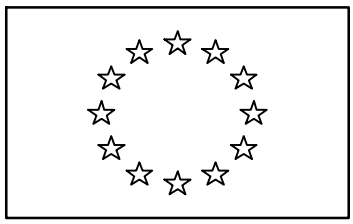
EUCOMP

Towards Comparable Health Care Data in the European Union

Part 5: Country profiles in tabular format
Volume B



EUROPEAN COMMISSION

North Eastern Health Board

Bord Slainte An Oir Thuaiscirt

Contents

Volume B

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Country profile: Italy

Code	1		
Description	Introduction and historical background		
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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	The Ministry of Health bears main responsibility for financing and functioning of health care: This Ministry drafts the National Health Plan. Together with Parliament and the National Health Council it establishes the legal, operative and financial framework for the National Health Service		
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	Regional Health Authorities draft regional health plans and evaluate local service efficiency. Management of services is decentralised		
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	197 "Aziende Sanitarie Locali" (USLs) (operative structures of local government authorities) run health care programmes and facilities, for areas with an average of 292.000 inhabitants (from a minimum of 15.000 to a maximum of 1.500.000 persons		
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			
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	Doctors, dentists and pharmacists are entitled to practise, if they are entered in provincial registers. Nurses, midwives and paramedical personnel are organised in associations		
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	Many voluntary organisations are engaged in health care like the Italian Red Cross.		
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	Text: The Italian health system is a regional system of health protection, where the constitutional autonomy of the regions is fully recognised, with concomitant financial responsibility and taxation powers		
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	The Ministry of Health drafts a three-year National Health Plan, which is an instrument of central regulation of the NHS. The Treasury presents the annual health budget to Parliament as part of the general budget		
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

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	The Ministry of Health prepares the budget on basis of plans submitted by regional health authorities. The Treasury then submits the budget to Parliament Programme allocations are determined by Regions on the basis of the Regional Health Plan. The National Health Fund is approved yearly by Parliament
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	Since 1988 allocations to Regions are based on size of age-weighted resident population, health migrations between regions and on type of services provided.
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	The Ministry of Health drafts a three-year National Health Plan, which is an instrument of central regulation of the NHS. The Treasury presents the annual health budget to Parliament as part of the general budget. Health care budgets are allocated to Regions on the basis of Regional Health Plans.		
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	Within the National Health Fund current and capital planning are separated to permit the application of selective criteria for allocating funds in order to reduce disparities between regions. Capital expenditure is managed by the Ministry for the Budget		
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	Funds for capital expenditure are distributed on basis of size of residential population and number of hospital beds with additional ad hoc allocations. The aim is to achieve regional equity (taking into account epidemiological indicators) in terms of resource distribution		
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 the integrated and contract model. This categorisation is based on the organisation, of hospital care. Providers in public hospitals are paid on basis of the integrated model and the public contract model, but there is a significant group of hospitals (38% of total) which are "accredited" private hospitals.		
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	Doctors working only within the NHS: 98.362, i.e. 1,7 doctors/ 1000 population All doctors entitled to practise: 343,288, i.e. 6 doctors/1000 population In Italy there are 1,787 hospitals, of which 56% public, 38% "accredited private" and 6% private. There are 274.251 public beds and 69.768 private beds. Together 6 hospital beds/1000 population		
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	All citizens registered with the local health office may choose a GP on the list in the local area		
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	Access to secondary care by referral from a GP for care within the public system. However many patients go directly to hospital emergency wards		
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	
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	
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	Basic health care is provided by family doctors and paediatricians. Family doctors (general practitioners and paediatricians for children below 14 years) have a contract with the public health system. They may not work in hospitals or "accredited" private facilities. They may treat non-NHS private patients. Range of services: Preventive health care (in theory but not in practice), basic medical care and referral for secondary care
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	Specialists provide outpatient care either in private practices or in territorial services (public or private).
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	Specialised ambulatory medical services are provided in public, accredited private and fully private hospitals and by specialists working full or part time for the NHS or fully independently Some specialists in ambulatory services work under contract, others work on an integrated base.
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	First aid stations also provide basic care out of hours and in tourist locations		
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	Public hospitals are integrated. They are independent or managed by the Local Health Offices. Doctors working in them are salaried and work either full- or part-time. Some private hospitals are contracted. 56% of hospitals and 80% of hospital beds were public in 1996, most belonging to local authorities. In absolute numbers: 274.251 public beds and 69.768 private beds in 1996 Through the Nineties there were attempts to rationalise hospital treatment and to reduce hospital expenditure in line with international standards by e.g. reducing number of public hospital beds, ensuring an occupancy rate of beds not less than 75%, establishing alternative facilities (eg. day hospitals).		
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			
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			
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			
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	The Ministry of Social Care develops guidelines for social care and co-ordinates activities of state administration and other providers working for the elderly. Regions, Municipalities and Local Health Units organise social care and manage its financing.		
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	Private for profit and not for profit institutions supply services		
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	Family members are required legally to care for the elderly: spouses followed by children (usually female) followed by daughters -in-law		
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	Financing of social care: NHS provides residential nursing home care for the elderly. Ministry of Interior finances attendance allowances for dependent people. Financial aid and workplace assistance is being considered for families taking care of the frail elderly		
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	There is no explicit health/social care demarcation policy.		
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			
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	GP income is part salary plus elements related to list size, hours available and whether home visits are performed. Payments related to these elements vary by years of service, patient age and cost of living The methods of payment to specialist physicians is a mixture of integrated or contracted: Specialists may: -work completely independently receiving widely varying fees; -work independently under an agreement with the NHS receiving set fees: -work in a private ambulatory facility under an agreement; -work as a hospital employee. They may receive fee payments or salaries or a combination depending on the mode of employment (see above).		
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	As of 1.1.1995 hospitals are financed by regions on the basis of Diagnosis Related Groups. This has reduced the average length of stay. A national list of payment rates was established following a study of DRG-related costs in a sample of hospitals. Regions may establish their own rates.		
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	In 1992 the health care sector was financed by governmental taxes (27%), social insurance (42%) and by out-of-pocket expenditures (31%).		
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	Main body(ies) responsible for providing health care cover to beneficiaries are the Ministry of Health, Regional Health Authorities and Local Health Offices. All residents, without exemption, including foreigners resident in Italy are covered by the system. Opting out is not permitted or encouraged but might be possible in the future.		
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 NHS provides universal comprehensive health services to all residents		
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			
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			
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	
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	Alternative medicine like homeopathy is excluded. Recent reductions in benefits package relate to the reduction of the number of medicines, which are free or partially paid for by the NHS. There is variation in the groups exempt from payment for facilities.
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	Private health insurance still limited
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	There are supplementary company-operated health funds and private insurance policies
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	Most policies cover visits to non-NHS specialists, diagnostic tests and inpatient stays in purely private facilities
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	The population covered consists of affluent groups and some professional groups of the population.
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	The NHS provides universal comprehensive health services to all residents, some of which are subject to charges, although many patients are exempt. Costs of ambulatory diagnostic tests are limited to a maximum of 70.000 LIT per test depending on the number and type of tests ordered. Visits to specialists are limited to 30.000 LIT. Co-payment of 6.000 LIT for persons exempt from payment. Some regional variation because regional autonomy has been granted in setting fees. No co-payment for essential antenatal check-ups. Inpatient care: No charges for stays in communal wards of public and « private accredited » hospitals. Stays in private hospitals or to private wards in public or private accredited hospitals paid for by patients. Drugs: 3 categories of drug: i) essential drugs for serious illness free to all patients; ii) drugs for less serious illness, patients pay 50% of cost, with exemptions for: children up to age 6; persons over 65 with a family income below 70.000 LIT/annum; persons over 60 on the minimum pension and certain groups of unemployed (income-related); social pension beneficiaries; patients with very serious illness or those awaiting organ transplants; iii) Non-prescription drugs, patient pays full cost. For a one-item prescription, patient pays LIT 3.000, for two items, LIT 6.000, except for those fully invalid on service grounds. Medical aids and prostheses: 100% self-participation for eyeglasses and prostheses, except for disabled persons and certain groups of children (e.g. those with malformations at birth). Part of the cost of eyeglasses and prostheses is eligible for tax relief
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 expenditure was 7.1% of GDP. In 1995 this was 7.7%. Public health expenditures were 63.9% of total health expenditure or 5.4% of GDP (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 public expenditure was 63.9% of total health care expenditure. I 1995 in-patient care was responsible for 47.0% of total health expenditure and pharmaceuticals for 17.3%, Investment took 3.4% (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	New plans to make the system more contract-based, as in the Netherlands that is to integrate services funded by health insurance with services provided by the NHS.
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	Future developments concern reduction in number of services provided free of charge by the NHS and. reduction in number of people exempt from payment. Integration of insurance-funded services is expected.
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	Proposals exist to introduce a mixed system where some services are covered by health insurance as in the Netherlands
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: Luxemburg

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

Code	1.1
Description	Introductory overview

Contents

The Grand Duchy of Luxembourg is a constitutional monarchy located in western Europe, bordered by Belgium to the west and north, Germany to the east and France to the south. The site of its capital, Luxembourg city, was first fortified in 953 and became an independent fiefdom of the Holy Roman Empire in 1364. Initially ruled by a Count and then by a Duke, Luxem-bourg was established as a Grand Duchy by the Congress of Vienna in 1815. The ruling house of Nassau came to the throne of Luxembourg in 1890; the present Grand Duke, Jean, succeeded his mother in 1964.
Luxembourg's climate is temperate and its rural landscape dominated by gently undulating agricultural land and forest. The Ardennes Mountains extend from Belgium into the north of Luxembourg. The south-west of the country is the focus for its heavy industry, while in the south-east, along the banks of the River Moselle which divides Luxembourg from Germany, various white and sparkling wines are produced.
Luxembourg is the smallest of the European Union member states, with an area of 2586 km 2 . Its population was estimated to be 420 416 in July 1997 (of whom over one fifth lived in the capital) and is gradually increasing (1.16% up from 1996). Luxembourg's relations with its neighbours are close. In 1921 it forged economic union with Belgium, covering trade and most financial matters, including currency (either Belgian or Luxembourg francs are valid currency in Luxembourg); and the Benelux partnership of Belgium, Luxembourg and the Netherlands followed in 1944.
Luxembourg's population, chiefly Roman Catholic, are impressive linguists; it is standard to be trilingual in Letzeburgesch (a German dialect, which is the national language), French (the main language of official documents and legis-lation) and German. English, Italian and Portuguese are also widely used, as these are the first languages of substantial communities now settled in Luxem-bourg. The lingua franca between all of these communities is generally French.

The Grand Duchy's government is composed of a 12-member Cabinet (Council of Ministers), headed by a Prime Minister and Vice Prime Minister who are selected from a directly elected unicameral Chamber of Deputies and appointed by the Grand Duke. The chamber comprises 60 members elected for a five-year term from party lists in multi-member constituencies; it usually includes representatives of a number of Green and special interest parties along-side the more established centre-left and conservative groups. The Christian Democrats usually hold the balance of power in each coalition government. Voting is universal and compulsory from the age of 18. The country is divided into three administrative districts: Diekirch (north), Grevenmacher (south-east) and Luxembourg (south-west).
Luxembourg's stable, prosperous economy features moderate growth, low inflation and low unemployment (4.0% in January 1997). Its gross domestic product (GDP) was $10 billion (in US $PPPs) in 1995; per capita GDP was $24 500 (in US $PPPs). Agriculture accounts for some 5% of GDP and is based on small, family-owned farms. Grains and potatoes are the main crops, and livestock (especially cattle) are raised. Vineyards are concentrated in the south-east of the country. The industrial sector was until recently dominated by iron and steel production, as part of the Luxembourg-Lorraine iron-mining basin occupies the south-west of the country; but this has now diversified into other manufacturing industries, producing textiles, chemicals, tyres and other mechanical goods. Services, especially banking and telecommunications, also now account for a major part of Luxembourg's GDP. Luxembourg city is an important international financial centre.

Health indicators
Life expectancy at birth in Luxembourg in 1997 was 74.24 years for men and 80.52 for women. Life expectancy for the whole population in 1995 (77.41 years) was almost equal to the EU average (77.44 years) and well above the WHO European Region average (72.46 years). Infant mortality saw a slight increase over the two years to 1997 (5.1 per 1000 live births), but, as in most of the European Region, is decreasing over the longer term (from 7.09 per 1000 live births in 1990 and 8.28 in 1985). The population is ageing and, of the (approximately) 420 000 population, only 200 000 are economically active. The leading causes of death in Luxembourg in 1998 were diseases of the circu-latory system (cardiovascular and cerebrovascular disease) followed by cancer, respiratory diseases and external causes (accidents and suicides).

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

Code	1.2
Description	Historical background
Contents	Health care delivery A French visitor to Luxembourg at the close of the eighteenth century descibed the inhabitants of the country as of “generally robust…physical constitution”. However, this may have been in spite of, rather than due to the health care available at that time! The same witness described the hospital at Pfaffenthal (built a century earlier, in 1684) as “defective in all proportions.…the rooms are too damp, too dark and could more justifiably be called prisons than rooms fit to receive patients”. Deficiencies in the provision of health care had not gone unnoticed by the state. The first existing official document referring to health care in Luxembourg, in 1732, forbids medical practice without licence; and throughout the follow-ing century the government would continue to attempt to register and control all those who claimed skills in the provision of health care. Administrative units set up for this purpose in 1818, the “Medical Commissions”, were estab-lished in each district to regulate “everything relative to the exercise of the different branches of the art of healing”. Their duties included: examining and judging the capacity and qualifications of those established to practice any branch of medicine (i.e. doctors, dentists, surgeons, midwives, pharmacists, oculists and herbalists); granting certificates of qualification to practice; en-suring satisfactory medical practice in their area on an ongoing basis; and per-forming surveillance for contagious diseases on their territory. By 1841, Luxembourg had become a Grand-Duchy independent of the Netherlands but under the sovereignty of its King. At his (King William II’s) instigation, the Medical Commissions were supplemented by a body which still exists to this day: the Medical College. From that date the College, com-posed of a president appointed for life by the King and six members (four doctors and two pharmacists) appointed for life by the Grand Duke, directed the health service of the Grand Duchy. In the same year, miners boring for rock-salt discovered the hot springs which led to the foundation of the spa at Mondorf-les-Bains – a valued health care resource for well over a century to come. In 1843, a Royal Ordinance on the organization of the health service produced the first list of all persons authorized to exercise any branch of the “art of healing”. In that year, 44 doctors, 2 dentists, 128 midwives, 21 pharmacists and 7 veterinary surgeons came forward for registration. This number of health personnel increased only gradually until the last decade of the century when the number of recruits started to rise sharply. At the turn of the twentieth century, the leading causes of death (according to Luxembourg’s mortality statistics, first collected in 1902) were communi-cable diseases: typhoid, smallpox, measles and scarlet fever. Their hazards had long been known; as early as 1800, under French rule of Luxembourg, the authorities had appealed to the population to bring their children forward for free smallpox vaccination. In 1902 a Grand-Ducal decree introduced an im-pressive system for monitoring communicable diseases. All doctors and mid-wives were to make written notification of any case of a specified eight dis-eases to the local health inspector, whose duty it was immediately to transmit this information to the President of the Medical College; he then drafted a weekly report on this subject to the government. In an effort to obtain as complete a picture as possible of disease prevalence, a financial incentive of 1.5 francs was offered to doctors and midwives for every notification made. The system’s list of notifiable diseases has been much modified over the past century; its basic structure less so. Throughout the history of Luxembourg’s health care system the vast majority of medical personnel have been not state-employees, but self-employed workers. Whether operating from hospital facilities or from elsewhere, with very few exceptions, doctors have been paid on a fee-for-service basis by their patients (who have, in the last century, been reimbursed by the health insurance funds). Current exceptions to this fee-for-service system are some salaried medical professionals at two of Luxembourg’s hospitals. The neuro-psychiatric hospital, established in the late nineteenth century, was the last to be run by the state but was brought into line with all other hospitals by legislation in 1998 and will henceforth, like them, be run by an independent administrative board. The Centre Hospitalier de Luxembourg (CHL), the main hospital in the capital, continues to pay its medical staff on a salary system. Until the early twentieth century, the majority of hospitals – 13 establish-ments in 1918 – were run by religious organizations. Local authorities ran four establishments in 1918 and the national steel company (ARBED) ran three near its major plants. The state played a minor role, directly managing only three hospitals in 1918. Over the century, the relatively cheap health care re-source provided by religious orders has receded. Higher “secular” staff costs were a principal reason why the hospital sector started to need state subsidy later in the century; the 1976 law on hospital planning provided for this and also formed the first attempt by the state to influence planning in the hospital sector. During the twentieth century, the total number of health care facilities has also tended to fall due to ongoing rationalization and to the decline of certain facilities such as independent midwifery practices. Thus from 33 general and maternity hospitals/facilities and 2 psychiatric establishments in 1953, numbers have dropped to a total of 14 acute care hospitals in 1999 –

soon to reduce to 13 when two of the smaller establishments are replaced by a larger single one (a plan known as the “New Hospital Project”).

Health care financing
Compulsory health insurance for manufacturing and industrial workers was introduced in Luxembourg in 1901, following the similar scheme introduced in Germany by Bismarck in 1883. Insurance developed quickly, and there were already 73 individual funds by 1903. By 1925, the insurance sector had grown in complexity and diversity, and legislation was required to codify the sickness insurance, the accident insurance (introduced in 1902) and the old age/incapacity6 insurance (introduced in 1911) into one system. The same law substantially increased the benefits paid, and was further amended in 1927 and 1933.
After the Second World War, Luxembourg retained elements of the German insurance system which had replaced Luxembourg’s Code des Assurances Sociales during the German occupation in 1940–1944. Most significant amongst these elements was the extension of insurance to cover pensioners. In 1952, the compulsory insurance was further extended to civil servants and other cate-gories of public employees; in 1958, to the independent professions (e.g. businessmen and craftsmen), in 1963 to farmers and in 1964 to the independent intellectual professions (e.g. doctors, architects and lawyers).
By 1973, the working population, their families, and all pensioners were covered by compulsory health insurance. The insurance was run by 11 sick-ness funds, to which people were automatically allocated according to their professional group. The level of contributions was set by the individual funds and varied considerably between them.
By now, however, it was increasingly hard for the sickness funds to cover the increasing costs of health care simply from the contributions they received. The financial situation of the funds (particularly that of the funds for manufac-turing and industrial workers) was perilous. In 1974, legislation was therefore passed to allow significant injections of state resources, up to 40% of the funds’ total receipts. The 1974 reform also standardized contribution levels across all sickness funds, and stated that these were to be set by the government from now on.
In 1978, further reform established an administrative union of the different sickness funds. Although nine individual funds for different professional groups continued to exist, they lost much of their power. Negotiation of rates with providers was now undertaken by the Union and risk was pooled across all funds so that the year-end deficit of one could be covered by the profit of another.
Even with the added boost of state funding, however, the sickness funds were in financial trouble again by the early 1980s; so legislation in 1983 ex-tended patient co-payment for treatment in an attempt at cost-containment.
This resulted in a one-off reduction in health care costs, after which they started to rise again. Further reform was to follow in 1992. The government originally intended to abolish the (now nine) separate sickness funds, but faced with strong opposition from professional groups settled for a compromise. The funds were allowed to continue only as agencies for direct contact with the insured citizen, 7 while all of their responsibilities except the actual administration of reimburse-ment to members were transferred to the Union of Sickness Funds. The 1992 Act also introduced a new financing system for hospitals; instead of the previous uniform per diem payment system, which encouraged spiralling hospital costs, each hospital was to negotiate its own individual budget directly with the Union of Sickness Funds. This change came into force from 1 January 1995.

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

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 system is split between prevention and treatment, in terms of both provision and financing. For the most part, preventive services are the respon-sibility of the Ministry of Health; interventions are provided by a few public services and by private practitioners and non-profit associations paid from the Ministry budget. Curative treatment is a shared responsibility of the Ministry of Health and the Ministry of Social Security. The former supervises the organization of health services and subsidises the hospital sector, while the latter is responsible for the sickness insurance system. (This split is not entirely clear-cut; the sickness insurance system has reimbursed preventive dental care services since the 1970s and an increasing number of other services, e.g. breast cancer screening and hepatitis B vaccination, since legislation in 1992.) Ministries other than Health and Social Security involved in health-related areas include: • the Ministry of Environment as regards air and water pollution, waste, noise pollution; • the Ministry of Family Welfare as regards homes for elderly people including nursing care, home aid services, services for the handicapped; • the Ministry of Labour as regards safety at work; • the Ministry of Housing as regards housing projects and subsidies for indi-vidual homes; • the Ministry of Education as regards training of some health professionals and health education in schools; • the Ministry of Transport as regards traffic safety; • the Ministry of Justice as regards policy on illegal drug use. Responsibilities of the Minister of Health The Minister of Health defines and implements health policy, prepares legis-lation, ensures the implementation of laws and regulations on health and health services and authorizes, supervises and funds public and private health institu-tions and services. The Minister is supported in these duties by several services within the Ministry of Health, dealing with human resources, financing, legislation and coordination. The heads of these services and the Director General of Health (who is the head of the Directorate of Health – see below) are members of a small body which advises the Minister, called the bureau Ministériel. General legislation on the organization of the health and social sectors, and various specific laws on institutions and organizations working in the health sector, require representatives of the Ministry of Health in various inter-disciplinary committees and boards. Examples of bodies with such Ministry of Health representation would be: committees within, or run by other govern-ment departments and private associations; boards of organizations such as hospitals or the Luxembourg Red Cross; committees overseeing contracted-out health and social sector work. For all these duties, the Ministry employs about 30 staff. The Directorate of Health also reports to the Minister of Health, as the executive administration for public health in Luxembourg. It has its own responsibilities, such as to study the overall health situation in the country, to advise public authorities on public health matters, to oversee the implementa-tion of laws and regulations on public health, to take immediate measures to protect public health in the face of any threat and to contribute to health policy on the national and international level. The Directorate employs about 110 staff in the following divisions: • the Division of Health Inspection which deals with public health inspec-tion, communicable diseases and environmental health; • the Division of Preventive Medicine which is responsible for preventive services and health promotion; • the Division of Curative Medicine which is responsible for the planning and control of hospital care, quality control in laboratories and the super-vision of the practice of health professionals; • the Division of School Health which supervises school health services; • the Division of Occupational Health which is responsible for the planning and control of occupational health services; • the Division of Pharmacy which advises the Minister on the licencing of medicines and supervises the practice of professional pharmacists; • the Division for Protection against Ionising and Non-Ionising Radiation. In addition, the Service of Social and Therapeutic Activities (AST) is responsible for promoting and supervising services dealing with handicap, mental illness, drug addiction and home nursing services. Most of these services are contracted out to the non-profit private sector. This service, which has until now operated outside the Directorate of Health and has reported directly to the Ministry of Health, is in early 1999 in transition towards becoming the Division of Social Medicine within the Directorate of Health. About one third of the directorate's staff work in the field, for example in school health services in secondary schools, screening services for sight and hearing impairment. Although the Directorate and the Ministry function separately, the Directo-rate is also the ministry's source of expert advice on health care questions. Thus an important part of the Directorate's work is

feeding into consultations by the Ministry on policy questions, and the Ministry draws upon the Directo-rate's staff resources for representation in committees and working groups.

Ministry of Social Security
Two sections of the Ministry of Social Security are responsible for the sickness insurance system. The General Inspectorate of Social Security supervises legal, regulatory, statutory, contractual and financial operations, and the Office of Medical Control deals with disability at work, authorizations for reimburse-ment (including those for treatment abroad), medical profiles, supervision of outpatient care and abuse of the health system by patients.
Insurance is compulsory, and is managed and provided by the Union of Sickness Funds in conjunction with nine individual agencies to which people are allocated on the basis of their professional occupation. Services eligible for reimbursement are registered on lists adopted jointly by the Ministers of Health and Social Security.
Hospital budgets are negotiated annually between each individual hospital and the Union of Sickness Funds. All such negotiations must be endorsed by the Minister of Social Security.

Other government ministries
The Ministry of Health collaborates with the Ministry of Education on school health services and on the training of health professionals and the approval of professional qualifications from abroad.
The Directorate of Health's Division of Occupational Health collaborates with the Ministry of Labour to supervise safety in the workplace.
The Ministry of the Environment has lead responsibility for dealing with air and noise pollution, water and sanitation and waste disposal. On a local level such environmental issues form the main health-related activities of local authorities (since curative and preventive care and health promotion are run on a national basis). On a national level, the Ministry of the Environment's duties involves some coordination with the Ministry and Directorate of Health. Much of the work of the latter's Division of Health Inspection relates to environmental health threats.
The Ministry of Justice chairs an Inter-Ministerial Committee on Drugs to coordinate policies on drug abuse between all ministries involved in the problem of drug abuse. The Ministry of Family and Social Welfare shares with the Ministry of Health the cost of home nursing services, rehabilitation and family planning clinics. The Ministry of Housing liaises with the Directorate of Health over health inspections of state-provided housing. The Ministry of Transport is responsible for legislation on transport safety, and for information campaigns to the public on transport safety issues.

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

Code 2.2

Description Regional government

Contents

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

Code 2.3

Description Local government

Contents Local authorities have legal responsibility for public health protection in Luxembourg. In practice, however, many local authorities only discharge environmental reponsibilities such as the supply of drinking water, sewage and waste disposal, housing and local traffic regulation.

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

Code	2.4		
Description	Insurance organisations		
Contents			
Source	European Observatory on Health Care Systems	***Year***	1999

Code	2.5		
Description	Professional groups		
Contents	Health professionals in Luxembourg are represented by two different types of professional groups: • Groups which are the official interlocutors with the government on any changes to the law which may affect their members. It is a legal require-ment for the government to consult these groups on any draft legislation. These groups basically consist of the Medical College which represents doctors, dentists and pharmacists; and the Superior Council of Certain Health Professions which represents all other health professionals. • Individual professional associations, of which one has developed for every specialism – there is no legal requirement for the government to consult these groups individually on legal changes, but in practice it usually does.		
Source	European Observatory on Health Care Systems	***Year***	1999

Code	2.6		
Description	Providers		
Contents	The nongovernmental sector A major role is played in preventive health care by the non-profit nongovern-mental sector. Most preventive and health promotion services are contracted out to the non-profit sector and funded by the state (or in some cases by the new long-term care insurance). The Luxembourg League for Prevention and Medico-Social Action and the Luxembourg Red Cross jointly organize a net-work of community health service providers under the title Service medicosocial et social polyvalent de secteur. This network provides community preventive health services (such as school health services) for areas whose local authorities do not; and its local representatives also form an important channel for distribu-tion of health education material from the Directorate of Health. Other preven-tive services which require the attention of an individual practioner (such as vaccination, breast cancer screening, family planning advice and antenatal care) tend to be provided by private sector physicians, and are financed by the sick-ness insurance or by the state. Non-state providers are even more significant in curative health care, since all hospitals operate independently of the state and doctors are almost all self-employed. In terms of insurance, however, the private sector's role is minor. In 1994 voluntary health insurance schemes reimbursed benefits worth only 2.2% of those reimbursed by the Union of Sickness Funds.		
Source	European Observatory on Health Care Systems	***Year***	1999

Code	2.7
Description	Voluntary bodies
Contents	Luxembourg has a few voluntary organizations for the representation of patients with certain diseases; but voluntary workers hardly feature in the provision of health care. Possibly the strict regulations on the practice of all health professions tend to discourage an active role for volunteers, who are usually unqualified. In addition, the attitude towards voluntary care seems to be that since Luxem-bourg is a prosperous country, it ought to pay health professionals an adequate wage to provide high quality care. Luxembourg has a few voluntary organizations for the representation of patients with certain diseases; but voluntary workers hardly feature in the provision of health care. Possibly the strict regulations on the practice of all health professions tend to discourage an active role for volunteers, who are usually unqualified. In addition, the attitude towards voluntary care seems to be that since Luxem-bourg is a prosperous country, it ought to pay health professionals an adequate wage to provide high quality care.
Source	European Observatory on Health Care Systems ***Year*** 1999

Code	3
Description	Planning, regulation and management
Contents	Primary care The supply of primary care in Luxembourg is dictated by demand, since patients have free choice of primary care provider and there is no legal means to limit the volume of medical activity. For that reason, it is hard for the state to plan. Nor (since European Union legislation introduced the mutual recognition of medical qualifications) is there any legal means to curb the flow of medical personnel into Luxembourg. To practise in Luxembourg, physicians simply need approval of their (foreign) diploma by the Ministry of Health (if delivered in an EU member state) or by the Ministry of Education (if delivered in other countries) and an authorization from the Ministry of Health. Luxembourg's remuneration and licencing system is attractive, as a licence to practise in Lux-embourg means automatic access to remuneration by the compulsory health insurance system. So the number of physicians practising in the country will probably continue to increase for the forseeable future. The supply of dentists is also increasing whilst, in contrast, the opportunities for pharmacists are limited because the total number of pharmacies in the country is controlled. Secondary/tertiary care The hospital sector in Luxembourg is regulated by the law on hospitals of 28 August 1998. Numbers of hospitals and minimum standards for hospital services are planned via regulations (the so-called National Hospital Plans) enacted under this law. Hospitals are administered by boards of administrators, who are responsible for the general policy of the hospital. Hospitals are independent of the state although there may be representatives of the state on some boards (if so, state representatives are usually in the minority). The financing of hospitals is drawn from two sources: 1. Each hospital negotiates its operating budget with the Union of Sickness Funds, without the direct interference of the state. 2. Major investment costs for construction and equipment are financed by the state at a rate of 80%. Significant new equipment has to be authorized by the Minister of Health. All requests for investments and authorizations, and all draft legislation related to the hospital sector, must be submitted to the "Permanent Hospitals Committee". This Committee is composed of representatives of the government, the Union of Sickness Funds, the Federation of Hospitals, the medical pro-fession, and other health professions, and is chaired by the Director General of Health. The services of the Directorate of Health generally give technical advice to the Committee. In May 1999, legislation allocated 26 billion LUF for the modernization and reconstruction of all remaining acute hospitals and for the creation of some new national services such as heart surgery and radiotherapy. A commissioner appointed by the government is responsible for the appropriate use of state resources by hospitals. Tight state planning and regulation apply to the development of public health services (e.g. the laws on occupational health, school health services and preventive interventions during pregnancy and early childhood) and the health care financing system, which is the subject of a complex legislative frame-work.
Source	European Observatory on Health Care Systems ***Year*** 1999

Code	3.1		
Description	Extent of system decentralisation (deconcentration, devolution, delegation, privatisation)		
Contents	There is little decentralization of the health care system to regional power in Luxembourg. The role of local authorities is for the most part restricted to various environmental health reponsibilities such as the supply of drinking water, sewage and waste disposal, housing and local traffic regulation. Some local authorities also provide community preventive health care such as school health services, and some play a fairly powerful role as the owners of hospitals (or a lesser one simply as members of their administrative boards).		
Source	European Observatory on Health Care Systems	***Year***	1999

Code	3.2		
Description	Existence of national health planning agency/plan		
Contents			
Source	European Observatory on Health Care Systems	***Year***	1999

Code	3.3		
Description	Supervision of the health services		
Contents	The Medical College and the Superior Council of Certain Health Professions are disciplinary bodies (the former for doctors, dentists and pharmacists, and the latter for all other health professions). However, they have extremely weak powers; they can remonstrate with irresponsible or negligent professionals, but cannot fine them nor prevent them from practising. A Surveillance Committee, set up by the Ministry of Social Security, determines when a health professional has made an “unjustified deviation” from the fee schedule for individual medical acts. It can summon the provider in question to a hearing, can carry out an investigation and can warn providers. Two arbi-tration bodies known as the Lower and Upper Council for Social Insurance can go further, to suspend providers from health insurance for up to six months, ask them to return fees received, or fine them up to LUF 500 000.		
Source	European Observatory on Health Care Systems	***Year***	1999

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

Code	3.4.1		
Description	Third party budget setting and resource allocation		
Contents	The budget of the compulsory health insurance system, which takes account of future financial developments and needs within the system, is the responsibility of the General Assembly of the Union of Sickness Funds. The state's contribution to compulsory health insurance is limited to 40% of its total budget and the Union of Sickness Funds is obliged to balance its budget by maintaining a reserve at all times. However, in addition to con-tributing to the main insurance coverage system, the state wholly or partly funds a wide range of other goods and services – e.g. health promotion activities and other preventive and public health services, maternity services, investment in hospital infrastructure and technology, social care services and some training. The administration (and funding) of some of these budget categories is shared between the Ministry of Health and other Ministries; for example, the Ministry of Education meets most of the cost of the training of health care personnel. Because of Luxembourg's small size, few decisions about the allocation of health care resources are delegated to local authorities. However, hospital budgets are determined individually by negotiation between each hospital's administrative board and the Union of Sickness Funds. In these negotiations the power of local authorities and powerful local personalities can come into play.		
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			
Source	European Observatory on Health Care Systems	***Year***	1999

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

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	The fundamental principles of the Luxembourg health system are free choice of the provider by the patient, compulsory health insurance, and compulsory provider compliance with the fixed fees-for-service set for the insurance system.		
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			
Source	European Observatory on Health Care Systems	***Year***	1999

Code	4.4		
Description	Freedom of choice		
Contents			
Source	European Observatory on Health Care Systems	***Year***	1999

Code	4.5		
Description	Referral system		
Contents			
Source	European Observatory on Health Care Systems	***Year***	1999

Code	5		
Description	Out-patient care		
Contents			
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	Primary health care in Luxembourg is provided mainly by general practitioners (GPs) who are self-employed and mostly work in single practices. However, GPs have no gatekeeping role, so they are in com-petition with specialists to whom patients can go directly even for primary care. Primary care providers charge the fees negotiated between their profes-sional representatives and the Union of Sickness Funds, and they are bound to respect these fees by law. Patients pay GPs directly, on a fee-for-service basis, and are later reimbursed by their compulsory (or voluntary, where applicable) sickness fund. However, most medical consultations are subject to a non-reimbursable patient co-payment.		
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			
Source	European Observatory on Health Care Systems	***Year***	1999

Code	5.2		
Description	Dental care		
Contents	Primary dental care is provided by private dental practitioners, and reimbursed (up to a 1334 LUF ceiling) at 100% of the agreed rate as noted in the statutes of the sickness funds. Even dental prostheses considered necessary are reimbursed at 100% of this rate if the patient has undergone annual dental check-ups in the previous two years.		
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			
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			
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			
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	Management structures differ almost between every hospital. All hospitals are run by Administrative Boards, which negotiate separately with the Union of Sickness Funds for their hospitals' annual budgets. There is a steady decrease – albeit from a relatively high level – in the number of hospital beds per 1000 population and their utilization rate over the last 3 decades. In comparison to other western European countries Luxembourg appears to have a relatively high number of hospital beds per 1000 population and higher than average utilization rate as measured by admission rate, occupancy levels and especially length of stay. However, the average length of stay shown in Table 4 could be deceptive; the inclusion of figures from the neuro-psychiatric hospital (and possibly of medium-term care beds) pushes up the overall figure, explaining why length of stay appears so high for Luxembourg (15.3 days in 1995). More accurate information is likely to be available from now on, as data on acute hospitals are now clearly separated from the rest. In 1997, for example, the average length of stay in the 11 general hospitals ranged between 5.5 and 9.3 days		
Source	European Observatory on Health Care Systems	***Year***	1999

Code	6.1		
Description	Hospital categories		
Contents	Secondary and tertiary care is provided by 14 acute care hospitals spread throughout the country (including the neuro-psychiatric hospital at Ettelbrück). One of these, a hospital for maternity services, is run for profit by the private sector. Of the remaining 13, around half are run by local authorities and half by non-profit (mainly religious) organizations. None of Luxembourg's acute-care hospitals is maintained by the state. The number of acute-care hospitals will shortly reduce to 13 when two of the smaller establishments are replaced by one larger facility in a plan known as the "New Hospital Project". In 1997 a total of 2533 beds were maintained by the 14 hospitals, i.e. 6.13 beds per thousand inhabitants. 5400 people (2.6% of all employment in Luxembourg) worked in these 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			
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			
Source	European Observatory on Health Care Systems	***Year***	1999

Code	8.1
Description	Maternal and child health: family planning and counselling
Contents	Much primary care nursing is provided by “medico-social centres” on contract to the national and local authorities. The centres are administered jointly by the Luxembourg Red Cross and the Luxembourg League for Prevention and Medico-Social Action. Centres are spread throughout the territory of Luxembourg, and are involved in the provision of child health clinics, school health services, assessment of handicapped children and health education and antenatal advice. “Social nurses” from the centres combine the role of health visitors and social workers. Legislation covering the protection of mothers and babies envisages at least five medical examinations and one dental examination during pregnancy and one medical examination within ten weeks after delivery. Antenatal care is not compulsory, but there is a financial incentive for mothers to use antenatal services, because receipt of child benefit is conditional on the completion of certain medical examinations. Antenatal care and postnatal care for mothers is given by private obstetricians and midwives, and reimbursed (at 100%) by the sickness funds. Almost all preventive medical examinations of infants and young children (up until 4 years of age) are performed by private paediatricians in maternity hospitals and services and in independent practices (charged on a fee-for-service basis and reimbursed at 100% by the funds). A few of such examinations are performed at the child health clinics of the Red Cross free-of- charge. Children are screened for metabolic disorders at birth, for vision defects between 6 months and 4 years, and for hearing defects at the ages of 6 months and 30 months. These screenings are performed by special services under the Directorate of Health and are free-of-charge. Immunizations within Luxembourg’s official vaccination programme (which follows the WHO Expanded Programme on Immunization) are offered free-of- charge as the Ministry of Health covers the cost of the vaccines themselves and the doctor’s fee is 100% reimbursed by the sickness funds. Immunization is not compulsory in Luxembourg, but is highly recommended; information and encouragement on the subject of vaccination is given to parents (and prospective parents) by paediatricians and NGOs providing facilities for small children. However, efforts by the government and NGOs to encourage vaccination may now have to be stepped up, in the face of increasingly active campaign groups drawing attention to the dangers and side-effects of vaccination. A rigorous survey of immunization coverage published in 1997 (Enquête de Couverture Vaccinale au Grand-Duché de Luxembourg) found measles vaccine coverage of 91.1%. This is a surprisingly high figure given that vaccination is not compulsory.
Source	European Observatory on Health Care Systems
Year	1999

Code	8.2
Description	School health services
Contents	Much primary care nursing is provided by “medico-social centres” on contract to the national and local authorities. The centres are administered jointly by the Luxembourg Red Cross and the Luxembourg League for Prevention and Medico-Social Action. Centres are spread throughout the territory of Luxembourg, and are involved in the provision of child health clinics, school health services, assessment of handicapped children and health education and antenatal advice. “Social nurses” from the centres combine the role of health visitors and social workers. Legislation states that preventive health services must be provided for children at school from the age of four years. School health services, comprising medical surveillance of schoolchildren and health promotion activities, are in a few cases by local authorities but more often by the Luxembourg League for Prevention and Medico-Social Action and the Red Cross, and in the case of secondary schools by the Division of School Health in the Directorate of Health. A “Healthy Schools” project is run by the Ministry of Education. Contraceptives are only provided on medical prescription, and are not reimbursed by the sickness funds unless they are prescribed for therapeutic purposes (in which case authorization for reimbursement must be obtained from the Office of Medical Control). However, contraceptives are provided free-of-charge in family planning centres to young people and to those who cannot afford them. Family planning centres also offer sex education sessions for secondary schools on a voluntary basis and counselling for marital problems, abortion, rape and sexual abuse. Abortion was legalized in 1978, but there are no statistics on the number of abortions performed.
Source	European Observatory on Health Care Systems — ***Year*** 1999

Code	8.3
Description	Prevention of communicable diseases
Contents	HIV incidence has remained fairly constant in Luxembourg since 1985, with 30 known new infections in 1998 (average incidence 1985–1997 was 28 new infections per year). HIV/AIDS prevention activities are the responsibility of the Division of Preventive Medicine. The division itself focuses on information campaigns aimed at the general public and particularly at young people. Specific action for risk groups such as prostitutes, prisoners and drug addicts, and anonymous, free HIV tests (performed on request and accompanied by counselling) are mainly carried out on contract by the private (non-profit) sector. Some of this work is done at the “Counselling Centre for AIDS”, set up and run by the Red Cross on state funding. HIV tests are processed by the National Laboratory of Health and the laboratory of the Centre Hospitalier de Luxembourg (CHL). A National AIDS Surveillance Committee was set up by the Minister of Health as early as 1984 on the advice of the World Health Organization. The Committee advises on national AIDS policy and provides for collaboration with organizations such as WHO, the Council of Europe and the EU. All private non-profit organizations active in this area are represented on the Committee.
Source	European Observatory on Health Care Systems — ***Year*** 1999

Code	8.4
Description	Prevention of non-communicable diseases
Contents	Cancer screening is run by the Directorate of Health, the Union of Sickness Funds and the Luxembourg Cancer Foundation. Cervical cancer screening has been available in Luxembourg since the 1960s, and uptake of this service has been high ever since the 1970s, during which decade mortality from cancer fell from 10 to 2.5 persons per 100 000. Screening takes place at private practices and family planning clinics. Breast cancer screening is carried out in private medical practices and in the radiological services of hospitals, and all costs are paid directly to service providers by the sickness funds. A programme for the early detection of non-insulin dependent diabetes is being developed by the Division of Preventive Medicine, specialists working in diabetes care and the Diabetes Patient Association.
Source	European Observatory on Health Care Systems — ***Year*** 1999

Code	8.5
Description	Occupational health care
Contents	Employers in Luxembourg, as in other EU member states, have to comply with European legislation on occupational health. In 1994 the European Community legislated to require all member states to establish a national occupational health service (Directive 89/391 EEC). Luxembourg's National Occupational Health Service has been operational from 1 January 1995, to promote the occupational health of employees of private sector organizations which do not have an in-house occupational health unit. The service is funded via a charge levied on all affiliated employers. Since 1995, seven occupational health services have been created. Beside a national (semi-public) service which deals with workers in the world of commerce and skilled manual workers, there exist two company services for the chemical and rail sectors, and four inter-company services which are responsible for workers in the sectors of steel, banking, health and small and medium-sized enterprises. The Directorate of Health's Division of Occupational Health oversees the work of the 35 physicians working in these seven occupational health services for the private sector, and is responsible (with the Inspectorate of Labour within the Ministry of Labour) for analysing the impact of nuisances to workers' health in every business in Luxembourg (about 16 000 companies with 210 000 workers). The physicians' duties are: to identify and assess risks in the work-place; to perform the medical examinations required by law; and to advise on organization of the workplace, health education, hygiene, etc. The second part of Directive 89/391 extends the requirement for occupa-tional health service cover to the public sector, but Luxembourg has not yet implemented this requirement.
Source	European Observatory on Health Care Systems — ***Year*** 1999

Code	8.6
Description	All other miscellaneous public health services
Contents	Luxembourg's Ministry of Justice chairs an Inter-Ministerial Committee on Drugs to coordinate policies on drug abuse between all ministries involved in the problem of drug abuse (e.g. Health, Family Welfare, Education, Justice) and several national organizations active in this field. The implementation of national policy is facilitated by a National Prevention Centre on Drug Addiction and by a complex network of nongovernmental organizations, including centres for young addicts, substitution programmes and streetworkers. The Service of Social and Therapeutic Activities (soon to become the Division of Social Medicine within the Directorate of Health) also shares the task of combating drug abuse in Luxembourg. The service is also responsible for Luxembourg's "focal point" within the European Monitoring Centre for Drugs and Drug Addiction, and other EU initiatives; and for contact with numerous other supranational organizations active in drug policy – the Council of Europe, the United Nations, and so on. The Division of Preventive Medicine of the Directorate of Health is involved in planning and organizing prevention programmes and health promotion campaigns in collaboration with schools, health professionals and social services. The major public health problems in Luxembourg are: risk behaviour leading to increased risk of cancer (principally smoking); unhealthy nutrition; alcohol abuse; risk behaviour leading to HIV contraction; accidents. Recent initiatives on priority issues include: Cancer prevention: A multiannual programme focusing on mammography, cervical cancer screening and the hazards of sun and UV-ray exposure has been set up by the Division of Preventive Medicine and the Division of Radio-protection. Smoking: Promotion of non-smoking, in partnership with the Luxembourg Cancer Foundation, concentrates on exhibitions and "Smoke-Busters" clubs for schools, promotion of World Anti-Tobacco Day and legislation curbing smoking in public places and tobacco advertising. Drink-driving: The Road Safety Association and the Division of Preventive Medicine together ran a media campaign encouraging young drivers not to drink; recent campaigns by the Ministry of Transport have also focused on the young as a target group. Nutrition and physical activity: There are ongoing public information campaigns on healthy eating, and within general promotion of healthy lifestyles more emphasis has recently been placed on increased physical activity. Health education in schools: The Division of Preventive medicine produces health education magazines several times a year to be distributed in schools, as there is particular emphasis on the young as a target group Healthy Cities: in 1998, the Division of Preventive Medicine launched a "Healthy Cities" project, with the support of the Ministry of the Interior and of local authorities. The National Committee against Alcohol Abuse: This Committee is in charge of policy on alcohol abuse, including epidemiological studies, treatment of abusers, counselling of their families and health education campaigns.
Source	European Observatory on Health Care Systems — ***Year*** 1999

Code	9
Description	Social care related to health care
Contents	Much primary care nursing is provided by "medico-social centres" on contract to the national and local authorities. The centres are administered jointly by the Luxembourg Red Cross and the Luxembourg League for Prevention and Medico-Social Action. Centres are spread throughout the territory of Luxembourg, and are involved in the provision of child health clinics, school health services, assessment of handicapped children and health education and antenatal advice. "Social nurses" from the centres combine the role of health visitors and social workers. In 1998 a new law (dated 8 September) was passed to regulate the relationship between the state and nongovernmental organizations working in social care. The law covers accreditation and funding of care services and cooperation with service providers.
Source	European Observatory on Health Care Systems — ***Year*** 1999

Code	9.1
Description	Organisation and financing of social care
Contents	The sector's services include (as well as those mentioned above) AIDS and drug addiction prevention activities, resources for single parents, shelter for the homeless and youth training. Services are organized by independent NGOs or jointly by the Luxembourg League for Prevention and Medico-Social Action and the Luxembourg Red Cross through the network of community health service providers entitled Service medicosocial et social polyvalent de secteur. The Service of Social and Therapeutic Activities (planned to become the Division of Social Medicine within the Directorate of Health) is responsible for promoting and supervising services dealing with handicap, mental illness, drug addiction and home nursing services. The Division advises on policy in this sector, taking into account the views of nongovernmental organizations (NGOs) aired in consultative committees. It also runs the Luxembourg focal point of the European Monitoring Centre on Drugs and Drug Addiction. Luxembourg's nursing homes and "integrated centres" for the elderly, homes and day centres for the mentally ill and disabled and special schooling for mentally-handicapped children are a responsibility either of the Ministry of Family and Social Welfare or the Ministry of Health and of the Ministry of Education. These services (except schools) are public institutions managed according to private law or contracted out to the private (non-profit) sector. Luxembourg's psychiatric care system was until recently extremely centralized. In 1990 Luxembourg had the highest number of psychiatric beds in Europe, almost all in the state-run neuro-psychiatric hospital at Ettelbrück which was founded over a century ago. Reform of this system was long over-due, and after wide consultation it is planned gradually to replace it with five psychiatric inpatient units (at the existing hospital and four regional acute-care hospitals) and two specialist units for children and adolescents. The rest of the neuro-psychiatric hospital will be given over to special units for geronto-psychiatry and rehabilitation and to units for medium and long-term psychiatric care.
Source	European Observatory on Health Care Systems — ***Year*** 1999

Code	9.2
Description	Role of central/regional/local government
Contents	The state's role in this sector consists mainly of issuing care providers with accreditation, funding them and managing their contracts. As well as the Ministry of Family and Social Welfare and the Ministry of Health, the Ministries of Women, Labour, Housing, Education, Youth and Justice are also involved in overseeing this wide sector.
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	The financing and provision of long-term care was not covered by health insurance until very recently. Instead, long-term care patients received, under certain conditions, an allowance from the Ministry of Health. In addition most of the long-term care services were subsidised by the state. In June 1998, the Chamber of Deputies passed legislation introducing long-term-care insurance. The state is to contribute 45% of the budget and the remainder is to be met by contributions paid from employment and taxable income, and a special contribu-tion from the electricity providers. Benefits have been paid since January 1999. Items covered include home and institutional nursing care, rehabilitation, home aid, nursing appliances, counselling and other social support for the elderly and the physically handicapped. Rehabilitation, nursing appliances and psy-chiatric care are still covered by the sickness funds. During the passage of the law, the federations of NGOs and the unions for workers in the social care sector agreed on a new scheme for remuneration. Remuneration is now committed to rise by a greater margin than will be reim-bursed by the state. Finding the funds to meet this shortfall from 2000, when the state ceases to do so, may cause severe problems. The extra funds provided by the reform for the financing of long-term care are, however, extremely welcome. The insurance presently only covers the provision of care for the elderly and the physically handicapped, but if the current scheme is seen to work well over the next few years, it may be ex-tended to include services for AIDS victims, drug addicts and the mentally ill.
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	Luxembourg imports all pharmaceutical products, so retail prices are usually based on those used in the country of origin which is generally Belgium, Germany or France (because translation of labelling adds to the cost of import-ing from other countries). A comprehensive list of drugs approved for use in Luxembourg is maintained by the Directorate of Health's Division of Pharmacy. The list serves a dual purpose as both national formulary and guide to reim-bursement; against each drug is marked its retail price and the percentage of this price which will be reimbursed by the Union of Sickness Funds. Reim-bursement percentages were, until 1995, assessed and allocated by the Divi-sion of Pharmacy; since then the Union of Sickness Funds has officially taken over this task, but on the basis of work still done by the Division of Pharmacy. The list is divided into categories • normal rate (most drugs): the Union of Sickness Funds covers 80% of the cost of these drugs; • preferential rate: drugs which have a precise therapeutic purpose, usually with regard to long-term or particularly serious illnesses (cancer, severe hypertension, etc.) – the Union of Sickness Funds covers 100% of the cost of these drugs; • reduced rate: drugs classed as for "comfort" purposes, e.g. minor painkillers, anti-flu drugs, energizers – the Union of Sickness Funds covers 40% of the cost of these drugs • non-reimbursed items: for example, vitamin supplements, tonics and several products for which there is commercial advertising are included on the list as they are officially approved for use in Luxembourg, but 0% of their cost is reimbursed. Patients present their medical prescription and their insurance card and pay the non-reimbursable percentage of the drug cost (i.e. in most cases 20% of retail price) at a pharmacy in order to obtain their medicines. The pharmacy takes the prescription as proof of advance medical authorization, and also uses it as documentation when claiming back the rest of the drug cost from the Union of Sickness Funds. Drugs administered during a visit to a doctor or during hospital treatment do not fall within the above system; they are respec-tively claimed back by doctors or charged to hospital budgets. Hospitals base their drug budgets on the retail prices quoted by the state list. New drugs have to be authorized for entry to the Luxembourg market by the Minister of Health, who signs each authorization on the basis of advice from the Directorate of Health's Division of Pharmacy. Part of the authoriza-tion process involves a reconnaissance by the Luxembourg authorities to check that the retail price (based on the price in the country of origin) is justifiable. The Division's duties also include supervising the practice of professional pharmacists and advising on authorization of new pharmacies. In early 1999 there were 79 pharmacies in the country; 53 were public (run by self-employed pharmacists, but on concession from the state) and the private sector ran the remainder. The number of pharmacies in the country is controlled, as new pharmacies require authorization by the state. A new pharmacy can open if a commune demonstrates the demand for it and the Division of Pharmacy gives authorization. However, the number of pharmacies tends to remain fairly con-stant. The seniority of Luxembourg's qualified pharmacists is assessed on a points system throughout their working lives, and on reaching a certain number of points a pharmacist is eligible to inherit the management of any public pharmacy which falls vacant (which happens automatically when the holder of the state concession reaches the age of 70). Until 1995, patients had to advance the total cost of a drug to the pharmacy, and themselves received reimbursement at the relevant percentage (usually 80%). Since 1995, the patient has only advanced the non-reimbursable percentage. The justification for moving to the present system was that the state could delegate certain monitoring tasks, such as gathering information on doctors' prescribing patterns, to pharmacies. To pay pharmacies for this extra work, an administration charge which pharmacies had been required to pay to the Union of Sickness Funds since 1983 (5% of the official price of each drug) was abolished. However, some observers argue that the new system contains incentives to increase expenditure on pharmaceuticals. Before 1995, patients were far more aware of the cost of pharmaceuticals. Since then, patients (and their doctors) have known that they will not have to advance the total drug cost even temporarily, so they are keen to be prescribed more, and more expensive, drugs. A possible future reform in this sector (which has been suggested by the Union of Sickness Funds) would be the inclusion within the approved drug list of guidance to doctors on which drugs to prescribe. Indeed some sections of the list already do so. The aim of such guidance is to influence the prescribing behaviour of doctors – but again opinion differs as to whether this is out of concern primarily for service quality or for cost containment. Cost contain-ment is not yet a prominent feature in Luxembourg; as far as pharmaceuticals are concerned, patients expect to be (and usually are) given a prescription dur-ing a medical consultation. There is little discussion of trying to encourage Luxembourg's physicians to prescribe generic drugs.

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	The government publishes (and revises every three years) a list of pieces of costly, specialized medical equipment which cannot be purchased by hospitals without special authorization of the Minister of Health. In early 1999 this list specified 31 categories of health care technology (although as a result of the 1998 law on hospitals this number is soon to be reduced). Under the 1976 law on hospital planning, the Minister of Health authorizes this equipment to be installed in hospitals according to the needs of the population estimated in each National Hospital Plan. The authorization process includes consultation with the Permanent Hospitals Committee, an advisory board composed of representatives from the government, Union of Sickness Funds, hospitals and the health professions. The 1998 hospital law provided for up to 80% of the cost of this equipment to be met by the state, so hospitals are unlikely to purchase these costly items without applying for authorization and funding from the Ministry of Health. Less costly items are reimbursed by the Union of Sickness Funds.

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	There is no full university in Luxembourg (students can only complete their first two years of study in the country) nor a medical school. The 20 or so medical students from Luxembourg each year therefore receive their training aboad, mainly in Belgium, France or Germany. Dentists and graduate nurses are also trained abroad – in short, any health profession requiring more than three years' training after secondary school will require a period of training abroad. Following completion of their training, physicians simply need approval of their foreign diploma by the Ministry of Health (if delivered in an EU member state) or by the Ministry of Education (if delivered in other countries) and authorization from the Ministry of Health to practise in Luxembourg. Professional qualifications requiring three years of training (e.g. the basic nursing qualification and those for paramedics, laboratory technicians and surgical assistants) can be gained in Luxembourg itself. The Ministry of Education takes the lead in determining policy for this training; it takes place at the Technical College for Health Professions which has a main campus in Luxembourg city and two annexes at Esch and Ettelbrück.

