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Germany opts for Australian Diagnosis-Related Groups

Reinhard Busse

As reported in *Euro Observer* No. 1/2000, a "Reform Act of Statutory Health Insurance (SHI) 2000" was passed by the German parliament in late 1999. Included in that law is a major change in calculating hospital reimbursement. The change involves the introduction of a new payment system based on case fees, taking "complexities and co-morbidities" into account (with psychiatry exempted), which will be uniform for all hospitals. In other words, although they did not prescribe a certain system in the Act *per se*, the lawmakers sought the introduction of Diagnosis-Related Groups (DRGs). In keeping with the German style of 'self-regulation' or 'self-government', the Act left the actual decision on the system to joint negotiations between the federal hospital organisation on the one side and the association of sickness funds together with the private health insurers on the other. The Act stipulated only two requirements: first, that the DRG system chosen should already be established somewhere – a rare (if not the first) case of a country legally requiring the copying of another's experience; and second, the decision had to be made by 30 June 2000, otherwise the government would have been entitled to make a decision and introduce the system via ordinance (a good example of the legal enforcement of self-regulation).

The representatives of both self-government sides travelled around the world, asked for expert opinion, had to read (or disregard) unrequested information and, on 30 June, decided to go for the Australian refined DRGs. The official reason given was its modernity with 409 basic categories which are in turn sub-divided into up to four sub-categories by age and/or severity levels (the actual Australian system uses 661 DRGs).

The Australian system will not, however, be copied on a 'one-to-one' basis. Rather, three important steps will modify it:

- Certain services not affecting all hospitals or patients will be transformed into surcharges and discounts. Education and training, responsibility for emergency cover as well as costs for persons accompanying patients (mainly children) are mentioned in this regard.
- The actual number of DRGs used in Germany will be defined; the target number is 600 to 800. While the Australian severity level classification itself will be copied, the number of sub-categories used for reimbursement will be limited to three (i.e. a theoretical maximum of 1,227 DRGs).
- The 'relative weights' of the DRGs will then be calculated using German cost data. These three tasks have to be completed by 31 December 2001. The new system itself will then be introduced on 1 January 2003.

By introducing the Australian DRG-system, Germany is abandoning both its

own development of so-called case fees and procedure fees, as well as the current mixture of *per diems* (which vary between hospitals) and uniform case and procedure fees. The current change is the latest in a long development.

The 1972 Hospital Financing Act introduced 'dual financing' and the 'full cost cover principle'. 'Dual financing' refers to the fact that investment costs are covered by the *Länder* and running costs by the sickness funds (plus private patients). In order to be eligible for investment costs, hospitals have to be listed in the hospital plans which are set by the *Länder*. Regarding running costs – which include all personnel costs as hospital physicians are salaried employees of the hospitals – the 'full cost cover principle' meant that whatever the hospitals spent had to be reimbursed. The actual remuneration was done through *per diem* charges which were retrospectively calculated by the *Länder* for each hospital. While *per diem* all locations were equal for all patients and specialities within the hospital, again, they differed between hospitals.

The 1984 Hospital Restructuring Act introduced prospectively negotiated *per diem* charges which were based on expected costs. Coverage of excess costs was *de jure* limited. *De facto*, however, hospitals received full compensation through adjustments of charges. In addition, the Act opened up the possibility of including capital costs in *per diem* charges if investments would lower running costs in the medium or long term. From that time onwards, 'dual financing' also meant 'dual planning', with the number of hospitals and hospital beds being planned at *Länder* level. Staff numbers and hospital day numbers, meanwhile, were subject to negotiations between hospitals and sickness funds within the framework of negotiating *per diem* charges.

Through the 1989 Health Care Reform Act, the sickness funds gained the right to contract additional hospitals and to de-contract listed hospitals. The latter process is, however, complicated – and therefore rare – since firstly the funds have to agree to do it jointly, and secondly it needs the approval of the respective *Land* government.

