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Structural reforms for Germany's health care system?

Markus Wörz and Reinhard Busse

The governing coalition in Germany between the Social Democrats and the Green Party managed to regain a slim majority in the federal general elections on 22nd September 2002. However, Chancellor Schröder must now govern with a parliamentary majority of only four, compared to ten during the previous legislature. During its new term in office, the government has set its sights on fighting unemployment, consolidating the public budget and decreasing ancillary wage costs in order to promote employment and strengthen German industry's international competitiveness. Therefore, the first important measure to be implemented has been the creation of two 'super ministries' - one for the economy and labour and the other for health and social security – out of the former three ministries for economy and technology, labour and social security, and health. Primarily, this bundling of competencies aims to promote concerted reforms in labour market and economic regulation. It also means more responsibilities for Ulla Schmidt, Minister for Health and Social Security, whose competencies will cover health care, as well as social insurance and assistance, pensions, disease prevention and rehabilitation, and disabled people.

On 16th October 2002, the Social Democratic and Green parties endorsed their coalition agreement which sets out the government's plans for the new legislative period. The coalition agreement announced the introduction of preliminary legislation (*Vorschaltgesetz*) aimed at preparing for structural reform in the health sector, and motivated by the desire to avoid increases in statutory health insurance (SHI) contribution rates. Indeed, the stability of contribution rates may be in danger as the SHI recorded a deficit of €2.8 billion in 2001 (corresponding to 1.3% of total public expenditure on health and 2.3% of total SHI expenditure in 2000) and also posted a deficit during the first half of 2002. Since the statutory sickness funds are prohibited from incurring long-term debts, the only way to avoid increasing contribution rates is to contain costs.

The government moved quickly and introduced it's first two bills on statutory health insurance into Parliament in the first week of November 2002. They contain the following measures:

- Raising the income threshold for mandatory insurance from a gross monthly salary of €3375 to €3825. This increase was one of the main health policy issues discussed during the electoral campaign.[1] Thus, people with high earnings up to the new threshold* will be forced to remain within the SHI and will not be allowed to opt-out in favour of private health insurance;
- A one-year freeze in remuneration rates within the hospital sector and for the ambulatory and dental sectors;

* According to government estimates, this change affects 50 000 to 60 000 people (approximately 0.09% of all people insured in the SHI) while the Association of Private Health Insurance Funds puts this figure at 750 000 people (1.1% of SHI insured).

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– Inclusion of patented pharmaceuticals into the reference pricing system, the introduction of higher discounts on pharmaceuticals for sickness funds, and reductions on prices for orthodontic services;
– Cuts (approximately 50%) in the funeral allowance benefits per insured;
– A freeze in contribution rates to the statutory sickness fund until 31st of December 2003.

With these immediate measures the government hopes to save the statutory health insurance funds a total of approximately €3 billion.

The coalition agreement includes several other demanding reform measures. Currently, statutory sickness funds have an obligation to contract with all SHI accredited physicians who also have a monopoly for the provision of outpatient medical services. The government envisions a modification of this obligation whereby hospitals will also be allowed to provide outpatient services. In addition to collective contracting with health care providers, the statutory sickness funds will be allowed to make 'selective contracts with defined quality standards'. The agreement does not elaborate further but it is probable that these additional contracts will be based on higher prices for quality. In addition, the coalition agreement states that sickness funds will be given the opportunity to compete on incentive and bonus systems but again, does not give further details.

Improved quality will be promoted by continuing with disease management programmes (DMPs) for chronic illnesses. DMPs are an innovation in German health care policy and were legally established in November 2001. The intention is that statutory sickness funds will be allowed to offer DMPs to their insured with chronic illnesses. Since subscription of a sickness fund member to a DMP is linked to the risk adjustment scheme between statutory sickness funds (by ascribing every participant in DMPs higher standardised expenditure for risk adjustment)[2] there will be an incentive for funds to offer their insured DMPs or to attract new members into DMPs.

