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International Forum on Common Access to Health Care Services



Ministerial discussions at the International Forum

The International Forum on Common Access to Health Care Services is a new initiative developed by the Minister of Health and Social Affairs in Sweden, Lars Engqvist, together with the ministers of health in New Zealand, Annette King, and the United Kingdom, John Hutton. The initiative aims to give participating politicians, policy-makers and researchers from different countries a forum to exchange knowledge, experience and ideas on equitable health care provision. The participation of ministers of health is based on a shared belief that health systems with

universal access to care have both the ability and power to develop efficient health services in an increasingly globalised society, and the shared will to pursue progressive solutions to this end.

The International Forum convened its first conference in Stockholm on 30–31 January 2003 where ministers of health from seven countries – Chile, Germany, Greece, New Zealand, Slovenia, Sweden and the United Kingdom – discussed equity issues in health care. Further information on the conference, including the Observatory papers that accompanied discussions, is available from the website of the Swedish Ministry of Health and Social Affairs, www.social.regeringen.se. The next meeting of the International Forum will take place in May 2003 in London.

The January conference concluded with a Declaration by its participating Ministers, and we reproduce it here in its entirety.

Programme Statement

The group

We, Ministers of Health from Chile, Germany*, Greece, New Zealand, Slovenia, Sweden and the United Kingdom met in the International Forum on common access to health care services, 30–31 January 2003, in Stockholm.

We represent a group of countries with different political, organisational and financing structures, united by the value that health systems shall ensure all citizens universal and

equitable access to good health care. In our countries we are working to improve the provision of health care services in ways that lay the foundations for a high level of confidence and good health outcomes in the entire population.

We have come together to debate and scrutinise progressive and evidence-based solutions on how to shape equitable and high quality health care services accessible to all people.

**Due to a last minute obligation, Ms. Ulla Schmidt, Minister for Health and Social Security, was represented by Mr. Klaus Theo Schröder, State Secretary.*

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.

Challenges

In all our countries, pressures on the health services are growing through demographic change, new technologies and medicines. At the same time, people's demands and expectations are increasing. They have a different attitude to health provision, and want choice, responsive services and to be involved in the care they receive. We will respond to these challenges.

Values and principles

We share common values and principles in the way we provide and pursue improvements of health care for our populations. These are:

People are at the centre – primarily patients but also health care staff.

Common access – meaning universal health care according to need, not wealth.

Equitable access – meaning good care on equal conditions for all people, regardless of social circumstances or where in the country you live.

Health care is a *public responsibility* based on solidarity, with collective rather than individual rights, and governed by democratic institutions.

The health system rests on *solidarity in funding* – either through taxation or social insurance or a mixture of the two – in a financially sustainable way.

Health care services are based on a *plurality of service providers* public, non-profit and private in accordance with societal goals.

These are principles and values that we share both for our own countries and in our approach to health systems developments globally.

Strategic directions

We believe that within this framework of principles and values it is both possible and desirable to improve the performance of our health services, and the patient's experience.

The first exchange of country experiences of different policy measures has outlined the following strategic directions for improvements.

The prime objective is responsiveness to patients by offering coherent care systems that can cater to a variety of health needs during the life-span: care that is of high quality, safe, affordable, easily accessible and with minimal waiting times. Each patient is to be met with respect and empathy. The health care will provide information on best practices, the good examples as well as on problems and bottlenecks.

For health services to be provided on a truly equitable basis, they need to be tailored to the needs of all patients, and respect their diversity. We will pay attention to overcoming any barriers to access with an emphasis on the health needs of vulnerable groups of people.

We recognise that primary health care will play an increasing role in the health care system. It will require substantial development to meet health needs in accordance with best practice and scientific development.

We will be innovative in applying new evidence-based methods and management models to meet both basic and more specialised care needs. Our health services will be constantly modernised by the introduction of new cost-effective and safe medical technologies.

An improvement in the quality of health services is important for the patient as well as for the efficient use of existing resources. Therefore, the sustained improvement in the quality of health services requires of us continuous exchange about the best methods and standards, taking into account the latest findings.