Prospective case fees and procedure fees were introduced from 1996 for a limited segment of in-patient care. The former are supposed to cover all costs during a hospital stay, while the latter are reimbursed on top of the (slightly reduced) *per diem* charges. Case fees are based on a combination of a certain diagnosis (4-digit ICD-9, partly separated into 'elective' and 'emergency') and a specific intervention (i.e. open appendectomy attracts a case-fee different from that for laparoscopic appendectomy). Case-fee definitions include a specified maximum length of stay which will be covered. If the actual length of stay exceeds this maximum (which happens in around 3 per cent of all cases), extra days are reimbursed separately. Procedure fees are only based on an intervention and more than one procedure fee may be remunerated per case. Both the fee definitions as well as the number of reimbursement points for both the (more than 70) case fees and the (almost 150) procedure fees were originally set through an ordinance by the Federal Ministry of Health, while the monetary conversion factor for the points was negotiated at *Land* level. A law in 1997 transferred the responsibility for maintaining and further extending the fee catalogue to joint negotiations between the sickness funds and the hospital organisations.

The proportion of cases reimbursed through prospective case fees in Germany has been less than a quarter, with wide variations both between hospitals and specialities. For example, while no case fees exist for medical, paediatric or psychiatric patients, more than 50 per cent of cases in gynaecology and obstetrics, and about two-thirds of ophthalmologic cases, are reimbursed in this way. Both the number of different case fees and procedure fees offered, and the volume provided, are subject to budget negotiations at hospital level. On average, the service spectrum of a hospital includes 32 different case fees and 42 procedure fees.

All other cases are currently reimbursed by a two-tier system of *per diem* charges: a flat hospital-wide rate covering non-medical costs and a department-specific charge covering medical costs including nursing, pharmaceuticals, procedures, etc.

Case fees, procedure fees and *per diem* charges are all part of the budget for each particular hospital. These budgets are not budgets in the sense that the hospital will get an amount of money independent of actual activity. Instead, the budgets are targets established during the negotiations between the sickness funds and the hospital. The target budget establishes service numbers (for cases to be reimbursed by case and procedure fees as well as for cases reimbursed by *per diems*) as well as the *per diem* fees. Due to the multitude of payers, the hospital receives the actual money on a patient-by-patient basis through the respective sickness fund.

If the hospital reaches exactly 100 per cent of its target activity then no financial adjustment has to be made. If actual activity is higher than the target, i.e. if the hospital has been reimbursed above the target budget, then it has to pay back a certain part of the extra income: 50 per cent of case fees for transplantations; 75 per cent of other case and procedure fees; and 85–90 per cent of *per diems*. In other words, activity above the target is only reimbursed at 50, 25 and 10–15 per cent respectively. If actual activity is lower than the target, i.e. if the hospital's total reimbursement has not reached the target budget, then it receives 40 per cent of the difference. This sum is divided according to utilisation between the funds, i.e. actual case fees, procedure fees and *per diems* are then higher than originally negotiated.

By law, the introduction of the German-type Australian DRGs in 2003 has to be 'budget-neutral'. That is, the total expenditure on hospitals may not be larger (or indeed smaller) than under the current system. Consequently, it remains to be seen how two emerging tensions will be dealt with. The first tension is at hospital level, and concerns each hospital individually. For a budget based on a DRG system may be quite different

than the historical budget – with all the implications for staffing and potentially available services – and each hospital will be required to make the relevant changes on its own.

The second tension is at the system level, between the idea of reimbursing all hospital cases according to calculated costs per DRG (which means fluctuating expenditure according to utilisation) and the legal requirement for stable contribution rates (which implies that expenditure may only increase as much as the income of the sickness fund members). To overcome this, tying the reimbursement value inversely to utilisation might very well be the chosen solution. Advantages but also problems of such a system can be studied using a well-established case, namely the German ambulatory care sector.

Bosnia and Herzegovina:

Health system reform implementation at a critical stage

Elke Jakubowski and Haris Hajrulahovic

The democratic government structures in Bosnia and Herzegovina (BIH) were established with the 1995 Dayton Agreement. BIH comprises two entities: the Federation of Bosnia and Herzegovina (FBIH) and the Republic of Srpska (RS), each presiding over approximately one half of the territory and two-thirds and one-third of the population respectively. The central government is charged with conducting foreign, trade and fiscal policy, immigration and asylum policy, inter-entity transportation and air traffic control, while the FBIH and RS entity governments are charged with overseeing internal functions. The Dayton Agreement also established the Office of the High Representative (OHR) to oversee the implementation of the civilian aspects of the Agreement.