However, the development of DMPs is a difficult process. First, a Coordinating Committee, established in September 2001 as a result of the SHI Reform Act, (2000), which is made up of representatives from the sickness funds, physicians and the hospitals association,[3] has the task of proposing chronic illnesses suitable for DMPs. In January 2002, the Coordinating Committee proposed the following four illnesses: diabetes (Type I and II), coronary heart diseases, asthma and breast cancer. It is then the task of the Coordinating Committee to develop evidence-based guidelines as the basis for DMPs, with the statutory sickness funds and health care providers being responsible for developing actual DMPs based on these guidelines. Finally, the Federal Insurance Office must accredit the DMPs. So far, the legal application procedure for a DMP has only been fulfilled for diabetes II and breast cancer, with the first charter for a DMP being signed on 14th of October 2002 for breast cancer. According to the government's plans, DMPs should continue to be developed for other chronic illnesses and they are also seen as a means of promoting integrated care and overcoming the strict separation between in-patient and outpatient sectors. For example, hospitals currently are not allowed to provide ambulatory services and consequently diagnoses are often performed twice, once by the outpatient physician and again in the hospital with DMPs; now hospitals will also be allowed to provide ambulatory services.

Moreover, it is envisaged that integrated care will become standard practice for people with chronic illnesses and that there will be improved coordination between GPs, specialists, hospitals, rehabilitation facilities and other health care providers. In particular, GPs will be given an enhanced gatekeeping role by actively advising patients on which services, specialists and facilities they should utilise. Currently, patients can access specialist services without a GP's referral and indeed, the free choice of physician is so popular amongst citizens that the government will not remove this choice altogether.

The government also announced the establishment of a new 'German Centre for Quality in Medicine' whose tasks will include developing guidelines on the treatment of chronic diseases, making decisions for the statutory benefit package and undertaking cost-benefit analysis on pharmaceuticals. This announcement is remarkable insofar as the task of developing evidence-based guidelines has been delegated to the recently established Coordinating Committee (see above) and decisions on the statutory benefits package is currently the responsibility of the Federal Committee of Physicians and Sickness Funds (FCPSF). Notably, both the Coordinating Committee and the FCPSF have been criticised on the grounds that despite their decisions affecting circa 90% of the population, they are neither transparent nor democratic, and that they impede competition under EU law by operating as trusts. Therefore, this may indicate that the government is considering an overhaul in institutional design.

As a further reform measure, prevention is to become an autonomous pillar alongside acute care, rehabilitation and long-term care, with the government intending to pass a specific law on disease prevention. The government also announced the introduction of mammography-screening for women between 50 and 70 years old and the establishment of interdisciplinary breast cancer centres. The detailed announcement on the introduction of mammography-screening is something of a windfall gain to the government as a decision to adopt this measure was already made by the federal associations of the SHI in September 2002.

Strengthening the rights of patients is also a key aspect of the government's coalition agreement. This will be implemented through the introduction of a Patient's Charter and introducing a patients' representative at the federal level akin to the current government representative for disabled people. Indeed, a Patient's Charter has existed in Germany since 1999, having been developed by the conference of the health ministers of the German Länder. However, the existing

Patient's Charter was further developed and expanded by a working group containing representatives from all health care sector stakeholders, and was presented to the federal ministers for justice and health on 16th of October 2002. The revised charter focuses on patients' information rights. Furthering patients' rights, the government also announced its intention to pass a law on genetic testing which will be based on the principles of voluntary testing, non-discrimination against people who have tested for a predisposition to certain illnesses, data confidentiality and mandatory patient consent prior to any transfer of genetic information and restricting genetic information to medical practitioners; that is, bodies such as insurance agencies will not be allowed access to the results of genetic tests undertaken by patients.

According to the Minister of Health and Social Security, the government's reform programme will be developed until Spring 2003. On 12th November 2002, Ms Schmidt also announced the establishment of an Experts Commission whose remit will be the development of reform proposals for the sustainable financing of the SHI system, pensions and long term care insurance, and for securing justice between generations. The latter is a core concept promoted by the Green Party and aims to ensure that one generation does not burden the following with unsustainable (public) debts. As far as SHI is concerned, the Commission will also develop proposals on how emphasising the importance of prevention can contribute to avoiding illnesses as well as financially stabilising social security. The Commission's final report is expected in Autumn 2003 and the government will then consider further reform in the area of social security based on its recommendations.