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	The Division of Health Inspection within the Directorate of Health is by law the mandatory adviser to local authorities on public heath questions, and monitors public health activities in a wide range of sectors. Its work divides into two parts: public health inspections, and information dissemination. In early 1999 the Division employed 2 doctors, 4 health inspectors (i.e. qualified nurses with extra specialist training) and one agricultural expert, as well as support staff. The Division's health inspectors examine: • water safety standards • food standards • safety in sports centres and tourist facilities • public health in rural areas • public health in schools (in cooperation with the Division for School Health and the Ministry of Education) • public health in state-provided housing (in cooperation with local authorities) • health standards in nursing homes • public health issues related to burials and cemetery maintenance.		
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	Numbers of doctors practising in Luxembourg have risen steadily over the last three decades, from 362 in 1970 to 563 in 1981 and 766 in 1990. In 1997, there were 344 general practitioners, 656 specialists and 277 dentists in the country, about half of whom practised in the capital. However, the population to be served has also increased over time, and the number of doctors per 1000 population in Luxembourg is still fairly low in comparison to the western European average. The number of doctors practising in Luxembourg will probably continue to increase for the forseeable future, because the country has an attractive remuneration and licensing system and, since European Union legislation introduced the mutual recognition of medical qualifications, there has been no legal means to restrict the influx of medical personnel. Once in Luxembourg, physicians have to compete in the market to attract patients, who have free choice of primary care provider; but there is no medical unemployment in Luxembourg. The same situation applies to dentists, whilst in contrast the op-portunities for pharmacists are limited because the total number of pharmacies in the country is controlled. Before the 1990s, there was very little data on the number of nurses practising in Luxembourg. In 1992 registration of nurses and other health professionals was made compulsory, and there is now a state-maintained register of qualified nurses and other health professionals in the country. This put the number of nurses practising in 1998 at 3294, of whom 2467 were general nurses and the remainder specialists in various areas of health care. There is a general steady increase of numbers of health professionals practising in Luxembourg, although data on numbers of certified nurses have been lacking until recently.
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	With a few exceptions, doctors in Luxembourg are self-employed and paid on a fee-for-service basis (and have to accept the fixed statutory fee levels). The exceptions to this rule are a few doctors in the neuro-psychiatric hospital, and the unique salary system of the Centre Hospitalier de Luxembourg (CHL). In the CHL all medical professionals' earnings (from normal fee-for-service payments) are centrally pooled and then reallocated by hospital management as salaries. This system dates from the CHL's origins; the hospital was set up in the early 1970s, at a period when principles of social solidarity were strongly felt, so its salary system was designed to reallocate income more equitably between different health professions. This system benefits professionals (such as paediatricians) who produce fewer chargeable units than others due to, for example, longer consultation times, and it removes the incentive for such pro-fessionals to increase their unit output at the expense of quality of service. In practice, however, professionals at the CHL are subject to the same fee-for-service incentives – albeit to a lesser extent – than those at other hospitals, because CHL management monitors earnings and will question those who generate low levels of income. It is important to note that from the point of view of the patient, even the doctors in CHL are paid on a fee-for-service basis; the patient still has to pay the set fee at the point of use. The neuro-psychiatric hospital at Ettelbrück was the last to be run by the state, but was brought into line with all other hospitals by legislation in 1998 and will henceforth, like them, be run by an independent administrative board. Its existing staff will continue to be paid as civil servants for the rest of their careers, but new recruits will be remunerated as private employees. Services will be charged for on a fee-for-service basis. Besides doctors, the only other major group of health professionals who are self-employed are physiotherapists. Almost all other health professionals are waged employees, and their remuneration level is negotiated between unions and employers.
Source	European Observatory on Health Care Systems — ***Year*** 1999

Code	13.1.1
Description	Integrated or contracted
Contents	
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	All services given by health professionals are defined by the Ministers of Social Security and Health on the basis of proposals from a board of experts. They are set out in the two volumes of fee schedules or “nomenclatures” which are published each year; one volume covers the services given by doctors and dentists and the second the services given by other health professions. The “nomenclatures” set out the value of each service, and the fee level for that service is calculated by multiplying the value by a factor (the “standard fee”) which is negotiated each year between the Union of Sickness Funds and organi-zations representing health professionals. Professionals then have to accept the statutory fee levels set. A surveillance committee, set up by the Ministry of Social Security, is re-sponsible for determining when a health professional has made an “unjustified deviation” from the statutory fee levels. In the case of “unjustified deviation”, a number of sanctions can be taken. The provider can be suspended from health insurance for up to six months, issued with a warning, asked to return fees charged or fined (up to LUF 500 000 for individual doctors). Having paid for ambulatory care, an insured patient is reimbursed most of the fee at the rate set by law, minus a proportion which is forfeited as a co-payment. For example, reimbursement is currently set at 80% of the fee for the first visit by a general practitioner to the patient in any 28 days (i.e. co-payment at 20%), 95% for the first visit made by a patient to a GP or for any specialist consultation, and 100% for further visits.
Source	European Observatory on Health Care Systems — ***Year*** 1999

Code	13.2
Description	Methods of hospital payment
Contents	Until 1995, hospitals were financed on the basis of a uniform per diem payment, lump sum payments for various surgical operations, and fee-for-service remu-neration of physicians. However, a shortfall resulted, and to attempt to cover costs a prospective payment system has been in operation since 1995. The sickness funds transfer prospective budget payments directly to individual hospitals. Patients are also required to pay a small daily fee. Individual hospital budgets are negotiated between the Union of Sickness Funds and the hospitals themselves. The budgeting and payment process starts early each year. Before 1 April the Ministry of Social Security circulates to hospitals an assessment of external factors which could affect hospital budget-ing. The signatory parties (the Union and the hospitals) have until 1 May to negotiate the terms of the budget. Each hospital drafts its budget, based on a combination of historical data, inflation, changes in career structures, agree-ments with trade unions and so on. (Supplementary personnel costs are re-negotiated each year; the most important category is nursing staff, where all parties in the Luxembourg system have agreed to use the Canadian PRN system for measuring workload in nursing units.) Each hospital’s budget is submitted by 1 June to the Union of Sickness Funds for verification. The Union has until 1 September to submit any final disagreement to a Hospital Budget Committee which must reconcile the signatory parties. Hospitals receive three categories of payments: 1. Non-activity-related (hospital maintenance) payments, paid each month: this pays for the cost of keeping the hospital ready to treat patients; 2. Activity-related payments, paid according to units of activity accomplished and documented in invoices presented by the hospital to the sickness funds (or to the state in some cases – e.g. maternity care, of which the government funds 100%). To be reimbursed, a hospital has to establish an individual bill for each patient; 3. Bonuses of up to 2% of the total hospital budget, which are payable if the hospital follows a quality programme determined by the Union of Sickness Funds. Major investment costs for construction and equipment are financed by the state at a rate of 80%. Significant new equipment has to be authorized by the Minister of Health, in accordance with the National Hospital Plan. There is no overall budget for running costs as each hospital negotiates its operating budget with the Union of Sickness Funds, without the direct interference of the state
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	Health care services in Luxembourg are financed by health insurance. The insurance falls into two categories: statutory and voluntary. The statutory insurance system is the main source of finance for health care in Luxembourg and contributes by far the largest share of its cost. This share has remained fairly stable over the last few years.		
Source	European Observatory on Health Care Systems	***Year***	1999

Code	14.1		
Description	Main features of tax based systems		
Contents			
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			
Source	European Observatory on Health Care Systems	***Year***	1999

Code	14.2
Description	Main features of social health insurance
Contents	Main system of finance and coverage Statutory health insurance Health care services which are necessary and useful and administered in the most economic way possible are financed by the statutory health insurance system which covers 99% of the population. The exceptions who are not covered are civil servants and employees of European and international institutions (who have their own health insurance funds) and any unemployed person who is receiving neither unemployment benefit nor a public pension. The compul-sory health insurance is managed and provided by the Union of Sickness Funds and nine individual agencies to which people are allocated on the basis of their professional occupation. The health insurance has three sources of finance; contributions from the state (a maximum of 40% of the total), from employers (about 30% of the total) and from insured individuals (about 30%). Contributions are collected centrally for all branches of social security by the Common Centre of Social Security and are allocated to the Union of Sickness Funds. The state's contribution to the funds is set at 10% of the total contributions of the active work force and 250% of the total contributions of pensioners (although if pensioners' contributions rise above 31% of the contributions of others, the state will pay only a 10% contribution for all categories). The state's contributions are limited to a maximum of 40% of the total resources of the insurance system. The employer's share of the contributions varies from sector to sector of the labour market. The employers of most salaried employees pay an equal sum to that paid by their employees; the army, the police force and the prison service pay the entirety of their employees' contributions; employers pay nothing toward voluntary insurance schemes joined by their employees and nothing, by definition, toward the health insurance of the self-employed. Individuals' health insurance contribution rates depend on whether they are economically active or not. Economically active individuals' contributions are calculated as a percentage of their gross income. This contribution is subject to a maximum limit which is activated when income reaches five times the "minimum guaranteed income". The minimum guaranteed income is set by law (in early 1999 it was 46 878 LUF per month). Individuals with income under this minimum (who should in any case be on state benefits) do not con-tribute to health insurance. To calculate pensioners' contributions, the same percentage is applied to their income but the minimum cut-off point is 30% higher than the minimum guaranteed income; pensioners with income below this cut-off point do not contribute to health insurance. On several occasions in the past, the resources of Luxembourg's sickness funds have failed to cover their expenditure and they have needed state sub-sidy. To prevent any recurrence of such shortfall the Union of Sickness Funds is now obliged to balance its budget by maintaining a reserve of between 10% and 20% of the total expenditure of the insurance system. This expenditure is reviewed annually and, if the reserve bypasses the fixed limits, an "alarm" device signals the need for specific actions – e.g. increase of contribution rates, or regulation of the volume of consultations and services. The contribution rates are reset by the General Assembly of the Union by 1 January each year. In early 1999 the contribution rates for financing of the health insurance were: 5.1% (of gross income) for health care itself; 0.3% for a monthly living allowance during illness for the self-employed and those salaried employees who benefit from continuation of salary for the first four months of illness; 5% for an adequate monthly living allowance for those employees who do not so benefit. The Union of Sickness Funds is responsible for paying for all the benefits directly provided on a fee-for-service basis in Luxembourg and abroad and for hospitals' expenditure, but the individual sickness funds continue to reimburse the recipient for certified expenditure on goods and services. Doctors are paid on a fee-for-service basis (with the exception of a few doctors working in the neuro-psychiatric hospital, and the unique salary system of the Centre Hospitalier de Luxembourg). Doctors have to accept the fixed statutory fee levels; there is no distinction between doctors on the basis of whether they work from within hospitals or not. Having paid for ambulatory care, the insured patient is reimbursed most of the fee at the rate set by law, minus a proportion which is forfeited as a co-payment. Reimbursement is currently set at 80% of the fee for the first visit by a general practitioner to the patient in any 28 days (ie. copayment at 20%), 95% for the first visit made by a patient to a GP or for any specialist consultation, and 100% for further visits. All services given by health professionals are defined by the Ministers of Social Security and Health on the basis of detailed proposals from a board of experts (the Nomenclature Committee). They are set out in the two volumes of fee schedules or "nomenclatures" which are published each year; one volume covers the services given by doctors and dentists, and the second the services given by other health professionals. The "nomenclatures" set out the value of each service, and the fee level for that service is calculated by multiplying the value by a factor (the "standard fee") which is negotiated each year between the Union of Sickness Funds and the organizations representing health professionals. The state maintains a comprehensive list of drugs approved for use in Luxem-bourg, and the cost of most drugs on the list is 80% reimbursed by the sickness funds.

	However, drugs used for the treatment of specified long-term or serious illnesses are 100% reimbursed, drugs classed as for “comfort purposes” are reimbursed at 40%, and others are not reimbursed. Drugs administered during hospital treatment do not fall within the above system, but are charged to hospital budgets. In hospital, sickness insurance covers the cost of a second class room minus a small patient co-payment of LUF 219 per day. Patients must pay extra if they want a first-class room or greater flexibility in the timing of elective inpatient and outpatient care and they can do this through additional, voluntary health insurance. The state meets all the costs of maternity care; maternity service costs are charged directly by hospitals to the Union of Sickness Funds, and the Union seeks reimbursement from the government. People can opt to pay contributions to continue their membership of the statutory health insurance scheme even if their employment is terminated or if they have chosen to stop working.
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	The Union of Sickness Funds reimburses costs of treatment outside the hospital sector according to rates set in the statutes of the Union of Sickness Funds, which define the diseases, treatments and drugs which are excluded from reimbursement. Health care services of which most or all of the cost is covered by statutory insurance include: • Medical care and dental care • Treatments given by other health professionals, on medical prescriptions • Laboratory analyses • Most dental and orthopaedic prostheses • Pharmaceutical products • Products and equipment necessary to treatments covered by • Hotel costs of a hospital stay • Outpatient or inpatient care costs • Convalescent care • Transport costs. Services not covered include: • Most antenatal tests for chromosomal anomalies and foetal malformations • Some infertility treatments (and those which are allowed require detailed certification and, in some cases, prior authorization) • Ostiodensiometry • Surgical or laser treatments of refraction • Surgical treatment of obesity, unless there is a detailed medical report stating that all previous non-surgical treatments have failed (and even then treat-ment is subject to certain limitations) • Replacement of breast implants for which no authorization was given by the health insurance in the first place. The services of health professionals are reimbursed within the sickness insurance system rather than from hospital budgets, even if they practise within hospital premises. Relations between the sickness funds and health care providers practising in Luxembourg are defined in collective agreements. There are separate agree-ments between the Union of Sickness Funds and each type of provider, i.e. doctors, dentists, other health professionals, medical analysis and clinical biology laboratories, establishments for therapeutic care, e.g. the thermal baths at Mondorf-les-Bains, the specialist establishment for functional rehabilita-tion, suppliers of orthopaedic prostheses, pharmacists, opticians, the Luxem-bourg Red Cross (for blood transfusions, and preparation and provision of blood and blood products) and providers of transport services for those taken ill or the victims of accidents. Medical care The patient is reimbursed 80% of the fee for a home visit by a general practi-tioner (i.e. 20% co-payment) for the first visit in any 28-day period. Subse-quently the co-payment decreases – visits are reimbursed at a rate of 95%. Visits to the doctor's surgery by the patient, or to any specialist, are also reimbursed at a rate of 95%. Pre- and post-natal care is reimbursed at a rate of 100%. When doctors are summoned by the emergency services the cost 100% reimbursed. There are limitations on the number of GP visits, or visits to more than one doctor of the same specialism, within certain time periods. Dental care and dental prostheses Up to an annual sum of LUF 1334, 100% of dental bills are reimbursed by the sickness insurance system. Beyond that sum, all dental services are reimbursed at 80% of agreed rates according to the statutes of the Union of Sickness Funds. The cost of dentures is reimbursed at 100% of agreed tariffs provided the patients have their teeth examined each of the proceding two years. However the agreed rate may be a small proportion of the real cost to the patient. Co-payment is waived for the provision of a few dental prostheses, whilst those which are not considered necessary are not reimbursed at all. Orthopaedic prostheses The cost of prostheses which are deemed necessary is reimbursed at 100%, according to the statutes of the Union of Sickness Funds. There is a co-payment of LUF 2743 for orthopaedic shoes. There are small co-payments for the repair of permanent prostheses, and limitations on the frequency of replacement and repair which can be charged to sickness insurance. Treatments given by health professionals other than physicians or dentists Most treatments which given by nurses are reimbursed at 100% of the cost to the patient. The first eight physiotherapy sessions per year are reimbursed at 80%; sessions exceeding that number, and any session as part of inpatient hospital treatment, are reimbursed at 100%. Speech therapy is reimbursed at 100% of the rate set in the state-endorsed lists, as long as treatment is under-taken within the time limit specified; sessions exceeding eight per year require prior authorization. Midwives' services endorsed as necessary at delivery are

reimbursed at 100%: other, pre-natal services rendered by midwives require a 20% co-payment from the patient.
Functional rehabilitation
The treatment of victims of accidents or illness who require functional rehabili-tation is undertaken in the one specialist establishment in the country, and reimbursed at rates which vary according to the treatment needed. Medical recommendation of such treatment, and the treatment plan, is examined by the Office of Medical Control, which reports to the Ministry of Social Security, before authorization is given. Authorization must be renewed after three months
Laboratory analyses
Costs of laboratory analyses, which are performed at Luxembourg's National Laboratory of Health, in the laboratories attached to hospitals or in private laboratories, are 100% reimbursed by the sickness insurance system.
Pharmaceutical products
The Directorate of Health maintains a comprehensive list of drugs approved for use in Luxembourg. The list displays the retail price of each drug, and the percentage of its price which will be reimbursed by the sickness funds (as long as the drug is medically prescribed). The list is divided into categories:
• normal rate (most drugs): the sickness funds cover 80% of the cost of these drugs;
• preferential rate: drugs which have a precise therapeutic purpose, usually with regard to long-term or particularly serious illnesses (cancer, severe hypertension, etc) – the sickness funds cover 100% of the cost of these drugs;
• reduced rate: drugs classed as for "comfort" purposes, e.g. minor painkillers, anti-flu drugs, energizers – the sickness funds cover 40% of the cost of these drugs;
• non-reimbursed items: for example, contraceptives (unless prescribed for a therapeutic purpose), vitamin supplements, tonics and several products for which there is commercial advertising are included on the list as they are officially approved for use in Luxembourg, but 0% of their cost is reim-bursed. Drugs administered during hospital treatment do not fall within the above system, but are charged to hospital budgets.
Products and equipment necessary to treatments covered by insurance
These are listed on annexes to the statutes of the Union of Sickness Funds, and are reimbursed at set rates according to their sale price (or a fixed reference price for certain products).
Convalescent care
After major surgery, a serious illness or lengthy hospitalization, a patient can claim the cost of convalescent care, in a recognized establishment, for more than 21 days at a maximum daily fee of LUF 823. Cures at the thermal baths at Mondorf-les-Bains which have been recommended by a physician and are on the state-endorsed register of reimbursable treatments are reimbursed at 100%; others may be reimbursed at 80% or 60%.
Transport costs
The sickness insurance system covers:
• ambulance or aerial transport by public emergency service in case of emer-gency (reimbursed at 100%);
• non-urgent ambulance transport at 70% if operated by public ambulance service and at 40 LUF/km if by private ambulance service;
• taxi transport (reimbursed at 28 LUF/km) to hospital or other treatment centre for certain medical treatments (eg. dialysis, chemotherapy, radio-therapy) if this treatment is required 4 times or more within 90 days;
• a set rate of reimbursement (7 LUF/km) for patients using other forms of transport to obtain treatment (calculated on the basis of the shortest possible route).
There are very detailed rules for the reimbursement of these costs, in some cases requiring prior authorization.
Visual and hearing aids
Spectacles and contact lenses are reimbursed at rates set in the statutes of the Union of Sickness Funds. However, certain circumstances merit exceptions (i.e. 100% reimbursement) for shatterproof or tinted spectacle lenses, contact lenses, and replacement of any visual aid more than once every two years. Medical prescriptions are required for contact lenses, spectacles with shatter-proof or tinted lenses, spectacles for children under 14 years, and the first artificial eye to be fitted. Some spectacle frames are free; others are reim-bursed up to a ceiling of LUF 1600. Hearing aids are reimbursed at 100%.
Blood- and plasma-derived products
Blood- and plasma-derived products are mainly administered during hospital treatment, and are paid for by the sickness insurance system at rates agreed between the Union of Sickness Funds and the Luxembourg Red Cross (which supplies them

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

Code	14.4
Description	Complementary sources of finance
Contents	
Source	European Observatory on Health Care Systems ***Year*** 1999

Code	14.4.1
Description	Voluntary health insurance
Contents	As a proportion of total benefits reimbursed, voluntary health insurance has always been limited as the compulsory public system reimburses so many services. For example, benefits reimbursed by voluntary health insurance funds were worth only 2.2% of those reimbursed by the Union of Sickness Funds in 1994. However, 75% of the active population do belong to voluntary comple-mentary health insurance schemes, which they will use to pay for services which are not classed as necessary or useful. An example of such a service would be first-class hospital accommodation. The state encourages Luxembourg-based voluntary insurance via tax relief on premiums. Three insurance providers should be mentioned. Mutual Medico-Surgical Fund (CMCM) The main Luxembourg-based voluntary health insurance scheme is the Caisse Médico-Chirurgicale Mutualiste (“Mutual Medico-Surgical Fund”) or “CMCM”. The following services are covered by the CMCM: • hospital costs not covered by the statutory insurance (i.e. co-payments) • additional charges for a private room in hospital • pre- and post-operative treatment costs • dental prostheses not covered by the statutory insurance • convalescence costs • diagnostic, medical, operative and hospitalization costs for a surgical inter-vention abroad • partial reimbursement where no agreement exists on the cost of a treatment • health care provided during a journey abroad Members of CMCM mainly use it to reclaim co-payments for hospital services in Luxembourg, the cost of orthodontal treatment and the cost of services in other countries. Mutual aid societies Mutual aid societies, of which membership is based on profession, offer little more than limited life assurance. However, the tax system strongly encourages membership of these societies by exempting them from revenue and property tax and making contributions to them deductible from income tax, and they have one very important feature – membership of CMCM requires prior membership of a mutual aid society. German health insurance funds Various German health insurance funds have started to try their luck on the Luxembourg market. Their opportunities are limited because of the wide range of benefits covered by either statutory insurance or the CMCM; but a few hypothetical scenarios do offer them an opening. For example, reimbursement for hospital care outside Luxembourg requires prior authorization from the Union of Sickness Funds. If a patient is severely ill, and is referred to one of the nearby teaching hospitals in France or Germany, the Union is extremely unlikely to refuse authorization – but people may fear such an eventuality. In addition, if a Luxembourger wishes to have the option of hospital care outside Luxembourg for a condition which is not severe, he or she may welcome the opportunity of German fund membership.
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			
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	Luxembourg's health care expenditure as a share of GDP is far below the western European average, and the lowest amongst its immediate neighbours Belgium, France and Germany; however Luxem-bourg's expenditure per capita (in US $PPPs) on health care seems to be one of the highest in Europe. This apparent contradiction has two explanations. Firstly, per capita expenditure figures based on the resident population can be mis-leading since a significant minority (about 25%) of Luxembourg's insured workers are commuters coming from the neighbouring countries. Secondly, Luxembourg's per capita GDP is one of the highest in the EU. In Luxembourg, as in other western European countries, total expenditure on health care has significantly increased in real terms since the 1970s; the proportion of total expenditure accounted for by the public sector has remained constantly fairly high, and is still one of the highest in Europe. This reflects the (past and present) supreme importance of the public, compulsory insurance system in the financing of health care in Luxembourg. The compulsory health insurance's administrative costs were estimated to be 4.4% of total public expenditure on health in 1998. Reimbursement procedures are rendered more complicated by the fact that a certain proportion of people covered by Luxembourg's health insurance actually live outside the country, so insurers need to be familiar with fees and reimbursement conditions both within and outside Luxembourg. For this reason administrative costs are unlikely to reduce in the near future. National data on the compulsory health insurance system break down the expenditures of the system into three main categories: goods and services reimbursed, cash payments (mainly for capital investments) and maternity services which are classed separately as being 100% financed by the state. In 1997, expenditure in these three categories was 29 264 million LUF, 4138 million LUF and 2072 million LUF respectively for 313 686 insured persons.
Source	European Observatory on Health Care Systems — ***Year*** 1999

Code	15.1
Description	Structure of health care expenditures
Contents	
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			
Source	European Observatory on Health Care Systems	***Year***	1999

Code	17.2
Description	Content of reforms and legislation
Contents	The 1976 law on hospital planning formed the first attempt by the state to influence planning in the hospital sector. It had two principal aims: • to try to limit and regulate the development of the hospital sector; • to create a legal framework through which the state could subsidise the hospital sector, for which hospitals' representatives had been pressing for some time. This legislation provides the legal context within which successive National Hospital Plans in 1982, 1989 and 1994 have determined the levels of hospital infrastructure and equipment deemed necessary to serve Luxembourg's popu-lation. 1977: Legislation introduced preventive interventions during pregnancy and early childhood. Regular medical checks for mothers and infants were to be reimbursed by the sickness insurance funds. 1980: A Law on the Directorate of Health replaced earlier legislation (1952) on public health officers. It defined new areas of responsibility for the Directo-rate, and organized the administration to perform these tasks. 1980: Legislation established as a separate entity the National Laboratory of Health (which had previously come under the control of the Director General of Health). 1982: First National Hospital Plan. 1987: A Law on School Health (replacing regulations of 1919) introduced a requirement for thorough medical check-ups for schoolchildren at certain ages, in addition to annual shorter screenings. The law also provided for individual health counselling for pupils and emphasized the need for close cooperation with mental health services within education. 1989: Second National Hospital Plan. 1990: Law on the development of hospital services, building on the 1976 law on planning. 1994: Law on occupational health services. This legislation, codifying Lux-embourg's efforts to protect the health of workers at the workplace and to prevent accidents and occupational diseases, implemented an EU Directive (Directive 89/391 EEC) to set up a national occupational health service. 1994: The Third National Hospital Plan continued to steer the allocation of hospital beds and equipment towards a more equitable reflection of the needs and geographical distribution of the population. It dealt with the allocation of acute beds, research into the quality of care and patient safety and develop-ment of alternatives to long-term hospital care (bearing in mind increasing rehabilitation needs, especially of the elderly). 1994: Legislation creating the National Prevention Centre on Drug Addiction. This centre is financed by the Ministry of Education, and is responsible for coordinating preventive activities in the field of drug addiction. It has been operational since 1995. 1998: (July) A new law on hospitals succeeded the previous laws on hospital planning (1976) and development of hospital services (1990) which had intro-duced a basic structure for financial contributions by the state towards invest-ment in hospitals' infrastructure and equipment. The new law set a range of rates for these contributions depending on the type of investment, and also introduced standards and guidelines for the organization of hospitals and hospital departments and defines the rights of patients. It forms an important part of Luxembourg's preparation for its fourth National Hospital Plan, which is likely to be finalized in 2000 or 2001.
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	The main objectives for future action are: to define minimum standards for hospital services; to promote the quality of care and the continuity of care between hospitals and primary health care services; to improve hospital infor-mation systems; to improve the monitoring of outcomes of health care activities; and to secure the rights of the patient. Better integration of doctors into hospital financing systems may also be a priority.
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	The early development of the health insurance system was described under “Historical Background” above. Since 1970, the most significant changes in the system have been the reforms of 1974, 1978, 1992 and 1998. There were also minor changes in 1981–1983. 1974: Legislation on sickness fund benefits: this legislation established uni-formity of benefits for all categories of persons insured across all sickness funds, and redefined the state’s contributions to the financing of the sickness insurance. Also in this law the sickness insurance system started to recognize the importance of (and the duty to reimburse) preventive care, by offering 100% reimbursement of dental treatment if the patient had had a dental check-up each year for the previous two years. 1978: Further reform of the sickness funds created a “risk community” among all funds so that end-year deficit of some funds could be covered by surplus of others, and allowed the state contribution to the financing of the funds to grow to almost 40%. 1981–1983: Minor legislation on sickness funds and health personnel brought increases in co-payment levels, refinements in the pharmaceutical reimburse-ment system, reduction of remuneration for doctors and a framework for the adjustment of pay of hospital employees with the cost of living. 1992: Major reform of the sickness insurance system: in original drafts of this legislation the government intended to abolish the nine separate sickness funds, but faced with strong opposition from professional groups it had to compromise, allowing the funds to continue to exist as agencies for direct contact with the insured citizen. All other responsibilities (most notably direct reimbursement to providers), were transferred to the Union of Sickness Funds. Also under the 1992 law the state agreed to subsidise sickness funds for pensioners at a far higher rate (250% of their contributions) than for the currently employed (10%), because pensioners consume more health care than the active population and their contributions to health care are lower. State input to all funds was formally limited to 40% of their total budget. Finally, for cost containment purposes, the 1992 law defined the nomen-clature of all medical and nursing acts, set a time limit for the conclusion of contracts between providers and the Union of Sickness Funds, and introduced a new financing system (from 1 January 1995) for hospitals. The new system abolished the uniform per diem payment system, which encouraged spiralling hospital costs, and instead mandated each hospital to negotiate its own individual budget directly with the Union of Sickness Funds. This system still excludes individual doctors working in hospitals, who continue to be paid on a fee-for-service basis. 1998: Legislation introducing insurance to cover the cost of long-term care. Until 1998, the lack of insurance to cover long-term care for the elderly and the handicapped was a source of concern in Luxembourg. 1998 legislation started to fill the gap, introducing insurance covering home and institutional nursing care, rehabilitation, home aid, nursing appliances, counselling and other support for the elderly and the mentally and physically handicapped. The state pays 45% of the cost of such care, and the remainder is met by the insured person’s contributions and by levies on the patient’s estate revenues, if any. Benefits have been paid since January 1999. Possible future changes The long-term-care insurance described above covers care for the elderly and the mentally and physically handicapped. Services for AIDS victims, for drug addicts and the mentally ill are not yet covered, and these may be candidates for inclusion in future if the current scheme is seen to work well over the next few years. Another possible target for reform is the continued parallel existence of the Union of Sickness Funds and the nine individual funds, which is thought to lead to wastage and unnecessary extra bureaucracy.		
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	A “Health For All” paper was prepared by the Directorate of Health and pub-lished by the Ministry of Health in 1994. It set priority targets in the following areas: Cardiovascular diseases: Reduction of mortality from diseases of the circula-tory system by at least 30% by the year 2002 (from 486/100 000 in 1988–1990 to 340/100 000 in 2002); reduction of mortality from coronary disease (in the under-65s) by 20% by the year 2002 and (in over-65s) by 30%; reduction of mortality from stroke by 25% in the under-65s and 30% in the over-65s by the same year; promotion of healthy nutrition and physical activity and reduction of alcohol consumption and smoking, and detection of other risk factors. Cancer: Reduction of lung cancer deaths by 15% in the under-65s by the year 2002 (i.e. from 24/100 000 in 1988–1990 to 20/100 000) via a strategy to reduce smoking overall in the population by one third (from 33% in 1987–1990 to 22% in 2002); to reduce mortality from breast cancer in the vulnerable popula-tion by 25% by the year 2002 via promotion of screening programmes; to promote cervical cancer screening and reduce cervical cancer deaths to 3 in 100 000 by 2002. Accidents: Reduction of mortality from accidents by 25% by the year 2005. Prevention campaigns to reduce road traffic accidents have had no impact on young people (age group 15-24 years) so these are to be the priority target group; a secondary priority will be the over-65s. Diabetes: Increasing information available on the disease; primary prevention via health education on nutrition, etc; promotion of early detection of the dis-ease in order to prevent complications. Communicable diseases: Revision of the surveillance system, updating of the immunization programme and an AIDS/HIV prevention strategy defined until the year 2003. Mental health: Reduction of suicide and attempted suicide; reduction of preva-lence of mental illness; improvement of the quality of life of persons with mental and psychological problems (no numerical targets specified). Environmental health: Creation of an Environmental Health Service, overseen by the Directorate of Health’s Division of Health Inspection; increased attention to actions to limit polluting emissions and destruction of the ozone layer, and to air quality, water quality, food standards, waste disposal, urban habitats and protection against ionising and non-ionizing radiation. (Much of this area is covered by European Community or international law). Health at school : Emphasis on the importance of the existing system for medi-cal surveillance in schools; reinforcement of the school as a health promoting environment via health education, safe facilities, good nutrition and sport. Occupational health: Ten objectives relating to the improvement of health and safety at work (which were mainly taken up in legislation passed in 1994).
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

Code	17.5
Description	Conclusions
Contents	The fundamental principles which guide the health care system in Luxembourg are the coverage of the whole population by the compulsory insurance system which pays for the majority of services, and the patient's right to choose his/her preferred provider (who is reimbursed at the rates set by the insurance system). The attitude taken in Luxembourg is that patients in the late twentieth century can easily access information about the range of health care available; they are expected to do so and exercise informed choice, taking responsibility for their own health. Of course, transparency of information about health care providers is crucial to this principle. Only if there is adequate information is the patient's "informed choice" authentic. This central principle of free patient choice applies not only to the primary health care provider, but also – through voluntary insurance coverage – to the standard and location of secondary care. The importance which Luxembourgers attach to free choice by the patient means that Luxembourg is unlikely in the foreseeable future to introduce a referral system between primary care providers and secondary and tertiary care. Evaluation and cost containment Luxembourg is a rich country. Unsurprisingly, therefore, cost-containment in the health care system has not been as urgent a priority in Luxembourg as elsewhere. Some claim that the lack of real expenditure contraints has resulted in inadequate evaluation of capital projects in the health sector – for example, the state may in the past have made capital grants to hospitals without rigorous prior evaluation of the value or effectiveness of the project or equipment planned. As in many fee-for-service systems, monitoring of health care delivery seems to have been more focused on quantity, than quality of output. Even if true in the past, this tendency has receded in recent years. Reformers have tried to develop the sense that even in a rich country, the insured citizen and potential patient has a right to expect money to be spent in the most effective way. Thus evaluation of service quality and effectiveness needs to play a major role. Integrating such evaluation into the mentality of the health care professions has been a key aim of recent legislation. For example, a law passed in 1998 limited the accreditation of hospital services to only five years at a time. At the end of that period services must seek re-evaluation and accreditation; in addition hospital managers are being encouraged to perform regular internal assessments between (in preparation for) external evaluations. Thus the state hopes to estab-lish qualitative evaluation and the concept of value-for-money as an accepted part of health service planning and delivery. Other challenges for the future Generally, the main internal challenge facing the Luxembourg health system in future is the need to take on board the modern tools of evaluation and cost-containment and tailor them to complement the principal characteristics of the current system. More specifically, key areas which will require hard work and attention over the next few years will be the new long-term-care insurance system (and other changes in social care), and the administration of the pharma-ceutical reimbursement system. However, other challenges have resulted from external factors, and these will also need to be addressed. In particular, the "Decker and Kohll " judgments of the European Court of Justice have special significance for Luxembourg. Briefly, EC Regulation 1408/71 (which coordinates EU member state social security systems) stipulates that patients seeking medical treatment in another member state must seek prior authorization from their own social insurance provider if they wish the costs of their treatment reimbursed. However, encouraged by the free movement of people, capital, goods and services within the European Union internal market, in 1998 two Luxembourg citizens challenged the requirement for prior authorization before the European Court of Justice. The Court ruled that the Luxembourg sickness insurance system: • had infringed Articles 30 and 36 of the Maastricht Treaty (on the free move-ment of goods in the Community) by refusing reimbursement of the cost of a pair of spectacles bought in Belgium on the grounds that no prior authori-zation had been sought (the Decker judgment); • had infringed Articles 59 and 60 (on the freedom to provide services through-out the Community) in refusing to reimburse for treatment by an orthodontist based in Germany (the Kohll judgment). In Luxembourg, people are already used to seeking goods and services in different member states which may only be half an hour's drive away. The Decker and Kohll judgments encourage them to treat health care no differently from other goods and services. Yet the impact for the sickness funds will probably be manageable as long as the judgments apply only to ambulatory health care services, not to inpatient care. If (as is thought likely) the principle of the judgments is extended via a further court case to cover inpatient care, the implications for the system will be more significant. Firstly, inpatient care is generally more expensive than ambulatory care, so the cost to Luxembourg's system – of paying for medical treatment received abroad whilst not benefiting from the service activity within the national economy – would be greater. Secondly, if patients sought inpatient care abroad to such an extent that Lux-embourg hospitals became seriously underused and had to close, this would impact upon the equity of distribution of care throughout the country. Luxembourg's health care planners will need to monitor the possible impli-cations of the judgments carefully. Some

	of those implications, however, may be positive. The Decker and Kohll judgments can be seen as an incentive to ensure that Luxembourg's health care is of such high quality that citizens are not tempted to look elsewhere; and to develop evaluation and accreditation standards to be able to prove this high quality to the consumer

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

Country profile: Netherlands

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

Code	1.1		
Description	Introductory overview		
Contents	Although under the national constitution Dutch government is obliged to take measures for the advancement of public health, the health care system is based on a complex division of responsibilities, in which the government and government institutions, but also private organisations and independent professionals and their associations are allocated their own share of responsibilities. Since 1988 this system has been undergoing rapid transformations, with the traditional relationships developing towards a more market-oriented health care system, in which parties like providers of care, financers and consumers are acting in new roles. The government will retain overall responsibility, but will act more from a background position. At the moment, however, government plays an active role in directing the necessary reforms and regulating the new relationships between parties in the field of health care.		
Source	Interrnational Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999	**Year**	1996

Code	1.2		
Description	Historical background		
Contents			
Source	Interrnational 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	Interrnational 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	In the present situation the Minister of Health, Welfare and Sport has overall responsibility for the health services and the power to issue orders, guidelines and instructions, in accordance with acts of Parliament. He holds a key position in respect of health care standards, planning and construction, training and remuneration of health care staff. He also determines the level of income-dependent contributions to be paid to the various statutory insurance funds and the benefits to be provided. A number of advisory bodies, of which the most important are the National Council of Public Health and the Health Insurance Council, also fulfil an important forum function for the many private organisations active in the field of health care.		
Source	Interrnational Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999	***Year***	1996

Code	2.2		
Description	Regional government		
Contents	Administrative and executive responsibility at regional and local level lies with the twelve provinces (regional facility planning) and the well over 700 municipalities (preventive services).		
Source	Interrnational Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999	***Year***	1996

Code	2.3		
Description	Local government		
Contents	Administrative and executive responsibility at regional and local level lies with the twelve provinces (regional facility planning) and the well over 700 municipalities (preventive services).		
Source	Interrnational Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999	***Year***	1996

Code	2.4		
Description	Insurance organisations		
Contents			
Source	Interrnational Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999	***Year***	1996

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

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

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

Code	3		
Description	Planning, regulation and management		
Contents	Administrative and executive responsibility at regional and local level lies with the twelve provinces (regional facility planning) and the well over 700 municipalities (preventive services).		
Source	Interrnational 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			
Source	Interrnational 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	Interrnational Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999	***Year***	1996

Code	3.3		
Description	Supervision of the health services		
Contents	The Health Inspectorate, attached to the Ministry, supervises compliance with health care standards.		
Source	Interrnational Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999	***Year***	1996

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

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

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

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

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

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

Code	3.4.8		
Description	Recent changes in resource allocation system		
Contents			
Source	Interrnational Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999	***Year***	1996

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

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

Code	4.3
Description	Ownership: public, private, mix
Contents	Almost all hospitals (88%) and other services are private institutions, working on a non-profit base.
Source	Interrnational Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999
Year	1996

Code	4.4
Description	Freedom of choice
Contents	
Source	Interrnational Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999
Year	1996

Code	4.5
Description	Referral system
Contents	The general rule is that patients first visit their general practitioner. This procedure is mandatory under the sickness fund scheme, except in the case of emergency. Most private insurance companies also stipulate that patients should first consult the general practitioner. The general practitioner thus functions as the "gatekeeper" of the health care system. He can refer patients to independent specialists, out-patient departments, or to hospitals for admission. General practitioners are informed by specialists of diagnosis and treatment so that they can take over the treatment when the patient is referred back. Patients who no longer need specialist care in the short stay hospitals, can be referred to nursing homes, convalescence centres or psychiatric hospitals. The general practitioner can also mobilize home care by the "Cross" organisations or refer to other professionals like physiotherapists.
Source	Interrnational Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999
Year	1996

Code	5
Description	Out-patient care
Contents	Since the seventies the government has tried to advance cohesion in extramural care by stimulating teamwork. This policy has been partially successful. In 1995 there were 150 health centres, in which on average three to four general practitioners, a similar number of district nurses, one or two social workers and physiotherapists work together with supportive staff in shared premises. More recent policy aims have resulted in a large number of substitution experiments in home care for the elderly, for terminally ill and early discharged patients.
Source	Interrnational Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999
Year	1996

Code	5.1
Description	Medical care
Contents	
Source	Interrnational Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999
Year	1996

Code	5.1.1		
Description	General practitioner (solo-, group practices)		
Contents	A typical Dutch GP is independent, owns his own premises and is assisted by a receptionist or practice assistant. He serves an average population of 2165 inhabitants (1995). For many diagnostic procedures general practitioners rely on external facilities. A diminishing proportion of general practitioners, now 11%, usually in rural areas, have a pharmacy of their own. A general practitioner is responsible for round the clock availability of service, seven days a week. This is usually achieved on a rota basis in local tenancy groups with other general practitioners in the area. House calls belong to the normal tasks. Although general practitioners are not involved in hospital treatment, they do visit hospitalised patients, but not as a rule. Most GPs (54%) work alone, 31% work on a partnership basis and 16% work in a group practice.		
Source	Interrnational Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999	***Year***	1996

Code	5.1.2		
Description	Medical specialist with own premises		
Contents	Independent specialists, working in their own premises, are especially found among ophthalmologists, dermatologists, allergologists, psychiatrists and orthodontists.		
Source	Interrnational Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999	***Year***	1996

Code	5.1.3		
Description	Out-patient department		
Contents	Independent specialists, working in their own premises, are especially found among ophthalmologists, dermatologists, allergologists, psychiatrists and orthodontists. Other specialists only work in hospitals and provide ambulatory care in the outpatient departments. Also specialists of the categories, mentioned above, can have their working place in hospitals and their outpatient departments.		
Source	Interrnational Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999	***Year***	1996

Code	5.1.4		
Description	Combined services: health centres		
Contents	The practices of well over 8% of GPs are part of a health centre, which is mostly run by a private foundation or association and encouraged by government subsidies.		
Source	Interrnational Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999	***Year***	1996

Code	5.2
Description	Dental care
Contents	Most dentists in the Netherlands work in their own premises. They serve an average population of about 2100 inhabitants (1995). Others find employment in intramural care, Municipal Health Services (youth dental health), army, university, government, and health insurance funds.
Source	Interrnational Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999
Year	1996

Code	5.2.1
Description	General dentist
Contents	The dentist in general practice is entitled to practice dentistry to its fully extent. His scope is not limited to "hard tissue" (teeth), but also concerns "soft tissue". Important tasks are the early detection of teeth defects, parodontal defects, defects of the mucous membrane and defects in the relation jaw muscles and joint. Like the general practitioner the dentist plays the role of "gatekeeper" in health care. The vast majority of the Dutch population visits his dentist regularly for preventive examination. Therefore, primary and secondary prevention are important characteristics of dental care. Main tasks of the dentist are: -diagnostics; -prevention ; -restorative care; -prosthetic care; -orthodontic care; -surgical care.
Source	Interrnational Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999
Year	1996

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

Code	5.3
Description	Pharmacists
Contents	The qualified pharmacist is entitled to: -the preparation of drugs and delivery, directly or after receipt; -control and examination of drugs; -surveillance of drugs use by patients (medication surveillance); -consultation of physicians regarding pharmacotherapy; -information about drugs for physicians; -information about drugs for patients. The vast majority of pharmacists work in the officinal pharmacy as the established pharmacist or as second pharmacist. Another part is employed as hospital pharmacist in intramural health care. Other fields of activity are industry and university. The officinal pharmacist (established and second) serves an average population of 7256 inhabitants (1993). He receives a fee per prescription. This dispensing fee is negotiated between insurers and pharmacists and approved by the Central Agency of Health Care Tariffs.
Source	Interrnational Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999
Year	1996

Code	5.4
Description	Midwifery
Contents	Primary care obstetrics is mainly in the hands of midwives. About 30% of births take place at home. In the Dutch country profile midwifery is described distinctly , because midwifery is considered a medical profession in the Netherlands and therefore midwifery has a place in health care different from other countries. In the Netherlands midwives can be consulted without referral. They have an autonomous competence for judgement and decision (referral included) and the complete responsibility for antenatal, natal and postnatal care in low and medium-risk obstetrics, including the final inspection six weeks post partum. Furthermore, extramural midwives render services to women who had their child in an intramural institution (hospital, maternity clinic) and went home soon after the delivery. Midwives play an important advisory role in the field of family planning. The vast majority of midwives (85%) is active in extramural care from own practices or practices shared with other midwives. A small group (15%) is employed by hospitals or is in a partnership with gynaecologists.
Source	Interrnational Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999
Year	1996

Code	5.5
Description	Paramedical care
Contents	Paramedical professions in the Netherlands are: physiotherapist, ergotherapist, speech therapist, dietician, therapist training method Cesar, therapist training method Mensendieck, dental hygienist and podotherapist. After referral by a practising physician, the physiotherapist applies one or more of the following therapies: movement therapy, massage therapy and physical therapy in a strict sense i.e. the application of physical stimuli, electrotherapy, ultra-sound therapy, thermotherapy, hydrotherapy, balneotherapy and electrodiagnostics, with the exclusion of the application of ionising beams. Most physiotherapists (70%) are active in extramural health care. They normally work in independent practices with one or more physiotherapists. The other part is employed in intramural institutions. A small group is active in the field of sports, occupational health, special schools and municipal health services. After referral by a practising physician, the ergotherapist observes impediments in daily activities and labour, trains patients in coping with these impediments, whether or not with application of expedients, and advises patients with regard to living and working conditions and provisions needed. Ergotherapists are employed in both extramural and intramural care, but predominantly in intramural institutions. The speech therapist examines speech defects under the responsibility of a practising physician or dentist and improves speech abilities of patients by relief of deficiencies of breath regulation. Speech therapists are active in the field of health care, both extramural and intramural, but also in other sectors. In extramural care they normally work in their own practices. In intramural care they are employed by hospitals, nursing homes, psychiatric institutions etc. In the education sector, speech therapists are active in primary and special education. The dietician composes diets for medical purposes adjusted to patients under the responsibility of a physician or dentist and advises patients with regard to their diet. Dieticians have a wide range of employment possibilities. They have independent practices in extramural care or may be employed by "Cross"-organisations. In preventive health care they may be employed in the field of health education and information. About 30 % is working in extramural care, but 45%, however, is employed in intramural care (hospitals, nursing homes etc.). Others are employed in education, industry, research and government. The therapist training method Cesar aims at the realisation of a motorial learning process, corresponding to diagnosis, the therapeutical goal, agreed with physician and patient, and the individual motorial capacities of the patient. Cesar-therapists can be active in different fields of health care. The vast majority is self-employed in own practices. Furthermore, there are employment possibilities in intramural care (hospital rehabilitation hospital or nursing home), but also in preventive health care and education. The therapist training method Mensendieck aims, after referral by a practising physician, at the realisation of self-analysis and correction of patient's attitude and movement in order to abate and prevent complaints regarding the motorial apparatus. Self-responsibility plays an important role in this method. Mensendieck-therapists can be active in different fields of health care. The vast majority is self-employed in their own practices. Furthermore, there are employment possibilities in intramural care (hospital, rehabilitation hospital or nursing home), but also in preventive health care and education. The dental hygienist examines teeth under the responsibility of a practising dentist and reports about dental conditions and surrounding tissues, cleans teeth, applies preserving and preventing means at teeth and surrounding tissues and provides patients with information regarding dental hygiene. The majority of dental hygienists (80%) is employed in extramural care. Others are employed in intramural care or in professional training. Most dental hygienists are employed by dentists. A few are working in independent practices, treating patients after written referral by dentists or dental specialists. After referral by a practising physician, the podotherapist applies corrective and protective therapies concerning foot functions, treats external defects of the skin of the foot and prevents and treats nail defects. Podotherapists mostly work in extramural care (85%) in independent practices. Others (13%) are active in both extramural and intramural care and a few (2%) are employed in intramural care only.
Source	Interrnational 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	utch community nursing care and home help services are organised on two main levels: 1.National level: National Association for Home Care; 2. Regional level: 38 Regional Cross Organisations; 2a: 85 Home help organisations and 31 Home care organisations. The National Association for Home Care is an umbrella organisation for community nursing and home help services and has four duties: 1 policy making on the national level; 2 promotion of the interests of its members, i.e. the regional organisations; 3 engaging in collective bargaining with government and insurance companies; 4 provision of services to the Regional Cross Associations, home care and the home help organisations. In 1990 the two umbrella organisations for community nursing and home help services were merged into the National Association for Home Care. At this moment this integration is also taking place at the regional level. It is expected that this integration will result in more efficiency in home care and will help avoid unnecessary overlap between home nursing and home help services. In the middle of 1993, 31 home care organisations had already been integrated, providing both community nursing and home help services. The 38 regional cross associations provide community nursing only and the 85 home help organisations provide home help services only. Community nurses are employed by the Regional Cross Associations or by the integrated Home care organisations. The regional cross associations consist of a number of so-called basic units. A basic unit has a chief nursing officer (head nurse), about ten community nurses, and two or three auxiliary nurses work in a team. A basic unit is assigned to a defined geographical area (about 35000 inhabitants). Within this team each individual nurse, or a sub-team of a few nurses and an auxiliary nurse, is assigned to a specific sub-area. Most of the home care organisations have integrated teams in which community nurses and auxiliary nurses and qualified home helps work together. In addition there are separate teams of unqualified home helps, who mainly perform household tasks. Regional cross associations and home care organisations can be reached 24- hours-a day and care can be provided in the evenings, nights and weekends if necessary. Patients are entitled to a maximum amount of nursing care at home: 2.5 hours a day or three visits a day, for an unlimited period of time. Patients, who need more intensive home nursing for a limited period of time, mostly terminal patients or patients waiting for admission to a nursing home, can make an appeal to additional home care. This additional home care is provided by private organisations or by foundations related to the regional cross associations. Because the regional cross associations and the home care organisations are the main providers of home nursing and also because there is no information about the number of private organisations for (intensive) home care, this description of home nursing in the Netherlands focus mainly on the Cross Associations and integrated home care organisations. Patients can contact the cross associations or home care organisations themselves because no referral is needed. Traditionally, the assessment is carried out by a community nurse (first level nurse), who is also going to provide the nursing care or who delegates the care to a second level nurse. In the regional cross organisations this is still the case. However, most home care organisations, delivering home nursing as well as home help services, intend to combine the assessment of patient's need for help and for nursing care. Community nurses (first level nurses) are qualified to perform all of the following tasks: 1 assessment of the need of care; 2 hygienic and other personal care (e.g. bathing, help with lavatory, help with activities of daily living); 3 routine technical nursing procedures (such as injections, dressings, stoma care, bladder wash out); 4 more complicated technical nursing (e.g. epidermal anaesthesia, handling respirator, and catheterization); 5 patient education; 6 psychosocial activities;7 encouraging help e.g. from family members, neighbours, friends etc.; 8 evaluation of care. Auxiliary nurses (second level) are also qualified to perform most of the tasks mentioned above, except the assessment of the need of care, more complicated technical nursing procedures and the evaluation of care. In addition, auxiliaries more often provide hygiene care and usually do not provide psychosocial support. Home helps are employed by the home help organisations or by the integrated home care organisatons. Most of the home care organisations have integrated teams in which community nurses and auxiliary community nurses and qualified home helps work together. In addition they have separate teams of unqualified home helps, who only carry out household tasks. Traditionally in most home help organisations (qualified) home helps do not work in teams, they work as soloists. In most regions of the Netherlands there is only one home help or home care organisation. Consequently, people formally do not have a choice when they need home help services. No formal referral is needed, so potential clients can contact the home help services directly. Traditionally, the assessment of needs is made by a home help organiser, mostly someone with a training in social work, who is not involved in direct patient care. Most integrated home care organisations have chosen a special assessment team consisting of a few persons with a nursing background and a few persons with experience in assessing needs for home help services (mostly social workers). After the assessment the care is allocated by the home help organiser. Because there are waiting lists the most desirable amount of care can not always be provided and dependent on the urgency of the needs, most clients have to wait a number of weeks or even months before they actually receive the

assessed care. Reassessment is made by the home help organiser at least twice a year. The actual home help is provided by different categories of home helps: qualified home helps, unqualified home helps and "alpha-helps", the latter being home helps for a maximum of twelve hours a week, which is the limit below which they do not have to pay social security contributions. A particular aspect of home care is maternity home care. Maternity centres provide qualified personnel for the assistance of midwives or general practitioners during the confinement and for the care for mother and child during a week after the delivery especially with regard to home deliveries or maternity care at home after intramural confinement. These maternity centres function under the auspices of the National Association for Home Care.

Source Interrnational Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 ***Year*** 1996

Code 5.7

Description Out-patient mental health care services

Contents

The most important categories of mental health care institutions are: 1 Regional institutions for ambulatory mental health care (RIAGG); 2 Consultation Bureaus for Alcohol and Drugs Addicts; 3 Out-patient departments of psychiatric and general hospitals; 4Independent psychiatrists. Regional institutions for mental health care (RIAGG). There are 58 regions, from 150.000 to 300.000 inhabitants, in which extramural mental health care is provided by a regional institution for ambulatory mental health care (RIAGG). Within this institution distinct teams are functioning for youth, adults, the elderly and psychotherapy. Around the clock service is offered during 7 days a week. Immediate access is possible (no referral is needed), but patients also are referred to the RIAGG by general practitioners, visiting nurses, social welfare, school health, home help services etc. The work of the RIAGG can be divided into three main tasks: treatment, prevention and services. Treatment comprises intake and examination, followed by referral, mediation, consultancy or treatment. Treatment can be given to persons of all age categories with psychiatric and psychosocial problems. During the treatment attention is paid to psychological, biological and social aspects of complaints. The aim of prevention is to further, that people learn to sort out their life and social problems themselves. Assistance should be supplied by people in their immediate environment. Preventive projects are directed to change the social systems in which people live. An example of a preventive project is the prevention of psychiatric hospital admission. RIAGG services can be divided into internal and external services. Internal services comprise supervision, intervision, advising and consultation. External services are mainly consultation activities, supporting extramural health care workers (general practitioners, school health, home nursing) in their responsibility for people with psychosocial complaints. The Riagg has an obligatory connection with the Consultation Bureau's for alcohol and drugs.Consultation Bureau's for alcohol and drugs. There are 17 Consultation Bureau's for alcohol and drug addicts with all together 64 establishments. The treatment by these institutions is directed to the physical aspects of alcohol and drug abuse, but also to the underlying psychological problems, which are part of addicts' behaviour and social background problems. Specialist teams are operating for alcohol addicts and drug addicts. Direct access is possible, but many people are referred by social welfare institutions, other mental health care institutions, municipal health services and the like. Treatment is without financial consequences for the patient. The financing of these institutions is the responsibility of the Ministry of Health, Welfare and Sports and the Ministry of Justice. Out-patient departments of psychiatric and general hospitals. Outpatient departments of psychiatric and general hospitals are therapeutical provisions for patients with psychic and psychiatric problems who do not need intensive or specialist treatment. One category of patients is those who are discharged from intramural care, the other is referred to by e.g. general practitioners. Though all outpatient departments are connected with a hospital, not all are part of the hospital complex. Sometimes they have been established in "outstations", located elsewhere. Independent psychiatrists About 1100 psychiatrists are operating independently and yet are contracted by health insurance funds. Many of them combine this independent practice with a job in a hospital, RIAGG, or other institution, so that in fact about 300 FTE's are active. Patients, adults as well as children, normally are referred by general practitioners. After examination the psychiatrist advises the general practitioner, refers to another institution or continues treatment. Government policy is directed to co-operation agreements of these independent psychiatrists with RIAGG.

Source Interrnational Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999 ***Year*** 1996

Code	5.8		
Description	Ambulance services and patient transport		
Contents	The fields of activity of the "Centrale Posten Ambulancevervoer" (CPA's) (Central Post for Ambulance Services) is determined by the provinces who draft a plan with respect to the number of ambulances and in the distribution. Local authorities are obliged to work together in the organisation of the CPA's. These posts not only receive emergency calls, but requests for regular ambulance transport pass through these offices. Transport and transporters are delegated and directed from these CPA's. These transporters may be private companies, Municipal Health Services or hospitals. Ambulances are exclusively used for recumbent transport. Furthermore, there is also the so-called transport of patients in a sitting position, for which taxis can be used, or in the case of handicapped persons, wheelchair buses. Health insurance funds pay for this if transport is medically necessary, and the patient has paid the yearly contribution of Dfl. 139.50 (1995). In some cases, compensation may be paid to patients using their own private car. In most cases persons who are privately insured must pay a certain percentage constituting their "own risk" for all provisions, including patient transport.		
Source	Interrnational Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999	***Year***	1996

Code	5.9		
Description	Medical laboratories		
Contents	For their support regarding diagnostic tests, general practitioners can make use of a variety of institutions. Hospital facilities (e.g. radiation, clinical chemistry) are at their disposal and sometimes hospitals compiled their diagnostic capacity in the so-called "diagnostic centre" of the hospital. Diagnostic centres have also been established outside hospital. Moreover, there are (juridical) independent medical laboratories and medical laboratories, which are incorporated in hospital organisations and which often are connected with a thrombosis service. Blood samples can be taken at the laboratory, but also at geographically dispersed locations and at the patients' home, if the necessity is indicated by the general practitioner. Services that can be rendered to the general practitioner are: - clinical chemical tests; - haematological tests; - bacteriological and serological tests; - examination of urine, faeces, stomach content; - ECG (including judgement of the results).		
Source	Interrnational Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999	***Year***	1996

Code	6		
Description	In-patient care		
Contents	Almost all hospitals (88%) and other services are private institutions, working on a non-profit base. Most medical specialists work in hospitals. Two-thirds of them are free entrepreneurs, often working in partnerships. They have contracts with hospitals for the use of hospital facilities and employ their own staff.		
Source	Interrnational Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999	***Year***	1996

Code	6.1		
Description	Hospital categories		
Contents	The hospital system comprises general, categorial (single specialty) and university (teaching) hospitals. They all have out-patient departments, which form an integral part of the hospital system. Moreover psychiatric hospitals, institutes for the mentally deficient and nursing homes are counted under intramural care. In the past 15 years many hospitals have had to combine forces, resulting in a reduction in the number of beds. This has been compensated by promoting short-stay facilities and day care, and by on the one hand providing more diagnostic facilities to general practitioners while on the other reinforcing extramural care.		
Source	Interrnational Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999	***Year***	1996

Code	6.2		
Description	Other in-patient provisions		
Contents	In the Netherlands a distinction is made between intramural care and semi-mural care. Because this distinction is not known in other countries semi-mural care is discussed under intramural care. The sector semi-mural care brings together different types of care for patients for whom complete hospitalization is not necessary or desirable and for whom normal out-patient services are insufficient. Patients are treated mainly during the daytime (except maternity clinics). Most of the services in this sector have medical and/or paramedical characteristics: maternity clinics, nurseries for toddlers under medical supervision, centres for convalescence day treatment, day centres for the disabled, abortion clinics and institutes for oncological and radiotherapeutical day treatment. Private (for profit) clinics are also classified in this category, because they provide only day care treatment in plastic surgery, ophthalmology, dermatology, flebology and orthopaedics. In the case of the institutes for sensorily disabled, treatment and nursing is combined with education and professional training. In family replacement homes and regional institutes for supervised residence, psycho-therapy and social guidance is emphasized in combination with supervised residence. These institutes offer transitional care for discharged psychiatric patients. They also function as homes for lighter cases of mental deficiency with supporting care from an intramural setting.		
Source	Interrnational Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999	***Year***	1996

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

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

Code	8		
Description	Prevention and public health services		
Contents	Many government and non- government organisations play a role in the field of prevention and health protection. Traditionally health protection is the role of central government (e.g. monitoring of food, drinking water, and environmental protection), but tasks also have been delegated to lower authorities. Local authorities and their Municipal Health Services (GGD's) are charged by law with collective prevention, but private organisations, are also active.		
Source	Interrnational 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	The "cross" organisations also provide preventive care for children (0-4 years), including PKU/CHT screening and early detection of developmental disorders.		
Source	Interrnational Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999	***Year***	1996

Code	8.2		
Description	School health services		
Contents	The Municipal Health Services are responsible for school health (4-19 years), including youth dental hygiene.		
Source	Interrnational Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999	***Year***	1996

Code	8.3
Description	Prevention of communicable diseases
Contents	The Municipal Health Services are responsible for school health (4-19 years), youth dental hygiene, prevention of TBC, sexually transmitted diseases and AIDS. The national immunisation program is carried out by the "cross" organisations under supervision of the National Institute of Public Health and the Environment
Source	Interrnational Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999
Year	1996

Code	8.4
Description	Prevention of non-communicable diseases
Contents	The Municipal Health Services are responsible for psycho-hygiene (in co-operation with RIAGG's*). Voluntary organisations are active in many fields e.g. the promotion of screening for breast and cervical cancer, the prevention of addiction (drugs, alcohol, tobacco and gambling) and mental problems like depression and suicide. General practitioners take cervical smears in the prevention program of cervical cancer and they also give flu vaccination for seniors.
Source	Interrnational Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999
Year	1996

Code	8.5
Description	Occupational health care
Contents	Occupational health care is mainly provided by independent services on behalf of civil service, business, trade and industry.
Source	Interrnational Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999
Year	1996

Code	8.6
Description	All other miscellaneous public health services
Contents	The Municipal Health Services are responsible for preventive programs, health education and information and epidemiology.
Source	Interrnational Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999
Year	1996

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

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

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

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

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

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

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

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

Code	10.1		
Description	Pharmaceuticals		
Contents	Pharmaceuticals in the Netherlands include pharmaceuticals in a strict sense as well as wound dressings and bandages. Pharmaceuticals in a strict sense are divided in pharmaceuticals on prescription (of a medical profession), pharmaceuticals obligatory supplied by a pharmacist (or a dispensing physician) and over the counter medicines. This last category can be freely sold in a drugstore or in any other shop. Wound dressings and bandages can be freely sold by any retailer.To control the expenditure on pharmaceuticals the government fixed the prices. This means that the average in a group of equal therapeutic value determines the price. If more expensive drugs are chosen the patient must pay the difference.		
Source	Interrnational Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999	***Year***	1996

Code	10.2		
Description	Therapeutic appliances		
Contents	Therapeutic appliances in the Netherlands contain all kind of devices for performing a certain physical function. These devices range from glasses to artificial legs and wheel chairs. Most therapeutic appliances are especially made to order or adapted to the patient by specialised professionals or specialised companies.		
Source	Interrnational Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999	***Year***	1996

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

Code	11		
Description	Other services		
Contents	Other services consist of activities that in general are not being defined as health care in a strict sense, but of activities of which the costs are adopted in the national health accounts of many countries. Other services consist of the administrative expenditures in the health care sector (an integral part of the Dutch health accounts), and the expenditures on Research & Development and the expenditures on Training & Education in health care. These last two subjects are no part of the Dutch health accounts.		
Source	Interrnational Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999	***Year***	1996

Code	11.1		
Description	Education and training of personnel		
Contents			
Source	Interrnational Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999	***Year***	1996

Code	11.2		
Description	Research and development in health		
Contents			
Source	Interrnational Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999	***Year***	1996

Code	11.3		
Description	Environmental health and control of drinking water		
Contents			
Source	Interrnational Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999	***Year***	1996

Code	11.4		
Description	Health programme administration and health insurance		
Contents			
Source	Interrnational Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999	***Year***	1996

Code	11.5		
Description	Administration and provision of cash benefits		
Contents			
Source	Interrnational Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999	***Year***	1996

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

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

Code	13.1		
Description	Methods of payment to (specialist) physicians		
Contents	Sickness funds pay capitation fees to general practitioners. The full tariff applies for the first 1600 compulsorily insured patients on the list, and a lower tariff for those exceeding this number. The fee consists of several elements: net income, pension contributions and practice costs. Tariffs are negotiated between the Association of General Practitioners and the Association of Sickness Funds and must be approved by the Ministry. For tariffs for privately insured patients there is an analogous procedure with the coordinating office of insurance companies. Privately insured patients pay their general practitioner a fee-for-service, which may be reimbursed by their insurance company if these services are included in the package, and taking account of possible deductibles. Medical specialists receive fees, specified per item of care, from publicly as well as privately insured patients. Fees of general practitioners and specialists for the privately insured are higher than for those insured under the Sickness Funds.		
Source	Interrnational Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999	***Year***	1996

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

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

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

Code	13.2		
Description	Methods of hospital payment		
Contents	Hospital budgets are fixed annually. Tariffs are negotiated with financers and finally approved by the Central Agency of Health Care Tariffs. Wages for non-medical staff are the result of negotiations between labour unions and health care employers		
Source	Interrnational Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999	***Year***	1996