Health care is a sole competence of each entity, and the right to receive health care is granted by constitutional law to all citizens. In the RS, authority over the health system is centralised with planning, regulation and management functions being undertaken by the Ministry of Health in Banja Luka. In the FBIH meanwhile, health system administration is further decentralised into ten cantons, with each having its own ministry of health and being responsible for the provision of primary and secondary health care. The central ministry of health of the FBIH is located in Sarajevo and coordinates cantonal health administrations at a federal level. In effect, therefore, health care for the total of 3.6 million population is administered by twelve separate ministries of health.

Health care financing is maintained throughout compulsory insurance for employees. Contributions are shared equally between employers and employees, and amounted to 18 per cent of gross salary in June 2000. It is estimated that BIH is spending about 12.7 per cent of its US$ 7.5 billion gross national product on health care, of which around 60 per cent is derived from public sources.[1] These include external funds which in 1997 accounted for as much as 50 per cent of the total public expenditure.[2] Contribution collection in the country is poor, owing to a high unemployment rate combined with a large non-contributing informal economic sector. This low level of contributions in the public sector contrasts with the considerable levels of out of pocket private expenditure, explained by substantial cost-sharing and by informal under-the-table payments.[1]

The payment for hospital services by the social insurance funds is based on a retrospective invoice system with line item charges; with actual payments being adjusted by the fund administrators.

The provider payment systems and the health care delivery apparatus are in large part inherited from the system before the war, and rely heavily on secondary specialised and hospital care. However, there is now political commitment in both entities to reorient health care services delivery towards primary health care. This will be achieved through the strengthening of family medicine teams and the creation of training programmes in family medicine in the medical faculties of Banja Luka, Sarajevo and Mostar. Finally, a shortage of trained and skilled health professional and management personnel are common problems affecting health care delivery in Bosnia and Herzegovina as a whole.

Assisted by the World Health Organization (WHO), longer term strategic plans for health system development have been developed in both entities following restructuring and rehabilitation action immediately after the war. Although the strategic plans are two separate documents, they are follow similar lines. Both entities embarked on the preparation of the legal framework

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for the reform of their health systems and several laws related to health protection, health insurance and the pharmaceutical sector have been adopted.

Commentary on health care reform implementation

Elke Jakubowski

Overall, the implementation of health system reform in the health care sector in Bosnia and Herzegovina has been unhurried and might have even further decelerated in light of the general elections in November 2000. Much activity has focused on the development of strategic plans and a comprehensive legal basis for selective health care sectors. However, there has been little operational progress in terms of health system changes. Several factors contribute to the difficulties experienced in implementing change. Institutions such as health ministries, health insurance funds and health care providers have lacked the technical infrastructure and management capacity to implement change in the short term. The weak development of the regulatory function at central levels has also proved to be a barrier in implementing strategic health system objectives in the medium and longer term.

In addition, the ministries of health do not have enough executive powers to implement a number of pressing measures in the health sector; such as the introduction of practical steps to increase the availability of essential drugs in
hospitals. It is often the case that authority in BIH cannot be clearly demarcated between local and central levels, and that even where it is divided between central, regional/cantonal and local levels, there are difficulties with taking system-wide decisions. It is also a consequence of the Dayton agreement that the country is operating two distinct health care systems. International technical cooperation and support for development is very considerable in financial terms, but has suffered from a lack of inter-agency coordination at the system level.

Finally, operational planning for health system reform in the country is substantially impeded by a lack of sufficient baseline information such as the available financial and human resources. On the other hand, BIH has made notable progress in a number of fields, for example in the availability of trained people, financial resources and institutional infrastructures in specific areas such as the pharmaceutical sector and family medicine. Another example is ongoing work to develop a regular forum between the ministries of health of both entities in order to coordinate reform implementation; for example, in the field of health promotion. This implies that the country has increased its potential for effective health care reform implementation along the strategic lines for health system reform that it has already spelled out.

