This edition of the Template is a revision of the 2013 template modified for the Asia Pacific Region, based on the 2010 template prepared by the European Observatory on Health Systems and Policies, written by (in alphabetical order):

Bernd Rechel, Sarah Thomson and Ewout van Ginneken

It has been adapted to the needs of the Asia Pacific region by (in alphabetical order):

Syed Masud Ahmed, Peter Annear, Ravindra Rannan-Eliya, Judith Healy, Dale Huntington, Benjamin Lane, Walaiporn Patcharanarumol, Anna Rodney and Xu Hongyi
Contents

Introduction v
Acknowledgements vi
Notes for authors vii
Acronyms ix
How to use this guide x
Preliminary pages in HiTs xii
Chapter 1: Introduction 1
Chapter summary 1
1.1 Geography and sociodemography 1
1.2 Economic context 2
1.3 Political context 3
1.4 Health status 4
1.5 Natural and human-induced disasters 8
Chapter 2: Organization and governance 10
Chapter summary 10
2.1 Overview of the health system 10
2.2 Historical background 13
2.3 Organization 14
2.4 Decentralization and centralization 15
2.5 Policy and planning 16
2.6 Intersectorality 17
2.7 Health information management 18
2.8 Regulation 19
2.9 Patient empowerment 25
Chapter 3: Financing 29
Chapter summary 29
3.1 Health expenditure 29
3.2 Sources of revenue and financial flows 32
3.3 Overview of the public financing schemes 34
3.4 Out-of-pocket payments 45
3.5 Voluntary private health insurance 48
3.6 Other financing 51
3.7 Payment mechanisms 53
Chapter 4: Physical and human resources 57
Chapter summary 57
4.1 Physical Resources 57
4.2 Physical Resources 61
# Contents

**Chapter 5: Provision of services** 65

Chapter summary 65

5.1 Public health 65

5.2 Patient pathways 66

5.3 Primary/ambulatory care 67

5.4 Inpatient care 69

5.5 Emergency care 72

5.6 Pharmaceutical care 73

5.7 Rehabilitation/intermediate care 74

5.8 Long-term care 75

5.9 Services for family/informal carers 76

5.10 Palliative care 76

5.11 Mental health care 77

5.12 Dental care 78

5.13 Complementary and Alternative Medicine (CAM) and Traditional Medicine 79

5.14 Health services for specific populations 79

5.15 Disaster Risk Management for Health (DRM-H) 80

**Chapter 6: Principal health reforms** 81

Chapter summary 81

6.1 Analysis of recent major reforms 81

6.2 Future developments 82

**Chapter 7: Assessment of the health system** 84

Chapter summary 84

7.1 Stated objectives of the health system 84

7.2 Financial protection and equity in financing 85

7.3 User experience and equity of access to health care 86

7.4 Health outcomes, health service outcomes and quality of care 87

7.5 Health system efficiency 90

7.6 Transparency and accountability 92

**Chapter 8: Conclusions** 93

**Chapter 9: Appendices** 94

9.1 References 94

9.2 Further reading 94

9.3 Useful web sites 94

9.4 HiT methodology and production process 94

9.5 About the authors 94
The Health Systems in Transition (HiT) profiles are country-based reports that provide a detailed description of a health system and of reform and policy initiatives in progress or under development in a specific country. Each profile is produced by country experts in collaboration with an international editor. In order to facilitate comparisons between countries, the profiles are based on a template, which is revised periodically. The template provides detailed guidelines and specific questions, definitions and examples needed to compile a profile.

HiT profiles seek to provide relevant information to support policy-makers and analysts in the development of health systems. They can be used:

- to learn in detail about different approaches to the organization, financing and delivery of health services and the role of the main actors in health systems;
- to describe the institutional framework, the process, content and implementation of health care reform programmes;
- to highlight challenges and areas that require more in-depth analysis;
- to provide a tool for the dissemination of information on health systems and the exchange of experiences between policy-makers and analysts in different countries implementing reform strategies; and
- to assist other researchers in more in-depth comparative health policy analysis.

Compiling the profiles poses a number of methodological problems. In many countries, there is relatively little information available on the health system and the impact of reforms. Due to the lack of a uniform data source, quantitative data on health services are based on a number of different sources, including the World Health Organization (WHO) Western Pacific Country Health Information Profiles, national statistical offices, the International Monetary Fund (IMF), the World Bank, and other relevant sources considered useful. Data collection methods and definitions may sometimes vary, but are generally consistent within each separate series.

A standardized profile has certain disadvantages because the financing and delivery of health care differ across countries. However, such a profile also offers some advantages, because it raises similar issues and questions. The HiT profiles can be used to inform policy-makers about experiences in other countries which may be relevant to their own national situation. They can also be used to inform comparative analysis of health systems. The HiT series is an ongoing initiative and the material is updated at regular intervals. Comments and suggestions for further development and improvement of the series are welcome and may be sent to apobservatory@wpro.who.int.
Acknowledgements

The initial HiT template was developed by Josep Figueras and Ellie Tragakes as part of the work of the WHO Regional Office for Europe for the WHO Conference on European Health Care Reforms, Ljubljana, Slovenia in 1996.

The 2007 revision was edited by Elias Mossialos, Sara Allin and Josep Figueras and written by Sara Allin, Reinhard Busse, Anna Dixon, Josep Figueras, David McDaid, Elias Mossialos, Ellen Nolte, Ana Rico, Annette Riesberg and Sarah Thomson with Jennifer Cain, Hans Dubois, Susanne Grosse-Tebbe, Nadia Jemiai, Suszy Lessof, Martin McKee, Laura MacLehose, Anna Maresso, Monique Mrazek, Richard Saltman, Ellie Tragakes and Wendy Wisbaum.

The 2010 iteration was written by (in alphabetical order) Bernd Rechel, Sarah Thomson and Ewout van Ginneken with support from Reinhard Busse, Josep Figueras, Matthew Gaskins, Cristina Hernández-Quevedo, Suszy Lessof, Anna Maresso, David McDaid, Martin McKee, Sherry Merkur, Philipa Mladovsky, Elias Mossialos, Gabriele Pastorino, Erica Richardson, Richard Saltman, Peter Smith and Matthias Wismar.

This edition of the template is based on the 2010 template created by the European Observatory on Health Systems and Policies. In 2013 the template was adapted for the Asia Pacific region by (in alphabetical order) Peter Annear, Ravindra P. Rannan-Eliya, Judith Healy, Dale Huntington, Walaiporn Patcharanarumol, Anna Rodney, and Xu Hongyi. In 2015 that edition was further revised by Syed Masud Ahmed, Peter Annear, Judith Healy, Dale Huntington, Benjamin Lane, and Walaiporn Patcharanarumol, with the assistance of Warisa Panmanustweechai, Angkana Sommanustweechai, and Wichukorn Suriyawongpaisal; with editorial support provided by Rheea Hermoso-Prudente.
Writing a HiT is complex and APO editors will support authors throughout the process.

The role of the editors

The APO assigns editors to work with authors on each HiT who:

- are responsible for the timely production of the HiT;
- provide technical guidance to authors, including the provision of the *WHO Style Guide, Second Edition*, for advice on the house style, including standard spelling conventions and a standard set of tables; and sample HiTs that give a sense of what a typical profile is like;
- brief authors at the beginning of a project on the HiT template process;
- may join the writing team if needed, to ensure completion of peer review-ready draft; and
- are responsible for revisions based on peer review, in consultation with the authors.

The role of the authors

The lead author is selected in consultation with the APO Secretariat, Research Hub, and/or nominated institute by the country. The lead author will select a team of co-authors and will be responsible for liaising with the editor. Authors should follow the structure and main headings of the template. However, they are not expected to provide information on all areas. Discussion with the editor will determine which areas should be covered. In addition, authors, the lead author in particular:

- assume responsibility in writing chapters as well as advising/providing input into other chapters;
- should discuss tables and figures with the editor, including who will produce them and at what stage in the drafting process, and to state explicitly if data are not available or reliable;
- cite reports on implementation of reforms and comment on what is actually taking place;
- adequate citations and references in the required format;
- compile a list of acronyms, consolidate all chapters, and ensure references are complete and cited appropriately;
- cross-reference between sections to avoid repetition; and
- ensure HiTs are produced in a timely manner; and are not overly long.

The role of the APO secretariat

The APO secretariat oversees the entire HiT project, and provides support for the authors and editors. The secretariat:

- facilitates/manages a consultation process of selection of the editor; the final decision is based on agreement among the author team, research hub, and the Secretariat;
- manages the peer review; and
- manages copy editing and production.
Authorship policy

The APO's policy on authorship is in line with academic norms (see the International Committee of Medical Journal Editors’ Uniform Requirements for Manuscripts Submitted to Biomedical Journals; www.ICMJE.org). Its policy on authorship is intended to give credit to all those who have made a substantive contribution by writing or rewriting parts of the text.

Unless there are particular circumstances, first authorship will be held by the lead national author, followed by other national authors who have written parts of the HiT and by the editors, who should be listed last. Ideally, no more than six authors should be named to allow all of them to be included on the cover and in standard format databases. Where more than six authors have been involved, they will all be listed in the inside cover of the published HiTs, but the cover will only show the name of the first six author and the editors.
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALOS</td>
<td>Average length of stay</td>
</tr>
<tr>
<td>AMR</td>
<td>anti-microbial resistance</td>
</tr>
<tr>
<td>ANAES</td>
<td>National Agency for Accreditation and Evaluation in Health</td>
</tr>
<tr>
<td>CAM</td>
<td>Complementary and alternative medicine</td>
</tr>
<tr>
<td>CHF</td>
<td>Congestive heart failure</td>
</tr>
<tr>
<td>COPD</td>
<td>Chronic obstructive pulmonary disease</td>
</tr>
<tr>
<td>CT</td>
<td>Computed tomography</td>
</tr>
<tr>
<td>DALE</td>
<td>Disability-adjusted life expectancy</td>
</tr>
<tr>
<td>DDD</td>
<td>Defined daily dose</td>
</tr>
<tr>
<td>DMFT</td>
<td>Decayed, missing or filled teeth</td>
</tr>
<tr>
<td>DRG</td>
<td>Diagnosis-related group</td>
</tr>
<tr>
<td>DTP</td>
<td>Diphtheria, tetanus and pertussis</td>
</tr>
<tr>
<td>GATS</td>
<td>General Agreement on Trade in Services</td>
</tr>
<tr>
<td>GDP</td>
<td>Gross domestic product</td>
</tr>
<tr>
<td>GP</td>
<td>General practitioner</td>
</tr>
<tr>
<td>HALE</td>
<td>Health-adjusted life expectancy</td>
</tr>
<tr>
<td>HLY</td>
<td>Healthy life years</td>
</tr>
<tr>
<td>HTA</td>
<td>Health technology assessment</td>
</tr>
<tr>
<td>IT</td>
<td>Information technology</td>
</tr>
<tr>
<td>MRI</td>
<td>Magnetic resonance imaging</td>
</tr>
<tr>
<td>NGO</td>
<td>Nongovernmental organization</td>
</tr>
<tr>
<td>NHA</td>
<td>National Health Account</td>
</tr>
<tr>
<td>NHS</td>
<td>National Health Service</td>
</tr>
<tr>
<td>OECD</td>
<td>Organisation for Economic Co-operation and Development</td>
</tr>
<tr>
<td>OOP</td>
<td>Out-of-pocket (payment)</td>
</tr>
<tr>
<td>OTC</td>
<td>Over-the-counter</td>
</tr>
<tr>
<td>PET</td>
<td>Positron emission tomography</td>
</tr>
<tr>
<td>PHC</td>
<td>Primary health care</td>
</tr>
<tr>
<td>PPP</td>
<td>Purchasing power parity</td>
</tr>
<tr>
<td>SHA</td>
<td>System of Health Accounts</td>
</tr>
<tr>
<td>SHI</td>
<td>Social health insurance</td>
</tr>
<tr>
<td>VHI</td>
<td>Voluntary health insurance</td>
</tr>
<tr>
<td>WTO</td>
<td>World Trade Organization</td>
</tr>
</tbody>
</table>
How to use this guide

This new edition is designed to simplify the HiT authorship process. Navigation of the template has been clarified by separating the various elements that make up the template and introducing a number of visual indicators which are described below.

