you-go principle of contributions and expenditure ensured a sound financial basis for health care financing even during the two World Wars, mega-inflation in 1923, the economic crisis of 1929 and the introduction of a totally new currency in 1948.

Collective victories of the medical profession over funds and other professions

The shift from monetary to service benefits corresponded with a growing number of health professionals. This trend reflects a broader transformation in nineteenth century industrial society to what has been called a “professional society”. Health care services were one of the solutions which the rising class of professionals offered as a means of addressing social and physical problems, and they basically received legitimization for doing so from most sections of society. However the “socialization” of professional health care developed alongside deep conflicts over income and power. The conflicts between the sickness funds and physicians working in the ambulatory sector on a for-profit basis were one of the major factors which shaped Germany’s current health care system. Office-based physicians played, and still play a dominant role not only within the ambulatory sector but also affect the health care sector as a whole. Until 1933 they gained major victories over the quasi-public funds, over other health professions and over physicians working in the public or non-profit private sector. The 1883 legislation did not address what relationship funds should have with doctors nor what the qualification of health care professionals should be, leaving both these matters up to the funds. Doctors initially hardly took any notice of this regulation, but from the 1890s they fought for autonomy and income through strikes and lobbying. The underlying developments were the extension of the number of patients with insurance coverage, the restricted access of insured patients to doctors, the dependence and low status of employed panel doctors from the worker-dominated funds and the doubling of the physician/population ratio from 1887 to 1927. From 1900 onwards the medical profession managed to nationalize their campaign and to convince the rival panel and private doctors to express uniform demands. The most successful interest group was the Leipzig Union, later called the Hartmann Union which was founded in 1900 and whose membership grew from 21 doctors to nearly 75% of all German physicians by 1910. In a way their demands were paradoxical: on the one hand, they demanded free (or increasing) access to statutory insured patients under the slogan “free choice of doctors for patients but not for funds”. But on the other hand, they tried to restrict the size of the public sector in order to keep private patients or – from the perspective of panel doctors – in order to share the income from statutory funds with as few physicians as possible. Except for a period of real fee-for-service remuneration in the 1960s and 1970s, this conflict has remained a feature of German health care politics until today. Since the 1911 Imperial Insurance Regulation did not address any of these demands, physicians threatened to go on strike shortly before it took effect in 1914. In December 1913, the government intervened for the first time in the conflict between funds and physicians. The Berlin Convention made joint commissions between physicians and funds obligatory in order to channel the conflict into a constructive negotiation process. The ratio of doctors to fund members was now legally fixed at a minimum of 1:1350

which joint registering committees had to put into practice. Contracts with physicians had to be agreed with all funds collectively. After the Berlin Convention had expired at the height of inflation in 1923, office-based physicians went on strike repeatedly. Some funds responded by setting up their own health care centres which – although few in number – were perceived by the medical profession as a menacing throwback to nineteenth century conditions and to the socialization of medical services. Private practitioners also felt threatened by the establishment of a broad diversity of services for prevention, health education and social care which were delivered by local communities and welfare organizations. The government also responded to the strikes and created the Imperial Committee of Physicians and Sickness Funds (which still exists today as the Federal Committee) as the joint body responsible for decisions regarding benefits and the delivery of ambulatory care. Emergency regulations during the economic and political crises of the early 1930s introduced co-payments for patients, the supervision of doctors through a medical service of the sickness funds and a doctor/fund-member ratio of 1:600. In return, ambulatory physicians were granted a legal monopoly for ambulatory health care (1931) for which they had been lobbying (with gradual success) over the preceding decades. These regional physicians' associations obtained the right to negotiate complex contracts with statutory health insurance funds and to distribute their payments amongst their medical members. The regulations reflected a major collective victory by ambulatory physicians over sickness funds, hospital doctors, medical officers in community health and other health care professionals. State regulations had already subordinated non-medical professionals (such as midwives and nurses) under the medical profession since 1854 and they now restricted their autonomy further by completely prohibiting them to contract directly with statutory health insurers. Although practitioners of natural therapies and remedies were promoted ideologically during the first years of the Nazi regime, their status as free traders was restricted from 1939 when their certification and practice were submitted to the control of regional medical/ public health officers. The ambulatory monopoly for physicians in private practice meant that it was now legally prohibited for medical officers to provide curative services, for sickness funds to buy and supply pharmaceuticals or medical services, and for hospitals to treat outpatients. Thus, the legalization of the physicians' ambulatory monopoly contributed substantially to their division from the hospital sector and to the marginalization of community health services. The separation of inpatient and outpatient care was also enhanced by the rapid expansion and specialization of acute hospital care with the majority of personnel working full-time since the 1920s. The number of inpatient beds tripled from 1885 to 107 per 100 000 inhabitants in 1938. The separation between inpatient and outpatient care was further promoted by the division of financing and planning responsibilities between the corporatist associations of funds and physicians and the public agencies at the state and community level each with their particular traditions of health administration and legal frameworks. Another factor contributing to the division of inpatient and outpatient sectors was the early specialization and professionalization of the medical profession. The pioneering role of German physicians in empirical scientific research in medicine had been strongly supported by regional and national authorities since the 1880s. By the turn of the century, most medical faculties provided chairs for all major clinical and basic science sub-specialties which again were made obligatory subjects for medical students by 1920. Medical and specialist training continued to be science-oriented and based in hospitals only, as is still the case today. The exceptional specialization process was a result of these trends and of the competition amongst the medical profession for income and operational fields. Conversely, the specialization and subsequent professionalization (including full-time occupation and separate professional organizations) increased intra-professional rivalries further – both between medical professionals in the private and the public sector and between generalists and specialists (a conflict which is currently as important as ever).

Continuity and change during the national-socialism period

During the national-socialist (Nazi) regime, the fundamental structures of health care financing and delivery were maintained. The regional and the newly-founded national physicians' association were established as public bodies (1934). They were also granted the right to make decisions on the registration of office-based physicians by themselves without negotiation with sickness funds. In return they were forbidden to strike and were made responsible for emergency care in the ambulatory sector as well as for the administration and control of all ambulatory physicians. During the war, social insurance coverage was extended to pensioners (1941). In contrast to the continuity in structure, the management of health care and the balance of power amongst the main actors was changed during the Nazi regime. In 1933, socialist and Jewish employees and the majority of workers' representatives in sickness funds were expelled by law. Sickness funds (1934), community health services (1935), nongovernmental organizations dealing with welfare or health education and the health care professions' organizations (1933–1935) were each centralized and submitted to a leader who was nominated by the National-Socialist Party (following the so-called Führer-prinzip). Self-administration became penetrated by nominated members of the National-Socialist Party. The participation of workers and employers was reduced to functions in an advisory council. In addition physicians and local communities were allowed to send representatives to the council. Access to adequate health care was increasingly restricted or denied to the Jewish population and other stigmatized minorities due to the national-socialist state's and party's politics of expulsion, exclusion from social life, murder and detention in concentration camps. (During the

Second World War the general civilian population and soldiers also experienced restrictions on their right to adequate health care services which they had acquired by social or private health insurance.) From 1933 onwards, public funds for social care, welfare and health education were diverted towards satisfying the political targets of racial purity, eugenics and social control. Aryanization of the health care system entailed that one fourth of employees in sickness funds and about one third of the doctors working for local community welfare services were forcibly released from service in 1933. Subsequent laws prohibited Jewish doctors to treat patients with statutory insurance (1933), non-Jewish patients (1937) and to practice medicine at all (1938). Thus 12% of physicians in the country (and 60% of doctors practising in Berlin) were restricted from delivering health care. The majority of the medical profession – the profession with the highest membership in the national-socialist party – welcomed the exclusion of Jewish doctors as an advantage for increasing their own income within the context of competition for patients. In addition, the balance of power was shifted further from the funds to the physicians.

Post-Second World War

After the Third Reich fell on 8 May 1945, health care and virtually all other sectors of German society began to bifurcate into systems that became virtually diametrical. The three zones occupied by western allies were to become the Federal Republic of Germany (FRG) whilst the Soviet zone was to become the German Democratic Republic (GDR). Both states operated separately from 1949 until they became unified in 1990 after peaceful protests by GDR citizens for social and political reform. Health care in the first years of post-war Germany was characterized by ad hoc public health interventions aimed at handling and preventing epidemics and distributing scarce resources for health care. The western allied forces basically supported and relied upon existing personnel and structures in health care and administration. The British administered health affairs in a more centralized fashion whilst the French tried to restrict centralized powers within their zone and the whole of the western part of the country. The Americans concentrated mainly on ad hoc policies, tried unsuccessfully to establish a public health school and blocked the re-establishment of the physicians' monopoly until the 1950s.

The national health service system in the German Democratic Republic (GDR)

In contrast, the Soviets took a strong interventionist role from the beginning. They took an authoritarian approach in order to control infectious diseases and, despite the protests of physicians, gradually introduced a centralized state-operated health care system. They called 60 health experts to advise them on designing a new model. This model came to be influenced by the traditions of social hygiene in the community health care services of the Weimar period, and by emigrants who had returned from Britain, Sweden and the Soviet Union where the design of those health care systems had been influenced strongly by German doctors who had left the country during the 1920s. The resulting GDR health care system differed from its Soviet counterpart through a structural division between ambulatory and hospital services which in practice, however, often operated closely together on the same premises. In addition, the principle of social insurance was de jure maintained with workers and employers sharing premium costs but with administration concentrated in only two large sickness funds, one for workers (89%) and one for professionals, members of agricultural cooperatives, artists and the self-employed (11%). De facto, however, the role of the social insurance system was extremely limited. As in most socialist countries, health care personnel were employed by the state and delivered ambulatory care to a small degree in solo practices but mainly through community-based or company-based health care centres which usually were staffed by multiple medical disciplines and other health care professionals. Local communities provided preventive services for health education, child and maternity health and specialist care for chronic diseases such as diabetes or psychiatric disorders. These health care services were complemented by comprehensive state support for social measures, e.g. housing, child day-care and crèches which also supported the policy for increasing the population and workforce. Thus, they realized a type of health care system which the political left aspired to also in the Federal Republic of Germany and many other western countries until at least the 1960s. However, due to under-financing and under-investment, a shortage of personnel and modern technologies or due to qualifi-cation deficits the quality and modernization of the GDR health care system gradually began to fall behind the standards of western industrialized countries from the 1970s onwards. Shortly after the National Health Conference had decided to introduce profound health care reforms and to increase investments and personal resources in 1989, the opening of the Berlin wall ended the political sovereignty of the German Democratic Republic.

The continuation of the social insurance system in the Federal Republic of Germany (FRG)

The local sickness funds, labour unions and the Social Democratic Party cam-paigned for a single insurance fund for health, old age and unemployment in order to increase the bargaining leverage over the monopoly that ambulatory physicians already enjoyed in different regions. However, the conservative Christian Democratic Party won the first elections in 1949 and by 1955 had basically restored the health care system which had existed at the end of the Weimar period on a national level (in coalition with the employers). Sickness fund contributions were now shared equally between employees and employers as well as representation (except in the substitute funds). The insurance for work-related accidents and invalidity continued to be entirely financed by employers, yet trade unions were granted a 50% representation. (Due

to the power of the allies, the health insurance and health care system in the western part of Berlin were governed by slightly different arrangements: e.g. a unified health insurance was maintained until the early 1960s.) Self-administration became predominantly a field for corporatist repre-sentatives with relatively little transparency and democratic rights for insured members. Private ambulatory physicians were again granted a monopoly with the corresponding rights, power and duties. In addition the legal ratio of physicians to fund members was increased to 1:500 and then abolished com-pletely in 1960 in favour of professional self-regulation after the Constitutional Court had declared the freedom to choose one's work a constitutional right. The period from 1955 to 1965 has been characterized as a period of struggle concerning structural reforms aiming to reduce costs which a coalition of physicians, sickness funds, media and health product companies was able to avert. From 1965 to 1975, costs for health care increased substantially based on growth in the national economy and was partly due to rising prices and wage costs (including the secularization of hospital personnel), demographic trends, the complementary use of more expensive technology and the modern-ization and expansion of health care services. Ambulatory physicians developed an increasingly sophisticated system of fee-for-service remuneration. New services for secondary prevention and partly for occupational medicine were put under the auspices of office-based physicians which saved costs for local community health but also decreased its role within the health care system. The 1970s also saw an extension of reform-oriented social, psychiatric and nursing services which were mainly delivered by private non-profit organi-zations at the community level. In addition, new membership groups were brought under the roof of statutory health insurance (e.g. farmers, disabled persons and students). In 1972 the responsibilities of states and funds in financing hospital reform were clarified and manifested towards the "dual financing" method which made funds pay for services and personnel while states were to finance investments and running costs. Therefore, it is important to note that the growth of the health care sector and health care expenditure was the result of an explicit political strategy. It aimed at overcoming the infrastructural deficits and shortcomings caused by the destruction suffered during the Second World War as well as the insufficient mode of financing hospital investment that existed at the time. After the oil crisis (i.e. from 1975 onwards), the continued increases in costs became perceived increasingly as a cost-explosion and attracted subse-quent criticism of health care providers' financial and status interests. The era of cost-containment in the statutory health insurance began in 1977 with the introduction of the Health Insurance Cost-Containment Act. It ended the period of rapid growth in health care expenditure, especially in the hospital sector. Since 1977, the sickness funds and providers of health care have been required to pursue a goal of stability in contributions which has remained the main cost-containment target in health care ever since. This requirement is defined as pegging increases in contribution levels with the rate of increases in contribu-tory income. Ensuring compliance with the intentions of this legislation is one of the main tasks of the Concerted Action in Health Care, a round-table for the rival corporatist organizations to decide on how to contain costs jointly. The committee has been extended over the years to about 130 representatives but due to continued conflicts basically has not met its political expectations. The basic principle behind "German-style" cost-containment was an income-oriented expenditure policy to guarantee stable contribution rates. This was an important objective in a time of economic restructuring and growing inter-national competition, since the contributions are jointly paid by employers and employees. Therefore, increases in contribution rates were (and still are) perceived to be a question of international competitiveness. The drive for cost-containment, which intensified after reunification, was realized through a long series of legislation (see the section on Health care reforms) that employed various measures primarily: • budgets for sectors or individual providers • reference-price setting for pharmaceuticals • restrictions on high cost technology equipment and number of ambulatory care physicians per geographic planning region • increased co-payments (both in terms of size and number of services) • the exclusion of young people from certain dental benefits between 1997 and 1998.

The transfer of the FRG health care system to GDR

The public protests of GDR citizens for political and economic reforms led to the fall of the Berlin wall in November 1989 and ended the sovereignty of the German Democratic Republic. In 1990, the transitional GDR government and the FRG government signed the Treaty of German Reunification which reflected the political decision to integrate the 17 million citizens in GDR quickly and comprehensively into the Federal Republic of Germany system. The trans-formation to standards in the FRG did not only affect the (widely-criticized) political and economic system but also the systems of social security and health care which the public regarded more positively. Yet ideas for a third way, for example, one uniform health insurance system for the former GDR or the whole of Germany, were dismissed on practical, political, legal and lobbyist grounds. Only minor compromises were made concerning the financing and delivery of health care. For example, the Treaty of Reunification granted the community health care centres (polyclinics) only five-years' grace after which they were to negotiate jointly with regional physicians' associations. But the time limit and the restrictions on remuneration that could be achieved by these centres – they received per capita payments instead of the fee-for-service that office-based physicians collected – did not offer great prospects for the future. By May 1992, 91% of physicians who previously had worked in different ambula-tory public settings were running their own practices. There are only a few polyclinics (in Berlin and the

federal state of Brandenburg) which have still managed to continue operating either as a network of distinct solo-practices or as a cooperative. In addition, the FRG health insurance types expanded quickly into the the eastern parts of the country. However, this has resulted in a lower percentage of privately insured citizens (2% versus 10%) and a higher proportion of local fund members (61% versus 42%). The federal government supported the upgrading of the infrastructure through an immediate aid programme of several billion Deutsche Marks. Investments were directed mainly towards hospitals and nursing homes.
Health care reforms in Germany of the 1990s
These extraordinary tasks increased the pressure on the system and contributed to the increasing speed of health care reform legislation in the 1990s: the Health Care Structure Act (1992), the Health Insurance Contribution Rate Exoneration Act (1996), the First and Second Statutory Health Insurance Restructuring Acts (1997), the Act to Strengthen Solidarity in Statutory Health Insurance (1998) and the Reform Act of Statutory Health Insurance 2000 (1999). Key elements of the Health Care Structure Act were:
• the introduction of legally fixed budgets or spending caps for the major sectors of health care;
• a partial introduction of a prospective payment system in the hospital sector (case-fees and procedure-fees for selected treatments beginning in 1996) instead of the previous system of covering full hospital costs;
• a loosening of the strict separation of the ambulatory and hospital sector (e. g. ambulatory surgery in hospitals became possible);
• the introduction of a positive list of pharmaceuticals (which was later abolished), increased co-payments, and restrictions for opening new prac-tices in ambulatory care;
• the introduction of a risk compensation scheme to redistribute contributions among sickness funds;
• the freedom to choose a sickness fund for almost all the insured population.
The Health Insurance Contribution Rate Exoneration Act and, more explicitly, the First and Second Health Insurance Restructuring Acts repre-sented a shift from cost-containment to a possible expansion of private payments. Co-payments were now viewed as a means to put new money into the system. These laws included: the cancellation of the budgets in ambulatory care and the spending caps for pharmaceuticals; increased co-payments for inpatient care, rehabilitative care, pharmaceuticals, medical aids, and trans-portation (to the hospital); an exclusion of young persons from certain dental benefits (mainly crowns and dentures) but also the privatization of the relation-ship between dentists and all other patients for these treatments; and an annual flat premium of DM 20 for the restoration and repair of hospitals which had to be paid entirely by the insured. The Act to Strengthen Solidarity in Statutory Health Insurance reversed almost all of these changes since they were perceived by the new government to violate the basic principles of the statutory health insurance system, namely uniform availability of benefits, equally shared contributions between employers and employees, financing depending only on income and not on risk or service utilization, and the provision of services as benefits-in-kind. The Reform Act of Statutory Health Insurance 2000 does not have one central theme but rather tries to address a range of (perceived) weaknesses of the system by strengthening primary care, opening opportunities for overcoming the strict separation between the ambulatory and inpatient care sectors, intro-ducing new requirements for health technology assessment and quality assurance, as well as supporting patients' rights. In addition, the payment system for hospital care will be changed.

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| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 2000 |

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| ***Code*** | 2 |
| ***Description*** | Main functions of key bodies in the organizational structure and management of health care administration |
| ***Contents*** | |

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| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 2000 |

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| ***Code*** | 2.1 |
| ***Description*** | (Con-)Federal/National government, Ministry with main responsibility for health care and other ministries with health care competence |
| ***Contents*** | Organizational structure and Management A fundamental facet of the German political system – and the health care system specifically – is the sharing of decision-making powers between the Länder and the federal government, with further powers governing statutory insurance schemes being delegated to nongovernmental corporatist bodies. Corporatism has several important aspects. Firstly, it hands over certain rights of the state as defined by law to corporatist self-governed institutions. Secondly, the corporatist institutions have mandatory membership and the right to raise their own financial resources under the auspices of, and regulation by the state. Thirdly, the corporatist institutions have the right and obligation to negotiate and sign contracts with other corporatist institutions and to finance or deliver services to their members. A separate group of actors are the courts which will be dealt with separately after the federal, Länder and corporatist levels The German constitution (known as the Basic Law) requires that living conditions shall be of an equal standard in all Länder. However, health promotion or protection is not specifically mentioned as a goal. (This was different in the German Democratic Republic where Article 35 of the constitu-tion named health protection as a state objective.) As mentioned, the constitution defines areas of exclusive federal legislation and concurrent legislation. Health is not an area exclusive to federal legislation and specific topics relevant to health are included in the concurrent legislation. For example, social benefits, measures against diseases which are dangerous to public safety, protection against ionizing radiation, certification of physicians and other health profes-sions, pharmaceuticals and drugs, and the economic situation of the hospitals. However, federal law – where it exists in these areas – takes precedence over Länder legislation. In addition, parts of environmental policies fall into this category. Implicitly, all other aspects of (public) health are therefore the res-ponsibility of the Länder.<br>Federal level At the national (i.e. federal) level, the Federal Ministry for Health and the parliament are the key actors. The Ministry of Health is divided into five divisions with two subdivisions each:<br>• administration and international relations<br>• pharmaceuticals/medical products and long-term care<br>• health care and statutory health insurance<br>• protecting health and fighting disease<br>• consumer protection (mainly food-related) and veterinary medicine. Before 1991, the (sub)divisions dealing with statutory health were part of the Ministry for Labour and Social Services while most of the other (sub) divisions were part of the Ministry for Youth, Family, Women and Health.<br>The subdivision responsible for long-term care, including social long-term care insurance was transferred from the Ministry of Labour and Social Services to the Ministry of Health only in 1998. The Federal Ministry of Health is assisted by subordinate authorities with respect to scientific consultancy work and the performance of certain tasks:<br>• The Federal Institute for Pharmaceuticals and Medical Devices (BfArM), is the major licensing body for pharmaceuticals and supervises the safety of both pharmaceuticals and medical devices;<br>• The German Institute for Medical Documentation and Information (DIMDI) has the task of providing public and professionals information in all fields of the life sciences. After initially concentrating on health care and medicine, DIMDI now offers a broad collection of databases covering the entire spectrum of life sciences and social sciences;<br>• The Federal Institute for Communicable and Noncommunicable Diseases (Robert-Koch-Institute) which has the tasks of surveillance, detection, prevention and control of diseases;<br>• The Federal Institute for Sera and Vaccines (Paul-Ehrlich-Institute) for the licensing of sera and vaccines;<br>• The Federal Centre for Health Education (BZgA) has the objective of maintaining and promoting human health<br>• The Federal Institute for Health Protection of Consumers and Veterinary Medicine (BgVV) which is charged with improving consumer protection in the areas of food, chemicals, cosmetics, veterinary pharmaceuticals and diseases, crop protection and pest control. Another task is the licensing of veterinary pharmaceuticals.<br>The first three institutions are the successors of the former Federal Health Institute which was more independent of the ministry but was dissolved after being accused of mishandling the requirement to carry out HIV testing of pharmaceuticals produced from human blodd plasma. Other federal institutions relevant to the health care system is the Federal Insurance Office and the Federal Supervisory Office for the Insurance Sector. In 1977, the Concerted Action in Health Care was created as an advisory body to the government. Its main tasks are collecting and presenting data on the medical and economic situation of the health care system with the aim of advising both the government and the corporatist institutions on improving the effectiveness and efficiency of health care. Further, the Concerted Action makes recommendations on improvements in remunera-tion systems, health care delivery and the |

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| | structure of the health system. This committee consists of about 65 members from all relevant organizations in the German health care system plus experts in the Ministry of Health. Since 1985, the Concerted Action has been backed by an advisory council, which produces an annual report or a so-called special report if specific ques-tions have been posed by the Minister of Health, something which became the rule in the 1990s. The advisory council consists of seven medical, economics and nursing experts in the field of health care. The members are appointed by the Minister of Health. The annual reports are highly valued as a source of data and useful recommendations but their impact on the improvement of the health care system is not really clear. Since 1999, the Ministry of Health also has an Ethics Council composed of thirteen persons covering the disciplines of biology, law, medicine, nursing, philosophy, psychology, social sciences and theology. Another advisory body used to be the Federal Health Council which dealt with matters related to the promotion of public health and the prevention of illnesses and diseases. Other federal ministries relevant to health include the Ministries for the Environment and Nuclear Energy and for Education and Research. |
| ***Source*** | European Observatory on Health Care Systems ***Year*** 2000 |
| ***Code*** | 2.2 |
| ***Description*** | Regional government |
| ***Contents*** | Länder level<br>The federal structure is represented mainly by the 16 state governments and, to a very small extent, by the state parliaments. In 1998, 13 out of the 16 Länder governments had a ministry which mentioned “health” in its name. However, none has an exclusive health department. In most of these Länder it is most commonly combined with Labour and Social Services (which is also the case in the three Länder which do not mention health in the name of a ministry), less commonly with family or youth affairs, and only in one Land is it combined with environmental affairs. This combination used to be more common in the 1970s and 1980s. Within a Land’s Labour Ministry, health is typically one of four or five divisions. In Lower Saxony for example, the health division is further sub-divided into units concerned with:<br>• public health services and environmental hygiene<br>• health promotion, prevention and AIDS care<br>• state-owned hospitals<br>• hospital planning<br>• supervision of health professions and their professional institutions<br>• psychiatry and illegal drugs<br>• pharmaceuticals and supervision of pharmacists and their professional institutions.<br>Most other areas affecting health such as traffic, city planning or education are controlled by other ministries. |
| ***Source*** | European Observatory on Health Care Systems ***Year*** 2000 |
| ***Code*** | 2.3 |
| ***Description*** | Local government |
| ***Contents*** | |
| ***Source*** | European Observatory on Health Care Systems ***Year*** 2000 |

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| ***Code*** | 2.4 |
| ***Description*** | Insurance organisations |
| ***Contents*** | The payers' side is made up of autonomous sickness funds which are organized on a regional and/or federal basis. In mid-1999 there were 453 statutory sickness funds with about 72 million insured persons (50.7 million members plus their dependants) and 52 private health insurance companies covering around 7.1 million fully insured people. Sickness funds can be differentiated into seven different groups: • 17 general regional funds known as Allgemeine Ortskrankenkassen (AOK) – their federal association is based in Bonn; • 13 substitute funds known as Ersatzkassen – Siegburg; • 359 company-based funds known as Betriebskrankenkassen (BKK) – Essen; • 42 guild funds or Innungskrankenkassen (IKK) – Bergisch-Gladbach; • 20 farmers' funds or Landwirtschaftliche Krankenkassen (LKK) – Kassel; • 1 miners' fund known as Bundesknappschaft – Bochum; • 1 sailors' fund or See-Krankenkasse – Hamburg. All funds have non-profit status and are based on the principle of self-government, elected by the membership. In most funds, the management is made up of an executive board – responsible for the day-to-day management of the fund – and an assembly of delegates deciding on bylaws and other regulations of the fund, passing the budget, setting the contribution rate and electing the executive board. Usually, the assembly is composed of representatives of the insured and employers whilst only in the substitute funds do representatives of the insured population comprise the whole of the assembly. Both the representatives of the employees/insured and of the employers are democratically elected every six years. Many representatives are linked to trade unions or employers' associations. The total number of sickness funds has decreased steadily since the AOKs and the substitute funds were legally opened to all those seeking insurance through the Health Care Structure Act. The first wave of mergers in 1994/1995 affected the AOKs. As some of them were very small, they merged into single AOKs per Land. In 1995, the IKKs followed – partly before they opened themselves to outside members. The latest wave of mergers has been that of the BKKs, also often as a prelude to competition. By the beginning of 1999, the "open" BKKs had more members than those which remained "closed", i.e. with an exclusive in-company membership. By law, sickness funds have the right and the obligation to raise contributions from their members which includes the right to determine what contribution rate is necessary to cover expenditure. The Health Insurance Contribution Exoneration Act of 1996 interfered with this right by legally lowering the contribution rates of all sickness funds on 1 January 1997 by 0.4%. Corporatist institutions similar to the sickness funds exist in other health-related statutory insurance schemes as well:<br>• accident funds for statutory accident insurance covering curative and rehabilitative care services for work-related accidents and diseases;<br>• retirement funds for statutory retirement insurance which is responsible for most rehabilitative measures;<br>• since 1995, long-term care funds which were formed by the existing sickness funds. |
| ***Source*** | European Observatory on Health Care Systems |
| ***Year*** | 2000 |

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| ***Code*** | 2.5 |
| ***Description*** | Professional groups |
| ***Contents*** | Corporatist level<br>For the statutory health insurance scheme, corporatism is represented by the (statutory health insurance-contracted) physicians' and dentists' legal associ-ations on the provider side and the sickness funds and their associations on the purchasers' side. Physicians' associations exist in every Land following the principles of federalism; since there are several physicians' associations in three Länder (North Rhine-Westphalia which has two; Rhineland-Palatinate four; and Baden-Württemberg four), the total number of associations is 23. In addition, there is the Federal Association of Statutory Health Insurance Physicians based in Cologne. Every physician treating sickness fund members on an ambulatory basis has to be a member of their respective physicians' association. The associations distinguish between their "ordinary" members, i.e. physicians in private practice, and other members, mainly hospital physicians who are extra-ordinarily accredited to treat patients on an ambulatory basis (see the section on Primary and secondary ambulatory health care). All associations have an elected "parliament" as well as a board elected by those representatives. Recently, following the Psychotherapy Act, psychologists with a subspecialization in psychotherapy were admitted to the physicians' associations. This was done in order to equalize the terms of the provision and reimbursement of psychotherapy between physicians and psychologists. Dentists accredited by the statutory health insurance are organized in the same way as physicians, i.e. through dentists' associations in the Länder as a Federal Association of SHI Dentists. The hospitals are not represented by any legal corporatist institution but by organizations based on private law; they are, however, increasingly charged with legal responsibilities as well. The hospital organizations have Länder organizations as well as a federal organization based in Düsseldorf.<br>Outside the scope of the statutory health insurance, legally established professional chambers exist for physicians, dentists, pharmacists and veterin-arians. By law, all these health care professionals must be a member of their respective chamber at Land level. The chambers are regulated by laws of the Länder. They are responsible for secondary training and accreditation (i.e. of specialist training after university) and continuing education, setting pro-fessional and ethical standards as well as for community relations. To coordinate these affairs at federal level, the Länder associations have formed federal chambers which are, however, based on private law and therefore can only pass recommendations. Professionals organized in chambers enjoy certain ex-clusive rights, e.g. the right to maintain their own pension schemes. Nurses, midwives, physiotherapists and other groups are not considered to be professionals in the legal sense and are therefore not organized in chambers.<br>There are more than 100 medical scientific organizations; they are united in the Association of the Scientific Medical Societies (AWMF). Physicians' organizations outside the corporatist field are of two types: the more professional type and the more political lobbying/economic type. The former includes the general practitioners' organization as well as similar organizations for other (sub)specialties. These organizations work both on professional standards as well on defending their interests among the wider group of all physicians.<br>Another type of professional organization is the local physicians' unions which have, as their main functions, continuing education and providing a forum for physicians from all sectors working in a particular regional area. The organiza-tions, which are clearly designed for lobbying, comprise the Organization of German Doctors – Hartmann Union – as the successor of the Leipzig Union which was formed in 1900 to defend the economic interests of physicians (see the section on Historical background) – and has its main membership base in the ambulatory sector, and the Marburg Union, which was formed in 1948 to defend the rights of hospital physicians. Another organization is the Organi-zation of Democratic Physicians which often finds itself in opposition to the traditional physicians' organizations since it views itself as a lobby for better health and health care rather than better working conditions for physicians. The main voluntary organization of nurses with a professional focus are the independent German Nursing Association and the Federation of German Nurses' Associations as the representation of Catholic, Protestant and Red Cross nurses' associations. Similar but less known organizations exist for other groups such as physiotherapists or midwives. Psychologists are represented by the professional Organization of German Psychologists. The most important organization for pharmacists outside the corporatist sector is the German Pharmacists' Organization which is the lobby group for pharmacists with private pharmacies (who have a monopoly in the distribution of pharmaceuticals; see the section on Pharmaceuticals). Together with the pharmacists' chambers it forms the Federation of Pharmacists' Organizations. The organization of the German pharmaceutical industry has recently seen a change since the large, research and international companies have formed their own organization, the Association of Research-based Pharmaceutical Companies (37 manufacturers representing more than two thirds of the market), so that the remaining Federal Association of the Pharmaceutical Industry (approximately 300 members) has become the organization of smaller companies only. Part of the underlying reasons for the split were disagreements over whether to support negative or positive lists, i.e. prescription exclusions. Two further associations represent pharmaceutical |

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| | manufacturers with special interests: The Federal Association of Pharmaceutical Manufacturers (with approximately 300 members) for OTC producers and the smaller German Generics Association (until 1999, Association of Active Pharmaceutical Companies) for generics producers. The last important group on the providers' side is the Federation of Voluntary Welfare Associations as the head organization of the six leading non-profit associations which own and manage hospitals, nursing homes, home care agencies and ambulance transportation. In the latter area, the non-profit organizations actually provide the majority of services. The six associations are the Workers' Welfare Association (having its roots in the social-democratic workers' movement), the German Red Cross, the Catholic German Caritas Association, the Association of Protestant Welfare Organizations, the Welfare Organization of the Jews in Germany and the Association of Independent Voluntary Welfare Organizations. Turning to the payers' side, the 52 major private health insurance companies (in 1997) are represented through the Association of Private Health Insurance, a rather powerful lobby group when it comes to defending the private health insurance sector. Of the 52 private insurers, 25 are traded on the stock market. |
| ***Source*** | European Observatory on Health Care Systems ***Year*** 2000 |

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|---|---|
| ***Code*** | 2.6 |
| ***Description*** | Providers |
| ***Contents*** | |
| ***Source*** | European Observatory on Health Care Systems ***Year*** 2000 |

| | |
|---|---|
| ***Code*** | 2.7 |
| ***Description*** | Voluntary bodies |
| ***Contents*** | Other actors<br>Voluntary organizations outside the above-mentioned legal actors are too numerous to be listed. They may be differentiated by their main focus of interest (i.e. scientific, professional, political lobbying or economic) and by the group they represent.<br>Insurees or patients are not represented by any powerful organizations. While a large spectrum of disease-specific self-help groups exist (with a total of up to 10 000 members), they do not represent all patients. A small General Patients' Association is not well known (or invited to parliamentary hearings as are most of the above mentioned organizations). An interesting development is that the mainly publicly funded Foundation for the Testing of Consumer Goods (and Services) as well as other consumer protection agencies have recently turned their attention towards the health care sector. They have started to investigate hospitals and other providers and to advise the public accordingly. All of the above named organizations are politically independent, i.e. not associated with particular political parties. |
| ***Source*** | European Observatory on Health Care Systems ***Year*** 2000 |

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|---|---|
| ***Code*** | 3 |
| ***Description*** | Planning, regulation and management |
| ***Contents*** | Planning, regulation and management Federal level Issues of equity, comprehensiveness and the rules for providing and financing social services are regulated at the federal level. All statutory social insurance schemes are regulated through the Social Code Book (SGB) – the cornerstone of social insurance legislation – but fall within the authority of different ministries. All parts of the Social Code Book have regulated the statutory insurance schemes in the new eastern Länder since 1 January 1991, in the same way as in the western Länder, except for certain special, mainly transitional regulations. Health-related social services are regulated through several statutory insurance schemes with statutory health insurance being the most important one. Others include accident insurance, retirement insurance (which includes responsibility for most rehabilitative measures) and, since 1995, long-term care insurance. Statutory health insurance (under the authority of the Federal Ministry of Health since 1991) is dealt with in Social Code Book V (SGB V) which is amended and supplemented by various reform laws. Book I defines the general rights and responsibilities of the insured, and Books IV and X define responsi-bilities and administrative procedures common to all social insurance agencies. Chapter 1 of SGB V defines the basic principles of the statutory health insurance. The remaining chapters regulate the following issues:<br>• mandatory and voluntary membership in sickness funds (chapter 2);<br>• contents of the sickness funds' benefit package (chapter 3);<br>• goals and scope of negotiations between the sickness funds and providers of health care, most notably the physicians' associations (chapter 4);<br>• organizational structure of sickness funds and their associations (chapters 6 and 7);<br>• financing mechanisms including the risk compensation scheme between funds (chapter 8);<br>• tasks and organization of the medical review boards (chapter 9);<br>• collection, storage, usage and protection of data (chapter 10);<br>• special regulations for the eastern part of Germany (added through the Reunification Treaty as chapter 12).<br>Chapter 4 is the core chapter regulating the corporatist – or self-regulated – structure of the statutory health insurance system. It defines what has to be and what may be self-regulated through joint committees of funds and providers (e.g. the details of the benefit package or the relative point values for services) or through direct negotiations (e.g. the total remuneration for ambulatory or dental care); the level at which these negotiations have to take place; how the composition of the joint committees is decided; what happens if they cannot agree etc. (details will be discussed in the appropriate sections). While the rules are defined by parliament through the SGB V at federal level, the Federal Ministry of Health is responsible for supervising whether the federal associations of physicians and sickness funds as well as the joint committees comply (see also under Corporatist level). The supervision of sickness funds operating countrywide is the responsibility of the Federal Insurance Office which is also charged with calculating the risk-structure compensation mechanism between all sickness funds. Long-term care is also regulated under the authority of the Federal Ministry of Health through Social Code Book XI (SGB XI) which is similar to SGB V in its main content (although it is only about one third as long). Other health-related duties at the central level include legislation in the areas of pollution and ionising radiation, which is the responsibility of the Federal Ministry for the Environment and Nuclear Energy, and the supervision of private health insurance companies by the Federal Supervisory Office for the Insurance Sector (under the authority of the Federal Finance Ministry). |
| ***Source*** | European Observatory on Health Care Systems |
| ***Year*** | 2000 |

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|---|---|
| ***Code*** | 3.1 |
| ***Description*** | Extent of system decentralisation (deconcentration, devolution, delegation, privatisation) |
| ***Contents*** | Länder level The Länder governments are responsible for maintaining hospital infrastructure. They attempt to fulfil this duty through hospital plans and funding the hospital investments outlined in those plans. The investments are paid for independently of actual ownership of the hospitals and according to the priorities of the Länder government. While the responsibility for major investments (i.e. buildings and large-scale medical technology) is undisputed, it is unclear whether the Länder are responsible for building maintenance and repairs. With the exception of Bavaria, all Länder have refused to pay for these since 1993. As a measure of compensation for hospital maintenance and repair, the Second Statutory Health Insurance Restructuring Act (Second SHI Restructuring Act) introduced an annual fee of DM 20 to be paid by all insured people for three consecutive years. However, this annual fee was cancelled in 1998. A second major responsibility of the Länder is public health services (subject to certain federal laws concerning diseases which are dangerous to public safety). About half of the Länder operate them themselves while the other half delegate responsibility to local governments. The public health tasks comprise supervision of employees in health care institutions, prevention and monitoring of transmissible diseases, supervision of commercial activities involving food, pharmaceuticals and drugs, environmental hygiene, counselling, provision of community-based psychiatric services, health education and promotion and clinical examination of school children. Since the 1970s, most of the preventive measures, such as screening programmes and health checkups for both children and adults, were included in the sickness funds' benefits package and thus are carried out by office-based physicians (details of this can be found in the section on Public health services). Additionally, the Länder are responsible for undergraduate medical, dental and pharmaceutical education and the supervision of the regional physicians' chamber as well as the regional physicians' association(s) and the sickness funds operating in the Land (see also under Corporatist level). The Länder coordinate their (public) health activities through the Working Group of Senior Health Officials and the Conference of Health Ministers. However, both are unable to pass binding decisions. In addition, the Länder have established various joint institutions to enable them to perform certain tasks. For example the Länder of Berlin, Bremen, Hamburg, Hesse, Lower Saxony, North Rhine-Westphalia, and Schleswig-Holstein maintain the Academy of Public Health Services in Düsseldorf to train their public health physicians. A similar academy is run by Bavaria with the support of Baden-Württemberg, Rhineland-Palatinate, the Saarland, Saxony, and Thuringia (so that only Mecklenburg-Western Pomerania and Saxony-Anhalt run their training for public health physicians independently). A joint institution of all Länder is the Institute for Medical and Pharmaceutical Examination Questions which is responsible for preparing and evaluating written examinations in the under-graduate education of physicians, dentists and pharmacists.<br>Corporatist level The corporatist institutions on the payer side, i.e. the sickness funds, have a central position within the statutory health insurance system. The Social Code Book defines their rights and responsibilities (see above). The sickness funds have the right and the obligation to raise contributions from their members and the right (and obligation) to determine what contribution rate is necessary to cover expenditure. Their responsibilities include negotiating prices, quantities and quality assurance measures with providers on behalf of all sickness funds' members. Services covered by such contracts are usually accessible to all fund members without any prior permission from the fund. Permission is, however, necessary for preventive spa treatments, rehabilitative services and short-term nursing care at home. In cases where there is doubt, the sickness funds must obtain an expert opinion on the medical necessity of treatment from their Medical Review Board, a joint institution of the sickness funds. A reform to make these benefits (together with non-emergency ambulance transportation and physiotherapy) optional, i.e. to leave it to the individual sickness fund to decide upon inclusion of these services in its benefits catalogue, failed late in 1996 as the sickness funds threatened to remove these benefits altogether. Their main argument was that sickness funds without these benefits could offer lower contribution rates which would attract a healthier clientele. This would widen the gap in contribution rates and possibly force generous funds out of the market since expenditure for voluntary benefits would have been outside the risk compensation mechanism between the funds. The corporatist institutions on the provider side have to provide all personal acute health care services. The most prominent examples are the physicians' and dental physicians' associations which have both a corporatist monopoly and the mission to secure ambulatory care. The monopoly means that hospitals, communities, sickness funds and others do not have the right to offer ambulatory medical care. The mission includes the obligation to meet the health needs of the population, to guarantee provision of state-wide services in all medical specialities and to obtain a total, prospectively negotiated budget from the sick-ness funds which the physicians' associations distribute among their members The legal obligation to deliver ambulatory care includes the provision of sufficient emergency services within reasonable distances. The physicians' associations must provide health services as defined both by the legislator and through contracts with the sickness funds. The physicians' associations must provide a guarantee to |

the sickness funds that this provision meets the legal and contracted requirements. Due to the necessity of intervening and controlling delivery in this way, the physicians' associations were established as self-governing bodies. This facilitates their work which is constantly influenced by doctors' freedom of diagnosis and therapy and supports the principle of a democratically legitimized cooperative. Ambulatory medical care is therefore the classic sector in which the corporatist institutions have the greatest power. The Social Code Book V concentrates mainly on regulating the framework, i.e. generic categories of benefits, goals and scope of the negotiations between the sickness funds and the physicians' and dental physicians' associations. These negotiations determine both the financing mechanisms and the details of the ambulatory benefit package. As a general rule, both the scope of services which can be reimbursed through the sickness funds and the financing mechanisms are tightly regulated, sometimes legally but usually through negotiations between providers and sickness funds. The most important body for the joint negotiations between sickness funds and physicians concerning the scope of benefits is the national-level Federal Committee of Physicians and Sickness Funds. Established in 1923, it is the oldest joint institution in the German statutory health insurance system. It consists of nine representatives from both sides (usually chairpersons of the respective associations), two neutral members with one proposed by each side, and a neutral chairperson who must be accepted by both sides and who has the decisive vote if no agreement can be reached. During the last few decades, the committee has issued 16 guidelines to regulate the prescription of pharmaceuticals, medical aids and care by non-physicians such as physiotherapists, the needs-based planning of the distribution of physicians in private practice, and the inclusion of new technologies and proce-dures into the catalogue of ambulatory benefits. The guidelines have different audiences. The first group of guidelines tries to steer the behaviour of all office-based physicians individually. The needs-based planning guidelines provide the framework for actual planning at Länder level through Länder Committees of Physicians and Sickness Funds (see the section on Human resources and training). Finally the guidelines on evaluating technologies set the criteria for the actual decisions on individual technologies by the Federal Committee itself. The Second SHI Restructuring Act gave the Federal Committee new competencies in July 1997. It is now responsible for technology assessment of the existing catalogue of ambulatory benefits, for defining a positive list for care by non-physicians and for guidelines defining rehabilitative entitlements. The Federal Committee has several su-committees, one of which had made proposals for decisions concerning the effectiveness of new diagnostic and therapeutic methods according to a set of criteria that were outlined in guide-lines first passed in 1990. After the extension of the committee's mandate, this subcommittee was renamed the Medical Treatment Subcommittee and passed new evaluation guidelines (see the sections on Health care benefits and rationing and Health care technology assessment). Another separate joint committee of physicians and sickness fund re-presentatives makes decisions on the relative value of all services in the ambulatory part of the benefits catalogue, i.e. the Uniform Value Scale (see the section on Payment of physicians in ambulatory care). Due to the absence of corporatist institutions in the hospital sector, hospitals contract individually with the sickness funds. Usually, all sickness funds with more than a 5% market share in a particular hospital negotiate the contract with that hospital. However, the conditions regarding both the range and number of services offered and the remuneration rates are valid for all sickness funds. After the Federal Ministry for Health had unsuccessfully proposed to make the hospital organizations corporatist bodies, a weaker regulation was included in the Second SHI Restructuring Act to widen the hospital organizations' legal powers, e.g. to negotiate the catalogue of prospective case and procedure fees with the sickness funds. The Reform Act of SHI 2000 has further strengthened this "quasi-corporatist" status by introducing a Committee for Hospital Care which is made up of 19 persons: nine from sickness funds, five from the hospitals, four from the Federal Physicians' Chamber and the chairperson of the Federal Committee of Physicians and Sickness Funds. In addition, a Coordinating Committee between the two committees will be charged with identifying areas of over- or under-utilization as well as with passing treatment guidelines. The Coordinating Committee has 20 members: nine from the sickness funds, three each from the Federal Association of SHI Physicians and the German Hospital Organization, two from the Federal Association of SHI Dentists, one from the Federal Physicians' Chamber and the chairpersons of the two committees. Supervision of corporatist decisions – be they made by an individual corporatist institution, in the form of a contract or a decision by a joint committee – is a multi-layered endeavour involving self-regulatory institutions themselves, the government and the civil courts. "The government" is the Federal Ministry of Health in cases concerning countrywide sickness funds, federal associations of sickness funds and providers, joint institutions between them as well as their decisions and contracts. For actors, decisions and contracts on the Länder level, the government is the statutory health insurance unit within the Länder ministry responsible for health. Supervision and enforcement can be divided into several levels: • the formal governmental approval of decisions taken by self-regulatory bodies; • the governmental right to override self-regulatory decisions if these are not taken according to the law; • legal threats to institutions that intentionally or unintentionally do not fulfil their prescribed tasks. While the threats of closing sickness funds are related mainly to financial instability or incompetence, the ultimate threats to physicians' and dentists' associations are more related to their behaviour as corporatist institutions. As a first step, a state commissioner may be installed if no board is

elected or if the elected board refuses to act according to its legal responsibilities (§ 79a SGB V). In the case that 50% or more members of an association refuse to treat patients who have insurance with a sickness fund, the association loses its legal monopoly to provide ambulatory care which is then passed to the sickness funds (§ 72a SGB V). Both of these threats were only introduced in 1992 (in force 1993) as a result of the announcements by self-governing associations to disobey certain legal requirements. The instalment of a state commissioner has been used only once. In 1995, the government of Lower Saxony removed the board of the dentists' associations due to its refusal to sign required remuneration contracts with the sickness funds. It installed a senior government official as state commissioner who then signed contracts on behalf of the dentists' association. Only afterwards were the board members allowed to return to office.
Social courts Many corporatist decisions as well as governmental regulations may be challenged before the social courts which exist at the local, regional, and federal level. They rule in cases of dispute between individuals and social insurance institutions or between social insurance institutions. Within health care, examples include: patients suing their sickness fund for not granting a benefit; physicians disputing the calculations of the Claims Review Arbitration Committee; or medical device companies objecting to the non-inclusion of their product into the benefits' catalogue by the Federal Committee of Physicians and Sickness Funds. Decentralization of the health care system As may be seen from the above, the German health care system is highly decentralized with the most striking component of it being delegation of state power to corporatist actors. While most of the legal rights and obligations of the corporatist associations of sickness funds and providers are the result of a long process, the transfer of the Federal Republic of Germany system to the former German Democratic Republic constituted a real delegation of respon-sibilities by the government to corporatist actors (see the section on Historical background). Privatization is another important feature of the German health care system. Some health care sectors are in fact based entirely on private providers, e.g. the office-based ambulatory and dental care sectors or the distribution of pharmaceuticals through private pharmacies. In other sectors, both private non-profit and for-profit providers co-exist with public providers, e.g. in the hospital sector and the social care sectors. Private insurance companies also co-exist alongside the statutory sickness funds.
The usual term "decentralization" does not capture the entire realm of German-style federalism however. At first sight the considerable power of the Länder might look like a case of devolution but this is not a true description as powers were never passed down from the federal level to the Länder; the latter had existed before the Federal Republic (which, in fact, was founded by the Länder). Instead, the opposite of devolution took place in Germany: the Länder passed certain rights and responsibilities, as defined in the constitution, to the federal level and retained others. Deconcentration is only of minor importance in the German health care system, e.g. in the area of public health services. This is due to the fact that most levels of administration (with the exception of some Länder admini-strations) do not have any sub-level administrative offices as all political units from the local level upwards have their own autonomous, elected representatives and governments.