We consider the cost-effective provision of health services to be necessary in order to provide maximum benefits for patients and to ensure sustainable health care financing. One way of increasing cost-effectiveness is to foster comparability and monitoring of outcomes with regard to both health care providers and health care fund holders. Competition of this type is not an end in itself, but serves to achieve informed choices by patients and an efficient use of resources.

We will adapt our systems to meet

regional and local health care needs. At the same time we recognise the necessity for national (and international) collaboration in the area of highly specialised care and research, so as to ensure universal access also of more cost-intensive treatments.

We will work for an inclusive workforce development that facilitates professional development, embraces new working methods, and offers a stimulating working environment and participation in decision-making. Out-dated hierarchies should be replaced by teamwork and shorter decision processes.

We consider it completely consistent with the principles outlined above to make use of a plurality of care providers – public, private and not-for-profit. Constructive dialogues with private interests will be welcomed. The different non-public entrepreneurs that may work within the publicly financed system, should, however, comply with standards and rules set out for all care providers. It is a political responsibility to define the rules. Then measures conducive to shaping a two-tier health care system, in which care is governed by the financial means of patients rather than their medical needs, will not be accepted within the publicly funded system. Neither should private insurances or other private payments provide means of 'jumping queues' in the public system.

Sustainable funding of health systems is based on systems where citizens, in solidarity, pool resources and share risks and benefits. Economic discipline and efficiency are then conditions for upholding the social goal of universal care. Depending on the specific situation in the country there could be a case both for increasing resources and curbing expenditures.

It is documented that health care with revenues from general taxation or social health insurance is associated with improved equity, better cost control, economies of scale and better purchasing power over providers. Such funding systems are also more progressive than private health insurance and out-of-pocket payments, which are both highly regressive.

Sharing of evidence in support of common access to health care services

We will further analyse performance measured in different parameters such as universality of coverage, quality, productivity, availability of staff and cost-containment. In doing so, we can already conclude that available empirical evidence indicates that our systems are competing well with other systems, including market-based ones.

We are committed to improving accountability of our system by improved monitoring of health outcomes, access to care, health practices, waiting times, quality assurance and performance in order to facilitate a continuing modernisation of public health services. The objective is to get a dialogue grounded in trust with well-informed, confident and participating citizens.

We will stimulate research and studies in order to identify the best policy options.

The next step

The political and technical dialogue between us as representatives of like-minded countries at this first meeting has brought into focus several important elements vital to our efforts in pursuing reform.

We conclude that a network for sharing progressive thinking and evidence on improvements of health care services among countries is essential in order to sustain the societal goal of universal access to health care services.

Here we recognise that our strength lies both in diversity – finding solutions that fit our national organisational and financial situation – and in unity – our common values and will to share experiences and evidence.

We intend to go forward with a mutually beneficial programme of work and experience exchange. In doing so, we will take into account programmes already underway in other international settings (WHO, OECD, etc.) which are helpful to our aims.

We ministers will meet together in London in May this year, and in Wellington in 2004 to discuss the challenges we face, the direction we wish to go, and to agree on a programme of work to look at the kind of issues we can best address together.

We affirm that:

Solidarity and equity of access are at the heart of our health care systems.

These values are a core part of our different social traditions, but they will only retain their rightful place if we are bold in our attitude to reform.

Simply affirming the value of solidarity

and equity is not enough: we must recast the means of attaining them in a modern setting.

We will secure the essential values of our health systems by:

- Engaging creatively and effectively with the private sector to further our public service goal;
- Ensuring solidarity and sustainability in funding;
- Encouraging diversity of provision, and local engagement;
- Placing patients and their choices at the centre of reform.