Separating content instructions from explanatory text

Content instructions and questions are positioned on the left hand side of the page.

Indicator for an ‘essential’ section.

Explanatory text, examples and helpful notes are positioned on the right hand side of the page.

Differentiating between essential and discretionary sections

Indicator for a ‘discretionary’ section. The decision to include/exclude a section should be made in conjunction with the editor.

These sections should be covered.

Authors are not expected to answer all questions and provide information for all sections. Discretionary sections should only be covered if they are of genuine national or international relevance, and reliable information is available.

Tables and figures

Table 1.1 Indicator for a Table or Figure.

You should discuss the data in the text in detail, especially if you are concerned about discrepancies between the data presented in the figures and what you know from your own experience.

Include a comparative dimension in your discussions, drawing on comparators suitable for the specific country.

Please supply data for figures in an Excel spreadsheet.

When comparing a number of countries, especially when using a line chart, please limit the number of countries to no more than five or six.

Remember to include your data sources.
Bibliographical references

Please use the Harvard (also known as the author–date) system.

Citations are made within the text in parentheses, e.g. (Taylor, 1996) or (Taylor, 1996; Connor, 2002).

Full references should be listed alphabetically in the References section of Chapter 9 Appendices. Some examples are shown on the right.

Please consult the WHO Style Guide for further information (available from the editor).

Book

Chapter in a book

Journal article

Web site

Unpublished data
Unpublished data should be referenced in the text only and should not appear in the reference list at the end unless it is available to readers.

Style


WHO has its own house style: a particular way of using language and design chosen to meet its particular needs. Use of a house style makes its publications consistent and professional, increasing WHO’s credibility and strengthening its reputation as a leading source of reliable health information.
Preliminary pages in HiTs

Preface
This is the standard introductory section common to all HiT profiles.

Acknowledgements
This is the standard acknowledgements page. Please adapt it to reflect the input of particular individuals and organizations and acknowledge sponsorship.

Example of standard acknowledgements
The Health Systems in Transition (HiT) profile on xxxxxxxx was written by xxxxxxxx (affiliation) and xxxxxxxx (affiliation). It was edited by xxxxxxxx (affiliation).

The Asia Pacific Observatory on Health Systems and Policies is grateful to xxxxxxxx for reviewing the report.

The authors are grateful to everyone at the Ministry of xxxxxxxx and its agencies (xxxxxxxx) for their assistance in providing information and for their invaluable comments on previous drafts of the manuscript and suggestions about plans and current policy options in the xxxxxxxx health system. The authors are particularly indebted to xxxxxxxx, who contributed by sharing his/her notes on health services organization and providing national statistics.

The current series of HiT profiles has been prepared by the staff of the Asia Pacific Observatory on Health Systems and Policies. The Asia Pacific on Health Systems and Policies is a partnership between xxxxxxxx.

The production and copy-editing process was coordinated by xxxxxxxx, with the support of xxxxxxxx.

Special thanks are extended to the WHO Regional Office for Western Pacific for all databases, from which data on health and health services were extracted; and to the World Bank for the data on health expenditure in the Western Pacific countries. Thanks are also due to national statistical offices that have provided data. The HiT reflects data available in Month 0000.

List of abbreviations
Please provide a list of the abbreviations and terms in full used in the profile.
Philippines HiT abstract

Consistent with its commitment to the Alma Ata in 1978, the Philippine Government adopted the Primary Health Care (PHC) approach in 1979 to achieve health for all Filipinos by year 2000. The promulgation of the Local Development Code (RA 7160) in 1991 was in line with the community participation ideals of PHC (1992-1999) as it devolved responsibility for health care was devolved to Local Government Units. The Health Sector Reform Agenda was introduced in 2005 to address problems in health care delivery at local level brought about by the devolution proves. Issues of poor accessibility, inequities and inefficiencies of the health system have been the target of health reforms over the last 30 years.

Hospital, public health, financing, local health system and regulatory reforms comprised the HSRA approach. In 2005, the DOH streamlined the reform program to ensure access and availability of essential and basic health packages by reducing the four reform areas, namely: 1) designating providers of basic and essential health service package in strategic locations; 2) assuring the quality of both basic and specialized health services; and 3) intensifying the current efforts to reduce the public health threats brought about by endemic, vaccine-preventable and priority diseases. Although studies have yet to be done on the impact of reforming health service delivery, implementation of strategies to improve the hospital services and public health programs have shown some positive gains.

However, huge disparities in health outcomes across income groups and geographic areas and challenges in ascertaining physical and financial access to health services as evidenced by high out-of-pocket expenditures, concentration of physical and human resources for health in urban areas and migration of health professionals still exist. The focus of future developments in health should be towards providing universal health care for Filipinos, starting with improving access of the poor and vulnerable to health services.

Source: APO, Philippines HiT Vol. 1 No. 2 2011
Executive summary

The executive summary should provide an outline of the HiT (in no more than 3000 words), following the key headings included in the profile, with a particular focus on the assessment of the health system, the main challenges and the major conclusions (Chapters 7 and 8).
This chapter sets the whole HiT in context and gives readers a sense of the geographic, economic and political setting in which the health system operates. It also covers health status in some detail so that readers can understand the health challenges the system faces.

Chapter summary

Please provide a summary of the whole chapter (maximum 300 words).

1.1 Geography and sociodemography

Briefly outline the country’s geography, including information on:

- neighbouring countries
- terrain/climate, if relevant (one sentence)

Comment on the data in Table 1.1 [see overleaf] including, where relevant, the implications for health and health care of:

- age and ageing of the population
- rural/urban distribution of the population
- citizenship requirements
- migration and displacement ethnic, cultural, and linguistic composition of the population
- educational attainment
- religion
- family structure
- any other characteristics that affect health

This will also be used in the executive summary.

Please identify where there are disputed frontiers or territories not fully under control of the national government. The editor will discuss with you how to present these issues sensitively. Also note any dependent territories where the national government has responsibility for the health system.


Data on age structure of the population, gender balance, growth, birth, death and fertility rates will be drawn from the World Bank World Development Indicators database (http://publications.worldbank.org/WDI/indicators).

Can be internal and international migration; refugees, and displacement
Chapter 1: Introduction

<table>
<thead>
<tr>
<th>Table 1.1</th>
<th>Trends in population/demographic indicators, selected years</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total population</strong></td>
<td></td>
</tr>
<tr>
<td>Population, female (% of total)</td>
<td></td>
</tr>
<tr>
<td>Population ages 0–14 (% of total)</td>
<td></td>
</tr>
<tr>
<td>Population ages 65 and above (% of total)</td>
<td></td>
</tr>
<tr>
<td>Population ages 80 and above (% of total)</td>
<td></td>
</tr>
<tr>
<td>Population growth (average annual growth rate)</td>
<td></td>
</tr>
<tr>
<td>Population density (people per sq km)</td>
<td></td>
</tr>
<tr>
<td>Fertility rate, total (births per woman)</td>
<td></td>
</tr>
<tr>
<td>Birth rate, crude (per 1000 people)</td>
<td></td>
</tr>
<tr>
<td>Death rate, crude (per 1000 people)</td>
<td></td>
</tr>
<tr>
<td>Age dependency ratio (population 0–14 &amp; 65+: population 15–64 years)</td>
<td></td>
</tr>
<tr>
<td>Distribution of population (rural/urban)</td>
<td></td>
</tr>
</tbody>
</table>


### 1.2 Economic context

Give a general overview of the country’s current economic situation and its implications for health and the health system including, if relevant:

- employment/unemployment
- social and living conditions, including occupational/employment mix
- distribution of wealth
- economic crisis
- any other major events leading to the current status

Comment on the data in Table 1.2, focusing on implications for health and health care.

Suggested databases
- World Bank Development Indicators
- UN Population Division

GDP should be expressed in local currency.
Table 1.2  Macroeconomic indicators, selected years

<table>
<thead>
<tr>
<th>Total population</th>
<th>1980</th>
<th>1990</th>
<th>2000</th>
<th>2010</th>
<th>Latest year</th>
</tr>
</thead>
<tbody>
<tr>
<td>GDP (local currency)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GDP, PPP (constant US $)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GDP per capita</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GDP per capita, PPP (current international US$ or Euro)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GDP average annual growth rate for the last 10 years (%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public expenditure (% of GDP)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash surplus/deficit (% of GDP)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tax burden (% of GDP)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public debt (% of GDP)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Value added in industry (% of GDP)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Value added in agriculture (% of GDP)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Value added in services (% of GDP)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Labour force (total)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unemployment, total (% of labour force)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poverty rate (please define how poverty is measured in your country)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Income or wealth inequality (Gini coefficient or other measure)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Real interest rate</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Official exchange rate (US$)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Suggested data source: http://publications.worldbank.org/WDI/indicators
Notes: e.g. any abbreviations not given in the List of abbreviations, or any clarification of data

1.3 Political context

Give a brief overview of the country’s system of government. Please consider:
- how centralized/decentralized the system is and what authority each level of government has
- the main political party/parties and their relative share of the vote
- governance indicators
- major changes in recent years

It may be helpful to clarify if the country is a parliamentary or presidential democracy; to mention the relative strengths of the executive, legislative and judiciary if these affect health; and to indicate whether there is a system of checks and balances for parliament and the courts.

E.g. World Bank World Governance Indicators
Discuss broadly how policy decisions are taken and responsibilities shared. Please consider:

- the role of organized interest groups (such as trade unions or employer federations) in health policy-making, including civil society
- membership of international organizations that affect health
- major international treaties that have an impact on health

1.4 Health status

Throughout this section, please check and comment on data quality, coverage and completeness.

Comment, as far as data permit, on changes in health indicators. Explain briefly any artefacts or political manipulation of data.

Where relevant, please draw on health interviews or health examination survey data and hospital activity/episodes data.

Please consider issues relating to AMR, and emergency health threats.

Please discuss with the editor which data to include, which data sources to use, any contested or sensitive issues, and level of specificity to report, e.g. rounding of percentages.

Table 1.3 Mortality and health indicators, selected years

<table>
<thead>
<tr>
<th>Total population</th>
<th>1980</th>
<th>1990</th>
<th>2000</th>
<th>2010</th>
<th>Latest year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life expectancy at birth (total)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Life expectancy at birth (male)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Life expectancy at birth (female)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mortality rate (total)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mortality rate (male)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mortality rate (female)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Suggested data source: http://publications.worldbank.org/WDI/indicators
Briefly outline the three main causes of mortality. Discuss, where relevant, any differences in Tables 1.3 and 1.4:

- between women and men
- by socioeconomic or ethnic group and level of education
- across regions (by age)
- over time (by age)
- vital registration data; if available, use ICD 10

Use the Global Burden of Disease study data base. Also use international sources to the extent they are available.

Describe overall patterns of mortality including deaths outside of hospitals. Discuss with the editor use of sub-national data sources to supplement national level sources.

Table 1.4 Main causes of death, selected years

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Communicable diseases</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All infectious and parasitic diseases (A00-B99)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tuberculosis (A15-A19)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexually transmitted infections (A50-A64)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV/AIDS (B20-B24)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Noncommunicable diseases</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Circulatory diseases (I00-I99)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Malignant neoplasms (C00-C97)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colon cancer (C18)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer of larynx, trachea, bronchus and lung (C32-C34)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breast cancer (C50)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cervical cancer (C53)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes (E10-E14)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental and behavioural disorders (F00-F99)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ischaemic heart diseases (I20-I25)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cerebrovascular diseases (I60-I69)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic respiratory diseases (J00-J99)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Digestive diseases (K00-K93)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>External causes</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transport accidents (V01-V99)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suicide (X60-X84)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ill-defined and unknown causes of mortality (R95-R99)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Suggested data sources: http://www.who.int/healthinfo/mortables/en/; national mortality data
Very briefly, discuss how policy efforts have affected causes of death over time. Please consider:

- intersectoral policies on determinants of health
- primary prevention

**Table 1.5** DALY (disability-adjusted life expectancy), and HLY (healthy life years), selected years

Suggested data sources: Global Burden of Disease

**Table 1.6** Morbidity and factors affecting health status, selected years

**Suggested data sources:**

Tobacco and Alcohol:
http://www.who.int/chp/steps/reports/en/index.html
http://www.who.int/tobacco/surveillance/policy/country_profile/en/

Diabetes:

Physical activity:
Related publications (up to 2006) listed by International Physical Activity Questionnaire (iPAQ): http://www.ipaq.ki.se/publications.htm

Include the following factors if possible:

National data on morbidity by age and gender (e.g. prevalence/incidence of diabetes, cancer, myocardial infarction, stroke).

