HEALTH CARE
AND
GENERAL PRACTICE
ACROSS EUROPE

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This book contains an overview of general practice and primary care medicine in Europe. It includes a clear description of the rapidly changing situation in Eastern Europe, in so far as this situation is clear at all. The book is meant for those who require a systematic general briefing on the similarities and differences in the position of general practitioners and primary care physicians in countries near and far. It has been produced at the request of the Dutch College of General Practitioners on the occasion of the WONCA Congress 1993, held in The Hague.

Each chapter starts with a short general description of the country concerned and then goes on to describe several aspects of the health care system in general, before focusing on the position of the general practitioner. The book is a reference book or 'gazetteer' rather than a book that can be read like a novel from the first chapter to the last. It contains information compiled from a variety of sources, which has been checked and double-checked by a network of national co-ordinators involved in a large-scale empirical study on GP Task Profiles. With the exception of the countries of the 'Commonwealth of Independent States', Serbia and some of the very small countries, all European countries are covered. Even Israel, which is part of the European Region of the WHO has been included. In all 32 countries have been described.

From the descriptions it is clear that the position of the general practitioner is stronger in some countries than in others; parallel access to specialists means competition, while a fixed list of patients encourages GPs to take personal responsibility for the medical problems of registered patients. In some countries professional training is firmly established as a central activity of medical schools and universities, fed by fully staffed departments of general practice. In other countries the long march into the universities has still to begin. There is a vicious circle of low social esteem, poor education, poor earnings and heavy competition with the more glamorous, hospital based, part of medicine. Countries that have broken this vicious circle, like the United Kingdom, Denmark and The Netherlands, started by creating a College of general practitioners as a strong professional organisation which elbowed its way into the universities and finally achieved postgraduate training courses, which became obligatory for the profession of general practitioner. Aided by protective measures, like limiting direct access to specialist care and providing the GP with the role of gate-keeper or co-ordinator, general practice forms the solid base of these countries' health care system. And there the GP is highly esteemed, reasonably well paid and there is no lack of new recruits for the job. Without a well-organised professional organisation which can lobby and convince the general public and politicians of the benefits of a GP-based health care system, the vicious circle cannot be broken. It is good news for the future of general practice that Eastern Europe seems so positive about it. This forms an impulse for continuous reflection on the place and task of the GP. In any profile of the new European GP the element of personal care seems to be crucial. It has got a very high priority in health care reforms in the former East Bloc countries. And in some Scandinavian countries, like Norway, Finland and possibly Sweden, a more functional approach to primary care delivery is being replaced by a 'personal doctor system', where a patients are listed with the doctor of their choice.

Not only Eastern Europe is changing, most countries in Western Europe are in a state of permanent health care reform. For all these changes, knowledge about what is going on next door, or even some blocks away, is crucial in order to avoid painful and costly mistakes. Like Bismarck said: it is wise to learn from one's experiences; it is even wiser to learn from the experience of others.

The country

Albania, one of the smaller Balkan countries, is surrounded by Montenegro, Serbia (Kosovo), Macedonia, Greece and the Adriatic and the Ionian Sea. Until 1990, the Albanian government of those days maintained a policy of self-sufficiency and isolationism in an attempt to conserve a pure kind of marxism-leninism. This has degraded Albania to the status of a third world country, the poorest in Europe. With the fall of communism elsewhere in Europe, Albania was forced to start a policy of cautious liberalisation. International relations were established and religion was no longer forbidden. The elections of March 1991 were won by the socialists (ex-communists), but this government did not last. The general crisis caused a well-publicised boat migration to the Italian coast, where most refugees were, however, sent back to Albania. Many more emigrants made it to Western Europe and Greece, where a few hundreds of thousands of mainly young male Albanians are now thought to reside legally or illegally, sending back part of their income to Albania. Historically, half of the ethnic Albanians were living in other countries already, especially in Kosovo. The economic situation will remain difficult for a long time, due to high unemployment, a ruined industry and lack of western skills. Other sectors, such as agriculture, show brighter prospects. For a country with the economic standards of Albania, the health status of the population is higher than one would expect. (133,34,88)

Statistical key figures

Population		Natality, mortality and health	
population in mln.	3.3	births per 1000	24.0
per sq. km.	113	fertility rate/ child.p.woman	2.8
% ann.growth 80-91	1.9	% contracept.preval. (a)	na
% urban	35	deaths per 1000	5.8
% under 15	32.6	% infant mortality (under 1)	4.5
% over 65	5.3	life expectancy (men)	69
		life expectancy (women)	74
Development and economy			
compuls.education (yrs)	10		
TV sets per 1000 pop.	83		
GDP per head in \$	790		

(a) contraception was illegal until 1991

Organisation of health care

In Albania all health agencies form part of a single management system, which is headed and administered by the Ministry of Health and Environment. The second level of the administrative pyramid is the health authorities in the 36 districts. The third level is the directors of the individual health care institutions, of which there are several types:

- village health posts ('ambulancas'), generally staffed by a nurse/midwife;
- rural health centres for a group of villages, usually staffed by some general practitioners and nurses, a dentist, and sometimes also medical specialists or others;
- various types of urban health centres, some with emphasis on prevention and/or primary care, others are actually specialist diagnostic and treatment centres;
- rural and urban pharmacies;
- district hospitals of different sizes;
- one university hospital in Tirana.

In towns, there is no clear distinction between primary and secondary care. Health services are in a poor state. Typical are the high quantity of personnel and service points available and the low quality. There has been little maintenance and investment in the last decades, and the social upheaval of 1990-1992 caused a lot of damage to the infrastructure. After graduation, knowledge and skills of health care personnel are not being maintained. Vaccination programmes are gradually failing, stocks in pharmacies and hospitals are

critically low, and poor hygiene and defective facilities have created ideal conditions for epidemics. The new government, in power since March 1992, has formulated a policy for health care restoration and reform in March 1993. This policy document has been debated during an international donor conference in Tirana in April 1993. Some key elements of the new policy are: improvement of the infrastructure with less quantity and more quality, primary health care as the foundation of all health care, decentralisation and regionalisation, and the introduction of market elements. (151,34)

Health financing and insurance

Nearly all health services belong to the state and health care is paid from the state budget. Services are provided in kind and free of charge to all citizens, except for drugs for ambulatory patients and some other services. Some illegal payment by patients does occur. For 1993 the government budget for health care is approximately \$ 30 million, and a similar amount is expected from foreign donors. Since the end of 1992 it is legally possible to set up private practices, pharmacies, etc., but so far very few practitioners have made use of this opportunity. Further privatisation is a goal of the government. As an interim measure, charges for health care will increase. As a long-term goal, the government wants to introduce a system of health insurance in Albania. (151)

Secondary care

Out-patient secondary care is supplied by specialist polyclinics and out-patient departments of hospitals in towns. In-patient care is provided by districts hospitals. Most smaller, so-called rural or zonal hospitals have been closed. The district hospitals in the capitals of the nine future regions of Albania will be upgraded to regional hospitals with more specialisms and more equipment than other district hospitals. As in other areas of the health care sector, buildings, equipment and knowledge are in bad shape and need upgrading. The number of hospital beds will be further diminished from the present 4 to 3 per 1000 inhabitants. (151,34)

Primary care and general practice

Primary care has been, and still is, taken care of by the health services mentioned above. The emphasis of primary care has always been on prevention, especially antenatal care and immunisations. Family planning was forbidden under the communist regime and health education limited. Preventive services have been deteriorating because of inadequate housing, lack of equipment, low motivation of personnel and disintegrating family structures. The government has the intention to establish a network of real primary health care services, consisting of full preventive and basic curative care. This network of ambulancias and urban and rural health centres will be smaller than in the past, but of higher quality. A number of foreign donor countries are ready to help the Albanians, especially the European Community. This help entails the restoration of buildings and equipment, and a massive retraining programme for GPs, nurses and midwives. It also includes the establishment of a department of Family Medicine within the medical faculty. This department will be put in charge of the organisation and implementation of a postgraduate training in order to educate physicians to become family doctors or general practitioners like those in Western Europe. The first batch of newly trained family physicians is expected to enter practice by 1996. It is also the intention of the Ministry of Health to make a clear distinction between primary care and secondary care. In the future, access to secondary care will be by referral only. Present 'polyclinics' in cities, where mostly specialist care is given, will be attached to hospitals. (151,34,88)

Payment and income of GPs

All doctors are state employed and thus salaried. Salaries are insufficient to support a family because of the rapid increase of the cost of living. Some illegal charging of patients by doctors does occur. So far, no private practices have been opened, although this is now legally possible. More legislation and administrative procedures have to be developed

before private medicine can really take off. In the mean time, plans are being made to charge patients for ambulatory care in state facilities. However, taking into account the very low purchasing power of the Albanian population, space for co-payments is quite limited for the time being.

Training and education of GPs

A large campaign of professional re-education and improvement of scientific information will be needed to reorganise and rebuild medical care in Albania. Inputs from foreign countries and institutes will be required in many fields: rehabilitation of the infrastructure, development of training programmes, the supply of drugs, proliferation of equipment and scientific information and co-operation between institutes in the West and Albanian institutions. Undergraduate training of physicians now lasts 6 years, plus a six month internship. Clinical specialisation takes 3 to 4 years. A two-year specialisation in general practice will be realised in the near future. The curriculum for this specialisation has to be developed in 1993 and 1994, in the frame work of a project sponsored by the European Communities. The curriculum of the medical faculty needs restructuring and updating. Modern teaching materials are lacking, especially basic laboratories and textbooks. The number of students admitted to the medical school should probably be diminished. A regular programme of postgraduate refresher courses does not yet exist.

● AUSTRIA

The country

The federal republic of Austria is situated in Central Europe. It consists of nine fairly independent federal provinces (Bundesländer) each divided into administrative districts (15 Stadt- and 84 LandPolitische Bezirke). The distribution of the population over the country is uneven because of the mountainous landscape. Most people live in the plains. Only Vienna has more than 1.5 million inhabitants, which is almost 20% of the population. The federal president is formal head of state, directly elected for up to two six-year terms. The two-chamber Federal Assembly consists of the National Council (Nationalrat) elected for four years by a form of proportional representation and a Federal Council (Bundesrat) elected by the nine provinces. At the beginning of this century Vienna was the capital of the powerful Austro-Hungarian Monarchy. After World War I, in 1918, this empire collapsed and Austria changed into a relatively small state. Ten years after the Second World War the allied armies of occupation left the country. As a neutral state Austria acted as a mediator between East and West during the years of the Cold War. The country has been very successful in rebuilding the economy after the Second World War. The government put about a quarter of the country's manufacturing sector under state control. After these became loss-making in the mid-1980s the government initiated a privatisation programme. Tourism, both in summer and in winter, has remarkably expanded in the last decades and now is an important contributor to the economy. In 1989 the country applied for EC membership which is expected to be effectuated in 1995. (133,85,89)

Statistical key figures

Population

population in mln.	7.8
per sq. km.	92
% ann.growth 80-91	0.2
% urban	58
% under 15	17.4
% over 65	15.2
% over 75	7.1

Development and economy

human development index	96
compuls. education (yrs)	9
TV sets per 1000 population	475
GDP per head in \$ (ppp)	17,265

Natality, mortality and health

births per 1000	12.0
fertility rate/child.p.woman	1.5
% ann.fert.reduction 1980-91	0.6
% contraceptive preval.	71
deaths per 1000	10.6
% infant mortality (under 1)	0.74
% under 5 mortality (U5M)	0.90
% ann.reduction U5M 1980-91	5.8
% DPT immunised at age 1	95
life expectancy (men)	72.6
life expectancy (women)	79.2

Organisation of health care

The Federal Ministry of Health, Sport and Consumer Protection is the supreme health authority, responsible for central administration, formulating health policy and for drafting laws and general directives and for technical supervision of health services and training. The Federal Ministry does not exercise power over the local health services. The direct executive and financial power over these services is the exclusive responsibility of the provinces. The Governor of each province, assisted by a Health Advisory Council, is responsible for implementing the directives of the federal ministry. A supervising health officer (Landessanitätsdirektor), which is supported by various specialists, exercises executive power over the health services in the provinces. The district health authorities supervise the communes in carrying out federal and provincial measures. Each district authority has a health officer as well as centres for maternal and child health, school health services, general health examinations and other services. The communes are obliged by law to engage a medical officer to assist the local authorities in local health affairs. Communes may collaborate for this purpose. (90,9,91,119)

Health financing and insurance

A comprehensive social insurance system for employees, the Allgemeines Social Versicherungsgesetz (ASVG) was established in 1956. This scheme covers three programs: sickness, work accidents and pensions. In 1967 a scheme was established for public employees, the Beamten-, Kranken und Unfallversicherungs Gesetz (B-KUVG). The latest stage in the process of extending the scheme was the introduction in 1978 of an insurance scheme for agricultural workers and for the self-employed (the selbstständige Erwerbstätige - GSVG). There are also regional sickness insurance funds in each province (Gebietskrankenassen) and several large company funds (Betriebskrankenassen). The sickness funds, which are also responsible for collecting patient contributions, function as autonomous bodies supervised by the Ministry of Social Administration. Enrolment in the health insurance system is automatic for all employees. Voluntary insurance is available for others and is particularly important for additional sickness benefits. A variety of services is included in the health insurance scheme, both for employed person and their dependants. All of an insured person's children up to the age of 18 and students up to the age of 26 are considered dependants, as are under certain circumstances, elderly or infirm relatives living with the insured person. More than 99 percent of the population is covered by the insurance system. Doctors need a contract with the sick funds in order to be reimbursed and may present their bills directly to the appropriate social insurance fund. The number of contracts is negotiated between the doctors' associations and the funds.

Health expenditure	81	82	83	84	85	86	87	88	89	90	91
- abs. per head in ppp\$	780	817	868	908	984	1046	1109	1191	1298	1383	1448
- % of GDP	8.2	8.0	8.0	7.9	8.1	8.3	8.4	8.4	8.4	8.3	8.4
expenditure on pharmacy											
- abs. per head in ppp\$	90	96	102	105	115	118	124	138	147	156	na
- % annual growth		6.4	6.5	3.5	8.8	2.4	5.8	10.7	6.6	6.5	na

In 1990 the total expenditure for health care was 13.2 billion US\$ or 8.4% of GNP. Nearly half of that amount is spent on institutional care and one-thirds on out-patient care. The biggest part of this expenditure is financed via social insurance (56.4%) and taxes (23.8%) while private insurance (6%) and direct payment (13.8%) make up the rest. (40,118, 84,151)

Secondary care

The Federal Ministry responsible for health is responsible for the supervision of hospitals and for general legislation. The enactment of regulations and executive and financial matters are the responsibility of the provincial government. The public and private hospitals as well as independent out-patient health clinics are subject to the hospital legislation, and no hospital may be set up or operated without a licence from the provincial government. A hospital can be awarded public status only if it is a non-profit institution and meets the requirements of the Hospitals Act. It must be accessible to everyone, have the same rate of charges for equivalent services and may set aside no more than one-fifth of its beds for patients who pay higher rates. Besides being administered by the federal government or the provinces, a public hospital may be administered and managed by a commune, a public body, a foundation or public fund, or by any other body that has legal status. Within the regions three levels of hospital care are provided in Austria: general hospitals, special hospitals and central hospitals. Beside the acute care hospitals there are special institutions for long-term care, rehabilitation and other forms of special care. The table below shows the numbers of hospital beds and the acute hospital admission rate (reference year 1990). (91,151)

In-patient care beds per 1000 population	10.2
Acute hospital beds per 1000 population	6.0
Admissions per 100 population in acute hospitals	20.5

Primary care

The whole population has access to primary health care, which is mainly provided by independent, privately practising general practitioners and specialists. Each individual is free to choose a physician who has a contract with his health insurance fund. Urgent treatment is provided by the out-patient department of hospitals (Ambulanzen). In addition there are many independent out-patient centres, which are run by the social insurance agencies and which provide medical specialist care (selbstständige Ambulatorien). The centres also have short-term beds for diagnosis and/or treatment. In large towns special emergency medical services are used. There are also domiciliary nursing services and services for the elderly, chronically ill and disabled. When needed, patients are referred by general practitioners and specialists to the independent centres or to the out-patient department of hospitals, except in cases of emergency, when direct access is possible. The decisions on admission to and discharge from hospital are taken by the hospital physicians responsible. The central government is trying to reduce the number of acute care hospital beds and at the same time encourage home care. There are co-payments for admitted patients per hospital day, up to the 28th day of stay in hospital. (40,9,91,151)

General practice

In 1993 Austria had 9113 general practitioners of whom 4300 were independent contractors (Vertragärzte). Health insurance funds are free to offer a contract to a general practitioner and when selecting general practitioners may require postgraduate qualifications. In this way the funds can control the number and quality of GPs and the distribution over the country. General practitioners must be available from 9.00 a.m. until 7.00 p.m. on weekdays. There is no twenty-four-hour obligation for GPs because there is a special deputising service for the weekends. Ordinary out-of-hour services are arranged by local agreements among general practitioners, in the large cities these services are provided by a central facility. Per April 1993 the number of doctors and the average population per doctor were as follows

	abs.	inhab.per doctor
GPs (Praktische Ärzte)	9113	855
Specialists (Fachärzte)	9733	801
Dentists (Zahnärzte)	3076	2535
Postgraduate Trainees (Ärzte in Ausbildung)	6643	1174
Foreign doctors	752	10372
Total doctors	29317	266

(Included in the number of doctors are 273 so-called Amtärzte, doctors in public service without a practice of their own).

More than 90% of general practitioners work alone, co-operation with others is not stimulated, neither within the profession nor with other health workers. Austrian general practitioners provide a variety of diagnostic and laboratory facilities. Children up to the age of fifteen have at least one preventive health examination per year and elderly people also have the right to a yearly health check. Family planning and perinatal care are also predominantly provided by the general practitioner. For perinatal care a special mother-and-child pass exists. All school children are under the supervision of a physician, but there are no special school health units. (9,91,119)

Payment and income of GPs

Austria has different remuneration system that operate in parallel. Each province has more or less its own remuneration system with its own fees. Differences between the schemes are not large, however. In some of the provinces the system has more characteristics of a capitation system while in others it is more like fees for services. Patients are not listed with a GP. The patient is tied to a treating doctor for a maximum period of three months only. The patient is provided every three months with a so-called 'Krankenscheck' from his health insurance fund. This document, which the patient hands to the doctors, is necessary for the doctor to be remunerated. Both capitation fees and the tariffs for separate services are negotiated between associations of GPs and the autonomous Austrian health schemes. Patients insured with the ASVG are free from costs for out-patient services, while members of BSVG and GSVG must pay 20% of the doctor's bill themselves. (40,93,89)

Training and education of GPs

Austria has 3 universities, which had 16544 medical students in 1989. In that year some 1600 persons completed their undergraduate training with a medical degree (Dr. Med. Univ.). General practice is not included in the undergraduate medical curriculum at the universities and there is no special GP vocational programme. In order to become a general practitioner in Austria, doctors must complete a three-year vocational training which is entirely hospital based. A few of the trainees spend three months in a teaching practice. It is considered a professional duty for all GPs to take part in continuing medical education but there is no form of check on participation. (84,89)

● BELGIUM

The country

Belgium is a small but densely populated country north of France. It has been a hereditary constitutional monarchy since 1830. The king has only minor political power. The 212 member Chamber of Representatives is elected by proportional representation. The country consists of nine provinces (and from 1994 even one more) and 600 municipalities. But probably more significant is the heterogeneity of its population, culturally as well as geographically. Roughly speaking, Belgium is divided between Flemings, the Dutch speaking population in the north west, and Walloons who live in the south east and speak French. Brussels is a third separate community, bilingual, with its own regional government. In the eastern part of the country there is a German speaking minority (1% of the population), yet with an own consultative parliament. Flemish/Dutch, French and German are the official languages in Belgium. Until now the central government has been able to carefully balance the interests of the communities by increasingly devolving power to the different regions. This will result in 1994 in a federation of Flanders, Wallonia and Brussels. Although social security will remain a national competence, health care is going to be a competence of the linguistic communities. With Luxemburg and The Netherlands Belgium has an economic co-operation within the Benelux. (133,105,151)

Statistical key figures

Population

population in mln.	10.0
per sq. km.	327
% ann.growth 80-91	0.1
% urban	97
% under 15	17.9
% over 65	14.9
% over 75	6.6

Development and economy

human development index	96
compuls. education (yrs)	12
TV sets per 1000 population	447
GDP per head in \$ (ppp)	17,474

Natality, mortality and health

births per 1000	12.6
fertility rate/child.p.woman	1.6
% ann.fert.reduction 1980-91	0.6
% contracept. preval.	81
deaths per 1000	10.4
% infant mortality (under 1)	0.8
% under 5 mortality (U5M)	1.0
% ann.reduction U5M 1980-91	3.7
% DPT immunised at age 1	94
life expectancy (men)	72.4
life expectancy (women)	79.1

Organisation of health care

Belgium has a highly privatised system of health care supply, which is very complex and relies for a great deal on private initiative. Because of its high degree of 'laissez-faire' it is sometimes regarded as a non-system. With a large number of non-governmental organisations, struggling for independence and maintenance of their position, the organisation is competitive in nature. Of all European systems, the one in Belgium probably most resembles the system in the USA. Direct government involvement is limited to regulation and partial funding. And direct governmental activity concerning health care delivery is almost absent. Most health services are organised at the regional level. In each province there is at least one health inspectorate body. Insurance premiums are set by negotiations between the medical profession and social affairs authorities. Planning of hospital care and the training and education of health personnel is still a governmental responsibility. After the federation will be realised health care will belong to the competence of the community governments. This may reduce current frictions between the central level and the authorities of both communities. (40,105,86)

Health financing and insurance

Financing is largely separated from planning of health care. Belgium has two social health insurance schemes: one general scheme compulsory for all employees and their dependents and covering a broad range of risks and another scheme, also compulsory,

covering only 'great risks' for the self-employed. A key position in the insurance scheme is taken by the five Health Insurance Associations, 'mutualities', supervised by the National Sickness and Disability Fund. The mutualities have different religious and political backgrounds and they stem from mutual aid societies, which originated in the early 19th century. Until recently, an Act of 1894 was the main Act on the legal status of mutualities. In 1990 it was revised, but the central role of the non-profit mutualities in health insurance was confirmed and continued. Mutualities are more than just the accounts department of health care, they are also entitled to take initiatives in the provision of care. Two large associations dominate health insurance scene. The National Alliance of Christian Mutual Funds with some 4.5 million members and the National Union of Socialists Mutual Funds with some 2.5 million members. Another major historical feature of the mutualities is their decentralised character. Indeed, after World War II the collection of health insurance premiums was centralised and embedded in the social security system. Funds are collected by the National Office of Social Security (ONSS/RSZ) and consists of premiums from employers, employees and self-employed as well as subsidies of the government for the benefit of the unemployed, the aged and the poor. The ONSS/RSZ is then responsible for the distribution of these funds via the National Sickness Insurance Institution (INAMI/RIZIV) to the six Health Insurance Associations. The membership of a mutuality is compulsory for all employees, the self-employed and their dependents. The premiums and benefits are identical for all mutualities and fixed by the government. Health care expenditure and expenditure on pharmaceuticals are stated below.

Health expenditure	81	82	83	84	85	86	87	88	89	90	91
- abs. per head in ppp\$	674	747	801	839	879	931	992	1081	1153	1242	1377
- % of GDP	7.2	7.4	7.6	7.4	7.4	7.6	7.7	7.7	7.6	7.6	7.9
expenditure on pharmacy											
- abs. per head in ppp\$	108	115	125	126	138	146	158	178	187	193	205
- % annual growth		6.3	8.5	0.6	9.7	6.1	8.2	12.3	5.4	3.0	6.4

The Belgian health care is financed for 52% from social insurance premiums, 27% from taxes, 21% from direct payments and only 2% from additional private insurance. So, a substantial part is financed by co-payments. In order to discourage the use of the health care services patients must pay a relatively high fee for various services (the so-called 'ticket modérateur'). For out-patient care there is a restitution system by which bills are paid in advance by the patient who is only partially reimbursed by his fund. Generally, patients have to pay 20-25% of the costs for primary care themselves. Widows, elderly, handicapped and orphans, referred to by the abbreviation 'VIPO's', are given higher reimbursement rates. There are also co-payments for pharmaceuticals. Lowest income groups are exempted from co-payments.(40,117,86)

Secondary care

The task of primary and secondary care are not well defined, which result in overlapping activities and competition among physicians. Many specialists in fact provide primary care. People have free access to any medical specialist, in his private practice or in hospital out-patient departments, and fees are normally reimbursed even when the patient has not been referred. People can also apply for hospital admissions, the necessity of which will be judged by a hospital doctor. Most hospital doctors also work in both the out-patient department of a hospital and in a private practice on their own premises. Especially between both World Wars mutualities established so-called polyclinics in which a number of specialist services have been concentrated. In addition to a small basic salary physicians work in an agreed fee-for-service scheme. Mutualities took this initiative in order to control costs for their members. There are several hundreds of these polyclinics now. The number of hospitals and hospital beds is quite high. Most hospital beds are in private or semi private

facilities. These are run by bodies such as societies for mutual aid, religious communities etc. Public facilities are usually managed by boards appointed by municipalities. Technical and financial control is exercised by the Ministry of Public Health and Environmental Affairs. Hospitals have to meet requirements for appropriate structural and organisational standards and must be compatible with national and regional hospital plans. In 1989 the country counted 307 general hospitals of which 173 were privately owned. A characteristic of both the private and public hospital sector in Belgium is their small units. The patient has complete freedom of choice with regard to the institution. The medical care costs, to be distinguished from costs for nursing care and lodging, are directly remunerated per service by the insurance fund to the hospital. These costs are calculated according to a so-called 'production profile', which includes the type of medical service, the diagnosis, the nursing activities, and the age of the patient. The other costs are budgeted according to some parameters, like the type of medical services rendered, the number of beds, the age of the building etc. Bed supply and hospital admission rate are indicated in the table below (reference year 1989). (105,117,119,114)

In-patient care beds	9.8
Acute hospital beds per 1000 population	5.6
Admissions per 100 population in acute hospitals	17.0

Primary care

Home care is a high priority in Belgium, and the country has a well developed system of community nursing services. The most important organisations in community nursing are those of the White and Yellow Cross, a national federation with nine provincial associations and 180 local departments. At the local level each department employs 20 to 40 nurses, supervised by a head nurse. They usually work in a team, but within each team every nurse takes care of her own specific area. The local units are supported and controlled by the provincial associations which also determine the number of nurses locally. The White and Yellow Cross is accessible 24 hours a day and care can be delivered round the clock. Two other smaller community nursing institutions are 'Solidarity for the family', organisations linked to the 'mutualités' and 'Child and Family'. The last is specialised in preventive health care for children under the age of five. (139,119,141)

General practice

Medical care outside the hospitals is provided by numerous general practitioners as well as by specialists operating both from their surgeries in solo practices. Group practices do exist but are still rare. In 1990 there were 16,840 general practitioners and 14,160 medical specialists in the country. This equals to a number of 319 inhabitants per physician and 588 inhabitants specifically per general practitioner. These are among the highest doctor and GP densities in Europe. Both medical specialists and GPs are directly accessible for the public in Belgium. No referral is required. The division of tasks between specialists and GPs is not well defined, which results in mutual competition and overlapping activities. There are no restrictions for general practitioners to establish. There are also no limits in the number of people served. Every patient can choose the doctor he or she prefers at that moment. GPs do not have a list of patients, so a stable patient-doctor relationship is not evident. This is detrimental to follow-up of treatments and continuity of care in general. Since specialists are not making home visits, GPs are competitive by providing care at patient's homes, even when patients are well able to come to the surgery. In 1985 over 50% of the general practitioners' patient contacts were during home visits. In order to increase the quality of care the government is stimulating more office consultations. In 1970 the percentage of home visits was still 57 percent. Belgian GPs usually work long hours. Often their practice is open from early in the morning until late in the evening, and in most cases there is no appointment system. The average number of contacts per GP is 11 a day. Newly established general practitioners have fewer consultations. It usually takes years to build up a practice. To earn a living in this initial period, a sideline job is indispensable. (139,40,117)

Payment and income of GPs

General practitioners are paid directly by the patient on a fee-for-services basis. Since 1964, after a major dispute between health care suppliers and the state, there has been a system whereby the level of medical fees is negotiated by a national commission of doctors and a similar commission of representatives of the 'mutuelles'. The agreement (nomenclature) has to be ratified by a given percentage of doctors (60%) in each province. The agreed fees are the basis of reimbursement but the individual doctor may charge higher fees if he or she does not agree with the 'convention'. There are governmental incentives for doctors to agree with the 'convention'. The last few years have seen attempts by the government to make doctors more cost conscious and to abolish these exceedings of tariffs. The high GP density is a negative condition for GPs' income. During the 80s the average income of GPs decreased, but since 1990 there is an upward trend. There is no unanimity among GPs about how to change this situation. Some suggest to introduce compulsory referral from GP to specialist, in order to improve the position of the GP. Another suggestion, being experimented already, is central medical record keeping by GPs on a voluntary basis. The mutualities pay a fixed amount per file. But most effective would be a restricted influx of physicians. Since their funding is directly related to the number of students the universities are utterly opposed to this option. (40,117,114)

Training and education of GPs

There has been no limitation in access to the medical profession in Belgium. So far, the country has a liberal attitude as regards the access to medical faculties as well as the regional distribution of general practitioners. Recently proposals have been made for a stronger selection of medical students after the first year. In 1989 the number of universities amounted to seven, with eleven medical faculties and a total number of 15833 medical students. In two universities general practice is a part of undergraduate teaching to all medical students. Five universities, four in Flanders and recently the one in Liège, have professorships in general practice. The study takes seven years, and after having graduated professional vocational training includes a theoretical course of 200 hours combined with a practical training of two years altogether. The practical part is usually spent in one's own practice. In addition the trainee has to attend fortnightly half-day courses in a small group, supervised by a specially trained experienced general practitioner. Half of the practical period may also be spent in a hospital. A totally different option is to be in the practice of a GP trainer for the whole period. However, the number of those trainee practices is at present still far from adequate. Since there were hundreds of physicians lacking GP certification, a special two-year part-time course has been developed for them to obtain certification. These GPs practise as a GP under the supervision of a tutor. Continuing education on a voluntary basis is arranged by the universities, scientific societies, and local groups of general practitioners, often sponsored by the pharmaceutical industries. (93,49)

● BULGARIA

The country

Bulgaria is a Balkan state by the Black Sea. The country became an independent state in 1878. Later it has been a part of the Ottoman empire. In the year 1945 the Communist Party came to power. Finally, in 1878 the plan economy was rejected and the population voted in favour of a constitution with political pluralism and freedom of opinion. In contrast to other countries of the former East bloc, reforms in Bulgaria were also initiated by the communists. The new head of state is a president who is directly elected by the people. The president nominates the prime minister as the head of the government. The one-chamber national assembly counts 200 members elected by proportional representation. The economic structure of the country was always tightly bound to the Soviet Union with an industry producing only goods for the Soviet market. The disintegration of Comecon led to an enormous economical crisis and the country is now suffering under a necessary but painful restructuring programme backed by the IMF. The seaside regions of the Black Sea used to be popular holiday centres, but intensive industrial activity has reduced their attractiveness nowadays. (133,151,112)

Statistical key figures

Population

population in mln.	8.99
per sq. km.	81
% ann.growth 80-91	0.1
% urban	68
% under 15	20.1
% over 65	13
% over 75	na

Development and economy

human development index	90
compuls. education (yrs)	8
TV sets per 1000 population	249
GDP per head in \$	2250

Natality, mortality and health

births per 1000	13
fertility rate/child.p.woman	1.9
% ann.fert.reduction 1980-91	0.9
% contracept. preval.	76
deaths per 1000	12
% infant mortality (under 1)	1.7
% under 5 mortality (U5M)	2.1
% ann.reduction U5M 1980-91	1.6
% DPT immunised at age 1	99
life expectancy (men)	69
life expectancy (women)	75

Organisation of health care

The health care system is in a period of transition. For the time being the structure of provision is still hierarchical and territorial with polyclinics and health posts at the base, district hospitals in the middle and regional and special hospitals at the top. Territoriality has been effectuated in the district principle, by which specific categories of the population are geographically allocated to facilities and staff. These districts are categorial and different in size. For instance, a paediatric district has a population of about 1000 children under the age of 15, while gynaecological and obstetrical districts enclose some 18000 inhabitants. For the other adult population there are therapeutical districts and for dental care dental districts. Large companies of 1000 to 2000 employees are factory health districts. In rural areas this subdivision is useless; the population of several villages together is considered a rural district. In rural districts the provision of health services is more integrated. Under the current political and social changes, a process of transforming both the financing of health care and the management of the health care infrastructure is going on. There is a strong commitment to free choice by patients of facilities and health care providers and towards an insurance based system of finance. According to the new constitution of the republic of Bulgaria, adopted in 1991: 'The citizens are entitled to health care which shall guarantee accessible medical aid and to free medical care in accordance with provisions and procedures defined by law. The health care of the citizens shall be financed from the state budget, employers, personnel or joint insurance payments and other sources in accordance with provisions and procedures defined by law.' At this moment co-payment exists for dentures, abortion on demand, certain cosmetic procedures, infant creches and part of the costs of drugs prescribed by hospital doctors. Also in 1991, amendment and

alteration of the Public Health Law was enacted which now permits private practice. The legislation concerning health insurance of the population is being worked out. (144,112)

Health financing and insurance

Health care is provided by the state and has a 100% coverage of the population. Health care may become less dependent of the government after plans for a social insurance system have been realised. The state budget finances directly or indirectly most of the health care facilities in Bulgaria. The allocations of resources for the institutes directly coming under the Ministry of Health originate from the central budget, while the health services falling under responsibility of the local People's Councils are financed from the local budgets. The company health services are financed by both the People's Councils and the industrial enterprise whose workers they serve. The health budget is drawn up in compliance with financial norms and targets which have been developed for that item of budget. When additional, unforeseen needs arise they are met by extrabudgetary subsidies. In the year 1990 the health expenditure was 7.4% of the National Income. Reform of the health financing system will most probably result in a drastic decentralisation of planning and financing. Decentralised budgets should improve the efficiency and will lead to a better adaptation of health care supply to the needs of the population.