Without doubt the German health policy agenda is a very full one for the next legislative period and it will be interesting to see how much success the government will have in accomplishing all of its reform programme. In particular, it will be a difficult task to transform the sophisticated plans of the coalition agreement into policy within the space of only a few months. Furthermore, the implementation of any wider structural reforms based on recommendations from the newly established Experts Commission would need to avoid skirting too close to the next general election in Autumn 2006. Thus, the next legislative cycle will be a crucial time for German health policy.

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Will hospital management reform in Portugal work?

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Traditionally, Portuguese public hospitals perform poorly in terms of efficiency, accountability and cost containment. During the 1980s and 1990s, Portuguese policy makers failed to define policies to improve the achievement of these objectives but in 2002, new pressures for change emerged as severe economic problems beset Portugal and the public debt greatly surpassed the 3% ceiling allowed by the EU Stability Pact. The State is currently under pressure to cut public spending and to implement structural reforms,[1] thus urging the new centre-right coalition government to carry out reforms in the hospital sector. Despite protests from key stakeholders, a new hospital management law was passed through parliament in September 2002.

The new law follows similar trends in other countries (such as the UK) by moving NHS hospital management structures away from a single-category of public status (see below), with significant implications for the future of hospital settings in Portugal. This article analyses the potential impact of this reform, which paradoxically has been hailed both as a path-breaking measure and as a law that was hastily pushed through without adequately ensuring the necessary background conditions for the delivery of its policy objectives.

Current problems

The Portuguese health care system is based on a National Health Service (NHS). Hospital supply is dominated by public provision and most hospitals belong to the NHS. Despite attempts to decentralise with internal market reforms in 1997, hospitals remained under central control and the hospital sector continues to dominate the health system. Hospitals operate with high allocative and technical inefficiencies, with low levels of accountability, which, in turn, contributes to cost containment problems.[2] Some reasons for this are:

– Doctors have little incentive to be productive in public hospitals: they have dual employment status in the public and private sectors; the payment system based on salaries does not reward productivity and doctors maximise income by doing overtime in NHS hospitals and working in the private sector.

– Hospital administrators have weak incentives to operate within budgets as there are no penalties for overruns; they have little decision-making autonomy with regard to investment and human resources and low levels of control over doctors' activities.

Over the last ten years, no major reform had tackled these problems but in 2002 discussions began on potential changes to hospital management status.

Hospital management reform

The new hospital management law[3] required the amendment of the 1990 NHS Law and explicitly targets two objectives: improving efficiency and accountability and avoiding potential withdrawal of services resulting from any potential lack of financial resources. Key changes introduced by the new law are:

– A change from the collective negotiation of health professionals' contracts to individual labour contracts.

– Changing the concept of the 'NHS hospital' to the new concept of 'Network of health care providers' (*Rede de prestação de cuidados de saúde*) which includes four types of hospitals (see Box).

– Other changes include the introduction of performance evaluation, funding by activity related payments (not based on DRGs but on the provision of specified services, eg. surgical procedures), and establishing freedom of choice of provider for patients.

In October 2002, the Minister announced that 34 former NHS hospitals (out of 114) were to be converted into 'hospital-companies'. For these hospitals, debt levels are to be capped at a maximum of 10% of the total amount of equity shares, or 30% if approved by state shareholders. Ten other hospitals are to remain as public providers under public management (Category 1). So far, no further plans have been announced regarding changes to the management status of the remaining hospitals. However, there was strong opposition to the new legislation, with trade unions and professional associations (including doctors, nurses and civil servants) organising protests that included two general one-day strikes during the bill's discussion in parliament and after the law had been passed.