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

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

Code	13.2.3		
Description	Recent changes in payment method		
Contents			
Source	Interrnational 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	Data on the financing of health care in the Netherlands can hardly be compared from year to year without extensive explanations. There are two reasons for this. Up to 1988 the Ministry of Welfare, Health and Culture annually published the "Financial Survey of Health Care" as an Annex to the budget. From 1989 the title of this publication was changed to "Financial Survey of Care", as an expression of the policy target to integrate health and social care, which were brought together in the sector "care". This political line was not followed by Statistics Netherlands, which maintained its list of health care provisions on behalf of the statistics "cost and financing of health care". That is why in the "Financial Survey of Care" the total expenditure on care was 55.8 thousand million guilders in 1992, while Statistics Netherlands computed 47.9 thousand million guilders, limited to health care in he strict sense. Authors dealing with comparison of health care data and continuing to rely on the "Financial Survey" risk using an incorrect total and numerator and as well as an incorrect share of general taxation, because especially with regard to provisions in the social care sector government subsidies dominate. For example, in publications based on the "Financial Survey" general taxation contributes up to 10%, in publications of Statistics Netherlands only 5%. Within the framework of organisational and financing reforms in health care, some provisions (e.g. pharmaceuticals) have been brought under the Exceptional Medical Expenses Act. This meant the elimination of these provisions from the packages of the private insurance companies, because the Act mentioned applies to every citizen. This explains the increase of social security as financial source in the data 1991-1992 in the following table, accompanied by a decrease of the addition of individual payments/private insurance.
Source	Interrnational Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999
Year	1996

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

Code	14.2		
Description	Main features of social health insurance		
Contents	The sickness insurance system in the Netherlands is built on three pillars: the Exceptional Medical Expenses Act (AWBZ), the Sickness Fund Act (ZFW) and private insurance.		
Source	Interrnational 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 Exceptional Medical Expenses Act provides compulsory insurance for all residents, originally covering the high costs of long-term care e.g. hospital stays of longer than one year, stays in nursing homes, institutions for the physically and mentally handicapped. In recent years other provisions have become part of the AWBZ package e.g. ambulatory mental care, pharmaceuticals and therapeutical appliances, audiological care, genetic counselling and preventive care like vaccinations and the detection of congenital metabolism disorders. Other costs of health care are covered either by the sickness funds (under the Sickness Fund Act), or by private insurance. The sickness funds are compulsory for employees with an income below a yearly fixed level (58,100 guilders per year on 1-1-1994) and social security benificiaries (including the elderly). 61% of the population is covered under this scheme. Civil servants employed by provincial and municipal governments are covered by a compulsory insurance scheme (6% of the population), which is similar to a private insurance.		
Source	Interrnational Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999	***Year***	1996

Code	14.2.2		
Description	Extent of population coverage		
Contents	The Exceptional Medical Expenses Act provides compulsory insurance for all residents. The sickness funds are compulsory for employees with an income below a yearly fixed level (58,100 guilders per year on 1-1-1994) and social security benificiaries (including the elderly). 61% of the population is covered under this scheme.		
Source	Interrnational Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999	***Year***	1996

Code	14.2.3		
Description	Stipulations in premium contribution		
Contents	The contribution to the AWBZ is income related and consists of a fixed percentage (in 1994: 8.55%) of income under the first bracket of taxation. The administration of benefits is handled by the patient's insurer, sickness fund or private insurance. The contributions to the sickness funds are paid by employers (in 1994 5.15% of the employee's gross wage) and by the employees (in 1994 1.2% of their gross wage). Moreover a nominal contribution per insured person is paid to the insurer (fl. 185 per year per adult; half this amount per child with a maximum of two children). The level of contributions is fixed by the government yearly.		
Source	Interrnational Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999	***Year***	1996

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

Code	14.2.5		
Description	Provision for risk adjustment		
Contents			
Source	Interrnational 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 Exceptional Medical Expenses Act (AWBZ) covers the costs of extended hospital stay (more than one year), home care, nursing homes, out-patient and intramural psychiatric care, care for the physically and mentally handicapped, pharmaceuticals, therapeutic appliances, genetic counselling and audiological services. The sickness fund insurance covers medical care (general practitioners, out-patient specialists), physiotherapy, speech therapy, midwifery, dental care, short stay and day care in hospitals, patient transport and maternity care. AWBZ and sickness fund benefits are provided in kind.		
Source	Interrnational Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999	***Year***	1996

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

Code	14.4.1		
Description	Voluntary health insurance		
Contents	There is no compulsory insurance for the self-employed and salaried people with wages above the cut-off level. Premiums are nominal and are to some extent risk-related. The premium is paid directly to the private insurance company.		
Source	Interrnational 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	Private insurance companies. For a small additional amount the sickness funds offer their insured a voluntarily supplementary insurance for provisions such as dentures and spectacles. Civil servants employed by provincial and municipal governments are covered by a compulsory insurance scheme (6% of the population), which is similar to a private insurance.
Source	Interrnational 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	Generally privately insured often can select the composition of their "insurance package" and are free to choose a fixed amount as deductibles in return for premium reduction. Private insurance companies mostly reimburse the costs of care to their clients within the boundaries of the chosen "package" of the insurance. For a small additional amount the sickness funds offer their insured a voluntarily supplementary insurance for provisions such as dentures and spectacles.
Source	Interrnational Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999
Year	1996

Code	14.4.1.3
Description	Proportion of population covered
Contents	About 33% of the population are privately insured with one of the many private insurance companies.
Source	Interrnational 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	At the moment co-payments are levied under the sickness fund scheme for maternity care (intramural and extramural), for dental provisions like dentures, crowns and false teeth, and for transportation of patients except transport by ambulance. Other forms of co-payments concern clinical plastic surgery, psychotherapy, physiotherapy, home care and therapeutic appliances. Spectacle lenses are partially reimbursed. Drugs are free at fixed prices. This means that the average in a group of equal therapeutic value determines the price. If more expensive drugs are chosen the patient pays the difference. Under the AWBZ scheme co-payments are required during stay in institutions. Under private insurances individual payments depend on the composition of the chosen insurance package.
Source	Interrnational 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	Interrnational Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999	***Year***	1996

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

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

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

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

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

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

Code	17.1		
Description	Determinants and objectives		
Contents	In the eighties the Dutch government decided to reform the health care system. The Dekker committee pinpointed five major problems in the system: a fragmented funding structure, the lack of solidarity in private health insurance, the lack of incentives for efficiency, the detailed government regulations and the increasing costs. With these shortcomings in mind the committee proposed a new basic health insurance package. This package includes more financial incentives for insurers, providers and consumers. At the heart of the reforms is the introduction of a basic health insurance package for all residents, covering the bulk of essential health and social services. This will account for approximately 90% of all current medical and social services, namely: general practitioner services, prescribed drugs, medical/nursing aids and appliances, paramedical services, preventive care, obstetric and maternity services, nursing, treatment and care for the elderly and the mentally and physically handicapped, rehabilitation, medical and surgical treatment and associated short-term hospital stay, psychosocial care, dental care and transportation services. Apart from the compulsory basic insurance, the insured person may opt for voluntary supplementary insurance covering provisions such as cosmetic surgery.		
Source	Interrnational Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999	***Year***	1996

Code	17.2		
Description	Content of reforms and legislation		
Contents	In the future system, the present sickness funds and private insurers will act as general health insurers. Patients will be free to choose their insurer. Insurers will be obliged to accept all applicants irrespective of risk and/or health status, and will not be allowed to differentiate premiums according to risk. The premium to be paid is split into two parts. Citizens will pay a large proportion of the costs of health care (approximately 80%) as a percentage of their taxable income. This part, levied together with regular taxes by the tax department, will be deposited in a central fund. In addition, individuals will pay a flat rate premium directly to the insurer. The fixed premiums may vary, according to the coverage and the administrative		
Source	Interrnational 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	Interrnational 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	Interrnational 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	Interrnational 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	Interrnational Comparison of health care data, Kluwer Academic Publishers, Dordrecht, 1999	***Year***	1996

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

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

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

Country profile: Norway

Code	1		
Description	Introduction and historical background		
Contents			
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999	***Year***	1998

Code	1.1		
Description	Introductory overview		
Contents	In Norway, like in the other Nordic countries, the health service is a public matter. All Nordic 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***	1998

Code			
Description	Organizational structure and management of health care administration		
Contents			
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999	***Year***	1998

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***	1998

Code	2.1
Description	(Con-)Federal/National government, Ministry with main responsibility for health care and other ministries with health care competence
Contents	The governmental institutions also offer health services such as examinations, treatment and advice to the other parts of the health sector. In addition, the Government owns and runs a limited number of hospitals/institutions which mostly provide services in connection with national functions. Air-ambulance service is under the responsibility of the Government.
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999
Year	1998

Code	2.2
Description	Regional government
Contents	There are 19 counties in Norway. The county councils run, own, and have the responsibility for the hospitals. It is also the county councils that have the responsibility for offering the population specialised services including specialised treatment. The specialised treatment is given both at outpatient clinics, in hospitals, and by private practising specialists The county councils have also the responsibility for laboratory services and ambulance services. The county councils must offer dental treatment to persons under the age of 21 and to mentally disabled persons and persons who are offered service by the municipal health care sector.
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999
Year	1998

Code	2.3
Description	Local government
Contents	It is the municipalities that have the responsibility for the primary health care, including both prevention and curative care such as: -Diagnose, treatment and rehabilitation. This includes the responsibility for general medical treatment (including medical home visits), physiotherapy and nursing (including health visitors and midwives). -Nursing and care in and outside the institutions. The municipalities have the responsibility for running the nursing homes, home nursing and other activities (e.g. home help). The health services in and outside the institutions are, to a varying degree, organised jointly within the same municipal department for treatment and care. In recent years, the individual services have been increasingly integrated into the municipal services.
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999
Year	1998

Code	2.4
Description	Insurance organisations
Contents	
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999
Year	1998

Code	2.5
Description	Professional groups
Contents	
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999
Year	1998

Code	2.6
Description	Providers
Contents	
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999
Year	1998

Code	2.7
Description	Voluntary bodies
Contents	
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999
Year	1998

Code	3
Description	Planning, regulation and management
Contents	The county councils run, own, and have the responsibility for the hospitals. It is also the county councils that have the responsibility for offering the population specialised services including specialised treatment. The municipalities that have the responsibility for the primary health care, including both prevention and curative care.
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999
Year	1998

Code	3.1
Description	Extent of system decentralisation (deconcentration, devolution, delegation, privatisation)
Contents	The activities within the various areas of service and in relation to different staff groups (professions) within the health service are regulated by the present legislation at the various administrative levels (e.g. municipalities and counties). The most important statutes with relation to the health sector are the following: The Act for the Health Services in the Municipalities etc., The Act for Hospitals etc., The Act for the Mentally Disabled, The Act for Dental Treatment, The Act concerning Governmental Supervision of the Health Services and the Act concerning Social Security.
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999
Year	1998

Code	3.2
Description	Existence of national health planning agency/plan
Contents	
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999
Year	1998

Code	3.3
Description	Supervision of the health services
Contents	According to regulations, every institution providing health services is obliged to establish an internal supervisory system to ensure that the institution is run in accordance with the statutes and guidelines. The National Board of Health and the Regional Medical Officers (One Regional Medical Officer in each county) is responsible for overall supervision of the health services. The Regional Medical Officers carry out supervision of the entire health service and the health staff. The supervisory authorities also act as complaints board. The Norwegian Board of Health and the Regional Medical Officers process complaints against both institutions and individual health workers. Initially, the Regional Medical Officers evaluate the complaints and may, in the event of irregularities being found, direct criticism against the parties involved. If there are grounds for introducing more serious sanctions against an institution or staff, the complaint may be forwarded to the Norwegian Board of Health. If the institution is run unacceptably the Norwegian Board of Health may order changes to rectify conditions. If the health staff break the rules, the Norwegian Board of Health may forward a reprimand or warning, or suspend or recall authorization/approval as health staff. It is also possible for patients to forward complaints to the person in charge of the institution (e.g. the municipal board concerning the rights to health service according to statutes concerning health services in the municipalities) or to the Norwegian Patient Insurance Board, if someone claims for compensations as a consequence of events within the public health service.
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999
Year	1998

Code	3.4
Description	Financial resource allocation
Contents	
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999
Year	1998

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	1998

Code	3.4.2		
Description	Determination of overall health budget		
Contents			
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999	***Year***	1998

Code	3.4.3		
Description	Determination of programme allocations		
Contents			
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999	***Year***	1998

Code	3.4.4		
Description	Determination of geographical allocations		
Contents			
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999	***Year***	1998

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***	1998

Code	3.4.6		
Description	Approach to capital planning		
Contents			
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999	***Year***	1998

Code	3.4.7		
Description	Capital investment funding		
Contents			
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999	***Year***	1998

Code	3.4.8		
Description	Recent changes in resource allocation system		
Contents			
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999	***Year***	1998

Code	4		
Description	General characteristics of the organizational structure		
Contents			
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999	***Year***	1998

Code	4.1		
Description	Integrated or contract model		
Contents	The integrated model prevails in Norway.		
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999	***Year***	1998

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***	1998

Code	4.3		
Description	Ownership: public, private, mix		
Contents			
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999	***Year***	1998

Code	4.4		
Description	Freedom of choice		
Contents	Patients are free to choose a general practitioner.		
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999	***Year***	1998

Code	4.5
Description	Referral system
Contents	The general practitioner acts as gatekeeper.
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999
Year	1998

Code	5
Description	Out-patient care
Contents	
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999
Year	1998

Code	5.1
Description	Medical care
Contents	
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999
Year	1998

Code	5.1.1
Description	General practitioner (solo-, group practices)
Contents	40% of general practitioners is employed by municipalities. They also may work partly in private practice and partly under contract.
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999
Year	1998

Code	5.1.2
Description	Medical specialist with own premises
Contents	The specialised treatment is given both at outpatient clinics, in hospitals, and by private practising specialists.
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999
Year	1998

Code	5.1.3
Description	Out-patient department
Contents	The specialised treatment is given both at outpatient clinics, in hospitals, and by private practising specialists.
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999
Year	1998

Code	5.1.4		
Description	Combined services: health centres		
Contents			
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999	***Year***	1998

Code	5.2		
Description	Dental care		
Contents			
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999	***Year***	1998

Code	5.2.1		
Description	General dentist		
Contents			
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999	***Year***	1998

Code	5.2.2		
Description	Dental specialist		
Contents			
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999	***Year***	1998

Code	5.3		
Description	Pharmacists		
Contents	The pharmacies are mainly privately owned, but they are subject to strict public control.		
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999	***Year***	1998

Code	5.4		
Description	Midwifery		
Contents			
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999	***Year***	1998

Code	5.5		
Description	Paramedical care		
Contents			
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999	***Year***	1998

Code	5.6		
Description	Home nursing and home care (maternity home care included)		
Contents			
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999	***Year***	1998

Code	5.7		
Description	Out-patient mental health care services		
Contents			
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999	***Year***	1998

Code	5.8		
Description	Ambulance services and patient transport		
Contents			
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999	***Year***	1998

Code	5.9		
Description	Medical laboratories		
Contents			
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999	***Year***	1998

Code	6		
Description	In-patient care		
Contents			
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999	***Year***	1998

Code	6.1		
Description	Hospital categories		
Contents	The hospitals can be divided according to the variety and complexity of the treatment given (e.g. number of specialities at the hospital) and the size of the institution (e.g. number of beds in relation to the population in the region with the right to be treated). Thus the following division can be used: Local hospitals, Central hospitals, Regional hospitals (with connection to the universities) and hospitals covering the whole country.		
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999	***Year***	1998

Code	6.2		
Description	Other in-patient provisions		
Contents			
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999	***Year***	1998

Code	7		
Description	Relationship between primary and secondary care		
Contents			
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999	***Year***	1998

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***	1998

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***	1998

Code	7.3		
Description	Imbalance between primary and secondary care		
Contents			
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999	***Year***	1998

Code	8		
Description	Prevention and public health services		
Contents	It is the municipalities that have the responsibility for the primary health care, including prevention: -Promote health and prevent illness and injuries and in relation to that organize and run the school health services, the health centres, child health care by health visitors, midwives and physicians. The heath centres offer pregnancy check-ups, control and provide vaccinations according to the recommended immunization programmes.		
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999	***Year***	1998

Code	8.1		
Description	Maternal and child health: family planning and counselling		
Contents	It is the municipalities that have the responsibility for the primary health care, including prevention: child health care by health visitors, midwives and physicians, and pregnancy check-ups at the health centres.		
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999	***Year***	1998

Code	8.2		
Description	School health services		
Contents	It is the municipalities that have the responsibility for the primary health care, including prevention: -Promote health and prevent illness and injuries and in relation to that organize and run the school health services		
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999	***Year***	1998

Code	8.3		
Description	Prevention of communicable diseases		
Contents	The municipalities control and provide vaccinations according to the recommended immunization programmes.		
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999	***Year***	1998

Code	8.4		
Description	Prevention of non-communicable diseases		
Contents			
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999	***Year***	1998

Code	8.5		
Description	Occupational health care		
Contents			
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999	***Year***	1998

Code	8.6		
Description	All other miscellaneous public health services		
Contents			
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999	***Year***	1998

Code	9		
Description	Social care related to health care		
Contents			
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999	***Year***	1998

Code	9.1		
Description	Organisation and financing of social care		
Contents			
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999	***Year***	1998

Code	9.2		
Description	Role of central/regional/local government		
Contents			
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999	***Year***	1998

Code	9.3		
Description	Role of other organisations		
Contents			
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999	***Year***	1998

Code	9.4		
Description	Responsibility of family members		
Contents			
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999	***Year***	1998

Code	9.5		
Description	Financing of social care		
Contents			
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999	***Year***	1998

Code	9.6		
Description	Explicit health/social care policy		
Contents			
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999	***Year***	1998

Code	10		
Description	Medical goods and health care technology assessment		
Contents			
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999	***Year***	1998

Code	10.1		
Description	Pharmaceuticals		
Contents	In Norway, most pharmaceutical products are reimbursed according to a system based on diagnoses and approved products prescribed by a doctor. A condition is long-term need for the product, equipment or accessories.		
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999	***Year***	1998

Code	10.2		
Description	Therapeutic appliances		
Contents			
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999	***Year***	1998

Code	10.3		
Description	Health care technology assessment		
Contents			
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999	***Year***	1998

Code	11		
Description	Other services		
Contents			
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999	***Year***	1998

Code	11.1		
Description	Education and training of personnel		
Contents			
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999	***Year***	1998

Code	11.2		
Description	Research and development in health		
Contents			
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999	***Year***	1998

Code	11.3		
Description	Environmental health and control of drinking water		
Contents			
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999	***Year***	1998

Code	11.4		
Description	Health programme administration and health insurance		
Contents			
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999	***Year***	1998

Code	11.5		
Description	Administration and provision of cash benefits		
Contents			
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999	***Year***	1998

Code	12		
Description	Manpower in health care		
Contents			
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999	***Year***	1998

Code	13		
Description	Fees, rates and salary structure		
Contents			
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999	***Year***	1998

Code	13.1		
Description	Methods of payment to (specialist) physicians		
Contents			
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999	***Year***	1998

Code	13.1.1		
Description	Integrated or contracted		
Contents			
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999	***Year***	1998

Code	13.1.2		
Description	Type of payment		
Contents			
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999	***Year***	1998

Code	13.1.3		
Description	Method for deciding fees/salaries		
Contents			
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999	***Year***	1998

Code	13.2		
Description	Methods of hospital payment		
Contents			
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999	***Year***	1998

Code	13.2.1		
Description	Method of payment		
Contents			
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999	***Year***	1998

Code	13.2.2		
Description	Method for deciding rates		
Contents			
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999	***Year***	1998

Code	13.2.3		
Description	Recent changes in payment method		
Contents			
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999	***Year***	1998

Code	14		
Description	Main system of financing and coverage (tax based, insurance based, mixture)		
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. In Norway, block grants are earmarked for specific purposes, including the health services. 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***	1998

Code	14.1		
Description	Main features of tax based systems		
Contents			
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999	***Year***	1998

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***	1998

Code	14.1.2		
Description	Extent of population coverage (excluded groups)		
Contents			
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999	***Year***	1998

Code	14.2		
Description	Main features of social health insurance		
Contents			
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999	***Year***	1998

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***	1998

Code	14.2.2		
Description	Extent of population coverage		
Contents			
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999	***Year***	1998

Code	14.2.3		
Description	Stipulations in premium contribution		
Contents			
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999	***Year***	1998

Code	14.2.4		
Description	Competition between insurance schemes		
Contents			
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999	***Year***	1998

Code	14.2.5		
Description	Provision for risk adjustment		
Contents			
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 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	In Norway, there is user charge for medical consultations with both general practitioners and specialists. The health insurance offers full reimbursement for treatment of children under the age of 7 years, treatment of industrial injuries, pregnancy and children and certain other cases (e.g. treatment of dangerous contagious diseases, psychotherapy and person under the age of 18 years, and treatment of prison inmates). There may also be a user charge for physiotherapy, and for treatment of patients in a nursing home.		
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999	***Year***	1998

Code	14.4		
Description	Complementary sources of finance		
Contents			
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999	***Year***	1998

Code	14.4.1		
Description	Voluntary health insurance		
Contents			
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999	***Year***	1998

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***	1998

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***	1998

Code	14.4.1.3
Description	Proportion of population covered
Contents	
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 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	In Norway, there is user charge for medical consultations with both general practitioners and specialists. The health insurance offers full reimbursement for treatment of children under the age of 7 years, treatment of industrial injuries, pregnancy and children and certain other cases (e.g. treatment of dangerous contagious diseases, psychotherapy and person under the age of 18 years, and treatment of prison inmates). There may also be a user charge for physiotherapy, and for treatment of patients in a nursing home. In Norway, most pharmaceutical products are reimbursed according to a system based on diagnoses and approved products prescribed by a doctor. A condition is long-term need for the product, equipment or accessories. There are no user charges for hospitalization . Adults pay for their own dental treatment. Dental treatment, except for orthodontics, is free of user charges for people under the age of 18 years. The same applies to certain other groups: e.g. mentally retarded, elderly, long-term ill and disabled people. Under the present scheme, reimbursement is granted for charges that exceed a certain annual amount. The system covers all those insured, both adults and children, who are living permanently or temporarily in the country. Thus a cost ceiling is imposed in connection with the charges for medical care, psychological treatment, necessary pharmaceutical products and transport paid for by the National Insurance Scheme. When the ceiling is reached patients will receive a card granting them full reimbursement from the National Insurance Scheme for the rest of the year. The cost ceiling for one of the parents extends to children under the age of 16. As per January 1 1998, the cost ceiling was NOK 1,290 per year. Children under the age of 7 are free of charges.
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999
Year	1998

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	1998

Code	15
Description	Health care expenditure
Contents	
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999
Year	1998

Code	15.1		
Description	Structure of health care expenditures		
Contents			
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999	***Year***	1998

Code	15.2		
Description	Total and public health expenditure as % GDP		
Contents			
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999	***Year***	1998

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***	1998

Code	16		
Description	Import and Export		
Contents			
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999	***Year***	1998

Code	16.1		
Description	Import		
Contents			
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999	***Year***	1998

Code	16.2		
Description	Export		
Contents			
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999	***Year***	1998

Code	17		
Description	Health care reforms		
Contents			
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999	***Year***	1998

Code	17.1		
Description	Determinants and objectives		
Contents			
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999	***Year***	1998

Code	17.2		
Description	Content of reforms and legislation		
Contents	Five new statutes concerning the health sector are at present under evaluation at the Department for Health and Social Welfare. The new rules will involve changes in the framework governing the various areas. The actual proposals concern: Act for Health Workers, Act Concerning Specialist treatment, Act Concerning the Mentally Ill, Act Concerning Patient Rights and Act Concerning Health and Social contingency preparedness. In addition, a family doctor scheme has been agreed to ensure that every citizen in the country receives the offer of a permanent physician in the primary health service. The scheme should be fully implemented from 2000.		
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999	***Year***	1998

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***	1998

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***	1998

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***	1998

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***	1998

Code	17.3		
Description	Health for all policy		
Contents			
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999	***Year***	1998

Code	17.4		
Description	Reform implementation		
Contents			
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999	***Year***	1998

Code	17.5		
Description	Conclusions		
Contents			
Source	Health Statistics in the Nordic Countries 1997, NOMESCO, Copenhagen, 1999	***Year***	1998

Country profile: Portugal

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

Code	1.1
Description	Introductory overview
Contents	Country background Physical and human geography Portugal is part of the Iberian Peninsula which lies in the south-west of Europe. The archipelagos of Azores (nine islands) and Madeira (two islands) in the Atlantic Ocean also form part of Portugal. The mainland is 91.9 thousand km² with 832 km of Atlantic coastline and an inland border with Spain that stretches for 1215 km. It is one of Europe's smallest countries, measuring 560 km northto south and only 220 km from east to west. Portugal's two main cities are Lisbon (resident population 1 834 000 in 1995) and Porto (population 1 188 000in 1995). The River Tejo, which rises in Central Spain, divides the country into two distinct geographical areas. The northern and central regions are characterized by rivers, valleys, forests and mountains – the highest range is the Serra da Estrela, peaking at Torre (1993 m). The south is less populated and, apart from the rocky backdrop of the Algarve, much flatter and drier. Portugal has a temperate climate influenced by the Atlantic Ocean. However, it experiences considerable variations in climate; the southern region of the Algarve can experience extremely high temperatures in midsummer whilst, during winter, the north receives plenty of rain and temperatures can be chilly, with snowfall common in the mountains, particularly in the Serra da Estrela range. As a result, the natural flora is very varied. It is possible to find not only species from western Europe, but also those characteristic of Mediterranean countries. The total population of Portugal was 9 893 000 (mid-year estimate 1997), which represents a small decrease of 1.9% over the last decade. The demographic profile follows that of other west European countries with an increase in life expectancy at birth from 71.15 years in 1980 to 74.9 years in 1996 (51). The median age of the population has risen from 31 years old to 36 years old over a ten-year period 1986–1996, whilst the dependency ratio has fallen from 79.7 in 1984 to 68.3 in 1994 (based on the relation of the population under 20 and over 65 years of age to the 20–64 year olds). Demographic changes have followed an improvement in the socioeconomic conditions. Economy Economic growth which began in early 1994 has gathered pace and real GDP growth increased to an estimated 3.5% in 1997. This growth is as a result of stronger domestic demand and new export capacity (31). The GDP per capita was 1.7 million Escudos or US $PPP 13 672 or Euros PPP 12 783 in 1997 (32). The inflation rate was just above 2% in 1997, down from 3.2% in 1996 (31). Unemployment has fallen slightly from 7.3% of the total population in 1996 to 6.9% in 1997; however, it is still considerably higher than the rate of 5.5% in 1993. The main industries are textiles, tourism and agriculture. The textiles sector is the only sector of the manufacturing industry which has sustained its share of the total workforce whilst service industries connected to tourism have seen an increase from 13.4% to 17.3% of total employment (1980–1993). Political and administrative structure Portugal has been a constitutional democratic republic since 1974, when the revolution put an end to the dictatorship of the Salazar-Caetano regime. The main institutions of the state are the President of the Republic, the parliament, the government and the courts. Both the President and the parliament are elected by direct universal suffrage. Minister. Portugal's administrative system comprises 18 districts and 2 autonomous regions (the islands of Azores and Madeira). The islands have their own political and administrative structures, although executive power remains with the central government. The President appoints a Minister of the Republic to represent the Republic in each of the autonomous regions. These Ministers are proposed by the national government. The districts are further divided into municipalities and boroughs. The municipalities have their own level of elected government. Macau is a small territory situated to the south of China which formally has been under Portuguese sovereignty since 1887. The Sino-Portuguese Joint Declaration on the Question of Macau, which was signed in April 1987, declares that China will resume sovereignty over the territory on 20 December 1999. Health indicators The health of the Portuguese population can be summarized as follows: • life expectancy at birth has continued to develop favourably in the past twenty); • indicators of child health are improving, and are near the average European rate. The infant mortality rate decreased fivefold between 1970 and 1990, the perinatal mortality rate by 66%; • there have been improvements in women's health – female mortality from all cancers has been declining since the early 1970s. Improvements in health status of the Portuguese population are connected to a general improvement in economic and social conditions (e.g. housing, education, sanitation, communication and transport infrastructures), as well as to the increase in human, material and financial resources devoted to health care. Despite the overall improvement in living

standards, there are inequalities between the regions, and probably between social classes. These disparities are evident in the variation of some health indicators, e.g. mortality rates and infant mortality rates, as well as in inequalities of access, e.g. the ratio of in-habitants to hospitals and the ratio of inhabitants to health professionals.
After diseases of the circulatory system which account for 29.59% of all deaths, cancers represent five out of the eleven leading causes of death. For diseases caused by lifestyle or behaviour, trends are not so clear; however, the mortality from road traffic accidents is the highest in Europe.

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

Code	1.2
Description	Historical background
Contents	Historical background Portugal's health care system is complex as a result of its historical develop-ment. In order to examine the existing system it is important to recognize some of the main factors which have influenced the development of the Portuguese health care system to date. Prior to the eighteenth century, health care was provided only for the poor by the hospitals of the religious charities called Misericórdias.They still exist in Portugal but no longer provide acute hospital care. During the eighteenth century, the state established a limited number of teaching hospitals and public hospitals to supplement the charitable provision. This was further extended in 1860 with the appointment of salaried municipal doctors who pro-vided curative services to the poor. The development of public health services did not begin until 1901. The first act of public health legislation in 1901 enabled the creation of a network of medical officers responsible for public health. A further public health law was introduced in 1945, which established public maternity and child welfare services. It was also under this law that the national programmes for tuber-culosis, leprosy and mental health, which were already operating, were legally established. The more recent development of health services can be traced back to 1946 when the first social security law was enacted. Health care provision at this time followed the German Bismarckian model which provided cover to the employed population and their dependants through social security and sickness funds. This social welfare system was financed by compulsory contributions, shared between employees and employers, and provided out-of-hospital curative services, free at the point of use. Cover was limited to industrial workers in the first instance. Other sectors of the workforce and their dependants were added through extensions to social security coverage in 1959, 1965, 1971 and 1978. Primary health care was not the subject of public intervention until the 1960s when new powers were established for its financing and organization. Despite the efforts made prior to 1970, the following major problems still existed: • asymmetry in the geographic distribution of health facilities and human resources with concentration in urban areas; • poor sanitation and inadequate population coverage; • centralized decision-making; • no linkage or coordination among existing facilities and providers, and little evaluation; • multiple sources of financing and a disparity of benefits between different population groups; • a discrepancy between the intentions of legislation and policy and actual provision of health services; • low remuneration of health professionals. So by 1979 legislation had been introduced to establish: • the right of all citizens to health protection; • a guaranteed right to health care that was "universal, comprehensive and free of charge" through the NHS; • access to the NHS for all citizens regardless of economic and social back-ground; • the provision of integrated health care including health promotion, disease surveillance and prevention; • a tax-financed system of coverage in the form of the NHS for which the government was responsible. (Only when health care could not be provided through the NHS would services provided outside the NHS be covered). Despite the development of a unified publicly financed and provided health care system and the incorporation of most of the health facilities previously operated by the social welfare and religious charities, some aspects of the pre-1970s system persisted. In particular the health subsystems (from the Portuguese subsistemas) continued to operate which covered a variety of public and private employees. These schemes were offering better services and greater choice of provider than would be available under the NHS. Consequently the trade unions, which ran and managed some of the funds, forcefully defended them on behalf of their members. In the autonomous regions of Azores and Madeira, health policy followed the same general principles, but was implemented locally by the regional govern-ments who retained some flexibility. At the beginning of the 1990s the health care system in Portugal continued to face problems such as: • an inadequate supply of public ambulatory services, resulting in an increase in attendance at hospital emergency departments; • dissatisfaction of consumers and professionals with public services; • a major increase in health expenditure and extreme difficulties with cost control; • lack of responsiveness to the needs of some vulnerable groups, such as the elderly, drug addicts, alcoholics, and AIDS patients; • difficulty in reducing mortality due to traffic accidents and lifestyle diseases. Discussion of how these problems are being addressed through further reforms is included in each section of this report. The relevant legislation and reforms are discussed in detail in the section Health care reforms.

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

Code	2
Description	Main functions of key bodies in the organizational structure and management of health care administration
Contents	The Portuguese health care system is characterized by three co-existing systems of health care coverage: the National Health Service (NHS), special insurance schemes for certain professions, and voluntary private health insurance schemes. In this section the various bodies, organizations and institutions which make up the health care system will be outlined. Firstly the internal structure of the Ministry of Health will be described. Then other national and regional government authorities with a role in health care will be examined. Finally the private sector and the health subsystems, including the functions and responsibilities each has within the health care system, will be reviewed.

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 central government, through the Ministry of Health, holds the main responsibility for the regulation, organization and direction of the health care system as a whole. The Ministry of Health is responsible for developing health policy and over-seeing and evaluating its implementation. It is also responsible for the coordi-nation of health-related activities of other Ministries, such as social services, education, employment, sport, the environment, the economy, housing and town planning. The core function of the Ministry is the regulation, planning and management of the National Health Service (NHS). Many of the planning, regulation and management functions are in the hands of the Minister of Health. The Secretary of State is a junior Minister and has responsibility for the first level of coordination. The Ministry is made up of five Directorates and seven Institutes. These are: The General-Secretariat of the Ministry of Health Provides technical and administrative support to the other sections of the Ministry, coordinates their work and provides assistance to staff within various Government offices. The General Directorate of Health (GDH) Regulates, directs, coordinates and supervises all health promotion, disease prevention and health care activities, institutions and services, whether or not they are integrated into the NHS. The General Inspectorate of Health Performs the disciplinary and audit function for the National Health Service in collaboration with GDH and audits NHS institutions and services. The General Directorate of Health Infrastructures and Equipment Assesses, regulates, plans and coordinates the procurement of equipment and provides technical support for the programme of NHS building work. Supported by regional directorates. The Department of Human Resources Regulates, directs and evaluates human resource activities for the NHS, namely professional education and practice. Directly oversees schools for the training of nurses and technical staff working in health. The National Institutes are as follows: The National Institute of Pharmaceuticals and Medicine The National Institute for Medical Emergencies The Portuguese Blood Institute The Service for Drug Addiction Prevention and Treatment The Institute of Financial Management and Informatics The Social Services for Health Personnel The National Institute of Health, Doctor Ricardo Jorge This institute promotes scientific research in the field of health and is the main reference laboratory for the public health sector. It also functions as the national observatory and surveillance centre on health. There are also three vertical programmes run by national bodies attached to the Ministry of Health: the National Prevention Council Against Tobacco Consumption, the National Committee on AIDS and the National Council of Oncology. Legal provision is made for a National Health Council, which is a consul-tative body for the Ministry of Health. Its function, in theory, is to represent all those concerned with the performance of health care providers: patients; health care employees; government departments in charge of health-related activities and other bodies. In reality the Council has never met and does not function, possibly because the Ministry and its departments feel threatened by a potential loss of power to the Council. Other Ministries Ministry of Finance: The creation of new posts within the NHS, whether hospital-based or not, requires the approval of the Ministry of Finance. The Ministry of Finance also determines the budget for the NHS based on a submission from the Ministry of Health. See the section on Third-party budget setting and resource allocation for more information about this process. Ministry of Employment and Social Solidarity: This Ministry is responsible for social benefits, such as pensions, unemploy-ment benefit and incapacity benefit. In 1995, 9.5% of GDP was allocated to social security. Of this 73% was spent on pensions, 11.3% on unemployment benefits and 6.0% on disability benefits. The interface and collaboration between this Ministry and the Ministry of Health has improved in recent years. Joint projects include a review of certification for absence from work, a programme to improve coordination between health and social care services and an initiative to improve continuity of care for the elderly. Ministry of Education: The Ministry of Education is responsible for undergraduate medical education and for academic degrees such as Masters and PhDs. Specialty training, however, is the joint responsibility of the Medical Association and the Ministry of Health.

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

Code	2.2
Description	Regional government
Contents	Regional health administrations (RHAs) The Portuguese NHS, though centrally financed by the Ministry of Health, has a strong regional structure of health administrations. There are five regional health administrations in Portugal: North, Centre, Lisbon & Tagus Valley, Alentejo and the Algarve. In each region a regional health administration board, accountable to the Minister of Health, manages the NHS. The regional health administrations (RHAs) are responsible for the local implementation of national health policy objectives. They coordinate all levels of health care and allocate resources to hospitals and health centres. They work in accordance with principles and directives issued in regional plans and by the Ministry of Health. Their main responsibilities are the development of strategic health administration, coordination of all aspects of health care provision, management of hospitals and health centres, establishment of agree-ments and protocols with private bodies, and liaison with central bodies, Misericórdias and other private non-profit bodies, and municipal councils. The regional health administration boards have specific duties to: • draw up regional plans and budgets, and to monitor and be accountable for them; • guide, coordinate and monitor NHS management at regional level; • represent the NHS in and out of court; • regulate the supply of health providers in the region and guide, coordinate and monitor their performance; • contract with the private sector to provide health care for NHS beneficiaries in each region, subject to national agreements on this matter; • continuously evaluate the outcomes and outputs attained; • coordinate transportation of patients within both the public and private sectors. Regional health administrations are subdivided into eighteen sub-regions each with a sub-regional coordinator. North: main offices in Porto, covers the administrative districts of Braga, Bragança, Porto, Viana do Castelo and Vila Real; Centre: main offices in Coimbra, covers Aveiro, Castelo Branco, Coimbra, Guarda, Leiria and Viseu; Lisbon and Tagus Valley: main offices in Lisbon, covers Lisbon, Santarém and Setúbal; Alentejo: main offices in Évora, covers Beja, Évora and Portalegre; Algarve: main offices in Faro, covers the district of Faro. Since 1998 each regional health administration (RHA) has established a regional agency (RA) within it. The RA is an autonomous part of the RHA with responsibility for contracting with hospitals, health centres and independent groups of doctors. Its two main functions are to increase citizen participation in health decision-making and to develop the separation of purchasing and provider functions.

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

Code	2.3
Description	Local government
Contents	Below the region and sub-region are the municipalities. Health issues at this level are under the jurisdiction of the Municipal Health Commission. For the purposes of health care provision, boundaries are based on natural communities rather than administrative areas, i.e. some communities may be included in neighbouring municipalities. This ensures that services are provided more quickly and easily. In some cases the larger urban communities have their own system of organization of health care in order to meet the particular needs of the population. There are a number of initiatives being undertaken in coopera-tion with the municipalities such as promoting greater traffic and pedestrian safety and encouraging physical exercise. Nutrition is also being promoted in close cooperation with the media, the educational system, sports organizations and local authorities.

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

Code	2.4
Description	Insurance organisations
Contents	Health subsystems The historical remnants of the social welfare system persist in the form of health insurance schemes for which membership is based on professional or occupational category. These are often referred to as health subsystems (subsistemas) and this term will be used throughout the report. In addition to the cover provided by the NHS, about 25% of the population (There is no exact figure for the number of people covered by the subsystems as double-counting may occur due to people belonging to more than one subsystem.) are covered by the health subsystems. Health care is provided either directly or by contract with private or public health care providers (in some cases by a combination of both). Access is generally limited to members of a specific profession and their families. The main funds operating in the public and private sector are: • ADSE (Assistência a Doença dos Servidores do Estado) for civil servants; • ADM (Assistência na Doenca aos Militares) for military personnel (including administrative staff). It has three separate bodies: ADME (Assistencia na Doenca aos Militares do Exercito) for the army, ADMA (Assistencia na Doenca aos Militares da Armada) for the Navy and ADMFA (Assistencia na Doenca aos Militares da Forca Aerea) for the Air Force; • IOS-CTT (Instituto das Obras Sociais dos CTT) for post office workers; • PT-ACS (Portugal Telecom – Associacao de Cuidados de Saude) for the employees of the public telecom operator; • SAMS (Servicos de Assistência Médico-Social) for bank employees and associated insurance workers. It has three regional branches: Central, North, South and Islands; • SSINCM (Servicos Sociais da Imprensa Nacional Casa da Moeda) for the workers at the national mint; • SSMJ (Servicos Sociais do Ministerio da Justica) for workers of the Ministry of Justice; • SSCGD (Servicos Sociais da Caixa Geral de Depositos) for the workers of the main public bank. There are also a few additional smaller funds. Most health subsystems are members of the National Association of Health Subsystems. The largest fund ADSE covers 15% of the population and is controlled by the Ministry of Finance. It includes amongst its members all employees of the NHS, creating a perverse situation where medical professionals and other pro-fessionals are entitled to supplementary care that is not available to patients within the NHS. Some of the funds are associated with and run by trade unions and managed by boards of elected members. Most of the schemes are compulsory for employees but do not preclude the beneficiary from seeking services directly from the NHS. However, the health subsystems do usually give more freedom of choice to the beneficiaries than they may otherwise have within the statutory system. Whilst users are free to purchase services wherever they choose, most use the private sector for ambu-latory care and the NHS for non-elective surgical interventions. A few schemes provide health services directly, in which case members will be expected to seek care from these doctors in the first instance.
Source	European Observatory on Health Care Systems
Year	1999

Code	2.5
Description	Professional groups
Contents	Professional associations and unions There are three main representative organizations for doctors: the Medical Association and two trade unions. The Medical Association represents the strong corporate interests of the medical profession and membership is obligatory. The Association's functions include: • accreditation and granting of licences to practise; • accreditation and certification of specialist training (joint responsibility with the Ministry of Health) (see the section on Human Resources and Training); • enforcing the disciplinary code with powers to censure doctors; however, few doctors are actually censured in practice. An equivalent body for nurses (the Portuguese Nurses' Association) was established in 1998 with similar powers to the Medical Association. There is also a national association for dentists, which maintains the dental register and receives and investigates complaints against dentists with the power to suspend (though this has never happened). The representative body for the pharmaceutical profession is the National Association of Pharmacists, for which membership is compulsory. It covers pharmacists and others licensed to work in industry, laboratories and enterprises and is the legal representative of people with a degree in pharmaceutical sciences. In the same way as the Medical Association, it has regulatory and disciplinary powers. The National Association of Pharmacists also has a powerful corporate role. It operates as a fund which handles the majority of pharmaceutical pay-ments between the NHS and the pharmacists. As mentioned before, almost 95% of pharmacists are members of the National Association of Pharmacists; however some choose to remain independent. The Association offers incen-tives in order to maintain membership rates such as computers, software, continuous education and other services which are of benefit to the pharmacist.
Source	European Observatory on Health Care Systems
Year	1999

Code	2.6
Description	Providers
Contents	Private sector Private health care providers mainly fulfil a supplementary role to the NHS rather than providing an alternative to it. Most private sector activity continued to prosper despite the establishment of the NHS and now mainly provides diagnostic, therapeutic and dental services as well as some ambulatory consul-tations, rehabilitation and psychiatric care services. The key institutions are private practitioners, Misericórdias, and private hospitals, clinics and facilities. The majority of specialist consultations take place in the private sector whereas the public sector provides the overwhelming majority of general consultations. Overall the private sector accounts for 30% of all medical consultations. Misericórdias Misericórdias are independent charitable institutions. Misericórdias Lisbon is an exception; it is a public enterprise which means that the Board is nominated jointly by the Ministry of Health and the Ministry of Employment and Social Solidarity rather than elected by members. Misericórdias currently operate very few hospitals, despite their historical role as one of the main providers of health care. The hospitals currently operated by Misericórdias provide services which include orthopaedics, plastic surgery, internal medicine and complementary therapies. There are usually no acute or emergency services in these hospitals. There has been a shift in focus of the work of Misericórdias and other religious organizations from health to social care. They are now the main providers of social care and psychiatric and rehabili-tation services in Portugal. Private hospitals, and other privately provided services In 1996, 42% of hospitals in Portugal were privately owned. Of these almost half belonged to for-profit organizations. However only 22.5% of the total bed stock is privately owned. See the section on Secondary and tertiary care for more information about hospitals and hospital beds in the public and private sectors. One of the main areas of private activity is in the provision of diagnostic tests and examinations: pathology, blood tests and X-rays are mostly provided privately. In addition treatment by physiotherapists and dental care are largely provided by the private sector. Private health insurance companies On the financing side, the main private actors are the private health insurance companies. Voluntary health insurance (VHI) was introduced in 1978. Initially only group policies were offered but since 1982 individual policies also have been offered. Approximately 10% of the population were covered by private insurance in 1998. Most policies are in the form of group insurance provided by the employer: less than 10% of people with private health insurance have individual policies.
Source	European Observatory on Health Care Systems
Year	1999

Code	2.7
Description	Voluntary bodies
Contents	Public and consumer groups There is currently no official organization which advocates on behalf of patients in Portugal. There are a number of quite active disease-based advocacy groups such as those based around diabetics, haemophilia and HIV and AIDS. These are narrow interest groups which usually promote the allocation of more resources for the care and treatment of patients in that particular disease group.
Source	European Observatory on Health Care Systems
Year	1999

Code	3
Description	Planning, regulation and management
Contents	The boundaries between the main functions in the system – planning, regula-tion, financing and management – overlap, due to the integrated nature of health provision, i.e. the government is both the main provider and third-party payer.
Source	European Observatory on Health Care Systems
Year	1999

Code	3.1
Description	Extent of system decentralisation (deconcentration, devolution, delegation, privatisation)
Contents	Most RHAs will try to follow national policies but there is no obligation to do so. Consequently each region pursues national policies at a different pace. Decentralization of the health care system The five regional health administrations were established by law in 1993 under the NHS Statute. Previously the hospitals had been the direct responsibility of the General Directorate of Hospitals and the health centres fell under the direct hierarchical authority of the General Directorate of Primary Health Care. These two directorates were merged to form the new General Directorate of Health in the Ministry of Health. The separation of primary care from secondary and tertiary care within the hierarchy of the Ministry was reflected in the way in which services were organized locally. This reorganization was part of a broader strategy to try and integrate and coordinate further levels of provision. Previously the NHS was organized regionally through 18 regional health administrations (RHAs). However these had no responsibility for health centres and acted simply as the disbursers of funds for hospitals. The rationalization of the RHAs into five regions has been accompanied by devolution of financial responsibility. RHAs are given a budget from which they have to provide health care services for a defined population allowing them greater autonomy over the way in which the budget is spent.
Source	European Observatory on Health Care Systems
Year	1999

Code	3.2
Description	Existence of national health planning agency/plan
Contents	Planning The Portuguese Constitution stipulates that the economic and social organization of the country must be guided, coordinated and disciplined by a national plan. Thus, planning is at the heart of the system of government. The national plan must ensure, for example, the harmonious development of different sectors and regions, the efficient use of productive resources, and the equitable division of resources amongst the population and between regions. There are central, regional and sectoral planning bodies. Central planning for health is mainly carried out by the General Directorate of Health, based on plans submitted by the regional health administration boards (RHAs). As the NHS does not have its own central administration, most of the planning, regulation and management functions are carried out by the Ministry of Health. The Director General of Health has no direct hierarchical authority over the RHAs but is able to make suggestions and advise.
Source	European Observatory on Health Care Systems
Year	1999

Code	3.3
Description	Supervision of the health services
Contents	The development of mechanisms for giving citizens a voice about their health care is being developed by regional agencies (RAs) as part of their remit. A citizens' representative, who will act as an intermediary between the RHA and the people, will be involved in the development of local health systems (see section on Primary health care). The citizen representative will be chosen either by the local municipal council or a consumer group, where the latter exist. There are formal mechanisms for consumers to make complaints. In every public medical institution there is an office where patients can complain about any aspect of the NHS (called the Users' Office). All complaints are dealt with through the Users' Office and may be referred, in extreme cases where there is evidence of medical negligence, to the Medical Association in order for the case to be pursued. Patients are free to write directly to the regional coordina-tors or the Minister of Health or to pursue their case through the courts. This is, of course, expensive and few people do so. On the whole there are few com-plaints. The majority relate to organizational aspects such as waiting times or aspects of the service rather than technical matters regarding a specific treat-ment or intervention. More mechanisms are being introduced to encourage citizens' participa-tion in health; to increase patients' trust in the health system, to encourage the population to take responsibility for its own health and obtain better quality and more appropriate care for users. Regulation The Portuguese system is highly normative, with extensive regulation. There are numerous and sometimes very restrictive controls over pharmaceutical goods, high-technology equipment and the education, training and registration of health personnel. The defined rules and procedures, however, are not always adhered to or enforced. The main responsibility for regulation and national quality standards lies at the central level with the General Directorate of Health. Presently there is a Sub-Director of Quality who is responsible for standards within health care provision. A plan to establish a separate institute for quality was announced at the beginning of 1999. This body will have the same status as other institutes within the Ministry of Health and will produce guidelines for the accreditation of medical facilities. The National Institute of Pharmaceuticals and Medicine (INFARMED) was established in 1993. This body is responsible for the regulation of pharmaceu-ticals and medical equipment. It is supported by the Pharmaceutical Inspection Service, Pharmacovigilance Service and The Official Laboratory for Pharma-ceutical Quality Control. A full description of their respective functions is given under Regulation and Control of Pharmaceuticals. Management Primary care health centres (described under Primary health care) are directly under the managerial control of the RHAs. Public hospital services are currently managed by a four-member council or hospital board, consisting of a director, usually a doctor, and a general administrator (both appointed by the Minister of Health), a head doctor and a head nurse (both elected by peers). There is, however, an experiment to allow public hospitals to be put under the control of private sector management. The legal reform which enabled this practice was part of the 1990 Law on the Fundamental Principles of Health. This stated that management of NHS institutions and services could be handed over to the private sector through management contracts. These con-tracts could be applied to the whole health institution, i.e. hospital or health centre, a particular service or any functionally autonomous part of them. Health institutions and services managed in this way would be included in the NHS, thus obliging the management authorities to guarantee access to health care in the same way as other NHS services. This experimental type of management is currently operating at the Fernando Fonseca Hospital in Amadora, part of Lisbon. By granting hospitals public enterprise status, it releases them from the constraints of public employment regulations. In order to facilitate the movement of personnel from the public hospitals to the privately-managed hospitals, the state guarantees a position for all personnel if they return to the NHS within three years. This is causing huge retention problems for the privately-managed hospitals as many doctors leave their jobs just before the three-year deadline is reached. Evaluation of these hospital reforms was expected in April 1999.
Source	European Observatory on Health Care Systems
Year	1999

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

Code	3.4.1
Description	Third party budget setting and resource allocation
Contents	Third-party budget setting and resource allocation The NHS budget is set annually by the Ministry of Finance based on historical spending and the plans put forward by the Ministry of Health. Capital and current expenditure are separated, with the Ministry of Health retaining control for all capital expenditures. The Institute of Financial Management and Informatics, which is the department responsible for financial management within the Ministry of Health, prepares estimates detailing the resources required to support planned activities. The estimate of total expenditure for the current year is adjusted by the expected increase in the level of consumption, salary levels and the rate of inflation. The global budget for health is ultimately determined by the Ministry of Finance based on macro-economic considerations. The Ministry of Health allocates a budget to each regional health administration (RHA) for the provision of health care to a geographically defined population. This budget is currently set on the basis of historical and activity costs. Up until recently the RHA had little freedom over how to spend the budget and acted as a disburser of funds in respect to hospitals. Recent reform proposals intend to increase the purchasing role of RHA to move the system gradually towards a contract model of health care. The health subsystems, whose revenues are frequently from employer and employee contributions, allocate according to a system of reimbursement to both members and to providers. A few of the schemes also employ doctors and provide services directly for their members. The private health insurance schemes, whose revenue is from risk rated premiums mostly fund health care for their enrolees through retrospective reimbursement.
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	Capital planning A separate central investment plan governs capital outlays within the NHS. Capital investment is the responsibility of the General Directorate of Health. Most of the investment is provided internally by the Portuguese state budget through the Central Administration's Investment and Development Plan (PIDDAC). There has also been joint funding of hospital and health centre developments with the European Union through the European Regional Development Fund (ERDF). Legislation in 1988 gave the Ministry of Health total control over the procurement and installation of high-technology equipment in the NHS and private sector. The legal guidelines for installing heavy equipment established ratios of equipment per inhabitant. In 1995 new legislation was passed which abolished the population ratios. However, the principle of prior authorization by the Ministry of Health for equipment within the NHS was retained. In 1998 Portugal published a national list of health equipment which describes the distribution of specific items of equipment and services through-out Portugal. It gives information regarding such things as the regional varia-tions in the number of items of equipment, the numbers in public and private facilities and the age of equipment. It is not clear at present how useful this document will be for planning purposes. As there are currently no mechanisms in place for regulating the distribution of health equipment in the private sec-tor it can do little more than highlight the inequalities in distribution. It is also unlikely that ratios will be reintroduced in the NHS as they lack sensitivity to other local characteristics such as the availability of equipment in the private sector. (See Mechanisms for controlling health care technologies under the section Pharmaceuticals and health care technology assessment for more in-formation.)		
Source	European Observatory on Health Care Systems	***Year***	1999

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

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	In 1996, Portugal had 211 hospitals: 122 public and 89 private. Almost half of the private hospitals belong to for-profit organizations. The sharp decline in hospitals owned by Misericórdias between 1970 and 1980 follows the incorporation or “nationalization” of these facilities into the NHS during this decade. Misericórdias currently operate hospitals and facilities in the areas of rehabilitation, long-term care and residential care for the elderly, disabled and chronically sick (see the section on Organizational structure of the health care system).
Source	European Observatory on Health Care Systems
Year	1999

Code	4.4
Description	Freedom of choice
Contents	Patients must register with a GP. Theoretically, there is freedom of choice of GPs. People can choose among the available clinicians within a geographical area. Some people seek health care services in the area where they work but most choose a GP in their residential area. GPs work with a system of patient lists, on average approximately 1500 patients. There are GPs with patient lists exceeding 2000 and others with fewer than 1000. People may change GP if they apply in writing, explaining their reasons, to the RHA board. There is no statutory limit to how often someone may change their GP.
Source	European Observatory on Health Care Systems
Year	1999

Code	4.5
Description	Referral system
Contents	Referral process and links between primary and secondary care The first point of contact within the public system is the GP in a health centre (HC). Theoretically, people have no direct access to secondary care and GPs are expected to act as gatekeepers, i.e. patients should have a prior consulta-tion with a GP before they can access specialist hospital or ambulatory services. Frequently, there is a delay in obtaining a consultation depending on the specialty. In reality, most people go directly to the emergency department in hospitals if they have any acute symptoms. A very large number of the attendees at hospital emergency units do not however need immediate care. People who go to emergency departments and genuinely need specialized care are immediately referred. There are user charges for emergency visits (currently Esc. 400 for visits to health centres and Esc.1000 to hospital emergency departments). How-ever these do not appear to affect the inappropriate use of emergency services. Those patients who are covered by the health subsystems can go directly to private hospitals and specialists allowed by their schemes. Private doctors can also refer them to NHS hospitals. Those patients covered by private health insurance may be eligible for private specialist consultations but this will de-pend on the benefit package offered.
Source	European Observatory on Health Care Systems
Year	1999

Code	5
Description	Out-patient care
Contents	Primary health care Primary health care in Portugal is delivered by a mix of private and public health service providers. In this section, primary health care will be taken to cover all health care provided out-of-hospital by both generalists and specialists, and other non-specialist care and services such as dental care services, physiotherapy, radiology, and diagnostic services.
Source	European Observatory on Health Care Systems
Year	1999

Code	5.1
Description	Medical care
Contents	Challenges and reforms The major problems currently facing primary health care are: • Inequitable distribution of health care resources; Although there are a large number of health centres inland, there is a lack of health care personnel (mainly doctors and nurses) because the coastal areas are more attractive. • Difficult access to primary health care; Barriers to accessing health centres means that excessive numbers of people go directly to hospital emergency departments. • Very limited public provision of services in continuing and home care; • Weak reputation of the public primary health care system; For many people, the system lacks credibility and therefore encourages many patients to seek second opinions from private doctors or hospital out-patient departments; • Lack of quality control programmes; There is no quality assurance process. • Lack of coordination; There is very little coordination between primary health care centres, hospital doctors, hospitals and private doctors, leading to unnecessary repeat examin-ations and tests, which merely waste time and have no impact on health outcomes or quality of care. • Lack of motivation of general practitioners; GPs in many places work in isolation and with poor incentives for produc-tivity due to their salaried status. • The shortage of qualified ancillary staff in health centres. Recent health care reform proposals aim to tackle these problems by: • increasing accessibility • improving continuity of care • increasing GP motivation, through changes in the payment system • stimulating home care services • identifying quality. A number of pilot projects were established in 1995. Of particular interest is the Alfa Project which began in the Lisbon and Tagus Valley Region. The objectives of these projects were: • to increase GPs' job satisfaction; • to increase patients' satisfaction with primary care services; • to increase access to public health services – a greater availability of post-natal care, care centred on the citizen and more time for consultations; • to improve quality; • to rationalize prescriptions of pharmaceuticals and the number of diagnostic tests and examinations. The Alfa Project experimented with a revised GP payment scheme in which groups of GPs were given overtime payments and other incentives in return for an assurance of providing 24-hour cover and adequate referral and follow-up of patients. A preliminary internal evaluation of these pilots indicated that the integrated models were successful, mainly because there was an improvement in satisfaction from both citizens and providers. Some of the principle ideas behind the reforms have been adopted nationally and new methods of remunera-tion for GPs are being introduced (see the section on Payment of health care professionals). More radical reforms to grant greater autonomy to health centres have been proposed but not yet enacted. These would grant both financial and adminis-trative autonomy to the centres. There is currently no solidarity between GPs who often feel isolated within the health centre. The proposal aims to increase a sense of team spirit by establishing smaller groups of GPs within the centre. Each group of doctors would be contracted by the RHA and would be accountable to the RHA for the care they provide. In order to encourage doctors to join the scheme the RHA are considering offering incentives such as bonus-payments, improved quality of premises and a special credit scheme for equip-ment and investment in facilities (this is awaiting approval from the Ministry of Finance). One of the additional responsibilities which will form part of the contract is the provision of 24-hour cover.
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	Due to the long waiting times for access to diagnostic facilities in the health centres, many patients prefer to go directly to emergency care services in hospitals or the private sector. In emergency departments the full range of diagnostic tests can be obtained in a few hours. This leads to excessive demand at emergency departments and considerable misuse of resources as expensive emergency services are used for relatively minor complaints.		
Source	European Observatory on Health Care Systems	***Year***	1999

Code	5.1.4
Description	Combined services: health centres
Contents	Public sector Primary health care in the public sector is mostly delivered through publicly funded and managed health centres (HCs). Each of them covers an average of 28 000 people. They employ in total 30 000 people (including regional health administration personnel). Of these, 25% are doctors (mostly general practi-tioners) and 20% are nurses. There are on average 80 health professionals per centre, but some have as many as 200, others as few as only one medical doctor. Centres currently have no financial or managerial autonomy but are directly run by the regional health administrations (RHAs). The Ministry of Health allocates funds to the RHAs which in turn determine the budget of each centre based on historical and activity costs. Most primary health care is delivered by GPs in the health centre setting. However, some health centres also provide a limited range of specialized care. This is a result of the integration of social welfare medical services into the National Health Service at the end of the 1970s. Specialists who had worked for the Department of Social Welfare were transferred and given contracts in the newly established NHS health centres. The specialists who work in HCs belong to the so-called ambulatory specialities such as mental health, psychiatry, dermatology, paediatrics, gynaecology and obstetrics and surgery. However, very few of these posts will be filled when present incumbents leave. The range of services provided by GPs in HCs is as follows: • general medical care, for the adult population and the elderly • prenatal care • children's care • women's health • family planning and perinatal care • first aid • certification of incapacity to work • home visits • preventive services, which include immunization and screening for breast, cervical and prostate cancers.Facilities The number of health centres and health posts has continued to grow throughout the 1980s and 1990s with a total of 2424 primary care medical units in 1996. The facilities provided by each health centre (HC) vary widely across the country in terms of the physical structure and layout of the HCs: • Some HCs were purpose-built and are therefore of a reasonable size, with a rational distribution of space, and discrete and segregated areas for different purposes; • Some HCs, mainly those in large cities, were incorporated into residential buildings and consequently many are badly designed and are not patient-friendly; • Some HCs, mainly those in rural areas which are operated by Misericórdias or belong to the church, were established in ancient hospitals and monas-teries (in the 1960s).
Source	European Observatory on Health Care Systems
Year	1999