Secondary care

Like most systems in Central and Eastern Europe health care heavily relies on medical specialists. Specialist care is provided by both hospitals and polyclinics, on an out-patient basis. In both kinds of facility secondary care is accessible without referral. Gynaecologists, paediatricians and specialists in internal medicine provide an important part of primary care. In 1990 the country counted 256 hospitals with 10 beds per 1000 inhabitants. The hospitals can be divided in district-, provincial- and regional institutions according to the area they serve. There is also a reasonable number (184) of Sanatoria providing various services. The total number of doctors was 28500, or one per 316 inhabitants. Compared to countries in Western Europe this is a high GP density. As a result of the rural depopulation in the last decades, health resources have concentrated in towns and cities. In some areas facilities in the countryside have become relatively sparsely distributed. (77,144)

Primary care

Primary medical care in Bulgaria is, like the administrative division of the country, organised in four levels: the district, the province, the region and the national level. Primary health care is provided by polyclinics, which are general health centres offering various preventive, diagnostic, therapeutic and convalescent services. The polyclinic can be a separate unit or a department of a district hospital or provincial hospital. Five types of polyclinics can be distinguished according to the number of people served and the range of services rendered and the degree of specialisation. Polyclinics of type I provide services in all major medical specialisms for a large number of people. The clinics of type V, on the other extreme, only provide core services and to a relatively small population. Polyclinics of type I to III are mainly situated in larger cities and towns while those of type IV and V are predominantly located in bigger villages. In rural areas the rural health service centres serve the people of one or two smaller villages with therapeutic, paediatric and dental care. In 1989 there were 3732 general polyclinics and 10096 for infants. Polyclinics are staffed with a variety of medical personnel. The bigger ones have different types of medical specialists besides the district doctor, nurses, midwives and dentists. Special is the position of the feldscher, who is an assistant to the doctor in rural areas. (144,112)

General practice

Of all doctors in Bulgaria only 17%, which is a number of 4845, is working as a district doctor in a polyclinic. This is one district doctor per 1857 inhabitants. They provide first contact medical services for a patient with non-urgent conditions and, in co-operation with the district nurse, they have a co-ordinating task with respect to the families in their district.

District doctors as members of the health care team, perform a variety of functions, preventive as well as diagnostic, therapeutic and convalescent. Most of the time the doctor is assisted by a nurse. He or she works for eight hours a day of which approximately two hours are spent on home visits. The consulting time for each patient is at least ten minutes in the surgery or 30 minutes at home. Although many district doctors have specialist certification, usually in internal medicine or paediatrics, they do not administer a lot of treatments themselves. Their task perception is somewhat narrow, and often limited to referring patients to the appropriate specialist in the polyclinic or hospital. The patients also have direct access to out-patient specialists without seeing the district doctor. The status of the district doctor is low. (144,112)

Payment and income of GPs

With the exception of the odd newly established private doctor, physicians are state employed and have a salary. In independent private practices doctors are remunerated on a fee-for-service basis. In the new health legislation remuneration will be further elaborated. Related to the low status of the district doctors is their low income, which again has a negative impact on their motivation. A better training of general practitioners and the change towards free choice of doctor for patients should improve professional freedom and autonomy and consequently their status. (144,112)

Training and education of GPs

There are five medical universities in Bulgaria. In 1989 a program to restrict the number of students was introduced. In 1991 only 1600 students were allowed to enter the medical faculties. The basic medical education takes six years, including one practical year of internship. Until recently, to become a district doctor no special postgraduate training was required. The GP specialism has now been introduced and the postgraduate training will take four years. General medicine will thus be established as a full specialism with rights equal to any other specialism. This should result in a better position, more prestige and higher satisfaction in the profession. (93,144,112)

The country

After the end of World War I a kingdom of several ethnic groups came into being in 1918. In this kingdom, later named Yugoslavia, the heterogeneity of the population often gave rise to internal problems. At the end of World War II the people's republic of Yugoslavia developed into a socialist country. After 1948 a policy of independence with respect to the East Bloc was developed. During the last decades the federation disintegrated gradually. Croatia and Slovenia, the economically most developed republics, decided to become independent. Yugoslavia reacted by using authority and military force in an attempt to accomplish the idea of a 'greater Serbia'. In 1991 this resulted in a bloody war, which could not be brought to an end, despite efforts of the international community. In 1993 the situation remains worrisome and a severe threat to peace all over the Balkans. Circumstances in the Republic of Croatia are very difficult. The war has caused enormous damage, and society has been disrupted by the 600.000 displaced persons and refugees from occupied Croatian territories and Bosna and Hercegovina. (133,94,105)

Statistical key figures (sources:37,99)

Population		Natality, mortality and health	
population in mln.	4.8	births per 1000	11.7
per sq. km.	85	fertility rate/ child.p.woman	1.7
% ann.growth 80-91	na	% contraceptive prevalence	na
% urban	58	death per 1000 pop.	10.9
% under 15	21	% infant mortality (under 1)	1.0
% over 65	12	life expectancy (men)	68
		life expectancy (women)	76
Development and economy			
compuls.education (yrs)	8		
TV sets per 1000 pop.	na		
GDP per head in \$	4440		

Organisation of health care

During the last years in the former federation, health care in Croatia was a highly decentralised, 'self-governing' organisation with the main power at community level (municipalities with about 30-50.000 inhabitants) and in work organisations (factories and others). Formal decision-making used to be with the 'self managing community of interest in health', consisting of assemblies of health workers representatives and users of health care services. These bodies were responsible for co-ordination, planning and resource allocation. The actual power was, however, usually an informal liaison of local political bureaucracy with health authorities. As the economic situation in the country deteriorated and the pressure of numerous newly trained health workers increased, the shortages and restrictions dominated health care. After political changes and the proclamation of an independent state a new value system was introduced, decision-making was centralised and the power of ministries increased. Privatisation of health care became a priority. However, due to war, an orderly development of a new health system turned out to be unfeasible and was postponed. (150,94,101,105)

Health financing and insurance

Most of health care facilities are financed nowadays by the State Health Fund, which was created in 1991. This Fund is based on compulsory health insurance of employees, self-employed people and agricultural workers. The relatively high level of health benefits could not be funded from the modest income of the fund. The resulted financial problems have been solved by co-payments, imposed by the government, for various health services. Principles of a new structure are still in discussion; new legislation is being developed. It is to be expected that the new system will be based on compulsory health insurance and a public/private mix of services. (94,101,105)

Secondary care

Hospital care is provided by regional hospitals that usually serve several districts and 'medical centres'. In these centres out-patient and in-patient care are integrated and patients from these centres were exclusively referred to the district hospital of that medical centre. The new government is trying to disintegrate medical centres and introduce totally free access to specialist care. Despite the well-developed primary care hospital bed supply is relatively high: 5.6 per 1000 inhabitants. However, due to the war many beds have been destroyed. From the total of 27 regional and general hospitals 15 have been damaged as a result of hostilities; and five out of 33 special hospitals were damaged. In 1991 the total number of physicians amounted 8,948, or one per 514 inhabitants. Only 198 of them were self-employed. Bed supply and hospital admission rate are shown below; the reference year is 1991. (150,94,101,156).

In-patient care beds per 1000 population	6.52
Acute hospital beds per 1000 population	3.89
Admissions per 100 pop. in acute hospitals	10.3

Primary care

The specific organisation of what is called primary health care started already with so-called 'hygienic services' in the early twenties. In those days A.Stampar started health centres in rural areas providing integrated care for most urgent health issues: MCH, school health services, control of infectious diseases, tuberculosis and, most important, an intensive health education. Private practice did not exist until 1952, when the new health centres started to cover urban and rural areas. The core of health centres (or 'home of health' in the national language) consisted of teams of general practitioners, office nurses and visiting nurses. The role of the team was to provide comprehensive health care and co-ordinate the efforts of different dispensaries and other external units of the health centre. In contrast to the original concept, more and more specialists started working in health centres, especially gynaecologists, paediatricians, school health specialists and occupational health specialists. Particularly urban health centres have grown disproportionately and became organisations with several hundreds of employees. In fact, they became out-patient departments (polyclinics) of hospitals. From the total number of 98 health centres, at present 21 have been destroyed or damaged, while 13 are situated in occupied territories. In 1991 2286 physicians were active in primary health care (one per 2,010 citizens). Almost 40% of them (a number of 888) have been qualified as a GP specialist. Of all primary care doctors 103, or 4.5% is self-employed. The present situation is a transitional one. The promised 'privatisation' still has not been elaborated very well and, anyhow, ideas about the future of health centres are still vague. General practice (now more often and preferably called family medicine) is, once again, heavily promoted by health politicians expecting cost containment and the achievement of a more balanced utilisation of services. Free choice of GPs was introduced in practice. Although general practice now has been recognised as an independent discipline, its future depends on the position to be acquired in the professional and academic world. (94,101,30,105,156)

Payment and income of GPs

Payment for doctors in Croatia is quite modest due to general economic conditions. All physicians in health centres and hospitals are employed and have salaries. Private practices, ran by self-employed physicians, can make an income of out-of-pocket payments. Independent general practitioners are offered a contractual arrangement by the state fund, with payment on the basis of yearly capitation fees. At present, private practice is forbidden for those doctors who are appointed in the public system, but it is negotiated in the procedure for new legislation.

Training and education of GPs

Until 1989 the undergraduate medical education lasted 5 years. Since 1989 a six-year undergraduate study has been introduced. After two years of additional internship one can work as a practising physician. Two medical schools in Croatia both have a chair of general practice. Specialisation in general practice (as postgraduate vocational training in general practice is usually indicated in Croatia) has been part of the regular educational programmes since 1961, and it has been one of the first countries in the world to have a special postgraduate training course for GPs. This training takes a period of three years and it is organised by university departments of general practice. Despite this history specialist training to become a general practitioner is still no obligation.

● CZECH REPUBLIC

The country

Before the First World War, the Czech states belonged to the Austrian part of the large Habsburg Monarchy. In 1918, when the monarchy collapsed, the federal republic of Czechoslovakia was one of the newly created countries. After the peaceful abolition of the federation, in 1992, the Czech and Slovak republics went their own way as new independent countries. But even more than this separation the country is coping with the consequences of decades of communist rule. Since the 'Velvet Revolution' in November 1989 it has been building up a market economy and modernising society. Health care is challenged to alter a downward trend in the health status of the population. In the 1950s health statistics used to be comparable to those in former West Germany and better than those of Austria. At present, the life expectancy for men has stagnated and that for women has only increased slightly. And infant mortality rates have fallen behind those in Western Europe. (133,29)

Statistical key figures

(ref. year: 1991 unless otherwise indicated; additional sources: 58,57)

Population		Natality mortality and health	
population in mln.	10.3	births per 1000	12.6
per sq. km. (a)	122	fertility rate/child.p.woman	1.8
% ann.growth 80-91	0.04	% ann.fert.reduction 1980-91 (a)	0.9
% urban (a)	74	% contracept. preval.	16.5
% under 15	20.6	deaths per 1000	12.5
% over 65	12.7	% infant mortality (under 1)	1.0
% over 75	5.3	% under 5 mortality (U5M) (a)	1.3
		% ann.reduction U5M 1980-91 (a)	3.9
		% DPT immunised at age 1 (a)	99
Development and economy		life expectancy (men)	68.1
human development index (a)	92	life expectancy (women)	75.6
compuls. education (yrs)	9		
TV sets per 1000 population (a)	410		
GDP per head in \$ (ppp) (a)	3,140		

(a) referring to both the Czech and Slovak republics

Statistics on health care (reference year 1991; source:58)

Hospitals	408 (with 131,474 beds / per 1000: 12.8)	
	general	169 (8.1 per 1000)
	special	151 (2.5 per 1000)
	balneological	88 (2.2 per 1000)
Physicians	34,311 (or 1 per 300 inhabitants)	
	in general hospitals	8405
	in special hospitals	797
	in baln. institutes	396
	in out-patient care	19682
Out-patient care units (polyclinics)		5203
Inhabitants per	community doctor	1527
	dentist	2150
	comm.gynaecol. (women only)	6679
	comm.paediatr. (children only)	1000

CZECH AND SLOVAK HEALTH CARE SYSTEMS

For general information and health statistics of on these countries separately, see the relevant page. The description below applies to both countries.

Organisation of health care

The inheritance of the former communist period was a system with the following features:

- in each geographically defined area (districts with some 100,000 or region with some 1 million inhabitants) all services of health care were organised in and provided by only one organisation, namely the District/Regional Institutes of National Health
- all health care workers were employed by one of these institutes with fixed salaries
- management was appointed by district or regional authorities and with approval of the Communist Party
- catchment areas of facilities and providers were strictly defined and patients did not have freedom of choice
- health care was provided practically free of charge to the whole population.

In December 1990, the Czech government found agreement on a new draft of health legislation. A new health care system should have regard to the following basic principles:

- prevention and health promotion have to be strengthened
- universal access to a state-guaranteed basic package of care
- health policy making and delivery of service highly decentralised
- abolition of state monopolies and development of privatisation
- functional integration of services within territorial networks
- increased autonomy of health care providers
- emphasis on out-patient care and community participation
- a compulsory social health insurance scheme covering essential services
- a new additional scheme to provide care that is not covered by the public scheme
- freedom for patients to join doctors and services of their choice.

Until now, in the Czech republic the District and Regional institutes of National Health have been abolished, and most of the facilities, such as hospitals, became economically and legally independent entities. A lot of out-patient and general practice services have been taken over by individual providers. Essential facilities and services will not be privatised, and many other will only be privatised under the condition that the specific health care function will not be damaged. In Slovakia the process of change is somewhat slower. The Ministries of Health will continue to be involved in general policy making, in carrying out some public health tasks and in managing highly specialised clinical institutions. Dealing with environmental problems, which are causing health problems to the population in several regions, will call for the government to take an active role. (29,153,58)

Health financing and insurance

The financing of health care was done by the state exclusively from taxation. In 1993 7.7 % of the Czech Republic's gross national product will be spent on health services. There is an upward trend in this share; costs of health care are rising sharply. Expenditure in the federation increased from 2.8% of the gross national product in 1970 to 3.3% in 1980, to 4.5% in 1990. Breaking down the cost for different sectors of health provision shows that the share of hospital care equals that of out-patient care. Percentages are given in the table below.

Institutional care	37.2 %
Out-patient care	37.2 %
Pharmaceutical care	17.9 %
Other facilities	7.7 %

In both countries a compulsory social health insurance scheme has been adopted. In the Czech republic this scheme has already been implemented. From January 1993 premiums are paid by the insured; for those not earning a wage the state is paying. Facilities are no longer state funded from tax revenues, but by budget. The level of budgets is determined

by the production level, using a list of procedures and prices. In Slovakia, implementation has not yet started. Apart from that, the insurance scheme in this country will not be a copy of the Czech one. For instance, hospital doctors will continue to be salaried while GPs will have a capitation fee and doctors in out-patient care most probably will have a mix of capitation and fee-for-service. Another difference is in the degree of privatisation, which is intended to be less developed in Slovakia than in the Czech republic.

Secondary care

In the Czech republic the structure of out-patient care is rapidly changing now. The strict hierarchical and territorial organisation in districts is being given up. Facilities are or will be managed independently of the state. They have more freedom to set the boundaries of their catchment area, where they no longer have the monopoly. On the other hand, people have more freedom of choice where to go with health problems. Enterprise based primary medical care is going to be stripped of its curative tasks and will partly be restructured into occupational care. The health administrative structure, the former bureaucracy, has been decentralised and made independent of the state. In Slovakia, most probably, changes will not be far-reaching. The territorial organisation will be maintained and the Institutes will not be privatised in the same way and as fast as in the Czech republic. With respect to hospitals and staff the Czech republic is somewhat better equipped than Slovakia (see also statistics on the relevant pages). In 1991 the number of in-patient care beds in the Czech republic was 12.8 per 1000 inhabitants as against 11.7 per 1000 in Slovakia. Anywhere, a remarkable fact is the importance of balneological institutes, which are concentrated in some parts of the country, with 2.2 and 2.1 beds per 1000 inhabitants respectively. Comparable difference between the two countries is found in the physician ratios: one per 300 citizens in the Czech republic and one per 334 in Slovakia. (29,153,58)

Primary care and general practice

The provision of primary care is different for various population groups. The concept of family medicine did not exist in the system of the former federation of the two countries. Most employees used to apply to their company doctor for primary care (although the district doctor also could be seen; only 75% of the employees were covered by company doctors). These doctors, mostly having their surgery on the company's premises, are under the control of the Companies Institute of National Health. Primary care for children up to the age of fifteen is, and to some extent was, provided by district paediatricians. Women should see primary care gynaecologists with their health problems. District doctors, finally, see the remaining adults. Also directly accessible are dentists (stomatologists), ophthalmologists (for glasses only) and dermatologists (for venereological treatment only). Physicians are usually assisted by a nurse, also for administrative tasks. Primary care is mainly provided in outpatient clinics (polyclinics) or, in rural areas, in medical posts. These district medical posts can be seen as satellites of polyclinics. Many district doctors complain about being overloaded and about the scarcity of supplies and equipment. This results in very high referral rates. As a consequence, specialist care has been overemphasised and status, motivation and skills of district doctors are relatively low. The very high share of women in medical professions seems to be another source of complaints. Since they have to combine their job with family tasks, absence is high, e.g. when children are ill at home. As has been explained, this structure is in transition. The categorial approach will be left and primary care will be less fragmented and more generalistic. However, to become effective, much more time is needed than just for implementing a new structure. Managers and providers of health care have to learn their new role. Extensive refresher courses for future GPs will be indispensable. These programmes are still in an initial stage of development. Implementation is being partly supported by training institutes in Western Europe. The separation of both countries has delayed these activities. Beside health personnel, patients should be re-educated as well. One can hardly expect that the attitude of seeking care of the highest possible degree of specialisation will change from one day to the next. In contrast to the situation in general practice in most countries of Western Europe the reform

in Czechia and Slovakia is aiming at an integration of preventive services and health promotion with primary care. (151,154,58)

Payment and income of GPs

A salary was the only remuneration scheme for physicians in former Czechoslovakia. As a result of the reform, GPs, primary care paediatricians, primary care gynaecologists, stomatologists and other specialists in out-patient care may now become independent practitioners. In Czech primary care doctors now have the choice of becoming independent or having an employment contract with the legal body of the health centre or polyclinic. Independently working physicians are remunerated by fees for services. Compared to Western countries income of physicians is low; it does not exceed the wage of a skilled labourer. And although specialists have higher status, their income is, unlike Western colleagues, even lower than that of district doctors. (154,58)

Training and education of GPs

Doctors in both countries are trained at university-based medical schools. In the Czech republic there are seven of these medical schools and in Slovakia three. Up to 1990 four kinds of medical doctors were trained in separate faculties: general physicians, paediatric doctors, physicians in social hygiene and stomatologists (dentists). In 1991 this system was abolished. The faculty of stomatology will continue to teach separately, while the other three now offer an integrated general medical training programme of six years. In 1991, a total number of 14492 medical students took part in the programme and 1453 graduated. A postgraduate specialisation of at least 2.5 years is compulsory for all graduates. There are no less than twenty basic specialisms in the countries, among which general medicine. After this period there is a second optional stage of specialisation, taking three to five years. The Institutes for Postgraduate Education of Physicians and Pharmacists in Prague and Bratislava are involved in vocational training. It is expected that the monopoly of these institutes will disappear soon. As regards continuing education, every doctor is required to attend a training programme once every three to five years. (29,154,153)

• DENMARK

The country

With its large peninsula and many islands situated between the North Sea and the Baltic Sea, Denmark is midway between Northern Europe and the countries of Central and Western Europe. In the literal sense, this position will be even more important after planned road and rail links will be finished. This smallest of the Scandinavian countries is a constitutional monarchy with a king as the ceremonial head of state. Greenland and the Farøes belong to the kingdom, but have a high degree of autonomy. The one-chamber parliament, the Folketing, is elected for a period of four years. As a result of the large number of parties on the political scene, governing means forming coalitions. The referendum is a possible way out in the event of hot political issues if consensus cannot be achieved. In this way the Treaty of Maastricht has been rejected initially, which was a threat to Denmark's position as an EC member. In May 1993, however, 57% of the population voted in favour of 'Europe'. The living standard in Denmark is among the highest in Europe, as the tax rates, necessary to pay the generous welfare system. (133,17)

Statistical key figures

Population		Natality, mortality and health	
population in mln.	5.14	births per 1000	12.6
per sq. km.	119	fertility rate/child.p.woman	1.68
% ann.growth 80-91	0.2	% ann.fert.reduction 1980-91	1.0
% urban	87	% contracept. preval.	63
% under 15	17.0	deaths per 1000	11.6
% over 65	15.1	% infant mortality (under 1)	0.75
% over 75	7.0	% under 5 mortality (U5M)	0.9
		% ann.reduction U5M 1980-91	1.0
		% DPT immunised at age 1	95
Development and economy		life expectancy (men) ('90)	72.0
human development index	79	life expectancy (women) ('90)	77.7
compuls. education (yrs)	9		
TV sets per 1000 population	528		
GDP per head in \$ (ppp)	17,628		

Organisation of health care

Overall responsibility for health care lies with the Ministry of Health. The national Board of Health has an important role in the co-ordination of the system and advises the minister. The planning and management of health care facilities and staff are largely decentralised to the counties (Amt) and municipalities (Kommune), which regularly draft plans for health policy and development of health service in their territories. The central government may issue guidelines as to the content of regional plans. The hospitals and a great deal of the out-patient care sector, among which general practice, are the competence of sixteen regions (the city of Copenhagen is one of them) each with 250,000 to 550,000 inhabitants. The remaining primary care facilities, like most of the preventive care and community nursing, belong to the domain of the municipalities. (105,115,17,123,24,31)

Health financing and insurance

The system is for about 85% financed by mainly local and regional taxes; the remaining 15% is paid by the patients themselves. The counties can levy a proportional income tax, and they are free to determine the rate. Health expenditure is a major part of the regional budgets; about two-thirds of its total is spent on it. The central authorities apply a system of grants to equalise and supplement local resources. Regions with a lot of elderly persons, bad housing and other factors associated with increased health needs receive extra money from the state. Since 1973 the health insurance system covers 100% of the population via a compulsory tax financed insurance scheme, or, properly speaking, two schemes. People are free to join the scheme of their choice. Group 1 members have access, almost free of cost, to comprehensive health care, including free medical care from the general

practitioner and free specialist care after referral. Use of services is clearly regulated. Almost 95% of the population has chosen this group 1 scheme. People in group 2 have the freedom to consult GPs or specialists of their choice, without limits and at any time, but they are charged for fifty per-cent of the costs of out-patient care. As regards public health services and hospital in-patient care both schemes are similar, ie. free of user charges. Co-payments exist, however, in the field of dental services, ophthalmology and pharmaceutical care. Reimbursement rates for prescribed drugs are the same for people in group 1 and 2, namely 75% for essential drugs and 50% for others. From the summer of 1993, drugs with the lowest costs will be the reference for reimbursement. (25,17,138,12,119,31,142). An overview of health care expenditure and expenditure on drugs is given in the table below.

Health expenditure	81	82	83	84	85	86	87	88	89	90	91
- abs. per head in ppp\$	637	697	717	758	807	818	890	972	1013	1051	1151
- % of GDP	6.8	6.8	6.6	6.4	6.3	6.0	6.3	6.5	6.5	6.3	6.5
expenditure on pharmacy											
- abs. per head in ppp\$	58	63	67	70	77	83	81	92	92	97	136
- % annual growth		8.6	6.4	5.5	9.3	7.9	-2.0	12.9	0.6	4.5	40.5

secondary care

Most specialist care is provided by hospital-based salaried medical specialists. A limited number, mainly ophthalmologists and E.N.T specialists, are independent private practitioners. Except in cases of emergency, for hospital care and specialist care group 1 insured people need a referral. Referrals are made to the admission department of a hospital, that will subsequently allocate the patient to a doctor. So, no direct referrals are made to an individual specialist. If necessary, a patient is further referred to a more specialised hospital outside his region. In such cases there is clearance of health costs between regions. Regions often have mutual agreements on use of health facilities. On the basis of the degree of sophistication the following types of hospitals can be distinguished: local hospitals, specialised regional hospitals, highly specialised hospitals and categorical hospitals. Their total number amounts to 106. In the table below this number is broken down into the categories mentioned and into the supply of beds (reference year 1990).

	units	beds
highly specialised	6	8661
specialised regional hospitals	20	10501
local hospitals		
- with at least 3 clin.departments	12	3189
- with a surgical department	37	4139
other somatic hospitals	15	1545
psychiatric hospitals	16	3910
total	106	30145

The overall hospital bed ratio is 5.9 per 1000 of the population; the acute bed ratio is 4.8 per 1000 individuals. Health care institutes are usually publicly owned; a few hospitals are in the hands of unions of patients and only two are private. (132,41)

Primary care

A variety of services is involved in primary health care: general practice, community nursing, mother and child care, preventive services and school health care. The general practitioner has the first contact and, if necessary, other professionals are called in. Primary care nurses, usually employed by municipality services for public health and social work, are working in the field of preventive health care and post medical treatment. For long-term care for the old and chronically ill, nurses make home visits, usually on request of or in collaboration with the patient's general practitioner. In the planning of other than GP services, such as preventive dental care, school health and home care, municipalities play an important role. Also nursing homes for the elderly belong to the responsibility of the municipalities. The last few years these long term care institutions have a policy to let their inhabitants keep their own GP. (139,143)

General practice

In 1990 there were 14,277 physicians in Denmark, or an average of one per 360 citizens. Among them were 3208 general practitioners (or one per 1609 inhabitants) and 840 specialists working in out-patient care. GPs are independent practitioners. Less than 40% still works single handed, mainly those in rural areas, but more and more partnerships and group practices are formed. A remarkable thing is the absence of multidisciplinary health centres in Denmark. Apart from a few doctors who practice acupuncture and osteopathy there is no private general practice in Denmark. GPs have contracts with the public scheme, represented by the county, to provide care to patients registered with them. GP establishment policy and the administrative settlement of GPs' bills are all done at county level. Registration with a general practitioner in one's region is compulsory for patients insured under scheme 1. For these patients normally a change of doctor is possible only once a year or, if there are special reasons, at a maximum of four times a year. Yet, it happens only rarely. List size is relatively low in Denmark; an average of well over 1400 people. Facilitated by this fact and by the remuneration system, which is a combination of capitation fee and fee-for-service, preventive medicine is strongly developed. General practitioners play an important role in carrying out antenatal examinations, providing postnatal care and care of preschool children. Doctors are obliged to do a health check on every child every year. GPs are also writing certificates, e.g. for admissions to mental or addict institutions). For out-of-hours services GPs can use locums but many of them share a cover rota with colleagues. Usually arrangements are made by GPs in a county. As a rule, the practice has to be open from 08.00 till 16.00, from Monday to Friday and in addition for two hours a week. On a typical day the Danish GP has an average of 26 office consultations, vis-a-vis or by telephone, and two or three home visits. (17,136,143,123)

Payment and income of GPs

There is a mixed remuneration system for general practitioners, which is aimed at keeping patients in primary care as long as possible. A capitation part is made up by a fixed fee per 'group 1' insured patient. This fee is paid every three months. In addition, every patient-doctor contact, which is called 'basic service', is remunerated separately. Within this basic service certain activities or procedures are, again, subject to extra payment (e.g. some curative services, like removing warts or large wound treatment; certain diagnostics, such as urine test and taking a blood sample; perinatal care; contraceptive care; socio-medical co-operation; provision of certificates). These are called 'additional services'. Approximately two-fifths of the GP's income is from capitation fees and about the same part consists of fees for items of service. Capitation fees are only paid for patients older than 16 years. Apart from these payments there are allowances for practice costs (office expenses, staff etc.) which is a fixed amount. Fees and tariffs are negotiated every two years between the Sickness Insurance Negotiation Committee for the health authorities and the Danish Organisation of General Practitioners (PLO). Every six months the fees are adapted to the current price level. Practice premises and equipment are owned by the GP(s). On entry he

also has to buy the goodwill of the practice, which should be estimated up to 60% of the gross income of the practice averaged over the last three years. (40,41,31)

Training and education of GPs

To become a GP, vocational training is obligatory. The first stage of this postgraduate programme takes one year and a half and is the same for all graduates whatever their specialisation: six months in a surgical department, six months in a medical department and six months in general practice. The next stage, for those who want to become a GP, is a 36 months training, of which at least half a year must be spent in general practice. GP vocational training, mandatory since 1983, can be received in the University Departments of General Practice in Aarhus, Odense or Copenhagen. Nowadays about one-thirds of all GPs, mainly the younger ones, are certified this way. There are 100-120 training-practices to educate the new general practitioners needed each year. All doctors in the country have an obligation to engage in continuing medical education. The Danish Medical Association as well as the County Medical Associations have the responsibility to supply appropriate educational programmes. Doctors are allowed by their contract to follow courses for six days per year. The average general practitioner, however, only spends two and a half days on this continuing medical education. Pharmaceutical firms are very active with short symposia or evening meetings for general practitioners. About one-thirds to half of the GPs have organised so called '12-man groups', which are meant for exchange of experience, and sometimes engage in medical audit. (84,52,93)

● ESTONIA

The country

Estonia is the northernmost and smallest of the three Baltic states. The Estonian language shows some affinity with Finnish. The country became an independent republic in 1918, and lost its independence forcibly for well over half a century in 1940. In August 1991, after some years of political tensions and military intimidations, the country declared its full independence. Despite pressure from the Soviet Union the independence could be maintained, and later that year it was recognised by the disintegrating Union. Not only the current presence of Soviet troops, which are supposed to leave in due course, but also the large Russian speaking minority (almost 40%) are reminders of the past. Those inhabitants, whose parents have not been born in the country, are not automatically given citizenship of the new republic. They will have to apply for it and will have to meet certain requirements. As a very small country Estonia's economic position is quite fragile since old markets have gone and new ones have not yet been established.(133,28)

Statistical key figures (sources:37,99)

Population		Natality, mortality and health	
population in mln.	1.5	births per 1000	14.4
per sq. km.	35	fertility rate/ child.p.woman	2.1
% growth 91-92 (a)	-5.5	% contraceptive prevalence(a)	24
% urban	72	death per 1000 pop.(a)	12.6
% under 15	24	% infant mortality (under 1)	2.0
% over 65	11	life expectancy (men)	66
		life expectancy (women)	75
Development and economy			
compuls.education (yrs)	11		
TV sets per 1000 pop.	na		
GDP per head in \$	6,200		

(a = personal information) (Sources show quite different infant mortality rates; the mean of both values has been taken in this table)

Organisation of health care

In the period before the second World War health care was provided by independent doctors and by hospitals that were partly private and partly state owned. In Estonia, being part of the Soviet Union, a centralised health system was introduced. The system was underfinanced, resulting in loss of effectiveness, despite the gradual increase in the number of physicians and the growing degree of specialisation of the medical staff. Health care is organised in three levels. The Department of Health in the Ministry of Social Affairs is for general policy making, licensing and other general regulations, and part of the financing. The regional level is responsible for hospital care. Some regions still have responsibility for primary care as well, but this will probably change. The lowest level, the municipalities, are organising primary health care in polyclinics and, in more remote areas, in the smaller ambulatorio's. Polyclinics have a more extensive range of specialisms than ambulatorio's and are sometimes combined with a hospital. In the area of a polyclinic health districts of 2,000 to 3,000 inhabitants are the basic units for primary care provision. School health care and occupational health care, both mainly of curative nature, are also polyclinic based and administered by paediatricians and 'company doctors'. Currently there are moves towards decentralisation of medical care and the implementation of general practitioners. Most probably occupational health care in its current form will no longer be part of the primary care system. The number of organisational levels will be reduced to two. It will be either the region or (a group of) municipalities that will be the second level for the organisation of health care.(105,28)

Health financing and insurance

Like many aspects of health care, financing is going to change. There used to be a 100% state financing. But now a compulsory insurance scheme has been developed covering the whole population. Employers are paying some 13% premium on the wages of their employees. There is still an additional financing from tax resources. Later financing will be decentralised and become the responsibility of regions or municipalities. In due course hospitals will be financed according to budgets. In the year 1990 Estonian health care expenditure amounted to 3.2 per-cent of the national income. Expenditure on pharmacy are not available, but even if so, that figure would not really make sense since a large proportion of drugs was supplied as foreign humanitarian help.

Secondary care

There are 20 larger general hospitals with the full range of specialisms and diagnostic services and treatment. Fifteen of them are (regional) county hospitals and five are hospitals for larger towns. There is also a large number of smaller local hospitals. Part of these hospitals are satellites of regional hospitals, while others are independent. Finally there are special hospitals, with attached out-patient departments, for psychiatry, tuberculosis, oncology etc. These hospitals are situated in Tallinn, the capital, and in Tartu. Until now hospitals are state owned, but after decentralisation this will most probably change, at least partly. Secondary care is also provided by polyclinic based specialists. Usually polyclinics are attached to a hospital. In larger towns, however, there are seven independent polyclinics that provide out-patient specialist care. Hospital bed supply and admission rate are shown below (reference year 1992).