New pharmaceutical initiatives in Finland

A new Pharmacotherapy Development Centre (PDC) for Finland was established on 3 March 2003, with an annual budget of €1.3 million and nine staff members.¹ Whilst Finland has a National Agency for Medicines (NAM), which controls the marketing authorisation of medicines, the PDC is an independent unit, with a remit to provide doctors with “balanced information on new medicines and treatments”. The aim is to cater to the needs of doctors whose already over-stretched schedules leave little time to sift through the large volumes of information on new medicines, different product brands and their prices.

Rational prescribing

According to Hannes Wahlroos, Director General of NAM, any potential overlap between the two entities will be avoided if the new PDC’s work concentrates, as its name suggests, on the therapeutic values of new and older medicines, comparing the clinical value of medicines and passing this data on to the doctors prescribing them.

One of the PDC’s tasks will be to tackle

the problem of over-prescribing. According to Dr Terhi Hermanson, Senior Medical Officer at the Ministry of Social Affairs and Health, under-prescribing may occur for certain conditions, for example, in different types of depression or for cancer pain, but in some cases the problem lies in over-prescribing by physicians or the concurrent use of many different medicines by patients. The PDC will work towards ensuring that the right kind of medication is prescribed when it is needed and will also encourage physicians to promote drug-free alternatives where these are appropriate.

The PDC also expects to make an impact on the rising costs of drug expenditures to the health insurance system as well as to patients. Previously, doctors may have continued to prescribe an original product even after the patent had expired and cheaper alternatives had come onto the market. Moreover, according to Dr Hermanson, the growth in pharmaceutical costs experienced in Finland over the last few years is not due to a substantial increase in the number of prescriptions but resulted

mostly from expensive new medications being put onto the market and marketed very effectively. By providing doctors with comparable data, the PDC hopes to ensure that rational prescribing is based on information about whether these new, more expensive medicines are actually more effective than older equivalents.

The PDC's promotion of rational prescribing also will act as a valuable resource for doctors, especially with the introduction of new rules in Finland for the substitution of generic medicines (see below). In one sense, generic substitution by pharmacists will alleviate pressures on busy doctors having to ensure themselves that patients obtain the cheapest product containing the same substance. However, it is still the case that doctors, as well as pharmacists, must be able to explain to patients how various medicines vary from one product to another and why generic substitution for a cheaper drug may or may not be appropriate in each individual case.

New law on generic substitution

The timing of establishing the PDC coincides with new legislation on generic substitution which will come into force in April 2003. The new law requires pharmacists to replace a pharmaceutical prescribed by a doctor for a cheaper equivalent product, if one is available. Compiling the catalogues on generic medicines that are substitutable falls under the remit of the NAM and alternative products that will appear on the Agency's substitution list will be subject to strict criteria:

- (i) the preparation must contain the same active ingredient;
- (ii) it must contain the same amount of active ingredient;
- (iii) it must be in the same form (for example, tablets or drops);
- (iv) the biological equality of the products must have been duly demonstrated; and
- (v) the preparations must be in the same ATC (Anatomic Therapeutic Chemical

Code) classification, in which a substitution can be made safely. However, based on this criteria, there are some drug groups that cannot be put on the substitution list, such as medication for epilepsy, arrhythmia and insulin.

The new law was prompted, in large part, by the steady and steep rise in spending on medicines, which has grown at an average rate of 10% since the early 1990s and registered a 12% increase in 2001, totalling €1.8 billion in that same year. Reimbursements for medicines paid out by the Finnish Social Insurance Institution have risen at the same rate, totalling €768 million in 2001. Overall, the share of pharmaceutical spending of total health care expenditure in Finland has increased from 9% to 15% in the last decade.

The generic substitution law reflects a similar cost containment strategy to that adopted in Sweden, whose generic substitution legislation came into effect in October 2002. In Finland, the new law is expected to save €15 million in drug reimbursement costs in its first phase. This calculation covers only the savings gained by the Social Insurance Institution through pharmacists replacing drugs prescribed by doctors. It does not take into account other potential savings that may accrue from increased price competition between pharmaceutical companies, who in the face of generic substitution, may instigate price cuts for established drugs still under patent.