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| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 2000 |

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|---|---|
| ***Code*** | 3.2 |
| ***Description*** | Existence of national health planning agency/plan |
| ***Contents*** | |

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|---|---|---|---|
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 2000 |

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|---|---|
| ***Code*** | 3.3 |
| ***Description*** | Supervision of the health services |
| ***Contents*** | |

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| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 2000 |

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|---|---|
| ***Code*** | 3.4 |
| ***Description*** | Financial resource allocation |
| ***Contents*** | |
| ***Source*** | European Observatory on Health Care Systems |
| ***Year*** | 2000 |

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|---|---|
| ***Code*** | 3.4.1 |
| ***Description*** | Third party budget setting and resource allocation |
| ***Contents*** | Third-party budget setting and resource allocation Germany does not have one budget for health care. Instead, there are 17 tax-based budgets (one at federal level and 16 at Länder level) and currently 453 sickness fund budgets (not counting other social insurance budgets, reimbursement through private health insurance companies etc.). All tax-based budgets are determined by individual parliaments acting on a proposal from their respective government. On the federal level, health care-related financing is part of the budgets of the ministries of health, defence (in terms of free health care for soldiers), interior (in terms of free health care for police officers and partial reimbursement of private health care bills for permanent public employees), education and research. On the Länder level, health-care related financing mainly flows from the budgets of the ministries of health, and also the ministries of science. The health ministries cover, for example, capital investments for hospitals – which vary greatly from Land to Land (see below) – as well as public health services. The science ministries are responsible for medical and dental education including the university hospitals. Sickness funds do not have fixed pre-determined budgets, but have to cover all the expenses of their insured members. This means that the contribution rate has to be adjusted if income does not match expenditure. As mentioned in the section on Historical background earlier, the main political goal in health policy has been to restrict the sickness funds' expenditure to a level where it matches income (or – more precisely – to limit expenditure growth to the rate of growth of contributory income in order to keep contribution rates stable). To that end, sectoral budgets or spending caps were introduced (see the section on Health care reforms). In terms of resource allocation, two issues should be kept in mind: • All these budgets within the statutory health insurance system are budgets on the providers' side and not on the payers' side. While some budgets, in effect, also limit the expenditure of individual funds (e.g. capitation payments to the regional physicians' associations for ambulatory care), others do not have (nor intend to have) that effect, since for example expenditure under a hospital budget or a pharmaceutical spending cap is divided between funds according to actual utilization of their particular members. (In addition, if private patients are also taken into account, then the providers' budgets are not budgets in the strict sense.) • All these budgets are based on historical expenditure patterns and not on a needs-based formula (such as the resource allocation working party (RAWP) approach in the United Kingdom). As mentioned above, legislation has aimed mainly to contain increases in expenditure. To that end: a) budgets/ spending caps were introduced which were based on actual expenditure in a previous year (often the year before the legislative act, so as to avoid any changes after proposing or passing the act; for example the pharmaceutical cap for 1993 was based on 1991 expenditure) and/or b) growth rates were legally limited. In both situations, regional differences in expenditure levels remained untouched. The issue has only recently been discussed publicly with reference to caps on pharmaceutical expenditure. The overall flow of finances in the German system is outlined in Fig. 12. Since the financing side has been described in the section on Health care finance and expenditure, and payment for pharmaceuticals has been dealt with in the section on Pharmaceuticals, the following sections focus on the payment of hospitals and physicians. |
| ***Source*** | European Observatory on Health Care Systems |
| ***Year*** | 2000 |

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|---|---|
| ***Code*** | 3.4.2 |
| ***Description*** | Determination of overall health budget |
| ***Contents*** | |
| ***Source*** | European Observatory on Health Care Systems |
| ***Year*** | 2000 |

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|---|---|---|---|
| ***Code*** | 3.4.3 | | |
| ***Description*** | Determination of programme allocations | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 2000 |

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|---|---|---|---|
| ***Code*** | 3.4.4 | | |
| ***Description*** | Determination of geographical allocations | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 2000 |

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|---|---|---|---|
| ***Code*** | 3.4.5 | | |
| ***Description*** | Health care budget decision-making at national/regional/local level | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 2000 |

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|---|---|---|---|
| ***Code*** | 3.4.6 | | |
| ***Description*** | Approach to capital planning | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 2000 |

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|---|---|---|---|
| ***Code*** | 3.4.7 | | |
| ***Description*** | Capital investment funding | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 2000 |

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|---|---|---|---|
| ***Code*** | 3.4.8 | | |
| ***Description*** | Recent changes in resource allocation system | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 2000 |

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|---|---|---|---|
| ***Code*** | 4 | | |
| ***Description*** | General characteristics of the organizational structure | | |
| ***Contents*** | Health care delivery system A key feature of the health care delivery system in Germany is the clear institutional separation between the publicly provided public health services, primary and secondary ambulatory care through office-based physicians and hospital care which has traditionally been confined to inpatient care. The separation between the latter two is stricter than in all other countries and only the Health Care Structure Act eroded this separation somewhat by allowing day-surgery in hospitals and a limited amount of ambulatory pre- and post-inpatient care. | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 2000 |

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|---|---|---|---|
| ***Code*** | 4.1 | | |
| ***Description*** | Integrated or contract model | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 2000 |

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|---|---|---|---|
| ***Code*** | 4.2 | | |
| ***Description*** | Organisational relationship between third party payers and providers | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 2000 |

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|---|---|---|---|
| ***Code*** | 4.3 | | |
| ***Description*** | Ownership: public, private, mix | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 2000 |

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|---|---|---|---|
| ***Code*** | 4.4 | | |
| ***Description*** | Freedom of choice | | |
| ***Contents*** | Patients are free to select a sickness-fund-affiliated doctor of their choice. According to the Social Code Book (§ 76 SGB V), sickness fund members select a family practitioner which cannot be changed during the quarter relevant for reimbursement of services for that patient. Since there is no mechanism to control or reinforce this self-selected gatekeeping, patients frequently choose direct office-based specialists. | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 2000 |

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|---|---|---|---|
| ***Code*** | 4.5 | | |
| ***Description*** | Referral system | | |
| ***Contents*** | Germany has no gatekeeping system. | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 2000 |

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|---|---|---|---|
| ***Code*** | 5 | | |
| ***Description*** | Out-patient care | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 5.1 | | |
| ***Description*** | Medical care | | |
| ***Contents*** | Primary and secondary ambulatory health care All ambulatory care, including both primary care and outpatient secondary care, has been organized almost exclusively on the basis of office-based physicians. The majority of physicians have a solo practice – only around 25% share a practice. Their premises, equipment and personnel are financed by the physicians. | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 2000 |

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|---|---|---|---|
| ***Code*** | 5.1.1 | | |
| ***Description*** | General practitioner (solo-, group practices) | | |
| ***Contents*** | Family practitioners are GPs and physicians without specialization. General internists and paediatricians may choose whether they want to work as family practitioners or as specialists (§ 73 SGB V). This is important, since specialists and family practitioners have different reimbursable service profiles. Despite efforts by the federal government to improve the status of family practice in the ambulatory care sector, the number of office-based specialists has increased more rapidly than those of general practitioners over the past few decades so that GPs, as a share of all office-based physicians, dropped to less than 40% in 1998. | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 2000 |

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|---|---|
| ***Code*** | 5.1.2 |
| ***Description*** | Medical specialist with own premises |
| ***Contents*** | Ambulatory physicians offer almost all specialties; the most frequent ones are listed in Table 10 together with their development in the 1990s. The table also provides information on two aspects which link the ambulatory and the hospital sector. Firstly around 5% of all office-based physicians have the right to treat patients inside the hospital. This is mainly the case for small surgical specialties in areas where the hospital has so few cases that a physician operating once or twice a week is sufficient. All other physicians transfer their patients to hospital physicians for inpatient treatment and receive them back after discharge, i.e. post-surgical care is usually done by office-based physicians and not by the hospital surgeons. Secondly, in addition to the office-based physicians, around 11 000 other physicians are accredited to treat ambulatory patients. These are mainly the heads of hospital departments who are allowed to offer certain services or to treat patients during particular times (i.e. when practices are closed). Taking reimbursement as a proxy for activity, the latter group provides around 2% of all ambulatory services (and the outpatient departments of the university hospitals around 5%). Not included in Table 10 are the 7 800 physicians who work as salaried physicians in ambulatory practices. |
| ***Source*** | European Observatory on Health Care Systems — ***Year*** 2000 |

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|---|---|
| ***Code*** | 5.1.3 |
| ***Description*** | Out-patient department |
| ***Contents*** | |
| ***Source*** | European Observatory on Health Care Systems — ***Year*** 2000 |

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|---|---|
| ***Code*** | 5.1.4 |
| ***Description*** | Combined services: health centres |
| ***Contents*** | |
| ***Source*** | European Observatory on Health Care Systems — ***Year*** 2000 |

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| ***Code*** | 5.2 |
| ***Description*** | Dental care |
| ***Contents*** | |
| ***Source*** | European Observatory on Health Care Systems — ***Year*** 2000 |

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|---|---|
| ***Code*** | 5.2.1 |
| ***Description*** | General dentist |
| ***Contents*** | |
| ***Source*** | European Observatory on Health Care Systems — ***Year*** 2000 |

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|---|---|---|---|
| ***Code*** | 5.2.2 | | |
| ***Description*** | Dental specialist | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 2000 |

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|---|---|---|---|
| ***Code*** | 5.3 | | |
| ***Description*** | Pharmacists | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 5.4 | | |
| ***Description*** | Midwifery | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 2000 |

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|---|---|---|---|
| ***Code*** | 5.5 | | |
| ***Description*** | Paramedical care | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 5.6 | | |
| ***Description*** | Home nursing and home care (maternity home care included) | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 5.7 | | |
| ***Description*** | Out-patient mental health care services | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 5.8 | | |
| ***Description*** | Ambulance services and patient transport | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 5.9 | | |
| ***Description*** | Medical laboratories | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 6 | | |
| ***Description*** | In-patient care | | |
| ***Contents*** | Secondary and tertiary hospital care As mentioned, German hospitals concentrate on inpatient care. Only university hospitals have formal outpatient facilities, originally for research and teaching purposes. Recently, their role in providing highly specialized care on an ambula-tory basis (e.g. for outpatient chemotherapy) has been recognized through special contracts with the sickness funds. Day surgery is another new area for German hospitals. | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 2000 |

| | |
|---|---|
| ***Code*** | 6.1 |
| ***Description*** | Hospital categories |
| ***Contents*** | There are around 2260 hospitals with approximately 572 000 beds (6.97 beds per 1000) and an average occupancy rate of a little over 80%. Of the 2030 general hospitals, around 790 hospitals are in public ownership, 820 have private non-profit status and 420 are private for-profit hospitals, with bed shares of 55%, 38% and 7% respectively (see also the section on Decentralization of the health care system). Hospital beds per capita vary between Länder (see the section on Payment of hospitals). In 1994, beds in university hospitals accounted for 8.3% of all general and psychiatric hospital beds, beds in hospitals enlisted in state hospital plans for 87.5%, beds in hospitals additionally contracted by sickness funds for 1.5% and beds in hospitals without such contracts, i.e. purely for privately insured patients, for 2.7%. That is, over 95% of all beds are publicly financed as far as investment costs are concerned. As mentioned earlier, this is independent of ownership. In addition, approximately 1400 institutions with 190 000 beds (2.32 beds per 1000) are dedicated to preventive and rehabilitative care. Compared with general hospitals, ownership is very different for preventive and rehabilitative institutions with 15%, 16% and 69% of beds being public, non-profit and for-profit respectively. In 1998, the general and psychiatric hospitals' workforce amounts to 1.038 million persons or 850 400 full-time equivalents (of which 12% physicians), which is around 4% less than the employment peak reached in 1995. The pre-ventive and rehabilitative institutions' workforce amounted to 91 500 full-time equivalents (of which 8% physicians), around 10% less than the peak in 1996. Until 1992, the number of hospital beds, inpatient cases, and length of stay had changed continuously but gradually and had been foreseen by all parties involved. The decreasing number of acute hospital beds was largely compensated by beds in newly opened preventive and rehabilitative institutions. The shorter length of stay was almost equalled by the increasing number of inpatient cases so that both the occupancy rate and the number of bed days per capita had remained stable. The first hospitals faced with restructuring initiatives were those in the east after reunification in 1990 since they had to adapt to the western standards in infrastructure, planning, and financing. Since 1993, hospitals in the west and in the east have been faced with a rapidly changing environment with challenges through fixed budgets, the possibility of deficits and profits, ambulatory surgery, and the introduction of prospective payments from 1996. This has changed utilization data much more rapidly than was previously the case. Between 1991 and 1998, the average length of stay in general and psychiatric hospitals fell by 24% in the western part and even by 35% in the eastern part of the country. In preventive and rehabilitative institutions, it fell only by 15% and 18% respectively. During the same period, the number of general and psychiatric hospital cases per 1000 population has risen by 6% in the western parts and 24% in the eastern parts of the country. The resulting number of bed days per person has therefore fallen in the whole country. Occupancy rates in the western parts have decreased while they have increased in the eastern parts of the country. In preventive and rehabilitative institutions, occupancy rates had reached the (high) level of 1995 before occupancy rates in the whole country dropped sharply as a result of the Health Insurance Contribution Rate Exoneration Act. In summary, after a remarkably short time, almost all structure, utilization, and expenditure data look very much alike for the whole country. These developments in the hospital sector as well as in the preventive/ rehabilitative sector are much less visible if data are combined. Taken together, the German hospital sector appears to be more stable than it is in reality. In international comparison, the total number of hospital beds, admissions and length of stay are well above average. While the number of beds in German acute hospitals has reduced since 1991, it has not fallen by more than in France or the Netherlands, i.e. Germany's bed capacities have remained about 150% of the EU average. |
| ***Source*** | European Observatory on Health Care Systems |
| ***Year*** | 2000 |

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|---|---|
| ***Code*** | 6.2 |
| ***Description*** | Other in-patient provisions |
| ***Contents*** | |
| ***Source*** | European Observatory on Health Care Systems |
| ***Year*** | 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 7 | | |
| ***Description*** | Relationship between primary and secondary care | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 7.1 | | |
| ***Description*** | Planned or actual substitution policies for inpatient care | | |
| ***Contents*** | Day surgery: While hospitals have been allowed to offer surgery on an ambulatory or day-case basis only since 1993, day-case surgery is not new in Germany. Due to the separation of the hospital and the ambulatory care sector, surgeons, ophthalmologists, orthopaedic surgeons and other specialists in private practice have performed minor surgery for a long time. Since the 1980s, this has been supported through the introduction of new items in the Uniform Value Scale, both to cover additional costs of the operating physician (equipment, supporting staff, etc.) and to cover necessary anaesthesia. In 1991, day surgery accounted for almost 2% of sickness funds' expenditure in the ambulatory care sector. In 1993, additional items for post-operative care were introduced. The frequency of these items may be used to estimate the extent to which ambulatory surgery is taking place in Germany, although they do not allow a distinction between hospital-based and office-based day surgery since remuneration is done under the same norms (i.e. those of the ambulatory care sector). Day surgery increased rapidly in the first half of the 1990s with growth rates higher than anticipated when budgets were fixed. Growth rates are even higher if the volumes of points for the services is taken into account since procedures with the smallest surcharge increased only by 27% while those with the highest surcharges increased by more than 300% between 1990 and 1994. According to Asmuth et al. (1999), approximately 45% of hospitals offered ambulatory surgery and 55% of hospitals ambulatory pre- and/ or post-inpatient care in 1997. | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 7.2 | | |
| ***Description*** | Degree of co-operation between primary and secondary health care providers | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 7.3 | | |
| ***Description*** | Imbalance between primary and secondary care | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 2000 |

| | |
|---|---|
| ***Code*** | 8 |
| ***Description*** | Prevention and public health services |
| ***Contents*** | Public health services While the specific tasks of the public health services – and the level at which they are carried out – differ from Land to Land, they generally include activities both linked to sovereign rights and care for selected groups, such as: • supervision of employees in health care institutions • prevention and monitoring of communicable diseases • supervision of commercial activities involving food, pharmaceuticals and drugs • certain areas of environmental hygiene • counselling in health and social matters • providing community-oriented (social) psychiatric services • health education and promotion • physical examinations of school children and certain other groups. The services are delivered by roughly 360 public health offices across Germany which vary widely in size, structure and tasks. In the first decades of the Federal Republic's history, the Länder defended their responsibility for public health services against several attempts by the federal government to extend its influence to this sector. However, in the 1980s they lessened their resistance which led to the inclusion of several public health activities in the Social Code Book, thereby transferring provision from the public health services to office-based physicians. Originally, immunizations, mass screening for tuberculosis and other diseases, and health education and counselling used to be in the hands of the public health services. Since the 1970s, however, the rules of the Social Code Book have been extended to include many of these services. Before 1970, only ante-natal care was included in the sickness funds' benefit package. Since 1971, screening for cancer has become a benefit for women over 20 years and men over 45 years. At the same time, regular checkups for children under the age of four were introduced (and extended to children under the age of six in 1989 and adolescents in 1997). Also in 1989, dental group preventive care for children under 12 years (e.g. in kindergartens and primary schools) and individual dental preventive care for 12–20 year olds became sickness funds' benefits (individual preventive care was extended to 6–20 year olds in 1993). Regular health checkups such as screening for cardiovascular and renal diseases and diabetes for sickness funds' members above 35 years were also introduced in 1989. A last amendment in 1989 was the introduction of health promotion as a mandatory task for sickness funds (abolished in 1996). Legally, immunizations and the support of self-help groups have also been considered a health promotion activity (until 1996; since 1997 the respective article is headed "disease prevention"). After health promotion and prevention was lost by the public health service, it became even less visible to the public and much smaller in size. The number of physicians working in the public health service decreased from 4900 (1970) to 3300 (1996), whilst the number of dentists employed in the public health service decreased even more, from 2500 to 800 and that of social workers from 4000 to 2500 (all figures for the west only). After inclusion of health promoting and disease prevention measures in the benefits' catalogue, the ambulatory care physicians control a large share of preventive services. For some services, they actually have a legal mandate (screening and checkups), which includes the obligation to deliver these services, while for others the physicians were able to negotiate fees with the sickness funds (e.g. immunizations). Thus, preventive services are now delivered under the same regulations as curative services which means that their exact definition is subject to negotiations between the sickness funds and the physicians' associations. The shift in responsibilities for immunizations how-ever has had the result that immunization rates are rather low by international comparison. |
| ***Source*** | European Observatory on Health Care Systems — ***Year*** 2000 |

| | |
|---|---|
| ***Code*** | 8.1 |
| ***Description*** | Maternal and child health: family planning and counselling |
| ***Contents*** | |
| ***Source*** | European Observatory on Health Care Systems — ***Year*** 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 8.2 | | |
| ***Description*** | School health services | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 8.3 | | |
| ***Description*** | Prevention of communicable diseases | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 8.4 | | |
| ***Description*** | Prevention of non-communicable diseases | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 8.5 | | |
| ***Description*** | Occupational health care | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 2000 |

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|---|---|---|---|
| ***Code*** | 8.6 | | |
| ***Description*** | All other miscellaneous public health services | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 2000 |

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|---|---|---|---|
| ***Code*** | 9 | | |
| ***Description*** | Social care related to health care | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 2000 |

| | |
|---|---|
| ***Code*** | 9.1 |
| ***Description*** | Organisation and financing of social care |
| ***Contents*** | Social care Social care is delivered by a broad variety of mainly private organizations who complement family and lay support for the elderly, the mentally ill and for physically and/or mentally handicapped. Funding is generally based on the principle of subsidiarity with a priority of private (out-of-pocket or insurance) over public subsistence. Compared to health care, however, public resources from federal states and local communities contribute a greater share of the monetary and – to a smaller degree – service benefits in social care because recipients are often not entitled to employment based insurance benefits or because insurance benefits do not cover the needs. The Länder are responsible for the planning (and guaranteeing the provision) of institutionalized care and schools for children with special needs. Most providers of institutional care belong to the six welfare organizations united in the Bundesarbeitsgemeinschaft der Freien Wohlfahrtspflege (see section on Organizational structure and management). Welfare organizations have established 60 000 autonomous institutions with nearly 1.2 million employees. In social care, they run 50% of old age homes, 80% of homes for handicapped and nearly 70% of institutions for youth. Other typical features of social care in Germany are:<br>• the traditional legal priority (§ 93 BSHG) for welfare organizations to deliver social care;<br>• the statutory insurance for long-term care;<br>• the provision of comprehensive care for severely physically or mentally handicapped in institutions separate from the community;<br>• regional differences in community integrated services;<br>• a legal quota for the employment of disabled employees;<br>• special schools which offer education for children who do not match with secondary or handicapped schools (e.g. children with learning deficits and behavioural disorders).<br>In 1995, 8.3% of the population living in Germany (6.6 million) were officially recognized as severely disabled (which is not the same as “needing care” – see below). Four per cent were younger than 25 years old and 51% of them were 65 years or older – accounting for one fourth in this age group – giving Germany the highest registered rate of severe disability amongst the elderly in western countries. Of the working-age, severely disabled 17.9% were unemployed, i.e. 1.7 times more than in the general population. The majority of the elderly (91%) live in their homes in the community. In 1996, 5% of people aged 65–79 years and 8.2% of those aged 80–84 lived in old age institutions. The proportion of the elderly living in homes rose with increasing age to 17.6% amongst those aged 85–89 years and to one third of people aged 90 years or older. There were 8300 old age homes with an average of 80 inhabitants. Fifty-one per cent of old age home residents received nursing care funded by statutory long-term care insurance.<br>Statutory long-term care insurance<br>Statutory long-term care insurance was introduced in 1994 – as book XI of the Social Code Book – following increasing concerns amongst the public about the situation of the elderly and a public debate about inadequate access and support for nursing care especially in the ambulatory sector. All members of statutory sickness funds (including pensioners and unemployed) as well as all people with full-cover private health insurance were declared mandatory members – making it the first social insurance with practically population-wide membership. The long-term care insurance scheme is administered by the sickness funds (as an entity that is separate from the health insurance part but without any separate associations) and by the private health insurers. The requirement to pay contributions began in January 1995 with ambulatory benefits available from April of that year. Benefits for care in institutions were available from July 1996. According to the principles of the statutory health insurance scheme, members and their employers contribute jointly 1.7% (until June 1996, only 1%) of monthly gross income, i.e. 0.85% each. In order to compensate the employers for the additional costs on wages, a public holiday was turned into a working day. As an exception, the Land of Saxony retained the holiday and the contribution is split between employee and employer 1.35% to 0.35%. Applicants are examined and categorized by the regional medical review boards which are jointly run by all statutory sickness funds (while the private health insurers mainly contract for this examination). Entitlement to insurance benefits is given when care is expected to be necessary for at least six months (hence, long-term care). Short-term nursing care continues to be funded by the sickness funds (and the private insurers if included in the package). The benefits of long-term care insurance are graded according to types, frequency and dura-tion of need for nursing care: • Grade I: support is necessary for at least two activities in the areas of body care, eating and mobility (at least once daily) as well as housekeeping (at least several times a week) with an overall average duration of at least 90 minutes daily. • Grade II: support is necessary at least three times daily with an overall average duration of at least 3 hours daily. • Grade III: support is necessary around the clock including nights with an overall average duration of at least 5 hours daily. Everybody with an entitlement to ambulatory nursing services is given the choice between monetary support for home care delivered by family members (Grade I DM 400 monthly, Grade II DM 800, Grade III DM 1300, plus a professional substitute for up to DM 2800 a year to cover holidays) or professional |

ambulatory services as in-kind benefits (up to DM 750/1800/2800 monthly). In addition, caregivers who care for their family member at home can attend training courses free-of-charge and are insured against accidents, invalidity and old age. For persons needing institutionalized nursing care, benefits are available for day or night clinics, as well as institutional care in old age or special nursing care homes (benefits up to DM 2000/2500/2800 monthly). The income of the long-term care funds exceeded their expenditure during the first year three years by more than DM 9 billion – which was mainly due to the fact that funding began earlier than benefit provision – but reached almost a steady state in 1998. By the end of 1998, 1.71 million people (2.4% of all insurees) received benefits or services funded from statutory long-term care insurance (not counting entitled people who were privately insured), 1.2 million (1.7% of all insurees) received ambulatory benefits and 510 000 (0.7%) received institutionalized care (of those around one tenth in homes for the handicapped). The percentages of entitled persons are age-dependent and reach from fewer than 0.6% below the age of 50, via 1.7% between 60 and 65 years, and 4.7% between 70 and 75 years to 29.6% in the group of 80 years and older; age-dependency is steeper for institutionalized than for ambulatory benefits: less than 0.1% are entitled below the age of 30 but 11% of the insurees of 80 years and older are entitled. One half of the persons entitled to ambulatory benefits are classified into group category I, almost 40% into category II and a little over 10% into category III. Seventy-seven per cent of these persons choose monetary benefits. Less than 10% choose only benefits in-kind (i.e. professional care at home) and 12% choose a combination of professional and lay support. Short-term care, day or night clinics are utilized to a very small degree only – partly because of insufficient provision especially in rural areas. The beneficiaries entitled to institutionalized care are grouped into higher categories on average: around 40% each into categories I and II and more than 20% into category III. Professional care in the ambulatory sector is paid on a fee-for-service basis while institutionalized care is financed by per diem charges. The prices are negotiated between care funds and provider associations at Länder level. The duty to guarantee access to professional ambulatory care has been legally handed over to statutory care funds while the Länder remain obliged to guarantee access to institutionalized care. In the case of nursing care the principle of dual financing means that the Länder have to cover investment costs fully for institutions and partly for ambulatory suppliers. The Länder are also responsible for planning but they are legally not allowed to limit the number of providers in the ambulatory sector so that competition is enhanced. The Social Code Book XI ended the legal priority of welfare organizations over private for-profit providers explicitly in order to introduce competition for prices and quality. Thus, for-profit providers take part in the annual negotiations with care funds. In practice, however, private providers and welfare organizations usually agree on asking prices before the annual negotiations with the payers. The introduction of statutory insurance benefits for long-term care strengthened the self-supporting capacities of people in need of care. The work of caregivers – most of them women – was officially recognized by financial compensation and by integration into the social security system. However statutory care insurance provides basic rather than comprehensive support for entitled people and their families, many of whom still have to rely on additional benefits from public assistance funds belonging to local communities. In 1997, public assistance contributed around 10% less to supporting nursing care than in 1995. Since insurance benefits do not cover accommodation costs for old age homes, the elderly who are institutionalized are particularly affected. Welfare organizations and self-support groups have also presented the criticism that the care needs of demented patients and severe cases are not met adequately due to the narrow criteria determining long-term care. The somatic orientation of services and their payment, as well as the grading of benefits according to severity are said not to support the legally prescribed principle of "rehabilitation before nursing care". The introduction of long-term care insurance also led to an increase in the number of active nurses and professional old age caregivers, especially in the ambulatory sector. The number of full-time staff in inpatient and outpatient nursing care increased by one third within three years to 289 000 professionals in 1996 and is expected to increase further because of demographic factors.

Mental health care

Since a parliamentary committee report in 1975 which criticized the institu-tionalization and low quality of care for people with long-term mental illness, mental health care in the Federal Republic of Germany shifted gradually to offering community-integrated services. During the process of de-hospitalization the number of beds for the mentally ill was reduced from 150 000 in the FRG in 1976 to 69 000 in Germany in 1995. During the same period the duration of stay in psychiatric hospitals was decreased from an average of 152 to 44 days. The situation of mental health care in the eastern part of Germany in 1990 was similar to FRG conditions before the psychiatric reforms in the 1970s. The lack of specialized community-integrated services was further aggravated by staff shortages. Thus, big institutions with 300 to 1800 beds provided a relatively low quality level of care. Sixty per cent of inpatients were judged as not needing hospital care in 1990. Consequently local, state and national funds promoted the provision of long-term care homes and ambulatory services within communities in the eastern part of the country particularly. However social integration and access to services in the community are still judged to be inadequate although currently Germany enjoys a favourable position by inter-national comparison. In 1995, between 24% and 40% of the institutionalized mentally ill were still estimated as not needing any sort of institutionalized care. 10 000 hospital

patients could still be transferred into homes for long-term care. The dehospitalization process led to an increase of homes for long-term mental care within the community which are funded by subregional funds. There were as many as 250 ambulatory psychosocial services in 1992 which offered advice and therapy to 8000 mentally ill patients. The decentralization of care did not necessarily entail the decentralization of finance and planning capacities. Thus, ambulatory services are characterized by substantial regional differences depending largely on budgets and the policy of local communities to contract with private deliverers. Public health offices deliver social-psychiatric services themselves for the most disadvantaged people amongst the mentally ill by offering home visits and counselling. There is a general lack of comprehensive services based in the community. Day-clinics, which are mostly attached to the psychiatric departments of hospitals, are funded by sickness funds or by retirement funds as social rehabilitation if patients are entitled to these benefits. Hospitals also offer flexible services for crisis intervention which are usually paid by health insurance or public assistance. Ambulatory care for the mentally ill is also supported by the increasing number of psychiatrists, neurologists and psychotherapists working in the ambulatory care sector (see the section on Primary and secondary ambulatory health care). In addition the process of dehospitalization for psychiatric patients was accompanied by an increasing number of private hospitals which offer short-term care/rehabilitative care for patients with addiction problems and psychosomatic disturbances (which lie outside the Länder hospital plans).
Social care for physically and mentally handicapped
Social care for physically and/or mentally handicapped people in Germany is characterized by well-equipped and highly-specialized institutions and schools. Although these comprehensive services are increasingly offered within communities on an outpatient basis, institutionalized care still plays a major role especially for severely disabled people with multiple handicaps. Similar to the situation of the mentally ill, there is a broad variety of private organizations and local community initiatives which offer support for the handicapped and their families. Yet because of unclear financial responsibilities, those affected do not have a concrete right to specific community-integrated services, including integrated kindergartens and schools. This again leads to great regional differences and under-provision in rural areas.

***Source*** European Observatory on Health Care Systems ***Year*** 2000

***Code*** 9.2

***Description*** Role of central/regional/local government

***Contents***

***Source*** European Observatory on Health Care Systems ***Year*** 2000

***Code*** 9.3

***Description*** Role of other organisations

***Contents***

***Source*** European Observatory on Health Care Systems ***Year*** 2000

***Code*** 9.4

***Description*** Responsibility of family members

***Contents***

***Source*** European Observatory on Health Care Systems ***Year*** 2000

| | | | |
|---|---|---|---|
| ***Code*** | 9.5 | | |
| ***Description*** | Financing of social care | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 9.6 | | |
| ***Description*** | Explicit health/social care policy | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 10 | | |
| ***Description*** | Medical goods and health care technology assessment | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 2000 |

| | |
|---|---|
| ***Code*** | 10.1 |
| ***Description*** | Pharmaceuticals |
| ***Contents*** | Pharmaceuticals Regulations concerning the pharmaceutical market present a dichotomy. On the one hand, the distribution of drugs through wholesalers and pharmacies and their respective surcharges on ex-factory prices are regulated in great detail. On the other hand, regulations concerning the pharmaceutical industry's pricing and the need to prove efficacy are remarkably liberal. The growing realization that a significant proportion of drugs possessed a level of effectiveness which was unproved and questionable led to the introduction of the mandate for drug licensing in the 1976 Pharmaceutical Act (effective from 1978). Before that, products only had to be registered with the Federal Health Office as drugs. Registration regulations called for only minor examinations concerning possible toxic effects. Also, the new regulation affects only newly developed pharma-ceuticals because the 1994 Pharmaceutical Act Amendment Law extended the deadline for licensing pharmaceuticals already on the market to the year 2005 (see the section on Health care technology assessment). The pharmaceutical industry in Germany is amongst the most powerful in developed countries and contributes significantly to the export market (pharma-ceutical export surplus in 1998: DM 10.8 billion). Around 1100 pharmaceutical companies with 115 500 workers are operating in Germany (1997). The market covers "public" pharmacies (providing prescription drugs, prescription drugs which could also be sold over-the-counter, and self-prescribed over-the-counter [OTC] drugs) and hospital pharmacies. In 1998, public pharmacies – which are actually all privately-owned and which have a monopoly over drug dispensing except to hospitals – sold drugs for DM 52.0 billion while hospitals purchased drugs with an ex-factory volume worth DM 4.8 billion. The DM 52.0 billion were the sum of ex-factory prices (27.1 billion), surcharges by wholesalers (3.5 billion, ca. 13% of ex-factory prices) and pharmacies (13.5 billion, ca. 50% of ex-factory prices) as well as value-added tax (6.4 billion). The pharmacy surcharge and the tax are among the highest in west European countries. Of the DM 52.0 billion, 44.4 billion were for prescribed drugs and 7.6 billion for OTC drugs. The DM 44.4 billion included about 7.2 billion for potential OTC drugs (i.e. almost half of all potential OTC drugs are prescribed by physicians). Of the DM 44.4 billion, the statutory health insurance paid DM 33.4 billion (and received a rebate of 2 billion) while 3.6 billion was sold to privately insured people and 5.4 billion were co-payments by sickness fund members (which was 20% more than in 1997 and even 60% more than in 1996). Assuming full reimbursement by the private health insurers, patients paid a total amount of DM 13.0 billion or 25% of total ambulatory drug expenditure themselves. In 1997, the average number of prescription forms per sickness fund member was 12.1 (with an average of 18.6 prescribed packs). More than 55% of all prescriptions were written by general practitioners, 18% by internists and 7% by paediatricians. An analysis of prescriptions is undertaken annually by a sickness fund affiliated institute. Although this report does not provide patient data which could be used to evaluate appropriateness it is nevertheless of value for the assessment of trends in physicians' prescribing behaviour. The report is based on a comprehensive sample of prescriptions (GKV-Arzneimittelindex) in the ambulatory care sector, jointly maintained by several corporatist associations. The structure of the pharmaceutical market has been defended by both the pharmaceutical industry and the physicians' associations as beneficial for the "therapeutic freedom" of physicians. Due to this structure, it is not surprising that drugs without any or clear evidence of therapeutic effectiveness are among the most widely sold pharmaceuticals. Federal legislation has mainly concentrated on cost-containment issues.<br>Pharmaceutical cost containment<br>Pharmaceutical expenditure has been an effectively controlled area of German health care expenditure, at least if one takes the perspective of the statutory sickness funds. Rather steep increases were always followed by decreases. The major elements of this ability to control drug expenditure are cost-sharing measures (see Out-of-pocket payments under the section Complementary sources of finance), prescription limitations (see the section on Health care technology assessment), reference prices introduced in 1989 and lastly the phar-maceutical spending cap from 1993 to 1997 and again since 1999. Reference prices The idea behind reference prices was to establish an upper limit for the costs reimbursable through the sickness funds. Their legal basis is § 35 SGB V. This stipulates that reference prices are defined: • for drugs containing the same substance • for drugs with similar substances • for drugs with comparable efficacy. While the Federal Committee of Physicians and Sickness Funds is respon-sible for the identification and classification of drugs, the federal associations of sickness funds do the actual price-setting. Due to lowered prices for drugs formerly above the reference price, these regulations led to decreasing prices for reference priced drugs but the pharma-ceutical industry partly compensated these through above-average increases for non-reference priced drugs. For the sickness funds, the savings are currently estimated to be in the range of DM 3 billion per year, i.e. roughly 9% of their pharmaceutical expenditure. For patients, reference prices had two effects. Generally, pharmaceuticals priced at or below the reference price for that substance were co-payment free (until 1992). More specifically, if a patient with insurance sickness fund wished to use a more expensive alternative, he or she had to pay the difference out of their own pocket. For all prescribed drugs without a reference |

price, the patient had to pay a co-payment of DM 3 per package – instead of DM 2 previously (§ 31 SGB V). These new regulations led to an increase of co-payments by about one third but subsequently – due to the increasing number of reference-priced drugs – by 1992 it fell to the 1988 level. While in 1989 reference-priced drugs accounted for only 15% of the drug market, this share increased to about 30% in 1992 and has been above 60% since 1997. The Act to Strengthen Solidarity in SHI introduced tighter regulations for the setting of reference prices, i.e. they now may not be higher than the highest price in the lowest third of the market. For 202 out of a total of 446 drug groups with reference prices, prices were supposed to be lowered from 1 April 1999 for a saving of approximately DM 550 million. However, this reduction was stopped legally and reference prices altogether came under legal threat when a pharmaceutical company successfully sued. Early in 1999, a court argued that price setting by the sickness funds violated European Union cartel regulations. Therefore, the health minister plans to put reference prices on a new legal basis, i.e. fixing them through an ordinance issued by the Ministry of Health.
Spending cap The spending cap for pharmaceuticals imposed a real reduction in pharmaceutical expenditure which accounted for DM 26.7 billion in 1992 (west). Based on the 1991 expenditure of DM 24.4 billion, it reduced future spending to a maximum of DM 23.9 billion per year. In the case of overspending in 1993, any excess spending up to DM 280 million each would have been clawed back from the physicians' associations (from physician remuneration) and the pharmaceutical industry. From 1994 to 1997, the physicians' associations (in the west as well as in the east) were liable for any overspending with no upper limit; this liability was in force for every single association in the case of over-spending, even if total pharmaceutical spending remains below the cap. At the same time as introducing the spending cap, the reform act imposed a price cut of 5% for existing drugs not covered by reference pricing and a price freeze for new drugs, both measures applying for 1993 and 1994. The result of all three cost-containment measures in the Health Care Structure Act – i.e. a price moratorium, new cost-sharing regulations and the expenditure cap – in their first year of operation was a reduction of 18.8% in sickness funds' costs for pharmaceuticals in the ambulatory sector. This figure represents a reduction for the sickness funds of DM 5.1 billion from the 1992 expenditure or DM 2.2 billion more than had been required. Of these savings, around DM 1 billion was attributable to price reductions. Almost another DM 1 bil-lion was the result of the new cost-sharing regulations. Only about 60% of the total reduction was attributable to changes in physicians' prescribing behaviour. Physicians reduced the number of prescriptions by 11.2% and increased their prescriptions for generics instead of the original products. Due to subsequent increases, regional caps were exceeded in some of the 23 regions in 1994 even though national figures remained within the total (hypothetical) spending cap. While this remained the case for the western part of the country in 1995 as well, overspending occurred in the eastern part (which were not affected by the 1993 cap) where the increase in pharmaceutical expenditure was so high that per capita expenditure in 1995 was almost 13% higher than in the west. Since the legislation allowed overspending in one year to be rectified in the next, no sanctions were imposed in 1995. However, some of the regions also exceeded the 1995 budget and therefore, in September 1996, the sickness funds instigated proceedings to claim back money from nine regions which have overspent their budget by up to 11.3%. The physicians' associations resisted payment, arguing that they could not effectively manage overall or physician-specific drug expenditure, due to untimely and unspecified data. Despite the rises in pharmaceutical expenditure in 1996 – when nationwide spending exceeded the cap, leading to agreements in several states to even out the overspend in coming years – the spending cap proved to be an effective method of short-term reduction and long-term modification of pharmaceutical expenditure. A review of published studies showed that the initial reduction was mainly attributable to physicians who had on average prescribed drugs of a higher quality, while the others reduced their prescriptions mainly on the basis of price. With the Second SHI Restructuring Act the regional spending caps for phar-maceuticals were abolished from 1998 and were replaced by practice-specific soft targets to exclude both certain types of drugs (list under development) and drugs for patients with certain indications (i.e. opiate addicts, patients post transplantation, etc.). It was more than doubtful that there would have been any effective mechanisms of sanctioning over-prescribing. In addition, the legal limit for over-prescribing and paying-back had been set at 125% of the target (§ 106(5a) SGB V). While retaining these targets for individual practices, the Act to Strengthen Solidarity in Statutory Health Insurance reintroduced spending caps for pharmaceuticals at the regional level. Physicians' associations are now liable for any over-spending up to 105% of the cap. As a kind of compen-sation, debts resulting from the former spending cap (see above) were waived.

| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 2000 |
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| ***Code*** | 10.2 | | |
| ***Description*** | Therapeutic appliances | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 2000 |

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| ***Code*** | 10.3 |
| ***Description*** | Health care technology assessment |
| ***Contents*** | Health care technology assessment (HTA)<br>Regulation and control of health technologies in Germany was not a major issue in the past. Although German regulations, especially licensing for pharma-ceuticals and medical devices, meet international standards, other types of technologies have not received the attention they deserved. Since the peculiarities of regulation of health technologies in Germany depend on the structure and organization of the health care system, when analysing the status-quo the sector of health care (ambulatory, hospital, rehabilitative care, non-physician care), type of technology (drugs, devices, procedures (medical, surgical, non-physician)) and the level of regulation (licensing, coverage decisions within the statutory health insurance schemes and diffusion and use of technology) have to be taken into account. While certain aspects are dealt with in other sections as well, a summary of the main issues follows.<br>Licensing of pharmaceuticals<br>Drug licensing for new drugs became mandatory only in 1976. The licensing of pharmaceuticals is currently the most regulated area of medical technologies in Germany. The admission of pharmaceuticals for humans into the market falls under the responsibility of the Paul-Ehrlich-Institute (blood, blood products, sera and vaccines) and the Federal Institute for Pharmaceuticals and Medical Devices (BfArM) (all other drugs). This is done through mandated processes specified by the Pharmaceutical Act which took effect in 1978 and a set of guidelines issued by the Ministry of Health. The criteria for licensing pharma-ceuticals are: scientifically proven efficacy and safety. This includes the results of phase I to phase III (controlled clinical) studies. However, only a marginal beneficial effect of the new drug needs to be demonstrated with a small sample in order for it to be sufficient to fulfil the efficacy criteria. Cost-effectiveness is of no importance. This has led to the increasing admission of active substances with merely minor modifications rather than the introduction of real product innovations. Licensing is, in any case, limited to five years, after which one needs to apply for an extension. Besides regular admission, an accelerated admission process is also possible. This is intended for drugs which, on the basis of their potential therapeutic value, show considerable public interest, but still no sufficient data with which to judge therapeutic efficacy. In this case, it can be decreed that within a certain period data should be systematically collected on the drug's efficacy in order to reappraise its therapeutic value. This procedure is relevant for orphan drugs (i.e. those used to treat very rare diseases) and in instances when companies try to expedite the licensing procedure. However, this procedure is very rarely adopted. Although currently not widespread, an increasingly used strategy for approval is the mutual recognition procedure, in accordance with the EC-directive 75/319, which came into effect in Germany on 1 January 1995. Based on this directive, a manufacturer whose drug has been admitted in another country may also apply for the drug's admission in Germany. Market admission may only be refused by the BfArM if a public danger exists. In this case, a procedure of arbitration enforced by the European Agency for the Evaluation of Medicinal Products (EMEA) would be initiated, and eventually adjudicated through a determination by the European commission. Homeopathic and anthroposophic drugs are exempted from the licensing procedure according to the AMG since they are subject to registration only. Requirements for registration refer mainly to the quality of the basic products and the manufacturing process as well as to the durability of the final products. Registered homeopathic drugs do not need to prove their therapeutic efficacy unless they are to be licensed for a specific purpose. In this case, a manufacturer has to apply through the regular admission procedure. The characteristics of the admission of homeopathic and anthroposophic drugs and fixed combinations of phytotherapeutics are regulated explicitly in guidelines issued by the Ministry of Health. An exception to this are prescription drugs that are produced and sold in pharmacies in quantities of up to 100 units per day. A similar exception exists for homeopathic drugs produced in quantities of less than 1000 units per year. A third exception are drugs currently being tested in phase III clinical trials. Since 1978, when the AMG came into effect, approximately 16 000 drugs have been licensed and about 1 750 homeopaths registered. A substantial number of pre-AMG drugs are still on the market. These had to apply for licensing within an appointed time or be removed from the market. The dead-line was 30 April 1990 and 70 000 drugs were removed by January 1993 accordingly. Since a substantial number of drugs did not have a chance to prove their efficacy, another deadline (31 December 1999) for submitting licensing applications was established. If a manufacturer renounces its application for licensing a certain drug, the drug may be marketed until the end of 2004 without any proof of therapeutic benefit. Currently, only about one third of the drugs on the market are of proven efficacy according to the AMG. Market admission is not linked to an obligatory comprehensive and systematic post-marketing surveillance system. However, physicians and other professionals are requested to report problems they or their patients have encountered with drugs and medical devices to the BfArM. The BfArM is required to maintain a database of all side effects, contraindications and other problems emerging from the use of drugs. Records are assessed by medical, pharmacological and toxicological experts. A specific course of action on different levels according to a predetermined plan is dependent |

upon the severity of the problem. In the most extreme cases, the market license may be withdrawn.

Coverage of pharmaceuticals

For most drugs, market entry also means that they may be prescribed and covered by the statutory health insurance schemes. However, there are a few but important exceptions which are gaining increasing attention:

• Since 1983 drugs for certain conditions (common colds, drugs for the oral cavity with the exception of antifungals, laxatives and drugs for motion sickness) are legally excluded from the benefits' package for insured people over 18 years old (§ 34(1) SGB V).

• The Social Code Book allows the Minister of Health to exclude "inefficient" drugs (i.e. they are not effective (for the desired purpose) or combine more than three drugs the effect of which cannot be evaluated with certainty (§§ 2, 12, 34(3) and 70 SGB V). The evaluation of these drugs takes into account the peculiarities of homeopathic, anthroposophic and phytotherapeutic drugs. A negative list according to these principles came into effect on 1 October 1991. It was revised in 1993 and contains about 2200 drugs.

