Euro Observer

Newsletter of the European Observatory on Health Care Systems

Autumn 2002
Volume 4, Number 3

Contents

If you would like more information about the Observatory please contact: European Observatory on Health Care Systems, WHO Regional Office for Europe, 8 Scherfigsvej, DK-2100 Copenhagen Ø Denmark.

Tel: +45 39 17 14 30
Fax: +45 39 17 18 70
E-mail: observatory@who.dk
www.observatory.dk

Health insurance reform (again) in The Netherlands: will it succeed?

Hans Maarse

The new government in The Netherlands – a coalition of the Christian Democratic Party (CDA), the Liberal Party (VVD) and the Pim Fortuyn Group (LPF) – that took office in 2002 has agreed to restructure health insurance by 2005.[1] An earlier attempt to implement a substantial reform package in health insurance failed in the early 1990s. Key elements of this previous reform (originated by the Dekker Commission and subsequently referred to as the 'Simons plan' after the then State Secretary for Health) included the integration of all social and private health insurance programmes into a single mandatory scheme and the introduction of some competition between health insurers. The new plan follows on the heels of ten years of incremental change that has altered the landscape of Dutch health insurance significantly. Interestingly, many of these small-scale incremental reforms were originally part of the Simons plan.[2]

Initiatives in health insurance reform are not new. The previous Dutch government had sought to place such reform on the political agenda by publishing a general outline for a new health insurance structure in 2001. The primary goals of the proposed reform were to make health care more consumer-driven by giving consumers more free choice, to increase competition in health care and to enhance the role of health insurers in the management of health care.[3] One year earlier, employer and employee associations had already agreed to compromise on a proposal to restructure health insurance.[4] The most recent plan draws in many respects on both these previous initiatives.

The main elements of this new health insurance reform can be summarised in ten points:

(1) Statutory and private (voluntary) health insurance will be integrated into a single and mandatory scheme. As a consequence, the traditional dividing line between statutory health insurance for acute care (*Ziekenfondswet, ZFW*) and voluntary health insurance and, consequently, between sickness funds and private health insurers will vanish. However, the exceptional medical expenses scheme (AWBZ), another statutory health insurance programme mainly covering various forms of long-term care, will not be integrated into the new scheme, at least not in the short term.

(2) The new health insurance scheme will have a private structure. Citizens will no longer be insured automatically but will be obliged to purchase a health plan themselves. However, if the government's capacity to regulate the new health insurance scheme will be seriously restricted by the European Commission's third non-life insurance directive,[5] the private structure will need to be reconsidered.

(3) The health services basket will be more or less similar to that of the present statutory health insurance scheme for acute care (ZFW).

(4) The insured will have a free choice of health insurer and will be able to switch to a different insurer once a year.

The European Observatory on Health Care Systems is a partnership between:
The World Health Organization Regional Office for Europe, The Government of Greece, The Government of Norway, The Government of Spain, The European Investment Bank, The Open Society Institute, The World Bank, The London School of Economics and Political Science, and The London School of Hygiene and Tropical Medicine.

(5) Any form of risk selection by the health insurers will be prohibited; they must accept each applicant.

(6) All insureds will pay a community-rated premium set by each insurer (so premiums may vary by insurer). However, the part of an insured's premium paid by his/her employer will remain wage-related.

(7) An effective risk adjustment system will be developed in order to compensate for differences in risk profiles and to achieve fair competition.

(8) All children under 18 will be covered free by the new scheme. The government will pay insurers for children out of tax revenues.

(9) The government will compensate families and single people for higher premiums incurred as a result of the shift from income-related premiums to flat-rate premiums. Compensation will be provided through a reduction in income tax and the introduction of an individual health insurance subsidy.

(10) A mandatory minimum deductible will be introduced. The insured may opt for a higher deductible in exchange for a lower premium rate.