Reform potential and critical problems

The new law was motivated by cost containment and mainly by 'de-budgeting' (accounting) objectives in that new debts from 'hospital-companies' no longer count towards the public deficit. In one sense, the new law is path-breaking in that it constitutes a rupture with the usual 'do nothing' policy in the face of escalating public debt levels. More importantly, the law introduces higher flexibility into hospital management (for example, in recruiting personnel and in procurement) and has the potential to improve levels of accountability and efficiency, partly by professionalising hospital management, breaking down lobby group pressure through the removal of collectively negotiated salaries, and by proposing new payment systems.

Nonetheless, the possible drawbacks should not be overlooked. First, the government's vision for the health care system has not been clarified as yet: for example, it is not clear how the new law's conferral of freedom of choice of provider relates to the current gatekeeping system in Portugal in which patients enter the hospital system via a referral from their general practitioner. This raises the more fundamental question of whether the underlying health system model is based on provider competition or on co-ordination under central or local planning. Second, the experience of hospitals with public ownership and private management have been discussed and applied in other countries, but to date the evidence on efficiency has been inconclusive and difficult to compare.[4] Third, this law makes it easier for the State to privatise hospitals in future, and lastly, it is not certain whether the set of conditions that are necessary to deliver the reform's stated policy objectives can be satisfied. Some of these conditions include:

The segmentation of the hospital system implies greater complexity in managing the health care sector. It demands adequate regulation and much higher levels of resources for monitoring and supervision. However, the Ministry of Health has not had much success in properly regulating and monitoring the Amadora-Sintra Hospital, the only Portuguese example of a public hospital with public ownership and private management (Category 2). The contract between the State and the hospital management company revealed gaps in regulation and there has been no adequate monitoring of activity and public financing. Recently, there has been a series of disputes between the hospital and the State over the lack of proof of paid activities in financial flows. The case is now before the courts and the firm Deloitte & Touche has been contracted to audit the hospital.

The selection criteria for the 34 hospitals to be converted into 'hospital-companies' were based on size (between 200 and 300 beds) and amount of debt whilst the 10 hospitals that retained public management status were selected due to

NEW CATEGORIES OF HOSPITALS

1. **Public providers with financial and administrative autonomy but under public management (under public sector administrative law);**
2. **Public providers with administrative, financial and asset management autonomy, under (contracted) private management (also under public sector administrative law).**
3. **Providers under corporate law, with equity shares and the State as the exclusive shareholder (State ownership of 100% of equity). These hospitals are informally called 'hospital-companies' (*hospitais-empresa*). The State owns their capital via numerous public agencies that act as statutory shareholders.**
4. **Private providers contracted by the State (under corporate law).**

their impact on the local community, their large budgets and their teaching status. Since hospitals with between 200 and 300 beds seem to be the least costly hospitals in the system,[5] this might imply the eventual creation of a two-tiered system of hospital management whereby the State is left to directly manage only the most problematic and expensive hospitals. Moreover, if regulatory mechanisms do not clearly define clinical-management responsibilities for each type of hospital, there is the possibility that the privately managed hospitals might selectively choose less resource-intensive patients and direct the more complex cases to hospitals under public administration. This might undermine the government's cost containment objectives in the hospital sector.

The regulatory mechanisms for entry and exit within the hospital 'industry' have been overlooked in the new law. There are a very small number of private health management providers with an explicit interest and expertise in the health sector but there are no provisions either on penalties for mismanagement or on procedures in cases of bankruptcy.

Improvements in accountability depend on the adequate use of resource allocation tools and on providing information on performance. Past experience shows that the use of resource allocation methods has been poor and problematic[2] and the Portuguese health sector has no precedent for releasing information on performance indicators.

Conclusions

Leaving aside ideological considerations on the desirability of public or private provision of hospital care, some necessary conditions for delivering the objectives of the new hospital management policy do not seem to be satisfied. This is undoubtedly an ambitious policy that touches on crucial problems of the hospital system and aims to raise standards. However, any improvement in the current system will depend strictly on the government's capacity to regulate, monitor and supervise, to institute methods of cooperation and coordination and to develop appropriate resource allocation methods.