Code	5.2
Description	Dental care
Contents	Dental care The publicly-funded oral health care system in Portugal is not very compre-hensive. There are very few NHS dentists, so people normally use the private sector. Some dentists contract with one or more of the health subsystems. Each scheme defines its own list of eligible treatments and fees. The schemes are usually slow to pay and the fees are low. Those dentists not under contract may provide care to patients covered by the schemes; patients pay directly and are then reimbursed by the scheme. As well as dentists, dental hygienists (who have a more limited training) provide dental care though it must be under the direction of a dentist.
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			
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			
Source	European Observatory on Health Care Systems	***Year***	1999

Code	5.6		
Description	Home nursing and home care (maternity home care included)		
Contents	Home care is expanding as a result of a joint venture between the Ministry of Health and the Ministry of Employment and Social Solidarity, called the Integrated Support Plan for the Elderly. In some regions, an infrastructure to deliver support to the elderly has been developed in partnership with RHAs, municipalities and private providers, such as Misericórdias. As part of this inter-ministerial project, the state is facilitating vocational training opportunities in areas such as domiciliary care and informal health care as part of a job creation scheme. Currently in the Lisbon and Tagus Valley region, there are about 20–30 local projects to create local social networks of care. The division of payment between the NHS and the social security department depends on the type of care provided by the project, i.e. nursing care or home help.		
Source	European Observatory on Health Care Systems	***Year***	1999

Code	5.7		
Description	Out-patient mental health care services		
Contents	Mental health Mental health services are run under the aegis of the General Directorate of Health. Mental health centres are run on a district basis, except in the large cities. Centres are linked closely to the RHAs and to the district hospitals. Mental health centres rely on links with all health services in the community. They provide various services: • ambulatory care, given (preferably in the centre itself) by mental health teams • psychiatric services for patients in crisis • psychiatric services for patients with long-term problems. Every mental health centre has a staff member responsible for child mental health. There has been a massive reduction of acute psychiatric and long-term beds in recent years as part of a process of de-institutionalization. Most mental health services have been integrated with general hospitals.		
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	Diagnostic and therapeutic services Portugal also has a large independent private sector which provides diagnostic and therapeutic services to NHS beneficiaries under contracts called “convenções”. These medical contracts cover ambulatory health facilities for laboratory tests and examinations such as diagnostic tests and radiography (they are scarce in medical consultations). The contracts operate as follows: the NHS publicly declares the terms of service and prices that the NHS is willing to pay. All providers who are prepared to meet the criteria and who meet basic quality standards can register. A list of all those providers who have registered is published annually. In principle, patients can choose from any of the providers who appear on the contracts. Many patients actually go directly to the emergency departments of hospitals where they can obtain all necessary tests within a much shorter time. Prices do not vary according to the level of service which means providers have little incentive to improve the quality of services.		
Source	European Observatory on Health Care Systems	***Year***	1999

Code	6
Description	In-patient care
Contents	Trends in hospital numbers have been similar to those in other European countries. There has been a significant decrease in the number of hospitals over the last 30 years – from 634 in 1970 to 211 in 1996 (a reduction of 67 %). Most hospital services are provided according to the integrated model, i.e. directly by the NHS. However, non-clinical services, e.g. maintenance, security, catering, laundry and incineration have for some time been outsourced to the private sector. Also, diagnostic and therapeutic services in the ambulatory sector are mainly provided by the private sector to the NHS through all-willing provider contracts. A very limited number of clinical services are being contracted out, usually in specific areas where waiting list reductions are needed, for example, cataracts. Health resources are concentrated in the capital, Lisbon, and along the coast. There are no specialized or central hospital facilities in the regions of Alentejo and Algarve and only five and three district hospitals respectively. Many of the hospitals inland lacked resources and had poor facilities com-pared to those in Lisbon and Porto. The investment programme in recent years has concentrated heavily on these poorer rural regions and the hospitals there have benefited greatly. In fact, many of the district hospitals inland now have better facilities than those in the coastal areas. The total number of hospital beds in 1996 was 39 212. Government-controlled hospitals accounted for 30 392 beds or 77.5% of total beds in. The beds in the charitable hospitals have become obsolete since the 1980s as a result of nationalization and the specialization of these organizations in the provision of rehabilitation, psychiatric and long-term care. The decline in total bed numbers between 1980 and 1990 actually reflects a dramatic de-cline in beds within the NHS. This has been accompanied by an increase in the number of privately-owned beds. The number of hospital beds per 1000 population, according to WHO statistics, has dropped by 11% over the period 1990 to 1995/1996. This is mostly due to the decline in hospital beds for the long-term care of the elderly and mentally ill. The decline is less dramatic, if only acute beds on the mainland of Portugal (-1.2% over the same period) are included. Portugal has one of the lowest number of hospital beds per 1000 population in western Europe (4.1) just below Spain (4.3) and above Turkey (2.5) and Ireland (3.7). As has been noted previously, there is an uneven distribution of resources between the regions. For most indicators of resources both human and material, the regions of Alentejo and Algarve are the worst off. The Algarve not only has the lowest number of total beds but also has the lowest number of beds per capita. The Lisbon and Tagus Valley Region has the highest proportion of total hospital beds (nearly 40%) and has a similar per capita concentration as the Central Region. Both Spain and Portugal have fewer hospital beds than the European average. The numbers have declined slightly between 1985 and 1995 but not nearly as dramatically as the steep decline in numbers experienced in other countries. Many of the cuts in bed numbers in other countries were due to a perceived oversupply, resulting from changes in technology, such as day surgery, and the increasing number of drug treatments which have reduced the demand for hospital beds. In other European countries a large proportion of the bed reductions were in long-term and psychiatric beds which did not account for such a high proportion of total beds in Portugal and Spain where services in these sectors were less developed. Utilization The number of outpatient appointments per capita has increased steadily since 1990. The average length of stay decreased between 1990 and 1996 from 9.6 days to 8.0 days. The occupation rate has remained fairly low at about 75% since 1993. A slightly higher average length of stay can be seen, if these figures include all facilities (i.e. long-stay beds for chronic, elderly and psychiatric patients). Similarly occupancy rates are even lower if the autonomous regions and non-acute sector NHS hospitals are included. Admission rates increased dramatically throughout the 1970s and 1980s but have now stabilized at ±11% in the 1990s. Length of stay has fallen in line with trends in the rest of Europe due to advances in technology. The occupancy rate has been fairly consistent at around ±70%. Compared to other western European countries, Portugal has a relatively low number of hospital beds per 1000 population and an average utilization rate, measured by admission and occupancy rates.
Source	European Observatory on Health Care Systems
Year	1999

Code	6.1		
Description	Hospital categories		
Contents	Hospitals are classified according to the services they offer: • central hospitals provide highly specialized services with advanced tech-nology and specialist human resources; • specialized hospitals provide a broad range of specialized services; • district hospitals are located in the main administrative district and provide a range of specialist services; • district level-one hospitals only provide internal medicine, surgery and one or two other basic specialties.		
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			
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	Public health services The public health services in Portugal are responsible for surveillance of health status and identification of its determinants. Public health services are also responsible for health promotion and disease prevention at community level and for the evaluation of the impact of health promotion and disease prevention activities. The organization of public health services nationally is the responsibility of the General Directorate of Health (GDH). The GDH is responsible for the establishment of programmes, definition of strategy and approval of national plans. At a regional and local level the main actors are as follows: • Local health authority – an extra level of administration in the public health system, which consists of a public health doctor usually in a health centre; • Public health doctors and sanitary technical staff; • Regional health authority – work in health sub-regions and support public health services through the provision of regional laboratories; • GPs – responsible for health promotion as part of their day-to-day work including family planning, antenatal services and screening programmes. Public health doctors have the primary responsibility for the promotion of health and surveillance of disease. However in many health centres these responsibilities are transferred to GPs. Their responsibilities include: • Ensuring compliance of local services, e.g. restaurants, hotels, etc. with health and safety standards; • environmental inspections of places of work; • building safety and housing inspection; • communicable disease surveillance and notification. Reform of public health services There is a policy to strengthen public health at both regional and local levels through provision of epidemiological expertise and leadership functions in health promotion issues. Of particular note is the establishment of SARA (Rapid Response System), a new information and management system for health emer-gencies, whether related to food safety, communicable diseases or environ-mental health. This project aims to build a national information network for all public health staff, connecting all levels of public health care. It will provide the basis for the continuous development of standard guidelines and enable rapid responses to such emergencies. Public health doctors currently have a low status within the NHS and there are problems with recruitment (half of all public health doctors' vacancies were unfilled in 1998). Their work up to now has been to act as health inspectors and occupational health officers, which was heavily bureaucratic and meant working to old directives. The aim of the latest reform is to link the development of "local health systems" with the new public health structures, giving public health doctors a broader remit for the health of the population. New teams of public health doctors and nurses will be established. By creating these new "public health units" previously disparate resources will be brought together. A National Health Observatory is also being established as part of the National Institute of Health which will be responsible for coordinating disease surveillance. Health promotion and disease prevention activities Some of the health education initiatives are run as vertical programmes by separate bodies within the Ministry of Health, e.g. the National Prevention Council against Tobacco Consumption and the National Committee on AIDS. Proposals have been put forward to establish a Drug and Alcohol Institute in order to bring together the work of all government sectors on this issue. This would be a multi-ministerial initiative led by the Prime Minister. It should be noted, however, that vertical programmes have tended to have low success rates.
Source	European Observatory on Health Care Systems — ***Year*** 1999

Code	8.1
Description	Maternal and child health: family planning and counselling
Contents	
Source	European Observatory on Health Care Systems — ***Year*** 1999

Code	8.2		
Description	School health services		
Contents			
Source	European Observatory on Health Care Systems	***Year***	1999

Code	8.3		
Description	Prevention of communicable diseases		
Contents	Portugal has one of the highest immunization rates against measles in the European Region at 99% (1996/1997). Immunization rates against other diseases are also quite high: tuberculosis 86.6%, diphtheria 93.5%, tetanus 93.5% and poliomyelitis 92.6% (all figures for 1997). Responsibility for the implementation of the national immunization programme lies with the health centres, whose activities include school health services. Such high rates of immunization may be due to the strong network of primary health care centres built up during the 1980s.		
Source	European Observatory on Health Care Systems	***Year***	1999

Code	8.4		
Description	Prevention of non-communicable diseases		
Contents			
Source	European Observatory on Health Care Systems	***Year***	1999

Code	8.5		
Description	Occupational health care		
Contents			
Source	European Observatory on Health Care Systems	***Year***	1999

Code	8.6		
Description	All other miscellaneous public health services		
Contents			
Source	European Observatory on Health Care Systems	***Year***	1999

Code	9		
Description	Social care related to health care		
Contents			
Source	European Observatory on Health Care Systems	***Year***	1999

Code	9.1
Description	Organisation and financing of social care
Contents	Social care There is very little state provision of community care services in Portugal, including long term care, day centres and social services for the chronically ill, the elderly and other groups with special needs such as the mentally ill and the mentally and physically disabled. There is a traditional and cultural reliance on the family as the first line of care in Portugal. This reliance on an informal network of care is particularly strong in rural areas. However, demographic changes such as the increase in female employment and a breakdown in the extended family due to migration to urban centres, mean that many people are no longer able to rely on such informal care. As in many other European countries, Portugal faces a growing elderly population and the pressure to provide social as well as medical care is increasing. Elderly care Some social services are provided in each region through the Ministry of Social Security. However, Misericórdias which are independent charitable organiza-tions are the key providers of social care services. Day centres for the elderly provided 41 195 places in 1998 according to the Ministry of Social Security. They provide a range of services including activities, meals, food to take home, laundry services, bathing and even assistance with obtaining medication and attendance at health centres. A small means-tested contribution is usually charged. Residential care provided by the public sector is often of poor quality and lacks sufficient resources. Means-tested assistance is available, and social services will pay a proportion of residential costs depending upon income. The alternative is the homes run by Misericórdias and other non-profit institutions which are of better quality and only request a nominal contribution from patients and their families. There is currently no regulation of nursing homes. All homes are in the private sector and very expensive.
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	There still remain several general obstacles to the development of social care in Portugal: • lack of provision, very few nursing homes and none in the public sector • lack of trained personnel • no tradition of community care • regarded as family responsibility • lack of tools and skills to develop social care, i.e. few educational courses, etc. The state continues to encourage the Misericórdias to invest in social care and develop the basic infrastructure of services and facilities through reinvestment of money obtained from the NHS for hospital facilities which were nationalized during the 1970s. Ownership of many of the properties, which had been incorporated into the NHS at the end of the 1970s, was handed back to the Misericórdias in 1982 following a change of government. Despite the fact that the hospitals had been rebuilt or refurbished with public funds in the intervening years, the NHS rents back the facilities. Most of the new funds generated by this policy are being reinvested by the Misericórdias in social care.		
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	Regulation and control of pharmaceuticals Since 1990 several legislative changes have resulted from the implementation of EC Directives, such as that to guarantee the quality and safety of pharmaceuticals. In addition, programmes of public information and education on the rational use of pharmaceuticals were also developed and cost-containment policies were adopted. The National Institute of Pharmaceuticals and Medicines (INFARMED) was established in 1993. Since 1994, its remit has been widened to cover not only pharmaceuticals but also medical equipment and other medical products. INFARMED is responsible for approving all drugs which are to be reimbursed by the NHS and set co-payment levels. Recently, INFARMED have introduced some measures of cost-effectiveness into the assessment process of drugs. Currently, INFARMED can request cost-effectiveness data but the Technical Commission, which evaluates drugs, does not automatically provide it for phar-maceuticals. In 1998 INFARMED issued guidelines about how best to carry out cost-effectiveness studies, provoking a discussion about the possibility of their mandatory use in drug approval. The guarantee system for the quality and safety of pharmaceuticals is a complex one and is not limited to the industrial process. Due to the unique features of the pharmaceutical market, decisions are not made under normal market conditions. Pharmaceutical production is controlled by a strong system of regulation. The following authorities enforce the standards for the quality and safety of pharmaceuticals: A) Pharmaceutical Inspection Service This body verifies the adequacy of industrial procedures and their control systems. B) Pharmacovigilance Service The National Pharmacovigilance Centre is an INFARMED body, in operation since 1992. It deals with: • the monitoring of drug safety • recalls, if adverse reactions occur which were not previously identified • rapid withdrawal of a pharmaceutical product from the market. The National Pharmacovigilance Centre cooperates with the European Agency for the Evaluation of Medicinal Products based in London. This joint work has been very useful because of the discussion and help exchanged as well as the incentive it has provided to implement rules agreed at European level. Relationships with other European Pharmacovigilance Centres are also being developed. The Quick Alert System and participation in meetings of the Working Group of the Medical Commission for Portuguese Medicines contributes to the increasing safety of pharmaceutical products used in Portugal. C) The Official Laboratory for Pharmaceutical Quality Control This national laboratory has the following tasks: • to study pharmaceuticals; • to test the efficiency of dossier evaluation and the efficacy of inspection of industrial production; • to link with the National Pharmacovigilance Centre. Sanitary and homeopathic products are also regulated by INFARMED. Regulation of medical devices Medical devices are regulated according to Directive 93/42 EEC and a national directive of 1995. The notifying institutions are the National Institute of Health for active medical devices and INFARMED for non-active medical devices. Regulation and control of pharmacies Pharmacies must be owned by a qualified pharmacist. All drugs, including over-the-counter drugs (OTC) can only be sold in a pharmacy. It is not permitted for drugs of any sort to be sold through other outlets. In addition to this regulation which reduces competition, the location of pharmacies is highly regulated. There is a maximum number of pharmacists permitted in each community. The Ministry of Health decides whether there is a need for a new pharmacy in a developing and expanding residential area. In the first instance there must be proof of at least 5000 new clients. If another pharmacy already exists within 200 metres of the proposed site, the licence to open a new one will not be granted. As a result of the barriers to entry into the market, established pharmacists have a monopoly over the drug market. There is presently a limited service within hospitals for dispensing pre-scriptions to outpatients. Only those drugs which carry no co-payment are allowed to be dispensed. The idea of extending pharmacy services in hospitals to allow direct sales by the NHS is being debated within the Ministry of Health. Similarly, in health centres only those vaccinations which are provided free of co-payment are dispensed directly by the health centre. Otherwise patients have to take their prescriptions to a private pharmacist whether or not they receive the prescription from a NHS doctor in a health centre or from an out-patient department of a hospital. Pharmaceutical policy Portugal's pharmaceutical expenditure was 2.2% of GDP in 1996 – a very high position in the OECD ranking. However the country ranks lower in terms of pharmaceutical expenditure per

capita – 282 US $PPPs. Generic prescribing in Portugal is virtually non-existent, accounting for as little as 0.1% of total market share in 1995. There is a national formulary of drugs, which is only used by NHS hospitals for inpatient prescriptions. This does not extend to health centres or outpatient services. Guidelines on prescribing behaviour are issued to doctors, and directors of health centres are encouraged to draw up local formularies. However these are simply guidelines and have no mandatory powers. The lack of a national drug list for ambulatory care together with the powerful influence exerted by the industry over doctors, could be one reason for the high levels of expendi-ture on pharmaceuticals in Portugal.
Portugal has made attempts to control expenditure on pharmaceuticals through agreements with industry. However, some of them have been unsuccessful to-date. In 1997 a budget cap was introduced as a means of controlling costs. This was the result of a voluntary agreement between the government and the pharmaceutical industry in which the industry agreed to pay back to the NHS 64.3% of the excess over 1996 expenditure. The repayment will only apply to expenditure between 4% and 11% above 1996 levels. Industry would not be liable for spending outside these limits. This policy created a perverse incentive that once expenditure had exceeded the limit, expenditure was inflated further. By the middle of the first year, growth in expenditure on pharmaceuticals was already up by 16%. Another pharmaceutical policy currently being implemented is the use of reference pricing for drugs. Since 1991 (Decree Law 72/91) the price of drugs has been established using an artificial price based on comparisons with other countries. An attempt was made in 1998 to introduce reference pricing. This system groups drugs according to their active ingredients and sets a reference price for the group (often the average or lower-priced drug in the group). In Portugal, if two drugs of similar properties were already on the market, any new drug entering the market had to be priced at least 10% cheaper than the existing products. But this policy has been shrouded in controversy. Some products were misclassified and it is still unclear whether this controversy will have tarnished the policy irredeemably or whether the government will persist with its implementation.
Pharmaceutical co-payments
Prescription drugs in Portugal are subject to variable co-payments. Patient co-payments on pharmaceutical products are based on efficacy and effectiveness criteria with full payment attached to those drugs deemed to have no clinical value. Since 1992, there have been three categories of NHS co-payment. Pensioners are eligible for a lower level of co-payment on Category B and C drugs. In 1995 a new policy was introduced whereby private sector prescriptions were subject to cost-sharing by the NHS – previously only available for prescriptions provided in the NHS (Decree Law 272/95 de 23/10). The rationale of this reform was to reduce the number of private prescriptions being taken to health centres to have them repeated on a NHS prescription. However it led to an inevitable rise in the drugs bill.
Pharmaceuticals used by some vulnerable groups are fully paid for by the NHS. The following therapeutic categories are fully covered:
• anti-diabetic drugs
• anti-epileptic drugs
• anti-Parkinson drugs
• anti-neoplasmic and immuno-modulator drugs
• growth and anti-diuretic hormones
• specific drugs for haemodialysis
• drugs for cystic fibrosis treatment
• drugs for glaucoma treatment
• drugs for haemophilia treatment
• anti-tuberculosis and anti-leprous drugs.

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	Mechanisms for controlling health care technologies Portugal does not have a tradition of technology assessment. However, since legislation enacted in 1988, prior authorization by the Ministry of Health has been necessary before the procurement and installation of some of the more sophisticated equipment both in the public and private sector. In 1995 new legislation lifted the restriction for some equipment (CT and MRI scanners). A National List of Health Equipment was drawn up and published in 1998. This list details the distribution of specific items of equipment and services throughout Portugal. It was not primarily intended as a tool for determining the distribution of equipment but clearly it will enable planners and hospitals alike to identify areas where there are gaps in service provision. There are currently no methods for regulating the distribution of health equipment in the private sector. Most heavy medical equipment is located outside hospitals in private facilities. The private sector is more flexible and predisposed to innovation and therefore outstrips the public sector in the acquisition of high technology equipment. In fact, about 67% of this kind of equipment belongs to the private sector. The majority of this investment has taken place in the last ten years, particularly in the past five years (21% of all high technology equipment has been purchased in the last five years). Hospitals reimburse private clinics for the use of equipment providing a strong incentive for this provision pattern to continue. The distribution of technology is also disproportionate between regions. The concentration of equipment in the coastal area forces people to travel to access certain treatments or tests. There is, for example, an enormous imbalance in the provision of radiotherapy. People only have access to this type of treatment if they go to Lisbon, Porto or Coimbra. This has not only social and economic impacts, but also contributes to the waiting lists of these hospitals.
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

Training
There has been a boom in medical training and a large increase in the number of women going into the profession both as medical doctors and other health staff.
Doctors
The number of doctors entering the workforce per 100 000 population in Por-tugal in 1995 was 4.1. This is the lowest in western Europe. The number of dentists was also one of the lowest with just 0.8 per 100 000 along-side the Netherlands and Belgium, 0.7 and 0.6 respectively. There are currently five medical schools in Portugal (two in Lisbon, one in Coimbra and two in Porto). Two new medical schools are due to open in 2000. All medical training programmes follow the same curriculum and are divided in two phases, which last for three years each: i. the core programme which covers the basic sciences ii. the clinical programme with practical sessions, oriented to practice and specialized procedures. A curriculum reform to shorten this university degree to only five years is in preparation. After university, all graduates must then undertake a general internship for 18 months, with 6 months training in general practice and public health and a year in hospital training. On completion of the internship medical graduates are recognized as medical doctors and are free to practice medicine without supervision. However, if they want to follow a medical career in the NHS, they must go on to further specialization. The training for different specialities varies as follows:
• Hospital specialties – three to six years
• General practice/family medicine – three years
• Public health medicine – postgraduate course for 18 months, followed by one year's experience in a public health setting.
The government is jointly responsible, with the Portuguese Medical Associ-ation, for the accreditation and certification of specialist training for medical graduates. The specialist training varies according to each specialty. For instance, internal medicine and neurosurgery take six years of training whereas anaes-thesiology takes only four years. The duration of specialist training is defined by the specialist colleges of medicine. The specialist must be skilled in the diagnostic and treatment procedures of his/her own specialty and must have proficiency in some techniques related to the field. He/she also has to do some research work and publish articles, which are valued in curriculum analysis. At the end, he/she must be evaluated and, after recognition of aptitude, can apply for a hospital position or go on to clinical practice. The most popular specialty is internal medicine with 1601 doctors in 1996. General practice and public health are less attractive careers at present. The medical curriculum is highly hospital-oriented and although there are three general institutes for family practice in Coimbra, Lisbon and Porto the training related to primary health care and general practice is obtained mainly through field experience.
Nurses
To train as a nurse, one must have undergone at least 12 years of school education. The course lasts three years and on successful completion the academic degree of bachelor and the professional title of nurse are granted. There is another degree (licence) for which there is a one-year programme. There are no nursing auxiliaries or equivalents in Portugal. If a nurse wants to specialize, there are several fields:
• Midwifery – postgraduate course, lasting 22 months, after 2 years of clinical experience;
• Paediatric nursing – postgraduate course, lasting 22 months, after 2 years of clinical experience;
• Psychiatric nursing – 2 years of postgraduate experience and 18 months postgraduate study in mental health and psychiatry;
• Community nursing – 18 months of postgraduate study, after 2 years of clinical experience.
The current priorities expressed by the nursing profession include the develop-ment of a code of ethics, legislation on the practice of nursing and the creation of a regulatory body for nursing. Since 1998, nurses have established their own professional body, the Portuguese Nurses' Association which has similar powers to the Medical Association.
Other health care professionals
Since 1986, three state-funded and two private schools of dentistry have opened. Previously, oral health care was provided by stomatologists (the name given to doctors who specialized in dentistry) who undertook three years' dental training after their medical degree. Another grade exists – that of odontologist. This grade was introduced by the government at a time when there was a severe shortage of dentists. This training has been replaced by the main degree in dental medicine which is awarded by higher education institutions.
Alternative Medicine Practices
Despite the general trend towards recognition of alternative health care providers, the Portuguese still prefer mainstream medicine. There are some acupuncturists, chiropractors and homeopaths, but they have not as yet been recognized by the Ministry of Health.

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			
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	Human resource planning All staff within the NHS are civil servants and all new posts have to be approved by the Ministry of Finance. A numerus clausus was introduced in 1977 which limits the number of places available in medical schools. This was in response to the excess of doctors created after the revolution in 1974, when many doctors from the colonies returned to Portugal in order to complete their training. The distribution of medical personnel is not controlled or regulated by the state. However the high levels of investment in regional facilities outside Lisbon and Porto in recent years means that they are more attractive to doctors wishing to work in a well-equipped environment. Human resources and training There has been a significant increase in the size of the health care services labour force, from 2% of the total workforce at the end of 1974 to 2.7% in 1998. Human resources According to the Portuguese Medical Association, there are 29 000 medical doctors in Portugal. The data of the Department of Human Resources showed that 21 132 of these were employed by the NHS in 1995, the majority in secondary care. General practitioners, i.e. those specialized in family medicine, account for 35% of the total number of doctors, 46% are hospital doctors and less than 3% public health doctors. There has been a steady increase in the number of active doctors in Portugal since 1990. Before this there was a rapid increase from as few as 0.95 per 1000 in 1970 to 2.83 in 1990. Portugal has very closely followed the European average. However it has many fewer physicians per 1000 population than either Italy or Spain. Portugal has steadily increased the ratio of nurses to inhabitant but remains a long way below the European average. Spain and Italy also have lower than average numbers of nurses per capita. Progress with expansion of nurse numbers has been slow and Portugal has one of the lowest ratios of nurses to inhabitants in Europe. About 74% of nurses work in central and district hospitals and only 20% in primary care services and 3% in psychi-atric services. The number of dentists remains low at 0.26 per 1000. The number of certified nurses rose considerably during the 1970s from 0.97 per 1000 to 2.24 per 1000 in 1980. The number of pharmacists in Portugal is also low compared to other southern European countries, with a ratio approxi-mately half that of Spain and Italy.
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	Payment of Doctors Within the NHS, all doctors are paid a salary and are government employees. This fixed salary is established according to a matrix linking professional category and time of service, independent of any productivity measure. Different modes of employment exist in the public sector with different levels of remuneration: 1. Full-time: 36 hours per week; 2. Extended full-time: 45 hours per week (40% more pay than full-time); 3. Exclusive employment: the doctor is not allowed any private practice (50% more pay than full-time); 4. Part-time; this option is not compatible with the position of head of service; 5. Extended full-time and exclusive employment; this a combination of items 2 and 3 above (60% more pay). These additional payments, together with other variable components such as overtime (i.e. work in the NHS over and above the hours stipulated in the contract for such things as on-call duties), make up a significant part of total remuneration. In Lisbon, 36% of all medical salary costs are now for overtime. In general, doctors perceive their salaries to be relatively low and therefore feel justified in exercising their right to augment their income through private sector activity. However, if overtime payments, which make up a large proportion of income, are taken into account, the total income per doctor is high in comparison to the average wage. Particularly in rural hospitals where there is a small number of doctors and on-call duties come round frequently, overtime can account for the majority of a doctor's income. There has been little reform or innovation in the primary care sector. However, in 1996, the Lisbon and Tagus Valley RHA initiated the Alfa Project which changed the remuneration of doctors. See the section Primary health care for a fuller description of these reforms. Groups of GPs were given extra overtime payments and other incentives in return for an assurance of providing 24-hour cover and adequate referral and follow-up of patients on their lists. It hoped to reduce the excessive demand at hospital emergency departments in the cities and subsequently reduce cost. Following this experiment with a variable payment based on capitation the government is now introducing a new system of reimbursement for GPs. Participation in the scheme is voluntary and experimental. The mixed system comprises a basic guaranteed salary plus: • Capitation payment based on list size adjusted for population profile; • Fee-for-service for target services, e.g. home visits and minor surgery; • Target allowances for preventive care; • Payment for an episode of care, i.e. overall service to pregnant women including postnatal care. Half of NHS salaried doctors also work in the private sector and many independent doctors also work under contract for the NHS. The NHS, the health subsystems and private insurance negotiate fees independently with doctors. Fees charged to the NHS are generally the lowest. Private fees are not regu-lated by the government but are subject to a range of reference prices set by the Medical Association. Thus in practice private doctors are free to determine their fees and will set them according to reputation. There is, however, a legal requirement to display a price list, though this is not widely conformed to.
Source	European Observatory on Health Care Systems
Year	1999

Code	13.1.1
Description	Integrated or contracted
Contents	
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			
Source	European Observatory on Health Care Systems	***Year***	1999

Code	13.2
Description	Methods of hospital payment
Contents	Payment of hospitals Hospital budgets are drawn up and allocated by the Ministry of Health even though funds are disbursed through the RHAs. At present, public hospitals have a global budget that is mainly based on historical data. However, in practice, this initial budget allocation is more indicative than normative. Because public hospitals operate with open-ended budgets, overruns are mostly automatically covered by supplementary allocations. The system has very weak incentives to encourage cost-containment or efficient practices. Traditionally, the global budget is based on the previous years' allocation, adjusted for inflation but in recent years, a part of this global budget (10% in 1997) was based on diagnosis-related groups (DRGs). The Government planned to expand the allocation on this basis in 1998. The establishment of regional agencies in each regional health administration in 1998 aimed to change the way in which resources are allocated within the NHS. They are an autonomous section of the RHA which are developing a role as purchasers of hospital and clinical services. The first regional agency was established in 1997 and was subsequently recognized and endorsed by the Ministry of Health. There are now agencies in each of the five regions. The aim is to change hospital payment from a retrospective to a prospective budget and to introduce an element related to production costs, i.e. a budget based on predicted costs rather than an historical budget. 1999 is the first year of budget negotiations based on contracts and prospective budgets to involve all hospitals and RHAs. It is proposed that, in its first year of operation, 3% of hospital budgets will be allocated through contracts with the remainder being allocated on an historical basis. It is hoped that this proportion will increase year on year. The agency negotiates with the hospital board whose responsibility it is to ensure the requirements of the contract are met. The hospital board should establish contracts within the hospital with those who have internal responsi-bilities. Contracts are negotiated with both public and private institutions though, in the first instance, with NHS hospitals. This system is expected to increase accessibility to more efficient and better quality services. The power of the agencies is currently quite limited as the leverage of the purchaser is not suffi-cient to close a hospital or even a service or ward within a hospital. However, it is expected that the loss of a guaranteed income for hospitals based on historical costs and the introduction of productivity-related payments will in-crease cost awareness and increase incentives for efficiency. Besides direct transfers from government, public hospitals also generate their own revenue from payments received from patients for special services (individual rooms, for example), payments received from beneficiaries of the health subsystems or private insurance, and flat rate charges. In theory the health subsystems should reimburse NHS hospitals on a fee-for- service basis for services provided to beneficiaries. However, in practice, very few enrolees actually declare their membership when receiving care in NHS hospitals and thus the transfer of resources between funds and the NHS does not take place. An historical agreement was reached in 1998 between the PT-ACS, which is the sickness fund for public telecom operators, and the Ministry of Health. The PT-ACS has agreed to take full responsibility for the cost of health care provision for its members in return for a capitation payment from the NHS of Esc. 30 000. This agreement could establish the basis for further political ne-gotiations between the Ministry of Health and the National Association of Health Subsystems. However it seems that at the moment any plans to remove the duality of the system would be opposed by the National Association of Health Subsystems. Private insurance schemes vary in the method of reimbursement. On the whole, this is on a fee-per-item basis, reimbursed retrospectively either to the individual patient or to the hospital who will bill the insurance company for the full costs of care.
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	Health care finance and expenditure The Portuguese health care system is a mix of public and private financing. The NHS, which provides universal coverage, is predominantly funded through general taxation. The health subsystems, which provide comprehensive coverage to about a quarter of the population, are funded mainly through employee/employer contributions (including state contributions as an employer). A large proportion of funding is private, mainly in the form of direct payments by the patient and to a lesser extent in the form of premia to private insurance schemes and mutual institutions, which cover respectively 10% and 7% of the population. Taxation accounts for the largest amount, with 61.6% of the total health expenditure (THE) financed in this way in 1997. This includes expenditure on direct provision within the NHS and in the form of subsidies to the health subsystems which operate for public sector employees. The proportion attributed directly to social insurance schemes is only 4.8% (1996). Out-of-pocket payments accounted for 44.6% of THE in 1995. This is one of the highest in Europe (see the section on Out-of-pocket payments).		
Source	European Observatory on Health Care Systems	***Year***	1999

Code	14.1
Description	Main features of tax based systems
Contents	Public financing Taxation The NHS is mainly financed directly by taxes. A soft budget for total NHS expenditures is established within the annual national budget. Actual health expenditures usually exceed the budget limits by wide margins, requiring the approval of a supplementary budget. Apart from direct transfers from govern-ment, the NHS has its own receipts that are mostly generated and spent by hospitals. These include payments received from patients for special services such as individual rooms, payments from beneficiaries of health subsystems and private insurers, payment received for the hiring of premises and equip-ment, income from investment, donations, fines, admission charges and co-payments (for drugs, consultations and diagnostic tests). In total this accounts for about 7% of total NHS revenues and is estimated to account for as much as 20% of the overall hospital budget. Health subsystems The health subsystems, which pre-date the establishment of the NHS, are normally financed through employer/employee contributions, with a large contribution paid by the state as employer. Contributions by employees are obligatory for most funds. Most beneficiaries of public sector health subsystems contribute 1% of their salary. In private subsystems the contribution can vary, sometimes beneficiaries pay nothing at all. The employee's contribution is really symbolic with the larger part paid by the employer. Generally the benefits received exceed those provided within the NHS. The employer-employee contributions are often insufficient to cover the full costs of care and consequently a significant proportion of costs are shifted onto the NHS. Most enrolees of these funds do not declare their membership when receiving treatment within the NHS, thus exempting the funds from responsi-bility for the full costs of care for their members.
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	
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	Health care benefits Theoretically, there are no services explicitly excluded from NHS coverage. However, throughout Portugal, there are some types of care which should be provided by the NHS but which are not available in practice (for example, adult dental care). In these cases activity is mostly in the private sector and reimbursed by the NHS. Apart from these instances, the NHS, at least in theory, is totally comprehensive. Regarding direct provision, the NHS predominantly provides hospital care, GP and mother and child care. Specialist and dental consultations, and diagnostic services are more commonly provided in the private sector and reimbursed by the NHS. There are also gaps in provision due to geographical inequities. Some areas, for example, are unable to provide certain specialist services to the population. Pharmaceuticals A national drug formulary of active substances and ingredients lists all drugs approved for use in Portuguese NHS hospitals. Any drugs which are prescribed to inpatients, yet do not appear in the formulary, must be approved by a committee of pharmacists and doctors in each hospital. About 30% of drugs prescribed in hospitals are outside the formulary. In the ambulatory sector and outpatient departments, doctors are free to prescribe any drug. Waiting lists Waiting lists are often viewed as a means of rationing care in the public sector as people may be encouraged to opt for the private sector. The results of a recent study in Portugal suggest that waiting lists are a growing problem. The number of patients on waiting lists amounted to almost 15% of total hospital discharges in a single year. There is currently a census taking place of patients on waiting lists. Early results suggest there are more people than expected on waiting lists. However this may be due to duplication, with some patients appearing on two or more waiting lists for the same procedure at different hospitals. It is not possible to identify any areas of health care where explicit choices have been made about rationing. There have been discussions about defining a “basic package” of health care benefits, but until now there has been no indication of such a policy being implemented. Though rationing may not happen explicitly, it may occur implicitly within the NHS as a result of diffi-culties in access, the absence of specialists and doctors in rural areas and the lack of supply of certain services.
Source	European Observatory on Health Care Systems — ***Year*** 1999

Code	14.4
Description	Complementary sources of finance
Contents	
Source	European Observatory on Health Care Systems — ***Year*** 1999

Code	14.4.1
Description	Voluntary health insurance
Contents	Voluntary health insurance Approximately 10% of the population have taken out some form of voluntary health insurance (VHI). Mostly this is group insurance provided by the employer: less than 10% of people with health insurance have individual policies. Policies tend to be selective in nature and lack comprehensiveness. The majority of VHI policies in Portugal are valid for only one year and consequently companies have the power to cancel the contract and/or refuse to renew the contract. As age is strongly associated with increased health care costs, many companies will try to exclude anyone over the ages of 65 or 70 years old. A tax reform in 1988 made most health expenditures, including co-payments and payments to private doctors, fully deductible from taxable personal income. Tax deduction for health insurance premiums was covered by a general ceiling on insurance premiums up until 1999 when a stand-alone limit was introduced. This policy meant there was little incentive to purchase or use private insurance. The value of this implicit government subsidy has been estimated at 4.8% of direct tax revenues or between 0.2% and 0.3% GDP. Incentives are skewed in favour of out-of-pocket expenditure. Corporate insurance policies are more generous as the corporate tax laws are more liberal. Even so, few firms currently provide private group health insurance. It seems likely however that if there is to be any further growth in the market it will be in the area of group and employer insurance policies. The main reasons for a potential growth in the private insurance market can be summarized as follows: • the tax incentives which encourage high earners and companies to take out private health insurance; • the social status which VHI confers on enrolees as it is indicative of a certain level of income; • the difficulty in accessing the NHS and dissatisfaction with the services provided. Mutual funds About 7% of the population are covered by mutual funds, which are funded through voluntary contributions. They are non-profit organizations that provide limited cover for consultations, drugs and more rarely some inpatient care. They do not exclusively provide health benefits to associates so it is difficult to calculate the health component of the contributions.
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	Out-of-pocket payments In recent years, there has been increasing use made of co-payments in health care with the aim of making consumers more cost aware. Out-of-pocket payments have consistently accounted for about 45% of total health expenditure in Portugal over the last ten years. The majority of this expenditure is on drugs, over 50% in 1994/1995. The share of out-of-pocket expenditure on drugs has increased significantly from 46.2% in 1989/90 to over 55% in 1994/1995. Medical, nursing and paramedical services and therapeutic products make up the bulk of the rest. These three items of expenditure represent over 90% of a household's out-of-pocket pay-ments on health care. The co-payments on pharmaceuticals vary from 40% to 100% depending on the therapeutic value of the drug. Pensioners pay a reduced co-payment and the chronically ill are exempt from co-payments on some courses of medication. More detail about the level of co-payment for pharmaceuticals is given in the section on Pharmaceutical co-payments. Within the European Union, Portugal has one of the highest levels of out-of- pocket payments for health care . Flat rate payments exist for consultations (primary care Esc.300 , hospital outpatients Esc.600 central and Esc.400 district hospital), emergency visits (health centre Esc.400 and hospital Esc.1000), home visits (Esc.600) and diagnostic tests and therapeutic procedures (variable). (Note: all figures for 1998). Transportation costs are paid by the patient, except in special circumstances, such as when the patient has to travel a long distance, when costs are subsidized. Patients are exempt from co-payments and user charges if they are classed as "low income" (i.e. in receipt of supplementary benefit or unemployed), have special medical needs (i.e. the physically handicapped or those with chronic illnesses) and special patient groups such as pregnant women, children up to 12 years of age, drug addicts in rehabilitation and chronic mental patients.
Source	European Observatory on Health Care Systems
Year	1999

Code	14.4.3
Description	External sources of funding: employers, fund raisers etc.
Contents	External funding Since 1994 there has been a programme of investment in health care services, co-financed by the European Union. Through the European Regional Development Fund (ERDF) significant investments have been made. For each co-financed project the Portuguese contribution must be at least 25% of total investment. The external funding complements the Ministry of Health's own capital expenditure plans.
Source	European Observatory on Health Care Systems
Year	1999

Code	15
Description	Health care expenditure
Contents	Health care expenditure Total health care expenditure in Portugal measured as a share of GDP was 8.2% in 1996. The proportion rose steadily from as little as 3% in 1970 to its present level. Portugal spends marginally less than the western European average of 8.4% (1996); however, there has been a convergence over time. Portugal now spends more than both Italy and Spain despite having spent considerably less than both these countries in 1970. Compared to the other southern European countries, it appears that Portugal has not contained health care expenditure growth as successfully. The amount spent on health care has risen both in absolute terms and in relative terms over the last three decades. Portugal's GDP spend on health care is near to the western European average of 8.4%. It is one of the highest in western Europe with only Germany, France, Switzerland and the Netherlands spending a larger percentage of GDP on health care. Methodological difficulties with calculating both health care spending and the size of GDP mean that direct comparisons should be made cautiously. Using instead US $ purchasing power parity (PPP) per capita as a measure of health care expenditure, Portugal falls well below the European Union average. Portugal spent US $PPP1125 per capita on health care in 1997 which is similar to other EU countries such as Spain (US $PPP1168) and Ireland (US $PPP1324). Within the EU only Greece spends less per capita (US $PPP974).
Source	European Observatory on Health Care Systems — ***Year*** 1999

Code	15.1
Description	Structure of health care expenditures
Contents	In Portugal the proportion of total health expenditure which is from public sources, i.e. money raised through taxation or health subsystems (that are frequently publicly funded), is 60% the lowest in the European Region. Other southern European countries have slightly larger proportions of public expenditure, such as Spain with 78.7%, Italy 69.9% and Greece 74.8%. Portugal contrasts with the northern European tax-based systems such as Sweden (83.3%), the United Kingdom (84.5%) and Norway (82.2%). Public health expenditure as a percentage of total health expenditure in Portugal has fluctuated over the last 20 years between 55% and 65% of total.
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	Inpatient care accounted for 36% of total expenditure in 1995, whereas ambulatory care was only 24%. Inpatient care as a percentage of total health expenditure has been rising. Pharmaceuticals consume a growing proportion of health expenditure up from 20% in 1980 to over 26% in 1996. As in many other health systems, despite attempts to prioritize primary health care over specialist hospital-based medicine, expenditure on ambulatory care services remains lower than on inpatient care. In the Portuguese health system, the reliance on hospitals may be due in part to the difficulties that health centres have in providing ambulatory care to the population, resulting in large numbers of the population attending emergency departments or specialist outpatient clinics.		
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	Health care reforms Over the last few decades, the Portuguese health care system has undergone several periods of reform. Each reform has to an extent reflected the particular political, social and economic organization of the country at that time. Several common characteristics can be identified: • Many of the reforms were not implemented in the way that they had been conceived (at least, not until late in the reform process); • Many remnants of the pre-reform policies and models persisted; thus new policies and models were added to the old rather than replacing them; • Most of the reforms were of a purely legislative nature and lacked substance about their practical execution.		
Source	European Observatory on Health Care Systems	***Year***	1999

Code	17.1
Description	Determinants and objectives
Contents	Aims and objectives Debate on health care reform has taken place in Portugal since the 1980s. Successive governments have reacted in different ways to the problems of the health sector and the perceived crisis in the health care system. Despite the diversity of attitudes, it is possible to identify a series of values and principles on which there is virtual consensus in the Portuguese society. These values and principles, despite being interpreted differently, have remained constant throughout cyclical changes in the sector since 1976. The following can be considered consensual values: • unconditional safeguarding of human dignity; • the right to health protection; • solidarity among all Portuguese citizens in order to guarantee that right; • recognition of the social nature of health care delivery; • respect for the democratic values of citizenship. These have provided the basis for a set of principles specific to health policy measures: • the principle of universal coverage; • the principle of equity of access and utilization; • the principle of financial protection guarantee, bearing in mind the high costs patients may incur; • the principle of enabling freedom of choice of providers, whenever possible within available resources. The reform proposals passed in the early 1990s, however, seem to diverge from these fundamental principles and recommended organizational change which promotes a greater role for the private sector, individual responsibility and entrepreneurial management in the NHS.
Source	European Observatory on Health Care Systems
Year	1999

Code	17.2
Description	Content of reforms and legislation
Contents	Reforms The problem of lack of coordination between hospitals and health centres and the large numbers of patients by-passing the referral system has prompted reform. One of the reform proposals, which has been on the agenda since the foundation of the NHS, is the development of local health units. The idea was to link a hospital (or several hospitals) with a number of health centres based partly on geographical proximity and partly on the balance of specialities and availability of an accident and emergency department. These “health units”, whose main focus was health care institutions, were established but they failed to achieve any improvements in coordination and did not fulfil the aim of integrating, coordinating and facilitating continuity of care. The latest reform, enacted in May 1999, goes further and proposes the establishment of “local health systems”. These would include private institu-tions and local councils as well as the medical services provided within the NHS. These local health systems are expected to lead to a more adequate and functional interlinking between secondary and primary, public and private care. They aim to change the present scenario of lack of coordination among services and embrace a broader sense of health care with the focus on the population. They are community-based and include all providers, both public and private, as well as representatives of citizens’ groups (either someone nominated by the municipal council or a consumers’ association where they exist). The pro-posal is to calculate population-based budgets based on total health expenditure in the area covered by the health system. These resources will then be allocated at a local level amongst all providers based on an assessment of health needs in the area. The RHAs are currently developing a methodology to assess health needs on which decisions about financing priorities and allocations will be based. Reforms One of the main problems facing hospital services in Portugal is the excessive use of emergency departments for non-urgent treatment. In the 1998 National Health Strategy, a number of objectives were set out including: • reducing waiting lists through more efficient services • an increasingly patient-friendly service with a special effort to cut waiting times • reorganization of emergency departments • contracting-out of activities and projects that are considered priorities. A policy announcement was made at the beginning of 1999 that outpatient departments would be reorganized to give priority to patients with referral letters. As an incentive to patients to use the primary care services and to promote the use of the GP gatekeeping function, those patients without letters of referral of patients bypassing the referral process. Another major change for hospital services is the change in their funding from allocation based on historical budgets to contracted budgets. The Regional Agency (part of the RHA) will contract with the hospital board who will, in turn, contract with a multidisciplinary team of health professionals for the delivery of services in fulfilment of the contract. (This process is more fully described in the section on Payment of hospitals.) Reforms and legislation The legislative process dominates the system of policy-making in Portugal. The Assembly of the Republic, the main legislative body, passes general acts of legislation called leis which cover the most important policy rules and guide-lines. These general laws, however, are not sufficient to warrant the practical implementation of the law. Further legislation, in the form of Decree-Laws, regulatory decrees, simple decrees, legal documents and ministerial dispatches, is required before implementation can proceed. The most important of these secondary pieces of legislation is the Decree-Law. Below are set out the key pieces of legislation referred to throughout this report. Income tax reform, Decree-Law 442-A/88 and 442-B/88, 30 November 1988 Limits on the amount of tax-deductible private health expenditure were abolished. Households are allowed to recoup an amount equal to their marginal tax rate (e.g. 40% for the highest income households). Previously there were limits on the amount of out-of-pocket expenditure which could be deducted (50% at most) and some types of expenditure such as pharmaceuticals were excluded. Eligible expenditure includes the full cost to the patient of drugs both over-the-counter (OTC) and the cost-sharing component of NHS prescrip-tions. Health insurance premia are deductible up to a ceiling of Esc 70 000. This ceiling was for all insurance premia; this has been changed by a subsequent decree in 1998 to be a stand-alone ceiling for health insurance premia. See the section on Voluntary health insurance. The Law on the Fundamental Principles of Health, Law 48/90, 24 August 1990 The key principles set out in this piece of legislation were: • That the NHS was no longer to be seen as the main form of provision, but as one of several entities (both public and private) involved in the delivery of care; • That the State should promote the development of the private sector and provide incentives

for the expansion of private insurance;
• That the NHS should be structured and should function according to consumers' interests;
• That care provided by the NHS should be provided 'practically free' rather than free at the point of use (in other words legitimising the use of co-payments in the NHS);
• That the management of NHS facilities could be contracted out to the private sector.
This legislation also included a charter of patient's rights and duties.
Drug Statute, Decree-Law 72/91, 8 February 1991
In 1991, the Government adopted the Drug Statute, in response to EC Directives. This law, which legislates for a reorganization of the pharmaceutical system, regulates the process from the introduction of a product onto the market right up to marketing and sales. The application of rules to blood and human plasma derived drugs was also reformed. Co-payments in the area of pharmaceuticals were also revised to introduce the criteria of necessity and social justice. This has enabled those in disadvantaged circumstances such as the chronically ill to benefit from free medication.
NHS Statute, Decree-Law 11/93, 15 January 1993
This piece of legislation concerned the organization of the NHS and was in line with the broad principles set out in the 1990 law.
• The number of RHAs was reduced from 18 to 5 and simultaneously they were given greater powers and autonomy to coordinate hospital activities;
• Within each region, health centres and hospitals were to be merged to form health units, in an effort to ensure better continuity of care;
• Rules were created to facilitate the transition or, at least, the temporary transfer of civil servants from the NHS to the private sector;
• Full-time salaried doctors were allowed to engage in private practice;
• NHS co-payments were established on the basis of ability-to-pay (i.e. not only flat-rate payments);
• An 'alternative health insurance' scheme was proposed, which would be a substitute for the NHS (i.e. people would opt out of the NHS). Private insurance companies would receive a capitation payment from the government for each person opting out of the NHS;
• A variety of forms of private management of NHS facilities were to be encouraged.
Drug co-payments, Decree-Law 272/95, 23 October 1995
This decree extended cost-sharing by the NHS to include prescriptions written by private doctors. Previously this had only applied to NHS prescriptions, causing a problem with private prescriptions being brought to NHS health centres to be repeated.

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	Health for all policy Portugal is committed to the WHO health for all policy and regularly presents reports about the health situation in Portugal. The last report, “The Health of the Portuguese”, was published in July 1997 and the next one is already being prepared. The National Health Strategy, is based on the health for all principles and sets a number of outcome targets – the first time this has happened in Portugal. It sets out a coherent plan for health with measurable targets. It gives precedence to health gains and focuses less on the economic constraints in which health care services must be provided. The first strategic document of this sort was produced in 1996. The main purpose of this document is to ensure good population health and a situation of wellbeing for the largest possible number of citizens. To accomplish this higher mission, the health sector should be run according to the explicit and coherent objectives set out in the health strategy, using resources obtained in a fair and sustainable way. This document is not an operational document, nor does it set out clear policies for implementation; but it does act as a framework within which all health institutions should operate. A work plan will be developed for each year based on an agreement between central and regional authorities. The first evaluation of progress against the targets and objectives that have been set will take place in 1999.		
Source	European Observatory on Health Care Systems	***Year***	1999

Code	17.4
Description	Reform implementation

Contents

Reform implementation

It is important to bear in mind, when considering any of the reforms in Portugal, that the stated aims and objectives and the legislative record do not necessarily correspond to the actual changes and developments on the ground. Many of the more interesting and successful reforms have developed from small pilots and experiments. On the other hand, many potentially positive reforms have never come to fruition because of an association with a failed experiment. There has been substantial legislative activity and some radical reform proposals have been put forward. However, relatively few of the measures have been fully implemented. The process of reform has been incremental with the slow enactment of varied policy measures which have changed the system gradually since the 1980s. Many of the measures, which have been proposed and partially implemented, have not been fully evaluated, both due to the pace of the process but also due to a traditional lack of activity in this area. One of the main aims of the present reforms has been to improve coordina-tion between primary and secondary care. This was the main determinant for the amalgamation of the Directorate of Primary Health Care and the Directorate of Hospitals at the ministerial level, the formation of local health units at local level and the delegation of responsibility for hospital and health centre budgets to RHAs. Yet all these measures have failed to deliver an improvement in the continuity of care for patients. One fundamental reason for this may be the lack of a clear separation between the system of public and private provision and between the NHS, health subsystems and private insurance schemes. This means that patients shop around for their care, duplicating the use of services and of course preventing adequate follow-up and referral procedures which facilitate good continuity of care. The lack of a social care programme also means that, on discharge from hospital, follow-up and rehabilitation care is almost non-existent or is provided by independent organizations. As well as a failure to have the desired outcome, there are some examples of failure to implement legislation. The attempt to establish an alternative health insurance scheme never got off the ground. This was mainly due to a lack of interest from private insurance companies but also, in part, due to a change in personnel at ministerial level. This idea is being revisited and due to stagnation in the private health insurance market, companies are now revisiting the possi-bility of offering an opt-out insurance. An independent commission (Conselho de Refexão sobre a Saúde), which reported in 1998, proposed that the single most important reform needed in the Portuguese health care system would be the clear separation between the NHS and the other public and private schemes. Despite widespread agreement with its conclusions, the commission's report holds weak powers of execution. There are many obstacles to the successful implementation of reform in Portugal which can be identified:

- strong and well-organized interest and professional lobbies;
- high and changing public expectations, including lack of cost-awareness and a view that they have a right to health care;
- variable commitment to reforms across the regions;
- little published or independent evaluations of the reform experiments;
- system is in constant state of transition;
- high level of interest in the outcomes;
- high professional expectations which do not match available resources in an economically poor country;
- too many reform proposals being attempted at any one time without the necessary intellectual and human resources to support the process;
- dispersal of financial resources to many small projects means that reforms are never seen through to completion or given a fair chance of succeeding.

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

Code	17.5
Description	Conclusions
Contents	Conclusions Despite the extensive programme of legislative reform of the Portuguese health care system in recent years, there remain a number of key challenges if the objectives of an equitable, efficient and quality service are to be attained. When the Portuguese NHS was founded in 1979, it was envisaged that it would provide universal and comprehensive cover to all citizens, free at the point of use. Despite universal coverage being achieved, some citizens are entitled to additional benefits and greater choice through membership of health subsystems or through private voluntary insurance. Equity of access has not been fully realized due to differences in the regional distribution of human and capital resources and the differential access to specialist services. The extensive use of flat-rate co-payments in the NHS (only since legislation in 1993 have co-payments been means-tested) and the large increase in the number of services for which co-payments were charged during the 1980s, means that the NHS does not, in fact, provide services totally free at the point of use. In fact, according to OECD data on health expenditure, Portugal has the highest level of out-of-pocket payments in Europe. Even if this data is an overestimation of the true level of out-of-pocket payments, individuals are bearing significant direct costs for their health care. Where such a high proportion of the burden of payment falls on the individual directly there are equity implications. Exemptions for low-income and other vulnerable groups have been introduced for some co-payments but the ability to access and obtain quality services may depend on the affordability of the user charges. Further research into the actual level of individual households' expenditure would be useful to measure the impact of user charges on equity in access to health services and on health status. The multiple systems of coverage which persist in Portugal cause inefficiencies such as duplication of services as well as a lack of overall cost control due to the open-ended state subsidies paid to some of the public sector health subsystems. One means of reducing the number of repeat tests, etc. is the development of a unified system of identification – "the user's card" – combined with a system of medical records, which is currently under consideration. This would facilitate improved coordination and transfer of in-formation between the different levels of provision and the different sectors. The user's card would also include information about cover and enable billing by the NHS of the health subsystems and private insurance schemes. A clearer separation of the systems, however, would be resisted by a number of interest groups – firstly, by those people who currently enjoy the additional benefits and greater freedom of choice offered by health subsystems; secondly, the medical professionals and other private operators who benefit financially from private consultations and the high utilization rates of private facilities. As in many other European countries, Portugal faces the problem of controlling expenditure growth on drugs and pharmaceuticals. The industrial lobby and the professional lobby are both very strong. The drug market is characterized in Portugal by freedom of prescription for doctors (outside the hospital inpatient setting), lax price controls on the drug companies and a monopoly position for the pharmacist who sells the drugs. Despite attempts by the government to regulate the sector, it remains largely limited to the quality and safety of drugs. Government regulation of pharmacists actually protects their monopoly position and the method of payment creates perverse incentives for the dispensing of more expensive products. Measures to control volume rather than price may be needed through the use of proxy demand measures which affect doctors' and pharmacists' behaviour. Regulation may also be re-quired to control the procurement and distribution of medical equipment in both the NHS and the private sector for which a system of technology assess-ment could provide the necessary information. The orientation of current reforms towards health gain, through the imple-mentation of the National Health Strategy, have increased the emphasis on service quality and increased patient satisfaction. The combination of salaried employment and the freedom to practice privately of most NHS doctors does not, however, provide real incentives to improve the quality of services within the NHS. Large numbers of patients bypass the system of referral within the NHS and go directly to specialists covered either through private insurance or health subsystems. In NHS hospitals stronger incentives are needed to increase the productivity of doctors and to restrict the hours of private practice in order to improve the service provided to NHS patients. However, a reversal of the 1993 reforms, which allowed full-time doctors to practice privately, would be strongly resisted by doctors. In Portugal the high levels of demand at hospital emergency departments, including many non-urgent cases, are indicative of poor service standards at health centres. Reforms to the payment of GPs, which would introduce capitation and target payments, have been piloted. In order to ensure basic levels of service for the general population such schemes should be extended. In addition an adequate supply of well-trained GPs must be guaranteed. The majority of Portuguese respondents (over 65%) in a recent European survey of public attitudes to health care expressed dissatisfaction with the way health care operates in Portugal. Only 16.4% of respondents expressed any satisfaction at all. This represents a fall from about 20% in the same survey conducted in 1996. This is perhaps indicative not of a poor quality of clinical services but of poor customer service standards such as long waiting times, under-investment in facilities and the low morale of staff

working in the health sector. It should be noted that other sources, such as the Health Interview Survey, 1995/1996, carried out at a national level, showed different results. Despite the increase in per capita spending in Portugal overall levels of satisfaction appear to have declined. Any inference from these results that the health care system has deteriorated would fail to acknowledge the likely changes in public expectations and the role of the media, which has, as in many other European countries, tended to highlight the “bad” cases. In an attempt to improve patient choice and to increase service quality, reforms initiated by legislation in 1990 and enacted in 1993 brought about a shift towards a greater role for the private sector. It recognized that the NHS was no longer to be seen as the main form of provision, but as one of several entities (both public and private) involved in the delivery of care. It also gave more purchasing autonomy to the enlarged regional health administrations (RHAs) through a process of devolution and combined responsibility for both hospitals and health centres, with a view to improving coordination. The implementation of these changes has been incremental with a gradual transition of hospital budgets from those based on historical and activity costs to contracts for services provided. Recent legislation (1999) allows for the establishment of local health systems which should further the goal of decentralized financial accountability. These local health systems are intended to have devolved decision-making powers for the allocation of health budgets between all health care provider organizations in a defined area. The intention of these reforms is to improve not only the efficiency of the NHS services but also to improve quality and patient choice. However, without adequate regulation of the private sector the benefits of better quality come at a price and may actually contribute to total expenditure growth. The introduction of a purchasing function for the RHAs needs time in order that the necessary capacities, both as purchasers and amongst public providers, can be developed. In addition the emphasis on needs-based purchasing cannot be realized without adequate information. In conclusion, the Portuguese health care system continues to experience incremental change. It is in a period of transition. Previous reforms have followed different directions. In the 1970s, reforms were focused on the introduction of comprehensive universal coverage with the establishment of the NHS. The end of the 1980s saw a shift towards individual responsibility and private initiative with the liberalization of the private sector and active encouragement of its development, culminating in the 1990 legislation which, however, was never fully implemented. Already by 1993 the enabling legislation reiterated public responsibility for health care but with the state acting as a purchaser rather than provider within a mixed economy of provision. The focus for the beginning of the next decade is on health outcomes as set out in the National Health Strategy (18). This new direction, if it is allowed to guide future developments, may result in the Portuguese health care system being more responsive to the health needs of the population. In conclusion, there are a number of challenges still facing Portugal which are to be addressed through structural health care reform, in line with official policy objectives. Firstly, the whole system is to be reoriented towards the attainment of health gains. Secondly, equity between citizens is to be improved, bearing in mind their needs and expectations. Finally, the efficient utilization of available resources is to be promoted.