• Additionally, drugs for "trivial" diseases (such as common colds) which can usually be treated by treatments other than drugs may be excluded (§ 34(2) SGB V). A list of this type has not yet been worked out.

The coverage of drugs is also regulated in the pharmaceutical guidelines of the Federal Committee of Physicians and Sickness Funds and forms part of the contract between the two sides at the federal level. These guidelines, which are legally binding, attempt to steer the appropriate use of different groups of pharmaceuticals. They limit the prescription of certain drugs to certain indica-tions (e.g. anabolics to cancer patients), specify that they may only be used after non-pharmaceutical treatments were unsuccessful (e.g. so-called chondro-protective drugs) or in a few cases, disallow any prescription by the sickness funds (e.g. drugs to quit smoking). However, the overall effect of these guide-lines is doubtful, especially since very few drugs with mainstream indications were affected. In mid-1998, the Federal Committee amended its pharmaceutical guidelines to exclude drugs for the treatment of erectile dysfunction and drugs to improve sexual potency such as Viagra. The committee argues that individually very different behaviour does not allow the determination of a standard of disease upon which to base economic considerations. In its opinion, the responsibility of the sickness funds ends where personal lifestyle is the primary motive for using a drug. This case demonstrates that the criteria for exclusions are less explicit than for medical technologies, so that decisions depend de facto on the common will of both sides. Accordingly, the Federal Social Court disapproved of the general exclusion of drugs for the treatment of erectile dysfunction and instead demanded measures against their misuse. In early 1999, the Federal Committee passed pharmaceutical guidelines that were completely new. These state explicitly that the licensing of pharma-ceuticals is a necessary but not sufficient precondition for coverage by the social health insurance system. Apart from the above-mentioned legal exclusions, the guidelines list five reasons for not including drugs in the benefits' catalogue: 1. they are not necessary for treating diseases – this is the Viagra argument 2. other pharmaceuticals are more effective and/or cost-effective 3. non-pharmaceutical strategies are more effective and/or cost-effective 4. combination therapy if monotherapy is more effective and/or cost-effective 5. if they have not been proven to be effective. The number of drug groups for which prescriptions are limited or prohibited has been greatly enlarged. Examples are anti-rheumatic drugs for external use (for reasons 2 and 3 above) and lipid-lowering drugs (for reasons 3 and 4). Additionally, an annex lists all groups with legal and other prescription exclusions and limitations; in case of limitations, reasons for exceptions and the necessary documentation are provided. Originally, the 1993 Health Care Structure Act had called for a "positive list" of reimbursable pharmaceuticals to be developed by the Federal Ministry of Health. This regulation, however, was dropped only weeks before it was supposed to be put into effect on 1 January 1996. The Federal Minister of Health decided not to pursue the idea of a positive list and justified this by citing the successful cost-containment measures in the pharmaceuticals sector, the otherwise rising costs for chronic patients due to OTC purchases and, most importantly, the threat to smaller pharmaceutical companies. While this decision was welcomed by the pharmaceutical industry, it was faced with criticism by both the sickness funds and the Social Democratic Party. However, the Reform Act of SHI 2000 has again introduced the mandate for a positive list which has to be passed by the Federal Council upon proposal of the Federal Ministry of Health. The Ministry will be supported by an expert commission when preparing the proposal.

Licensing of medical devices

Since 1 January 1995, the Medical Devices Act (MPG) which translates the corresponding European Union (EU) directives into German law has been in effect. According to the EU directives 90-385 (active devices that can be implanted such as pacemakers) and 93-42 (medical products other than those active devices that can be implanted and in vitro diagnostic substances), devices marketed in Germany must conform to the essential requirements contained in the Medical Devices Act. In contrast to drugs, medical products and devices are defined as instruments, appliances, materials and other products, which do not produce their main effect in a pharmacological, immunological or metabolic way. The licensing of medical devices is the responsibility of authorized institutions (notified bodies) which require accreditation through the Federal Ministry of Health. The question of safety and of technical

suitability for the planned operational purpose of a device is the primary criterion for the market admission of medical products and devices. As opposed to drugs, medical devices do not need to prove that they are beneficial in terms of potential health gain in order to be marketed. Devices marketed in Germany are reviewed for safety, and for whether they technically perform as the manufacturer claims. The EU Medical Devices Directive 93-42, which covers most devices, established a four-part classification system for medical devices. The rules for classification take into account the risk associated with the device, the device's degree of invasiveness, and the length of time the device is in contact with the body. The classification of a medical device governs the type of assessment procedure the manufacturer must undertake to demonstrate that the device conforms to the relevant directive's requirements. Coverage decisions about medical devices and mechanisms to steer their diffusion and usage differ depending on their use (i.e., whether they are used directly by patients or whether they are used as part of medical or surgical procedures in the ambulatory medical or the hospital sector).

Coverage of medical aids (devices directly used by patients)

Medical aids comprise devices such as prostheses, glasses, hearing aids, wheelchairs or respirators. Similar to non-physician care, insured people are entitled to medical aids, unless they are explicitly excluded from the benefit catalogue through a negative list issued by the relevant ministry (§§ 33 and 34 SGB V). The Federal Ministry of Labour and Social Affairs (responsible for SHI at that time) has explicitly excluded aids with small or disputed therapeutic benefit or low selling price (e.g., wrist belts, ear flaps, etc.). The regulations for the coverage of non-excluded medical aids are complex and therefore are only briefly described. The federal associations of the sickness funds publish a medical aids cata-logue, which contains among others:

• a legal account of who may be entitled to medical aids debited to statutory health insurance
• an alphabetical catalogue of all medical aids
• the medical aids listing which can be provided on the accounts of statutory health insurance.

The medical aids listing represents a positive list of services which can be provided through the debiting of the statutory health insurance scheme. The decision to include medical aids in this list lies exclusively with the federal sickness funds' associations. Steering of diffusion and usage: The Federal Committee of Physicians and Sickness Funds guidelines limit the prescription of medical aids to the following cases: assuring the success of medical treatment, prevention of threatened health damage, preventing the health endangerment of a child, and avoidance or reduction of the risk of long-term care.

Ambulatory medical treatment

The regulation of medical technologies in the ambulatory care sector is combined with its reimbursement, since coverage procedures are linked to the value assigned to them. The responsible coverage body is the Federal Committee of Physicians and Sickness Funds. This committee has several subcommittees, one of which is responsible for approving reimbursable medical technologies. Until 1997, the subcommittee on New Diagnostic and Therapeutic Procedures had to decide on the effectiveness of technologies which were proposed by either a (regional) physicians' association, the Federal Association of SHI Physicians or a federal sickness funds' association (§ 135 SGB V). Since 1 July 1997, the committee has also been responsible for the evaluation and re-evaluation of existing technologies; its name has been changed accordingly to the Working Committee on Medical Treatment. Until 1997, the subcommittee worked according to a set of criteria, outlined in guidelines by the Federal Committee of Physicians and Sickness Funds. New technologies could only be proposed when they were perceived to be 'necessary' from a physician's point of view and when enough data were available for their evaluation.

Approval required that one of the following criteria be fulfilled:

• at least one randomized controlled trial, or
• at least one case-control or cohort study, or
• at least two of the following studies – time series comparison, non-controlled clinical trials, studies that show a change in relevant physiological para-meters, expert statements based on scientific evidence.

This system could be influenced by a number of factors, leading to decisions that were not necessarily based on sound scientific evidence, but rather on interest and opinion. After critiques concerning the existing procedure and the extension of the committee's mandate to (re)evaluate existing technologies, new guidelines were passed in October 1997. The evaluation is now based on the three criteria of benefit, medical necessity and efficiency. In addition, the procedure has been changed. The Working Committee on Medical Treatment will prioritize technologies for evaluation. This result is announced publicly and medical associations and possibly individual experts are invited to submit evidence concerning the three criteria mentioned. The Working Committee will then examine the quality of the evidence presented by the applicant, the medical association(s) and individual experts as well as the results of its own (literature) searches. Therapeutic procedures will be classified according to five categories: I randomized controlled trials IIa other prospective studies IIb well-designed cohort or case-control studies IIc temporal or regional comparisons III other studies and opinions. Diagnostic procedures are ranked into four: Ia studies demonstrating a benefit in patient outcome Ib controlled study under routine conditions which allows the calculation of sensitivity, specificity and predictive value II other studies allowing at least the calculation of

sensitivity and specificity III other studies and opinions. For both types of procedures, at least one study with level I evidence is necessary. Somewhat illogically, however, lower evidence is accepted for existing technologies if no level I evidence is available. In its decision-making, the Federal Committee uses three categories: 1. to be included/retained in the benefit catalogue 2. may not be provided in the statutory health insurance system 3. does not fulfil the criteria completely, i.e. not included in benefit catalogue but may be provided by individual sickness funds if they decide to do so. Early in 1998, the committee published its first announcement listing two existing technologies for re-evaluation – i.e. bone densitometry and methadone substitution – and six new technologies for evaluation. A second announcement in June 1998 listed an additional seven new technologies for evaluation. Managing usage: Another committee consisting of physicians and sickness fund representatives – the Valuation Committee – is charged with setting the relative value in the Uniform Value Scale (§ 87 SGB V). This process applies to new procedures as well as to established services. Another important task is a description of the reimbursable technology and its indications for use. However, currently only a part of all procedures listed in the Uniform Value Scale are indication-specific. A revaluation may be initiated when frequency statistics provide evidence for over-(and under-) utilization of services. In this case, the service in question may be devalued in order to rebalance utilization rates by incentive. In the Valuation Committee, financial interest and intraprofessional distribu-tion conflicts can play a dominant role. The fee distribution system of the physicians' associations may lead to decisions resulting in outcomes unintended by the Federal Committee of Physicians and Sickness Funds. Clinical practice guidelines and managed care elements are increasingly used to guide medical decision-making. Hundreds of guidelines have been developed over the last two years by scientific medical societies, about 80% of which are related to therapy, including treatment with drugs. However, most of them are of questionable methodological rigour and no data are available as to the extent of their adoption and use in everyday clinical practice.

Hospital sector

For the hospital sector, an authoritative committee, similar to the Federal Committee of Physicians and Sickness Funds, has been lacking. Until now, the introduction of new procedures and technologies has usually been managed by individual hospitals in the context of budget negotiations. Such considerations have not been a priority in comparison to general financing considerations, as given in the Hospital Financing Act (see the section on Payment of hospitals). However, two recent reform laws have changed the situation. • After the Second Statutory Health Insurance Restructuring Act had trans-ferred the responsibility for maintaining and further developing the catalogue to joint negotiations between the sickness funds and the hospital associations from 1999, the federal hospital organization on one side and the federal associations of sickness funds (together with the private health insurers' organization) on the other founded a so-called coordinating committee which is assisted by working groups for specific purposes. • More importantly, the new Committee for Hospital Care (see the section on Planning, regulation and management) will be charged with health tech-nology assessments for technologies used in the hospital sector. It is also expected that the treatment guidelines to be developed by the Coordination Committee, as well as the process of defining groups for case-fees under the new payment system (from 2003) will stimulate this work.

Expensive medical devices

Agreements upon the diffusion of expensive medical devices ("big ticket technologies") and their distribution between the ambulatory and hospital sector has been called a never-ending story. This judgement is the result of various attempts of corporate and legislative bodies to improve planning of expensive medical devices in the light of increasing costs and new types of devices such as extra corporeal shock-wave lithotripsy. Until 1982, when the Hospital Cost-containment Act came into effect, no regulations concerning expensive medical devices existed. With this law, it became mandatory for expensive devices to be subject to hospital planning. Devices that were not part of an agreement could not be considered in the per diem charges and thus could not be re-financed. In contrast, expensive devices in the ambulatory care sector had only to be notified to the physician associ-ations. This unequal situation remained essentially unchanged until the Health Care Reform Act of 1989. Between 1989 and 1997, diffusion and regional distribution of expensive medical equipment for supply to the population covered by the mandatory health insurance was controlled intersectorally, through joint committees involving both the hospital and ambulatory sector. The Second SHI Restruc-turing Act abolished these committees with effect from July 1997. Site planning was carried out by committees formed at the state level. These committees consisted of representatives of the hospitals, physicians' associations, sickness funds and a state representative. This planning committee negotiated aspects of the joint use of devices by third parties, service requirements, population density and structure, as well as the operators' qualifications. Since the Health Care Structure Act came into effect in 1993, the Minister of Health could determine which devices fell under the Committees' auspices (§ 122 SGB V). However, the Minister did not execute this right and the Committees defined what is expensive medical equipment. On 30 June 1997, the following devices fell within this definition in almost all states: • left heart catheterization units • computer-tomographs • magnetic resonance imaging devices • positron-emission tomographs • linear accelerators • tele-cobalt-devices • high-voltage therapy devices • lithotripters. It seems, however, that this arrangement has not proved to be as effective as

intended. From 1993 to 1997, the total number of these devices increased from 2118 to 2845. However, in some states, agreements between the committee partners yielded closer cooperation between the hospital and ambulatory care sector. In Lower Saxony for example, in 1997 57% of magnetic resonance imaging devices, 46% of computer-tomographs, 24% of left heart catheterization units and 20% of tele-cobalt-devices, high-voltage therapy devices and litho-tripters were operated jointly by hospitals and ambulatory practices. As a result of the abolition of the joint committees, it is now the task of the self-governing corporate bodies to guarantee the efficient use of expensive equipment via remuneration regulations. This could also lead to an even steeper increase in the number of expensive medical devices, since previous procedures of site planning have been annulled.
Discussion
There are considerable inconsistencies in the different health care sectors with regard to coverage decisions and the steering/managing of diffusion and usage of health technologies in Germany. In general, the ambulatory sector appears to be much more regulated than the hospital sector. Explicit coverage decisions regarding medical and surgical procedures are currently non-existent for the hospital sector. This is due to the fact that coverage of medical devices and expensive medical equipment falls under budget negotiations at hospital level and hospital plans at state level. Services provided by non-physician professionals, such as physiotherapy, are explicitly excluded by the government or are covered through collective contracts. Clearly, this unequal situation is due to the strict separation of the hospital and the ambulatory care sector which constitutes a barrier to regulation approaches and to making HTA an effective instrument in Germany. There is scope for improving this situation. One initiative, funded by the Federal Ministry of Health, has stimulated HTA activities in Germany from the viewpoint of decision-making at the federal and corporate level. As a result of this initiative, the German Scientific Working Group Technology Assessment for Health Care has been set up. The Reform Act of SHI 2000 charged the German Institute for Medical Documentation and Information (DIMDI) with the task of establishing a database containing relevant HTA results as well as with supporting decision-making processes by the Federal Committee and other actors. As mentioned, the act also introduced a Committee for Hospital Care which will commence its work in 2000. The coordination of its decisions with those of the Federal Committee is one of the tasks of the equally new Coordinating Committee.

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| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 2000 |

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| ***Code*** | 11 |
| ***Description*** | Other services |
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| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 2000 |

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| ***Code*** | 11.1 |
| ***Description*** | Education and training of personnel |
| ***Contents*** | Training<br>The training of health care professionals is a shared responsibility between the fields of education, health care, professional self-regulation and government. Most current debates arise out of the tension between the various stakeholders. According to the federal structure, the 16 Länder are generally responsible for regulating and financing education as well as for registering and supervising professions including health professions. However, health professions differ traditionally from other professions in terms of the national regulations concerning their primary education and by the virtual autonomy of their chambers for regulating specializations (secondary professional education) and continuous education. National standards for curricula and examinations were introduced in 1871 for medical studies, in 1875 for faculties of pharmacy and in 1907 for the training of nurses. Today uniform curricular frameworks exist for 16 out of 22 non-academic health care professions (e.g. therapists, technical assistants, doctors' assistants, paediatric nurses, nursing assistants, emergency and transport staff, etc.). National legislation is currently also under way for carers of the elderly.<br>Primary professional education and registration<br>Primary training of non-academic as well as academic professionals is basically free-of-charge in Germany. However private schools with course-based training for therapeutic professions demand fees of DM 600–1000 per month. Parti-cipants of practice-based training in health care institutions such as nurses in training receive a basic income. University education is financed by the states while practice-based training at hospitals is basically funded by statutory in-surance funds as part of their financial contracts with individual hospitals. Most German universities offer a degree in medicine (36), dentistry (31) and/or pharmacy (23); veterinary medicine is a discipline at 5 faculties. There are also many facilities for the primary training of nurses (42 000 beginners at 1050 centres in 1995), therapeutic professions, e.g. physiotherapists or dieticians (12 000 beginners, 340 centres), technical assistants (5800 beginners, 110 centres), ambulance workers (1900 beginners, 30 centres) or professional carers of the elderly (16 000 beginners, 125 centres). Primary training of most non-academic health professionals requires an advanced degree after secondary school and usually takes three years. Access to German universities is (usually) limited to people with an A-level equivalent (13 years of school). Academic health education is among the subjects for which places are distributed centrally according to school marks, waiting times and special quotas (e.g. foreigners or disabled persons). Fifteen per cent of medical students are accepted by way of interviews at individual universities. University studies last between 4 years (pharmacy) and 6 years (medicine). The curriculum for academic health care professions is highly standardized and organized around 3–4 central examinations. However, in 1999, a long sought-after clause was integrated into the national regulation for medical studies which allows individual medical faculties to offer curricula reform while preserving basic national standards (e.g. two centralized final examinations). The political target was to facilitate profound innovations towards more bedside-teaching, primary care orientation, problem-solving skills and the integration of basic science with clinical subjects. The first reformed medical curriculum was set to begin as a second track for 63 students at Berlin Humboldt University in autumn 1999. Since the beginning of the 1980s cost considerations have motivated health policy-makers to try to reduce university places for health care studies (while those responsible for education have not generally agreed). Since 1990, the number of graduates has dropped by about 15% to 9500 medical graduates and 1800 dentists. Thus in 1998, the number of academic health care graduates (16 500 including veterinary medicine) equalled the number of economic graduates and superseded law graduates by about 4000. In addition, 5700 psychologists graduated from university. After graduation, health care professionals are eligible for registration at the Länder ministries responsible for health, except medical doctors who receive full state recognition only after having worked in clinical practice for 18 months.<br>Secondary professional training (specialization) and continued education<br>Medical and veterinary graduates are obliged to specialize (e.g. general practice, internal medicine) while specialization is optional for the other health care professions. The different federal states recognize a maximum of 8 specialities in pharmacy, 3 in dentistry, 48 in veterinary medicine, 7 in psychology and 12 in nursing. The number of medical specialities has increased from 14 in 1924 to 36 in 1998, supplemented by another 50 subspecialties (e.g. pneumology) or additional qualifications (e.g. allergology). Practice-based specialization usually takes two or three years in non-academic and four to six years in academic health care professions. The duration of specialization in general medicine has been increased from three to five years in 1998 in order to strengthen the quality and professional status of future family practitioners. Yet, general practitioners amounted to only about 20% of the physicians receiving their specialty diplomas from medical chambers during the 1990s. The low generalist/specialist ratio has been interpreted as a result of deficient training facilities in ambulatory care, lower income prospects and a lower prestige due to the socialization of medical doctors in secondary and tertiary hospital care. Therefore, since 1999 the sickness |

funds and the private health insurers have been obliged to finance incentives to GP trainees and to senior family practitioners during the office-based training period (minimum two out of five years). Physicians' associations agreed with the programme despite scepticism about undue interventions in professional autonomy. A high drop-out rate of non-academic health professionals from professional training and practice has been interpreted as a result not only of the employment situation for women but also of relatively low job satisfaction in hierarchical structures and limited prospects for intra-professional development and social mobility. The shortage of nurses was another factor which motivated the introduction of course-based specialization facilities at polytechnic colleges during the 1980s. In 1995, 634 nurses graduated in nursing sciences at 11 universities for applied sciences and one private university. Part-time or full-time courses are increasingly offered for other non-medical professions as well, for example, physiotherapists, speech therapists or carers of the elderly. Polytechnics and private institutions also offer a variety of courses in areas such as health promotion and hospital management. Public health used to be a medical specialty exclusively until 1989 when postgraduate courses were gradually introduced at nine universities, predominantly in medical faculties. The two-year part-time courses are free-of-charge and offer about 300 places to university and partly to polytechnic graduates from medical and non-medical disciplines. Quality management is another part-time qualification which has been introduced in recent years at five state medical chambers, private institutions and some polytechnics. Continuous education is voluntary and self regulated by health care pro-fessionals.
Some general issues
Current debates on the education of health care professions in Germany reflect the tensions between and within the fields of education, health care and professional self-regulation. Some issues have been raised at least since the turn of the century. For example, interpersonal skills and the ability to synthesize knowledge are perceived to be underrepresented in nearly all types of health care education compared to curricular requirements for factual knowledge which have been increased in response to the developments and specialization in medicine. While the practice-based training of health professionals (e.g. in geriatric care) is criticized as lacking broader educational and pedagogic support for trainees, course-based education at universities is criticized as preparing students insufficiently for their future work either in research or in general health care practice. Some quantitative and qualitative issues have gained particular political importance during recent debates and reforms designed to meet future challenges in health care. Traditionally, strong political and professional values concerning free choice have made restrictions to accessing university education or professional practice (especially for self-employed professions such as ambula-tory doctors) a highly contentious issue. There is now broad agreement in German society that future and existing health care professionals should be better qualified in primary care, health promotion, rehabilitative care or interdisciplinary cooperation. However, it has turned out that it is not sufficient to add these topics to the content of course syllabuses while the majority of German health trainees are still nearly exclu-sively based, trained and specialized in secondary and tertiary hospitals for acute care. One of the major challenges in health care training will therefore be to introduce or increase the role, funding and infrastructure of education based in the community.

***Source*** European Observatory on Health Care Systems ***Year*** 2000

***Code*** 11.2

***Description*** Research and development in health

***Contents***

***Source*** European Observatory on Health Care Systems ***Year*** 2000

***Code*** 11.3

***Description*** Environmental health and control of drinking water

***Contents***

***Source*** European Observatory on Health Care Systems ***Year*** 2000

| | | | |
|---|---|---|---|
| ***Code*** | 11.4 | | |
| ***Description*** | Health programme administration and health insurance | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 11.5 | | |
| ***Description*** | Administration and provision of cash benefits | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 2000 |

| | |
|---|---|
| ***Code*** | 12 |
| ***Description*** | Manpower in health care |
| ***Contents*** | Human resources Physicians<br>The number of active physicians in Germany has been rising constantly over the last 25 years. The average increase, however, has stabilized at around 2% in the 1990s – as compared to average rates of 3% growth in the 1980s. Of a total of 357 700 physicians in 1998, 287 000 are active – a rate of 3.5 per 1000 population. Of these, 135 800 work in hospitals, 124 600 in ambulatory care (112 700 as SHI-accredited physicians, 7800 as salaried physicians and 4100 purely for private patients), 10 500 in public health services, administration or corporatist bodies and 16 100 in other areas (e.g. pharmaceutical industry). According to §§ 99–105 of the Social Code Book V, needs-based plans have to be developed to regulate the number of SHI-affiliated office-based physicians. Originally, the intention was to guarantee that less numerous specialties would also be available in rural areas. Since the 1980s, however, the focus has been on avoiding over-supply. Since 1993, the Social Code Book regulates matters so that new practices may not be opened in areas where supply exceeds 110% of the average number for the particular specialty in question. Accordingly, the Federal Committee of Physicians and Sickness Funds has developed guidelines which define these limits. The guidelines classify all planning areas into one of 10 groups – ranging from large metropolitan cities to rural counties – and define the need per group as the actual number of phy-sicians working in counties of that group in 1990 (divided by the population). Accordingly, “over-supply” is defined as 110% of that figure. Factors such as age, gender, morbidity or socioeconomic status of the population or the supply of hospital beds are not taken into account. Due to this definition, the need for certain specialties varies widely (up to a factor of 7.5) since differences are frozen. In early 1999, out of a total of 417 planning areas 380 were closed for setting up new surgical practices, 370 for paediatricians and 363 for derma-tologists. For general practice, however, only 212 areas were closed meaning that almost 50% had not reached the defined maximum.<br>Nurses and other health professions<br>Since nurses are legally not considered to be a profession, they do not need to register and hence no good data on nurses are available. Estimates put numbers in an about average position within the WHO European Region. An interesting instrument was included in the Health Care Structure Act namely the introduction of nursing time standards. Through this instrument, a daily documentation of nursing activities put every patient in one of nine categories with a standardized amount of necessary nursing time between 52 and 215 minutes per day. The total amount of minutes per ward and per hospital could be calculated into the necessary nursing staff for the unit. Nursing time standards were introduced to end the period of (perceived) nursing shortages. It was expected that new jobs would be created. However, the Second SHI Restructuring Act abolished the regulation for the official reason that the standard had led to almost 21 000 new nursing positions between 1993 and 1995 when the lawmakers had anticipated only 13 000. The conditions for independent health care professionals other than physicians – such as physiotherapists or speech therapists – are regulated in the Social Code Book (§§ 124 and 138 SGB V). § 124 regulates the licensing of providers who must fulfil certain prerequisites (training, practical experience, practice equipment, contractual agreements) if they want to participate in the care of the insured.<br>Human resources Physicians<br>The number of active physicians in Germany has been rising constantly over the last 25 years. The average increase, however, has stabilized at around 2% in the 1990s – as compared to average rates of 3% growth in the 1980s. Of a total of 357 700 physicians in 1998, 287 000 are active – a rate of 3.5 per 1000 population. Of these, 135 800 work in hospitals, 124 600 in ambulatory care (112 700 as SHI-accredited physicians, 7800 as salaried physicians and 4100 purely for private patients), 10 500 in public health services, administration or corporatist bodies and 16 100 in other areas (e.g. pharmaceutical industry). According to §§ 99–105 of the Social Code Book V, needs-based plans have to be developed to regulate the number of SHI-affiliated office-based physicians. Originally, the intention was to guarantee that less numerous specialties would also be available in rural areas. Since the 1980s, however, the focus has been on avoiding over-supply. Since 1993, the Social Code Book regulates matters so that new practices may not be opened in areas where supply exceeds 110% of the average number for the particular specialty in question. Accordingly, the Federal Committee of Physicians and Sickness Funds has developed guidelines which define these limits. The guidelines classify all planning areas into one of 10 groups – ranging from large metropolitan cities to rural counties – and define the need per group as the actual number of phy-sicians working in counties of that group in 1990 (divided by the population). Accordingly, “over-supply” is defined as 110% of that figure. Factors such as age, gender, morbidity or socioeconomic status of the population or the supply of hospital beds are not taken into account. Due to this definition, the need for certain specialties varies widely (up to a factor of 7.5) since differences are frozen. 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| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 2000 |

| | |
|---|---|
| ***Code*** | 13 |
| ***Description*** | Fees, rates and salary structure |
| ***Contents*** | |

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|---|---|---|---|
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 2000 |

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|---|---|
| ***Code*** | 13.1 |
| ***Description*** | Methods of payment to (specialist) physicians |
| ***Contents*** | Payment of physicians in ambulatory care The payment of physicians is not straightforward, but is subject to a process involving two major steps. Firstly, the sickness funds make total payments to the physicians' associations for the remuneration of all SHI-affiliated doctors. This releases them from the duty of paying the doctors directly (§83 SGB V). Total payment is usually negotiated as a capitation per member or per insured person. The capitation – which varies between substitute and other funds within a Land and between Länder – covers all services by all SHI-affiliated physicians of all specialties. Secondly, the physicians' associations have to distribute these total payments among their members according to a Uniform Value Scale and additional regula-tions. Prior to payment, the physicians' associations have to check, record and sum up the data that comprise the basis of these calculations. All approved medical procedures are listed in the Uniform Value Scale (EBM). While the coverage decision is made by the Federal Committee of Physicians and Sickness Funds, a separate joint committee at the federal level, the Valuation Committee, is responsible for the Uniform Value Scale. This scale lists all services which can be provided by physicians for remuneration within the statutory health insurance system. Besides 147 basic services (consultations, visits, screening etc.), the services are ordered by specialty. The chapter on surgery and orthopaedic surgery lists 355 services, the chapter on ear, nose and throat 97, the chapter on internal medicine 87, etc. Each service is allocated a point value (hence the name "value scale") and lists certain preconditions for claiming reimbursement, e.g. particular indications for use or exclusions of other services during the same visit. At the end of each quarter, every office-based physician invoices his/her physicians' association for the total number of service points delivered.<br>While physicians receive monthly payments based on previous figures, their actual reimbursement will depend on a number of factors:<br>• Since 1997, the number of reimbursable points per patient is limited – with the limit varying between specialties and between Länder.<br>• The total budget negotiated with the sickness funds is divided by the total number of delivered and reimbursable points for all services within a regional physicians' association, i.e. the monetary value of each point cannot be predicted as it depends on the total number of points. The monetary value is then used to calculate the physicians' quarterly remuneration.<br>• The actual reimbursement may be further modified through the Remuner-ation Distribution Scale which is different for every physicians' association. Through this measure, minimum and/or maximum point values for the different specialities and/or different service categories are regulated to adjust for large variations between specialties.<br>The reimbursement is further subject to control mechanisms to prevent over-utilization or false claims. Physicians may be subject to a utilization reviews at random or if their levels of service provision or hospital referrals per capita are higher than those of colleagues in the same specialty and under comparable circumstances. To escape financial penalties, the physician has to justify the higher rates of utilization and referral which may be due to a higher number of severely ill patients. Utilization review committees and utilization review arbitration committees with an equal number of physicians and sickness fund representatives are responsible for these controls. The physicians' associations were successful in their efforts to include a regulation in the Second SHI Restructuring Act to end the use of fixed budgets and to return to real fee-for-service. On the one hand, this resulted from an increase in allegations by physicians that some of their colleagues had submitted false claims and, on the other hand, that the size of the predetermined budgets was too small to cover all necessary services. Before this legal stipulation could be turned into reality, the new government reintroduced fixed budgets for 1999 through the Act to Strengthen Solidarity in Statutory Health Insurance. An analysis of the development of physician reimbursement between 1988 and 1995 shows that – due to both higher numbers of physicians and higher levels of service provision per physician – reimbursement between 1992 and 1995 remained almost constant per physician and actually decreased per service delivered. The above-mentioned limit of points per patient was a partial solution to these problems. However, in spite of the moderate growth rates in remuneration per physician, the income of office-based physicians has remained rather high, which is partly due to the high increases in reimbursement from private patients (see the section on Private health insurance). The average income varies between a little more than DM 150 000 for general practitioners and DM 250 000 for ENT physicians (see Table 21), i.e. between three and five times as much as blue-collar workers and between two and three times as much as white-collar workers. |
| ***Source*** | European Observatory on Health Care Systems |
| ***Year*** | 2000 |

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|---|---|---|---|
| ***Code*** | 13.1.1 | | |
| ***Description*** | Integrated or contracted | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 2000 |

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|---|---|---|---|
| ***Code*** | 13.1.2 | | |
| ***Description*** | Type of payment | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 2000 |

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|---|---|---|---|
| ***Code*** | 13.1.3 | | |
| ***Description*** | Method for deciding fees/salaries | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 2000 |

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|---|---|
| ***Code*** | 13.2 |
| ***Description*** | Methods of hospital payment |
| ***Contents*** | Payment of hospitals Since 1993 and more dramatically since 1996, the German hospital sector has experienced considerable changes due to fixed budgets, the possibility of deficits and profits, ambulatory surgery, and the introduction of prospective payments. Previously, since the 1972 Hospital Financing Act which had introduced dual financing and the full cost cover principle, circumstances had been more fa-vourable for hospitals in Germany. Dual financing means financing of investment costs through the Länder and of running costs through the sickness funds (plus private patients). The running costs include all personnel costs, as hospital physicians are salaried employees of the hospitals. The heads of medical departments usually have the right to charge private patients for medical services on top of the hospital charges. In order to be eligible for investment costs, hospitals have to be listed in the hospital plans which are set by the Länder. These plans often also list the specialties which are necessary, and even the number of beds per specialty, for every hospital. Since 1989, a hospital has been legally defined as an institution to treat sick patients or to deliver obstetric services which is continuously staffed by physicians and "in which patients can be lodged and fed" (§107 SGB V); in the following these hospitals will be referred to as general and psychiatric hospitals. The development of hospital bed capacities, and the money invested in hospitals, varies widely between Länder. Between 1991 and 1998, Berlin reduced its bed numbers from the highest number per capita by more than a third. Brandenburg and Saxony have reduced their capacities from well above to well below average. On the other hand, due to only modest reduc-tions, Bavaria and Rhineland-Palatine have moved from well below average to average numbers per capita. In international data, preventive and rehabilitative institutions are often in-cluded in hospital data. These institutions, however, are not listed in hospital plans and receive no reimbursement of investment costs by the state govern-ments, but instead have to rely solely on reimbursement through negotiated contracts. As regards running costs, the full cost cover principle meant that whatever the hospitals spent had to be reimbursed. The actual remuneration was done through per diem charges which were retrospectively calculated by the states for each hospital. However within each hospital, all per diems were equal. The original Hospital Financing Act remained the main legal basis for the German hospital sector until 1992, since the federal cost-containment acts dealt with issues outside the hospital sector. This was partly due to the power of the federal states which had to agree to all decisions affecting hospitals. Thus only minor legislation on hospital services was included in the 1981 Health Insurance Cost-containment Amendment Act, restricting postnatal hospital stay to six days except in the case of medical need for a longer stay, and requiring hospitals to agree purchases of "large (high cost) medical technology" with ambulatory physicians (see the section on Health care technology assessment). The 1984 Hospital Restructuring Act introduced prospectively negotiated per diem charges which were based on expected costs. Coverage of excess costs was de jure limited. De facto, however, hospitals received full compensation through adjustments of charges. In addition, the act opened up the possibility of including capital costs in per diem charges if investments would lower running costs in the medium or long term. From that time onwards, dual financing also meant dual planning, with the number of hospitals and hospital beds being planned at state level, while staff numbers and hospital day numbers were subject to negoti-ations between hospitals and sickness funds within the framework of negotiating per diem charges. Since the Health Care Reform Act, hospital and sickness fund associations have been obliged to negotiate contracts concerning quality assurance (which took several years to be put into practice). In addition, the sickness funds gained the right to contract with additional hospitals and to de-contract hospitals. The latter process is, however, complicated – and therefore happens rarely – since firstly the funds have to agree to do it jointly and, secondly, it needs the approval of the respective Land government. The Health Care Structure Act was the first major law in the cost-containment area to affect the hospital sector. This reform was possible since the Social Democratic Party, which was the opposition in the lower chamber or Federal Assembly but the ruling party in most states at that time, had agreed to it. The hospital sector was affected by several new regulations, as follows. Increases in sickness fund expenditure for inpatient treatment were tied to the increase in contributory incomes for 1993 to 1995. To facilitate this, the full-cost cover principle was abolished, i.e. the hospitals were allowed to make both profits and deficits, and fixed budgets were calculated for each hospital (for budgets see below). The growth rates of the budgets were to be based on estimates published in advance by the Federal Ministry of Health (and retro-spectively adjusted for the actual growth rate). In addition, however, the law allowed several exceptions for higher growth rates which led to expenditure increases well above intended growth rates. Secondly, nursing time standards were introduced (see the section on Human resources and training). Since it was calculated that new nurses would have to be employed as a result of this innovation, a budget exception was allowed in this case. Hospitals were allowed to offer ambulatory surgery and ambulatory care of inpatients for a few days before and after their inpatient treatment (see the section on Health care delivery system). The incentives for these services were initially weak, however, since remuneration was included in the fixed budgets. Prospective case-fees and procedure-fees were introduced |

from 1996 for a limited segment of inpatient care. Politically, fixed budgets in the hospital sector were presented as an interim measure until this new prospective payment system took effect. Case-fees are supposed to cover all costs during a hospital stay while procedure-fees are reimbursed on top of the (slightly reduced) per diem charges. Case-fees are based on a combination of a certain diagnosis (4-digit ICD-9, partly separated into elective and emergency) and a specific intervention (i.e. open appendectomy attracts a case-fee different from that for laparoscopic appendectomy). Procedure-fees are only based on an intervention and more than one procedure-fee may be remunerated per case. The number of points for both the (currently more than 70) case-fees and the (currently almost 150) procedure-fees were originally set through an ordinance by the Federal Ministry of Health, while the monetary conversion factor was negotiated at Land level. However, when the number of points was fixed by the ministry, it assumed a point value of DM 1 (approximately US $0.55). The number of points were calculated by taking the real costs of a relatively small sample of patients with the diagnoses/interventions in question and assuming a 15% reduction in average length of stay, which was still calculated to be two to five times higher than those for comparable DRGs in the USA. In spite of this longer (calculated) length of stay, case fees are only about 40–50% as high as comparable DRG reimbursements in the USA (see Table 17). In addition, German case-fee definitions include a specified maximum length of stay which will be covered; if the actual length of stay exceeds this maximum (which happens in around 3% of all cases), extra days are reimbursed separately. The proportion of cases reimbursed through prospective case fees in Germany is less than a quarter, with wide variations both between hospitals and specialties. According to Asmuth et al. (1999), 12% of hospitals receive no prospective payments while in the remaining hospitals they account for 25% of both cases and reimbursement volume (for case-fees alone: 18% of cases with 15% of bed-days). While no case-fees exist for medical, paediatric or psychiatric patients, more than 50% of cases in gynaecology and obstetrics and about two thirds of ophthalmologic cases are reimbursed in this way. Both the number of different case-fees and procedure-fees offered and the volume provided are subject to budget negotiations at hospital level. On average, the service spectrum of a hospital includes 32 different case-fees and 42 procedure-fees (Asmuth et al. 1999). The Second Statutory Health Insurance Restructuring Act transferred the responsibility for maintaining and further extending the benefits catalogue to joint negotiations between the sickness funds and the hospital associations from 1999. Accordingly, early in 1998 the federal hospital organization founded a so-called coordinating committee to work with the federal associations of sickness funds and the private health insurers' organization. All other cases are currently reimbursed by a two-tier system of per diem charges: a flat hospital-wide rate covering non-medical costs and a department-specific charge covering medical costs including nursing, pharmaceuticals, procedures, etc. Case-fees, procedure-fees and per diem charges are all part of the budget for each particular hospital. These German-style budgets are not budgets in the sense that the hospital will get an amount of money independent of actual activity. Instead, the budgets are targets established during the negotiations between the sickness funds and the hospital. The target budget establishes service numbers (for cases to be reimbursed by case and procedure fees as well as for cases reimbursed by per diems) as well as the per diems. If the hospital reaches exactly 100% of its target activity, then no financial adjustment has to be made since the sum of all case and procedure fees plus the per diems exactly equals the target budget. If actual activity is higher than the target, i.e. if the hospital has been reimbursed above the target budget, then it has to pay back a certain part of the extra income – 50% of case fees for transplantations, 75% of other case- and procedure-fees and 85–90% of per diems. In other words, activity above the target is only reimbursed at 50%, 25% and 10–15% respectively. If actual activity is lower than the target, i.e. if the hospital's total reimbursement has not reached the target budget, then it receives 40% of the difference (since 1 January 2000; it was 50% in 1999). This sum is divided according to utilization between the funds, i.e. actual case-fees, procedure-fees and per diems are then higher than originally negotiated. Due to above average increases in hospital expenditure, this area has been the concern of health policy for a long time. While expenditure per bed and day has continued to rise in the last few years, expenditure per case has actually declined since 1996, meaning that efficiency has risen. The development of the ratios in Table 18 is another indicator that the former GDR health care system has been rapidly assimilated. The Reform Act of SHI 2000 mandates the introduction of a new payment system for hospitals based on case-fees for all patients (except psychiatry). It has to be developed until the end of 2001 and will be introduced in 2003.

| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 2000 |
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|---|---|---|---|
| ***Code*** | 13.2.1 | | |
| ***Description*** | Method of payment | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 2000 |

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|---|---|---|---|
| ***Code*** | 13.2.2 | | |
| ***Description*** | Method for deciding rates | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 13.2.3 | | |
| ***Description*** | Recent changes in payment method | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 2000 |

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|---|---|---|---|
| ***Code*** | 14 | | |
| ***Description*** | Main system of financing and coverage (tax based, insurance based, mixture) | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.1 | | |
| ***Description*** | Main features of tax based systems | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.1.1 | | |
| ***Description*** | Main body(ies) responsible for providing health care cover to beneficiaries | | |
| ***Contents*** | Contributions towards statutory health insurance with its current 453 sickness funds constitute the major system of financing health care in Germany. Sickness fund membership is compulsory for employees whose gross income does not exceed a certain level (a little less than EURO 40 000/year in the western parts of the country [in 2000: DM 77 400] and around EURO 32 000/year in the parts in the former GDR [DM 63 900]) and is voluntary for those above that level. | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 2000 |

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|---|---|---|---|
| ***Code*** | 14.1.2 | | |
| ***Description*** | Extent of population coverage (excluded groups) | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 2000 |

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|---|---|---|---|
| ***Code*** | 14.2 | | |
| ***Description*** | Main features of social health insurance | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.2.1 | | |
| ***Description*** | Organisation of main body responsible for insuring/providing coverage | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.2.2 | | |
| ***Description*** | Extent of population coverage | | |
| ***Contents*** | Currently, 88% of the population are covered by the SHI; 75% are mandatory members and their dependants while 13% are voluntary members and their dependants. Nine per cent of the population are covered by private health insurance, 2% by free governmental health care (i.e. police officers, soldiers and those doing the civil alternative to military service) while only 0.1% are not insured. | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 2000 |

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|---|---|
| ***Code*** | 14.2.3 |
| ***Description*** | Stipulations in premium contribution |
| ***Contents*** | Contributions are dependent on income and not risk, and include non-earning spouses and children without any surcharges. Contributions are based on income only (i.e. not on savings or possessions); income is liable to contributions up to an upper level (which is the same as that for the right to opt out or become a voluntary member). The total sum of the income of all the insured up to that level (the so-called contributory income) is among the most important figures in health policy since its growth rate from year to year determines the level of cost-containment. Growth in average contributory income is not necessarily the same as wage increases. Higher than average wage increases for workers earning less increase the contributory income disproportionately, while rising unemployment – especially hidden unemployment through people leaving the workforce and becoming “dependants” – has a moderating effect. Contributions are shared equally between the insured and their employers. Taking the current average contribution rate of 13.5% as an example, the insured persons pay 6.75% out of their pre-tax income below the threshold and the employer pays the same amount in addition to wages. For people with earnings below a threshold of DM 630, only employers have to pay for contributions (at a rate of 10% for all funds). Until 1998, income up to that level was not liable for sickness fund contributions. In the case of retired and unemployed people, the retirement and unemployment funds respectively take over the financing role of the employer. |
| ***Source*** | European Observatory on Health Care Systems |
| ***Year*** | 2000 |

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|---|---|
| ***Code*** | 14.2.4 |
| ***Description*** | Competition between insurance schemes |
| ***Contents*** | Traditionally, the majority of insured people had no choice over their sickness fund and were assigned to the appropriate fund based on geographical and/or job characteristics. This mandatory distribution of fund members led to greatly varying contribution rates due to different income and risk profiles. Only voluntary white collar members – and since 1989 voluntary blue collar members – had the right to choose among several funds and to cancel their membership with two months' notice. Other white collar workers (and certain blue collar workers) were able to choose when becoming a member or changing jobs. Since this group grew substantially over the decades, around 50% of the population had at least a partial choice in the early 1990s. The Health Care Structure Act gave almost every insured person the right to choose a sickness fund freely (from 1996) and to change between funds on a yearly basis with three months' notice (from 30 September 1996 to 1 January 1997). All general regional funds and all substitute funds were legally opened up to everyone and have to contract with all applicants. The company-based funds and the guild funds may choose to remain closed but if they open up, they too have the obligation to contract with all applicants. Only the farmers' funds, the miners' fund and the sailors' fund still retain the system of assigned membership.<br>To provide all sickness funds with an equal starting position or a level playing field for competition, a risk structure compensation scheme to equalize difference in contribution rates (due to varying income levels) and expenditure (due to age and sex) was introduced in two steps (1994 and 1995 – the latter included retired insurees and thereby replaced the former sharing of actual expenses for retired persons between funds). The compensatory mechanism requires all sickness funds to provide or receive compensation for the differences in their contributory incomes as well as in averaged expenditures. For both sexes, average expenditure for benefits included in the uniform, comprehensive package is calculated for one-year age brackets using actual expenditure data (i.e. the actual calculation is always retrospective and only estimated for the current year). The sum of these average expenditures for all members of a sickness fund determine that fund's contribution need. The sum of all funds' contribution needs divided by the sum of all contributory incomes determines the compensation scheme's rate which is used for comparing actual contributions and contribution need to calculate the compensated sum paid to those funds receiving compensation from the scheme, or the sum required from those funds making payments into the scheme. In doing so, the risk compensation mechanism also equalizes for different income levels between the members of the funds as well as differences in the number of dependants (since they are included on the expenditure side whilst they enter the calculations of actual contributions as zero). The impact of both the free choice and the risk structure compensation scheme on the structure of the sickness funds, the actual movement of members between funds, the development of the contribution rates and transfer sums between funds can be summarized as follows:<br>• Even before the period of actual free choice for the insurees began, sickness funds began to merge (see the section on Organizational structure and management).<br>• Increasingly, members leave one fund and join another. While no data on actual moves are available, net losses/gains in membership numbers may be taken as an indicator. For example, the AOKs have lost 479 000 members in 1997, 400 000 in 1998 and 292.000 in 1999 while the BKKs have gained 335 000, 516 000 and 971 000 members respectively. These net losses/gains are correlated to the contribution rates of the funds, i.e. funds with higher than average contribution rates lose members while those with lower than average rates gain members.<br>• The importance of the contribution rate is further highlighted by a survey study. For people who have moved from one fund to another, lower contributions were cited as the prime motive (58%) while for people considering a move, both the contribution rate and better benefits are equally important. People not considering a move regard better benefits to be more important. People joining a sickness fund for the first time mostly cited other reasons for choosing a particular fund – presumably advice from their family, friends or their employer.<br>• The risk compensation scheme has narrowed contribution rates between funds. This trend is especially observable in the west but recently also in the east. While in 1994, 27% of all members paid a contribution rate differing by more than one percentage point from the average, this number has dropped to 7% in 1999.<br>• The movement of members between funds has not equalized the different risk structures (which would result in diminishing transfer sums) but the first opportunity to change between funds desegregated membership further, i.e. the healthier, younger, better-earning people moved more often and towards cheaper funds, which in turn has increased the transfer sums. This development implies that a risk compensation mechanism will be needed permanently, and not only temporarily until the risk structure has become equal. |
| ***Source*** | European Observatory on Health Care Systems |
| ***Year*** | 2000 |

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|---|---|---|---|
| ***Code*** | 14.2.5 | | |
| ***Description*** | Provision for risk adjustment | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 2000 |

| | |
|---|---|
| ***Code*** | 14.3 |
| ***Description*** | Health care benefits and rationing; recent reductions in benefits package and variations in extent between different insurance plans |
| ***Contents*** | Health care benefits and rationing Health care benefits Through chapter 3 of the Social Code Book V, the following types of benefits are currently legally included in the benefit package, usually in generic terms: • prevention of disease • screening for disease • treatment of disease (ambulatory medical care, dental care, drugs, non-physician care, medical devices, inpatient/hospital care, nursing care at home, and certain areas of rehabilitative care) • transportation. In addition to these benefits in kind, sickness funds have to give cash benefits to sick insurees after the first six weeks during which employers are responsible for sick pay. While employers have to pay 100% of income, sickness funds pay 80% for up to 78 weeks per period of illness. From 1989 to 1996, a third type of benefits was health promotion measures offered by sickness funds directly to their members. While the Second SHI Restructuring Act had abandoned this benefit, it has been partly reintroduced through the SHI Reform Act 2000. While the Social Code Book regulates preventive services and screening in considerable detail (e.g. concerning diseases to be screened for and intervals between screening) but leaves further regulations to the Federal Committee of Physicians and Sickness Funds, the latter committee has considerable latitude in defining the benefits catalogue for curative, diagnostic and therapeutic procedures. The decision-making process concerning coverage is described in more detail in the section on Health technology assessment. All covered procedures are listed in the Uniform Value Scale together with their relative weights for reimbursement (see the section on Payment of physicians in ambulatory care). The range of covered procedures is wide, ranging from basic physical examinations in the office via home visits, antenatal care, care for terminally ill patients, surgical procedures and laboratory tests to imaging pro-cedures including MRI. Until 1997, exclusions were not explicitly possible but the mandate to (re)evaluate technologies made this possible. Currently, osteodensitometry is the first benefit under consideration for exclusion. While benefits for ambulatory care are legally defined in generic terms only, one can observe more details in the description of dental, especially prosthetic benefits in SGB V. One reason is the de facto dysfunction of the Federal Committee of Dentists and Sickness Funds. The SHI Contribution Rate Exoneration Act's regulation to remove crown/denture treatment from the benefits catalogue for persons born after 1978 (even though they still had to pay the full sickness fund contribution rate) was politically contentious. The Act to Strengthen Solidarity in SHI reintroduced these benefits. The non-physician care sector comprises the personal medical services of professionals other than physicians, such as physiotherapists, speech therapists, and occupational therapists. Insured patients are entitled to such services unless they are explicitly excluded by the Federal Ministry of Health which is currently not the case (§§ 32 and 34 SGB V). According to §138 SGB V, non-physician services may be delivered to the insured only if their therapeutic use in connection with recommendations regarding the assurance of quality is recognized by the Federal Committee of Physicians and Sickness Funds. In the Federal Committee's guidelines for Non-physician Care and Medical Aids, the conditions for the prescription of these services are regulated. Therefore, non-physician care may be ordered only if a disorder can be recognized, healed, mitigated or aggravation can be prevented; health damage can be prevented; health endangerment of children can be avoided; and risk of long-term care can be avoided or decreased. As mentioned previously (see the section on Organizational structure of the health care system), psychologists sub-specialized as psychotherapists are the exception to the rule as they have become members of the physicians' associations and therefore no longer have the status of "non-physicians". The range of services provided in the hospital sector is determined through two factors: the hospital plan of the state government, and the negotiations between the sickness funds and each individual hospital (a result of the fact that the hospitals do not have a collective corporatist body). While the decision of the state government determines the flow of capital for investments, the negotiations determine whether the costs for running these services are reimbursed by the sickness funds. This dual financing is the result of the 1972 Hospital Financing Act (see the section on Payment of hospitals). Home nursing care is regulated separately. Due to the split in responsibilities between sickness funds and long-term care funds, there is a lack of regulation. The Second SHI Restructuring Act mandates, however, that the Federal Committee will also pass guidelines for this sector. Priority-setting and rationing: the public's and the experts' view According to a representative population survey in 1998, the majority of the public – in the west as well as in the east – favours unlimited funding for health services more than the setting of limits. Almost 50% of the respondents wanted the extra money to be gained through lower spending on other things, while higher general taxation or higher social insurance contributions are supported by only a few. Visible differences between east and west appear in the options "more private health insurance" and "higher charges for patients". In the east, support is only half of that in the west (where it is also weak). If priorities do have to be set, they should be set by doctors – with stronger backing for this option in the east – with the public and health service managers as joint second choice. Limiting the benefits' catalogue to a core of essential services is rejected as are priorities based on age. In summary, the notion of rejecting |

rationing in favour of equal treatment opportunities independent of age, income or status is stronger in the east, possibly due to a longer history of advocating equity. In a similar survey in 1993, 55% of respondents were of the opinion that sickness funds should pay for everything while 41% thought that they should not cover certain diseases: smoking-related diseases 32%, alcohol-related diseases 28%, injuries through risky sports 26%, drug abuse 23%, abortion 11%, stress-induced diseases 3% and pregnancy 1%. In another 1995 survey, 41% of respondents favoured the inclusion of health risks in the calculation of sickness fund benefits, mainly through bonuses for healthy lifestyle (29%) and less frequently through extra contributions for people with risky behaviours (7%). In a further survey in 1998, a three-quarter majority favours restrictions in the area of pharmaceuticals. Seventy-four per cent are of the opinion that drugs lacking explicit proof of effectiveness should not be paid for by the sickness funds. Seventy-three per cent are in favour of restricting physicians' choice to cheaper drugs in cases where pharmaceuticals differ in price but not effectiveness. Another survey in the summer of 1998 showed that the majority of the population (59%) backed the decision of the Federal Committee of Physicians and Sickness Funds to exclude drugs such as Viagra on the basis of lifestyle (see the section on Pharmaceuticals). In 1997, physicians agreed with the public that large or significant efficiency reserves exist in the German health care system (89%). Contrary to the public's view, 70% of them believe, however, that rationing is inevitable. Fifty-nine per cent say that rationing already exists. Health care experts in a 1995 Delphi survey expected further restrictions in health care and limitations on therapeutic freedom, mostly within five years, i.e. by the year 2000. Most of them welcomed changes in the coverage procedure for new drugs, supplementary insurance policies being offered by sickness funds (which currently is illegal), the introduction of a gatekeeper system and – to a lesser extent – bonuses and penalties in conjunction with yearly checkups. The obligation to use the cheapest diagnostic or therapeutic measure was re-jected by a small majority while large majorities rejected the idea of lessening the quality of care due to economic restrictions, the right to choose a doctor freely or rationing by age, income or status.