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Health care reform in the Republic of Moldova

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Since independence in August 1991 the Republic of Moldova has been in transition from a centralised political and economic system to a more market-oriented system. The collapse of the USSR brought severe economic and social problems at the same time as creating opportunities for progress. GDP fell by over 60% between 1991 and 1999[1] and in 1997 it was calculated that 90% of the population were living on less than US$2 per day[2] and 21% living on less than US$0.50 per day, less than 30% of the national minimum subsistence level.[3] At the same time health indicators were worsening. The health system found itself both unable to provide adequate, consistent and affordable basic health care or to sustain the enormous provision of specialist care that it had been designed for and that was drawing funds away from the basic care level. A number of preventive programmes, such as the national immunisation programme, were on the verge of collapse in the early 1990s and increasing informal charges had deterred many from attending health facilities at all. The inherited system was highly centralised and planning was designed around funding bed numbers in specialist facilities with little real opportunity for effective local level planning. Although there was concern about the political and social implications of reducing capacity, the government realised that health reform had become a pressing issue.

Reforms

A number of reform steps have been initiated since 1999 when the government passed laws on the 'Minimal Package of Free Medical Assistance Guaranteed by the State' and the 'Regulation on Fees for Health Services' which legalised formal payments for some health services and allowed the privatisation of the dental and pharmaceutical sectors. Although some legislation had been passed on aspects of social insurance and other funding issues, concerted reform efforts began in 1998 after the publication of the strategy document *Health Strategy 1997–2003*, which identified a number of thematic priorities that were later developed into practical steps (the 'five pillars' of the health reform strategy) in the joint Government of Moldova/World Bank project financing agreement.[1] The five

themes are as follows:[4] (1) restructuring the network of medical services and redistributing the overcapacity of resources from tertiary medical care to primary care; (2) strengthening the primary care network by financing the establishment of an efficient network of general doctors and allocating extra funds to primary care; (3) legalising (previously informal) payments for services, and preventing payments for random or excessive medical services, especially those that are burdensome to the poor; (4) setting up a new medical services package which would correspond to available budgetary resources; and (5) centralising medical care financing with the aim of improving the distribution of funds between sectors.

Implementation

The Republic of Moldova began the health reform process cautiously. Privatisation of many dental clinics and pharmaceutical services was implemented relatively early but major efforts to address the unaffordably large provision of specialist care and to channel funds from this sector towards strengthening primary care did not really take off until 1998 when a medium hospital restructuring plan was agreed. Since then, Moldova has made major inroads into redeveloping the health system to meet the needs of the country and it has also successfully negotiated and approved a US$20 million financing agreement with the World Bank to support further reform efforts.

One of the key reform measures undertaken so far includes the development of a minimum package of medical care. Although the package is, in reality, not yet available to all due to funding constraints, it is helping guide health planning towards providing a minimum level of basic services with whatever funds are available. The move from bed numbers to a weighted population measure in planning the health budget also represents a big step in making health planning more realistic and closer to the needs of the population. In a major move to ensure more accountability and that local needs are reflected in health planning, the creation of the regional health structure has brought a high level of decentralisation to the health system.

Responses to the call for strengthening primary care services began in 1997 with the establishment of family medicine training. Since then, over 2000 staff have been trained in aspects of family medicine and over 500 'family medicine centres' have been opened. To support the family medicine plans, the state and regions are now obliged to give at least 22.75% of the overall health budget to primary care (35% of the local budget), up from a level previously around 10%. The massive restructuring of secondary and tertiary care has resulted in a reduction of over 50% in staffing and bed numbers at this level. This restructuring is supposed to have released additional funds to the primary care sector, however, whether all funds released through these reductions have been passed to the primary care sector or even remained within the health sector itself is unclear as primary care facilities remain severely under-funded and under-equipped. The newly agreed World Bank health-financing package should shortly bring additional resources into the primary care sector.