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

Country profile: Spain

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	The Ministry of Health and Consumption prepares the Integrated Health Plan based on the plans of the Autonomous Communities' (AA.CC.'s), the combined State-AA.CC. plans and the State plans. Other Ministries with competence in the field of health care the Ministry of Defence and the Ministry of Justice		
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	The Departments of Health of those AA.CC.'s which are now responsible for integrating and managing their own health systems (Catalonia, Andalusia, Basque Country, Valencia, Galicia, Navarre and the Canaries), are independent of the central government health organisation, the so-called National Health Institute (INSALUD). This will eventually be the case for all AA.CC.'s. Below AA.CC-level the country is divided in 126 Health Areas and 2.488 Basic Health Zones.		
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			
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			
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			
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	The National Health System (Sistema Nacional de Salud) consists of seventeen regional health services. Legislation introduced in 1997 enables a proper separation of financing, purchasing and provider functions. Public provider organisations are able to become fully autonomous in a system of public financing and public and private provision. Thus public provider organisations may become independent legal entities with full autonomy in the management of their own resources ("gestion patrimonial").		
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			
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	The transfer of management responsibility to the AA.CC.'s constitutes devolution of authority from INSALUD to the AA.CC.'s. The intention is that this will eventually be the case for all AA.CC.'s Legislation from 1997 enabling the proper separation of financing, purchasing and provision and the establishment of directly managed organisations as legally independent entities constitutes a delegation of authority from INSALUD.		
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	The Ministry of Health & Consumption prepares annual integrated health plans based on AA.CC. plans, State-AA.CC. plans and State plans.		
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

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	The annual budget is established by the Ministry of Health & Consumption in co-operation with other Ministries. AA.CC.'s determine their own programme allocations but are obliged to provide services specified under the Social Security law. Transfer of central state health budgets to AA.CC.'s initially was based on cost of service. This will gradually change to financing based on the size of the covered population. Following the recommendations of the Abril Commission in 1991 the financing system began to move from one of retrospective allocations to prospective budgeting based on estimated activity using among other things measures of case mix. Annually budgets are allocated to hospitals based on prospective financing of estimated costs.		
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	Characteristic for the Spanish health care system is the integrated model.		
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	The NHS runs 25 % (198) of the hospitals; 19 % is managed by other public organisation and 56% is in private hands.		
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 may choose any general practitioner working in the health zone in which they live. Those living in cities of more than 250.000 inhabitants may choose any doctor practising in the city		
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	For access to secondary care patients must be referred by a general practitioner.		
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	Ambulatory care is traditionally highly developed in Spain.
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	
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	
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	
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	Ambulatory care is highly developed in Spain - the "sistema de cupo" facilitates access to specialists; many diagnostic techniques which in other countries more often done on an inpatient basis practised in an ambulatory setting in Spain that historically has had fewer beds. General policy is for care to be provided on an ambulatory basis wherever possible. Ambulatory services include: -outpatient consultations; -therapies such as dialysis; -radiotherapy; -rehabilitation; -diagnostic tests; -day hospitals; -ambulatory surgical units.
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	In Basic Health Zones primary care teams have been organised for work in health centres; 21.080 general practitioners and 4.752 paediatricians are connected with the National Health System (NHS). In the new model introduced in 1984 primary health care is provided by primary care teams working from health centres. These teams of health and non-health professionals are organised in basic health zones. They supply basic health services, home visits; preventive and health education activities; antenatal and postnatal care; basic diagnostic services; physiotherapy; and some oral health services. This model now covers 61% of the population. Important differences in implementation of this basic model in different AA.CC.
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	The General Health Law of 1986 introduced important changes in the organisation of secondary care: - Unification of separate networks of services in one health care system in each of the AA.CC.'s; - Integration of all secondary care (ambulatory and inpatient) on one level.		
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	Services are based on the hospital serving the health area. Services provided by the public health system are integrated .NHS contracts services from non-NHS hospitals where necessary. Because there are many private hospitals the systems reveals a mixture of integration and contract: Ownership of hospitals: Of the total of 787 hospitals the NHS owns 25% (198 hospitals), Other public entities 9% (149 hospitals) and Private is56% (440 hospitals). Of the total of 86 Psychiatric hospitals the NHS owns 9%, Other public entities 35% and Private is 56%. From the Geriatric and long stay hospitals the NHS owns 9%, Other public entities 25%, and Private is 66%.		
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			
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			
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	Governments of the AA.CC.'s and local authorities are mainly responsible for planning, control, funding and supply of social and health services. A large share of public long-term care services is currently financed by the AA.CC.'s. Local authorities also provide funding. The supply of services from for- profit and not-for-profit private organisations is increasing.		
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	Governments of the AA.CC.'s and local authorities are mainly responsible for planning, control, funding and supply of social and health services. A large share of public long-term care services is currently financed by the AA.CC.'s. Local authorities also provide funding. The supply of services from for- profit and not-for-profit private organisations is increasing.		
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			
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	The Civil Code specifies an alimony duty between relatives: 1) spouse, 2) descendants, 3) ascendants. Carers of frail elderly may receive that person's pension after their death		
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			
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			
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	The method of payment to specialist physicians is a mixture of integration and contract. Doctors working in public hospitals are salaried. Primary care doctors are salaried and work full-time in the new model. Those employed under the old model work as single-handed practitioners, part-time for the public health system, are not organised geographically and are paid on a capitation basis. 74% of public general practitioners work under the new model 26% under the old model. In the public sector: work 0,7 GPs per 1.000 inhabitants', in the private sector: 0,1 GPs per 1.000 inhabitants.		
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	The allocation of hospital budgets by AA.CC.'s. and INSALUD has been modified in recent years. Programme contracts ("contratos programas") between financing entities and hospitals have been developed. Therefore measures of hospital production have and are being developed. A Unit of Weighted Activity was developed by INSALUD in 1993. Subsequently some AA.CC.'s. have adapted this. The intention is that hospitals will gradually move from financing based on historic costs to prospective financing of agreed levels of activity. Rates are established by negotiation of programme contracts between financing entities and hospitals. Recent changes in payment method were introduced following the recommendations of the Abril Commission (1991).
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 national health system is considered to be tax-financed. Compulsory social security taxes are levied with a fixed contribution rate. State financing amounted to 77% in 1995. All residents are covered. In 1995 INSALUD covered 39% of the population and the Autonomous Communities 61% of the population. Statutory insurance schemes exist for civil servants and the armed forces, some of which are linked to the social security system and some of which are linked to private insurance organisations. Taxes contributed for 53.7% to the financing of health care and social insurance for 26.6%. Out-of-pocket expenses accounted for 19.7%
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	
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			
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			
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			
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	
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	The NHS does not finance: -plastic surgery not related to accidents, disease or congenital malformation; - psychoanalysis and hypnosis; -spa treatments and rest cures; -sex change surgery other than that necessary for the treatment of pathological intersexual conditions; - some drugs are excluded from social security financing schemes. Some differences occur between distinct special schemes within the public health system. E.g. co-payments for drugs vary. There is no co-payment for drugs in the occupational schemes.
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	
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	Private insurance companies offer especially free choice of doctor and access to specialists
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	Private insurance companies offer especially free choice of doctor and access to specialists
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	9% of the population have personal private insurance; 1,7% have private insurance cover contracted by their employer (1995). 8% of the adult population covered by the public health system also have private health insurance. Only 1,8% of the population are covered exclusively by private insurance.
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	Ambulatory care: no co-payment. Inpatient care: no co-payment. Drugs: actively employed contribute 40% (10% for some products to a limit of 400 Pesetas). Pensioners, temporarily disabled, hospitalised patients and over 65 year olds with insufficient means make no contribution. Active and retired civil servants contribute 30%. Toxic syndrome patients: 0%. AIDS patients: 10% to a limit of 439 Pesetas. Chronic treatments: 10% to a limit of 439 Pesetas. Medical aids and prosthesis: some contribution for acoustic and visual aids may be required. Prostheses and other equipment for physically disabled people: no contribution.
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 5.6% of GDP and in 1995 this was 7.3%. In 1995 public health expenditure was 78.7% of total health care expenditure or 5.7% of GDP (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	Public expenditure amounted to 78.7% of total health expenditure in1995. In-patient care had a share of 45.2% in total health care expenditure and pharmaceuticals had a share of 19.6% (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: Sweden

Code	1		
Description	Introduction and historical background		
Contents			
Source	European Observatory on Health Care Systems	**Year**	1996

Code	1.1		
Description	Introductory overview		
Contents	Sweden is situated in the eastern part of the Scandinavian peninsula. It covers an area of 449 964 square kilometres, with forests covering 58% of the land area. The capital is Stockholm, which is also the largest city. The country is unevenly populated, with a high concentration of inhabitants in the coastal regions and the south. 84% of the population live in urban areas. The population is about 9 million (1995). Swedes are the predominant ethnic group, constituting roughly 90% of the population. Other residents include people from Finland, South America, the Middle East, Asia and the Balkans. The main language is Swedish. 90% of the population belong to the Lutheran church. The educational system reaches the entire population resulting in a literacy rate of 99%. Living standards are among the highest in the world. Life expectancy is high, and infant mortality rates are among the lowest in the world. Sweden is a monarchy with a parliamentary form of government. The King is the head of state, but his position is only symbolic and power rests with the Parliament. The Parliament has 349 seats, 310 of which are directly elected and the rest are divided between political parties on the basis of votes received nationally. The Cabinet under the leadership of the Prime Minister carries executive power. Sweden has a mixed state and private economy, based to a large extent on services, heavy industries and international trade. Sweden's natural resources include forests, iron ore, copper, lead, zinc, silver, uranium and water power. The agricultural sector accounts for less than 5% of GNP. Heavy industries dominate the manufacturing sector, and include motor vehicles, machinery and ships. About half of industrial output is exported. Exports amount to about 30% of GNP. There are three different levels of taxation: government, county and municipality. On average a Swede pays most of his or her taxes to the municipality in which she or he lives. It is the state's obligation to provide good health and other social services to all residents of Sweden. An advanced and extensive system of social security provides universal benefits for sickness, maternity and unemployment, children, the elderly and disabled. Health care is both publicly provided and financed. The country is divided into 26 county councils which are mainly responsible for financing and provision of health care.		
Source	European Observatory on Health Care Systems	**Year**	1996

Code	1.2
Description	Historical background
Contents	The roots of Sweden's present health care system go back several hundred years. As early as the beginning of the 17th century, towns and cities employed physicians to provide public primary care. The central government employed physicians for the provision of primary care in the provinces. Sweden's first hospital, the Serafimerhospital, was set up in Stockholm in 1752. Its 8 beds were supposed to meet hospital care needs for the whole population of Sweden and Finland (at the time ruled by Sweden). Since then, the provision of hospital and other health care has been predominantly a public responsibility. In 1765 the "Diet of the four Estates" paved the way for a number of hospitals to be established by permitting locally collected resources to be spent locally if the authorities intended to use it for building a hospital. One hundred years later, there were 50 hospitals with a total of approximately 3000 beds. Most of these were small, with only 10–30 beds. They initially had only one physician each and they provided no out-patient care. Most health care services were provided by physicians outside hospitals. By 1860 Sweden had 472 physicians, but only 53 worked in somatic hospitals and 9 in mental hospitals. Public provision has always accounted for a large proportion of total health care provision. Initially, the central government was responsible for this and administration was carried out by the Collegium Medicum. In 1813, the Sundhetscollegium took over, in 1878 this body became the Royal Medical Board which in 1968 was transformed into the National Board of Health and Welfare, the body which is still responsible for supervision of health and social services. In 1862, county council administrative units were established, as a secondary level of local government and were given the power to levy taxes on their residents. Health care become one of their principal duties. This marked the beginning of the present structure of the Swedish health care system, which is characterised by a strong degree of decentralization. However, health care responsibilities were transferred from central government to the county councils over a long period of time. In the 1860s, only acute-care somatic hospitals had their ownership transferred from the central to the county council level. The central government still maintained a significant measure of control. Hospital physicians (and others) were appointed by the King-in-Council, and the Sundhetscollegium maintained surveillance of hospital functions. With the Hospital Act of 1928, county councils became legally responsible for providing hospital care to their residents. Initially the Act excluded a number of key responsibilities such as out-patient care, the treatment of mental patients, epileptics and provision of long term care. During the 1930s, county councils successively took responsibility for the provision of various non-hospital health care services, such as the services of district nurses and midwives, maternity and paediatric health care and child dental care. In 1948 the county councils were obligated to provide out-patient care, in 1951 long term care, and in 1967 mental care. At the end of the 1930s fewer than one in three physicians held a hospital post. Ambulatory care was offered primarily by private practitioners, in their own offices or in the hospital. In 1946 a National Health Insurance Act was passed by Parliament, and implemented in 1955. This was an important step toward universal coverage, providing for physician consultations, prescription drugs, and sickness compensation. A considerable expansion of the health sector took place following the second world war and continued throughout the 1960s and 1970s. In particular, this involved the hospital sector and at the time the Swedish health care delivery system became more hospital-based. At this time there was also further transfer of responsibilities to the county councils. In 1970, as part of the "seven-crown reform", out-patient services in public hospitals were taken over by the county councils. Patients were asked to pay seven crowns to the county council for each out-patient consultation and the county council was compensated directly by the health insurance authority for the remainder of the cost. The considerably reduced fee incurred by the patient made health care more accessible to low-income groups. The reform also meant that physicians in hospital out-patient departments became salaried employees of the county councils. At the same time hospital physicians were no longer allowed to treat private out-patients in county council facilities. In 1971, the retail drug distribution industry was nationalized, and reorganised into a state-owned company called the National Corporation of Pharmacies. During the 1980s, in accordance with the constitutional reform of 1974, responsibility for all health care was decentralized to the county councils. Both university hospitals (the Karolinska Hospital of Stockholm and the Academic Hospital of Uppsala) also passed from State to county council ownership in the early 1980s. Since 1980 public vaccination programmes have also been the responsibility of county councils. The overall objective of the public health services was stated, in the 1982 Health Care Act, to be the provision of "good health care on equal terms for the entire population". The Act gave the county councils full responsibility for health delivery related matters, i.e., they were to be

	responsible for health promotion and disease prevention in addition to providing health care for their residents. In 1985, the Dagmar Reform, was introduced, which changed the basis of health insurance reimbursement for ambulatory care to the number of inhabitants and specific social criteria of the counties. This was to be paid directly to county councils. In 1988 the national parliament prohibited the county councils and municipalities from increasing their tax-rates between 1990 and 1994. This led to increased interest in improving health service productivity and efficiency. The county councils were fully responsible for the financing and provision of health care between 1983 and 1992. In 1992, a major change was introduced through the ÄDEL-reform, whereby the responsibility for long term inpatient health care and social welfare services to disabled individuals and to the elderly became the responsibility of local municipalities. As a result of this reform, one fifth of total county council health care expenditure was transferred to the municipalities. The central government also made it possible for the municipalities, subject to agreement with their corresponding county councils, to temporarily (for five years) assume county council responsibilities for primary care on an experimental basis. In 1995, municipalities became responsible for the care of those suffering from long-term mental illnesses (the "psychiatric" reform).
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 Swedish health care system is a regionally based, publicly operated national health service. It is organised on three levels: national, regional and local. The county councils, on the regional level, together with the central government, are the basis of the health care system. Overall responsibility for the health care sector lies at the national level, with the Ministry of Health and Social Affairs. National level The principal responsibility of the central government of Sweden is to ensure that the health care system runs efficiently and according to its fundamental objectives. This is the responsibility of the Ministry of Health and Social Affairs. It prepares Cabinet business and deals with policy matters and legislation in health care, social welfare services and health insurance. It allocates financial assistance and acts as a supervisor of the activities in the county councils. The government may legislate on temporary ceilings on county council and local municipality tax rates. The National Board of Health and Welfare has a supervisory function over the county councils as it acts as the government's central advisory and supervisory agency for health and social services. The Board supervises implementation of public policy matters and legislation in health care and social welfare services. Its role includes supervising, monitoring and evaluating developments in all areas of social policy. Its most important duty is to follow-up and evaluate the services provided to see if they correspond to the goals laid down by the central government. All health care personnel come under the supervision of the Board of Health and Welfare. The function of supervision of personnel within the county councils is based on The Supervision of Health and Medical Personnel Act of 1980. The Ministry of Health and the National Medical Disciplinary Board decide on disciplinary measures in the event of complaints or possible malpractice. If responsibility for misconduct lies with health care personnel, the matter is handled by the National Medical Disciplinary Board. The Board acts on reports from The National Board of Health and Welfare, the patient, or relatives of the patient. The Board may limit or withdraw the right of practice of a health care professional. In addition there are central government bodies associated with the Ministry of Health and the National Board of Welfare. One of the most important is the Swedish Council on Technology Assessment in Health Care (SBU), whose principal objective is to promote the use of cost-effective health care technologies. It reviews and evaluates the impact of both new and existing technology from medical, social and ethical perspectives. Information on results is disseminated to central and local government officials and medical staff to provide basic data for decision-making purposes. Another government body is Spri (The Swedish Institute for Development of Health Services), which works on planning and efficiency measures. The Institute works with health statistics, health quality and health economics. Spri is jointly owned by the central government and the county councils. The National Corporation of Swedish Pharmacies is a state monopoly which owns all pharmacies and thereby maintains a countrywide distribution system. It operates community pharmacies and hospital pharmacies under one year contracts with the county councils. Besides this, the National Corporation of Swedish Pharmacies is responsible for providing fact sheets and other information about drugs to the public and to physicians. The Medical Products Agency is a central government agency whose principle task is to control pharmaceutical preparations. All drugs sold in Sweden must be approved and registered by the Agency. The National Social Insurance Board handles national social health insurance, and acts as a supervisor for the local insurance offices. The Board administers the social insurance system and sees that it runs efficiently. The national public drug system and health insurance system are strongly linked to health care, prescription of drugs and prescription of sick-leave. The Federation of County Councils is a collaborative national interest organisation for the 23 county councils and three municipalities, Gotland, Gothenburg and Malmoe. The Federation is directed by a politically elected board. The main task of the Federation is to look after the mutual interests of its members, to assist them in their activities and to keep informed about matters of concern to the county councils. The Federation represents the county councils in all major policy matters in contacts with the central government and personnel organisations. It also works as the employers' central association for negotiating wages and terms of employment of the personnel employed by the county councils. The federation is not subordinated to the central government or any of its administrative agencies. Political

representatives meet monthly to discuss health policy issues and important economic questions. The Federation finances activities through member fees.

The corresponding national level body for municipalities is the Swedish Association for Local Authorities, forming an organisation for the 288 municipalities. The tasks of the Association are to promote and develop local self government, to safeguard local government interests, to promote co-operation between local authorities and to provide local authorities with expert assistance. The Association is financed in part by membership fees paid by Sweden's local authorities. Fee levels are determined on the basis of the number of residents in a given local authority area and the local authority's financial position. Additional financing – roughly half – comes from charges for services purchased from the local authorities.

Source	European Observatory on Health Care Systems	***Year***	1996

Code	2.2
Description	Regional government
Contents	Regional level Public responsibility for health care belongs to the county councils, whose members are elected every fourth year concurrently with national and local municipal elections. The council members mainly represent the same political parties as in the National Parliament. As of today, there are 23 county councils. Three large municipalities (Gotland, Gothenburg and Malmo) have chosen not to belong to any county council and therefore have the same health care responsibilities as the county councils. A county council is an independent regional government body, which, like a local municipality, has the right to levy a proportional income tax on its residents. The population in the county councils ranges from some 250 000 to 1.7 million. Within each county council there are usually several health care districts, each with the overall responsibility for the health of the population in its area. Some of the county councils' income is received from the state and national insurance system, but two-thirds of their income is generated through county council taxes. The county councils are in charge of the health care delivery system from primary care to hospital care, including public health and preventive care. The county councils have overall authority over the hospital structure and are responsible for all health care services. Usually, the local parliament elects a political board that chooses its own executive and administrative organisation. It is the executive staff that ensures that health care delivery runs efficiently at the hospital. The hospital boards may choose entirely on their own how they want to organise their management as long as they fulfil their obligations concerning health care delivery. There are no guidelines or directions regarding the organizational structure of county councils. They are free to choose whatever structure they consider suitable, corresponding to their responsibilities. Local self-government has a long tradition in Sweden. The county council is the organ of local independence over county services. In administrative terms, county councils have the character of independent secondary level local governments. Their authority shall not, however, intrude upon the municipalities' constitutional rights and powers. In January 1984, the 23 county councils and three municipalities were grouped into six medical care regions: the Stockholm Region, the South Eastern Region, the Southern Region, the Western Region, the Uppsala-Örebro Region and the Northern Region. The rationale for establishing these regions has been to facilitate co-operation between the county councils and the three municipalities in highly specialized treatment (tertiary care). Top clinical hospitals are, by agreement, organised at the level of the six regions and run individually by the county councils. Each of the regions serves a population averaging more than a million. There is no large administrative structure associated with the six regions. Instead, small regional offices have been established to deal with matters related to the financing and production of tertiary care. In these six regions there are a total of nine regional hospitals which are highly specialized. With the exception of Örebro, they are also affiliated to medical schools and function as research and teaching hospitals. The regional hospitals provide secondary care to the population in their respective county councils, in addition to highly specialized tertiary care. The 1982 Health Care Act requires the county councils to promote the health of their residents and to offer equal access to health care. They are also required to plan the development and organisation of health care with reference to the needs of the population. The general authorities and responsibilities given to the county councils are stated in the Local Government Act. The most important special authorities and responsibilities given to the county councils are stated in the Health Care Act. The overall responsibility is stated in Paragraph 3: "Every county council shall offer good health and medical services to persons living within its boundaries. In other respects too, the county council shall endeavour to promote the health of all residents". The county councils are generally organised into geographical health care districts, each managed by their own political board. A district usually comprises one hospital and several primary health care units. Within these districts the primary health care services are often subdivided further into geographic primary health care districts. A primary health care district is usually the same geographical area as the local municipality, although larger cities correspond to more than one health care district. The county councils have the authority to negotiate the establishment of new private practices and the number of patients they can see during a year. Since the private provider must have an agreement with the county council in order to be reimbursed by social insurance, the county councils are able to regulate the private health care market. If the private provider does not have any agreement or if the private provider does not use the regulated fee schedule, a private patient will have to pay the full charge to the provider. Private health care is quite

	limited, with only about 8% of physicians working full time in private practice. It is mainly in the larger cities that private practices are common.
Source	European Observatory on Health Care Systems ***Year*** 1996

Code	2.3
Description	Local government
Contents	Local level At the local level, Sweden has 288 municipalities which also have their own areas of responsibility. The municipalities are not subordinated or accountable to the county councils. Like the county councils, the municipalities are governed by local councils elected every fourth year and also have the right to levy taxes on their population. The traditional organisation of the municipalities involves a Municipal Executive Board, a Municipal Council and several local government committees. The Municipal Executive Board leads and co-ordinates all the Municipal's business and acts as a supervisor for the committees. The Board is responsible to the Council for following up matters that could possibly influence the development and economy of the municipality. The Municipal Council decides on the goals and budgets of all community-run businesses. It is also its duty to make decisions about taxes and on the organisation and tasks of committees. The municipalities are responsible for social welfare services, child care, care of elderly, disabled persons and long term psychiatric patients, care of environmental hygiene and for school health services. In 1992, municipalities took over the responsibilities of the care of elderly and disabled from the county councils (the ÄDEL-reform). As a result they now operate public nursing homes and home care. In a similar way on 1 January 1995 they also took over responsibility for the care of those suffering from long-term mental illnesses including their living conditions, employment and support.
Source	European Observatory on Health Care Systems ***Year*** 1996

Code	2.4
Description	Insurance organisations
Contents	
Source	European Observatory on Health Care Systems ***Year*** 1996

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

Code	2.7		
Description	Voluntary bodies		
Contents			
Source	European Observatory on Health Care Systems	***Year***	1996

Code	3		
Description	Planning, regulation and management		
Contents			
Source	European Observatory on Health Care Systems	***Year***	1996

Code	3.1
Description	Extent of system decentralisation (deconcentration, devolution, delegation, privatisation)
Contents	Decentralization of the health care system Decentralization is a key concept associated with the development of the organisation and management of the Swedish health care system. Except for some national policy development, legislation and supervision, the responsibility for health care is devolved to local governments. Responsibility for financing and providing health services has been devolved to the county councils, while responsibility for financing and delivering long term care for the elderly, the disabled and long term psychiatric patients has been devolved to local municipalities. The county councils and local municipalities enjoy a considerable degree of autonomy in relation to the central government and the local municipalities in turn are not, however, subordinated or accountable to the county councils. Each are governed by locally elected councils. The laws on health care and social services allow the county councils and municipalities to impose taxes to finance their activities. Sweden's health care system is also characterised by decentralization within each county council. Since the 1970s, this has applied to financial responsibilities within each county council. The degree of decentralization, organisation and management varies substantially between county councils, therefore a full account of planning, management and organisation reforms would require county specific descriptions. A summarised description of the decentralization of Swedish health care responsibilities since the 1970s is given below. By the end of the 1970s it was evident that county council revenues would not continue to increase at the same pace as earlier; cost containment therefore became an important issue. The expansion and differentiation of the health sector had furthermore made it difficult to plan and manage the provision of health services by detailed central county long-term plans. Incentives that would increase productivity and efficiency became important elements in the future development of planning and management systems. Generally, several local health care districts within each county council were formed, each with an overall political responsibility for the health of the residents of this area. In a decentralization reform of the 1980s, the county councils, at a different implementation pace, decentralized financial responsibility for health care activities by introducing global budgets; the districts became responsible for resource allocation within the districts. Central county councils managed the districts by allocating the budget among the districts. Many districts, most of which managed a hospital and several primary health care centres, started to practice the same principles of global budgeting within the district; financial responsibility was decentralized to hospital and departmental and primary health care centre levels. The professional heads of departments were cost responsible for their activities. This meant a shift of focus with respect to planning of health services from politicians to professionals. The introduction of global budgeting and cost centres were not, however, considered enough. The system performed well with respect to cost containment, but productivity was still considered low. In the late 1980s, systems of transfer pricing began to replace cost centre management; health service providers were to be reimbursed through prospective per case payments instead of through activity budgets. The decentralization of financial responsibility is since then a trend, even though the pace of introduction varies both across county councils and specialities. By the end of the 1980s, 20 out of 26 county councils planned to reimburse general and medical ancillary departments with per case payments, and to establish a total cost responsibility at direct patient care departments. Free services were to be abolished. Again, the pace of introduction varied. In 1992, for example, 40% of the hospital clinical chemistry laboratories and 20% of the hospital radiology departments were managed as profit centres. Profit centre management was more common in densely populated regions than in scarcely populated regions, and more common at large hospitals than at small ones. Profit centre management has in the 1990s also been introduced in direct patient care departments. This is, however, more difficult to achieve; much work has in the late 1980s and early 1990s been focused on establishing product systems for direct patient care departments. DRGs have so far been one of the most common product classification systems with respect to in-patient somatic care. Where this has been implemented, districts, or special purchasing organisations, reimburse the hospitals prospectively per case based on product descriptions. In the area of privatisation of health services, there has not been much activity. Some county councils, for example, Stockholm, have privatised as many general ancillary services as possible, however most county councils, have not undertaken much privatisation. Again, it should be emphasised that variations in strategies and policies exist between county councils. All in all, not many health service activities have been privatised and most health care services are still provided by facilities owned by county councils.

Several problems have emerged in connection with the decentralization of financial responsibility. There is a lack of experience in managing units through transfer pricing, product descriptions are difficult to achieve in health services, and the accounting system is not sufficiently developed to support a decentralized management system as it was designed to support a county level centrally planned management system. Furthermore, there are some indications that cost and revenue responsibility is not always adequately followed through by the corresponding authority; districts and departments in some cases report that they have cost responsibilities for activities they cannot control.

Source	European Observatory on Health Care Systems	***Year***	1996

Code	3.2
Description	Existence of national health planning agency/plan
Contents	Planning and management Sweden's approach to health care planning and management is currently in a state of change. The traditional planning approach, which had been based on the command-and-control model, with an emphasis on allocative planning and prioritisation, was appropriate to serve the needs of the system during a period of growth and expanding infrastructure. During the more recent period of retrenchment, however, there has been a growing awareness on both the national and county levels, that allocative planning approaches may be less adequate. During the 1970s, health care planning was pursued through long term plans, drawn up following the yearly budgeting process. Normative standards were applied, such as the number of beds per capita. Changes in sickness profiles and illness inequalities between different socio-economic groups were not connected to the principle plans. During the 1980s there were several developments marking the beginning of significant changes in approaches to planning of health care services as well as the focus of health planning. The planning perspective of medical specialists was replaced by the principle of planning based on the needs of the residents. Needs were to be determined through epidemiological studies undertaken locally, regionally and nationally. Along with the needs-focused orientation to health care planning, there emerged a growing interest in public health issues. Cross sectional strategies were initiated both nationally and locally. Preventive health services were emphasised, and the scope of health planning encompassed not only health services but also social services. The 1982 Health Care Act was an important landmark for several reasons. It completed the successive process of transfer of responsibility for all health services provision from the national level to the county council level; it formalized the needs-based approach to health care planning; it made county councils responsible for preventive care and health promotion; and it constituted the framework for health planning and health activities. The official goals with respect to health care are stated as follows in the Act: The fundamental objectives of health care in Sweden are good health and health care on equal terms for the entire population (Paragraph 2, Swedish Health Care Act of 1982). The Act requires the county councils to promote the health of their residents and to offer equal access to health care. The county councils should plan the development and organisation of health care with reference to the need of the residents. Planning responsibility also includes health services supplied by other providers such as private practitioners and physicians in occupational medicine. The Dagmar Reform of 1985 reinforced the responsibility of county councils for health services provision, as well as the needs-based orientation of planning. This reform, intended to consolidate county councils' planning authority over ambulatory care visits to physicians, changed the way that the social insurance fund reimbursed private ambulatory providers. Previously, social insurance reimbursements were made directly to private providers on a fee-for-service basis. Through the Dagmar Reform the county councils were made cost liable; they had the authority to approve which private practices should be reimbursed by national insurance as well as the number of patients the practices could see per year. The payments were in practice still made from the national insurance to the private practices. However, payments were balanced according to a fixed capitation-based budget for each county council. If the national insurance payments exceeded the fixed capitation budget, the county counsils had to balance the expenditures. County councils' planning capacity was thereby strengthened, as they could now plan annual budgets for primary care services (publicly and privately provided), using also demographic criteria. Since the 1980s, the county councils have therefore played a significant role in health care planning. Central government's role has generally been limited to setting overall goals and guidelines, legislation and supervision of activities. At the county council level, the planning of health care is the responsibility of political boards. The county councils are divided into several health care districts, each with a political board of its own. The districts are often geographically based, usually comprising one hospital and several health centres. This means that the hospitals in practice are formally managed by district politicians through district boards. Hospital managers are, however, like all of the administrative staff, civil servants. Despite the above changes, however, the resulting planning approach was still fundamentally consistent with the traditional emphasis on allocative planning mechanisms. The focus of planning on need did not affect the structure of health care supply. Structural issues were still discussed and planned through the same planning mechanisms as in the 1970s. Furthermore, cost containment had become an important planning issue in the 1980s. It became evident by the end of the 1980s, that productivity development in the Swedish health care sector was low

compared to other sectors. The county councils could no longer finance increasing costs through increased county council tax revenues. The issue of promoting productivity increases and efficiency were now important planning factors for the county councils. Furthermore, patients' preferences were considered to have been neglected in the past.

Developments in the 1990s have been in the direction of planned markets. A number of county councils have introduced management systems in which specific purchaser functions have been established and separated from the provider functions. The purchasers – public administrators of the health care system – represent the patients and purchase health services on their behalf from public and/or private providers.

Efforts to introduce planned market elements in the public health care sector have been far more widespread than contracting out of services. By 1994, 14 out of 26 county councils had established separate purchasing functions. The organisation and working methods of purchasers vary widely across county councils. Some have focused on promoting public health, collaboration with social services and regional social insurance offices. The needs of the residents have been an important starting point in their work. Others have focused on price and volume negotiations with different providers. The demand for health services has then been a more important starting point than the need of the residents. It is important to note that all purchasers have been established within the framework of the county councils and as providers are here also publicly owned, there is an artificial contract model within an integrated system. A more detailed description of the role of purchasers will be provided in a later section.

Key elements characterising the planned market approach to planning and management include greater patient choice over provider, such that the patient increasingly comes to influence the conditions under which he or she receives care; and efforts to translate increased patient choice into more cost-effective service delivery through the design of appropriate budgetary systems. Reimbursement contracts are often complemented with volume or cost ceilings, promoting some possibilities to manage total costs. Even those county councils that have not introduced purchaser functions and/or profit centres at any level, are in the 1990s developing a more market oriented health sector. The national ÄDEL reform of 1992, shifting the responsibility for health care of the elderly and disabled from county councils to local municipalities, resulted in new contractual arrangements between local municipalities and county councils: local municipalities have to reimburse the county council if they cannot provide a place in a nursing home for elderly patients that were considered fully treated at the hospital by the hospital doctor, and were ready to be discharged. Furthermore, the increased possibilities for patients to choose health care provider also means that reimbursement tends to follow the patient's choices. County councils thus have to pay for services provided to their residents by another county council. The same reimbursement principles apply within county councils between districts.

The planning and management of health services before 1980, the 1980s and 1990s can be summarised as follows. In the period before 1980 the prevailing planning and management ideology was focused on judgements and demands by the medical profession's representatives. In the 1980s focus shifted towards public health based planning and management including budget allocations according to needs of the residents. In the 1990s, there has been a shift toward planned market solutions to health care planning and management.

Source	European Observatory on Health Care Systems	***Year***	1996

Code	3.3
Description	Supervision of the health services
Contents	Regulation An important role for the central government is to establish basic principles for health services through legislation and recommendations. The most important of these is the Health Care Act of 1982. Other laws regulate the responsibilities and obligations of personnel, confidentiality, the qualifications needed to be able to practice medicine and rules on handling patient records. The Ministry of Social Affairs is responsible for developments in health care, social insurance and social services. The Ministry draws up terms of reference for government commissions, presents proposals for Parliament on new legislation and prepares government regulations. The National Board of Health and Welfare is the government's central advisory and supervisory authority in health and social services; its mission is to follow up and evaluate services provided and to ensure that services are in accordance with central government goals. Regulations produced by the National Board of Health and Welfare state that regular, systematic and documented work should be conducted to ensure quality of care. All staff are furthermore formally obliged to participate in quality assurance programmes, although the extent of active participation is in practice still modest. The National Board of Health and Welfare is also the licensing authority for physicians, dentists and other health service staff. If a patient suffers an injury or disease in connection with medical treatment, or is exposed to the risk of suffering an injury or disease because of the treatment, the provider is obliged to report the incident to the National Board of Health and Welfare. Should faults or negligence in the treatment be attributable to members of staff, the incident can be referred to the National Medical Disciplinary Board. Referrals to this board can also be addressed by patients or patients' relatives. The National Medical Disciplinary Board cannot, however, act on its own initiative. The Board is a separate authority with an organisation somewhat similar to that of a court and can decide on disciplinary measures. Claims for financial compensation for a patient who has suffered an injury are covered by the so called patients' insurance and not by the Board. Since 1995, every institution providing health services has a legal obligation to provide compensation for injuries which have occurred in the course of provision of these services. The institutions are insured to meet demands for compensation from patients. The Medical Products Agency is the government agency that decides on registration of new drugs. The activities of this agency are regulated by a law governing medical products which has been adapted to EU regulations. The supply of pharmaceutical products is the responsibility of The National Corporation of Swedish Pharmacies. The Drug Act of 1993 constitutes the basis for all activities connected with pharmaceuticals and drug distribution in Sweden. The Act on Retail Trade in Drugs is a special law that gives the state the exclusive right to conduct retail trade in drugs; the government decides by who, and on what terms, retail trade in drugs may be conducted. Through an agreement with the National Corporation of Swedish Pharmacies, the state has assigned to this body its exclusive right to retail trade in drugs. The agreement states that The National Corporation of Swedish Pharmacies is responsible for ensuring pharmaceutical supply at uniform prices throughout the country and at the lowest possible cost to both individual consumers and to society. Annual contracts with the county councils and local municipalities require the National Corporation of Swedish Pharmacies to stock drugs approved by the Swedish Medical Products Agency that have been prescribed by qualified physicians. Since 1993, the National Social Insurance Board has negotiated the prices of medical products with pharmaceutical companies. Patient fees for drugs are charged according to the law on reimbursed drugs. The government sets the patient fees for drugs reimbursed by the National Sickness Insurance, i.e., drugs included in the National Drug Benefit Scheme. The list of drugs included only covers out-patient treatment drugs and is established by the Ministry of Health and Social Affairs. Another central government regulatory power is the determination of the per diem fee level that local municipalities must pay to county councils for fully treated disabled and elderly patients according to the ÄDEL reform and for fully treated long term psychiatric patients according to the "Psychiatric reform". The county councils are through The Health Care Act responsible for the provision and financing of health services. They regulate the private practitioners' market in the sense that by approving establishments they also authorise reimbursement of the practitioner by the National Social Insurance Board. They cannot, however, stop a practitioner from establishing a practice; their regulatory power is restricted to financial control systems. Quality

The maintenance of a high level of quality in the health care system and continuous efforts toward quality improvements have been issues of major interest in Sweden over a long period of time. At the present time, resources are limited and it is believed that it is important to demonstrate quality in the services provided. Quality committees at management levels are working to produce systems to develop and improve quality. Sometimes special officers are responsible for quality. In 1994, the National Board of Health and Welfare produced a new regulation, according to which regular, systematic and documented work to ensure quality shall take place in the health services. Health care workers are obliged to integrate continuous and methodical quality assurance activities into their daily routines. The patient's needs are often the decisive factor when the objectives for these programmes are established. The federation of County Councils has taken initiatives to support the county councils in their participation. Several county councils have established quality committees or assigned a special quality assurance manager to support the hospital and the health centres in developing systems for quality assurance and continuous quality improvement. Some county councils also have a special budget for quality improvement activities. In hospitals, quality committees at management levels are becoming common. Health care staff meet in order to continuously observe their performance and seek possibilities for improvement. In the case of estimates of patient satisfaction, hospitals and health centres sometimes perform investigations of various kinds, for example, telephone interviews and questionnaires. The professional part of quality control is related to supervision and evaluation of clinical work. The Swedish Medical Association, for example, has introduced a programme for quality assessment in different specialities. In 1991–92 the Swedish Society for General Medicine initiated a national working group for quality assurance. Most of the work is being done in practices locally or regionally. Interest in quality assurance among politicians within the county councils has grown during the last few years, focusing mainly on access to health care services and continuity in careSwedish health care legislation provides for the protection of the patient's integrity. Health personnel are obliged to inform a patient about his state of health and the available types of diagnostic procedures and treatment. The patient's identity is protected in various registers. The county councils are required to organise in their areas one or more regional boards of trustees. These trustees facilitate the contacts between the patients and the health personnel, and supply patients with any help needed.

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 The size of the overall health care budget in Sweden is determined by tax revenues, patient out-of-pocket payments, reimbursements from the National Social Insurance Board, and state grants. The county councils' total health care budget is determined by income tax revenues, state grants, patient fees and reimbursements from other third party payers for treatment of patients who do not belong to the county council in question. The following figure describes the financial flows within the health care system (excluding care of the elderly and disabled). Since the financial and political responsibility for health care is decentralized to the county councils, it is difficult to exactly connect the financing sources with different activities within the county councils. The reason for this is that most county council activities are financed through county tax revenues and the county councils have responsibility for other activities as well, besides health care. The total costs for the county councils were in 1994, SEK 118 billion; 55% were costs for highly specialized (tertiary) regional care and county (secondary) care, 15% were costs for primary health care and 4% were costs for dental care. Three per cent were costs for central administration and 23% were costs for activities other than health care, e.g., education and cultural activities and care of mentally retarded. The county councils finance their activities mainly through county taxes and general state grants, 72% and 9% of total income respectively. These resources are not earmarked for special activities. An additional 2% of county council income comes from specially designated state grants for such items as clinical training and research. Patient fees for in- and out-patient health services account for 2.2% of total county council income, 1.3% represents patient fees for public dental care, and 6.2% are reimbursements from other county councils and local municipalities. The National Social Insurance System reimbursements to the county councils are made within the so called DAGMAR reform, and involve reimbursements for ambulatory care provided by the county council or by private practitioners connected to a regional insurance office. The allocation between county councils is determined according to criteria of need. The allocation formula considers differences in mortality, sickness leave, premature retirements and elderly people living on their own. The National Social Insurance System also reimburses the county councils for dental care and travelling costs because of sickness, rehabilitation activities, etc. The total grants and reimbursements from the state to the county councils were in 1994, 11.2% of total county council income, with 5.9% consisting of a tax equalization grant, i.e., more is allocated per resident to those county councils that have relatively low tax revenues per resident. The model for allocating the state tax equalization grant is under consideration by a parliamentary committee. A suggestion for a revised model according to need, based on expected remaining life years among individuals and socio-economic factors, was suggested in an official report in 1994. No official decisions have been made, however. Most resource allocation decisions regarding health services are political decisions made by county councils. However, by tradition, central government and the county councils collaborate extensively on planning and resource allocation regarding highly specialized regional (tertiary) health services and certain investments in high technology. According to the Health Care Act the central government decides on the grouping of county councils into health care regions. The Act also states that county councils should collaborate within these regions with respect to highly specialized health care. The collaboration on specialized hospital care and the existence of grants means that it is difficult to make a clear distinction regarding resource allocation responsibilities between the central governments and the county councils.
Source	European Observatory on Health Care Systems — ***Year*** 1996

Code	3.4.2
Description	Determination of overall health budget
Contents	
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	Health care delivery system Primary health care and public health services Primary health care is mainly publicly provided. Primary care services deliver both first-level curative as well as preventive care through public primary care centres. As of today, Sweden has 950 health centres, each of which provides services to 20 000–50 000 inhabitants. The health centres are administered by the county councils. The aim of the primary care level is to improve the general health of the people and to treat diseases and injuries which do not require hospitalisation. Patients attend physician consultations by appointment, but most health centres give the patient the opportunity to come during certain hours in the day without an appointment. District physicians provide treatment, advice and prevention. Primary care services also include clinics for children, vaccinations, maternity controls, health checks and consultations as well as certain types of treatment. Others directly employed at this level are nurses, midwives, physiotherapists and gynaecologists, who also are a part of the health centres. The personnel's work in health centres is organised such that co-operation between different professional categories is facilitated. District nurses have a special role as many first contacts with the health care system are their responsibility. It is the health centre nurses that do the first intake of patients, and if necessary direct them to the health centre's GP or refer them to the hospital. They also make home visits, especially to the elderly. Medical treatment, advice and support are given by district nurses both at clinics and when visiting patients in their homes. However, they do not have independent responsibility; they act under the physicians' advice. District nurses also have the right to prescribe certain pharmaceuticals and midwives to prescribe contraceptives. In January 1994, a new law was introduced, changing the structure in the work of physicians in primary care. According to the law every resident in Sweden would have had the right to choose their own family physician. However, the law was withdrawn and the county councils can use the family physician system if they wish, but they will not be forced to introduce it. Still, all residents shall have the right to choose a continuous physician contact in primary health care. The Family Doctor Act resulted in increased privatisation of primary health care services, as some GPs that were employed by the county councils saw in this Act an opportunity to start a business of their own with public funding.
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			
Source	European Observatory on Health Care Systems	***Year***	1996

Code	4.4		
Description	Freedom of choice		
Contents	Freedom of choice During the 1980s and particularly the 1990s, patients have been given considerable possibilities to choose between health care providers. Freedom of choice gives the patient the right to choose a primary health centre or hospital within the same level of care. However, patients cannot always make choices about care on higher levels of referral. In the majority of the county councils it is possible to choose which hospital the patient wishes to use. One method available to the county councils to influence the decisions of patients is to differentiate the fees patients have to pay for the services. If a patient wishes to receive medical care at a hospital outside the county council in which he or she resides, a referral may be required. In inpatient care, the patient has the right to choose a department for treatment or surgery outside or inside the county councils. Certain special rules apply when a patient chooses a hospital outside the county council boundaries.		
Source	European Observatory on Health Care Systems	***Year***	1996

Code	4.5		
Description	Referral system		
Contents	The GP is not necessarily the first contact for patients with health problems, nor does she or he have a role as gatekeeper to other levels of care. Despite this, the GP often provides first contact services especially for the adult and elderly populations with mainly physical health problems. People with mental health problems, especially relationship or sexual problems, usually apply directly to psychiatric services. In many cases the GP is the first contact for children, although this function is shared with paediatricians or the district nurse. Intake of women with specific female health problems is mostly a function delivered by obstetricians, gynaecologists or the district nurse within the health centre. When the medical resources available at the primary care level are insufficient for a specific patient, the patient may be transferred to county or regional care. The referral process varies from place to place. Usually, the GP makes an appointment with a specialist, a diagnostic centre, laboratory or a hospital, or the patient makes the appointment with a referral letter. Some GPs refer patients for diagnosis and treatment, and others only for consultation.		
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	As noted above, GPs do not have a monopoly of primary health care. People seeking out-patient medical care can also go to a private clinic, or apply directly to a hospital out-patient department, as a prior referral from a GP is not necessary. Patients may choose the specialist and the outpatient department that they wish, but not the level of care. On entering a hospital, the patient receives treatment from a specialist in an outpatient clinic or the emergency room, depending on the acuteness of the illness. Within the general system, the county councils have many different patterns of care. It is up to each county council to decide on how to serve the population with primary care. One of the major changes during the last few years has been that the responsibility for care of elderly has moved from the county councils to the municipalities, under the principle that wherever one lives, one's municipality should provide care. This is also the case for psychiatric treatment and care for the mentally disabled. In 1992, the central government made it possible for the municipalities, subject to an agreement with their county councils, to make a temporary transfer (for five years) of county council responsibilities for primary care on an experimental basis. Seven municipalities and their respective county council took part in this experiment. Swedish GPs working in the public sector are employed by the county councils and receive a monthly salary in relation to their qualifications and work schedule. They do not receive fees from patients. Other personnel working in public health centres are also directly employed by the county councils and receive a monthly salary. Most GPs, 89%, work in primary health care centres. In addition to local health centres and family physician surgeries, primary care is also provided by private physicians and physiotherapists; at district nurse clinics; and at clinics for child and maternity health care. Because of efforts made by the central government and the county councils to develop primary care in the last few decades, as well as the recent discussion on the implementation of the family physician system, research activities are common in primary health care. Research in general practice and/or family medicine is carried out by a number of organisations in Sweden, with funding often provided by national organisations, such as the National Board of Health and Welfare. County councils and health centres also allocate budgets for research in general practice.
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			
Source	European Observatory on Health Care Systems	***Year***	1996

Code	5.2		
Description	Dental care		
Contents			
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	The organisation of hospitals varies somewhat across hospitals, depending on their size and the political committees in charge. However, despite certain small differences, hospitals are basically hierarchically organised. The most common structure involves a hospital director, an advisory physician to the director with no managerial responsibilities, and the departments, each with a head and two levels of physicians. There is no nursing director and the departments match the medical specialities, with sub-departments for sub-specialties. Sweden had a very high ratio of beds to population, at 15.1 per 1000 population in 1980 compared to 10.7 beds for the western European average. However, the number of beds has decreased significantly since then. Since 1992 when the ADEL-reform was implemented, 31 000 patients in long-term somatic care were taken over by the municipalities, thus further reducing the number of hospital beds. As a result, the number of beds per population in 1994 stood below the western European average. During recent years, the number of days per person per year in short-term care has decreased for all age groups. The number of beds in short-term care has decreased from 4.6 per 1000 inhabitants in 1985 to 3.2 per 1000 inhabitants in 1994. In long-term care also, the number of in-patient days has decreased per person per year in most age groups. Reductions in average length of stay are illustrated in Table 5, where it is shown that average length of stay in 1993 was about one-third of that in 1970, and about one-half of that in 1990. The reduction can be explained in part by increases in productivity generated by new medical technology. Changes have also occurred in the area of psychiatric care during the last ten years. People with mental handicaps tend not to be institutionalized, but are rather being taken care of by the municipalities. At the same time as reductions have been made in in-patient care, more out-patient and so-called "alternative" forms of care have been established. In order to reduce waiting-time for certain necessary treatments and operations, in 1992 the central government and the Federation of the County Councils agreed to guarantee certain types of medical care within three months from being placed on a waiting-list. The investigations and treatments covered include surgery for coronary artery disease, hip and knee replacement, cataract surgery, gallstone surgery, inguinal hernia surgery, surgery of prolapse and incontinence and hearing-aid tests. As long queues existed during the 1980s in public care for certain treatments, e.g. hip joint replacement and cataract surgery, several persons chose to pay for the treatment themselves at private clinics rather that wait for publicly provided care. In the larger cities there are several private providers for patients needing surgery or internal medicine. However, in the last few years private in-patient care has mainly been confined to nursing homes for chronically ill within geriatric and psychiatric care, and to some smaller private hospitals. Around 200 nursing homes are privately owned and operated. Lately, private clinics offering elective surgery have been established. Table 7 below shows the distribution of public and private hospital beds for selected years to 1993. There are significant regional differences between the county councils concerning private care providers. It is mainly the larger county councils that have the most private providers. Public hospitals are larger and have specialized sectors and highly specialized equipment. They also have a different patient distribution. Compared to public hospitals, private hospitals concentrate on care that anticipates smaller investments. This could be due to a general uncertainty regarding future guidelines of the county councils concerning private hospitals.
Source	European Observatory on Health Care Systems
Year	1996

Code	6.1
Description	Hospital categories
Contents	For conditions which require hospital treatment, medical services are provided at county hospitals and regional hospitals. In Sweden, a relatively large proportion of the resources available for medical services have been allocated to the provision of care and treatment in hospitals. Sweden has about 90 hospitals which, depending on their size and degree of specialization, include regional hospitals, central county hospitals, and district county hospitals. At county hospitals, somatic care is provided in a number of specialist fields, partly in-patient care and partly out-patient care. County level health care covers patients with critical conditions or other illnesses requiring access to special resources. These resources are concentrated in one or a few hospitals within each county. Today, Sweden has 26 central county hospitals, each of which usually corresponds to each county council area. These also serve as district hospitals for their neighbourhood. In these hospitals there are about 15–20 specialities and the average number of short-term beds are 450 per hospital. In the district county hospitals, of which there are a total of 56, there are at least four specialities, including internal medicine, surgery, radiology and anaesthesiology. The average number of short-term beds are 137 per hospital. For highly specialized care, Sweden has six large medical care regions, each serving a population averaging at least one million. The regional medical care system is responsible for those patients whose problems require the collaboration of a large number of specialists. Their activities are regulated by agreements between the county councils within each region. Sweden has nine regional hospitals which are highly specialized, of which eight are affiliated to a medical school and also function as research and teaching hospitals. Each hospital is administered by its local county council and has an average number of about 900 short-term beds per hospital. These hospitals have a greater range of specialist and sub-specialist fields than at the county level, including for example, neuro surgery, thoracic surgery, plastic surgery and highly specialized laboratories. These hospitals provide the full range of medical specialities, and are available for referral patients with particularly complex conditions requiring collaboration among sub-specialists and sophisticated diagnostic or treatment facilities. Although the central government contributes to regional hospital costs associated with teaching and research, the hospitals are administered by the county within which they are located. The regional hospitals also provide secondary level of care to the residents of their county councils.
Source	European Observatory on Health Care Systems — ***Year*** 1996

Code	6.2
Description	Other in-patient provisions
Contents	
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 Health status in Sweden is relatively high by international standards although recently it has been noted that differences in health status between different social groups are growing. The overwhelming majority of Swedes enjoy good health but there is a trend showing that certain social groups are falling behind. In 1991, the Public Health Committee published a national strategy for health with guidelines for future work to improve the health of the population, particularly disadvantaged groups. This strategy includes co-operation, emphasis on activities at the local and regional levels, different activities on the national level, research and training. In 1992, the National Institute of Public Health was established by the government. It is responsible for operating health promotion and disease prevention programmes, especially those of a multi-sectoral character, at the national level. Initially the Institute is expected to run special programmes focusing on alcohol, drugs, tobacco, unintentional injuries, children and youth, and women exposed to particular health risks. County councils and local authorities have joint responsibility for health care and well being. However, the ultimate duty to offer people the help and support they need rests with local authorities. The municipalities play a central role in preventive measures, such as alcohol abuse and in caring for alcohol abusers. They also have responsibility for issuing liquor licences, imposing restrictions and monitoring the serving of alcohol in restaurants as well as of beer in shops. About 3% of total health care expenditure, excluding drugs and dentistry, goes to health promotion. Health promotion is primarily concentrated on disease prevention. Children are, for example, immunised against the most common childhood diseases Preventive and population oriented health care has been integrated with primary health care. General health education is given in schools by a teacher or by a school nurse and/or physician. Health education on tobacco, eating and/or alcohol are all functions often delivered by GPs. 75% of GPs are also involved in providing fundoscopy; over 90% of GPs are involved in immunisation of children and paediatric surveillance; they provide preventive services to women, i.e., making cervical smears; and all GPs examine for breast cancer. Midwives, district nurses and GPs all provide family planning services. Practical public health work takes place at the local level, in the child care sector, in schools, in institutional housing for the elderly and in the workplace. The National Board of Health and Welfare has a distinguished role of supervising and monitoring the public health activities of county councils and municipalities. An epidemiological centre (EpC) has been established to monitor and analyse health status and the social situation of the entire population, as well as morbidity hazards and social maladjustment. The centre is expected to be of major importance in the future development of welfare policy in Sweden. On the regional level, some county councils have organised special units for community medicine that monitor and analyse health development in the county.
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	Social care Social care in Sweden includes social welfare services, care of the elderly, the disabled and psychiatric patients. The 288 municipalities are in charge of social care. They each have a population ranging from about 5 000 to 700 000 and like the county councils, they are governed by local councils elected every fourth year. The traditional organisation of the municipalities includes a Municipal Executive Board, a Municipal Council and several local government committees. The Municipal Executive Board leads and co-ordinates all the Municipal's business and acts as a supervisor for the committees. The board is responsible to the council for following up matters that could possibly influence the development and economy of the municipality. The Municipal Council makes decisions of all community-run businesses. It is their duty to make decisions about goals, budgets, taxes, the committees' organisation and tasks. It is only recently that municipalities acquired responsibility for the elderly and disabled. This followed a decision by the national parliament in 1992, when these services were transferred from the counties to the municipalities. The reform also gave financial responsibility for these services to the municipalities. The services are financed by direct taxes levied on the population of the municipality, by national grants and by the recipient of care. The decision involved approximately 31 000 individuals. The responsibility of municipalities includes all types of institutional housing (including nursing homes) and care facilities for the elderly. The municipalities also have to provide health care to residents within institutional housing and in the future may additionally have the responsibility for home nursing care. Factors leading to this transfer of responsibility were the unsatisfactory co-operation between the county councils and the municipalities, and the belief that combined responsibility for health care and social services provision for the elderly and disabled will lead to more cost-effective results. In addition, the growing numbers of elderly have led to a search for alternative solutions. The basic principle of Swedish care of the elderly is that everyone who so wishes has the chance to remain at home irrespective of illness or diminished capacity. Great efforts have been devoted to making it possible for the elderly and disabled to be cared for at home. The home help service is thus the most extensive area of operations within the sector and about 3% of the population receive help. Special nursing staff make home-visits and provide necessary services 24-hours a day. The social welfare services are responsible for the home help services which include shopping, cleaning, cooking, washing and personal hygiene to those elderly people living at home who cannot cope on their own. The home service has changed to become more care giving and less service aimed. The fees for this service vary between municipalities and according to the numbers of hours of help provided. The fees are subsidised and the recipient of care only pays a portion of the costs, with this usually depending on her or his income. Today, a total of 150 000 people are employed in connection with care of elderly. It is the municipalities' duty to provide residential care as needed, including nursing homes, old peoples houses and group-living for people with senile dementia and the handicapped. Around 130 000 elderly people live in special forms of housing. Municipalities have the financial responsibility for elderly patients receiving acute hospital care and at geriatric clinics, if these patients have been fully treated and can be discharged. Nursing homes do not have a permanent physician but they have a physician to contact when needed. It is the medically responsible nurse's or sometimes the physiotherapist's duty to contact a physician when a patient needs care. It is the patient herself or himself who pays for medical attention. The care is generally considered to be adequate and of high quality. This goes for both the care given in nursing homes as well as care and help received at home by the elderly. Recent surveys indicate that an overwhelming majority of the elderly are very satisfied with the level of care that they receive. The day-care activities for which the municipalities are responsible include day centres, rehabilitation and activities running somatic day-care. Major changes in this took place in the period 1991–1995, with efforts to decrease expenses. Both the absolute and relative number of people receiving home service has decreased even though the number of old people has increased. This has been made possible by the increased number of special housing arrangements for the elderly, i.e., group living, residential care and nursing homes. It should be noted that social services are publicly provided by the municipality and the personnel working in the sector are directly employed. However, the services can be carried out either by public providers, or the municipality could have a private entrepreneur handling part of the services. Only 4% of the municipalities' total costs involves costs for private entrepreneurs. Barely half of the municipalities use private entrepreneurs. They are most commonly contracted in home services.

Source	European Observatory on Health Care Systems	***Year***	1996

Code	9.1
Description	Organisation and financing of social care
Contents	
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	Pharmaceuticals Measured either by the percentage of GDP spent on pharmaceuticals or per capita expenditures in 1993, Sweden had relatively low drug expenditures compared to other European countries and the United States. It should be noted, however, that Sweden has experienced substantial increases in pharmaceutical expenditures since 1993. The Drug Act of 1993 is the basis for all activities regarding pharmaceuticals and drug distribution in Sweden. It classifies pharmaceuticals into three categories: prescription drugs, i.e., drugs that require consultation with a physician; over the counter drugs (OTC), also called non prescription drugs; and drugs that may only be used at clinics possessing special resources. The Act on Retail Trade in Drugs gives the state the exclusive right to conduct retail trade in drugs. The National Corporation of Swedish Pharmacies has an agreement with the state according to which it has been assigned the exclusive right to retail trade in drugs. The agreement runs to 1 January 1997. The National Corporation of Swedish Pharmacies was founded in 1971 when the government took over the operation from the former privately owned pharmacies. Two thirds of the stocks are owned by the state and one third by The National Corporation of Swedish Pharmacies' pension foundation. According to the agreement between The National Corporation of Swedish Pharmacies and the state, The National Corporation is responsible for ensuring a good drug supply at uniform prices throughout the country and at the lowest possible pharmaceutical costs to the individual consumer and to society. By a one year contract with the county councils and local municipalities, The National Corporation of Swedish Pharmacies is responsible for the supply of drugs to the health care units. The Swedish Medical Products Agency, a central government agency, is responsible for the control of pharmaceutical preparations. The National Corporation of Pharmacies is obliged to stock drugs approved and registered by the Swedish Medical Products Agency. These drugs must be prescribed by practising physicians. The National Corporation of Swedish Pharmacies is required to maintain a countrywide distribution system and decides which sales outlets it wishes to have and where they are to be located in order to fulfil the requirement of availability. In 1994 The National Corporation of Swedish Pharmacies operated 789 community pharmacies and 91 hospital pharmacies. The National Corporation of Swedish Pharmacies is additionally responsible for providing factual information about drugs to the public and to physicians. Patient fees are charged according to the law on reimbursed drugs. The government sets patient fees for drugs reimbursed by the national social insurance system. Reimbursements for drugs are paid directly to the National Corporation of Swedish Pharmacies from the National Social Insurance Board and from the public and private health care providers. Deductions are made for the part that the patient has to pay. Private medical insurance coverage of health expenditures may cover expenditures on drugs, and it is possible that employees may be reimbursed by their employer for drug expenditures. To what extent insurance or companies cover these expenditures is not known. Such cost coverage is most likely of little significance. Given that a drug has been registered by the Medical Products Agency, the Drug Benefit Scheme consists of two categories of drugs: a list established by the Ministry of Health and Social Affairs including drugs that are completely free for the patients; and drugs that do involve out-of-pocket charges for the patients. Patient charges are set by the central government. The patient fees were in 1995 SEK 160 for the first item on a prescription and SEK 60 for the following items. A prescription by a physician can include OTC drugs. Only OTC drugs included in the Drug Benefit Scheme are reimbursed. The National Health Insurance scheme also includes a high cost protection plan, such that the national insurance system covers all individual health care and drug costs, should they exceed a certain amount per twelve year period. Out-of-pocket payments for drugs not included on the list of free drugs may be fully reimbursed by the National Social Insurance Board anyway, should the patient reach the limit of the high cost protection. The National Social Insurance Board's role as price setting body is regulated by law. This law also decides on the rules regarding the reference price system, which was introduced in 1993. According to the reference price system, generic products can be established on the market after the original patent has expired. The Medical Products Agency decides on which drugs should be considered generic. The National Social Insurance Board reimburses the National Corporation of Swedish Pharmacies for an amount that exceeds the lowest price on the market plus 10%. The patient can choose a more expensive drug than the one the physician has

prescribed, but must pay the difference between the price and the part that the National Social Insurance Board reimburses. The initial effect of the reference price system was that costs of products for which there was a reference price decreased by SEK 388 million the first year.