The Ministries of Health of the FBIH and the RS have jointly agreed to work with the European Observatory on Health Care Systems to produce the first Health Care System in Transition (HiT) profile on Bosnia and Herzegovina. It is anticipated that the HiT, in providing reliable information, will contribute to health system development at the strategic and operational level by, for example, serving as a tool for operational planning in health system reform implementation.

The participation in and the contribution to the ongoing dialogue over health system development in Europe is expected to generate further lessons in a mammoth task: developing a health care system in a post-conflict society.

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"Hospitals in a Changing Europe"

Observatory Summer School 2000

Anna Dixon and Judith Healy

Participants from over 24 European countries gathered at the end of August in the harbour village of Cavtat, near Dubrovnik, which again played host to the annual Observatory Summer School. The theme, "Hospitals in a Changing Europe", was linked to a forthcoming Observatory book to be published by Open University Press (edited by Martin McKee and Judith Healy). The topic attracted considerable interest since hospitals across Europe face increasing challenges with changing disease patterns, pressure to contain hospital costs, higher expectations from patients, and rapidly advancing technology and methods of patient care. Taught by Observatory staff and invited experts, the 80 participants explored their experiences of hospital reform through lectures, workshops and discussion groups.

Dubrovnik provided a fitting location for the Summer School since Croatia has experienced enormous upheaval over the last decade, but now has good reasons to be optimistic. The transformation from 'war-zone' to a thriving society is no more apparent than on the beautiful Dalmatian coast. The recent election of President Stipe Mesić has brought

At the opening of the 2000 Summer School, from left to right:

Dr Elias Mossialos (Research Director, Observatory);

Mr Stjepan Mesić (President of Croatia);

Prof Martin McKee (Research Director, Observatory);

Prof Julian Le Grand (Richard Titmuss Professor of Social Policy, London School of Economics & Political Science);

Prof Ana Stavljenić-Rukavina (Minister of Health of Croatia);

Prof Stjepan Oreškovič (Summer School Coordinator, Andrija Štampar School of Public Health).

renewed democracy to Croatia and has sparked further development and reform of all sectors including health care.

Participants at the Summer School were welcomed by Stipe Oreškovič from the Andrija Štampar School of Public Health in Zagreb (co-organiser of the School) and Srdjan Matic from the Open Society Institute on behalf of the Observatory partners. Josep Figueras (Head of the Observatory Secretariat and Research Director) then explained the work of the Observatory and the significance of hospital reform.

Hospitals are not normally noted for promoting health (as distinct from treating illness). This was one of our themes. Maggie Davies (Health Development Agency of England – one of the sponsors of this year's School), and Erio Ziglio (Regional Adviser, Health Promotion and Investment for Health, WHO Europe) reminded us of the broader public health perspective: how does a hospital contribute to improving the health of its patients and surrounding population? Workshop participants debated how policy makers make investment decisions given the range of competing priorities, and were invited to contact the Health Promoting Hospitals network of WHO. Per Gunnar Svensson of the International Hospital Federation continued this theme, covering issues from targeting health promotion at patients and staff, to reducing the adverse environmental impact of the hospital through better public transport networks, reduced energy consumption and proper waste disposal.

Policy makers involved in efforts to restructure hospital systems and to improve hospital performance need to understand not only why hospitals are as they are, but so too the current and future pressures for change. Judith Healy (Observatory) outlined the origins of modern hospitals and the ideas that have influenced hospital design. Reinhard Busse (Observatory) analysed the external pressures for change upon a hospital, such as changing populations and patterns of disease. Nigel Edwards (NHS Confederation, UK) spoke about the enormous impact of new technologies on hospital care, including the expanding opportunities for minimally invasive surgery. In another session, he spoke on the extent to which treatment now provided in hospitals could be undertaken in community-based facilities, such as day surgery clinics. These sessions raised interesting questions as to what today's hospitals might look like in the future, and were discussed in group sessions designed by Suszy Lessof (Observatory) and Anna Dixon (Observatory). Participants also debated the contentious issue of how to close hospitals in countries with excessive or unevenly distributed numbers of hospitals.