***Source*** European Observatory on Health Care Systems ***Year*** 2000

***Code*** 14.4

***Description*** Complementary sources of finance

***Contents***

Complementary sources of finance Even though statutory health insurance dominates the German discussion on health care expenditure and health care reform(s), its actual contribution to overall expenditure is only a little more than 60%. Other statutory insurance systems for retirement, accidents and more recently for long-term care contribute 1–3% each so that statutory insurance as a whole has been the source of finance for 66–68% of total health expenditure for the last 25 years. In the German statutory insurance-based system, three other main sources of finance can be identified: taxes, out-of-pocket payments and private health insurance (see below). According to OECD data, taxes have been overtaken as the major complementary source by out-of-pocket financing in the early 1990s – a trend which is expected to be seen more clearly in the figures for 1998. However, a recent re-calculation of health expenditure for 1992 and 1994 by the Federal Statistical Office puts out-of-pocket spending 1.4% lower (while taxes are roughly placed equal and private health insurance almost 1% higher. Taxes as a source of finance are used for various purposes in the health care system. Among them are reimbursement of parts of the private health care bills for permanent public employees, health insurance contributions or reimbursement of health care bills for persons on welfare, free governmental health care, capital investment costs for hospitals, public health services, and subsidies for the farmers' funds (while other funds do not receive any tax income).

***Source*** European Observatory on Health Care Systems ***Year*** 2000

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|---|---|
| ***Code*** | 14.4.1 |
| ***Description*** | Voluntary health insurance |
| ***Contents*** | Private health insurance<br>In the German system private insurance has two facets, to fully cover a certain portion of the population and to offer supplementary insurance for insurees of the sickness funds. Both types are offered by 52 private health insurers which are united in the Association of Private Health Insurance Companies. In addition, there are around 45 other very small and usually regional private health insurers. In terms of premiums, the full-cover segment is more than four times as large as the supplementary insurance segment. |
| ***Source*** | European Observatory on Health Care Systems ***Year*** 2000 |

| | |
|---|---|
| ***Code*** | 14.4.1.1 |
| ***Description*** | Organisation of voluntary health insurance: public, quasi public, private, not for profit |
| ***Contents*** | |
| ***Source*** | European Observatory on Health Care Systems ***Year*** 2000 |

| | |
|---|---|
| ***Code*** | 14.4.1.2 |
| ***Description*** | Type and nature of services covered |
| ***Contents*** | Fully privately insured patients usually enjoy benefits equal to or better than those covered by statutory health insurance. This depends, however, on the insurance package chosen; e.g. it is possible not to cover dental care. In the private health insurance market, premiums vary with age, sex and medical history at the time of underwriting. Unlike in statutory health insurance schemes, separate premiums have to be paid for spouses and children – making private health insurance especially attractive for single people or double-income couples. Since premiums rise – often steeply – with age, and (re)entry of pri-vately insured people into statutory sickness funds is not permitted in ordinary circumstances, private insurers are obliged to offer an insurance policy with the same benefits as in the SHI at a premium that is not higher than the average maximum contribution in the sickness funds. Up until now, however, this option is hardly ever chosen. Unlike SHI, privately insured people generally have to pay providers directly and are reimbursed by their insurer. While a price list for privately delivered medical services exists as an ordinance issued by the Federal Ministry for Health, physicians usually charge more – by a factor of 1.7 or 2.3 (which are the maximum levels for reimbursement by the government and by most private health insurers for technical and personal services respectively) or even more. The real fee-for-service reimbursement for privately insured people has led to cost increases which are on average almost two thirds higher than in the SHI – and in ambulatory care, where SHI cost-containment was most successful, even twice as high. The second market for private health insurers is supplementary insurance, e.g. to cover extra amenities like hospital rooms with two beds or treatment by the head-of-service. Since sickness funds are legally not allowed to offer these extra policies, people must obtain insurance from private health insurers. It is estimated that in 1997 around 7 million people had some kind of supplementary insurance. This figure had risen considerably from 1996 due to the introduction of the new insurance segment to cover crowns and dentures which were excluded from the benefits package for people born after 1978 (but which subsequently were reintroduced). |
| ***Source*** | European Observatory on Health Care Systems ***Year*** 2000 |

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|---|---|
| ***Code*** | 14.4.1.3 |
| ***Description*** | Proportion of population covered |
| ***Contents*** | The 7.1 million (9% of the population) with full-cover private health insurance consist of three main groups: • formerly SHI-insured persons who have opted out once their income reached the level above the threshold; • self-employed people who are excluded from SHI unless they have been a member previously (except those who fall under mandatory SHI cover like farmers); • active and retired permanent public employees such as teachers, university professors, employees in ministries etc. who are excluded de facto as they are reimbursed by the government for most of their private health care bills (they receive private insurance to cover only the remainder). |
| ***Source*** | European Observatory on Health Care Systems |
| ***Year*** | 2000 |

| | |
|---|---|
| ***Code*** | 14.4.2 |
| ***Description*** | Out-of-pocket payments: main cost sharing measure (partial reimbursement, co-payment) by care category: ambulatory, inpatient, drugs, medical aids and prostheses |
| ***Contents*** | Cost-sharing has a long tradition within the German health care system, the most traditional sector being the pharmaceutical sector. In this area, nominal cost-sharing had increased over the years, but cost-sharing as a percentage of total costs had remained stable at less than 5% of pharmaceutical expenditure until 1992 (when it was 3.5%). Through the Health Care Structure Act, cost-sharing was regulated anew in two steps, the first being the introduction of new co-payments according to the price of the pack (1993) and later according to pack size (1994). These measures doubled patient cost-sharing to 8% in 1993 and to 9% in 1994. The Health Insurance Contribution Exoneration Act increased this to DM 4/6/8, accounting for more than 10% of total expenditure and only six months later the Second SHI Restructuring Act increased this further to DM 9/11/13 and 14% of expenditure for prescribed drugs. The new co-payment levels also meant that more than 20% of prescribed drugs had to be paid entirely by the patients which increased the volume of directly bought OTC-drugs. The new coalition government lowered the co-payments through the Act to Strengthen Solidarity in Statutory Health Insurance to DM 8/ 9/ 10, effective from 1 January 1999, which lowered co-payments to around 11% of expenditure. In other areas, cost-sharing was reduced in the 1970s by enlarging the benefits catalogue (i.e. denture treatment) but later cost-sharing was increased again. New areas for cost-sharing since the 1980s are charges for inpatient days in hospitals, rehabilitative care facilities and ambulance transportation. Most of these measures were cost-containment measures to shift spending from the sickness funds to patients – they were not intended to reduce overall spending, for example, patients were told that the co-payment for hospital treatment had to be paid to cover food. In the 1989 Health Care Reform Act, cost-sharing was advocated for two purposes; firstly, to raise revenue (to reduce expenditure for dental care, physiotherapy and transportation and making the patient liable for pharma-ceutical costs above reference prices) and secondly to reward “responsible behaviour” (again dental treatment) and rewarding good preventive practice with lower co-payments. These cost-sharing regulations were part of a complete re-structuring of co-payments resulting in generally higher cost-sharing than previously. Cost-sharing was increased markedly in 1997. Crown and denture treatment were removed from the benefits catalogue for everyone born after 1978. Pharmaceutical co-payments were increased markedly as well as co-payments for spa treatment and rehabilitative care. For people born before 1979, dental care also became the major sector to test market-oriented instruments. Prosthetic treatment was no longer an area of direct reimbursement through the sickness funds but patients were required to obtain treatment on a private billing basis and received a fixed sum from the sickness fund retrospectively. Through this regulation, prosthetic treatment became the first area within German statutory health insurance to work on the basis of “contracts” between patients and providers. While the law had established limits for private billing until 1999, the ministry estimated that at least one third of dentists overcharged. Accordingly, the regulation was abolished late in 1998 in favour of the former co-insurance regulation. Patient cost-sharing is limited by a range of measures: • People with very low incomes and those on unemployment benefits or on social welfare are exempted from most cost-sharing requirements – with the notable exception of co-payments for hospital treatment (§ 61 SGB V). • Persons up to the age of 18 years are exempted from cost-sharing except for co-insurance payments for crowns/dentures and co-payments for transportation. • For all other sickness funds’ members, yearly cost-sharing for pharma-ceuticals, non-physician care and transportation (but not for hospitals and rehabilitation) is limited to a maximum of 2% of their gross income for single people (§ 62 SGB V). If two or more people are dependant on this income the threshold is lower.4 Co-insurance payments for crowns/dentures are lowered for these persons. • Chronically ill patients who have paid at least 1% of their gross income for pharmaceuticals, non-physician care and transportation are exempted from these payments for the further duration of that chronic illness. In contrast to the previously-mentioned limit, this exemption applies only to the respective person individually. |
| ***Source*** | European Observatory on Health Care Systems ***Year*** 2000 |

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|---|---|
| ***Code*** | 14.4.3 |
| ***Description*** | External sources of funding: employers, fund raisers etc. |
| ***Contents*** | |
| ***Source*** | European Observatory on Health Care Systems ***Year*** 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 15 | | |
| ***Description*** | Health care expenditure | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 15.1 | | |
| ***Description*** | Structure of health care expenditures | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 2000 |

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|---|---|---|---|
| ***Code*** | 15.2 | | |
| ***Description*** | Total and public health expenditure as % GDP | | |
| ***Contents*** | Health care expenditure Germany's health care system is expensive by international comparison, both in absolute figures and – even more visibly – as a percentage of GDP. While health care expenditure had remained stable at around 8.7% of GDP in the Federal Republic of Germany between 1975 and 1990, it has risen considerably since reunification and bypassed that of other countries. The main reason for the high expenditure level compared to GDP is due to the fact that health expenditure in the east is almost as high as in the west while the GDP is still much lower. Public expenditure's percentage share of total health expenditure has re-mained constant since 1975 and is comparable to most other countries with statutory health insurance and also to Scandinavian countries. | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 15.3 | | |
| ***Description*** | Health care expenditure by category (%) of total expenditure on health care | | |
| ***Contents*** | Due to the strong ambulatory care sector offering (almost) all specialties, expenditure on hospital care is low by international comparison. It has, however, risen considerably over the last thirty years with increases above those for contributory incomes in most years. The high increases in hospital expenditure in the early 1970s may be explained both by the introduction of hospital planning to address a perceived shortage of hospital beds and the full cost cover principle. However, even since 1975 hospital expenditure has been the area of German health care that has been least constrained in its growth, with an increase from 1.9% of GDP per capita in 1975 to 2.4% in 1995. This accounts for almost two thirds of the increases in sickness fund expenditure since 1975 and the total increase since 1988, i.e. the phase of major cost-containment legislation. Only recently has hospital expenditure been controlled better. On the other hand, capital investments decreased steadily until 1990 after which they went up again temporarily due to investments in the east after unification. | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 2000 |

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|---|---|---|---|
| ***Code*** | 16 | | |
| ***Description*** | Import and Export | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 2000 |

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|---|---|---|---|
| ***Code*** | 16.1 | | |
| ***Description*** | Import | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 2000 |

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|---|---|---|---|
| ***Code*** | 16.2 | | |
| ***Description*** | Export | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 2000 |

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|---|---|
| ***Code*** | 17 |
| ***Description*** | Health care reforms |
| ***Contents*** | Health care reforms The major objective: cost-containment Since 1977, the sickness funds and providers of health care have been required to pursue a goal of cost-containment in health care through a policy of maintaining contribution stability. This requirement is defined as holding increases in contributions level with the rate of increase in contri-butory income. Ensuring compliance with the intentions of this legislation is one of the main tasks of the Concerted Action in Health Care. The era of cost-containment in the German statutory health insurance sector started in 1977 with the introduction of the Health Insurance Cost-Containment Act. It ended a period of rapid growth in health care expenditure, especially in the hospital sector. This growth was intentional on the part of politicians in order to overcome infrastructural deficits and shortcomings, caused by the destruction during the Second World War and an inadequate method of financing hospital investment. The basic principle behind German-style cost-containment was an income-oriented expenditure policy to guarantee stable contribution rates. This was an important objective in a time of economic restructuring and growing inter-national competition, since the contributions which cover all ambulatory care, pharmaceuticals and all hospital care (with the exclusion of hospital investment and some dental treatment) are jointly paid by employers and employees. Rises in contribution rates therefore became a question of international competitive-ness. A series of cost-containment acts employing various tools were used, in-cluding: • budgets for sectors or individual providers • reference-price setting for pharmaceuticals • restrictions on high cost technology equipment and number of ambulatory care physicians per geographic planning region • increased co-payments (both in terms of level and number of services) • the exclusion of young people from certain dental benefits between 1997 and 1998. These acts led to a moderation of health care expenditure growth and stabilized sickness funds' expenditures as a proportion of GDP per capita (in western Germany between 6% and 7% since 1975). However, this stability has not been acknowledged in discussions about health care expenditure, since the factor being used by both politicians and employers (and to a much lesser extent, the employees/ insured) has been the contribution rate alone. This is increasing slowly but regularly (from 10.4% in 1975 to 13.5% in 1999), with cost-containment measures having only minor and transient effects. These effects were often even more moderated by exceptional increases after the publication of new cost-containment proposals, i.e. in the time-span before coming into effect. The equivalent expenditure curve in late 1988 became known as "Blüm belly" after the then responsible Minister. A fact often overlooked is that rising health care expenditure (which rises in line with GDP) is not responsible for an increase in contributions, but for the shrinking proportion of GDP used for wages from which all social insurance contributions are financed. Thus, larger profits by employers, a higher level of unemployment and wage increases below productivity have led to this situation. The mid-90s' debate about social expenditure has been dominated by employers and economists who believe that using an even smaller percentage of GDP for wages will be the solution to the current economic crisis with high numbers of unemployed – a questionable belief which is hardly supported by hard data. The budgets have been of varying forms and efficacy but have been generally more successful in containing costs than any of the other supply or demand-side measures which largely failed. Table 22 provides an overview of the rise, fall and resurrection of budgets and spending caps. A full account of all cost-containment measures and their (relative) success is provided by Busse and Howorth (1999). |
| ***Source*** | European Observatory on Health Care Systems |
| ***Year*** | 2000 |

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|---|---|
| ***Code*** | 17.1 |
| ***Description*** | Determinants and objectives |
| ***Contents*** | |
| ***Source*** | European Observatory on Health Care Systems |
| ***Year*** | 2000 |

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|---|---|
| ***Code*** | 17.2 |
| ***Description*** | Content of reforms and legislation |
| ***Contents*** | Reforms and legislation The codification of Social Code Book V (SGB V) through the Health Care Reform Act provides a useful starting point for listing the major health care reform acts. Health Care Reform Act Besides codifying the social insurance legislation (or rather renewing the 1911 version), the Health Care Reform Act (which came into force on 1 January 1989) changed the following aspects of German health care:<br>• option to choose sickness fund or to opt out was extended to blue-collar workers above the income limit (i.e. putting them on par with white-collar workers)<br>• new benefits for long-term care<br>• introduction of "no claim" bonus models<br>• introduction of health promotion and increase in preventive services<br>• differentiation of co-payments for dentures depending upon regular dental examinations<br>• introduction of reference prices for pharmaceuticals and medical aids<br>• introduction of negative list for pharmaceuticals based on inefficiency<br>• introduction of quality assurance measures<br>• introduction of public committees to regulate expensive medical technologies jointly in the ambulatory and the hospital sectors<br>• introduction of a right for sickness funds to selectively contract with hospitals<br>• increased scope for the medical review boards of the sickness funds to in-clude hospitals.<br>Health Care Structure Act The Health Care Structure Act (the majority of which came into force on 1 January 1993) was introduced because it was felt that cost-containment was not as successful as it should be. The act pursued two different strategies:<br>• increased emphasis on clear-cut cost-containment measures such as budgets<br>• more competition to enhance efficiency, especially between sickness funds and in the hospital sector.<br>The key elements of the act and their market intentions can be classified as follows:<br>• freedom to choose a sickness fund for most of the insured population (from 1996)<br>• introduction of a risk compensation scheme to redistribute contributions among sickness funds (from 1994)<br>• abolition of the full cost cover principle for hospitals<br>• partial introduction of a prospective payment system for hospitals (case-fees and procedure-fees for selected treatments from 1996)<br>• lessening of the strict separation of the ambulatory and hospital sector (e.g. ambulatory surgery in hospitals became possible)<br>• introduction of "smart card" instead of paper documentation for the insured population<br>• introduction of a positive list of pharmaceuticals (from 1996; but regulation abolished in 1995)<br>• introduction of legally fixed budgets or spending caps for the major sectors of health care (originally limited until 1995)<br>• increased co-payments (for pharmaceuticals introduction of co-payments for products with reference price and differentiation according to price (1993) or pack size (from 1994))<br>• tighter restrictions on the number of ambulatory care physicians<br>• introduction of reimbursement claims auditing of ambulatory care physicians at random.<br>The "Third Step" of health reform After a draft bill failed, the government proceeded with a small-scale act embedded in a more general act to support economic growth. The health care part was the so-called Health Insurance Contribution Rate Exoneration Act (the majority of which came into force on 1 January 1997) and contained the following measures:<br>• exclusion of operative dental treatment and dentures from the benefits catalogue for persons born after 1978 (subsequently abolished in 1998)<br>• reduction of all contribution rates by 0.4 percentage points on 1 January 1997<br>• reduction of benefits for rehabilitative care<br>• increased co-payments for pharmaceuticals and rehabilitative care<br>• reduction of health promotion benefits.<br>The First and Second SHI Restructuring Acts, which followed and came into force on 1 July 1997 and 1 January 1998 respectively, represented a shift away from strict cost-containment. The new policy restricted employers' contributions on the one hand and expanded market mechanisms on the other hand, as well as increasing the share of private money in the system. In this respect, co-payments were presented as a means to put new money into the system (and no longer as a means to decrease utilization). Other measures included the cancellation or modification of anti-market instruments such as budgets and collective contracts. The measures introduced in these two acts included:<br>• for operative dental treatment/dentures a privatization of relationship between patient and dentist, i.e. patients have to negotiate services and ultimately prices with the dentists and receive only a flat rate from their sickness fund (from 1998);<br>*• establishment of a link between an increase in the contribution rate of a sickness fund to an increase in the co-payments for the insured of that fund;<br>* • the option for sickness funds to introduce "no claim" bonus, deductibles and higher co-payments; |

* • the option for all insured to choose “private” treatment with reimbursement by sickness fund at contract rate;
* • cancellation of the budgets in ambulatory care and the spending caps for pharmaceuticals (from 1998);
• increased possibilities for non-collective contracts between sickness funds and providers;
• transfer of the responsibility for maintaining and further developing the catalogue of prospective payments from Ministry of Health to self-government (sickness funds and hospital organizations) and abolition of public committees for expensive medical devices;
• introduction of an annual amount of DM 20 per insured (not shared with employers) for restoration and repair of hospitals;
*• increased co-payments for inpatient care, pharmaceuticals, medical aids, ambulance transportation and dentures (for those still covered) (partially abolished in 1998);
• establishment of a link between an increase in the contribution rate of a sickness fund to higher co-payments for the insured of that fund;
*• introduction of new hospice care benefit;
• abolition of public committees for expensive medical devices;
• new requirements for HTA in ambulatory care.
An asterisk (*) denotes that the measures were subsequently abolished in 1998 (effective 1 January 1999). In effect, the 1996/1997 acts broke several traditional rules of the system such as: • uniform availability of benefits • contributions shared equally between employers and employees • financing depending only on income and not on risk or service utilization • provision of services as benefits-in-kind. The abolition of these reforms – as well as the reversal in the trend to shift costs onto patients while easing the financial pressure on providers – became the most important part of the health policy programme of the opposition parties. In anticipation of such a policy reversal after the elections, the sickness funds undermined the implementation of the de jure end of forcing providers to limit their income for the sake of cost-containment. They refused to sign contracts but agreed they would re-consider this standpoint after the election, i.e. if the government had remained in power. Regarding the instruments addressing the relationship between the insured and the funds, however, the picture was less clear: some sickness funds exercised the right to introduce “no claims” bonuses while deductibles or higher co-payments were not introduced. Due to public dissatisfaction and the expected variation in co-payment rates, the government itself postponed the enforcement of its proposal, i.e. to link an increase in the contribution rate of a sickness fund to higher co-payments for the members of that fund.
Act to Strengthen Solidarity in SHI After the change of government in the autumn of 1998, the Act to Strengthen Solidarity in SHI reversed the above-mentioned changes that were not in line with traditional approaches (marked with an asterisk above). In addition, co-payment rates for pharmaceuticals and dentures were lowered and budgets or spending caps reintroduced for the relevant sectors of health care – and in the case of dental care defined more strictly than ever before. Dental care received particular attention in 1998: even though charges were legally limited for an initial period of three years after privatization of dental care, a large number of dentists overcharged from the beginning. This behaviour, together with the restrictions on the benefits catalogue and the offers of private insurers to sell new insurance policies, contributed to a growing level of dissatisfaction amongst the population.
Development perspectives: Reform Act of SHI 2000 After the short-term Act to Strengthen Solidarity in SHI, the current government introduced a new medium- to long-term reform into parliament in June 1999, which was passed in a modified form in December 1999. This Reform Act of SHI 2000 has been effective since January 2000. This reform tries to pick up many of the system’s weaknesses (see Conclusions in the following section). Its key features are as follows: • Removal of ineffective or disputed technologies and pharmaceuticals from the sickness funds benefits catalogue: A number of measures have been introduced in this area including strengthening health technology assessment through the establishment of a new unit within DIMDI to inform decision-makers (especially those in the corporatist institutions) about the effectiveness and cost-effectiveness of health technologies. The regulations concerning the – more or less inactive – joint committee of dentists and sickness funds will be tightened. This means that the ministry can set these committees deadlines for the evaluation of technologies for inclusion or exclusion from the benefits catalogue. In addition, decision-making under corporatist arrangements is extended to the hospital sector by establishing a Committee for Hospital Care as well as a Coordinating Committee. While these measures are on the whole undisputed (or rather go unnoticed by the public), the third measure, that is the introduction of a positive list of reimbursable drugs, has been opposed by the pharmaceutical industry, especially the smaller companies with a high percentage of disputed products. The Federal Ministry of Health is now authorized to issue a positive list upon approval by the Federal Council. A nine-person commission consisting of experts in clinical medicine and pharmacology will be charged with its preparation. The measures addressing the benefits’ catalogue are accom-panied by mandatory treatment guidelines and new quality assurance regulations. • Improvements to the cooperation of general practitioners, ambulatory specialists and hospitals: In this respect, the new act allows contracts between sickness funds and providers which cross the line between the ambulatory and the inpatient sectors. For example, a group of providers could contract with funds to provide both kinds of care. To promote a (volun-tary) gatekeeping function amongst general practitioners, the act allows sickness funds

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| | to give their members a bonus if they access specialists via their general practitioner. • Budgets and reimbursement:The proposal called for the introduction of global budgets for sickness funds through which they would have been legally obliged to spend only as much money as they receive through contributions. In addition, it called for a change in hospital financing from the dual approach (i.e. where hospital investment costs are financed by the Länder and recurrent costs by the sickness funds) to a monistic way (i.e. one in which the sickness funds would have to cover all costs including capital costs) – through a new case-fee system covering all patients. In ambulatory care, the budget for general practitioners will be separated from that for ambulatory specialists. The financing and reimbursement aspects of this reform received by far the largest public attention. While most actors said that they agreed in principle with the aim of these measures, they were opposed to different elements. The physicians presented the fiercest opposition to the global budget. They openly threatened to ration benefits by putting patients on waiting lists for drugs and procedures (which had been unknown up until now except for transplants). The physicians, however, were divided about the issue of separate budgets for general practitioners. Both physicians and hospitals were afraid that they might be the losers if certain parts of their budgets were used for transsectoral contracts. The employees of physicians' practices and hospitals threatened industrial action because they were afraid that jobs might be cut as a result of the global budget. The sickness funds welcomed global budgets and, in principle, also the monistic financing of hospitals but insisted on having the power to plan hospital capacities as well. The Länder, while happy to leave capital financing to the sickness funds, wanted to retain their power to decide upon hospital capacities. In the end, the act finally passed did not contain a requirement for global budgets but retained sectoral budgets which will be reduced by the expenditure necessary to finance care delivered under transsectoral contracts. The proposal to change hospital financing to a monistic approach failed in the Federal Council. As far as the reimbursement of the running costs is concerned, from 2003, a new payment system based on uniform case-fees taking complexities and co-morbidities into account will replace the current mixed system of per diems, which vary between hospitals, uniform case fees and procedure fees. Psychiatry will remain the only specialty exempted from the new reimbursement system. As proposed, the ambulatory care budgets will be divided between primary care physicians and specialists; the actual division will be determined by the Valuation Committee. |
| ***Source*** | European Observatory on Health Care Systems ***Year*** 2000 |
| ***Code*** | 17.2.1 |
| ***Description*** | future development of planning: move to be integrated/move to contract based |
| ***Contents*** | |
| ***Source*** | European Observatory on Health Care Systems ***Year*** 2000 |
| ***Code*** | 17.2.2 |
| ***Description*** | tax based system: change in population coverage; opting out permitted/encouraged |
| ***Contents*** | |
| ***Source*** | European Observatory on Health Care Systems ***Year*** 2000 |
| ***Code*** | 17.2.3 |
| ***Description*** | insurance based system: development of the degree of benefit coverage in the future |
| ***Contents*** | |
| ***Source*** | European Observatory on Health Care Systems ***Year*** 2000 |

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|---|---|---|---|
| ***Code*** | 17.2.4 | | |
| ***Description*** | voluntary health insurance: changes in uptake; plans for change | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 2000 |

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|---|---|---|---|
| ***Code*** | 17.3 | | |
| ***Description*** | Health for all policy | | |
| ***Contents*** | Other health (care) objectives – health for all As mentioned, public health in Germany is mainly a responsibility of the Länder. Public health services are organized under their supervision and are outside the scope of the SHI system. However, priority-setting in this area does not seem to be high on the agenda. Only one Land (North Rhine-Westphalia) has set targets for public health. It passed a set of ten health targets in 1994, which follow some of the WHO health for all targets but are more detailed in naming specific responsibilities of specific institutions and groups. Other Länder have initiated their own targets since 1997/1998. The German discussion about WHO's health for all by the year 2000 pro-gramme was initially rather short. An extensive book on urgent health needs of the population in Germany (FRG) and subsequent objectives and targets did not lead to a change in health policies, possibly since they were published at a time when both the public and the politicians were preoccupied with other (i.e. unification-related) problems. The only visible outcome of the debate was the mandate contained in the 1989 Health Care Reform Act that sickness funds should undertake health promotion activities. Health objectives and targets gained (renewed) attention early in 1997 when the sickness funds were looking for new ways of competing. Health promotion having been legally abolished at the end of 1996, health care targets was the only remaining area in which the benefits' catalogues differed between funds. A senior manager of the federal association of company-based sickness funds proposed that sickness funds set their own individual health care targets which they should try to pursue through managed care and disease management tools. Health system analysts supported the use of health care targets by the sickness funds but argued for common targets on which sickness funds' performance could be judged. | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 2000 |

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|---|---|---|---|
| ***Code*** | 17.4 | | |
| ***Description*** | Reform implementation | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 2000 |

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| ***Code*** | 17.5 |
| ***Description*** | Conclusions |
| ***Contents*** | Conclusions The German system puts more emphasis on free access, high numbers of providers and technological equipment than on cost effectiveness or cost-containment per se (in spite of all the cost-containment acts which have been passed). The public supports these priorities and, if they are used as criteria for assessing the system the German system of health care appears to work well. Waiting lists and explicit rationing decisions are virtually unknown. These priorities are further supported by the complicated decision-making processes. While the framework for the statutory health insurance system and co-payment levels are set by law at the national level, most decisions on the actual contents of the uniform benefits catalogue and the delivery of curative health services are made through joint negotiations between the associations of the physicians and the sickness funds both at regional and national levels. Cuts would therefore require the (unlikely) support of both the sickness funds and the providers. Only those bodies outside the corporate field such as the Advisory Council have proposed a stricter and more unpopular approach. Currently, however, a shift has begun towards evidence-based medicine, health technology assessment etc. as well as support for cuts in benefits according to such evidence. The most important topics for current and future reforms are: financing and reimbursement, health technology assessment (HTA), the fragmentation of health care between sectors and payers and collectivism versus competition. Financing and reimbursement: A major controversy centres on the financial situation of SHI. There is now growing recognition of the fact that the perceived cost explosion in German health care never happened. This perception has led to efforts to contain costs and the policy of income-oriented expenditure in health care with the aim of stabilizing contribution rates. Although the absolute amount of health care expenditure has increased fivefold since 1970, health care expenditure as a percentage of GDP has remained relatively stable – at least until reunification. This is even more remarkable, since a number of new services had been introduced in health care, such as prevention measures. It is now perceived that there is a financing crisis rather than an expenditure crisis or cost explosion. Two facts are especially relevant to this matter. Firstly, the high level of unemployment narrows the financial basis of the social insurance system. Secondly, labour is responsible for an ever-decreasing share of the national income while the share of capital is increasing in parallel. These factors result in a relative reduction in the financial flow to the social insurance system, since contributions are based only on labour. However, due to reunification, health care expenditure as a percentage of GDP has risen substantially (and now remains at a higher level) since health care costs per capita are almost the same in the eastern as in the western part of Germany while GDP is not. Cost-containment will therefore remain high on the political agenda and budgets appear to be here for the foreseeable future. Another focus will be on changes to the reimbursement mechanisms that currently favour unnecessary or excessive treatments, such as the remaining per diem charges in hospitals which will be replaced by an all-encompassing case-based system from 2003. Health Technology Assessment: There are considerable inconsistencies in different health care sectors regarding the regulation of health technologies in Germany as well as the licensing, coverage and steering of diffusion and use of technologies. In general, the ambulatory sector is much more heavily regulated than the hospital sector in terms of coverage decisions and diffusion and use of technologies. Licensing, as a prerequisite for providing services to be reimbursed by the SHI, applies to pharmaceuticals and medical devices (independently of the health care sector in which they are used). While almost all licensed pharma-ceuticals are covered by the SHI, coverage decisions for medical and surgical procedures in the ambulatory care sector are made explicitly through a joint commission of sickness funds and physicians. Explicit coverage decisions are currently non-existent for the hospital sector regarding medical and surgical procedures. This is due to the fact that coverage of medical devices and expensive medical equipment falls under budget negotiations at hospital level and hospital plans at state level. Services provided by non-physician professionals, such as physiotherapy are explicitly excluded by law or are covered through collective contracts. The future direction, as laid out in the Reform Act of SHI 2000, is both to extend existing health technology assessment mechanisms to other sectors, especially the hospital sector, and also to ensure that assessments and coverage decisions are coordinated between sectors. In addition, the new treatment guidelines are an attempt to steer the appropriate use of technologies. Separation between sectors: One definite weakness is the fragmentation of the German system, especially the separation between the SHI and the Social Retirement Insurance (which covers the majority of rehabilitative care) on the one hand and between ambulatory care and inpatient care on the other hand. There is also the separation of inpatient care and rehabilitative care from long-term care, which has a long tradition and involves different actors. The exact extent of the duplication of services and the number of inappropriate referrals which are either made too early (due to sectoral budgets) or too late (due to difficulties in communication) are not exactly quantifiable. There is however a broad consensus that there are, at least potentially, negative consequences for patients. Related to the separation issue is the weak role of primary care and the absence of gatekeepers (e.g. general practitioners) to steer the patient through |

the system. The sickness funds are ambiguous about this issue: on the one hand, they claim to support gatekeeping by primary practitioners, on the other hand, many of their “disease management” and other models may be intended to increase their own role in gatekeeping. The Reform Act of SHI 2000 has addressed these issues firstly by allowing contracts between the sickness funds and intrasectoral groups of providers and secondly by giving the funds the option to introduce gatekeeping on a voluntary basis. The future direction of reform is to increase the role of general practitioners which requires a strengthening of their position vis-à-vis office-based specialists; improvement of training for guiding patients through the system; and finally, increase awareness in the population about the ability of the general practi-tioners to guide them. Office-based specialists, on the other hand, will increasingly have to face competition with the hospital sector, which will gradually provide more and more ambulatory treatment. While this would open new opportunities for the hospitals to compensate losses from further reduced inpatient capacities, it will further aggravate the problem of large, often duplicate capacities for specialized ambulatory care. Future health care reforms will probably have to deal with this issue, which requires a consensus between all actors including the Länder. Collectivism versus competition: Throughout the history of the German statutory health insurance system, regulations have become much more uniform. In the late nineteenth century, individual sickness funds contracted with individual physicians. Later, individual sickness funds contracted with physicians’ associations. Then, certain sickness funds negotiated together but differences remained between the so-called primary funds and the substitute funds. The 1989 Health Care Reform Act was an attempt to strengthen the purchasers’ side by standardizing and centralizing all negotiating procedures while at the same time standardizing the benefits catalogue. By introducing a risk compensation mechanism, the 1993 Health Care Structure Act led to a narrowing of differences in contribution rates. The Act also introduced free choice of funds for members and therefore competition between funds. True market competition is not possible, however, since the sickness funds have to offer (almost) the same benefits for a very similar contribution rate; in addition, the range of providers is also the same since they are contracted collectively. In this situation it is not surprising that funds – particularly the more successful ones in terms of gaining new members – are demanding greater flexibility for selective contracting. Health policy-makers are cautiously supporting them while trying to retain a system with equal access and service quality for all the insured population. Possibilities for selective contracting are therefore increased only gradually, e.g. in the latest Reform Act of SHI 2000 by removing the requirement to get approval to contract selectively from the respective physicians’ association. Recent preliminary court verdicts have supported the move towards selective contracting for the reason that joint decisions of sickness funds constitute monopoly power. The issue will remain a case for debate in future.

| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 2000 |
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# Country profile: Greece

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| **Code** | 1 |
| **Description** | Introduction and historical background |
| **Contents** | |
| **Source** | European Observatory on Health Care Systems **Year** 1996 |

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| **Code** | 1.1 |
| **Description** | Introductory overview |
| **Contents** | Greece, or the Hellenic Republic as it is officially called, lies at the southernmost end of the Balkan peninsula. It covers an area of 131 957 km2. It is bordered to the north-west by Albania, to the north by the Former Yugoslav Republic of Macedonia and by Bulgaria, to the north-east by Turkey, to the east by the Aegean Sea, to the south by the Mediterranean Sea, and to the west by the Ionian Sea. Greece's topography is highly diverse. The numerous islands in the Aegean and Ionian Seas occupy about one-fifth of its territory. Much of the land is mountainous and rugged, less than a fourth is lowland, and about one-fifth is forested.<br><br>Greece's population according to the 1991 census was 10 259 900, giving an overall population density of about 78 persons per km2. The capital is Athens, with a population of about 3 400 000.<br>The majority of Greeks (about 97%) belong to the Greek Orthodox Church, while there are small groups of Moslems, Jews, Roman Catholics and Protestants. In recent years there has been a large influx of illegal immigrants, mainly from Albania, and to a lesser extent from Poland, Romania, Russia and other eastern European countries.<br><br>Agriculture in Greece employs about 24% of the work force and accounts for about 11% of the gross domestic product (GDP). The main crops include wheat, tomatoes, corn, grapes, olives, potatoes, barley and fruits. Pastures, which occupy about two-fifths of the land area support sheep, goats and cattle. Industry employs about 26% of the workforce, and accounts for nearly 30% of the GDP. Main products are food, beverages, textiles, chemicals, clothing and transport equipment. Tourism and shipping are major sources of income. Fishing is relatively limited, and mining is of minor importance to the economy.<br><br>Natural resources include lignite, bauxite, iron ore, zinc and lead, and a few offshore petroleum and natural gas fields. The deposits of bauxite and iron ore are rich in metal content, but lignite is of low quality and there are no coal deposits. Less than one-third of the land is arable, the rest consisting mainly of barren mountains. Forests have been depleted and soil erosion makes reforestation difficult.<br><br>Greece is a parliamentary democracy with a 300-member unicameral Parliament whose majority party leader is the Prime Minister. The President, elected by Parliament, holds a largely ceremonial position. The largest political parties in the 1980s and 1990s are the Panhellenic Socialist Movement (PASOK) and New Democracy (about 80% of the vote in elections of recent years).<br><br>Education is free and compulsory for nine years (ages 6 through 15). The literacy rate is 94%. Life expectancy in Greece is among the highest in Europe and in the world. |
| **Source** | European Observatory on Health Care Systems **Year** 1996 |

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| ***Code*** | 1.2 |
| ***Description*** | Historical background |
| ***Contents*** | Following Greek independence in 1830 and until the end of the nineteenth century, no more than 10% of the active Greek population had coverage for health care by any type of statutory body. In 1922 The Ministry of Hygiene and Social Welfare was established. The level of care provided at that time was rudimentary compared to that in other European countries. Municipalities and communities controlled the few existing municipal and communal hospitals, while some large hospital institutions were controlled by the state at national level. Some private hospitals were also in existence.<br><br>The first serious governmental action intended to increase coverage of the population involved the establishment of the Social Security Organization (IKA) in 1934. This was to provide health and pension coverage to blue- and white-collar workers in urban areas and in industries employing more than seventy workers, and resulted in coverage of approximately one-third of the population.<br><br>In 1941 temporary public hospitals were established to serve the war needs, and remained thereafter.<br><br>The next major step followed in 1953 with legislation intended to establish a National Health Service. The target was to decentralize health care competencies to the health regions and through them to the district health councils. Regional health councils would provide expert opinion on health care needs based on population, morbidity, etc. criteria, and would provide for the necessary equipment and building installations. Although the system foreseen by the legislation was hospital- and physician-based, it presented for the first time the perception of a needs-based approach to the health care system. However, the law was never implemented and in practice the opportunity was lost.<br><br>The 1960s saw a period of rapid economic growth during which a number of financial institutions, such as banks, established their own insurance funds financed mainly out of employer contributions. These funds provided full and high quality insurance coverage for their employees. During this period, social health insurance schemes were also established for public sector employees and self-employed professionals. Farmers and their families, who at that time comprised more than 50% of the Greek population, were for the first time provided with coverage in 1961 when legislation establishing the Agricultural Insurance Organization (OGA) was passed and subsequently implemented. This was the second major landmark after the earlier establishment of IKA covering blue- and white-collar workers. In addition, a network of rural medical stations was established, staffed mainly by a doctor (a graduate of a medical school doing one year of obligatory service), a nurse and a midwife.<br><br>Despite very high rates of economic growth during the 1960s and 1970s, public health care expenditure remained less than 2.5% of the GDP. With the exception of IKA, which developed its own health care infrastructure for its insured population, mainly in urban areas, all insurance funds contracted health care services from private specialist physicians in the case of primary health care services, and from public or private hospitals in the case of secondary care. Thus, the private sector expanded rapidly during that period due to the growth in numbers of physicians in solo private practice, as well as the erection of many small-scale private hospitals. The state, on the other hand, had only developed some public hospitals in large cities, while continuing to subsidize a number of charity hospitals.<br><br>The dictatorship of 1967–1974 tended to consolidate this pattern of health care services, although it was during this period that the first attempts to organize a comprehensive health care system emerged. In 1968, a plan for health care reform (L. Patras plan) was presented by the Ministry of Health with the following aims:<br><br>* expansion of the public sector in the provision of services through the establishment of new public hospitals;<br>* geographical redistribution of services in order to reduce regional inequalities;<br>* improvement in health care services for the rural population;<br>* the introduction of a family doctor system;<br>* efforts to cope with the great shortage in nursing personnel;<br>* improvements in environmental programmes;<br>* improvements in the levels and quality of psychiatric care.<br><br>In addition, the first proposals for a National Health Service were made by the Minister of Health, aiming at the harmonization of insurance fund regulations and the introduction of an agency that would be the sole source of funding. This agency would accumulate all insurance contributions and reimburse physicians and hospitals on a fee-for-service basis following |

negotiations with the medical associations. There were also provisions for the geographical redistribution of resources, and the introduction of a system of primary health care based on general practitioners who would gradually replace private specialists.

By the end of the planning period (1973), only a small portion of the health care reform plan had been implemented, public expenditures on health care had actually dropped, while the proposals on the establishment of a National Health Service were abandoned.

Following the restoration of democracy in 1974, political and social pressures as well as the growing numbers of problems in the health care system intensified the need for health care reform, making this an issue of high priority for the new government. In 1976, a working party of the Centre of Planning and Economic Research (KEPE) prepared a study on the health care system, indicating the main problems and proposing measures for their solution similar to the ones noted above. According to this study the main problems included the following:

* lack of harmonization of finance and coverage;
* geographical inequalities in the provision of services, especially between rural and urban areas;
* large gaps in the provision of services in the rural areas;
* absence of capital development in public hospitals;
* lack of coordination between the Ministry of Health and other governmental bodies;
* methods of payment that encouraged inefficient and unethical practices, creating conditions for the development of an underground economy in the health sector.