Number of hospital beds	14,777
Hospital admissions per 100 population	17.2

The total hospital bed ratio by 1992 is 8.0 per 1,000 inhabitants. In the total amount of beds a number of 2,107 psychiatric beds is included. If these psychiatric beds are excluded the ratio is one per 8.3 per 1,000.

Primary care

As has been described above, primary care in the polyclinics is provided mainly by district doctors, district nurses, paediatricians, gynaecologists and company doctors, usually in co-operation with otolaryngologists, neurologists, surgeons and ophthalmologists. Basically, all other specialists can also be seen without referral. In the ambulatorio's teams are smaller and consist usually of a district doctor, a paediatrician and some nurses. In a number of remote areas feldchers are still active. Feldchers are all-purpose health workers who assist physicians. Their work includes the care of minor medical and surgical conditions, supervision and follow-up of more major conditions under the supervision of the physician, routine and regular preventive care (immunisation, screening, health education and supervision of sanitation). District doctors and paediatricians are making home visits; gynaecologists as well as company doctors usually don't. Future changes will make primary care more independent from hospital care, and primary medical care will be more concentrated in one person, called a family physician. Primary care will be decentralised most probably to the level of one or more municipalities. It has already been agreed that family medicine will be a specialism with its own training programme. People will be free to choose their doctor. This means at least partial abolishment of the district system. Private practice will no longer be forbidden but they are not given priority in developing the health care system. At present most private practitioners are specialists. (105)

Payment and income of GPs

Except the few private doctors, physicians have a salary. The level of doctor salaries is dependent on the qualification level of the physician, which is related to the number of years of experience and task performance. In hospitals there is some additional variation in

payment among the specialisms. Recently in primary care differentiation has been introduced according to the number of patient contacts the doctor has. In general, the number of doctors is relatively high, which restricts the opportunities for earning a good living out of the job. In combination with the low status of doctors this results in the fact that their income does not exceed the wage of a skilled labourer.

Training and education of GPs

Since 1991, when general practice was recognised as a specialism, a training programme was introduced. After six years of undergraduate training there is a two year period of compulsory internship. Then one is allowed to practice as a physician. Specialism training takes another three or four years. The new curriculum in general practice /family medicine is a three year programme, mainly spent in a practice with a trainer and with supporting courses at the university. For those doctors who have started to work in a practice, there is a two year part-time programme at the University of Tartu. Since March 1993, when first exams took place, 26 graduates have completed this programme. The Centre for postgraduate medical education of Tartu University offers postgraduate courses in all specialisms, and now in general practice too. In Estonia doctors have to re-register every five years. To meet the requirements a certain minimum number of credit point have to be collected in postgraduate courses.(93)

The country

Finland is a fairly young state. It has been a part of Sweden until the early 19th century, and subsequently a grand duchy under Russian control. The independence came in 1917 and a republican constitution was adopted two years later. The country has been governed mainly by coalitions with no absolute majority for one party. Finland has a low population density and most of the population lives in the south and west. The north is very sparsely inhabited. The population has grown very slowly during the last decades; in the 1960s many people emigrated to Sweden. Forestry has traditionally been the major economic activity. Nowadays the share of metal industry and engineering in the economy is almost equal to that of the forest industries. After World War II, in which Finland has not been involved, the country had to pay considerable reparations to the Soviet Union. Later bilateral trade with the Soviet Union has grown up to 20% of the foreign trade volume. Now that the Soviet Union is no longer existent a shift towards closer relationships with Western Europe is visible. The problems of its neighbours to the east have resulted not only in an increased political freedom of movement, but also in loss of the major market. The current economic downturn has to be compensated by overtures to the EC. (133,85)

Statistical key figures

Population

population in mln.	5.0
per sq.km.	15
% ann.growth 80-91	0.4
% urban	60
% under 15	19.3
% over 65	13.2
% over 75	5.7

Development and economy

human development index	96
compuls. education (yrs)	9
TV sets per 1000 population	488
GDP per head in \$ (ppp)	15,999

Natality, mortality and health

births per 1000	13.1
fertility rate/child.p.woman	1.8
% ann.fert.reduction 1980-91	2.3
% contracept. preval.	80
deaths per 1000	9.8
% infant mortality (under 1)	0.58
% under 5 mortality (U5M)	0.7
% ann.reduction U5M 1980-91	2.3
% DPT immunised at age 1	90
life expectancy (men)	71.4
life expectancy (women)	79.3

Organisation of health care

Health care in Finland is for its major part organised as a public service. In the field of out-patient care there is an additional private sector. There are three levels of health service administration. At national level this is the Ministry of Social Affairs and Health. At the provincial level there are twelve Departments of Social Affairs and Health. The community level, finally, consists of 461 communes with their Health Boards. In Finland local authorities are responsible for most of the health services. The communes differ widely in size and population - from 500,000 to less than 1,000 - but their responsibilities are basically the same in every case. For this reason small communes co-operate by forming intercommunal organisations for supply of health services. State control is exerted by means of funding. There are overall national health care plans, approved by the government, concerning personnel and financing. Within these national plans local authorities make up five year plans. If the communal plans are acceptable and in conformity to the national plan, the community receives state subsidies amounting to half of their costs on average. Subsidies are graded according to the prosperity of the communes from 29% to 66%. From the beginning of 1993 state control has been diminished and the communes get a lump sum based on their population and their economic status. At present, the communes are free to decide about the allocation of money to health care, to education etc. A special health problem is mortality among middle-aged men which is much higher in Finland than in most of the industrialised countries. The main reason for the excessive male death rate is

cardiovascular disease. There are some regional and socio-economic variations of mortality. Apart from this excess mortality, Finnish middle aged and old men are notable for their high rate of chronic morbidity. (105,80,3)

Health financing and insurance

In the public sector half of the cost of hospital care and the local health centres is financed out of communal taxes and half by the state. For out-patient care in the private sector the entire population of Finland is covered by sickness insurance which is run by the National Social Insurance Institution (NSI). This Institution has its own network of district and local offices. This compulsory sickness insurance scheme is funded by premiums from employers and employees, and grants from the state and communes. There is also an additional voluntary health insurance scheme, which is mostly used for children under the age of five. Due to long waiting lists in the health centres in the larger cities, this category visits private doctors. Co-payment exists for pharmaceutical and dental care and the services of private doctors.

Health expenditure	81	82	83	84	85	86	87	88	89	90	91
abs.per head (ppp\$):	588	649	710	760	855	911	979	1044	1147	1291	1426
% of GDP	6.6	6.7	6.9	6.9	7.2	7.4	7.4	7.2	7.2	7.8	8.9
expenditure on pharmacy											
abs.per head (ppp\$)	61	64	71	76	83	88	94	100	108	122	141
% annual growth rate		4.8	11.6	6.9	9.5	5.9	7.6	5.5	8.2	12.6	16.4

In 1988 the total health budget had the following sources of funding: communes (35%), state (34%), co-payments by patients (18%), the National Social Insurance scheme (10%), private insurance (2%) and employers and others (1%). (44,132)

Secondary care

In 1989 the number of hospitals amounted to 439. For in-patient medical treatment the country has been subdivided into 21 hospital regions, run by intercommunal organisations. In every central hospital of a region the most common specialisms are available. For the more rare specialisms the 21 regions are grouped into five university-hospital areas (Helsinki, Turku, Oulu, Kuopio and Tampere). In Finland no distinction is made between those hospitals treating acute patients and those for chronic cases. Most chronic patients are nursed in health centre hospitals where they can be near their homes and families. Chronic patients requiring specialist treatment are admitted to central hospitals. Hospital out-patient departments are only accessible for examinations after patients have been referred from a health centre (except in cases of emergency). Hospital doctors are salaried for 36 hours per week and are free to run a private practice in their spare time. A minority of the hospitals is privately owned. Recently the number of beds started diminishing especially in psychiatric wards. The table below indicates the number of beds in hospitals and the admission rate (the reference year is 1990). (44,132)

In-patient care beds per 1000 population	12.5
Acute care hospital beds per 1000 pop.	4.3
Admissions in acute hospitals per 100 pop.	16.3

Bed supply is high in Finland. Recently, the number of beds in hospitals, especially in psychiatric wards, has been diminished.

Primary care

Primary health care has been a policy priority in Finland since 1972. In 1982 Finland and the

World Health Organisation signed an agreement by which Finland got the status as a 'pioneering country' for the WHO Health for All programme. At the onset of the 1970s, 90% of all health resources were devoted to specialised hospital services, leaving only 10% to primary care. Health costs were rising almost twice as fast as the Gross Domestic Product. Nevertheless, the health status of the population was not improving. The Primary Health Care Act of 1972 made a shift and emphasised primary care, prevention and regional and social equality in the availability of services. The proportion of primary health care to total health care costs increased to 40% while, at the same time, real growth of health costs diminished. As the core of primary care, every commune has a health centre, either of its own or shared with neighbouring communes. Health centres provide a full range of primary health care services including dental care, physiotherapy, laboratory and X-ray facilities, an emergency unit, a maternity and child health unit and a local hospital for acute and chronic patients. This availability of primary care beds to GPs and nurses in health centres, is a special feature of the Finnish system. A health centre is not necessarily established in one single building. Components may be separately located and yet form one organisation. The number of health centres is 223, of which 117 serve single communes and 106 cover two or more. The minimum population base for a communal health centre is 10,000 except in sparsely populated areas where it can be smaller. Most centres have at least four general practitioners. There are two types of nurses: those for primary health care, with traditional education and those for public health, whose education has been more oriented towards preventive health care. Nurses have important responsibilities in the patient's first contact with health care. (143,95,75,62,140)

General practice

There were 15,299 doctors in Finland in 1993, with 3,160 working as a general practitioner in health centres. General practitioners have an important role in the Finnish health centre. They are actively involved in all services rendered by the centre: curative care, emergency care, rehabilitation, X-ray diagnostics, forensic medicine and care for the chronically ill. Usually, however there is a division of responsibilities with respect to occupational health, mother and child health, family planning, health promotion and health education and administrative tasks. Few health centres have their own specialist doctors but consultants can be called in. The centres account for almost three-quarters of patient contacts in primary care. The rest is seen in private practice or by a hospital out-patient department in acute cases. The general practitioner makes home visits only to those elderly or chronically ill people who are entitled to 'home care'. All other home visits are made by community nurses. Usually, there is no personal registration system kept in the health centres. General practitioners have a collective responsibility for the area of the health centre. This does not promote continuity of care. Since nowadays more and more people are seeking more personal care with a doctor of their choice, currently the organisation of the health centres is being changed to meet these needs. Collective responsibility will be replaced by individual responsibility for patients registered with the GP of their choice. Change is now going on in health centres towards reorganisation of the work so that each doctor will have a list of patients and a more personal responsibility for the treatment of the patients on his list. (143,95,75,62,140)

Payment and income of GPs

Ninety-five per cent of all general practitioners work in the health centres as salaried medical officers for 37 hours per week. Additional fees exists for night duties and on-call work. In their spare time GPs are allowed to work in private practice. For these private practice services the general practitioner is paid on a fee-for-service basis. Only five per cent work exclusively in private practice. GP salaries and working conditions are negotiated every two years between the Finnish Medical Association and the Municipal Institute of Labour Relations, representing the municipalities. (40,62,44,140)

Training and education of GPs

The basic medical education in Finland takes six years, followed by a compulsory internship of one year. Thereafter the physician is allowed to practice independently. GP vocational training is optional. There are chairs in General Practice in four out of five universities. General practice is one of the 30 recognised specialisms in Finland. To become a general practitioner, a five years vocational training is required. One year of general training spent at any medical post, two years in hospital departments and two years in health centres. The trainee must work as a GP under the supervision of a more experienced doctor and also participate in training courses, organised by the universities or by the College of General Practitioners. Continuing medical education is voluntary in Finland and not required for maintaining a specific appointment or certification. (67,84,51,93)

The country

France is large and spacious, and situated both in North-Western Europe and in Southern Europe at the same time. Demographic contrasts between rural parts, partly even depopulated, and highly urbanised areas, like Paris and its surroundings, are sharp. From being an agricultural nation in the first half of this century, France has developed into an important industrial power, with high technology as an important branch. Yet it is still one of the largest agricultural exporters in the world; and its wine is renowned. The president, who is much more than a ceremonial head of state, is elected for seven years by an absolute majority of votes, mostly in a second round run off election. The president appoints the prime minister. The parliament has two chambers: the directly elected National Assembly and the Senate elected by local councils. In contrast to most of the other larger countries in Western Europe France, is highly centralised; in many respects Paris is the nerve centre. (133,151)

Statistical key figures

Population

population in mln.	56.4
per sq. km.	102
% ann.growth 80-91	0.4
% urban	74
% under 15	20.1
% over 65	13.8
% over 75	7.0

Development and economy

human development index	97
compuls. education (yrs)	12
TV sets per 1000 population	400
GDP per head in \$ (ppp)	18,219

Natality, mortality and health

births per 1000	13.1
fertility rate/child.p.woman	1.77
% ann.fert.reduction 1980-91	3.3
% contracept. preval.	79
deaths per 1000	9.2
% infant mortality (under 1)	0.83
% under 5 mortality (U5M)	0.9
% ann.reduction U5M 1980-91	3.3
% DPT immunised at age 1	95
life expectancy (men)	73
life expectancy (women)	81.1

Organisation of health care

The pluralistic health care system is an attempt to reconcile solidarity and liberalism by means of a combination of collective financing and a public and private sector for the delivery of health care. Within the centralised governmental system, health care is the responsibility of the Secretary of State for Health, who, in turn, is answerable to the Minister of Health and Social Affairs. As regards health care, the ministry has control of the health insurance schemes, it is the provider of health grants, it determines the level of doctors' fees and the prices of pharmaceuticals. The 22 regions and 95 departments are all involved to a certain extent in financing and delivering health care. In the regions a Director of Health and Social Affairs and a medical inspector are responsible for the public health care system and the public hospitals. At departmental level too, these responsibilities are with a director and an inspector. The 'Caisse Nationale d'assurance-maladie de travailleurs salariés' is the national umbrella organisation of the public health insurance scheme. It is responsible for an equal availability of health care and general budget control. Besides there are 22 'Caisses regionales' and 129 'Caisses départementales'. (117,78,81,147)

Health financing and insurance

Ninety-nine percent of the population in France is mandatorily protected by the national health insurance programme. There are three major health insurance schemes and several smaller ones. The largest one, managed by the above-mentioned 'Caisse Nationale' covers the medical costs of all employees, industrial workers, pensioners and unemployed people, and their dependants. Eighty per cent of the population belong to this category, which is usually called the General Scheme (Régime Générale). Contributions to the General Scheme are paid by both the employers and employees, who pay an average of 30% and

70% respectively (although there are substantial variations between different sectors). The two other important schemes are those for agricultural workers and for the self-employed. Benefits of these schemes are less comprehensive and there are higher rates of co-payment. The health insurance organisations have a pyramidal structure, with a national office for each scheme, regional co-ordinating offices and local offices. The insurance system is based on direct payment of the physician by the patients and reimbursement of part of the charges by the health insurance companies. There are high rates of co-payments in France for several medical services: for the first month of hospital care, for doctor's costs in primary care and for most drugs. Exceptions to this co-payment scheme can be made for various diseases and groups. Some groups of the population, such as the unemployed, have a maximum on co-payments in a given period of time. The rates of co-payment vary according to the kind of service:

- 75% of the agreed fees for general practitioners and dentists
- 65% of the costs of allied medical services
- 100% or 70% or 40% of the costs of prescribed drugs, the level depending on the kind of drugs prescribed
- 80% of the costs of hospital treatment during the first thirty days of hospital stay
- 65% of the costs of diagnostic tests.

Health costs resulting from co-payment of almost 80% of the population are covered by mutual societies. About 2% of the population has an additional private health insurance with a commercial company. French national health expenditure, 105 billion US\$ in 1990, or 8.8% of the Gross Domestic Product, is relatively high among countries in Western Europe. It was financed from the following sources: social security (65.1%), private households (16.0%), Friendly Societies (5.9%), state and local authorities (3.7%) and other sources (1.2%). (117,118,81,147)

Health expenditure	81	82	83	84	85	86	87	88	89	90	91
- abs. per head in ppp\$	805	881	941	1037	1083	1135	1193	1295	1415	1528	1650
- % of GDP	7.9	8.0	8.2	8.5	8.5	8.5	8.5	8.6	8.7	8.8	9.1
Expenditure on pharmacy											
- abs. per head in ppp\$	132	142	148	159	175	185	194	216	238	256	276
- % annual growth		8.0	4.3	7.7	9.7	5.8	4.6	11.7	10.1	7.6	7.8

Secondary care

The French hospital services consist of different types of establishments: public hospitals accounting for well over 70% of all available beds, private for-profit hospitals and private non-profit hospitals, together accounting for some 30% of the beds. Public and private hospitals are financed in the same way by means of global monthly budgets paid directly by local clearing houses. Hospitals have an out-patient clinic for out-patient care. Referrals by a GP are not required to obtain specialist care in the hospital or the out-patient clinic. The insured person is free to choose between a public and private hospital approved by the sickness funds. Daily fees, paid as co-payment when admitted to hospital may not be reimbursed by private additional insurance. The total number of practising physicians in 1990 was 152,096, which equals an average of one doctor per 370 inhabitants. Almost half of them are consultants. It should be noted that the spread of doctors varies greatly. Supply in the Paris region and along the Mediterranean Sea is very much higher than in the countryside. The following table shows the hospital bed supply and the admission rate (the reference year is 1990). (139,81,110)

In-patient care beds per 1000 population	9.7
Acute hospital beds per 1000 population	5.2
Admissions per 100 population in acute hospitals	21.0

Primary health care

There is a policy to reinforce primary health care in France and especially preventive care. Primary medical care is provided both by general practitioners and independent specialists working from their own premises. In most cases the general practitioner is an independent doctor practising alone. A small number of GPs work in health centres. Health centres are established and managed by municipalities, voluntary societies and other organisations. These health centres are generally officially recognised to operate as a part of the social security system. Community nursing is organised by the municipalities as well as by private non-profit institutions. Preventive and curative services are usually not integrated but mostly rendered by separate institutions. Home care is provided to a large extent by the so-called 'Libérales', independent nurses who are reimbursed on a fee-for-service basis. (17,81,110,23)

General practice

Patients are free to choose the physician. Thus, people are not registered with a doctor. For out-patient care people can apply to general practitioners or specialists. GPs account for well over two-thirds of office consultations and almost all of the home visits. However, there are certain primary medical care services in which specialist treatment is the norm, e.g. French women tend to visit a gynaecologist instead of their general practitioner. About one-thirds of all contacts with private physicians are made during home visits. Since referrals by a general practitioner to specialist care are not required, GP do not have a gate-keeping role. The number of general practitioners in 1991 was 59828, or an average of 943 inhabitants per GP. Almost one-thirds of the GPs are hospital-based and thus salaried; they do not make home visits. Another 15% are employed in health centres. The remaining GPs all work alone. The remark about the unequal geographical distribution of doctors also applies to GPs. Although there is a trend towards increasing numbers of general practitioners working in group practices, the prevailing payment system in France does not encourage the formation of group practices with shared premises and staff. (17,136,78,81,23)

Payment and income of GPs

General practitioners in independent practice, like out-patient specialists, are remunerated by fees for service. GPs in health centres and hospital based general physicians are salaried. In the sickness fund scheme there is a general regulation on fees (the so-called 'nomenclature'). Necessary adjustments to the specifications of this schedule are advised by a three-party committee. Additionally, regular negotiations between the sickness funds and unions of independent doctors aim at national agreements ('convention nationale') on contracts and conditions. Individual doctors have the freedom to join the convention (to be 'conventionné'). In fact, almost all doctors do so. General practitioners who subscribe to the convention can be divided into two groups. The largest group (86%) bills according to the fee schedule, and their patients are reimbursed the full charge minus the co-payment rate. Services not included in the fee schedule are not subject to this restriction. A second group (12%) consists of doctors designated by the sickness fund because of their academic position, experience or professional reputation. These doctors may charge higher fees, within certain limits. The surplus amount, however, has to be paid by the patient. A third, very small group, only two per cent of the doctors, does not conform to the convention and is free to fix a level of charging themselves. Their patients are reimbursed at a very low rate. (40,110,147)

Training and education of GPs

Due to an abundant supply of doctors competition among them is fierce in France, and especially in the cities. There is no establishment policy for general practitioners and there is also no restriction on the number of students entering medical school. There is, however, a restriction on the number of places in the second academic year and strict selections take place at the end of the first year. There is a medical faculty in 41 universities in France. In

1989 the intake in the first academic year was 12,660 medical students. (This first year is combined for medical and dental undergraduates; Les Sciences Fondamentales). Only 4100 of them are admitted to the second year. After six years' undergraduate medical training, a vocational training of two years is obligatory for future general practitioners. This programme, called 'années résidentes', consists of an internship in hospitals and in an out-patient care setting under supervision of selected practitioners. After successful completion the trainee is certified as a Doctor of Medicine with the title Médecin Généraliste. As yet there is no system of re-certification. Continuing medical education is optional for general practitioners. The varied supply of courses has to be paid partly by the GP and is partly sponsored by health authorities and/or the pharmaceutical industry. (84,93)

The country

Germany is a federal state consisting of 'Länder' which include both city and territorial states. The sixteen Länder (eleven in the former Federal Republic of Germany and five in the former German Democratic Republic) have their own national status and legislature but are integrated into the federal republic as a whole. The regional distribution of the population is marked by heavy concentrations in certain areas, such as the Ruhr and the Rhine-Main area. The Chancellor, who is elected by the parliament ('Bundestag') on the nomination of the federal president, is head of the government. The federal assembly has two chambers: the Bundestag with 662 members elected for four years, partly directly and partly by proportional representation and the 68-member 'Bundesrat' chosen by the 16 state governments. After the fall of the Berlin Wall in October 1990 the FRG and the GDR became one nation again, after 45 years. The integration of the former communist state into the market system of the West Germany is a gigantic operation with tremendous difficulties. The costs of unification were greatly underestimated and there is a significant cultural gap between the eastern and the western part of Germany. Although Germany is a dominant economic power in Europe, unification demands great financial efforts. Additionally, the instream of hundreds of thousands of refugees from several countries is a considerable social burden too. (133,151,109)

Statistical key figures

Population		Natality, mortality and health	
population in mln.	78.7	births per 1000	13.3
per sq. km.	221	fertility rate/child.p.woman	1.4
% ann.growth 80-91	0.5	% ann.fert.reduction 1980-91	5.2
% urban	84	% contracept.preval.	na
% under 15	16.0	deaths per 1000	11.1
% over 65	14.9	% inf.mortality (under 1)('90)	0.71
% over 75	7.2	% under 5 mortality (U5M)	0.9
		% ann.reduction U5M 1980-91	5.2
		% DPT immunised at age 1	94
		life expectancy (men)('89)	72.6
		life expectancy (women)('89)	79
Development and economy			
human development index	96		
compuls. education (yrs)	12		
TV sets per 1000 population	378		
GDP per head in \$ (ppp)	19,521		

Organisation of health care

The absence of one single centre of power makes the German health care system a good example of a pluralistic health care system. Private initiative, semi-public organisations and governmental organisations have mutually divided power in an intricate system of co-operation and negotiations. The federal government only plays a minor role in health care; considerable power has been delegated to the sixteen federal states, e.g. in the field of hospital planning. The legal framework for out-patient health care is up to the federal government. At the federal level the Ministry for Health and the Ministry of Labour and Social Affairs are responsible for legislation concerning health care. An important institution is the Concerted Action in Health Care (Konzertierte Aktion im Gesundheitswesen) which was founded in 1977 and has 64 members from the insurance agencies, the medical profession, employers, labour unions, pharmaceutical industry and politicians. They give advice with respect to the rationalisation and efficiency of the health care system as a recommendation. The task of transforming the state-run health care system of the former German Democratic Republic into an enterprise modelled on the Federal Republic's social insurance plan, will require substantial changes. The out-patient system based on public clinics was changed. About 15,000 physicians who settled down had to buy new equipment, hire staff and rent office space by themselves in order to become private practitioners. The German Hospital

Association estimates that it will cost at least 20 billion dollars to bring the hospitals in the eastern part to the standards of those in the western part of the country. (117,119,109)

Health financing and insurance

Approximately 93% of the German population nowadays is covered against the cost of illness through the public health insurance schemes, either on a compulsory or on a voluntary basis. There are several different types of health insurance fund. In 1989 there were 1153 Statutory Health Insurance Companies ('Gesetzlichen Kranken Versicherung' or 'GKV Kassen') of which 669 company health insurance funds ('Betriebskrankenkassen'), 267 local health insurance funds ('Ortskrankenkassen'), 152 craftsmen's health insurance funds ('Innungskrankenkassen') and 19 farmer's health insurance funds ('Landwirtschafts-krankenkassen'). The level of insurance contributions is set by the individual health insurance funds. Although medical benefits are determined by the federal government, this government does not give financial support to the health insurance funds. To collect the necessary financial resources for independent operation, the insurance funds are entitled to set the level of employers' and employees' social insurance premiums. Only seven percent of the population is privately insured by one of the 44 private insurance companies ('Privatkrankenkassen'). Furthermore, approximately eight per cent of the population uses private insurance on a supplementary basis. The insurance funds and the medical profession are organised into units at the level of the states. General guidelines, as well as doctors fees in out-patient care, are negotiated at federal level between national associations of the funds and the medical profession, while regional variations are negotiated within the states. Determination of the resources to be allocated to the health facilities also belong to the domain of the 'Länder', the states. Benefits under the public health insurance schemes include medical and dental treatment, drugs and appliances, hospital care and in certain cases home care. In 1989 Germany spent a total of 259 billion Dmark on health care, which was financed from the following sources: by taxation (12%), by social insurance premiums paid by employees (27%), by premiums paid by employers (30%), by direct payment by employers (15%), by private insurance paid by employees (5%) and private insurance paid by employers (2%). The remaining 9% of health care costs are funded by direct co-payments by users. Above a certain income ceiling there are personal charges for prescribed drugs, for in-patient hospital care and for dental treatment. Out-patient care is practically free of forms of cost sharing. (117,118,119,109,55,56)

Secondary care

In 1989 Germany had 3510 hospitals (3069 in the eastern part and 441 in the western part) with a total of 837,000 beds. Partly they were publicly owned (1400) and partly private, of which 1100 on a non profit basis and 1000 on a profit basis. The total number of doctors in that year was 178,000, which is one physician per 442 inhabitants. Of them, 109,000 were working in hospitals (62%), an average of one per 718 inhabitants. A sharp division is made between institutionalised care and out-patient care. This division is of more importance than between medical specialists and general practitioners, who both deliver out-patient care as independent professionals. All hospital admissions are by referral and hospitals have in general no out-patient clinic. People are free to choose any hospital for referral. The institutionalised care sector is very strong. Until recently there was a shortage of nursing personnel in this sector, resulting even in the closing of facilities. During the 1980s several cost containment measures were taken to decrease the high cost of institutionalised health care. The health care reform act of 1989 introduced an out-of-pocket payment of 10 DM (7 \$) a day, with a maximum of fourteen days a year. The 1992 reform Act introduced financial budgets and a case related remuneration of the hospitals. The table below, only referring to the former FRG, shows bed supply and the admission rate for the year 1990. (109,55,56)

In-patient care beds per 1000 population	10.4
Acute hospital beds per 1000 population	7.5
Admissions per 100 pop. in acute hospitals	18.5

Primary care

Primary health care in Germany is mainly provided by 'Niedergelassene Ärzte', independent GPs and specialists. Physicians dominate the out-patient care scene; other health professionals are often involved as employees of the physician. Nursing care is provided by various types of nurses working in 'Sozialstationen' funded by the public insurance companies and often run by religious organisations. To promote home care there is financial support for families caring for a chronically ill patient at home. In the field of preventive care all patients above the age of 35 have a check-up every two years for early detection, primarily of coronary and circulatory diseases. Screening programmes for cancer and children are available for every insured person. (139,109)

General practice

In 1989 there were 29,000 general practitioners and 40,000 out-patient care specialists in the country (western part), an average of 870 inhabitants per out-patient doctor. Out-patient health care is characterised by a free choice of physician and by the position of the doctor as a free entrepreneur. The physicians are controlled by the 'Kassenärztliche Vereinigungen', which are statutory institutions responsible for providing primary health care to the population. Services are in kind, i.e. patients do not have to pay the doctor's bills. Patients are not necessarily listed with a general practitioner. The access right is given by the certificate ('Krankenschein'). These certificates which are valid for three months prove to the doctor that the patient is currently covered by health insurance. The doctor notes all treatments on the certificate for which he later bills to his association of sick fund doctors (the 'Kassenärztliche Vereinigungen'). The associations pay their member doctors the negotiated fee for each service. About 18% of the out-patient care doctors (GPs and out-patient specialists) worked in a partnership or group practice in 1989. There is an increasing trend to this form of practice. However almost half of these practices of more than one doctor consist of married couples. Home visits made by the general practitioner are universal in out-patient care and make up of some 20% of his workload. Generally GPs and specialists do not make hospital visits. In the former GDR in 1989, primary care was provided from 12,602 state owned health centres (Polikliniken, Ambulatorien, Ambulanzen, Staatlichen Arztpraxen, Betriebspolikliniken etc.) by 20,840 primary care physicians. Only 340 doctors were working in a private practice. These health centres with employed doctors are allowed until 1995, so the pressure on doctors to become independent contractors in the short term is great. Nearly all of the primary care doctors in the former GDR already had done so by October 1992 but many of the others are unlikely to take this step, which requires large investments. For the time being, physicians in the east will be paid at a rate that is 70% of that paid to colleagues in the west. In due course this difference will gradually be reduced. (2,6,109,55,56)

Payment and income of GPs

To be eligible to bill for out-patient care services, doctors must be members of a regional association of physicians. Hospital based doctors who are paid a salary by the hospital at a level dependent on specialism and seniority, are organised in the 'Marburger Bund'. Every year the sickness funds and the regional associations negotiate a global budget by multiplying the number of insured persons by an agreed amount per covered person. The sickness funds transfer the revenues they collect from employers and employees to the regional association of doctors which reimburse their members on a fee-for-service basis. The role of the physicians' associations as payers is unique for Germany. In order to stay within budget limits there is a relation between the volume and the amount: the higher the volume, the lower the reimbursement per claim in the next quarter. This system has turned out to be an effective way to control physicians' fees; from 1977 to 1989 fees increased at an annual rate of only 1% while the expenditure for out-patient care rose by 5.4%. Doctors whose service patterns differ substantially from the norm are invited to discuss their practices with the regional physicians committee. (7,117,109,55,56)

Training and education of GPs

In 1990 there were 37 medical faculties in Germany (28 in the former West Germany and 9 in the former East Germany). Basic medical training takes 7.5 years, including two years of full-time internship. There was no containment of the number of students entering medical school but there is a strong selection during medical training. There were however 12,000 students in 1990 who obtained a medical degree and the German constitution guarantees all qualified students the opportunity to pursue the occupation of their choice, resulting in an oversupply of doctors. Therefore medical faculties have begun to limit the size of their classes. Vocational training for GPs is not compulsory in Germany; having finished medical school, a doctor is allowed to practice general medicine without restrictions. He or she is then called a 'Praktische Arzt'. The title 'Facharzt für Allgemeinmedizin' (specialist in general medicine), however, is restricted to those doctors having finished a four-year vocational course. In 1985, 30% of all GPs had followed this vocational training. Continuing medical education is optional and there are no arrangements, so far, for the periodic review of competence. (84,93,109)

The country

Largely surrounded by sea, Greece is situated at the south extreme of the Balkan peninsula. The population is unevenly distributed over the country; some 30% lives in Athens. The past sixty years have been turbulent with a fascist administration in the late thirties, World War II, followed by a civil war until 1949 and a harsh dictatorship from 1967 until 1974. In that year the monarchy was abolished and the country is now a republic. There is a single-chamber parliament of 300 members, directly elected for four years by a system of proportional representation. The president is elected for five years by the parliament. Hostilities in former Yugoslavia have isolated the country from the rest of Europe and are fostering ethnic tensions, especially in the north. Since 1981 Greece has been a member of the EC. Compared to the other EC members, however, the economy is still a source of concern. The many places of ancient interest and the fine islands of the Aegean archipelago are popular tourist destinations. (133,85)

Statistical key figures

Population		Natality, mortality and health	
population in mln.	10.2	births per 1000	9.8
per sq. km.	78	fertility rate/ child.p.woman	1.4
% ann.growth 80-91	0.5	% ann.fert.reduction 1980-91	3.1
% urban	63	% contracept.preval.	na
% under 15	19.7	deaths per 1000	9.1
% over 65	13.9	% infant mortality (under 1)	0.90
% over 75	6.3	% under 5 mortality (U5M)	1.1
		% ann.reduction U5M 1980-91	6.7
Development and economy		% DPT immunised at age 1	na
human development index	93	life expectancy (men)	75
compuls.education (yrs)	9	life expectancy (women)	79
TV sets per 1000 pop.	195		
GDP per head in \$ (ppp)	7,779		

Organisation of health care

In 1983 the then socialist government passed a law on the introduction of a National Health System. In those days health care was characterised by considerable inequalities in the access and quality of care, uneven distribution of health resources, oversupply of doctors and severe scarcity of nurses and almost an absence of primary medical care. As a result of the inadequacy of the public system a high proportion of health consumption was in the private sector. The National Health System Act was an attempt to create a more comprehensive public scheme and to have more control of the private sector. Under the Ministry of Health, Welfare and Social Insurance a Central Health Council and Regional Health Councils have been created. Tasks of these councils are identifying priorities and policy strategies and advising the government, and regional authorities, on health planning and development. Members of the councils are representatives of the health professions, trade unions and laymen appointed by the authorities. Next, the NHS aimed at achieving full time employment of doctors in the public system and thus diminishing attachments to both public and private practice. Thirdly, primary health care was developed by means of a network of health centres and the promotion of general practice (in order to curb the trend towards more and more specialisation). Additionally training of medical and nursing staff was taken up. The many categorial health insurance funds remained in existence. Some of them are very large, like the one for industrial workers - IKA - and the one for agricultural workers - OGA - which together cover some 75% of the population. But there are numerous small funds. Only the IKA fund has its own health centres and medical posts, mainly in the cities. The other funds provide care from public hospitals and by contracting private practitioners. Especially in rural areas, funds are hardly able to provide care in sufficient quantity and quality. The NHS Law still allows the health insurance funds to contract out

specific out-patient or hospital services to private facilities or practitioners. Also this law does not prohibit the creation of private (mainly high tech) diagnostic services. So, the provision of health care is a mix of public and private supply. The public (state) supply is mainly hospitals and health centres in rural areas. These facilities are free. The health insurance funds are also suppliers, sometimes with facilities of their own but mostly by means of contracted private supply. Finally there are the real 'private' clinics and practitioners. These have a living thanks to shortcomings in the regular services. Despite improvements since 1983 the health care system still has many features of former days. The government has not been successful in developing primary care (health centres) in urban areas. And also there are still notable differences in the services and coverage of the many health insurance funds. (66,126,105)

Health financing and insurance

The compulsory health insurance funds (e.g. for employees in private companies, for the agricultural population, for civil servants, merchants, priests and many others) cover almost the whole population. The health insurance funds are compulsory and (except one) financed by contributions from their members: employees pay one-thirds of the premium and the employer two-thirds. The level of the premium is 6.8% of the wages; benefits vary per fund. The exception mentioned is the OGA fund; public budget covers the expenses for the agricultural population. The state is an indirect financier by subsidising the public hospitals. The sources of health care funding are: taxation, health insurance funds and private payments.