The proposed health insurance reform can be understood as a complicated attempt to redefine the balance between efficiency and solidarity. Competition is clearly seen to be the key to fostering efficiency. Risk solidarity will be ensured by the formal ban on risk selection, by mandatory community rating and by developing a new risk adjustment scheme to compensate insurers for differences in their risk profiles. Income solidarity will mainly be ensured by the introduction of family-related health insurance subsidies. Both forms of solidarity are further supported by the creation of a universal mandatory scheme, putting an end to the present dividing line between statutory and private voluntary health insurance. Because much is still unknown, one can only speculate about the overall redistributive impact of the reform (that is, who pays how much for what?).[6]

Implementing the new scheme will be expensive. The cost of free coverage for children under 18, the general reduction in income tax and the health insurance subsidies to families is currently estimated to be €3.7 billion. However, the rise in expenditure will be largely offset by the fact that the government's annual grant to the statutory health insurance scheme (€3.3 billion in 2002) will disappear along with the abolition of the ZFW.

The proposed reform certainly implies a radical change for health insurance in the Netherlands, particularly in the transition from a statutory to a private health insurance scheme and in the shift from income-related contributions to community-rated premiums. The new scheme also brings significant changes for private health insurers, since both risk-rated premiums and risk selection will be prohibited.

The new scheme can also be seen as a political compromise between the Christian Democratic Party and the Liberal Party. The Christian Democrats insisted on the free coverage of children under 18 and the introduction of health insurance subsidies to families to compensate them for having to pay higher premiums. Both arrangements stem from the priority they place upon family values. The Liberals were successful in securing the introduction of a tax cut as general compensation for the higher health insurance premiums.

Will the proposed reform really be implemented in 2006, as planned? This is a relevant question, given the Netherlands' experience with health insurance reform in the past. The following factors seem to be critical. First, the new scheme will be expensive. Now that the prospects for economic growth are somewhat bleak, it may well turn out to be too expensive, particularly if one takes into account the fact that the provision of health insurance subsidies will push up administrative costs and increase the need for monitoring to prevent fraud. Furthermore, the growth of administrative costs conflicts with the new government's overall goal of substantially cutting public sector administrative costs.

A second critical factor relates to the effectiveness and robustness of the proposed compensation mechanisms. Will it really be possible to design such a scheme? The lesson of the failed health insurance reform of the early 1990s was that redistributive effects should never be underestimated politically. No-one wants to pay more for their health insurance after reform without getting more from it. The losers will claim full compensation for higher premiums, pushing up costs and, consequently, making reform less feasible.

Third, one may raise the question of how the reform will contribute to solving the problem of waiting lists – one of the main issues during the recent elections that caused a landslide in Dutch politics.[7] The new government seems to assume that competition in the health insurance market will solve this problem, which is an optimistic, if not heroic, assumption since the government has also stated that there will be very little room for additional budgetary resources to reduce waiting lists in the years to come.

Fourth, there are serious questions regarding the impact of competition in health insurance. Formal risk selection by health insurers will be prohibited but subtle forms of cream skimming, for example, by selective marketing or creating administrative obstacles in the enrolment process, may be far more effective in generating profits for health insurers than tough negotiations with providers concerning the price and quality of care.

Fifth, there are doubts regarding stakeholder support for health insurance reform. For instance, how will private health insurers react? As with the Simons plan, private health insurers fear a substantial growth in government intervention in their business. In addition, employers may organise opposition to the proposed reform when they find out how much it will cost them. The opposition of private health insurers and employers was a major cause for abandoning the Simons reform in the early 1990s.

Sixth, the proposed reform has already been criticised for not being far-reaching enough. The insured may indeed switch

from one insurer to another but other than that, government regulation seriously restricts their freedom of choice. For instance, regulation allows for very little variation between health care plans, while requiring health insurers to charge community-rated premiums has a similar effect.

Finally, much depends upon the political stability of the new government. There is some scepticism in this respect because of the LPF's participation in the coalition, a completely new phenomenon in Dutch politics. Will the LPF remain a stable political factor with a permanent and strong electoral base after the scandalous murder of its charismatic leader, Pim Fortuyn, on 6 May 2002?