In 1994, approximately 15% of the total drug costs, including prescription as well as OTC drugs, were financed by hospitals, 25% by patients, and 60% by the National Social Insurance Board through the Drug Benefit Scheme. The costs for the Drug Benefit Scheme have increased by 12.7% per year on average during the last 10-year period. The total cost was SEK 11 billion in 1994. Between 1993 and 1994 the cost increase was 16%. The total cost for the Drug Benefit Scheme has also increased substantially as a share of total health care expenditure, rising from 9% 1990 to 13% 1994. This cost increase for the Drug Benefit Scheme is considered to be an important issue in Swedish health care. Those measures that have been introduced – such as the reference price system in 1993, the gradual increase in patient fees, the exclusion of some drugs from the Benefit Scheme – have not reversed the trend of increasing costs in a satisfactory way.

A parliamentary committee is presently considering a reform of the financing of the National Drug Benefit Scheme with the objective, among other things, to contain costs. One issue that is considered to be cost driving is the open third party payment system. Prescribing physicians, public as well as private, have no direct incentives to keep drug costs at a low level. Nor do the patients. The committee suggests that the cost responsibility for drug treatment should be transferred to the county councils, and that the principles for high cost protection should be examined.

An interim report produced in 1995 suggests, inter alia, that patients should pay for full drug prices up to a limit of SEK 500 per year, 50% of the drug prices in the interval SEK 501–1000 and 10% in the interval SEK 1001–3500. Costs of drugs that exceed SEK 3500 per year would be fully covered by the National Drug Benefit Scheme. This would mean that no individual will have to pay more than SEK 1000 per year for drugs. Furthermore, it is suggested that the list on free drugs should be abolished. The National Sickness Insurance should complement this with a general high cost exemption scheme so that no individual would have to pay out-of-pocket fees exceeding SEK 2000 per twelve month period for prescribed drugs and out-patient care. To encourage more rational drug prescription, it has been the committee's objective to reform the National Drug Benefit Scheme so that actual drug costs should be made noticeable to patients and the prescribing physicians. The committee suggests that the cost responsibility for the National Drug Benefit Scheme should be decentralized and transferred from the National Social Insurance Board to the county councils. The committee also suggests that price regulation of drugs included in the Drug Benefit Scheme should be conducted by a central national body with the objective of making drugs available for all people throughout the country and at uniform prices, but with real influence on price regulation by the county councils.

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	Education and training Physicians are trained at the six medical schools of the Universities of Lund, Gothenburg, Linkoping, Stockholm (Karolinska Institutet), Uppsala and Umeå. Medical education is entirely financed by the state and is linked to the university hospitals and other parts of the health services, such as primary health care. The number of medical students is limited and every year some 900 students start medical training programmes. To become a registered physician a student must successfully complete a programme of study of five and a half years, followed by a 21-month training period in general medical care, and a written examination. On registration a physician is authorised to practice, but almost all physicians choose to continue their studies in order to qualify as a specialist. This requires five years of service in one of the 60 recognised specialist fields. To become a consultant or head of department, a physician needs five years of postgraduate specialist training. To work in a health centre, a physician needs to be specialized in general practice. Education for nurses is available at about 30 nursing colleges which are spread all over the country. They are normally run by the county councils. About 3500 students begin nursing education every year. Training of nurses consists of three years of basic education following which specialist training can be pursued. Nurses can choose to train in midwifery, intensive care, anaesthesia, community or children's nursing. Specialist training programmes last 40 to 60 weeks. Training in occupational health nursing lasts 10 weeks after a general nursing education and two years' post-certification experience. Education and training Physicians are trained at the six medical schools of the Universities of Lund, Gothenburg, Linkoping, Stockholm (Karolinska Institutet), Uppsala and Umeå. Medical education is entirely financed by the state and is linked to the university hospitals and other parts of the health services, such as primary health care. The number of medical students is limited and every year some 900 students start medical training programmes. To become a registered physician a student must successfully complete a programme of study of five and a half years, followed by a 21-month training period in general medical care, and a written examination. On registration a physician is authorised to practice, but almost all physicians choose to continue their studies in order to qualify as a specialist. This requires five years of service in one of the 60 recognised specialist fields. To become a consultant or head of department, a physician needs five years of postgraduate specialist training. To work in a health centre, a physician needs to be specialized in general practice. Education for nurses is available at about 30 nursing colleges which are spread all over the country. They are normally run by the county councils. About 3500 students begin nursing education every year. Training of nurses consists of three years of basic education following which specialist training can be pursued. Nurses can choose to train in midwifery, intensive care, anaesthesia, community or children's nursing. Specialist training programmes last 40 to 60 weeks. Training in occupational health nursing lasts 10 weeks after a general nursing education and two years' post-certification experience.
Source	European Observatory on Health Care Systems
Year	1996

Code	11.2		
Description	Research and development in health		
Contents	Research Medical research in Sweden is characterised by strong links between basic research and clinical research and by the integration of research and development with health care services, particularly at the university hospitals. The state was previously regarded as having primary responsibility for research and development, nevertheless many physicians employed by the county councils have engage in research, on their own initiative within the framework of their duties. The county councils' attitude to responsibility of research and development has changed in the last few years. It is now accepted that the county councils and the municipalities have a partial responsibility for initiating and financing research and development. Of total national resources invested in research, 13% is allocated to medical research.		
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	Human resources and training In 1994, Sweden had about 305 000 people publicly employed in the health services in the county councils, i.e., about 8% of all employees in the country. From the 1960s through the 1970s and part of the 1980s, the number of health sector personnel experienced steady growth. In the early part of this period, this growth was part of Sweden's policy objective to increase numbers of health care personnel. As a result, there was a roughly two-and-half fold planned increase in the number of new medical students from 1960 to 1980. This period coincided with the wide popularity of central planning techniques which attempted to achieve an appropriate mix of specialities as well as a geographical distribution of physicians according to criteria aiming at equity. In more recent years, some of the growth in health care personnel can be attributed to a shortening of working hours and a growing proportion of part-time employees. In the late 1970s and early 1980s debate over whether excessive numbers of physicians were being produced resulted in planned declines in the numbers of new medical students, thus giving rise to a substantial slow-down in the rate of increase of physician numbers during the 1980s. Between 1992 and 1993 growth levelled off, and from 1993 onward the number of health care personnel has declined every year. This has been partly due to financial pressures and changes in the work done by the personnel. The above trends are reflected in Table 9 showing the development in numbers of health care personnel in Sweden. It can be seen that there was general upward trend for most categories of personnel until about 1985–90. The number of active physicians per 1000 population has increased steadily since the 1970s, levelled off in the period 1985–90, and began to decline after 1991. The number of certified nurses peaked a few years earlier than that of physicians. In the years to come, it is expected that recruitment of new health care personnel will grow, and the health sector may even experience some problems in the beginning of the next century. The average age of physicians is above 45 years and the number of retirements will increase substantially in the early part of the next century. However, the trend differs for different groups of personnel, reflecting a different balance between supply and demand. At the present time there is a shortage of nurses, especially nurses with specialist skills. In the case of physicians, a small surplus has started to appear in the last few years. The number of inhabitants per physician varies between the county councils from 216 to 458, and the average for the whole country is 330 inhabitants per physician (1994). The regional distribution of physicians is not wholly satisfactory, as there are difficulties in recruiting physicians to certain geographical areas and certain specialist fields. There is a shortage of GPs especially in some metropolitan and isolated rural areas. The number of physicians in Sweden is below the western European average, while the number of nurses is greater. The number of female physicians is significantly higher than the EU average of 23%: 36% of physicians in 1994 were females. In medical schools women at present represent 50% of all medical students. A Supervision of Health Care Personnel Act requires the county councils to organise boards of trustees, whose duties are to facilitate the contacts between patients and health personnel and to supply patients with any help needed. Certain special regulations are designed to protect the patient's identity in various computerised registers, for instance those on HIV, cancer, hospital discharge and congenital malformations.
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 Physicians (as well as all other health care staff) working in public facilities within the integrated system are paid salaries. Primary health care centres are usually reimbursed through global budgets or by capitation. Family doctors who emerged after the introduction of the Family Doctor System are paid partly on the basis of capitation and partly fee-for-service. These payment methods were introduced as financial incentives for family doctors to attract patients. Private practitioners connected to regional insurance offices and private specialists are paid on the basis of fee-for-service. The rates are determined by the National Social Insurance Board which is also responsible for making the payments. The private providers also have the right to charge the patient fees according to the fee level determined by the county council. Following the Dagmar reform in 1985, the county councils control expenditures by approving private establishments and restricting the volume of patients the practitioners can see. In the case of contracting out primary health centre services, special contracts between the county councils and the contractor are signed. The patient fees are generally not full cost recovery charges; the treatment costs as a rule have nothing to do with the patient fees that are charged. This is the case with respect to publicly provided health care and publicly provided dental care. Full cost recovery fees only exist in private health care when the provider does not have an agreement with the county councils or is not connected to a regional social insurance office, and to a limited extent, for public dental care for people above 18 years of age and for private dental care. The National Social Insurance Board reimburses private dentists through a fee-for-service system.
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

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	Payment of hospitals Until recent years, hospitals were reimbursed through a payment system developed in the 1960s and 1970s during the period of health services expansion. This was based on the use of annual budgets which include the cost of all hospital staff, drugs, supplies and equipment. If a hospital accumulated a deficit, this was covered by the county councils. During the 1980s, efforts to develop cost control mechanisms led some county councils to introduce "clinical budgets", whereby clinical departments were obliged to carry deficits on to the subsequent year, while a portion of surpluses could be kept for specific purposes such as staff training. This was considered successful for the purposes of containing costs. Recently, there has been more variation between county councils' payment systems. Many county councils have introduced purchasing arrangements. In 1994, 14 county councils had introduced some form of purchaser-provider organisation. The purchasing organisations negotiate with hospital health care providers and establish financial and activity contracts. These contracts are often based on fixed prospective per case payments, complemented by price or volume ceilings and quality considerations. DRGs are the most common case system with respect to short term somatic care. The extent of use of DRGs and other classification systems varies between regions and county councils, however. Per case reimbursements for complicated cases that greatly exceed the average cost per case may be complemented by per diem payments. Not all activities are usually reimbursed prospectively per case; several activities, for example, psychiatry, geriatrics and emergency services are usually financed through global budgets and specialized regional hospital health services are often reimbursed through retrospective patient related fee-for-service systems . In those county councils that have not introduced purchasing arrangements, per case payments are still used for payments between hospitals and districts and between departments within hospitals. An important issue in recent years with respect to the allocation of resources is the increased options for patients to choose among health care providers, hospitals as well as primary health care providers. At the same time that the freedom of patients to choose health care provider has increased substantially in the 1990s, the allocation of resources has been affected, since the payment usually follows the patients' choices. Districts or county councils have to reimburse the provider chosen by the patient.
Source	European Observatory on Health Care Systems — ***Year*** 1996

Code	13.2.1
Description	Method of payment
Contents	
Source	European Observatory on Health Care Systems — ***Year*** 1996

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			
Source	European Observatory on Health Care Systems	***Year***	1996

Code	14.1
Description	Main features of tax based systems
Contents	Main system of finance and coverage Swedish health care is predominantly publicly financed through taxation. In the most part this involves proportional county council income taxes levied by each of the 26 counties on their populations. These tax revenues are used mainly for financing health care, as well as other services. Some 77% of total county council expenditures are health care expenditures, while the remaining 23% are expenditures on other services, including activities within social welfare, culture and public transportation. Other health care financing sources include state grants, the major part of which is disbursed directly to the county councils and a smaller via the social insurance system. There is also finance from the national social insurance system and private expenditure, (i.e., out-of-pocket flat fee payments at points of service) and a very small proportion of total health care expenditure is financed by private insurance. Some 72% of total health care income of the county councils was in 1993 derived from tax revenues. Other income sources of significance are grants and payments for certain services received from the central government which amounted to 11.2%. Out-of-pocket contributions from consumers amounted to 3.5% of total county council income, and 6.2% were reimbursements from other county councils and/or municipalities for health services to their residents. The redistribution between the national social insurance system and the county councils is of two types. First there is a transfer of resources by which the county councils receive grants that depend on specific performance. The grants are based on certain features of the county, such as for instance regional facilities. Second are general grants for the services the county councils provide. The social insurance system is centralized at national level and is headed by the National Social Insurance Board. Insurance is compulsory, and covers individual income losses due to illness, individual expenditures for prescribed drugs and health care services, foremost in ambulatory and dental care. The insurance also covers all individual expenditures for drugs and health service consumption exceeding a high cost protection limit. Annual compensation for loss of income is an important item covered by insurance. Employers pay income-compensation from the second day until the 14th day of sickness, after which the national health insurance pays individuals 75% of their income. Reimbursement for health care and drug costs is paid directly to the responsible public or private providers after deduction is made of the part that the patient has paid to the health service provider or pharmacy. The size of reimbursement is established annually by the government. The main part of health insurance is financed by employer's contributions (80%) and the rest by specific transfer payments from central government (20%). Both private and public employers pay, a contribution per employee to the health insurance system, in 1996, this was 5.28% of the employee's salary. It may be noted that there is an interdependence between the two insurance functions, i.e., against health care costs and income losses. An inadequate or delayed provision of medical care might cause excessive expenditure of income compensation and production losses. The state grants, outside the social insurance system, are financed through national level progressive income taxes and indirect taxes. In total, the financing system is progressive, i.e., people with higher income contribute a higher proportion of their income to health financing (through taxes and direct payments) than people with lower income. In 1990, 13% of household gross income was spent, in one form or other, on health care.
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	The Swedish system provides coverage for all persons who are resident in Sweden regardless of nationality. In addition, coverage for emergency attention is provided to all patients from EU/EEA countries and seven other countries with which Sweden has a special convention. The services available are highly subsidised and some services are provided free of charge.		
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

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

The Swedish health care system is characterised by good access to health care services of a high quality and expectations of these services are usually very high. This is a result of Sweden's prosperity, medical and technological developments, and a welfare-orientated ideology. The main objectives of health care are good health and care on equal terms for the entire population. Diagnosis and treatment are the principle tasks of medical care. No basic or essential health care or drug package is defined. Instead there are some definitions as to what falls within and outside the domain of health care and some general guidelines regarding the priorities of the health care sector.

One priority is that medical care should be easily accessible for anyone not feeling well or having a disease. Everyone who needs medical attention should be able to receive it. At the same time, the responsibilities of health care are limited to care which demands the clinical personnel's special skills. In the event of sickness or injury, patients are guaranteed medical attention by the appropriate medical institutions with the competence and resources to deal with the problem.

Limited resources and growing demands on the health care sector require some choices to be made between competing alternatives. In 1995, an official report on health care priorities suggested three major principles as guidelines:

* The principle of human rights: all humans have equal value and equal rights irrespective of their personal qualities and positions in society.
* The principle of need or solidarity: resources expended should focus on the human being or the sector that is in greatest need.
* The principle of cost-effectiveness: when choosing among different sectors or actions, a reasonable relationship between costs and effects, should be obtained – measured in improved health and higher quality of life.

The above three principles are ranked, so that the principle of human rights takes precedence over the principle of need and solidarity. The principle of cost-effectiveness is subordinated to the other two. Guidelines are distributed by the National Board of Health and Welfare, but it is up to the county councils to establish their own priorities. There are five levels of priorities to be followed according to the guidelines.
Priorities for political/administrative prioritzation: Priority description of care needed
1. Care of life-threatening acute diseases and diseases which without treatment will lead to a longer invalidity or too early death. Care of serious chronic diseases. Palliative care in the final phase of life. Care of people with reduced autonomy.
2. Prevention with documented benefit. Rehabilitation etc. according to the definition in the Health Care Act.
3. Care of less serious acute and chronic diseases
4. Borderline cases
5. Care for other reasons than disease or injury

In accordance with the guidelines above, some hospitals have started not to perform in vitro fertilisation and mammography unless the patient pays for the services herself. For non-acute diseases or less serious conditions a Guarantee of Care within a reasonable time-period was implemented in 1992 and includes 10 selected diseases, such as hip joint replacement and cataract surgery. This obliges the county councils to provide certain diagnostic tests and treatments within three months from the time the patient has been placed on a waiting-list. If they cannot provide it within three months, they must offer the patient treatment at another public hospital.

Source	European Observatory on Health Care Systems	***Year***	1996

Code	14.4
Description	Complementary sources of finance
Contents	Complementary sources of finance The revenue sources for health care in Sweden are the following: taxation, including mainly proportional income taxes as well as indirect taxes; the national social insurance system; private expenditure, i.e., out-of-pocket payments; and private insurance. Swedish national accounts do not present data for sources of revenues. The relative magnitude of these revenue sources can be gauged through expenditure figures. These indicate that in 1993, 70% of total health care expenditure was public (i.e. tax-financed) expenditure, and 13% subsidies from the social insurance system. Therefore about 83% of total health care expenditure represented expenditure of the statutory system, with the remaining 17% constituting private expenditure. It is estimated that private insurance accounts for about 2% of total health care expenditure, and the remaining 15% private out-of-pocket payments.
Source	European Observatory on Health Care Systems ***Year*** 1996

Code	14.4.1
Description	Voluntary health insurance
Contents	Voluntary health insurance Private insurance is limited in Sweden, accounting for 2% of total health care expenditure. The Swedish insurance company, Skandia, began to offer health insurance in 1985, and the company is today the largest in the business with about 20 000 persons insured. In addition, there are about 5–10 other companies offering private health insurance. Private health insurance is taken out to cover, for example, additional costs as a consequence of a child's disease, the costs which are not covered by the statutory system, and the costs of medical care at private hospitals. The national health insurance scheme does not reimburse patients for inpatient care at these hospitals. In 1992, yearly fees for a private health insurance policy varied between SEK 3000–4000 for the age group 19–54 years, and SEK 6000–9000 for the age group 55–64 years. Usually, it is not possible to purchase private insurance after the age of 60 years. At the end of the 1980s there was growing interest in insurance that provided the right to immediate care at private hospitals. The reason for this was probably the growing queues within public health care for certain kinds of medical treatment. When the Guarantee for Care was introduced, the queues slowly decreased. However, since 1996, they have started to grow again and it is likely that the number of people with private insurance as a result will start to increase once more.
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 There are direct consumer charges for medical services, which take the form of flat rate payments. Until 1991, central government strictly defined maximum direct consumer charges for physician visits and so on. Since then, county councils have been able to determine their own fee schedule for out-patient care. However, there are upper limits to this as the public sector is not allowed to charge more than the average cost of producing the service. In practice, consumer charges are usually set far below the cost of production. The fee for consulting a physician in the primary health care services, varied in 1996 between county councils from SEK 60 to SEK 140. For consulting a specialist at a hospital the fees varied in 1996 from SEK 100 to SEK 260. For in-patient care pensioners pay a fee of SEK 75 per day for each day they spend in hospital. For all others except children under the age of 16 years the fee is SEK 80 per day. For children under the age of 16 years no fee is charged. The central government has decided upon a high-cost exemption scheme for all residents of Sweden. This means that an individual's charges for health care for a period of a year, including visits to physicians, district nurses, physiotherapists, etc. and prescribed drugs, may not exceed SEK 1800 (1996). On reaching this figure, the patient is entitled to free care and free medicines for the remainder of the twelve month period, which is calculated from the first visit to a physician or the first purchase of medicines. The high cost exemption scheme is included in the national health insurance scheme and financed by the National Social Insurance Board. The list of drugs that do require out-of-pocket payments is established by the National Social Insurance Board. Co-payments for prescribed drugs are, in contrast to co-payments for health services, uniform throughout the country and determined by the central government. The copayments for prescribed drugs were in 1995 SEK 160 for the first item on a prescription and SEK 60 for each of the following items. In primary care clinics, vaccinations, health checks and consultations as well as certain types of treatment are provided free of charge to all children under school age. Ante-natal care is also free. Dental care is provided free of charge to all children and young people up to the age of 19 years. For adults there is a public dental insurance which subsidies dental care exceeding a cost of SEK 700 per year. The national health insurance scheme also partly subsidies part of dental care costs for drugs included in the National Drug Benefit Scheme, purchased on a physician's or a dentist's prescription. Out-of-pocket contributions from consumers amount to 3.5% of county council revenue. Reimbursement for health care and drug costs is paid directly to the responsible public or private health service providers by the National Social Insurance Board after deductions for the part that the patient has paid to the authority. The size of reimbursement is established annually by the government.
Source	European Observatory on Health Care Systems
Year	1996

Code	14.4.3
Description	External sources of funding: employers, fund raisers etc.
Contents	
Source	European Observatory on Health Care Systems
Year	1996

Code	15
Description	Health care expenditure
Contents	Several points can be noted. First, total expenditure on health care increased from 1970 to 1991, and began to decrease in 1991, both in terms of current and constant prices. In terms of per capita spending in PPP adjusted US dollars, health care expenditure began decreasing since 1990. These trends illustrate the expansion phase of the 1970s in particular and also of the early 1980s, and the cost containment efforts since the mid 1980s. However, total health expenditure as a share of GDP reached a peak in 1980, and has steadily declined since then. Another point to note is that public expenditure as a share of total health expenditure appears to have decreased since 1980. Sweden's total expenditure on health as a share of GDP is slightly lower than the western European average. Health care expenditure as a share of GDP is plotted along with the trends of selected European countries. The trend for Sweden differs from the average in several respects. First, the increase between 1970 and 1980 is significantly higher in Sweden, reflecting the expansion phase of the 1970s. Second, Sweden shows a decreasing trend since 1980, while most other countries illustrated in the figure have experienced an increase since 1980. However, Sweden still had a share well above western European average in 1990, even if the trend between 1980 and 1990 is a decreasing share, as opposed to the average trend. Third, the share of GDP in Sweden has declined significantly in the early 1990s, contrary to the increasing trend for the countries shown. From 1992 Sweden is actually below western European average.The sharp decrease between 1991 and 1992 can partly be explained by the ÄDEL reform. Some expenditures earlier defined as health care expenditure were from then on defined as social (non-health) expenditures.
Source	European Observatory on Health Care Systems
Year	1996

Code	15.1
Description	Structure of health care expenditures
Contents	Two trends can be discerned. First, pharmaceutical expenditure as a share of total health care expenditure has increased substantially in recent years. This increase has been identified as an important issue (see Section on pharmaceuticals and health care technology assessment). Second, the share of investment has declined significantly since 1980. Possible explanations are a levelling off that occurred after the expansion phase of the 1970s, and that cost containment became an important issue in the 1980s.
Source	European Observatory on Health Care Systems
Year	1996

Code	15.2
Description	Total and public health expenditure as % GDP
Contents	
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	Determinants and objectives The Swedish health care sector has been undergoing gradual change over the past few decades, with the pace of reform accelerating in the late 1980s and early 1990s. Reforms have been initiated both at the national level (sometimes resulting in legislation) and at the county council level. The locally initiated reforms are mainly associated with the introduction of new management systems and new organisational structures. While equity issues were the main concern of the reforms of the1970s and early 1980s, cost containment became the main focus in the late 1980s and efficiency in the early 1990s. Today there is a renewed focus on cost containment. The objectives of the reforms will be described in detail later, together with descriptions of the contents of the reforms.		
Source	European Observatory on Health Care Systems	***Year***	1996

Code	17.2
Description	Content of reforms and legislation
Contents	Health care reform policy National reforms After the Second World War the health care sector underwent considerable expansion. This continued throughout the 1960s and 1970s. Much of the structural development was focused on transferring the responsibility for health care from the state to the county councils. With The Seven Crowns Reform of 1970, privately provided out-patient services at county council managed hospitals were taken over by the county councils. The physicians at out-patient hospital departments were employed and salaried by the county councils. In addition, it was stipulated that all patients should pay a uniform fee of SEK 7 at the point of service. The new fee structure had important implications with respect to equity in access to the health care delivery system. The new flat fee system replaced the earlier arrangement whereby the patient paid full cost recovery fees directly to the out-patient department physicians, and received 75% reimbursement by the regional insurance office. The most important objective of the reform was to assist low-income persons who under the previous system avoided physician consultations because they did not know the final individual costs. Another objective of the reform was to promote the establishment of primary health units outside the hospital by making it less profitable for physicians to work in out-patient departments. According to the Health Care Act of 1982, the county councils received responsibility for health services. Financial responsibility as well as resource allocation decisions were decentralized to the county council level. Furthermore, the county councils were to allocate resources according to the need of the residents. The Act includes a health for all policy; "The fundamental objectives of health care in Sweden are good health and health care on equal terms for the entire population" (paragraph 2). The Act formalized the policies that had been developed in the 1960s and 1970s: that health care should be considered in relation to other social services and should include preventive responsibilities as well as diagnosis and treatment. The focus on equity in the delivery of services was strongly emphasised. Special attention was to be given to vulnerable groups, e.g., elderly, immigrants and early retirees. The DAGMAR Reform of 1985 transferred the financial responsibility for ambulatory health care provided by public providers and private practitioners connected to regional social insurance offices from the National Social Insurance Board to the county councils. Instead of the regional social insurance offices reimbursing ambulatory services according to a fee-for-service system, the National Social Insurance Board began to disburse general health care grants to the county councils on a per capita basis adjusted for social factors. The main objective of the reform was to establish county council control over private establishments by having the authority to approve these and through control over reimbursement of private providers. An Act in 1991 on experimental work in municipality delivered primary health care, granted seven local municipalities responsibility for providing and organising primary health care. In 1991 some directives were included in the Health Care Act regarding the total medical and administrative management responsibility in diagnostic or treatment departments. These new directives are referred to as the "Senior chief physician" reform. The senior chief physicians should be medical specialists, and are appointed at the discretion of county councils if they consider it necessary for patient safety. The appointment is thus a county council decision. The ÄDEL reform of 1992 transferred responsibility for providing long term care and social welfare services to the elderly and disabled from county councils to local municipalities. The objective of the ÄDEL reform was to gather all planning and financial responsibilities for services to the elderly and disabled under one entity, the municipalities. Clear incentives were introduced to reduce the number of elderly patients waiting to be discharged from acute care hospitals. As a consequence of the reform, the local municipalities have to pay county councils for care delivered to patients at hospitals when the patient is considered to be fully treated by a hospital doctor. The reform has significantly affected the structure of the health care system in Sweden. In 1992, a national guarantee for patients was introduced. The guarantee was the result of an agreement at the national level between the Ministry of Health and Social Affairs and the Federation of County Councils. The objective was to reduce waiting times for ten elective hospital treatments that had long waiting times. According to the national guarantee, no patient should have to wait for more than three months for treatment. Otherwise the hospital must arrange for the patient to be offered treatment at another hospital within the three month period. Waiting times were reduced substantially during the first two years. However, most patients chose to wait for treatment at "their" hospital, even if the waiting time exceeded three

months.

In 1993, the Swedish Parliament passed a handicap reform resulting in the inclusion of two new paragraphs in the Health Care Act. The county councils' responsibility to provide rehabilitation, technical aids etc. was emphasised. Specially designated state grants were disbursed to the county councils during a 4-year period.

In 1993, a reference price system for drugs was introduced. Generic products can be established on the market after the original patent has expired. The Medical Products Agency decides which drugs should be considered generic. According to the reference price system the National Social Insurance Board reimburses the National Corporation of Swedish Pharmacies for an amount that exceeds the lowest price on the market plus 10%. The patient can choose a more expensive drug than the one the physician has prescribed. However, the patient has to pay the difference between the price and the part that the National Social Insurance Board reimburses. The initial effect of the reference price system was that costs for products for which there was a reference price decreased by SEK 388 million the first year.

Two acts substantially changed certain of the conditions for primary health care providers. The Family Doctor Act came into effect 1 January 1994 as did the Act on Freedom to Establish Private, Publicly-Funded Practices. The Family Doctor Act enabled the county councils to organise out-patient primary health care so that all residents within the county council should have access to and be able to choose a family doctor. Payment of the family doctors by the county councils are to be partly based on a monthly fixed fee (capitation) per listed individual, and partly on fee-for-service. The family doctors were given financial incentives to attract patients. The objective of the reform was mainly to improve accessibility and continuity in primary out-patient care. The Act on freedom to establish private practices deprived the county councils of their regulatory power with respect to signing agreements with private practitioners to control their number and reimbursements.

The county councils were to have implemented the family doctor reform by the end of 1995, but in June 1995, the new social democrat government which came into power in 1994 abolished both the Family Doctor Act and the Act on Freedom to Establish Private Practices. However, the implementation of the Family Doctor Act up to that time did result in the efforts to develop primary health care systems. These varied between county councils, as implementation of the reform was influenced by traditions in each separate county council. Urban areas for example, generally have a stronger tradition of private general practices. Although the Family Doctor Act was abolished, residents of Sweden maintain the right to choose a continuous physician contact in primary health care. The responsibilities of primary health care are now regulated through the Health Care Act which was somewhat altered with the abolishment of the Family Doctor Act. Furthermore, the county councils again have the right to sign agreements on reimbursements for new private establishments.
Since 1995 the responsibility of the local municipalities has been extended further through the Psychiatric Reform. This legislation means that local municipalities have the financial responsibility for fully treated patients, i.e., patients with three months consecutive in-patient psychiatric treatment. After three months, the local municipalities shall provide housing, occupation and some rehabilitation services. The objective of the reform was to improve psychiatric patients' quality of life. The reform is followed up and evaluated by the National Board on Health and Welfare.

A drug reform is presently under consideration because of rapidly increasing drug costs. One issue that is considered to be driving costs is the open third party payment system. Both public and private physicians, as well as patients, have no direct incentive to keep drug costs at a low level. A proposal suggests that cost responsibility for drug treatment be transferred to the county councils, and that the principles for high cost protection be examined.
County council reforms
The reforms initiated at county council level are almost exclusively associated with the introduction of new management and organisational systems.

The decentralization of financial responsibility to the county council level according to the Health Care Act of 1982 was carried further by decentralization efforts within each county council. Changes in county council management systems reflect goals and problems that county council politicians and responsible officials have encountered. County council health care before the beginning of the 1980s was characterised by rapid development and expansion; real resources increased together with county council areas of responsibility. Development was financed through general economic growth in Sweden and increased tax revenues. Important goals for county councils as well as the state were to create a health care system capable of meeting the objectives stated in the Health Care Act regarding good health on equal terms. However, in the beginning of the 1980s it was evident that county council revenues could no longer increase at the same pace as in previous years; the rapid expansion along with increasing wages since the 1970s, gave rise to increasing costs for the health care sector which could no longer be sustained. Cost containment therefore became an important

health care policy issue for the county councils. As a result the principle of global budgeting was introduced. Health care districts received global budgets from the county council. Many districts subsequently adopted the same principles in their management of departments and primary health care.

Global budgeting was, however, questioned in many county councils as it was not clear that the budgets represented a fair allocation between districts. A national official report also established that there was great variation in resource allocation practice within and between county councils. Global budgeting based on the need of the residents was suggested as a solution to variations between county councils and districts. By the end of the 1980s, 14 out of 26 county councils had developed a model for global budgeting according to the need of residents. Since such a solution created financial winners and losers among districts, implementation were usually introduced incrementally over several consecutive years. The systems varied but were usually mainly based on demographic variables. Some county councils also included indicators on health status, e.g., statistics of remaining life years and sick leave, or on health status as indicated through population surveys.

Global budgeting however, did not provide enough incentives to increase productivity. The productivity development of the health care sector was considered low compared to other sectors. New payment schemes were introduced in order to increase productivity. By the end of the 1980s, 20 out of 26 county councils intended to establish full cost responsibility at direct patient care departments. General and medical ancillary departments were to be reimbursed according to per case payment schemes. The dimension of ancillary departments was to be based on the demand for services. The dominant reimbursement system was, however, still global budgets, at district as well as departmental levels.

In the early 1990s some county councils initiated more substantial changes in management systems. Dalarna, Stockholm and Bohus were the first county councils to do so. These reforms, referred to as "The Dala model", "The Stockholm model" and "The Bohus model", included most issues that had been discussed in the 1980s, i.e., resource allocation according to the need of the residents, per case payment schemes, total cost responsibility in direct patient care departments, and transfer pricing systems. Several county councils have introduced solutions in which separate purchasing organisations have been established. In 1994, 14 out of 26 county councils had introduced such models. The purchasing organisations vary among, and in some cases within the county councils. Some county councils have introduced one large central county council purchasing organisation, while others have introduced purchasing organisations at the district level. Two county councils, Dalarna and Bohus, have introduced local purchasing organisations; each local municipality boundary constitutes one purchasing organisation. It appears that the choice of purchasing organisation is strongly influenced by traditions of organising health care activities within the county council, rather than by rational choices.

The county councils were influenced by the local municipalities as well as other countries, such as for example, England, when they decided on the introduction of purchasing organisations. Within the integrated (public) system, purchasing is similar in that all the purchasers are established within the county council organisation, the purchasers and providers belong to the same public organisation, and the actual negotiating with providers is performed by administrative staff. Besides the level at which the purchasing organisations are established, practice varies as regards contractual arrangements between purchasers and providers, and the discretion for the purchasers versus the providers, for example, whether prices are established by the central county council or in negotiations between purchasers and providers. Furthermore, the way purchasing organisations work varies, between as well as within county councils. Initially the restrained financial situation played a significant role for all purchasers. Price and volume negotiations and cost containment have been important issues. Other important issues have varied in focus between purchasers, e.g., the promotion of public health and collaboration with social services and regional social insurance offices.

The purchaser-provider relationship has not developed exclusively in the integrated system, but has also involved purchasing from private providers, though to a much smaller extent. Private providers involve both hospital and primary care providers.

The institutional relationship between purchasing organisations and health care providers has called for new contractual arrangements, or reformed payment schemes. The contracts are usually based on prospective per case payments complemented with price or volume restrictions and quality guarantees. DRGs are the most common per case payment base in short term somatic care. Weighted visits are a common per case payment base with respect to out-patient care. However, the extent to which different per case payment systems have been adopted varies substantially between county councils and hospitals. Per diem payments may in some cases complement per case payments. Psychiatric care, geriatric care and emergency services are usually reimbursed through contracts based on subscription charges. Highly specialized and resource intensive regional (tertiary) health care services are often

reimbursed through a fee-for-service system. Primary health care providers may be reimbursed through capitation or global budgets.

It should be noted that new contractual arrangements have been introduced also among those county councils that have not established a purchasing organisation, and at several organisational levels. The development of payment schemes within departments has been a somewhat separate issue from the third party payment schemes between purchasing organisations and providers. By the end of the 1980s, it was common to introduce total cost responsibility at direct patient care departments; this usually meant that prospective per case payment schemes between direct patient care departments and ancillary departments were introduced. These solutions have so far been more widespread than purchasing organisations purchasing care from direct patient care departments. Furthermore, several of the reforms initiated at the national level have resulted in new contractual arrangements. The ÄDEL reform and the Psychiatric Reform have introduced contractual relationships between the county councils and the local municipalities. The national health care guarantee created contractual relations between county councils. The highly specialized regional health care services have long since been reimbursed through fee-for-service based contracts. Finally, the increased opportunities for patients to choose among health care providers have generated new contractual relations between districts and county councils, since the reimbursements usually follow the choices of the patients.

The increased possibilities for patients to choose health care provider reflect the growing consumer orientation of the health care system. At the end of the 1980s and beginning of the 1990s, the patients' freedom of choice was an important policy issue among politicians. Its implementation has been more similar throughout the country and more extensively instituted compared to the purchaser-provider split and reformed payment schemes. In all county councils, patients can choose which family doctor or health centre to visit. In many county councils the patients can also choose in which hospital they wish to receive treatment, with a referral and in several cases, even without a referral.

Public debate has to a great extent focused on the issue of the development of a competitive environment in health care. This has several dimensions. The new contractual relationships mentioned above have enhanced competition. The increased possibility to choose health care provider combined with the resources following the choices of the patients have also resulted in a competitive environment, as health care providers may loose revenues because patients choose alternative providers. However, since patients are insensitive to prices in a third party payment situation, effective competition is over quality and access and may not be conducive to cost effective services. In the long run it may be contrary to the objective of cost containment. The development of a competitive environment does not involve privatisation – whereas the Family Doctor Act resulted in a substantial increase in private general practitioners, the trend toward privatisation is otherwise almost negligible.

The new roles established by the introduction of purchasing organisations have resulted in initial difficulties for purchaser representatives in establishing clear and strong roles, because of asymmetric information favouring the provider side. Crucial time lags still exist with respect to cost accounting in several county councils. The results of cost control efforts are variable among different parts of the health care system, with cost control difficulties persisting, for example, in the case of out-patient drugs. Despite these difficulties, the reforms appear to have had some positive impacts. Cost awareness among health care personnel has increased, and cost containment methods have improved as a result of new management systems and organisational structures. Total health care costs (in constant prices) have shown an annual decline of 1–2% in recent years. Clearly, health care expenditures have been successfully controlled in Sweden, which is the only OECD country that has reduced health care expenditure in the 1990s. In addition, productivity gains have emerged within regional and county care. There is no evidence that quality has been negatively affected by the newly introduced management systems and organisational structures.

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	Health for all policy As previously mentioned, the Health Care Act of 1982 contains a Health for All Policy. The Act states that "The fundamental objectives of health care in Sweden are good health and health care on equal terms for the entire population" (paragraph 2). The Act formalises policies that were being developed in Sweden since the 1960s and 1970s: that health care should be considered in relation to other social services, and that it should include preventive care as well as diagnosis and treatment. The Act places a strong focus on equity, with special attention to care of vulnerable groups.		
Source	European Observatory on Health Care Systems	***Year***	1996

Code	17.4
Description	Reform implementation

Contents

Reform Implementation
Extensive reference has been made throughout the previous sections of this study to reform implementation issues. This section will focus only on some constraints encountered on the levels of reform planning and implementation.

Swedish experiences with health care reforms illustrate some of the difficulties involved in adopting a co-ordinated approach to the process of change. The reform work has been focused on solving one problem at a time. for example, cost containment was an important issue during the 1980s resulting in the introduction of global budgets. At the end of the 1980s and beginning of the 1990s productivity development was considered too low, therefore prospective payment schemes, purchasing organisations, and increased possibilities to choose provider were introduced. It would appear that every reform of management systems creates a situation demanding a new reform. A co-ordinated reform approach which considers all relevant health policy goals might have been more effective.

A number of factors make a co-ordinated reform strategy difficult to achieve. Apart from conceptual difficulties involved in taking a global view to the reform process, whereby all health policy goals (such as cost containment, cost-effectiveness, high quality, equal access, etc.) are considered simultaneously, additional difficulties include changes of government, the political decision making process even within the same government, and possible inconsistencies between decisions taken at the national and local levels. For example, the political ideology at the central government level changed twice in the 1990s: between 1991 and 1994 the government was non-socialist, whereas before 1991 and since 1994 the social democrats formed and now form the government. Important issues for the non-socialist government included extended options for patients to choose health care provider, easier access to the health care market for private practitioners and establishment of competition between health care providers. The Family Doctor Act and the Act on freedom to establish private practices was introduced during the non-socialist regime. The social democrat government focuses on other issues, such as public health and collaboration between different providers.

Another issue involves the inertia of organisations, which can be observed however favourable the organisational environment in which to implement reforms. For example, in some county councils there are substantial discrepancies between word and deed with respect to reform implementation. The observed unwillingness to fully accept some of the reforms may be explained by the fact that county councils are very large organisations with important values and interests at stake. In addition new solutions may challenge the established balance of power, for example between different professional groups or between administrators and politicians.

Source	European Observatory on Health Care Systems	***Year***	1996

Code	17.5
Description	Conclusions

Contents

Conclusions

The Swedish health care system has undergone many changes throughout the 20th century, and has been particularly influenced by the prevailing ideology in Sweden after the Second World War. Throughout this period it has formed an important part of Sweden's welfare state. A major objective has been to create an equitable system in which all people have the right to health services, irrespective of income, sex, age, etc. Furthermore, it has been understood that the people should not only have equal access to health services identified as an essential health care package, but should have equal access to health services of high quality. Thus, equity and quality have been key issues in the development of the Swedish model.

Important features of the Swedish health care system are that it is publicly financed, mainly through county council tax revenues, and publicly provided, by hospitals and health centres owned and managed by the county councils. The county councils are independent regions with political boards, and through the 1982 Health Care Act they have the legally binding obligation to plan for all health services. This legal obligation, combined with the successive transferral of health care responsibilities from the state to the county councils, means that the Swedish system is a rather mature decentralized system. The decentralization of responsibilities has furthermore continued within the 26 county councils, such that local districts have rather strong discretionary powers as regards management of health services.

In the 1970s, 1980s and particularly the 1990s, the health care system has been subjected to several reform processes. Specific problems and issues considered politically important in each period have determined the objectives of the reforms. An overall view of the three decades indicates that equity and quality were the predominant issues in the reforms of the 1970s and early 1980s, cost containment was the most important issue at the end of the 1980s, and efficiency was the overriding consideration in the early 1990s. The reforms have been initiated both at national and county council levels, and often several different reforms have run parallel to each other.

The developments throughout the county councils have been fairly similar, at least when studied over several decades. Introducing global budgeting, budgeting based on the needs of the residents, transfer pricing, profit centre management, increased possibilities to choose among providers, per case payment schemes etc. have been discussed in most county councils. Variations have occurred with respect to timing in the introduction and implementation of reforms. Thus, at a given point in time, the management systems have varied between county councils, sometimes substantially. In the long run, however, the development is similar in all county councils. This suggests that county councils should have been able to learn from each other by evaluating and following up implemented changes, though this is an issue that has usually been neglected. There is good reason for county councils to spend effort and time on evaluations of reforms in the future.

Some lessons emerge from the implementation of management reforms initiated at county council level. Coordination problems have resulted from the operations of purchasing organisations and the increased possibilities for patients to choose among health care providers. The increased possibilities to choose among providers has been an important policy issue among politicians, at national as well as county council level. The problem some purchasers have encountered is that their purchasing activities may or may not coincide with the preferences of the patients; the patients may choose another health care provider than the one the purchaser has negotiated and signed a contract with. Two different control paradigms have been introduced simultaneously. The magnitude of this coordination problem varies among county councils. Local level purchasers in densely populated areas in county council border areas seem to have been particularly affected.

There is a need at national and county council levels to take into account of and balance all relevant objectives of publicly provided health services simultaneously (for example, cost containment, efficiency, quality and equity) in the future management of reform processes, as opposed to letting specific problems prevailing at each separate point in time determine the contents of reforms. There are several examples illustrating how reforms focused on isolated problems have generated the demand for new reforms. The actual possibilities of designing reforms that take into account all relevant objectives simultaneously are, however, limited. The objectives, or the relative importance of different objectives often change over time. Furthermore, different objectives may be inconsistent with each other. Nonetheless it could be argued that reform planners should take into account possible contradictory effects of reforms in designing and implementing them.

Despite a piecemeal approach to reform implementation, the management and organisation of

Swedish health care have improved as a result of the reforms. The decentralization of financial responsibility is a key explanatory factor. Cost awareness has increased, as has the interest for more and better financial information which has improved cost accounting systems. The reforms have contributed to solving important problems at critical times, such as reducing cost increases and increasing productivity.

Today cost containment has again been raised as an important policy issue. As a result, there is less focus on per case payment schemes and productivity incentives. Among politicians there appears to be some uncertainty as to which direction should be taken on certain policy issues. The incentives created in the early 1990s were appropriate with respect to the situation prevailing at the end of the 1980s and the beginning of the 1990s. The problems of today are not the same as then and seem to be more difficult to tackle. Cost containment issues and restructuring on the provider side, especially hospital services, are being emphasized. The introduction of market-like incentives are less prominent today, Many county councils have introduced differentiated patient fees in order to control the patient flows towards a lower level of care. Freedom of choice seems less important an issue today compared to the early 1990s.

In addition to the task of balancing the objectives of the health care system, a number of further challenges remain. The general decline in the economy, the need to further reduce health care expenditures, etc., trigger several difficult questions. Can quality be maintained? Can efficiency be improved further? What is the trend regarding equity in the health care system? How will patients' rights develop? How should structural changes on the provider side be managed? Is there a future for the purchaser-provider split? These are questions which will occupy the minds of policy makers and health care planners and officials, as well as the wider public, in the years to come.

Source	European Observatory on Health Care Systems	***Year***	1996

Country profile: United Kingdom

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

Code	1.1
Description	Introductory overview
Contents	The United Kingdom of Great Britain and Northern Ireland (UK) is made up of four constituent countries, namely: England, Scotland, Wales and Northern Ireland. The population of the United Kingdom has reached nearly 60 million, the majority of which is urban (over 89% in 1995). The dependency ratio, defined as those under 20 years of age and those over 64 years of age in relation to the population aged 20–64 years, has actually fallen from 79.8 (1979) to 70.1 (1995), despite a rising life expectancy at birth from 73.12 (1979) for both men and women to 77.40 in 1997. The leading causes of death in the United Kingdom are diseases of the circulatory system including both cerebrovascular diseases and ischaemic heart disease. Cancer accounts for over 200 deaths per 100 000 popu-lation and is followed by diseases of the respiratory system, which account for about 110 deaths per 100 000 population. Of cancer deaths the most common are from lung, breast, colorectal and prostate cancer which together account for about 62 000 deaths each year. The United Kingdom has one of the worst age-standardized mortality rates for breast cancer for women under 65 in western Europe (22.4 deaths per 100 000 compared to 15.1 in Sweden in 1995). Deaths from coronary heart disease dropped by 38% between the early 1970s and late 1990s and from stroke by 54% over the same period. Compared to other European Union (EU) countries, England has one of the worst rates of coronary heart disease. For people aged under 65 years it is two and a half times worse than France (the country with the lowest rate in the EU) amongst men and over four times worse for women. Politics The United Kingdom is a constitutional monarchy governed by two houses of representatives (the democratically elected members of parliament (MPs) of the House of Commons and the hereditary and life peers of the House of Lords). Elections take place at least every five years for the House of Commons under a first-past-the-post electoral system based on constituencies. The Prime Minister is the leader of the majority party in the House of Commons (since 1 May 1997 Rt. Hon. Tony Blair, leader of the Labour Party). The Prime Minister appoints the cabinet of ministers. The issues of devolution, reform of the House of Lords and reform of the voting system for European, national and local elections were put forward as part of the current Labour Government's election manifesto. Reforms have recently been introduced creating a National Assembly in Wales and a Scottish Parliament. The process of devolution to the Northern Ireland Assembly is still under negotiation. Until May 1999 Scotland and Wales were governed centrally through Westminster. All their 'national' affairs were overseen by the Secretary of State for Scotland and the Scottish Office in Scotland and London, and similarly the Secretary of State for Wales and the Welsh Office in Wales and London. With the establishment of the Scottish Parliament and Welsh Assembly the respon-sibility for health, education, agriculture and industry will be devolved. Currently the National Health Service (NHS) in Scotland is administered by the Department of Health in the Scottish Office, the NHS in Wales through the Welsh Office and in Northern Ireland there is a joint Department of Health and Social Services which runs the Health and Personal Social Services (HPSS). Most of the discussion in this report refers to health services in England. The organization and management of the health services in Scotland, Wales and Northern Ireland is similar to the English system, but some important differences apply. The United Kingdom has been a member of the European Union since 1972. Members of the European Parliament (MEPs) were elected on the basis of a proportional system with party lists for the first time in 1999. In England the system of local government is made up of directly elected representatives of county and city councils (39 and 7 respectively). Northern Ireland is made up of 26 districts. Scotland is made up of 9 regions and three island areas: Orkney, Shetland and the Western Isles. Wales is made up of eight counties. There remain a number of dependent territories: including Ber-muda, the Falkland Islands, Gibraltar, Guernsey, Jersey, Isle of Man, Montserrat, and South Georgia. Hong Kong returned to Chinese rule on 1 July 1997. Economy GDP grew by 3.12% over the period 1996–1997. This follows a period of little growth between 1990 and 1995 when the average change in real GDP was only 1.3% per year. This however was slightly above both the OECD and western European average. The United Kingdom had a gross public debt of 60.5% GDP in 1997. There is currently debate about whether and when the United Kingdom should participate in European Monetary Union, which began on 1 January 1999. The total labour force is 49.3% of the population, of which 62.8% work in the service industries, 25% in manufacturing and construction, 9.1% in government employment (includes all NHS employees), 1.9% in energy and only 1.2% in agriculture. Agriculture is intensive and highly mechanized and produces about 60% of food needs. Primary energy production accounts for about 12% of GDP. Services, especially financial services, account for the largest proportion of GDP.
Source	European Observatory on Health Care Systems
Year	1999

Code	1.2
Description	Historical background
Contents	Health services The discussion in this section traces some of the main developments in the UK National Health Service (NHS) over the last fifty years with particular emphasis on those features that remain relevant for understanding the nature of the service today.3 The National Health Service (NHS) came into operation in 1948 following the provisions of the NHS Act of 1946. This Act was of crucial importance in establishing the post-Second World War pattern of health service finance and provision in the United Kingdom. It introduced the principle of collective responsibility by the state for a comprehensive health service, which was to be available to the entire population free at the point of use. Freedom from user charges was a key feature of this approach which placed heavy emphasis on equality of access. The political consensus for establishing the NHS was built during the war and was in tune with other welfare state initiatives in areas such as social security, education and housing, which were being developed at this time. However not every group subscribed fully to this consensus. Most notably, the medical profession was initially opposed to some of the proposed features of the newly established NHS. The Royal Colleges – the professional bodies that represent different medical specialties led by consultants (senior specialists) – and general practitioners (GPs) were strongly opposed to any loss of professional autonomy. They wanted independence from bureaucratic interference and were especially concerned about proposals that would have placed the health serv-ice under local government control. In the event, skilful negotiation by the Minister of Health, Aneurin Bevan, obtained the support of the medical pro-fession for the establishment of a central government-run NHS with a number of concessions to demands for professional autonomy. Thus GPs were allowed to operate as independent contractors within the NHS while hospital specialists, although salaried employees of the NHS, were allowed to retain a large degree of control over their conditions of employment. They were also permitted to retain the right to private practice alongside their NHS work. These conditions of service remain largely unchanged today. One of the assumptions behind the establishment of the NHS was that there was a “backlog” or “stock” of ill health that would be made good by the new service, after such time demand would level off or fall. In the event, of course, this did not happen and demand in the 1950s outstripped the funding that was made available. One consequence of limited funding was extreme pressure on an under-resourced hospital service. Recognition of this problem led to the 1962 Hospital Plan which proposed major new capital funding over the next ten years and introduced the concept of the district general hospital (DGH). The DGH represented a planned approach to hospital provision whereby a unit of between 600 and 800 beds would cater for all the general medical needs of a population of between 100 000 and 150 000. This pattern of hospital provision has persisted until the present day and is one reason why a number of commen-tators said that the NHS internal market – introduced by the reforms of 1991 – would be characterized by a series of local monopolies. Organizational structure Some of the main elements of the present day organizational structure of the NHS can be traced back to the major changes that were introduced through the NHS Act of 1973. This Act introduced a new hierarchical command and control system. At the apex there was the Ministry of Health headed by the Minister of Health. Below the Ministry there were regional health authorities (RHAs) with broad planning responsibilities. Beneath the RHAs there were 90 area health authorities that were, in turn, divided into districts administered by a district management team. These were all introduced in 1974 under the provisions of the 1973 Act. It was the district that generally had responsibility for the operation of the district general hospital. This new system had barely been introduced, however, when major problems started to emerge. Some of the most important of these were beyond the control of the health service. For example, the sustained expansion of welfare state expenditures in most advanced industrial countries was interrupted in the mid-1970s as sharp increases in oil prices and worldwide economic recession led to calls to cut back public expenditures. This led to increased pressures on NHS budgets. At the same time, however, it was becoming clear that the new system was cumbersome with its multiple tiers of administration, slow in making decisions and costly to administer. As a result, the Merrison Royal Commission was set up in 1976 to consider the best use and management of resources in the NHS. The Commission reported in 1979 and recommended that, inter alia, a single tier of health authorities should be established to take over the func-tions of areas and districts. Following these recommendations, 192 district health authorities (DHAs) were created in 1982. Despite variations in their number, size and functions, DHAs (now simply referred to as ‘health authori-ties’) remain important units in the administration of the NHS today. Another important development during the 1970s dealt with the equity of resource allocation between different regions of the country. Until the 1970s annual resource allocations were based largely on past allocations with some minor adjustments for particular circumstances. This resulted in some major inequities between different regions. To address this problem a Resource Allo-cation Working Party (RAWP) was set up in 1975 with the task of developing a formula for allocating

resources on a more equitable basis. The Working Party reported in 1976 and recommended a formula for allocating funding between different regions based upon their respective health 'needs'. These needs were measured in terms of the region's population size, age and sex composition, and its levels of morbidity. The RAWP formula was adopted and, although subject to several subsequent modifications, the principle of weighted capitation payments based upon population health needs has remained an im-portant basis for resource allocation within the NHS. Yet another important development in the history of the NHS occurred in 1979 when the government of Margaret Thatcher was elected with its commitment to a programme of radical economic and social reform. This government saw public expenditure and state involvement as the source of Britain's economic difficulties and embarked upon a major programme of privatization. Although early policy on privatization in relation to the NHS was restricted mainly to contracting-out of ancillary services (i.e. laundry, catering and clean-ing), the government's belief in the superior efficiency of private sector practice led to major changes in management arrangements. An inquiry into the management of the NHS was set up in 1983 under the chairmanship of Sir Roy Griffiths, a managing director of a chain of supermarkets. Adopting private sector business principles, the Griffiths Inquiry reporting in 1993 recommended a move away from the old-style 'consensus' management towards a system of 'general' management with general managers at the unit, district and regional levels. New boards, responsible for policy and strategic planning on the one hand and operational management on the other, were also established at the centre. This system, based upon local management decision-making and a clear line of accountability from the top to the bottom of the NHS, was designed to replace the previous system, which was based largely on administration within a bureaucratic hierarchy. General management was an important precursor of more dramatic market-based reforms which were to follow. Despite the Griffiths' reforms and the government's strong belief in the superior efficiency of the private sector, the NHS was not fundamentally affected by major organizational change for most of the 1980s. It is possible that the government was wary about extending its radical programme to a sector which successive opinion polls continued to show enjoyed deep and widespread support. However, following intense debate about inadequate spending on the NHS – which took place towards the end of 1987 – Mrs Thatcher announced an internal review of the NHS under her own chairmanship. This review and its recommendations led to the reforms embodied in the NHS and Community Care Act 1990 which were implemented on 1 April 1991. These reforms intro-duced an 'internal' or 'quasi' market to the NHS and represented the greatest change to its organization and management in its entire history. The internal market separated the responsibility for purchasing (or com-missioning) services from the responsibility for providing them. The main purchaser function was assigned to the health authorities (supplemented increasingly by general practice fundholders) while the provision of services was made the responsibility of NHS trusts. Trusts were expected to compete with each other for service contracts from purchasers. The internal market, albeit with numerous modifications and restrictions, was used as the primary mechanism for the allocation of health care resources throughout much of the 1990s. With the election of a Labour Government in 1997, however, priorities changed. Their plans for the NHS were set out in the White Paper, The new NHS: modern, dependable, published in December 1997. The approach pre-sented in this White Paper and several subsequent documents, including the current NHS Bill, is designed to replace emphasis on market-based processes with far more emphasis on planning, collaboration and partnership-working. The main features of the 1991 reforms, and the ways in which current proposals indicate that they will be modified, will be analysed extensively in subsequent sections of this report.

Primary care services

Before moving on to consider these recent developments, however, it is worth highlighting another trend which has taken place since the 1980s, namely, the increased emphasis placed upon primary care. Although the United Kingdom has a well-developed system of primary care compared with most other countries, this sector received little attention from policy-makers in comparison with the acute sector until the mid-1980s. The independent contractor status of general practitioners (GPs), established back in 1948, meant that services had developed piecemeal and coordination with hospital-based community health services was poor. Following an extended period of discussion and consulta-tion in the second half of the 1980s, major changes were implemented through the introduction of a new GP contract in 1990. Through this contract, GPs became more accountable to family health service authorities (FHSAs), the primary care counterparts of district health authorities. DHAs and FHSAs were actually merged in 1996. Among other things, GPs were required to produce annual reports, contain pharmaceutical prescriptions within indicative budg-ets, and meet targets for various health screening and preventative services. At the same time, payments systems were changed to offer incentives for im-proved performance and to make them more responsive to patients' needs. Following closely on the heels of this change, GP fundholding was intro-duced through the NHS and Community Care Act 1990. From an early experi-mental status, primary care-based purchasing became a central element of the NHS during the 1990s. Not only did fundholding expand dramatically in terms of the number of GPs involved but also several variants of the scheme were introduced. Probably the most ambitious of these variants was the total purchasing pilot scheme introduced in 1995. Through this scheme, selected groups of practices were allocated budgets with which they could purchase potentially all of

the secondary and community health services received by their patients. While the new Labour Government has abolished GP fund-holding – on the grounds of inequity and unacceptably high transaction costs – it has retained an emphasis on the 'primary care-led NHS'. Since April 1999 all GPs have been required to join a primary care group: these are larger area-based groupings of GPs that have responsibilities for commissioning as well as primary care provision. (Primary care groups are discussed further in the sections on Organizational structure and management and Health care reforms.)

Public health services

Public health medicine has a long history in the United Kingdom. Its origins can be traced back to the middle of the nineteenth century when the main Acts of Parliament concerning public health issues were passed. A total of 17 pieces of legislation were passed between 1848 and 1890, of which six affected the delivery of public health services through administrative and structural changes. It was, however, the Public Health Act of 1875 which represented landmark legislation. This consolidated previous legislation, giving a clear account of the powers and responsibilities of local sanitary authorities. It laid the founda-tions for modern public health (no changes were made for more than 60 years). Many successes were achieved by the turn of the century including im-provements to water supply and sewerage, street cleaning, working and living environments and personal hygiene. The strong legislative framework com-bined with the growing power and effectiveness of local Medical Officers of Health made a crucial contribution to these improvements. Having played a significant role in the organization of health services during the Second World War, Medical Officers of Health assumed that the develop-ment of a National Health Service would be part of local government with an expansion of services provided by local authorities. However, the strength of political opposition by the British Medical Association, the Royal Colleges and the voluntary hospitals to local government control meant that the role of public health and Medical Officers in the NHS was minimal. During the reorganization of public health into community medicine and with the establishment of regional, area and district health authorities in 1974, the position of Medical Officer of Health was abolished. It was not until the 1980s that there was renewed discussion about the role of public health doc-tors. Possibly the most significant document to influence the future direction of public health services was the Acheson Report. In 1986 the then Secretary of State set up an inquiry team under the chair-manship of the Chief Medical Officer, Sir Donald Acheson, to consider the future of the public health function. Published in 1988, the report identified five main problems: lack of information about the health of the population; lack of emphasis on health promotion and disease prevention; confusion about the roles and responsibilities of public health doctors; confusion about the responsibility for communicable disease control; and lack of information about outcomes on which to make informed choices. Following the enactment of the NHS and Community Care Act 1990 a new opportunity for public health arose. The Health of the Nation report published in July 1992 aimed to shift the focus from the delivery of clinical services to health. It encouraged health authorities to take on a more strategic role, namely that of maintaining and improving the health of the local population. The most recent initiative in the public health area has been the publication of the present government White Paper Saving Lives: Our Healthier Nation in July 1999. The White Paper builds on the earlier Green Paper Our Healthier Nation and sets out the government's future strategy for public health policy. The present organization and development of public health services are described in the section on Primary health care and public health services.