The working party proposed the unification of the services of the three major insurance schemes (IKA, OGA, and TEVE explained in detail in the social insurance funds section) which covered about 85% of the population as well as any others who wanted to join, the creation of a unified fund, and the introduction of a family doctor system. However, due to political and medical opposition, the proposals were never passed into legislation.

Four years later (1980), a team of experts in the Ministry of Health worked out a plan for the reorganization of the system (Doxiades Plan). The plan anticipated the creation of a planning agency for the coordination of health care provision and the development of a network of rural health centres, staffed mainly by family doctors. When the plan came as a bill to Parliament, it faced strong opposition both by physicians and members of Parliament, and was rejected without any discussion.

In 1981 the Socialist Party (PASOK) came to power and the prevailing conditions were mature for a radical change of the Greek health care system. The main core of proposals remained almost unchanged and thus in 1983 the government passed legislation incorporating these and introducing a national health service (NHS). This law can be characterized as the major legislative reform ever attempted in the Greek health care system. The provisions of this reform, as well as the extent of its implementation, will be discussed in some detail here as these set the background for the description of the various aspects of the Greek health care system in the sections that follow. The reform embodied the following principles:

* Equity in the delivery and financing of health care services: There was to be universal coverage and equal access to health services; the state was to be fully responsible for the provision of services to the population.

* Primary health care development: Special emphasis was to be placed on the development of primary health care; a system of referral was to be established.

* A new public-private mix in provision: Primary and secondary health care services were to be provided mainly by public health centres staffed by general practitioners, and by public hospitals; publicly provided health care services were to be expanded (health centres, new teaching hospitals, expansion of existing hospitals, new technology, increase in capital expenditures, etc.); establishment of new private hospitals was to be prohibited, while those already in existence were to either close or be sold to the public sector.

* Decentralization in the planning process, improvements in management, and community participation: A Central Health Council (KESY) was to be established, which would play an advisory role to the Ministry of Health on health policy and research issues. Health councils were to be established at regional level with planning and administrative responsibilities. The members of these bodies were to be representatives from the insurance funds, health care providers, trade unions, medical schools, the Ministry of Health, etc.

* Payment methods for health care providers: NHS doctors and other staff would be fully and exclusively employed by the NHS, and would be paid by salary.

Based on the above principles, the 1983 legislation provided for the establishment of health

centres in rural as well as urban areas. These were to be staffed mainly by general practitioners and other health professionals, providing comprehensive primary health care services and implementing health promotion and disease prevention programmes within their respective communities. The health centres were to be attached to a local or regional hospital and patients referred to the hospital by the health centre's doctors.

In addition, the 1983 legislation anticipated the unification of the main insurance funds (though this was not made wholly explicit) with the infrastructure of IKA (the main insurance fund, covering 50% of the population) incorporated with that of the NHS. Moreover, no doctors working in the NHS were permitted to practise privately. Doctors, therefore, had to choose between exclusively salaried employment in the public sector or totally private employment. It was envisaged that this measure would reduce private health care expenditure and eliminate unethical practices by doctors.

Implementation of this legislation was to begin immediately and the following steps were to be taken in the period 1983–1988:

* substantial increase of public health expenditure: at least 4.5–5% of GDP was to be devoted to health;
* substantial increases in the salaries of doctors;
* substantial increase in public expenditure on capital outlays: 18 new hospitals were to be built, 3 of which were to be large regional university hospitals; 20 already existing hospitals were to be expanded; advanced technology was to be installed in provincial hospitals; 400 health centres were to be built, of which 180 were to be in rural and 220 in urban areas;
* definition (in the near future) of the financial relationship between the NHS and the insurance funds.

The 1983 legislation and plans for its implementation were, however, only partially followed through:

* The rural health centres were established, equipped and staffed, and began operation as planned; in urban areas no health centres were established. Today 176 rural health centres and 19 small hospital-health centres operate, covering the primary health care needs of about 2.5 million persons. However, staffing of the rural centres is considered inadequate. In urban areas, primary health care services are provided mainly by IKA polyclinics for IKA members. There are also private providers who are contracted to the various insurance funds and hospitals (see the section on primary health care for more details). In 1987 there was a plan for IKA services to merge with the NHS, however, this plan was never implemented;

* Three large university hospitals were established (Ioannina, Patras and Crete), and certain improvements in hospitals and hospital departments were undertaken. In the private sector a large number of clinics were closed down or absorbed by the public sector and the establishment of new hospitals was prohibited. As a result, the number of hospitals actually declined and the ratio of private to public hospital beds shifted in favour of the latter. However, the establishment of private diagnostic centres was permitted and a large number opened during the 1980s and 1990s. As a result of the expansion in diagnostic centres, most of which have contracts with insurance funds, the insurance fund budgets have been heavily burdened through the provision of expensive and unnecessary diagnostic services induced mainly by doctors employed by the insurance funds;

* The employment of doctors exclusively by the NHS became a major issue. According to the law, doctors employed by the NHS were not allowed to exercise private practice. Their salaries were almost doubled but the restrictions on private practice were never strictly enforced with the result that the practice continued;

* The unification of the major funds and the establishment of a common fund never materialized. The mechanisms of financing and reimbursement remained unchanged. The Ministry of Health continued to determine premium levels and fees paid by the insurance funds to the health care providers. These fees were lower than the actual costs, especially in the case of hospital care, with the result that hospital budgets became increasingly dependent on government subsidies. The ratio of budget to insurance fund financing of hospitals changed from 40:60 in the 1970s and early 1980s, to 88:12 in the early 1990s. Whereas financing responsibility shifted substantially toward the state, in practice there was no change in the relationship between the NHS and the insurance funds and the funds continued to operate as before;

* The establishment of rural health centres represented the biggest project in the country to develop primary health care, but in fact this process stopped short with the failure to implement this portion of the 1983 legislation in urban areas, as well as with the failure to implement a referral system anywhere in the country;

* Decentralization in the planning process never materialized. A Central Health Council was established, but its role is minimal. The regional health councils were never established.

The decade of the 1980s was devoted mainly to implementation of portions of the 1983 legislation, the establishment of the NHS and the expansion of public health services. In the early 1990s, the emphasis shifted in the direction of managerial and market changes due to macroeconomic constraints and ideological and political changes. In 1992, the conservative government introduced new reforms that altered some of the provisions of the 1983 legislation. Specifically these were as follows:

* Primary health care centres previously financed through hospital budgets now became autonomous and financed through district health budgets;
* Doctors employed in public hospitals became free to choose full- or part-time employment within the NHS, allowing some private practice;
* The establishment of new private for-profit hospitals and clinics was once again permitted, with certain requirements concerning quality of services;
* Patients' freedom of choice and initiative were emphasized.

In addition to this legislation, other adjustments made in this period included the imposition of certain co-payments and fees in the case of drugs and visits to out-patient hospital departments and in-patient admissions. The most important measure in this period involved a huge increase in per diem hospital reimbursement rates (by 600%) which created deficits in the insurance funds for the first time.

The problems of the Greek health care system that have led to numerous efforts to initiate radical reforms persist to the present day, and are now held to be more pressing than ever. Another major reform proposal was put forward in 1995–1996, in an attempt to deal with all the major shortcomings of the system that the 1983 reform failed to resolve. This will be discussed in the section on health care reforms.

***Source*** European Observatory on Health Care Systems ***Year*** 1996

***Code*** 2

***Description*** Main functions of key bodies in the organizational structure and management of health care administration

***Contents***

***Source*** European Observatory on Health Care Systems ***Year*** 1996

| | |
|---|---|
| ***Code*** | 2.1 |
| ***Description*** | (Con-)Federal/National government, Ministry with main responsibility for health care and other ministries with health care competence |
| ***Contents*** | The Ministry of Health and Welfare is the leading institution in developing and financing health policies. The Ministry is responsible for provision and financing of the National Health Service as well as health and social services for the poor, the elderly and the disabled; a very small part of health and social services is provided by municipal authorities. Local authorities (52 districts or prefectures), through the Ministry of Health, play a limited role in the administration of 128 NHS hospitals and 176 rural health centres. The Central Health Council (KESY) and Committees for AIDS, Drugs, Cancer, etc., play an advisory role to the Minister.<br>Central administration<br>The Ministry of Health and Welfare, through its central and regional services, has the responsibility of planning and implementing health-related activities for public health, medical care and social welfare (social security was separated from the Ministry of Health in September 1995). The Ministry also coordinates health-related programme activities of private institutions and individuals. The central administration consists of the Minister, two Under-Secretaries of State and two Secretaries General (one for health and one for welfare) on the political side. On the managerial side, there are three general directorates: one for public health and medical care; one for administration of the Ministry and the entire system; and one for welfare. There has been much discussion about establishing a new general directorate for NHS management, taking the responsibilities related to the health care services from the three directorates, particularly the first two. The main factor favouring this change is that under the present structure there is no clear vision for public health and health care. The current management structure arranges the various services of the Ministry of Health and Welfare under its three directorates:<br><br>Directorate General of Health:<br><br>* public health<br>* environmental health<br>* primary health care<br>* development of hospital units and blood donation<br>* mental health<br>* medicines and pharmacies<br>* health professions<br>* medical care of civil servants.<br><br>Directorate General of Welfare:<br><br>* social housing and development of welfare units and professions<br>* family and child protection<br>* social work and welfare<br>* elderly and disabled people.<br><br>Directorate General of Administrative Support:<br><br>* personnel<br>* education<br>* organization and procedures<br>* informatics<br>* finance<br>* property evaluation<br>* biomedical technology<br>* technical services<br>* international relations<br>* health education and information<br>* civil planning for emergency<br>* European Union (EU) and other project development.<br><br>There are a few services subordinated directly to the Minister (legal coordination sector, press office and public relations, secretariat of the Central Health Council, strategic planning and policy analysis unit, and offices for problems due to drug use, and related to equity of the sexes) as well as services functioning under special provisions (office of audit board, statistical service, etc.).<br><br>The Central Health Council (KESY) was established following the 1983 reform. KESY functions as adviser to the Minister on health policy matters especially in the field of the structure and the function of the NHS. KESY is composed of: |

* 3 representatives from the Pan-Hellenic Medical Association (PMA)
* 14 representatives from the health profession trade unions and university faculties
* 2 senior officers from the Ministry of Health
* 2 governors of the biggest social insurance funds (IKA, OGA)
* the Chairman of the National Drug Organization
* 3 members appointed by the Minister of Health and Welfare from the scientific and social fields.

The Chairman of KESY is elected only by the medical members of the Council. Several councils and committees work under KESY. Until now, KESY has not managed to produce innovative policies and programmes for the NHS or to establish new regional bodies foreseen by the 1983 legislation. Mainly due to its medically-oriented composition, KESY has focused particularly on the medical field, at the expense of the other professions and interests of the health care system.

In September 1995, the Ministry of Labour and Social Insurance took over the supervision of the operation and financing of social insurance funds and the services they provide. This was previously the responsibility of the Ministry of Health, Welfare and Social Insurance, which subsequently became known as the Ministry of Health and Welfare. The Ministry of Defence is responsible for the financing and management of 13 military hospitals which have remained outside the NHS, while the responsibility for the health of prisoners rests with the Ministry of Justice.

As a result of the 1983 legislative framework, the health-related functions of other Ministries were taken over by the Ministry of Health, which shared joint responsibility with the other Ministries for these areas. The areas concerned were: environmental health with the Ministry of Environment and Public Works; medical education with the Ministry of Education; occupational health with the Ministry of Labour, and nutrition with the Ministry of Agriculture. Thus, theoretically, the Ministry of Health and Welfare is charged with the responsibility for developing health policy in all these areas. In reality, some overlaps between Ministries result in excessively bureaucratic procedures and delays in decision-making, due to unclear lines of responsibilities among ministers and officials.

***Source*** European Observatory on Health Care Systems ***Year*** 1996

***Code*** 2.2

***Description*** Regional government

***Contents***

***Source*** European Observatory on Health Care Systems ***Year*** 1996

***Code*** 2.3

***Description*** Local government

***Contents***

***Source*** European Observatory on Health Care Systems ***Year*** 1996

| | |
|---|---|
| ***Code*** | 2.4 |
| ***Description*** | Insurance organisations |
| ***Contents*** | The insurance funds (IKA, OGA, TEVE, and others) have been under the jurisdiction of the Ministry of Labour and Social Insurance since September 1995. They play a significant role in the provision and financing of ambulatory services. IKA, the largest social insurance fund (50% of the population) covering mainly blue- and white-collar workers, is responsible for the financing and provision of health care services through its wide and decentralized network of primary health care facilities (over 200 urban polyclinics and clinics). OGA, the second largest social insurance fund, covers farmers and their families (25% of the population) who use the NHS services (i.e. rural health centres). The rest of the funds provide health care services to their beneficiaries mainly through contracts with private physicians for the ambulatory sector, and public or private hospitals for secondary and tertiary health care services. Secondary and tertiary care is provided by NHS hospitals which are publicly owned and financed mainly by the state budget as well as by the insurance funds. Apart from the Ministry of Health and the social insurance funds, the private sector plays a significant role in health care provision.<br>Social insurance funds<br>Out of a total of about 300 different social insurance organizations, about 40 provide coverage against the risk of illness to nearly the whole Greek population. Membership of the funds is compulsory for the employed population and its dependants, and is based on occupation. Most of the funds are administered as public entities and operate under extensive control by the central government. The range of services covered, the type of doctors to whom access is permitted, and the contribution rates are at present determined by the Ministry of Labour and Social Insurance and the Ministry of National Economy; until September 1995 they were determined by the Ministry of Health, Welfare and Social Insurance. The determination of these issues tends to depend on the priorities of the government at a given point in time and on the extent of political pressure exerted by different occupational groups. During the 1980s, a number of small funds covering small occupational groups were merged by ministerial decrees which did not take into consideration the financial ability of the stronger funds to support the weaker ones.<br><br>The main groups of social insurance organizations, the size of population covered, and occupational groups covered are as follows:<br><br>* IKA (Institute of Social Insurance): 50% of the population; urban population, i.e. blue- and white-collar workers;<br>* OGA (Organization of Agricultural Insurance): 25% of the population; rural population (i.e. agricultural workers);<br>* Civil servants: 7% of the population;<br>* TEVE-TAE (Fund for Merchants, Manufacturers and Small Businessmen): 13% of the population; merchants, manufacturers and shop owners;<br>* OTE, DEH, banks: 2.5% of the population; telecommunications, electricity and banking personnel.<br><br>IKA is the largest scheme in Greece and provides pension, sickness insurance and welfare benefits. Until 1982 its main sources of finances were employer and employee payroll contributions. Since 1982 the fund receives generous subsidies from the central budget. IKA provides services directly to its members. It employs doctors paid by salary to provide primary medical and dental services and owns a number of clinics where primary and secondary care are provided. But these facilities exist only in major urban centres and are not capable of satisfying the entire demand. Thus the scheme contracts out to some private doctors for primary health care services reimbursed on a fee-for-service basis. It also contracts out to a number of private clinics reimbursed on a per diem basis with additional fees for certain diagnostic and curative procedures. Its members can, in addition, receive free treatment at public hospitals which are reimbursed on the same lines as the private clinics. The prices of the services paid are determined by the Ministry of Health, and are subject to approval by the Ministry of Labour and Social Insurance.<br><br>OGA covers the rural population. It initially offered hospital care cover. Coverage for primary health care services started in the 1960s and is provided by the health care centres (built under the new system following the 1983 legislation) and a network of rural health stations and rural clinics, staffed by specialists and graduate doctors who are obliged to serve for at least one year in rural areas after their graduation. Coverage for pharmaceutical care was introduced in 1982. OGA is financed by earmarked general taxation; its members do not pay contributions and co-payment rates for the services provided are negligible, except in the case of drugs.<br><br>TEVE was created in 1934 in order to provide insurance coverage to shop owners and manufacturers. It covered a very limited range of primary health care services, mainly |

diagnostic tests and general practice services, until 1980 when the range of benefits expanded. It also covers hospital care and expenditure on pharmaceuticals. It is financed by its members' contributions which vary according to the insured person's occupation and income. The schemes of those employed in banks provide the greatest range of benefits. They are financed mainly by employer and employee contributions. Primary health care is provided by contracted private doctors and secondary care by public and private hospitals of the choice of the insured. The fund covers visits to doctors, and hospital, dental and pharmaceutical care.

The fund covering public employees started operating in 1963. It does not include everyone employed by the central government and the public agencies, because half of these persons are employed on a contract basis and are insured with IKA. The total number of those employed in the public sector (central government and other public entities and agencies) is not known. It is estimated that the scheme covers about 700 000 persons which includes public, civil and military employees and their dependants. In 1990 the various schemes for bank employees provided coverage for about 1.8% of the total insured population, while another 1% is covered by small funds for public utilities employees.

IKA, OGA and TEVE-TAE cover nearly 90% of the total insured population. About 9% of the total insured population is covered by the public sector, the public utilities and the bank schemes. The rest of the population is covered by the remaining large number of very small funds.

Every year the number of IKA members increases not only for demographic reasons or reasons related to employment trends in the occupations covered, but also because small insurance sickness funds are periodically incorporated into IKA. On the other hand, the number of persons insured by OGA has continuously decreased since 1989. The total number of insured persons and the total number of persons insured in funds supervised by the Ministry of Labour and Social Insurance exceed the total population of Greece, mainly because certain segments of the population are insured in more than one fund. It may be noted, too, that whereas most funds are financed by employer and employee contributions, OGA is financed mainly by the state through general (earmarked) taxation.

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| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1996 |

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|---|---|
| ***Code*** | 2.5 |
| ***Description*** | Professional groups |
| ***Contents*** | |

| | | | |
|---|---|---|---|
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1996 |

| | |
|---|---|
| ***Code*** | 2.6 |
| ***Description*** | Providers |
| ***Contents*** | |

| | | | |
|---|---|---|---|
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1996 |

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|---|---|
| ***Code*** | 2.7 |
| ***Description*** | Voluntary bodies |
| ***Contents*** | |

| | | | |
|---|---|---|---|
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1996 |

| | |
|---|---|
| ***Code*** | 3 |
| ***Description*** | Planning, regulation and management |
| ***Contents*** | The Greek health care system is highly centralized and regulated. Virtually every aspect relating to health care financing and provision is subject to control by the Ministry of Health. Moreover, the Ministry of Health has never seen its role as extending beyond the areas of financing and provision. Thus, while exercising (until recently) strong regulatory control over insurance funds and public hospitals (for example, with respect to appointments and budget approval), it is not involved in ongoing planning activities in numerous areas, including ensuring a minimum level of benefits to be provided by insurance funds; provision of health care services and facilities using needs-based criteria; planning of health care manpower; determining priorities with respect to patterns of care to be provided; determining priorities across regions; or allocating resources according to specific criteria.<br><br>Specifically, the Ministry of Health and the Government exercise strict regulation and control in the following areas:<br><br>* Social insurance funds, though self-governed bodies by law, are strongly regulated by the Ministry of Health and the Ministry of Social Insurance as well as the Ministry of National Economy. These ministries determine the range of services to be covered, contribution rates, and types of doctors to whom the insured have access. Key factors influencing the ministries' decisions are the government's prevailing priorities and the political pressure of different occupational groups.<br><br>* The Ministry of Health determines the number of personnel employed in hospitals, the skill mix, terms of employment and salary levels. Every appointment in the public health sector must be signed by the minister. Hospital administrators have very little leeway with respect to hospital management and organization, as these are regulated by law.<br><br>* The Ministry of Health approves all budgets. Financial management in all publicly provided services (hospitals, health centres and all other services) is strictly regulated, leaving no room for any kind of manoeuvre by hospital or other administrators.<br><br>* All administrators in public health care institutions are appointed on the basis of their political affiliation with the ruling party in the government, and not because of relevant training or other qualifications. There are in fact few trained administrators in the Ministry of Health, in public hospitals, or in any other public health-related institution.<br><br>* It is not only the Ministry of Health which has regulatory powers over health-related areas, but also other ministries, which often gives rise to conflicting priorities. The most striking example is in the area of pharmaceutical pricing, which is controlled by the Ministry of Trade.<br><br>The 1983 legislation had attempted to rectify some of the above shortcomings in two ways: through the establishment of the Central Health Council, which intended to play an advisory role to the ministry in the areas of health policy and research; and through provisions for the establishment of regional health councils with planning and administrative responsibilities. However, as the latter were never established, the Central Health Council has been seriously impeded in its ability to carry out its tasks. Moreover, the Ministry of Health has avoided employing health scientists on a permanent basis, and the resulting temporary committees have failed to produce any long-term plan that would be acceptable to the various ministries involved in health.<br><br>Nonetheless, some serious steps toward the development of planning activities have been undertaken very recently. Since the beginning of 1996, a major political goal has involved putting into effect a four-year plan for the two regions comprising the Aegean islands. Reasons leading to the selection of these regions include their remoteness from major urban centres, and the relative underdevelopment of health care services. Objectives of the plan are the following:<br><br>* reorganization of primary health care services;<br>* upgrading of hospital units;<br>* introduction of comprehensive emergency care services;<br>* introduction of specific public health activities (screening for women, trauma centres, retraining programmes for doctors in provision of emergency care in nonhospital settings).<br><br>Financing for the plan has been secured, and the plan has already gone into effect. The two regions in question have recently become members of WHO's Regions for Health Network.<br><br>Similar plans are currently under preparation for other areas of Greece. |

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| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1996 |

***Code*** 3.1

***Description*** Extent of system decentralisation (deconcentration, devolution, delegation, privatisation)

***Contents***

The structure of the NHS is based on the regional and district division of the country, i.e. the 13 regions and 52 prefectures or districts ("nomoi"). The average population size is 200 000 for the districts (excluding Athens and Thessaloniki) and 800 000 for the regions (excluding Athens). Each of the prefectures has at least one district hospital. Each of the regions should have (according to the 1983 plans) one regional hospital which is in most cases a university teaching hospital. However, at present only 7 of the 13 regions have large university teaching hospitals, while the remaining regions are served by the regional hospital of the nearest region in the case of tertiary care.

The 13 regions are in principle (based on the 1983 legislation) responsible for planning and coordinating regional development for the whole country. The government has appointed the Peripheral (Regional) Secretaries General since 1986, and also defined the composition of the regional councils. These comprise the Secretary General (Chairman), the prefects of the region and representatives from municipal authorities. Separate regional health councils, related to the Central Health Council, and regional health departments were introduced by the 1983 act to advise the government on the health needs of their local populations. These were intended to play a significant role in determining priorities and proposals for addressing local needs. However, due to lack of human resources (managers, scientists, etc.) and lack of a managerial structure, they have not become operational. Thus, the regions have no responsibilities at present.
The 52 districts, or prefectures, are responsible for the provision of a whole range of services to the population of their catchment area: education, social policy, public works, agriculture, sports, etc. The services also include primary and secondary health care, and public health services. With regard to health care, the prefectures have or have had a number of functions including:

* distributing the health budgets to the hospitals and other NHS providers in the prefecture as determined by the Ministry of Health and the Ministry of Finance;
* approving new personnel for these services, subject to further approval by the Ministry of Health;
* managing the provision and financing of health services offered to the public employees and the farmers;
* certain tasks of environmental and public health.

However, in practice, the administration of the whole system has for many years been run centrally, because of the low level of power given to the districts and discontinuities in policy due to political changes. Recent developments suggest that decentralization processes are about to begin.

Since 1 January 1995, the district mayor and the council have been elected directly by the population instead of being appointed by the state (Ministry of Internal Affairs). More recently, the government announced that the regional administration will be reorganized to permit the decentralization of certain responsibilities to the regional level in all areas of social services. This will bring control of health services and public health to the regional level, with central government retaining control of financing responsibilities. If this materializes in conjunction with the planned health care reforms, the decentralization of the health care system, in the form of deconcentration, will be set into motion.

As to the local level of the system, the municipalities and the communities play no significant role in the provision or financing of health care services, except in the large cities. For example, the Mayor of Athens has established four small primary health care centres to cover the first aid needs of the populations living in the four areas of the municipality of Athens (each with an average population of 200 000 inhabitants). Recently, other municipalities have taken initiatives to develop primary and social care services for their citizens.

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| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 3.2 | | |
| ***Description*** | Existence of national health planning agency/plan | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 3.3 | | |
| ***Description*** | Supervision of the health services | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 3.4 | | |
| ***Description*** | Financial resource allocation | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 3.4.1 | | |
| ***Description*** | Third party budget setting and resource allocation | | |
| ***Contents*** | Third-party budget setting and resource allocation<br>The third-party payers are mainly the government and the social insurance funds, as private insurance plays a comparatively small role in the financing of the system. The Greek health care system is a combination of the public contract model and the public integrated model. However, in view of the significant size of out-of-pocket payments, the voluntary out-of-pocket mode of finance and delivery is also relevant in characterizing the Greek system. | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 3.4.2 | | |
| ***Description*** | Determination of overall health budget | | |
| ***Contents*** | Resources for health care are allocated on a historical basis both at the central and the district level, with no other criteria playing a role in determining allocation. The state budget allocation for health is divided between expenditures incurred by the Ministry of Health and those incurred through the country's 52 districts. Each year, the previous year's allocation is adjusted by an amount equal to the rate of inflation plus new employment and investments. Central level expenditures include expenditures on administration, public health, insurance fund subsidies, subsidies to public hospitals, research expenditure, insurance services to civil servants, etc. The resources allocated through the districts include state administrative expenses for the civil servants employed in the health directorates of the districts, and mainly subsidies for public hospitals, health centres, rural doctors, and emergency services in the districts. | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 3.4.3 | | |
| ***Description*** | Determination of programme allocations | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 3.4.4 | | |
| ***Description*** | Determination of geographical allocations | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 3.4.5 | | |
| ***Description*** | Health care budget decision-making at national/regional/local level | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 3.4.6 | | |
| ***Description*** | Approach to capital planning | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 3.4.7 | | |
| ***Description*** | Capital investment funding | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 3.4.8 | | |
| ***Description*** | Recent changes in resource allocation system | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 4 | | |
| ***Description*** | General characteristics of the organizational structure | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 4.1 | | |
| ***Description*** | Integrated or contract model | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 4.2 | | |
| ***Description*** | Organisational relationship between third party payers and providers | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 4.3 | | |
| ***Description*** | Ownership: public, private, mix | | |
| ***Contents*** | The private sector<br>The 1983 changes to the system were intended to bring most of the voluntary portion of the health care system and a large part of private sector (especially in the case of secondary care) into the NHS. However, many Greeks not wholly satisfied with publicly provided services, turned to the private sector, especially in the case of primary health care. In the period 1983–1992 the establishment of new private hospitals was prohibited, and efforts were made to absorb at least a portion of private hospitals into the public sector. This policy was only partially successful, as some 200 small clinics with inadequate facilities and some 20 hospitals with luxury facilities and high quality staff resisted. They fought to survive by signing contracts with private insurance companies (a continuously growing sector) and more recently also with the social insurance funds. In 1992, the restriction on the establishment of private hospitals was removed. Since 1985, there has been significant growth in the establishment of private diagnostic centres by doctors and other health care professionals: there are currently about 200 such centres in the entire country. In addition, a significant portion of specialist care is offered by physicians in private practice, who are either contracted by various social insurance funds or paid directly by the patient on a private basis. Rehabilitation services (physiotherapists, etc.) and services for the elderly (geriatric homes) are predominantly offered by the private sector. The Ministry of Health and Welfare encounters many difficulties in its efforts to monitor the system, in the absence of regional health authorities and subsequent to the transfer of social insurance to the Ministry of Labour in 1995. | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 4.4 | | |
| ***Description*** | Freedom of choice | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 4.5 | | |
| ***Description*** | Referral system | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 5 | | |
| ***Description*** | Out-patient care | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 5.1 | | |
| ***Description*** | Medical care | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 5.1.1 | | |
| ***Description*** | General practitioner (solo-, group practices) | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 5.1.2 | | |
| ***Description*** | Medical specialist with own premises | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 5.1.3 | | |
| ***Description*** | Out-patient department | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1996 |

| | |
|---|---|
| ***Code*** | 5.1.4 |
| ***Description*** | Combined services: health centres |
| ***Contents*** | PHC provider settings<br>According to the 1983 health care reform legislation, primary health care (PHC) was to be provided by health centres and their provincial clinics in both rural and urban areas. This law, which for the most part is still valid today, laid the foundations for the first time for an NHS. In the area of PHC it anticipated the establishment of a sufficient number of health centres and provincial clinics, as decentralized units covering the health needs of all the citizens in the entire country. Nearly all the health centres envisaged by the legislation for rural areas were constructed and began to offer primary health care services during the 1980s. However, in the case of urban areas, the provisions of the law did not materialize, and the pre-reform situation remained unchanged. This essentially meant the continued operation of a variety of provider settings, both public and private, with significant inequalities in the range of services provided and in their quality.<br><br>The various primary health care provider settings can be classified as follows:<br><br>* PHC provided through the NHS: This includes health centres (in rural areas), provincial clinics, and public hospital out-patient departments. These services are financed mainly through the state budget, and to a smaller extent by insurance funds.<br><br>* PHC provided through social insurance funds: This includes polyclinics owned and operated by specific insurance funds (mainly IKA). These services are financed by the social insurance funds.<br><br>* PHC offered through local authority services: This category includes few clinics and welfare services. These services are financed by the state budget through the Ministry of Interior.<br><br>* PHC provided by the private sector: This includes physicians in private practice who are contracted with one or more insurance funds (financed by the respective insurance fund), physicians in private practice who are not contracted with any insurance fund (financed by out-of-pocket patient payments or voluntary health insurance), and private hospital out-patient departments (financed mainly by out-of-pocket payments or voluntary health insurance).<br><br>Each of the above will be discussed in turn.<br>PHC provided through the NHS<br>One-hundred-and-seventy-six health centres have been established in rural areas alone, with the intention of providing preventive, curative, and rehabilitation services to their catchment areas (14 000–15 000 population on average). Although they were intended to act as gatekeepers to the health care system, in fact this has not occurred. The health centres are staffed by doctors (who are mainly pathologists, paediatricians and a few general practitioners) and nurses, all of whom are full-time salaried employees of the state. On average there are seven beds per centre for one day of medical treatment. The number of doctors employed in each health centre depends on the size of its catchment area.<br><br>Following the 1983 reform, the construction of health centres was carried out quickly (1984–1986) and the equipment they were provided with was initially appropriate for the first stage of their operation. Health centres have in fact fulfilled their objective to increase access to PHC in rural areas at least in part, and they constitute an excellent organizational structure upon which to build an effective PHC service. However due to a number of staffing, financial and organizational problems, their actual performance has fallen short of expectations.<br><br>Specifically, most health centres suffer from inadequate staffing, as only 48% of foreseen medical positions were actually filled. It is difficult to recruit doctors in sufficient numbers because of living conditions in rural areas, fewer opportunities for private practice and generally low salaries. Moreover, since 1990 the Ministry of Health has recruited limited numbers of new health care personnel because of a general restriction on employing new public sector employees. The best staffed health centres are those close to major urban areas. The staffing shortages in professions other than doctors, though significant, are somewhat less serious (62% of nursing positions, 55% of paramedical positions, and 62% of administrative staff positions have been filled).<br><br>Most doctors working in health centres (roughly 70% of the total) are specialists, as training in general practice was not established until 1987 and is generally inadequate.<br><br>In addition, health centres have not had managerial and financial autonomy to develop their own policies. They are financed via hospital budgets and they are still administratively attached to district hospitals. They, therefore, have to compete for resources with the hospitals' clinical |

departments, and given their lack of financial autonomy, are not in a position to formulate their own priorities.

Despite these difficulties, there is evidence that health centres are becoming increasingly accepted by the public, and that the flow of rural patients to out-patient departments has been somewhat reduced.

About 1500 provincial clinics are administratively attached to health centres and are staffed by publicly employed rural doctors, who, in some cases, are assisted by nurses and midwives. Rural doctors are medical graduates who are required to spend at least one year in a rural area upon graduation. Their lack of clinical experience raises concern about the quality of the services they deliver.

The out-patient departments of public hospitals also fall into the category of NHS-provided PHC. These are a very significant provider of PHC services for urban populations (though of course anyone is free to use these providers). Out-patient departments operate on an appointment basis. All persons, irrespective of type of insurance coverage (or lack of coverage) are entitled to use these services.

PHC provided through social insurance funds

The 1983 legislation had made provisions to include the services and infrastructure of IKA (the largest insurance fund, covering roughly 50% of the population) as part of the NHS. This, however, never took place. IKA and a small number of other insurance funds own and operate their own primary health care facilities, where a number of specialists provide care to fund members that is free at the point of service. IKA offers by far the largest number of fund-owned PHC services through a broad and decentralized network of polyclinics and clinics. Doctors and other health care personnel are employed on the basis of a full- or part-time salary. IKA provides its members with a wide range of preventive, diagnostic and curative services, while most other funds provide a more limited range of services through their own facilities. Services not offered by fund facilities (whether IKA or other funds) are provided by public (NHS) hospitals and private providers, mainly specialists, who are contracted by the funds. Private physicians or diagnostic centres contracted by insurance funds are generally paid on a fee-for-service basis. In the case of remote areas where membership size is small and thus does not justify the construction of IKA facilities, IKA contracts rural doctors whom it pays on a capitation basis.

Problems faced by IKA in connection with its PHC services include the following:

* High accessibility without significant financial, organizational or administrative restrictions.

* Most visits are to specialists while visits to pathologists or family doctors are limited, thus resulting in ineffectiveness as there is no filtering mechanism.

* The quality of services is questionable as there are no quality control programmes. In a recent survey only four out of ten persons stated that they were satisfied with IKA services, whereas eight out of ten said they would prefer to be members of the Funds for Civil Servants, Bank Employees, or others, where there is full freedom of choice.

* There is a limited family physician system, and there is no referral system for hospital care from pathologists to specialists, thus making for lack of continuity in care and lack of guidance for the patient on how to use the health care system effectively.

* Many IKA patients also use private providers on a private basis because they do not trust IKA's health services or because they want a second opinion.

The OGA fund is a special case in that it is financed through the state budget, and its members, being agricultural workers, are provided with PHC services in the rural health centres.

PHC offered through local authorities' services

Some municipalities and communities offer social services (services for the elderly, and prevention and welfare centres), but in addition often provide preventive care and prescriptions. Some of the large municipalities have also begun to establish small clinics. The significance of these services is as yet very small and no data are available that show the aggregate volume of services offered. For example, some data collected for the municipality of Athens indicate that Athens has five consulting centres with 167 doctors of various specialties, 102 additional nursing and administrative staff, and microbiology laboratories.

PHC provided by the private sector

Because Greece has a large number of doctors relative to its population, many are obliged to find supplementary professional employment by practising medicine on a private basis. In addition, dissatisfaction on the part of the public with publicly provided services has led to a large and growing demand for privately provided services. This is confirmed by the high percentage of private health care expenditure in total health care expenditure and by the size of

the extensive black economy in the health sector. Today an increasing proportion of doctors, even those working in hospitals or in polyclinics of insurance organizations, maintain a private practice or clinic and offer PHC services.

Doctors in private practice include the following groups:

* Doctors employed by the NHS on a full-time basis, who “illegally” maintain a private practice, offering services the cost of which is covered by the patient's personal income (out-of-pocket payments).

* Doctors employed part-time by the NHS (approximately 300) who also legally maintain a private practice.

* Doctors working in polyclinics of insurance organizations (mainly IKA) who also legally maintain a private practice, attracting clients mainly from the insurance funds that employ them. The cost of these services is fully covered by the patients.

* Doctors contracted to one or more funds, who work in their private practices and are paid by a fee-for-service system based on fixed prices.

* Doctors, who for various reasons cannot or do not want to be contracted to the health funds, providing services on an exclusively private basis. They are paid by the fee-for-service system and prices are determined by market rules. The cost is fully covered by the patients (or partially by private insurance).

***Source*** European Observatory on Health Care Systems ***Year*** 1996

***Code*** 5.2

***Description*** Dental care

***Contents***

Dental care
Dental care, as part of PHC, is provided to a limited extent: by dentists in the NHS at hospitals and health centres; by dentists in polyclinics of the insurance funds, mainly IKA; by dentists contracted to the funds; and by private dentists. Financing in the first case comes from the state budget, in the second from employee and employer contributions, in the third from contributions and the patient's personal income, and in the last case exclusively from the personal income of the users.

The number of inhabitants per dentist on a national level is only 986 while for health centres and IKA the figure is 6668 and 5563 respectively. This reveals the immense private expenditure on dental care in Greece. The dental care offered by health centres to OGA beneficiaries includes fillings and dentures, but not visits to private dentists. There is no co-payment and the dentists are paid according to the NHS doctors' salary. IKA covers fillings, dentures and mobile prosthesis for its beneficiaries. It also covers orthodontics for children under the age of 15. It does not cover services offered by private dentists. The patients do not participate in the cost. The dentists are part-timers receiving a salary and having the right to operate a private practice. Some funds contracted dentists for the dental care of their beneficiaries. In such cases the doctors are paid fee-for-service according to a determined price list. Other funds offer a free choice of dentist. In these cases the patient pays the dentist and is later reimbursed by the fund. Reimbursement rates are usually lower than market prices, and the patient covers the difference.

The dental care provided by IKA and NHS health centres and OGA is considered by the users to be of low quality. In the end most of the beneficiaries (mainly IKA and OGA) turn to private dentists. It has been estimated that one-third of total private health care expenditure goes to dentists. A recent survey showing the frequency of visits to private dentists/doctors by IKA members indicated that dentists rank first, followed by gynaecologists. The quality of services offered by the insurance funds through private dentists is considered adequate.

***Source*** European Observatory on Health Care Systems ***Year*** 1996

| | | | |
|---|---|---|---|
| ***Code*** | 5.2.1 | | |
| ***Description*** | General dentist | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 5.2.2 | | |
| ***Description*** | Dental specialist | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 5.3 | | |
| ***Description*** | Pharmacists | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 5.4 | | |
| ***Description*** | Midwifery | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 5.5 | | |
| ***Description*** | Paramedical care | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 5.6 | | |
| ***Description*** | Home nursing and home care (maternity home care included) | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 5.7 | | |
| ***Description*** | Out-patient mental health care services | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 5.8 | | |
| ***Description*** | Ambulance services and patient transport | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 5.9 | | |
| ***Description*** | Medical laboratories | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1996 |

| | |
|---|---|
| ***Code*** | 6 |
| ***Description*** | In-patient care |

***Contents***

Provider settings for specialized ambulatory care
The Greek health care system has a strong hospital orientation. The weaknesses of PHC services discussed in the previous section are associated with the significant use of hospital out-patient departments as a first point of contact, as well as secondary care in the form of specialized ambulatory medical services. Because of the absence of a referral system, the freedom of the patient to refer himself/herself to virtually any type of care, and the multiplicity of provider settings offering both primary and secondary care, the dividing line between primary and secondary care in the case of ambulatory services becomes very blurred.

Secondary level ambulatory services are thus offered by out-patient hospital departments (both public and private) and by private physician practices, which are almost exclusively run by specialists in areas other than general practice. Both of these provider settings, as noted in the previous section, also provide PHC. In addition, secondary level ambulatory care is offered by a growing number of private diagnostic centres.

All public hospitals and many private hospitals have out-patient hospital departments, which operate on a walk-in basis or by appointment. In the case of public hospitals, both out-patient and emergency services are offered on particular days determined on a rotating basis, at least in densely populated urban areas where there is more than one public hospital in close proximity. Any person has access to these services regardless of type of insurance coverage (or even lack of coverage) and regardless of nationality. The same applies to emergency care. This arrangement has emerged as a result of the philosophy behind the 1983 reform aiming at the establishment of an NHS, which was to provide universal population coverage regardless of fund membership.

In recent years significant amounts of capital have been invested in medical technology in private diagnostic centres. This has been made possible by the development of new technologies in health and the relatively slow response of the public sector in adopting them. Most of these investments were made in the area of ambulatory care not only because of their high profitability but also because the NHS law of 1983 had forbidden the establishment of private hospitals (until 1992 when the 1983 provision was abolished). Therefore the number of private diagnostic centres, especially after 1985, increased by 25% a year. Seventy per cent of these diagnostic centres are concentrated in the Athens area; Thessaloniki follows with 12.5%.

Diagnostic centres are contracted by insurance funds which pay on a fee-for-service basis. The large number of diagnostic centres and the intense competition that has been created often leads to over-consumption. The lack of controlling mechanisms for patient referral results in insurance funds being called upon to pay large amounts of money for high-cost provisions that most of the time cannot be justified. It is worth noting that in 1990–1991, although the prices for computed tomography (CT) scanning remained stable, the two big funds IKA and OGA had to pay double the amount paid in the previous year in the private sector.

Today the private diagnostic centres are equipped with the most modern medical technology and can offer the most unusual examinations. Due to the quick introduction of biomedical technology in the health system, especially through private diagnostic centres, there are today 12.5 CT scanners and 21.5 ultrasound scanners per one million inhabitants, while the corresponding ratios over the average of the EU are 5 and 13.5 respectively.