The real question is perhaps how much priority should be given to health insurance reform at all under the present circumstances. Although the existing structure of Dutch health insurance is far from optimal, it is certainly not a fundamental cause of the current crisis of performance in Dutch health care. The structure of the market for health care delivery is far more problematic. It suffers from a lack of capacity and, in particular, the absence of powerful incentives to do things better. Reorganising health care delivery – for instance, by introducing performance-related payments, by creating more room for innovation and by liberalising the tight regulation of capacity planning – would probably be a better way of improving performance than restructuring health insurance. The great danger is to waste political energy on the wrong issues. The new policy paradigm that draws heavily on the managerial role of health insurance probably expects too much from health insurance. Be that as it may, one could argue that restructuring health care delivery should be a prerequisite for any successful management strategies led by health insurers.

REFERENCES

1. The Netherlands Government. *Werken aan vertrouwen. Strategisch Akkoord voor Kabinet. [Acting upon trust. Strategic Covenant for the Government].* The Hague: CDA, LPF, VVD; 2002.

2. See for instance, den Exter A, Hermans HE, Dosljak M. *Health Care Systems in Transition: The Netherlands.* Copenhagen: European Observatory on Health Care Systems; 2002 (forthcoming).

3. Ministry of Health Welfare and Sport. *Vraag aan bod. Hoofdlijnen van Vernieuwing van het Zorgstelsel, Tweede Kamer, 2000–2001. [Focus upon Demand. An outline for a Renewal of Health Care].* 27855, Nos. 1–2. The Hague: Ministry of Health, Welfare and Sport; 2001.

4. Sociaal Econonomische Raad. *Naar een Gezond Stelsel van Ziektekostenverzekeringen [Towards a healthy system of health Insurance].* Den Haag: SER; 2000.

5. Mossialos E, McKee M. *EU Law and the Social Character of Health Care*. Brussels: Peter Lang, 2002.

6. Evans B. Going for the gold: the redistributive agenda behind market-based health care reform. In: M Peterson (ed). *Healthy Markets: The New Competition in Medical Care*. Durham/London: Duke University Press, 1998 pp. 66–103.

7. Maarse H. The politics of waiting lists in Dutch health care. *Eurohealth* 2002;8(4) (forthcoming).

Hans Maarse is Full Professor in Policy Science (with special reference to health care), Faculty of Health Sciences, University of Maastricht.

18 steps to Finnish health service reform

The Finnish Ministry of Social Affairs and Health announced a package of health sector reform proposals on 9 April 2002 as part of the country's national project to ensure health care functions and the availability and quality of health care services. The proposals will be prioritised and implemented in wide cooperation with regional authorities, municipalities, NGOs and other stakeholders. The Government also announced that grants to municipalities, which provide health services in Finland, are to be increased by €57 million in 2003.

The National Project on Safeguarding the Future of Health Care Services is based on 18 groups of recommendations. Below is a summary of the main points:

1. Health promotion: Local authorities should assess the needs and organisation of social welfare and health services, with emphasis on heath promotion, illness prevention and the regional collaboration of services.

2. Ensuring access to treatment: Special health care and public health legislation should specify time frames for access to treatment. Patients should receive basic health care within a three-day waiting period, be able to see a specialist within three weeks of referral, and get treatment normally within three months. By 2003 uniform national criteria should be created for waiting lists.

3. Quality control: Revenues from the Finnish Slot Machine Association should be used to fund the creation of national preventive care and treatment proposals. Hospital district authorities and primary health care units should prepare regional preventive health care and treatment programmes for the main classes of illness.

4. Ensuring expertise: In-service training should be covered in health legislation by the end of 2003. Proposals on the content and implementation of

such training should be drawn up by the same date. Finally, a further €10 million should be devoted to in-service training from 2004.

5. Technology assessment: FinOHTA, the Finnish Office for Health Care Technology Assessment, should be developed into an evaluation unit to assess the effectiveness of health care methods. The 'Rohto' (drug) project on the rational use of pharmaceuticals should become a permanent body with an annual budget of €1.3 million from 2004.