Major factors influencing health status (e.g. smoking, alcohol consumption, diet, physical activity, housing, poverty, education, violence, injury/road trauma, water and sanitation, etc.).

Report information either as a table (if data are available) or in the text.
More recent publications:

Obesity:
International Association for the Study of Obesity (IASO):  http://www.iaso.org/resources/obesity-data-portal/

Comment on maternal, child and adolescent health indicators, including trends over recent years. Use MDG indicators.

Table 1.7 Maternal, child and adolescent health indicators, selected years

<table>
<thead>
<tr>
<th>Total population</th>
<th>1980</th>
<th>1990</th>
<th>2000</th>
<th>2010</th>
<th>Latest year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adolescent pregnancy rate (15–19 years)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adolescent birth rate</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Termination of pregnancy [abortion] rate*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Perinatal and neonatal mortality rate</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Postneonatal mortality rate</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infant mortality rate</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under-five mortality rate</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternal mortality rate</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV Antenatal</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measles immunization</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% Stunting</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% Underweight</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* discuss legal issues where appropriate
Comment on the country’s dental health status.

Summarize and comment on immunization in general, including coverage of children from all socioeconomic, ethnic and regional groups. Indicate whether immunization figures are reliable.

Discuss any major health problems of policy significance that have occurred in the last decade.

Outline major health challenges facing the population as a whole and certain subpopulations (such as ethnic minorities or socioeconomic groups). Include information on the proportion of the population with access to safe water and air pollution (if relevant and data are available).

Comment on the country’s health status relative to other countries and regional averages.

1.5 Natural and human-induced disasters

Outline major health challenges facing the population as a whole and certain subpopulations (such as ethnic minorities or socioeconomic groups). Include information on the proportion of the population with access to safe water and air pollution (if relevant data are available), as well as exposure to natural and human-induced hazards.

Include information on decayed, missing or filled teeth (DMFT) if data are available.

e.g. major outbreaks or epidemics

Provide information as a table (if data are available) or in the text.

Please note that comparison across countries of mortality and morbidity data should be made with extreme caution because of potentially significant methodological variation in data collection and differences in definitions.

Refer to Figure A.1.1 in the Western Pacific Region Framework for Disaster Risk Management (page 38).

Also refer to the United Nations Office for Disaster Risk Reduction [http://www.unisdr.org/asiapacific]
Comment on the frequency and scale of natural and human disasters, and implications on population health.

WHA 64.10 2011 resolution on "Strengthening national health emergency and disaster management capacities and resilience of health systems" website: http://apps.who.int/gb/ebwha/pdf_files/EB128/B128_R10-en.pdf?ua=1


"Natural Disaster Profiles" website: http://www.who.int/hac/techguidance/ems/natprofiles/en/


Chapter 2: Organization and governance

This chapter provides an overview of how the health system is organized, governed, planned and regulated; its main actors and their decision-making powers; and patient empowerment. It forms the basis for all the following chapters.

Chapter summary

Please provide a summary of the whole chapter (maximum 500 words).

2.1 Overview of the health system

Briefly outline how the whole health system is organized. Please consider:

- the overall legal framework, highlighting key or recent legislation
- the main actors in the system and the roles and responsibilities they fulfil in the overall governance/management structure; summarize the full range of private sector actors
- whether there is one or several government service delivery systems operating in parallel (e.g. at regional or local level); if there are several, describe the relationship between them
- the main actors’ decision-making powers
- the main links to other sectors

Health systems are understood in line with the *World Health Report 2000* as combining three elements:

- the delivery of health services (both personal and population based)
- activities to enable the delivery of health services (specifically finance, resource generation and governance)
- governance activities that aim to influence other sectors where they affect health.


This approach emphasizes the scope of health systems beyond health care.

Public health is a social and political concept aimed at improving health, prolonging life and improving the quality of life among whole populations through health promotion, disease prevention and other forms of health intervention.

Cross-reference to Section 2.6 Intersectorality.
There is sometimes confusion in the use of the term “public health” to mean, alternately, the health of the population collectively and the delivery of health care through government services. In this Template, we adopt the following definitions:

**Public health:**
Public health interventions focus on maintaining the wellbeing of populations rather than simply individuals and involve the assessment of the health of communities, the formulation of public policies designed to achieve national health priorities and access to health promotion, prevention and care for all people. Common public health issues include vaccination and control of infectious diseases, motor-vehicle safety, safer and healthier foods and drinking water, healthier mothers and babies and access to family planning, exercise and diet and recognition of tobacco use and alcohol as health hazards. [See Page 61 Section 5.1 Public Health.]

**Government health services**
We use the term “government health services” specifically to describe service delivery by government-owned and -run facilities at all levels of care, primary, secondary and tertiary. Commonly, governments own and run health care facilities at national, regional and local level, including specialist and tertiary care hospitals, secondary care facilities with minor surgery and health centres from primary care. Not all health services are delivered by government and care is frequently delivered by private or non-government providers outside of the government health system.
Private health services

Private health services include health care and medicines provided by entities other than the government. Private health services may be delivered by for-profit private medical providers or by non-government organizations. Non-government organizations may be for-profit providers or not-for-profit or charitable organizations. Careful regulation of private health care providers is generally needed to ensure standards set by the state, mainly regarding safety, value and efficiency, are met.

The extent of decentralization should be discussed in Section 2.4

This diagram should give a simplified overview of the health system as a whole (e.g. financing mechanisms and service delivery by different providers), including the government health system, the private sector (profit and non-profit) and (where relevant) the social care system.
2.2 Historical background

Give a very brief account of the evolution of the health system to set the context for the current system. Please consider:

- major political developments
- socioeconomic factors and sociocultural developments

Details of policy-making and implementation of reforms (especially during the last decade) should be discussed in Chapter 6 Principal health reforms.

See the insert on page 61, section 5.1.
Chapter 2: Organization and governance

2.3 Organization

Outline the administrative structure of the government health system (the broader health system is shown in Fig. 2.1). Please consider:

- major structures of government health and health service provision
- major structures of private health service provision (profit and non-profit, etc.)
  - the main geographical/administrative tiers within the government system
  - the nature of the relationships between them

Briefly describe the role of the main actors responsible for the financing, planning, administration, regulation and provision of health care. These should include the actors depicted in Fig. 2.1. Please consider:

- the ministry of health
- other ministries and government agencies
- regional/local governments (or health authorities)
- other public agencies at national and regional level
- the private sector
- patient/consumer groups
- provider organizations and professional groups/associations
- any other important and relevant organizations

Major structures of government health include intersectoral planning mechanisms [details should be covered in Section 2.6], as well as infrastructure for primary prevention and health service delivery (details should be covered in Section 5.1).

e.g. national health service, national insurance system, system based on competing health insurance funds

Regulation

- e.g. ministry of finance, as well as ministries providing health care for their employees and families such as the ministry of defence
- e.g. providers, insurers, manufacturers, distributors, stakeholder lobbyists
- e.g. physicians’ associations, nurses’ associations and trade unions
When describing the main actors, refer briefly to the main organizational changes in the last 10 years. Please consider:

- major changes in organization
- new bodies that have been established or are in the process of being established
- changes in role of any institutions in connection with health care
- health policy and systems research

Discuss principal health reforms in Chapter 6.

Comment on the extent of decentralization in the health system. Please consider:

- shifts in decentralization and centralization
- decentralization of governance mechanisms

Four major types of decentralization can be distinguished:

**Deconcentration:** passing some administrative authority from central government offices to the local offices of central government ministries.

**Devolution:** passing responsibility and a degree of independence to regional or local government, with or without financial responsibility (i.e. the ability to raise and spend revenues).

**Delegation:** passing responsibilities to local offices or organizations outside the structure of central government such as quasi-public (nongovernmental) organizations, but with central government retaining indirect control.

**Privatization:** transfer of ownership and government functions from public to private bodies, such as voluntary organizations and profit-making and non-profit-making private organizations.
Chapter 2: Organization and governance

- decentralization of powers and financial responsibilities
- context factors currently supporting or hindering decentralized decision-making

2.5 Policy and planning

2.5.1 Policy formulation

Summarize the national policy on UHC.

Briefly outline the main features of the process of policy formulation, implementation and evaluation. Please consider:
- priority setting by different tiers in the system
- setting the policy agenda
- implementation
- assessment and evaluation

2.5.2 Current Planning

Describe the current approach to planning in the health system. Please consider:
- overall health planning cycle (national, regional, district, local government, health insurance funds, etc)
- national health planning agencies for health or health services, human resources and infrastructure
- involvement of the health sector in multi sectoral disaster risk management for health, including implementation of International Health Regulations as well as humanitarian assistance

Of ten the boundaries between planning and regulation functions and between planning and management functions are not clear-cut. The nature, characteristics and relative significance of these functions will differ among countries.

Discussion of planning, management and regulation should refer back to the organization chart in Section 2.1.

Specific problems encountered with recent policy measures should be discussed in Chapter 6.

Cross-reference to Chapter 6 Principal health reforms.
2.5.3 Role of development partners in policy and planning

Discuss the role of development partners in policy and planning, if relevant.
Discuss issues of alignment and harmonization and coordination of ODA inputs, if relevant.

2.6 Intersectorality

Describe how health is taken into account by other ministries and agencies, at all tiers of government.
• consider multi-sector mechanisms (do they exist, how do they work)

Summarize any national or regional initiatives/targets to identify and reduce inequalities in health, in intersectoral processes and/or mechanisms.

The determinants of health are factors that affect the health of a population. They are influenced by policy decisions in a wide range of sectors, from agriculture and nutrition to education, employment, housing and transport.
So-called “health in all policies” emphasize intersectorality and aim to engage with other sectors to identify the impact of their policies on health determinants and health.

Please consider:
• food safety
• planning and coordination of Disaster Risk Management activities (natural and human-induced hazards)
• policies on taxation, marketing and sales regulation of tobacco, alcohol and food
• environmental policies
• climate change
• engagement with nongovernmental organizations (NGOs) and civil society
• AMR
• zoonosis

Please consider:
• programmes to reduce the impact of poverty on health
• how health hazards other than poverty are identified and addressed, e.g. industrial hazards, housing, water supply
• the main problems and challenges as well as any future reform plans (Cross-reference to Chapter 6 Principal health reforms).
2.7 Health information management

2.7.1 Information systems

Describe the information systems in place for collecting, reporting and analysing data on activity, service and quality. Please consider:

- data collection, analysis and dissemination
- data quality
- linkages to financing
- requirements for providers (both public and private) to report data
- legislation on freedom of information
- health-related research and development
- meaningful involvement of patients, health professionals and the wider public
- whether information systems reflect various levels of care (such as primary or hospital care), different population groups (such as adolescents or people living with HIV) or are gender sensitive
- whether information management system for emergencies exists

2.7.2 Information management system for emergencies

Please consider:

- disaster risk management for health mechanisms
- measures to address AMR and other emerging health threats
2.8 Regulation

Describe to what extent the government and other actors play a regulatory role at national, regional and district levels. Please consider:

• organizations at each level that carry out a regulatory function (e.g. ministry of finance, ministry of health, parliament, NGOs, professional associations, and other statutory authorities)
• national health plans for health or health services
• national policy statements

2.8.1 Regulation and governance of third-party payers

Describe how the government and other actors play a regulatory role in relation to public and private purchasers and how it steers policy by setting strategic direction and regulation. Please consider:

• the organizations at different levels that carry out a regulatory function
• whether purchasing organizations reflect government health priorities in their purchasing plans
• decentralization of purchaser organizations and regulation by local/regional/national government
• definition of the benefits package
• mechanisms of accountability
• private insurers
• regulatory arrangements relating to cross border health care purchasing and provision

To summarize the different regulatory functions in the health system, you may wish to consider to what extent regulatory functions are centralized (e.g. at ministry of health, ministry of finance level), decentralized (e.g. to regulatory agencies, health authorities or private organizations), or delegated. Regulation refers to the setting, monitoring, and enforcement of standards.