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|---|---|---|---|
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1996 |

| | |
|---|---|
| ***Code*** | 6.1 |
| ***Description*** | Hospital categories |
| ***Contents*** | In-patient care<br>The three main categories of hospitals are: (1) NHS public hospitals, (2) public hospitals operated by the Ministry of Defence, IKA, the Ministry of Education and the Ministry of Justice (i.e. military hospitals, IKA hospitals, teaching hospitals and hospitals for prisoners respectively), and (3) private hospitals, the overwhelming majority of which are private for-profit institutions. In terms of hospital numbers, the NHS owns and operates almost 32% of the total number of hospitals, private hospitals constitute about 62% of the total, while the remaining roughly 6% are non-NHS public hospitals. However these percentages are misleading with respect to hospital bed numbers, as the privately owned hospitals tend for the most part to be quite small. In terms of bed numbers, therefore, total NHS hospitals account for almost two-thirds (63.5%) of beds, private sector beds under one-third (28.8%) and other public hospitals 7.7%.<br><br>The NHS hospitals include 96 district hospitals which provide secondary care services to their catchment areas. These hospitals typically have 100–200 beds, and serve populations ranging from 50 000 to 500 000 persons. They provide emergency care and general hospital services covering a variety of specialties. The 23 regional hospitals provide tertiary, or highly specialized care, in addition to secondary care. NHS hospitals are financed by the state budget and sickness funds.<br><br>The non-NHS hospitals include 13 military hospitals (2088 beds), access to which is confined to military personnel and their families, and which are financed by the Ministry of Defence. The 5 IKA hospitals (881 beds), for persons who are members of the IKA social insurance fund, are financed by IKA. The 3 small teaching hospitals (309 beds) included in this category are the only hospitals that are exclusively teaching hospitals, and are financed by the Ministry of Education; there are several other teaching hospitals which are not exclusively so, and these are owned and operated by the NHS.<br><br>Private sector hospitals in some instances provide high quality care with luxury standards (concerning hotel facilities) and are concentrated mainly in the urban areas of Athens and Thessaloniki. For the most part they are small clinics with under 100 beds and are poorly staffed. These hospitals are financed partly by sickness funds which have contracts with the hospitals in question for services offered to the funds' patients, and partly by private out-of-pocket patient payments and voluntary insurance.<br><br>The NHS hospitals are financed primarily by the state budget and to a lesser extent by sickness funds. These can be characterized as a combination of the integrated (directly employed) and contract (indirect) models: they are integrated to the extent that the NHS hospitals are owned and financed by the state, but NHS hospital services are also contracted by the social insurance funds for their patients. In the case of non-NHS public hospitals, all three groups follow the integrated model, as in all three the employer and third-party payer are one and the same. The case of IKA differs in that it is an insurance fund (rather than the state) that is the employer and third-party payer. |
| ***Source*** | European Observatory on Health Care Systems |
| ***Year*** | 1996 |

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|---|---|
| ***Code*** | 6.2 |
| ***Description*** | Other in-patient provisions |
| ***Contents*** | The regional distribution of secondary level hospital beds tends to be uneven, with the urban areas of Athens and Thessaloniki being better served, as well as Crete, Epirus and western Greece which recently (in 1990) acquired large university teaching hospitals. The construction of new public hospitals in areas distant from the major urban areas in more recent years represents an effort to address this problem.<br><br>In the case of tertiary care, 7 of Greece's 13 regions are covered by at least one large NHS highly specialized hospital, while the remaining regions are covered by the hospital(s) of the neighbouring region or Athens and Thessaloniki.<br><br>There are broad discrepancies among regions regarding cross-regional patient flows. Crete, Epirus and western Greece, with newly acquired specialized services, show some autonomy with regard to serving the needs of their residents, and attract patients from surrounding districts. By contrast, districts which are close to the major urban areas of Athens and Thessaloniki show the largest patient flows toward hospitals of these urban centres. In part this is due to the prevailing inability of some district general hospitals to readily fulfil specialized needs. In addition, the absence of a referral system and the freedom of patients to refer themselves to virtually any NHS hospital draws patients to the major urban centres, which tend to have a concentration of higher-standard hospitals.<br><br>This problem of strong interregional flows could be partly alleviated by the development of one-day care units throughout the district hospitals. This type of care has recently made its appearance in Greece, but is as yet fairly limited: in 1992 there were 144 such beds in 4 regions (Central Macedonia, Thessaly, Attica, and Crete). Moreover, such care is offered only within large, highly specialized regional hospitals. The significance of one-day care units is being increasingly recognized and more such units are developing in the both the public and private sectors. |
| ***Source*** | European Observatory on Health Care Systems — ***Year*** 1996 |

| | |
|---|---|
| ***Code*** | 7 |
| ***Description*** | Relationship between primary and secondary care |
| ***Contents*** | |
| ***Source*** | European Observatory on Health Care Systems — ***Year*** 1996 |

| | |
|---|---|
| ***Code*** | 7.1 |
| ***Description*** | Planned or actual substitution policies for inpatient care |
| ***Contents*** | |
| ***Source*** | European Observatory on Health Care Systems — ***Year*** 1996 |

| | |
|---|---|
| ***Code*** | 7.2 |
| ***Description*** | Degree of co-operation between primary and secondary health care providers |
| ***Contents*** | |
| ***Source*** | European Observatory on Health Care Systems — ***Year*** 1996 |

| | |
|---|---|
| ***Code*** | 7.3 |
| ***Description*** | Imbalance between primary and secondary care |
| ***Contents*** | |
| ***Source*** | European Observatory on Health Care Systems — ***Year*** 1996 |

| | |
|---|---|
| ***Code*** | 8 |
| ***Description*** | Prevention and public health services |
| ***Contents*** | Public health services<br>The public health system consists of a centralized service within the Ministry of Health and public health departments in each of Greece's 52 districts. There are public health doctors both in the Ministry of Health (22 in number) and in the decentralized public health departments (55 public health doctors, 15 doctors of social medicine, 250 public health supervisors, 200 nurses, and 570 others). This service is responsible for monitoring the health of the population, especially as regards environmental factors, immunization, prevention of communicable diseases, hygiene, collaboration with health services, and overall supervision.<br><br>In practice, however, not all of the above tasks are carried out effectively, primarily because of poor staffing in the public health departments due to low remuneration, low status of public health doctors, and their poor training in the field of public health. There are only 15–20 specially trained public health doctors in the country. The status, pay and conditions of service of public health doctors are low in comparison to clinical doctors, even for those employed at the Ministry of Health. The education of public health doctors is inadequate as the medical school programmes are limited, and the only postgraduate programme is offered by the National School of Public Health.<br><br>A number of public health activities are run by the Ministry of Health. These include:<br><br>* public campaigns on nutrition, smoking, AIDS, thalassemia, diabetes, etc.;<br>* the operation of 12 diabetes centres throughout the country;<br>* the operation of 5 prenatal screening centres for thalassemia;<br>* the establishment in 1995 of the National Centre Against Drug Abuse.<br><br>The planned health care reforms, in combination with the decentralization (or deconcentration) of process which is about to begin (the establishment of administrative mechanisms at the regional level), are to involve the setting up of regional public health structures with the following responsibilities:<br><br>* determining and interpreting factors regarding the health status of the population;<br>* identifying the requirements for health (promotion, planning, efficiency, and service effectiveness);<br>* developing information services;<br>* identifying and controlling possible outbreaks of communicable diseases;<br>* promoting health by health education, public counselling, vaccination, immunization, screening, etc.;<br>* monitoring the health effects of the environment and initiating actions;<br>* identifying the needs of special groups (elderly, disabled, mentally ill, etc.);<br>* providing appropriate education and research facilities.<br><br>As part of the five-year plan (1995–1999) undertaken jointly with the EU and financed in part by EU structural funds, the National School of Public Health is to be renovated and upgraded. In addition, one central and five peripheral public health laboratories will be established.<br><br>The level of immunization against measles in Greece is at 45%; this is well below the western European average of 79%. |
| ***Source*** | European Observatory on Health Care Systems — ***Year*** 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 8.1 | | |
| ***Description*** | Maternal and child health: family planning and counselling | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 8.2 | | |
| ***Description*** | School health services | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 8.3 | | |
| ***Description*** | Prevention of communicable diseases | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 8.4 | | |
| ***Description*** | Prevention of non-communicable diseases | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 8.5 | | |
| ***Description*** | Occupational health care | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 8.6 | | |
| ***Description*** | All other miscellaneous public health services | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1996 |

| | |
|---|---|
| ***Code*** | 9 |
| ***Description*** | Social care related to health care |
| ***Contents*** | |
| ***Source*** | European Observatory on Health Care Systems — ***Year*** 1996 |

| | |
|---|---|
| ***Code*** | 9.1 |
| ***Description*** | Organisation and financing of social care |
| ***Contents*** | Social care<br>State-run social services include Mother and Child Centres (PIKPA) and Centres for Disabled Persons. There are 112 PIKPA units all over the country (half of them in Athens) offering PHC for pregnant women and newborn children. There are 17 centres for disabled persons, especially for children and adults up to 25 years of age, with 1305 beds in the entire country.<br><br>Many municipalities and communities offer social services through Elderly Centres (KAPIs) and Prevention and Welfare Centres. Centres for the elderly are meeting places for the elderly and very often also provide preventive care and prescriptions. The centres were established during the last decade and are today considered a successful institution for the protection of the elderly in Greece. There are 250 such centres throughout the country. The prevention and welfare centres provide welfare and rehabilitation services to people with special needs.<br><br>Both the centres for the elderly and the prevention and welfare centres employ mainly nursing personnel; however, in many cases there is a doctor who prescribes for those with chronic diseases, so that people can avoid having to visit polyclinics or hospital out-patient departments.<br><br>In addition to these two types of centres, during the last three years some of the larger municipalities have opened small clinics, offering very few services. Unfortunately there are no data on these services for the entire country, although some have been collected from the Municipality of Athens which has the most developed infrastructure to date. According to this information, the Municipality of Athens today has 5 consulting centres with 67 specialists and with microbiology laboratories. There is also a mobile diagnostic unit with 7 doctors. In addition to the doctors, there are 102 nursing and administrative personnel. Of the users of these services, 40% are IKA members, 24% uninsured persons, 13% civil servants, and the remaining are from other funds. In 1991 there were 93 816 visits to the clinics of the Athens Municipality. The Municipality of Aghia Paraskevi has a clinic with 6 doctors, and the Municipality of Kessariani a preventive centre for children. It is quite possible that other large municipalities in other parts of the country have small clinics with not more than 100 doctors.<br><br>Long-term care for the elderly is provided almost exclusively by the private sector, or in the form of home care which remains the custom in Greece, as in other Mediterranean countries.<br><br>In the area of psychiatric care, there are 11 public psychiatric hospitals, of which 9 are NHS hospitals with 6351 beds, and 2 non-NHS hospitals with 399 beds. Psychological rehabilitation units are attached to 9 of these hospitals. In addition, 40 public hospitals (district and regional) have psychiatric departments, while an additional 10 hospitals provide the services of 1–2 psychiatrists, although with no psychiatric department. There are also 30 hostels and 15 vocational training centres for psychiatric patients. Recently, with the assistance of EU structural funds, 31 new psychiatric centres and hostels were established, which include vocational training and other services, and an additional 6 are currently under construction. Each is attached to the nearest respective hospital with psychiatric facilities. Several hundred apartments for psychiatric patients have been established in the proximity of the psychiatric centres. |
| ***Source*** | European Observatory on Health Care Systems — ***Year*** 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 9.2 | | |
| ***Description*** | Role of central/regional/local government | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 9.3 | | |
| ***Description*** | Role of other organisations | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 9.4 | | |
| ***Description*** | Responsibility of family members | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 9.5 | | |
| ***Description*** | Financing of social care | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 9.6 | | |
| ***Description*** | Explicit health/social care policy | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 10 | | |
| ***Description*** | Medical goods and health care technology assessment | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1996 |

| | |
|---|---|
| ***Code*** | 10.1 |
| ***Description*** | Pharmaceuticals |
| ***Contents*** | Consumption of pharmaceuticals in Greece is very high. In 1989 the number of drug items consumed per capita was the second highest in the EU, surpassed only by France. This is in part due to highly excessive prescribing of expensive antibiotics, as well as to the absence of cost-effective measures to influence drug consumption. Drug expenditures in 1991 amounted to 2% of the GDP, compared to 0.6–1.5% in most other countries (with the exception of Germany which is the closest to Greece at 1.8%).<br><br>Domestic demand is satisfied by both imports and domestic production, part of which is also exported. There are about 100 pharmaceutical companies in Greece, half of which are industrial and the other half commercial. Fifteen are controlled by multinational companies and another 15 collaborate with foreign pharmaceutical companies. The Greek pharmaceutical industry is highly concentrated, with the top 10 companies controlling 43% of the market.<br><br>In 1983, the Ministry of Health and Welfare established the National Drug Organization (NDO), which is the main body in Greece responsible for the administration and supervision of the pharmaceutical sector. The NDO approves, rejects, or renews the license for every drug in circulation; it develops drug-related research and technology; it provides the Ministry of Trade with advice on pharmaceutical pricing; it participates in the production and distribution process through investment and research; and it authorizes the establishment of new pharmaceutical companies.<br><br>The NDO additionally controls some smaller companies, one of which is Pharmetrica, which is responsible for carrying out the statistical and economic evaluation of drugs.<br><br>The Ministry of Health and Welfare supervises and finances the NDO. The Ministry of Trade is responsible for pharmaceutical pricing. Prices are subject to approval by the Minister of Finance and the Minister of Health.<br><br>There are 7698 pharmacies and about 130 drug wholesalers in Greece. Pharmaceutical companies distribute their products to wholesalers (who in turn distribute them to pharmacies) and to hospitals, in the ratio of roughly four-fifths to one-fifth respectively. Consumers obtain their supplies from pharmacies and hospitals in approximately the same proportion: four-fifths from pharmacies and one-fifth from hospitals. The flow of drugs from wholesalers or pharmacies to hospitals is extremely small (about 1%).<br><br>There are virtually no policies being pursued to improve cost-effective consumption of pharmaceuticals. The following policies in fact run counter to cost-effectiveness:<br><br>* Prices of domestic drugs are set on the basis of the cost of the drug's basic ingredient with mark-ups for formulation, promotion, distribution, etc. The original manufacturer receives a premium of 14%, thus resulting in inflated transfer prices. Because of the difficulties involved in determining the drug's basic ingredient when the drug is imported, it is in the interests of producers to import drugs and doctor prices, rather than to manufacture them locally. As a result, the market share of imported drug sales has been steadily increasing in recent years, rising from 18.3% in 1987 to 44.8% in 1994. At the same time, no incentives are given to Greek producers to promote their production. In addition, older and less expensive drugs are withdrawn from the market and replaced by more expensive ones. This has resulted in a 280% increase in hospital drug expenditure during the last five years, while drug consumption over the same period has increased only by 12%.<br><br>* Not all social insurance funds have a positive or negative list. The insurance fund IKA has a positive list, which is also followed by OGA, however, it is not always enforced as doctors can prescribe unlisted drugs by justifying the prescription. Efforts are being made within IKA to change doctors' prescribing behaviour through monitoring. A recent study has shown that in 1994, 35% of drugs prescribed by a group of IKA doctors were not on the positive list. Following the imposition of sanctions, this percentage of prescribed drugs dropped to 15% in 1995.<br><br>* There is no promotion of generics, and generics are sold by both foreign and domestic companies under different brand names (termed "copies"). Prices of generics were recently set at 86% of the brand drug. However, price competition is limited because pharmacists are strongly prohibited from dispensing any substitute.<br><br>* There is no reference price system in operation.<br><br>* The recent introduction of co-payments on drugs has failed to curb demand, and there has |

been no monitoring or evaluation of the co-payment system.

* There is inadequate coordination among the representatives of providers, users and regulators.

* Doctors frequently over-prescribe drugs, and effective monitoring of the prescribing activities of insurance fund doctors is limited. IKA is an exception in this regard, as it has computerized medical profiles and monitors doctors on a monthly basis.

Recently, the Ministry of Trade announced a new policy for drugs to cut down the cost by up to 10%. Wholesaler prices on imported drugs will be defined according to the three lowest among EU countries. Wholesaler and pharmacist profit margins will be reduced by 1% each. A new positive list for drugs will be introduced for social insurance beneficiaries and a type of reference price will be formulated (financial limit per insured person per therapeutic category).

While these measures are in the right direction, further steps must be taken:

* recognition of intellectual property and drug patents; according to EU regulations, Greece had to conform to this by 1998;
* definition of over-the-counter (OTC) drugs as distinct from prescribed drugs;
* development of the market for generics;
* control of sales promotion and efforts to educate the public so as to avoid excessive use of drugs;
* price policy according to cost-effectiveness evaluations;
* monitoring the providers' prescription behaviour;
* development of a single classification system of drug codes;
* development of distribution per unit-dose;
* computerized link between the National Drug Organization, the Ministry of Trade, the social insurance funds and hospitals;
* development of medical audit systems monitoring the use of strict positive or negative lists.

***Source*** European Observatory on Health Care Systems ***Year*** 1996

***Code*** 10.2

***Description*** Therapeutic appliances

***Contents***

***Source*** European Observatory on Health Care Systems ***Year*** 1996

***Code*** 10.3

***Description*** Health care technology assessment

***Contents***

***Source*** European Observatory on Health Care Systems ***Year*** 1996

***Code*** 11

***Description*** Other services

***Contents***

***Source*** European Observatory on Health Care Systems ***Year*** 1996

| | |
|---|---|
| ***Code*** | 11.1 |
| ***Description*** | Education and training of personnel |

***Contents***

Training and education of health care personnel
Medical students pursue their studies in seven university faculties of medicine (Athens, Salonica, Patras, Ioannina, Heraklion, Larissa and Alexandroupolis, each of which is the capital of its respective region). All programmes follow almost the same curriculum, and are considered to be of high quality. Basic medical studies last six years. For a doctor to be recognized as a specialist a further 3–6 years of postgraduate study is required. Medical graduates may practise without additional qualifications, however, the overwhelming majority of these go on to acquire a specialization. The medical curriculum is highly hospital-oriented, and contains little training related to PHC or family medicine.

The government has made some efforts to limit the numbers of medical students, however, not as a result of the Ministry of Health planning according to needs. Instead, the Ministry of Education has recently imposed a policy whereby the number of new students entering medical schools has been stabilized at a certain level, thereby no longer permitting increases in new entrants to medical schools. As a result, doctors are still being overproduced though to a lesser extent than earlier. A substantial number of Greek medical students pursue their studies abroad, thus exacerbating the problem of oversupply.

Upon completion of basic medical studies, graduates are required to enter their names on waiting lists at the Ministry of Health, according to their desired area of specialization. The allocation of students among specialties is determined centrally by hospital demand. The waiting times vary substantially according to specialty, and are generally lowest in the case of general practice which generates the lowest amount of interest. About 3000 doctors (plus an additional 1000 in the army) are waiting for a post or doing their compulsory service at a rural station.

Efforts to promote general practice as a specialty resulted in the establishment of a postgraduate programme in general practice in 1984, lasting three years. The training takes place mostly in a hospital setting, with only three months training in a PHC setting. In addition, a doctor who has practised for at least five years can become a GP upon completion of a six-month course. However most Greek doctors continue to prefer careers as hospital specialists rather than as GPs. Since 1995, GP specialist training lasts four years, with one year training in a health centre.

Continuing education is the responsibility of the hospitals and of scientific medical societies. Legislation in 1994 established a postgraduate education department within the Ministry of Health in collaboration with the Central Health Council (KESY) which acquired this responsibility in the last decade, in order to organize continuing education programmes.

Public health doctors must pursue a year's postgraduate training course at the National School of Public Health (Athens). Almost all doctors who graduate from this school return to their initial specialty, however, because they do not have a serious incentive to work in this area. As a result, half the posts of district health directors are not staffed. Since 1985 the National School of Public Health has run two other postgraduate programmes for health services management and sanitary engineers. Twenty students (mainly hospital employees) are trained annually on every course. Additionally some 50 persons (up to now) have taken such courses abroad. In 1994 the Ministry of Health announced 20 scholarships for studies abroad in the fields of management, health promotion, planning, etc. Also, 1996 is the starting year of the Public Administration School that offers a health planning management course. In the last 3–4 years, a number of senior hospital officers have pursued one-month on-the-job training abroad (in connection with HOPE, British Council, etc.).

There are 10 schools of nursing, 3 of which provide 4 years of training for qualified nurses, public health nurses, and visiting nurses; while 7 provide 3 years of training. There are also 54 schools (1 in each district) for auxiliary nurses with 2 years' training, and 1 nursing school which is part of the University of Athens. There are also 3 midwifery schools which provide 4 years of training and 21 secondary schools providing technical, professional and hospital education for 2 years.

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| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 11.2 | | |
| ***Description*** | Research and development in health | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 11.3 | | |
| ***Description*** | Environmental health and control of drinking water | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 11.4 | | |
| ***Description*** | Health programme administration and health insurance | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 11.5 | | |
| ***Description*** | Administration and provision of cash benefits | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1996 |

| | |
|---|---|
| ***Code*** | 12 |
| ***Description*** | Manpower in health care |
| ***Contents*** | In Greece the total labour force is 4 053 000 persons, while the unemployment rate is 9% (1993). There has been a significant development of health manpower from 1.5% of the total employment at the beginning of the 1970s to 3.3% today (135 000 persons).<br><br>The total number of doctors (including the first three groups in the table) amount to 28.5% of total employment in the health sector, while nurses constitute 30%, dentists nearly 8% and pharmacists nearly 6%.<br><br>Total employment in the health sector more than doubled in the period 1970–1992. On the basis of personnel per population, physician numbers more than doubled, dentists doubled, nurses (since 1975) nearly tripled, and midwives (since 1980) showed only a small increase. Graduating physicians, since 1980, tended to be stable though with some fluctuations, while the number of nurses graduating in 1991 was five times greater than in 1980.<br><br>Specialized doctors tend to be concentrated in public hospitals and urban IKA polyclinics. The 18% of doctors appearing under private out-patient practices refers to doctors who are exclusively self-employed in their own practices – this does not include doctors who are employed directly in the public system or by social insurance funds (specifically IKA) and who simultaneously operate private practices. It is interesting to note that whereas the public-to-private distribution of hospital beds is roughly 71 to 29, the corresponding distribution of specialized doctors between the public and private sectors is roughly 81 to 19, revealing the substantial understaffing of private sector hospitals. Moreover, it can be seen that rural health centres and clinics, presumed to cover the PHC needs of about 25% of the total Greek population (the rural population), are staffed by only 5% of the total of specialized doctors. These primary care settings are staffed mainly by physicians with no training beyond basic medical training. This underscores the serious staffing shortages prevailing in rural areas.<br><br>In the case of dentists, the table shows that the majority work in private practices, a few are contracted by insurance funds to serve the needs of fund members, and even fewer work in rural health centres.<br><br>Nurses are concentrated overwhelmingly in public hospitals, thus revealing the serious shortages of nursing staff in private hospitals and in virtually all PHC settings (i.e. rural health centres and clinics, IKA polyclinics, and private practices).<br><br>The main problems in the area of human resources and training in Greece are the following:<br><br>* oversupply of doctors, dentists and pharmacists;<br>* poor distribution of doctors among the various medical specialties (e.g. too many surgeons and gynaecologists, and very few general practitioners, geriatricians and public health doctors);<br>* shortages and inadequate education of nurses;<br>* shortages and inadequate education of other specialists (managers, health economists, biomedical engineers, statisticians, medical computer analysts etc.);<br>* poor distribution of health manpower (especially doctors and nurses) among the regions;<br>* imbalances between demand and supply.<br><br>In Greece, there is some limited planning by KESY (the Central Health Council) and the Ministry of Education related to manpower. Priorities do not follow any measures of demand or need. There are limited policies based on projections and no efforts are made to match supply with demand through the educational system. Thus, the only figure appearing in recent health manpower requirements is the vacancy of permanent posts in the NHS public hospitals (35 367 posts) and the health centres (3671 posts). Nearly 12% of these posts must be staffed by doctors and 48% by nurses.<br><br>If the above posts were to be staffed, they would represent a 12% increase in the number of doctors, and a 46% increase in the number of nurses. However, financial constraints and the bloated public sector in terms of public employee numbers, have led to the imposition of restrictions in the hiring of public employees. Exceptions have been made only for the health and education sectors, thus permitting the opening of 5000 new positions in health since March 1994. But even in the absence of these restrictions it would not be possible to fill the nursing positions because trained nurses are not available in such numbers. In the case of doctors, whose numbers are excessive but whose distribution among specialties and geographical regions is inappropriate, it is unlikely that these positions could be filled in accordance with needs across specialties and across regions.<br>Physicians<br>As in other countries, Greece shows a continuous upward trend. The average annual rate of |

increase in 1980–1992 has been nearly 4%. The number of doctors in Greece per population has consistently been above the western European average.

There are, however, very wide regional variations in the doctor-to-population ratios, ranging from a low of only 1.6 per 1000 population in the region of central Greece to a high of 5.7 in the region of Attica, which comprises Athens. Attica, concentrating about 34% of Greece's total population has 52% of all doctors.

Such an uneven distribution has prevailed for many years, leading in 1968 to a legislative act requiring young doctors to practise for at least one year in rural health centres and clinics upon completion of their basic medical training. Hence, as was noted earlier, rural health centres and clinics are staffed mainly by unspecialized doctors. As this measure focuses only on unspecialized doctors, it has done little to alleviate the problem with respect to specialists. More recently this law was modified, and at present only doctors who intend to specialize in general practice are required to work in rural areas. This has been part of recent efforts which are being made to develop general practice as a specialty, and eventually to staff rural health centres and clinics with GPs.

In fact, the geographical maldistribution of doctors is greatly compounded when looked at from the point of view of particular specialties: 80% of anaesthesiologists, 73% of radiologists, 70% of microbiologists, 70% of cardiologists, 70% of orthopaedic specialists, 75% of gynaecologists, 88% of psychiatrists and 90% of neuro- and plastic surgeons offer their services in the two largest cities, Athens and Thessaloniki. Some specialties have only a rather symbolic presence in other regions.

In addition to the poor regional distribution of doctors, there is also poor distribution among specialties. Only about 2.2% of all doctors are general practitioners, and if pathologists are added to GPs, this proportion rises to just over 14%, which is quite low compared to other countries of western Europe. In fact, general practice as a specialty is almost unknown in Greece, and as a rule is not highly regarded, probably because of the relative underdevelopment of PHC – hence the very low numbers of doctors who specialize in this area.

Nurses

Nursing personnel constitute 30% of the total health care personnel. Greece shows an upward trend which has accelerated since the mid-1980s. In addition, it can be seen that the number of nurses in Greece per 1000 population is substantially lower than in any of the countries shown.

As in the case of doctors, there is a significant maldistribution of nurses by provider settings, by nursing categories, and by regions. It was noted earlier that 79% of all nurses work in public hospitals. With an additional 11% employed in private hospitals, there is a mere 10% left to cover PHC needs. PHC is most severely understaffed by nurses in Greece.

In addition, there are also shortages of qualified nursing staff. There has been some improvement in this area: in 1990, 63% of all nurses had a middle or higher degree certificate compared to 55% in 1980. However this is still inadequate, as there are still too many nurses with insufficient training. In 1990 the ratio of nurses with a higher degree per hospital bed was only 0.3 nurse per bed, when in other EU countries this ratio ranged from 0.65 to 1.2 per bed.

Finally, the regional distribution of nurses is highly uneven. Interestingly, an examination of the regional distribution of only qualified nurses working in NHS hospitals does not show as wide regional variations as in the case of the distribution of all nurses in all provider settings throughout the country. In fact, the fairly remote region of Epirus has the same ratio of qualified nurses per population as Attica (comprising Athens), while central Macedonia and Crete show nearly as high ratios as Attica. This suggests that NHS hospitals tend to attract qualified nurses among their staff regardless of their location.

Future projections

According to projections of numbers of health care personnel, it has been estimated that the number of doctors will increase by 15% in the period 1995–2000, and the number of nurses by 24%. While representing sizeable increases, these rates of change are actually lower than those corresponding to the period 1990–1995. In the case of doctors, this may be the result of policies recently initiated by the Ministry of Education (discussed above) to stabilize the number of positions in medical schools. The higher rate of increase of nurses relative to doctors suggests that the present imbalance in the doctor-to-nurse ratio will begin to be redressed. According to these projections, it should be possible to staff all existing public sector posts for doctors (financial considerations permitting) by the year 2000, while an additional 13% of doctors will be looking for a position.

In view of the magnitude of imbalances in health care personnel, the solution can only be pursued over the longer term. Quite clearly, no solution is possible in the absence of planning in the educational system which takes into account the distribution of medical specialties and professions. Although some steps in the right direction have begun to be taken, any attempted

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| | solution will require significant further investments in education to provide training in those areas that currently are facing serious shortages (training of nursing personnel, retraining of existing nurses, GPs, specialists in family medicine, health economists, managers, etc.). |
| ***Source*** | European Observatory on Health Care Systems ***Year*** 1996 |

| | |
|---|---|
| ***Code*** | 13 |
| ***Description*** | Fees, rates and salary structure |
| ***Contents*** | |
| ***Source*** | European Observatory on Health Care Systems ***Year*** 1996 |

| | |
|---|---|
| ***Code*** | 13.1 |
| ***Description*** | Methods of payment to (specialist) physicians |
| ***Contents*** | Payment of physicians<br>All health care personnel employed within the NHS, (i.e. rural health centres and NHS hospitals) are salaried employees of the state.<br><br>Doctors who work in IKA polyclinics are paid on a salary basis by IKA. Private doctors and dentists who are contracted by the social insurance funds are paid on a fee-for-service basis. The fees are generally set at a very low level, thus providing doctors with the incentive to charge the patient additional fees which are usually paid unofficially.<br><br>Unofficial payments to hospital doctors are also a prominent feature of the Greek public hospital sector. Following the introduction of the NHS after 1983, doctors received relatively high salaries. As a result, some progress was made at that time in reducing unofficial payments. However, while doctors now on average receive salaries which are approximately double that of other public employees, these are much lower in relative terms than in the early NHS period, thus creating incentives once again for doctors to supplement their income through unofficial payments. It is estimated that unofficial payments increase doctors' salaries by about 40% on average.<br><br>Other health care personnel, especially nurses, are paid salaries which are at roughly the same level as the average of public employees.<br><br>Quite clearly, payment methods for providers give no efficiency-promoting incentives, and moreover encourage the continuation of the practice of unofficial payments. |
| ***Source*** | European Observatory on Health Care Systems ***Year*** 1996 |

| | |
|---|---|
| ***Code*** | 13.1.1 |
| ***Description*** | Integrated or contracted |
| ***Contents*** | |
| ***Source*** | European Observatory on Health Care Systems ***Year*** 1996 |

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|---|---|
| ***Code*** | 13.1.2 |
| ***Description*** | Type of payment |
| ***Contents*** | |
| ***Source*** | European Observatory on Health Care Systems ***Year*** 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 13.1.3 | | |
| ***Description*** | Method for deciding fees/salaries | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 13.2 | | |
| ***Description*** | Methods of hospital payment | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 13.2.1 | | |
| ***Description*** | Method of payment | | |
| ***Contents*** | Payment of hospitals<br>Public hospitals are reimbursed by social insurance funds on a per diem basis. Traditionally, per diem fees have been kept below average per diem costs (thus allowing the budgets of social insurance funds to be in surplus until 1993). In 1992 per diem fees were increased by 200% and in 1993 by an additional 600%, thus throwing the insurance funds into deficit. These huge increases were prompted by the conservative government's policy, at that time, to decrease public expenditure on hospitals.<br><br>Prior to these increases in per diem fees, only about 12% of hospital revenues came from the fees paid by the insurance funds, with the remaining 88% coming from a state subsidy (this includes payment of salaries to hospital personnel, to be discussed below). At present, the contribution of the insurance funds has increased to about 30% of total hospital revenues. However, this actually resulted in creating significant deficits for the hospitals, as the insurance funds were not in a position to sustain the huge increases in per diem fees.<br><br>The state subsidy of hospitals is in principle based on a prospective budget for salaries and investment. However, in practice the state budget pays retrospectively for all hospital expenses incurred excluding sickness fund reimbursement. The system is therefore open-ended and demand-led, containing no incentives whatsoever to encourage cost-containment or efficient practices. | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1996 |

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|---|---|---|---|
| ***Code*** | 13.2.2 | | |
| ***Description*** | Method for deciding rates | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 13.2.3 | | |
| ***Description*** | Recent changes in payment method | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1996 |

| | |
|---|---|
| ***Code*** | 14 |
| ***Description*** | Main system of financing and coverage (tax based, insurance based, mixture) |

***Contents***

Main system of finance and coverage
The health care system in Greece is financed by a mix of tax-based and insurance-based statutory financing (supplemented by a high proportion of voluntary financing). As such, it cannot at the present time be classified as falling under either the predominantly "Beveridge" or the "Bismarck" type of financing system. Rather, looked at from a long-term perspective, it can be considered as being in a transition phase from predominantly insurance-based (the Bismarck model) to being predominantly tax-based (the Beveridge model).

Until 1983, health care was financed predominantly by social insurance, supplemented by subsidies from the state budget. The 1983 health care reforms sought to change this through the establishment of what was intended to be a tax-financed National Health Service. These reforms were only partially implemented. What is more important from the point of view of financing, however, is that the 1983 reform plan concentrated exclusively on the provision of health care services, and did not deal with the financing side. In one article of the legislation, it is stated that the financial relationship between the insurance funds and the NHS would be defined in the near future. This never took place, and as a result, the numerous social insurance funds in existence simply continued to operate as before. The increased state budget financing that did occur, given the increases in publicly provided services that ensued, simply meant growing public subsidies of hospitals and social insurance funds.

The state budget, financed through taxation at the central level only, is responsible for financing of the following: rural health centre and rural clinic expenditures (which were established as part of the NHS), salaries of personnel in public hospitals, subsidies of public hospitals (involving payments to hospitals over and above the per diem fees paid by the social insurance funds), subsidies of the social insurance funds, and subsidies of civil servant health insurance, capital investments, public health, medical education, etc.

There are currently as many as 300 social insurance funds, about 40 of which cover the bulk of the population. Membership in the funds is compulsory and is based on occupation. Therefore there is no freedom in choice of fund, nor is there any competition among funds. Most of the funds are public entities, and while they are autonomous, they operate under extensive control by the central government. The state budget allocation for health is divided between expenditures incurred by the Ministry of Health and those incurred through the country's 52 districts, not only for health but also for welfare and other benefits.

Most of the funds obtain the bulk of their resources through employer-employee contributions which are income-related, the levels of which are set by the Ministry of Labour and Social Insurance. On the whole, contributions amounted to about 77% of total fund revenues in 1991, however, there are significant differences among funds concerning the proportion funded by contributions. In the case of OGA, for example, covering the agricultural population, sickness funding is exclusively through the state budget with no contributions from farmers. In addition, employer-employee contribution ratios vary significantly across funds. In IKA (the largest fund which covers white- and blue-collar workers) this ratio is two-thirds by the employer and one-third by the employee.

The state budget contribution to the social insurance funds has been steadily increasing in recent years, due to the continuously growing deficits of the funds. Until 1992, the deficits were confined to the area of pensions, with the sickness area actually showing surpluses. These surpluses were, however, artificially maintained through the government's policy of setting low rates for insurance fund reimbursements to public and private health care providers. In 1993, following large increases in the fund reimbursement rates (set by the government), the sickness branches of the insurance funds began to show deficits as well, thus increasing the share of the subsidy from the state budget. Contribution rates have as a result also gradually increased since 1990. In IKA, they now stand at about 7.65% of income (for health only). Funds that had higher contribution rates have not been requested to increase their rates, while funds with lower rates have been requested to gradually increase theirs.

During the late 1980s, the relative contribution of the state budget was increasing, compared to the contribution of the social insurance funds. However, during the 1990s this trend appears to have been reversed, with the relative importance of the insurance funds growing as a result of the increasing burden of health service financing noted above.

Population coverage and the basis of entitlement to coverage varies in accordance with provider settings and their associated sources of finance. Since implementation of the 1983 legislation, there has been a significant expansion in access to health care facilities and coverage of the population. At the present time there are two main principles of entitlement:

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| | one is entitlement on the basis of citizenship in the case of out-patient services provided by the NHS, and the other is entitlement on the basis of insurance contributions for services which are provided and/or financed by insurance funds. In addition, there are certain parallel services offered by the Ministry of Defence, consisting of 13 military hospitals and offering services exclusively for the respective employees and their families.<br><br>Entitlement on the basis of citizenship involves two types of provider settings: rural health care centres (providing primary health care), and NHS hospital out-patient departments (for both primary health care and emergency services), both of which belong to the NHS. According to law, any Greek citizen (as well as any citizen of an EU country) can receive services at any out-patient department of a NHS hospital, or at a rural health centre. In practice, any person from any country (including illegal immigrants) can receive care at these two provider settings.<br><br>Entitlement on the basis of insurance contributions applies to all other provider settings. These include urban polyclinics owned by insurance funds, in-patient care provided by NHS hospitals, and private providers (whether private practices or diagnostic centres or hospitals) who are contracted with insurance funds. Coverage for these services is provided only for insurance fund members and their families. Pensioners continue to be covered by the fund they belonged to while working, and pay their own contribution. The unemployed belong to an unemployment fund financed by the budget, and are covered by IKA services for a period up to 12 months.<br><br>Finally, there is also entitlement to services by virtue of being poor. The poor are entitled to free out- and in-patient care at public hospitals. |
| ***Source*** | European Observatory on Health Care Systems ***Year*** 1996 |

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|---|---|
| ***Code*** | 14.1 |
| ***Description*** | Main features of tax based systems |
| ***Contents*** | |
| ***Source*** | European Observatory on Health Care Systems ***Year*** 1996 |

| | |
|---|---|
| ***Code*** | 14.1.1 |
| ***Description*** | Main body(ies) responsible for providing health care cover to beneficiaries |
| ***Contents*** | |
| ***Source*** | European Observatory on Health Care Systems ***Year*** 1996 |

| | |
|---|---|
| ***Code*** | 14.1.2 |
| ***Description*** | Extent of population coverage (excluded groups) |
| ***Contents*** | |
| ***Source*** | European Observatory on Health Care Systems ***Year*** 1996 |

| | |
|---|---|
| ***Code*** | 14.2 |
| ***Description*** | Main features of social health insurance |
| ***Contents*** | |
| ***Source*** | European Observatory on Health Care Systems ***Year*** 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.2.1 | | |
| ***Description*** | Organisation of main body responsible for insuring/providing coverage | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.2.2 | | |
| ***Description*** | Extent of population coverage | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.2.3 | | |
| ***Description*** | Stipulations in premium contribution | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.2.4 | | |
| ***Description*** | Competition between insurance schemes | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1996 |

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|---|---|---|---|
| ***Code*** | 14.2.5 | | |
| ***Description*** | Provision for risk adjustment | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1996 |

| | |
|---|---|
| ***Code*** | 14.3 |
| ***Description*** | Health care benefits and rationing; recent reductions in benefits package and variations in extent between different insurance plans |
| ***Contents*** | Health care benefits and rationing<br>There are very wide variations in the range of services provided by the numerous social insurance funds, as well as in the quality of those services. Most funds provide reimbursement of primary, secondary, pharmaceutical and dental care, and in some cases also reimbursement for spectacles, and diagnostic and laboratory tests. IKA, the largest fund, offers the most comprehensive package, which includes almost everything except cosmetic surgery. OGA (the fund covering the agricultural population) offers dental care only up to the age of 18, while TEVE (covering shop owners and manufacturers) and some smaller funds do not offer dental care at all.<br><br>In addition, most of the funds provide income allowances for lost income due to illness, maternity benefits, spa treatment, and others.<br><br>It is important to note that there have been no reductions in benefit packages in recent years. In fact, benefits have, in the case of some funds, even increased. |
| ***Source*** | European Observatory on Health Care Systems ***Year*** 1996 |

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|---|---|
| ***Code*** | 14.4 |
| ***Description*** | Complementary sources of finance |
| ***Contents*** | According to official figures, tax revenues until 1992 constituted the most important source of financing of the Greek health care system, with statutory insurance and private sources contributing roughly equally. The private sources do not include voluntary insurance. The large relative contribution of private sources are to some extent due to the underground economy in health care, which is a major problem in the system. It has been estimated that unofficial payments constitute about 50% of total private payments for health care. In more recent years, due to government financing restrictions and increases in premiums, state subsidies have been reduced while social insurance financing has correspondingly increased its share. |
| ***Source*** | European Observatory on Health Care Systems ***Year*** 1996 |

| | |
|---|---|
| ***Code*** | 14.4.1 |
| ***Description*** | Voluntary health insurance |
| ***Contents*** | It is estimated that approximately 5–8% of the Greek population take out some voluntary health insurance. This is as yet a relatively small proportion, but has been growing quite rapidly and is expected to continue to increase. There are numerous private insurance companies, both Greek and foreign, offering private health cover. Reasons for taking out private health insurance in Greece include comprehensive coverage for services provided by private providers (physicians in private practice, private diagnostic centres, and private hospitals) as well as coverage for supplementary services not included or partially included in the statutory system. |
| ***Source*** | European Observatory on Health Care Systems ***Year*** 1996 |

| | |
|---|---|
| ***Code*** | 14.4.1.1 |
| ***Description*** | Organisation of voluntary health insurance: public, quasi public, private, not for profit |
| ***Contents*** | |
| ***Source*** | European Observatory on Health Care Systems ***Year*** 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.4.1.2 | | |
| ***Description*** | Type and nature of services covered | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.4.1.3 | | |
| ***Description*** | Proportion of population covered | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1996 |

| | |
|---|---|
| ***Code*** | 14.4.2 |
| ***Description*** | Out-of-pocket payments: main cost sharing measure (partial reimbursement, co-payment) by care category: ambulatory, inpatient, drugs, medical aids and prostheses |
| ***Contents*** | Out-of-pocket payments<br>Out-of-pocket payments in Greece take the following forms:<br><br>* co-payments for health care services covered by the statutory system (as well as payments in full for services not covered by social insurance);<br>* official private payments, including payments to private physicians, private diagnostic centres and hospitals;<br>* and unofficial, or under-the-table payments, particularly in the hospital sector.<br>Co-payments for health care services covered by the statutory system<br>It should be noted that Greece is the only country in the EU where cost containment in the health sector has not been a major policy issue, and where as a result very few cost-containment measures have been implemented in recent years. A major policy objective in the 1980s and early 1990s has in fact been expansion of public sector expenditure and provision. Since the health care reform legislation of 1983, establishing the NHS, coverage of the population has increased, and the benefit packages of sickness funds have expanded. Newly instituted out-of-pocket payments therefore include only the following:<br><br>* Pharmaceuticals: Since 1992, 25% of the cost of drugs has been paid by the patient. This applies to all major insurance funds. Exceptions are made for certain categories of patients who pay 10%, and for persons with chronic conditions who are wholly exempted. Since the new rates of co-payments for pharmaceuticals were introduced in 1992, there has been no effort as yet to measure the impact on consumption. It is possible that some vulnerable groups may have been negatively affected (for example the elderly on very low pensions). There is some evidence to suggest that doctors sometimes try to avoid the imposition of a co-payment on an elderly or other patient who appears to have difficulty in paying by indicating that the patient's condition is chronic (in which case the patient is exempted from the payment).<br><br>* Out-patient consultations in hospitals: Since 1992, all out-patients who are not receiving emergency treatment pay 1000 drachmas (this does not apply to follow-up visits). Members of the OGA fund (the rural population) and the poor are exempted (a total of about 25% of the population). However, in the case of certain insurance funds, the patient is entitled to be reimbursed for this amount by his/her respective fund. In the cases of IKA and TEVE, (about 65% of the population) reimbursement is not possible. For comparative purposes, it may be noted that a private doctor receives 2200–4000 drachmas per consultation from a sickness fund. In the private sector, most doctors charge 5000–10 000 drachmas per consultation (though in some instances, such as in the case of doctors who are university professors, the fee can be as high as 20 000 drachmas per consultation). Out-patient consultations decreased slightly in 1993 when this fee was imposed, and increased again in the following year.<br><br>In addition to the above, there are certain co-payments which are imposed on certain items, particularly by some of the smaller funds. For example, the TEVE-insured pay 25% of laboratory test costs and public servants' dependants pay 10%. The number of funds is large, and the benefits are variable, so it is not possible to go into these in detail. The four larger funds, insuring approximately 90% of the population, cover almost all benefits in full. However, it is also the case that members of IKA (which is the largest fund) have the option to visit private doctors and hospitals contracted with IKA, in which case IKA pays only a portion of the cost, with the patient being responsible for the remainder. The co-payments here are variable, depending on the type of service received. This arrangement is optional, however, as the IKA member who does not wish or is unable to pay is entitled to visit IKA polyclinics which are entirely free-of-charge, or to go to public hospitals which, as part of the NHS, are also free. Most co-payments which do exist have been in place for a number of years (with the possible exception of new services that have been added to the benefits packages due to new medical technologies and the like), and there have been no recent changes imposed by cost-containment considerations.<br>Private payments to physicians in private practice, private diagnostic centres and hospitals<br>Whereas virtually all Greek citizens have coverage for health care services through statutory insurance or the NHS, there is a large private sector consisting of consultations with physicians in private practice, visits to private diagnostic centres, as well as private hospitals for in-patient care. This is due to dissatisfaction with publicly provided services.<br>Unofficial payments<br>These are especially prominent in the case of in-patient care, and are made to doctors, mainly surgeons, in public but also in private hospitals. These payments are also made in the case of out-patient care. The rationale is to jump the queue or to secure better quality services and greater personal attention by the doctor. Unofficial payments are considered to be a major |

problem in the Greek health care system. It is estimated that about half the total private expenditure on health care involves informal payments. There is no really reliable estimate of the size of the unofficial market, partly because it is so widespread, and partly because of the complexity of the Greek health care system.

Almost 60% of total out-of-pocket payments (official and unofficial) are made to doctors and dentists, 20% go toward pharmaceuticals, with the rest being mainly expenditures on private diagnostic centres and private clinics. Out-of-pocket payments (both official and unofficial) represent roughly 6% of household income (1990 figures).

***Source*** European Observatory on Health Care Systems ***Year*** 1996

***Code*** 14.4.3

***Description*** External sources of funding: employers, fund raisers etc.

***Contents***

External sources of funding
With the assistance of EU funds, Greece has undertaken a reform of portions of the psychiatric sector. Financing of the project was initiated in 1983 and ended in 1994. With 15 000 million drachmas contributed by the EU and an additional 5000 million by Greece, this project has resulted in the establishment of 31 psychiatric centres plus an additional 6 that are currently under construction, each of which is attached to the nearest hospital with psychiatric facilities. The project has also included renting of several hundred apartments for psychiatric patients in the proximity of the health centres. Several other services have been included, such as vocational training for the patients. Despite certain implementation delays, the EU has commended Greece for the progress made and the success of this programme.

In 1994, the Ministry of Health, in collaboration with the Ministry of National Economy, introduced a five-year plan (1995–1999) which was approved by the EU. The plan is being funded, two-thirds by the EU structural funds and one-third by the Greek government, and includes: the upgrading or construction of 15 hospitals; the improvement of the National School of Public Health; the expansion of the Ambulatory Emergency Service in the entire country; a new National Blood Bank; the establishment of one central and five regional public health laboratories; the establishment of a National Research, Evaluation and Quality Assurance Centre, and several projects for hospital informatics and health manpower education.

A final project being funded in part by the EU is Interreg, which involves the establishment of cross-border public health laboratories. This is a joint project with Albania and Bulgaria.

***Source*** European Observatory on Health Care Systems ***Year*** 1996

***Code*** 15

***Description*** Health care expenditure

***Contents***

***Source*** European Observatory on Health Care Systems ***Year*** 1996

| | | | |
|---|---|---|---|
| ***Code*** | 15.1 | | |
| ***Description*** | Structure of health care expenditures | | |
| ***Contents*** | The share of public expenditure increased until 1990 and the subsequently declined not because of an absolute drop but because of more rapid growth of private expenditure. The proportion of in-patient care has been steadily increasing throughout the period, reaching the rather high percentage of about 59% in 1992, which reflects the strong hospital orientation of health care. The share of pharmaceuticals, by contrast, has been continuously declining, and only in 1992 registered a small increase. The share of investment nearly doubled in the period 1970–1975, increased further in 1980–1985, and subsequently stabilized at between about 6% and 7% of total expenditure. | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 15.2 | | |
| ***Description*** | Total and public health expenditure as % GDP | | |
| ***Contents*** | Health care expenditure<br>Over the period 1970–1993 health care expenditure in Greece has increased substantially in constant prices, in per capita US $PPP, and as a share of the GDP. It can be seen that the greatest increases have occurred in the period 1980–1990, reflecting increases that have occurred in both the public and private shares of spending. The development from public to private shares is in fact quite interesting when examined in the light of the 1983 reforms. While there was a significant growth in public sector expenditures following the reforms, there was also significant growth in private expenditures, especially after 1990. There was an increase in the public share of total expenditure from 81% in 1985 to 84% in 1990, after 1990 the public share dropped to 75–76%. That is, from 1985–1990 public expenditures were growing faster than private expenditures, but from 1990 onwards private expenditures were growing faster. This reflects the partial, at best, success of the 1983 reform with respect to its intention to increase public expenditure on health at the expense of private expenditure.<br><br>There is an another issue which should be noted concerning the OECD figures of health care expenditure in Greece. A number of studies suggest that OECD figures underestimate the size of both public and private expenditure on health in Greece. According to the Greek interpretations of the national accounts, health care expenditure may account for as much as 7.2–7.4% of the GDP. | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 15.3 | | |
| ***Description*** | Health care expenditure by category (%) of total expenditure on health care | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 16 | | |
| ***Description*** | Import and Export | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 16.1 | | |
| ***Description*** | Import | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 16.2 | | |
| ***Description*** | Export | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 17 | | |
| ***Description*** | Health care reforms | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1996 |

| | |
|---|---|
| ***Code*** | 17.1 |
| ***Description*** | Determinants and objectives |
| ***Contents*** | At present, a number of factors have combined to push the reform process forward. These factors include the changing international political environment, macroeconomic constraints, the lack of policy formulation mechanisms in the health sector, the technical and administrative inefficiencies, and social and behavioural patterns. The main reasons underlying the initiation of health care reforms in 1994–1995 are the following:<br><br>* absence of appropriate financial mechanisms with respect to levels of care, regions and social insurance funds, resulting in inequalities in population coverage and access to health care services;<br>* absence of cost-containment measures, coordination of payments, effective incentives to the providers, pricing policies, etc.;<br>* high centralization of the system, so that there is no local evaluation and decision-making following priority setting based on the health needs of the population;<br>* absence of effective managerial structures and organizational-administrative policies which would create incentives for health care personnel to be more productive and efficient;<br>* lack of a referral system due to the underdeveloped family physician and PHC system;<br>* unequal distribution and education of health care personnel;<br>* old fashioned and bureaucratic role of public health at the central level of government and in the districts;<br>* lack of quality and audit control programme, resulting in low credibility in the system and low citizen satisfaction levels.<br><br>The objectives underlying the reform of the health system are in brief:<br><br>* to create a coherent policy to improve health care with intersectoral coordination and a strong emphasis on public health (promotion, prevention, etc.);<br>* to decentralize the system and encourage citizen participation by providing equal access financially and geographically, and by establishing organizational structures permitting citizen participation;<br>* to improve management and quality of care through incentives for improved performance and specific budgets for education;<br>* to create incentives for cost-effectiveness, by enforcing budget limits and by cutting down levels of waste (in the prescribing of drugs, the provision of excessive diagnostic tests and doctors' visits);<br>* to update facilities where necessary;<br>* to provide family medicine with continuity of care;<br>* to promote primary health care. |
| ***Source*** | European Observatory on Health Care Systems |
| ***Year*** | 1996 |

| | |
|---|---|
| ***Code*** | 17.2 |
| ***Description*** | Content of reforms and legislation |
| ***Contents*** | Highlights of major reform proposals and legislation:<br><br>* In 1934, the Social Security Organization (IKA) was established, providing insurance coverage to blue- and white-collar workers (about one-third of the population at that time).<br><br>* In 1953, the first legislation attempting to establish an NHS appeared, however it was never fully implemented.<br><br>* In 1961, the Agricultural Insurance Organization (OGA) was established, providing coverage for the agricultural population.<br><br>* In 1968, the L. Patras Plan was presented by the Ministry of Health, aiming at the introduction of an NHS, the reduction of regional inequalities, introduction of a family doctor system based on GPs, improvements in the quality of various services provided, and the introduction of a unified fund. After some half-hearted attempts to implement portions of the legislation, the plan was dropped.<br><br>* In 1976, a working party at the Centre of Planning and Economic Research prepared a study detailing the shortcomings of the health care system and proposing the creation of a unified fund, unification of the services provided by the three largest insurance funds; and the introduction of a family doctor system. The proposals never passed into legislation.<br><br>* In 1980, the Doxiades Plan formulated at the Ministry of Health produced a legislative proposal including the establishment of a planning agency for the coordination of health care provision, and the development of a network of rural health centres staffed by family doctors. The plan was rejected by parliament.<br><br>* In 1983, the PASOK government put forward a comprehensive reform plan that included many of the principles that had appeared in earlier reform proposals, plus some additional principles believed to underlie the successful establishment of an NHS: equity in delivery and financing of health care; development of primary health care including a referral system; expansion of public provision of primary and secondary care services and a limitation of privately provided services; and decentralization in the planning process with improvements in management and community participation. In brief, the plan focused on the development of a fully integrated system of public provision, with a focus on equity, decentralization, and management reforms. The plan was passed in Parliament in 1983, and implementation began almost immediately. A major shortcoming of the plan was that it did not deal effectively with the financing aspects of the system, leaving the crucial relationship between the social insurance funds and the newly established NHS undefined.<br><br>* In 1992, the conservative government passed legislation which emphasized the following: patient freedom of choice and private initiative; abolishment of restrictions on the construction of private hospitals; hospital freedom to hire private consultants; social insurance fund freedom to contract with any providers; financial and administrative responsibilities for rural health centres transferred from district hospitals to districts; new planning and management techniques; and new financial accountability and audit systems. Most of these provisions (mainly those in the public sector) were never implemented because of delays and a subsequent change of government which stopped the implementation process.<br><br>The most recent reform proposals:<br><br>In January 1994, the PASOK government (which had again come into power in October 1993) abolished most of the articles of the 1992 legislation passed by the conservatives. At the same time the Minister of Health established two committees:<br><br>* a local committee including Greek experts both from Greece and abroad systems (Karokis, Polyzos, Roupas, Sissouras, Theodorou, Yfantopoulos), which produced a Report on the Organization and Management of Health Services in Greece, detailing the shortcomings of the system;<br>* an international committee (Abel-Smith, Calltrop, Dixon, Dunning, Evans, Holland, Jarman and Mossialos), which visited many health services and received information from the local committee members, and which produced a Report on the Greek Health Services in June 1994. The main points of this report were for the most part incorporated into the reform plan that was subsequently formulated.<br><br>In addition, the Minister of Health established three local committees to examine in detail the |

reform issues in:

* unification of the sickness funds – decentralization
* organization and management of the system – manpower
* GP network – PHC.

