HOSPITAL MANAGEMENT IN SEVEN COUNTRIES

SOUTH AFRICAN HOSPITAL STRATEGY PROJECT

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FOREWORD

This report was prepared in response to a request from Health Partners International Ltd, the terms of which are set out in Annex 1. The seventh country, the Czech Republic, was subsequently added since in several ways it represents a complete contrast to the original selection.

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The King's Fund is extremely grateful to all the above for their extensive and very rapid response to our request for assistance with this project.

King's Fund

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OVERVIEW

This report contains material relating to countries with quite different health care systems and different systems of government. But they are all, to a significant degree, facing similar problems. In particular:

1. All countries are aiming to find ways of setting effective limits to hospital spending as part of general policies towards the containment of public expenditure; further, in all the countries surveyed, significant weaknesses in incentive structures have been identified which require reform irrespective of the need to contain total spending.

2. The aim of expenditure control has been pursued by creating a tougher operational environment, mainly but not exclusively financial. All have set, or tried to set, firm annual limits for hospital spending as a whole and some have progressed to more detailed financial controls, ie at the level of the service or procedure.

3. In hospital systems which rely largely on public provision - the UK, NZ and Sweden - this has been accompanied by formal separation of responsibility for financing care from its provision - the purchaser-provider split. Where the bulk of hospital provision is in private (including non-government, but not-for-profit) hands and hence finance and supply were already distinct, policies have been aimed at making financing/purchasing more effective. Perhaps the most fundamental obstacle is the question of clinical knowledge on the part of purchasers/financiers. Most do not have it and consequently their ability to determine the composition of hospital output - eg by eliminating ineffective procedures or selective control of the rate of innovation - is limited even where in principle they have the power to do so.

4. Efforts to contain spending have at times resulted in conflicts with medical and other clinical staff. In some extreme cases, where fee levels or rates of pay have been at stake, there has been industrial action or the threat of it. More common, however, has been an increase in attempts to engage professionals in management either through formal representation on decision-making bodies or through delegating financial and operational authority to clinicians. The measures described here have yet to bite substantially on clinical freedoms, though they shape the climate within which clinical decisions are made.

5. In most countries, there have been moves towards giving hospitals greater freedom to manage their affairs, even where as in the Netherlands or the UK they are at the same time subject to stricter constraints in other areas.

6. The structure of management within hospitals is another topic of continuing development. Most countries are attempting reforms of management structures within hospitals including decentralisation of financial responsibilities to clinical

groupings/directorates as well as engagement of clinicians in the wide management of the hospital.

7. There are tensions around getting the right balance between centralisation and decentralisation, both within health care systems as a whole and individual institutions. The rhetoric of greater decentralisation is not always matched by reality.

8. Shifts of the share of resources away from hospitals to primary and community services are rare, even where the policy rhetoric supports it. The evidence in favour of such a shift is equally limited.

Within this set of common features lies a considerable variety of approach.

1. While in the UK and NZ, national health services have been reformed by national policies, in other countries, reform has proceeded on a local basis. The best example of this is Sweden where hospitals are owned by local authorities which have not adopted a uniform approach to reform. In Brazil and the Czech Republic, local authorities are gaining responsibilities for hospital management. In Canada also the approach has varied as between the provinces while the Netherlands - uniquely among the countries considered here - has introduced reforms offering users different insurance 'packages' and hence competition or choice on both the demand and supply side of the health care market.

2. The UK is the only country which has taken a major step in the direction of giving general practitioners genuine influence over hospital budgets through its system of fundholding.

3. While there is agreement that the financial framework within which hospitals work should be tougher, the means of achieving that differ. In particular, no clear view has emerged as to the desirability and feasibility of moving towards DRG-based systems and to more detailed contract structures.

4. As far as management within hospitals is concerned, no single model emerges. The desirability of clinical engagement is widely recognised, but no common way of achieving it has been identified.

5. Equally, although quality of care is a concern in all countries, at least at a nominal level, the emphasis put on good clinical outcomes and the methods used to promote quality vary widely.

Concluding Reflections

All the countries surveyed are in the grip of reform, spurred on by broadly the same pressures. All are travelling hopefully rather than with confidence that the changes they are undergoing will succeed in whatever terms are appropriate to each society. A few general points can be made in conclusion:

- the reforms described here are staging posts not end points. In the case of NZ and the Netherlands in particular, the vision underlying the current reforms has only been partially realised.

- assessment of the merits of particular initiatives or policy instruments is inherently difficult, but no country has made a systematic attempt to monitor the impacts of the policies that each has pursued.

- it follows that the policies described here should be seen as part of a global process of learning by doing.

THE UK

UK

Overview

The system of hospital management in the UK has undergone rapid change during the past four years, but the origins of those changes go back to the beginning of the 1980s when the Conservative Government elected in 1979 began to develop its wider policy of reshaping the public sector. This stemmed from a number of very broad objectives such as 'rolling back the frontiers of the state'. In the NHS, that has meant a sustained attempt to increase the efficiency of resource use rather than to offload the cost of health care or responsibility for provision onto the private sector.

The reshaping of the public sector as a whole has consciously drawn on the private sector for ideas, a policy which reached its fullest extent in the privatisation of nearly all the nationalised industries. In respect of hospitals, the policy took the different form of introducing management methods and structures which, to a greater or lesser degree, were modelled on those in use in the private sector. The idea of general management was introduced in the early 1980s following a report by a senior private sector businessman, Roy Griffiths, while at the same time, hospitals were required to put out a range of support services to competitive tender. With the 1990 NHS and Community Care Act, the Government took the further step of introducing some of the elements of a market in hospital services while retaining hospitals in public ownership.

With a very few exceptions, all hospitals, acute and non-acute, psychiatric and non-psychiatric, are now constituted as trusts, independent, in a day-to-day sense, from the management of the NHS as a whole - ie the NHS Executive and the Department of Health. Trusts own the physical assets they use, contract directly with the staff they employ, have their own accounts and their own governing body, the trust board. For reasons which become clear below, in crucial ways they differ from private sector firms: the closest analogy is with those public utilities remaining in public ownership since some critical freedoms, particularly those relating to capital, are denied them. In principle, trusts are in competition with each other for NHS (and other) sources of finance.

As far as their internal management is concerned, trusts are largely free to make their own arrangements with the exception of the composition of the trust board, where little latitude is available. Other arrangements, particularly those relating to finance and audit, are also tightly prescribed as well as certain recruitment procedures, particularly for clinical staff.

The introduction of trusts was justified at the time in the following terms:

- A stronger sense of *local ownership* and pride
- Encouraging local initiative and *greater competition*
- Improving *choice*
- Improving *quality of service*
- Improving *efficiency*
- A range of *freedoms* which are not available to health authorities

In strict terms, it is not possible to provide evidence that the expectations have been realised. Although the trust regime has been subject to a good deal of analysis, very little research has been done which can be used to demonstrate how effective the new arrangements have been and the extent to which any benefits that have resulted could have been attained under the previous regime, ie through greater delegation with the existing structures. However, three main conclusions may be drawn:

First, the external regime to which hospitals are subject remains restrictive: they have little latitude to develop new 'lines of business' where this requires substantial investment, without approval from the NHS Executive.

Second, they enjoy substantial freedom as to their internal arrangements: as a consequence, no single pattern of management has emerged: in respect of staff pay and conditions, that freedom has yet to be widely exploited because of staff-side opposition.

Third, although the trust regime was envisaged as a liberating one as far as hospital management are concerned, the pressures on hospital to improve performance have never been greater. These pressures have arisen, not from competition, but from a series of centrally driven requirements, specifically the *Patient's Charter*, the Waiting Time Initiative and centrally imposed efficiency targets combined with strict budget limits. These initiatives were introduced to deal with perceived weaknesses in hospital performance.

The *Patient's Charter* is part of a large *Citizen's Charter* initiative designed to make public services more user-responsive. The *Charter* does not confer substantive rights to service; rather, it specifies process targets such as waiting times within outpatient departments. All hospitals are required to comply with these targets.

The Waiting Time Initiative is designed to tackle the Achilles heal of the NHS, long waiting times for elective surgery. Initially waiting times over two years were targeted; these have now been virtually eliminated and in most parts of the country waits over 18 months are rare. Some purchasers are aiming to reduce maximum waits to one years or even less.

Efficiency targets are designed to produce more activity per pound spent. These are set nationally and left to purchasers to extract from provider trusts through the contracting process.

At the same time, there have been increases in demand across virtually all hospital services as well as changes relating to medical training and staffing which have threatened the viability of some hospitals by making it hard to maintain cover for emergency services. These pressures are not related to the 1990 reforms, at least not directly, but they have added substantially to the pressures on hospital management.

Thus trusts have been genuinely allowed certain management freedoms, but they continue to operate within very severe constraints as far as their external environment is concerned. That environment has been increasingly demanding and, as far as

government policy is concerned, is primarily centrally driven. In that process purchasers have in effect been the instruments to extract efficiency targets and other quantifiable goals such as waiting list reduction, ie they have played a *de facto* management role, though an arm's length one, in contradiction to the purposes set out when the 1990 reforms were introduced.

Hospital Governance and Accountability

The UK has a small private hospital sector which carries out elective work nearly entirely for those with private health insurance. It receives virtually no public finance and will be ignored in what follows.

Since the foundation of the NHS, responsibility for hospital services has been largely a local matter as far as the day-to-day provision and management of services has been concerned. The precise hierarchy of control has changed over the years. Immediately prior to the 1990 reforms, the structure was as shown in Diagram 1.

[Diagram 1 here: Central Department/Region/District/Hospital(s)]

This structure had been introduced in the early 1980s so as to simplify what had previously been a more complex hierarchy involving a further layer of management. The regional organisations then were and strictly still are statutory organisations with considerable *de iure* and *de facto* independence of the central department. That is about to change: the new regional structure will be an arm of the NHS executive, so the structure soon to come into effect will be more centralised than the one it replaced. However, unlike other parts of central government, the NHS is not constituted as an agency but remains within the Department of Health. The idea of agencies within central government emerged in the late 1980s after the first round of civil service reform, focused on financial management was felt to have run its course. Agencies are in principle distinct from departments and operate within framework documents, or quasi-contracts with their parent departments. No such arrangement applies to health.

As far as the structure of control is concerned, the most significant change introduced by the 1990 Act was the division of the District's role into two. The District became a financier/purchaser of health services but lost its direct responsibility for running hospitals which became the responsibility of trusts.

The overall structure of management is set out in the next diagram.

[Diagram 2 : Central department/NHS Executive/regional Executive]

The diagram shows that trusts are accountable upwards in two main directions: to purchasers for services and to the NHS Executive, at regional level, as far as their financial performance is concerned, including access to capital resources. The purchasers in turn are accountable to the regional level of the Executive.

The main features of trust status are as follows. Trusts may:

- acquire, own and dispose of assets to ensure the most effective use is made of them;

- make their own cases for capital developments direct to the NHS Executive (NHSE);

- borrow money, within annually agreed limits, primarily for new building and equipment and for upgrading existing buildings;

- create their own management structures;

- employ their own staff, determine their own staffing structures, and set their own terms and conditions of employment;

- advertise their services, within the guidelines set down by professional codes of practice on such advertising.

When trusts were created a variety of configurations resulted. Thus in some cases a single hospital on a single site forms a trust. In other cases, trusts comprise the full range of hospital services as well as community health services. There are also a substantial number of community trusts and specialist mental health trusts both of which typically own small hospitals which would not normally carry out acute work other than in the field of mental health. In a few cases hospital sites are shared between trusts.

The introduction of trust status for hospitals (as well as other services such as community health services and ambulances) is now virtually complete. The same arrangements apply to all trusts whether they are teaching hospitals or community or ambulance trusts.

The appointment of chairs and other non-executives to trust boards is the responsibility of the Secretary of State (though in practice largely delegated to regional level). Appointment of executives is the responsibility of the trust: that is true for medical staff as well, but there are national rules governing selection procedures for consultant-grade (these specify for example the composition of the appointment board). Boards are collectively responsible for the broad policies their hospitals pursue.

Trusts have a status similar to nationally owned industries, ie they are not established under the Companies Act but have many of the characteristics of companies. Their contracts with district purchasers however do not have legal status though other contracts, eg with suppliers, do.

In principle the composition of hospital activity, ie the range of services they provide, is determined by those purchasing services from them - initially the 'reduced' district health authorities. In practice, hospitals still enjoy substantial leeway in what they do and how they do it, since purchasers have not generally imposed themselves at a detailed level. Instead, most contracts have been defined in broad or block terms. However, hospitals are obliged to meet the requirements of the *Patient's Charter* and

to reduce waiting times for elective treatment as a result of national policy initiatives. These are centrally determined initiatives aimed at produced national results - quite different from the initial 'theory' of the purchasing agency choosing services which best met local needs.

Trusts' lines of accountability are complex as will emerge from later sections. The main criticism of the current position is that trusts have no local accountability. Non-executive directors are sometimes seen as playing that role, but it is recognised that as they are appointed by the Secretary of State, they have no democratic legitimacy.

As a result of one or two major financial scandals identified by external audit but relating to the period prior to the reforms, codes have been issued to trust boards covering such matters of declaration of interest (eg share holdings in companies which might be suppliers), openness in relation to information and other related matters. The role of the non-executives is in itself seen as part of the accountability structure with regard to financial probity. They run the audit committees which each trust must have and monitor the work of the external auditors.

As becomes clear below, trusts operate within tight constraints in respect of capital finance: they are subject to compulsory internal and external audit and other less important requirements such as annual reports and meetings. These constraints still leave open a great deal of scope for trusts to determine their own ways of working in respect of internal management structures, eg the extent to which they devolve budgets to local offices or divisions of a hospital and how they organise the relationship between clinicians and managers. We return to this below..

Before trusts became the almost universal organisational structure for hospital services, hospitals remained under the direct control of district health authorities as so-called directly managed units, and hence for a time the two regimes ran side by side. The two regimes are compared in Annex UK1.

Finance

The funding of health services is divided into two broad streams (and some smaller ones ignored here): hospital and community health services and general medical and dental services. The latter pay for general practitioners, their support staff and the drugs and other resources they use. The former pay for hospitals and services in the community such as district nursing.

At the time of the foundation of the NHS, the distribution of hospital services between different parts of the country was very uneven. In the period since then, there has been a sustained policy of equalising the availability of hospital services as between different parts of each component of the UK. In the 1960s, the main emphasis was on the creation of a network of district general hospitals providing most hospital services for their local population. In most parts of the country outside the larger urban areas, each district had its own hospital (plus sometimes smaller community hospitals). In the 1970s and subsequently the emphasis has been on evening-up the allocation of revenue funds relative to local needs for service using an explicit formula relating to the characteristics of local populations. Initially the formula approach was applied to

Regional Health Authorities, leaving regions a good deal of latitude as to the distribution of funds within the areas for which they were responsible. Under the 1990 Act the formula applies to the areas covered by district purchasers which are much smaller.

The objective of the formula is to equalise the availability of services relative to need. Over the years different ways of measuring need have been used and although the same or similar factors have been used - age structure, standardised mortality rates - their weighting has been changed and, in the latest reformulation, new factors introduced. Allowance is also made for factor cost differences. Although the formula may be criticised on the grounds that the available data do not properly allow for differences in need between areas, eg morbidity may not be perfectly correlated with mortality, there is little quarrel with the principle of equalisation.

As a result of the 1990 reforms, districts and hospitals contract for the provision of services, but any one hospital trust may contract with any district. Thus while in rural areas or the smaller cities and towns, hospitals will receive nearly all their finance from one purchaser, more specialised hospitals (eg the Royal National Orthopaedic, a tertiary centre in North London) may contract with most districts in the southern half of the country.

In addition to district-level purchasing, the 1990 Act introduced GP fundholding. Under this scheme, large general practices were allocated funds for a range of hospital and other services which they could use to buy from any hospital they wished: as a result, most hospitals now contract with a number of general practices as well as district purchasers. The fundholding scheme was introduced on a very limited basis, initially to a small number of practices and covering only a narrow range of activity. But coverage has expanded rapidly since. In a number of areas, experiments are underway with total fundholding, ie GPs hold the funds for all hospital services and in that sense effectively supplant the district-level purchaser. The fundholding scheme now applies to more than one third of all patients and will apply to about half in the coming financial year.

These arrangements do not apply to capital finance: in principle trusts may borrow from the private market but as public sector interest rates are lower they have no incentive to. In both cases however the scale of their borrowing is strictly controlled by the region of arm of the NHS Executive, but they receive a formula allocation for smaller works, eg purchase of equipment, vehicles or minor works within which they are allowed discretion, ie do not need to seek approval on a case by case basis. Trusts are free to seek income from the private sector both from private insurers and from other sources such as companies seeking some sort of occupational health service. No allowance is made for this in their public funding.

Trusts own the assets they employ and are free to dispose of those they no longer need. They are not free to carry out major investments without the approval of the regional arm of the NHS Executive, which also requires support from the hospital's main purchaser. Furthermore, as a result of the Private Finance Initiative, (which is a government-wide policy to finance projects within the public sector), they must now attempt to finance any major development in co-operation with the private sector.

Trusts have two main financial duties: to earn a specified rate of return on the value of their capital assets, currently six per cent, and to meet what is termed an external financing limit imposed on a case by case basis, ie according to their specific financial circumstances. In broad terms what this means is that the regional executive will specify how much of their investment requirements must be met from internal resources (depreciation plus retained surpluses).

These requirements must be met on a year by year basis. Overall, therefore the financial regime to which trusts must work remains tight. Normally they cannot secure income for more than one year ahead (although some purchasers agree longer period contracts) but they have no scope for building up reserves against sudden losses of income arising for example from the loss of a contract.

This makes it hard for trusts to adapt to sudden changes in demand such as would arise in a competitive environment. It is doubtful therefore whether the existing financial regime is compatible with the introduction of competition for clinical services on a widespread basis.

Hospital Management and Organisation

In general, and with the exception of financial regulations, UK hospitals have been free to make their own management arrangements. Most, however, operated a so-called consensus model, within which there were three lines of command, administration, medical and nursing, which met at the top. In the early 1980s, however, what is known as general management was imposed by the Government with the aim of providing a clear line of accountability to a chief executive for the hospital as a whole (and subsequently units of the hospital or smaller sites away from the main hospital).

The introduction of general management has been generally regarded as successful: there is no pressure to revert back to the previous system of consensus management. Formal demonstration of its effectiveness is impossible, but given the range of policy initiatives with which hospitals had to deal prior to the reforms, particularly the introduction of competitive tendering for support services, and later ones, such as the introduction of a formal business planning process, it is hard to see how the previous structure would have coped.

The trust regime does not prescribe how trusts should organise themselves internally, with the exception of the structure of the Board of Management. The chair is a non-executive appointed by the Secretary of State (in practice that normally means the region): there are five other non-executives appointed in a similar way plus the chief executive, finance director, medical director, nursing director and one other executive. The executives are appointed by the Board itself. Hence, effectively, the chief executive is chosen by the chair and other non-executives and must retain their confidence.

Boards are free to make their own working arrangements but in practice are influenced by a number of central requirements, eg model financial standing orders designed to ensure that trusts conform with the general requirements of public sector

accountability. However, as far as internal management arrangements are concerned, there are no centrally imposed requirements and as a result, no one form of organisation has emerged. Furthermore, trusts are not dependent on any other organisations, eg for estates or supplies, except insofar as they freely contract with them, with the exception of the external audit function, which is carried out by the District Audit Service - which operates under the aegis of the Audit Commission - which sets its own terms of reference.

Prior to the 1990 reforms, a few areas experimented with directorate structures to which budgets were delegated and the reforms themselves have encouraged this form of organisation: Diagram 3 shows one such structure.

[Diagram 3 here]

A few areas require comment:

First, as a result of the competitive tendering initiative (now termed market testing) hospitals have been required or encouraged (depending on the area of work) to put some areas of work out to competition and, as a result, substantial cost savings have been made. This process has not extended to clinical areas. Purchasers may seek competitive tenders for clinical work, but the number to have done so remains small. Most contract income is secured as a result of bilateral negotiation between hospital trusts and district-level purchasers and GPs. Most contracts are set in broad terms - so-called block contracts- and hence represent a negotiated form of global budget.

Second, the need to deal with a range of purchasers as well as the requirements for business plans, strategic plans and business cases has led to the introduction of a range of new jobs and functions centred round planning and information. These are often attached to specific specialties or groups of specialties.

Third, the relationship between managers and clinicians (doctors and nurses) has received sustained attention without any one solution emerging. There is general encouragement to engage clinicians in management but the Government has not prescribed how that should be done. It remains an area of genuine experiment and learning.

Fourth, although the notion of decentralisation of responsibility within hospitals has received some support and practical application, eg through the creation of budgets at specialty level, other factors particularly the centrally imposed requirements relating to the *Patient's Charter* and Waiting Times, have worked to centralise control and hence to shift the balance of power within the hospital from clinicians to general management. This shift however is most noticeable outside the clinical sphere in terms of the financial constraints which general managers(now known as chief executives) must impose on the activities of their clinicians by virtue of the contracting environment in which they now work. As Stephen Harrison has put it (1995):

> *Many provider managers have also taken the view that 'cost and volume' contracts - that is, ones which specify that a finite number of cases of a certain type are to be treated for a specific price - are preferable to 'block' contracts,*

which specify type and volume of caseload only in the vaguest terms. It follows that what is specified externally for contract purposes must also be specified internally for management purposes, so that resource management has become a vehicle for controlling clinical behaviour so as to conform with the requirements of the contract (p 168).