The financing mechanisms in place for third party payers should be discussed in depth in Section 3.5.

There are three principal models of the organizational relationship between purchasers and providers: integrated, contract and direct payment to providers (Section 3.4). The model used will usually also determine the regulatory framework.

e.g. ministry of finance, ministry of health, parliament

Cross-reference to Section 3.5
Voluntary health insurance.
2.8.2 Regulation and governance of providers

*Organization*: describe how the government and other actors play a regulatory role in relation to providers at national, regional and district levels (such as through setting strategic direction, regulation, standards, guidelines). Please consider:

- ownership, governance and management arrangements for providers
- organizations that carry out a regulatory function
- licensing/accreditation/registration mechanisms of health care organizations, e.g. hospitals
- mechanisms to ensure that professional staff or provider organizations achieve minimum standards of competence; function-specific inspectorates for public health and safety

*Quality*: describe the mechanisms in place to ensure and monitor the quality of care provided. Please consider:

- systems at national/regional level

While many definitions for quality of care have been proposed, a useful broad definition is as follows: “The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.” (Institute of Medicine. Crossing the Quality Chasm: A New Health System for the 21st Century. Washington D.C.: National Academy Press, 2001). The IOM proposed that a high quality health care system is one where services are:

- Safe - avoiding injuries to patients from the care that is supposed to help them (misuse).
- Effective - providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse).
Chapter 2: Organization and governance

- Patient-centered - providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.
- Timely - reducing waits and sometimes harmful delays for both those who receive and those who give care.
- Efficient - avoiding waste, in particular waste of equipment, supplies, ideas, and energy.
- Equitable - providing care that does not vary in quality because of personal characteristics, such as gender, ethnicity, geographic location, and socioeconomic status.

2.8.3 Registration and planning of human resources

Summarize the mechanisms (if any) for planning human resources. Please consider:
- limits to the number of training places
- areas of training
- training facilities
- retraining

Cross-reference to Section 4.2.3 Training of health workers.

Cross-reference to Section 2.5 Planning and section 4.2 Human resources.

Where relevant, cross-reference to Section 7.4.2 Health service outcomes and quality of care.
2.8.4 Regulation and governance of pharmaceuticals, medical devices and aids

Summarize the regulation of pharmaceutical products. Please consider:

- responsible regulatory bodies
- market authorization
- quality of medicines (locally manufactured and imported)
- pharmacovigilance
- patent protection
- classification of pharmaceuticals
- categories of over-the-counter (OTC) pharmaceuticals
- advertising
- conflicts of interest and corruption
- research and development
- adherence to international standards

Medicines of good quality are an important access criterion.

Cross reference to Section 5.6 Pharmaceutical care

e.g. general sales list, pharmacy supervised

e.g. the International Federation of Pharmaceutical Manufacturers & Associations issues voluntary codes of ethical practice on manufacturing and marketing;

e.g. ethical standards, training, registration, certification, revalidation and disciplinary procedures

Cross reference to Section 4.2.2 Professional mobility of health workers

Refer to http://apps.who.int/gb/ebwha/pdf_files/WHA63/A63_R16-en.pdf

Please consider complementary and alternative medicines.

e.g. a single medicines agency (or do several bodies have executive regulatory responsibilities), role of ministry of health
Summarize the regulation, and enforcement (existence or lack thereof) of wholesalers and pharmacies. Please consider:

- number and extent of formal and informal pharmacies/drug sellers
- to what extent are pharmacies regulated
- entry requirements for new pharmacies
- generic substitution
- regulation of counterfeit drugs

Summarize policies to regulate and enforce cost-effective use of pharmaceuticals. Please consider:

- measures aimed at influencing physician prescribing behaviour
- measures aimed at separating prescribing and dispensing by physicians in government and private sectors
- measures aimed at pharmacists
- measures aimed at stopping the sale of prescription drugs without a prescription
- how these policies are monitored and any penalties applied (in theory and practice) by regulatory bodies (e.g. fines)

Summarize the system for pricing prescription pharmaceuticals. Please consider:

e.g. the Pharmaceutical Inspection Convention and the Pharmaceutical Inspection Co-operation Scheme (PIC/S) are international instruments that aim to improve co-operation in the field of Good Manufacturing Practices between national regulatory authorities and the pharmaceutical industry.

Generic substitution is the substitution of a product, whether marketed under a trade name or generic name, by an equivalent product that contains the same active ingredients and is usually cheaper.

- e.g. information, prescribing by active ingredient, prescribing budgets, prescribing guidelines, prescribing feedback

Refer to WHO policy on separation of prescription and dispensing drugs

- e.g. substitution by pharmacists, dispensing budgets, margins that encourage generic dispensing
- e.g. use of National Essential Medicines list
- e.g. use of IT, inspections
Chapter 2: Organization and governance

- profit-control scheme, reference pricing scheme or direct price controls
- composition of prices of medicines, i.e. ex-factory/manufacturer price, wholesaler (profit) margin, pharmacy margin (or profit) and any taxes
- regulation of OTC products

Summarize any system for public reimbursement of pharmaceuticals. Please consider:
- factors that determine whether a product will be reimbursed
- a national essential drug list or reimbursement list (positive list, negative list)
- use of cost–effectiveness criteria in addition to safety, efficacy and effectiveness

Summarize the regulation of medical devices and aids. Please consider:
- the process of purchasing/procurement
- controls on acquisition
- public and private sectors

2.8.5 Health technology assessment

Describe the system for health technology assessment (HTA). Please consider:
- organizations involved
- principal activities
- methods used
- number of evaluations
- links to the policy-making process

If no HTA agencies exist in your country, describe any evaluations produced by NGOs or external agencies.

HTA is the systematic evaluation of the effectiveness, costs and impact of health care technology with the aim of informing health policy-making.

Possible sources: Therapeutic Goods Administration; http://www.hitap.net/ http://www.eunethta.net/
2.8.6 Regulation of capital investment

Summarize the regulation of capital investment, if existing, e.g. hospital construction. Please consider:

- systems to ensure equitable geographical distribution of capital and the right balance of investment across different levels of care
- efforts to use capital investment to improve strategic and service delivery, and achieve health policy objectives
- level of government responsible for regulation
- public and private sectors

2.9 Patient empowerment

2.9.1 Patient information

Describe the level of information available to patients when making decisions about accessing health services. Please consider:

- health literacy and patient education
- information on the quality of health services
- recording and publication of medical errors
- freedom of information legislation
- information for ethnic minorities, adolescents and other target groups, and translations into minority languages
- whether the population has (or is likely to have) a clear sense of the benefits to which they are entitled, e.g. health literacy

Cross-reference to Section 2.7.1 Information systems.
2.9.2 Patient choice

Briefly outline the extent of patient choice. Please consider:

- the different types of choice available to patients, such as choice of insurer, provider, treatment, etc.
- evidence on whether/how/which individuals exercise choice
- competition between purchaser organizations for consumers/insurees
- evidence on how the current level of individual choice affects equity and efficiency

2.9.3 Patient rights

"The relationship between physicians, their patients and broader society has undergone significant changes in recent times. While a physician should always act according to his/her conscience, and always in the best interests of the patient, equal effort must be made to guarantee patient autonomy and justice. The following Declaration represents some of the principal rights of the patient that the medical profession endorses and promotes. Physicians and other persons or bodies involved in the provision of health care have a joint responsibility to recognize and uphold these rights. Whenever legislation, government action or any other administration or institution denies patients these rights, physicians should pursue appropriate means to assure or to restore them." – from the Preamble of the WMA Declaration of Lisbon on the Rights of the Patient

For the full text on patient rights, please see http://www.wma.net/en/30publications/10policies/l4/.

For additional information, please refer to http://www.who.int/genomics/public/patientrights/en/.

Summarize what has been done at national or local level to implement WHO’s patient rights framework. Please consider:

- definition of patient rights
- legislation
- enforcement

Choice is a complex issue. Some argue that choice has intrinsic value, while others value its instrumental potential (e.g. to increase responsiveness, to facilitate competition, to improve quality and to empower people).

In addition, acceptable levels of choice for individuals are likely to vary between countries and between different groups within a country. Individual choice may be associated with costs and benefits.
2.9.4 Complaints procedures (mediation, claims)

Describe any mechanisms in place for patient complaints and how often they are used. Please consider:
• complaints procedures for institutions and other health care actors
• patient/user advocates employed within institutions (ombudsman)
• compensation for health care-related harm
• burden of proof

2.9.5 Public participation

Provide a brief overview of public participation in your country. Include any mechanisms by which members of the public can influence purchasing decisions by political or administrative means:
• individually
• collectively
• opportunities for litigation

Briefly summarize any arrangements to enable physical access to health facilities for disabled people

e.g. people with physical disabilities, using wheelchairs or with visual or hearing impairment

Cross-reference to the relevant sections of service delivery in Chapter 5

Provision of services.

e.g. psychiatric hospitals, acute hospitals

e.g. representation in decision-making bodies; electing the board of purchaser organizations; participating in surveys

e.g. appealing to court
If surveys of user or public satisfaction with purchaser or provider services are carried out, please describe what their results show.

If possible, supply a table with survey results.

2.9.6 Patients and cross-border health care

If patient mobility is an issue in your health system and data are available, briefly describe the main cross-border care issues. If not relevant, present nor significant, please indicate. Please consider:

- patients going abroad for treatment
- patients coming from abroad to receive treatment
- national criteria defining who is entitled to receive treatment abroad
- information on cross-border health care
- medical tourism
- eligibility and access by overseas foreign workers

Potential data sources:

The Gallup World Poll: Database: https://worldview.gallup.com

Cross-border health care refers to any health-seeking practice by individuals outside their own country. This affects tourists, retirees, inhabitants of border regions sharing cultural or linguistic links, migrant workers, individuals aiming to benefit from perceived higher quality health care, and people sent by the health system to overcome capacity restrictions. Also consider refugees and asylum seekers.

Cross reference to section 5.14 Health sources for specific populations
This chapter considers how much is spent on health and the distribution of health spending across different service areas. It describes the different sources of revenue for health, focusing on how revenue is collected, pooled and used to purchase health services and pay providers. It also describes health coverage – for example, who is covered by compulsory prepayment, which services are covered, the extent of user charges and other out-of-pocket (OOP) payments and the role played by voluntary health insurance (VHI).

Chapter summary

Please provide a summary of the whole chapter (maximum 500 words).

3.1 Health expenditure

Please comment on the following tables and figures. Please consider:

• main trends over time
• reasons for changes/position in relation to other countries
• differences between national and international data sources
• the fiscal context

This will also be used in the executive summary. Please begin the summary by referring to the country’s health financing policy framework or objectives and include a cross-reference to Chapter 7, which outlines the health system’s stated objectives.

This section looks at how much money is spent on health and how it is distributed across services and population groups.

The fiscal context refers to the ability of the government to mobilize tax (including payroll taxes and compulsory health insurance contributions) and other public revenues, and the need for these to be balanced with total public spending. The fiscal context is important because the more money the government has, the more it can spend on health.

The following measures shed light on the fiscal context and are presented in Table 3.1, page 26:

• public expenditure (as % of GDP)
• cash surplus/deficit (as % of GDP)
• public debt (as % of GDP)
• cross-reference to Section 1.2 and Table 1.2.
Table 3.1  Trends in health expenditure in country, 1995 to latest available year

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total health expenditure (US$) PPP per capita (1995 or constant prices)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total health expenditure as % of GDP</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean annual real growth rate in total health expenditure*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean annual real growth rate in GDP</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public expenditure on health as % of total expenditure on health</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private expenditure on health as % of total expenditure on health</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Government health spending as % of total government spending</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Government health spending as % of GDP</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OOP payments as % of total expenditure on health</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OOP payments as % of private expenditure on health</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>VHI as % of total expenditure on health</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>VHI as % of private expenditure on health</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Calculated as the mean of the annual growth rates in national currency units at 1995 GDP prices.