Health expenditure	81	82	83	84	85	86	87	88	89	90	91
- abs. per head in ppp\$	208	217	236	247	282	323	321	334	384	400	404
- % of GDP	4.5	4.4	4.6	4.5	4.9	5.4	5.2	5.0	5.4	5.4	5.2
expenditure on pharmacy											
- abs. per head in ppp\$	68	61	69	73	81	93	89	88	90	98	94
- % annual growth		-9.9	12.7	6.1	10.8	14.1	-4.5	-0.8	2.6	8.3	-4.1

Insured patients are basically entitled to use hospital out-patient and in-patient care and care provided in health centres free of charge. But in many cases there are co-payments (e.g. for drugs, medical aids, glasses). Many people use private services for which considerable direct payments are made; the total amount is estimated at well over 3% of GNP (which is additional to the percentage in the table above). (117,126,54,134)

Secondary care

Since primary care is poorly developed the system relies heavily on secondary care, which is provided from public and private hospitals. There is an oversupply of physicians (most of them specialists) and hospital beds. The number of practising physicians has increased sharply in the last decades and is now 34,336 (1990) which is one doctor per 300 inhabitants. Since its introduction the NHS has pursued a policy of fulltime employment of doctors in the public scheme and has prohibited their working privately as well. However, a full separation has not yet been realised. Doctors, as well as facilities, are quite unevenly distributed. Athens, with 31% of the population, has 56% of the physicians and 48% of the hospital beds. As a consequence rural areas are underserved. In contrast to the supply of doctors there is a severe shortage of nursing personnel and other qualified hospital staff. Understaffing of nurses is about one-thirds. In 1990 the number of in-patient beds was 51,329 of which one-thirds were private, mostly in small units of less than 50 beds. The geographical distribution of beds is again very uneven. In Athens the bed ratio is over 9 per 1000 inhabitants while in Thrace it is under 3. Listed below are hospital beds per 1000 of the population and the admission rate per 100 (reference year 1990).

In-patient care beds per 1000 population	5.1
Acute care hospital beds per 1000 population	4.0
Admissions per 100 pop. acute hospitals	7.9

Public hospitals are partly state subsidised (ranging from 50% to 90% and the level depending on the operative hospital price policy of the government); in addition the health insurance funds pay fixed amounts per treated patient per day. Admission to public and contracted hospitals is possible only on referral. Access is free to out-patient care. The private hospital sector is slowly diminishing because the NHS does not allow private hospitals to expand or even transfer ownership of facilities. Partly as a result of shortages and long waiting times the quality of public services is perceived as being low. That is why people turn to the private sector. (103,66,126,54,134)

Primary care

Much hospital out-patient care has the character of primary care. Real primary care is provided by health centres and medical posts run by the NHS and the IKA fund. NHS health centres, of which there are now 180 out of 400 planned, function as decentralised units of regional hospitals and medical posts are decentralised units of a health centre in remote areas. Primary care is not yet comprehensive since health centres only cover part of the population, mainly in rural areas. The centres face the problem of understaffing and lack of diagnostic facilities. And those doctors attached to the centres often are inexperienced physicians or medical graduates waiting to enter specialist training. The IKA centres in the towns are often crowded and staffed by doctors also working privately. Contrary to the initial intentions, prevention and health education have not been realised in health centres up to now. Drugs are supplied by NHS and private pharmacies and hospital out-patient wards. Some rural doctors dispense drugs themselves. The NHS only reimburses drugs mentioned on a positive list to fixed prices. There is 20-25% co-payment, except in some cases of long term illness. (66,126,54,134,105)

General practice

Until 1984 there was no postgraduate programme in general practice. Primary care in health centres was intended to be GP focused, but GP-like services are provided by paediatricians, specialists in internal medicine, obstetricians and pathologists. Still the GP is an almost unknown phenomenon in the Greek health care system; nowadays their number is about 850 (almost 2.5% of all physicians). GPs work in health centres and have a list of 1800 - 2500 registered patients. They are employed by the NHS and not allowed to work privately. Health centres in towns and cities have not yet been developed, so general practice is absent there. This has, at least also, economic reasons. The health care budget has not been sufficient to fund necessary development of facilities both in urban and rural areas. Many proposals for the establishment of health centres could not be accepted. (103,17,105)

Payment and income of GPs

Salaries of GPs are independent on the number of patients on their list. There are no other sources of income. The income level of GPs is, roughly speaking, comparable to that of specialists. Other doctors in out-patient care may have different payment schemes, depending on whether they work in private practice under contract or are state employed. Doctors in public hospital out-patient wards and health centres are all salaried. Doctors working for IKA are also salaried but receive in addition fees for services in their private practice. Those contracted to certain funds have contracts on a fee-for-service basis and also work privately. In the countryside primary care services are partly provided by graduates of the medical schools who are obliged to work for one year in rural areas. These doctors are not employed by the OGA fund but by the government. (126,117,105)

Training and education of GPs

Undergraduate medical education takes a six-year period. Medical graduates may practice without any additional qualification. After graduation one year of practice in primary care in rural areas is compulsory to all of them. Training for hospital specialisms lasts four to six years. Since 1985 there has been a three-year GP training. Physicians who have already practised for at least five years may become a GP by following a six-month course. Continuing medical education is the responsibility of individual doctors, medical associations and scientific societies. (17,93,105)

The country

The republic of Hungary, officially named Magyar Köztársaság, is a landlocked state in central Europe. The country in its current form resulted from the break up of the Austro-Hungarian double monarchy in 1918. After World War II it came under the communist sphere of influence. A slow but irreversible shift away from communism toward democracy took place in the late 1980s and early 1990s. This move was significantly more gradual than in the neighbouring countries. After the elections in the spring of 1990, a change in the constitution ended the Communist Party's leading role. The new centre-right coalition government opened the frontiers and declared its intention to have a free market economy. Hungary, already a member of the Council of Europe, has the intention of integration with the rest of Europe, especially the EC. (133,85)

Statistical key figures

Population		Natality, mortality and health	
population in mln.	10.6	births per 1000	11.6
per sq. km.	114	fertility rate/ child.p.woman	1.8
% ann.growth 80-91	-0.1	% ann.fert.reduction 80-91	1.0
% urban	61	% contracept.preval.	73
% under 15	19.9	deaths per 1000	13.4
% under 15	19.9	% infant mortality (under 1)	1.6
% over 65	13.4	% under 5 mortality (U5M)	1.7
		% ann.reduction U5M 80-91	3.9
		% DPT immunised at age 1	99
Development and economy		life expectancy (men)	67
compuls.education (yrs)	10	life expectancy (women)	74
TV sets per 1000 pop.	409		
GDP per head in \$	3,103		

Organisation of health care

After the Second World War, the Hungarian health care system was shaped to a large extent according to the Soviet model. The Ministry of Health was in charge of all health matters. This system, largely created in the 1950s, appeared to be rigid, although later some changes, especially in the 1980s, took place. Administratively, the country has been divided into nineteen counties plus the capital of Budapest, with municipalities within each county. The administration of hospitals is at the county level, while primary health care programmes are managed at municipal and village levels. In addition, industrially based health services have had exceptional priority in Hungary in the past. However, after the political changes in 1990 the need for health care reforms was recognised. By the new Public Health Act the structure of public health was reorganised. Facilities were placed under the control of the Ministry of Welfare, and in a hierarchical system with tiers at national, county, and municipal level. Other health sectors were also subject to change. The concept of family medicine was introduced, integration of hospital care and out-patient care started, a social sickness insurance scheme was created and private doctors arrived on the scene. The occupational health care in enterprises will probably be privatised too. It will prove difficult to make the shift from old to new. Hungary has a comparatively high number of physicians, most of them specialists. Hospital care and out-patient specialist care dominate the health care system. Because there is no sound primary care foundation, resources are used inefficiently. The deterioration of standards of treatment and care and the scarcity of elementary equipment are evident. These are reasons for undertaking initiatives to strengthen primary health care and to pay more attention to public health research. Another important motive for change is the health status of the Hungarians which is relatively poor and has exhibited a downward tendency in the last few years. (74,32,18,105,150)

Health financing and insurance

Most of the cost of operating and maintaining health care facilities in Hungary, including supply of prescribed drugs, used to be funded from the state budget, and allocation of resources was based on a medium-term financial plan, which determined the proportion of national income that could be used for health purposes. The redistribution of resources has been more decentralised in recent years, with local communities now having a more important say in the allocation process. This process of decentralisation will probably be extended in the future in order to stimulate an efficient use of health resources and improve quality of care. However, since the government is giving priority to economic reform and development, the health care sector still suffers from underfinancing and shortages. Primarily, problems in health care seem to be closely related to economic problems. In 1992 a social insurance scheme was introduced, which is financed from premiums. The compulsory social insurance is 54% of the salaries; 44% is paid by the employers and 10% by the employees. One-thirds of the sum is for health insurance and two-thirds for pensions and social expenditure. In principle, the social health insurance scheme still offers comprehensive health care to the whole population. Although resources are still limited as they were before 1992, now there is more variety in supply and patients have more freedom of choice to choose providers and facilities. As a consequence the payment system has changed as well. Now it is more 'production' related. Private practitioners are paid on an out-of-pocket basis, but that is not new. Private doctors already existed and besides, tipping was not unusual in the pre-1992 period. It is expected, however, that a larger part of health care will be financed from private payments and private insurance. National expenditure on health care is given below. (105,149,150)

Health expenditure 1990

abs. per head in \$	183
% of GDP	5.9

Secondary care

In-patient care institutes include university clinics and national institutes for highly specialised care, general hospitals (subdivided into metropolitan, county, district and municipal hospitals) and categorical hospitals and sanatoria, maternity homes, after-care hospitals for chronic patients, and homes for patients with chronic or mental diseases. Out-patient specialist care is provided in out-patient departments of hospitals, in separate out-patient clinics and in polyclinics. In Budapest and the main county towns, specialised polyclinics and dispensaries provide full specialist care in close collaboration with the county general hospital. Treatment and standards of cure in these clinics are high, and the demand for direct services of specialists in these institutions is growing. In rural and often poorer areas, supply of secondary care is less flourishing due to severe understaffing and lack of equipment. This inequality is also inherited from the 'ancien regime'. A long-lasting postponement of investments in new hospitals has produced a deterioration of standards of cure, and the shortage of funds has resulted in an overall scarcity of elementary equipment. To provide some kind of specialised professional medical service in a relatively cheap way, the network of out-patient clinics was expanded in the sixties. These clinics were intended to relieve the overburdened and overused hospitals. Since staff lacked relevant in-patient care background, they were not capable of dealing with the patients referred by primary care doctors. The total number of physicians in Hungary (1987) was 30,924, in other words one doctor per 345 inhabitants. Variation around this average is considerable. Hospital bed supply and the admission rate are shown in the following table (reference year 1988). (131,85)

in-patient care beds per 1000 population	10
admissions per 100 population	na

Primary care

The primary health care system included family doctors, paediatric services and also dental services. Family doctors used to be responsible for long-term care of patients with chronic diseases, district dentists provided dental care for populations of defined areas. In the 1980s, for economic reasons, efforts were made to strengthen primary care. Specialist care, previously delivered at hospitals, was transferred to health centres and villages. Community nursing has been organised at district level and carried out by district nurses, who visit patients (mainly elderly people) in their homes. (105,131)

General practice

In its proper sense, general practice or family medicine had no official position in the health system before 1992. Primary care was carried out by general physicians, paediatricians, gynaecologists and physicians attached to enterprises. Now patients, and families, can register with a doctor of their choice. These physicians are now going to work more and more as GPs. They can work as employees of the municipality, as they did before, or be independent and contracted to the municipality as the body responsible for health care. Main tasks of these new GPs will be: provision of acute care, care for chronically ill, if necessary, referring patients to out-patient clinics or hospitals, screening of the practice population and health education. This is a much broader package than any doctor had before and it will take time before all GPs have adapted to all of its aspects.

Payment and income of GPs

Nowadays there is a mixed payment system. GPs employed by the municipalities have a salary, the level of which is dependent on the number of patients on their list. Contracted private GPs are remunerated by a flat capitation fee. So, their income is dependent on the size of the practice population. Private GPs without a contract rely exclusively on fees for items of service, paid directly by the patients. In addition to regular sources of income, many physicians in Hungary used to receive substantial extra money from tipping. It is most unlikely that this custom will have disappeared following the 1992 reforms. Income of physicians is not high in Hungary; it is somewhat below the average income in the country. (18)

Training and education of GPs

Basic medical education takes six years. After completion, primary specialisation may be achieved after a four to five year training period in clinics, hospital wards or medical services, and after completion of some obligatory courses. Primary specialisation is available in 29 disciplines. With respect to the training programme for general practice: it takes five years altogether, and includes special training and courses in internal medicine (6 months), paediatrics (3 months), and public health (1 month). A new curriculum for general practice / family medicine will be developed. For district doctors already in practice and company doctors who want to enter general practice, a special programme was made in March 1993. (93)

● ICELAND

The country

Iceland, an island state located in the North Atlantic Ocean, and with a very small population, was founded more than a thousand years ago by Norwegian seafarers during the Viking age of exploration. After a long period of Danish domination (since the 16th century) Iceland became a separate state under the Danish crown in 1918. However, these constitutional ties were broken on June 17, 1944, when Iceland terminated the treaty with Denmark and became a republic. In spite of its physical isolation, throughout history Iceland has remained very much a part of European civilisation. The standard of living is on a par with the other European countries. Geothermal and hydropower provides most of the country's heating and electricity. The modern economy is based heavily on fishing and a broad variety of fish products (70% of export earnings, 13% of employment), but also includes manufacturing and services as well. Some recent conflicts concerning fishing rights between Iceland and the EC (especially with the UK) have led to a treaty in 1991, which allowed Iceland to reserve most of its fishing rights for its own benefit. The head of state is a president, elected directly for four years. The single-chamber parliament, elected by proportional representation also for a period of four years, has 63 members altogether. (133,85)

Statistical key figures

Population

population in mln.	0.255
per sq. km.	2
% ann.growth 80-91	1.1
% urban	91
% under 15	25.0
% over 65	10.8
% over 75	4.5

Development and economy

human development index	98
compuls.education (yrs)	8
TV sets per 1000 pop.	na
GDP per head in \$ (ppp)	17,269

Natality, mortality and health

births per 1000	17.6
fertility rate/ child.p.woman	na
% ann.fert.reduction 1980-91	na
% contracept.preval.	na
deaths per 1000	7.0
% infant mortality (under 1)	0.55
% under 5 mortality (U5M)	0.7
% ann.reduction U5M 1980-91	na
% DPT immunised at age 1	na
life expectancy (men)	75
life expectancy (women)	80

Organisation of health care

With the confirmation of the health insurance funds by law in 1936, health care became a substantial part of the welfare state in Iceland. This was further underlined by the 1978 Health Service Act which formulated the rights of access to health service for everybody at any given time. In Iceland, the Ministry of Health and Social Security has the supreme responsibility for the policy and administration of health affairs. The Health Councils, however, are in charge of the practical execution, planning and co-ordination. All over the country there are eight medical areas (municipalities) each with its own Health Council. Such an area consists of at least one hospital and several health centres. The head of the council is the Area Chief Medical Officer, one of the physicians appointed by the Minister. As a consequence of the small size of the population and the need for efficiency, a centralisation of the financing system of Iceland's health care system has taken place. This is in contrast to developments in most of the other European countries. In addition there is a tendency in policy towards more cost sharing. (65,64)

Health financing and insurance

Standards of public health are among the highest in the world. Hospital services are provided entirely without charge, and other medical services are offered at very low cost. Dental care is partially subsidised for children of three to five years of age and for the elderly. Until 1972 the health care system was founded on compulsory health insurance.

The insurance funds were paid by contributions from the insured, the state (25%) and the municipalities (25%). After 1972 the funds were subsidised from tax revenues, of which 80% came from the state and 20% from local government. In 1989 this system was abolished again and the role of the health insurance funds was taken over by the State Social Security Institution (SSSI). Since then the role of the state in financing has increased, among other things by taking over all the running costs of health centres, while the role of the SSSI and the local government decreased. The financing from private payments remained at a level of 12-13%. With respect to medicines, since 1974 the fixed prices for prescribed drugs have been low and permanently used drugs for special diseases are totally reimbursed. User charges for out-patient care, such as visits to GPs and specialists, have become somewhat higher in 1992. The payment of user charges is restricted to a maximum amount per individual per year. Since 1977 hospitals have been financed on the basis of yearly budgets directly paid from national taxes. (65,64) Total expenditure on health care and pharmacy is listed below.

Health expenditure	81	82	83	84	85	86	87	88	89	90	91
-abs per head in ppp\$	680	758	827	825	890	1074	1220	1330	1372	1379	1447
-% of GDP	6.6	6.9	7.6	7.0	7.1	7.8	8.0	8.6	8.6	8.3	8.4
expenditure on pharmacy											
-abs per head in ppp\$	100	116	144	136	154	169	179	188	203	211	203
-% annual growth		16.0	24.6	-5.6	13.5	9.6	5.7	5.2	7.9	4.3	-4.1

Secondary care

As a consequence of the number of small towns scattered over the country, some of which are isolated, Iceland has a lot of small hospitals (20-60 beds). These hospitals are divided into categories according to their capacities. Before 1972 hospital care was paid by the health insurance funds. Now a fixed budget system exists, directly financed from national taxes. With respect to Iceland's health care personnel, 715 physicians, 1920 nurses/midwives, 1328 qualified auxiliary nurses and 219 dentists worked in the health sector in 1989. The 715 physicians can be subdivided as follows: 511 in hospital health service, 189 in non-hospital settings (of which 158 general practitioners and 31 practising specialists), 15 in administrative functions, and 75 in medical research and education. The overall physician rate is one per 357 inhabitants, which is high compared to other countries in Western Europe, but circumstances here are hardly comparable. Since 1985 patients no longer need a referral from a GP to see a specialist. The table below shows the number of acute hospital beds and the admission rate (reference year 1990). (65,64,113, 132)

In-patient care beds per 1000 population	4.9
Acute hospital beds per 1000 population	4.5
Discharges per 100 pop. in acute hospitals	16.6

Primary care

The first health centre was built in Iceland about 20 years ago. As early as 1973 the Parliament decided to establish health centres all over the country. This project is now almost finished. Most health centres operate in conjunction with a hospital. Sometimes the health centre is a unit on the hospital premises. The centres are very modern and well-equipped and often include diagnostic facilities such as ECG and X-ray machines, all in conformity to the standards recommended by the Icelandic College of Family Physicians. Three types of health centres can be distinguished: category 2 with at least two physicians besides other staff (there are about 34 of these centres), category 1 with 1 physician (their number is about 18), and category 0 staffed with nurses or midwives only but having facilities for regular consultation by a physician. Before 1989 doctors, midwives, nurses, physiotherapists in health centres were appointed by the Minister on the recommendation

of the Board of Directors of the health centre. Since 1989 they have been directly appointed by the Board of Directors. (65,64,70,124)

General practice

Tasks of general practitioners in Iceland are not easily comparable to those of their colleagues in, say, Denmark. General practitioners are specifically involved in maternity care, child health care, and school health service. In Reykjavik this is done in co-operation with obstetricians and paediatricians. General practitioners do not usually conduct deliveries. Nor do they treat patients in hospital. At the moment, about 160 men and women are in practice as general practitioners. This is one-fifth of all physicians, or one GP per 1615 inhabitants. Only a fraction of them is independently working in private practice. Since 1989 funding of health centres has been the state's responsibility, and all health personnel, including general practitioners, are now civil servants. Patients in Iceland may seek their own general practitioner, with whom they are not registered anyway. Referrals to specialist care are no longer mandatory. (65,64)

Payment and income of GPs

General practitioners in health centres get a fixed salary from the state, on the basis of a negotiated general contract, and an additional fee-for-service from the State Social Security Institution. The latter is a relatively large part. The few general practitioners who do not work in health centres also have a mixed payment system; they are paid per capita and also have an additional fee-for-service. (65,64)

Training and education of GPs

Since 1970, family medicine has been recognised as a specialism in Iceland. Undergraduate training takes 6 years. The postgraduate training consists of 1 year clinical training at a hospital, to be followed by one of the following three options:

- a. a two-year practical period in general practice in a health centre supervised by a general practitioner,
- b. one year training in internal medicine, and
- c. an 18 months training period totally spent in paediatrics, psychiatry, gynaecology and obstetrics or surgery (with a minimum of 4 months each). As an alternative for the above mentioned three optional programmes the trainee may choose a vocational training abroad lasting at least four years. Nowadays, indeed, most doctors take this last option and get their postgraduate degree in countries like the USA, Sweden and Canada. (65,93,64)

the country

The Irish Republic is situated at the extreme west of Europe. Constitutional head of state is a president, now a woman, who is directly elected for seven years. The executive head, the Taoiseach, is appointed by political parties having majority in the assembly, the Dáil Éireann. The Dáil Éireann, is directly elected for five years by proportional representation. In the early 1920s the 26 counties of Ireland became independent of Great Britain while six counties of Ulster remained within the UK. This was the start of a two-year civil war. The relationship with the UK is dominated on the one hand by feelings going back to this period and on the other hand by strong social and economic links. Many Irish have emigrated, and still do, to the United Kingdom. As an EC member since 1973 Ireland has received significant economic aid. Nevertheless it is one of the poorer members of the community. (133,85)

statistical key figures**Population**

population in mln.	3.5
per sq. km.	50
% ann.growth 80-91	0.3
% urban	57
% under 15	19.0
% over 65	11.2
% over 75	4.4

Development and economy

human development index	95
compuls.education (yrs)	8
TV sets per 1000 pop.	271
GDP per head in \$ (ppp)	11,442

Natality, mortality and health

births per 1000	15.0
fertility rate/ child.p.woman	2.15
% ann.fert.reduction 1980-91	3.4
% contracept.preval.	na
deaths per 1000	8.9
% infant mortality (under 1)	0.82
% under 5 mortality (U5M)	0.1
% ann.reduction U5M 1980-91	3.1
% DPT immunised at age 1	65
life expectancy (men)	72.0
life expectancy (women)	77.0

organisation of health care

The health system is a mix of public and private schemes. Conditions for access to services vary depending on level of income, as will be explained below. The Minister and the Department of Health are responsible for policy making in the field of health care. The execution has been largely left to several agencies. Important in the planning and organisation at regional level are the eight Health Boards. In its region, varying in size from 200,000 to over one million inhabitants, a Health Board is responsible for operating the services with respect to community care services, general hospital services and special hospital services. The division 'community care services' consists of preventive health services, general practice services and other domiciliary services (e.g. dental care and public health nursing). Parallel to the public system there is a private sector mainly run by doctors also involved in the public system.(117,48,21)

health financing and insurance

Most important source of financing is central taxation (85 to 90%). Secondary sources are contributions from eligible persons and user charges. Three categories of eligibility determine what services have to be paid for and what services one is entitled to without charge. These categories are:

I Those below a certain income ceiling (approx. 6300 Irish pounds a year for individuals) and 'unable without undue hardship to arrange GP services themselves' are entitled to the full range of public services without charges: GP services and prescribed medicines, specialist out-patient and hospital services, dental care and ophthalmologic care. Some 38% of the population (many pensioners) is covered by this scheme. The 'medical card' which is required for this category is provided by the Health Boards.

II People not belonging to category I with an annual income below some 16000 pounds,

mainly employees and their families ($\pm 47\%$ of the population) have coverage of specialist out-patient care, hospital services and maternity and infant welfare within the public service. There is no coverage of GP services and the cost of drugs (except those for specific chronic illnesses) is reimbursed only as far as they exceed an amount of 35 pounds a month, for three consecutive months. Besides there are several co-payments.

III The 15% of people with higher incomes are liable to pay hospital consultants fees and are not entitled to the maternity and infant scheme. The remaining part is identical to category II.

There is free access, whatever the category, to treatments for infectious diseases, community protection programmes and hospital treatment for certain diseases for children under 16. Well over 40% of the population, those in categories III and II who want a supplementary health insurance, have entered the Voluntary Health Insurance scheme. Subscribers can make a choice from a range of so-called plans, which provide different coverage to different premiums. These premiums are income tax deductible. Public hospitals are financed on the basis of prospectively determined overall budgets. Recently these budgets have linked to the type and volume of services provided. In the funding of public as well as private hospitals the Diagnosis Related Groups (DRGs) methodology is used to allocate resources. Total health care expenditure and expenditure on pharmacy are summarised below. (145,117,64,48,21)

Health expenditure	81	82	83	84	85	86	87	88	89	90	91
- abs. per head in ppp\$	484	496	519	538	570	582	593	620	652	748	840
- % of GDP	8.8	8.4	8.5	8.2	8.2	8.1	7.7	7.3	6.9	7.0	7.3
expenditure on pharmacy											
- abs. per head in ppp\$	72	76	74	79	86	92	93	105	121	137	na
- % annual growth		6.7	-3.1	6.8	8.7	6.6	1.6	13.1	15.1	12.7	

Secondary care

The General Hospital Programme provides acute in-patient care in acute hospitals, of which there are three types. First there are the public hospitals administered by the Health Boards: the large Regional hospitals, the County hospitals and the District hospitals. These are all directly state financed. The second type are the Public Voluntary Hospitals, partly owned by religious orders and partly by boards of governors. In this heterogeneous category there are teaching and non-teaching hospitals, cottage hospitals and special hospitals. Public Voluntary hospitals are largely state funded. The third and smallest category consists of the private hospitals which are funded exclusively from patients fees. Of the 5223 practising doctors in 1988, 2978 (57%) was working in hospitals as a consultant (1100) or non-consultant, e.g. House Officer, Registrar (1878). Doctors providing out-patient care in hospitals are normally salaried, while hospital consultants have a contractual income related to the number of their public patients. Most hospital doctors also work in the private scheme on a fee-for-service basis. About 10% of the consultants works exclusively in a private practice. The table below shows the number of acute hospital beds and the admission rate (reference year in-patient care beds 1989; rest 1990). (64,21)

In-patient care beds per 1000 population	6.0
Acute hospital beds per 1000 population	3.5
Admissions per 100 pop. in acute hospitals	14.9

Primary care

Community health services include general medical service, community nursing and care for long term illness, refunding of above-ceiling cost of drugs for categories II and III, maternity and infant care, dental, ophthalmologic and aural services. Dental services are provided by some 330 salaried Health Board dentists and 800 private dentists on a fee-for-service basis (1988). In 1989 1099 pharmacists were participating in the Choice of Doctor scheme, in which prescribed drugs are provided to Category I without charge. Community nursing services, provided by the Health Boards through 1289 public health nurses (1989), include: care for acute chronic and terminally ill people in their homes, care and supervision of the frail and elderly and handicapped, monitoring health of children (until the end of primary school) and ante/postnatal care. In some areas cervical cytology tests are done. Poor liaison exist between community nursing and general practitioners. The Nursing Board is for registration, undergraduate training and examination (also of midwives) and postgraduate training. (117,48,21).

General practice

The total number of GPs is 2245, or 0.64 per 1000 population (1988). General Medical Service in the public scheme is provided by only part of them; 1568 GPs participate in the Choice of Doctor scheme (Category I). Only this part of the population (38%) is registered with a GP. The remaining 677 GPs work exclusively in the private sector or in occupational medicine. Entrance of GPs in the public scheme is regulated by the Health Boards. Since demand for positions exceeds supply GPs have to compete for vacancies. Although, strictly speaking, this would not apply to categories II and III, the code of practice is that patients who are referred to a consultant would normally require a referral letter. Thus, in practice GPs have a gate-keeping position to secondary care. Besides seeing patients under the public scheme, GPs see private patients (indeed part of the doctors only see private patients). It is not allowed to accept fees from category I patients. Although there are some group practices in cities, Irish GPs predominantly work alone. (17,117,64,21)

Payment and income of GPs

GPs are private entrepreneurs. For their public patients they receive a variable capitation payment depending on age, sex and geographical location of their patients. Calculations and payments to GPs and pharmacists are made by the General Medical Services Payments Board. In the contract there are also provisions for pensions, sickness benefit, holiday pay, maternity leave for female doctors and support for continuing medical education. In addition GPs receive a lump sum for practice cost. Their other patients pay a fee-for-services. These fees are different for surgery contacts and domiciliary visits. (117,64,21).

Training and education of GPs

After six years students are graduated in medicine. For registration as a medical practitioner one year of internship is required. Minimum postgraduate training for GPs (to entitle them to later entrance in the Choice of Doctor scheme) is two years, of which at least six months have to be spent in general practice. A special GP vocational training is not yet obligatory. The Irish College of General Practitioners, which determines training criteria, recommends at least three years of vocational training. Candidates for vocational training programmes are selected by regional training committees. Continuing medical education is organised by academic and professional organisations and encouraged and co-ordinated by the Postgraduate Medical and Dental Board. (17,48,93)

The country

The republic of Israel is situated in the Middle East at the eastern end of the Mediterranean Sea. It was recently accepted into the European Region of the World Health Organisation. As a Jewish nation, which is surrounded by predominantly Islamic countries, in its current form it has a relatively short history. Although as early as the 1920s, Jewish immigrants already claimed the land, it was only after the second World War in 1948 that the formal foundation of modern Israel took place. But to this day the territory is heavily disputed by the Palestinians. This conflict has been a recurring source of tensions in the region. Recently, Israel and the Palestinians have started an early dialogue in order to find a peaceful solution of this highly delicate question. Its population has grown rapidly since its founding due to immigration of Jews from Eastern Europe, North Africa, Russia and other countries.