The latter two points run together. Up to 1990, hospital consultants enjoyed discretion as to whom and how they offered care. They operated their own waiting lists and were not subject to any targets for processing patients through them. In general, the pressure on hospitals to improve performance in respect of waiting times for elective surgery or to increase efficiency as measured in terms such as cost per case, or throughput per bed, has led to some reduction of consultant level discretion. These centrally imposed pressures have been strengthened by reports by the NHS' external auditors which have identified the scope for change and improvement. The rapid growth in day surgery, urged on purchasers and through them hospital providers by the NHS Executive, and continued reductions in lengths of stay can be attributed to this combination of factors.

Another source of pressure comes from government attempts to promote 'evidence-based medicine'. To support purchasers, the government instigated a series of initiatives designed to help them make informed purchasing decisions. These included the establishment of the NHS Centre for Reviews and Dissemination at the University of York which has just begun publication of a series of assessments of the world literature relating to particular areas of clinical practice and the *Effective Health Care Bulletins* which have a similar remit. The initiative is also supported by a research and development programme the definition of which is in principle at least taken out of the hands of existing providers.

The result of much of this work has been to underline the extent to which current medical practice is not supported by systematic evidence on effectiveness and the lack of satisfactory outcome measures. The point is being approached where purchasers will start to identify modes of treatment which they will not pay for on effectiveness grounds.

A related but distinct source of pressure arises from changes within primary and community health services. The strengthening of general practice together with the spread of fundholding has led, or perhaps it should be said is leading, to a change in perception of the role of the hospital and of the links between hospitals and other services. As a result, hospital medical staff are having to adapt their mode of working to external requirements, be these for outreach services, for changes in the availability of particular services such as diagnostics and for agreed protocols for the treatment of patients such as diabetics whose needs span both primary and secondary care. Some of these changes have been stimulated by GP fundholding which has had the effect of making hospitals more responsive to primary care than has been traditionally the case. A recent report by the National Audit Office identified a number of areas of improvement: see Table 1.

[insert Table 1 - Effects of Fundholding]

Because so many factors have been changing at one and the same time, it is hard to reach a clear view as to how the balance of power has shifted as between medical staff and managers: a recent survey summed up the changes that have taken place in a simple balance sheet, set out in Table 2.

[insert Table 2 - Consultants' up and downs]

Overall, the trust regime appears to have been successful, if success is judged by reference to the opinions of those running hospitals under the 'old' regime. The old district organisation is now seen as completely outmoded, whereas in contrast the trust regime does allow genuine scope for local action. To illustrate that judgement, here is an extract from a recent case study of a small number of trusts:

> *Many managers in all the trusts spoke of being more responsive to client wishes rather than continuing to provide a service that was largely professionally and traditionally driven. It was not always clear why recent changes made this more possible although some spoke of an element of compulsion in the form of contracts placed by fundholding GPs. In this trust, the implication was that a new sense of self-confidence and self-direction brought with it an atmosphere conducive to "challenging all the professional barriers, all the things that have happened before" so that in this atmosphere of innovation, the idea can be expressed, if not actually put into operation that "everything is done with the clients' needs in perspective first, and the professional needs following up the rear". However, no reference is made to responding to need identified by the purchaser in its role as assessor of local need and certainly many field staff in this trust felt that the very reverse of this process was happening with increasing workloads and prioritising activities that had organisational i.e. financial issues as their origin severely limiting both the quality and quantity of care delivered. For field staff, the best way of being client driven was to spend time with individual clients who 'are their own best judge of what they need' (staff meeting Trust 4) (A Study of Three NHS Trusts: The Managers' Account, 1995,* RCN, p29).

That said, it is hard to find evidence in specific terms, ie changes which could not have taken place under the 'old' regime. In particular, the directly managed unit became obsolete almost before it had been implemented as a form of decentralised management within the health authority. If that form of management structure had continued, it could have embodied more of the freedoms that trusts now enjoy. But although those freedoms appear to be valued by those responsible for running trusts, how significant they are is very hard to demonstrate. Another commentator has argued that, at the time of writing (1993), there was very little to show: in particular, the board structure which sharply distinguishes a trust from a directly managed unit, has not demonstrated 'added value':

> *Boards appear to represent a major investment of management time as well as financial resources for, to date, a very limited return - very much as the researchers on commercial boards might have predicted (eg Demb and Neubauer, 1992). In addition, trust boards face two particular obstacles not normally confronted by their commercial counterparts. Firstly, the NHSME*

set out to try and recruit business people as non-executive directors who did not have product knowledge. Secondly, the NHS has a long tradition of senior officers judging their successes with the members of their authorities on the extent to which they could achieve quiet acquiescence. In the long-term, therefore, it is questionable whether trusts in their current form will continue to be the preferred model of providers in the purchaser/provider split, either with the NHSME or local purchasers. It is conceivable that they will slowly give way to a range of not for profit and private providers with alternative arrangements for governance (*HSMR*, Aug 94, p211).

Monitoring and Reporting

Hospital performance is monitored in several ways:

District purchasers focus largely on performance against contracts and financial performance within the contracting period; such monitoring is normally confined to numbers of cases and other simple measures. Purchasers are also the channel through which information on *Patient's Charter* standards is obtained and published.

NHS Executive at regional level focuses on the annual cycle and beyond. It requires submission of annual business plans, strategic plans covering up to five years ahead and major investment plans for which business cases must be made.

There is no government system of accreditation or quality control and no centrally determined requirement for hospitals to publish information on their performance other than in financial terms, except in Scotland were a small range of outcome indicators are published. The one exception to this is the *Patient's Charter*, performance against which is published annually.

There is however a system of external financial and efficiency audit, operated by the National Audit Office reporting to the Public Accounts Committee of the House of Commons and the Audit Commission which reports to Trust Boards and, in the event of serious failure, the public at large.

The 1990 Act made medical audit a compulsory activity but it did not provide for publication of results. Now defined more widely as clinical audit, it still remains a 'closed' activity within the professions and is not formally linked to hospital management (in practice it may be). With the exception of Scotland therefore, there is no routine reporting on clinical performance at individual hospital level.

Annual reports are public documents and all trusts must hold an annual general meeting in public. No other information is systematically released to the public but data is returned on each treatment episode to the central department. In principle therefore the pattern of activity can be monitored; in practice this is not done in any useful way.

Regulation

The 1990 Act was intended to introduce some degree of market-like behaviour within the public sector and like any market this required a regulatory framework. The most effective instrument of regulation is the financial regime set out above which effectively means that any major bid for extra business must be approved by the regional executive and supported by the relevant district purchaser. Similarly, trusts must go through a public consultative process if they want to make a major change in service configuration, eg closure of a small hospital.

In addition to investment, prices are also regulated with a view to ruling out price discrimination, though that is believed to have occurred, eg in favour of fundholders.

In December 1994, an outline regulatory framework was published which set out rules governing mergers between trusts, as well as collusion and other forms of anti-competitive behaviour. It is too early to comment on the impact of this regime.

In general, the extent of genuinely competitive behaviour appears very limited, in part because many hospitals are effectively local monopolies, in part because purchasers still have not shaken off the old district role, ie they continue to think in terms of 'their' hospital, and in part because the scope of competitive behaviour from other sources such as community services providing hospital at home has not been developed.

Staffing and Labour Relations

When the NHS was established, all hospital staff became public servants, but not civil servants, with a highly centralised regime for the determination of pay and conditions of work. With minor exceptions, these were standardised across the whole of the UK. From 1970 in the case of doctors and dentists and 1983 in the case of nursing and allied professions, Pay Review Bodies were established which recommend how large annual increases should be.

This system largely remains intact, but it is the Government's intention to change it in favour of local pay determination. The first moves towards local pay were made before the 1990 Act but little came of them then and progress since has been slow: both professionals and non-professionals have resisted it.

The Pay Review Bodies have supported the notion of local pay determination and most trusts are keen to adopt it. But staff resistance has been strong. Both the professional and the non-professional workforce is highly unionised. During 1995, industrial action was threatened by professional groups and others. It did not materialise but it was effective in slowing up the process of introducing local pay and ensuring that some national element is retained.

This system has 'delivered' real pay increases for professional staff. The same has not been true for other grades which have felt the effects of competitive tendering in terms of job losses and reduction in pay and working conditions.

Management Capacity

The critical change in recent years has been the introduction of general management. In the past, hospital administration was, like the civil service, largely a closed world. When general management was introduced, chief executive posts were opened up to allcomers and as a result, a number of 'outsiders' were recruited from the private sector and other organisations such as the armed forces. With a few notable exceptions, those recruited from outside have not lasted long in top positions. However, there has also been an increase in the number of chief executives recruited from the medical, nursing and paramedical professions.

These, and other senior posts, are available only on limited term contracts (and performance pay) following a trend common across the UK public sector to remove jobs for life.

Process of Change

The changes briefly described here have almost entirely been brought about as deliberate acts of government policy. Each major reform took some years to phase in: thus the creation of trusts was spread over five 'waves' and the creation of GP fundholding remains far from complete.

In other cases, such as the creation of district purchasing the change was, in formal terms, made overnight, but in practice it is arguably still not complete. The obstacle here has been the lack of skills, knowledge and information. Recent evidence suggests that the district purchasing function has had little impact on the pattern of hospital activity. GP fundholding, although restricted to only a limited area of hospital activity, appears to have had greater impact.

Thus the main constraint on getting more benefits from the new structures would appear not to be shortage of 'good' managers but rather the lack of a knowledge base which would allow management, including clinical management, to be effective. This weakness of course is not a consequence of the new NHS structure: rather, the new structure has served to emphasise it. More generally, the new structures both inside and outside the hospital have stimulated a vast learning both within each organisation and in the form of training and courses provided by outside bodies.

Political uncertainty makes it hard to see what direction policy will now take. If the Conservatives remain in power, some further moves in the direction of privatisation of supply may be expected, probably in the form of privately built and maintained hospitals. If Labour forms the next Government, the trust regime seems likely to remain but in an altered form. The Opposition Party has indicated it will retain the split between purchaser and provider trusts. Internal management freedoms seem likely to persist but board structure is likely to be changed so as to make boards more representative of local interests.

Table 1
UK: Effects of fundholding: National Audit Office survey

What improvements in service, if any, have been obtained through practice contracts?

	Achieved	Not Achieved	No Change Needed	No Reply
			%	
Information:				
Faster response to GP enquiries	54	19	24	3
Faster receipt of discharge letters	54	38	4	4
Agreed protocol for referrals	40	36	19	5
More informative discharge letters	45	41	11	3
Diagnostic Services:				
Reduced waiting time for X-rays	43	12	41	4
Faster reporting of X-ray results	39	24	36	1
Faster reporting of pathology results	48	8	43	1
Other:				
Fewer follow-up outpatient attendances	49	40	7	4

What new services, if any, has the practice set up or planned to provide in the practice premises?

	Provided	Planned
	%	
Consultant outpatient clinics	54	25
Counselling	59	15
Physiotherapy	62	10
Minor surgery (non-general medical services)	37	19
Chiropody	33	16
A wider range of diagnostic tests	20	15

What improvements in service, if any, have been obtained through practice contracts?

	Achieved	Not Achieved	No Change Needed/No Reply to Question
		%	
Reduced waiting times:			
For non-urgent first outpatient appointments	70	23	7
For non-urgent hospital admissions	66	26	8

Source: National Audit Office, *General Practitioner Fundholding in England*

Table 2
UK: Consultants' Ups and Downs

	Ups	Downs
Pay	- Fought off local pay	- Salaries modest compared with other professionals, not kept pace with inflation
Merit pay	- Kept control of majority of merit awards	- Lost power over C awards
Employment	- Most new contracts mirror national conditions Job plans not monitored in many trusts	- New consultant appointments placed on local trust contracts - Introduction of job plans
Training	- Retained control of medical education and postgraduate training	- Medical schools changing traditional 'handed-down' curriculum
Appointments	- Retained majority on appointments panels	- Trust managers and non-executives on appointment panels
Performance	- Kept control of medical audit - New teams are led by doctors - Freedom to control working hours	- Internal market put methods under scrutiny - Government drive towards evidence-based medicine questions techniques - Limited involvement of managers in clinical audit - Reduced juniors' hours means more hands-on work - Shift from traditional 'firms' to teams
Accountability	- Retained self-regulation - Almost impossible to sack poor performers - Refused 'shop-a-doc' duties in contracts	- More lay people on GMC - GP fundholders demanding changes - Rising consumerism and *Patient's Charter* increased patients' demands - Purchasers control resources
Status	- Still most powerful group in hospital	- Own perception of lost power, low morale, failure to scupper reforms

		- Higher public expectations - Power shifted to other health professionals, eg GPs, nurses and midwives
Private work	- Kept freedom to do private practice	- Handful of trusts restricted private practice to own hospital

Source: *HSJ*, 9/11/95, p25

Annex: UK

UK: Comparison of the regimes of NHS trusts and directly managed units

Issue	NHS Trust	Directly managed unit
Management	Each Trust is run by its own Board of Directors. The Trust is free to determine its own management structure. Senior professional staff must be involved in management.	The DHA is responsible for the unit with the unit general manager (UGM) being responsible for day-to-day management. Internal management arrangements are subject to DHA approval.
Accountability	Each Trust board is directly accountable to the Secretary of State via the NHSME	Each unit is accountable to its managing DHA. The DHA is accountable to the RHA and the RHA is accountable to the Secretary of State via the NHSME.
Funding	Each Trust's income is largely derived from contracts with health authorities, GP fundholders and the private sector	Each unit's income is largely derived from contracts with health authorities, GP fundholders and the private sector
Services	Each Trust is free to determine the range and extent of services it wishes to provide, except that where a service must be provided locally a Trust can be obliged to provide it if it is the only units able to do so Each Trust provides the services which it is contracted to provide There is no requirement for a Trust to consult the Community Health Council on closures or changes in use	The range and extent of services offered by a unit are determined by the managing DHA Each unit provides the services which it is contracted to provide Closures and changes of use are subject to formal consultation with the Community Health Council
Employment of staff	Each Trust sets its own staffing structure and levels. It employs all its own staff, including consultants Each Trust is free to determine the pay and other terms and conditions of employment to *all* staff it employs. Staff transferring to a Trust retain their existing terms and conditions of service until changes are negotiated	Each unit determines its own staffing structure, but its staff are employed by the DHA or RHA Pay and other terms and conditions of employment of nearly all staff are subject to Review Body or national Whitley Council agreements or departmental determination
Financial duties	Each Trust has a statutory duty to break even taking one year with another. It is also required to achieve a 6 per cent return on assets and keep within its agreed EFL.	The managing DHA has a statutory duty to balance its budget each year. The UGM has a managerial imperative to ensure that the unit breaks even. The unit has to pay capital charges equivalent to depreciation and 6 per cent interest on its fixed assets
Prices	Each Trust prices to cover running costs, depreciation and return on assets	Each unit prices to cover running costs and capital charges (depreciation and interest)

Surpluses	Trusts may retain surpluses	Units cannot retain surpluses
Borrowing	Each Trust is free to borrow within its agreed EFL	Units have no power to borrow
Insurance	Trusts do not insure for clinical negligence. They may insure for other insurable risks	Units do not insure for clinical negligence or other insurable risks, with certain limited exceptions
Ownership of assets	Each Trust owns its assets. It is generally free to acquire and dispose of assets and retains the proceeds from any sales	Each unit's assets are owned by the Secretary of State or the health authority. Acquisition and disposal of assets are subject to control and regulation by the Department of Health, the RHA and the managing DHA. Retention of proceeds from sale is subject to decisions by the RHA
Capital	Each Trust makes its case for capital development to the NHSME. It funds the agreed programme from its own resources or by borrowing within its agreed EFL	Each unit makes its case for capital developments to the DHA or RHA. Funding is dependent on allocations from the regional capital programme

Source: NHSME *Working for Patients* (1990), in Saltman and von Otter *Implementing Planned Markets in Health Care*

NEW ZEALAND

NEW ZEALAND

OVERVIEW

New Zealand policy towards the health care sector as a whole and hospitals in particular reflects a wider policy towards the public sector as a whole, aimed at improving efficiency and redufcing public spending. New Zealand spends about 7.5 per cent of GPP on health, about 80 per cent of which comes from public funds. Across the public sector as a whole the changes made in the period 1984-1990 were massive. According to one assessment:

> *Not merely were they extraordinarily comprehensive - affecting to one degree or other the jobs and working environment of a high proportion of public servants and the content and delivery of all public services - but they were also implemented with breathtaking speed and vigour.(Boston et al, p388)*

Within the health sector a Government Task Force, reporting in 1988, identified a series of weaknesses in the new Zealand hospital system which can be summarised briefly as follows:

> Equity: the treatment of different people varies so much, and with so little pattern or logic, that it was inconceivable to us that the results could be regarded as fair;
>
> Efficiency: an Arthur Anderson study concluded that ' huge gains in terms of resources available for re-allocation or for other services are possible in the hospital sector. They range between 24 and 32 per cent of current operating expenditures;
>
> Service Integration: Integration between the primary and secondary sectors of health care leaves a lot to be desired;
>
> Morale: Information systems are deficient and management is weak. There is little pride in, or loyalty to the service. Sectional interests prevail and incentives to staff are often perverse.

The report's discussion of hospital management concluded that:

> *The first priority in reforming New Zealand public hospitals must be to make them more efficient and responsive to the consumer. They must have basic information systems, know their costs, have good role definition and accountability.*

Against that background, it is scarcely surprising that the Task Force recommended radical change. Its recommendations were not followed to the letter but they gave a clear steer in the direction which was eventually taken - a rapid move to a purchaser provider split as well as a series of other changes designed to remedy the weaknesses identified above.

The Task Force Report was followed up by a so-called 'Green and White' Paper in 1991 which led more or less directly to the structure to be described below and which came into effect two years later.

The paper identified eight weaknesses in New Zealand's health care system:

- Public hospital waiting times too long.
- Funding of system is fragmented.
- Problems with access to services.
- Lack of assistance for doctors making decisions.
- Lack of consumer control.
- Constraints on Area Health Boards to change services.
- Conflict in dual roles of purchasers and providers.
- Lack of equity.

A National Interim Provider Board was established to oversee the implementation of the reforms during the transitional period. The first report of the Board identified 12 perverse incentives in the 'old' system:

- Incentives for doctors to choose cheapest procedure were absent.
- Innovation was lost in bureaucracy.
- Hospitals have disincentive to treat more patients for fear of budget over-runs.
- Capital projects and proposals were deliberately over-inflated to insure against trim downs.
- Patients' incentives to use hospital services rather than general practitioners existed (because of significant primary care co-payments).
- Patients' incentives to describe ailments as accidents (to access the benefits of the Accident Compensation system).
- Area Health Boards had a disincentive to contract out, for fear of worsening relations with existing staff or redundancy costs.
- Area Health Boards pressured into funding high profile hospitals as opposed to more cost-effective community care.
- Public hospitals had few incentives to respond to public demand.
- Public hospitals had no incentives to gather costing records or other information required to determine cost-effectiveness.
- Incentive for Area Health Board to shift long-stay patients into private hospitals to shift costs onto Department of Social Welfare.
- No incentive for effective communication between providers to prevent duplication, particularly in diagnostic tests.

The reforms introduced to attack these perceived weaknesses appear quite similar to those introduced in the UK. They comprise a purchaser-provider split, with purchasing functions given to 4 Regional Health Authorities and provider roles to 23 Crown Health Enterprises (CHEs). The new structure is set out in Diagram NZ1.

Its most striking feature is the complete separation of the formal reporting lines for the purchasing and the providing roles.

The impact of the NZ reforms has not been systematically evaluated but it has been claimed that they have produced substantial cost savings (of the order of 15-20 per cent) largely through greater operational efficiency, some of it achieved by contracting out of ancillary services. However in the first year of operation, several Crown Enterprises went into deficit and additional funding had to be pumped in apparently because improved information systems were now identifying better what costs of provision were. In addition, and mirroring the UK waiting time initiative, additional funds have been targeted on waiting lists.

Assessing progress soon after the new structures came into effect, one observer (Ashton, 1995) has concluded:

> *that the efficiency gains that had originally been expected from the incentives associated with a more commercialised structure are not being achieved* (p 55).

Moreover:

> *while better information is now being collected about the cost of service provision, this information is not available to the public, on the grounds of commercial sensitivity. Therefore no conclusions can be drawn about the initial impact of the changes on the efficiency of service provision* (p 55).

However, the same author suggests, echoing comments made on the UK that the reforms are in their infancy.

> *As time progresses, continuing changes are also likely to occur in areas such as the configuration of services, the nature of contractual relationships, the choice of reimbursement mechanisms, the methods of monitoring and reporting, the degree of competition and structure of the market, and so on. Because of the flexibility of the contracting environment, numerous combinations of these variables are possible and different organisational structures and contracting arrangements are likely to emerge in different parts of the country* (p 57).

Recent discussions with purchasers and providers (personal communication) suggest that satisfactory contracting relationships are proving hard to develop. Information systems are typically poor, contracts remain in block form and the definition and measurement of activity problematic. RHAs are finding it hard to think and operate strategically; there are signs that the monitoring bodies are trying to fill this gap, although formally that is not their role.

Hospital Governance

The reshaping of the NZ health sector is part of a general restructuring of the public sector following to some degree private sector models. Thus on the provider side, hospitals have been established as Crown Health Enterprises. Most are based on one large hospital: smaller hospitals have formed the basis of community trusts. The Crown Enterprises have as their central objective: to be as successful and efficient as

comparable businesses that are not owned by the Crown.' However they are also required to 'exhibit social responsibility', with resulting tensions, noted below.

The Crown Health Enterprise Regime resembles the UK trust regime but is not identical to it. Formally they are limited companies, half owned by the Minister of Finance and half by the Minister for Crown Health Enterprises- thus the Minister for Health is not part of the ownership structure. Boards are appointed by the shareholders ie the Government and consist entirely of non-executives although CEO and Company Secretary attend meetings. Board members do not formally represent local interests.