6. Local services: Local health care services should be arranged as a functional package at regional level and provided in association with social services on the basis of responsibility for a particular catchment area, with inter-regional collaboration where a larger population base is required. Mental health outpatient, psychosocial and intoxicant abusers' services should be run as functional regional units together with private and third sectors. Local authorities should form broader regional units for municipal occupational health care.

7. Specialised health care: Hospital districts should be combined, or their collaboration expanded, to enable them to plan specialised health care in 'packages' and according to fields of responsibility. The specialised health care of regional hospitals not integrated into regional health service districts should be combined as part of the general hospital.

8. Information systems: A smooth information exchange (on patient records and administrative services) between regional and basic information systems should be created by no later than 2007. Patient records in the primary health care system should form regional data systems that are available nationally in accordance with data protection policy. University hospital districts should coordinate regional information management development work in their special fields of responsibility. €1.6 million should be allocated between 2004–2005 to modernise the national statistical and information service system for the health and social welfare sectors.

9. Structural reforms: Health care system reform should be developed in cooperation by the Ministry of Social Affairs and Health and the Association of Finnish Local and Regional Authorities and phased in progressively with plans for structuring regional local services as well as hospital district and specialised services. Project funding for the plans will be €8 million in 2003 and €30 million from 2004-07. A single Health Services Act should be created out of the existing legislation on primary health care and specialised health care.

10. Good management: Health service management training focusing on local and middle management should be planned by universities in collaboration with the Ministry and the Association of Finnish Local and Regional Authorities. Such training should be required by everyone seeking jobs in local and middle health service management.

11. Division of labour: The division of duties and authorisation of physicians and nursing staff should be reviewed. The need to revise the division of labour between other health care vocational groups should be investigated. Responsibility for writing sickness certificates for patients needing short periods of sick leave from their employment should be transferred from physicians to other health professionals.

12. Training allocations: To alleviate the current shortages in physicians, medical faculties should increase their annual medical student enrolment from 550 to 600 students in 2002. The training of other professional groups in the social welfare and health sector should be increased in line with the sector's labour demand forecasting committees. Ward manager training should be part of a health science masters degree programme or parallel specialisation studies done after completing a polytechnic degree. Annual enrolments for such Masters degrees should also be increased.

13. Other staff shortage measures: Physicians should serve as health centre doctors for no less than six months, and the relevant legislation on training and qualifications should be amended accordingly. The decree on qualification as a specialist should also be amended to ensure that at least half of the training period is performed at a health-service unit other than a university hospital.

14. Training coordination: An advisory board should be appointed to coordinate the development of training in the social welfare and health sector.

15. Pay systems: The special charges system for hospitals should be replaced by a pay system providing incentives and promoting efficiency. This system should allow hospital physicians to perform additional work for local authority employers outside working hours.

16. User charges: The user charges system should be reviewed and rationalised (including the setting of ceilings for specified services) by 2005.

17. National Health Insurance: The impact of national health insurance reimbursement rates should be assessed in relation to public and private sector service provision. Reimbursements for laboratory and imaging tests should be reduced by the end of 2002 to a level corresponding to actual costs. The health insurance system should be developed so that it does not create perverse incentives for the use of costly but less effective treatments.

18. Health care financing: Municipal health care services should have sufficient (additional) resources from 2003–2007 to meet the recommended need for services, with state subsidies for local authority social welfare and health care being gradually increased. €8 million in 2003 and €30 million from 2004–2007 should be allocated to support strategic (transitional) structural and operational service development projects.

This brief outline of Finland's health service reform measures is an abridged version of an article by Mark Waller, which originally appeared in the bulletin Socius, *(Vol. 2, 2002), published by the Finnish Ministry of Social Affairs and Health, with whose kind permission it is reproduced.*

Further details on the reform proposals are available from the Ministry's website: www.stm.fi

Challenges for Sweden's health care system

Wendy Wisbaum, Ana Rico and Richard Saltman

Sweden, with the world's oldest population and the longest life expectancy at birth in Europe, has a regionally-based, publicly operated health system that covers all residents and is mainly financed by regional taxes. County councils at the regional level are responsible for health care planning and delivery; and they also share with the central state the functions of financing and regulating the private health care market. Municipalities at the local level are responsible for social welfare services, including long-term care for the elderly and disabled. The Ministry of Social Welfare and Health oversees basic legislation and supervises the activities of local governments. The latter function is delegated to the National Board of Health and Welfare, a central government agency which is also in charge of licensing health professionals.