Statistical key figures (additional source:13)

Population		Natality, mortality and health	
population in mln.	5.2	births per 1000	21.4
per sq. km.	231	fertility rate/ child.p.woman	2.6
% ann.growth 80-91	2.1	% ann.fert.reduction 1980-91	1.2
% urban	99	% contracept.preval.	na
% under 15	34	deaths per 1000	12.4
% over 65	8.8	% infant mortality (under 1)	1.0
		% under 5 mortality (U5M)	1.2
		% ann.reduction U5M 1980-91	4.2
		% DPT immunised at age 1	88
development and economy		life expectancy (men)	74.9
compuls.education (yrs)	10	life expectancy (women)	78.4
TV sets per 1000 pop.	266		
GDP per head in \$	12,010		

Organisation of health care

Over 95% of the population is covered by a comprehensive health insurance which includes curative and preventive out-patient care as well as hospital care. The foundation for this care is in the strong egalitarian welfare ideology which prevailed in the state since its founding. The Ministry of Health performs two roles in the health care system. Its main function is the supervision and planning of health services provision. The second role of the Ministry is that of a direct provider of health care through Ministry hospitals and other curative and community maternal and child health clinics. The Ministry of Health is divided into three main branches: a medical division, the administration, and the planning and budgeting division. The medical division has the supervision of hospitals, psychiatric services, and geriatric and rehabilitation services. The Medical Division is also responsible for the National Public Health Service which has ultimate responsibility for environmental health, food supervision, public health laboratories, personnel and community health services. For administrative purposes the country has been divided into six districts and fourteen sub-districts. District offices are headed by medical directors who are centrally appointed. Despite the formal organisational and political power of the Ministry of Health, the sickness fund Kupat Holim Klalit is, in fact, to a greater extent responsible for the provision and delivery of health care to a large segment of the population. Kupat Holim Klalit is a sub-organisation of the Histadrut (the General Federation of Labour in Israel), and has decisive influence in national health matters. The broad membership base of Kupat Holim Klalit has been a source of power for both the Labour Party and the Labour Union. Three other small sick funds, Maccabi, Leumit and Meuchedet, provide medical services to the 30% of the population not covered by Kupat Holim Klalit. Together the sick funds provide comprehensive health care in kind, including out-patient care, hospital, pharmacy, convalescent and other services. The smaller sick funds do not have their own hospitals. Their patients may be admitted to hospitals of the government or Kupat Holim Klalit, who are reimbursed for these services. A

third component of the health care system includes voluntary non-profit institutions, like Hadassah Medical Organisation, religious and missionary hospitals, which may provide care to special segments of the population. In recent years there has been growth in the private sector, including private hospitals and nursing homes. Although the provision of private health care is still a limited phenomenon, its growth has been interpreted as a sign of dissatisfaction with public medicine. (105,121,155,2)

Health financing and insurance

Health care is funded from several sources. Most important are premiums paid on a voluntary basis by members of the sickness funds. Insurance premiums are paid partly by employees and partly by employers, who are required to do so by law. Self-employed individuals pay the full insurance premium. A second source of finance are tax revenues. However, the direct governmental allocation has decreased in recent years. The government is not only a direct provider of care through community clinics and hospitals but also subsidises the sick funds for the provision of certain services to their members. Financial support from abroad is a third source of funding. Various voluntary and charitable organisations, often focusing on specific issues such as mother and child care, ambulance services, cancer and other issues, rely on grants from outside the country. Finally, direct payments to private doctors and additional payments to private insurance companies are an additional source of financing of care. Almost all kinds of medical care are covered by the voluntary health insurance plans. In 1988, the Long-Term Care Insurance Law provided coverage for long-term nursing care. Presently, only dental care is not an insured service. This has resulted in the growth of a number of privately dental insurance plans. Only a small minority of the population is not covered by any plan. These uninsured are mainly found among the very wealthy and the non-Jewish minorities who were traditionally not members of the Histadrut trade union. Recent figures on health spending are listed below. (105,121)

Health expenditure 1990

abs.per head in \$	706
% of GDP	7.9

Secondary care

Hospitals have been established by public and voluntary agencies, Kupat Holim Klalit, the Ministry of Health and charitable and religious organisations as discussed above. There are a few hospitals in the private sector. Hospitals accessible to the population, no more than 30 kilometres from most communities and villages. In 1991 there were 192 hospitals in Israel, classified as follows: general care (46), psychiatric (26), chronic diseases (118), and rehabilitation (2). With regard to the ownership, 71 hospitals were private, 31 were government-run, 14 belonged to the Kupat Holim Klalit and the remaining 76 belonged to several other non-profit organisations. The total amount of hospital beds, in the same year, was 29,527 or 6.0 beds per 1000 inhabitants. Most physicians, including specialists, are salaried workers employed by Kupat Holim Klalit or the government, whose hospitals provide work for about a quarter of the total amount of Israeli physicians. Other physicians work for smaller health funds and other public institutions. Those who are not attached to hospitals mainly work in out-patient clinics. Since the 1970s Israel has quite a surplus of physicians. In 1985, about 12,800 physicians worked in the health sector, or nearly 335 inhabitants per physician. The surplus has grown dramatically since 1990 with the immigration of over 7000 physicians from the former USSR, of whom about 4200 have been licensed. Recently, government medical licensing examinations have been instituted for immigrants to limit the number who will go into practice and ensure a minimum level of competence. (105,121,155,2)

Primary care

Primary care is available to the population through a large network of out-patient clinics operated by Kupat Holim Klalit (1290 clinics in 1986) and the three other sickness funds. Although some physicians have their own private practices, most of the primary care physicians are attached to the out-patient clinics. In the larger urban clinics, doctor-nurse teams may be assisted by social workers, health educators and dieticians. Patients have the freedom to choose their primary care doctor within the sick fund clinic. The primary care clinics are located throughout the country in development towns, villages, semi-collective (the moshav) and collective agricultural settlements (the kibbutz). Doctors may attend the more isolated clinics only a few times a week and hence the day-to-day work of rural clinics is often done by nurses. Worthy of note are the kibbutzim which may be located in geographically remote areas, yet have qualified staff and well stocked facilities at their disposal. Non-insured people usually apply to out-patient departments of government hospitals (free of charge) or to private physicians (privately paid). When these persons go to primary care clinics they can be treated after payment of a small fee. (105,121,155)

Payment and income of GPs

Most doctors working in primary care are employed in salaried positions by one of the sick funds. The salaries are partly dependent on the number of patients on the list with supplements provided for care of infants or elderly patients. The level salaries are a result of negotiation between the Israel Medical Association, the sick funds and the government. In 1983, a stormy wage dispute was marked by a prolonged doctor's strike. (105,155)

Training and education of GPs

The four medical schools in Israel produce about 300 graduates a year. In addition many Israelis are educated in European medical schools and return to the country to practise on completion of their medical studies. All medical graduates must complete one year of general internship in order to obtain a licence to practise. There is a recognised programme for the training of specialists in family medicine lasting four years. It includes two periods of supervised practice in out-patient clinics (totalling 21 months) and two years of hospital rotations in internal medicine, paediatrics, psychiatry and elective rotations. Specialists in family medicine now comprise 10% of general practitioners in the country. (93)

The country

Italy is a large peninsula, surrounded by the Mediterranean Sea, the Adriatic Sea, the Ionian Sea and the Tyrrhenian Sea. It is the cradle of the glorious Roman culture and it has been a focal point in early civilisation. The country is unrivalled with respect to its art treasures, churches and museums. The Italian government hardly manages to organise and finance the protection and restoration of all these items of cultural value. On the other hand, this cultural heritage provides an important source of income for the economy, because of the enormous flow of tourists. Governments in modern Italy are usually granted only a short life. Since 1948 the country experienced more than fifty changes of government. Despite the abominable economic and political situation after World War II, the economy recovered remarkably. This progression however could not remove the dichotomy between the rich industrialised north and the poor agrarian south. In the north the unemployment is comparatively low and average incomes are high, meanwhile the south suffers from a considerable unemployment. Another national problem, with a history of many decades already, is the organised criminality which seems to have infiltrated important parts of society. The population seems to be fed up with the mafia and recently the government intensified its fight against it. (85,133,)

Statistical key figures

Population

population in mln.	57.7
per sq. km.	191
% ann.growth 80-91	0.2
% urban	69
% under 15	16.7
% over 65	15.4
% over 75	6.3

Development and economy

human development index	96
compuls.education (yrs)	8
TV sets per 1000 pop.	423
GDP per head in \$ (ppp)	16,896

Natality, mortality and health

births per 1000	12.7
fertility rate/ child.p.woman	1.30
% ann.fert.reduction 1980-91	2.4
% contracept.preval.	78
deaths per 1000	9.5
% infant mortality (under 1)	0.83
% under 5 mortality (U5M)	1.0
% ann.reduction U5M 1980-91	4.8
% DPT immunised at age 1	83
life expectancy (men)	72
life expectancy (women)	79

Organisation of health care

In many ways the Italian health system shows similarity to the British system. Both are national services, financed by funds voted by parliament, both distinguish primary care from secondary care, and both are structured by means of indicative regional planning and local managerial control. In 1978 the Servizio Sanitario Nazionale (SSN) law provided for the transformation from a social security health system into a national health system. In a way the organisation of health care takes place on five levels: the state, the regions, the communities, the local health units and the basic health districts. The first one, the state, is in charge of the political planning and regulation. The central power is the government, which oversees the health regions and reviews (and, if necessary, revokes) regional legislation. Other central health authorities are the National Health Council, which advises the government, and the Ministry of Health which in turn is advised by several boards and institutes. The second level concerns the regions, administrative areas providing every kind of health and social care. They form the main administrative body of the SSN, and are ultimately responsible for SSN provision. Each region (there are 20 of them) has its own elected council and ruling group (giunta), and administrative departments. The regions are divided in communities. The intended size of the communities is between 20,000 and 50,000, but in fact larger distinctions occur. The local health units, the so-called Unità Sanitaria Locale (USL) are either parts or combinations of communities. These USLs are responsible for the daily management of health services, and are in charge of the co-

ordination of hospitals. Although the SSN-law intended to divide the health units in smaller divisions (distretti) to organise primary care, for political and financial reasons only few USLs have been active in making districts work. Besides the provision of hospitals, (poly)clinics, and the contracting of GPs, the USL are responsible for health education, occupational health, pharmacy, family advice, child health care, veterinary care, and information services. Parallel to the National Health System, Italy has an extensive private sector. In some regions 50% of admissions are to private hospitals. Especially in large cities, private out-patient consultations are frequently used. (73,60)

Health financing and insurance

Total expenditure for the health services is determined yearly at central government level through the national budget. Funds are allocated quarterly to the regions. These funds are financed by contributions paid by each independent and/or employed worker, additional quota paid by employers for each of their employees, health taxes paid by independent workers, and the national government which covers the remaining expenses. So the intention that the SSN would change from mainly insurance funding to funding out of general taxation has never been fulfilled. Instead the contributions from state income even fell during the 1980s. Despite the intention of the SSN law to ensure services free at point of use, direct charges have been introduced for some non-hospital services (drugs, diagnostic examinations, therapeutic procedures). However, hospital care and curative treatment is provided free in hospitals, clinics and other establishments falling under the SSN. For special dental treatment partial reimbursement is provided. A few drugs, which are considered essential, are free of charge, excluding a small fixed fee for each prescription and a percentage of 30% up to 40% for non-essential drugs. For low income groups no charge is made. With respect to the private sector (which accounts for 20% of total health care expenditure), no limitations are imposed on private insurance companies. Citizens can decide not to use public services and go elsewhere (but in any case they have no choice subsidising the SSN by paying taxes). The private insurance companies can offer coverage for services supplied by the private sector. Total expenditure on health care and expenses on pharmacy are listed below. (17,73,12)

Health expenditure	81	82	83	84	85	86	87	88	89	90	91
-abs per head in ppp\$	616	687	716	746	814	849	955	1058	1150	1296	1408
-% of GDP	6.7	6.9	7.0	6.8	7.0	6.9	7.4	7.6	7.6	8.1	8.3
expenditure on pharmacy											
-abs per head in ppp\$	89	109	116	120	146	155	179	191	208	238	na
-% annual growth		23.1	6.2	3.9	21.1	6.6	15.4	6.7	8.9	14.3	na

Secondary care

More than half (about 65%) of the average local health budgets is spent on hospitals. The majority of hospitals is public, mostly directly managed by the USL, but some are contracted. The latter have different financing compared to the main USL hospitals, and are reimbursed by the SSN by a fixed sum per treatment. The Ministry of Health expects a general hospital to include at least four basic services: general medicine, surgery, obstetrics and gynaecology, and paediatrics. The public hospitals are divided into multi-zonal hospitals, controlled by the regional authorities, zonal hospitals, for which the USLs are responsible, and university institutes. In 1990 the SSN hospital network included 972 hospitals managed by the USLs, 8 university clinics linked to the SSN, 40 religious hospitals, and 669 nursing homes. Patients are referred for specialist examinations by their GP or go directly if fee-paying. Direct access for patients to psychiatric paediatric, obstetrics and gynaecology and ophthalmological out-patient department is allowed without referral from their GP. Referrals through the SSN can only be made by the GP with whom a patient is registered. Mutual referrals between specialists are now allowed within the SSN facilities.

There are three forms of out-patient specialist care: 1. hospital out-patient care, in which doctors are remunerated by extra payments (the number of patients per session is limited); 2. specialist care in free-standing public clinics and polyclinics (in these SSN clinics doctors are employed part-time on sessional fees, and SSN patients need to be referred by their GP); 3. specialist care in private clinics and private diagnostic facilities (laboratory services and radiology). These private doctors are contracted on sessional rates if they do not own the clinic. If they run the clinic, they are paid per contact by the USL, or directly by the patient, if they own the clinic. (73)

Primary care

Originally, the USLs were to be divided into districts to provide primary health care. The basic health and social services districts were intended by law as technical functional structures to provide first level services and emergency first aid. In the blue prints the district organisation is intended to be the structure for the provision of first level services. Staff working in the districts are employed by the USL. The range of users was to vary between 5,000 and 20,000 inhabitants for urban areas. In reality, the organisation of the districts proceeded very slowly and the structure of districts still differs considerably from one region to another. Primary care in Italy is dominated by general practitioners because of an excess of doctors and a relative lack of nurses and social workers. GPs usually work single-handed, though they may share clinic premises with one or more colleagues for financial reasons. Patients are registered with one single doctor, not with the doctors working in partnership. Professional nurses are playing an important social and professional role in the newly organised National Health Service. They can be positioned in the different hospital structures and clinics as qualified members of the health team, but can also be directly involved in other activities related to the institutional goals of the National Health Service. Professional nurses are organised in the Health Role according to qualifications or functional positions. Such qualifications are: a. Executive Professional Operator, who has didactic and managerial functions. b. Professional Operator Co-ordinator with co-ordinating functions, and 3. Professional Operator Collaborator, who has general and/or paediatric nursing assistance functions. (73,60,136)

General practice

There are approximately 62,000 GPs in Italy, which equals to a relative high density of one GP per 930 citizens. Over 40% of all GPs are underemployed, i.e. they have a very small list of patients. Before he or she can start working in a practice, a GP has to be admitted to a list of the USL administration. However every graduate doctor can register on this list for admission into general practice because no vocational training is required. Every three months, vacancies are filled according to that list. In every defined geographic area the optimum ratio is considered one GP for 1000 patients. When this ratio is reached, no more GPs are recruited. The maximum number of patients is 1500 or 1800 depending on establishment after or before 1979. Individuals aged 14 or older have to turn to a general practitioner for primary care, those under the age of 14 are registered on a list of a primary care paediatrician. The GP has the responsibility to organise the practice, and is free to employ nurses and/or other allied staff. These are paid by the GP, as they are not contracted by the USL. Nevertheless, partnerships and group practices of GPs and staff, like nurses, secretaries and receptionists, are still unusual (although some change can be noticed). In addition to surgery contacts physicians are performing home calls, which cover 20-30% of all contacts. (17,136,73,60)

Payment and income of GPs

Every three years negotiations take place between the Italian Medical Association and the National Health System. These include working conditions, capitation fees, remuneration, and compulsory postgraduate courses. GPs under the National Health Scheme are paid a fixed capitation fee by the USLs for each patient on their list. Every six months these fees are being adapted to possible increases in the costs of living. The capitation fee is

differentiated, depending on the patient's age and the number of years of experience of the GP. In addition, the GP receives a reimbursement of practice expenditure, and an amount to cover fees for liability insurance. Finally, about fifteen percent of the capitation fees are meant to cover their old age and disability pension fees. Those GPs who also work as a district medical officer, as a side line job, of course receive a salary for that part of their work. (40,73,60)

Training and education of GPs

Undergraduate medical education takes six years. In addition there is a compulsory six-months internship. However, this may be integrated in the final year of the undergraduate training period. No vocational training is compulsory to become a GP. Those who have completed the national vocational training scheme (the first ended in December 1992) have no precedence in being appointed for vacancies. After basic medical education an Italian GP can start a practice. However, since 1985 Italian GPs are obliged to follow postgraduate training courses. The minimum time to be spent on this form of continuing medical education is 32 hours per year. (93)

LATVIA

The country

As one of the three Baltic states, Latvia regained independence in 1991. Since it was annexed by the Stalin administration in 1940, it has been part of the Soviet Union. After 'glasnost' and 'perestroika' gave rise to the break up of the communist power block, the Latvians seized their opportunity. After a year of violence by Soviet troops, in September 1991 Latvia's independence was recognised by 'Moscow', by the State Council, which temporarily replaced the Congress of People's Deputies. The country's international relationships are at an in-between stage. On the one hand contacts with Russia, as a big neighbour its most obvious partner, have been disturbed. This country is currently holding back raw materials and other essential commodities. On the other hand new connections, e.g. in Western Europe, have not yet become well established. This situation has consequences for the economic situation. (133,28)

Statistical key figures (sources:37,99)

Population		Natality, mortality and health	
population in mln.	2.7	births per 1000	12
per sq. km.	41	fertility rate/ child.p.woman	1.9
% ann.growth 80-91	na	% contraceptive prevalence	na
% urban	70	death per 1000 pop.	13.5
% under 15	22	% infant mortality (under 1)	1.5
% over 65	12	life expectancy (men)	64
		life expectancy (women)	75
Development and economy			
compuls.education (yrs)	6		
TV sets per 1000 pop.	na		
GDP per head in \$	6,360		

(Sources show quite different infant mortality rates; the mean value has been taken)

Organisation of health care

With respect to health care, despite the intentions of changes no new legislation has taken place until now. So, basically the system of the time before the independence is still in force. A draft outline for a new law on social security and health care has been prepared. This law will especially affect the organisation of primary care. Currently health care is organised on a territorial basis in three layers, according to the administrative structure. The top level is the Ministry of Health as the planner and financier of the system. In-patient secondary care is provided at regional level in hospitals. Each region is divided into a number of districts, in size dependent on the population density. Primary care, and to a certain extent also out-patient secondary care services, are delivered per district from so-called polyclinics. In remote areas health stations provide care as satellites of the polyclinic. In urban areas there are separate polyclinics for adults and for children. Larger towns also have dispensaries for out-patient specialist care. Health care is basically freely accessible and covers the whole population. For drugs, medical aids and surgical appliances there is some co-payment. Allocation of care is geographically determined according to the place of residence. There is not yet free choice of doctor (and of patient). During the Soviet period health care suffered from lack of material investment. That is why facilities are often old fashioned and why there is a lack of sufficient essential equipment and instruments. (8,150)

Health financing and insurance

Health care is financed partly by the state and partly from municipal budgets. The whole population is entitled to all services. For some services there are co-payments. In general, resources for health care are limited so that more sophisticated diagnostics and treatment cannot always be provided at an optimal level. Health expenditure and expenditure on pharmacy are indicated below (ref. year 1992). (28,8)

Health expenditure 1992

- abs. per head in \$	10
- % of nat. income	2.4
Expenditure on pharmacy (89)	
- abs. per head in \$	2

Secondary care

In-patient care is largely separately organised from out-patient care. Out-patient care is mainly provided at district level by the specialists in polyclinics. These specialists, such as gynaecologists, surgeons, neurologists, ophthalmologists, endocrinologists and cardiologists are directly accessible, and thus provide a lot of primary medical care. Specialists in polyclinics have no appointments in hospitals. Hospital based specialists can be consulted without referral, however it will often be after the patient has been seen by a physician in the polyclinic which is affiliated to that hospital. For children under the age of fourteen there is a special system of provision with paediatricians and children's out-patient clinics. In 1992 the number of hospitals was 177 with a total number of 33,800 beds (which equals to 12.7 per 1000 population). The last few years this number has been reduced considerably; in 1989 the bed ratio still was 14.7 per 1000 population. With 10,700 physicians the ratio was one physician per about 250 inhabitants. (28,8)

Primary care and general practice

Polyclinics and the related health posts are the heart of primary care. Care is provided for the adult population in an area with well-defined boundaries. This area again is subdivided in districts of about 2000 adult inhabitants, where the district physician is responsible for primary medical care assisted by district nurses. As stated before, the district doctor is by no means the only provider of primary care. Children have their own supply of paediatric care, specialists are direct accessible and in the working situation people have their company doctor. In rural areas primary care is more integrated in smaller teams. There, the district doctor supplies a broader package of services to the whole population, including children. In 1992 the number of polyclinics was 342 and the number of polyclinics for children and women 288. Emergency services are rendered by ambulance teams all over the country. In the countryside these teams consist only of a doctor and a driver. In Riga there are also specialised first aid teams, for example, for cardiology and traumatology. Currently developed plans for change of the health care system envisage the introduction of general practitioners, probably both employed and independent. Implementation is hampered by lack of experience, not only with the organisation of general practice, but also with related models of change of the financing and payment structure. And probably more serious is the lack of necessary financial resources. Nevertheless, at present 20 general practitioners have qualified and most of them have started working as such). (28,8)

Payment and income of GPs

Until now, all doctors have been state employed. Their salaries are low, even in the Latvian context. In the future there will probably be independent GPs, but at present, with increasing gloomy economic prospects, conditions are bad for starting as a private GP. (8)

Training and education of GPs

After six years of undergraduate training, a two-year training in internal medicine is required to become a district doctor. Since 1992 a training programme in general practice has been developed. For doctors already practising for a number of years there is a special part time course. After successfully passing the exam they are entitled to work as a GP. A small number of physicians has taken this opportunity so far. New graduates can enter a two year training course in general practice. Soon a first group of twelve will complete this programme. (8,93)

The country

The southernmost and most populated of the Baltic states is Lithuania. Like the other two, it has recently regained its independence. After the German-Soviet Pact between Hitler and Stalin it was annexed in 1940 by the Soviet Union. The disintegration of communism helped the Baltic countries to achieve and maintain their independence, which in Lithuania was declared after a convincing result of a referendum in February 1991. Economically the country is now in a difficult position. For necessary supplies of energy and raw materials market prices have to be paid in hard currency. There will probably be an increased westward orientation, not only to its large neighbour Poland but also to the countries of Western Europe. (133,85)

Statistical key figures (sources:37,99)

Population		Natality mortality and health	
population in mln.	3.7	births per 1000	15.4
per sq. km.	57	fertility rate/child.p.woman	2.0
% ann.growth 79-89 (a)	0.8	% contracept. preval.	na
% urban	69	deaths per 1000 pop.(a)	11.1
% under 15	24	% infant mortality (under 1)	1.4
% over 65	11	life expectancy (men)	67
		life expectancy (women)	76
Development and economy			
compuls. education (yrs)	11		
TV sets per 1000 population	na		
GDP per head in \$	5,830		

(a= personal communication) (Sources show quite different infant mortality rates; the mean of both values has been taken in this table)

Organisation of health care

At present the health care system is going through radical changes. The turbulent economic and political situation, and the poor technical conditions make it hard to realise reforms according to formulated goals and objectives. Nevertheless, a new national health conception, based on the principles of the WHO's 'Health for all in 2000' programme, was created and subsequently discussed and approved by the parliament. In the communist past, the organisation of health care services was highly centralised. Now, the trend is towards a system with more executive power for the local authorities and partial privatisation. Most larger health care institutions, like hospitals, are subordinate to the Ministry of Health, while primary care is intended to be largely private initiative. As an advisory body the National Health Council advises the minister on health policy making and the implementation of priorities. In addition to the administration of the Ministry of Health, several other departments are still in charge of medical care. Departmental involvement with health care exists with respect to the army, civil aviation, and railway business. In future the provision of health care will be largely based on primary care provided by general practitioners and out-patient specialists. Since changes will be implemented gradually, nowadays the old hierarchical structure is predominant, with its territorial allocated resources. From general to special it includes medical stations in the districts (residential area, school or company), out-patient departments at regional level and, finally, general, special and academic hospitals. Independent general practice is a slowly growing sector, but it is intended to be important in the future. At present a number of physicians and nurses are working privately in addition to the public system. The development of private practice is stimulated by the government. (97,96)

Health financing and insurance

The existing centralised state budget financing system will be gradually changed into a mix of social insurance, supplemented by direct fees for specialised service as well as charity contributions. In the long run financing could be based on insurance alone, resulting in a system with both an obligatory and a voluntary health insurance scheme. During the Soviet-period, health care used to be entirely financed by the state. Now employers and employees have to pay an equal part of the insurance premium. These premiums make up 80 to 90% of the total health care budget. The rest of the amount needed for health care is funded from tax revenues. In general, financing of health care will be more and more decentralised to regions and municipalities. The level of health care expenditures has remained 3.5 to 4% of the national income for a series of years, until 1991 when it increased to 5.4%. Not included in this percentage, however, is medical assistance and humanitarian help from foreign origins. Especially the provision of medical drugs is for a significant part from abroad. (97)

Secondary care

Secondary care services are provided by hospitals and out-patient clinics and partly by polyclinics. There are no well-defined boundaries between primary and secondary care. People can see out-patient specialists directly. In 1991, the number of hospitals was 202, of which a large number are smaller local hospitals. There are several types of hospitals: district centre hospitals, other district hospitals and local or village hospitals. More specialist care is provided by the larger district hospitals of especially Vilnius, Kaunas, and Klaipėda. Some hospitals are part of scientific institutes or teaching clinics. In the near future academic clinics should provide high quality specialist care. Hospitals are still all state-owned, although decentralisation will probably change this situation within a few years. Hospital bed supply and admission rates are given below.

Number of hospital beds per 1000 population (91):	12.4
Hospital admissions per 100 population (90):	17.8

In addition to hospitals, secondary care is provided by specialists in polyclinics. These clinics are usually attached to hospitals. In larger towns, some polyclinics provide out-patient specialist care independently. In 1990 the number of polyclinics was 417. The total number of physicians in Lithuania presently amounts to about 16,584 of which some 570 have non-medical functions. With about one physician per 225 inhabitants, Lithuania ranks among the highest in the world in physician density. In the 1980s the increase of physicians was 28% and this number is still growing. (96,69)

Primary care and general practice

An active primary health care policy has high priority at present. The general practitioner or family doctor is to become the main figure in this system. Now primary out-patient health care is organised according to the territorial principle, i.e. attached to specific residential areas, schools, or places of work. Central in this system are the local therapist for adults and the paediatricians for children. Primary care is in fact provided by three kinds of institutions: medical stations, and out-patient departments. About 1000 medical stations provide first medical aid, like physical therapy, vaccination, antenatal care, and the sale of elementary medicines. They take care of the population of that district (inhabitants, workers or children). Care is largely provided by allied personnel. Ambulatories (total number 180), provide first medical aid to the rural population, and may offer clinical investigations, physical therapy procedures, and hospital day-time care. The medical staff consists of therapists, paediatricians, dentists, and allied personnel. In towns and regional centres, out-patient departments offer primary and specialised care. These institutions provide care for 25,000 to 100,000 individuals. They may work independently or as out-patient units of a central regional hospital. A large number of specialisms are represented in these out-patient departments. In 1991 the average contact rate for all health care institutions was 9.5 per

inhabitant. If only those facilities that are under the responsibility of the Ministry of Health are taken into account the contact rate is 7.2 per inhabitant per year. Of all physicians 9,056, or well over half, are working in out-patient care. The number of district physicians is 1,411, about 8%, and the number of pioneering GPs is between 100 and 200. (97,69)

Payment and income of GPs

Most doctors are still state employed and have a salary. Independently working doctors are paid by their patients on a fee-for-service basis.

Training and education of GPs

Until now medical education was strongly focused on specialisation. Since 1991 new centres for GP training have been created at the Kaunas Medical Academy and the Vilnius University. Besides, training programmes will be developed for primary care nurses and social workers. Of the practising physicians, especially district doctors and paediatricians are intended to be the future GPs. For this group a re-training programme was started in 1992. After completion, these physicians are qualified and certified as general practitioners. (93,97)

● LUXEMBURG

The country

Luxemburg, officially Grand Duchy of Luxembourg, is a constitutional monarchy and one of the smallest nations in Europe. The country has three official languages: Luxembourgish, French and German. French is mainly used in public administration, while Luxembourgish is spoken by native Luxemburgers on their own. After 1830, when the Belgians revolted against the rule of king William I of The Netherlands, Luxembourg was divided between Belgium and The Netherlands. The latter part was made a grand duchy, ruled by the Dutch king until 1867. After this year the neutrality of Luxembourg was guaranteed by the European powers and the duchy was given to the House of Nassau. Now Luxembourg is a member of the EC, belongs to the Benelux Economic Union, and has an economic union with Belgium (BLEU). The developed market economy is based on heavy industries (steel) and international trade and banking. More than 100 banks have branches in Luxembourg, and also the EC European Investment Bank headquarters in this country. (133,85)

Statistical key figures

Population

population in mln.	0.378
per sq. km.	146
% ann.growth 80-91	0.32
% urban	84
% under 15	17.2
% over 65	13.6
% over 75	6.0

Development and economy

human development index	95
compuls.education (yrs)	9
TV sets per 1000 pop.	na
GDP per head in \$ (ppp)	20,628

Natality, mortality and health

births per 1000	12.9
fertility rate/ child.p.woman	1.64
% ann.fert.reduction 1980-91	na
% contracept.preval.	na
deaths per 1000	9.7
% infant mortality (under 1)	0.9
% under 5 mortality (U5M)	0.9
% ann.reduction U5M 1980-91	na
% DPT immunised at age 1	na
life expectancy (men)	71
life expectancy (women)	78

Organisation of health care

The structure of the Luxembourgian health care system is based on a highly privatised hospital sector and doctors in independent practice. More than 50% of all hospitals is private and belongs to religious communities. The other hospitals are owned by local communities. Despite the major role of private initiative, hospitals, with only a few exceptions, are non-profit. Activities in the hospital sector are subject to government regulation. The Ministry of Health is charged with the organisation and planning, the establishment of new facilities and the extension of existing ones. For this purpose the country is divided in three areas: north, central and south. The 1982 hospital plan contains specified requirements as regards the building of new hospitals and the introduction of new medical services in existing hospitals. In its supervising role the Ministry is assisted by the Medical College and the Hospital Board. Tariffs and doctor's fees are centrally negotiated between organisations of physicians and the Union of the Sickness Funds and subsequently laid down in a collective contract. In 1993 a new hospital plan is going to be developed by the government. Its main purpose is to reduce the number of beds in hospitals and the number of hospitals participating in the emergency system. In contrast to the concern with hospitals, the establishment of individual practitioners is not regulated. Every medical doctor with appropriate certificates can start a practice and he or she is automatically recognised by the Social Security scheme. The establishment of new pharmacies is protected by a numerus clausus, and as a result, pharmacists have a more or less strong market position. As in many sectors of the Luxembourgian society, in health care it is difficult to recruit sufficient staff. Many health care workers are from foreign origin. Since remuneration and salaries are good as compared to the surrounding countries and the health care facilities are of a high quality level, this is no problem. (150,47,102)

Health financing and insurance

The Sickness Funds play a dominant role in the health insurance system. There are nine of these funds, for several categories of employees, farmers etc., and the whole population, regardless of their income level, is obliged to join their relevant fund. The Sickness Funds not only grant health care benefits (in kind), but also sickness and death benefits. Insurance contributions for the Social Sickness Funds are paid equally by employers and employees. The level of the premiums are determined by law and are income dependent. Self-employed people, farmers and voluntarily insured people pay a fixed percentage of their income. Some other groups, like students, chronically ill and invalids, are exempted from paying premiums. For them the government is paying subsidies. Certain types of care, like maternity care and long term psychiatric care, do not belong to the benefits of the Sickness Fund scheme. These services are funded separately by the government. All Sickness Funds use a restitution payment system, ie. the patients are reimbursed (after deduction of possible co-payment) after the bill has been paid to the doctor. For some medical services there are user charges. Main items of co-payment are: out-patient care (5%; for home visits 20%), drugs (variable percentages), dental treatment (5%, unless the insured has a yearly check-up), hospital care (fixed amount per day for lodging). After tariffs for medical services have been centrally negotiated and determined they are binding upon all health care providers, also in private insurance. The retail prices of drugs are fixed by the government. Alternative medicine has not been recognised by the social insurance scheme. The General Medical Council is reluctant to include it in the nomenclature of the medical services. About 80% of the population has some private health insurance, as a complement to the public scheme. Private health insurance is supplied by non-profit mutual insurance organisations as well as by commercial companies. They cover certain charges not refunded by sickness funds, such as expensive dental treatments and single room accommodation in hospitals. (47,117)

Health expenditure	81	82	83	84	85	86	87	88	89	90	91
-abs per head in ppp\$	716	750	787	855	930	978	1135	1219	1267	1392	1494
-% of GDP	7.1	6.9	6.8	6.6	6.8	6.7	7.3	7.2	6.9	7.2	7.2
expenditure on pharmacy											
-abs per head in ppp\$	103	105	109	122	137	149	173	189	202	216	na
-% annual growth		1.3	3.9	11.7	12.8	8.7	16.3	9.1	6.7	7.4	na

Secondary care

Specialist care may be provided in hospitals or in the specialist's private practice. Many physicians have a part-time arrangement in a hospital and additionally work in their private cabinets. The total number of physicians in 1990 (dentists not included) was 665, or one per 568 inhabitants. Roughly two-thirds of them (425) are medical specialists, which equals to one per 889 individuals. General hospitals, their number is 20, are usually small. They are classified according to the technical facilities or to the long or short stay character. Of all 3784 hospital beds (10.3 per 10,000) 60% is in private and 40% in public hospitals. The number of acute beds is 2560 (ratio 7.0 per 10,000). Patients are free to choose their hospital. With permission of the Sickness Fund people may even apply to hospitals abroad. In hospitals a considerable number of the staff are foreigner. In some hospitals they may make up for one-third of the total work force. Well over 10% of the physicians are foreigners. Like all physicians, specialists in Luxembourg are free to practice if they have acquired necessary certification. They are accessible without referral, so they are in a competitive relation with general practitioners. Since many specialists work privately as well as in a hospital, they can offer their patients a wide range of diagnostic and treatment facilities. (47,102,117)

Primary care

Although specialists also play a role in primary care, this is mainly the domain of the general practitioner. GPs are all working independently in private practice, mostly single handed. Their number is 225, or one GP per 1680 inhabitants. The number of general practitioners is steadily growing after a period of increasing specialisation and increasing numbers of specialists. The authorities however have recognised the need to restore the balance and encouraged general practice. Primary dental care is provided by 174 dentists. And the number of pharmacies is 72 countrywide. Domiciliary care is provided by trained nurses, mainly employed by hospitals, who visit chronically ill and physically handicapped patients in their homes. They carry out procedures prescribed by the responsible physician and provide general nursing care. In addition, a charitable organisation provides hygienic, domestic and cooking services for people living at home. Since 1989 allocation of home care is regulated. Only people older than 65, who have lived for more than ten years in the country, who are handicapped and in need of help of a third party and do not have a high income, are entitled to a monthly home care allowance. (47,102,117)

Payment and income of GPs

Like specialists, general practitioners are remunerated for the items of service they deliver. Fees are fixed by mandatory conventions negotiated between representatives of the doctors and the sickness funds. Since agreed conditions as laid down in the conventions are also applicable to private practice, medical activity outside the social insurance system is of little significance. General practitioners have their own premises, which they finance themselves to a large extent. (47,102)

Training and education of GPs

Since only the first year of undergraduate medical training is available in Luxembourg, medical training and education always takes place (at least partly) abroad. In order to be admitted as a doctor in Luxembourg one must be certified in the relevant discipline or specialism by the country where the training has taken place. Most medical students have had their training and education in nearby universities in Belgium, France and Germany. To become a general practitioner vocational training is now required according to operative EC directives. (93)

The country

The Netherlands is a small, most densely populated country, situated where Rhine, Meuse and Sheldt flow into the North Sea. Large parts of the country are below sea level. Formal head of the state is a queen. Executive powers, however, are with the government. The parliamentary democracy has two chambers; the First Chamber of 75 members is elected for six years by the 12 provincial councils, while the Second Chamber is directly elected for four years. Probably due to relative scarcity of living space, extensive regulation is a feature of the Dutch society. Despite the high degree of urbanisation no Dutch city has more than one million inhabitants. Parts of the country's extensive welfare system, developed in the 60s and 70s, are presently scrutinised in order to reduce its financial implications.