Crown Health Enterprises may borrow from the private sector and as the government borrowing rate is higher than the private they have an incentive to do so. They own the assets they use and their balance sheets contain a large amount of debt, a carryover from the old regime.

In other respects the financial regime is less demanding than that of the UK trust: they are not set a target rate of return on assets and they are not subject to an external finance limit. They may enter other areas of business in related and unrelated fields.

A survey of CEOs found that they are:

> *clear that there are benefits to their organisations of a businesslike competitive approach, although they are careful to distinguish between an 'approach' and full competition with tendering for contracts. They see competition acting as a stimulus to improving performance, particularly the use of benchmarks for comparing outputs between CHEs. They also see competition as a useful motivator for change within the organisation and a way of challenging staff.*

Finance

The system of hospital finance has been changed in three main ways: first, a start has been made towards equalising the resources available in different parts of the country. Second, with the introduction of a purchaser-provider split, most hospital revenues have to be earned through contract income. Third, finance for primary and secondary care has been integrated, in principle allowing a shift between different forms of provision.

When the new arrangements were introduced, the bulk of funding for Crown Health Enterprises was in the form of block budgets based on historical data How services should be defined for contract purposes and what price structures should be adopted is being determined at the regional rather than the national level. Thus, each of the four purchasers uses different approaches to defining contracts: they are trying to use disaggregated systems (ie based on DRSG or similar) but in practice most contracts appear to be of the block variety.

Accountability, Monitoring and Regulation

The lines of accountability for NZ hospitals were confused, prior to the 1993 reforms, with a tension between local communities and central government: a tension which the 1983 Area Health Boards Act did not resolve. The Board had between 8 and 12 members and were elected by their resident population. In 1998, concern about their management and financial expertise led to a reduction to 7 elected members and the introduction of government appointed members. The Boards were responsible only for hospital services. The 1991 proposals led to their abolition.

All Crown Health Enterprises are monitored by a central monitoring unit to which they must report a series of quality, operational and financial measurements: each is provided with a summary of its own performance data, together with the best, worst and average national scores. This process is largely a closed one, ie the information is not published on the grounds of commercial sensitivity.

In addition to this process, CHEs are subject to a wide range of reporting requirements, including an overall Statement of Intent, tabled in Parliament, 6 and 12 monthly reports also tabled in Parliament, patient based monitoring to the Regional Health Authorities and other returns to the Ministry of Health.

Finally, Crown Enterprises do not appear to have succeeded in obtaining a clear line of accountability. In particular, their social responsibility objective requires local involvement; according to Malcolm and Barnett (1994):

> *In the same way that CHEs cannot escape the community perception of their responsibility for meeting local needs, CHEs are unable to distance themselves from health status and access issues, properly the responsibility of the RHA. Most CHEs have actively sought to be partners with the RHA on issues related to health status and access, believing that they have good knowledge of needs in these areas, are close to local populations and have a responsibility to act as advocates. Some CHEs are undertaking their own research into health needs, and recognise that, particularly in certain service areas such as elderly care or mental health, staff had an understanding and population focus on services that might not be easily matched by the RHA.*

In contrast to the UK, there is a national regulatory structure. The Commerce Act 1986 applies to Crown Health Enterprises but ' it is not clear just how this general legislation will apply to the health sector, especially in cases where both purchaser and provider are public bodies and both hold a monopoly position. (Ashton 1995 p 51). However, it does appear to have ruled out a long term contract for a new mental health unit - five years was regarded as being the maximum that could be allowed. Furthermore, the Act has made national pay bargaining illegal, compelling CHEs to make their own pay settlements.

Although the most recent - 1993 - round of reforms allows for competition between CHEs and with the private sector, in practice it seems that competition will remain marginal because the geography of the country means that most hospitals have a local

monopoly. It seems likely therefore that the emphasis will be on performance or yardstick competition.

Internal Management

Reform of management structures predated the 1991 reforms. The new regime did not itself specify any particular form of organisation for Crown Health Enterprises. In 1988 management structures based on a sharing of power between the main interest groups within the hospital were replaced by general management, a change justified in terms similar to those in the UK ie consensus management found it hard to reach decisions which affected any one interest detrimentally. According to Jacobs (1994):

> *The management reorganisation experienced by New Zealand hospitals involved the replacement of earlier management structures with general managers. Previously, three executives - the chief executive, the medical superintendent and the chief nurse - formed the management team and ran the hospital under the authority of the hospital board. This was commonly referred to as 'triumvirate management'. Although the triumvirate system was the natural product of hospital development rather than a planned management structure ... it was seen by the government as a desirable and efficient structure that appropriately reflected the multi-disciplinary nature of the health service ... The principal features of the triumvirate structure were the equal status of all the team members and consensus decision-making. Although the introduction of 'generic general management' tended to coincide with the formation of the area health boards, it was a separate and distinct process that has continued under the CHE/RHA structure* (p 158).

These changes were accompanied by changes in personnel- an influx of people with commercial experience to senior management positions (many of whom have now left) and also restructuring within hospitals, through the creation of cost or responsibility centres, generally based on service divisions with budgets of their own along with transfer pricing for support services.

However, according to Malcolm and Barnett a more significant development has been that of service structure:

> *In larger CHEs a service management structure has been fully developed. In smaller CHEs, or those with dispersed or peripheral services, the structure usually also incorporates forms of primary care management based on the locality. Generally a flatter structure is present than in the former area of health boards, with services set up as business units with full accountability for performance, financial and otherwise.*
>
> *CEOs identified a number of benefits from this approach. It provides an accountability structure for quality assurance, team work between disciplines and for clinical outcomes within a given budget [5]. With many service managers responsible for both hospital and community aspects of care, it allows for better case management and identification of the full costs of episodes of care.*

In addition, most CEOs saw this structure as a way of involving clinicians in management. Within area health boards many clinicians had accepted service management in principle, but there had been failures of implementation. Several CHE CEOs saw this as an important challenge for the future and were seeking ways in which it could be achieved, including clinical directorships, with full devolution of budgetary responsibility and improved information systems. The emphasis on a 'customer focus' was seen as being reinforced by service management, enabling CHEs to focus on individual needs and maintaining a good profile in the community. This and other benefits were seen to outweigh any disadvantages, such as the need for co-ordination between services, and some of the problems of managing among dispersed sites.

However, other empirical work (Malcolm Alp and Bryson) underlines the variety of structures that have emerged.

As in the UK, clinical participation in management has been regarded as desirable, but not one formula has been proposed for ensuring it. A case study of what was then the Canterbury Area Health Board found a clinical director structure with delegated financial responsibility: an extract from this study is annexed.

Process of Change

In New Zealand, the reform process has been centrally driven. Nevertheless, some of the Government's intentions, eg to allow for competitive health plans, has not been realised. A recent official report (Department of Health, 1995) concluded that:

Reconfiguration of existing markets

With respect to the expected potential to break up existing markets and make efficiency gains through recreation of markets and reconfiguration of services, little change has occurred to date. In the area of laboratory services, for example, attempts to begin to change the current situation have been made, but negative provider reactions have so far delayed progress with these strategies. One area of change is continuing care. CHEs seem to be fairly rapidly withdrawing from providing these services as private providers pick them up (p 127).

Furthermore:

Monopoly-monopsony contracting is a not unusual phenomenon but does not usually involve the level of aggression and tension evidenced in some relationships during the 1994/95 contracting process. Tensions in relationships may to an extent reflect the 'big bang' approach of introducing change and the somewhat legalistic approach taken towards contracting, forced by funding constraints and risk aversion.

CHEs reported that the setting of prices and volumes did not have the feel of a true negotiation. If many, if not most, cases they were forced to take a lower price than they had planned for or wanted and at the same time were not able to reduce the volumes of service provided. This tends to exacerbate any deficit difficulties and in some cases has led to some bitterness. While CHEs are free to notify services from which they wish to withdraw there is a lengthy process to go through. Further, pricing of individual services and their specification is (1994/95) still rudimentary in many contracts and it is difficult for many CHEs to determine whether it is sensible to exit certain lines of business. Further still, services are interrelated and their removal would have implications for the viability of others. Thus few services have been withdrawn from - mainly long term care of the elderly (p 129).

Mooney and Salmond (1994) summarise its impact in the following critical terms:

There is little indication that the reforms were directed at health, or equity of health, or of health care. Where they fell down badly was with respect to the issues of consultation and ownership, especially with the community but also with the health care professionals. Apart from some limited work on community values on priority-setting, there is now no more knowledge of what the New Zealanders want from their health services than there was before the reform process was even thought about. That has to be one of the major criticisms of the whole process (p 178).

As a result, they suggest:

The lack of discussion of objectives in the early stages of the reforms now means that the reforms are met with at best suspicion and at worst outright hostility in several quarters in New Zealand society, including various health care professionals. This has led to a certain demoralisation of some of the key parties in the reform process. While there are considerable signs of buoyancy in the economy generally, with business confidence higher than it has been for many years, this rising confidence is not evident in the health care sector, where morale remains low.

The whole sector is racked with division between the various players. The institutional memory, the old structures, the old processes, the old players have gone - fair enough - but without there yet being any consensus about or commitment to the changes. This is particularly hard to achieve now at this stage of the reforms because of the fact that the objectives were not openly discussed and debated at the start of the whole process. There is a very clear lesson here for any country embarking on any reform process of its health service (p 178).

Against this background it is perhaps not surprising that the reforms are unpopular, both inside and outside the health care sector.

The New Zealand experience of the rapid introduction of a purchaser-provider split underlines that of the UK's. Introduction of an explicit contracting procedure achieves

little in itself. The purchasing role is complex and the scope within these two health systems for competitive behaviour very limited. It remains to be seen whether sufficient 'value-added' can be demonstrated, to counter the undoubted increase in transactions costs.

Annex: New Zealand: Internal Hospital Organisation

The Canterbury Area Health Board was responsible for running the 23 medical institutions in the Canterbury area.

In 1990 clinical directorates were established in the CAHB. This move was initiated by the new management as a response to the wider public sector reforms in process [28, p.2]. A clinical directorate was described as 'the minimum level at which a group of hospital doctors work together to deliver a particular service'. The doctors in a clinical directorate were represented by a colleague, known as the clinical director [28], who would manage the budget allocated to their service, on their behalf. Senior medical staff were asked to apply for clinical director positions, but many were reluctant to take on the new role.

In several specialties no-one was willing to become a clinical director. Previously all specialties were managed by an elected head, a position rotated between the senior clinical staff. Initially management differentiated between the clinical director and the head of department role. However, in the specialties without clinical directors, the distinction was blurred and the head of department was given the title of clinical director.

To provide the clinical directors with business skills, a management development program was established. Proposals were invited from a range of consultancy firms experienced in the field [28, p. 8]. A number of teaching modules were prepared and presented to the clinical staff. Participants were expected to gain an understanding of management skills, strategic thinking, measuring results and performance, total quality management and the application of marketing principles to health care. These modules were not well attended by medical staff.

Clinical directors were involved in the annual planning and budgeting process. Each clinical directorate became known as a health investment centre (HIC). All clinical directors played some part in the establishment of the operational plan for their HIC. In the two or three cases where the clinical director expressed some enthusiasm for his or her budgetary role, they were assisted by the management accountant and the information officer in developing their operating plan into a business plan [28, p. 7]. However, most of the clinical staff involved in this process suggested that budgets were given to them without consultation.

Many clinical directors found that their new role was quite different from what they had expected. They believed that they would receive control of a flexible budget. However, most found that 'budgets were basically fixed and they had little control over either budgets or work levels.' While some saw this as a short-term condition that would be fixed 'as the system evolved,' others suggested that 'all directors really did was to report cuts to their specialty.'

Some clinical directors saw their management role as a distraction from their primary objectives of making people better, and questioned the 'wisdom of using clinical staff in non-clinical [administrative] work' [29, p. 2]. Clinical directors seemed prepared to

work in an executive role but were reluctant to spend too much time generating and analysing information.

Source: Jacobs (1994).

SWEDEN

SWEDEN

Sweden provides a universal health service in which private provision and private finance play a very limited role. In the immediate post war years, hospital services expanded rapidly to the detriment of primary care. As a result, Sweden spends a high proportion of its budget on hospital services. GPs do not act as gatekeepers as in the NHS model; that is, Swedish citizens have a statutory right to go directly to specialists and many continue to do so.

During the 1980s, the Swedish health sector came under increasing financial pressure: in terms of the share of GDP absorbed by the health sector, it was and remains one of the more expensive systems. By the end of the 1980s, it was perceived as being in crisis and despite the high level of spending, queues for elective surgery have emerged, stimulating growth in private sector provision. Nevertheless, Sweden was the only OECD country which managed to reduce the total cost of health care between 1991 and 1993.

Health services in Sweden are primarily the responsibility of local governments, which enjoy considerable scope for making their own decisions as to how health services are organised. Each county (the 'upper tier' authority) provides primary and secondary care and tertiary services, while social and community services are the responsibility of municipalities.

Both the counties and the municipalities have the right to levy taxes on their inhabitants. A fraction of the federal tax is redistributed locally to adjust for special needs due to inequalities in age and social factors between regions.

Each county has a politically elected council. The counties are collectively organised in the Federation of County Councils which plays a major role in health policy, structural and manpower issues. This federation has a political board and one of its main tasks is to negotiate with the national government in matters of federal support and new legislation as well as to negotiate with the workers unions. The Health and Medical Services Act of 1983 states that the councils are responsible for planning and development of all health care in hospitals and in the primary health care sector.

Since 1 January 1992, the municipalities have had the responsibility of supplying care for the elderly in all types of institutional housing and care facilities including nursing homes. Most of this had previously been the responsibility of the counties. There are 284 municipalities; their central agency is the Swedish Association for Local Authorities.

In Swedish legislation, hospitals are not separately treated. There is no legislative boundary between in-hospital care and care given at out-patient clinics whether these are in the hospital building or outside in health centres and in the primary health care setting. Planning and providing primary health care is the responsibility of the counties as well as hospital care and in some counties primary health care is run by the same management as the local hospitals. The responsibility for the county councils to supply citizens with good care is the legislative basis. In which setting this is done is mainly a medical and not administrative question.

In 1947, the National Health Insurance Act was passed. This ensured that the whole population was covered for hospital care, physician services, outpatient services and drugs. The national health insurance programme was implemented in 1954. The Health and Medical Services Act of 1983 finalised formal decentralisation, giving the 24 county councils and three large municipalities full responsibility for the health care of their inhabitants.

In 1958, the counties were organised into seven medical regions, creating intercounty co-operative groups necessary for delivery of highly specialised services, each with slightly over 1 million inhabitants. In each region there is a regional hospital affiliated with a university and a medical faculty. These regional hospitals are research and teaching hospitals. They are all of them owned and managed by the county in which they are situated. The state pays for teaching and supplies a basic support for research. In addition, research is financed from both public and private funds.

Each county has a population of between 200,000 and 400,000. Typically there is a specialised central hospital in each county with 15 to 20 specialties and one to three district hospitals with emergency room, internal medicine, surgery, radiology and anaesthesitics. Some of these local hospitals in addition have orthopaedics, obstetric and paediatric services.

Whereas in the UK the Conservative Government's commitment to decentralisation to local government did not survive the early 1980s, in Sweden it has remained a genuine policy objective. Local politicians have been involved in both determining the shape of recent reforms and in the running of the new systems that have emerged. As a result, there is considerable variety between the different counties. However, the impetus to change - the need to make better use of public sector financial resources, and the rhetoric of change - the desirability of making decisions closer to the patient and providing choice - has been similar to the UK.

These reforms have, to a greater or lesser degree, embodied the following principles:

- patients are entitled to choose their primary care and hospital providers;
- elected officials should act as purchasers of services;
- responsibility for the provision of services should be delegated to providers;
- payment to providers should be performance-based;
- an increasing part of service delivery should be subject to competitive pressures.

Evidence on the impact of the new arrangements is not overwhelming. Some cost reductions are reported plus reduction in waiting times as well as changes in attitudes within hospitals towards patients and general practitioners.

Governance

As pointed out above, responsibility for hospital services is included as an integrated part of the county councils overall responsibility for health care. This responsibility rests on the 1983 Act and is carried out by local parliaments appointed in local political elections. This parliament only meets for a few days yearly to elect a political board

and to allocate resources to different areas such as local transportation and health care. The board, which mirrors the political spectrum in the local parliament, decides on allocations within the health care sector. The board is supported by an executive and administrative organisation.

For each hospital traditionally a political board is elected by the local parliament. This board selects and designs its executive and administrative support. This executive staff is responsible for the day-to-day delivery of health care within the hospital. Even in counties with (pseudo-)market oriented models and pre-payment systems this is the typical picture. In the county of Stockholm from 1996 there will be no political boards in the hospitals. Instead, there will be a more market oriented executive board producing care to the levels and quality decided by the political purchaser board. This system has been tried in a few other hospitals in other counties during the last couple of years.

In the traditional system and in systems currently being tried out, the hospital management is accountable to a local political body. Even the regional hospitals affiliated to universities have a local powerful political board. The county council has the full responsibility for all health care and for all resources, and the party with political majority in the council also has the majority in the hospital boards. Hospital boards and their executives may do anything within the law such as buy and sell equipment, build, employ the staff and cut down on the staff, and decide the staffing structure. In matters of hospital structure, the county council has the overall power and is accountable only to public opinion and the voters. Closing of hospitals or changing their status is, as in all countries, a difficult political task.

In most counties new models of finance and delivery have been tried. In at least six counties these models have been well defined. The aim has been to introduce a (pseudo-) market and in this process decrease the day-to-day function of the local political boards in favour of more executive expert functions. However, in none of these counties has this been possible to achieve. The exception, Stockholm county, is mentioned above. Even in this example the trust regime has not yet been in effect (except for one hospital mentioned in the introduction, which is run as a trust owned by the county and with an expert instead of a political board. This hospital will not be part of the new trust).

As a result, in the words of one study ' the politicians have been unwilling to "let go". Thus the structure looks more like administrative decentralisation rather than the creation of genuine free-standing agencies: the scope for county hospitals to make genuinely independent decisions eg on development of services is minimal. The basic lines of accountability remain 'local/political'.

Although this can be seen as a strength, it may also appear as a weakness, to the extent that lines between political and management action are blurred, making it harder for genuine decentralisation of activity to occur. The introduction of the purchaser-provider split may be seen as a means of making that possible, but as noted below, it may not be succeeding in doing so.

As implementation has occurred, there has been a basic conflict between freedom of individuals to go to the hospital of their choice and the desire of counties to 'protect' their own hospital. In areas where population is relatively dense, patients are choosing hospitals outside their own county and as money does follow patients, that has threatened the viability of some hospitals. In principle this could be the lever for radical change, but in practice it appears that counties have responded so as to maintain the status quo and, with a few exceptions, not actively to promote choice.

Overall, the new structure appears to be less radical than it may appear at first sight: a recent review (Arnell, 1995) concludes as follows:

> *In summary, and based on experiences in Swedish county councils, reforms towards internal markets with a weak separation between purchasers an providers rests on poor ground. Moreover, it is highly unlikely that this form of internal market will result in any structural changes as regards activities. The difficulties of introducing incentives for structural change, and the strive to revert to status quo, may indeed prove to be one of the most important problems of the monopolistic integrated model. In a stable environment, such a problem would be of minor importance. The health care industry is however characterised by rapid developments as regards new possibilities for treatment and diagnosis. When these circumstances are taken into account the lack of incentives for innovative behaviour, and the limits to structural change, becomes more serious* (p 21).

Finance

The centrepiece of reform in several counties has been the introduction of a purchaser-provider split. But the different institutional setting has meant that it has not emerged as clearly as in the UK, and it has taken different forms: see Table S1.

[insert Table S1]

How the new arrangements are working does vary substantially from area to area, so a simple summary is not possible. Two case studies are attached in the annex. These indicate that different pricing regimes have been tried and also different contracting arrangements.

The main instrument of hospital cost containment has been reform of the way that hospitals are financed away from global budgets towards cost per case structures, ie prospective payments: see Table S2:

[insert Table S2]

But, because these create an incentive to do more work, they have been modified in various ways:

> *Case-payment systems create incentives to carry out more activities and hence lead to potential problems with controlling total costs. The county councils trying the new solutions are well aware of this. Consequently, in the above-*

mentioned county councils, the contracts contain additional provisions which stipulate expenditure ceilings. These ceilings have been framed in different ways. In Dalarna, there are negotiated cost ceilings and/or discounts for different services. In other county councils, the reimbursement is gradually reduced if the volume of care exceeds the planned level. In Bohus, for example, reimbursement is reduced to 40 per cent of normal if the actual volume of care exceeds 101 per cent of that planned for. For volumes exceeding 104 per cent, there is no additional reimbursement. Thus, incentives to increase production only apply up to a certain level. Above that level, the incentives change.

As a rule, the decisions on reimbursements are based on average costs within each county. These calculations have in part resulted in large differences between hospitals. There are different strategies for handling the differences, but according to the general intention the reimbursement shall be the same for the same type of care, irrespective of what hospital provides the care. Differences, such as research and training in university hospitals, or special undertakings and preconditions, are to be treated separately and paid for through extra funding (Arnell, p 219).

New payments structures are also being introduced within hospitals, developing a tendency apparent before the recent changes to delegate authority to 'clinic' heads, a model which, as noted below, was already common.

Internal Organisation

Under the county council the hospital boards are free to organise their management. The Federation of County Councils supports each country and hospital with systems for financial handling and accounting commonly used to make comparisons possible. Financial requirements for public organisations are also described in laws not specific to the health care sector.

The number of short-term beds has decreased by 17% from 1991 to 1994 to 3400 per million population. This has been possible by the reform of care for the elderly and by new internal organisational patterns. Many hospital managers have tried to tear down the traditional boundaries between specialties and to regroup functions in divisions. These have often focused on a disease or an organ and not the treatment. One example is 'heart and lung' divisions with cardiology, lung-surgery and medicine and heart-surgery. Another is 'endocrinology' with endocrinologists and surgeons chairing wards, clinics and patients. In large hospitals with 50-60 different specialties this has helped to reduce the number of accountable groups down to 10-15. Even in smaller hospitals the principle of centres grouped around a group of patients or diseases rather than on the treatment has been common.