Despite the substantial financial incentives to adopt the generic substitution bill, the policy was subject to intense debate in the Finnish parliament and media, even prompting a public statement in October 2002 by the Minister of Social Affairs and Health, Maija Perho, in order to clarify some contentious issues and arguments.² Among her clarifications were that 9 out of the 15 EU member states already have some form of generic substitution in place, as do almost all of the US states. Moreover,

substitutions by pharmacists will not entail the mere switching to cheaper products but will be strictly regulated via the NAM substitution list, ensuring that only medicines of pharmacological parity are dispensed to patients. Because of this, there will be no change in the doctor-patient relationship, as some critics had argued.

According to Minister Perho, "whether or not doctors are informed about the brand name of a substitute medicine, when the active ingredients remain the same, is not a central feature as far the treatment of their patients is concerned. Information on whether patients have finished their courses of medication or whether they have bought the medicine at all, is far more important." As a final safeguard, a doctor can refuse to accept substitution for specific cases on the grounds of treatment; that is, if a patient has a bad memory or suffers from mental problems, the doctor can prevent the substitution of a different brand of medicine if he or she suspects that it will complicate patients' use of their medicine.

Finland's new pharmaceutical policy initiatives can be seen as the natural development of attempts since 1998 to promote rational and cost-effective prescribing. The dual strategy of disseminating crucial pharmacological data to doctors through the newly established PDC and the introduction of generic substitution legislation is aimed at delivering clinically effective treatment whilst curbing the cost of medicines in Finland.

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Health and health care in Turkey

Sarah Thomson and Ömer Saka

Turkey has the seventh largest economy of all European OECD countries measured in terms of total levels of gross domestic product (GDP). However, GDP per capita is the lowest amongst these countries.¹ This low level of GDP per capita is reflected in the poor health status of the Turkish population and the questionable performance of Turkey's health care system.²

Infant and maternal mortality rates in Turkey are much higher than in any other country in Europe, while estimates of life expectancy are lower. These indicators also vary between different parts of the country, suggesting a degree of health inequality within Turkey. In 1999, infant mortality in Turkey was 40 deaths per 1,000 live births, compared to a European Union (EU) average of 4.9, a Central and Eastern European (CEE) average of 11.3 and an Newly Independent States average of 17.8.³ The trend for maternal mortality is worse. WHO calculated a rate of 130 maternal deaths per 100,000 live births in 1998, although other sources quote a higher rate of 180.⁴ This compares to a European average* of 20.3 and a Central Asian Republics average of 42.6.

Poor health status in Turkey – both in absolute and relative terms – is associated with an unequal distribution of income, rapid urbanisation and health care system failures. In spite of successive reforms, the health care system continues to face problems of low population coverage, heavy reliance on out-of-pocket (OOP) payments and an uneven distribution of facilities and personnel, all of which lead to inadequate and unequal access to health services.

At the beginning of the 1960s, the government made its most structured attempt to establish a national health

service and extend coverage across the country, but the initiative fell short of its goals, largely due to limited financial and human resources. At the same time, the growth of the two social security schemes for private sector employees, blue collar public sector workers and retired civil servants and the establishment of a scheme for self-employed people led to the creation of a de facto system of multiple insurance schemes providing coverage to some, but not all, of the population. So although a universal health insurance scheme has been an objective of every government health plan since 1963, universal coverage remains an elusive goal.

Estimating the proportion of the population covered by the social security system is difficult and controversial. While official statistics show that it covers over 95% of the population, this figure is likely to be inflated by double counting.

Funding sources

Official statistics suggest that total expenditure on health care as a proportion of GDP is low in Turkey, relative to EU member states and CEE countries, although the actual volume of private expenditure is not known. Total expenditure has generally exceeded 3.0% of GDP and currently stands at 4.3% (in 2000). Underspending is most marked in the public sector; the size of the government's budget allocation for health care resembles that of low income countries, despite Turkey's middle income status. Public spending on preventive services is particularly low. Between 1992 and 1998, the proportion of the Ministry of Health's budget allocated to preventive services declined from 7 to 3%.