Statistical key figures

Population		Natality, mortality and health	
population in mln.	15.0	births per 1000	13.2
per sq. km.	365	fertility rate/ child.p.woman	1.7
% ann.growth 80-91	0.6	% ann.fert.reduction 1980-91	-1.1
% urban	89	% contracept.preval.	76
% under 15	18.2	deaths per 1000	8.6
% over 65	12.9	% infant mortality (under 1)	0.65
% over 75	5.3	% under 5 mortality (U5M)	0.8
		% ann.reduction U5M 1980-91	2.9
		% DPT immunised at age 1	97
Development and economy		life expectancy (men)	73.8
human development index	98	life expectancy (women)	80.1
compuls.education (yrs)	11		
TV sets per 1000 pop.	485		
GDP per head in \$ (ppp)	16,351		

Organisation of health care

The provision of health services has been structured in four layers. Collective disease prevention, the so-called basic echelon, includes immunisation, school health care, mother and child care and health education. Remarkably, this is organised separately from primary health care, also called the first echelon, which is dominated by private initiative. Primary care is a kind of archipelago of individual independent providers and organisations: general practitioners, district nurses, physiotherapists, midwives, pharmacists, home helps and general social workers. Generalistic primary care is, in most cases, directly accessible. Usually, patients need a referral from their GP to obtain specialist or (acute) hospital care (the second echelon). A third echelon consists of long term care in psychiatric hospitals, convalescent centres and nursing homes. National policy making and overall financial supervision is the responsibility of the Secretary of State under the Minister of Welfare, Health and Culture. Since interest groups are strong, in The Netherlands policy making, and even more its implementation, is a process of negotiating and finding consensus or compromise. Planning of hospitals and nursing homes, which are non-profit private initiatives, is a duty of the twelve provinces. The well over 700 municipalities are in charge of public health (the basic echelon). The need for cost containment and improvement of efficiency in health care has resulted in proposals for a new structure and financing system. At the moment the government tends to retreat and there is a shift from planning to self regulation, relying on market principles. Some parts of the plans have been implemented while others have been postponed. (117,130,83)

Health financing and insurance

There is a two-ply health insurance system: a public system, run by 'sick funds', for those below a certain income level (about 60% of the population) and private insurance for the other 40%. In addition there is a catastrophic illness scheme for the whole population. This last scheme, the so-called General Act on Exceptional Medical Expenses (AWBZ), is for

psychiatric hospital care, out-patient mental care, community nursing and nursing home care. It is financed from tax revenues. As a part of the health care reform, there is a tendency now to increase the scope of this Act. Sick Funds, the financiers of the public scheme (covering some 60% of the population), are non-governmental organisations, still working mainly at regional level (although this is also subject to change). Premiums are deducted from wages and salaries by the employers and paid on a fifty-fifty basis by both employees and employers. The national umbrella organisation of the sick funds, the Sick Fund Council, is an independent multi-party body advising the Minister on coverage and premium levels. The private scheme is financed by commercial and non-commercial insurance companies. Premiums depend on age, choice of package, optional cost sharing conditions etc.

Health expenditure	81	82	83	84	85	86	87	88	89	90	91
- abs. per head in ppp\$	771	819	865	893	933	990	1046	1101	1176	1286	1360
- % of GDP	8.2	8.4	8.4	8.1	8.0	8.1	8.3	8.2	8.1	8.2	8.3
expenditure on pharmacy											
- abs. per head in ppp\$	60	66	69	77	84	92	102	108	114	128	135
- % annual growth		9.8	4.2	11.6	8.9	10.1	10.3	6.0	6.0	11.7	5.9

There are plans to make one tax financed health insurance system for the whole population, covering 85% of health care costs and leaving 15% to be privately insured. Early in 1992 a first step has been made by bringing pharmaceutical prescriptions under the 'AWBZ' scheme. Further implementation has been postponed. (117,130)

Secondary care

For secondary care there are 120 general hospitals, 9 university hospitals and 36 categorial hospitals (1990). Not included in these numbers are psychiatric hospitals, institutes for mentally handicapped and nursing homes. Bed supply and admission rate in acute hospitals are indicated below.

In-patient care beds	11.4
Acute hospital beds per 1000 population	4.3
Admissions per 100 pop. in acute hospitals	10.3

During the past 15 years there has been an up-scaling among hospitals and a general reduction of beds. This has been compensated by promoting short stay facilities and day care and providing more diagnostic facilities to GPs on the one hand and by enforcing primary care on the other. The number of teaching hospitals for specialist training is 50. As a rule medical specialists work exclusively hospital based. Yet most of them, almost two-thirds, are not employed. Often working in partnerships, they are free entrepreneurs, employing their allied staff and with contracts for use of hospital facilities and space. In 1990 the total number of medical specialists in 1990 was 10,955, which equals to 1360 inhabitants per specialist. In addition to these consultants a limited number of general physicians is working in hospitals, mainly while waiting for entering a specialist training programme. For publicly as well as privately insured patients medical specialists receive fees for items of service (although differently specified). Since there are waiting times for some specialisms, there is a circuit now of some 40 private clinics. These relatively small facilities are mainly offering non-clinical treatments in plastic surgery, ophthalmology, dermatology, flebology and orthopaedics. (130,36)

Primary care

There is a well developed system of primary care, provided by GPs, district nurses and home helps, midwives, physiotherapists, dentists, pharmacists and general social workers.

Community nurses, their number being about 7000, are employed by 60 so called 'Cross Associations', independent foundations of private initiative and mainly tax financed. In addition to community nursing the Cross Associations provide maternity care, mother and child clinics and intensive home care. Although a lot of clients are referred by a GP, community nursing services are direct accessible. There are co-payments in the form of membership fees. A process of integrating community nursing and home help services in the same organisations is now underway. Home help services have already been brought under the same financing system as community nursing. Home help is direct accessible; use is regulated by rules and criteria and there are income dependent co-payments. Primary care obstetrics is mainly in the hands of midwives. Well over one-thirds of the deliveries are home deliveries; most of them attended by a midwife. There are 1116 midwives in The Netherlands; and 71% is independent (1991). Single handed practice is diminishing: in 1980 75% still worked alone, while in 1991 this was 34%. Sixty percent is under 40 years of age. They are paid on a fee-for-service basis. Belonging to primary care, but only accessible on referral, are physiotherapists. Their number has increased considerably over the last two decades; there are some 13,000 now, of which three-quarters work in primary care. Most of the physiotherapists work in independent private physiotherapy practices: 38% single handed, 21% in partnerships and 41% in larger groups. Treatment of publicly insured patients is only paid after authorisation by the Sick Fund. Privately insured also pay fees for service. Due to the fragmented structure of primary care, co-operation and co-ordination may be a problem, especially where different providers are dealing with the same patient. Since the seventies the government has tried to improve cohesion by stimulating teamwork. This policy has been partial successful. Nowadays there are 160 health centres, in which on average of three to four GPs, an equal number of district nurses, one or two social workers and some physiotherapists are working together with allied staff in shared premises. Apart from this, there are well over 400 multidisciplinary teams, however working on their own premises. More recent policy aims have resulted in a large number of substitution experiments in home care for the elderly, for terminally ill and early discharged patients. But whatever the policy, success will depend on voluntary participation of the health care field. (139,130,98,5)

General practice

Usually, the first contact with health care, in a broad sense, is the contact with the general practitioner. Although there is freedom of choice of a doctor, people are registered with a GP. A typical Dutch GP is independent, owner of the premises and assisted by a receptionist or practice assistant. For most diagnostic procedures many GPs rely on external facilities. A diminishing proportion of GPs, now 11%, has practice pharmacy of his own. A GP is responsible for 7x24 hours availability of services. This is usually achieved on a rota basis in locum tenancy groups with other GPs in the area. Making home visits belongs to the normal tasks. Although GPs are not involved in hospital treatment, admitted patients are visited, but not as a rule. The number of GPs is 6471, or one per 2319 inhabitants (1991); the majority (54%) still works in single handed practice, 31% has a partnership and 16% is in a group practice. For well over 8% of the GPs the practice is part of a health centre, which is mostly run by a private foundation or association. The proportion of female GPs is increasing from 4.7% ten years ago, until 13.2% now. It is also a relatively young population: two-thirds of all GPs are younger than 45. At national level there are two organisations of GPs. The LHV, the National Association of GPs, is an interest organisation, involved in negotiating tariffs and incomes, provision of practical services and the organisation of continuing medical education. About 95% of all GPs is member of the LHV. The Dutch College of General Practitioners, the NHG, is the organisation for professional development, e.g. the development of criteria for treatment of frequently occurring conditions. Two-thirds of the GPs are members of the NHG. (130,83,98)

Payment and income of GPs

For their publicly insured patients GPs have contracts with the sick funds, which pay a yearly flat capitation fee (the full tariff for 1600 publicly insured patients on the list and a lower tariff for those exceeding this number). The fee is an addition of several elements: net income, pension contributions and practice costs. Tariffs are negotiated between the LHV and the Association of Sick Funds (VNZ) and need approval of the Ministry. With respect to tariffs for privately insured patients there is an analogous procedure with the Co-ordinating Office of the insurance companies (KLOZ). Privately insured patients pay their GP a fee-for-service, which is reimbursed by their insurance company if GP services have been chosen in the package and possible deductibles are taken into account. The proportions publicly and privately insured patients on the list differ per GP, dependent on the level of prosperity of the practice area.(40,130)

Training and education of GPs

The obligatory registration as a GP can only take place after the fulfilment of a two-year special training programme. Registration has to be renewed every five year. GP training programmes are organised and carried out by the eight university departments of general practice that are also involved in undergraduate medical education. Vocational training is spent largely in the practice of an experienced GP trainer. In 1991 492 doctors were in training, of which 39% was female. The average waiting time between finishing the undergraduate programme and starting the GP vocational programme is 32 months now. (130,40,98)

The country

The western flank of Scandinavia, along the Atlantic Ocean, is largely formed by Norway. Thanks to the Gulf Stream it has open harbours throughout the year and a relatively mild climate, even far north of the Polar circle. The country is a constitutional monarchy with executive power in a prime minister and Council of State. The 165 members of the parliament, the Storting, are elected for four years, without the right of premature dissolution. Women play a more important role in politics than in other European countries. The economy, traditionally strongly dependent on forestry and fishing, received new impulses with the development of oil and gas reserves in the 1970s. Now, Norway is close to overtaking the UK as Europe's largest oil producer. However, the fall in oil prices resulted in inflation and unemployment. Recently inflation has decreased while unemployment remains high. The government is stimulating other industrial sectors in order to decrease the dependency on oil. Norway has so far been reluctant to enter the EC. In 1972 a referendum voted against it. A new application for membership has re-opened the debate in Norway. (133,85)

Statistical key figures

Population

population in mln.	4.24
per sq. km.	13
% ann.growth 80-91	0.4
% urban	75
% under 15	18.7
% over 65	16.4
% over 75	7.1

Development and economy

human development index	98
compuls.education (yrs)	9
TV sets per 1000 pop.	423
GDP per head in \$ (ppp)	17,219

Natality, mortality and health

births per 1000	14.3
fertility rate/ child.p.woman	1.92
% ann.fert.reduction 1980-91	-1.0
% contracept.preval.	71
deaths per 1000	10.5
% infant mortality (under 1)	0.70
% under 5 mortality (U5M)	0.8
% ann.reduction U5M 1980-91	2.9
% DPT immunised at age	186
life expectancy (men)	74
life expectancy (women)	80

Organisation of health care

Since the implementation of the Municipal Health Act in 1984, primary health care has largely been decentralised to a large extent. Hospitals and specialised services belong to the responsibility of the nineteen counties. To start at the top: general health policy making and legislation belongs to the domain of the Ministry of Health and Social Affairs which also has the ultimate responsibility for financing and planning. Other important central functions are with the Directorate of Health Services and the National Insurance Institute. The Directorate, now about to become recognised, is the central body, consisting of several departments: for primary health care, hospital care, provision of drugs, environmental health, and several administrative activities. The Provincial Health Office represents the central Directorate in a province. Its main duties are the administration of hospital services and the supervision of primary care services. The head of the Provincial Health Office is also a member of the Hospital Board. As a consequence of the 1984 act, the approximately 450 municipalities are responsible for planning, funding and the organisation of primary health care provision in their area. Four types of service are compulsory: general practice, physiotherapy, public health nursing and home nursing. The organising role of the municipalities implies, among other things, being a contractor and, in many cases, an employer of health providers. The total number of physicians in 1990 was 13,234, which is an average of one doctor per 320 inhabitants. (40,105,17,67,26)

Health financing and insurance

A compulsory national insurance scheme covers the whole population. Health care is financed from three sources: premiums paid by employees and selfemployed persons, contributions by employers and finally, contributions by the state, counties and municipalities. Financial resources of the counties and the municipalities mainly come from the central government, as a block grant, and partly from county and local taxation. Until 1984 these block grants were earmarked for health, which meant that at least that amount had to be spent on health care. After the funding system was changed in 1986, the health service grants were combined with other grants into one general block grant covering all activities of the municipality. There are no more restrictions regarding the amount to be spent on health care. The level of the block grants depend not only on the size of the population, but also on statistical measures indicating the local demand for health care. The insurance scheme offers in-patient treatment in public hospitals free of charge. Out-patient consultations of specialists is subject to cost sharing. In primary care home nursing and public health nursing is free of charge. With respect to doctors, prescribed drugs and physiotherapy, however, there are co-payments, up to a maximum amount per year. Some chronic disease groups are exempted from co-payment. Total expenditure on health care in general and on pharmacy in particular, on pharmacy are listed in the table below. (17,64,40,79,26)

Health expenditure	81	82	83	84	85	86	87	88	89	90	91
-abs per head in ppp\$	601	657	718	755	813	950	1043	1112	1128	1193	1305
-% of GDP	6.6	6.8	6.8	6.5	6.4	7.1	7.4	7.7	7.4	7.4	7.6
expenditure on pharmacy											
-abs per head in ppp\$	60	67	73	78	83	95	101	113	118	124	n/a
-% annual growth		10.8	9.9	6.4	6.5	14.3	6.9	11.3	4.4	5.6	n/a

Secondary care

Norway is well supplied with hospitals, which are quite evenly distributed throughout the country. The hospital system was re-organised during the 1970s. Planning and management of hospitals are the responsibility of the counties. Hospitals can be categorised according to a hierarchical structure of regional, county and district hospitals. In every county some county and districts hospitals can be found. Furthermore, each of the five health regions into which Norway has been subdivided has its own regional hospital, owned by the county in which it is located. Only the national hospital in the region of Oslo, which is highly specialised, is owned by the state. Medical staff in Norwegian hospitals consist exclusively of full-time salaried specialists. Admission to hospital can only be made by a hospital physician after referral by a GP. Hospital specialists are involved in both in-patient and out-patient care. Although there is a recent increase in specialists in private practice, the private sector is of little significance in hospital care. A few hospitals are owned by voluntary organisations, but these are non-profit and state financed. Only two hospitals are operating commercially. Hospital bed supply and admission rate are indicated below (reference year 1989). (105,50,64)

In-patient care beds per 1000 population	14.5
Acute hospital beds per 1000 population	4.2
Admission per 100 pop. in acute hospitals	14.4

Primary care

The importance of primary care as a basic element in the health system has been increasingly recognised. Historically, district doctors, who provided primary medical care in rural areas, were appointed by the Ministry of Health. Since 1984, the municipalities have been responsible for planning and provision of primary care. In that year the Municipal

Health Act was implemented, expanding the role of primary care in the health system. Another aim was to decrease the differences in level of provision of services among municipalities and bringing them more in line with local needs. Prior to the reform some municipalities had twice or even three times as many doctors and home nurses as other municipalities with comparable populations. The municipalities are now planning and organising primary health care, including health promotion, the provision of diagnostic services and non-specialised treatment of illness, as well as physiotherapy, rehabilitation and nursing care for patients in their homes. Most primary health care personnel became municipal employees. The Act allowed doctors and physiotherapists to choose whether be employed by the municipality or to be contracted as an independent practitioner. The majority of these professionals became contracted; some 40% of the doctors and well over 10% of the physiotherapists are now employed. In addition to the above-mentioned legislation, the government has developed a policy of stimulating health centres and multidisciplinary teamwork among groups of GPs, nurses, physiotherapists, etc. Nowadays, outside the main cities, the majority of GPs work in this kind of health centres. Even in the cities, where private practice predominates, most GPs work in small group practice. Community nursing is provided by two types of nurses: home nurses, who are mainly involved in curative care, and public health nurses, carrying out preventive activities. In addition, there are occupational nurses. (26,17,105,139)

General practice

The number of general practitioners in 1988 was approximately 3100; an average of 1360 citizens per GP. It is not unusual for physicians to work partly in private practice and partly under contract. Especially in rural communities, many GPs (district medical officers) combine customary GP tasks with public health activities. As a rule, GPs serve a geographically defined population within the boundaries of a municipality. Within these boundaries patients are free to choose a doctor. So far, there is no patient list system in Norway, although recently an experiment has started (see next section). With respect to the establishment policy, GPs in principle have a free choice to practice wherever they want. However, to become contracted to the insurance scheme they have to fit into the municipality plan. Most GPs employ medical secretaries. Some GPs also have nursing or laboratory staff. (40,67)

Payment and income of GPs

Payment conditions of physicians are the result of negotiations between the Ministry and the Norwegian Medical Association. Since this agreement is applicable to all doctors and local authorities general payment conditions have the same basis all over the country. According to the status of the physician several categories are distinguished in the payment scheme. A first group consists of salaried GPs employed by the municipalities. They receive a fixed salary, supplemented by compensation for overtime work. The second group, the independent practitioners, contracted by the health insurance scheme, have an income from three sources: a basic allowance from the municipality ($\pm 40\%$), which is meant to cover the practice costs, reimbursement for consultations and visits (fees for services), and direct payments by patients. Finally there is a small number of doctors working exclusively in private practice. Their only source of income is from fees for items of service they provide to their private patients. They are free to set the level of these fees. In May 1993, a three-year project trial has been introduced (the Personal Doctor Project) including a personal GP list system for all inhabitants of four municipalities in Norway. In this system, payment will be a combination of a basic per capita allowance, fee-for-services and direct payment from patients. (40)

Training and education of GPs

After a six year undergraduate training, there is an internship consisting of a one year training in hospital and six months as an assistant to a district medical officer. When general practice was established as a fully recognised specialism in 1985, rules for re-certification

were also put into effect. This re-certification takes place every five year and contains a number of requirements. At least one year has to be spent in general practice during the five year period and a minimum of 200 course hours must be proved. The third requirement is one of the following options: 1. three months practice in a hospital, 2. at least one month of 'structured' hospital service within a certain clinical branch, 3. at least 3 months of research in general practice, 4. a hundred additional course hours. In the basic medical education, teaching of general practice theory and skills are gaining importance. There are departments of general practice with several full-time and part-time academic positions at all four universities in Norway. (67)

The country

As a former East Bloc country, Poland is going through turbulent times now. In the last two hundred years, however, the country has suffered from foreign rule most of the time. During the 18th century and until 1918 it was divided between Russia, Prussia and Austria. Then it was sovereign until the outbreak of the Second World War. After this war the country was 'shifted' 200 kilometres to the west. The Allies agreed that loss of territory in the east was to be compensated by new territories in the west. After more than ten years of political activity by the independent trade union Solidarity, sustained by the influential Roman Catholic Church, communist predominance came to an end in September 1989. Solidarity gained an overwhelming victory in the elections and the first non-communist government in East Europe since the Second World War came to power. Lech Walesa became the first president. The economic inheritance showed an inefficient and unbalanced industrial structure, a high level of external debts and hyperinflation. The economic shock therapy has brought not only a private sector and trade with the West, but also a fall in wages and a high level of unemployment (133,85)

Statistical key figures

Population		Natality, mortality and health	
population in mln.	38.2	births per 1000	16.4
per sq. km.	122	fertility rate/ child.p.woman	2.1
% ann.growth 80-91	0.7	% ann.fert.reduction 1980-91	0.8
% urban	62	% contracept.prevalence	75
% under 15	25.2	deaths per 1000	9.9
% over 65	10.0	% infant mortality (under 1)	1.5
		% under 5 mortality (U5M)	1.7
		% ann.reduction U5M 1980-91	3.1
		% DPT immunised at age 1	98
Development and economy		life expectancy (men)	68
human development index	86	life expectancy (women)	76
compuls.education (yrs)	8		
TV sets per 1000 pop.	292		
GDP per head in \$	1690		

Organisation of health care

Health and social services in Poland are provided and owned mainly by the public sector. The Ministry of Health (MoH) takes the lead in developing health policies, though other ministries have parallel health care systems for categories of the population (such as the army, railway employees, miners, policemen etc.). These categorial systems offer a wide range of clinical services, sometimes duplications of the general scheme, but outside the competence of the Ministry of Health. For highly specialised treatment, for teaching and continuing medical education, ten health regions have been identified, each consisting of some five provinces. The heart of a health region is a Medical Academy and a teaching hospital. One level downward is the 49 provinces ('voivodships'), also an administrative level. Voivodship Health Departments have a delegated authority for the implementation and management of health programmes initiated by the ministry. The lowest, and probably most important, level in health care provision is the well over 400 local areas of integrated health and social services (Zespół opieki zdrowotnej, or ZOZs), serving 30,000 to 150,000 people. These areas, which have no administrative function, were implemented in 1974 in order to improve the linking of out-patient services to the hospitals. Voivodships each have between 3 and 33 ZOZs. These ZOZs are expected to have at least one hospital, several out-patient care facilities, emergency care, school health facilities and possibly industrial dispensaries. ZOZs should be equipped to provide most of the day-to-day primary care by units consisting of one or more teams of a general physician, a gynaecologist, a paediatrician, a dentist and allied staff. These ZOZ health care units serve 3000-5000 people. In rural areas teams usually only consist of a general physician, a nurse and a dentist. Although these out-

patient units are the usual point of entry of patients to health care, they can also apply directly to hospital out-patient departments. The integration of general, specialist and hospital care has been organised vertically, ie. a chief hospital specialist is responsible for the co-ordination and quality of care of his specialisms all over the ZOZ. Since ZOZs may have a population of 150,000 inhabitants this is a hard job. Horizontal integration of different disciplines is not well cared for. There is a peculiar health system parallel to the public scheme. It is not unusual for doctors with a full time appointment, to work privately at home for several hours a day. In cities there is the phenomenon of the so-called medical co-operative society, where doctors practise as a sideline. People have freedom of choice of doctor, which is highly valued, and pay on an out-of-pocket basis. It is striking, that the level of these fees is determined by the government. (152,105,92)

Health financing and insurance

The health care system has suffered from underfinancing for years and years and now, even more than ever, financial resources are scarce. Under these circumstances it is difficult for health care to adjust to the restrictive fiscal policy under the government's economic transformation plan. Since health care is still tax funded it is quite vulnerable to changes in the fiscal policy. More independent funding, e.g. from premiums, would secure a more stable and adequate funding. The national health budget is divided into a central component for the Ministry, and a regional component for the voivodships. The ZOZs are funded by the relevant voivodship. The ZOZs are provided with global budgets and these are largely free to spend according to their own priorities. At the national level, 80% of health care expenditure includes medical drugs, clinical hospitals, and some state sanatoria. Expenditure in the parallel health services of other ministries on drugs and salaries is also financed by the Ministry of Health budget. At the regional level, programs are financially supported through the voivodships, which receive their money directly from the Ministry of Finance. Health care covers the whole population and is almost free of charge. There are co-payments of 30% for drugs prescribed in out-patient care (except for pensioners and the chronically ill). However, the parallel health system (doctors working in private hours and in medical co-operative societies) is financed exclusively from out-of-pocket payments. (152)

Health expenditure 1987

-abs per head in \$	97
-% of GDP	5.7
expenditure on pharmacy 1990	
-abs per head in \$ (approx.)	29
-% of health budget	32

Secondary care

In 1988 the number of hospitals was 700. The highest level of specialist care is provided in the regional hospitals, mostly attached to the Medical Academies, and the National Health Institutes. The majority is formed by the local hospitals in the ZOZs. Many facilities are outside the jurisdiction of the Ministry of Health. For instance, 9% of the 250,000 beds and 9.7% of budget revenues of the health sector relate to the categorial schemes of other ministries. The Ministry of Transport alone controls 5650 beds and 3548 doctors. Specialists in the 5700 out-patient care units, or polyclinics, are also providers of secondary care (in addition to primary care; these two cannot be separated well). In secondary care there is a generally felt lack of equipment, and facilities are outdated and inefficient in use. All ZOZs in a certain province refer patients to their regional voivodship hospitals. Larger cities have centralised emergency services that serve as hospital emergency departments on a rota basis. Patients in Poland are free to go directly to the hospital out-patient department without referral. If the hospital specialist considers a certain case within the competence of

primary care units, the patient is simply referred back. Bed supply and the hospital admission rate are listed below (reference year 1988). (152,148)

In-patient care beds per 1000 population	6.5
Acute care beds per 1000 population	5.7
Admissions per 100 population	10.9

Primary care

Primary care is provided by general physicians, specialists in internal medicine, paediatricians, gynaecologists/obstetricians, dentists, midwives/feldshers, nurses and allied staff. In towns, these professionals work in teams from out-patient care centres under the direction of the ZOZ. In rural areas there are 3300 health centres where teams are less diverse and consist of a general physician, a nurse, a dentist and an assistant only. For a long time, primary health care has been highly neglected in Poland. Despite the official norm, prescribing no more than 2500 people in one district of primary health care, in reality one district serves an average of 6000 people. Moreover, there is a shortage of doctors and paediatricians in some areas. The oversized districts and the poor distribution of staff make planned visits by patients very difficult. Nationwide the available staff is basically sufficient, but should be deployed more efficiently. Most doctors spend no more than half of their time in professional activities. To a large extent they are involved in bureaucratic routine.

As mentioned above, primary care is also delivered by doctors working privately or in co-operative societies, in addition to their salaried job in the public scheme. This supply of health care meets the need to have a free choice of doctor and fills the gap of diagnostic equipment in the regular services. (127,152).

General practice

In its proper sense general practice does not exist in Poland. Health care is predominantly specialist care. Primary care is the task of general physicians, but also of paediatricians, gynaecologists and specialists in internal medicine. In rural areas many medical tasks are provided in combination by the general physician or district doctor of the health centre. This function probably most resembles the one of a general practitioner. But patients are not registered with any doctor. Patients are allocated to a doctor according to the place where they live. The categorial approach by which children, women, workers and other adults all have their special doctor is incompatible with the principles of family medicine. (152,105)

Payment and income of GPs

Doctors working in the public scheme are all state employed and have a salary. Many of them work additional hours in private practice at home and receive fees for service for these activities. Doctors participating in medical co-operative societies also charge fees for items of service. These fees, however, are lower, and only half is received by the doctor. The other half is for the co-operative. One of the reasons for taking up work on the side is the relatively low income of physicians.

Training and education of GPs

The six-year undergraduate medical education is followed by a one year hospital internship which must be completed in order to receive the right to practice. No specialisation is required to become a general physician or district doctor. So far medical education has been strongly specialist. In the near future, with foreign help, GP education will be implemented in the Medical Academies. At the same time a programme of continuing medical education will be developed in order to broaden the range of competence of doctors currently practising primary care. (93)

● PORTUGAL

The country

Twenty years ago the country was still a dictatorship. Now the republic, to which also the independent regions of the Azores and Madeira belong, has a president as the head of state, who is directly elected for up to two consecutive terms of five years. The assembly of 230 members is also elected directly for four years. The country has an impressive colonial past, but soon after the dictatorship came to an end the colonies became independent. During the past decades many Portuguese have emigrated to find jobs in countries like France and Germany. Agriculture is still an important factor in the Portuguese economy and industry is dominated by the manufacture of textile and footwear. Although the economy has benefitted from the EC membership since 1986, the country still belongs to the poorer part of the 12 countries.(133,111).

Statistical key figures

Population

population in mln.	10.5
per sq. km.	114
% ann.growth 80-91	0.1
% urban	34
% under 15	21.2
% over 65	13.1
% over 75	5.3

Development and economy

human development index	88
compuls.education (yrs)	9
TV sets per 1000 pop.	176
GDP per head in \$ (ppp)	9,225

Natality, mortality and health

births per 1000	11.8
fertility rate/ child.p.woman	1.42
% ann.fert.reduction 1980-91	3.5
% contracept.preval.	66
deaths per 1000	10.0
% infant mortality (under 1)	1.1
% under 5 mortality (U5M)	1.2
% ann.reduction U5M 1980-91	8.6
% DPT immunised at age 1	89
life expectancy (men)	70.9
life expectancy (women)	77.9

Organisation of health care

Since 1979 a National Health Service is covering the whole country with a network of hospitals and health centres. For a number of services, however, especially primary care diagnostics and certain hospital facilities, this system relies on private health care suppliers. The hierarchical structure of health care is similar to the administrative structure. The Ministry of Health is the first responsible. For planning there are five regions and eighteen sub-regions that are responsible for organisation and management of primary care and for co-ordination with the private suppliers and public hospitals (which are managed separately). For some time there has been a trend towards deregulation, decentralisation and more private participation. Formally, secondary care is only accessible after referral by a general practitioner, but since people show a strong preference for hospital care, they often use the backdoor of the emergency departments. Typical for the Portuguese system is a serious lack of a proper tertiary care in nursing homes. Care for the elderly and handicapped is mainly provided informally in the context of the family.(17,64,11,138)

Health financing and insurance

The National Health Service is financed from tax revenues. Hospital care and care in health centres are not free. The level of co-payment is dependent on the kind of care. There are other co-payments for prescribed drugs, X-ray and other diagnostic procedures. Essential drugs for diabetes, Parkinson's disease, epilepsy, cancer and tuberculosis are free. For medical aids (spectacles, hearing device etc.) there are also co-payments. Care provided by the private sector is paid by patients. Only civil servants and those with private insurance coverage are subsequently (partially) refunded. For several categories in-patient and out-patient care are completely free: children under 12, elderly, pregnant women, handicapped, unemployed with a minimum income and several categories of people with chronic and other diseases. Costs for health care are fully tax deductible. Primary health care is

absorbing a large portion of the health care budget. This is mainly due to high expenses for drugs and to the transfer of money (some 30%) to the private sector (for X-ray, laboratory etc.). The table below shows the total expenditure on health and those on drugs.