One of the primary reasons for introducing divisions or centres was to reduce the number of accountable groups to the hospital manager. With more than 50 independent departments it was difficult or impossible for the board and the manager to keep informed and to guide and interfere when the budget was not kept. The idea was taken from the industry and also constituted a smaller group of professional

leaders with which the manager could work. This organisational reform has been implemented in some form in most hospitals. According to Ham (1992):

> *Medical staff working within hospitals exercise a key influence on the use of resources and the setting of priorities. Senior doctors take on the role of clinic chiefs and provide medical leadership to their colleagues. Recent developments have sought to strengthen the role of clinic chiefs in the management of services. These developments have centred on appointing as clinic chiefs those doctors best able to do the job, providing management training, and making appointments on a fixed-term basis. Increasingly, too, clinic chiefs are taking greater responsibility for the management of resources with support from nurses and managers based in clinics* (p 135).

A previous King's Fund study (1990) found that:

> *Within hospitals, consultants manage their own work in much the same way as their colleagues in the NHS. However, an important difference is that in each specialty there is a designated clinic chief (or clinical director) who provides medical leadership. While individual consultants retain the clinical freedom to practice in the way they consider appropriate, the clinic chief provides overall co-ordination of the work of the clinic and represents his colleagues within the hospital. In this sense, there is a clearer system of medical management in Swedish hospitals than in NHS hospitals.*
>
> *Recent developments have sought to strengthen the role of clinic chiefs. For example, instead of the most senior doctors taking on this role there is now a move to appoint those clinicians best able to do the job. Furthermore, appointments are increasingly made on a fixed term basis, and county councils have been given greater freedom to set their own pay rates. In parallel, management training for clinicians has expanded.*
>
> *Linked to these developments, management arrangements within hospitals are being decentralised. This often involves the appointment of a manager and senior nurse to work alongside the clinic chief. In the case of smaller clinics, these staff may support two or more chiefs. Increasingly, too, budgetary responsibility is being delegated to clinics. Clinical budgets, or frame budgets as they are more usually known in Sweden, have existed in some counties since the 1970s, and they are now being introduced on more widespread basis. Thus, through a combination of measures, steps have been taken to increase incentives for efficiency within hospitals.*

Staffing and Labour Relations

The hospital staff may be employed by the hospital or by the county. In the second situation, that person may be offered a similar job anywhere in the county in times of changes. Usually the hospital board employs higher officials and specialised doctors and registered nurses in head positions. Others are employed by the executive and administrative group or by the departments.

The Federation of County Councils is the negotiating body with the national unions. On a local level negotiations are on working hours and part of the salary (individual performance). In principle all salaries are individually set.

Managers of hospitals have during recent years largely been recruited from the private sector. Most of these are professional economists. A few with medical backgrounds have been recruited internally.

The input of ideas from the private sector through the managers have been extensive and fruitful. Their capacity as chief executives has been superior. The thing that sometimes has been questioned is if economic principles from an industry producing goods can be used in health care, where the overall goal is to reduce the need for care. The lack of medical competence and understanding has sometimes been criticised, especially in times of great and painful changes.

It is often said that the revolution of a more market oriented model has failed due to bad management. The good ideas were not implemented. This may in part be true but the long tradition with strong local political boards running the 'provider-hospitals' and the traditional lack of incentives seem to have been more important obstacles.

Process of Change

The widespread interest in the beginning of the 1990s in testing new models with (pseudo-) market contents and principles resulted in at least six different local models. None of these have been a complete success. However, much has been learned from the experimentation and productivity rose substantially in all countries (even those without new structures). Interest in testing new models declined in 1994 and one reason was the new Social-Democratic political majority in the parliament and in many county councils.

However, another important reason for the decreased interest or reluctance to embark on new trials probably was the failure of the 'models' to solve difficult financial and structural problems. It was found that ideas were not enough. They had to be implemented in every little detail by people who for many years were used to work in another ideology. In addition their jobs were threatened by effective implementation. Competition between providers never actually occurred.

Two main effects remain. One is a less producer-oriented organisation. The other is the greater consumer choice and responsibility.

The new trend is co-operation and in many parts of the country two or three hospitals are joining together to support each other. In many of these cases, the alternative would be to close one of the hospitals, at least as an emergency facility. The trend to co-operate also extends to counties and in at least two parts of the country merging into one common organisation a 'large-county' is being prepared for. It is anticipated that this will lead to fewer hospitals and strengthen the care given by the local community and the primary health centres.

Annex (Taken from Anders Arnell)

Two counties, Sörmland and Östergötland, have made this split at county level, creating one political board (i.e., made up of elected county council members) responsible for purchasing services and a second board responsible for managing the county's organisational infrastructure of primary health centres and hospitals. Another county, Bohuslän, has established three separate districts each with its own purchasing and administrative boards. In a similar but arguably more radical reform, Stockholm (9 districts) and Dalarna (15 districts) counties have created local political boards which combine financial and administrative control over local primary health centres with the responsibility for purchasing hospital care for their districts' inhabitants. In the Stockholm and Dalarna approach, local boards are expected to utilise their control over hospital funds to closely monitor primary health care referrals to hospital, and to encourage primary health physicians and centres to provide an increased proportion of necessary services themselves (Saltman, 1990).

In all these reform models, individual hospitals and primary health centres will be transformed from dependent administrative units to something approaching public firms. They will no longer be funded through an automatically allocated budget, but will be expected to support themselves partially or entirely on the revenues each provider institution can generate within this new public market (Saltman and von Otter, 1992).

At present, the evolving structure of contracts in Swedish counties is not based on a detailed statement regarding price, quality, or volume (Bergman, 1992b). Rather, it is an agreement to provide care for a specific period. In effect, Swedish contracts establish a care relationship rather than specify the precise content of the relationship. They thus resemble the contracts that previously existed within the Dutch health care system between the sick funds and the hospitals (Saltman and de Roo, 1989). That is, the financing board behaves more like a financial intermediary, rather than acting as a prudent purchaser, as is the case in the selective cost-based contracting undertaken by preferred provider organisations (PPOs) in the United States. This raises interesting questions about what the new Swedish contracts actually accomplish. They don't act as hard contracts that restrict patient options or define precise care characteristics. Instead, they define a general but short-term rather than permanent relationship between purchaser and provider. The implication of the Swedish contracts is that potentially, sometime in the future, the purchasing board could decide to change the contract conditions to specify cost and volume or to place the contract with a private provider instead. Thus, although existing revenue flows haven't changed, anticipation has been created among hospitals and physicians that they could change in the future, especially if the financing board were not satisfied with a particular provider institution's performance.

In turn, although the new contract structure has not changed revenue flows, it has influenced the balance of power within the Swedish health care system. This shift involves two components. First, where local boards control both primary health centres and the purchasing of hospital services, hospital physicians must pay more attention to the desires and concerns of the primary care doctors. Second, worried about future changes in the contract structure, all physicians feel they must pay more

attention to the politicians and managers who run these boards. As a consequence, the introduction of contracts has generated a shift in the prior distribution of power within the health sector: Hospital specialists have lost some of their leverage over hospital decisions, whereas general practitioners (GPs) (in Sweden, as elsewhere, less respected in physician circles) and managers have gained. Hospital specialists are still far from powerless, of course. However, the use of contracts may help Nordic hospital administrators and politicians achieve their long-term goal of making hospital specialists more managerially accountable (Saltman, 1985).

The available evidence indicates that these measures have had some success. For example, in a review of experience with frame budgets, Hakansson (1986) reported that staff viewed budgets positively and had become more cost conscious. The savings achieved in the experiments analysed by Hakasson resulted mainly from a reduction in the use of drugs and diagnostic tests and through not filling vacancies.

This conclusion is supported by experience at the Department of Thoracic Medicine at the Karolinska Hospital in Stockholm (Unge, personal communication). With an annual budget of approximately 20 million crowns (£2 million), the Department employs 17 doctors and 80 other staff. The clinic runs the Department in association with a manager and a senior nurse. It is expected that the Department will treat an agreed number of patients each year within its budget. If the workload exceeds the target than the budget may be increased but the payments are such that this does not act as a major incentive. More importantly is the ability to vary items of expenditure within the budget and to retain a proportion of savings.

The Department cannot increase the numbers of doctors employed without the approval of the hospital director and the board of politicians responsible for running the hospital, but otherwise has considerable discretion in the use of the budget. If the budget is underspent, the Department retains 50 per cent of the savings. Changes in clinical practice introduced in the Department include a reduction in diagnostic tests, and a reorganisation of nurse staffing to appoint more qualified nurses and to reduce the number of nursing assistants. In addition, a new computer system has been introduced, and the cleaning of the Department has been contracted out to a private firm.

Although the Department is at the forefront of efforts to manage the use of clinical resources more effectively within hospitals, it is not unique. Similar initiatives have been taken in other counties and there is now considerable pressure to extend these initiatives throughout the health service. However, difficulties have been experienced in persuading managers to move from central hospital administration to work in the clinics, and doctors do not always have the necessary skills or interest in management. Also, there is an active debate about whether nurses as well as doctors can be appointed as chiefs. In one experiment in Vasteras opposition to decentralised management reached the point in which 200 doctors called for the abolition of the new management units (Ievins and Revenas, 1990).

Table S1

Sweden - Examples of purchasing organizations in the county councils in 1993

County council	Purchaser organisation
Bohus	14 *local purchasers* are allotted resources according to a population-based model. An administrative staff divided into four offices negotiates with the health care provider
Dalarna	15 *local purchasers* are allotted resources according to a population-based model. Administrative staffs which are to some extent shared negotiate with the health care provider
Stockholm	9 *purchasers at district level* are allotted resources according to a population-based model. Administrative staffs negotiate with the health care provider
Sörmland	The county council board of directors is the *central purchaser*. An administrative staff negotiates with the health care provider

Source: Arnell and Svarvar (1994)

Table S2

Sweden: Examples of prospective payments to hospitals for short-term somatic care in 1993

County council	Administrative level which sets principles	Activities in inpatient care	Activities in outpatient care	Cost control
Bohus	County council	DRG (weights developed at Gothenburg hospitals)	Its own classification	Reimbursement of 40 per cent if volume exceeds 101 per cent of the plan; over 104 per cent, no reimbursement
Dalarna	Local purchaser	Mixed depending on service and purchaser	Mixed	Cost-ceilings and/or discounts depending on purchaser
Stockholm	County council	DRG (adjusted Norwegian weights)	Its own classification	Reimbursement of 50 per cent at the most if volume exceeds the plan
Sörmland	County council	Mixed DRG for several surgical spheres (adjusted US Medicare weights)	Its own classification	Reimbursement of 40 per cent if volume of inpatient care exceeds the plan; reimbursement of 10 per cent if over 105 per cent less reduction in outpatient care

Source: Arnell and Svarvar (1994)

CANADA

CANADA

In Canada, health care provision is largely a matter for the component provinces working within the same general framework set by federal legislation, the Canada Health Act 1984. This sets out the following principles:

- Universality, *which requires that 100 per cent of the insured persons of the province must be entitled to the insured health services of the provincial health insurance plan on uniform terms and conditions.*

- Comprehensiveness *in insuring all medically necessary health services.*

- Accessibility *by insured persons to medically necessary health services on uniform terms and conditions and without barriers, including charges to patients for insured health services.*

- Portability *of insured health coverage for insured persons when they move within Canada or travel inside or outside the country.*

- Public administration, *ensuring that the provincial health insurance plan is administered on a non-profit basis by a public authority appointed or designated by the provincial government and subject to audits.*

With some variation round services such as dentistry and ambulance, all provinces provide a universal health service to all its citizens largely free at the point of delivery. Although it is largely a publicly financed system, the bulk of hospital services are provided by non-government agencies, ie non-profit organisations overseen by boards of trustees. Consequently a purchaser/provider split is inherent in the system. Physicians are largely paid on a fee for service basis, including those working in hospitals.

Canada spends about 10 per cent of its GDP in health - the highest among those with national health systems. Half of that goes on hospital care - in 1990 the highest proportion in OECD countries.

The Canadian system has been subject to strong upward cost pressures, with medical specific inflation running at twice the level of general inflation. Thus the main reasons for higher spending appear to have arisen from within the health care system itself. That has led to pressures for better control and efficiency gains. The result has been a proliferation of initiatives designed to contain costs and also to improve the accountability of doctors and hospitals. Their nature varies from province to province: the examples given below are largely taken from Ontario. In general, however, the Canadian system has not, unlike the UK or NZ, been the subject of a single major wave of restructuring. Nevertheless, both provincial and federal governments are united in pursuing policies aimed at reducing overall budget deficits and at health and social spending in particular. Last year's federal budget announced cuts from 1996 to 1998 in transfers to provincial governments for social programmes. In Ontario, plans have been announced to cut hospital spending by 18% over three years. More generally, there has been a marked tendency for greater government involvement in

hitherto private hospital affairs aimed at improving financial control. According to Fulford and Sutherland (1988):

> *In Ontario, the confrontation between the ministry and hospitals and the subsequent amendments to the* Public Hospitals Act, *followed directly from a decision by a substantial number of large hospitals to refuse to operate within the funds allocated by the ministry. These hospitals set budgets that anticipated large deficits, some in the range of $15 to 20 million. The hospitals, in essence, dared the ministry not to provide the money. It was a situation in which the government either had to let the hospitals write the provincial budget or act quickly and firmly, and it chose to act. The hospitals then decided they would rather operate in a fashion acceptable to the ministry than be operated by someone named by the ministry. Hospitals have more or less accepted the fact that they, as well as schools and other kinds of public institutions, must operate within an assigned amount of public money* (p 241).

As a result:

> *Financial control of hospitals by the ministry is less complete than legal control, but is equally effective. For most public hospitals, 85-95% of operating funds come from their provincial ministries or from ministry financed hospital insurance commissions. Hospitals also receive operating income from preferred accommodation and from revenue producing activities such as TV rentals, and parking. Income is also generated from third-party payers such as Worker Compensation Boards and from investments, donations, direct-pay patients and payments for out-of-province patients. Revenue from these last two sources can be substantial in hospitals on an interprovincial or international border or with a multiprovince function. Through the budget allocation process the Ministry can support or discourage the establishment or expansion of patient care or educational programs. The ministry can also determine the involvement of the hospital in regional or joint ventures* (p 241).

Finance

Hospitals are financed on block budget basis, determined through bilateral negotiation within each province, according to factors such as workload, length of stay, inpatient days, demography and inflation. However, the influence of historical spending levels on their allocations remains strong. In the past, global budgets have not been very rigidly enforced but since the late 1980s, attempts have been made to make them stick. Within this broad picture there are provincial variants. For example, in Ontario hospitals are allowed to keep operating surpluses and also to generate income from medical sources such as US business and non-medical sources such as parking. This does not hold elsewhere.

Capital funding is controlled by a variety of mechanisms in different provinces but in all cases prior approval is required from the relevant Minister for Health. The purchase of expensive items of equipment is also controlled. Accordingly, it appears that Canada

has been able to avoid some of the cost pressures arising from competitive purchasing of such assets.

A number of provinces are looking to reform hospital finance and a number of experiments are underway using different varieties of case-mix and cost-based systems, described by Botz (1993) as follows:

> *In order to provide stronger incentives to improve cost efficiency, many government health agencies throughout North America have abandoned per diem funding and introduced case-mix-based hospital funding (DRG or CMG). Under case-mix systems, hospitals are credited for the types and numbers of cases (products) they deliver rather than the actual quantity of services (patient days) they provide. Similar cases are credited at a fixed or a prospective rate that is largely independent of their length of stay or the actual cost of resources. The fixed rate is based on the average cost and length of stay in an average-sized hospital with an average number of a particular type of case (economies of scale).*
>
> *The incentives inherent in case-mix funding are evidenced by the impact they have had in jurisdictions where prospective payment has been implemented. The most obvious and financially compelling incentive is to minimise lengths of stay; hospitals receive the same credit, for example, for a stroke patient discharged in 20 days as one charged in 30 days. Throughout Canada and the US, average lengths of stay and total patient days have decreased coincidentally with the introduction of case-mix-based funding as they have in countries such as the UK which have not introduced it.*
>
> *Another important incentive in case-mix funding is cost reduction. Hospitals with lower costs are "rewarded" insofar as they retain all funds in excess of their actual expenditure. This has led to increased efforts by hospitals to reduce the numbers and costs of diagnostic tests, and the costs of supplies such as hip prostheses or implantable lenses. Under case-mix funding, such utilisation-control and cost-reduction measures do not compromise hospitals' funding entitlement; under the traditional global funding system, however, it often does. Another area of experiment is 'performance-related finance'. In Alberta, hospitals able to demonstrate cost advantages are awarded more funds.*

These examples indicate that the search for effective funding formulae continues. Technical problems abound: examples include the definition of severity, dealing with the very long stays known as outliers, the complexity of formulae that attempts to solve them create, appropriate and consistent costing rules, and the treatment of scale and quality effects.

The extent of provider competition is very limited but does appear to exist in some areas. Until recently:

> *Canadian hospitals have traditionally been protected from competitive forces. Small hospitals that are under-utilised and inefficient have been protected by*

> *government and have been allowed to continue to operate. Hospitals running deficits were routinely rescued by government. In recent years, however, Canadian hospitals have begun to show some of the features of hospitals in a competitive system. Marketing functions have emerged in some hospitals, and hospital strategic planning processes have taken on a more 'private sector' tone* (Fried *et al.*, p 155).

This study found that one third of hospital chief executives perceived themselves as in a competitive environment although half perceived little or no competition.

Some attempts are being made to increase competitive pressures. In Ontario, there are a small number of so-called Health Service Organisations, not unlike Health Maintenance Organisations which might be able to develop in ways similar to GP fundholding or even beyond it to include specialist services.

Governance

All hospitals have a board of trustees, their number varying from 12-24. Hospital boards are elected in some cases, appointed in others: their composition varies but many include representatives from the community, professionals and other staffs and the chief executive officer.

The board is responsible for the broad objectives and policies and for the appointment of the chief executive, who is accountable to the Board. The board itself is accountable to the provincial government for the financial viability of the hospital. The board would normally approve major changes in the pattern of services. According to Rathwell (1992):

> *The most striking feature of self-governing hospitals in Canada is the clear distinction between the board of trustees and management. The board is responsible for the overall economic viability of the hospital, for all policy matters, and for determining strategic direction. Management is responsible for the day to day running of the hospital, including the granting of admitting privileges to physicians. Management administers and attends board meetings but does not vote. This separation of policy and planning and implementation is seen as a particular strength of the Canadian system. Indeed, with few exceptions, all of the hospital CEOs interviewed did not wish to become voting board members as they felt that by doing so their ability to manage the hospital would become severely compromised.*

Thus in principle and unlike the UK, there is a clear distinction between policy and implementation. According to Rathwell, the strength of this system is perceived in Canada to be the strength of the links to the local community.

> *In Canada, because of the way board members are appointed (or elected), hospitals tend to have a close association with their local communities. The separation of the responsibilities of the board and management is seen as a distinctive attribute of the Canadian system. The rolling together of the board's strategic role with the operational responsibilities of management (as*

is the case in Britain) is considered to be dangerous, as operational matters and not strategic policy would dominate. The consensus of opinion was that were this to happen, the hospital would become inward looking and develop services that would seek to maintain its long term viability but which may not be in the best interests of its local users. In this respect, it is argued that the Canadian system of separate responsibilities for board and management is far more advantageous for ensuring that hospital services accord with local needs, than is the case for self-governing hospitals in Britain (p 328).

On the other hand, however, the boundary between what is strategic and what is operational is often far from clear.

Despite this structure, the issue of accountability has been hotly debated in recent years. In 1992, the Ontario Hospitals Association passed a resolution indicating an intention to change its by-laws in respect of:

- open Board meetings
- limiting Board member tenure
- increasing staff involvement in Board and Management Committees
- broadly based community representation on the Board
- audited financial statements being made public
- community consultations.

At the same time, Guidelines were issued for most of these areas.

Monitoring

Accreditation is voluntary but it is widely seen as the mechanism which hospital boards can demonstrate to their local community that their hospital meets certain national standards. A recent survey found that, the common response from hospital CEOs in Canada was that, as the competition between hospitals increases, those who are not accredited by the Canadian Council on Health Services Accreditation will be the losers in the scramble for patients. In addition to this role, the Council also operates a clinical review procedure based on prospective medical audit.

A series of further initiatives by various bodies have been taken to monitor performance in cost and quality terms: including performance reviews and benchmarking programmes.

In addition, some provinces have instruments of local accountability. For example, Ontario has a system of District Health Councils - local planning bodies consisting of consumers and providers. In principle these should:

> *... ensure that decisions on health care matters are taken at the local instead of the provincial level. DHCs thus are 'local advisory bodies with a mandate to identify local health needs, evaluate alternatives, establish priorities and make recommendations to the Minister of Health within the Ministry's policy framework'* (Bell, 1986, p 73).

The DHC is a cross between the District Health Authorities (DHAs) and Community Health Councils (CHCs) found in Britain. It has the planning responsibilities of the DHA but not its executive authority. It represents the interest of the consumer and the health care user as does the CHC but does not deal with user complaints like the CHC. In Ontario, hospitals are supposed to discuss with their local DHC any new service programme or capital development. However, because their role is only to advise the Provincial Ministry of Health on these issues, hospitals often by-pass the DHC and go straight to the Ministry with their proposals.