Moldova's health reform process has proceeded at a steady pace to ensure that key stakeholders lend their support to achieve the goals laid out in the 1997–2003 strategy document. It is unlikely that users of the health system will have yet felt many benefits from the reforms, as the major changes have been undertaken only recently. However, as long as funds released from restructuring are reinvested back into the health system, benefits to the population should be realised in the near future. Three factors have supported the reforms to date:[5] first, change was in the interest of all key-decision makers and the political risk of change was spread throughout all levels of government. Second, agreement was reached between the central Ministry of Health and the regional health authorities on a medium term restructuring plan for the reform process. Finally, consensus was reached among donors and the World Bank on the direction and pace of reform.

Conclusions

The Republic of Moldova has just passed ten years of independence. It has been a decade of great challenges for the health system and one that has resulted in a number of changes. Immediately post-independence, the health system faced both worsening population health indicators and severely diminished resources for the health system. The new reforms are now beginning to address some of the pressing issues of the health system and the picture for population health is gradually showing improvement. Moldova has started the process of rationalising the size of its health system, both in terms of facilities and staff and has also begun innovative training for health staff in new methods of management and care. Although the health system still has far to go in ensuring equal access to all to a basic level of care, Moldova is on its way towards meeting this goal.

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Health care system in Belarus

Ellie Tragakes

Belarus was a founding member of the Commonwealth of Independent States (CIS) in 1990 and became a newly independent state (NIS) in August 1991. The break-up of the Soviet Union signaled the collapse of the economy, with massive declines in industrial and agricultural production. While recent years have seen high rates of economic growth, this has not been based on a restructuring of the economy and has occurred despite heavy government intervention, with strong central control of all lines of economic activity. However, good economic performance has not translated into overall improvements in economic wellbeing, and poverty remains a significant problem. The government's approach to change in the health sector is also characterised by traditional governance patterns where the key aim since independence has been to safeguard the status quo as much as possible in order to avoid disruption to the delivery of services. Policy makers and health services managers have focused efforts on keeping the system functioning, with few attempts to introduce explicit reforms. In turn, parliament has concentrated on creating a comprehensive legal basis for the provision of health care and to date, legislation has clarified or restated the previous soviet-style legal framework for health care, in particular, the explicit commitment enshrined in Article 45 of the Belarus Constitution, to providing health care services free at the point of delivery for the entire population.

Change and obstacles

The most important document for health sector change is the 'Conception of Health Care Development in the Republic of Belarus' (1998) which, beyond confirming the commitment to universal coverage, addresses the need to: focus on prevention and health promotion; develop primary care; improve system management; improve efficiencies in resource management; promote different forms of ownership; improve staff training and enhance the quality of services. However, most actual change in the health sector has been the result of small-scale adjustments to management and financing mechanisms. There has been a shift towards some decentralisation of decision making to the regions and the Ministry of Health has established a special unit to analyse trends and examine policy options. In addition, there has been a shift in stated priorities from highly interventionist medicine to a stronger commitment to primary health care, including a redesign of curricula for general practice, and an emphasis on the development of nursing.

The private sector, though still underdeveloped, is establishing itself on two fronts: through an increase in the number of physicians offering private consultations, and through pilot schemes involving quasi-private polyclinics offering non-essential dental and cosmetic services for a fee. Whilst remaining state enterprises, these institutions have considerable autonomy in that they must cover their costs and are free to manage their financial resources. However, their expansion is likely to meet significant obstacles given political concerns surrounding any scheme that could place equity at risk, and the lack of a clear legal framework to regulate the charging of fees and the disposal of profits.

Most private contributions take the form of under-the-table payments to doctors and nurses, and there is anecdotal evidence suggesting that these payments have increased since independence. However, health service utilisation rates, including hospital admissions and outpatient visits, remain very high in comparison with other NIS countries and in fact, have been increasing in recent years. Although it cannot be concluded from this that vulnerable groups have not been adversely affected, these trends suggest that the problem of under-the-table payments may not have resulted in as great a decline in overall access to health services as has been experienced in other countries in the region.