Figure 3.1  Health expenditure as a share (%) of GDP in selected countries, latest available year
Figure 3.2  Trends in health expenditure as a share (%) of GDP in comparable countries, 1990 to latest available year
Figure 3.3  Health expenditure in US$PPP per capita in the selected countries, latest available year
Figure 3.4  Public sector health expenditure as a share (%) of total health expenditure in selected countries, latest available year

Note: If the data needed for Tables 3.2 and 3.3 are not available, include one table with information on spending by service category and/or service input.

Use the WHO data, or national data available, in case WHO has no updated data.
The other countries selected (up to three) should be chosen in discussion with the editor[s], have particular relevance for your country (neighbours, similar historical/socioeconomic background, etc.) and be the same as in the later figures on hospital beds, physicians and nurses.
Use WHO data for Figures 3.2, 3.3.
Summarise the uses of government health funding by major budget category highlighting the main trends and issues and using national statistics (refer to Table 3.2). Please comment where necessary on:

- health system administration
- education and training (pre-service and in-service)
- public health, health prevention and health promotion
- medical services (primary, secondary, tertiary)
- pharmaceutical supplies
- mental health care
- diagnostic and ancillary services

<table>
<thead>
<tr>
<th>Expenditure</th>
<th>% of government health expenditure</th>
<th>% of total health expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health system administration</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Salaries and bonuses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- National, regional and local administrative overheads</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education and training</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Pre-service</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- In-service</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Behavior Change Communication (nutrition, MNCH, NCD, tobacco, road safety, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Family planning</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Immunization</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Water quality assurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Food safety</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Disaster Risk Management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Surveillance and response</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Communicable Disease Control programs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Health information</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Regulation and enforcement</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

See Public Health definition in Section 5.1, page 61.

Note that if public health expenditure is unavailable, substitute MOH data with a footnote indicating such. Indicators are based on SHA classifications. Some of the categories may overlap. If this is the case, please make a note of it in the text.

For outpatient care, please distinguish between primary and specialist care.
Please summarize the key elements of health financing in no more than 500 words. Include information about:

- the different sources of revenue (government, ODA, OOP, SHI) for the health system and their relative share of total revenue
- coverage: who is covered (by the main system and by VHI), what is covered (by the publicly financed benefits package and the role VHI plays), how much of service cost is covered (the presence of user charges for services in the publicly financed benefits package)
- how compulsory sources of revenue are collected, pooled and used to purchase health services and to pay providers
- the composition of OOP payments

Consider using information from the most recent System Health Accounts (SHA).

e.g. general government budget, earmarked payroll taxes (social insurance contributions), OOP payments, VHI

e.g. formal user charges, direct payments for services not included in the benefits package, informal payments
Table 3.3  Sources of revenue as a percentage of total expenditure on health according to source of revenue, 2000, 2005, 2010, and last available years

<table>
<thead>
<tr>
<th>Source of revenue</th>
<th>% of total expenditure on health</th>
</tr>
</thead>
<tbody>
<tr>
<td>General government expenditure excluding ODA</td>
<td></td>
</tr>
<tr>
<td>ODA</td>
<td></td>
</tr>
<tr>
<td>OOP payments</td>
<td></td>
</tr>
<tr>
<td>VHI</td>
<td></td>
</tr>
<tr>
<td>Other (please specify)</td>
<td></td>
</tr>
</tbody>
</table>

Source: SHA 2011

Discuss the relative size, role and significance of each source of revenue. Please consider:

- any changes that may have occurred in recent years as well as the factors behind these changes
- the availability and reliability of data; if possible, indicate whether the figures presented here are likely to be an overestimate or underestimate of actual financing volumes

Please construct a pie chart [based on national statistics or National Health Accounts data from the most recent SHA showing the proportion of total health expenditure from different sources in the latest available year.

The diagram should serve as an introductory snapshot but also include details which will be explained in the following sections.
3.3 Overview of the public financing schemes

Most countries have a mix of compulsory and voluntary systems of financing. This section focuses on the public financing schemes (which is usually compulsory) and the way in which revenue from different sources is collected, pooled and used to purchase health services and pay providers.

The main sources of revenue usually include the following: allocations for health from the general government budget at national, regional or local level (including taxes earmarked for health that are part of the government budget); taxes; social health insurance contributions; mandatory medical savings accounts.

The section on VHI will discuss how voluntary prepayment is collected, pooled and used to purchase, including Community Bond Insurance schemes, Health Equity Funds and other localized contributory systems.

The section on OOP payments will discuss the extent of formal cost-sharing (user charges) and other OOP payments (informal payments).

Note: If OOP payments are the main source of finance, please say so.
3.3.1 Coverage

Example of Figure 3.6 Three dimensions to consider when moving towards universal coverage

Coverage has three dimensions:
- **Breadth**: the proportion of the population covered
- **Scope**: the range of benefits covered
- **Depth**: the proportion of the benefit cost covered


**Breadth: who is covered?**

Describe the different health financing schemes and the extent of population coverage (%) by each and the basis for entitlement.

Please consider:
- the legal basis for entitlement
- criteria for entitlement

This subsection should give the reader a clear picture of those covered by the public financing system. It should also give the reader an idea of those who are not covered or choose alternative forms of coverage. Cross references to the subsection on VHI may be necessary.

- e.g. through the constitution, law
- e.g. residence, employment status, membership of an insurance scheme, residence in specific geographical areas, insurance contributions
• whether membership of an insurance scheme is compulsory
• which groups are covered without having to make formal contributions
• any excluded groups, such as migrants
• practical barriers preventing some population groups from accessing health care even though they are entitled to it
• whether the health financing-related laws are properly enforced
• whether some population groups can join voluntarily (“opting-in”) or voluntarily leave (or are compulsorily excluded from) the statutory system (“opting-out”)

Most health systems have some form of standard package of benefits to which persons covered are entitled. This can be explicit (i.e. a list states all the benefits available or separate lists exist for various sectors) or it can be implicit (i.e. based on traditions and routine).

The services and products that may or may not be covered include diagnosis (including laboratory tests), treatment, prevention, health promotion, traditional, alternative, or complementary care services, rehabilitation, long-term nursing care, long-term care for older people and people with mental health problems, palliative care, occupational health care and prevention, accident related care, transport, after hours care, pre-hospital emergency care, patient information, optician services (e.g. sight tests, glasses), pharmaceuticals (outpatient and inpatient), dental care, renal dialysis, cosmetic surgery, antenatal care, care during childbirth and postpartum, termination of pregnancy, contraception, in vitro fertilization, organ transplantations and treatment abroad.

e.g. children, pensioners, unemployed, pregnant women

e.g. unemployed, foreigners, irregular immigrants
e.g. because it is necessary to apply for a health insurance card or access requires a permanent address
e.g. are there insured people who do not benefit from services or uninsured people who benefit from services?
**Scope: what is covered?**

Describe the range of benefits (goods and services) to which covered people are entitled. Please consider:

- whether the benefits are standard across the whole of the covered population or whether there is targeting of benefits
- the extent to which benefits are explicitly defined, gaps in benefits coverage
- any benefits explicitly excluded
- whether government financing systems can (and do) offer additional benefits over and above the established benefits package
- any cash benefits available

Describe the process of deciding which goods and services are to be included in/excluded from the benefits. Please consider:

- is responsible for/involved in the decision making process
- the criteria used as a basis for decision making
- the role of HTA
- any reductions in or expansions of the benefits package in recent years (services that have been excluded or added)

*Example benefits include:*
- e.g. through complementary or supplementary VHI
- e.g. sick pay, maternity benefits, disability, invalidity, cash payments for users of long-term care services, funeral benefits, cash benefits for family members caring for acute or chronically ill people, cash benefits for special groups (e.g. those with mental disorders or living with HIV/AIDS)
- e.g. safety, efficacy, effectiveness, cost effectiveness

Cross-reference to Section 2.7.2 Health technology assessment.
**Chapter 3: Financing**

**Depth: how much of benefit cost is covered?**

Briefly describe the extent of user charges in place for accessing benefits. Please consider:
- the services for which people have to pay user charges, e.g. outpatient prescription drugs, GP visits, stays in hospital
- whether any population groups are protected from user charges, e.g. through exemptions, reduced rates, VHI covering statutory user charges
- formal user charges as a percentage of public and total expenditure on health
- significant trends over time

**3.3.2 Collection**

**General government budget**

Briefly describe:
- the contribution to health financing of the government budget
- the mix of taxes used to fund the government budget, indicating which (if any) are earmarked for health and noting any significant changes
- the process/mechanism of tax collection (including responsible bodies, level of collection)
- the breakdown of percentage of local/regional/national taxation where these contribute to health financing

- progressivity of the total tax burden and of different types of tax (where possible use household survey data)

This section should give the reader a brief overview of formal user charges and their role in the health system, but should not describe these charges in detail since this will be done in the subsection on cost-sharing.

Cross-reference to Section 3.4 Out-of-pocket payments.

Progressive: a higher share is taken from the rich
Proportionate: an equal share is taken from all income groups
Regressive: a higher share is taken from the poor
Social health insurance pooled by a separate entity or entities

Describe the nature of these taxes/social insurance contributions. Please consider:

- whether health insurance contributions are earmarked for health or whether they are mixed with other sectors, such as pensions
- on what they are levied, e.g. gross/net wages, other income
- who is responsible for collecting them
- who is responsible for setting contribution rates
- whether there are differences in contribution rates by funds or type of member
- whether there are certain social groups that do not contribute
- whether contributions are shared between employers and employees and if so, in what ratio
- whether there are upper or lower thresholds on contributions
- whether the government contributes and if so, for whom and how much
- breakdown of how much is collected from employers/employees and how much from other sources
- progressivity of social insurance revenue

This section focuses on taxes or social insurance contributions used to finance health care that are pooled by entity or entities that are separate from the general government budget. These are often payroll taxes earmarked for health. They may be collected by health insurance funds, local government or central government, depending on the country context.

e.g. different rates for older people, self-employed, farmers, public employees, unemployed

e.g. transfers from the general government budget, flat-rate premiums

Other sources of tax revenue for health

Summarize the extent and role of other taxes. Please consider:

- sin taxes
- earmarked taxes
- national lotteries
3.3.3 Pooling of funds

Allocation from collection agencies to pooling agencies

Describe the different types of pooling that exist in your country.

Discuss whether or not there is an overall budget for the government financed system and how the process of setting this budget works. Please consider:

- whether decisions about the health care budget are made at different levels, e.g. national, regional, local
- the process of determining the size and content of the overall budget for the public financed system
- whether overspending has been a problem historically
- whether the same agency that collects funds also pools them

Discuss the process of transferring collected revenue to pooling agencies:

- describe the nature of the agencies responsible for pooling compulsory sources of revenue
- if revenue is pooled by one or more health insurance funds, describe any flows in addition to earmarked contributions, and the allocation mechanisms used
- if government agencies pool funds for health care, describe the process for determining the size of the budget held by each
- if there are “parallel” government health systems, describe the process for determining the size of their health budgets

This subsection focuses on any process by which financial resources flow from a collection agency to a pooling agency (e.g. from the ministry of finance to the ministry of health or from the tax agency or social security agency to a central health insurance fund). In some cases, the revenue collection and pooling functions are integrated (e.g. where health insurance funds collect their own contributions) and the resource allocation mechanism to poolers is therefore implicit.

Information on management of health insurance funds is provided in Section 2.8.1 Regulation and governance of third-party payers, page 16.

In these cases, the contribution mechanism is also the allocation mechanism to the pool
• if there are territorial pools, describe the allocation process from central to territorial levels.

If these pooling agencies are also purchasers, please refer the reader to the following section and discuss this issue there.

Allocating resources to purchasers

This subsection focuses on any process by which financial resources flow from a pooling agency or among agencies that pool funds to those that purchase services (e.g. from a central agency to health insurance funds or geographically defined purchasers such as local governments).

In some cases the revenue collection, pooling and purchasing function are integrated and the resource allocation mechanism to purchasers is therefore implicit (e.g. where statutory health insurance funds collect their own contributions). Even in these situations, however, there may be some redistribution or reallocation of resources among purchasers, which should be described in this section.