A hospital is a complex organisation that undertakes many activities and employs a proliferation of occupational groups. Hospital management therefore is extremely challenging, especially since a hospital depends upon its staff to produce high quality patient care. Judith Healy discussed the skill-mix in the hospital workforce, and Martin McKee (Research Director, Observatory) spoke about strategies to improve clinical performance, including the emerging concept of clinical governance.

Many countries are devolving more responsibility to managers and transforming hospitals into various types of autonomous public sector organisations. Alex Preker and April Harding (both of the World Bank) discussed a typology that classified hospitals along a spectrum from Ministry of Health units to privately owned entities. Reinhard Busse developed this theme by examining hospital governance and the implications of increased autonomy for hospitals coupled with increased external regulation. Essential to the efficient running of a hospital are adequate and appropriate information systems. Imre Hollo and Laszlo Balkanyi (both of the World Bank) gave practical guidance about establishing a hospital information system based on their experiences in Hungary.

The current crisis for many countries is how to both finance and restructure the hospital sector, which consumes a very large slice of their health budgets; up to 70 per cent in some eastern European

countries. It is increasing difficult to finance health services given the struggling economies of many of these countries, and their legacy of a hospital-dominated health system with excessive numbers of hospitals and staff. Julian Le Grand (London School of Economics) discussed the advantages and disadvantages of different methods of paying hospitals: whether traditional line item budgeting, global budgets, *per diem* or fee-for-service payments. In many countries, patients are increasingly paying out-of-pocket for health care, whether through official user charges, or through 'under-the-table' payments to low-paid hospital staff. Many hospitals in transition countries have suffered two decades of under-investment in deteriorating buildings and equipment. Nick Jennett (European Investment Bank) spoke about capital financing of the hospital sector, and discussed both the practicalities and the difficulties of public-private partnerships as one means of mobilising capital.

A half day was committed to country case studies: eight participants and Summer School faculty made presentations on hospital reform in the Czech Republic, Georgia, Germany, Hungary, Kosovo, Kyrgyzstan, Poland and Romania respectively. These highlighted the realities of trying to implement change in difficult circumstances, as well as the range of stakeholders that must be considered.

One of the highlights of the week was a visit to the Dubrovnik General Hospital and a talk by the hospital's Director of Medical Services. Ljiljana Betica Radic spoke about how the staff managed the closure of the old hospital and transfer to the new hospital, a move that had been interrupted by war ten years ago. Her presentation epitomised the challenges faced by those managing the delivery of hospital services in a turbulent policy environment.

The school programme, together with materials and presentations, can be found on the Observatory website: www.observatory.dk follow the links to Summer School 2000.

Turkmenistan: The state of reform

Elena Shevkun

Turkmenistan is a central Asian republic covering 491,200 km^2, of which approximately 80 per cent is desert. Nevertheless, there are plentiful natural resources, but capital for exploration and production in the country are lacking. After significant decline between 1994–1997, the economy has shown positive trends since 1998. And, in the longer term, the extensive hydrocarbon reserves are promising for a more prosperous economic development. The country is a presidential republic, having attained independence in 1991 after the disintegration of the USSR, and indeed political stability is maintained via very strong presidential powers. The president is the statutory head of the legislative, judiciary, and executive branches of government.

Economic difficulties have taken their toll upon the population of 4.4 million, of which some 40 per cent are younger than the age of 15 years. Health status deteriorated significantly during the last decade, and both communicable and non-communicable diseases remain a threat. An average life expectancy of 68.6 years and an infant mortality rate of 32.8 per 1,000 live births compare rather unfavourably with the European averages of 73.7 and 11.9 respectively. The corresponding average figures for all newly independent states (NIS) meanwhile, are 67.9 and 18.6.[1] Turkmenistan currently faces many challenges in the adaptation of its health system to the health needs of its population.

The country has opted for a steady, systematic approach to health care reform, in line with its policy on broader economic and social change. In 1995, the Presidential Health Programme outlined the principles and policy directions of the health care reforms for the 1995–2000 period. The stated aims of the reform processes are: decentralisation, enhancement of service efficiency, and a shift in balance from specialist services to primary health care (PHC). Yet, in reality decisions continue to be taken on an *ad hoc* basis, sometimes conflicting with the objectives and content of the programme.