According to official statistics, taxes accounted for 40.4% of health care funding in 1998, social security contributions for 31.5% and out-of-pocket payments for 28.1%. However, the proportion of

OOP payments is likely to be much higher, largely because national statistics are based on data collected from private providers, who may under-report revenue, but also due to the boom in private sector enterprise and activity and the rapid expansion of private health insurance during the 1990s. Informal payments are also an issue. Recent surveys suggest that many people regard corruption in the health sector to be a major problem. It seems clear that there are significant financial barriers to access in Turkey, although the precise distribution of private expenditure is not known.

Uneven distribution of health facilities and personnel

While there is an established network of primary care infrastructure throughout the country, the quality of services provided is questionable. The geographical distribution of secondary and tertiary health services and personnel is very uneven, and secondary and tertiary centres in urban areas tend to be used for primary care purposes. One third of hospital beds and almost half of all doctors are concentrated in the three largest cities and there are fewer personnel per capita in less developed regions of the country. Specialists are most unevenly distributed: Istanbul has almost 14 times as many specialists per capita as the eastern provinces of Mus and Van. As in other countries, these variations arise from socioeconomic and climatic differences between regions and the absence of strong financial or other incentives to encourage personnel to practise in less favourable regions.

Doctor and nurse to population ratios are comparatively low in Turkey, although the number of health personnel increased sharply during the 1980s and 1990s. The skill-mix of health personnel also restricts the delivery of effective health services, with too few nurses and midwives in relation to doctors and, until recently, too many specialists in relation to general practitioners.

During the economic liberalisation of the late 1980s, the government provided substantial incentives for investment in

* average of the countries in WHO's European Region.

private health care, such as generous public subsidies, reductions in import regulations and easier ways of financing the purchase of equipment. By the end of the 1990s, over 100 new private hospitals had been established, mainly in the largest cities. Growth has slowed since the economic crisis of 2001. Rapid expansion of the private sector has contributed to the development of health care infrastructure – particularly in terms of the accumulation of high technology – and may satisfy patients who are able to pay for private care, but it exacerbates existing inequalities in access to health care between those with different levels of income and those living in different parts of the country. The development of an unregulated private sector also raises concerns about quality and service outcomes.

Future prospects?

Attempts to reform the Turkish health care system have been hampered by political instability – between 1993 and 1997 Turkey had six different ministers of health – and fragmented policy making. In future, however, there is scope for improvement, particularly in terms of publicly funded and provided health care. Current health sector reform initiatives, including a project partly funded by the World Bank, involve organisational changes such as decentralisation of some responsibilities to regional level and re-structuring of the Ministry of Health.

Internal and external pressures – notably the prospect of accession to the EU – could precipitate changes to public structures more generally, which may lead to increased transparency and greater pressure for accountability. Such changes may also encourage improvements in the performance of the health care system and the state of the population's health.

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Health system decentralisation in Bosnia and Herzegovina

Elke Jakubowski and Jennifer Cain

As a republic of former Yugoslavia, the health system in Bosnia and Herzegovina was financed by 'self-managed' communities which ran health insurance, social security and disability insurance for employees and their families at the municipal level. At the federal level, risk pooling took place through a republic-wide, compulsory health insurance scheme, administered by a central insurance fund. During the war from 1992–95 health financing was organised directly by the republic's then Ministry of Health, while the health insurance fund practically ceased to operate. Provision of elective health care was reduced to a minimum, and a number of new provider units were established for emergency care. However, it is estimated that about 30% of health care facilities were destroyed or heavily damaged during the war.