The Athens School of Public Health examined the public health issues.

These committees were composed of politicians as well as social and professional representatives, and made recommendations that were included in three separate reports (January 1994). However, the unions, especially those of medical doctors, rejected the recommendations. Nonetheless, on the basis of the recommendations of the committees referred to above, the local committee of Greek experts (including members of all the local committees together with legal advisers of the Ministry of Health and the Parliamentary Health Commission), prepared a new proposal consisting of 100 articles (May 1995) to be submitted to Parliament. The opposition party fully agreed with the foreign experts' proposals, but rejected the proposed legislation.

The key elements of the proposed legislation were the following:

* A unified sickness fund: The main social insurance sickness funds transfer their funds for health care to one unified fund which is to purchase services for their members. The government will transfer to this fund all relevant subsidies which are allocated to health care.

* The resulting Unified Sickness Fund will be directly accountable to the Minister of Health, although it will be an independent public agency with a staff of experts and administrators in at least four divisions (collection of resources, distribution of resources to the NHS through regional bodies, supplies of drugs, quality control, research and monitoring).

* In addition, the proposal introduces prospective global budgets for hospitals and productivity incentives for health care personnel.

* Organizational change: The provision and financing of health care services will be split, with the Ministry of Health responsible for provision and the Unified Sickness Fund for financing. The proposal introduces a new organizational structure and administrative mechanism for provision. This involves the establishment of an NHS Management Executive at the central level, which is to supervise all NHS delivery services, and Regional Health Managers of Regional Health Directorates, to be responsible for delivery at the regional level. They are to collaborate with central and regional health boards, and are responsible for local needs assessment which is to form the basis for allocating the central fund's resources across regions. Regional Health Directorates include divisions of public health, clinical services, and monitoring the use of resources and facilities in collaboration with districts.

* Each hospital, according to the proposal, will be run by a specially trained and well paid general manager who is responsible to the hospital's Board and is also a member of it. A medical director will run medical services, while new managerial and financial structures will be introduced. NHS doctors will be periodically assessed and will face incentives and disincentives.

* A family doctor system: At the heart of the reform of health services is the establishment of a family doctor network in the whole country starting with urban areas. The 400 existing urban polyclinics and rural health centres will be upgraded. The whole country will be divided into 400 PHC units in which GPs will work in group or solo practices with lists of about 1500 registered residents. Each citizen served by the unified fund will be able to choose his/her GP. The GPs will be provided with space in the existing health centres, polyclinics and rural clinics or will practise from their own premises. Their remuneration will be based on contracts with the Unified Fund (with the exception of about 500 GPs who are already working in the system as full-time NHS and IKA employees and who will continue to be salaried employees). The 400 primary health care units, grouped on a regional and/or district basis, will be under the jurisdiction of their respective regional primary health care organizations. Ambulance centres will be upgraded through purchases of advanced equipment (ambulances, mobile units, helicopters, telematics, etc.).

* Focus on health promotion and prevention: Coherent plans for health improvement are to be developed, with emphasis on health promotion and disease prevention. The proposal provides for the establishment of a multidisciplinary public health service with trained public health doctors posted to work at the new regional level in collaboration with the existing district level. Laboratories for public health control are to be established, at least one in every region. Supervision at the central level and coordination with various national committees on different disease patterns is very important. A national committee and a special directorate in the ministry are to be created in order to make specific planning arrangements. Crash

programmes for the training of managers, public health doctors and GPs are to be initiated.

However, another opportunity was lost as Prime Minister Papandreou's illness at the end of 1995 resulted in postponement of the legislation and governmental changes (a new Prime Minister in 1996, a new Minister of Health, etc.). The proposed legislation was not submitted to parliament at the end of 1995 as planned.

In early 1996, due to the political changes the reform plan was modified into a less radical but more pragmatic proposal. The modified proposal focuses on the following main areas of change:

* reorganization of the NHS with a new managerial role adjusting to the new organizational structure;
* rationalization of resources on the financing side, possibly postponing the unification of the biggest sickness funds, and allocation of resources via regional global budgets based on specific criteria;
* decentralization of the health care services and creation of regional health authorities;
* establishment of public health regional authorities and laboratories, and upgrading of public health as a whole;
* giving the initiative to the social insurance funds to establish a GP network beginning in urban areas;
* education for health professionals emphasizing the role of the new fields in health promotion, social medicine, general practice, school medicine, various nursing specialties, biotechnology, health services management and economics, information systems and public health;
* upgrading emergency care (ambulances, mobile card-surgical units, helicopters, etc.);
* changing the financing principles of the health care system by introducing global budgets, cost accounting per department or case, productivity incentives to health care professionals (especially medical doctors) and by finding additional resources through specifically targeted state subsidies or cost savings from rationalization of expenses in drugs, medical supplies, etc.;
* continuous improvement in mental health programmes;
* focus on issues of quality of care and quality assurance; establishment of a National Centre of Quality Control.

This proposal will probably be presented to parliament in the very near future.

***Source*** European Observatory on Health Care Systems ***Year*** 1996

***Code*** 17.2.1

***Description*** future development of planning: move to be integrated/move to contract based

***Contents***

***Source*** European Observatory on Health Care Systems ***Year*** 1996

***Code*** 17.2.2

***Description*** tax based system: change in population coverage; opting out permitted/encouraged

***Contents***

***Source*** European Observatory on Health Care Systems ***Year*** 1996

***Code*** 17.2.3

***Description*** insurance based system: development of the degree of benefit coverage in the future

***Contents***

***Source*** European Observatory on Health Care Systems ***Year*** 1996

| | | | |
|---|---|---|---|
| ***Code*** | 17.2.4 | | |
| ***Description*** | voluntary health insurance: changes in uptake; plans for change | | |
| ***Contents*** | | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1996 |

| | | | |
|---|---|---|---|
| ***Code*** | 17.3 | | |
| ***Description*** | Health for all policy | | |
| ***Contents*** | Greece has not developed an official health for all policy. In the course of the last few years, several attempts have been made to initiate a process of developing such a policy, however they have all failed. | | |
| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1996 |

| | |
|---|---|
| ***Code*** | 17.4 |
| ***Description*** | Reform implementation |
| ***Contents*** | The reform proposals put forward during the post-war decades in Greece look like an unending process to try, on the one hand, to reform the health care system, and on the other to impose obstacles in implementing these health care reforms. Although the emphasis has varied somewhat from proposal to proposal, the main themes of the proposed reforms are remarkably similar: establishing an NHS; achieving equity in access and provision; consolidating the disparate and multiple sources of funding; addressing the weaknesses of PHC; establishing a family doctor system based on general practice; instituting a referral system; and achieving some degree of decentralization.<br><br>This suggests that reform planners, who have appeared with successive governments, have long been aware of the shortcomings of the health care system, and have also long been aware of the pressing need to address these shortcomings, and that they are not a new phenomenon but have been present for many years. The most important factor underlying the inability of successive governments to pass or implement the various legislative proposals involves political opposition to the reforms. There are as a rule three sources of political opposition: doctors' unions, representing the vested interests of their members, social insurance funds, which resist change and do not want to lose their traditional autonomy; and opposition parties in the government, which would rather impose their own particular version of reform and thereby directly serve the needs of their own particular clientele.<br><br>There are a number of factors that combined to permit the passing of the 1983 legislation and its subsequent partial implementation. First, the 1983 proposals had been discussed over many years, and similar proposals had been put forward under a variety of earlier governments. Therefore, by 1983 a certain political consensus regarding the need for reforms, had been achieved. Second, doctors' unions agreed with the need for reforms, and supported the PASOK government. Third, the PASOK government enjoyed broad popularity. Fourth, there was very widespread dissatisfaction with health care services. Finally, the severity of problems in the health care system had reached such proportions that change was almost universally viewed as being imperative.<br><br>The 1983 reforms, as noted above and throughout the discussions in this study, were partially implemented. The successful features of the reform can be briefly summarized to have included the following: establishment of the NHS; the significant expansion of public expenditure on health care; construction of rural health centres as well as a number of hospitals which significantly contributed to an improvement in access to health care services, especially for the rural population; and improved labour relations in the health sector, particularly during the initial five years of implementation. However, a number of issues were not addressed as planned, while certain new problems were inadvertently created during subsequent years. The rapid growth of the underground economy in health worked to undermine some of the achievements in equity; private expenditure on health increased significantly (though perhaps not to the same extent as public health expenditure); the family doctor system was not established; the urban health centres were not developed; the public health system was not developed; inequalities in provision through variable fund benefit packages persisted; the financial footing of the NHS and the social insurance funds became increasingly unstable; decentralization processes were not initiated; and there were perverse efficiency developments.<br><br>In part, the failure of the reforms on the financing side were due to the inadequate attention that was paid to the financial relationship between the social insurance funds and the newly established NHS, as well as inadequate attention to incentives and efficiency considerations, and hence can be attributed to faulty design of the reforms. Additional factors which worked to frustrate the implementation process included the generally inadequate administrative and institutional infrastructure, poor planning and management capabilities, and the custom of appointing persons to managerial and administrative positions on the basis of political considerations.<br><br>In the case of the present (1996) reform proposals, the situation appears to be somewhat optimistic. The proposals now under consideration do not include all the provisions of the 1994–1995 proposals, and hence are more easily acceptable to broader segments of the population. Moreover, there appears to be almost universal agreement once again that change is imperative, as the system is facing problems of extreme urgency. Opposition has been shown by the doctors' union, but only with respect to a provision of the proposal seeking to abolish full life tenure for new doctors entering the NHS. The Ministry recently offered financial incentives to doctors, so trade unions will in all likelihood accept the proposals. There is no other opposition to the proposed legislation, therefore it is expected to pass in parliament. |

The results of a recent public opinion survey show that the public generally views the expected changes favourably. There is evidence to suggest that as much as 70% of the Greek population now want radical as opposed to piecemeal changes in the health care system, and that moreover they are willing to pay for radical changes (through increased earmarked taxation), assuming that their increased expenditure will be effectively used for improvements in the system.

The health policy discussion of the last three years has raised public awareness of the issues and the problems, and has increased the public's expectations of an initiation of a process of change that promises to seriously address the shortcomings of the health care system.

| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1996 |
|---|---|---|---|

| | |
|---|---|
| ***Code*** | 17.5 |
| ***Description*** | Conclusions |
| ***Contents*** | Problems in PHC<br>The major problems of PHC are the following:<br><br>* There is a plethora of social insurance funds and providers especially in the urban areas, with different organizational and administrative structures, offering services that are not coordinated and that often overlap. There are significant inequalities with respect to contribution rates among the different funds as well as in the range and quality of services provided.<br><br>* There are serious deficiencies in the health service infrastructure and a weak public sector response to the contemporary needs of medical science. These deficiencies result in the public provision of a limited range of services, so that insurance funds increasingly contract out private providers for services not offered by the public system.<br><br>* There is a serious lack of properly trained medical and nursing personnel. The specialty of general practice is accorded low professional and social prestige and as a result there is a serious shortage of general practitioners (GPs). There is an estimated need for 5000 GPs, but today there are only 560. These shortages are covered by pathologists, paediatricians, doctors with no specialization and rural doctors, with corresponding limitations in the quality of PHC services.<br><br>* There are serious shortages in medical and nursing personnel at the health centres and the IKA polyclinics.<br><br>* Low salaries and lack of incentives result in an unwillingness among doctors to staff the health centres, leading to low productivity and arbitrary limitation of working hours.<br><br>* The absence of a family doctor system and referral system, especially in the urban centres, precludes continuity of care, and increases system ineffectiveness. According to a recent study conducted in the University of Patras, about one in two Greeks visits the same pathologist over time, while in the case of gynaecologists and paediatricians the proportion is even higher. This suggests that Greek people favour continuity of care and would be highly receptive to a family physician system.<br><br>* Limited availability of services during the night hours, especially in the urban centres, forces patients to use out-patient departments of the hospitals on duty or private doctors.<br><br>* Low credibility in the system induces many patients to seek a second opinion, very often from private doctors. This creates additional expenses, overloads the system and partially cancels out the character of free health care.<br><br>* Lack of quality control programmes, especially in prescribing and referring to private diagnostic centres for high-cost examinations, burdens the insurance funds with unjustifiable expenses for examinations and medicines that are often useless and even hazardous to patients' health.<br><br>The reforms currently being planned (see section on health care reforms) will attempt to deal with some of these issues. However, some necessary changes may be delayed due to the greater importance that the Greek state and society attach to the secondary and tertiary levels of care, where enormous amounts of money have been invested. Even though there is general agreement on the principle of establishing an integrated GP network through the rural NHS services as well as the urban IKA ones, no process designed to achieve this has been set into motion. Plans along these lines have, however, appeared periodically. For example, the Central Health Council produced such a proposal in 1987, and a committee formed by the Ministry of Health in 1994 for the purposes of reform planning made a similar proposal in 1995. In addition, a reform proposal in 1992 attempted to introduce a family physician system, but this was also shelved. While a programme for training general practitioners has been initiated, it is not sufficient for the purposes of producing GPs in sufficient numbers over a short period of time. Only one (Crete) of seven medical schools offers a complete PHC course of study to its students. The only efforts being made by the state and IKA at present focus on improving the current infrastructure of services by employing more staff (in view of exemptions to the current restrictions on hiring public employees in the health and education sectors) and upgrading the facilities.<br><br>A key objective of the 1983 reforms in Greece was to increase equity in access to health care services. This was to be achieved through the establishment of an NHS guaranteeing |

universal coverage and access to health care services. This objective was to some extent accomplished, particularly through the establishment of rural health centres and clinics, as well as by the establishment of large teaching hospitals in areas far from the major urban centres, where the larger and better equipped hospitals already in existence were concentrated. The network of rural health centres that was built during the mid-1980s in fact constitutes a solid structure upon which a PHC system can be built. In addition, the primary care services offered free-of-charge at all NHS hospitals increased access, as entitlement by virtue of the NHS was on the basis of citizenship and not fund membership.

The objective of equity was partially compromised, however, by the inadequate staffing and facilities of health centres which did not allow them to operate as effectively as originally planned, as well as by the development of the underground economy in more recent years.

The reforms currently under consideration attempt to deal with difficulties that were not effectively resolved by the 1983 reforms. These involve not only the equity issue, but also, and perhaps more importantly, the issues of efficiency, health gain, and quality of care, which had not been adequately addressed in the previous reform. These are all issues which are very important for the Greek health care system as they underlie some of its weakest points. Specifically, there are many sources of inefficiency, such as, for example, multiple sources of funding, open-ended provider payment systems, the absence of a referral system and family doctor system, and the uncoordinated public-private provider mix. The issue of health gain is one that has not been addressed, in view of weaknesses in public health and weaknesses (or nonexistence) in planning for health gain. Finally, quality of care is also an area that has only in very recent years emerged as a health policy issue.

Consumer choice, on the other hand, has not directly preoccupied reform planners to any significant degree, not has it been regarded as a major health policy issue. The reform legislation of 1992 did emphasize free consumer choice, however, this did not have any practical implications because consumer choice was largely free to begin with. Because of the structure of provision, and the lack of a referral system, free choice of provider has always been, for the most part, a characteristic feature of the health care system. It is only in the case of IKA polyclinics that certain limitations to free choice may exist.

If the key objective of the most recent reform proposal can be very briefly summarized, it could be said that most of the planned changes centre on the development of efficiency-promoting measures. Quality of care and quality assurance are additional important, though perhaps not so prominent, issues. Health gain, though not directly addressed, is at least indirectly making its appearance in the health policy agenda through the focus on development of the public health system and education for health promotion and public health specialists, as well as other related fields.

| ***Source*** | European Observatory on Health Care Systems | ***Year*** | 1996 |
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# *Country profile: Iceland*

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|---|---|---|---|
| ***Code*** | 1 | | |
| ***Description*** | Introduction and historical background | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 1.1 | | |
| ***Description*** | Introductory overview | | |
| ***Contents*** | In Iceland, like in the other Nordic countries, the health service is a public matter. All countries have well-established systems of primary care health care. In addition to systems of general practice, preventive services are provided for mothers and infants, as well as school health care and dental care for children and young people. Likewise, preventive occupational health services and general measures for the protection of the environment exist in all countries. The countries generally have a well-developed hospital service with advanced specialist treatment. Specialist medical treatment is also offered outside of hospitals. The health services are provided in accordance with legislation, and they are largely financed by public spending or through compulsory health insurance schemes. In all countries, however, a certain amount is charged for treatment and pharmaceutical products. Salary or cash allowances are payable to employees during illness. Self-employed people have the possibility of insuring themselves in case of illness. | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 1.2 | | |
| ***Description*** | Historical background | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 2 | | |
| ***Description*** | Main functions of key bodies in the organizational structure and management of health care administration | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 2.1 | | |
| ***Description*** | (Con-)Federal/National government, Ministry with main responsibility for health care and other ministries with health care competence | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 2.2 | | |
| ***Description*** | Regional government | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 2.3 | | |
| ***Description*** | Local government | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 2.4 | | |
| ***Description*** | Insurance organisations | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 2.5 | | |
| ***Description*** | Professional groups | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 2.6 | | |
| ***Description*** | Providers | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | |
|---|---|
| ***Code*** | 2.7 |
| ***Description*** | Voluntary bodies |
| ***Contents*** | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 |
| ***Year*** | 1997 |

| | |
|---|---|
| ***Code*** | 3 |
| ***Description*** | Planning, regulation and management |
| ***Contents*** | The role of the Government is significantly larger than that of the local and regional boards, where particularly the regional boards play a very limited role. |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 |
| ***Year*** | 1997 |

| | |
|---|---|
| ***Code*** | 3.1 |
| ***Description*** | Extent of system decentralisation (deconcentration, devolution, delegation, privatisation) |
| ***Contents*** | The health sector is regulated according to the health act of 1990. The administration of the health service is divided between the Government on one hand and regional and local boards on the other. |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 |
| ***Year*** | 1997 |

| | |
|---|---|
| ***Code*** | 3.2 |
| ***Description*** | Existence of national health planning agency/plan |
| ***Contents*** | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 |
| ***Year*** | 1997 |

| | |
|---|---|
| ***Code*** | 3.3 |
| ***Description*** | Supervision of the health services |
| ***Contents*** | The director General of Public Health has the overall responsibility for the supervision of health institutions, health staff, prescription of medicine, treatment of substance abusers and control of all public health services. The District Medical Officer carries out supervision in the district on behalf of the administration. The State Drug Inspectorate supervises pharmacies and pharmaceutical products. Complaints concerning the health services are addressed to the Director General of Public Health and the District Medical Officers who evaluate the complaints and make decisions. However, the institutions involved must also be informed about the complaints. In case of conflicts, the case has to be discussed by a special board (consisting of three persons appointed by the Supreme Court). Complaints can also be forwarded directly to this board. |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 |
| ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 3.4 | | |
| ***Description*** | Financial resource allocation | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 3.4.1 | | |
| ***Description*** | Third party budget setting and resource allocation | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 3.4.2 | | |
| ***Description*** | Determination of overall health budget | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 3.4.3 | | |
| ***Description*** | Determination of programme allocations | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 3.4.4 | | |
| ***Description*** | Determination of geographical allocations | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 3.4.5 | | |
| ***Description*** | Health care budget decision-making at national/regional/local level | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 3.4.6 | | |
| ***Description*** | Approach to capital planning | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 3.4.7 | | |
| ***Description*** | Capital investment funding | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 3.4.8 | | |
| ***Description*** | Recent changes in resource allocation system | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 4 | | |
| ***Description*** | General characteristics of the organizational structure | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 4.1 | | |
| ***Description*** | Integrated or contract model | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 4.2 | | |
| ***Description*** | Organisational relationship between third party payers and providers | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 4.3 | | |
| ***Description*** | Ownership: public, private, mix | | |
| ***Contents*** | Most of the nursing and old-age homes function as private foundations. | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 4.4 | | |
| ***Description*** | Freedom of choice | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 4.5 | | |
| ***Description*** | Referral system | | |
| ***Contents*** | Patients are free to contact a specialist, whereas treatment in hospital requires a referral either from a physician in the primary health care or from a specialist. | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 5 | | |
| ***Description*** | Out-patient care | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 5.1 | | |
| ***Description*** | Medical care | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 5.1.1 | | |
| ***Description*** | General practitioner (solo-, group practices) | | |
| ***Contents*** | The primary health care is run from the health centres and to a minor degree also by private general practitioners. The health centres have the responsibility for the general treatment and care, General practitioners in Iceland carry out the infant check-ups programme, which comes top on the top twenty list. | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | |
|---|---|
| ***Code*** | 5.1.2 |
| ***Description*** | Medical specialist with own premises |
| ***Contents*** | There are both private practising specialists and specialists connected to hospitals. |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 |
| ***Year*** | 1997 |

| | |
|---|---|
| ***Code*** | 5.1.3 |
| ***Description*** | Out-patient department |
| ***Contents*** | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 |
| ***Year*** | 1997 |

| | |
|---|---|
| ***Code*** | 5.1.4 |
| ***Description*** | Combined services: health centres |
| ***Contents*** | The primary health care is run from the health centres and to a minor degree also by private general practitioners. The health centres have the responsibility for the general treatment and care, examinations, home nursing as well as preventive measures such as family planning, maternity care and child health care, school health care, etc. Dental treatment is normally carried out by private practising dentists. In Reykjavik there is a school dental service. Such service is also provided at some of the health centres, that supply clinical facilities for private practising dentists. Physiotherapy is partly provided at the health centres, but mostly by private practising physiotherapists. Home nursing is provided by the health centres, whereas home help is part of the municipal social service system. |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 |
| ***Year*** | 1997 |

| | |
|---|---|
| ***Code*** | 5.2 |
| ***Description*** | Dental care |
| ***Contents*** | Dental treatment is normally carried out by private practising dentists. In Reykjavik there is a school dental service. Such service is also provided at some of the health centres, that supply clinical facilities for private practising dentists. |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 |
| ***Year*** | 1997 |

| | |
|---|---|
| ***Code*** | 5.2.1 |
| ***Description*** | General dentist |
| ***Contents*** | Dental treatment is normally carried out by private practising dentists. |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 |
| ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 5.2.2 | | |
| ***Description*** | Dental specialist | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 5.3 | | |
| ***Description*** | Pharmacists | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 5.4 | | |
| ***Description*** | Midwifery | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 5.5 | | |
| ***Description*** | Paramedical care | | |
| ***Contents*** | Physiotherapy is partly provided at the health centres, but mostly by private practising physiotherapists. | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 5.6 | | |
| ***Description*** | Home nursing and home care (maternity home care included) | | |
| ***Contents*** | Home nursing is provided by the health centres, whereas home help is part of the municipal social service system. | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 5.7 | | |
| ***Description*** | Out-patient mental health care services | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 5.8 | | |
| ***Description*** | Ambulance services and patient transport | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 5.9 | | |
| ***Description*** | Medical laboratories | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 6 | | |
| ***Description*** | In-patient care | | |
| ***Contents*** | There are three types of hospitals: Three highly specialized hospitals of which two are placed in Reykjavik and one in Akureyre, regional hospitals with a certain degree of specialisation, and local hospitals. The local hospitals also function as old-age and nursing homes. Other health institutions include rehabilitation hospitals and clinics for alcohol abusers. Most of the nursing and old-age homes function as private foundations. They are run by the municipalities, charity organisations etc. They are partly financed by user charge, but the major part of the financing is provided by the government either through the national pension scheme as is the case for the old age homes, or through the health insurance scheme as is the case for the nursing homes. | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 6.1 | | |
| ***Description*** | Hospital categories | | |
| ***Contents*** | There are three types of hospitals: Three highly specialized hospitals of which two are placed in Reykjavik and one in Akureyre, regional hospitals with a certain degree of specialisation, and local hospitals. The local hospitals also function as old-age and nursing homes. Other health institutions include rehabilitation hospitals and clinics for alcohol abusers. | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 6.2 | | |
| ***Description*** | Other in-patient provisions | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 7 | | |
| ***Description*** | Relationship between primary and secondary care | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 7.1 | | |
| ***Description*** | Planned or actual substitution policies for inpatient care | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 7.2 | | |
| ***Description*** | Degree of co-operation between primary and secondary health care providers | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 7.3 | | |
| ***Description*** | Imbalance between primary and secondary care | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 8 | | |
| ***Description*** | Prevention and public health services | | |
| ***Contents*** | In Iceland, consultation with a view to preventive health care for pregnant women and mothers with infants as well as school health care are free of charge. The health centres have the responsibility for the general treatment and care, examinations, home nursing as well as preventive measures such as family planning, maternity care and child health care, school health care, etc. General practitioners in Iceland carry out the infant check-ups programme, which comes top on the top twenty list. | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 8.1 | | |
| ***Description*** | Maternal and child health: family planning and counselling | | |
| ***Contents*** | In Iceland, consultation with a view to preventive health care for pregnant women and mothers with infants as well as school health care are free of charge. The health centres have the responsibility for the general treatment and care, examinations, home nursing as well as preventive measures such as family planning, maternity care and child health care, school health care, etc. General practitioners in Iceland carry out the infant check-ups programme, which comes top on the top twenty list. | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 8.2 | | |
| ***Description*** | School health services | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 8.3 | | |
| ***Description*** | Prevention of communicable diseases | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 8.4 | | |
| ***Description*** | Prevention of non-communicable diseases | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 8.5 | | |
| ***Description*** | Occupational health care | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 8.6 | | |
| ***Description*** | All other miscellaneous public health services | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 9 | | |
| ***Description*** | Social care related to health care | | |
| ***Contents*** | Home help is part of the municipal social service system. | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 9.1 | | |
| ***Description*** | Organisation and financing of social care | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 9.2 | | |
| ***Description*** | Role of central/regional/local government | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 9.3 | | |
| ***Description*** | Role of other organisations | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 9.4 | | |
| ***Description*** | Responsibility of family members | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 9.5 | | |
| ***Description*** | Financing of social care | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 9.6 | | |
| ***Description*** | Explicit health/social care policy | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 10 | | |
| ***Description*** | Medical goods and health care technology assessment | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 10.1 | | |
| ***Description*** | Pharmaceuticals | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 10.2 | | |
| ***Description*** | Therapeutic appliances | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 10.3 | | |
| ***Description*** | Health care technology assessment | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 11 | | |
| ***Description*** | Other services | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 11.1 | | |
| ***Description*** | Education and training of personnel | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 11.2 | | |
| ***Description*** | Research and development in health | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 11.3 | | |
| ***Description*** | Environmental health and control of drinking water | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 11.4 | | |
| ***Description*** | Health programme administration and health insurance | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 11.5 | | |
| ***Description*** | Administration and provision of cash benefits | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 12 | | |
| ***Description*** | Manpower in health care | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 13 | | |
| ***Description*** | Fees, rates and salary structure | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 13.1 | | |
| ***Description*** | Methods of payment to (specialist) physicians | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 13.1.1 | | |
| ***Description*** | Integrated or contracted | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 13.1.2 | | |
| ***Description*** | Type of payment | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 13.1.3 | | |
| ***Description*** | Method for deciding fees/salaries | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | |
|---|---|
| ***Code*** | 13.2 |
| ***Description*** | Methods of hospital payment |
| ***Contents*** | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 |
| ***Year*** | 1997 |

| | |
|---|---|
| ***Code*** | 13.2.1 |
| ***Description*** | Method of payment |
| ***Contents*** | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 |
| ***Year*** | 1997 |

| | |
|---|---|
| ***Code*** | 13.2.2 |
| ***Description*** | Method for deciding rates |
| ***Contents*** | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 |
| ***Year*** | 1997 |

| | |
|---|---|
| ***Code*** | 13.2.3 |
| ***Description*** | Recent changes in payment method |
| ***Contents*** | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 |
| ***Year*** | 1997 |

| | |
|---|---|
| ***Code*** | 14 |
| ***Description*** | Main system of financing and coverage (tax based, insurance based, mixture) |
| ***Contents*** | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 |
| ***Year*** | 1997 |

| | |
|---|---|
| ***Code*** | 14.1 |
| ***Description*** | Main features of tax based systems |
| ***Contents*** | In the Nordic countries, the health services are mainly financed by the public authorities. In Iceland, contributions are primarily made by the Government, while financing in the other countries mainly consists of country and/or municipal taxes with block grants from the Government With the exception of Greenland, citizens in the Nordic countries contribute directly through insurance schemes, partly by paying user charges. |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 |
| ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.1.1 | | |
| ***Description*** | Main body(ies) responsible for providing health care cover to beneficiaries | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.1.2 | | |
| ***Description*** | Extent of population coverage (excluded groups) | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.2 | | |
| ***Description*** | Main features of social health insurance | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.2.1 | | |
| ***Description*** | Organisation of main body responsible for insuring/providing coverage | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.2.2 | | |
| ***Description*** | Extent of population coverage | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.2.3 | | |
| ***Description*** | Stipulations in premium contribution | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.2.4 | | |
| ***Description*** | Competition between insurance schemes | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.2.5 | | |
| ***Description*** | Provision for risk adjustment | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.3 | | |
| ***Description*** | Health care benefits and rationing; recent reductions in benefits package and variations in extent between different insurance plans | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.4 | | |
| ***Description*** | Complementary sources of finance | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.4.1 | | |
| ***Description*** | Voluntary health insurance | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.4.1.1 | | |
| ***Description*** | Organisation of voluntary health insurance: public, quasi public, private, not for profit | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | |
|---|---|
| ***Code*** | 14.4.1.2 |
| ***Description*** | Type and nature of services covered |
| ***Contents*** | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 |
| ***Year*** | 1997 |

| | |
|---|---|
| ***Code*** | 14.4.1.3 |
| ***Description*** | Proportion of population covered |
| ***Contents*** | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 |
| ***Year*** | 1997 |

| | |
|---|---|
| ***Code*** | 14.4.2 |
| ***Description*** | Out-of-pocket payments: main cost sharing measure (partial reimbursement, co-payment) by care category: ambulatory, inpatient, drugs, medical aids and prostheses |
| ***Contents*** | The charge for consultation with a specialist is either ISK 1,400 plus 40 per cent of the remaining costs of the consultation or ISK 500 plus one third of the remaining 40 per cent. The reduced charge applies to pensioners, disabled and long-term unemployed as well as disabled and chronically sick children. The same rates also apply to outpatient specialist treatment in hospitals and emergency wards. Insured people pay ISK 1,000 for each laboratory test and for each X-ray treatment. The charge is ISK 300 for the group entitled to a reduced rate. User charge for persons who have been continuously unemployed for a period of 6 months or longer is the same as for pensioners. In Iceland, some pharmaceutical products for the treatment of certain diseases are paid entirely by the health insurance scheme, for other kinds patients pay the full cost themselves. In special individual cases, reimbursement by the health insurance scheme may cover more of the medicine costs than is described above. There is also a reference price system. For generic drugs of the same form, strength and package size, the reimbursement is calculated in relation to the maximum reference price, i.e. the lowest priced generic product. The present reference price list covers about 20 per cent of the registered drugs. There are no user charges for hospitalization. The health insurance offers reimbursement for dental treatment. Except for gold, fittings, bridges and orthodontics, there is a 75 per cent reimbursement for dental treatment of children under the age of 16 years. For the 16-yaer-olds, there is a 50 per cent reimbursement. Gold, fittings and bridges are refunded by 0 to 50 per cent for children aged 16 years and less, cf. special rules for this. Orthodontics may be refunded by up to ISK 100,000. Long-term illness and old age as well as disability pensioners get their costs fully or partially covered. For this group, 50, 75 to 100 per cent coverage may apply to costs of dental treatment, except gold, fittings and bridges. For treatment, including orthodontics, of congenital malformations, greater anomalies such as split palate and aplasies, accidents and illness, payments are made according to special rules. There is no subsidy for dental treatment for the rest of the population. Within the present system, the charges to be paid by patients in the age group 16-70 years are reimbursed if they, in the course of one calendar year, exceed ISK 12,000. The same applies to children under 16 years if the charges exceed 6,000. The patient charges are reimbursed for the following groups if they exceed ISK 3,000: Pensioners aged 60-70 years receiving full basic pension, pensioners aged 70 or more, and disabled persons and individuals who have been continually unemployed for 6 months or longer. If there is one or more children under the age of 16 in one family, they count as one person in relation to the cost ceiling. When the cost ceiling has been reached, an insured person will receive a rebate card which guarantees full or partial reimbursement for the rest of the year, according to certain rules. The cost ceiling scheme covers the following services: Consultation by a general practitioner or a specialist, home visit by a physician, outpatient treatment at hospitals or emergency wards as well as laboratory examinations and X-ray treatment. This scheme does not cover treatment for in vitro fertilization. |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 |
| ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.4.3 | | |
| ***Description*** | External sources of funding: employers, fund raisers etc. | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 15 | | |
| ***Description*** | Health care expenditure | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 15.1 | | |
| ***Description*** | Structure of health care expenditures | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 15.2 | | |
| ***Description*** | Total and public health expenditure as % GDP | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 15.3 | | |
| ***Description*** | Health care expenditure by category (%) of total expenditure on health care | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 16 | | |
| ***Description*** | Import and Export | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 16.1 | | |
| ***Description*** | Import | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 16.2 | | |
| ***Description*** | Export | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 17 | | |
| ***Description*** | Health care reforms | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 17.1 | | |
| ***Description*** | Determinants and objectives | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 17.2 | | |
| ***Description*** | Content of reforms and legislation | | |
| ***Contents*** | The Government is responsible for the health sector, but experiments are under way in two municipalities involving the transfer of the health services to the local government. In the some smaller municipalities outside Reykjavik, local hospitals are being merged with health centres into a joint institution. The hospitals in Reykjavik and the surrounding areas have increased their collaboration. Specialisation is on the increase in the major hospitals and the possibilities are currently being discussed for establishing a central and more advanced university hospital than what exists today. It is expected that substantial changes within the health care system are imminent and will entail greater involvement of local government as well as increased private enterprise.`Within the field of information and information technology, the Ministry of Health and Social Security has made a 3 - 5 year plan for developing and integrated information system for the health services. The plan includes development of electronic health care records, a closed information network for health care institutions, the development of telemedicine, and information services for the general public and health care personnel. | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 17.2.1 | | |
| ***Description*** | future development of planning: move to be integrated/move to contract based | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 17.2.2 | | |
| ***Description*** | tax based system: change in population coverage; opting out permitted/encouraged | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 17.2.3 | | |
| ***Description*** | insurance based system: development of the degree of benefit coverage in the future | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 17.2.4 | | |
| ***Description*** | voluntary health insurance: changes in uptake; plans for change | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 17.3 | | |
| ***Description*** | Health for all policy | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 17.4 | | |
| ***Description*** | Reform implementation | | |
| ***Contents*** | | | |
| ***Source*** | "Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

| | | | |
|---|---|---|---|
| ***Code*** | 17.5 | | |
| ***Description*** | Conclusions | | |
| ***Contents*** | | | |
| ***Source*** | “Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999 | ***Year*** | 1997 |

# *Country profile: Ireland*

| | | | |
|---|---|---|---|
| ***Code*** | 1 | | |
| ***Description*** | Introduction and historical background | | |
| ***Contents*** | | | |
| ***Source*** | Ministry of Health And Children | ***Year*** | 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 1.1 | | |
| ***Description*** | Introductory overview | | |
| ***Contents*** | The Irish healthcare system has a unique structure. It is a mixture of a universal health service, free at the point of consumption and a fee-based private system where individuals subscribe to insurance for coverage of medical expenses. It is also characterised by strong involvement of the voluntary sector, which in recent times has become increasingly publicly funded. | | |
| ***Source*** | Ministry of Health And Children | ***Year*** | 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 1.2 | | |
| ***Description*** | Historical background | | |
| ***Contents*** | The role of the state in health care has been evolving since the late eighteenth century from the locally funded provision of essential basic services, mainly for the very poor, to the wide and sophisticated range of services provided on a national basis for the whole community in the latter part of the twentieth century. The major responsibility for health policy in Ireland lies with the Minister for Health and Children and the Department of Health and Children, established in 1947. The Health Act 1970 established eight health boards, which are responsible for the provision of health and personal social services in their respective functional areas. In March 2000 the board in the most populous region -the east - was replaced by the Eastern Regional Health Authority which is delegating its service provision functions to its three area health boards to make services more responsive to local need and will also conclude 3-5 service agreements and annual agreements (provider plans) with voluntary service providers (major public voluntary hospitals and agencies providing services for persons with disability) in the area. The rationale for this change is to provide a more integrated patient focused service. | | |
| ***Source*** | Ministry of Health And Children | ***Year*** | 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 2 | | |
| ***Description*** | Main functions of key bodies in the organizational structure and management of health care administration | | |
| ***Contents*** | | | |
| ***Source*** | Ministry of Health And Children | ***Year*** | 2000 |

| | |
|---|---|
| ***Code*** | 2.1 |
| ***Description*** | (Con-)Federal/National government, Ministry with main responsibility for health care and other ministries with health care competence |
| ***Contents*** | The Healthcare System in Ireland<br>The major responsibility for health policy in Ireland lies with the Minister for Health and Children and the Department of Health and Children. This department is responsible for policy development and strategic planning of health services and for health care legislation. |
| ***Source*** | Ministry of Health And Children — ***Year*** 2000 |

| | |
|---|---|
| ***Code*** | 2.2 |
| ***Description*** | Regional government |
| ***Contents*** | Organisational Structure and Management of Health Care Administration<br>At regional level services are delivered through 8 health boards, established in 1971, serving populations of 200,000 to 1,300,000 with annual budgets in 2000 of IR£169 million - IR£750 million. Every board has elected local representatives, ministerial nominees and representatives of health professions employed by the Board. Each health board has a Chief Executive Officer (CEO) who has responsibility for day to day administration. The Health Act 1970 provides for the appointment of this statutory officer, who has specific responsibilities in the areas of staff appointments and pay, determining eligibility for health services and ensuring that budgets allocations are not exceeded. A chief executive officer is answerable to the board. The Health (Amendment) (No. 3) Act 1996 clarified the respective roles of health boards and their Chief Executive Officers by making boards responsible for certain defined functions relating to policy matters and major financial decisions and Chief Executive Officers responsible for executive matters. For administrative purposes, the work of each health board is divided into three programmes covering community care services, general hospital services and special hospital services (mainly hospital service for the mentally ill). In addition to their responsibilities for health services, the health boards are responsible for a long and diverse list of functions under the health acts and other various legislative acts. Certain welfare services are also provided by the boards; for example, they have responsibility for the payment of cash allowances, for the home help service, and for welfare homes for the aged. Health Boards administer the supplementary welfare allowance scheme on an agency basis for the Department of Social Community and Family Affairs, thus facilitating co-ordination of health and welfare services. The boards also co-ordinate the work of voluntary agencies working in their area.<br><br>Regional Government<br>At regional level services delivered through 8 health boards, established in 1971, serving populations of 200,000 to 1,300,000 with annual budgets in 2000 of IR£169 million - IR£750 million. Each board has elected local representatives, ministerial nominees and representatives of health professions employed by the Board. A chief executive officer is answerable to the board. Each Board has three programmes: - General Hospital Services; Community Care Services; Special Hospital Services. |
| ***Source*** | Ministry of Health And Children — ***Year*** 2000 |

| | |
|---|---|
| ***Code*** | 2.3 |
| ***Description*** | Local government |
| ***Contents*** | |
| ***Source*** | Ministry of Health And Children — ***Year*** 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 2.4 | | |
| ***Description*** | Insurance organisations | | |
| ***Contents*** | | | |
| ***Source*** | Ministry of Health And Children | ***Year*** | 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 2.5 | | |
| ***Description*** | Professional groups | | |
| ***Contents*** | Professional Groups<br>The health care professions are controlled by the Medical Council; Dental Council; Nursing Board; Opticians Board. Their remit includes registration and monitoring the suitability of professional education and training. Postgraduate Medical and Dental Board promotes and co-ordinates the development of postgraduate medical and dental education. The Pharmaceutical Society of Ireland is responsible for education, examination and registration of pharmaceutical chemists. | | |
| ***Source*** | Ministry of Health And Children | ***Year*** | 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 2.6 | | |
| ***Description*** | Providers | | |
| ***Contents*** | Providers<br>The 8 health boards/authorities are the main providers of healthcare and personal social services at a regional level. One of these - the Eastern Regional Authority - has delegated its functions as a provider to its three area health boards so that services in this most populous region can be more responsive to local need. The voluntary sector also plays an important part in the provision of health services. Such agencies range from major acute hospitals and national organisations to small community based support groups set up in response to local needs, particularly in the area of intellectual disability. | | |
| ***Source*** | Ministry of Health And Children | ***Year*** | 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 2.7 | | |
| ***Description*** | Voluntary bodies | | |
| ***Contents*** | Voluntary Bodies<br>Voluntary agencies in the Health Sector range from major hospitals and national organisations to small community based support groups set up in response to local needs, particularly in the area of intellectual disability. | | |
| ***Source*** | Ministry of Health And Children | ***Year*** | 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 3 | | |
| ***Description*** | Planning, regulation and management | | |
| ***Contents*** | | | |
| ***Source*** | Ministry of Health And Children | ***Year*** | 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 3.1 | | |
| ***Description*** | Extent of system decentralisation (deconcentration, devolution, delegation, privatisation) | | |
| ***Contents*** | Extent of System Decentralisation: - Deconcentration, Devolution, Delegation, Privatisation<br>The 8 health boards/authorities are the main providers of healthcare at a regional level. One of these - the Eastern Regional Authority - has delegated its functions as a provider to its three area health boards so that services in this most populous region can be more responsive to local need. The voluntary sector, which ranges from major hospitals and national organisations to small community based support groups set up in response to local needs also plays an important part in service provision at a regional level. | | |
| ***Source*** | Ministry of Health And Children | ***Year*** | 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 3.2 | | |
| ***Description*** | Existence of national health planning agency/plan | | |
| ***Contents*** | Existence of National Health Planning Agency/Plan<br>There is no separate national health planning agency. Planning is carried out by the Department of Health and Children, in consultation with the Department of Finance, the Chief Executive Officers of the Regional Health Boards and, where appropriate, with voluntary service providers and interest groups. | | |
| ***Source*** | Ministry of Health And Children | ***Year*** | 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 3.3 | | |
| ***Description*** | Supervision of the health services | | |
| ***Contents*** | | | |
| ***Source*** | Ministry of Health And Children | ***Year*** | 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 3.4 | | |
| ***Description*** | Financial resource allocation | | |
| ***Contents*** | Major capital expenditure is centrally funded and controlled. | | |
| ***Source*** | Ministry of Health And Children | ***Year*** | 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 3.4.1 | | |
| ***Description*** | Third party budget setting and resource allocation | | |
| ***Contents*** | | | |
| ***Source*** | Ministry of Health And Children | ***Year*** | 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 3.4.2 | | |
| ***Description*** | Determination of overall health budget | | |
| ***Contents*** | The overall health budget is determined annually by the Minister for Finance on the basis of representations made by the Minister for Health and Children. A system of multi-annual budgeting is currently being introduced to improve the planning of health services. | | |
| ***Source*** | Ministry of Health And Children | ***Year*** | 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 3.4.3 | | |
| ***Description*** | Determination of programme allocations | | |
| ***Contents*** | These are set out in the Service Plans, which regional health boards must agree annually and which must be approved by the Minister for Health and Children. | | |
| ***Source*** | Ministry of Health And Children | ***Year*** | 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 3.4.4 | | |
| ***Description*** | Determination of geographical allocations | | |
| ***Contents*** | | | |
| ***Source*** | Ministry of Health And Children | ***Year*** | 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 3.4.5 | | |
| ***Description*** | Health care budget decision-making at national/regional/local level | | |
| ***Contents*** | Healthcare Budget Decision Making at National/Local Level<br>Funds for the public health care system are allocated annually based broadly on demography and levels of services in each health board. The programme allocation is partly the responsibility of the Department of Health and Children and partly of the Health Boards. Boards, which receive allocations, based on health needs assessment, demography and service provision i.e. nature of the service provided. Each health board is responsible for allocating resources to the services it provides. The board management team is, in the main, responsible for determining service priorities and making recommendations to the board. | | |
| ***Source*** | Ministry of Health And Children | ***Year*** | 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 3.4.6 | | |
| ***Description*** | Approach to capital planning | | |
| ***Contents*** | Capital planning is carried out by the Department of Health and Children, in consultation with the Department of Finance, the Chief Executive Officers of the Regional Health Boards and, where appropriate, with voluntary service providers and interest groups. The health capital programme has been included in the National Development Plan 2000-2006. Demographic trends, appropriate regional self-sufficiency and the principal of equity are major determinants in this area. | | |
| ***Source*** | Ministry of Health And Children | ***Year*** | 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 3.4.7 | | |
| ***Description*** | Capital investment funding | | |
| ***Contents*** | | | |
| ***Source*** | Ministry of Health And Children | ***Year*** | 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 3.4.8 | | |
| ***Description*** | Recent changes in resource allocation system | | |
| ***Contents*** | The inclusion of capital funding for health in the National Development Plan 2000-2006 means that indicative funding has been set out for the seven-year period of the Plan. It is recognised that there has been an imbalance between primary and secondary care particularly in the area of capital spending. In recent times acute hospitals have been receiving about 70% of the capital investment. In that context the funding balance for health capital has been shifted in the National Development Plan in such a way that, on the basis of current projections, the hospital/ non-hospital split over the Plan period as a whole will be equalised.<br><br>Under the Health (Amendment) (No.3) Act 1996, regional health boards must agree an annual Service Plan and submit it to the Minister for approval. The Plan must set out the services which a health board will deliver for the funding they have been allocated. Any over run in spending becomes the first charge on the next year's budget. Up to now public voluntary hospitals received their funding directly from the Department of Health and Children. However from 2000 onwards the funding of the major voluntary hospitals in the eastern region (the most populous region) will be channelled through the recently established Eastern Regional Health Authority which has a remit to conclude service agreements with the public voluntary agencies (and with its area health boards) for the provision of services.<br>In relation to revenue funding, an element of Casemix has been introduced in recent years into the funding of public acute hospitals. A Casemix project operates in 31 of the 56 public acute hospitals (casemix is the comparison of activity and costs between hospitals). A small portion of funding is allocated to these hospitals on the basis of their performance within the group. However, the system is budget neutral, and any funding deducted from hospitals is distributed to the other hospitals in the group on the basis of their positive performance. This funding amounts to less than 1% of the total acute hospital sector financial allocation, although funding to individual hospitals on foot of casemix adjustments may be as high as 3% of overall budget. Up to recently major voluntary agencies providing services for people with disabilities received their funding directly from the Department of Health and Children rather than from their regional health board. However that funding is now channelled through the health boards on the basis of service agreements between the boards and the voluntary agencies. | | |
| ***Source*** | Ministry of Health And Children | ***Year*** | 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 4 | | |
| ***Description*** | General characteristics of the organizational structure | | |
| ***Contents*** | | | |
| ***Source*** | Ministry of Health And Children | ***Year*** | 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 4.1 | | |
| ***Description*** | Integrated or contract model | | |
| ***Contents*** | | | |
| ***Source*** | Ministry of Health And Children | ***Year*** | 2000 |