The vast majority of physicians are hospital specialists. They are publicly employed and receive a salary, with extra payment for working non-regular hours. Most general practitioners (GPs) are also public employees, although some now receive a fixed fee per patient on their list. Private practitioners, who require an agreement with county councils for reimbursement, are paid according to their negotiated contracts. Some 90% of GPs have a further credential. In 1997, of all physicians working in primary care, 7% were independent private practitioners, and 12% worked in independently managed (but often publicly owned) health centres. For ambulatory care, most patients can choose between local health centres and hospital outpatient departments. Approximately 46% of outpatient visits are in hospitals. During the 1990s, outpatient and community care expanded, while inpatient care decreased. This was due to the combined effect of a rapid increase in day surgery and the transfer of responsibilities for elderly hospital patients to municipalities' community care network following the Adel reforms. In 1997, there were 10% fewer physicians in Sweden than the EU average. The country has a shortage of physicians in isolated rural areas and an overall shortage of skilled nurses across the country.

There is no officially defined basic health care package, although coverage decisions are made according to three guiding principles: human rights; need or solidarity; and cost-effectiveness. Equity and quality have been very important overall issues in the development of the Swedish model. Restrictions apply for dental care (only children under 19 are fully covered by the public system), and pharmaceuticals (only drugs included within the Drug Benefit Scheme are publicly subsidised).

The Swedish health care system has three main sources of revenue: taxes; national social insurance payroll contributions; and private expenditure, and there is some redistribution by the national government. The breakdown of public health care financing in 1999 was: 69% regional taxes; 25% social insurance, as well as transfers from central government; 8% other sources, of which patient fees are 3%. Regarding county councils' total health care expenditure, in 1999, 62.3% was for secondary and tertiary care; 22.4% for primary health care; 9.5% for psychiatric care and 5.8% for geriatric care. Municipalities charge for the social welfare services they provide, but fees, usually income-related, are heavily subsidised.

County councils determine out-of-pocket payments (within the framework of the nationally set fee ceilings: approximately €210 annually), and exemptions (currently in place for patients suffering from certain chronic conditions). Payments by patients for non-covered items have become relatively larger, in that the public portion of total health expenditures has fallen from about 92% in 1980 to about 83% in 1998. Co-payments apply for outpatient care and pharmaceuticals, up to the annual ceiling. Private health insurance covers only around 70 000 individuals and is usually supplementary coverage, paid for by employers. Total real expenditure on health (after accounting adjustments) fell somewhat during the 1990s and in 1998, it stood slightly below the EU average, reflecting a sustained effort to increase overall service efficiency.

Reforms and challenges

In the early 1990s, a recession and cost containment efforts led to a sharp 25% drop in the number of health sector employees and to a lower rate of increase in real public health care expenditures.

Concerns about bureaucratic rigidities and a growing desire by patients to be able to choose their public provider led to a series of reforms in the early 1990s focusing on planned markets. These reforms centred around purchaser/provider splits in about half the county councils; new management/organisation schemes; and new contractual arrangements based on prospective per case payments. These competitive arrangements inside the pubic sector created expanded opportunities for patients to choose among public health care providers.

These management system reforms, predominant throughout Sweden in the 1990s, raised concerns about lack of coordination, a piecemeal approach to service delivery, and equity. By the end of the 1990s, reform initiatives shifted to increasing cooperation among purchasers and providers and re-centralising some delegated powers to higher management levels.

Other reforms during the 1990s included improving accessibility (reducing waiting times), enhancing quality, increasing patients' rights, containing pharmaceutical expenditure (through a reference price system), and extending county

councils' responsibilities over the regulation of private provision.