Some provinces have acted directly on pay as part of controls operating on the public sector as a whole. These bite on nursing pay and that of other hospital workers but not on physicians. In respect of physicians, a number of attempts have been made to curb spending by introducing caps on their remuneration within the fee for service system or examining other ways of remuneration such as session contracts or salaried positions.

Internal Organisation

An earlier King's Fund (1990) study found that:

> *Day-to-day management is in the hands of a chief executive, and there is usually a chief of medical staff employed on a salaried basis. In larger hospitals, there will also be chiefs of major clinical services, or clinical doctors. Doctors who have admitting privileges are private practitioners and they are organised as the hospital's medical staff. In practice, management responsibility is usually shared between the board of trustees, the chef executive and the medical staff.*
>
> *Doctors in Canada enjoy considerable freedom to practice in the way they consider appropriate. Subject only to the overall constraints imposed by global hospital budgets and the fee schedule, each doctor is able to determine the place and form of treatment for his patients. In this respect, Canadian doctors are in a similar position to their UK counterparts, although the existence of chiefs of medical staff and of clinical services has created a clearer structure for the organisation of medical work. This structure involves an element of hierarchy between doctors in which the ultimate sanction is the withdrawal of admitting privileges for doctors whose practices are deemed to be unacceptable. The Canadian approach to medical management enables chiefs of staff to encourage their colleagues to participate in peer review and themselves to assess performance by analysing data gathered for reimbursement purposes.*
>
> *There is growing interest in the involvement of doctors in management (LeTouze, 1986) and in achieving closer integration between hospital management and clinical activity. ... this is partly a response to increasing financial constraints and to the different set of incentives faced by managers and doctors. Although there has been little experience of clinical budgeting, some of the new structures which are emerging - for example, at Sunnybrook Hospital in Toronto - closely parallel those which exist at Guy's Hospital and other large teaching hospitals* (p 85).

There has been interest in recent years in involving clinicians in management: for example, within Ontario by-laws issued in 1990 developed by the Ontario Medical Association and the Ontario Hospital Association which state that not only are medical staff responsible for the quality of care but they are also expected to participate in the hospital's planning, policy setting and decision-making. A number of hospitals have introduced cost centres for clinical groups, on the lines of the resource management initiative in the UK. Some hospitals are developing new structures with the aim of involving clinicians in management but it is clear from recent research that the situation on the ground varies a great deal, making generalisations hazardous.

A typical hospital management structure is shown in Diagram C1. The medical staff have two distinct positions in the Diagram. The chief of staff and the Medical Advisory Committee are an integral part of the hospital organisation, where the organised medical staff is free-standing. Following Sutherland and Fulton:

> *The MAC is, in Ontario and some other provinces, given major statutory responsibilities. It must, in many situations, provide advice to the board, and the board is obliged to consult it. The Ontario Public Hospitals Act states: "The Committee shall advise and collaborate with the administration in all decisions affecting patient care including the allocation of space, the allocation of beds by department and the development of facilities," and the Committee shall "approve plans and priorities for the use of funds in all departments and divisions". MAC members in Ontario teaching hospitals are appointed by the board. In other hospitals, the MAC is elected. The MAC is composed of all chiefs of clinical departments and major sub-departments or divisions, which in a large teaching hospital results in a membership of 30 to 60 physicians. The MAC may also have nonvoting members from the administration, the board, the nursing department and occasionally from other departments. By law, in Ontario, the chief of staff is the chairman of the MAC. The chief of staff is usually appointed by the board and, therefore, is, in theory, its agent rather than being primarily a representative of the medical staff. MAC advice and decisions are received by the board via the presence of MAC minutes as part of the agenda of board meetings* (p 242).

In a number of hospitals, relations between management and medical staff are handled by a Joint Conference Committee. A number of hospitals have introduced cost centres for clinical groups, on the lines of the resource management initiative in the UK.

Process of Change

Unlike, for example, New Zealand or the UK, it is hard to identify a single white paper or commission report leading to a general restructuring of the health care system. Restructuring initiatives vary from province to province, covering a continuum from decentralisation to centralisation. But behind these diverse efforts lies a common purpose - the containment of public expenditure in general and that on social policy programmes in particular.

Furthermore, the agenda for reform remains long: Sutherland and Fulton set out the following daunting list, most of which apply to the other countries considered here.

Problems and Issues Include:

- a system still dominated by the concept of cure; and a patient group increasingly dominated by degenerative diseases that cannot be cured;
- an emphasis on physical perfection and quantity of life, with death as the enemy, and a continuing although perhaps slightly reduced neglect of emotional distress, environmental stress and the quality of life;
- a system dominated by the medical model (a unidisciplinary domination promoted be fee-for-service and characterized by episodic and fragmented care);
- health services which are primarily reactive rather than proactive. Services are regularly provided, often in large volume, because some individual or group or public policy failed to prevent easily preventable disease or injury;
- information systems and payment arrangements that are inappropriate for health care networks which must increasingly deliver multidisciplinary and long-term care;
- an incompatibility between paternalistic providers (who tend to wish to decide what kind of care the user gets as well as from whom, where and at what cost), and the modern trend towards user decision making based on complete information.
- conflict between individual needs or benefits and collective needs or benefits. The public has, in the past, been told, and providers still often believe, that the objective is 'the best health care for everyone.' To meet this objective is now impossible and not socially desirable because of the massive trade offs required. Perfect care for anyone usually means a decreased amount of care for someone else who is also in need;
- a major gap between what the system is capable of (with the resources available) and what is delivered;
- great uncertainty and ambiguity about consumer and community roles, including confusion with respect to technocracy versus democracy;
- an increasing governmental interest in the quality of health care but profesional objection to quality review by anyone but practicing peers;
- a wish for an integrated system but privately controlled segments of the system that plan and operate independently;
- ignorance as to which things are worth doing or which are most useful, which makes it difficult to reduce resource consumption rationally. This situation will remain until information systems are markedly improved.

THE NETHERLANDS

THE NETHERLANDS

Overview

Although the Netherlands hospital system is largely decentralised into private, not-for-profit ownership, there has been a tradition of regulation of a detailed nature by the central government. A recent OECD study characterised the old regime as follows:

> *There are few* financial *incentives for consumers, insurers or producers to act efficiently. Consumers insured with sickness funds benefit from virtually free health care and have no incentives to restrain their demands. The sickness funds are reimbursed from a general fund for all realised claims expenses and consequently have no financial incentive to select efficient providers. Moreover, they are obliged to enter into contracts with any local provider who wishes to provide services to their members. This means that they act as passive funders of care rather than as active, cost-effective purchasers of services. Private insurers are more cost-conscious, but they find it easier to compete by avoiding enrolling individuals who represent poor risks than by choosing cost-effective providers. This is reinforced by the fact that their policy holders tend to enjoy free choice of provider. GPs are paid by capitation and have incentives to refer to specialists patients whom they might treat themselves. Specialists are paid by fee-for-service and are rewarded for unnecessary as well as necessary care. Because hospitals are now paid by global budgets it is arguable that they have inadequate incentives to respond to changes in demand. This dichotomy in incentives induces considerable tension between the specialists and hospital managers* (1993, p 94).

In 1988, the Dutch Government set out four reasons for reform:

> *Firstly, the* uncoordinated financing structure *for health care and social welfare (homes for the aged, family assistance programs and social work) stood in the way of cost-effective substitution of care. Closely interrelated forms of health care delivery were frequently artificially separated by multiple financing mechanisms and complex regulations. For instance, primary care and hospital care, home care and nursing home care, and family assistance programs and homes for the aged were all financed from different sources and with different payment mechanisms.*
>
> *Secondly, the system was characterised by a* lack of incentives for efficiency. *This was true for producers of care, consumers and insurers. The financing system was such that in many cases efficient behaviour was financially punished, while inefficient behaviour was financially rewarded.*
>
> *Thirdly, the* detailed government regulation had negative effects. *The very detailed regulation of capacity planning in health care had turned out to be unworkable. This failure was due to the complexity of the planning process, the many parties involved, their conflicting interests, and the lack of clarity of the regulation. A major problem was the relationship between planning and financing. Planning and financing decisions were made separately, causing*

many problems. None of the involved parties were fully responsible for the consequences of their decisions. Further, the centrally regulated remuneration system of providers impeded flexibility and efficient allocation.

Fourthly, there were several problems with the health insurance system *which were related to the existence of different insurance schemes with different premium structures, as well as to the fact that competition in the market for private health insurance was not regulated* (de Ven and Rutten, pp 12-13).

As part of the overall economic policy of the government, a strong emphasis is placed on the containment of labour costs. Lowering the premium level for social insurance arrangements is one of the main targets in this policy. As a consequence, high priority is given to overall cost containment or 'budgetary discipline' as it is known. This refers to governmental regulation that strictly prescribes that expenditures that exceed the health care macro-budget in one year have to be compensated in the next - or even in the same year if possible. All kinds of measures are taken to stop individual organisations off-loading deficits to other actors in the health care sector.

The overall diagnosis of health care expenditure growth in the Netherlands has been made in terms of market failure. Therefore several measures are being taken to strengthen market conditions. The overall picture is not one of a well-balanced market structure, but several important things have been changed. Hospital management is facing the following major changes:

- loans for capital investments are no longer guaranteed by the government. This means that banks now ask hospitals for business plans that can demonstrate that the exploitation basis for the organisation is healthy. Banks also force hospitals to build surpluses to create reserves up to 15-20% of the annual exploitation expenditures.

- in urban areas financiers have become more selective in financial support of expansion plans of hospitals. They are starting to stimulate division of labour patterns between hospitals and mergers between support facilities like laboratories.

- revenue deficits of hospitals were usually automatically compensated for by negotiating a higher production level for the next year. This has come to an end as from 1996. Sickness funds can compensate for their own deficits only by rising the nominal fee for their policy holders. Sickness funds from now on have a strong incentive to stabilise the hospital expenditure level and in practice it can be demonstrated that this incentive works. Sickness funds have become tougher in their relations and negotiations with the hospitals.

A large part of the reform and of much subsequent public debate in the Netherlands turns on the structure of the insurance rather than market structure on the provider side. However these changes do have implications for the provision of hospital services, since they open the way for insurer/provider negotiations over the volume, price and quality of care and hence some degree of competition. To the same end, entitlements are to be fixed in terms of services, not specific types of provider thereby

creating some scope for competition between providers. Van de Ven and Rutten (1995) explain this as follows:

> *The insurers are expected to function as an intermediary between consumers and the providers of care. To a high degree, insurers and providers will be free to negotiate the contractual terms. In law, the standardised benefits package of the basic insurance will not be described in terms of institutions like hospitals or nursing homes, but rather in terms of types of care. For instance, the entitlements of the insured will no longer be described as the 'services provided by the licensed rehabilitation centres' but as 'rehabilitation services'. Any provider meeting certain quality standards is allowed to offer these services. This will greatly increase the possibilities for cost-effective substitution of care. Insurers will be allowed to selectively contract with providers and offer different insurance contracts, as long as they provide coverage for all the types of care as described by law. Flexibility in the description of the standardised benefits package should pave the way for setting up alternative health care delivery and insurance arrangements, such as health maintenance organisations and preferred provider organisations. Consumers will be free to choose among different insurers, picking the standardised benefits package they like the most. Some people will prefer a traditional health insurance contract with free choice of provider while others may prefer a limited provider plan with a lower premium. Furthermore, the premium paid will reflect the efficiency and cost-generating behaviour of the contracted health care providers. In this way it is expected that a situation will arise in which:*
>
> - *the insured are being rewarded for choosing efficient insurers and choosing cost-effective providers of care*
>
> - *providers are being rewarded for effective and efficient provision of care* (pp 16-17).

These changes have encouraged existing hospitals to consider mergers and also some entry by 'for profit' private sector providers. However, legally these clinics can only provide daycare. They also have difficulties in getting contracts from insurers, as in Dutch culture there is much opposition to for-profit organisations in health care (for-profit hospitals are not allowed by Dutch law). Most private initiatives have been focusing on niche markets, defined by existing waiting lists. In such cases, hospitals have taken counter-measures, effecting in several cases a breakdown of these lists and a subsequent destruction of the niche. However, at this stage it is hard to detect any noticeable impact on the internal management of hospitals or to detect the effects, eg on insurers, suggested by Van de Ven and Rutten actually materialising.

Finance

Until 1983 hospital finance was open-ended- hospitals were reimbursed, largely on a per diem basis. Since 1983, hospitals have had prospective, annual, global budgets negotiated with local insurers, public and private, and approved by the Central Agency

for Health Care Tariffs. Budgets cover both public and private patients and they cover most costs with the exception of fees for specialists.

The current situation is that there are budget parameters that determine the amount of money available for a hospital. The insurers negotiate on the production level of services, to be offered for this money. By dividing the budget through the agreed production level 'prices' for categories of activities are determined. In fact these are not prices but units of account. They are used for administrative purposes only to help the insurers to pay the hospitals on a regular basis for their services and to negotiate additional funding if production is exceeding the agreed levels.

In the current budget allocation system a fixed and a variable part is defined. The fixed part is defined as costs that cannot be influenced, like the capital investments in the existing buildings. Budget negotiations are on the variable part of the budget, that will be enlarged in the coming years up to 60% of the overall budget. In 1996 costs of interest on loans and renewal of buildings are to be transferred from the fixed to the variable part. Such changes are made to create larger incentives for hospital managers to improve efficiency. Until last year, managers did not bother about interest rates on loans, as the expenditures were paid for anyway. In the new situation the government sets parameters for interest and renewal expenditures, so managers have to become proactive to contain expenditures in this area.

However, the current system is planned as a transitional one. As said before, the government is working on a system of product definitions for hospital services. Parallel to this, research is being done to design a set of prices for hospital services with a direct relationship to actual costs. At the end of this century the government wants to switch to a system in which itself sets a macro budget for hospital expenditures and maximum prices for defined hospital services. Under such conditions real negotiation processes between hospitals and insurers on volume as well as costs are to be expected.

A recent development promises progress. Specialist fee-for-service income has never been part of the hospital budget. After several efforts, the government last year found a way to introduce a macro budget for the fee-for-service income. This budget defines, from 1996 on, the amount of money Dutch specialists can generate on a fee-for-service basis. Under this macro-budget specialists, insurers and hospital directors last year negotiated local and regional budgets and production arrangements for 1996 and one or two following years. These fee-for-service budgets are integrated in the hospital budgets, giving hospital managers a new power basis to control medical specialist activities. The new situation implies that for the first time specialists have explicitly committed themselves to financial and volume limitations to their work. At the same time they have understood that it is in their interest to participate actively in hospital management to prevent the development of a situation in which administrative and nursing managers exclusively control these limitations. In this way a new incentive has developed for medical specialists to share in the hospital management process by taking managerial positions.

As these developments indicate, the aim of recent policy in the Netherlands has been to move away from a government regulated environment for hospital services towards a

more market-orientated framework. However, within the apparently highly regulated environment, effective control was often weak. However, Saltman and de Roo (1989) suggest:

> *The Ministry of Welfare, Health and Cultural Affairs confronts what can be viewed as semisovereign provider institutions, each owned by a legally independent foundation, each segmented by religious and political as well as level of service considerations, each fiercely independent, and each obligated under law to fulfil a publicly delegated function. Each Dutch hospital and the specialist partnerships within it has a carefully defined and defended zone of professional and territorial independence. Similarly, each hospital has its own particular arrangement with the ministry and seeks to advance its position by leveraging that arrangement to its advantage. The Dutch government, while officially determining the size of the health system's revenue stream, finds itself unable to direct the use of these funds in what it believes to be the most efficient manner. Thus, the ministry seeks to rein in local autonomy in order to improve the national economy and the create a uniform administrative framework within which to achieve more efficient service delivery. Yet the Dutch hospital and its physician partnerships continue to retain the upper hand. Protected by their continued control over the central elements of clinical power, sanctified by historical and cultural tradition, supported more or less willingly by their equally powerful peers, and secure in their influence over the local population, Dutch hospitals continue to view the national government's efforts to define policy objectives as encroachments on their ancient rights, and continue to support these initiatives with little more than lip service* (p 790).

In principle, the new arrangements will strengthen the hand of the insurer/payers, but it remains unclear how they employ the necessary knowledge as well as bargaining power to achieve this. The bargaining power of insurers is not that large, even now there are only 20 large insurers left after large-scale mergers. Many hospital have de facto regional monopolies that give them a strong position. Their position is strengthened as the demand for services exceeds the supply. Insurers cannot afford themselves to create waiting lists deliberately. In fact, insurers compete by offering escape from waiting lists. This clearly contributes to a strong negotiating position of the hospitals.

At the same time in most cases there is rather open communication between hospitals and insurers. Under market conditions Dutch culture promotes collaboration and co-makership more than for competition and domination. Insurers also are not eager to get involved in the hospital managerial process, as they fear the administrative costs of such an approach.

The main policy at this moment is to give insurers real entrepreneurial risk in their operations. Private insurers always have had such risks, so the government concentrates on the sickness funds. The funds get a share of the total amount of premium money that is annually collected in a 'central fund'. The money is divided by use of simple parameters: age, sex, geographic area and the number of insured with a working inability. This way of dividing the money does not correspond completely to

the actual expenditures of the sickness funds. But the government has turned down proposals to refine the parameters.

Until last year the funds escaped from problems by a mutual compensation system. Surpluses of one fund were transferred in a voluntary way to other funds. Now the government has ruled that the level of compensation has to be decreased annually and has to be zero in 1998. As this concerns the income-dependent premium, the implication is that exploitation deficits in the next years have to be translated in raising the additional flat fee. As mentioned above, until now the sickness funds informally have agreed to use the same flat fee. In the next years the sickness funds with above-average exploitation costs have to become more efficient purchasers. This inevitably will put the negotiations with hospitals under higher pressure.

Accountability

Dutch hospitals (academic hospitals excepted) are independent institutions, established by social group initiative (churches, labour unions etc) and owned by foundations (charities). The board members are appointed by co-option. In some cases social organizations have a right of appointment. Legally the hospitals workers have the right to appoint one board member.

This situation must be understood in terms of the basic corporatistic structure of the Dutch society. The initiative on social arrangements is basically in non-governmental hands. Financing of the arrangements is in terms of premiums. The government is of course involved and has controlling powers, but is not the centre of overall control. In fact, policy making power in health care (and in other social areas) is spread over professional groups, employer groups, labour unions and the government.

Hospitals agree with insurers on budgets. These arrangements are to be approved by a quasi-governmental organisation (COTG, Centraal Orgaan Tarieven Gezondheidszorg). The government has certain legal rights to give general instructions for COTG-policies. Hospitals get their budgetary money by billing the insurers for production activities. So, every time a patient is discharged, a bill is sent to the insurer for the in-patient days. The insurers themselves have to control the appropriateness of the billing. The private insurers are controlled in this respect by accountants who have to approve the financial annual report (like elsewhere in the business area). The sickness funds are controlled by the 'Ziekenfondsraad', a quasi-governmental organisation that functions as accountant for the health insurers. Hospitals are not accountable to the government or to local populations. They are obliged to give information to governmental organizations on their activities for statistical purposes only.

Internal Organisation

About 60% of the medical specialists works on a fee-for-service basis in independent hospitals. The other 40% work on salary either in academic hospitals or on salary in the independent hospitals. Mainly psychiatrists, rehabilitation specialists, laboratory specialists and paediatricians work on salary in the non-academic hospitals.

Forty years ago, specialists had practice at home and used hospitals as facilities for nursing and operation services. In the 1960s hospitals changed from 'open' to 'closed' in that they only admitted patients from specialists with an admittance contract to the hospital. These contracts did not allow specialists to practice in more than one hospital and transferred the outpatient activities to the hospital building in a special outpatient department.

In this way a close interdependency developed between hospitals and a group of contracted specialists. Traditionally, specialists defined this relation as one with an organisation that offered facilities to them. During many years this was more or less an adequate definition. In 1982 the open end financing of hospitals was replaced by a budgetary system. This created a few problems. The hospitals were not able any more to follow unrestrictedly the expansion of the specialist work. This created tensions between specialists and hospital managers, between managerial and professional value systems. Doctors stressed clinical freedom and managers claimed the right to set financial, procedural and material limits to this freedom.

The admittance contract describes in global phrases rights and obligations of specialists and the hospital. Specialists are required to become members of the medical staff, the assembly of specialists practising in the hospital. The staff has to approve admittance of new specialists and specialties, appointment of new hospital directors and major changes in the hospital structure and operating procedures. The staff board is the linkage to the hospital directors. The board also has the right to take disciplinary action in case of malpractice. In this situation there are two structural problems: the staff board has no formal power over the staff members and there is no clear and formally fixed demarcation between the power and authority areas of the medical staff and the managers. In practice, there is an extensive grey area in which claims of managers and doctors on decision making rights overlap.

The situation is an enduring source of conflict that only can be handled if there is a collaborative culture in the hospital. The tensions between the medical and managerial sector, as generated by the introduction of the budgetary system and the subsequent discussion on limits to clinical freedom for a long time as prevented the emergency of such a collaborative culture.

Today the following lines towards the establishment of a new equilibrium can be observed. First, a substantial amount of hospitals switch to a divisional structure. Divisions are led by two or three directors: a medical specialist (as patient care director in the case of two managers, or medical manager in case of three managers), a facility manager and (optional) a director of nursing services. n the most ideal form the specialist in appointed by the divisional medical staff, recruited from the staff members themselves and combines the directorship with part-time patient care. In practice divisional staff members often are not willing to do the job, so an outsider is recruited.

In this way hospitals try to bridge on the operational level the conflict of administrative and patient care interests. This solution strongly depends on the capacity of directors to develop a practical way to integrate the administrative and patient care value systems. In practice results are limited but promising. The main problem is the relationship between the medical staff and the medical/patient care director. It is

difficult for staff members to recognise the managerial role of their colleagues. And professional power in conflict situations generally overtakes administrative authority. For this reason most conflicts are not ended by use of managerial power/authority but by formal or informal negotiations. Dutch hospitals are more like networks than hierarchies, conflict resolution is more a matter of negotiation than of using formal managerial power.