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

Code	2
Description	Main functions of key bodies in the organizational structure and management of health care administration
Contents	Organizational structure of the health system The structure of the UK health system is currently undergoing major organizational change following the election of a Labour Government in May 1997. Their plans for the NHS were set out originally in a White Paper, The new NHS: modern, dependable, published in December 1997. The Health Act 1999, which gives a legislative basis to many of the changes set out in the White Paper, received royal assent on 30 June 1999. In addition numerous executive letters and guidance notes setting out the details of the government's plans have been issued. These plans are intended to build on some of the successes of the previous Conservative Government's reform programme but to replace certain important elements of it. In the following account the exist-ing system is described together with the main changes either implemented already, in the process of implementation or planned for the future. Most of the discussion in this report refers to health services in England. These account for about 80% of total United Kingdom public expenditure on health and personal social services. The remainder is spent in Scotland (11%), Wales (6%) and Northern Ireland (3%). The organization and management of the health service in these countries is similar to the English system, but some important differences apply.
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 Department of Health The Department of Health (DoH) under the direction of the Secretary of State for Health, together with his team of five ministerial colleagues, is responsible for health and personal social services in England. Separate responsibilities are held by the Secretaries of State for Scotland, Wales and Northern Ireland. In England the Department sets overall health policy, including policies on public health and those relating to the health consequences of environmental and food matters. It also has overall responsibility for the NHS. There are three main branches. First, there are a series of groups and divisions with specific area or profes-sional responsibilities, e.g. the Public Health Group, the Social Care Group, the Nursing Group and the Research and Development Division. Second, there is the office of the Chief Medical Officer (CMO). The CMO is responsible for offering expert medical advice to the whole department. Third, there is the NHS Executive (NHSE), under the direction of the Chief Executive, which is responsible for leadership and a range of central manage-ment functions in relation to the NHS. The NHSE supports ministers in the development of health policies and is responsible for effective management and the cost-effective use of resources in the NHS. As well as its headquarters based in Leeds the NHSE has eight regional offices located around the country. These offices are responsible for the regional implementation of national policies and, with this aim in mind, monitor the performance of health authorities. They occupy an important position in the chain of accountability from the local level to the centre. A recent innovation, at the ministerial level, was the appointment in 1997, for the first time, of a Minister of State with specific responsibility for public health. The minister has a wide-ranging brief including public health monitor-ing and strategy; health promotion; notifiable and communicable diseases, including AIDS; family planning; and food safety. At the moment, particular emphasis is being placed upon the need to address health inequalities. Another innovation of some importance was the establishment of a division within the Department of Health with specific responsibility for leading a programme of research and development geared to policy questions of direct relevance to the NHS. The first director of this division was appointed in 1991 and a strategy designed to make NHS decision-making research-based was launched. Since then, a national research and development programme, together with a series of regional programmes, has played a major role in commissioning and funding research related to the needs of the NHS. Other ministries The present Labour Government places considerable emphasis on the co-ordination of policy across ministries (the term 'joined-up government' has been coined). This approach highlights the role of other ministries with responsibilities for health and health-related matters. These include: • The Department of Social Security which has responsibility for social welfare payments (e.g. income support, invalidity and disability benefits); • The Department of the Environment, Transport and the Regions which has responsibility for personal social services administered through local government authorities; • The Ministry of Agriculture, Food and Fisheries which currently has responsibility for food standards (this may change if the Food Standards Bill introduced in parliament in June 1999 is passed into law); and • The Department for Education and Employment which funds the training of medical students and other health professionals.
Source	European Observatory on Health Care Systems
Year	1999

Code	2.2
Description	Regional government
Contents	
Source	European Observatory on Health Care Systems
Year	1999

Code	2.3		
Description	Local government		
Contents			
Source	European Observatory on Health Care Systems	***Year***	1999

Code	2.4		
Description	Insurance organisations		
Contents			
Source	European Observatory on Health Care Systems	***Year***	1999

Code	2.5		
Description	Professional groups		
Contents	Professional bodies The British Medical Association is both the doctors' professional organization and also an independent trade union protecting the professional and personal interests of its members. Its membership is made up of more than 80% of British doctors. Professional registration and regulation of the medical profession is the responsibility of the General Medical Council. Similar organizations exist for other professions such as the British Dental Association. There are also several trade unions that represent health care workers. The main unions are UNISON, which represents the interests of people working in the public services and essential industries, and MSF which represents over 60 000 professional, craft, technical, scientific, medical and nursing staff within the NHS. In addition, each of the medical specialties is governed by a Royal College, which is responsible for the assessment and awarding of qualifications in the specialty and in most cases continuing medical education, the issuing of clinical guidelines and medical auditing.		
Source	European Observatory on Health Care Systems	***Year***	1999

Code	2.6
Description	Providers
Contents	The National Health Service In the organizational structure of the NHS as it existed following the 1991 reforms and prior to the current reform plans, there are four main organizations; namely, regional health authorities, district health authorities, general practice fundholders (GPFHs) and NHS trusts. Regional health authorities (RHAs) At the time of the 1991 reforms, and in the period immediately following them, there were 14 RHAs in England. These regions carried out a range of monitoring and performance management roles on behalf of the NHS Executive. As part of this function, each district health authority had a contract with the regional office specifying the tasks it was expected to carry out over the next year and it was held to account to the regional office for its actual performance. NHS trusts were similarly accountable for their performance to regional officers. In 1994, in an effort to reduce management costs, the number of regions was reduced from 14 to 8 and their staffing levels were reduced substantially. At the same time they were converted into regional offices of the NHS Executive. This meant that they lost a good deal of their previous autonomy and that the line management link between the centre and the regions was strengthened. District health authorities (DHAs) As was pointed out in the previous section, under the terms of the NHS and Community Care Act 1990, responsibility for purchasing or commissioning health services in the NHS was separated from the responsibility for providing them in 1991. This arrangement was dubbed an 'internal' or 'quasi' market. Within this system, the main purchasing function was allocated to district health authorities (DHAs). DHAs were corporate bodies operating under the general direction of a chairperson, appointed by the Secretary of State, and a board comprising executive and nonexecutive directors. In 1991 there were just under 200 DHAs catering for resident populations of, on average, 250 000 people, although the actual size range extended from 100 000 to 800 000. Each DHA was required to assess the health care needs of its population and, from its weighted capitation-based budget, commission a range of services from providers to meet these needs. Each DHA had a department of public health responsible for carrying out needs assessment. A contract system was introduced to formalize the link between purchasers and providers. Over time, a series of mergers took place between DHAs with the aim of realizing economies of scale. By 1998 the number of DHAs had fallen to 100. With the conversion of RHAs to regional offices of the NHS Executive, there is now only one tier of health authority and so DHAs are referred to simply as 'health authorities'. Family health service authorities (FHSAs) Within the NHS, there has been a long-standing distinction between primary care (delivered by general practitioners and associated staff) and hospital services. From 1991, DHAs were responsible for hospital services while primary care was the responsibility of family health service authorities (FHSAs). However, as part of the effort to coordinate primary and secondary care effectively, DHAs and FHSAs were merged into single authorities from 1996. General practice fundholders and other primary care-based purchasers At the same time as DHAs were allocated a purchasing function in 1991, 294 GP fundholding schemes (GPFHs) were introduced. These were selected GP practices which were allocated budgets with which they could purchase directly a range of diagnostic and elective procedures on behalf of the patients registered with them. (The bulk of services for these patients were still, however, purchased by the DHA). At the beginning, GP fundholding was very much an experimental scheme, but the number of practices covered by the scheme grew rapidly each year. B 1998 there were 3500 GPFHs. As fundholding grew in scale, and the commitment of the Conservative Government grew towards primary care-based commissioning, several variants of fundholding emerged. Some fundholders sought to economize on manage-ment costs by combining into multi-practice consortia: there were 100 of these 'multi-funds' in 1998. Even more radically, in 1995, the government approved the establishment of 53 total purchasing pilot sites (TPPs). These were single or multi-practice GP sites, covering populations of between 12 000 and 80 000 people, that were given the opportunity to purchase potentially all of the hospital and community health services for the patients registered with them. With the introduction of a second wave of TPPs in the following year, there were 80 TPP sites nation-wide by 1998 for an account of models of purchasing developed in the United Kingdom over the 1990s). GP commissioning groups Despite the formidable growth of GPFHs, multi-funds and TPPs, many GPs remained unhappy with the fundholding experiment. For some there were ideological objections; for others, the practicalities were unattractive. As a re-sult of these reservations, a number of GPs chose to form 'Commissioning Groups'. These were non-fundholding collectives of GPs who worked with their local DHAs in an effort to jointly determine purchasing priorities and strategies. Aproximately 7000 GPs belonged to such groups in 1998 compared with just over 19 000 GPs associated with fundholding models of purchasing. NHS trusts

Turning to the supply-side of the internal market, providers of services were given greater freedom and autonomy through the creation of NHS trusts. These trusts were within the NHS and run by a board of directors comprising executive and nonexecutive members. Trusts were expected to compete for contracts from DHAs and GPs for the provision of clinical services. By 1998, all acute hospitals, community health service providers and ambulance services had acquired trust status.

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

Code 2.7

Description Voluntary bodies

Contents

Voluntary and consumer groups
There is a plethora of advocacy groups working on behalf of patients in the United Kingdom. Many are disease-based advocacy groups, such as those which promote the interests of people suffering from AIDS, osteoporosis, diabetes, leukaemia, cancer, etc. Others work on behalf of people with mental illness (MIND) and particular patient groups such as the elderly (Age Concern). As well as providing support and information for patients and their families, these groups work to improve the care and services provided by the NHS. In addition, the independent Patients Association works to further the interests of patients in general. Other more formalized mechanisms for public input into the health care system are through community health councils, described in more detail below, and representatives on primary care group boards.
Community health councils
Community health councils (CHCs) were established in 1974. They provide a link between the NHS and the community, separating the management of service provision from the representation of patient and community interests. There are currently 207 CHCs in England and Wales (16 health councils in Scotland and 4 health and social services councils in Northern Ireland that perform similar functions to CHCs). Each CHC has around 16–30 members; half are local authority nominees; a third are elected by the local voluntary sector; and a sixth appointed by the Secretary of State for Health (or Secretary of State for Wales for Welsh CHCs). CHCs are funded from a national budget held by the NHS Executive, but are independent of the NHS management structure, each other and the Association of CHC for England and Wales (ACHCEW). Health authorities are required to consult formally with CHCs on substantial variations in service provision, provide information required by the CHC in carrying out its public duties and arrange an annual meeting between the authority and CHC members. In the light of the current reforms the future of the CHCs is currently under discussion.

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

Code	3
Description	Planning, regulation and management
Contents	Planning, regulation and management Planning The NHS can be characterized as a publicly owned and financed health system within which there are strong lines of vertical accountability. Over the 1990s some of the central command and control features have been loosened as responsibility for decision-making has been partly devolved to local organi-zations and agencies. Within this context, planning takes a number of different forms and is undertaken by several different agencies. Expenditure planning Total expenditure on the NHS is still tightly controlled from the centre. Expenditure planning, for both capital and recurrent expenditure, takes place as part of the government's general public expenditure planning process, through which the level of funding to be made available to the NHS for the following year is determined. The Department of Health determines the allocation of this funding to regions, and regions determine district allocations (see the sections on Health care finance and expenditure and Financial resource allocation for further discussion of NHS finance, expenditure and resource allocation). Service planning Although there is no detailed national plan for service planning purposes, each year the Department of Health issues an executive letter setting out the priorities and planning guidance for the NHS. The guidance for 1998–1999, for example, set out the government's general aims for the coming year, identified specific pressures which it expected the NHS to manage, and identified areas for develop-ment. The aims covered improving the public's health, a commitment to fairness in the health service, developing the quality of services and promoting partner-ship and collaboration. Pressures to be managed included the provision of prompt and effective emergency care, the maintenance of guarantees and standards for maximum waiting times, and ensuring financial stability. Specific areas identified for development were: the provision of comprehensive mental health services, the development of a leading role for primary care, improving clinical and cost effectiveness, giving greater voice and influence to users, meeting the needs for continuing health care and developing NHS organizations as good employers. The new Labour Government and planning guidance In a departure from previous practice, the new government produced national guidance on the priorities for a three-year period – 1999/2000–2001/2002 – in September 1998 under the heading Modernising Health and Social Services. This document is wider in scope than previous guidance. It sets out a new direction for the health service based upon tackling the root causes of ill health, breaking down barriers between service providers and placing greater emphasis on the quality of services. The guidance identifies priority areas where the NHS is expected to take a lead responsibility and other areas where it is expected to share lead responsi-bility with local government social services departments. In the case of NHS lead responsibility, the service is expected: • to reduce waiting lists and waiting times in line with quantitative targets; • to undertake specific measures to develop primary and community services in order to address inequality, improve quality and convenience for patients, and increase efficiency; • to meet targets for reducing deaths from heart disease by providing high quality, cost-effective and responsive services for the prevention and treat-ment of coronary heart disease; • to improve the quality, effectiveness and speed of access to cancer services in the areas of prevention, screening and palliative care. Areas where the NHS and local government social service departments are expected to take lead responsibility and work together are: • reducing health inequalities by improving the health of the worst-off in society at a faster rate than the rest of the population (this will include strategies to reduce unwanted teenage pregnancies, ensure fair access to services for black and ethnic minority groups, reducing smoking, increasing childhood immunization rates and reducing drug dependency); • improving the mental health of the population, and improving the treatment and care of those with mental health problems, through the provision of a comprehensive set of high quality, effective and responsive services; • ensuring the provision of services which help adults achieve and sustain maximum independence in their lives through, inter alia, reducing avoidable admissions to hospitals, developing preventative services and respite care, and providing additional support to informal carers. Alongside these plans, the government is developing a national framework for assessing performance in the NHS. This will cover six dimensions of performance, namely: health improvement, fair access, effective delivery of appropriate health care, efficiency, patient/user experience, and health outcomes. It is intended that this framework will underpin accountability agreements between regional offices and health authorities, and between health authorities and primary care groups. Planning and public health Setting priorities for the achievement of specific health improvement targets in relation to

particular diseases and disabilities has its origins in a major public health planning exercise undertaken by the previous Conservative Government. The Health of the Nation strategy, launched in 1992, identified five priority areas for reducing mortality and morbidity – namely, heart disease and stroke; cancers; mental illness; sexual health; and accidents – and set 25 quantified targets for achieving reductions in rates of mortality and morbidity over given timescales. This was the first time that such a strategic planning approach had been adopted in the United Kingdom. The present government published its own plans for public health in a Green Paper, Our Healthier Nation, in February 1998 which was followed by a White Paper, Saving Lives: Our Healthier Nation, in July 1999. This expresses a commitment to setting goals for improving population health with more emphasis placed upon the social and environmental determinants of health and in particular the need to reduce health inequalities. Among other things this will involve taking into account the effects of poverty, unemployment, poor housing and environmental pollution. This strategy is intended to replace the Health of the Nation strategy and includes revised targets for the four key areas of cancer, coronary heart disease and stroke, accidents and mental health.

Planning by health authorities

The national priorities and planning guidance issued by the NHS Executive sets the context within which health authorities are expected to develop their own plans. Until recently, these were presented in the form of health strategy and purchasing plans, often extending over planning periods of up to five years ahead. Under the government's new approach they are now formulated in terms of service and financial frameworks. These plans are normally prepared by the planning, finance and public health departments of each HA and need to be approved by the HA board comprising chair, chief executive and other execu-tive and nonexecutive members. Although these plans usually pay a good deal of attention to local needs, strong accountability to the NHS Executive means that strong emphasis tends to be placed upon the achievement of national priorities. These priorities figure prominently in the assessments carried out by regional offices as part of their performance management function. New responsibilities placed upon health authorities, as part of the new Labour Government's plans, involve drawing up health improvement programmes (HImPs) for their areas. These programmes are expected to bring together a range of health and social care agencies, together with other organi-zations, e.g. voluntary organizations and private sector firms, in the production of plans for improving the health of local people. HImPs are seen as a vehicle for formulating a local response to national priorities and targets, and of deter-mining local priorities for action. In addition, some areas of extreme deprivation have been designated health action zones (HAZs). These will receive special assistance for the development of plans aimed at raising health standards among deprived groups.

Planning and NHS trusts

During the 1990s, NHS trusts have been required to produce business plans. These set out their expectations in terms of income and expenditure and have been an important component of the capital planning process. Under the internal market arrangements, trusts wishing to undertake major capital investments have been required to obtain support – in the form of statements of purchasing intentions – from those HAs who intend to purchase services from them. GP fundholders and other primary care-based purchasers have also been required to produce annual purchasing plans.

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

Code	3.1
Description	Extent of system decentralisation (deconcentration, devolution, delegation, privatisation)
Contents	Decentralization and regulation in the internal market The 1991 reforms and subsequent measures were designed to increase efficiency, quality and choice through the creation of decentralized, market- type mechanisms. They represented a move away from hierarchical, or vertically integrated, forms of organization towards models based on purchaser-provider separation and contractual relationships.The degree of autonomy offered by these arrangements was, however, strictly limited. As pointed out above, both purchasers and providers were accountable to the regional offices of the NHS Executive, and these offices operated a strong performance management system. In addition, the NHS Executive exerted strong control over DHAs and trusts in terms of planning and service priorities. These issues are discussed more fully in the discussion of regulation below. The new Labour Government and the new NHS While in opposition, the Labour Party had been sharply critical of the internal market, arguing that it had led to fragmentation, inequality, increased bureau-cracy and lack of accountability. On gaining office its first major policy document on the NHS, the White Paper The new NHS: modern, dependable, set out Labour's plans for the future of the service. The stated intention is to replace competition within the internal market with a system based upon collaboration and partnership between the different agencies responsible for health and social care A major change is occurring through the abolition of GP fundholding and its variants, and its replacement with primary care groups (PCGs). PCGs are groupings around GP practices in a geographical area to which all GPs – both former fundholders and non-fundholders – belong. These groups have been live since 1 April 1999. They will be far larger than previous primary care-based models, covering populations ranging from 50 000 to 250 000 people. It is envisaged that PCGs will progress through four developmental stages over time, culminating in the formation of primary care trusts. The government's plans also envisage a far greater degree of interagency collaboration with PCGs working closely with local government social services departments. NHS trusts are continuing to be responsible for the provision of services, but their short-term contractual relationships with purchasers are being replaced with longer-term service agreements. More emphasis is being placed on collaborative working between commissioners and providers instead of market-type competition. With the former regional health authorities becoming regional offices of the NHS Executive, district health authorities are now simply referred to as 'health authorities'. The functions of health authorities are increasingly shifting towards strategic planning as PCGs assume greater responsibility for commissioning services. The HAs are responsible for drawing up plans for 'health improvement programmes' in their areas in collaboration with PCGs, trusts and local government authorities. As before, there are lines of accountability from HAs and trusts to the NHS Executive and to its regional offices. In fact, these lines of accountability to the centre appear likely to be rather stronger than they were under the previous government.
Source	European Observatory on Health Care Systems — ***Year*** 1999

Code	3.2
Description	Existence of national health planning agency/plan
Contents	
Source	European Observatory on Health Care Systems — ***Year*** 1999

Code	3.3
Description	Supervision of the health services
Contents	Regulation In common with most health care systems, the UK system has long been subject to a variety of regulatory policies. In this section, some of the long-established forms of regulation are discussed briefly. However, most of the discussion concentrates on new approaches to regulation developed in the 1990s as a part of managing the evolving internal market, and to the systems of regulation being developed by the present government as part of its new approach to the NHS. Regulation of professional standards One of the most important areas of regulation applies to the standards expected of clinical professionals. By and large, this function has traditionally been performed through a system of professional self-regulation. Thus the General Medical Council regulates the education, training and professional standards of doctors while the UK Central Council of Nursing and Midwifery performs a similar function for its members. At the present time, however, a number of well-publicized instances of the failure of professional self-regulation to pre-vent serious professional malpractice have led to official proposals and plans for greater external regulation. Medical workforce planning The Medical Workforce Standing Advisory Committee advises the Secretary of State on developments relating to the overall supply of and demand for doctors in the United Kingdom. Following the recommendations contained in its 1995 report, the system of workforce planning has been recently overhauled. An advisory group on medical (and dental) education, training and staffing has been created – chaired by the Chief Medical Officer – which is responsible for developing a national strategic policy. Local medical advisory groups have been set up to advise regional officers on medical staffing aspects of NHS trusts. These groups are designed to ensure that individual trust policies are consistent with national standards and objec-tives. Trusts are required to include information on medical staffing strategies in their business plans and, although medical staff are now employed directly by trusts, the trusts are nonetheless expected to act in accordance with national objectives. Regulation of hospital standards NHS hospitals are not subject to formal regulation through systems of accredi-tation, as in some countries, although nongovernmental organizations such as the King's Fund in London have offered an accreditation service which a number of NHS and private hospitals have taken up. However, official regulation does apply in the cases of mental health institutions, which are subject to official inspections, and residential care and nursing homes, in which nursing and safety standards are regulated. Regulation of the pharmaceutical industry Another area where there has been long-standing regulation – both on clinical and financial grounds – is in relation to the pharmaceutical industry. All new products are subject to rigorous testing on safety grounds before they can be licensed for use. Moreover, the profits that pharmaceutical firms make through their sales to the NHS are regulated through the Pharmaceutical Price Regulation Scheme (PPRS). This is a nonstatutory scheme negotiated between the Depart-ment of Health and the Association of the British Pharmaceutical Industry, which has been in operation since 1957. The scheme operates at the level of a company's total business with the NHS rather than in relation to individual products. A company's return on capital is calculated by assessing profits minus allowable costs. A 1996 report to parliament argued that the PPRS has a number of strengths. It claimed the PPRS promotes reasonable prices; contributes to a strong industry capable of successful investment in research and development; provides continuity and stability; encourages innovation; and is administra-tively simple. Nonetheless the report also claimed that PPRS has a number of disadvantages such as a lack of transparency, a tendency to encourage ineffi-ciency and to undermine cost containment policies, and to act as a barrier to price competition. The most recent five-year PPRS agreement expired in 1998 and the govern-ment is currently seeking to replace it with a statutory system. Regulation of the internal market Notwithstanding these long-established regulatory mechanisms, it is the new pressures posed by the introduction of the internal market in 1991 and by the subsequent plans for the replacement of the internal market, which have attracted most attention in relation to regulatory policy. The 1991 reforms placed heavy emphasis on the need to introduce competi-tion into the NHS as a spur for improved performance. The government's expectations of competition were stated unequivocally: ... a funding system in which successful hospitals can flourish ... will encourage local initiative and greater competition. All of this in turn will ensure a better deal for the public, improving the choice and quality of services offered and the efficiency with which these services are delivered. Thus competition between providers for contracts from purchasers was expected to widen choice, improve quality and increase efficiency. From the outset, however, there were a number of experts who questioned the theoretical and empirical case for expecting competition

to have these effects in the health care market. In particular, fears were expressed about an overemphasis on efficiency to the detriment of quality and equity. The government's response to these concerns was to develop a system of what became known as 'managed competition'. In essence, this involved using competition, or contestability, as an incentive for increased efficiency, but regulating the market so that excessive competition did not jeopardize other objectives. Early examples of market regulation appeared in the guise of 'core' services that each health authority was expected to purchase from its local provider to ensure that access to key services was maintained for their local population. Beyond this, the whole raft of purchasing and planning priorities, described in the preceding section, was used to regulate the purchasing activities of health authorities, albeit in the form of 'guidance' (backed up by management sanctions) rather than through prescribed rules of behaviour. But probably the most explicit use of regulation occurred in relation to restrictions on provider behaviour. From the beginning, it was made clear that NHS trusts would have limited freedom over their financial affairs. Thus trusts could not behave as profit-seeking firms; rather, they were required to make a 6% return on their capital assets and to break even. Pricing policy was also regulated. They were expected to price their services on the basis of average costs and could not, except in exceptional circumstances, engage in marginal cost pricing or cross-subsidization. The most vivid statement of regulatory policy towards providers was contained in the guidance document published by the NHSE in 1994, The operation of the internal market: local freedoms, national responsibilities. This set out criteria for the NHS Executive to use when carrying out activities such as: approving mergers and joint ventures between providers; managing provider restructuring and closures; and in preventing collusion (with the possible adverse consequences of higher prices, lower quality and barriers to entry) while encouraging collaboration which is in the interests of patients. The significance of The operation of the internal market: local freedoms, national responsibilities is that it makes explicit the need to manage or regulate the market, while claiming that the internal market was never intended to meet all of the aims of the NHS on its own. This signalled a move away from dependence on competition and a greater reliance on planning and regulation. This is a trend that has continued with added emphasis by the new Labour Government.

The new NHS and its regulatory framework

A prominent feature of the present government's approach to regulation in the NHS is a strong emphasis on measuring and improving quality standards. To achieve this aim a number of new agencies are being set up. These include a National Institute of Clinical Excellence (NICE) and a Commission for Health Improvement (ChIMP). The NICE will be responsible for assessing evidence on the clinical and cost-effectiveness of existing and new treatments and for producing clear guidance for clinicians. At the outset it is expected that the Institute will carry out 30–50 appraisals per year which will be used as the basis for clinical guide-lines. This approach will be bolstered by the specification of national service frameworks that will spell out how services should be best organized to cater for patients in different service areas. To ensure that good quality services are actually delivered, the government intends to establish a Commission for Health Improvement. This is designed to provide independent scrutiny of local services and will intervene when local action fails to address deficiencies. (A full state-ment of the government's plans in these areas is contained in A First Class Service: Quality in the new NHS published by the Department of Health in 1998). One of the first outputs from the government's new approach to regulation through performance assessment was the publication of clinical indicators and high-level performance indicators in June 1999. Through its new performance assessment framework, the quality and efficiency of services are measured in terms of six main areas; namely, improvements in people's health, fair access to services, the delivery of effective care, efficiency, the experiences of patients and their carers and health outcomes. The June 1999 publication reports on the performance of each NHS trust in terms of six main clinical indicators and also on health authority performance. The clinical indicators include such measures as deaths in hospital within 30 days of surgery, deaths in hospital within 30 days of emergency admission with hip fracture for patients aged 65 and over and rates of emergency re-admission to hospital within 28 days of discharge. The indicators used to measure health authorities include size of inpatient waiting list per 1000 head of population and five-year survival rates for breast and cervical cancer. Other aspects of planning and regulation to be carried out as part of the government's plans for the new NHS – such as health improvement pro-grammes – have been outlined in earlier sections and are reviewed again at the end of this report.

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

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

Code	3.4.1
Description	Third party budget setting and resource allocation
Contents	Third-party budget setting and resource allocation The NHS budget The budget for the NHS is set annually as part of the overall public expenditure planning process. As was described in the section Main system of finance and coverage, until recently ministers from spending departments submitted expenditure bids for the next financial year to the Treasury. Following a process of consultation and negotiation, Treasury Ministers determined the spending totals for each department. While this was an extremely effective method of short-term expenditure control, the arrange-ment has been criticized because it inhibits longer-term expenditure planning. Last year, for the first time, spending totals for the following three years were announced. This decision followed the results of a wide-ranging, comprehen-sive spending review which looked at numerous aspects of public expenditure and its planning. Once the overall budget has been announced, the Department of Health determines the breakdown of the allocation between the two main health sectors: namely, 'hospital and community health services' and 'family health services'. The former, as the name implies, covers acute and community hospital services, while the latter covers primary care. (Note: the Department of Health allocations relate to England; separate allocations take place in Scotland, Wales and Northern Ireland. Also it is worth noting that several current policy initiatives are blurring the distinction between budgets for secondary and primary care, through the development of integrated budgets.) Hospital and community health service budgets Following the determination of the total budget for hospital and community health services, the allocation to regional health authorities is made. The current weighted capitation approach to regional allocations dates from the 1976 Resource Allocation Working Group (RAWP) report. This Group produced a formula for allocating budgets to regions based upon their population size, their composition in terms of age and gender, their levels of morbidity (using standard mortality ratios as a proxy) and unavoidable geographical differences in the costs of providing services. The original RAWP formula indicated substantial discrepancies between regions in terms of the distance of their actual allocations from their target allocations (based upon the formula). In particular, the regions surrounding London were shown to be substantially "over-funded" while those in the North were "under-funded". Over the period 1977–1985, the RAWP formula was used to reduce variations around target levels of spending and to produce a greater degree of interregional equity. By 1985 the government decided that discrepancies around regional targets had been largely eradicated and the RAWP formula required some fine tuning. Accordingly, a review of the formula was commissioned. As a result of this review, adjustments were made that mainly had the effect of reducing the importance attached to differences in the needs-based element, that is the standardized mortality ratios. In 1990, in anticipation of the introduction of the internal market, the RAWP formula was replaced by an alternative weighted capitation formula although the principles of the RAWP formula were retained. Yet another review, carried out by a team from the University of York, reported in 1994. Their work – based upon the most sophisticated econometric modelling undertaken to date – differed from earlier approaches by incorporating a wider range of health status and social factors in the needs-based element. Thus health status measures included the incidence of limiting long-standing illness and low birth-weight babies, while social factors included unemployment rates and the numbers of lone elderly households. While not all of the recommendations of the York group were accepted by the government, their work forms the main basis of the current system for allocating funds to regions. Allocations from regional health authorities to district health authorities have been based on a variety of approaches. Most regions use a variant of the national allocation formula but tend to adjust it in the light of historic allocations and local circumstances. During the 1990s the task of subregional allocations has been made more complicated by the emergence of a plurality of purchasers. This has required allocations to be made not only to district health authorities but also to GP fundholders and total purchasing pilot sites. While there has been general agreement about the desirability of basing all of these allocations on weighted capitation formulae, reliable formulae for application in the case of small populations are not generally available. As such most allocations have relied heavily on historic patterns of costs and activity. Family health service budgets Although the principle of weighted capitation funding is well established in relation to hospital and community health services, no such approach has been developed in relation to allocations between the family health services responsible for funding primary care in different parts of the country. As a result there are substantial variations in expenditure per head between family health service areas. Moreover these variations do not seem to reflect needs-based, hospital and community health service variations. In the future, the formation of primary care groups can be expected to lead to greater consistency in the funding of primary care as formulae are developed for budgetary allocations. In the short term, however, it is expected that most PCGs will have funds allocated to them by health authorities on the basis of patterns of activity and cost.

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

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

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	On the supply-side, there are approximately 230 independent medical/ surgical hospitals in the United Kingdom. Five main groups (General Healthcare Group Ltd, Nuffield Trust Ltd, BUPA Hospitals Ltd, Community Hospitals Group and PPP Columbia Healthcare Ltd) dominate the market. These five groups account for just over 60% of hospitals and a combined share of approximately 65% of total private beds.		
Source	European Observatory on Health Care Systems	***Year***	1999

Code	4.4		
Description	Freedom of choice		
Contents			
Source	European Observatory on Health Care Systems	***Year***	1999

Code	4.5		
Description	Referral system		
Contents	Patient referral to hospital specialists is made by GPs. This GP 'gatekeeping' role is an important element of the NHS. Unlike many other countries, NHS patients do not have direct access to specialists other than in special circum-stances, e.g. attendance at hospital accident and emergency departments.		
Source	European Observatory on Health Care Systems	***Year***	1999

Code	5		
Description	Out-patient care		
Contents			
Source	European Observatory on Health Care Systems	***Year***	1999

Code	5.1		
Description	Medical care		
Contents	Primary health care services The United Kingdom has a highly developed system of generalist, primary care delivered by general medical practitioners (GPs) and associated staff (e.g. practice nurses and community nurses) as part of the NHS.		
Source	European Observatory on Health Care Systems	***Year***	1999

Code	5.1.1
Description	General practitioner (solo-, group practices)
Contents	General practitioners (GPs) Over 99% of the population are registered with GPs who provide 24-hour access and a range of preventative, diagnostic and curative primary care services (those not registered with GPs tend to be homeless people and those in temporary accommodation). Approximately 90% of patient contacts with the NHS are with GPs. Patients may select a GP of their choice, although choice is restricted within geographical areas. The incidence of patients changing their GP – other than for reasons of changed residential location – is low. Most people have a long-standing relationship with their GP. On 1 October 1998 there were 27 392 general practitioners practising in 8994 practices in England. This produces an average practice size of around three GPs. The average practice size has increased over time with over 63% of practices currently comprising four or more doctors. Less than 10% of practices are currently single-handed, compared with 50% in 1952. The average patient list size per general practitioner on 1 October 1998 was 1866. The average list size has fallen by 7% over the last ten years. The average GP carries out 10 000 consultations per year. The number of consultations per GP has risen over the last ten years at about the same rate as list sizes have fallen. Since the establishment of the NHS in 1948, GPs have been self-employed professionals who provide services to the NHS under contract. This independent contractor status gives GPs considerable autonomy. The terms and conditions of the GPs' contract with the NHS are negotiated nationally between the doctors' representatives and the government. The latest version of this contract (1990) introduced some major changes. It was designed to increase patient choice by requiring practices to provide more information about their services; to make their terms of service more explicit; and to relate payments more closely to performance. (These performance-related payments are discussed more fully in the section Payment of health care professionals.) A central Medical Practices Committee has the responsibility for reviewing and controlling the spread of GP practices around the country. Any new practice can set up in an area that is designated 'open' by the Committee; in contrast, new practices can only be set up in exceptional circumstances in areas which are considered to be over-doctored and therefore designated 'restricted'. Various other health professionals are involved in the provision of primary health care services: namely, practice nurses, district nurses, midwives and health visitors. Practice nurses are generally registered general nurses who are employed by GPs to work within practices. They undertake a wide variety of tasks including chronic disease management, health promotion activities, immuni-zations and health assessments of elderly people. The number of practice nurses employed by GPs has increased by almost fourfold over the last ten years so that by October 1998 there were 10 358 full-time equivalents working in the NHS. In addition, there are community-nursing staff who are formally employed by community hospital trusts, although they are often attached to, and work with GPs and other primary care professionals. These include district nurses, midwives, health visitors, chiropodists and various therapists (e.g. physio-therapists, occupational therapists). Health visitors are registered general nurses who have undertaken a course of further training. They concentrate on visiting families with babies and very young children in their own homes. They offer advice and are generally concerned with the prevention of ill health and health promotion. There are approximately 12 600 health visitors in England. In recent years, increasing emphasis has been placed upon the creation of primary care teams, comprising GPs and associated nursing staff. While these have worked effectively in some areas, problems of joint working and the split management responsibility between GPs and community trusts have inhibited their performance in many places.
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	Private primary care There is very little privately financed primary care in the United Kingdom. Successive user opinion polls have revealed a high level of satisfaction with NHS GP services and so there is little scope for private practice to address perceived failings of the NHS, such as lengthy waiting times for elective surgery in the hospital sector. A recent innovation has seen the appearance of private primary care centres located at certain London mainline railway stations, offering immediate consultations for a standard fee of £35. These are designed to address the needs of busy working people who experience difficulty making normal GP appointments but are, so far, on a very small scale.		
Source	European Observatory on Health Care Systems	***Year***	1999

Code	5.2		
Description	Dental care		
Contents	Dental services Dental services are provided as part of the NHS by independent general dental practitioners who have service agreements with their local health authorities. The number of dentists on health authority lists grew by 14.4% in the ten years 1988/1989–1998/1999, so that by 1998/1999 there were 17 245 dentists listed. However, the number of adult courses of NHS dental treatment rose by just under 9% over the same period, resulting in a slight fall in the number of courses of treatment per dentist. Over this period, courses of private dental treatment, provided, for the most part, by the same independent practitioners, have expanded considerably. In some areas, patients find it difficult to obtain NHS-funded treatment and have switched to private treatment. The section on Complementary sources of finance reports how about £500 million per year is currently spent on private dental treatments. The government's own plans in relation to dental services have concentrated on reducing inequalities in dental health status and overcoming difficulties with access to NHS treatment.		
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	Pharmaceutical services Pharmaceutical services are provided mainly by community pharmacists, who supply drugs and appliances prescribed by GPs. In 1997/1998 there were 10 503 contracting pharmacies, a number that has remained fairly constant over the last ten years. The number of prescriptions dispensed, on the other hand, has grown by 38% over the last ten years, amounting to 505.8 million prescriptions in 1997/1998. Rising expenditure on pharmaceuticals is a major policy concern of the government. Expenditure is now within a cash-limited budget. Current government plans are also designed to extend the role of community pharmacists and to make better use of their skills. To this end, a series of pilot projects have been launched, such as those involving extended advice from pharmacists for patients with medication-related problems. The NHS (Primary Care) Act 1997 also gives health authorities more flexibility in providing additional pharmaceutical services. The Department of Health will be publishing a strategy for community pharmacy in the near future.		
Source	European Observatory on Health Care Systems	***Year***	1999

Code	5.4		
Description	Midwifery		
Contents	Midwives are registered general nurses who have undertaken further training focused on women's health during pregnancy and childbirth. Working in the community, they provide services to pregnant women and have responsibility for mother and child for 28 days following delivery. There are around 5000 midwives in England.		
Source	European Observatory on Health Care Systems	***Year***	1999

Code	5.5		
Description	Paramedical care		
Contents			
Source	European Observatory on Health Care Systems	***Year***	1999

Code	5.6		
Description	Home nursing and home care (maternity home care included)		
Contents	District nurses are registered general nurses who provide skilled nursing care for patients in their own homes. There are about 10 000 district nurses in England.		
Source	European Observatory on Health Care Systems	***Year***	1999

Code	5.7		
Description	Out-patient mental health care services		
Contents			
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			
Source	European Observatory on Health Care Systems	***Year***	1999

Code	6.1
Description	Hospital categories
Contents	Secondary and tertiary care The NHS hospital system is a hierarchical one comprising three tiers. The middle tier comprises district general hospitals. District general hospitals The district general hospital (DGH) is the bedrock of the system. They were originally introduced in the 1960s in order to provide a comprehensive range of services to populations of between 150 000 and 200 000 people. Despite a number of changes in organization, the model of the DGH remains the basis of NHS hospital provision today. DGHs are wide in terms of the scope of services they provide – in 1991/1992, for example, there were over 200 hospitals carrying out work in 300 or more of the 500 'health-related groups' used to classify clinical activity. The central idea underlying the DGH is that there are benefits in terms of both superior quality and lower costs from providing a number of different services from the same site. There were, however, considerable variations in their scale of activity: the largest carried out over 100 000 episodes of care per year, while the smallest performed only about 10 000. Because the DGH system was developed as a planned system, the distribution of hospitals is such that access to services is generally good throughout the country. This does not mean, however, that there are no variations in access. The pre-1948 distribution of hospitals left a highly unequal legacy between different regions in terms of the quality and quantity of provision. Parts of this legacy persist today, such as the heavy concentration of teaching hospitals in London. There is also a substantial backlog of maintenance and repair work necessary in order to bring parts of the system up to acceptable standards. As part of the programme to improve the quality of the capital stock within the NHS, both the previous government and the present one are committed to the Private Finance Initiative (PFI). This is a partnership programme designed to encourage private investment in the public sector. At the start of 1998, there were 15 projects planned with a total capital value of £1.2 billion. Ten further schemes were announced in April 1998 taking the total capital value to £2.3 billion. Clinical activity within a typical DGH is organized in terms of specialty departments comprising teams of consultants (i.e. senior specialists) and their teams of junior doctors (similar organizational arrangements exist in tertiary hospitals). Specialists and their juniors are responsible for conducting out-patient clinics at the DGH, where they see patients referred to them by GPs, and for providing inpatient treatments. Doctors and nurses working in the NHS hospitals are employed on a salaried basis. (Details of the payments systems for doctors and nurses are discussed in the section on Financial resource allocation.) Regional and supra-regional specialties Above the DGH in the hierarchy, there are tertiary level hospitals offering highly specialized services in addition to secondary care. These services typically include neurosurgery, heart and liver transplants, renal services and certain cancer treatments. They are often offered by teaching hospitals and may operate at the regional level or the supra-regional level. Patients are nor-mally referred to these hospitals by their specialist colleagues at the district level, when it becomes clear that highly specialized treatment is necessary. Small-scale community hospitals At the other end of the spectrum there are small-scale community hospitals. These may have up to 200 beds, but typically have up to 50 beds, some of which are available for GPs to manage their patients directly. Facilities offered vary from hospital to hospital but they will often have a range of diagnostic facilities, operating theatres, minor injuries units and, sometimes, day-hospital facilities. Community hospitals have had a rather chequered history in recent years. The general move towards concentrating services on larger sites, for reasons of cost and quality, has led to a reduction in their number. Between 1980 and 1990, the number of hospitals with less than 50 beds fell from around 600 to just over 400. However, the emphasis placed upon treatment in primary and community settings during the 1990s has led to renewed support for smaller, community-based hospitals. Some of those GPs with control over their budgets, such as the total purchasing pilot sites, have sought to develop their community hospitals as an alternative to expensive and unnecessary, acute hospital care – particularly in the case of elderly people. Private hospitals and clinics There are about 230 independent medical/surgical hospitals in the United Kingdom (mid-1998) with operating theatres registered to take inpatients according to Independent Healthcare Association (IHA) figures. The market is dominated by five main hospital chains: General Healthcare Group Ltd (of which BMI Healthcare is a subsidiary), Nuffield Nursing Homes Trust Ltd (who operate Nuffield Hospitals), BUPA Hospitals Ltd, Community Hospitals Group PLC. and PPP Columbia Healthcare Ltd. These alone own 61% of all independent hospitals and have a combined share of 65% of the total number of private beds in independent hospitals. A number of independent hospitals opened in the early 1990s (see Table 14). Many of the more recent hospitals to have been built are on NHS sites. Since the decision by the Labour Government to proceed with a number of PFI projects it is likely that most of the independent hospitals built in future will not be fully equipped hospitals on independent sites

but part of NHS hospital develop-ments. It is noticeable that there has been some vertical integration between the insurance function and hospital ownership in United Kingdom private health care market, with both PPP and BUPA heading up the league tables of private hospital ownership and private health insurance. One way for the major hospital groups to strengthen their market position has been through acquisitions and mergers. However the number of mergers and acquisitions has not accelerated in the 1990s due in part to the findings of a report on private health care by the Monopolies and Mergers Commission, which stated that further mergers and integration would be against the public interest. Instead since 1996, two of the main insurers have established net-works of preferred providers. The first network of this kind was launched by BUPA in May 1996 which included 150 hospitals (the majority of which are operated by the main chains of hospital operators). PPP Healthcare followed in February 1997 with its own network. This is expected to have 170 hospitals, including NHS hospitals with private patient units. These networks constitute a major change in the private hospital sector in recent years and could have significant implications for smaller non-affiliated hospitals. The take-up of this 'restricted' insurance policy has been high and as these two companies dominate the insurance market, those providers excluded from the networks could see a significant reduction in admissions. This shift, taken together with the strong incentives offered to private specialists and consultants to encourage them to refer their patients to a preferred provider, could result in independent hospital closures. By mid-1998, 4000 of the 20 000 privately practising consultants had signed up to the BUPA partnership which may account for as much as 50% of all private work. Table 15 indicates the estimated number of operations and procedures carried out in independent hospitals in 1992/1993. It shows that abortions were the commonest procedure (13.2%). Excluding abortions, most clinical activity was for elective surgery covering such procedures as cataract removals, hernia repairs, hip replacements and stripping of varicose veins. Comparisons with 1986 data do indicate, however, that there has been a substantial growth in rather more complex procedures, such as coronary artery bypass grafts and other heart operations, in recent years. In addition to the large amount of acute health care, a small amount of private health care was provided in NHS hospitals. For the most part, private acute services are supplementary to NHS provision – offering shorter waiting times for procedures that are available through the NHS. In some cases, however, private provision has effectively replaced NHS provision because its scale is insufficient to meet user needs, e.g. termination of pregnancies.

Numbers of hospital beds: some comparative data

The United Kingdom had approximately 4.5 hospital beds per 1000 population in the mid-1990s. This is one of the lowest levels in western Europe and contrasts markedly with countries such as Norway (13.5), France (10.5) and Germany (10.2). The rate of decline in the United Kingdom has been greater than in both France and Germany.

Private beds

British for-profit companies dominate ownership of private hospital beds in the private and independent sector (over 50% of the total). For-profit companies own 65% of beds in the private sector. This figure is up from 41% in 1979. Charitable and religious groups own a significant proportion (34% of the total number of beds). The total numbers of beds in the independent sector has seen a decline since 1995 when the total number peaked at 11 681. By 1998 there were 10 852 beds, representing a reduction of 829 beds or 7.1%. This follows similar trends in the NHS as a result of the shift towards day surgery and outpatient treatment for a number of complaints.

NHS amenity beds and private patient units

There are 3000 authorized amenity beds in the United Kingdom NHS, of which the majority (about 1600) are on ordinary NHS wards. Amenity beds refer to beds that are available for the treatment of NHS patients for an extra charge usually in a private room. NHS trusts can offer services and accomodation to private patients in what are known as NHS pay beds. Consultants are authorized to use a certain number of NHS bed days for private patients in a given year. Another NHS/private partnership is the use of dedicated private patient units, which are either entire wards or wings in NHS hospitals that are dedicated to private patients. In mid-1998 there were 78 units of this sort with nearly 1400 beds.

Utilization and performance of hospitals

Average lengths of stay have fallen from over 25 days in 1970 to less than 10 days in 1996. (It should be borne in mind, however, that much of the large fall between 1970 and 1985 resulted from the closure of long-stay institutions. Since then the fall has continued but at a slower rate).

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			
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	Public health services Responsibility for the promotion and maintenance of public health in the United Kingdom is shared by a number of different levels within the Department of Health and the NHS. Central government The current government was the first to appoint a minister with responsibility for public health. The Minister has a broad remit covering several government departments as well as specific responsibilities in relation to policies on, for example, tobacco and food safety. At the present time, a major responsibility for the minister is to lead the development and implementation of the health strategy set out in Saving Lives: Our Healthier Nation. Also at the central government level, the Chief Medical Officer – within the Department of Health – provides independent medical advice on public health matters across the whole department. The Annual Report of the Chief Medical Officer reports on the state of public health in England and identifies areas for improvement. Health authorities Health authorities have major responsibilities for pursuing population-based, public health strategies within a framework set out by the Department of Health. Each HA has a department of public health under a medically-trained director who is an executive member of the board. The director of public health is required to produce an annual report which documents the state of the local population's health and strategies for improving it. Within the department a consultant in public health medicine will have specific responsibility for the control of communicable diseases. During the 1990s, departments of public health have played an increasingly important role in developing local health strategies and carrying out health needs assessments as a basis for the HAs' purchasing strategy. Most HAs have a health promotion department, often as part of the department of public health. General practitioners GPs have traditionally responded to individual patient demands and have not been prominent in population-based health programmes. However, the 1990 contract sought to increase the role of GPs and other primary health care professionals in the area of public health by offering a range of financial incentives for achieving immunization and disease-screening targets. Systems of performance-related payments were subsequently introduced for health promotion and chronic disease programmes. These programmes involve registration, data collection and the provision of advice. They include maintaining registers of patients with hypertension, coronary heart disease and stroke; maintaining registers of patients' smoking habits; monitoring diet and physical activity; carrying out annual health checks on people over 75 years of age; and carrying out cervical and breast cancer screening. Despite the expansion of public health activities in primary care settings, concerns persist about the ability of GPs to carry out effective public health functions. This potential limitation is of particular importance given the increasing power being devolved to GPs for the allocation resources as part of the move towards a primary care-led NHS. New approaches to public health The 1992 White Paper, The Health of the Nation, provided a national public health strategy for England for the first time. It set priorities and quantified targets for mortality reductions in five key areas: heart disease and strokes, cancers, mental illness, sexual health, and accidents. Although it represented a considerable step forward, the Health of the Nation approach was widely criticized for placing too much emphasis on individual behaviours as an explanation of poor health, and for disregarding important social determinants of poor health, particularly inequality and poverty. The Government's approach to public health was set out in the Green Paper Our Healthier Nation, published in February 1998. Following wide public consultation, the new health strategy was published in the White Paper Saving Lives: Our Healthier Nation in July 1999. The government's declared aim is to find "a third way between the old extremes of individual victim blaming, on the one hand, and nanny-state social engineering, on the other". An important feature of the new approach is an emphasis on improving the health of the worse-off in society and narrowing health gaps. Partnership working between central government, local health authorities, local government, voluntary organizations and the business sector is also a key feature of the new approach. This approach will be taken forward through the health improvement programmes (HimPs) to be developed by all health authorities in collaboration with their local partners. In addition, 26 specially designated health action zones (HAZs) – located in areas of particular social and economic deprivation – have been targeted for particular action. These HAZs receive central funding and are designed to improve health by wide-ranging policies involving the participation of local partners in, inter alia, health, housing and employment.
Source	European Observatory on Health Care Systems
Year	1999

Code	8.1		
Description	Maternal and child health: family planning and counselling		
Contents			
Source	European Observatory on Health Care Systems	***Year***	1999

Code	8.2		
Description	School health services		
Contents			
Source	European Observatory on Health Care Systems	***Year***	1999

Code	8.3		
Description	Prevention of communicable diseases		
Contents	The United Kingdom level of immunization – at 91% – places it slightly above the mid-point in the distribution for western European countries in the WHO European Region. Since 1995, parental concerns about MMR (measles/mumps/rubella) vaccine have led to a fall in uptake and the latest Department of Health published figure (1998/1999) shows that rates have fallen to 88.3% at the age of two years. Immunization rates against other diseases such as diphtheria, tetanus, pertussis and poliomyelitis are similarly high in the United Kingdom at or around 93%. Immunizations are the responsibility of GPs, who receive target payments for attaining certain levels of immunization amongst patients on their list. The responsibility for communicable disease control lies with the department of public health within each health authority. Most have a consultant responsible for the control of communicable disease who would take action in the event of an outbreak, such as meningitis or E coli.		
Source	European Observatory on Health Care Systems	***Year***	1999

Code	8.4		
Description	Prevention of non-communicable diseases		
Contents			
Source	European Observatory on Health Care Systems	***Year***	1999

Code	8.5		
Description	Occupational health care		
Contents			
Source	European Observatory on Health Care Systems	***Year***	1999

Code	8.6		
Description	All other miscellaneous public health services		
Contents			
Source	European Observatory on Health Care Systems	***Year***	1999

Code	9
Description	Social care related to health care
Contents	Social care Social care in Britain is usually defined as long-term care in residential or nursing homes for people with mental illness, people with learning difficulties and elderly people, together with a range of domiciliary services provided for people in their own homes. Responsibility for making sure that these services are provided is shared between local government, social services departments and the NHS. This joint responsibility has led to long-standing problems of poor coordination that current policy reforms are seeking to overcome (see below). In common with many other countries, UK policy over the last 30 years has favoured 'care in the community' as an alternative to long-stay institutional care for people with mental illness or learning difficulties. As a result, nearly 100 000 people have been discharged into the community between the 1960s and 1980s. Throughout this period, however, there have been concerns that rates of discharge have exceeded the rate at which alternative services are be-ing provided in the community. In recent years, some highly publicized – but also highly atypical – cases of violence involving discharged mental health patients have led to a reconsideration of some aspects of this policy. Informal carers look after those who are sick, disabled, vulnerable or frail. Britain has an estimated 5.7 million carers and one in six households – 17% – contains a carer. Of the estimated 5.7 million carers, 1.7 devote at least 20 hours a week to caring. Of those, 855 000 care for 50 hours or more. Most caring is based on close personal relationships. Another key feature of government policy in the 1980s and early 1990s was the encouragement of the private long-term care sector. This was part of the general preference of the government of that time for private provision over public sector provision, wherever feasible. For example, in the case of long-term care places for elderly people, between 1980 and 1994 the number of places in private residential homes rose from just under 36 000 to over 164 000. The number of places in local authority residential homes fell from approxi-mately 114 000 to under 69 000. As was pointed out in the section on Complementary sources of finance, much of this growth in private sector residential care was fuelled by publicly-funded, social security payments. This was, of course, at variance with the thrust of 'care in the community' which favoured care at home rather than institutional care. In 1986 Sir Roy Griffiths, a policy adviser of the Prime Minister Margaret Thatcher, was invited to examine the issue. His report, pub-lished in 1988, formed the basis of the community component of the NHS and Community Care Act 1990 and its main elements were implemented in April 1993. The Griffiths proposals continue to form the basis of community care policy in the United Kingdom today. Under this policy, local government social service departments are respon-sible for identifying needs, setting priorities and developing plans. At the individual level, case managers assess individuals and make sure that appropriate packages of care are provided. These packages will typically involve both domi-ciliary care and residential care sometimes publicly, but increasingly privately, provided. Between 1992 and 1995, for example, the proportion of home-care contact hours provided by independent contractors rose from 2% to 29%. To overcome the perverse incentives for residential care presented through the social security system prior to 1993, central government transferred monies from social security to local authorities to be spent on care packages. In some cases, this is used to fund residential care where the case manager deems it necessary and the patient is eligible for public funding. However, particularly in the case of elderly people, private funding is becoming increasingly necessary. At the present time, anyone with assets of £16 000 or more (including their equity holding in their home) is not eligible for assistance through public funding. As was pointed out in the section on Complementary sources of finance, this requirement has led to widespread concern about elderly people having to sell their homes to fund long-term care and was the subject of a recent investigation by a Royal Commission which reported in early 1999. Other current policy developments in relation to social care allow the NHS and all health-related aspects of local government – not just social services – to delegate commissioning and providing functions to one another and pool budgets. These powers are designed to enable organizations to work together in the best interests of users and look more carefully at the mix of professionals providing services. Additionally, changes are being made to existing legislation governing transfers of money from the NHS to local government. The NHS can already transfer money to local authorities for a limited range of mainly social service functions. This power has been expanded and a new reciprocal power introduced for local authorities to transfer funds to the NHS where such a transfer will better meet the objectives of the local authority. All these new powers will be available from April 2000. Ensuring adequate quality standards in social care, especially in the case of residential care, has been a long-standing concern. With the provision of care (for often vulnerable people) distributed among thousands of different sites, this is clearly a complex task. Periodic media reports have highlighted some worrying cases of poor standards and sometimes patient abuse. Legislation during the 1990s has sought to strengthen mechanisms for monitoring and ensuring satisfactory service standards. At the national level, the Social Services Inspectorate within the Department of Health plays an important role in the national monitoring and in-depth study of particular aspects of community care. At the local level, health authorities have been responsible for the

	inspec-tion of nursing homes, and local authorities for residential homes. However, under the government's current proposals (included in the White Paper Modern-ising Social Services: Promoting Independence, Improving Protection, Raising Standards), independent agencies with across-the-board responsibilities will undertake the inspection of nursing homes, residential homes and domiciliary care providers.
Source	European Observatory on Health Care Systems ***Year*** 1999
Code	9.1
Description	Organisation and financing of social care
Contents	
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	Pharmaceuticals The level of consumption of pharmaceuticals in the United Kingdom is relatively modest by international standards. In 1996/1997 just under 500 million pre-scriptions were dispensed through the NHS in England (nearly 600 million in the United Kingdom) – this amounted to approximately ten prescriptions per person in England (usually higher for the United Kingdom). This level of prescribing is between 30% and 80% lower than the corresponding figures reported in other western European countries such as France, Germany and Italy. The rate of drug consumption is, however, increasing in the United Kingdom. Between 1986/1987 and 1996/1997, the number of prescriptions dispensed increased by around 40% in England. The use of cost sharing in the case of pharmaceuticals is discussed in the section on Complementary sources of finance. This discussion showed that prescription charges have risen substantially over time but that, because of widespread exemptions, only around 14% of prescriptions are presently subject to charges. This means that the majority of the drugs bill for NHS prescriptions – which rose by over 70% in real terms in the ten-year period to 1996/1997 – is met by central government funding. In 1993 there were approximately 1500 pharmaceuticals eligible for pre-scription through the NHS. Since 1985 however, there has been a Limited List (or negative list) which excludes some products from NHS prescribing on the grounds of poor therapeutic value or excessive cost. In recent years, the government has launched several initiatives designed to control the growth of pharmaceutical costs and to encourage cost-effective prescribing. At the beginning of the 1990s, a system of indicative prescribing budgets was introduced for GPs. These were used by independent medical advisers at the local level in order to influence high prescribers. In addition, prescribing budgets were included within GP fundholding budgets and thereby gave fundholders an incentive to manage their prescribing more efficiently. From April 1999, as part of the nationwide primary care groups scheme, prescribing budgets for all GPs will be merged with hospital and community health service budgets and cash limited. The United Kingdom has a strong research-based pharmaceutical industry that makes a significant contribution to export performance. The profits of the industry have been regulated since 1957 through the nonstatutory Pharmaceutical Price Regulation Scheme (PPRS). The aim of this scheme has been to balance the needs of the NHS with the needs of a research-based industry. A new PPRS has been negotiated between the UK Health Departments and the pharmaceutical industry. The Health Act 1999 gives powers to impose statutory price and profit controls on those companies that elect not to sign up to the voluntary scheme. It is also expected that the newly-established National Insti-tute for Clinical Excellence will play a leading role in making recommendations about the cost-effective use of pharmaceuticals in the NHS. In the meantime the National Prescribing Centre and the Prescribing Support Unit have continued to provide support to medical and pharmaceutical advisers through information bulletins and other means.
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	Health technology assessment There is a national health technology assessment (HTA) programme that is funded as part of the NHS Research and Development Programme. This was established in 1993 and aims: to ensure that high quality research information on the costs, effective-ness and broader impact of health technologies is produced in the most efficient way for those who use, manage and work in the NHS. Since its inception the programme has allocated over £39 million to around 180 research projects. Examples of areas where work has been commissioned include screening for postnatal depression, management strategies for chronic fatigue syndrome, diagnostic tests for glaucoma, telemedicine and patient satis-faction. The HTA programme will support the National Institute for Clinical Excellence (NICE), which will play a significant role in directing research and disseminating results. NICE will also be informed by a “horizon scanning” unit at the University of Birmingham. This unit will be responsible for identifying new technologies likely to affect the NHS, with a view to encour-aging their evaluation and the production of evidence on their clinical and cost-effectiveness.		
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	Training Doctors The education and training of doctors in the United Kingdom covers three related stages: (i) undergraduate medical education (ii) postgraduate medical education (iii) continuing medical education. In England, students receive a five-year (or in some cases six-year) under-graduate education and training in medicine at one of 19 medical schools. These are part of the university system and are funded by the Higher Education Funding Council. The number of students entering medical schools in the United Kingdom grew steadily from 4311 in 1990 to 5091 in 1998. There are currently plans to expand the number of places for medical students by about 1000 places per annum by 2005. In England there will be expansion at some of the existing 19 medical schools and at least three new centres of medical education. There are currently four medical schools in Scotland, one in Wales and one in Northern Ireland. On completion of their undergraduate training, students enter a pre-registration year during which they have provisional registration with the General Medical Council (GMC) that allows them to practice in hospitals and primary care as pre-registration house officers under supervision. The pre-registration year is the final part of basic medical training and is overseen by the medical school. After successfully completing one year's training as a house officer, a doctor is eligible to apply for full registration with the GMC. Inclusion on the GMC's medical register is necessary to work in the NHS as a doctor and enables doctors to, for example, prescribe drugs and complete medical certificates. The subsequent career progression of a hospital doctor would generally follow the path of: • Senior house officer (minimum three to five years but often longer) under-going general professional and basic specialist training; • Specialist registrar (four to five years) undergoing specialist training; • Consultant specialist in the specialty of choice. This is the career grade and doctors should expect to reach this point in their mid-thirties. Doctors entering general practice follow a different path. After their pre-registration year as a house officer, (and possibly some experience as a senior house officer), they must undertake three years of vocational training with at least two years in hospital SHO posts and one year as a GP registrar. As a GP registrar, they work and train in general practice with a recognized GP trainer. Upon successful completion of this period they will receive a certificate which enables them to work in general practice, including as a GP principle. Doctors who have completed their formal medical training should continue to learn and develop through the concepts of continual professional develop-ment. This is central to 'lifelong learning' and underpins the key principle of clinical governance. Under this system doctors take responsibility for the main-tenance and development of professional skills which will improve services available to NHS patients. This is designed to keep doctors up-to-date with developments in their own area of practice. Nurses In order to work as a qualified nurse in the United Kingdom, an individual has to be registered with the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) and registration has to be renewed every three years. In March 1998 there were 637 449 qualified nurses, midwives and health visitors registered with the UKCC. This represents the pool from which nursing staff are drawn, although not all nurses on the register are currently working in the United Kingdom. The vast majority of nurses are employed by the NHS. In 1995, there were 305 160 whole time equivalents (wte) employed by the service. This compared with 57 775 (wte) employed by independent hospitals and nursing homes. In addition, there were also 10 478 (wte) working as GP practice nurses. When expressed in terms of the total number of individuals working as nurses, either full- or part-time, these figures amount to over half a million. With 90% of nurses being female, nursing represents the largest source of professional employment for women in the United Kingdom. The number of nurses employed directly by the NHS has remained fairly static since the late 1980s, whereas the number working in the independent sector has grown threefold and the number working as GP practice nurses by fourfold. Nursing retention and turnover was a major problem during the 1980s. Each year approximately one in ten nurses left the workforce and two thirds of these never returned. The reduction in alternative employment opportunities associ-ated with economic recession in the late 1980s and early 1990s relieved some of the pressure, but wastage and vacancy rates have once again risen in the late 1990s. Currently, nursing shortages are seen as a major problem. The scale of this shortage is estimated at between 8000 and 12 000 nurses. In an attempt to address this problem, the Secretary of State for Health has recently announced a new salary structure for nurses with a significant increase in the starting salary. A campaign has also been launched to persuade those who have left nursing to return to the profession. The system of nurse education and training in the United Kingdom was transformed by the implementation of a new policy in 1988. This was based

largely upon the UKCC's recommendations for the reform of nursing education. The new approach represents a full-scale reorientation of nurse education, away from on-the-job training to full-time study in colleges of further and higher education. Under this system, students are counted as supernumerary to service staffing requirements while acquiring on-the-job experience and their applied work is designed to be closely linked to course-based learning. In July 1999, the Secretary of State for Health launched a new strategy, Making a Difference for Nurses, Midwives and Health Visitors. The new strategy is designed to increase the supply of nurses, midwives and health visitors by improving their career prospects. It will allow training to be spread over more than three years by incorporating 'take-a-break' periods, introduce new path-ways into nursing via national vocational qualifications, and create new posts of nurse consultants who will take on senior roles while devoting at least half of their time to direct patient care for example.
Professions Allied to Medicine (PAMs)
The Council for Professions Supplementary to Medicine is responsible for registering practitioners, approving training courses and carrying out disciplinary functions for the following professions: art, music and drama therapy, chiropody/podiatry, dietetics, medical laboratory scientific officers, occupational therapy, orthoptics, orthotics and prosthetics, physiotherapy, radiography, speech and language therapy, paramedics and clinical scientists. At September 1998 there were 103 540 scientific, therapeutic and technical staff, 14% of the total NHS Hospital and Community Health Services staff. This group includes a wide range of areas of work, the main components of which were 14 550 (14%) physiotherapy staff, 12 080 (12%) occupational therapy staff and 11 290 (11%) radiography staff. A greater focus on rehabilitation is increasing demand for physiotherapy and occupational therapy services. Investment in PAMs training continues to increase and the professions remain a popular choice with students. In the last five years, the number of training places of occupational therapists has grown by 41% and for physiotherapists by 45%. Ways of widening access into these professions and encouraging applications from those employed in the NHS who wish to pursue a professional career are being considered.
Dentists
Dentists are required to complete five years' dental school training before practising as a dentist. However those wanting to go into general practice must also do a period of vocational training. There are a number of areas of dental specialty for which further training is required, e.g. oral surgery, orthodontics, restorative dentistry, dental public health, paediatric dentistry and others. The majority of whom work as consultants in hospitals (with the exception of public health dentists who work for health authorities). Those who wish to work as hospital dentists pursue a progression through hospital training grades (i.e. house officer, senior house officer, etc.) similar to that of doctors. There are a number of auxiliary positions including, dental hygienist, dental therapist, dental technician and oral health educator.