A number of challenges remain. Waiting lists for certain elective procedures have returned, and remain high on the political agenda. The newly re-elected Social Democratic government is committed to expanding the prior care guarantee (10 procedures) to all elective services. Sweden also has waiting times in primary care (i.e. two thirds of patients had to wait 5 days or more for consultation with a GP in 1997). Another access issue refers to the local community care network, which needs to be strengthened to deal effectively with new integrated care responsibilities devolved to municipalities in 1993. This is especially important given the high and rising proportion of 65+ population which will place higher demands on the health care system. Another important policy debate revolves around the role of private provision. Small but highly visible efforts made in the mid 1990s to expand its role within the primary care sector were later reversed under changing government coalitions and partly due to public opposition. The recent privatisation of the management of a general hospital in Stockholm might have a similar fate. Yet perhaps the main overall challenge the country faces is how to reach a balance between efficiency and responsiveness. Since the mid 1990s, economic recovery resulted in mounting pressure to increase public health expenditure from the Left and Green opposition parties, as public dissatisfaction with expenditure cuts rose. This, as well as the change in government, may be responsible for the moderate increase in public per capita expenditure registered since the late 1990s.

This article is based on: (1) the HiT profile on Sweden (2001), written by C Hjortsberg and O Ghatnekar and edited by A Rico, W Wisbaum and T Cetani; (2) Federation of County Councils, 2002. Swedish Health Care in the 1990s; and (3) Health care systems in eight countries: trends and challenges (2002), commissioned by HM Treasury and prepared by the European Observatory on Health Care Systems.

Serbia and Montenegro:
What lies ahead for the new union?

Jennifer Cain

The Belgrade agreement, which sets the terms for the realignment of relations between the two republics of Serbia and Montenegro and establishes relations with the European Union, was signed on 14 March 2002. Under this agreement, the Federal Republic of Yugoslavia (FRY), the only remaining state of the former Socialist Federal Republic of Yugoslavia, will be replaced with a new state to be named 'Serbia and Montenegro'. With the Belgrade agreement in place, Montenegro and Serbia agree to remain in the union for three years, after which both states have the option of holding referendums on independence.

Unlike its neighbour to the west, Bosnia and Herzegovina (BiH), which has created a federation of two states based on the US federal model, Serbia and Montenegro will act as a union of two countries, with separate currencies, markets, customs services and border controls. The new state will have specific federal authority (in areas such as foreign affairs, defence, international and internal economic relations, and the protection of human and minority rights) with the other main decision-making powers concentrated in the two states of Serbia and Montenegro. Although the parliaments of Serbia and Montenegro ratified the Belgrade agreement on April 9th, much work still needs to be done to restructure relations between the two states. One of the most important tasks is the drafting of the Constitutional Charter, which is targeted for completion in autumn 2002. This Charter will provide the highest legal basis for the new state union of Serbia and Montenegro, setting the guidelines for the four joint institutions, the Parliament, President, Ministerial council and Court.

If all aspects of the Belgrade agreement are implemented, the door will be open for Serbia and Montenegro to join the European Union's Stabilization and Association process, a programme designed to pave the way for integration into EU structures through programmes in trade liberalisation, financial assistance, democratisation and civil society, humanitarian aid for refugees, cooperation in justice and home affairs and development of a political dialogue. Southern European countries that have signed on to the Stabilization and Association Process are eligible to receive funds from the €4.65 billion Community Assistance Programme for Reconstruction, Democratisation and Stabilization (CARDS).

Health Care – the past

Historically, Yugoslavia had a very decentralised health system which collected income-related compulsory state health insurance contributions at the republic level. This system was further decentralised in 1974 with the introduction of community management programmes by local associations, pooling income contributions and allocating funds to providers at the community level. However, the Yugoslav experiment in decentralisation proved to be unsuccessful, through mismanagement and misallocation of public funds and the primary health sector suffered as the majority of community association funds went to hospitals.