The reforms have brought some changes, however, the basic organisational structure of the health care system still follows the standard model set down in Soviet time. The main source of funding remains the state budget. Total health expenditure as a percentage of Gross Domestic Product has shown a trend similar to the macroeconomic development: it collapsed from 3.2 per cent in 1991 to a level of 0.8 per cent in 1994, before then gradually recovering to 5 per cent in 1998. A state voluntary medical insurance scheme was introduced in 1996 and by 1998 covered about 7 per cent of total health expenditures. As well, fee-for-services has being introduced incrementally. Despite some attempts, however, there have not been significant changes in resource allocation and to provider payment mechanisms. The financial system is still administratively complex and inefficient.

Primary health care is a central focus of the reforms. The expansion of family practice and the reconfiguration of primary care services are strongly

1. *Health for all database*, WHO Regional Office for Europe, 1997 and 1998.

promoted. Since 1996 PHC has been provided by family physicians, but ambulatory specialists are also involved. PHC facilities are well distributed around the country with good access for the most of the population, and perform a gatekeeper function. However, the undergraduate and postgraduate training of health personnel needs to be strengthened, along with the infrastructure.

The hospital services are publicly owned and personnel employed in hospitals are salaried government employees. In the framework of the reforms, the Ministry of Health and Medical Industry has spent considerable effort rationalising the hospital network. The number of beds was reduced by 48 per cent during 1995–1999. In spite of this, bed occupancy rate at 72.1 per cent is still low. The average length of stay (13.4 days) also leaves scope for improvement. The largest part of the health budget is still allocated to hospitals and the persistence of line item budgeting does not enhance effectiveness.

While progress has been made in improving PHC and rationalisation of hospital services, further steps towards an overall reshaping of the health care system – particularly in terms of better links and balancing between its components – are needed. It is necessary that planning and resource allocation processes are better aligned with population need. However, a top-down approach to the country management is the main obstacle for the overall implementation of reforms; with little discretion and few managerial skills available at unit level. The reform process is nevertheless continuing. A concept of socioeconomic development up to 2010 known as *Maksatnama* was adopted by the government in 2000. It indicates further directions for the reforms, and provides hope for the future.

The HiT on Turkmenistan has been written by Chary Mamedkuliev (Ministry of Health and Medical Industry, Turkmenistan), Elena Shevkun (WHO Regional Office for Europe) and Steve Hajihoff (European Centre on the Health of Societies in Transition, UK).

An Update from the European Observatory on Health Care Systems Secretariat

The Observatory is currently preparing its work for the upcoming year. As many readers of the Euro Observer are involved in the production and dissemination of this work, the secretariat has prepared a brief explanation of the plans. These include the launch of tools to assist in HiT production, conducting analytic and comparative studies and strengthening the dissemination of products to policy makers. The planned products and related activities for the coming year are elaborated in following:

Health Care Systems in Transition (HiT) profiles

The production of HiTs as both a concise source of health care system information, and the monitoring and comparison of health care systems between countries, will continue as the backbone of the Observatory's work. HiT profiles planned for launch in 2001 include: Australia, Austria, Denmark, Finland, Italy, Latvia, Netherlands, New Zealand, Romania, Slovenia, Sweden and the Former Yugoslav Republic of Macedonia.

Several HiTs have already been commissioned and are planned for completion in 2001, among them: Armenia, Azerbaijan, Belarus, Bosnia and Herzegovina, France, Georgia, Greece, Ireland, the Russian Federation, and Turkey.

A number of countries drawn from western, central and eastern Europe as well as the newly independent states will have HiTs commissioned or updated during 2001. In addition, the Observatory is exploring opportunities to commission HiTs for key OECD countries which are frequently quoted in comparison with European countries.

Tools for HiT production

As the production of HiTs draws together a diverse group of contributors from central and eastern Europe, the newly independent states, and western Europe, the task of streamlining HiTs into similar format, terminology and writing styles has at times been a challenge. While supervising the production of the HiTs, the Observatory has received input from authors and editors on how to assist authors and editors during the writing process. Following these recommendations, the Observatory has produced three tools which will guide both authors and editors through the process of producing a HiT:

The HiT Handbook has been developed as a guide for authors during the writing process. It provides an overview of the Observatory and its functions, key figures involved in HiT production, HiT writing stages, contacts for writing, and detailed style and format instructions.