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	

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	Human resources The main employer of doctors in the United Kingdom is the NHS. Table 18 shows that in 1996 there were 102 610 doctors employed by the NHS or, in the case of GPs, holding contracts with it. This total comprised 19 940 UK-trained hospital consultants (together with 3740 consultants from overseas) and 27 490 UK-trained GP principals (together with 5700 trained overseas). Comparative WHO data on the number of nurses per 1000 population for the United Kingdom and selected countries over the period 1970–1995 suggest that the UK ratio of nurses-to-population grew over the period 1980–1990 but has, thereafter, remained fairly static. The ratio is currently below that found in Germany and Sweden, and the EU average, but above that found in France (in 1992). The UK figure also appears to be far more stable over time than those for other countries. The doctor-to-population ratio is the second lowest in western Europe. According to the 1998 NHS Executive census of the hospital workforce there were 1.21 hospital doctors of all grades per 1000 population in England. This figure does not include the number of GPs in the United Kingdom. The low international ranking of the UK nurse-to-population ratio is not quite so evident, but the United Kingdom is still in the lowest one third in western Europe. The numbers of active physicians per 1000 population rose slightly over the period; how the number of active dentists and pharmacists per 1000 population remained constant; and how the number of certified nurses rose from 3.5 per 1000 to 5.2 per 1000 between 1980 and 1990, remained constant and then fell slightly between 1990 and 1995, but then fell to 4.5 per 1000 population in 1996.		
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	Payment of Doctors Separate payments systems apply in the case of general practitioners and hospital doctors. General practitioners (GPs) General practitioners contract with the NHS to provide general medical services. The terms of this contract are negotiated nationally between the General Medical Services Committee – the GPs representation within the British Medical Associ-ation – and the Department of Health. The actual payment system set out in the national contract is a mix of fixed allowances, capitation fees and fees for a number of specific services. GPs are independent self-employed contractors to the NHS who provide general medical services (GMS). The arrangement is a statutory one, and the terms of service (TOS) and the fees and allowances payable are determined by Secretary of State following consultations with the profession's representatives – the General Practitioners Committee (GPC) – the GPs representation within the British Medical Association. The GP remuneration system GPs are paid by the NHS as independent, self-employed professionals under a "cost plus" principle. The payments they receive cover both their expenses (the "cost") in providing GMS and a net income for doing so (the "plus"). This level of income is reviewed annually by the Doctors' and Dentists' Review Body (DDRB) who then make recommendations for decision by the Government. GPs do not, therefore, receive a salary but are paid through a system of payments designed to deliver a certain level of gross income for the average GP. The basic elements of the current payment system are: Capitation fees – annual fees payable for each patient registered on their list amounting to just over half of gross income from fees and allowances. They provide an incentive for GPs to provide high quality services, thereby attracting and retaining patients. Allowances – are the next largest single element of gross income from fees and allowances for the average GP. They include basic practice allowance, paid in recognition of the basic or standing costs incurred in setting up and maintaining a practice. Health promotion payments – comprise payments for running health promotion and chronic disease management programmes, and for achieving target levels of coverage for childhood immunizations and cytology screening. Item of service payments – paid every time a GP provides certain services, contraception services being an example. These payments are, by definition, workload sensitive. Therefore for individual GPs the amount of income they derive from fees and allowances will depend on the number of registered patients on their list, whether or not they qualify for specific fees and allowances, the number, and level of activities undertaken and the performance achieved. The introduction of GP fundholding, and subsequent variants such as total purchasing, did not affect the ways in which GPs received their personal incomes. Fundholding budgets were for the purchase of hospital and community services and could not be used to supplement GP incomes. The financial incentives offered by this scheme were in the form of control over budgets to be spent on patient care and not in the form of personal financial incentives. Personal Medical Services (PMS) pilots From 1 April 1998, under the provisions of the NHS (Primary Care) Act 1997, a series of pilot sites were established which gave health authorities the power to contract directly with GPs on a local basis for the provision of services. They provide an alternative to the national GP contract, giving primary care professionals the opportunity to test different concepts for delivering GMS. These changes offer the opportunity for exploring potentially radical changes to the payments system for GPs. They not only permit local specification of contracts, including payments levels, but also allow for the pooling of budgets for purchasing hospital services and for GPs to be employed on a salaried basis. Primary Care Groups (PCGs) and Primary Care Trusts (PCTs) As pointed out earlier, all GPs were assigned to primary care groups in April 1999 and some will join primary care trusts in April 2000. Membership of PCGs and PCTs does not however affect the independent contractor status of GPs who remain self-employed. Hospital doctors Unlike GPs hospital doctors are directly employed by the NHS on a salaried basis. Their actual salary scales are determined by the government each year taking into account the recommendations of the Review Body on Doctors' and Dentists' Remuneration. In addition to their NHS earnings, full-time NHS consultants (i.e. senior specialists) are permitted to earn up to 10% of their gross income from private practice. Those consultants who opt for maximum part-time contracts are permitted to engage in private practice without restriction on their earnings by giving up payment for one NHS session per week. There has been extensive debate in the United Kingdom on the possible perverse incentives offered to NHS consultants by the combination of private and NHS earnings. In particular it has been claimed that private earnings might reduce both the time available for and commitment to NHS work. However, despite the frequency of these claims, there is little hard evidence on the subject. In addition to

their basic payments, selected hospital consultants receive merit awards, which are allocated by a peer review process. These merit awards fall into different categories and can represent sizeable additions to basic NHS salaries. The merit award system has come under some criticism recently for being too heavily based on research performance and for being too little concerned with medical performance. As a result the whole system is currently under review. Doctors are paid fee-for-service for private consultations and activity either directly by the patient who may then be reimbursed by a private insurance company if he/she is a policyholder, or by the private hospital/clinic at which the services are provided.
Private activity of doctors
It has been estimated that there are 17 100 consultants providing private specialist services in the United Kingdom (1992). Full-time doctors in the NHS are allowed to practice privately. However, they are limited to earning 10% of their gross income from this source. Those NHS doctors on maximum part-time contracts are allowed to practice privately without restriction. In return they have to give up one eleventh of their NHS salary. There is very little private activity in primary care. Only 3% of GP consultations are estimated to be in the private sector according to self-reporting in the General Household Survey. There are about 200 exclusively private GPs in the United Kingdom mostly concentrated in London practices. The main reasons for the lack of development in this area are that GPs are not allowed under their contract to see patients on their NHS list privately or to issue NHS prescriptions and there are currently few insurance products to cover primary care services. A growth in this area may occur depending on the success of walk-in clinics (see Private primary care in the section on Primary health care and public services). Other possibilities being experimented with are the siting of general practices on private hospital sites and the provision of company-paid private GP services.

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

Code 13.1.1

Description Integrated or contracted

Contents

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

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

Code	13.2
Description	Methods of hospital payment
Contents	Payment of hospitals The methods used for paying hospitals are currently under reform. In this section we describe the major move to a contracting system which took place in the 1990s – a move that is currently being revised. Under the provisions of the 1991 reforms a contracting system was intro-duced through which funds were transferred from purchasers (i.e. district health authorities and GP fundholders) to hospitals and other providers. Contracts specify what services are to be provided and the terms on which they are to be supplied. Initially, there were three types of contract: namely, block contracts, cost-and-volume contracts and cost-per-case contracts. Block contracts specified access by DHA residents to a range of services in return for a defined sum of money. Such contracts often included some form of indicative workload agreement. The lack of information for more detailed contracting was seen as justifying block contracts which gave hospitals a guaranteed sum of money in return for a broad service agreement. They were seen primarily as a mechanism for establishing a new system of hospital financing. Cost-and-volume contracts specified that a provider would supply a given number of treatments or cases at an agreed price. They allowed service specifi-cations to be made more specific than was generally the case with block con-tracts. Greater emphasis was placed upon services defined in terms of 'outputs' (i.e. patients treated) rather than in terms of 'inputs' (i.e. facilities provided). If the number of cases exceeded the cost-and-volume agreement, extra cases were often paid for on a cost-per-case basis. Cost-per-case contracts were defined at the level of the individual patient. Thus activity and expenditure were linked explicitly. Because they involved a considerable level of transaction costs, health authorities have tended to use cost-per-case contracts as a residual category in order to fund treatments that fall outside their block and cost-and-volume contracts. These have covered referrals of patients to hospitals with whom the health authority does not have a prospective contract, so-called 'extra contractual referrals'. Many services bought by GP fundholders have also been based on cost-per-case contracts. The initial expectation of this contracting system was that, as it became more refined, there would be a movement from block contracts to cost-and-volume and/or cost-per-case contracts. In practice however, a new form of contract emerged which has been described as a 'sophisticated block' contract. These typically involve a purchaser paying a hospital an agreed contract sum for access to a defined range of services or facilities. However, indicative patient activity targets or thresholds with 'floors' and 'ceilings' will also be included in the contract together with agreed mechanisms for further action if actual activity falls outside the specified range between the floor and the ceiling. This action could include additional work on data validation or further negotiation. A survey of district health authorities for the year 1994/1995 indicated that 69% of their main contracts with acute hospitals were in the form of sophisti-cated block contracts, 25% were cost-and-volume and 5% cost-per-case. The actual sums of money agreed in these contracts have been based on a variety of approaches. Historic evidence on the sums of money necessary to fund a defined level of activity played a large part in the specification of early block contracts. Over time, considerable effort has been devoted to refining hospital costing practices so that contract prices can reflect the costs of particular episodes of treatment more accurately. As part of this effort the NHS Case Mix Office has been developing a series of 'health related groups' – these are a UK equivalent of US diagnosis-related groups (DRGs). At the same time, the development of a market-based system meant that the negotiating skill and power of particular purchasers and providers also played a part in determining the sums of money received by hospitals. In terms of the analytical categories used to classify hospital payments systems in international studies, the NHS contract system can be described as a mix involving global budgets with elements of cost-per-case payments. In some of the more sophisticated arrangements there have also been payments related to length of stay. The contracting system introduced in 1991 was part of a wider move on the part of the government of that time to move from a system based on hierarchies to one based on contractual relationships. It represented a major cultural shift for the NHS and meant that considerable amounts of management time have been devoted to the annual tasks of writing, executing and monitoring contracts. The present government believes that management costs associated with the contracting process have not been justified and is in the process of replacing it with a system based on longer-term service agreements. This approach will retain the distinction between commissioners (purchasers) and providers but will aim to reduce transaction costs by using three-year agreements. It is also aimed at shifting the focus from an emphasis on cost and activity levels to one based on the quality of care. The new performance assessment framework, discussed previously, is part of this shift in emphasis.
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	Main system of finance and coverage The main system of health finance and coverage in the United Kingdom is less complex than in most other countries. The NHS is financed mainly through central government general taxation together with an element of national insurance (NI) contributions. In 1996/1997 93.7% of gross spending on the NHS in England was met from these two sources: 81.5% from the Consolidated Fund, that is, general taxation, and 12.2% from national insurance contributions. (Despite the separation of tax and NI payments for national income accounting purposes, NI contributions are nowadays tantamount to an income tax and eligibility for NHS services is not dependent on their payment). The remainder of NHS finance (6.3%) was raised through user charges (2.1%) – mainly charges for pharmaceutical prescriptions and dental charges; from repayments of NHS trust interest bearing debt (3.0%); and from other miscellaneous sources (1.2%) such as health authority capital repayments. Raising finance through general taxation means that there is a broad funding base, covering all forms of income, capital and expenditure taxation. Because the NHS finance component is not separately identified at the collection stage, it is not possible to specify the degree of progressivity in the payments system. However, to the extent that the overall tax system is broadly progressive, so the NHS finance system may be described as broadly progressive. Collection through general taxation also means that the costs of collection are kept low because funding destined for the NHS is collected as part of the general inland revenue, tax collection process. The general tax-based system of finance does, however, mean that the degree of transparency (i.e. the relationship between individual tax payments and the benefits received from the NHS) is low. Until recently (1998), an annual Public Expenditure Survey (PES) was undertaken to determine the levels of funding for public expenditure programmes, including the NHS. Through this process, ministers from spending departments submitted expenditure bids for the next financial year to the Treasury, and Treasury Ministers, through a process of consultation and negotiation, determined the amounts to be allocated to each spending department as part of the total public expenditure planning total. This system led to effective control of public expenditure on health care. In-deed, according to some commentators, it led to excessively effective control with insufficient spending on the NHS. In 1997 the government launched a Comprehensive Spending Review of all government departments' spending. Following the outcome of this review, expenditure plans were announced for a three-year period. In addition to general tax-based funding, there was an estimated £7474 million of private expenditure on health care in the United Kingdom in 1996 (20) – 14.6% of total spending on health care in that year. Fewer than 11% of the population had some form of private medical insurance. In addition, there were substantial amounts of private spending out-of-pocket. This took the form of payments for private medical care, payments for long-term care and co-payments for pharmaceuticals, dental and ophthalmic services. (There is a fuller discussion of private expenditure on health and social care in later sections of this report).
Source	European Observatory on Health Care Systems
Year	1999

Code	14.1
Description	Main features of tax based systems
Contents	Voluntary (private) health insurance Private medical insurance takes two main forms: employment-based, company insurance (which represents 59% of the total) and individual insurance (which accounts for 31%). The remaining 10% is made up of voluntary employee-paid groups whereby professional associations or trades unions act as umbrella organizations, but employees meet the costs of premiums themselves. It is also worth noting that in just under one third of company schemes employees meet all or part of the premium costs. Table 8 shows how the size of the private insurance market – as measured by the percentage of the population covered – has grown over the last 30 years. For most of the early period, coverage grew slowly so that by the end of the 1970s it represented about 5% of the population. During the 1980s, however, the sector expanded dramatically, primarily as the result of the growth of employment-based schemes. Coverage peaked in 1990 when 11.5% of the popu-lation were covered. Since then, the sector has stagnated, probably as a result of the combined effects of economic recession and a substantial increase in the real price of insurance premiums. These grew at an average rate of nearly 5% per year between 1991 and 1996. By 1996, private insurers provided coverage for 6.4 million people; this represented about 10.8% of the population. Examination of the socioeconomic status of those people with private in-surance coverage indicates that it is heavily skewed towards higher socioeco-nomic groups. Apart from major variations between socioeco-nomic groups, private coverage drops sharply for 'employers and managers' and 'intermediate and junior nonmanual' groups in the 65 years and older age group, as their employment-based coverage ceases. This pattern of coverage has remained largely unchanged over the last ten years. There has been little growth among lower socioeconomic groups or in the 65 and over age group, despite the introduction in 1991 of tax relief on medical insurance premiums for people over 60 years of age This policy was subsequently withdrawn in 1997. Private health insurance is used mainly to cover the costs of acute health care. In 1996 the total value of independent sector acute work was approxi-mately £2.4 billion. The prospects for future growth in private medical insurance in the United Kingdom are uncertain. On the one hand, waiting times for elective procedures in the United Kingdom are lengthy by the standards of comparable countries. This might be expected to increase the demand for private insurance coverage. Moreover, the long-term growth in income levels might also be expected to fuel the demand for private health care, given the relatively tight constraints on NHS funding resulting from government attempts to control the growth of public spending. Set against these factors is the fact that there has been no growth in private insurance during the 1990s, while the unfavourable short-term prospects for the economy do not seem likely to encourage additional consumer expenditures in this area at the moment. Public opinion polls do not suggest that people view private care as 'better' than NHS care (as in the case of, for example, private education), but do see it as 'quicker'. On a political level, the present Labour Government is less supportive of the private health care sector compared with the previous Conservative Government.
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	Eligibility for NHS care All persons normally resident in the United Kingdom are eligible for services through the NHS. The statute specifying the scope of the NHS is the National Health Service Act 1977. This Act requires the Secretary of State to promote a comprehensive health service designed to secure improvement in the physical and mental health of the population and to develop services for the prevention, diagnosis and treatment of illness. Under section one of the 1977 Act, all hospital and specialist services are to be provided free-of-charge, unless the law expressly permits charges to be made. Charges can be levied on insurance companies for treating patients following road accidents and inpatients who leave hospital during the day to do paid work (typically long-stay patients) may also be charged. Charges may also be made for drugs, optical and dental services. Following an amendment to the 1977 Act by section seven of the Health and Medicines Act 1988, overseas visitors are also liable to charges for services at a rate to be determined by health authorities on behalf of the Secretary of State. (Emergency medical treatment is available without charge to residents of other EU countries under reciprocal agreements).
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

Health care benefits and rationing

Unlike those countries in which the range of health care benefits covered under private or social health insurance plans is defined explicitly, the NHS does not specify an explicit list of services to be provided. At a general level, the 1977 Act imposes a number of responsibilities on the Secretary of State in relation to the provision of hospital and community health services. For example, there is a strict duty to provide for regular medical examinations for state school pupils. However, for the most part, there is a large degree of discretion about the range of services that are actually provided. Thus the Secretary of State is required to provide services 'to such extent as he considers necessary to meet all reasonable requirements'. These wide discretionary powers are relevant to the rationing debates that have taken place in the United Kingdom in recent years. These are discussed below. The responsibility for making available general medical practitioner (GP), dental, ophthalmic and pharmaceutical services lies with health authorities rather than the Secretary of State. Their duty is to arrange that practitioners in their area provide an acceptable level of service for the resident population. Once again, however, what constitutes an acceptable level of service remains vague. In the case of GPs, for example, their national contract states that they are obliged to provide patients registered with them 'all necessary and appropriate personal medical services of the type usually provided by general medical practitioners'.

The Patient's Charter

In an attempt to be more specific about patient rights and expectations in relation to the NHS, the Conservative Government introduced a Patient's Charter in 1991. This Charter – which was part of a wider initiative based on a Citizen's Charter – set out a number of NHS rights together with charter standards which the NHS was expected to meet (see Box 1). These are not, however, enforceable through the legal system. Subsequent published reports have provided infor-mation on comparative hospital performance in terms of Patient's Charter standards.

The Patient's Charter: Rights and Standards

Rights:

• To receive health care on the basis of clinical need, regardless of ability to pay;
• To be registered with a GP;
• To receive emergency medical care at any time, through your GP or the emergency ambulance service and hospital accident and emergency departments;
• To be referred to a consultant, acceptable to you, when your GP thinks it necessary and to be referred for a second opinion if you and your GP agree this is desirable;
• To be given a clear explanation of any treatment proposed, including any risks and any alternatives, before you decide whether you will agree to the treatment;
• To have access to your health records, and to know that those working for the NHS will, by law, keep their contents confidential;
• To choose whether or not you wish to take part in medical research or medical student training;
• To be given detailed information on local health services, including quality standards and maximum waiting times. You will be able to get this information from your Health Authority, GP or Community Health Council;
• To be guaranteed admission for virtually all treatments by a specific date no later than two years from the day when your consultant places you on a waiting list. Most patients will be admitted before this date. Currently, 90 per cent are admitted within a year;
• To have any complaint about NHS services – whoever provides them – investigated, and to receive a full and prompt written reply from the chief executive of your Health Authority or general manager of your hospital. If you are still unhappy, you will be able to take up the case with the Health Services Commissioner.

Standards:

• Respect for privacy, dignity and religious and cultural beliefs;
• Arrangements to ensure everyone, including people with special needs, can use the services;
• Information to relatives and friends about the progress of your treatment, subject, of course, to your wishes;
• An emergency ambulance should arrive within 14 minutes in an urban area, or 19 min-utes in a rural area;
• When attending an accident and emergency department, you will be seen immedi-ately and your need for treatment assessed;
• When you go to an outpatient clinic, you will be given a specific appointment time and will be seen within 30 minutes of it;
• Your operation should not be cancelled on the day you are due to arrive in hospital. If, exceptionally, your operation has to be postponed twice you will be admitted to hospital within one month of the second cancelled operation;

• A named qualified nurse, midwife or health visitor responsible for your nursing or midwifery care;
• A decision should be made about any continuing health or social care needs you may have, before you are discharged from hospital.
Source: Department of Health (1995) NHS: the patient's charter: a charter for England H SO, London.

The Labour Government came to office with a commitment to review the Patient's Charter and to produce a new one. The Government asked Greg Dyke, with a group of advisors, to review the Patient's Charter and his report, The New NHS Charter: A Different Approach was published by the Department of Health in 1998. Although Mr Dyke emphasized the importance of local rather than national charters, no decisions have yet been taken about the final form of the new approach.

Waiting lists

The Government elected in 1997 had made a specific commitment to reduce the number of people waiting for NHS treatment. Prior to the election, exten-sive public consultation had revealed waiting times to be a major source of public concern with the NHS.
The specific commitments were:
(i) no one should have to wait for more than 18 months for a hospital in-patient admission, and (ii) to reduce total numbers of people waiting by 100 000 below the 1 May 1997 figure by the time of the next election.
However, following a substantial increase in the numbers waiting during the first year of government, a subsequent pledge was made to reduce the total number of people waiting to the 1 May 1997 level by 1 April 1999. Figures for the total number of people waiting for hospital admissions are given in Table 6. These figures show that after rising until March 1998, the total number of people waiting has subsequently fallen. The government would like to achieve a position where no one is waiting for more than 12 months, but – although the numbers in this category are falling – there are now more people waiting between 12 and 18 months than when the government came to office. The number of people waiting for outpatient appointments is not included in the above figures. Figures collected on those still waiting over 13 weeks for a first outpatient appointment have shown an increase on the inherited position.

Pharmaceuticals

In the case of pharmaceuticals, the scope of NHS benefits is more explicit than in other areas. In 1985, a Selected List Scheme was introduced restricting the range of medicines that are available through NHS prescriptions. Schedule 10 to the National Health Service (General Medical Services) Regulations 1992 lists drugs which may not be prescribed on the NHS by general practitioners; Schedule 11 to the same regulations lists drugs which may only be prescribed to the specified types of patient or for the specified condition(s). In addition, the Department of Health seeks to influence prescribing behaviour through the periodic distribution of leaflets containing cost comparison charts for alterna-tive pharmaceutical products within particular therapeutic groups. There is also a British National Formulary (BNF) which is prepared by The Royal Pharmaceutical Society of Great Britain and the British Medical Association. This is mailed free to all doctors on a regular basis. Government policy in relation to prescribing in the NHS is currently in the process of change. Under the previous Conservative Government, services to be provided under the NHS (including pharmaceuticals) were left to local decision-making. The new Labour Government has a far stronger preference for national standards. As part of this approach, the newly-established National Institute for Clinical Excellence (NICE) issues guidance to local decision-makers about services of proven effectiveness and recommended for adoption by the NHS. In its first judgement NICE recommended that the newly licensed anti-flu drug Relenza should not be generally prescribed by the NHS because of lack of evidence regarding its efficacy in relation to high-risk elderly people.

Priority setting by health authorities

Following the implementation of the NHS and Community Care Act in April 1991, health authorities acquired major new responsibilities as purchasers or commissioners of health care. They assumed responsibility for assessing the health care needs of their populations and commissioning a mix of services which best met these needs. As before, however, the NHS remained a cash-limited service and so this task needed to be carried out within the constraint of fixed budgets. This meant that a series of choices needed to be made about which services were commissioned, in what quantities and for whom. The assignment of explicit responsibility for these decisions to health authorities was one of the main reasons for the heightened awareness about rationing in the NHS during the 1990s. Over this period there have been a number of high profile debates centering on the decisions of particular health authorities that have decided to restrict the range of services to be made available to their resident populations or decided not to fund particular services for particular individuals. Probably the most widely-publicised case is that of the so-called 'Child B' (Jaymee Bowen) which occurred in March 1995. The father of the child took Cambridge and Huntingdon District Health Authority to court for refusing to fund further chemotherapy and a second bone transplant for his daughter, who was suffering from leukaemia, on the grounds that the clinical prognosis was extremely poor. In fact the court found in favour of the health authority. The child actually received the treatment in the private sector, funded by a private donation, but

sadly died subsequently. Faced with the need to make difficult choices over decisions of this type, a number of approaches to priority setting have been developed. For its part, the central government has encouraged health authorities to involve the general public in decisions about rationing and priority setting. This stance was subse-quently supported by the all-party House of Commons Select Committee on Health in its report on priority setting (1995). At the local level, numerous methods for eliciting the public's views have been used including population surveys, public meetings, focus groups and, latterly, citizens' juries. Other initiatives have involved health authorities in elaborate exercises where expert and public inputs have been drawn upon to assist managers in determining priorities in relation to future spending. Methods of economic evaluation developed by health economists have also been drawn upon. Despite all these initiatives, however, a major study of priority setting, as carried out by health authorities, found that outright exclusion of services was rare and, where it did occur, was confined to peripheral services such as tattoo removals, cosmetic surgery and homeopathy. For the most part, health authorities sought to avoid major controversies by providing at least some services, and relying on traditional NHS approaches of waiting lists and rationing by clini-cians in the case of major service categories. In a recent review of rationing approaches, Hunter (12) has dubbed this approach 'muddling through elegantly'.

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

Code 14.4

Description Complementary sources of finance

Contents

Complementary sources of finance
The NHS dominates health care provision in the United Kingdom and it is financed overwhelmingly through general taxation. There are, however, some complementary sources of health finance. The NHS itself derives about 2% of its income from user charges. In addition, there are private, out-of-pocket payments for nonprescription medicines and also payments for private health care which may be funded out of pocket or through private health insurance. The share of total health expenditure accounted for by private payments rose from 3.1% in 1975 to 6.7% in 1990. Most of this growth was attributable to a rising share of payments from private insurance. During the 1990s, however, this share has remained almost constant and the overall share of private expenditure has fallen slightly.

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

Code 14.4.1

Description Voluntary health insurance

Contents

Private sector
In 1996 there were 25 private medical insurers offering coverage in the United Kingdom. Seven of these were non-profit, provident associations (e.g. BUPA, PPP Healthcare, WPA); the remaining 18 may be described as "commercial insurers", although some of them are mutual societies owned by their members (e.g. Norwich Union). Although the commercial insurers include five relatively long-established companies who entered the market before 1988, the majority of them entered during the late 1980s and early 1990s. With the increased competition from these new entrants, the provident associations have experienced a reduction in their market share in recent years.

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

Out-of-pocket payments

In the NHS hospital sector, small amounts of income come from charges for “amenity” beds which generally have more privacy than normal ward beds. But the main areas where charges are levied is the family health services in relation to pharmaceutical, dental and ophthalmic services.

Pharmaceuticals

Prescription charges were first introduced back in 1952, as the demand for services outstripped the expectations of the original architects of the NHS, and, apart from the period 1965–1968, have been in existence ever since. These charges have risen steeply over time. For example, the real charge (i.e. price adjusted for general inflation) rose by nearly 300% over the period 1971–1993. In 1998 the prescription charge amounted to £5.80 per item (about 57% of the average total prescription cost). There are, however, widespread exemptions from charges for children under the age of 16, elderly people, those on low incomes, for people with specific chronic conditions and for specified uses, e.g. contraceptive pills. By 1995/1996, 84% of prescriptions were dispensed to people claiming exemptions. Despite the existence of widespread exemptions, changes in prescription charges can have a noticeable impact both on government revenues and on the number of prescriptions dispensed. For example, it has been estimated by a group of leading academic researchers that the increase in prescription charges from £3.75 to £4.25 per item in 1993 resulted in the generation of £17.3 million in extra revenue for the government. It also resulted in a reduction of 2.3 mil-lion in the number of prescriptions dispensed compared with the number that would have been dispensed if charges had not risen. From 1953 to 1969, pharmaceutical prescriptions were the largest source of NHS income from charges. Since 1969, however, they have been exceeded by dental charges: for example in 1998/1999, income from prescription charges for England was £341 million whereas income from dental charges amounted to £420 million.

Dental services

Within the NHS, general dental services are provided by independent dentists under agreements made with local health authorities. There is currently a considerable amount of co-payment with individuals paying 80% of the cost of their treatment up to a maximum charge set at £348 in 1999/2000. NHS charges are not levied on certain patient groups, mainly children, those on low incomes and pregnant or nursing mothers. In 1998/1999 the average full cost of a course of NHS dental treatment was approximately £34. Many dentists offer services both to NHS patients and to private patients. In recent years disputes between dentists and the government over the fees offered for NHS work have led to some dentists withdrawing entirely from NHS work, and to others reducing the amount they undertake. Faced with difficulties in obtaining treatment under the NHS, patients in many areas have become private patients. This involves bearing the full costs of dental treatment. As a result private dental insurance has expanded rapidly in recent years. For example, Denplan Ltd (which was acquired by the major medical insurer, PPP, in 1994) currently funds about £60 million of private dentistry per year for 500 000 patients out of an estimated total private dental market of £500 million per year.

Ophthalmic services

During the 1980s there was general deregulation of ophthalmic services. From April 1989, free NHS eye tests have been restricted to certain priority groups; namely, children, students under 19 years of age and in full-time education, adults on low income and people who have, or are predisposed to, certain eye diseases. Entitlement to free NHS sight tests was reinstated to all aged 60 and over from April 1999. All other groups must seek private eye tests. Prices are usually in the range £16–£18. Most spectacles are now provided on a commercial basis by opticians, although NHS vouchers are provided to help certain priority groups, mainly children and those on low incomes, meet the cost of spectacles. Just fewer than four million vouchers were issued in 1996/1997 in England.

Social care

Within British health and social care policy, there has been a long-standing distinction between health care provided by the NHS, which is overwhelmingly free at the point of use, and social care provided through local government, which is means-tested. For much of the post-war period, however, this distinction was masked as local authorities often failed to levy charges for domiciliary social care and a large amount of long-term nursing care was provided free-of-charge by the NHS. A change in this situation started to occur in the 1980s as government policy encouraged the private provision of nursing and residential care at the expense of NHS and local authority provided care. To begin with, the financial impli-cations of the withdrawal of free NHS care were obscured because the social security system funded the newly provided private care. However, following the implementation of the care in the community component of the NHS and Community Care Act in 1993, this situation changed. Under the new arrangements, all individuals who require social care are subject to a needs assessment carried out by a case manager from their local authority social services department. On the basis of this assessment, an appropriate package of care – which may involve domiciliary or

	residential care – is identified. The individual is also assessed in terms of their income, and (in the case of residential care) in terms of the value of their assets, in order to determine what level of payment they will be required to bear privately. At the present time, anyone with assets in excess of £10 000 is required to make a contribution towards the costs of nursing home or residential care. Anyone with assets in excess of £16 000 is required to meet the costs in full. For the purposes of this calculation, a person's equity holding in their home is included as part of their assets and must be drawn upon to meet the costs of social care. This process has led to considerable complaint from those people, and their families and heirs, who have been expected to meet their long-term care costs in this way. Claims have been made that an implicit social contract between the government and elderly people has been broken. As a result, there has been much debate on the subject and numerous proposals have been made for reform of the system. In the light of these concerns, the Labour Government set up a Royal Commission on Long Term Care in 1997. The Commission published its report, With Respect to Old Age: Long Term Care – Rights and Responsi-bilities, in March 1999. Its main recommendation was that the costs of care should be split between living costs, housing costs and personal care. Personal care should be available after an assessment, according to need and paid for from general taxation: the rest should be subject to a co-payment according to means. At the time of writing the government is considering its response to the Committee's recommendations.
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	Health care expenditure Total expenditure on health care in the United Kingdom, for selected years, as recorded in the WHO health for all database. It includes expenditure in current and constant prices; per capita expenditure in US dollars purchasing power parities at current prices; health expenditure as a share of GDP; and public expenditure as a share of total expenditure. As would be expected, all of the expenditure series display a general upward trend. Health care expenditure as a share of GDP rose quite rapidly between 1970 and 1975; thereafter, in the wake of worldwide recession and restrictions on public spending which occurred in the mid-1970s, it grew far more slowly over the second half of the 1970s and throughout the 1980s. There was, once again, a marked increase in this share from 6% to 6.9% between 1990 and 1992, but since then it has stayed constant for the remainder of the 1990s. Public expenditure on health as a proportion of total expenditure fell from 91.1% to 84.1% between 1975 and 1990. Thereafter, however, the public share has remained fairly constant in the light of stagnation of the private health finance market during the 1990s. Because public expenditure on the NHS dominates expenditure on health in the United Kingdom, and because this public expenditure is subject to tight cash limits, levels of spending on the NHS are the subject of intense political debate. Over the last 20 years, particular attention has focused on the hospital sector as, according to many commentators, annual increases in funding have not been sufficient to meet increases in demand. For example, over the period 1981/1982 to 1989/1990 annual increases in real expenditure on hospital and community health services (i.e. cash increases adjusted for general inflation) amounted to an average rate of about 1.7%. In fact, if cash increases were adjusted by the rate of price inflation in the NHS hospital sector, the average annual rate of increase in expenditure was less than 1%. These figures contrast with unofficial estimates which suggest that the NHS requires annual increases in spending of around 3% per year to keep abreast of rising demands resulting from an ageing population, the introduction of new medical technologies and rising public expectations. According to many commentators, it was the build-up of funding pressures during the 1980s (and the political debate surrounding these pressures) that prompted the Prime Minister at the time, Margaret Thatcher, to instigate the inquiry which led to the 1991 reforms. Annual funding settlements for the NHS in general, and the hospital service in particular, were considerably more generous in the period immediately preceding and following the implementation of the 1991 reforms, but started to tighten up again in 1993/1994. In July 1998, following a far-reaching, comprehensive spending review, the new Secretary of State for Health, Frank Dobson, announced a three-year expenditure plan for the NHS with annual increases in real growth over the period 1999/2000–2001/2002 planned to average 4.7% per year. Despite the generally favourable response accorded to this announcement, the winter pressures on the hospital service in 1998/1999 once again led to headlines announcing an ‘NHS in crisis’. During debates about the adequacy of NHS expenditure, reference is often made to the smaller proportion of GDP devoted to health expenditure in the United Kingdom compared with most other similar countries. Total expenditure on health as a proportion of GDP, at 6.7% in the United Kingdom, is indeed lower than the western European average of 8.5%. On this measure, the United Kingdom ranks 20 out of 21 countries. Comparative data on public expenditure as a proportion of total expenditure on health for the WHO European countries indicate that the UK proportion of 85% is among the highest in western Europe. This highlights the fact that it is the low level of private expenditure on health which produces the low overall ratio of health spending-to-GDP in the United Kingdom.
Source	European Observatory on Health Care Systems
Year	1999

Code	15.1
Description	Structure of health care expenditures
Contents	Structure of health care expenditures The main categories of spending on health in the United Kingdom, as a proportion of total expenditure, over the period 1970–1997 show how spending on inpatient care represented over 50% of expenditure in 1980 but had fallen to 42% by 1995. Spending on pharmaceuticals displays a long-term upward trend and had reached 17.3% of total expenditure by 1997. The other noticeable trend has been the long-run decline of public investment as a percentage of the total investment, and a more modest decline in total investment since 1990.
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	Aims and objectives The period 1989–1999 has been one of unprecedented change for the NHS. First there were the radical market-based reforms introduced by the Conservative Government through the NHS and Community Care Act in 1991. These led to numerous changes in the period up to 1998. Then, following the election of a Labour Government in 1997, a new policy direction was announced. At the present time these policy changes are in the process of being implemented. In the following account, the determinants and objectives that led to the round of reforms introduced by the previous Conservative Government are discussed. Then discussion moves on to the current reforms being introduced by the Labour Government. The Conservative Government's reform programme was set out in the White Paper, Working for Patients, which was published in January 1989. This proposed a radical reform programme that was subsequently embodied in the NHS and Community Care Act 1990. It was this act which led to the introduction of an internal or quasi-market in the NHS. A combination of factors appears to have influenced the timing and direction of this change. The immediate cause was the funding crisis of the winter of 1987 which prompted the Prime Minister, Margaret Thatcher, to set up a high-profile ministerial review of the NHS, which she herself chaired. The early deliberations of the group were believed to have centred on alternative ways of NHS funding: ways that would avoid the constant funding crises to which the NHS was prone. However it soon became clear that the existing method of central tax-based funding was particularly effective at containing the growth in health expenditure. For this reason the United Kingdom, unlike many other countries was not subject to serious cost escalation. Recognition of this fact made ministers reluctant to interfere with funding mechanisms. As a result attention shifted to the way services were organized, managed and delivered. Within this new focus, a wider set of considerations became relevant. Throughout the 1980s a constant theme of government microeconomic policy had been a belief in the superior efficiency of the private sector. A central component of this belief was that the competitive environment, within which private sector firms operate, provides the necessary incentive structure for achieving greater efficiency. This had been the stated rationale for previous privatization schemes. As such there was an established commitment to a system of organization that could – with suitable modification – be applied to the NHS. The result was the introduction of an internal market into the NHS, with the claim that competition between providers would increase efficiency, offer wider choice and improve the quality of services. Thereafter a number of other factors came into play. It soon became clear that the wider, social objectives of health care required the market to be quite closely regulated, so a system of managed or regulated competition developed. This trend was reinforced on the political level as the unpopularity of a strongly market-based approach among the general public and many health care profes-sionals led successive ministers to distance themselves from aggressively pro-market stances. At the same time, the unexpected rate of growth and expansion of GP fundholding led ministers to attach increasing importance to primary care-based models of purchasing and to an eventual emphasis on a 'primary care-led NHS'. Throughout the 1990s, while in opposition, the Labour Party was sharply critical of the Conservative Government's market-based approach. The alleged inequity of the system, particularly the unequal treatment received by patients of fundholding and non-fundholding GPs and the heavy transaction costs of running a market system, were particular sources of criticism. For these reasons the Labour Party was committed to the abolition of the internal market. These pledges have started to be put into practice since the election of a Labour Government in May 1997, As mentioned above, the Labour Government's main criticisms of the internal market reforms are that they led to fragmented services, carried heavy transaction costs and were inequitable. There has also been criticism of the overemphasis on costs in the contracting system, and a belief that the quality of health care has been neglected. At the same time, however, there seems to have been an acceptance of the merits of the primary care focus of the previous reform programme and a desire to retain this emphasis in a way that avoids the perceived unfairness and fragmentation caused by GP fundholding. The Labour Government's own plans for the reform of the NHS were set out in the White paper, The new NHS: modern, dependable, published in December 1997. This set out a ten-year agenda that aims to replace competition and the internal market with a new-style system based on partnership working and collaboration. Since then, there has been a steady stream of NHS executive letters and guidance providing more details about implementation. At the time of writing, the Health Act 1999 is going through parliament containing details of those changes that require legislative approval. The main elements of the new approach are: • Maintenance of the separation of responsibilities for commissioning and providing but the replacement of annual contracts with three-year service agreements; • The abolition of GP fundholding and the formation of area-based primary care groups (PCGs) to which all GPs in an area will belong. 400 to 500 of these groups, formed since April 1999, will cater for average populations of 100 000 patients (see the section on Organizational structure of the health

system);
• The maintenance of health authorities (HAs) but with the intention that their activities should become increasingly strategic as PCGs assume the responsibility for commissioning services. A major responsibility for health authorities will be to take the lead on the development of health improve-ment plans (HimPs) in collaboration with other local agencies in their area;
• Maintenance of NHS trusts but with an obligation for them to work collaboratively with DHAs, PCGs and other providers;
• Far greater emphasis on the quality of care and health outcomes with the establishment of new methods of clinical governance. These include the establishment of the National Institute for Clinical Excellence for deter-mining and disseminating information on best clinical practice; the develop-ment of national service frameworks setting out recommended patterns of care in specific disease, disability and client areas; and the formation of a Commission for Health Improvement to monitor and improve standards at the local level;
• A far higher priority attached to reductions in inequality and deprivation. The commitment to this objective can be seen in the new approach to public health and the formation of 26 health action zones (HAZs). This latter initiative is focused on areas of particular deprivation and is designed to encourage collaborative working between the NHS, local government, local industry and voluntary organizations in order to improve the health of deprived populations.

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

Code	17.2
Description	Content of reforms and legislation
Contents	Reform of primary care Over the last ten years, an increasing amount of policy emphasis has been placed upon the primary care sector within the NHS. This process gained real momentum following the publication of a White Paper, Promoting Better Health, in 1987. This White Paper contained a number of measures designed to make general practice more responsive to market forces. It was followed by the new 1990 contract and the various organizational reforms, involving GP fundholding and its variants, which have been discussed already in the section on Organizational structure and management. Another significant event in the development of primary care occurred with the publication of the NHS executive letter, Developing NHS Purchasing and GP Fundholding, in October 1994. The subtitle of this document was Towards a primary care-led NHS. Much of the change resulting from the strategy set out in the executive letter has concentrated on primary care-based purchasing, but there has also been considerable emphasis on extending and improving primary care provision. As a result, many new services have grown up in primary care settings (e.g. a large expansion in primary care counselling services), while other services have been transferred from secondary care to primary care settings (e.g. specialist outpatient clinics held on primary care premises). The NHS (Primary Care) Act 1997 also set up a number of pilot projects around the country with the aim of expanding further the form and scope of primary care provision. The new government's current reforms discussed in the section on Organi-zational structure and management look set to continue this emphasis on a primary care-led NHS. In April 1999, 481 primary care groups were established involving all general practices within an area. These are designed both to improve the quality of primary care provision and to enable GPs and other primary care professionals to influence the nature of secondary care services provided for their patients. Comparative data on the number of outpatient contacts per person per year in the WHO European Region suggest that at 5.9 consultations per person in 1996, the United Kingdom has an average consultation rate amongst the countries of western Europe. The average number of patient contacts of those western European countries is 5.7. Reforms and legislation This section provides a chronological account of the main policy measures affecting the NHS that have been introduced over the period 1989 to 1999. Each measure is described only briefly as they have all been discussed more fully elsewhere in the report. 1989 Publication of the White Paper, Working for Patients, which set out the Conservative Government's plans for radical reforms of the NHS through the development of an internal market. 1990 The introduction of a new national contract for GPs aimed at improving performance and making the profession more accountable. The contract was introduced in the face of fierce opposition from the profession. 1991 The start of the implementation of the NHS internal market reforms following the embodiment of the proposals contained in Working for Patients in the NHS and Community Care Act 1990. The Health of the Nation Green Paper published setting out a public health strategy based on setting quantified targets and measuring performance against these targets. A research and development strategy for the NHS was launched with the aim of contributing towards evidence-based practice and policy. Publication of the Patient's Charter setting out for the first time the rights of patients and the standards of service they could expect from the NHS. 1992 A White paper on the Health of the Nation published confirming the approach outlined in the previous year's Green Paper. An additional 1400 doctors joined the GP fundholding scheme, bringing the total to over 3000 GPs caring for 6.7 million patients or 14% of the population. 1993 The start of the delayed implementation of the community care component of the NHS and Community Care Act 1990. 1994 An executive letter was distributed by the NHS Executive, entitled De-veloping NHS Purchasing and GP Fundholding, which set out an agenda for greater emphasis to be placed upon fundholding and extended versions of it (such as total purchasing) as part of the development of a 'primary care-led NHS'. Guidelines on regulation of the internal market were issued by the NHS Executive entitled The operation of the internal market: local freedoms, national responsibilities. 1995 The Health Authorities Act led to closer integration of primary and secondary care through the creation of approximately 100 merged district health authorities and family health service authorities. 1996 Regional health authorities were replaced by regional offices of the NHS Executive. A report Primary care: the future, published by the NHS Executive, setting out the results of an extensive consultation exercise on the future of primary care in the NHS. Following this publication, a White Paper Choice and opportunity: primary care, the future, was published setting out new models of primary care that the government intended to pilot, including practice-based contracts and salaried GPs.

1997 The NHS (Primary Care) Act was passed giving the go-ahead for the introduction of pilot schemes covering GP personal medical services. A new Labour Government was elected committed to the abolition of the internal market. The Labour Government sets out its plans for a reformed NHS in a White Paper The new NHS: modern, dependable. This describes an approach in which markets and competition will be replaced by collaboration and joint working. 1998 A consultation paper Our Healthier Nation was published, setting out the government's intended approach to public health. It placed consider-able emphasis on improving the health of the worse-off in society and to reducing health inequalities. A document A First Class Service: Quality in the new NHS was published setting out the government's plans for improving quality and clinical governance. This involved the establishment of the National Institute for Clinical Excellence and the Commission for Health Improvement. A White Paper Designed to Care – Renewing the National Health Service in Scotland was published setting out the reforms of the organization of the NHS in Scotland which will take place under the Scottish Parliament. This involved the establishment of primary care trusts under which mental health services, local health care cooperatives and community hospitals would operate. A White Paper NHS in Wales: Putting Patients First was published in January setting out the arrangements for the organization of the NHS in Wales under the responsibility of the Welsh Assembly. This involved the establishment of local health groups (equivalent to PCGs in England).
1999 Primary care groups went "live" on 1 April 1999. Report of the Royal Commission on Long Term Care for the Elderly, With Respect to Old Age: Long Term Care – Rights and Responsibili-ties, was published. The White Paper, Saving Lives: Our Healthier Nation, setting out the government's strategy on public health, was published. A document Fit for the Future – A New Approach was published in March 1999 which set out the Government's proposals for the future of the health and personal social services in Northern Ireland.

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

Code	17.4
Description	Reform implementation
Contents	Reform implementation As the preceding account has demonstrated reform of the NHS in the United Kingdom during the 1990s has involved some radical changes of direction. The 1991 reforms The reforms introduced by the Conservative Government in 1991 were part of a wider policy aimed at introducing a greater element of market discipline into the public sector where it was felt that such discipline had been lacking. The result of which, it was claimed, was inefficient bureaucracy and services that were not sufficiently responsive to user needs. The introduction of market-based approaches to the public sector was controversial and attracted a good deal of opposition. This was especially true of the NHS. From the outset, health care professionals (i.e. doctors, nurses and other professions allied to medicine) and the general public were generally seen as opposed to the direction of change. Most support came from NHS managers who experienced an increase in power vis-à-vis doctors. Despite this opposition, however, the government pressed ahead with its plans. The late 1980s and early 1990s was a period when strongly held conviction-led policies were pursued at the expense of a more consensual approach. Certainly this resulted in the implementation of major change, albeit sometimes at the cost of morale in different parts of the service. Over time however, possibly as a result of the continuing electoral unpopu-larity of some of the more radical changes, the government softened its stance. The emphasis on competition and the internal market was reduced as a system of regulated or managed competition was developed. The term 'purchasing' was increasingly replaced by the term 'commissioning' as attempts were made to move away from models based on spot purchasing to those on a more strategic, planned approach. GP fundholding The implementation process of GP fundholding is of particular interest. When fundholding was first introduced, it was an experimental scheme restricted to 303 practices. Even among the architects of the reforms it was widely seen as a 'sideshow' and not part of the main agenda. At the outset the scheme was strongly opposed by the British Medical Association. Over the ensuing seven years, however, the scheme expanded dramatically in scale and scope. By 1998 there were over 3500 fundholding practices covering 15 000 GPs. The BMA had long since withdrawn its opposition as increasing numbers of its members joined the scheme. A number of factors can be identified as contributing to the unexpected growth of fundholding. Firstly the experience of the early fundholders showed that they were able to improve the services received by their patients. Holding budgets gave them small but effective levers for improving services at the primary–secondary care interface. Others noted these advantages and sought to share them by joining the scheme. At the same time there is no doubt that the government's growing support for fundholding led them to offer a range of inducements (e.g. support for computer systems) that were not available to non-fundholders. Some GPs, although not attracted to fundholding per se, felt that by not becoming fundholders they would be seen as laggards and behind the times; such a perception, it was feared, could lead to the loss of patients. As a result they became reluctant fundholders. Taken together these factors contri-buted to the accelerated growth of fundholding. Not all GPs, however, joined the bandwagon. Many continued to harbour deep-seated ideological objections to fundholding on the grounds that it was inequitable and led to the rationing of services. These GPs sometimes formed non-fundholding commissioning groups. These have been important in the thinking leading to proposals for primary care groups. Policy evaluation Another area where there was a marked change of stance in the government's position was the evaluation of policy changes. In 1991 the government set itself firmly against evaluation of the reforms. It denied the need for an official programme of monitoring and evaluation and expressed the view that calling on outside academics or others to perform this role would be a sign of weakness. The consequence of this stance was that there was little firm evidence on the successes and failures of the largest reform to be undertaken in the history of the NHS. Gradually, however, this governmental stance shifted as it became apparent that it lacked good evidence of performance of the NHS. This hampered its political agenda as well as the scope for finessing policy on the basis of evidence. It was also totally inconsistent with the launch of the NHS R&D programme that was postulated on the need to base action on evidence. As a consequence of these various pressures, programmes of official evaluation started to be funded. This process has developed so far that it is now virtually impossible for a new policy initiative to be announced without an accompanying commit-ment being made to its evaluation. (In passing, it should be noted that this pro-evaluation stance is posing its own problems. Ministers and civil servants frequently look for definitive answers from research in complex areas of social change that cannot be provided.) The most up-to-date review of the evidence relating to the performance of the internal market reforms is contained in the King's Fund publication Learning from the NHS Internal Market: a Review of the Evidence (15). Material drawn from this source is presented in the conclusions of this report.

Current reforms
The change of government in 1997 led to a change of direction in health policy in the United Kingdom. A system based upon competition within the internal market is in the process of being replaced by one based upon partnership and collaboration. Although certain key elements of the 1991 reforms are being retained, e.g. the separation of responsibility for commissioning health services from the responsibility for providing them, the present government's expectation is that health authorities, trusts and other agencies will operate in partnership to bring about improvements in health services. The production of a health improvement programme by each health authority – in collaboration with other local agencies – is one vehicle for achieving this objective. Another feature of the new government's approach has been to place greater emphasis on the quality of care and health outcomes. To this end it has established a National Institute for Clinical Excellence (NICE), charged with the task of assembling evidence on best clinical practice and disseminating it throughout the NHS, and a Commission for Health Improvement (CHImP) to ensure that performance at the local level meets expectations. A number of commentators have pointed out that these agencies represent something of a return to a command and control approach following the devolution of the internal market period. Yet another important feature of the present government's approach is the importance it attaches to addressing social deprivation and to bringing about a reduction in health inequalities. One aspect of this policy has been the designation of 26 health action zones (HAZs). These are specifically designated areas of deprivation that are receiving central government funding – and certain new freedoms and flexibility – in order to bring about health improvements in their areas. Each HAZ is expected to pursue a seven-year programme, in the first instance. Partnership working between health authorities, trusts, primary care groups, local authorities, the voluntary sector and private industry is a key feature of the HAZ approach. It is far too early to comment on the success of the HAZ experiments (the first eleven HAZs were set up only in April 1998, with another fifteen following later in the year) although the programme is the subject of a Department of Health-funded independent national evaluation. A final feature of the new government's approach worthy of mention is the abolition of GP fundholding and its replacement with primary care groups (PCGs). While in opposition the government was opposed to GP fundholding on the grounds that it created inequitable services between the patients of fundholding GPs and those of non-fundholding GPs, and that it imposed heavy transaction costs through the proliferation of small-scale contracts. As a result, it has sought to retain the primary care-based focus of provision and commission-ing on a comprehensive basis by creating 481 PCGs. These were set up on 1 April 1999 and in contrast to fundholding, which was optional, all GPs have been required to join a PCG. Each PCG is managed by a board with GP, other primary care and health authority representation. They cover populations ranging from 46 000 to 257 000 patients. The government recognizes that individual PCGs are presently at different stages in their readiness to assume new functions and has therefore designated four stages for PCG development. These range from level one (where the PCG acts as an advisory committee to the health authority) to level four (where it becomes a free-standing body accountable to the health authority for commissioning care and with the added responsibility for the provision of community health services).

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

Code	17.5
Description	Conclusions
Contents	Conclusions The UK National Health Service was established over 50 years ago. At the time it was designed to provide comprehensive and universal access to health care on the basis of need rather than ability to pay. For this reason the overwhelming majority of services were provided free at the point of use. It was also decided to fund health care from general taxation rather than adopt the social insurance system used by a number of other European countries. These features remain an important part of the present NHS. Despite, the growth of user charges in some areas (e.g. pharmaceuticals, dental and ophthalmic services, long-term care for elderly people), most primary and secondary health care is still provided free at the point of use. Successive public opinion polls indicate that this system continues to command widespread public support and results show a strong attachment to the NHS as a national institution. Further-more, despite frequent funding 'crises' resulting from tight finance limits set by successive governments, there has been no serious attempt to move away from a system of general tax-based funding. However despite this continuity, there have been many management and organizational changes affecting the way in which services are delivered. The most radical of these was introduced in 1991 when the Conservative Govern-ment of the day, under the leadership of Margaret Thatcher, introduced an internal market. These changes have been described earlier in this report. However, it is worth reiterating that they represented a fundamental attempt to change the culture of the NHS by introducing private sector and market-style mechanisms into a large, public sector bureaucracy. (The earlier Griffiths' general management reforms of 1984 started this process but the reforms of 1991 represented a more widespread and radical programme). Evidence on the performance of the internal market, in terms of the criteria of efficiency, equity, choice and responsiveness, and accountability, has recently been reviewed by Le Grand et al (1998). They suggest that much of the evidence is inconclusive. On efficiency it is possible to point to increases in the Department of Health's cost-weighted index of activity over the early period of the reforms. This in-crease is more likely to have arisen through increases in funding than as a consequence of the reforms themselves. And yet there were substantial increases in management and transaction costs, although attributing these to the reforms themselves is problematic. The main research finding on equity relates to the two-tier system associated with GP fundholding (GPFH). This feature in particular was heavily criticized by the present Labour Government when they were in opposition. There is little research evidence to suggest that trust status improved the quality of care or that patient choice increased. However GP fundholders did succeed in bringing about a number of improvements in the quality of services, albeit on a small scale. They seemed to be more successful than health authority purchasers in obtaining responsiveness from providers. Regarding accountability, the reforms were associated with a quite marked increase in central control and upward accountability. These imposed substantial management costs in addition to costs associated with the functioning of the internal market. Overall, Le Grand et al conclude that it is perhaps remarkable that such a radical programme of reform should produce so few marked changes on the key criteria of performance. One possible explanation they put forward is that the internal market was not really put to the test; that is, its functioning was hampered because the incentives were too weak and the constraints too strong. On the other hand, the 1991 reforms did bring about some marked changes in culture and organization. The involvement of GPs in decision-making and an emphasis on devolved purchasing or commissioning is one such change. The general belief in the desirability of the purchaser–provider split is another one. Emphasis on the need for services to be both clinically effective and cost-effective – within an environment of accountability – was also strengthened through the 1991 reforms. Indeed it is these elements that have been retained in the reform programme currently being implemented by the Labour Government elected in 1997. Despite their opposition to the internal market whilst in opposition, separation of commissioning and providing roles, emphasis on primary care-based devolved decision-making, and a continued quest for improvements in clinical and cost effectiveness all remain important features of their approach. However, in contrast to the previous Conservative Government, they attach more impor-tance to collaborative working and partnership as mechanisms for achieving their objectives, rather than competition. Greater emphasis on the elimination of health inequalities and on health outcomes are also key features of the present government's approach. An ambitious new agenda for developing the NHS in collaboration with other agencies has been set out. It remains to be seen how successful these partnerships will be in achieving the fundamental objectives of greater efficiency, more equity, better quality, stronger responsiveness and clearer accountability.
Source	European Observatory on Health Care Systems
Year	1999