Today, Bosnia and Herzegovina has separate health care systems as a result of the division of the country into the Federation of Bosnia and Herzegovina (FBH) and the Republika Srpska (RS) by the 1995 Dayton Peace Accord, which made

health care organisation, finance and delivery the responsibility of these tiers of government, commonly known as 'entities'. A third health system was created in the district of Brčko in 2000 that covers an estimated 90,000 population.*

Comparative features

The FBH opted for a decentralised cantonal system of government, requiring each of the ten cantons to be responsible for its own health care administration. In contrast, the RS opted for a centralised system, with one ministry in its capital, Banja Luka, exercising decision-making power. The heterogeneous administrative structuring within the two entities results in 13 ministries of health for Bosnia and Herzegovina's 3.8 million population.**

In the FBH, health system income generation and resource allocation takes place at the cantonal level. Its Federal Health Insurance Fund (FHIF) only has a supervisory function. Until January 2002, there was a Croat inter-cantonal fund with some fund pooling, but risk

* The Dayton Agreement retained Bosnia and Herzegovina's international boundaries and created a joint multi-ethnic government. The national government was charged with conducting foreign, economic and fiscal policy. A second tier of government was also recognised, comprising two entities roughly equal in size: the Bosniak/Croat Federation of Bosnia and Herzegovina and the Bosniak Serb-led Republika Srpska. The FBH and RS governments were charged with overseeing internal functions, including health care. Brčko district is in the northeastern corner of the country and is an administrative unit under the federal sovereignty of Bosnia and Herzegovina; it is not part of either RS or the FBH and the district remains under international supervision.

** That is, one central ministry of health for FBH, one for each of its ten cantons, one for the RS and one for the independent district of Brčko.

sharing did not take place systematically between the ten cantons. At the level of individual cantons, their population bases were often too small for effective risk pooling. In the RS the Health Insurance Fund (HIF) is a central body, operating on the basis of solidarity and mutuality, that is legally responsible for the collection and allocation of funds to health care providers. The HIF central office sets prices and defines contracts with providers, and is responsible for internal audits, the pooling of funds, and some centralised procurements. Regional offices are responsible for the collection of contributions and resource allocation to providers.

The lack of portability of health insurance funds both between entities and within the FBH cantons means that citizens of one entity/canton are left without significant cost protection when in need of health care in another, and thus have to pay the full price for treatments received, raising serious equity concerns.* Moreover, health insurance revenue in both entities is subject to significant collection problems. Although formally, health insurance contributions are levied as a percentage of income (for example, for the working population in FBH health insurance contributions are based on 13% of employees' salary and 5% paid by the employer; in RS, employees and employers each contribute 7.5% of salaries) in practice, the impact of making health insurance contributions varies for different population groups. The current collection system seems to rely on targeting those groups which are considered to be more reliable in providing a steady source of contributions. For example, given the high levels of unemployment in Bosnia and Herzegovina as a whole, and the fact that salary payments in many sectors are often delayed, state sector employees, whose salary payments are more dependable, tend to provide the majority of contributions that are actually collected by health funds. Moreover, contributions from other groups such as the self-employed, farmers and pension-

ers are less consistent and are affected by general under-reporting of income.

The existence of a substantial informal economic sector also means that many potential contributors are bypassing the compulsory health insurance systems. Finally, under-the-table payments to health professionals are high, and it is reported that often bribes are needed to bypass waiting lists. This process has stimulated the development of a two-tier health care system, one private, for the wealthy and the other public, for the rest of the population. Thus, both entities struggle with similar health financing issues – resolving informal, out-of-pocket payments and securing insurance contribution collection specifically from farmers, private sector employees and the self-employed.

Reforms

In the FBH, where health funding is much more fragmented, recent legislation allows some transfer of resources across the cantons to be redistributed by the FHIF for tertiary care. The establishment of the 'Federal Solidarity Fund' in January 2002 aims at increased inter-cantonal cooperation to diminish inequities in access to health care by reducing duplication of services, enabling the movement of patients across locations to receive needed services where available, and potentially reducing the fragmentation of services between cantons and along ethnic lines. Moreover, lower income cantons will be able to benefit from expensive interventions. The fund is financed by contributions from cantonal health insurance funds (8% of their overall income), and general revenues. The aim is to resolve the problem of lack of contributions by non-earners and to help to equalise health revenues across FBH.