By 1992, after the break up of the Socialist Federal Republic of Yugoslavia, Serbia and Montenegro were the only two remaining republics comprising the FYR. At that time, FRY adopted Health Care Acts in the Montenegrin and Serbian Republics, re-centralising social insurance pooling at the republic level

and establishing republic-level health insurance funds to contract with local providers. Although a Federal Ministry of Health existed in FRY from 1992–2001, its role was confined to the regulation of pharmaceutical quality and production inside the borders of FRY and negotiating and managing international health relations and humanitarian aid. All matters of health system management, funding, allocation and delivery were under the authority of the republic ministries of health with the exception of the federal military health system which operates a handful of military hospitals for its conscripts and veterans.

What now for health?

The main health institutions in Serbia are the Ministry of Health, the health insurance fund, the institute of public health, and its health statistics office. Montenegro has a similar set of institutions plus a drug control agency (established in 1999). Health professionals are licensed to practice by the ministry of education in each republic and are allowed to practice in both republics with a valid licence. In the early 1990s physicians' chambers and professional associations were established and act to support physicians through continuing education and legal aid.

Both republics finance their health systems by compulsory social health insurance based on a 7.5% income contribution, matched by a 7.5% employer contribution, and contract directly with state providers at the municipal level. The private sector, both clinical and pharmaceutical, does not contract with the health insurance fund. There are no private insurance funds currently operating in either republic. The state health insurance fund, along with general public sector services, have reported large-scale debt in both republics. The combination of long waiting lists for services and low payment for health service professionals by the health insurance fund have encouraged the exchange of undocumented envelope payments prior to or after patient treatment.

Primary and secondary care providers operate out of first-level contact *dom zdravljas*, or health houses, and act as gatekeepers between ambulatory primary and secondary care and inpatient care. There are 160 *dom zdravljas* operating in Serbia, and 77 hospitals and 36 public pharmacies. In Montenegro, there are 22 *dom zdravljas*, 11 hospitals and 40 public pharmacies. The private sector was introduced in both republics in the late 1980s, allowing dentists to operate private clinics and by 1992, physicians were allowed to practice privately. The private sector encompasses 10% of the health system.

Considering the already decentralised approach to health systems management, and the concentration of administrative authority at the individual country level, there will be almost no role for health at the federal level. Current discussions focus on whether to maintain a federal agency for drugs or to create a Serbian drugs agency.

With regard to the health care system, except for the federal military health system, all aspects of financing and provision of health care will be managed at the individual state level. Thus, the change from Yugoslavia to Serbia and Montenegro, in many ways, legitimises the existing shadow relationship of the two republics and ensures their stability through the new relationship with the EU. This new relationship promises financial and technical support with modernising markets and public sector management, support that is sure to improve not only the democratic and economic stability of Serbia and Montenegro, but also the stability of health care system financing, a key step to improving the functioning of the entire health system.

Jennifer Cain undertakes research and dissemination at the European Observatory on Health Care Systems.

New study: Primary care in the driver's seat?

A workshop to discuss the Observatory's analytic study on primary care was held on 24–25 May in London, generously sponsored by the Nuffield Trust. The workshop brought together approximately 25 experts on primary care from all over Europe to debate reforms and innovations in primary care over the past decade.

The study will describe and analyse the diverse primary care delivery arrangements that exist in Europe (including characteristics of the Nordic and southern countries, the UK, social health insurance countries and the countries of central and eastern Europe) and explore the impact that recent organisational reforms have had upon that structure. Rather than attempting to assess the much larger area of primary health care, which incorporates a range of activities from public hygiene to occupational health, this study will focus on the current status and potential evolution of one key aspect of primary health care, namely the delivery of primary care clinical services. Drawing upon available research evidence, institutional experience and expert opinion, the study will examine what is known and what remains to be learned if primary care is to take on an increasingly central role in health services delivery.