Second, hospitals involve representatives of the medical staff in strategic management. Here great advances have been made in recent years. Medical specialists have committed themselves to participation in budgetary committees, investment committees and so on. Medical staff boards are developing medical policy plans and get experience in negotiating the integration of such plans into the overall strategic planning of the hospital.

Both processes imply a development towards the establishment and maintenance of a new equilibrium between administrative and patient care values, both on strategic and operational levels. Changes is slow and the change rate differs from hospital to hospital. And of course there are setbacks.

Of particular importance, if insurers are to impose pressure on providers is the question of quality. The CBO (National Organisation for Quality Assurance in Hospitals) was established in 1979 has led to a number of initiatives bearing on quality.

The CBO, which is independent and is supported financially by hospitals, has organised several consensus conferences and has taken the lead in developing standards and guidelines for use in health services. It also publishes an international newsletter on quality assurance and seeks to disseminate information about good practice. The CBO has taken a particular interest in medical audit and has stimulated the introduction of audit and peer review in both hospitals and primary care. The approach to audit in Holland is essentially voluntary but operates within a legal framework which places an obligation on health professionals to organise quality assurance activities.

In 1990 a conference of representatives of insurers, providers and patients came to an agreement on the role of the three parties. The agreements relate to the responsibility of the three parties and the government, the development of internal quality systems, the development and application of criteria, and the means (finances, legislation, information) necessary to establish this quality care policy. They are as follows:

- Primary responsibility for quality of care lies with providers
- Criteria for care have to be developed, preferably by providers: if possible in consultation with patients and insurers, who have their own responsibilities
- Internal quality systems have to be developed in all health care institutions; they must be accessible for external review
- External review is directed at internal quality systems; outcome of care may be reviewed as well
- Publication of data must be agreed to for quality assessment and quality assurance

- Providers must position themselves for external review, including publishing a yearly report
- Insurers are responsible for reviewing the efficiency and organisation of care
- Patient/consumer organisations are jointly responsible for reviewing the culture and the organisation of care
- Criteria for assessing quality of care must be included in contracts between provider and insurer; they must be developed in conjunction with patient/consumer organisations
- Patients complaints and assessment of patient/consumer opinions must be included in quality assessments.

Every hospital has a quality programme, so no one has gained an enduring competitive advantage with it. The net result of the whole quality discussion is a higher level of quality awareness, a substantial higher level of formalisation and elaboration of organisational rules and procedures, as well as a substantial higher expenditure level in this area for overhead and consultancy firms. At this moment the interest in quality issues seems to be receding. In the hospital-insurer contracts no interesting features on quality can be found yet.

Pay

Wages for non-medical hospital employees are decided by central bargaining between the representatives of hospitals and labour unions. This process is subject to government directives on the maximum annual growth of labour costs per employee, which leave some scope for bargaining about pay rates, hours of work, and fringe benefits.

As far as hospital doctors are concerned, they are paid on a fee for service basis. The fee for service system for paying hospital consultants creates an incentive for consultants to treat more patients and thereby increase their incomes. To counteract this, a new system of remuneration has been introduced in stages since 1979. This system involves a sliding scale of fees in which the payment per patient falls as the number of patients treated exceeds specified limits. The fee schedule is based on a norm or target income for each specialty determined in national negotiations between the medical profession and the financers of health services, and approved by the government. According to Schut (:

> *The market power of the medical profession not only stems from self-regulation but, as described earlier, is also strongly enhanced by government regulation. One of the most important sources of market power of physicians is the legal obligation for sickness funds to contract with all physicians in their region on nationally determined uniform conditions* (p 1450).

In practice, the system of 'regressive fees' as it is know in the Netherlands has not succeeded in controlling doctors' incomes because it regulates price but not quantity. The available evidence indicates that doctors compensate for the reduction in fees by increasing their workload and are thus able to achieve the target income they set for themselves rather than that established by the government. This had led the government to take a tougher stance in its bargaining over incomes.

Process

Unlike some of the other countries covered in this report, the process of reform unti l recently has been slow and extended. All the major groups- employers, insurers and physicians see themselves as adversely affected. Accordingly, there is a large gap between the intentions announced in 1988 and what has actually materialised. The pace of change in general has been slow, but particularly so in relation to the hospital sector.

This has led Saltman and de Roo to conclude that:

> *Unless and until those preconditions shift, however, it would appear likely that most meaningful hospital policy in The Netherlands will continue to be made at the local institutional level on an ad hoc and opportunistic basis. As one well-placed Dutch official summarised his frustration with the present policy stalemate, "If we don't do something, we'll have an earthquake, because we have a non-system. It's the most ingeniously devised complex of rules and regulations, but they do not fit together. We have 18,000 managers in health care organizations with no boss."* (p 793).

However, from the description given above, the process of reform is now gathering pace; as a result the external and the internal environment within which hospital work looks set to change considerably.

BRAZIL

BRAZIL

Overview

Brazil is a country of continental dimensions, with its 8.5 millions km^2 and approximately 150 million inhabitants. Until the middle of the 20th century, the population was concentrated in rural areas. The incipient industrialisation process was virtually restricted to Sao Paulo and Rio de Janeiro. This process was encouraged after World War II because the government offered subventions in order to upgrade Brazilian industry. During the second half of the century there has been a steady migration of people from rural to urban areas, in search of jobs and other advantages, leading to the rapid growth of large cities areas which can be observed today. This has led to inadequate living conditions due to the lack of infrastructure to accommodate this constant flow of newcomers.

Among other causes, this model of economic development has led, during the last decades, to demographic and epidemiological change. At the same time, the process of economic and social development has been very different between regions. Thus, dissimilarity has been one of the more important aspects of the economic and social situation in Brazil. There are some areas with very poor conditions of health care and some others where people have access to facilities equivalent to those existing in the more developed countries. North, northeast and middle-west are the 'poor' areas, while south and southeast are the 'rich' regions. There is one expression that is often used by public health professionals to describe the demographic and epidemiological transition, in this country full of contrasts: Brazil is a young country with gray hair (VERAS, 1993).

This introduction gives the background that shaped the development of the Brazilian social security system from the 1930s. During this period the health care system was concentrated in urban areas. People had access to some private doctors and to public and private facilities. The majority of the available services was of secondary private not-for-profit and public institutions.

The industrialisation process was accompanied by a social security system organised by professions. These organizations were called IAPs (Pensions and Retirement Institutes). They were responsible for providing medical care to all workers enrolled in each of them, as well as pensions. The public sector was still a supplier, even though not a very important one, and this was also the period when the private for-profit sector stated to grow, offering its facilities and services to the IAPs that did not own enough infrastructure to provide all the services that were needed.

Originally this model was supposed to be funded by the Federal Government, the workers and the employers, but the federal government's contribution was not an important source of funds. There was inequity in this model because of the differences among the different sectors: to start with, finance came mainly from the workers' salaries and people working in banks (IAPB) had different wages from those from the industries (IAPI) or those from commerce (IAPC), for example. Some of these institutions were able to build and maintain some facilities of their own. Once more, there were important regional differences, not solved by this structure.

The Brazilian model has another important characteristic: until the 1988 Constitution, public health policy - especially the control of infectious diseases - was divorced from medical care. There were two Federal Ministries directly in charge of the so called health policy: one was responsible for the Social Security and Medical/Hospital care and the other one was responsible for the control of health promotion programmes and activities. Therefore Brazil, like many other countries in Latin America, had a clear separation between 'preventive' (stereotyped as public health) and 'curative' (stereotyped as medical) systems. They even had separate sources of funds and budgets.

In 1964 there was a military 'coup d'etat', leading to a dictatorship, during which the workers and society as a whole did not have the freedom to express their needs and demands. In the 1960s the IAPs were centralised in one institute - the National Retirement and Pensions Institute (INPS) - responsible for the policymaking and the financing of medical care for all the people with regular jobs and their dependents. The 'regular jobs' were important because once more this system relied on employers and employees and on the wages that were officially reported. This National Institute had regional agencies in the states which were strongly linked to the central office. INPS took over the facilities that belonged to each IAP.

This process followed the industrialisation and the urbanisation growth and was consequently accompanied by an increase in the demand for health services. This increase was steady and practically obliged the state to take the easy course of contracting with private (for-profit and not-for-profit) sector hospitals and clinics, as well as for drugs and equipment; in order to be able to supply what was asked for. In Brazil today, the government is the greatest purchaser of private services. Undoubtedly, it has had a major role in the growth of the private sector, even the for-profit one, but without any corresponding requirement for efficiency or accountability.

This model for developing the health sector has limits: its funding cannot increase at the same rate as the demand for services. The consequence of this imbalance was a growing dissatisfaction with the services actually provided. The providers complained, the users complained, those who did not have access to the services complained, and, finally, this model was not sustainable. During the 1970s, the crisis became more acute and led to unrest within the professional associations (mainly the medical ones) and also in the whole of organised society. This was also the moment when Brazil was going back into democracy, and the workers and the citizens were once more getting used to freedom and started to ask for more control of Federal Government actions. In 1978, the INPS went through a change process, leading to a new organisational structure called the National Institute of Medical Care of the Social Security (INAMPS). This Institute was divided into several parts: some dealt with pensions, others with information systems, others with social security and some with medical care. Among these, medical care became a priority. This was still a centralised structure with regional (state) agencies. Once more, the facilities that belonged to INPS became part of INAMPS.

During the 1980s, there were some important changes in the direction of decentralisation, trying to reduce the importance of the federal government and

enhancing the role of the states and municipalities. In 1988 the new Constitution was promulgated. Among its provisions were many of the claims voiced by the 1970s social movements. In the health field it defined health as a right of citizenship, consisting of much more than access to health services or medical care. SUS, a national health system that should be the only one for the whole country, was created. Sooner or later, both Ministries were expected to combine bringing prevention and care closer together. This actually started to happen in 1990. Private institutions are free to adhere to SUS or to remain independent. Those who choose not to join SUS are not entitled to receive direct public funding.

It is established by law that SUS will offer, to all Brazilian citizens, three main benefits, among other things:

- Social work: in order to supply handicapped citizens;
- Health system: in order to provide health promotion and health care with equity to all Brazilian citizens;
- Social security: in order to secure the citizens and their dependents when they are unemployed (welfare) or retired.

Table 1 presents the evolution of numbers of hospitals and beds in Brazil between 1946 and 1989. It shows the predominance of the private sector and how its beds practically doubled between 1960 and 1980, without an equivalent increase in the public sector. This is a part of the explanation of Brazilian present health situation, with its peculiarities and complexities.

Current Position

Following this brief historical overview, we move on to the present Brazilian health system:

- The Government is the biggest purchaser of the system, for public health and health care services, both public (state and municipal levels) and private (for-profit and not-for-profit). At the same time, it is the only alternative as a health care supplier for those who cannot afford to pay directly for services or indirectly to HMOs, insurance companies or other providers and who are excluded from the economic process. On the other hand, it is practically the only provider of preventive care and health promotion activities.

- The national private sector is the biggest provider of health care to the population, nationally, with regional variations.

- The international private sector is the predominant supplier of equipment and drugs. It can be noticed from the above that the Brazilian government is directly or indirectly responsible for the payment of these inputs.

In the public system the Ministry, the State and the municipalities are supposed to be integrated within a more or less hierarchical structures for both services and decision-making. The formal hierarchy looks something like this:

- Federal level: Policy formulation and financial resource transfers
- State level: Control and evaluation/technical support to the municipal level
- Municipal level: Management of local services

In addition to this, issues such as control and regulation of expenditure and quality of services provided are being decentralised towards the municipal levels, bringing them nearer to consumers. This is considered to be a step towards accountability. This system is expected to meet the demands of all Brazilian citizens.

For SUS-dependent patients, the high technology end of the health care system lies mostly in public and university hospitals. The latter have an important role in the development of research, science and technology in health in Brazil. The alternative to these facilities, as far as complex care is concerned, is located in private hospitals who are independent from SUS.

The national private sector can be divided between those who decide to join SUS and the so-called supplementary system, responsible for the coverage of those who are able to pay for what they consider to be more efficient and better quality services. The supplementary system is said to deliver services to 20 to 30 per cent of the population, once more depending on the region. There are states where there are more independent private facilities and others where the government is a very important provider and practically the only purchaser. Even though SUS is meant to provide universal coverage, wealthy people don't usually use its services, excepting for the high technology system and/or facilities that are not available in their regions.

The 1988 Constitution sets out the 'Unified Health System - SUS'. In practice, it unified only the Ministry of Health with the 'Health Department' of the Social Security Ministry leaving out of this unification approximately 35 million people (upper and middle classes plus workers into the formal market) who have got private insurance schemes, mentioned in the previous texts as AMS. As a consequence, those more able to fight for changes and to control the system are not users of the public system. However, private insurance holders still use public funds for high cost procedures such as dialysis and chemotherapy as they are often not covered by the private schemes. SUS has very weak control over these schemes. After 1988 many for-profit private hospitals broke contracts with SUS, because of increased control.

Citizenship is not yet well established in Brazil. Therefore, it is easy to understand that very few initiatives reflecting concern with patients and communities have been started. Initiatives from the public sector, when they exist, deal typically with patients' rights; in the private sector, satisfaction surveys are sometimes carried out, but probably in order to keep (or not to lose) their patients and/or payers. Equally, a fully equitable distribution of resources is hard to achieve. There are more political and administrative pressures for resources from areas with more hospitals and health professionals, the richest areas of the country, thereby increasing inequalities. There is a significant diversion of financial resources from richer to poorer areas but insufficient to reduce inequalities.

In general, even though equity is a formal constitutional concern (at least for SUS), efficiency is not. In fact, even private hospitals do not seem worried with improving their work processes. Rather the contrary: instead of reducing costs they look for new payers to charge or reduce their concerns with quality or decrease services. The lack of professionalisation does not help prevent this. Therefore, accountability is not a strong feature of this health system.

[TABLE 1 ABOUT HERE]

The Hospital System

The Brazilian official health care system is divided into three main segments: public, formed by services belonging to federal, state and municipal governments; private, contracted and paid for by the public sector (SUS); and private liberal, either paid for by 'out of pocket' funds or contracted by personal insurances and health plans bought by employers. There are some intermediate services that have, at the same time, beds contracted with SUS and others with the so-called private liberal ie self employed sector.

Currently, the SUS hospital system consists of a small network of public hospitals, belonging directly to government, and a greater proportion of private beds, from for-profit and not-for-profit that have contracts with the public sector, are paid for with federal funds (Health Ministry) and controlled by the states and municipalities. SUS is currently responsible for approximately 75 per cent of inpatient care produced in Brazil. The combination of federal funding and state and municipal control is relatively new, because ten years ago control was at federal level and the funds, also federal, came from the MPAS (the former Social Security Ministry).

The private hospital network has expanded in two major stages in the last 20 years. In 1969, there were about 75,000 private beds and there are currently more than 610,000 - a growth of around 700 per cent. One part of this was clearly financed by the federal government through FAS (Social Development Fund) during the 1970s. According to Medici (1992), about 80 per cent of FAS resources have been used for expanding and modernising private sector capacity. More recently a second stage has been taking place with entrepreneurs getting interested in building new hospitals in close relationship with private payers who do not seem to be satisfied with services they are receiving from those already existing. An important issue is that this second stage of growth in the private sector has been taking place subsequent to the 1988 Constitution, where the right to health was established and SUS was defined as a publicly run system.

The growth in public hospitals has been heavily dependent lately on external funds (IBRD, for instance). Because of the decentralisation it was possible to observe an interesting phenomenon: federal hospitals (originally built by the Health Ministry or by the IAPs or INPS) have been handed over to the state and even to the municipal level (the exception was in Rio de Janeiro). Some state facilities have been turned over to municipalities, especially to those where the budget was sufficient to make the hospital work. Most of them were general hospitals, but some were psychiatric units or oriented towards hansenology, tuberculosis and others. In the last decade, those

specialised hospitals are slowly being transformed into general facilities, while maintaining some wards for the original disease. Ideally, all SUS related hospitals (federal, state, municipal and private) or beds (when only a part of the beds are used by SUS) are expected to have their everyday expenses paid for by SUS funds. Investments should come from other sources. Lately, some municipalities are identifying, among their roles in policy making, the possibility of directing a bigger percentage of their budgets to the health sector, enabling part of this investment to actually occur.

The purely private finance and provision of health care is called AMS (supplementary medical care). Its presence has become strong since the 1980s. It is said to offer coverage to between 20 and 30 per cent of the population. Table 2 shows a synthesis of the AMS, in terms of organisational models, per capita expenses, coverage, etc. It is difficult to get current data from these organisations, so these are official data presented in 1992 at an international seminar of private health systems.

[TABLE 2 ABOUT HERE]

Medical Groups are networks of organizations that either own the facilities they use (ambulatory facilities, hospitals and laboratories) or contract private services. These represent the first 'supplementary' model and is still the most widely used, even though it has been losing its market share to some of the others or to combinations of them. Co-operatives and the so-called self-managed have been the fastest growing models. The private co-operative has been accepted as a model in Latin America, in the present Mercosul environment. It can be found in several countries since 1992. Health insurance companies follow the general insurance model, but in Brazil they are usually more successful with banks or with companies that previously worked with other kinds of insurance. Managed plans are models similar to the 'self-managed', but managed by a third party organisation especially hired for this task.

Table 3 presents the figures related to kinds of facilities available in Brazil, according to ownership.

[TABLE 3 ABOUT HERE]

These data help to understand the different roles of the private and public sectors; the public is responsible for ambulatory (primary and secondary) care, while the private one is predominant in inpatient hospital care (secondary and tertiary care). Modern practices, such as long term care facilities or home care, are not yet adopted, even though it is generally accepted that they reduce the costs of medical care. In Brazil, this reduction has not yet been proved, among other reasons because actual costs in health are not known. A good guess is that, whatever these costs are, they are too high for this developing country.

The 'health district' is a new policy in Brazil, deriving from some international models. PAHO (Pan American Health Organisation) has been encouraging this concept throughout Latin America, under the name of SILOS (an acronym for Local Health Systems). These districts are defined as a geographic area where all health actions should occur, from health education and promotion to epidemiological and sanitary

surveillance and/or procedures using sophisticated technology. The district is an area where the public and private sectors are supposed to work in a co-ordinated manner, under the ruling of a single director. This director, nowadays, is chosen in different ways. The only common characteristic among all these district directors, a legal prerequisite, is that they cannot be owners or managers of private health organizations. Until recently most health managers were physicians in the public and private sectors. Very slowly these positions are being occupied by nurses, pharmacists, dentists and even managers or economists, among other professionals. Salaries earned by health managers are not competitive with those paid in other sectors, creating a situation where public or private administrators are not often interested in the health field as a career choice.

Municipalities are also coming to play an important part in health decision making. There are three managerial options for municipalities as far as SUS is concerned: 'incipient', 'partial' and 'semi-total'. These titles and their definitions relate to how municipalities use SUS funds. Each state has a previously established amount of resources to be transferred by the federal government, divided between hospital care and other procedures - all ambulatory care, specialised therapeutic activities - such as dialysis, chemo, radio or haemotherapy - and elaborate diagnostic methods - such as radiology, CT scans and haemodynamics. As of the end of 1995, NMRs were not regularly defined by SUS as a procedure to be offered. Nevertheless, it was done, changed under other procedures and paid for.

All of the municipalities within a state are expected to have their needs covered by these resources transferred to the state. In the 'incipient' and 'semi-total' conditions, the state is supposed to collaborate with the municipalities in the evaluation and control of the services rendered by the private and public (state and municipal) sectors. The state is still the big purchaser, being responsible for payment of services rendered. In the 'semi-total' condition, the municipality is expected to define, on its own, how private and municipal services are going to be purchased in order to satisfy their population needs. The resources, in this situation, flow directly from the federal government to the municipal one, even though the total amount for the state is still the same as 'previously established'.

The trend towards decentralisation seems clear. Even though a very small number of municipalities nationwide are under the 'semi-total' condition, it is a policy expected to enable the municipal health manager to define the population needs and try to satisfy them.

Municipal and regional managers are not always adequately prepared for their jobs because they often change when mayors or state governors change, eg, after elections, making long range planning difficult. Therefore, health needs are not always adequately identified. In Brazil it is common to say that the supply is dictated by the providers because those nominally in charge are unable to define and enforce what they consider to be regional and municipal priorities.

There has been an increase in attempts to give communities control over the management of health resources Since 1986 communities have been playing an important role, at least according to some policy-makers. As of 1990, in order to

receive regular transfers of funds from the federal government, it is expected from the state and municipal levels that they have implemented boards where, besides governmental, professional and workers representatives, there are also members chosen by the community, either from users of the services or from community councils, or whatever other criteria. These boards are established at all levels of the system: there is a national one, most states have their own and many municipalities work closely with theirs.

Another level of health policy discussion, at the regional, state and federal levels, is held by technical/political commissions. At the federal level they bring together the Ministry, representatives of the State Secretaries and of the Municipal Secretaries. It is called a tripartite commission. At the state level, there are state representatives as well as municipal ones, and they are called bipartite commissions. Finally, at the regional level, there are representatives of the states at the different regions and of the municipalities from the region. These are called Regional Committees.

Utilisation standards showed that around 1 in every 10 inhabitants of a municipality used a hospital bed per year. With closer control and with some 'gate keeper' procedures, these figures are starting to decrease. Nowadays, the average figure used for facility planning is near 9%.

In the 1980s, health planners were talking about 2 ambulatory consultations per inhabitant per year. By the end of that decade, SS alone was offering 1.62 (ranging between 2.03 in the South-East and 1.02 in the North-East) consultation/capita/year. Utilisation reviews at AMS (supplementary care) showed, in the same period, between 2.8 and 4.0 visits to physicians' offices/capita/year and their data related to inpatient care showed circa 7% internments of their insured population.