Statutory financing of the health system remains fully tax-based. Two attempts to introduce a social health insurance (SHI) system in 1992 and in 1996-97 failed due to insufficient support in Parliament, which expressed concerns over the country's insufficient industrial base to sustain SHI and fears that its introduction might lead to the curtailment of the range of health benefits available and ostensibly safeguarded under Article 45 of the Constitution. Moreover, attempts to explore how extra-budgetary funds might be brought into the health system, for example, mechanisms through which hospitals might generate additional income, have also met with opposition based on Article 45, which specifies free delivery. Aware of the limitations in existing resource allocation mechanisms, the Ministry of Health is supporting experimentation currently underway in the Vitebsk region, where districts are expected to set their budgets on the basis of inhabitant numbers. Capitation is expected to improve equity across jurisdictions, thus reducing inequalities in the volume and quality of available health care services, and to provide incentives for local health departments to switch resources from inpatient services to more cost-effective modalities of care. The government is also committed to the development of primary health care based on an extensive role for general practitioners who are to be compensated through a mix of capitation and fee-for-service. However, to date no changes have been introduced in payment methods; in fact, early pilot projects failed because the Ministry of Finance refused to allow changes and blocked capitation payments.

While continuing economic constraints pose limits to efforts to drastically restructure the health care system, the government's attention has been galvanised by the fact that demand for services is running at grossly unsustainable levels and that there is intense consumer dissatisfaction with health services. The Ministry of Health is seeking to further a reform agenda to address key concerns whilst safeguarding equity. Individuals working within the system perceive the following as being key problems:

- The population's interpretation of Article 45 as guaranteeing unlimited access to free health care on demand;
- The lack of resources available to meet levels of health care demand;
- The lack of a management framework or payment mechanisms that can be used to bring about improvements in resource utilisation and efficiency.

There also are serious concerns about current health care delivery. Challenges for primary care include the unsatisfactory standard of services provided, and the over-utilisation of services due to the absence of gate-keeping. In spite of efforts to establish training programmes for GPs, as yet very few have been actually trained. Outpatient contacts per person are the highest in the NIS and western Europe, and among the highest in CEE countries (and are growing). The lack of funds necessary to support primary care development is compounded greatly by the burden of massive inpatient provision. Belarus has a cumbersome secondary care system overprovided with beds and buildings and starved of resources. Bed numbers are not only higher than the NIS average, but Belarus is also one of the few countries where bed numbers are increasing. While the Ministry of Health favours transformation of rural hospitals into outpatient clinics or nursing homes, decisions in this respect are currently the responsibility of district executive committees, which are generally not inclined to undertake major changes.

Another key concern involves the size of the workforce, due to the huge costs incurred and the unnecessary visits and medical procedures that it generates. The oversupply of health care personnel is one of the most serious problems facing the health care system of Belarus. The number of physicians per population is the highest of all the countries in WHO's European Region (except Italy), and the number of nurses is also among the highest. This reflects the government's failure to address the issue of over-supply in medical education after independence. Attempts at reducing personnel numbers have been limited but some plans, such as introducing a numerous clauses within medical schools and extending the duration of training programmes, have been mooted.

Future outlook

Belarus has managed to maintain relatively intact a health care system that, in theory, provides a comprehensive package of care to the entire population, for the most part free at the point of delivery. This is remarkable in view of the economic crises the country has experienced, and in comparison with the turmoil and disruption faced by other republics of the former Soviet Union. Health care expenditure figures show that Belarus has the highest health care spending as a proportion of GDP among all NIS countries (except Georgia), which has amounted to about 4.5%–5% in recent years. While there remain concerns about the health status of the population (there have been declines in life expectancy, in line with other NIS), there have also been improvements in certain indicators, such as infant and maternal mortality rates which have been steadily declining. The relative stability of the last few years now permits the government to begin moving beyond survival strategies to more concerted reform efforts.

This article is based on the HiT profile on Belarus by L. Brusati, E. Tragakes, S. Lessof and G. Karnitski and edited by Ellie Tragakes, which will be published in early 2003.

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