Describe the market structure of purchasing. Please consider:

• the nature of the purchasers and the population for which they are responsible
• the number of purchasers
• whether people have choice of purchaser

Describe the method(s) used to allocate funds from pooling agencies to purchasers or to reallocate funds among pooling agencies/purchasers. Please consider:

• the basis for allocating resources
• whether the process is standardized across the country
• whether budgets are set for different sectors or programmes within the health system and if so, whether they are hard or soft budgets/risk-adjusted or not
• if a system of budgets is in place, please say how they are calculated

e.g. entire population of territory, people that are members of the particular scheme managed by the purchaser

Cross-reference to Section 2.9.2 Patient choice.

e.g. full retrospective reimbursement for all expenditure incurred; reimbursement based on a fixed schedule of fees; prospective funding based on expected future expenditure, using fixed budgets; risk-adjusted capitation
Chapter 3: Financing

Budgets may be calculated in the following ways:

- according to the size of bids from purchasers
- based on political negotiation
- according to historical precedent
- according to an input-based budget process also used by individual health facilities, as part of an overall “bottom-up” budget construction process for the sector (one type of historical precedent) based on some independent measure of health care need (i.e. risk-adjusted capitation)

If risk-adjusted capitation is used to allocate (or reallocate) resources, please consider:

- the stated purpose of risk-adjusted capitation
- the percentage of total allocations to purchasers made through risk adjusted capitation
- the resource allocation formula or risk adjustment mechanism, the process used to determine the formula/mechanism, and what the formula/mechanism involves

The organizational relationship between purchasers and providers is based on two models: integrated, or contract (note: health care providers can either be individuals or institutions):

Integrated: health care providers are directly employed (or “owned”) by the third-party payers.

Contract: health care providers are independent and are contracted by the third-party payers (be they public, private non-profit-making or private profit making, regional monopolies or competing), i.e. there is a separation between purchaser and provider functions and contractual or contract-like relationships between them (e.g. preferred providers).

In addition, direct payments by patients to providers play an important role in allocating resources to providers in many countries.
If relevant, please also consider:

- whether health resource allocations (e.g. from central to local government) are separate from allocations for other sectors, such as education and social services; if not, describe the mechanisms in place to define health allocations
- whether purchasers can vary their own resources (e.g. through cost sharing, charging additional per capita premiums or raising local taxes)
- whether purchasers bear financial risk (i.e. can they carry over a deficit or a surplus or borrow money)

If purchasers are responsible for collecting all or some revenue, there may be a system of reallocation between them (i.e. transfers of funds from one purchaser to another). If so, describe

- whether there have been any recent changes to the system of resource allocation or any are being proposed. Discuss reasons for these changes and any implications.

When describing a resource allocation formula or risk adjustment mechanism, please consider:

- risk factors or risk adjusters used
- weights applied to different factors
- how double counting is avoided
- whether there is adjustment for supply-side factors, such as the number or type of hospitals in a region
- whether adjustments account for “pure cost”
- factors that could affect the expected cost of service delivery and are part of the context (e.g. population density, remoteness) rather than something amenable to policy or efficiency improvement
- whether adjustments are made for socioeconomic factors
- whether specific types of morbidity (e.g. psychiatric, HIV or tuberculosis prevalence, cardiovascular disease prevalence) are used as factors
- whether there are any retrospective adjustments made to the allocations, based on actual expenditure
- whether there is a safety net or additional pool to cover exceptionally expensive treatments
3.3.4 Purchasing and purchaser–provider relations

Describe the process through which purchasers and providers interact.

If providers are integrated, please consider:
- how their behaviour/activity is controlled (e.g. through hierarchical management, norms, targets)
- what happens when provider organizations deviate from agreed plans/targets

If contracting is used, please consider:
- whether purchasers can contract selectively with individual providers (in theory and in practice)
- whether there is competition between providers for contracts from purchasers
- the main types of contract agreed between purchasers and providers
- the contracting process
- how contracts are monitored and enforced
- any cases where national competition authorities have intervened
- incentives to provide services to specific groups of people
- any examples and data/evidence available

If direct payments from patients form an important part of provider reimbursement, please consider:
- whether the insurer or regulator intervenes (e.g. through price controls, OOP payments limits, reporting requirements)
- whether payers/purchasers control providers and patients (in theory and in practice)
- whether there are any mechanisms to counter supplier-induced demand and if so, how these are implemented

The organizational relationship between purchasers and providers is based on two models: integrated, or contract (note: health care providers can either be individuals or institutions):

**Integrated**: health care providers are directly employed (or “owned”) by the third-party payers.

**Contract**: health care providers are independent and are contracted by the third-party payers (be they public, private non-profit-making or private profit making, regional monopolies or competing), i.e. there is a separation between purchaser and provider functions and contractual or contract-like relationships between them (e.g. preferred providers).

In addition, direct payments by patients to providers play an important role in allocating resources to providers in many countries.
3.4 Out-of-pocket payments

Describe the composition of OOP payments. Please consider:
- the relative contribution of direct payments, cost-sharing and informal payments
- whether informal payments are a feature of the health system and whether data on informal payments are included in calculations of private expenditure
- changes (decrease or increase) in the level of OOP payments and in which areas; explain why
- implications for financial protection and equity
- national policy debates concerning OOP payments

OOP payments include:
- Direct payments: payments for goods or services that are not covered by any form of third-party payment.
- Cost-sharing (user charges): a provision of health insurance or third-party payment that requires the individual who is covered to pay part of the cost of health care received.
- Informal payments: unofficial payments for goods or services that should be fully funded from pooled revenue.

Refer to Table 3.3, Section 3.2 Sources of revenues and financial flows (described on page 28).

Is there any research showing the distribution of OOP payments across the population, the structure of OOP payments (i.e. what services they are spent on) and their impact on catastrophic household spending and poverty levels?

Please refer to the 2015 HiTs from Bangladesh, Cambodia, China, Myanmar and Thailand for examples.

Provide a brief overview of the historical evolution of private expenditure on health.
- if OOP payments constitute the main source of revenue, please explain why revenue has not been generated through prepayment.

Cross-reference to Section 3.7 Payment mechanisms and Section 7.2 Financial protection and equity in financing and Section 7.3.2 Equity of access to health care.
3.4.1 Cost-sharing (user charges)

Cost-sharing can be direct or indirect, as set out in the box below.

**Direct methods of cost-sharing**

Co-payment: A fixed amount (flat rate) charged for a service.

Co-insurance: The user pays a fixed proportion of the cost of a service, with the third party paying the remaining proportion.

Deductible: A fixed amount to be paid by the user before a third-party payer will begin to reimburse for services. It is usually an annual amount of all health care costs or costs for a particular service that is not covered by the insurance plan.

**Indirect methods of cost-sharing**

Extra billing: Charges by the provider that are higher than the maximum reimbursement levels set by the third-party payer, leaving users liable to pay the difference.

Reference pricing: The maximum price for a group of equal or similar products (mostly pharmaceuticals) the third-party payer is willing to reimburse. If the actual price exceeds the reference price, the price difference must be met by the user.

OOP payments maximum: A defined limit on the total amount of OOP payments for which an insured individual or household will be liable for a defined period, over and above which the third party pays all expenses.

Benefit maximum: A defined limit on the amount that will be reimbursed by the third-party payer for a defined period, over and above which the user is entirely liable for payment.

Source: adapted from the European Observatory on Health Systems and Policies HIT Template

Complete Table 3.4 outlining which methods of direct or indirect cost-sharing are applied to each item or service and the mechanisms in place to protect specific groups of people.

Protection mechanisms may include reduced rates, exemptions for certain groups of people or for certain conditions, caps on patient OOP payments, generic or therapeutic substitution, complementary VHI covering statutory user charges.
3.4.2 Direct payments

Describe the extent of user payment at the point of use for goods or services that are not covered by prepayment. Please consider:

- the sorts of services for which people are most likely to make direct payments
- any issues arising
- any changes

Provide an overview of the system of formal user charges in place. Please consider:

- whether user-charges policy has explicit objectives; if so, whether the stated objectives have been achieved
- who is responsible for making decisions about the level of cost-sharing and protection mechanisms
- changes in policy

Discuss whether complementary VHI covering statutory user charges is available, what proportion of the population is covered by this form of VHI and whether it has any distributional implications.

3.4.2 Direct payments

Describe the extent of user payment at the point of use for goods or services that are not covered by prepayment. Please consider:

- the sorts of services for which people are most likely to make direct payments
- any issues arising
- any changes

Provide an overview of the system of formal user charges in place. Please consider:

- whether user-charges policy has explicit objectives; if so, whether the stated objectives have been achieved
- who is responsible for making decisions about the level of cost-sharing and protection mechanisms
- changes in policy

Cross-reference to Section 3.3.1 Coverage, the subsection on “Scope: what is covered?”, page 32 and Section 3.5 Voluntary health insurance, page 44.

Table 3.4 User charges for health services

<table>
<thead>
<tr>
<th>Health service</th>
<th>Type of user charge in place</th>
<th>Exemptions and/or reduced rates</th>
<th>Cap on OOP spending</th>
<th>Other protection mechanisms</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP visit</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient specialist visit</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient prescription drugs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient stay</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical devices</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (please specify)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: national statistics

e.g. raising revenue, cost-containment, reducing inappropriate demand

e.g. national/local government; statutory health insurance funds; are there regional variations in cost sharing?

Cross-reference to Section 3.3.1 Coverage, the subsection on “Scope: what is covered?”, page 32 and Section 3.5 Voluntary health insurance, page 44.

e.g. use of private providers, private elective surgery
3.4.3 Informal payments

If informal payments exist, please consider:

- the nature and magnitude of informal payments
- their prevalence (historically if possible) and size relative to official payments
- geographic variations in the prevalence of informal payments
- efficiency and equity implications
- problems or challenges encountered
- plans or expectations with respect to future developments in this area

Cross-reference to Section 7.2
Financial protection and equity in financing, Section 7.3.2 Equity of access to health care, and Section 3.7.2 Paying health workers.

3.5 Voluntary private health insurance

VHI is health insurance that is taken up and paid for at the discretion of individuals or employers on behalf of individuals. VHI can be offered by public or quasi-public bodies and by profit-making (commercial) and non-profit-making private organizations.

VHI can take the form of Community Based Insurance schemes, Health Equity Funds and other contributory financial schemes or employer-based schemes.

It is useful to think of VHI in relation to statutory coverage since VHI markets are generally heavily shaped by the rules and arrangements of the statutory health system. VHI plays different roles in relation to statutory coverage. Understanding differences in market role (summarized below) is important for three reasons. First, the role VHI plays is often correlated with market size, particularly in terms of its contribution to health expenditure. Second, a market’s role largely determines the way in which it is regulated. And third, as a result of its combined effect on market size and public policy towards VHI, market role may tell us a great deal about the likely impact of VHI on the attainment of health system goals, both within the market and in the health system as a whole.
### Explanatory note: VHI market roles

<table>
<thead>
<tr>
<th>Market role</th>
<th>Driver of market development</th>
<th>Nature of cover</th>
<th>Asian examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substitutive</td>
<td>Limits to the cover provided by compulsory insurance or tax-funded services: the proportion of the population eligible for compulsory cover or receiving subsidies.</td>
<td>Covers people excluded from compulsory insurance, allowed to opt out, or not eligible for subsidies.</td>
<td>Malaysia (foreign workers), Cambodia/Lao People’s Democratic Republic (community-based health insurance)</td>
</tr>
<tr>
<td>Complementary (services)</td>
<td>Limits to the benefit package provided by compulsory insurance or tax-funded services.</td>
<td>Covers services excluded from the social health insurance benefit package or standard package of care.</td>
<td>Australia</td>
</tr>
<tr>
<td>Complementary (user charges)</td>
<td>The depth of financial protection provided by compulsory insurance: user charges at government facilities; the proportion of the benefit cost met by social health insurance</td>
<td>Covers the proportion of user charges not reimbursed under social health insurance or ancillary charges at government facilities</td>
<td>Australia (excluding primary care), China, Japan, Korea, Cambodia/Lao People’s Democratic Republic (community-based health insurance)</td>
</tr>
<tr>
<td>Supplementary</td>
<td>Consumer satisfaction: perceptions about the quality of publicly financed care</td>
<td>Covers faster access to care and enhanced consumer choice of provider and amenities</td>
<td>Australia (excluding primary care), Hong Kong SAR, India, Fiji, Malaysia, Mongolia, Nepal, Sri Lanka</td>
</tr>
</tbody>
</table>