Obtaining these data is not easy in Brazil. Analysing the differences between them is not common and trying to modify the trends they show is even less frequent. Purchasers' interests are opposed to those of the providers, making all relationships difficult. These difficulties are bigger at the national level and should decrease with decentralisation, when patients stop being fictional characters and start having real names and problems. This means the empowerment of regional and local managers who are slowly beginning to look for new decision making criteria and accountable utilisation indexes, regarding basic services as well as complex procedures.

Quality initiatives, ranging from quality assurance to TQM and re-engineering, are being experimented with, especially because Brazilians are usually unhappy with the health care they get. Foreign models are very often discussed and there are some policymakers that feel tempted to adopt them without thinking about regional and national differences.

As in so many areas, bed supply differs among the regions. Table 4 shows regional variation in some chosen indicators. Once more, these data reflect severe inequities in access to health care.

[TABLE 4 ABOUT HERE]

Financing of the System

Brazil spends approximately 4.5 per cent of its GDP on health (about $18 billion in 1994). The 1988 Constitution defined a Social Security Budget. In 1994 the budget has three sources of revenue: treasury money (87.08 per cent), including earmarked profit taxation and funds coming from a special taxation programme on income (not income tax) and lotteries. 4.62 per cent came from revenue generated by the Ministries' own resources (licences delivered, fines and other services). Finally, there are some federal benefit plans (8.3 per cent).

These data reflect public expenditure at the federal level. There are additional resources coming from the state and municipal levels. They account for about US $14 billion. Private expenditures are not accounted, but they are estimated to reach US $7 billion.

Part of the federal resources are spent in Ministerial activities, from wages to health education activities and even in the hospitals that are still federally managed. Another part of these resources is used to pay for SUS services rendered by private hospitals. The last part of these funds is transferred to states and municipalities, in order to pay for the different services they deliver.

The money transfers are performed using a system very much modelled on the DRGs system. The Brazilian system does not have the statistical analysis upon which the north American model is based. It was designed using a group of physicians who studied around 300 different diagnostic groups, upon which a fee was paid prospectively. This system received the acronym AIH which stands for inpatient care. Ambulatory procedures are under a similar design called SIA. Both are, then, prospective, and their values in Brazil are often distorted by several factors. Among these are lobbies of specialists who try to have the procedures they usually perform being better rewarded than 'any others', overuse of those that get better paid in general in a particular period (nowadays, for instance, dialysis is adequately rewarded, as opposed to NMRs, but this varies widely); actual or fictitious overuse of any procedures, because of the high rates of inflation occurring in Brazil until 1994, without changes in the fees paid for the services rendered. Further difficulties include:

- extreme price difference between procedures without relation to complexity
- lack of control and evaluation mechanisms
- frequent frauds
- price list does not consider case severity
- incentives to do more of better paid procedures

There are some incentive rates for particular hospitals or procedures. For instance, hospitals that work with teaching and research may get an additional 25 to 75 per cent in order to encourage these activities. To be part of the cancer network (or cardiovascular, or orthopaedic or other critical areas) also may mean extra money, as well as being eligible to some UNICEF activities.

On the other hand, many Brazilian doctors are paid according to the volume of work they carry out, so they are interested in reporting high levels of activity.. In a country

like Brazil, control becomes very difficult, because there is not a tradition of public service in health. Therefore, quite often, physicians who bill the government in the morning are those responsible for the control in the afternoon. Municipalisation and the overall decentralisation process have been considered important in terms of allowing better control, because activities and reports on them are nearer to the common citizen. For instance, since the patient is more likely to know the physician's family, the physician might feel uneasy to overbill for what he did (or to bill for what he did not). With centralised control, nobody knows anybody and therefore anything can be done.

Supplementary medical care is financed either by 'out of pocket' money or by an employer/employee mix. This model also leads to inequity, because bigger employers can afford more expensive (?better) services; the same happens for better salaried population groups.

A large number of initiatives have been taken bearing on quality of care. There is a quality committee at the Ministry of Health trying to encourage the states to develop some projects:

a) outcome indicators - epidemiological data, population based, in order to identify critical areas for intersectoral activities.

b) outcome indicators for health services - institutional data, in order to identify results of medical/hospital care, in terms of hospital mortality and eventually avoidable deaths.

c) hospital accreditation - preliminary effort to develop a handbook, presently being tested in four states, by three different groups of professionals, on a voluntary basis. The original instrument was prepared by PAHO and is being adapted to Brazilian reality.

d) dissemination of quality management processes - many private organizations are providing services in quality management for health, even though they often lack experience in this field. The general idea is to find out whether there are successful experience and to disseminate them among health organizations.

e) clinical guidelines - in order to increase the efficiency of procedures, there is an effort to develop clinical outcomes for critical specialties.

f) consumer defence - to establish channels for consumer protection

There are also many isolated initiatives, in the public and private sectors with five years or less:

a) ISO certification;

b) Consulting services, concentrating in managerial processes;

c) Many hospitals are developing their own quality programmes, extremely different from one another;

d) Development of new technologies in order to increase efficiency.

Staffing and Labour Relations

In Brazil there are presently 2,500,000 workers in the health sector. This number represents 4 per cent of the economically active population. Physicians account for 70 per cent of the professionals with university education. As well as other features, the distribution of professionals in the country is very varied. The north-eastern region, that contains 29 per cent of the population, has only 19 per cent of the doctors. However, in the south-east, where 43 per cent of the population lives, 55 per cent of these professionals are established.

There are around 210,000 MDs in the country. It is estimated that in the 21st Century Brazil is going to have approximately 10 doctors/10.000 persons. This indicator is smaller than the figures observed in Argentina (27, 9/10.000), or Mexico (23, 8/10.000) or USA (25,9/10.000). There was a change in trend: until the 1970s most physicians were liberal professionals, while nowadays only 24.65 per cent do not have a regular job.

The increase in numbers of doctors started to occur in the years 1960 and 1970 because during this period a lot of private new medical schools were opened. this followed the economic development of this period, during the dictatorship (called the Brazilian economic miracle). This growth in the number of schools was not accompanied by a monitoring of the quality of the graduation processes. Since 1980 there were no new schools. Brazil has 80 medical schools who graduate about 8,000 new doctors per year. Of course, the concentration of schools varies greatly, because of the regional dissimilarity consequent to the socio-economic situation in Brazil. Once more, the south-east has the majority of schools, concentrated in Rio de Janeiro, Sao Paulo and Minas Gerais. The market place has encouraged, and in recent decades, graduate studies to become more specialised. This strategy makes it practically mandatory to acquire a specialist title, at least by taking medical residency programmes during two to four years after medical school. Some people say that this is also to supply adequate training to compensate for the poor quality of teaching in medical schools.

Nurses are also very important in Brazil. This professional group involves college graduate personnel as well as workers with technical, auxiliary and elementary backgrounds. The professional association to which they belonged had, in 1992, 264,386 persons enrolled. In this group 57,000 (21.6 per cent) had a university degree. This leaves nearly 80 per cent of nursing staff without this professional training and there is an estimate that about 60 per cent of this workforce does not have an adequate education level to perform the tasks they are supposed to.

Nevertheless, the health sector is still one that offers around 1.5 million jobs for professionals. Currently, due to the Brazilian economic situation, it is mostly in the service sector, including health , that new jobs are being created. These jobs are

equally distributed between the private and the public sectors. It is also quite common to find the same professional working in both sectors, public and private, which leads to an awkward situation. Very often, people talk about the poor quality of the public sector and the public servants. They forget that the public workers become private workers for part of their times. Since the private sector is in general more profitable than the public one, it may be said that is intentional. Among the jobs offered by the public sector, 35 per cent are at the federal level, 45 per cent at the state level and 20 per cent at different municipalities. The municipalities are presently increasing their share because of the municipalisation process.

Table 5 shows the professionals' situation in Brazil in this decade. Eventually, with better conditions of work and payment, it might be possible to improve the quality of the health care rendered in Brazil both in the public and private sectors. Ethics and accountability are still to be enforced, even though the technical aspects are acceptable.

There is not a clear policy in terms of continuing education and/or graduate studies. Therefore, there are problems in the upgrading of professional practices, for whatever sector and professional level. Not even in the public sector, where sounder policies should be expected, are these efforts perceived as regular. There have been several initiatives at different levels in the public sector, but they did not have effective follow-up.

In the 1970s and 1980s many graduate courses were started (at master and doctoral levels) in the health field, trying to enhance Brazilian research capability. Strangely enough, these are among the most widely used activities for upgrading the professionals. There are graduate scholarships, ideally designed as research incentives, that are used by professional workers as a salary complement.

Perspectives

Brazil is presently looking for alternatives in the funding of the health system. Some public university/high complexity/high technology services are offering a part of their beds to the supplementary system, which pays more realistic prices for certain procedures. Some specialists act like professional lobbyists, in order to increase the price for the procedures they perform. The results of their efforts is seen at the public and private sector rates. In Brazil it is a common saying that dialysis is nowadays what haemotherapy was in the 80s. For the next few years, purchasers bet on oncology treatment as the runner up.

Other managerial experiments are being developed, in order to increase the supply of health services. For example, the government loans public facilities to private organizations, and even pays a basic salary to the personnel. This private organisation is responsible for everyday operation, including investments, maintenance and eventual supplementary wages. Another alternative, still under observation, is contracting private organizations as third party managers and providers for health care in region. All alternatives are being studied. They are supposed to meet legal criteria and present a good equity/efficiency ratio.

It is difficult to guess where the Brazilian health sector is heading. There are some ideas and proposals turning more to the market place and others towards a more public orientation. What is commonly acknowledged is the fact that the public sector, or whether the management of its own facilities, or control of activities done by public and private institutions, or the control of expenditures and others have been highly ineffective. Decentralisation has been one step in the direction of improvement, even though not with results as adequate as desired. Regulations are at the same time very strict but not obeyed, perhaps because they are not feasible. For instance, a process of hospital accreditation is being tested in Brazil.

This country presents some interesting issues that should be dealt with simultaneously. There are hospitals working without being properly licensed. In some regions, licenses mean that the local health authority is relieved that someone decides to offer hospital care and not that the facilities answer legal requirements. In two states there is an examination regarding professional licenses for physicians. Those who do not pass the examinations can still have their practices, in the states that have the examinations as well as in the others. Some specialties have special courses, regulations and examinations. Many physicians practise the specialty without any of those. Quite often, these requirements are more strict for jobs as public servants while there are more applicants to work in private practices. As for equity issues, there are policy makers for whom to provide something (regardless of the quality) is better than to provide nothing because of certain standards; there are others for whom below certain standards, nothing is acceptable.

Health as a citizenship issue has been in the political agenda for many years, at least in speeches. The 1988 Brazilian Constitution establishes that every citizen is entitled to several rights such as health, education, justice and others. The Constitution also presents health as something much broader than medical or hospital care: the definition includes jobs, salaries, leisure, information, housing etc. In Brazil, the average citizen is still accustomed to look for whatever visible care he/she can get. Health services have been used as instruments of social control for years, both as medical policy and as a substitute for more equitable socio-economic policies. Exchanging this scenario for another one, where citizens can create healthier surroundings for their living conditions and discuss what their actual health needs are is a great challenge for the 21st century. This implies an expanded notion of what citizenship means.

Health conditions in Brazil are an outcome of the process that has been described. There are high mortality rates due to infectious diseases, to urban violence and to age-related conditions. Brazilian professionals have acquired the technology to deliver ambulatory care and reduce inpatient days; home care is also being discussed in some university settings. At the same time, neither SUS nor most of the AMS accept (pay for) these 'new' procedures, leading to an irrational use of already scarce resources.

This leaves Brazil with two extreme possibilities for the future. One is to increase the apartheid between Brazilians covered only by SUS and those who have the AMS or out of pocket alternatives. The other one is a situation where SUS becomes what it was designed to be: a universal system, with adequate answers to health needs, oriented by epidemiological criteria and not by what providers want to offer or by what

is better paid for, where professionals, managers and politicians are accountable towards a population of citizens.

[TABLE 5 ABOUT HERE]

Table 1 - Distribution of hospitals and number of beds according to ownership - public or private - 1946 to 1989 - Brazil

Ownership	Public		Private		Total	
Year	Hospitals	Beds	Hospitals	Beds	Hospitals	Beds
1946	392	-	1289	-	1681	-
1950		74976	-	87539	-	162515
1956	447	-	2958	-	2505	-
1960	-	97526	-	159845	-	257371
1967	469	-	2766	-	3235	-
1971	-	124601	-	242921	1595	367522
1975	1060	-	4110	-	5170	-
1980	-	122733	-	386435	-	509168
1989	1889	119530	5238	403365	7127	522895

Source: Data extracted from YIDA (1993), POSSAS (1983), SOUZA CAMPOS (1994), BUSS (1993) and IBGE (1989)

Table 2 - Supplementary Medical Care, Brazil, 1992

Variables	Medical Groups (HMOs)	Self Managed*	Health Insurance	Medical Co-operatives	Managed Plans	Total
Population (millions)	15.0	5.1	2.5	8.0	1.4	32.0
% Coverage	47	16	8	25	4	100.0
Yearly income (US$ billion)	2	1.5	0.85	1.4	0.27	6.0
Per Capita Expenses/ Month (US$)	12	28** 18***	28	14.5	16	

* self-managed is a denomination for plans who are directly managed by employers or by employees associations. This can be related to public or to private organizations.

** US $28 per capita/month is the average of how much the public organizations spend under this model.

*** US $18 per capita/month is the average of how much the private organizations spend under this model.

Source: Brazilian Medical Groups Association, 1992.

Table 3 - Health Care Facilities, Brazil, 1989

Facilities	Nos.	%
With inpatient services	7,127	100.0
Public	1,889	26.5
Private	5,238	73.5
Without inpatient services	27,704	100.0
Public	20,817	75.1
Private	6,887	24.9
Total	34,831	100.0
Public	22,706	65.2
Private	12,125	38.4

Source: IBGE - Anuário Estatistíco do Brazil, 1991.

Table 4 - Bed Distribution in Different Regions - Brazil, 1990

Regions	Population estimate (million)	Beds	Beds/1000 HAB	Hospitalization	Hospital/1000 HAB
North	9.37	19,865	2.12	1,025,361	10.94
Northwest	40.90	113,378	2.77	4,562,399	11.16
Southeast	60.08	260,612	4.34	7,994,745	13.31
South	21.49	91,474	4.26	3,186,478	14.83
Centre-West	8.89	37,566	4.23	1,715,925	19.30
Brazil	140.73	522,895	3.72	18,484,908	13.14

Source: IBGE, 1989 and Demographic Census, 1980 & 1991.

Table 5 - Physicians, Dentists, Nurses and Nursing Staff. Brazil and Big Regions, 1992

	Physicians		Dentists		Nurses		Nursing Staff	
Regions	No.	%	No.	%	No.	%	No.	%
North	6,070	6.23	2,850	2.92	2,477	2.54	9,933	10.18
North east	33,782	7.95	16,049	3.78	11,794	2.78	37,931	8.93
South east	128,598	20.52	75,144	11.99	31,251	4.99	162,942	26.00
South	27,800	15.43	17,031	9.45	8,351	4.63	36,408	20.21
Centre-West	12,716	13.50	7,535	8.01	3,174	3.37	17,172	18.24
Brazil	208,966	14.68	118,609	8.33	57,047	4.01	264,386	18.58

Source: Dal Poz and Varella, 1993

Coefficients are per 10,000 inhabitants.

CZECH REPUBLIC

CZECH REPUBLIC

The Republic's social and political revolution has been reflected in the health care sector. Before 1989 the Republic was part of a centrally managed state in which users had little choice. They were assigned to primary physicians who acted as gatekeepers and controlled all referrals to specialists. It was run by a three tier hierarchy of regional district and community levels. Although broad goals such as equity of access, ease of access and a comprehensive range of services were met, the system was seen, particularly in the light of revolution, as reflecting some of the worst features of state control such as unresponsiveness to the user. In 1992 therefore a major reform of the health care system was introduced.

The main features of that reform were:

- privatisation: transfer of ownership of health care institutions and practices to the municipal level and to private individuals,
- the introduction of a fee-for-service remuneration system,
- decentralisation: organisational and administrative changes such as the elimination of National Committees and decentralisation of the District and Regional Health Centres,
- changes in pharmaceuticals policy,
- changes in the higher education for medical personnel.

In the new system, the Ministry of Health has control only of national programmes, certain public health services, and teaching hospitals. All other health care services and facilities are now under District Authorities who are responsible to the Ministry of Interior. The Ministry of Finance has the responsibility of financing with a share of the premium income of the General Health Insurance Office and the branch insurance companies. The branch insurance companies are the responsibility of the Ministry of Social Affairs and the General Health Insurance Office (GHIO) is directly answerable to Parliament.

In terms of cost control, the reforms have been a disaster. The share of health expenditure in GDP rose from 5 per cent in 1989 to 8 per cent in 1994. According to the Ministry of Health the main factors responsible for the cost explosion are:

- the fee-for-service reimbursement system,
- the high number of doctors,
- the high number of hospitals,
- the material condition of health facilities.

Recently, a large series of measures were announced to deal with what were seen as the central weaknesses of the system: It is doubtful whether they will all be realised, or if they are, not quickly.

The recent reforms and planned reforms so far include:

- The introduction of a low co-payment for certain services in primary care with a ceiling on aggregate co-payments for services, effected on 1 May 1995; co-

payments for Hospitalisation and ambulatory care for listed services with a fixed annual ceiling are planned.

- The insurers' duty to contract with any doctor is abolished: from 1 Jan 1995 insurers can be selective about the doctors they contract with.

- In July 1994, a positive list was introduced to lower the number of prescribed drugs. There are plans to regulate prescriptions in hospitals further by reducing the number of drugs for prescription via a revised positive list that encourages domestic and generic products. Also planned is a limited budget for prescriptions in ambulatory care based on the number of patients and their age structure. Doctors who prescribe over a certain limit will be 'punished'.

- A further simplification of the point system is planned: in July 1994, 35 different services were aggregated.

- The introduction of decreasing per diem rates for hospitals (55 crowns) to encourage shorter stays and a reallocation of funds from hospitals to nursing homes were effected in the fourth quarter of 1994.

- There are plans to limit access to specialists without referral.

- A regulation of the number of hospitals and specialist facilities is planned between 1995-2005.

- Global budgets for hospital care - lump sums - are being considered. Also, the present system could be replaced by contracted capitation in 1995-96.

- The introduction of DRGs is planned for 1996-98.

Over and above the major structural change in provision which the Czechs are trying to bring about, their health sector has the further interesting characteristic of having, by international standards, too many doctors. Thirty thousand doctors and 130,000 hospital beds serve a population of 10.4 million. Out of the 30,000 ,too many are specialists and too few GPs: a majority are under 40 and the training of new doctors has not been cut back.

As things stand, hospitals, like other providers are paid on a fee for service basis. However, fees are set in terms of points. Each of some 4,500 different services have a points value which is in effect a health service currency and like any other currency may be devalued. Since 1992, its value has been reduced by about 40 per cent. In addition, different insurers may off different rates of exchange and so be more or less attractive to providers.

However, in the light of the rapid explosion in demand, a number of insurers appear to have gone bust with the result that districts have had to bail them out. In practice, local authorities have become the main financiers- certainly the financiers of last resort. As a result, hospital budgets in practice are the subject of local bargaining.

The pay of doctors working in the public sector is tightly controlled and indeed has been set at about the level of an industrial worker. Not surprisingly, the first post revolution strike took place in the health sector. Such control has the obvious effect of encouraging private practice, particularly when that is combined with fee for service and with a long standing tradition of paying doctors in kind even within a nominally free system.

The financial position of hospitals is insecure under the present arrangements ie they cannot rely on insurers companies paying up, and many are considerably in debt as a result. The intention of privatising facilities has been thwarted and largely remain on hold. No large hospital has been privatised though some smaller facilities have been: a number have been transferred to local authority ownership but others have been transferred for operational purposes but still remain owned by the state, as do the main teaching hospitals.

With these exceptions, hospitals come under the control of local authorities. The vast majority of hospitals in the Czech Republic are state-owned, privatisation has been slow and with little success. Of the 136 hospitals on offer for privatisation, only four have actually been privatised. None of the large hospitals has been privatised. 39 of the 51 Spa resorts are private. Despite the slow progress, government seems to be determined to continue a policy of privatisation. 32 hospitals were transferred to municipalities free of charge, and the Fund for National Assets (FNM) has reportedly sold 50 large polyclinics. On 27 September 1995, the cabinet turned down a proposal for taking 60 hospitals out of the privatisation scheme that had been submitted by the Minister for Privatisation Jiri Skalicky. Cabinet asked the Ministry of Health to investigate whether the hospitals could not be privatised.

According to Massaro *et al.*, this localised structure requires:

> *A well-planned capital investment policy ... to manage resource allocation and limit redundant capacity. The development of such a policy will require an articulation of national health priorities, including a public health agenda relating to facilities planning, regionalisation, and distribution of high-technology investments outside Prague and the few other population centers* (p 1874).

It can be seen from this brief sketch of the position in the Czech Republic that a rapid process of structural change can generate enormous problems for policymakers to tackle. No surprisingly, there are some calls within the central government for greater central control but aversion to the old system is so strong that in general private is still seen as inherently better than public, and with that, a 'free market' pricing structure ie fee for service charged to third parties.

The long list of proposed measures represent an attempt to make the new arrangements work. Among the ideas, the most radical appears to be a reform of insurance arrangements which the Prime Minister has recently announced.