| | |
|---|---|
| ***Code*** | 4.2 |
| ***Description*** | Organisational relationship between third party payers and providers |
| ***Contents*** | The Eastern Regional Health Authority (established in March 2000) will conclude service agreements with major voluntary agencies - both public voluntary hospitals and agencies providing services for persons with disability - for the provision of services. These agreements are of two types: a) 3-5 year agreements setting out the general principles by which both parties agree to abide and the standards relating to effectiveness, efficiency and quality of the service to be provided and b) an agreement (known as a provider plan) to be renewed annually setting out the services to be provided and the funds to be made available. The other 7 health boards have in recent years been concluding service agreements with major voluntary agencies providing services for persons with disability. Private health insurance companies make agreements with hospitals and with consultants (generally on a speciality basis) in relation to levels of charges and fees covered. |
| ***Source*** | Ministry of Health And Children — ***Year*** 2000 |

| | |
|---|---|
| ***Code*** | 4.3 |
| ***Description*** | Ownership: public, private, mix |
| ***Contents*** | There are three main categories of hospital: those owned and funded by the health boards, voluntary public hospitals providing services on behalf of some health boards/authorities. There are 56 Public Acute Hospitals with 12,292 beds and 18 private hospitals with about 2600 beds (including about 600 private psychiatric beds.) |
| ***Source*** | Ministry of Health And Children — ***Year*** 2000 |

| | |
|---|---|
| ***Code*** | 4.4 |
| ***Description*** | Freedom of choice |
| ***Contents*** | Category 1 patients i.e. those exempt from co-payments must choose a GP who participates in the public choice of doctor scheme. |
| ***Source*** | Ministry of Health And Children — ***Year*** 2000 |

| | |
|---|---|
| ***Code*** | 4.5 |
| ***Description*** | Referral system |
| ***Contents*** | Policy is for referral to hospital by a GP; patients who go directly to Accident and Emergency Departments must pay a consultation fee for the first visit in any episode of care whereas there is no charge for those who go on referral from a GP. |
| ***Source*** | Ministry of Health And Children — ***Year*** 2000 |

| | |
|---|---|
| ***Code*** | 5 |
| ***Description*** | Out-patient care |
| ***Contents*** | |
| ***Source*** | Ministry of Health And Children — ***Year*** 2000 |

| | |
|---|---|
| ***Code*** | 5.1 |
| ***Description*** | Medical care |
| ***Contents*** | |
| ***Source*** | Ministry of Health And Children |
| ***Year*** | 2000 |

| | |
|---|---|
| ***Code*** | 5.1.1 |
| ***Description*** | General practitioner (solo-, group practices) |
| ***Contents*** | General Practitioner (Solo Group Practices)<br>The number of practising general practitioners is just under 2300 and about 25% of that total work exclusively in private practice, that is they do not have contracts for the treatment of medical card holders. Approximately half of general practitioners work single-handedly. There has been some increase in the number of partnership practices but the number of large-scale practices is still relatively small. The size of the practice relates directly to the range of services that tend to be offered therein.<br>Given the historical development of general practice in Ireland, most general practitioners operate from their own privately owned centres of practice. Notwithstanding the private nature of these facilities, the doctors involved are eligible to apply for State grant aid for practice development where they have contracts for the treatment of medical cardholders. There are, however, also a number of State developed purpose built medical centres where general practitioners operate. These centres tend to provide a broader range of primary and community care services than simply general practice.<br>The State has sought to encourage the development of general practice (both in terms of premises improvement and services provided) through grant aid. Assistance is also available for practice support staff, including nurses and secretarial personnel. In addition, the State has actively promoted increased computerisation in general practice and sought to develop better linkages between general practice and other healthcare areas. |
| ***Source*** | Ministry of Health And Children |
| ***Year*** | 2000 |

| | |
|---|---|
| ***Code*** | 5.1.2 |
| ***Description*** | Medical specialist with own premises |
| ***Contents*** | Medical Specialists with Own Premises<br>Specialists work mainly in hospitals. Specialists are employed. Only 155 of the 1600 consultants (mostly senior medical grade) operate on a purely private basis. Salaried consultants may undertake private practice outside their contractual commitment to a public hospital. Some consultants opt to be contracted solely to supply services to the public hospital system but the majority opt to retain the right to undertake private practice. |
| ***Source*** | Ministry of Health And Children |
| ***Year*** | 2000 |

| | |
|---|---|
| ***Code*** | 5.1.3 |
| ***Description*** | Out-patient department |
| ***Contents*** | Out-Patient Department<br>All major hospitals have an out-patient department as part of the hospital |
| ***Source*** | Ministry of Health And Children |
| ***Year*** | 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 5.1.4 | | |
| ***Description*** | Combined services: health centres | | |
| ***Contents*** | Combined Services: Health Centres<br>Apart from G.P. practice premises, the statutory health authorities provide some 800 health centres which provide a range of services, for example: - Aural Service; Child Care Service; Child Health Service; Chiropody Service; Community Welfare Service; Dental Service; Services for the Elderly; Environmental Health Service; General Practitioner Service; Ophthalmic Service; Psychiatry Service; Psychology Service; Public Health Nursing Service; Social Work Service; Speech and Language Therapy Service. | | |
| ***Source*** | Ministry of Health And Children | ***Year*** | 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 5.2 | | |
| ***Description*** | Dental care | | |
| ***Contents*** | | | |
| ***Source*** | Ministry of Health And Children | ***Year*** | 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 5.2.1 | | |
| ***Description*** | General dentist | | |
| ***Contents*** | General Dentist<br>The Dental Treatment Services Scheme was introduced by the Department of Health and Children in 1994 in response to the need to provide more efficient dental services to adults (over 16 years of age) medical card holders. The responsibility for providing a dental treatment service to medical cardholders was transferred in 1994 from health board dentists to the private dental sector, under an agreement between the Irish Dental Association, health boards and the Department of Health and Children. The scheme is principally delivered by private dental practitioners and is administered by health boards. | | |
| ***Source*** | Ministry of Health And Children | ***Year*** | 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 5.2.2 | | |
| ***Description*** | Dental specialist | | |
| ***Contents*** | | | |
| ***Source*** | Ministry of Health And Children | ***Year*** | 2000 |

| | |
|---|---|
| ***Code*** | 5.3 |
| ***Description*** | Pharmacists |
| ***Contents*** | Pharmacists<br>Community pharmacy services under the Health Act, 1970 are provided through community pharmacies, which are the subject of a Community Pharmacy Contractor Agreement with a regional health board. There are three main community drugs schemes - the General Medical Services Scheme, the Drug Payment Scheme and the Long Term Illness Scheme. The General Medical Services Scheme is available to people who are unable without undue hardship to arrange for the provision of medical services for themselves and their dependants, including drugs and medicines. The Drug Payment Scheme is not means tested and is available to people who do not qualify for the General Medical Services Scheme. Under the Drug Payment Scheme, the balance of expenditure over a certain amount (currently £42 per month) incurred by individuals or families on approved prescribed drugs in a calendar month are met by the State. The Long Term Illness Scheme is available to people who are not eligible for the General Medical Services Scheme and have certain prescribed diseases or conditions. Under this Scheme drugs for the treatment of the prescribed condition are made available free of charge. This scheme is not means tested. Under the General Medical Services Scheme, pharmacists are reimbursed the trade price i.e. ingredient cost of the drugs, medicines and appliances dispensed by them plus the appropriate dispensing fee and VAT where applicable. The cost of private prescriptions to patients, which are reimbursed for example under the Drug Payment Scheme (where the specified threshold is exceeded) and the Long term illness Scheme covers the ingredient cost of the medicine, the retail mark-up on the ingredient cost a standard fee and VAT where applicable. |
| ***Source*** | Ministry of Health And Children — ***Year*** 2000 |

| | |
|---|---|
| ***Code*** | 5.4 |
| ***Description*** | Midwifery |
| ***Contents*** | Midwifery<br>The Maternity and Infant Care Scheme provides for pre-natal and post-natal care for all women regardless of means, and for their babies up to six weeks of age. The Scheme consists of a system of combined care, i.e. where the expectant mother is under the care of both her general practitioner and hospital obstetrician. It is believed that this is the best and most convenient form of ante-natal care for the majority of mothers. |
| ***Source*** | Ministry of Health And Children — ***Year*** 2000 |

| | |
|---|---|
| ***Code*** | 5.5 |
| ***Description*** | Paramedical care |
| ***Contents*** | Paramedical Care<br>Paramedical services such as physiotherapy, chiropody and occupational therapy are provided by regional health boards and voluntary agencies to the extent that resources permit. Health board resources in this area are concentrated on Category 1 patients (medical cardholders). |
| ***Source*** | Ministry of Health And Children — ***Year*** 2000 |

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|---|---|
| ***Code*** | 5.6 |
| ***Description*** | Home nursing and home care (maternity home care included) |
| ***Contents*** | Home Nursing and Home Care (Maternity Home Care included)<br>Home nursing is provided by the Public Health Nursing Service primarily to people in the lower socio-economic group; those with chronic illnesses i.e. multiple sclerosis, diabetes etc.; the terminally ill; the elderly; the disabled; those with intellectual disabilities and who require nursing care and to others, subject to the exigencies of the service. The services provided include wound dressing; medication; parental feeding; continence management and general nursing care. The Public Health Nursing Service also provides a home based child health and development service.<br>Current policy in Ireland is that on medical grounds, the delivery of babies should take place in consultant staffed maternity units. It is generally accepted that this policy has contributed to the marked decrease in the level of maternal, perinatal and infant mortality.<br>Because of the practice of hospital confinement over the last 20-25 years and the consequent unavailability of experienced practitioners in home delivery, difficulties have been experienced in providing services for women who wish to give birth at home.<br>Where a woman engages the services of a private midwife two-thirds of the cost is met by the health board, subject to a maximum of IR£650. In addition a number of pilot projects are underway. Following evaluation of these projects the policy, procedures and protocols necessary for domiciliary births will be developed. |
| ***Source*** | Ministry of Health And Children — ***Year*** 2000 |

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|---|---|
| ***Code*** | 5.7 |
| ***Description*** | Out-patient mental health care services |
| ***Contents*** | Out Patient Mental Health Care Services<br>Community based mental health services are provided by the health boards. These include day hospitals and day centres, in addition to community residential facilities. Patients are usually referred to the service by their general practitioner. The community mental health services are funded by the State through an annual allocation to each health board. |
| ***Source*** | Ministry of Health And Children — ***Year*** 2000 |

| | |
|---|---|
| ***Code*** | 5.8 |
| ***Description*** | Ambulance services and patient transport |
| ***Contents*** | Ambulance Services and Patient Transport<br>A regional health board/authority may make arrangements for providing ambulances or other means of transport for the conveyance of patients from places in the Board's functional area to places in or outside that area or from places outside the functional area to places in that area. Ambulance Services have been organised on a regional basis since the early 1970s and are funded by regional health boards, which are, in turn funded from general taxation by central government. The regional ambulances control centres operate under the auspices of regional health boards. |
| ***Source*** | Ministry of Health And Children — ***Year*** 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 5.9 | | |
| ***Description*** | Medical laboratories | | |
| ***Contents*** | Medical laboratories<br>Medical laboratories are located at general hospitals throughout the State. Each health board region is self sufficient in the provision of the full range of routine laboratory work while highly specialised tests would be referred to particular centres of expertise. A number of private laboratories also operate, some of which would provide certain services on a contractual basis to the public system. | | |
| ***Source*** | Ministry of Health And Children | ***Year*** | 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 6 | | |
| ***Description*** | In-patient care | | |
| ***Contents*** | | | |
| ***Source*** | Ministry of Health And Children | ***Year*** | 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 6.1 | | |
| ***Description*** | Hospital categories | | |
| ***Contents*** | Hospital Categories<br>Each publicly funded hospital has a designated role. The Department of Health and Children and the Hospital Council determines its specialties and consultant staffing. There are 56 acute hospitals with 12,292 acute beds and 18 private hospitals with about 2600 beds (including about 600 beds in private psychiatric hospitals) | | |
| ***Source*** | Ministry of Health And Children | ***Year*** | 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 6.2 | | |
| ***Description*** | Other in-patient provisions | | |
| ***Contents*** | | | |
| ***Source*** | Ministry of Health And Children | ***Year*** | 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 7 | | |
| ***Description*** | Relationship between primary and secondary care | | |
| ***Contents*** | Relationship between primary and secondary care<br>Statutory agencies i.e. regional health boards provide both primary care and some secondary care. A number of major acute hospitals are owned by voluntary (mainly religious) agencies but receive most of their funds from the Exchequer. A major impetus for the recent establishment of the Eastern Regional Health Authority is to provide for better integration of the services at all levels in the populous eastern region but in particular to provide for better integration between primary care and the secondary care provided by voluntary agencies which up to now had no clear structural link to the regional health board in the area. | | |
| ***Source*** | Ministry of Health And Children | ***Year*** | 2000 |

| | |
|---|---|
| ***Code*** | 7.1 |
| ***Description*** | Planned or actual substitution policies for inpatient care |
| ***Contents*** | Planned or actual substitution policies for in-patient care<br>It is policy to substitute day care / procedures for in-patient care wherever clinically appropriate. This policy is reflected in the considerable increase in day case activity in hospitals in the last 15 years. |
| ***Source*** | Ministry of Health And Children ***Year*** 2000 |

| | |
|---|---|
| ***Code*** | 7.2 |
| ***Description*** | Degree of co-operation between primary and secondary health care providers |
| ***Contents*** | Degree of co-operation between primary and secondary health care providers<br>The need for greater integration between primary and secondary care providers has been increasingly recognised particularly in the Eastern Region where many of the major hospitals are owned by voluntary agencies. This was one of the main reasons for the establishment in March 2000 of the Eastern Regional Health Authority (ERHA) with a remit to plan, commission and oversee the provision of services (whether provided by statutory or voluntary agencies) in the country's most populous region. The ERHA has a remit to conclude service agreements with both types of agencies. Several major hospitals throughout the country have established GP/ hospital liaison committees. Hospital social work departments also play a role in liaison between primary and secondary care. National Guidelines in relation to the preparation and monitoring of service plans emphasise the importance of service integration. |
| ***Source*** | Ministry of Health And Children ***Year*** 2000 |

| | |
|---|---|
| ***Code*** | 7.3 |
| ***Description*** | Imbalance between primary and secondary care |
| ***Contents*** | Imbalance between Primary and Secondary Care<br>It is recognised that there has been an imbalance between primary and secondary care particularly in the area of capital spending. In recent times acute hospitals have been receiving about 70% of the capital investment. Health capital funding has been included in the National Development Plan 2000-2006 and in that context the funding balance is being shifted in such a way that, on the basis of current projections, the hospital/ non-hospital split over the Plan period as a whole will be equalised. |
| ***Source*** | Ministry of Health And Children ***Year*** 2000 |

| | |
|---|---|
| ***Code*** | 8 |
| ***Description*** | Prevention and public health services |
| ***Contents*** | |
| ***Source*** | Ministry of Health And Children ***Year*** 2000 |

| | |
|---|---|
| ***Code*** | 8.1 |
| ***Description*** | Maternal and child health: family planning and counselling |
| ***Contents*** | Maternal and Child Health: Family Planning and Counselling<br>The provision of Family Planning Services is the statutory responsibility of the health boards. Each health board is obliged to ensure that an equitable, accessible and comprehensive family planning service is provided in its area. The policy on the provision of family planning services is based on the principle that all individuals should have the freedom to decide the number and spacing of their children and that a wide range of family planning methods is available. Pregnancy counselling is provided by a range of agencies, both professional and voluntary, and also by many health professionals, primarily general practitioners. The principal voluntary agencies receive State financial support |
| ***Source*** | Ministry of Health And Children — ***Year*** 2000 |

| | |
|---|---|
| ***Code*** | 8.2 |
| ***Description*** | School health services |
| ***Contents*** | School Health Services<br>The provision of school medical services is the statutory responsibility of the health boards. The service is based upon a comprehensive health examination of selected classes and/or on referrals from schools. The current policy in Ireland is that all areas undertake routine audiometric screening in schools and that children undergo vision screening within three years after entering the school system. There is a national minimum standard of dental screening with children in all areas undergoing screening in second and sixth class of primary school. Services are provided free of charge for all necessary follow-up services for defects discovered at such examinations.<br>A review of child health services has been carried out by the health board Chief Executive Officers and the report which emerged from this review, "Best Health for Children - Developing a partnership with Families", stresses the importance of the delivery of an equitable and high quality service which is standardised nation-wide. A National Child Health Committee is now co-ordinating the running of pilot programmes which are concerned with school medical services, quality assurance and the training of doctors and nurses, which when completed and evaluated will enable the service to be upgraded in all areas. |
| ***Source*** | Ministry of Health And Children — ***Year*** 2000 |

| | |
|---|---|
| ***Code*** | 8.3 |
| ***Description*** | Prevention of communicable diseases |
| ***Contents*** | Prevention of Communicable Diseases<br>Vaccinations against a range of communicable diseases including diphtheria, pertussis, tetanus, polio, haemophilus influenzae type B, measles, mumps and rubella, are available free of charge from family doctors to children up to the age of 2 years. Further booster immunisations are provided to children of school going age. Immunisation against tuberculosis is also offered in most parts of the country. The Department of Health and Children monitors the incidence of infectious disease through the notifiable disease reporting system and this information is supplemented by surveys in the community and laboratory settings. The establishment of a National Disease Surveillance Centre in 1998 will also assist in the surveillance and control of communicable diseases. |
| ***Source*** | Ministry of Health And Children — ***Year*** 2000 |

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|---|---|
| ***Code*** | 8.4 |
| ***Description*** | Prevention of non-communicable diseases |
| ***Contents*** | Prevention of non-communicable diseases<br>Prevention of non-communicable diseases is pursued mainly through health promotion policy. A Health Promotion Unit within the Department of Health and Children is responsible for the development of policy and implementation of national and local health promotion programmes independently or in conjunction with the statutory and non-statutory agencies. The 1996 Health (Amendment) (No. 3) Act placed a statutory obligation on regional health boards to develop and implement health promotion programmes. Each regional health board has a health promotion unit. A national health promotion strategy published in 1995 is currently being revised. In addition, prevention of two of the main non-communicable diseases - cancer and heart disease - is being pursued in the context of the National Cancer Strategy (1997) and the Report of the Cardiovascular Health Strategy Group (1999). A university Department of Health Promotion provides academic and research support in the area of health promotion generally. In the area of tobacco a National Office of Tobacco Control is the process of being established in 2000. A Government Decision in 1999 introduced a tobacco and health tax on all cigarette packs. This tax is allocated directly to the Department of Health and Children A number of interdepartmental committees are in existence which have a role, inter ail, in prevention strategy and policy in areas such as accidents and drug abuse. |
| ***Source*** | Ministry of Health And Children — ***Year*** 2000 |

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|---|---|
| ***Code*** | 8.5 |
| ***Description*** | Occupational health care |
| ***Contents*** | Occupational Health Care<br>Occupational Health Care is primarily the responsibility of the Health and Safety Authority, which operates under the aegis of the Department of Enterprise, Trade and Employment. |
| ***Source*** | Ministry of Health And Children — ***Year*** 2000 |

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|---|---|
| ***Code*** | 8.6 |
| ***Description*** | All other miscellaneous public health services |
| ***Contents*** | |
| ***Source*** | Ministry of Health And Children — ***Year*** 2000 |

| | |
|---|---|
| ***Code*** | 9 |
| ***Description*** | Social care related to health care |
| ***Contents*** | |
| ***Source*** | Ministry of Health And Children — ***Year*** 2000 |

| | |
|---|---|
| ***Code*** | 9.1 |
| ***Description*** | Organisation and financing of social care |
| ***Contents*** | |
| ***Source*** | Ministry of Health And Children — ***Year*** 2000 |

| | |
|---|---|
| ***Code*** | 9.2 |
| ***Description*** | Role of central/regional/local government |
| ***Contents*** | Role of Central/Regional/Local Government<br>The Department of Health and Children is responsible for the care of older persons and of persons with disability and along with the Department of Education and Science and the Department of Justice, Equality and Law Reform has responsibility for children in need of care and protection. The Health Nursing Homes Act 1990 sets standards for institutional care for older people and enables health boards to pay subventions based on means testing and level of care required, for older persons seeking accommodation in privately run long stay institutions. Health Boards them also provide long stay institutional care for which people contribute according to their income. There are about 23,000 elderly (5% of the elderly population) in institutional nursing care, spread almost 50-50 between the public and private sectors. Since national policy is that older people should be enabled to stay in their own homes as long as possible health boards also provide a range of day care facilities. Health Boards also provide services such as "meals on wheels" and home helps although these are not statutory entitlements. |
| ***Source*** | Ministry of Health And Children — ***Year*** 2000 |

| | |
|---|---|
| ***Code*** | 9.3 |
| ***Description*** | Role of other organisations |
| ***Contents*** | Role of Other Organisations<br>In some cases voluntary groups provide part of the community care services (e.g. home helps) as agents of the Health Board (for which appropriate grants are paid). Voluntary groups also provide some services in a philanthropic capacity. |
| ***Source*** | Ministry of Health And Children — ***Year*** 2000 |

| | |
|---|---|
| ***Code*** | 9.4 |
| ***Description*** | Responsibility of family members |
| ***Contents*** | Responsibility of Family Members<br>Family members are not legally required to provide care for elderly parents. |
| ***Source*** | Ministry of Health And Children — ***Year*** 2000 |

| | |
|---|---|
| ***Code*** | 9.5 |
| ***Description*** | Financing of social care |
| ***Contents*** | Financing of Social Care<br>Health Boards finance long term care in their own long stay institutions though charges are levied on elderly persons according to their income. Under the Health Nursing Homes Act 1990 health boards may provide subventions for the care of older persons being accommodated in private nursing homes. The level of subvention depends on the person's means and the level of care required. |
| ***Source*** | Ministry of Health And Children — ***Year*** 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 9.6 | | |
| ***Description*** | Explicit health/social care policy | | |
| ***Contents*** | Explicit Health/Social Care Policy<br>Current policy in relation to services for older people is largely based on the principles set out in the Years Ahead - A Policy for the Elderly. This called for the development of services to maintain older people in dignity and independence at home and, when this is no longer possible, to provide a high quality of hospital and residential care. A National Council on Ageing and Older People, funded by the Department of Health and Children, has a brief to advise the Minister for Health and Children, either in their own initiative or at the Minister's request, on all aspects of ageing and the welfare of older people. | | |
| ***Source*** | Ministry of Health And Children | ***Year*** | 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 10 | | |
| ***Description*** | Medical goods and health care technology assessment | | |
| ***Contents*** | | | |
| ***Source*** | Ministry of Health And Children | ***Year*** | 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 10.1 | | |
| ***Description*** | Pharmaceuticals | | |
| ***Contents*** | Pharmaceuticals<br>The wholesale price of medicines has been determined by means of successive agreements between the Department of Health and Children and the pharmaceutical industry, which deal with the pricing and supply of medicines. The current Agreement includes the following elements: -<br>*The price to the wholesaler of any new item of medicine introduced to the market and covered by the Agreement shall not exceed the currency adjusted United Kingdom wholesale price or the average of a basket of E.U. countries, whichever is the lower.<br>*Price freeze on the wholesale cost of drugs and medicines for the duration of the Agreement. | | |
| ***Source*** | Ministry of Health And Children | ***Year*** | 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 10.2 | | |
| ***Description*** | Therapeutic appliances | | |
| ***Contents*** | | | |
| ***Source*** | Ministry of Health And Children | ***Year*** | 2000 |

| | |
|---|---|
| ***Code*** | 10.3 |
| ***Description*** | Health care technology assessment |
| ***Contents*** | Health Care Technology Assessment<br>The 1994 Health Strategy acknowledged the importance of assessing health care technology and gave a commitment to introducing a formal system of technology assessment in Ireland. In May 1998 an Ad-hoc Group for Health Technology Assessment was established to recommend on the most appropriate structure to assess medical technology in Ireland. Their recommendations are under consideration by the Department of Health and Children. |
| ***Source*** | Ministry of Health And Children — ***Year*** 2000 |

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|---|---|
| ***Code*** | 11 |
| ***Description*** | Other services |
| ***Contents*** | |
| ***Source*** | Ministry of Health And Children — ***Year*** 2000 |

| | |
|---|---|
| ***Code*** | 11.1 |
| ***Description*** | Education and training of personnel |
| ***Contents*** | Education and Training of Personnel<br>This is a matter fort he Department of Education and Scinece in collaboration with the Department of Health and Children. In nursing and medical training joint appointments to third level are utilised. It is estimated that medical education accounts for about 14% of the costs of teaching hospitals |
| ***Source*** | Ministry of Health And Children — ***Year*** 2000 |

| | |
|---|---|
| ***Code*** | 11.2 |
| ***Description*** | Research and development in health |
| ***Contents*** | Research and Development in Health<br>The Health Research Board is the body charged with commissioning medical research on behalf of the Minister. It also advises the Minister on policy in this area. Substantial research funding is also gained from private sources including the Welcome Trust and pharmaceutical companies. |
| ***Source*** | Ministry of Health And Children — ***Year*** 2000 |

| | |
|---|---|
| ***Code*** | 11.3 |
| ***Description*** | Environmental health and control of drinking water |
| ***Contents*** | |
| ***Source*** | Ministry of Health And Children — ***Year*** 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 11.4 | | |
| ***Description*** | Health programme administration and health insurance | | |
| ***Contents*** | | | |
| ***Source*** | Ministry of Health And Children | ***Year*** | 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 11.5 | | |
| ***Description*** | Administration and provision of cash benefits | | |
| ***Contents*** | Administration and Provision of Cash Benefits<br>Health boards have responsibility for the payment of some cash allowances which fall within the remit of the Department of Health and Children e.g. the Infectious Diseases Maintenance Allowance, the Blind Welfare Allowance, the Domiciliary Care Allowance (for disabled children being cared for at home) and the Disabled Persons Rehabilitation Allowance. Other health related cash allowances e.g. the Disability Allowance, are funded and administered by the Department of Social, Community and Family Affairs. Health boards administer the Supplementary Welfare Allowance scheme on an agency basis for the Department of Social, Community and Family Affairs. | | |
| ***Source*** | Ministry of Health And Children | ***Year*** | 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 12 | | |
| ***Description*** | Manpower in health care | | |
| ***Contents*** | Manpower in Health Care<br>There are over 70,000 people employed in the public health service in Ireland and expenditure on staff represents about 70% of current public health expenditure. | | |
| ***Source*** | Ministry of Health And Children | ***Year*** | 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 13 | | |
| ***Description*** | Fees, rates and salary structure | | |
| ***Contents*** | | | |
| ***Source*** | Ministry of Health And Children | ***Year*** | 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 13.1 | | |
| ***Description*** | Methods of payment to (specialist) physicians | | |
| ***Contents*** | Methods of payment to (specialist) physicians<br>Essentially consultants are employed under the integrated model; consultants working in public hospitals are salaried but are able to practice privately outside their contractual hours. Payment to general practitioners for services provided to medical cardholders (that is, public patients, about 32% of the population) are made under a capitation system based on patient age and sex factors. Additional payments are also made to general practitioners in relation to certain specific services provided by them and not covered by the capitation scheme. General practitioners treating private patients set their own rates for services and treatment. | | |
| ***Source*** | Ministry of Health And Children | ***Year*** | 2000 |

| | |
|---|---|
| ***Code*** | 13.1.1 |
| ***Description*** | Integrated or contracted |
| ***Contents*** | Essentially integrated (as above).<br>This means: Essentially consultants are employed under the integrated model; consultants working in public hospitals are salaried but are able to practice privately outside their contractual hours.<br>Payment to general practitioners for services provided to medical cardholders (that is, public patients, about 32% of the population) are made under a capitation system based on patient age and sex factors. Additional payments are also made to general practitioners in relation to certain specific services provided by them and not covered by the capitation scheme. General practitioners treating private patients set their own rates for services and treatment. |
| ***Source*** | Ministry of Health And Children — ***Year*** 2000 |

| | |
|---|---|
| ***Code*** | 13.1.2 |
| ***Description*** | Type of payment |
| ***Contents*** | Type of Payment<br>Consultants are salaried for public patient work in public hospitals. They are paid by fee for private patients in public hospitals and fees for work in private hospitals. |
| ***Source*** | Ministry of Health And Children — ***Year*** 2000 |

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|---|---|
| ***Code*** | 13.1.3 |
| ***Description*** | Method for deciding fees/salaries |
| ***Contents*** | |
| ***Source*** | Ministry of Health And Children — ***Year*** 2000 |

| | |
|---|---|
| ***Code*** | 13.2 |
| ***Description*** | Methods of hospital payment |
| ***Contents*** | |
| ***Source*** | Ministry of Health And Children — ***Year*** 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 13.2.1 | | |
| ***Description*** | Method of payment | | |
| ***Contents*** | Method of Payment<br>Hospitals in Ireland are divided into (i) private hospitals and (ii) publicly funded hospitals. Publicly funded hospitals fall into two categories, namely (i) Health Board hospitals and (ii) Voluntary hospitals. Publicly funded hospitals receive a small amount of funding through private health insurance / fund-raising / health research projects, etc. However the majority of public hospital funding comes from the Department of Health and Children and is increasingly being channelled through the health boards.<br>A Casemix project operates in 31 of these public hospitals (casemix is the comparison of activity and costs between hospitals). A small portion of funding is allocated to these hospitals on the basis of their performance within the group. However, the system is budget neutral, and any funding deducted from hospitals is distributed to the other hospitals in the group on the basis of their positive performance. This funding amounts to less than 1% of the total acute hospital sector financial allocation, although funding to individual hospitals on foot of casemix adjustments may be as high as 3% of overall budget. | | |
| ***Source*** | Ministry of Health And Children | ***Year*** | 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 13.2.2 | | |
| ***Description*** | Method for deciding rates | | |
| ***Contents*** | | | |
| ***Source*** | Ministry of Health And Children | ***Year*** | 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 13.2.3 | | |
| ***Description*** | Recent changes in payment method | | |
| ***Contents*** | Recent Changes in Payment Method<br>Recent changes include the introduction of a casemix element as outlined under 2.1.6.10.2.1 above. Another change for the public voluntary hospitals in the eastern region is the introduction of a) 3-5 year service agreements setting out principles and standards and b) annual agreements (provider plans) setting out the level of service to be provided and the funds to be made available therefor. Hospitals owned by health boards are subject to the terms of the annual Service Plan which each regional health board /authority must, under legislation, agree and submit for approval to the Minister for Health. | | |
| ***Source*** | Ministry of Health And Children | ***Year*** | 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 14 | | |
| ***Description*** | Main system of financing and coverage (tax based, insurance based, mixture) | | |
| ***Contents*** | Main System of Financing and Coverage (tax based, insurance based, mixture)<br>The health sector in Ireland is predominantly financed by taxes: 75.8% in 1996. Funding From a National Lottery and the European Social Fund contributed a further 0.7% and 0.5% Respectively. Private sources consisted of out-of-pocket expenditures (12.1%), insurance (9.2%) and other (1.6%). From the year 2000 IR£132 million which will be raised as a result Of increased tobacco excises will go directly to the health services. | | |
| ***Source*** | Ministry of Health And Children | ***Year*** | 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.1 | | |
| ***Description*** | Main features of tax based systems | | |
| ***Contents*** | | | |
| ***Source*** | Ministry of Health And Children | ***Year*** | 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.1.1 | | |
| ***Description*** | Main body(ies) responsible for providing health care cover to beneficiaries | | |
| ***Contents*** | | | |
| ***Source*** | Ministry of Health And Children | ***Year*** | 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.1.2 | | |
| ***Description*** | Extent of population coverage (excluded groups) | | |
| ***Contents*** | Extent of Population Coverage (excluded groups)<br>Comprehensive tax financed health services are available to all. All persons, ordinarily resident, are eligible for health services. | | |
| ***Source*** | Ministry of Health And Children | ***Year*** | 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.2 | | |
| ***Description*** | Main features of social health insurance | | |
| ***Contents*** | | | |
| ***Source*** | Ministry of Health And Children | ***Year*** | 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.2.1 | | |
| ***Description*** | Organisation of main body responsible for insuring/providing coverage | | |
| ***Contents*** | | | |
| ***Source*** | Ministry of Health And Children | ***Year*** | 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.2.2 | | |
| ***Description*** | Extent of population coverage | | |
| ***Contents*** | | | |
| ***Source*** | Ministry of Health And Children | ***Year*** | 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.2.3 | | |
| ***Description*** | Stipulations in premium contribution | | |
| ***Contents*** | | | |
| ***Source*** | Ministry of Health And Children | ***Year*** | 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.2.4 | | |
| ***Description*** | Competition between insurance schemes | | |
| ***Contents*** | | | |
| ***Source*** | Ministry of Health And Children | ***Year*** | 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.2.5 | | |
| ***Description*** | Provision for risk adjustment | | |
| ***Contents*** | | | |
| ***Source*** | Ministry of Health And Children | ***Year*** | 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.3 | | |
| ***Description*** | Health care benefits and rationing; recent reductions in benefits package and variations in extent between different insurance plans | | |
| ***Contents*** | | | |
| ***Source*** | Ministry of Health And Children | ***Year*** | 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.4 | | |
| ***Description*** | Complementary sources of finance | | |
| ***Contents*** | | | |
| ***Source*** | Ministry of Health And Children | ***Year*** | 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.4.1 | | |
| ***Description*** | Voluntary health insurance | | |
| ***Contents*** | | | |
| ***Source*** | Ministry of Health And Children | ***Year*** | 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.4.1.1 | | |
| ***Description*** | Organisation of voluntary health insurance: public, quasi public, private, not for profit | | |
| ***Contents*** | Organisation of Voluntary Health Insurance: Public Quasi Public, Private, Not for Profit.<br>The Voluntary Health Insurance Board (VHIB) is a statutory not for profit organisation. BUPA Ireland, also a not for profit organisation is currently establishing itself in the Irish Market. The Health Insurance Act 1994 regulates the private market. Health insurance premiums are eligible for tax relief. The Health Insurance Act requires all insurers to comply with the principles of community rating, open enrolment and lifetime cover; and that insurers provide a minimum level of benefits across a range of services. | | |
| ***Source*** | Ministry of Health And Children | ***Year*** | 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.4.1.2 | | |
| ***Description*** | Type and nature of services covered | | |
| ***Contents*** | Type and Nature of Services Covered<br>Insurers provide a minimum level of benefits across a range of services. Generally speaking the privately insured are covered for private specialist fees and private accommodation in hospital. | | |
| ***Source*** | Ministry of Health And Children | ***Year*** | 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 14.4.1.3 | | |
| ***Description*** | Proportion of population covered | | |
| ***Contents*** | Proportion of Population Covered<br>At the end of February 2000, about 1.65 million of the population (43.5%) were covered for private health insurance. | | |
| ***Source*** | Ministry of Health And Children | ***Year*** | 2000 |

| | |
|---|---|
| ***Code*** | 14.4.2 |
| ***Description*** | Out-of-pocket payments: main cost sharing measure (partial reimbursement, co-payment) by care category: ambulatory, inpatient, drugs, medical aids and prostheses |
| ***Contents*** | Dental Care Treatment: - No charge for persons with full eligibility (Category 1 patients), children under 6 years of age and persons who are attending or have attended primary school up to the age of 14 years. Persons who pay pay-related social insurance contributions and their spouses are entitled to receive fully or partially subsidised dental care for a limited range of treatments. There is no charge for scalings, examinations and polishing for insured persons who satisfy certain contribution conditions. There are patient contributions for fillings, extractions and other services. Dentures are provided by, or on the direction of, the dental practitioner free of charge to persons with full eligibility. The insured person pays a contribution (50% in most cases). Patients in neither of the above categories pay full fees for all treatment and prostheses.<br>Out of Pocket Payments Main Cost Sharing Measure (partial reimbursement, co-payment) by care category: ambulatory, inpatient, drugs, medical aids and prostheses.<br>Ambulatory care: Category 1 patients are exempt from co-payments for health services. Category 1 eligibility is determined by personal income and circumstances. Category 2 patients attending Accident and Emergency Departments without a referral note from their general practitioner are liable for a charge of IR£25 for the first visit in any episode of care. Category 2 patients pay in full for GP services. In patient care: Category 2 patients pay a daily charge for public hospital accommodation to IR£26 per day to a maximum of IR£260 per annum. Drugs: Medical Card patients have drug costs covered. Category 2 patients are refunded for expenditure over IR£40 per month. Medical aids and prostheses: patient pays in full for prostheses and hearing aids unless they are medical card holders or social welfare recipients who may be eligible to have these costs refunded or covered by health authorities. |
| ***Source*** | Ministry of Health And Children — ***Year*** 2000 |

| | |
|---|---|
| ***Code*** | 14.4.3 |
| ***Description*** | External sources of funding: employers, fund raisers etc. |
| ***Contents*** | Grants from the state-owned National Lottery constituted 0.7% of total health expenditure in 1996. |
| ***Source*** | Ministry of Health And Children — ***Year*** 2000 |

| | |
|---|---|
| ***Code*** | 15 |
| ***Description*** | Health care expenditure |
| ***Contents*** | |
| ***Source*** | Ministry of Health And Children — ***Year*** 2000 |

| | |
|---|---|
| ***Code*** | 15.1 |
| ***Description*** | Structure of health care expenditures |
| ***Contents*** | The percentage of GDP spent on health care was 7.4% in 1987 and 6.3% in 1997. In 1997 Public health expenditure was 76.7% of total health expenditure or 4.9% of GDP. (Source: OECD Health Data 1999.) |
| ***Source*** | Ministry of Health And Children — ***Year*** 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 15.2 | | |
| ***Description*** | Total and public health expenditure as % GDP | | |
| ***Contents*** | In 1995 investment constituted 4% of total health expenditure. | | |
| ***Source*** | Ministry of Health And Children | ***Year*** | 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 15.3 | | |
| ***Description*** | Health care expenditure by category (%) of total expenditure on health care | | |
| ***Contents*** | | | |
| ***Source*** | Ministry of Health And Children | ***Year*** | 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 16 | | |
| ***Description*** | Import and Export | | |
| ***Contents*** | | | |
| ***Source*** | Ministry of Health And Children | ***Year*** | 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 16.1 | | |
| ***Description*** | Import | | |
| ***Contents*** | | | |
| ***Source*** | Ministry of Health And Children | ***Year*** | 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 16.2 | | |
| ***Description*** | Export | | |
| ***Contents*** | | | |
| ***Source*** | Ministry of Health And Children | ***Year*** | 2000 |

| | | | |
|---|---|---|---|
| ***Code*** | 17 | | |
| ***Description*** | Health care reforms | | |
| ***Contents*** | | | |
| ***Source*** | Ministry of Health And Children | ***Year*** | 2000 |

| | |
|---|---|
| ***Code*** | 17.1 |
| ***Description*** | Determinants and objectives |
| ***Contents*** | The determinants of reforms include: increases in population and in particular increases in the number of older people; the need for cost containment and greater accountability in the face of rising consumer expectations; the need for better service integration, particularly in a situation where historically major aspects of services, including many large acute hospital services, have been owned by the voluntary (mainly religious) sector; the requirement under EU competition regulations to open the private health insurance market to competition and to create a climate supportive of such competition and of competition in private health care provision generally.<br>Major reforms introduced in recent years include the following:<br>The Health Amendment (No.3) Act, 1996 which requires regional health boards / authorities to agree an annual service plan with the Minister within the limits of their allocated budget. Work is ongoing to include performance indicators in service plans. Accountability is also being enhanced through a series of expenditure reviews of different aspects of the health services and through a Value for Money audit commencing in the first half of 2000. An accreditation system for hospitals (initially for a number of major teaching hospitals) was launched in late 1999.<br>The establishment of the Eastern Regional Health Authority to provide for integration of health services particularly between the statutory and voluntary sectors in the most populous health board area. Voluntary hospitals will provide services on the bases of provider plans to be agreed with the health authority and to be included in the health authority's overall service plan. Voluntary agencies dealing with disability will provide services to health boards by way of annual service agreements.<br>A White Paper on Private Health Insurance was published in September 1999.<br>The objectives of reforms are to achieve equity in terms of access and health status; to achieve quality of service, both technical quality in terms of outcome and service quality in terms of consumer satisfaction; to improve accountability and to maintain the public/ private mix in health care funding and provision. |
| ***Source*** | Ministry of Health And Children — ***Year*** 2000 |

| | |
|---|---|
| ***Code*** | 17.2 |
| ***Description*** | Content of reforms and legislation |
| ***Contents*** | |
| ***Source*** | Ministry of Health And Children — ***Year*** 2000 |

| | |
|---|---|
| ***Code*** | 17.2.1 |
| ***Description*** | future development of planning: move to be integrated/move to contract based |
| ***Contents*** | |
| ***Source*** | Ministry of Health And Children — ***Year*** 2000 |

| | |
|---|---|
| ***Code*** | 17.2.2 |
| ***Description*** | tax based system: change in population coverage; opting out permitted/encouraged |
| ***Contents*** | There has been some decrease in the late 1990s in the proportion of the population in Category 1 (those exempt on hardship grounds from co-payments) - due to improved economic situation in Ireland rather than to any reform of the eligibility system. Category 2 patients pay in full for GP services but are entitled to public hospital services subject only to modest statutory charges. Any person can opt to be treated as a private patient either in a public hospital or in a private hospital. Currently about 43.5% of the population opt to have private health insurance cover. |
| ***Source*** | Ministry of Health And Children — ***Year*** 2000 |

| | |
|---|---|
| ***Code*** | 17.2.3 |
| ***Description*** | insurance based system: development of the degree of benefit coverage in the future |
| ***Contents*** | |
| ***Source*** | Ministry of Health And Children — ***Year*** 2000 |

| | |
|---|---|
| ***Code*** | 17.2.4 |
| ***Description*** | voluntary health insurance: changes in uptake; plans for change |
| ***Contents*** | The proportion of the population opting to have private health insurance cover has increased significantly and now stands at 43.5%.<br>A White Paper on Private Health Insurance published in September 1999, sets out the future framework for the market which will facilitate product development and greater competition whilst protecting stability and community rating. It sets out improvements to: the method of community rating, the arrangements for risk equalisation, the basis for public hospital charges to private patients, the structure of the Voluntary Health Insurance Board, the scope for product development and the focus of consumer information. The Government is also proceeding with the establishment of the Health Insurance Authority to undertake direct regulatory functions currently discharged by the Minister. Separate legislation will address the structure of the Voluntary Health Insurance Board (VHIB). VHIB was established as statutory organisation in 1957 to provide for the 12% of the population who did not, at that time, have eligibility for public health services. (Changes introduced in 1991 gave eligiblity for public hospital services to all people normally resident in Ireland). It is now the Government's intention, in keeping with EU competition law, to give full commercial freedom to the VHIB. Other important areas of action outlined in the White Paper relate to improving the delivery of private care through hospital accreditation, availability of wider data on hospital activity and technology assessment, as well as promoting wide ranging dialogue between interested parties through a Private Healthcare Forum. |
| ***Source*** | Ministry of Health And Children — ***Year*** 2000 |

| | |
|---|---|
| ***Code*** | 17.3 |
| ***Description*** | Health for all policy |
| ***Contents*** | Equity is one of the main principles underlying the National Health Strategy - Shaping a Healthier Future. A research unit on Health Status and Health Gain has been established in an existing academic Department of Health Promotion. The brief of the new unit is to identify the factors which contribute to inequalities in health in Ireland to develop a system to monitor changes in health status over time and propose effective ways in which inequalities can be redressed. The capacity to measure health status and risk factors has improved in recent years. Major national survey of lifestyles and risk factors - SLAN (survey on lifestyles and nutrition) took place in 1998 and will be repeated at regular intervals. A Public Health Information System (PHIS) has been developed which enables analysis of demographic, mortality data and potential years of life lost down to the administrative area of county (of which there are 26 in Ireland). PHIS and the Hospital In- Patient Enquiry System ( HIPE) provide important bases for work by the Departments of Public Health which have been established in each regional health board. The Department of Health and Children has recommenced publication of the Chief Medical Officer's annual report. The theme of the 1999 report is health inequalities. |
| ***Source*** | Ministry of Health And Children — ***Year*** 2000 |

| | |
|---|---|
| ***Code*** | 17.4 |
| ***Description*** | Reform implementation |
| ***Contents*** | |
| ***Source*** | Ministry of Health And Children — ***Year*** 2000 |

| | |
|---|---|
| ***Code*** | 17.5 |
| ***Description*** | Conclusions |
| ***Contents*** | |
| ***Source*** | Ministry of Health And Children — ***Year*** 2000 |