The RS has recently established the Health Insurance Fund Assembly, a commission working on regulatory issues addressing revenue collection, levels of contribution, scope of benefits, resource allocation formulas and reform of the contractual arrangements between

the health insurance funds and providers. The RS is also pursuing initiatives in the health care sector, by setting up a drugs authorisation agency; developing legislation to regulate capital investments in health care; initiating registration and licensing of health personnel; and establishing an accreditation agency for both public and private hospitals.

Both entities are developing strategic plans for reconstructing and reforming their delivery policies and systems. The strategic plans reflect a substantial shift towards emphasising prevention, health promotion and primary care. Basic benefit packages, to be provided under compulsory social insurance, are also under development. However, in the RS the plan is for the package to provide benefits only for the insured population (putting the government under pressure to ensure funding for vulnerable groups) while in the FBH, the aim is to establish a uniform, federation-wide package to ensure equal access.

However, reform progress and implementation is often hampered by inherited rigid bureaucratic structures and political resistance to change. Moreover, western aid seems to have triggered a 'rent-seeking' donor culture and a foreign aid dependency among politicians and professionals. On the other hand, it is clear that poor inter-agency coordination by the international community has made it difficult for the country's authorities to make efficient use of external voluntary resources in developing the health care system.¹

Prospects

The abrupt division of entities and decentralisation within the FBH has created a number of problems, including poor inter-entity coordination of health policies; lack of collaboration in fund administration and financial risk sharing in the FBH cantons; and uneven geographical distribution of resources in the entities and cantons. The absence of a transition process for health administration authorities and facilities to adjust capacity at decentralised levels has resulted in duplication of services in some areas and unmet health care demand in

* Economic barriers such as these also represent obstacles for refugees, who were displaced during the war, from returning to their areas of origin.



World Health Organization
Regional Office for Europe



Government of Greece



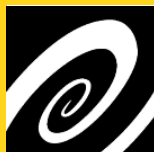
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others, often in rural areas where access is already hindered by lack of nearby facilities, health care professionals and pharmacies, as well as poor road conditions.

At the same time some improvements have taken place: facilities and equipment have been renewed, information systems have been improved and the country now has access to increased training programmes for health care personnel and improved management structures within health services. A primary reform focus for entities rests on

their further collaboration to create a unified health system strategy for the entire country to reduce the current fragmentation in organisation, finance and delivery of health care and to improve access to services.

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Observatory News

Health care financing in the Caucasus

Senior policy-makers from Armenia, Azerbaijan and Georgia met in Tbilisi, Georgia with staff from the Observatory and its partner organisations, as a part of the European Observatory on Health Care Systems, Caucasus Health Care Financing Workshop on 6–8 February 2003. The workshop contributed to current efforts at encouraging intra-regional collaboration to promote health sector reforms in the Caucasus countries.

Among the topics discussed were options for generating revenues and pooling funds in health care systems, exploring public, private and community prepayment methods, formalising informal out-of-pocket payments in the health sector, and poverty reduction strategies through sustainable health care financing. The Observatory's HiT profile on Georgia was also launched in Tbilisi, with Dr Amiran Gamkrelidze, Minister of Health and Social Affairs in Georgia, chairing this event.

The Observatory is grateful to the WHO Public Health Initiative for its generous financial support as well as the collaborative effort of its partners in organising and delivering this event.

Health care coordination in Spain

The Spanish Prime Minister, Jose Maria Aznar, opened a high-level policy discussion in Madrid with leading experts and policy-makers to explore different aspects of health care coordination in countries with decentralised health care systems.



Ana María Pastor Julián, Minister of Health, Prime Minister Aznar and the Observatory's Josep Figueras

The objective of the seminar, held on 6 February 2003, was to explore a series of coordination instruments recently adopted in western tax-based health care systems. It focused on devolved and federal OECD countries, contrasting them with the Spanish experience. Spain has recently drafted a bill on health care coordination within its decentralised health care system and offered an ideal context to discuss these issues. The seminar was organised by the Observatory and the Spanish Ministry of Health.

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