Under this system, each citizen would pay into a health account similar to a savings account as well as into a solidarity health insurance as at present. The citizen is then to allocate the funds in his/her account according to individual needs for routine services in the health sector. It could be part of the sickness funds' activities to keep the individual accounts. The distinction between the individual accounts and the solidarity insurance would have to be controlled by the state. If some of the funds in the individual accounts are not used up, they could be either transferred to the next quarter or paid out to the patient as a bonus. In case of an overdraft, either the patient has to bear the costs or the costs are transferred to the solidarity insurance. The solidarity insurance would only pay for emergencies.

The first step towards this system might be taken in 1996/97. It would be possible to cover completely the running costs of GPs. The individual accounts would not be mandatory. People above a certain income group could pay directly or via a commercial insurance system.

This proposal does not seem likely to be accepted but part of its underlying philosophy, that some responsibility should be put on the individual to pay through the introduction of co-payments for some services - at present there are none except for some drugs - is likely to be implemented. As noted in other countries considered here, health care reform begets further reform. In the case of the Czech Republic that prognosis seems particularly apposite.

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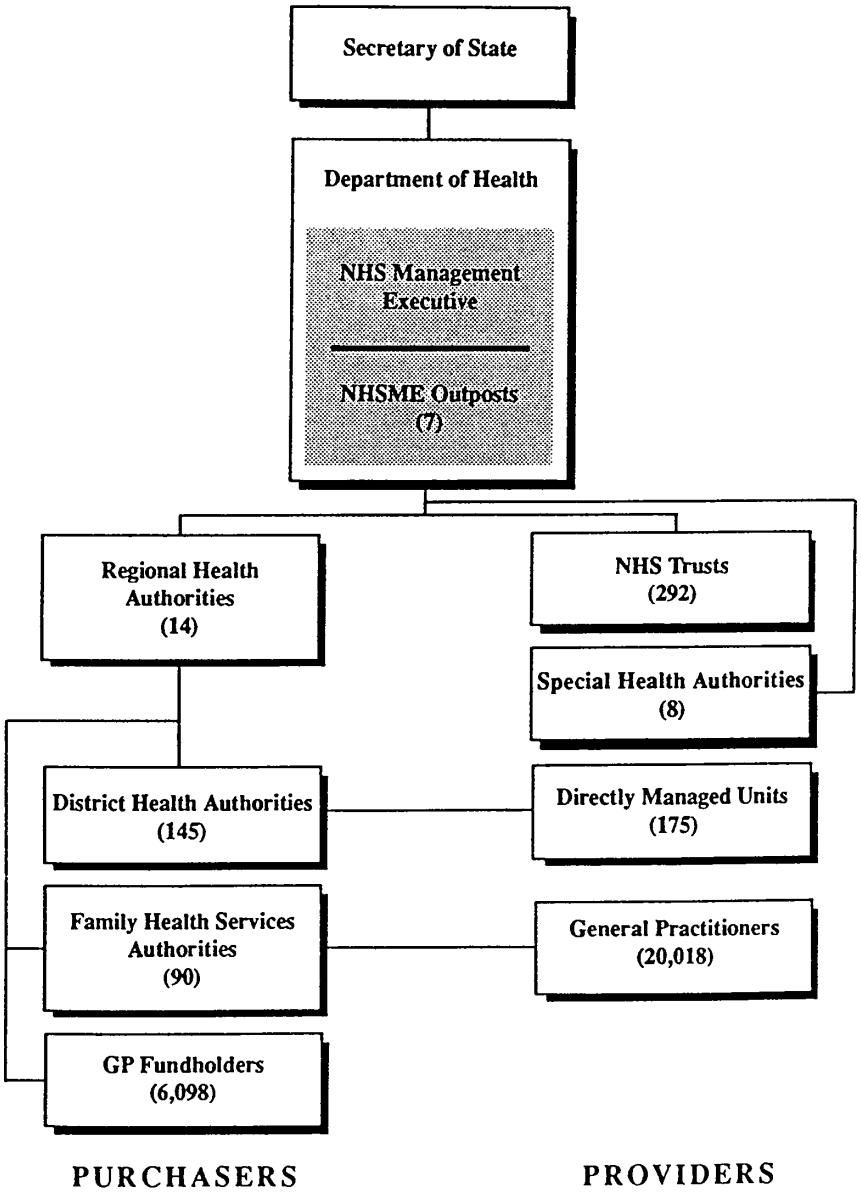
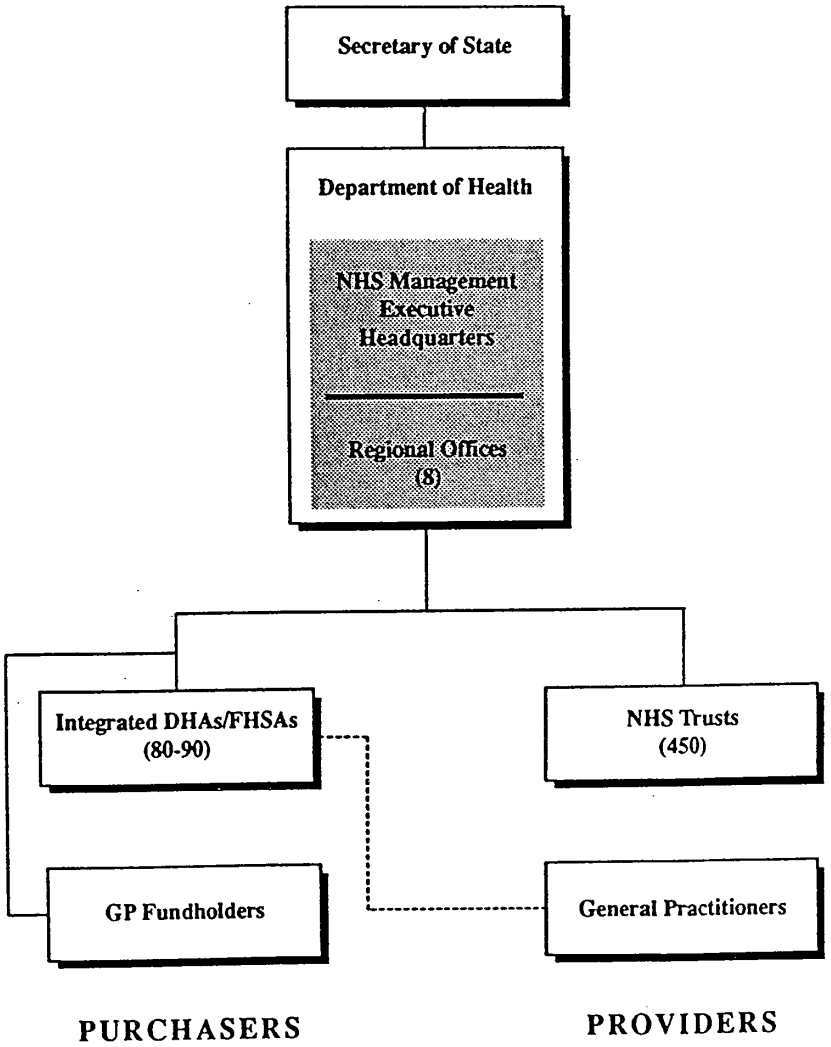
UK - DIAGRAM 1

EXISTING STRUCTURE OF THE NHS



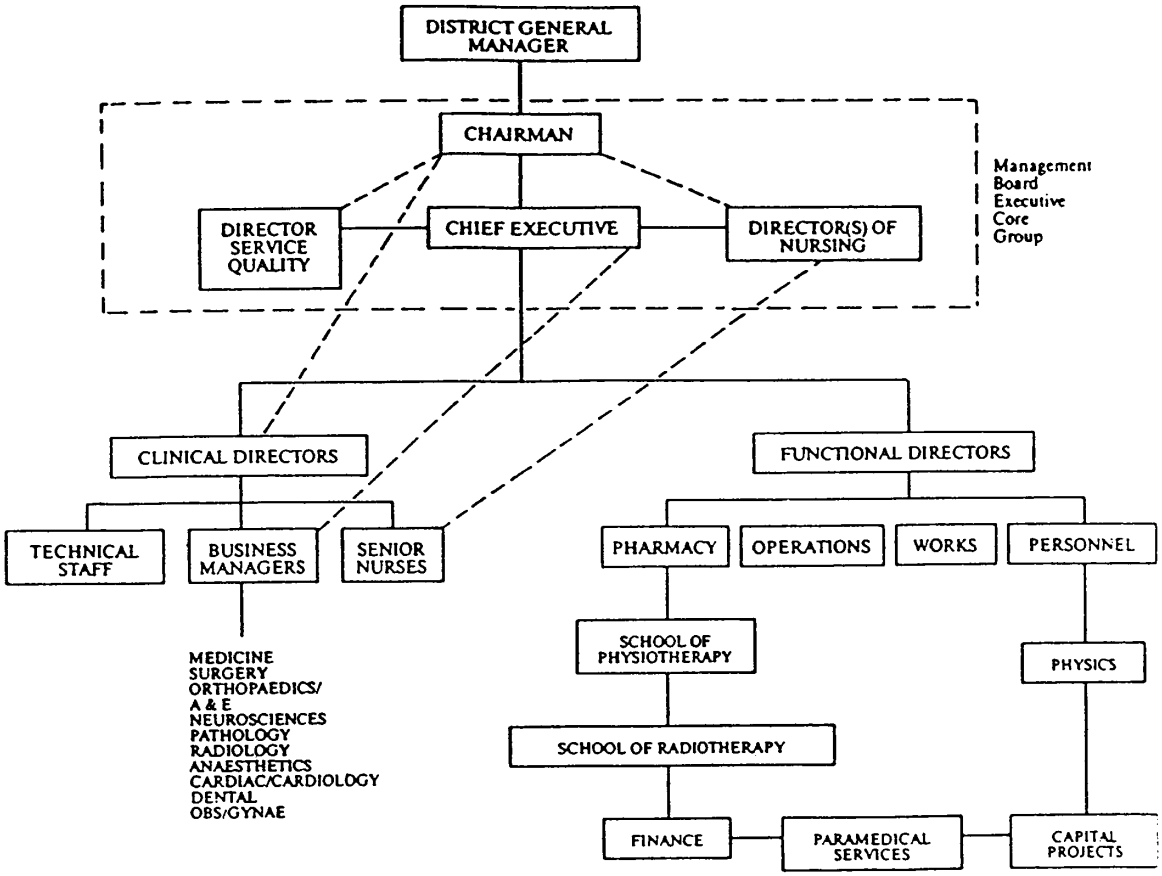
UK - DIAGRAM 2

NEW STRUCTURE OF THE NHS



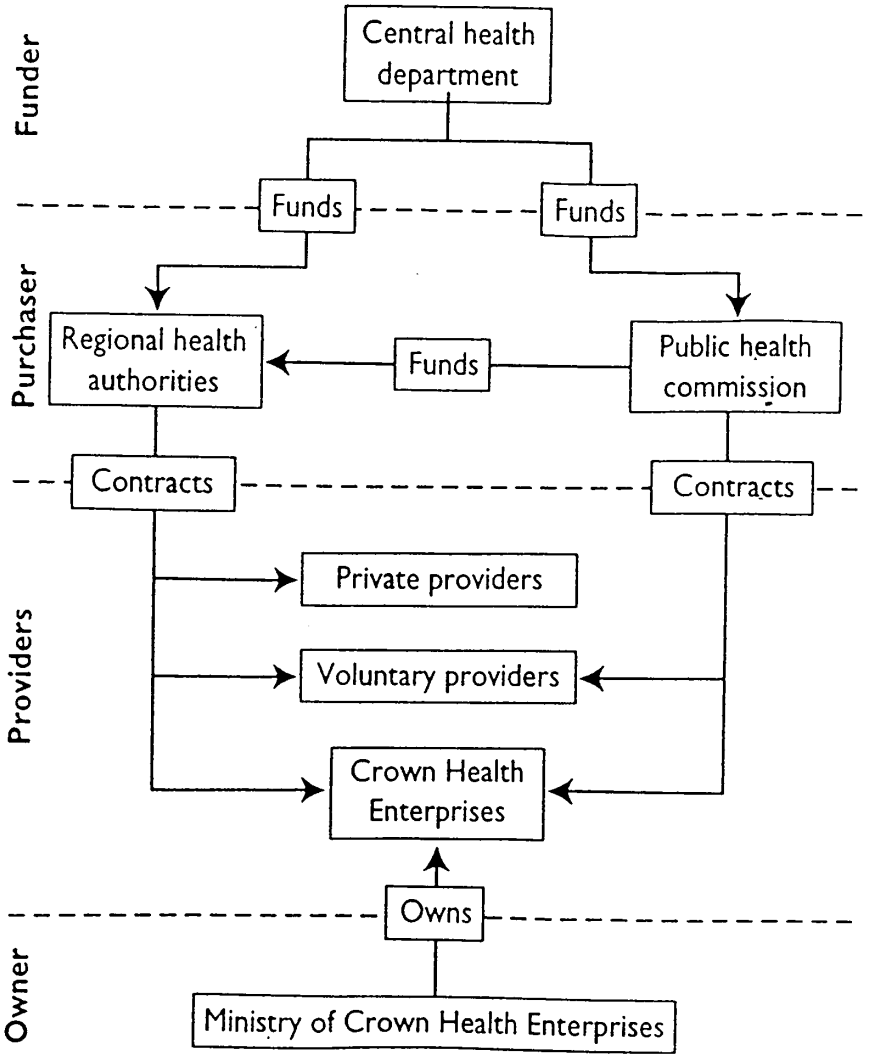
UK - DIAGRAM 3

HOSPITAL ORGANISATION



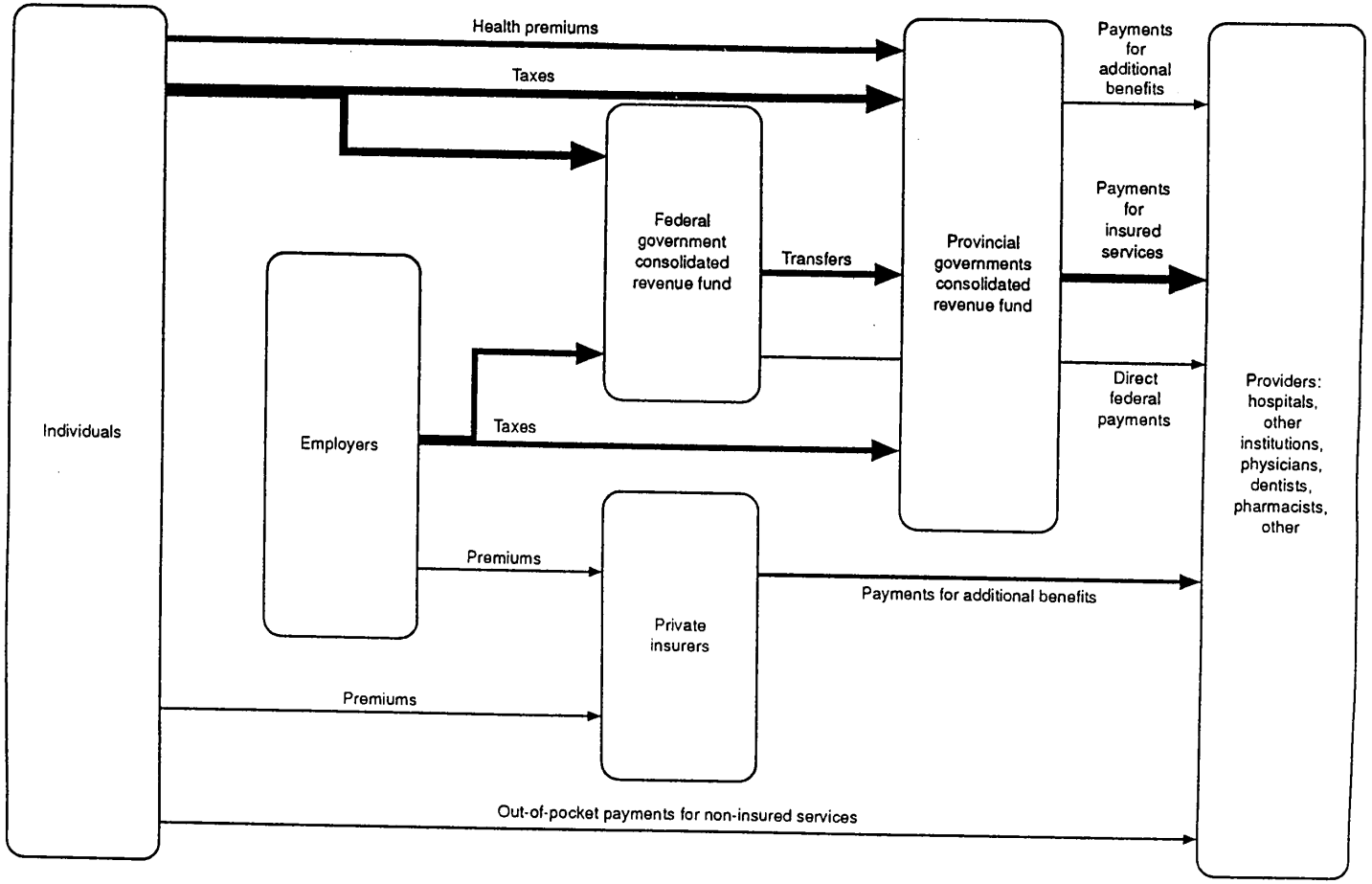
NEW ZEALAND - DIAGRAM 1

HEALTH SERVICE STRUCTURE AND ARRANGEMENTS IN NEW ZEALAND IN 1994



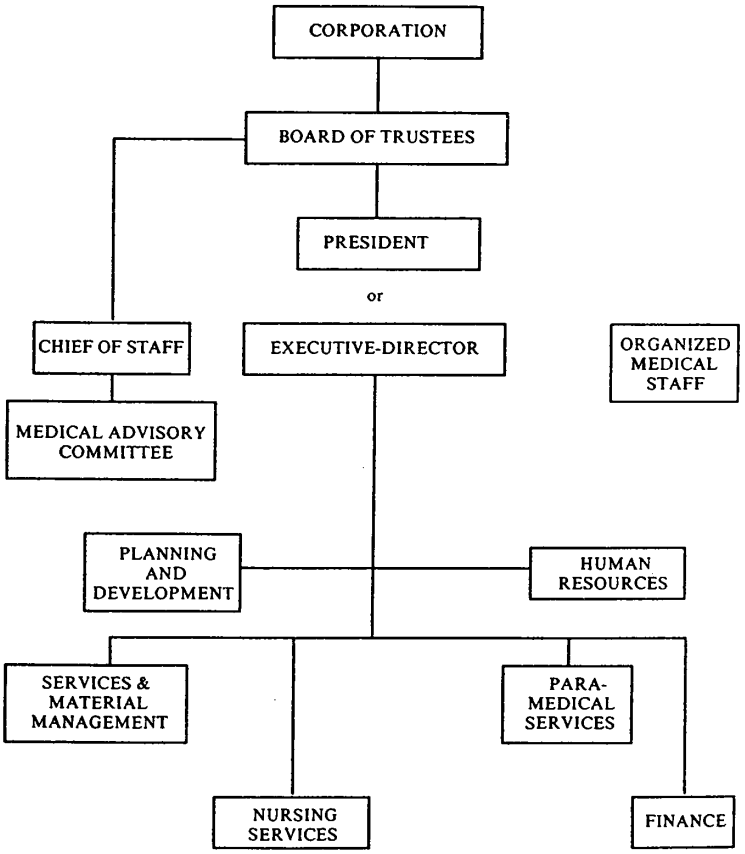
CANADA - DIAGRAM 2

FUNDING STRUCTURE OF CANADA'S HEALTH SYSTEM



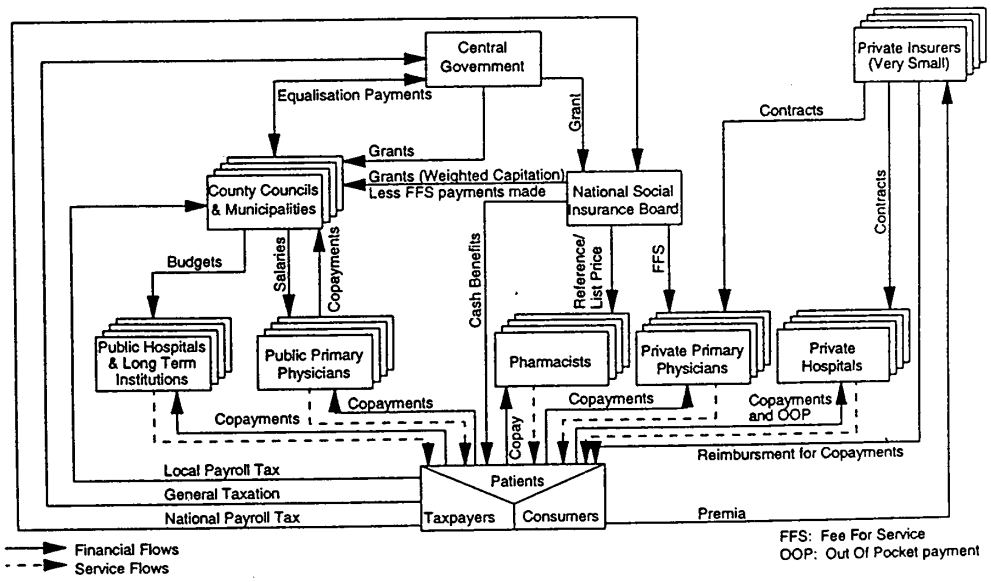
CANADA - DIAGRAM 1

THE ORGANISATION OF A TYPICAL ACUTE TREATMENT HOSPITAL



SWEDEN - DIAGRAM 1

KEY PARTICIPANTS IN THE HEALTH CARE SYSTEM IN SWEDEN



NETHERLANDS - DIAGRAM 1

KEY PARTICIPANTS IN THE NETHERLANDS HEALTH CARE SYSTEM, 1991