Health expenditure	81	82	83	84	85	86	87	88	89	90	91
- abs. per head in ppp\$	285	339	339	347	398	389	434	493	548	554	624
- % of GDP	6.4	6.3	6.2	6.3	7.0	6.6	6.8	7.1	7.2	6.7	6.8
expenditure on pharmacy											
- abs. per head in ppp\$	57	68	70	74	72	71	na	87	na	na	na
- % annual growth		18.4	2.8	6.0	-2.2	-2.2	na	na	na	na	

The state is the owner, provider and financier of health care as regards the NHS. Hospitals are funded by the NHS through pre-determined annual budgets. Nowadays, part of these budgets are output-related, for which the Diagnosis Related Groups (DRG) methodology is used. Out-patient care (health centres) budgets, responsible for 53% of the whole NHS budget, are determined by the Regional Health Boards (ARS) on the basis of historical costs with adjustments for inflation. In the future out-patient care budgets will also be related to outputs. The relationships with the private sector are settled by contracts, the so-called conventions. Parallel to the National Health System there are several smaller sub-systems, e.g. for civil servants and personnel of some large companies. Under these schemes patients are reimbursed for health care expenses. Private health insurance is a new phenomenon which is still developing. Foreign insurance companies are active on this market. (17,146,11,138,106)

Secondary care

Of the 137 general hospitals (1989) 82 are state owned. Twelve of them are central hospitals with a high degree of specialisation and often associated with medical schools. Half of the, usually smaller, private hospitals is for-profit and another half non-profit. The last category belongs to Misericordias, a national charitable organisation that used to have many more hospitals before the introduction of the NHS. In addition to general hospitals there are some 70 special hospitals, for psychiatry, maternity, paediatrics etc. The number of beds and the hospital admission rates are summarised below:

In-patient care beds per 1000 population (89)	4.6
Acute hospital beds per 1000 population (89)	3.6
Admissions per 100 pop. in acute hospitals (90)	10.6

Almost 20% of the in-patient care beds is in private hospitals. Of the total number of 28,016 physicians (which is one doctor per 375 inhabitants), one-thirds, or 9251, is specialist/consultant (1990). Apart from some primary care paediatricians and gynaecologists, specialists work in hospitals as civil servants exclusively. Secondary care is accessible after referral by a GP. People can choose the hospital to be referred to, but not the treating specialist in that hospital. Physiotherapy is provided in hospitals or by private practice. Mental health care is concentrated in secondary care (39 psychiatric hospitals) and out-patient mental health units. (59,11,138)

Primary care

Before the early 70s there was hardly any primary care. Before the introduction of the NHS in 1982 curative care was provided in social security medical posts by physicians who usually were appointed for no more than two hours a day, in which they had to see 12 patients. In those days health centres were only involved in preventive care. In the NHS health centres, of which there are 343, these two functions have been integrated. So, health centres are not only for curative care but, for instance, also for food hygiene, vaccination,

family planning and environmental health. Altogether in 1989 the centres had a professional staff of 8485 physicians and 5808 nurses. Part-time appointments are almost absent. Of all physicians in the health centres 74% or 6256 have a position as general practitioner. Other medical disciplines are public health, gynaecology, paediatrics, stomatology etc. In a minority of 140 health centres doctors have beds at their disposal; the total number is 3734, or some 25 per centre. In general, health centres are not equipped for carrying out X-rays and laboratory diagnostics. For these procedures patients are referred to private practices. In addition to health centres primary care is provided by well over 1800 extensions or health posts. In sparsely populated rural areas doctors sometimes serve more than one post. (59,138,136)

General practice

General practitioners have a dominant position in health centres; they are the providers of primary care. People have free choice of doctor and GPs have a list of, at least 1500, patients. GPs are state employed and they have a gate keeping function with respect to secondary care. The number of GPs in health centres is 7115 which equals to one per 1476 citizens. Almost half of the GPs is female ('89). Apart from contacts in the surgery they make home visits and they visit patients who have been admitted to hospitals. Although general practice is considered to be the foundation of the NHS, general practice and family medicine as a profession is still scarcely out of the egg. (111,59,138,136)

Payment and income of GPs

As civil servants general practitioners have a salary. Until now in this remuneration system there are no financial incentives for dedication and efficiency. This may change in the future; there are discussions and plans to create a mixed remuneration system, i.e. partly capitation fee and partly fees for certain items of service. Those doctors who also work privately, are exclusively paid on a fee-for-service basis by their private patients. The aim of the NHS with respect to medical staff is to reduce and finally abolish working in the private sector. (17,138,136)

Training and education of GPs

The six year undergraduate training is followed by 21 months internship, of which 6 months are spent in primary care. After successfully concluding this period one is entitled to registration as an independent medical practitioner or 'general clinician'. It is also a requirement for entering additional training programmes to become a hospital specialist, a public health physician or a general practitioner/specialist in family medicine. The last two specialisms have been recognised since 1980 and each takes three years. (93)

he country

Romania is situated in Southeastern Europe at the lower reaches of the river Danube and by the Black Sea. The country has been a communist dictatorship for 45 years, of which the last 25 years under president Ceausescu. The dark period ended in 1989, after a popular revolt, with Ceausescu's execution. Since November 1991 the country has a constitution and a two-chamber parliament, which is directly elected for a period of four years. Since the free elections of September 1992 did not yield a clear winner, the current government is a coalition of left parties which have a slight majority in the parliament. Compared to other countries in Central and Eastern Europe living conditions are worse. Reforms have hardly been introduced and it is expected that living standards will continue to fall and unemployment will grow before the long way upwards can be gone. The population's health status is alarming. Among the East European countries Rumania has the lowest life expectancy and is leading in maternal and chronic lung disease deaths. It ranks second in infant mortality and deaths from ischemic heart disease and chronic lung disease. (133,107)

tatistical key figures

Population		Natality, mortality and health	
population in mln.	23.2	births per 1000	16
per sq. km.	98	fertility rate/ child.p.woman	2.2
% ann.growth 80-91	0.4	% ann.fert.reduction 1980-91	0.8
% urban	53	% contracept.preval.	58
% under 15	23.3	deaths per 1000 pop.	11
% over 65	10.3	% infant mortality (under 1)	2.7
		% under 5 mortality (U5M)	3.4
		% ann.reduction U5M 1980-91	0.5
Development and economy		% DPT immunised at age 1	96
human development index	76	life expectancy (men)	68
compuls.education (yrs)	10	life expectancy (women)	73
TV sets per 1000 pop.	194		
GDP per head in \$	1,164		

rganisation of health care

Responsibility for all activities in the health field, including medical education and medical research, rests with the Ministry of Health. Parts have been delegated to a number of central bodies: the Supreme Health Council for tuning health objectives and programmes to other sectors, the Academy of Medical Science for supervision of medical research and the Medical Scientific Society for professional development and implementation. With respect to the health care provision, Rumania has been divided into 40 administrative districts, in addition to the capital, Bucharest, which has a separate status. In each district and in Bucharest a Health Directorate is responsible for co-ordination, organisation and implementation of health care activities. District populations range from 250,000 to 900,000; and the population of the Bucharest metropolitan area is even about 2.3 million. Health services are organised on the basis of territorial administrative divisions or places of work. In the pyramidal structure of provision in health districts hospitals, which come in several classes, and the attached polyclinics are on top. Primary care services are located in dispensaries, which are supervised by a polyclinic. As a result of more independent relations to the former Soviet Union since the early seventies, in Rumania the process of specialisation is not as developed as in other countries that used to be part of the East Bloc. Broad medical knowledge and general medicine have got more attention. Like other counties in Central and Eastern Europe, Rumania's health service has suffered from chronic underfunding and inefficient application of resources. Facilities are limited, there are shortages of drugs and equipment, and management is poor. Detailed decisions have to be made at central level, and services are insufficiently adapted to local needs. (105,150,87,151)

Health financing and insurance

Health care is provided free of charge to almost the whole population, and funded from public money. There are co-payments for prescribed drugs and certain other services. From 1986 to 1991 the average yearly budget for medical services amounted to 9% of the total state budget. This percentage has increased considerably since the early 80s, when it was about 5%. Until now the social insurance scheme, which also provides cash sickness benefits for the working population, does not apply to independent farmers and self-employed trade-persons. These people may obtain care from the public system but they have to pay for services. Financial resources are transferred from the central government to the health authorities in the districts, which decide about the allocation in conformity to the health plan of the district. (105,150,14)

Secondary care

In-patient care is taking place in hospitals. Out-patient secondary care is provided by polyclinics. Hospitals are focal points in secondary care in the districts and there are several types, depending on size and available functions. The smallest hospitals, in areas of about 30,000 inhabitants, have a capacity of at least 120 beds. The second type, with 250 beds or more, are situated in larger towns (100,000 inhabitants or more), not being the district centre. District principal towns have a district central hospital with at least 700 beds. In addition, there are categorial and university hospitals. Polyclinics are out-patient departments of hospitals. So, this is in contrast to other countries where polyclinics may also be separately organised. There is often an exchange of medical staff between the hospital and the attached polyclinics. Below the total number of physicians has been itemised. Subsequently supply of hospital beds and the admission rate are listed (reference year: 1991).

physicians in hospitals	18,987	(1 per 1221 inhabitants)
physicians in polyclinics	4,978	(1 per 4660)
physicians in dispensaries	18,137	(1 per 1279)
total	42,102	(1 per 551)
number of hospital beds	215,629	(9.3 per 1000 inhabitants)
hospital admissions		20.1 per 100 inhabitants

In line with the general deterioration of living conditions during the last few years, quality of health care, especially in hospitals, has decreased. Medical goods are scarce, many buildings outdated and diagnostic facilities insufficiently available. (150,151)

Primary care

The first level of contact in case of health problems is general medical care provided by medical dispensaries, which have been established in each commune or in each health district in towns. For the benefit of the working population and school children, there are dispensaries in enterprises and in schools. Every dispensary is subordinate to a polyclinic. If necessary patients are referred to this polyclinic. Primary care includes curative services as well as early detection of disease, and prevention. Dental primary care is also provided by dispensaries. A typical dispensary is staffed as follows: two physicians, two medical assistants, a midwife and an auxiliary staff. Until 1978, private medical practice was authorised for government physicians for up to twelve hours per week in addition to their appointment. In the following period, until 1989, it was greatly restricted. Nowadays, i.e. since 1989, physicians are again free to start private practices. At present, May 1993, the number of operative private practices is estimated 1000. The number of rendered licenses is grater, but by lack of financial resources licences have not yet been used. (150,151)

Payment and income of GPs

So far, general physicians, like specialists in polyclinics or hospitals, are state employed. So they receive a salary. The level of the salary is dependent on the qualifications and skills acquired and on the number of years of experience. On average the income level of physicians in Rumania is low; in 1992 it was about LEI 420,000 a year (which equals USD 1000)

Training and education of GPs

On completion of their undergraduate studies, all physicians follow a three-year practical training programme in out-patient and hospital services. After this three-year programme, physicians are entitled to work as general physicians in out-patient care. After two years of experience in a medical dispensary, they may acquire the title of 'Medic Principal', and after five years that of 'Medic primar'. These titles are grades of merit in the medical hierarchy. After passing a selection procedure, those who want to become a specialist, may enter a specialist training programme after the practical period of three years. This usually takes another three years. Since 1991 a special vocational training programme for primary care doctors has been developed. Admittance is dependent on the outcome of a selection procedure. The programme takes three years. Two years are spent on a training in internal medicine, paediatrics, obstetrics/gynaecology, surgery, ENT and ophthalmology. The third year is a practical period in a dispensary with a tutor GP. The first generation of GP trained in this scheme is expected in the Autumn of 1993. (93)

● SLOVAK REPUBLIC

SLOVAK REPUBLIC

The country

After the abolition of the communist powers in former Czechoslovakia, nationalist movements became stronger, especially in the Slovak part of the federation. The June 1992 elections resulted in a victory of the Slovak nationalist politician Meciar. Subsequently, both parts of the former federal republic agreed to go on as independent countries. Slovakia, in contrast to the Czech Republic, has always been more eastward oriented. The country basically faces the same problems as the Czech Republic, however, it is less industrialised and its position, more remote from the strong economies, is less favourable to successfully coming through this period of transition. Challenges to health care will be to improve the population's health status, as reflected in stagnating health outcome statistics, and promote efficacy of services. (133,29)

Statistical key figures

(reference year 1991 unless otherwise indicated; additional sources:57,29)

Population		Natality mortality and health	
population in mln.	5.3	births per 1000	14.9
per sq. km. (a)	122	fertility rate/child.p.woman	2.1
% ann.growth 80-91	0.6	% ann.fert.reduction 1980-91 (a)	0.9
% urban (a)	74	% contracept. preval.	12.1
% under 15	24.6	deaths per 1000	10.4
% over 65	10.5	% infant mortality (under 1)	1.3
% over 75	4.2	% under 5 mortality (U5M) (a)	1.3
		% ann.reduction U5M 1980-91 (a)	5.9
		% DPT immunised at age 1	99
Development and economy		life expectancy (men)	66.5
human development index (a)	92	life expectancy (women)	75.3
compuls. education (yrs)	9		
TV sets per 1000 population (a)	410		
GDP per head in \$ (ppp) (a)	3,140		

(a) referring to both the Czech and Slovak republics

Statistics on health care (reference year 1991; source:58)

Hospitals	217 (61,705 beds / per 1000: 11.7)	
	general	82 (7.6 per 1000)
	special	92 (2.0 per 1000)
	balneological	43 (2.1 per 1000)
Physicians	17,664 (1 per 334 inhabitants)	
	in general hospitals	8405
	in special hospitals	797
	in baln. institutes	396
Out-patient care units (polyclinics)		2005
Inhabitants per	community doctor	1708
	dentist	2419
	comm.gynaecol. (women only)	5961
	comm.paediatr. (children only)	1035

For a description of the health care system, see 'Czech and Slovak health care systems' after 'Czech Republic' at page 27.

The country

As the northernmost republic of the former Yugoslavia Slovenia gained independence in 1991. The 1990 free elections resulted in rejection of communism in all republics and regions except Serbia and Montenegro. In contrast to other parts of the former federation the independence of Slovenia could be accomplished without too many hostilities. International pressure prevented an invasion of the federal army. The country is one of the smallest in Europe. Despite its relatively sophisticated economy compared to the other republics of the former Yugoslavia, it will be quite a job to keep up internationally. (133,94)

Statistical key figures (sources:37,99)

Population		Natality, mortality and health	
population in mln.	1.9	births per 1000	12.0
per sq. km.	99	fertility rate/ child.p.woman	1.6
% ann.growth 80-91	na	% contraceptive prevalence	na
% urban	na	death per 1000 pop.	9.6
% under 15	20.5	% infant mortality (under 1)	0.9
% over 65	10.8	life expectancy (men)	69
		life expectancy (women)	77
Development and economy			
compuls.education (yrs)	10		
TV sets per 1000 pop.	na		
GDP per head in \$	7,630		

Organisation of health care

Although things are changing now, health care still has many features from the time of the federation. Health care has been organised according to the administrative structure of the country in three levels: national, regional and district. Health care has been decentralised to a high degree. Formerly, the application of the concept of self management resulted in concentration of important responsibilities and power in the 'communes', the basic unit of local government. Health care used to be largely controlled by councils of providers and users of health services (the so-called 'self-managing communities of interest of health care', which existed at district level as well as at regional level). However, this self-management structure does no longer exist in Slovenia. Now, health centres have a director, who is the first responsible person and who is appointed by the community. So, health care is still decentralised, but direct involvement of workers and the community has been reduced. One of the consequences of decentralisation is differences in the provision of health services between regions and districts. These differences are not only related to the setting of priorities, but also to the level of prosperity. Wealthier, often urban, areas may have a more extensive health care than poorer areas, mostly situated in the countryside. Yet, at central level a certain basic level of benefits is guaranteed. The provision of health services is characterised by a well developed system of primary care. In each health district a branched network of health centres and medical stations provides a package of public health services and general medical and nursing care. Hospitals are organised at regional level. The role of private practice is still marginal. In the late 1950s private practice was declared illegal. Some ten years later, when unemployment of physicians was increasing, it was re-introduced on a limited scale, to be dropped again in the 1970s. Now private practice is allowed again, but only few doctors make the shift because remuneration and other financial conditions are still unclear. (150,94,101)

Health financing and insurance

Only a modest part of the health budget is directly financed by the government. The self managing communities of interest used to have the role of health insurance organisations at local level. Now a national health insurance fund has been created which is managed by the Institute of National Health Insurance. Resources are allocated no longer to the self

managing communities of interest but directly to the health care institutions. Hospitals are financed on the basis of the produced bed-days. For primary medical care this year a new contract was introduced with a mixed payment system based on capitation allowances and fees for services as main elements. At central level the social insurance programme is a semi-autonomous organisation. The government has the legal right to interfere if national interests are at stake, e.g. by levying contributions, and freezing prices, wages etc. Now that cost containment is an acute problem the government is using this right as it did in the past, e.g. by restricting the coverage for certain services. This has already led to the introduction of co-payments for prescribed drugs, house calls, health spas and certain specialist procedures. Co-payments account for 5% of health care expenditure. Recently an insurance has been introduced to cover these co-payments. (94,101)

Health expenditure 1990

- abs. per head in \$	353
- % of GDP	7.2

Secondary care

Secondary care is provided from general hospitals at regional level. There are 11 of these hospitals. Hospital care is accessible after referral by a physician in one of the district health centres. There used to be an exclusive relationship between the regional hospital and the health centres of that region. But nowadays people may also be referred to other hospitals, depending on their choice or the doctor's preference. In addition to general hospitals there are special hospitals, e.g. for oncology, gynaecology, and certain infectious diseases. There are 14 special hospitals. The number of hospital beds was 5.6 per 1000 inhabitants (1984). The number of admissions in acute hospitals per 100 population was 15.6. There are 1882 physicians working in hospitals; 93 of them are general physicians, 1425 are specialists and 364 are trainees in several specialisms. (150,94,101)

Primary care

The core of the Slovenian health system is primary health care provided from health centres. Each commune or health district, which may vary considerably in the number of inhabitants, has one health centre. A health centre should be understood as a number of integrated decentralised facilities. Although it is one organisation it is not housed in one building. Apart from the main building most centres have a number of smaller health stations, staffed with primary care teams. In remote areas there are some health posts staffed with nurses only; their number is less than ten. Health centres differ in size from a staff of some 50 to several hundreds. The various health services to be integrated include curative medical care, preventive care and health promotion, occupational and school health, mental health, environmental surveillance, dental health care, rehabilitation, emergency services and sick leave administration. These services are organised in departments, and they are all co-ordinated by the district doctor, who work for the population in a certain geographically defined area. District teams consist, in addition to doctors, of stomatologists (for dental care), district nurses and social workers. Another department is involved in mother and child care. In these teams paediatricians and gynaecologists do the primary care for children up to the age of 14 and women. (Thus district doctors do not provide comprehensive care to the whole population of their districts). School and youth health teams, sometimes having their office in large schools, consist of general physicians and special school/youth health physicians, paediatricians, nurses and social workers. Occupational health, often located in larger companies, is mainly curative care for working people. It is provided by general and specialised physicians in co-operation with nurses. In summary, health services are usually provided at places where people work, stay or live by different teams of providers. It is all supposed to be co-ordinated by district doctors, who can rely on a health information system for each family. Community or district nurses also have an important role in the co-ordination. They make

home visits in the district and report to the district doctor. Health centres create programmes on the basis of demographic data, morbidity data and information on living and working conditions. (101,30)

General practice

Since primary care for children, women and the rest of the adult population is not provided by one physician the Slovenian health care does not have a general practitioner in the usual sense. The district doctor, especially those in rural areas, comes closest to it. In towns, with their abundant health care supply, the division of tasks in primary care is most developed, while in rural areas general physicians in health stations often combine several primary care functions. Until the beginning of 1993, lists of patients registered with a doctor were unknown. Primary care physicians used to work territorially, which means that they were responsible for the population of certain areas. This has also been changed. With the introduction of the new contract patients have to register with a particular doctor. Health centres are financed partly by capitation allowances. This requires doctors to keep a patient list. (30)

Payment and income of GPs

Physicians in the regular system have a salary. They are employed by the local or regional authorities, who receive capitation fees and fees for items of service provided by the doctors in the health centres and health stations. For this reason the administration of the health centres is much more complicated than it used to be. Private doctors work on a fee-for-service system, which is the same as the one for salaried colleagues. The current contract is not clear enough, so that GPs are reluctant to start a private practice.

Training and education of GPs

Undergraduate medical training still takes five years, followed by one year of compulsory internship. This internship may be directed towards internal medicine, surgery, gynaecology, infectious diseases or primary health care, dependent on the future intended position of the trainee. After this period one is recognised as a medical practitioner. Undergraduate training is being reformed now and it is going to last for six years. The subsequent internship will last for six months, possibly followed by a residency period of up to two years. Specialism training takes three to five years. Soon a new obligatory vocational training for general practitioners will start. The current postgraduate training in general medicine, three years of duration now, will be changed and extended to probably four years. (93)

● SPAIN

The country

Spain is the larger one of the two countries that together form the Iberian peninsula. It is a parliamentary monarchy with a relatively short history. The two chambers of the Cortes, the parliament, are both elected for four years. The prime minister is appointed by the king, who is the head of state. After the civil war (1936-1939) Spain was for a long time under the dictatorship of general Franco. He died in 1975, and in 1978 the democratic constitution set up a semi-federal state. The seventeen regions, with their own parliaments, enjoy a considerable degree of autonomy. Particularly in Catalonia and the Basque Country national identity is strong. Between 1960 and 1980 Spain was one of the fastest growing economies among the industrialised countries. In spite of the EC-membership in 1986, Spain's economic growth is now much slower. This slow-down, which is also strongly felt in the important tourist industry, together with a high unemployment rate, places some pressure on the current government. (150,133,104)

Statistical key figures

Population

population in mln.	39.4
per sq. km.	78
% ann.growth 80-91	0.4
% urban	78
% under 15	20.1
% over 65	13.7
% over 75	5.6

Development and economy

human development index	95
compuls.education (yrs)	10
TV sets per 1000 pop.	389
GDP per head in \$ (ppp)	12,725

Natality, mortality and health

births per 1000	9.9
fertility rate/ child.p.woman	1.4
% ann.fert.reduction 1980-91	4.1
% contracept.preval.	59
deaths per 1000	8.7
% infant mortality (under 1)	0.78
% under 5 mortality (U5M)	0.9
% ann.reduction U5M 1980-91	5.2
% DPT immunised at age 1	73
life expectancy (men)	74
life expectancy (women)	80

Organisation of health care

The 'Ley General de Sanidad' (General Health Law), passed in 1986, regulates the National Health Service by means of the integration of different public institutions and agencies (Social Security, AISNA, health care for the poor etc.). This process is not finished yet. The NHS has been strongly decentralised. To six of the autonomous communities health competences have been transferred completely. These communities are: Andalusia, the Basque Country, Catalonia, Navarra and the Valencian Country. Thus, the NHS is formed by the overall health services of the central administration operating through INSALUD, and the autonomous communities operating through their own Regional Health Services. Other important formulated purposes are the universalisation of care, which is practically achieved with a coverage of 99% of the population, as well as the change of the financial basis (from social security contributions to general taxes), and the extension of transfer of the management of care to regional governments. The public sector covers most of the out-patient health care, and runs two-thirds of all hospital beds in the country. The public health insurance system accounts for three-quarters of the total health care expenditure. A strong private sector used by higher income groups exist alongside the public scheme and covers about 6% of the population. In a lot of cities and large towns, out-patient clinics cover areas averaging 200,000 people. Each area has a number of smaller health care centres staffed by general practitioners, paediatricians, and some nurses. A plan to cover the whole population by integrated primary health centres has been formulated and now the system is in a period of transition. An important part of the general practitioners, however, still work individually on a part-time basis for the Social Security and also part-time in private practice. (42,76)

Health financing and insurance

The Spanish health system is currently financed by general taxation (80%) and specific social security contributions (20%). Public expenditure accounts for three quarters of the total health care expenditures. Since health financing has been decentralised, nowadays half of the health care budget is managed by the autonomous regions. Total health care expenditure and expenses on pharmacy are summarised below.

Health expenditure	81	82	83	84	85	86	87	88	89	90	91
-abs per head in ppp\$	365	398	428	437	452	472	522	598	682	774	848
-% of GDP	5.8	5.9	6.0	5.8	5.7	5.6	5.7	6.0	6.3	6.6	6.7
expenditure on pharmacy											
- abs per head in ppp\$	75	84	85	81	92	90	97	108	na	na	na
-% annual growth		12.2	1.1	-4.8	12.9	-2.2	8.4	10.7			

Hospitals in the social security system receive financial aid by virtue of prospectively determined operating costs. Savings return to the Central Social Security Fund. Nowadays more than 30% of all expenditures cover services provided by private practitioners. (130,42,4)

Secondary care

During the 80s hospital care in Spain suffered rigorous budget cuts. Modernisation was impeded by the scarcity of economic resources. However, since the end of that decade first attempts have been made to restructure hospital care into a improved model with services closer to the user, more adapted to the need of users and of a higher quality and an adequate level of technology. This has to be accomplished by sectorisation, extension of the network of centres and a more adequate flow of resources. Hospitals for advanced specialist medical care are situated in densely populated areas. Besides, there are a larger amount of general hospitals with less sophisticated equipment, and a network of categorical hospitals. All hospital care in the social insurance system is free, and is carried out by public hospitals or merged private hospitals. Secondary care includes the following types of services: out-patient hospital care, out-patient care in separate centres (out-patient clinics or 'Ambulatorios'), and in-patient care. Hospital physicians are paid by salary, and specialists working in out-patient clinics are partly salaried, and partly receive capitation fees. Normally the GP, as the first point of contact in the health system, will refer those patients who are in need of specialist or hospital care. Nevertheless, patients also have direct access to hospital emergency rooms, which are increasingly used, because of the bad quality of the non-hospital emergency services, the long waiting lists in some specialisms and the slow development of the new primary care system. In the new scheme specialists are allowed to do periodic consultations in out-patient settings. Because of large waiting-lists (particularly in specialised hospitals) patients with adequate incomes consult specialists in private practices. The table below shows the number of acute hospital beds and the admission rate (reference year 1989). (17,42,138)

In-patient care beds	4.3
Acute hospital beds per 1000 population	3.5
Admission per 100 pop. in acute hospitals	9.6

Primary care

The General Health Law of 1986 aimed at the implementation of a system based on a network of health centres in primary health care. The geographical and administrative unit in which primary health services are planned, managed and provided is the primary health care district, with a population varying from 40,000 to 200,000 people. In one district several health centres will usually be operative, each staffed with general practitioners,

paediatricians, nurses, midwives, social workers and ancillary staff, with a population varying from 5000 to 25,000 people. While professional autonomy and individual responsibilities are maintained, these staff members will co-operate as a team with shared objectives. Beside activities of curative and nursing care, they carry out preventive tasks. Nowadays about 60% of the population is covered by these health centres. The range of variation is considerable: in some areas the coverage amounts to 80% while in other places 20% is not exceeded. Therefore, today two primary health care systems co-exist. In the old system general practitioners work from large centres (*Ambulatorios*) or from small satellite centres (*Consultorios*) and combine private practices and very small appointments of two hours a day in the public system. Specialists are also involved in the *Ambulatorios*. Training of nurses used to be a task of organisations related to the Catholic Church. Now, nurses' training programmes are provided by universities. It is noticeable that special nurses' training for primary care is still non-existent. In 1990 about 158,500 nurses were active in Spain, which is an average of about 1.4 nurse to every practising doctor. (135,136,76,17)

General practice

In 1978, more by political than by professional pressures, Family and Community Medicine was legally recognised as a postgraduate specialism of General Medicine, with an appropriate vocational training. This was in line with the Alma Ata Declaration of those days. The minority of graduates who undertook this training then sought to develop primary care as a serious career perspective in its own right. Since this training is not compulsory, physicians may also enter primary medical care without it. However, because of the strong promotion of this specialism by the Ministry and because of the future requirement to be certified for primary care (resulting from EC regulation), for primary care doctors with at least five years of experience a more concise training programme was created. This training offered these doctors the opportunity to become certified in Family and Community Medicine. In 1982 the *Sociedad Española de Medicina Familiar y Comunitaria* was founded. This society supported the reforms of the Spanish health care as outlined above. Almost everyone in Spain is registered with a GP. In the old system, GPs are supposed to be available for two hours each day in the '*ambulatorios*' or '*consultorios*' because of their legal commitment with the *Seguridad Social*. In rural areas however, they are responsible for patients 24 hours a day. In the new scheme GPs work at least seven hours a day with the health centre. The GP is the first contact and gatekeeper, and normally it is the GP only who will refer a patient to a specialist in out-patient care or in a hospital. People have limited freedom of choice of the doctor they are registered with. (135,136,76,17)

Payment and income of GPs

In the old system the GP is paid by a combination of fixed salary and capitation fees. In the new scheme GPs working in health centres are salaried. Sometimes, in remote rural areas, their task is a combination of primary medical care and public health work. These doctors are paid extra for these last mentioned activities. In the new scheme GPs working in health centres are salaried. The level of this salary is dependent on characteristics of the practice population (age structure, social indicators, geographical dispersion, emergency service during off-duty hours, etc.). In some regions there is also a capitation part in the salary. This element of remuneration will be more important in the future, when free choice of doctor will be further developed. In addition, incentives to promote preventive activities will be introduced in due course. Those general practitioners who are also engaged in private practices receive a fee-for-service for that part of their job. (17,76,135)

Training and education of GPs

The recognition of Family and Community Medicine as a specialism is of recent time. The undergraduate medical education comprises three years of basic science, followed by two years of clinical studies. After graduation, doctors can start immediately in an independent private practice. But nowadays this is quite unusual, all the more since some postgraduate experience is required before they can be contracted with the social insurance bodies. The

postgraduate programme in Family and Community Medicine takes three years. Trainees spend eighteen months in hospital departments, including internal medicine, surgery and some specialisms. The last eighteen months of training are spent under tutorial supervision in special primary care teaching units. GP training in Spain is not flourishing. The number of trainees remains below expectations. GPs who have been practising for many years already are not inclined to join the programme; they want to be certified on account of experience. It has been suggested to combine the training programmes of GP and public health. (17,93)

● SWEDEN

The country

Sweden is the largest of the Scandinavian countries. The country is a constitutional monarchy, but the king only has a ceremonial role. Because of its policy of strict neutrality it was not involved in either World War. Living standards are quite high and due to almost uninterrupted social democratic rule for some sixty years, it is one of the most comprehensive welfare states in the world. But it is costly too; Sweden is also a leader in terms of taxation. Current economic problems have made painful consideration inevitable. Since the fundamental political change in 1991 that put an end to the Social Democratic government, principles of the Swedish welfare state have been in discussion. In foreign policy Sweden has also embarked on a new course by its application for EC membership. (133,85)

Statistical key figures

Population

population in mln.	8.6
per sq. km.	19
% ann.growth 80-91	0.3
% urban	84
% under 15	17.3
% over 65	17.7
% over 75	4.4

Development and economy

human development index	98
compuls.education (yrs)	9
TV sets per 1000 pop.	471
GDP per head in \$ (ppp)	16,927

Natality, mortality and health

births per 1000	14.4
fertility rate/child.p.woman	2.12
% ann.fert.reduction 1980-91	-2.0
% contracept.preval.	78
deaths per 1000	11.0
% infant mortality (under 1)	0.4
% under 5 mortality (U5M)	0.5
% ann.reduction U5M 1980-91	5.3
% DPT immunised at age 1	99
life expectancy (men)('90)	74.8
life expectancy (women)('90)	80.4

Organisation of health care

The central government and especially the provincial governments (County Councils, or 'Landstinget') form the core of the health care organisation. Almost two-thirds of health care expenditure are raised and spent by these County Councils, supplemented by tax-based central government funds and some 10% out of pocket contribution from consumers. The 26 County Councils act within quite narrow central guidelines. The Association of County Councils is the negotiating partner with the Ministry of Health and the National Board of Health. The councils are also in charge of health care delivery, from public and preventive health care to hospital care and nursing homes. Top clinical care (and teaching hospitals) are both organised at the higher level of six regional authorities and also run by the county council with federal grants. The Health and Medical Services Act of 1983 defines responsibilities assuring equal access to all citizens. Swedish health care is predominantly hospital oriented in spite of the encouragement of primary health care centres consisting of curative and preventive primary care services (GPs, district nurses, nursing homes, school health). Access to hospitals and specialists is direct and the network of PHC-centres now covers the whole country. (82)

Health care financing and insurance

Local and central taxation form the main sources, almost three-quarter, of health care funding. Beside that, some 18% stems from social security premiums paid by employers and supplemented with state subsidies and 9% from out of pocket contributions. Private health insurance is practically non-existent. All citizens are entitled to a broad package of cure and care with out of pocket contributions for out-patient medical care (with a maximum of 15 contributions); for dental care (60% under 2500 Skr. and 25% above and free care for children and adolescents). A similar contribution prevails for allied services (60 Skr. per treatment). Contributions for drugs consists of a minimal fee plus a proportional payment

with a maximum of 120 Skr. with an additional 10 Skr. per recipe. Institutional care is free up to one year. Over one year, institutional care implies a 80 Skr. per diem co-payment. Health expenditure and expenditure on pharmacy are indicated below. (119,141,82,19)

Health expenditure	81	82	83	84	85	86	87	88	89	90	91
abs.per head (ppp\$):	952	1035	1084	1152	1150	1165	1240	1303	1390	1455	1443
% of GDP	9.5	9.7	9.6	9.4	8.8	8.5	8.6	8.6	8.6	8.6	8.6
expenditure on pharmacy											
abs.per head (ppp\$):	62	70	74	76	82	86	95	93	116	120	na
% annual growth rate:	12.9	6.1	2.8	7.4	4.9	10.1	-2.3	25.1	3.4	na	

As a proportion of GDP the Swedish for many years spent an amount comparable to the USA. However, Swedish health care costs stabilised and even decreased in the 1980s.

Secondary care

General hospitals are subdivided into three hierarchical categories. For top clinical care there are six regional and teaching hospitals. The 26 district hospitals provide a comprehensive range of specialist care, while local hospitals only provide basic specialisms. All hospitals have outpatient departments accessible for patients without referral. Nursing homes and homes for the aged are considered as belonging to primary care. The distribution of hospital beds and the hospital admission rate is as follows (the reference year is 1991; admission rate 1990).