The study will consist of two parts: Part I contains chapters outlining the analytical framework of the study as well as background and contextual information on primary care. Part II contains edited papers commissioned from 27 experts in the primary care field, covering: purchasing; coordination; substitution and shared care programmes; the evolving public/private mix; contracts, incentives and payments systems; quality and performance; training and skill mix policies; and the role of new technologies. *Primary care in the driver's seat? Organisational reform in European Primary Care* (Edited by Richard Saltman, Ana Rico and Wienke Boerma) will be published in 2003 as part of the European Observatory on Health Care Systems Series with Open University Press.

The Observatory is grateful to the Nuffield Trust for Research and Policy Studies in Health Services for sponsoring this workshop.

Bridging research and policy-making in Venice

Venice is the city of bridges, a perfect setting to discuss the interim findings of an Observatory analytical study on effective purchasing for health gain. The workshop was held on 16-18 May and brought together 50 regional, national and international public health professionals. The focus of the study is on strategic purchasing as a central function for improving health system performance and assesses the organisation of purchasing health services and programmes in Europe through selected case studies. In addition, key experts look at theories of purchasing; the role of markets; consumer participation; defining public health objectives; governments' stewardship role; purchaser-provider contracts; financial incentives; the role of provider organisations; and clinical governance. Draft papers were discussed during the first two days of the workshop, and views on the findings were exchanged with Italian regional policy makers on the third. *Effective Purchasing for Health Gain*, J Figueras, R Robinson and E Jakubowski (eds) will be published in 2003 as part of the Observatory Series.

The Observatory is grateful to the Regional Governments of Veneto and Tuscany for generously sponsoring this workshop, and to Dr Luigi Bertinato from the Veneto region for his invaluable cooperation.

Paying for health care in Slovenia

The Observatory, in collaboration with the Slovenian Ministry of Health and the Slovenian WHO Liaison Office, organised a two-day workshop on financing and paying for health care on 28–29th May. The workshop followed the press launch of the HiT profile on Slovenia. Some 200 Slovenian participants from government and the health field were brought together along with international contributors who presented evidence on financing and resource allocation reforms in Europe and Australia. The workshop provided a platform for an exchange of views from a wide range of decision-makers and practitioners on health system financing and resource allocation reforms in Slovenia.

The Observatory is grateful to the Ministry of Health of Slovenia for sponsoring this workshop, and to all contributors, in particular Dr Vesna-Kerstin Petric.

Baxter Award

The Observatory has received the prestigious 2002 Baxter Award for its publication, *Funding Health Care: Options for Europe*, edited by E Mossialos, A Dixon, J Figueras and J Kutzin. Each year, the European Health Management Association gives the Award to an outstanding publication and/or practical contribution to excellence in health care management in Europe.

Just Published

Observatory Research Directors, Martin McKee and Elias Mossialos, contributed to the conference convened in December 2001 by the Belgian presidency of the European Union on the implications of European law for the social nature of health care. Two complementary books have emerged from this process:

EU Law and the Social Character of Health Care (E Mossialos and M McKee, with W Palm, B Karl and F Marhold). Written with the health and social policy community in mind, this book provides a comprehensive assessment of the main implications of EU law in certain key areas of health care.

The Impact of EU Law on Health Care Systems (Edited by M McKee, E Mossialos and R Baetens). Presenting a range of perspectives from the legal profession on the current situation and prospects for the future, this book provides an in-depth analysis on the expanding scope and impact of European law on health care.

Both books are published by P.I.E. Peter Lang, Brussels.
www.peterlang.net/all/index.cfm

For ordering details on any of the Observatory 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.

Telephone: +45 39 17 14 30, Fax: +45 39 17 18 70
E-mail: observatory@who.dk Website: www.observatory.dk

To join the mailing list, please contact
Anna Maresso
Observatory – London Hub
Tel: +44 20 7955 6288
Fax: +44 20 7955 6803
Email: a.maresso@lse.ac.uk

Euro Observer is published quarterly by the European Observatory on Health Care Systems, with major funding provided by a grant from Merck & Co., Inc., Whitehouse Station, New Jersey, USA.

Design and production by
Westminster European
westminster.european@btinternet.com

ISSN: 1020-7481