#### 3.5.1 Market role and size

Provide an overview of the market for VHI. Please consider:

- the role VHI plays and its relative importance
- the contribution of VHI to total expenditure on health and private expenditure on health
- the proportion of the population covered by VHI
- the factors that drive demand for VHI
- changes
3.5.2 Market structure

Describe the market structure of VHI. Please consider:

- the nature of those who buy VHI and, if possible, the relative market share of individuals and groups
- the characteristics of those covered by different types of VHI
- the nature, number and relative market share of the entities selling VHI

3.5.3 Market conduct

Provide an overview of the way in which VHI operates, noting any systematic differences in operation between types of insurer (e.g. profit-making versus non-profit making). Please consider:

- how premiums are set
- the scope (range) of benefits covered
- whether benefits are provided in cash or in kind
- the depth of benefits
- the nature of policy conditions applied to those purchasing VHI
- the nature of insurer–provider relations
- how insurers pay providers and who sets the level of provider remuneration
- the nature of the institutions and professionals providing VHI-covered services

- e.g. risk rated (based on individual risk), community rated (the same premium for all members of a community or group) or experience rated (adjusted based on claims history)
- e.g. the extent of cost-sharing for covered benefits and whether benefits are subject to ceilings (an upper limit)
- e.g. age limits for purchasing VHI, whether annual versus lifetime contracts, cover of pre-existing conditions, waiting periods
- e.g. are they private or public or do they operate in both sectors?
• the level of administrative costs incurred in the VHI market
• the profitability of the VHI market changes

3.6.2 External sources of funds: ODA

Comment on the evolution and use of ODA financing.

3.6 Other financing

If there are no other sources of funding, or if they are very insignificant, please say so.

3.6.1 Parallel health systems

Discuss the role of parallel health systems with respect to their financing role, the challenges they represent and their future role.

3.6.2 External sources of funds: ODA

Comment on the evolution and use of ODA financing.

E.g. administrative costs as a proportion of total premium income

E.g. claims ratios: benefits paid as a proportion of total premium income

3.5.4 Public regulation of VHI

Provide an overview of public regulation of VHI. Please consider:
• who is responsible for regulating the market
• how the market is regulated
• tax incentives or disincentives to take up VHI, such as tax relief, taxes on premiums, taxes on the receipt of benefits in kind
• policy debates about VHI

E.g. the types of regulation in place; examples include solvency margins, open enrolment, lifetime cover, community-rated premiums, systematic prior notification of premiums and changes to premiums and policy conditions, premium caps, minimum or standard benefits, cover of pre-existing conditions, risk equalization, consumer information requirements.

In some countries, there are parallel health systems providing services for employees and officials of certain national enterprises and ministries, such as the ministries of defence, transportation and others.

Cross-reference to any further details provided in Sections 3.3.3 and 3.3.4 on pooling and purchasing.

External sources of funds (ODA) refer to financial assistance for the health sector, which may take the form of loans or grants from bilateral or multilateral organizations.

Cross-reference to Section 3.2 Sources of revenue and financial flows.
3.6.3 Other sources of financing

Discuss the following, where they exist:

- Occupational health services and other medical benefits to employees provided by corporations and private employers or provided to certain special groups (e.g. soldiers, prisoners)

- Non-profit-making institutions serving households (excluding social insurance)

- Voluntary and charitable financing, e.g. national and international donations in cash or in kind from NGOs

- Mental health and social care services where these are funded separately from general medical services. If relevant, please consider:
  - user charges for institutional and community-based mental health services
  - exemption criteria, if any, from user charges
  - whether NGOs, donor organizations or religious organizations contribute significantly to the financing of mental health services

- Long-term care financing where this is funded separately from general medical services. If relevant, please consider:
  - whether some long-term care services are excluded from insurance coverage
  - if so, how they are financed (e.g. by NGOs or donor organizations)

Cross-reference to Section 5.8 Long-term care.
3.7 Payment mechanisms

See Box on p. 56 (Different Types of Payment Methods) for an explanation of the different types of payment methods.

3.7.1 Paying for health services

Please discuss how each of the following types of service are funded and cross-reference to the relevant sections in Chapter 5:
- public health services
- primary/ambulatory care
- specialized ambulatory/inpatient care
- pharmaceutical care

If robust data are available, please discuss any other relevant areas.

If relevant, please also discuss:
- any recent changes in the methods used to pay providers and their purpose
- any problems or issues that triggered the changes

This section should provide an overview of payment mechanisms used in the health system, with reference to Table 3.5 and the financing flow diagram shown in Fig. 3.6, as described in pages 51 and 29 respectively.

Discuss the transactions shown in the financial flow diagram and the incentives these transactions provide for providers.

Highlight any recent changes in how providers are paid and whether any evaluation of their effect has been carried out.

Where possible, distinguish between the method of paying health workers and the method of paying for services.

Where payments amount both to reimbursement for services and to the income of the individual delivering the service, this should be clearly noted.

In discussing how prescription medicines are funded, authors may consider the following:
- profit-control schemes, reference pricing schemes or direct price controls
- composition of prices of medicines, i.e. ex-factory price, wholesaler’s (profit) margins, pharmacy margins (or profit), and any taxes
- regulation of OTC products

E.g. rehabilitation, dental care, mental health care, alternative medicine
Extra information: Different types of payment method

Retrospective payment (reimbursement) at “full cost”: third-party payers (purchasers) reimburse providers after services are delivered, either without any clear constraints on the price or quantity of health services provided or according to a specific fee schedule.

Payment methods typically involve use of a fee schedule. Methods for fixing fees vary according to the way in which health care activity is measured (units of payment):

- individual fees for service or charge list: purchasers pay hospitals according to a price list of services provided (e.g. for the use of operating rooms, tests, drugs, medical supplies or doctors’ fees);
- per diem fees or daily charge: purchasers pay hospitals a daily charge covering all service and expenses per patient per day and this does not vary according to treatment;
- case payment: purchasers pay hospitals according to the cases treated (rather than treatments provided or bed days). Payment can be based on a single flat rate per case, but in most cases it is based on a schedule of payment by diagnosis; the most widely known case classification approach is diagnosis-related groups (DRGs).

Prospective payment: purchasers allocate revenues to providers before services are delivered or the total amount of payment is fixed in advance. Key policy issues relate to the basis on which the budgets are determined (e.g. capitation).

Payment methods (e.g. global budgets, line item budgets, capitation) cover the operating costs of the service provider over a given period of time. The budget may be calculated on the basis of:

- the actual costs of a particular provider unit (essentially a budget determined by retrospective payment);
- historical incrementalism (i.e. based on the previous year’s allocation adjusted for inflation and budget growth);
- the provision of inputs (i.e. based on the number of beds and/or doctors involved);
- the population covered (i.e. per capita);
- the volume of bed days;
- the volume and mix of cases.

Mixed methods: payment methods that combine retrospective and prospective methods (e.g. fee schedule-based reimbursement subject to volume/budget caps). In practice, there are no pure payment methods. Hospitals are usually paid on the basis of a combination of some of the above. For example, individual fees for service are usually combined with a daily charge to cover basic services, such
as nursing, food and overheads. In most payment methods, there is a budget component to fund investment. Similarly, most systems can be supplemented by bonus payments as an incentive to providers to achieve certain objectives. Direct payments from patients may also constitute an important part of the provider incentive environment.

Source: European Observatory, HiT Template for Authors, 2010

### Table 3.5 Provider payment mechanisms

<table>
<thead>
<tr>
<th></th>
<th>Ministry of Health</th>
<th>Other ministries</th>
<th>Regional ministry of health/health service</th>
<th>Local health authority</th>
<th>Central SHI institution</th>
<th>SHI funds</th>
<th>Other SHI systems</th>
<th>Private/voluntary health insurers</th>
<th>Cost-sharing</th>
<th>Direct payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>GPs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambulatory specialists</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other ambulatory provision</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospitals</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital outpatient</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dentists</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pharmacies</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public Health services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please complete the table by showing the different mechanisms by which payers pay providers, indicating whether payment is via:

- Budget – B
- Fee-for-service – FFS
- Per diem – PD
- Salary – S
- Capitation – C
- Case payment – e.g. DRGs
- Performance-related pay – P4P

Where a provider is paid through a combination of methods, please indicate the relative share of each payment mechanism.

Adapt and modify as appropriate.
3.7.2 Paying health workers

Describe how different categories of health workers are paid and who set their remuneration. Please consider:

- how rates and methods are established
- recent changes in payment methods and any evaluation of the effect of changes
- how the average income of health professionals compares with that of other equivalent professionals/the average national income

Consider the following groupings:

- doctors
- nurses and midwives
- dentists and dental auxiliaries
- pharmacists
- other health workers

If relevant, please consider (for each group):

- any incentives, both financial and nonfinancial
- any problems

Health workers may be paid in the following ways:

- fee-for-service (officially, from the third-party purchaser or patients, and unofficially as informal payments)
- salary
- capitation
- blended systems

Please distinguish between health professionals working in primary/ambulatory care or community settings and those working in hospitals and academic settings.

e.g. physiotherapists, alternative medicine

e.g. negotiation, regulation
Chapter 4: Physical and human resources

This chapter provides an overview of physical and human resources in the health system. Physical resources encompass infrastructure, capital stock, medical equipment and information technology (IT). The section on human resources discusses health workforce issues, such as planning, training and mobility.

Chapter summary

Please provide a summary of the whole chapter (maximum 300 words).

4.1 Physical Resources

4.1.1 Capital stock and investments

Current capital stock

Briefly describe the number, location, size and age of hospitals.

Briefly describe the number and location of primary care facilities. Please consider:

- property condition surveys available
- at various levels of care (e.g. primary, secondary, tertiary, intermediate, social care)
- whether appraisals of condition and performance feed into planning future strategies and investment
- Whether Safer Hospitals principles are followed in health facility construction and management

Also describe the condition of facilities. Please consider:

- property condition surveys available at various levels of care (e.g. primary, secondary, tertiary, intermediate, social care)
- whether appraisals of condition and performance feed into planning future strategies and investment

Please note that Section 4.1.1 focuses on buildings, not equipment.

Cross-reference to Section 2.8.6
Regulation of capital investment
Investment funding

Describe how capital investments are funded. Please consider:

- whether investment funding is separate from or covered through reimbursement for service delivery
- whether capital investment reflects stated public health priorities
- money borrowed through public allocations and the criteria for public investment
- the nature of any private borrowing
- public–private partnerships for investment in capital facilities
- investment funding through donation or sale/disposal of assets
- any differences between capital investment in hospitals, primary care facilities and intermediate, social, long-term, palliative or mental care facilities
- implications for capital investment funding of sharing facilities across borders

Distinguish here between capital investment funding and the ongoing funding of capital/life cycle/maintenance costs.

e.g. strengthening primary care

Public–private partnerships are public sector programmes and services that are operated and funded with private sector participation. They should be distinguished from privatization if the rules for profitmaking entities involved in public–private partnerships are set and enforced solely by government agencies.

4.1.2 Infrastructure

Describe the current infrastructure, including hospitals, health centers and other types of health facilities (numbers and geographic distribution). Please consider:

- the mix of beds in acute hospitals (Fig. 4.1)
- how trends in typical operating indicators compare with those in other countries (Fig. 4.2)
- how trends for acute hospitals (and other institutions) compare with those in other countries (Fig. 4.3)

Figure 4.1 Mix of beds in acute hospitals, psychiatric hospitals and long-term care institutions in country, per 1000 population, 1990 to latest available year

NOTE: Figures (bar graph) should have labels.
Figure 4.2  Operating indicators in country and selected countries, 1990 to latest available year, such as average length of stay (ALOS), occupancy rates, day cases as percentage of total surgery

Figure 4.3  Beds in acute hospitals per 1000 population in country and selected countries, 1990 to latest available year

4.1.3 Medical equipment

Describe briefly how major pieces of medical equipment are funded. Please consider:

- how the data in Table 4.1 (if available) compare with those in other countries
- whether basic equipment is available in sufficient quality and quantity
- differences between primary/ambulatory and inpatient care

Table 4.1  Items of functioning diagnostic imaging technologies (MRI units, CT scanners, PET) per 1000 population in latest available year

<table>
<thead>
<tr>
<th>Item</th>
<th>Per 1000 population</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRI units</td>
<td></td>
</tr>
<tr>
<td>CT scanners</td>
<td></td>
</tr>
<tr>
<td>PET</td>
<td></td>
</tr>
</tbody>
</table>

Sources: national statistics/ OECD Health Data

4.1.4 Information technology

Please provide data on Internet access and use (at home, school or work).