Inpatient care beds per 1000 population	10.8
Acute hospital beds per 1000 population	3.7
Admissions per 100 pop. in acute hospitals	16.3

The total number of practising physicians is 29,251 (in 1992), which equals an average of 350 inhabitants per physician. Some 70% of all doctors are hospital based. Most doctors are salaried employees; next to their hospital job only very few of them have a private practice. (65,84,132)

Primary care

In the last two decades the government and the county councils have seriously tried to stimulate primary health by creating multidisciplinary health centres, some also with nursing homes. The medical staff of a health centre consists of a number of GPs varying from two to ten. In some centres other specialists than GPs are in the team. Apart from primary medical care and some specialist care the range of professional activities in a typical health centre also includes school health, nursing and allied services, like physiotherapy. District nurses have a special role; they make home visits in well defined areas. There are about 850 health centres (1985). There are some 3000 GPs. In some metropolitan and isolated rural areas there is a relative shortage of GPs. Beside the health centres there is still a group of private physicians, contracted by the social security scheme and the County Councils. Originally a relic of the past and quantitatively of little significance, their number is now increasing due to the political changes and the preference of the population for 'personal' care. Occupational medicine may also be considered as belonging to the field of primary health care. Occupational health services are much further developed in Sweden than in most other European countries. (105,82)

General practice

The average of one general practitioner per 2870 inhabitants is, compared to other countries, quite low. The average number of consultations of 1.2 per year per person is also

low. In Sweden the GP by no means has a monopoly of primary medical care. Most people seeking out-patient medical care, apply directly to a hospital out-patient department. With the exception of doctors working independently in private practice, GPs are employed by the County Councils. More than most other Western European countries preventive and population oriented health care has been integrated in primary care. Active health promotion and systematic disease prevention programmes are considered to be as important as curative care. The position of general practice in Sweden is weaker than in other countries due to a strong hospital and specialist sector, also with respect to first contact with the health problems of patients. There are presently plans to change the primary health care system in Sweden to a system where one GP has a list of approximately 2000 patients. The doctor will either be employed by the local health authorities or work on a private basis. Other functions of the primary care system in the future are not well defined in these new plans. There is still political disagreement with respect to these plans and also the Swedish GPs have differing opinions about it. A political decision is expected before the summer of 1993. (40,119,82)

Payment and income of GPs

General practitioners receive a salary supplemented with benefits for extra work outside office hours. Part of the compensation is often also paid out in extra days off, which reduces the availability of the GP during the day. The small minority of private practitioners receive a fee-for-service payment. The Association of County Councils and the Swedish Medical Association negotiate annually about salary levels and other benefits. In 1992 a starting district physician received a salary of Skr.360,000 and a more experienced physician Skr. 380,000. In 1984 it was estimated that there was a relationship of 2.7 between the national average per capita income and the GP's income (by comparison: Denmark 3.6). (40,143)

Training and education of GPs

The number of medical students is limited in Sweden. Since the mid 1980s the number of graduated doctors has sharply declined (708 in 1991 versus 1055 in 1985). Basic medical education takes five and a half years. After this, a 21 month trainee period in general medical care followed by a written examination is compulsory for all physicians. A Licence of Practice can only be delivered after having passed this examination. To become a consultant or a head of department, five years of postgraduate specialism training is needed. Family medicine is regarded as one of the specialisms. To work as a GP in a health centre this specialist degree is required. Of the five years of the training programme, at least two years must be spent in general practice. In addition to practical training, courses followed by examinations have to be finished by the graduate before receiving the degree as a GP specialist. Continuing medical education has not yet been formalised. (40,93, 132,72)

The country

Switzerland is a confederation of cantons which is landlocked and situated in Central Europe. The high Alps, covering at least one-quarter of its surface area, form a major watershed of Europe. For many ages it has maintained one of the oldest democracies in the world. There are several ethnic communities: the largest one is German speaking and comprises 65% of the population; about 18% is French speaking; 10% speaks Italian, and a few per cents Spanish and Romans. For more than a century Switzerland has adopted a policy of strict neutrality, which has prevented, for instance, a United Nations membership until now. The economy is largely based on trade and banking. The industrial sector is heavily dependent on workers from abroad. Guest workers, most of them originating from Italy, make one-quarter of the total work force. Economic motives may affect the well conserved neutral status of the country, since becoming a full EC member is a policy objective now. (85,133)

Statistical key figures

Population		Natality, mortality and health	
population in mln.	6.7	births per 1000	12.6
per sq. km.	162	fertility rate/child.p.woman	1.6
% ann.growth 80-91	0.8	% ann.fert.reduction 1980-91	-0.6
% urban	60	% contracept.preval.	71
% under 15	16.4	deaths per 1000	9.2
% over 65	15.0	% infant mortality (under 1)	0.62
% over 75	7.1	under 5 mortality (U5M)	0.9
		% ann.reduction U5M 1980-91	1.8
Development and economy			
human development index	98	% DPT immunised at age 1	na
compuls.education (yrs)	9	life expectancy (men) ('90)	74.0
TV sets per 1000 pop.	406	life expectancy (women) ('90)	80.9
GDP per head in \$ (ppp)	21,747		

Organisation of health care

Switzerland has a system with primary and secondary health care. Patients, however, have a free choice of general practitioner, specialist and hospital out-patient care, and in addition a free choice of hospital within their canton. Due to the federal structure of Switzerland national government does not have much influence in the field of in-patient health care. These institutions are mainly run by the cantons. All doctors in independent practice and some private hospitals are free entrepreneurs guaranteed by feral law. Although the cantons are responsible for in-patient health care, their planning has little influence, because it is partly outweighed by the relatively great freedom for private enterprise in Swiss health care. The national law on social health insurance, dated from 1919, is right now in a process of a major revision. The actual law determines the structure of a basic insurance coverage, which the 'Krankenkassen' have to provide in order to be eligible for federal funding. Health care insurance, however, is not mandatory on federal level. This also falls under the responsibility of the canton. The result is diversity. For instance, in five of the 26 cantons social health insurance is mandatory for 100% of the population, whereas in other cantons mandatory insurance exists for specific groups only (for example, the elderly or low-income groups). Some cantons offer social insurance on a voluntary basis only. (118,15)

Health financing and insurance

Despite the diversity of health insurance regulation, about 98% of the Swiss population is covered by social health insurance offered by one of the 195 'sick funds'. During the last few years concentration in the health insurance market has been significant. The number of 'sickfunds' dropped from around 650 in 1978 to less than 200 in 1993. All in all, some 30% of the Swiss population have, apart from basic insurance coverage stipulated by law,

additional private insurance coverage. The so-called 'Grundversicherung' consists of a basic benefit package, including for example: out-patient medical care, allied services if prescribed by a doctor, prescribed drugs on the so-called 'Positiv Liste', laboratory tests, hospital stays and stays in a revalidation centre or health spa. Through additional - private - coverage the insured is eligible for treatment and care in private hospitals and doctors of their choice or for private wards in public hospitals (one or two beds per room; senior consultants). Swiss health care is financed by federal, cantonal and municipal government (25%), social insurance schemes (43%) and private health insurance and private payments (32%). Government subsidises social insurance funds with an allowance based on the number of insured persons with some adjustment for the age and sex distribution of the insured population. Sickness funds can set their own insurance premiums, which need the approval of the 'Bundesamt für Sozialversicherung'. Social insurance premiums are generally nominal (i.e. not income-related), individual (i.e. family members are not automatically included) and risk-based in the sense that premiums are related to age at the moment of entering public insurance and sex (with a maximum of 10% difference between premiums for men and women). Once social insurance has been entered, the premium remains the same except for general increases that are not related to age. Health care tariffs are negotiated between professional organisations and the 'Kantonalverband der Krankenkassen' (the organisation of sickfunds at the level of cantons). Three national committees decide on the coverage by social health insurance for, respectively, new medical technology and treatment, new medicines and new laboratory facilities. After approval by the committees, the new treatment, medicine or laboratory test is put on the 'Positiv Liste', which describes the basic benefits under social health insurance. The committees base their decisions on scientific as well as economic criteria. About one-third of the running cost of public hospitals are funded by municipalities and cantons, with a large variation among the cantons. Usually all investment cost of public hospitals are also paid by the cantons. (118,15,141,33)

Health expenditure	81	82	83	84	85	86	87	88	89	90	91
abs. per head											
in ppp\$	943	1008	1100	1163	1224	1267	1332	1435	1542	1640	1713
% of GDP	7.3	7.5	7.8	7.8	7.6	7.6	7.7	7.8	7.7	7.8	7.9
expenditure on pharmacy											
abs. per head											
in ppp\$	139	146	157	165	170	184	168	177	188	201	na
% annual growth rate		5.5	7.0	5.1	3.4	8.1	-8.7	5.4	6.1	7.2	na

Secondary care

About one-third of the cost of operating public hospitals is funded by municipalities and cantons. In addition to public hospitals, there is a private hospital system for which one-thirds of the Swiss population have entered additional insurance. Apart from public and private hospitals, there are five university hospitals: in Geneva, Lausanne, Zurich, Berne and Basel. The hospital organisation 'Vereinigung Schweizerische Krankenhäuser' distinguishes between four categories of hospital types: general hospitals (of which there were 277 in 1986), institutions for long-term care (386 in 1986), psychiatric hospitals (86 in 1986) and other types of secondary care institutions (50 in 1986). Senior medical specialists in public hospitals are usually salaried, but have the right to treat privately insured patients in the so-called private wards in hospital. Physicians in private practice are paid a fee-for-service. Payment for hospitals differs between municipalities and cantons, but has in recent years predominantly been based on a 'per diem' system plus some extras for expensive technologies and medicines. Social insurance also covers the cost of a stay in a private hospital up to an agreed maximum. The total number of practising physicians in Switzerland in 1990 was 20,030, which is an average of one doctor per 330 inhabitants. The table below

shows the number of in-patient and acute hospital beds per 1000 inhabitants and the admission rate. (90,118,15,137)

In-patient care beds per 1000 population (89)	9.5
Acute hospital beds per 1000 population (90)	6.4
Admissions per 100 population in acute hospitals (88)	13.6

Primary care

Apart from out-patient care physicians, allied services and dentistry, Swiss primary health care includes community nursing. Community nurses can be employed by municipalities or by specific organisations. Private initiative is very important in primary health care and in the field of home care. Municipalities, however, are becoming more and more important, especially in the co-ordination of the various providers of so-called 'Spitalexterne Krankenpflege, SPITEX'. SPITEX covers various primary care facilities such as nursing care, family assistance and the provision of hot meals, and is generally aimed at facilitating care at home for elderly or disabled people. In recent years a number of plans and projects have been launched to coordinate the diverse SPITEX-initiatives. Special attention is also drawn to the problem of funding SPITEX services, since these services are not covered by social health insurance in all cantons. A prerequisite for sound funding is a clearly defined service, provided to a clearly defined population. In many cantons standardisation is still missing. (15,141,110)

General practice

Primary medical care is provided by self-employed physicians. In 1992 over 11,000 physicians, about half the total number, provided out-patient medical care. Some 30% of these physicians were 'Allgemeinmediziner'; the remaining 70% consisted of medical specialists, working in out-patient care. There are no regulations on physicians' establishment in general practice. As a result, physicians are not evenly spread over the country. Physician density is somewhat higher in the French-speaking part of Switzerland and in urban areas. As has been said before, Swiss GPs do not serve as gatekeepers to higher specialised care. Patients have direct access to all types of out-patient medical care, either provided by medical specialists in out-patient departments of hospitals or in private practice. In out-patient care, the majority of doctor-patient contacts takes place in the physician's office, although home visits do occur (about 5% of all encounters in out-patient care in 1982). About 50% of the Swiss population contacts an out-patient care physician once a year for health problems. The number of patients that yearly visits a physician for preventive care differs with sex and region between one-thirds of the German-speaking men in the cantons of Bern and Zürich and 70% of the French-speaking women in Geneva. (15,110,23)

Payment and income of GPs

GPs are usually paid on a fee-for-service basis. Physicians' services are financed by social health insurance (about 60%), additional and private health insurance (about 4%) and patients' out-of-pocket payments (about 36%). It is customary that the patient pays the doctor first, after which he is reimbursed by his sickness fund. Fee schedules differ per canton and are subject to negotiations between physicians' associations and sickness funds. Relative values of items in fee schedules are partly resource-based and partly represent a compromise between cost-containing strategies of sickness funds and physicians' income expectations. (118,141,81)

Training and education of GPs

Physicians undergraduate training requires six years and concentrates particularly on fundamental and clinical sciences. Almost all physicians follow five to eight years of postgraduate training, although this training is optional. Postgraduate training as a GP results in a qualification as a FMH (Foederatio Medicorum Helveticorum) practitioner in general medicine. The training in general practice takes five years, of which one year in surgery, and two years each in, respectively, internal medicine and other disciplines. Continuing education is organised by various specialist associations. There are no arrangements for re-certification. At present a programme for permanent medical training and education is in discussion. (93,23)

The country

By its geographical position, Turkey is a link between Europe and the Middle East. Most of the extensive territory is situated in Asia Minor, only the area west of the Bosphorus belongs to Europe. And the political position is of a correspondingly intermediary character. Rooted in Islam and the heritage of the Ottoman past, Turkey created a political and administrative system according to a Western model. The president, as head of state, is elected by parliament for seven years. The cabinet, headed by the prime minister, is appointed by the president, and the single chamber Meclis with 450 members is directly elected for five years. Its political and strategic position have given Turkey an important role in managing the tensions and conflicts in the Middle East. In its aim to increase its orientation to the West, Turkey clearly intends to go beyond its current membership of NATO; it also wants to join the EC. A customs union with the EC is expected by 1995, full membership later. (133)

Statistical key figures

Population		Natality, mortality and health	
population in mln.	57.2	births per 1000	29.0
per sq. km.	73	fertility rate/ child.p.woman	3.6
% ann.growth 80-91	2.3	% ann.fert.reduction 1980-91	1.6
% urban	61	% contracept.preval.	63
% under 15	34.6	deaths per 1000	8.4
% over 65	4.2	% infant mortality (under 1)	5.6
% over 75	1.6	% under 5 mortality (U5M)	8.9
		% ann.reduction U5M 1980-91	4.2
		% DPT immunised at age 1	72
Development and economy		life expectancy (men)	63
human development index	69	life expectancy (women)	66
compuls.education (yrs)	5		
TV sets per 1000 pop.	174		
GDP per head in \$ (ppp)	3,551		

Organisation of health care

Health care in Turkey is provided by a number of separate agencies. The relative autonomy of these agencies is a hindrance to effective co-ordination of delivery. Two organisations are involved in formulating health policy, the Ministry of Health (MoH) and the State Planning Organisation. Other important organisations, such as the Social Insurance Organisation and the University Hospitals, pursue particular objectives but do not in fact determine policy. Health services provided by the Ministry of Health are administered at the provincial level by Provincial Health Directorates. Each of the 76 provinces has a Provincial Directorate of Health. Below this level there are two types of health organisations. The first one, which started in 1963 in the eastern provinces and covered the whole country by 1984, accounts for a programme of integrated preventive and curative services without charge, provided by health centres. As satellites to these health centres, midwife stations or 'health houses' for maternal and child health care have been established. Beside these integrated services, some vertical health organisations still exist to run health programmes for tuberculosis, mother and child care, family planning etc. Beyond the provision of primary health care, the MoH scheme maintains a large network of hospitals. However these hospitals contain only half of the national total of beds. Currently the government is working on a system in which the family physician will work by contract with the health insurance organisation. The hospitals will be decentralised and privatised. This process will start with the state owned hospitals. Beside the public health services a large private network of providers and facilities is a well integrated part of Turkish society, and accounts for well over half of total health expenditure. In addition, especially in rural areas, people consult a variety of traditional healers, like bone setters and mystics. Traditional birth attendants still deliver one-fourth of the babies. (105,100,150)

Health financing and insurance

In Turkey a large number of agencies is involved both as providers and financial intermediaries. On the provider side the relative magnitude of the public and private sectors is striking. The private sector accounts for approximately 55% of total expenditure, mostly for non-hospital services. MoH institutions are responsible for about 20% of total expenditure. On the funding side there are three main sources: the general state budget ($\pm 30\%$), the health insurance funds (20%), and out-of-pocket payments by users (50%).

Health expenditure	81	82	83	84	85	86	87	88	89	90	91
-abs per head in ppp\$	79	70	75	78	66	89	100	110	118	133	142
-% of GDP	-12.3	7.7	4.1	-15.9	36.1	11.6	9.8	7.5	13.3	6.4	
expenditure on pharmacy											
-abs per head in ppp\$	8	8	8	8	9	11	13	na	na	na	na
-% annual growth		0.4	0.4	1.15	5.1	22.0	19.1	na	na	na	na

Among the social security programs, the SSK (the Social Insurance Organisation) is the most important. SSK originally covered industrial and commercial workers (blue collar workers). The SSK has a large network of its own service facilities, i.e. hospitals and clinics, with salaried health personnel. Second largest programme is the retirement fund, which covers the retired government employees (white collar workers). The third one is a social security fund for self-employed persons and employees, such as merchants, artists and farmers. Turkish civil servants at both central and local level are covered by a separate social security programme. All together, about 50 percent of the entire population is currently covered by the social security protection for health services. Those who cannot benefit from social security protection, can rely on services from MoH facilities. (105,100)

Secondary care

In 1986 the total number of hospitals in Turkey was 736 controlled by the public scheme (499), the SSK (77), universities (23), other ministries and public organisations (24), private organisations (100) and minorities and foreign organisations (13). Whereas public health services are available without payment by the individual receiver, hospital treatment services have to be paid for at the point of delivery of care. Consequently many people are insured for these costs. Almost all patients make their own way to out-patient services without referral of a primary care physician. By lack of an appointment system, patients simply turn up and may wait for hours to be seen, thus causing stress to doctors and patients. About 40% of physicians work in full-time practice, 60% work for the Ministry of Health and several other public programmes. A substantial part of the latter, however, are also engaged in private practice when their official duties are completed. With respect to dentistry and pharmacy, private practice is of even greater importance. Especially in the larger cities, where this private market is heavily concentrated. The table below shows the number of hospital beds and the admission rate (reference year). (105,100)

In-patient care beds per 1000 population	2.1
Acute hospital beds per 1000 population	1.8
Admissions per 100 pop.in all hospitals	5.6

Primary care

The plan to cover the entire nation with accessible primary health care by means of health centres, did not prove to be completely feasible in practice. Although the building of health centres throughout the country has been successfully carried out, the 'socialisation programme', as it is called, has failed as a means of delivering primary health care. A major indication of this failure is the development and use of facilities for primary care purposes, not belonging to the plan. The Social Security Organisation SSK for example has developed

its own network. In addition there has also been an increase in private general practice. And as a result of a lack of co-ordination in primary care, hospital out-patient services have become overloaded with patients who actually should be treated at a generalist primary care level. (100,39)

General practice

The position of general practitioner, as such, is so far unknown in Turkey. Insufficient numbers of general physicians are working in cities because of a lack of health facilities, like buildings etc. Nevertheless, in rural areas, the work of health centre physicians is to a large extent comparable with the activities of a general practitioner, although a long-lasting relationship between physician and patient is missing. As considered from the supply side, the essence of the problem is that primary care is not a career perspective to Turkish physicians. Almost all of them work for one year in a health centre, mostly in underserved rural areas, but for no other reason than that it is obligatory on completion of undergraduate training. After this period, nowadays, a quarter of the graduates continue by entering specialist training. Remaining in primary care is usually seen as second best. Recently, new initiatives by the Turkish Medical Association and the Ministry of Health have been aimed at the development of general practice. (100,39)

Payment and income of GPs

The income of physicians working in health centres, which is a state salary, is relatively low. This income amounts to approximately \$700 per month, while the national mean income is about \$700 per month. The income of specialists is much higher and roughly comparable to that of colleagues in Western Europe. This is another reason why it is attractive for physicians to specialise. For their private practice activities doctors have fees for service, directly paid by the patients. (100)

Training and education of GPs

Undergraduate medical education takes six years. The first three years are devoted to basic and clinical sciences, years four and five to clinical clerkship programmes and year six to undergraduate internships. To become a general physician in primary care, subsequent postgraduate training is not required. Those who wish to enter a postgraduate specialist training have to pass a competitive examination, which is held during and after the compulsory medical service period in health centres. Plans with respect to the development of general practice include a GP vocational training. (100)

● UNITED KINGDOM

The country

The United Kingdom is a constitutional monarchy of three countries: England, Wales and Scotland and a province: Northern Ireland. At present, these do not enjoy a high degree of autonomy but are governed directly from London. The Queen is the Head of State but the executive power lies with the Prime Minister. There is a two chamber parliament. The lower chamber (The House of Commons), is elected by universal suffrage whereas the upper chamber (The House of Lords), is non-elected but has only limited powers. The country used to be highly industrialised, but nowadays, service industries are becoming more important. The discovery of North Sea oil made the UK the fifth largest oil producer in the world. However, revenues from oil exports have considerably diminished since the mid 1980s. Britain entered the EC in 1973 some years after its first application. Fear of loss of sovereignty still dominates the attitude of many British people towards the EC. (133,40)

Statistical key figures

Population

population in mln.	57.2
per sq. km.	234
% ann.growth 80-91	0.2
% urban	89
% under 15	19.0
% over 65	15.8
% over 75	7.0

Development and economy

human development index	97
compuls.education (yrs)	11
TV sets per 1000 pop.	434
GDP per head in \$ (ppp)	15,660

Natality, mortality and health

births per 1000	13.8
fertility rate/ child.p.woman	1.9
% ann.fert.reduction 1980-91-	0.5
% contracept.preval.	72
deaths per 1000	11.2
% infant mortality (under 1)	0.74
% under 5 mortality (U5M)	0.9
% ann.reduction U5M 1980-91	4.0
% DPT immunised at age 1	85
life expectancy (men)	73.2
life expectancy (women)	78.8

Organisation of health care

Health care has been provided since 1948 by a National Health Service (NHS), for which the Secretary of State for Health and the Department of Health are responsible. There are two important levels of management: the 14 Regional Health Authorities (RHA) and (in England) the 193 District Health Authorities (DHA). In Wales, Scotland and Northern Ireland the organisation is slightly different. Health Authorities are involved in the provision of hospital care, community nursing services and primary medical care. Providers of hospital care and community care are employed by DHAs. General practitioners and dentists are independent contractors to the NHS, through the Family Health Services Authorities (FHSA). In general, patients need referral from their general practitioner if services are required in secondary care. The UK has one doctor per 715 population. Attachment of physiotherapy and occupational therapy to general practice is rare; these services are hospital based. Parallel to the NHS, there is a private sector, which is small in primary care but significant in secondary care and currently increasing. (1,65,40,105)

Health financing and insurance

Health care is mainly tax funded and there is universal coverage of the whole population. Benefits are mostly available with no financial contribution at the time from patients though there are some exceptions (e.g. co-payments for dental care and some pharmaceuticals though children, pregnant women, the elderly and persons with chronic illness or in receipt of state benefits are in general excused from co-payments). A small part, about 10%, is financed by private insurance. Total health care expenditure and expenditure on pharmacy are summarised below.

Health expenditure	81	82	83	84	85	86	87	88	89	90	91
- abs. per head in ppp\$	525	551	612	648	683	741	798	853	914	988	1035
- % of GDP	6.1	5.9	6.1	6.1	6.0	6.1	6.1	6.1	6.1	6.2	6.6
expenditure on pharmacy											
- abs. per head in ppp\$	58	65	70	72	74	80	87	93	98	na	na
- % annual growth		12.4	6.4	3.6	3.2	7.9	8.4	6.7	5.2		

A reorganisation of health care funding was introduced in 1991. The reforms aimed at the promotion of accountability, competition and increased efficiency as well as putting an emphasis on preventative medicine. Hospital Trusts and fundholding general practice units (optional for practices with more than 8000 patients), were established. These have greater financial autonomy and the freedom to spend budget savings on patients benefits. However their spending is subject to a greater degree of accountability than previously. GP fundholders are free to negotiate contracts for diagnostic facilities, hospital consultant services and community services such as district nurses and chiropodists within their assigned budget. Prescribing costs are also included in the budget. GP budgets are presently based on previous spending but it is intended that they will eventually be determined by size and relevant characteristics of the practice population. If a fundholding practice has a surplus after one year, this may be used in the following year on improvements in the practice. Services for patients of non-fundholding GPs are purchased on their behalf by the DHA. For patients, these changes are intended to increase freedom of choice and decrease waiting times (25,20,27,145,45).

Secondary care

In the UK patients have no direct access to secondary care, except in an emergency, the GP has the role of gatekeeper. Until 1991, public hospitals were under the bureaucratic control of the NHS. Since the 1991 reforms, there has been an attempt to separate the purchaser and provider roles of hospital services. The purchasers are the fundholding GPs and DHAs and these contract with the providing hospitals within agreed prices and levels of quality. Hospitals may opt out of DHA control and become trusts. These hospitals are capable of providing services to a wider range of purchasers, acquire and dispose of property and land, generate funds in new ways and borrow money. The intended results of this reform are that money will follow patients to the most efficient provider of secondary care. There will be an increased cost awareness and medical specialists may be judged by the costs they generate. Until now, a limited number of hospitals have made the shift to be a Trust. The table below shows the number of hospital beds and the admission rate. (1,53,17,145)

In-patient care beds per 1000 population ('89)	6.4
Acute hospital beds per 1000 population ('86)	2.8
Admissions per 100 pop. in acute hospitals ('86)	12.9

Primary care

Of the total budget of the NHS (1990), 23% was devoted to all Family Health Services (general medical, general dental, pharmaceutical and ophthalmic) and a further 8.7% assigned to community health services (district nurses, health visitors etc). Primary care is mainly provided by district nurses, health visitors, midwives, pharmacists, opticians, dentists and GPs. Community nurses, health visitors and midwives are employed directly by the health service. The other professionals mentioned are self employed and independent. GPs have contracts with FHSAs. Physiotherapy is usually not part of primary care but may become so given the establishment of fundholding. Many GPs now have direct access to physiotherapy departments. (There are about 10,000 physiotherapists attached to

hospitals.) In 1990 there was one dentist per 3,100 inhabitants. Home help services are available but are not a direct part of the NHS. Main providers of community nursing are district nurses and health visitors. District nurses (approximately 15,000 in England in 1990 (1 per 3,130), care for patients at home and those in old peoples homes without nursing staff. Of the total population 7.3% were receiving treatment from district nurses (1988). Most district nurses are general practice attached which means that they are working for a specific practice population. There may be some overlap in the activities of district nurses and so-called practice nurses employed directly by the general practitioner. In contrast to district nurses, health visitors care for the healthy especially young children and their mothers (immunisation, providing information, child health assessments). They are also involved in some services for the elderly though their role in screening amongst the elderly has to an extent been taken over by practice nurses. The number of health visitors in England in 1990 was 1 per 4,765 people.(139,22).

General practice

The first Chair of General Practice in the world was created in 1963 in Edinburgh, Scotland. In 1952 the (English) College of General Practitioners (from 1967 designated 'Royal') was founded. These two facts show the long-standing tradition of general practice and general practitioners in the U.K. An important turning point in favour of general practice was the launching of a Charter for the Family Doctor Service by the British Medical Association in 1965. Negotiations on the details of the charter resulted in 1966 in a new contract with better conditions for GPs. The present high degree of professionalism in general practice is reflected by the well developed system of undergraduate medical education and vocational training, the supply of continuing medical education, the existence of university departments of general practice, its research tradition and the British Journal of General Practice. The general practice share of the total NHS budget (including pharmaceutical services) is 18.3%. Virtually the entire population is registered with a GP who provides both primary care and controls the access to secondary care for the patient. On average, patients see their general practitioner about four times a year. Fifteen percent of patient contacts involve a home visit. GPs do not have formal responsibility for the patients admitted to hospital. Most GPs work from purpose built premises many of which are owned by the GPs but a third are based in state owned health centres. Many of the premises have space for attached district nurses and health visitors. For every general practitioner in the UK, there are approximately two full time members of the ancillary staff team who work under his direct employment. The staff includes office personnel as well as the practice nurses who together with the attached district nurses, health visitors and local social workers, constitute a primary care team. The financial arrangements for general practice encourage partnership practice. The total number of GPs (trainees excluded) in the UK is 31,518 and is equivalent to 1892 citizens per general practitioner. The distribution by partnership size (England and Wales), is given in the table. (65,40,22,20,17,38,10)

	%
single handed	11
2 doctors	15
3 doctors	18
4 doctors	18
5 doctors	18
6 or more doctors	22

Payment and income of GPs

The remuneration system of GPs is a complex mixture of fees and allowances as specified in the contract. The contract is priced centrally and the government is advised by the Review Body on Doctors' and Dentists' Remuneration. The major payment is a capitation fee for each patient on the doctor's list. The level of the fee depends on the age of the patient with weightings for the elderly. A deprivation allowance is attached to the capitation fee for patients living in deprived inner city areas. In addition there are a number of fixed

allowances such as the basic practice allowance, the seniority payment (based on the number of years in practice) and additional payments for doctors in thinly populated areas. Finally there are fees for certain services such as those for undertaking minor surgery, vaccination and immunisation, home visits at night, contraception and maternity medical services. Since 1990 the payment system has included incentive payments for immunisation and cervical cytology uptake. Payments for health promotion clinics initially introduced in 1990 have been withdrawn and replaced by payments for carrying out specific health promotion programmes and management programmes for diabetes and asthma. Seventy percent of the ancillary practice staff employed by GPs (maximum two per GP), is reimbursed directly. The total pay for GPs is fixed so that as more GPs achieve target payments, there becomes less money available to distribute to those not achieving the targets (40,20).

Training and education of GPs

Although there is variation in the programmes, general practice training is undertaken by all 26 medical schools. All of them have independent departments of general practice. In undergraduate training, which takes five and a half years, training in general practice usually takes place in periods up to four weeks in which students are attached to a GP. The undergraduate training is followed by one year of internship in hospital in order to be registered as a doctor. Vocational training, compulsory to become a GP since 1980, includes a three year programme, one of which is spent as a trainee in general practice. University departments are not involved in vocational training, although staff may have a role in it. Vocational training is separately organised at regional level. Requirements for the examination for membership of the Royal College of General Practitioners result in a fair conformity of different training programmes. There is no re-certification of members of the RCGP. Continuing medical education is not compulsory, although it is strongly encouraged. Supply is large especially in larger cities. Most district hospitals have postgraduate centres with lecture and seminar rooms and provision for social contact. There has been a shift in the form of the courses: from mainly lectures by specialists more and more to small group courses organised by GPs themselves, e.g. in premises of a group practice. GPs get a fixed annual postgraduate education allowance if they can prove that they have attended certain types of training for at least 5 days a year. (84,52,51)

These definitions explain the statistics that almost all country descriptions have in common. Further explanation about sources, reference years etc. can be found in the references section.

na in a table means 'not available'.

urban population refers to percentage of the population living in urban areas as defined according to the national definition used in the most recent population census (UNICEF, 1993).

birth/death rates: annual number of births/deaths per 1000 population; rates are crude, which means that age structure of the population has not been taken into account.

total fertility rate: number of children born per woman if she was to live to the end of her child-bearing age, and bear children in according with prevailing fertility rates (UNICEF, 1993).

contraceptive prevalence: average percentage over the period 1980-1992 of married women aged 15-49 currently using contraception.

infant mortality: number of deaths of infants under one year of age per 100 live births.

under 5 mortality: number of deaths of infants under 5 years of age per 100 live births.

DPT immunisation: percentage of children fully immunised at the first year of age against diphtheria, pertussis (whooping cough) and tetanus.

life expectancy is the average number of years that a baby born in the reference year can expect to live (taking into account the average mortality risk of a cross-section of the population in that year).

human development index has been recently developed by the United Nations Development Programme. It is a combination of three indicators: life expectancy, literacy and whether the average income (in ppp) is sufficient to meet basic needs (see UN Development Programme, Human Development Report). Scores under 50 refer to 'low' human development, those between 50 and 80 as 'medium' and above 80 as 'high'. It should not be considered as an indicator of 'quality of life'.

GDP per head (in Purchasing Power Parity) is the indication of the sum of all output produced by economic activity in a country (goods and services exchanged for money or traded in a market system). Comparison of Gross Domestic Products in ppPs takes into account differences in price levels between countries. PPP statistics adjust for cost of living differences.

total expenditures on health include:

- private final consumption of medical care, i.e. outlays corresponding to the purchase of medical goods and services by households (whether or not reimbursed by a public agency) It includes thus the share of costs and charges paid by users and not financed by the public sector and self prescription medicines
- publicly financed consumption of medical care, i.e. services directly supplied by a public agency or collective service
- investments in in-patient care institutions, clinics and diagnostic centres
- administrative costs

DEFINITIONS

- costs of biomedical research and development
- industrial medical care
- outlays by non-profit institutions and private insurance (not already accounted for under private consumption).

total expenditures on pharmacy: expenditures on prescription medicines and self medication. Not included are pharmaceutical products consumed in hospitals. VAT, sales taxes and the salary of pharmacists when it is dissociated from the price of medicines are included.

The authors have compiled the descriptions in this book by using the statistical sources and literature references as listed in this section. Drafts have been reviewed by experts in the countries concerned. These persons have made, sometimes considerable, additions and changes in the text. It has not in all cases been possible to include the information contributed by the reviewers in the list of references.

Statistical key figures

Population

- pop./p.sq.km : The Economist (1992); ref.year 1990, unless otherwise indicated (uoi)
- % annual growth : UNICEF (1993); ref.year 1980-91
- % urb/ % under15 : The Economist (1992); ref.year 1990 (est.), uoi.
- % over 65/over 75 : OECD Health Data (1993); ref.year 1991, uoi.

Nativity, mortality and health

- births per 1000 : for OECD countries OECD Health Data (1993); ref.year 1991, uoi; for other countries: UNICEF (1993); ref.year 1991
- fertility rate/child.p.woman : OECD Health Data(1993); ref.year 1991 / also: UNICEF (1993); ref.year 1991
- % ann.fert.reduct. 1980-91 : UNICEF (1993); ref.year 1991
- % contracept. prev.1980-92 : id; ref.year 1992 or last available
- deaths per 1000 : for OECD countries OECD Health Data (1993); ref.year 1991, uoi; for other countries: UNICEF (1993); ref.year 1991
- % inf.mortality (under 1) : id.
- % under 5 mortality (U5M) : UNICEF (1993); ref.year 1991
- % ann.reduct.U5M 1980-91 : id.
- % DPT immuniz.at age 1 : UNICEF (1993); ref.year 1990-91
- life expectancy : OECD Health Data (1993); The Economist (1992); ref.year 1990, uoi.

Development and economy

- human development index : UN, Human Development Report (orig.)/ The Economist (1992)
- compuls.education (yrs) : The Economist (1992); ref.year latest available
- TV sets per 1000 pop. : UNICEF (1993); ref.year 1989.
- GDP per head in \$ (ppp) : OECD Health Data (1993); ref.year 1991, uoi.
- tot.expenditures on health : id; ref.years 1981-91, uoi.
- tot.expend.on pharmacy : id; ref.years 1981-91, uoi.
- Health expenditures 1981-91 : OECD Health Data (1993); ref.year 1991, uoi.
- Expend. on pharmacy 1981-91 : id.
- Inpatient/acute hosp. beds : OECD Health Data (1993); ref.years indicated.
- Hosp. admissions (acute) : id.

na in a table means 'not available'

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