A *HiT Handbook for Editors* has also been produced, providing several strategies for working with authors to get HiTs produced in a timely fashion within the prescribed stylistic frameworks.

A *Glossary on Health System Terminology*. Terminology in health care systems is often inconsistently applied, misunderstood and misused. Given this experience, coupled with requests from authors and editors to provide a glossary of terms for HiT writing,, the Observatory has extracted core definitions and terminology in the HiT questionnaire. This initial list has been expanded to create a glossary which includes key terms used in discussing health systems and health reform, references to sources of definitions and worked examples of such terms.

All of these materials are available in paper format and will be on the Observatory website in the coming year (http://www.observatory.dk). In future, authors and editors will receive these materials as a part of the standard briefing when commissioned to produce a HiT. If you are currently writing a HiT and would like these materials to be sent to you, please contact the Secretariat (observatory@who.dk).

Living HiTs

The 'living HiTs' initiative aims to test a model that could enable the updating of published HiTs on a regular basis. The model will thus involve the online

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The World Health Organization Regional Office for Europe
The Government of Norway
The Government of Spain
The European Investment Bank
The World Bank
The London School of Economics and Political Science and
The London School of Hygiene and Tropical Medicine
in association with the Open Society Institute

addition, supplementation, deletion and altering of current information to those HiTs available on the Observatory's website. These updates will come in the form of hyperlinks appearing in the text – the technical as well as format details are, however, still developed. The Observatory is planning to pilot this living HiT model with the Czech Republic, Germany, Hungary, Spain and the United Kingdom.

Studies

The Observatory is dedicated to publishing the European Observatory series with the Open University Press. This will include *analytic* studies which draw together existing evidence on central policy-making issues and performs in depth analysis of a health care issue across geographical borders in the European Region; and *comparative* studies which consist of periodical sub-regional studies for Europe, for example the newly independent states and central Asian republics, and provides a comparative, in depth analysis of key health systems issues in a regional context.

Four studies are due for launch in 2001, three analytical and one comparative. The first analytical study is *Funding health care: Options in Europe* which discusses emerging issues in funding, both in western and eastern Europe (including sustainability in CEE and CIS countries); the scope and impact of informal payments; and the funding of long-term care. The second analytical study is entitled *Hospitals in a changing Europe*. This study approaches the interface between hospital, primary care and the community, including changes in the internal organisation of hospitals and the future role of the hospital. The third analytical study is entitled *Regulating entrepreneurial behaviour in European health care systems* which touches on new experiences with encouraging entrepreneurial behaviour, and new regulatory mechanisms in response to the changing public-private mix. The comparative study is a feature on the *Central Asian Republics* which will be released in early 2001. Work on two further comparative studies is set to begin in 2001, focusing on the social health insurance countries in western Europe, and the applicant countries for accession to the European Union.

Dissemination

Dissemination has become increasingly central to the work of the Observatory as it moves away from the initial start up phase – which has focused on production – towards the proactive and targeted dissemination of established products to policy makers and other users.

Some dissemination activities are already well established, for instance the Observatory Summer School for senior policy makers from central and eastern Europe, which will continue in Dubrovnik in 2001. In other dissemination areas, the Observatory plans to innovate. For example, it will better utilise the use of media, the internet, conferences and HiT launches to make products more widely available in countries and international agencies. An integral part of making the products more accessible to policy makers across the European Region is the translation of the Observatory's publications. In 2001, the fundraising strategy will be devised to enable translations in the native language.

***Euro Observer* is looking for individuals wishing to act as national correspondents, to contribute on a regular basis. In addition, the Editorial Team welcomes submissions from individuals for publication in future issues.**

For ordering details on any of the publications mentioned in this issue, please contact the European Observatory on Health Care Systems, WHO Regional Office for Europe, 8 Scherfigsvej, DK-2100 Copenhagen Ø, Denmark.

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