The general context in which IT systems operate within a country is important. Access to the Internet will influence how IT can be used within the health system. This Section provides some background information.
Describe the use of IT in the health system. Please consider:

- the current level of IT use in primary care/secondary care/the health system in general
- the compatibility and coordination of IT systems in the health sector
- the proportion of primary care settings with computers
- plans or strategies for the development and use of IT systems within the health system
- electronic medical records or electronic health cards or plans for introducing them
- electronic hospital (or other health care facility) appointment booking systems or plans for introducing them
- information on the number of people accessing the Internet for health information, if available

Cross-reference to Section 2.7.1 Information systems, as well as relevant delivery sections.

Please note that patient information should be discussed in Section 2.9.1.

Describe the specialized IT system for emergencies and disasters

- the current level of IT use in primary care/secondary care/the health system in general
- the compatibility and coordination of IT systems in the health sector
- the proportion of primary care settings with computers
- plans or strategies for the development and use of IT systems within the health system
- electronic medical records or electronic health cards or plans for introducing them
- electronic hospital (or other health care facility) appointment booking systems or plans for introducing them
- information on the number of people accessing the Internet for health information, if available
- Existence of functional Emergency Operations Centers for health authorities, as well as emergency communications capacities and protocols

This section should describe the human resources available in the health system, both public and private sectors. Discuss the numbers of health workers (defined as “all people engaged in actions whose primary intent is to enhance health”). Where possible, compare trends with those in other countries.

How professionals are remunerated should not be discussed in this section [see Section 3.7.2 Paying health workers on page 52].
4.2 Physical Resources

4.2.1 Health workforce trends

Comment on trends for the professional groups shown in Table 4.2 and Figures 4.4–4.8. For each group, please consider numbers of full-time equivalent staff, the adequacy of staffing levels, geographical, and sectoral [public, private] distribution.

- doctors: primary care/ambulatory care doctors; hospital-based doctors; academic doctors;
- nurses and midwives: distinguish between the levels of nursing, including nursing assistants, and discuss nursing specialties available [e.g. psychiatric, paediatric, nurse practitioners, community nursing, and nurse practitioners]
- dentists and dental auxiliaries: distinguish between dental practitioners [primary care], specialist dentists [working in hospitals] and dental auxiliaries
- pharmacists: distinguish between hospital and community pharmacists

Distinguish as applicable general practitioners and specialists in ambulatory settings, and between different medical specialties.

Please make clear whether your country statistics on midwives are collected separately or included in the total number of nurses.

Dental auxiliary: a member of the dentist’s supporting team who helps in the provision of dental treatment.

Comment on the geographical distribution of each category of providers.
### Table 4.2 Health workers in country per 1000 population, 1995 to latest available year

<table>
<thead>
<tr>
<th>Total population</th>
<th>1980</th>
<th>1990</th>
<th>2000</th>
<th>2010</th>
<th>Latest Available year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care doctors</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialist physicians</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurses</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Midwives</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dentists</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Optometrists</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pharmacists</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychologists</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occupational therapists</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Radiographers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>etc</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Sources: national statistics/WHO data

---

**Figure 4.4** Number of physicians per 1000 population in country and selected countries, 1990 to latest available year

**Figure 4.5** Number of nurses per 1000 population in country and selected countries, 1990 to latest available year

**Figure 4.6** Number of physicians and nurses per 1000 population in the WHO European Region, latest available year

**Figure 4.7** Number of dentists per 1000 population in country and selected countries, latest available year

**Figure 4.8** Number of pharmacists per 1000 population in country and selected countries, latest available year
Also consider other health workers of particular relevance to your system, such as:

- public health professionals: distinguish between specialists in public health (trained as doctors) and other public health professionals (exclude primary care physicians who may perform public health duties)
- professionals allied to medicine: discuss other therapists, clinicians and scientists who work in the health system
- complementary and alternative medical practitioners: discuss providers of therapies outside orthodox medicine
- managerial staff: discuss senior management and administrative posts within the health system
- other particular roles/health workers
- medical technicians
- social workers or care workers
- outreach workers, community-based providers and other types of volunteers

### 4.2.2 Professional mobility of health workers

Briefly comment on professional mobility. Please consider:

- recruitment of health workers from abroad or the loss of staff to other countries
- the main countries involved
- reasons for health workers leaving/coming to the country
- any danger of so-called brain drain and, if so, any plans to remedy this trend
- adoption and implementation of WHO Global Code of Practice on International Recruitment of Health Personnel

Health professional mobility is any change of country after graduation to deliver health related services, including during training periods.

Cross reference to Section 2.8.3 Registration and planning of human Resource: WHO Global Code of Practice of International Recruitment of Health Personnel
4.2.3 Training of health workers

Describe the basic training of health workers. Please consider:

- requirements for specialization and further training
- whether continuing professional development is required
- the bodies responsible for setting educational standards
- the nature of any process of revalidation of qualifications to ensure medical competency
- whether pre- and in-service training for Disaster Risk Management is required or available

Cross-reference to Section 2.8.3 Registration and planning of human resources.

4.2.4 Doctors’ career paths

Describe the career paths of doctors, in both hospital and ambulatory settings. Please consider:

- how the promotion of doctors to different grades within hospitals is organized
- whether it is influenced by the directors of the clinic or department
- whether the decision is local (within the hospital) or national
- whether hospital management is involved in promoting staff
- whether there is much movement of doctors across hospitals, clinics or departments within hospitals, or countries

4.2.5 Other health workers’ career paths

Describe the career paths of other health workers, e.g. nurses, dentists and pharmacists. Please consider:

- mechanisms for career development
- whether health workers are leaving the sector in significant numbers

4.2.6 Dual practice

Describe the extent and nature of dual practice in the public and private sector (regulations, enforcement, and prevalence).
Chapter 5: Provision of services

This chapter concentrates on patient flows, organization and delivery of services. The respective subsections of this chapter primarily focus on the organization and provision of services, but should provide a brief summary on the accessibility, adequacy and quality of services, as well as current developments and future reform plans. These are covered in-depth in subsequent chapters (chapters 6 and 7).

Chapter summary

Chapter summary

Please provide a summary of the whole chapter (maximum 500 words).

5.1 Public health

Describe the organization and provision of public health services including settings, responsible organizations, nature of providers and functions. Please consider:

- environmental and communicable disease control functions
- mechanisms for notification and surveillance of disease outbreaks, environmental threats
- mechanisms for surveillance of the population’s health and well-being
- the organization of occupational health Services
- the organization of preventive services
- any established programmes of health promotion and education (include profit-making and non-profit-making organizations if relevant)
- national screening programmes for the whole or part of the population
- disaster risk management for health mechanisms
- measures to address AMR and other emerging health threats

Public health is a social and political concept aimed at improving health, prolonging life and improving the quality of life among whole populations through health promotion, disease prevention and other forms of health intervention.

Cross-reference to Section 2.6 Intersectorality.

e.g. surveys of health behaviour

These may include first aid and curative, preventive and rehabilitative services.

- e.g. immunization services, family planning and antenatal services
- e.g. programmes aimed at risk factors such as drinking, smoking, unhealthy diet and lack of exercise

These are organized programmes based on a population register with invitations to participate, integrated quality control and follow-up. There may also be opportunistic screening (e.g. a patient attending a physician for something else is offered a cervical smear or mammogram).
Chapter 5: Provision of services

Please comment on the accessibility of public health services, as well as their adequacy and quality.

5.2 Patient pathways

Provide a typical patient pathway or patient flow diagram. See the Box below for an example. In the text, please consider:

- whether such pathways differ significantly across the country, or by health condition

Refer to Section 1.4 Health status and relevant figures or tables.

Example: Patient Pathway

The 2006 study of dengue in children was carried out in two villages in the province of Kampong Cham (Khun&Manderson, 2007).

- The most frequent first treatment consisted of self-medication, and a few mothers used only traditional home remedies.
- The next step, when children failed to improve, was to visit a private clinic or arrange a home visit with a private practitioner.
- Only a minority sought care at Health Centres; a few bypassed the Health Centre and attended the Referral Hospital directly.
- When the treatment prescribed by private practitioners failed, the most common next step was to access a Health Centre or Referral Hospital.
- The authors of the study explained that women moved between sectors and sites of care according to circumstances, including availability, accessibility and affordability of service.

A more recent study found that trust in public and private providers in a rural location affected health-care-seeking behaviour, with very different results (Ozawa & Walker, 2011).

- Public providers were trusted for being honest, sincere, having good medical skills, not “bad-mouthing” people, explaining the status of disease, and having an effective referral system.
- Private providers were trusted for being friendly, gentle and sympathetic, having good personal interactions, being easy to contact and visiting patients’ homes, and allowing patients to owe them some money.
5.3 Primary/ambulatory care

Describe the organization and provision of primary care services (licensed and unlicensed), including settings, e.g. public and private, responsible organizations, nature of providers and functions. Please consider different models and settings of provisions:

- licensed providers (public and private)
- unlicensed providers (faith healers, traditional alternative medicine, drug sellers, unqualified practitioners)
- whether primary care providers are directly employed, contracted, or independent (FFS)
- the range of services available
- the role of private and as well as public and the proportions of consultations
- skilled birth attendants

Describe the functions of primary care providers. Please consider:

- role in health promotion
- preventative care
- management of chronic diseases
- mental health

Primary care refers to the individual’s first point of contact with the health system (private or public) and includes general medical care for common conditions and injuries. Health promotion and disease prevention activities, also a part of primary care, are described in Section 5.1 Public health.

Note: If specialists are mainly organized around a private-practice model (rather than in hospital), they may be included here under “ambulatory care”.

Ambulatory care refers to health services provided to patients who are not confined to an institutional bed as inpatients during the time services are rendered.

They may include the following categories: general medical care, diagnostic services, minor surgery, rehabilitation, family planning, obstetric care, perinatal care, first aid, dispensing of pharmaceutical prescriptions, certification, 24-hour availability, home visits, ambulance services and patient transport, nursing care for acute and chronic illnesses, palliative care, specific services for mental illness, preventive services (e.g. immunization, screening) and health promotion services (e.g. health education).
Describe the extent of choice and access to primary care. Please consider:

- choice of primary care provider and any restrictions with respect to changing providers, in theory and in practice
- whether patients have direct access to specialist (ambulatory and hospital) services
- whether the primary care provider has a gatekeeping role
- the referral process
- whether people have choice of hospital and specialist

Comment on the rural/urban distribution of primary care facilities/practitioners. Please consider urban primary care issues, and issues for remote populations.

Figure 5.1 Outpatient contacts per person in the WHO region, latest available year

Comment on the nature of outpatient contacts and the reliability of data

Reference any data available on first point of contact, or health seeking behaviors.

Cross reference to section 4.1.2.

Note: Pay particular attention to the Maternal and Child Health, communicable diseases, and NCDs.

Cross reference to sections 4.1.1 Capital stock and investments and 4.2.1 Health workforce trends

Include both public and private. Data source: Asia-Pacific at a Glance.

In many countries, outpatients are treated in hospitals. Please clarify whether data include outpatient visits in hospitals or whether they refer exclusively to outpatient contacts outside hospital.
Chapter 5: Provision of services

Summarize with what is known about the quality of primary care. Please consider:

- waiting time
- patient satisfaction
- differences between licensed and unlicensed providers
- skilled birth attendants
- other relevant indicators

Describe major changes in recent years, current problems/challenges and reform plans.

5.4 Inpatient care

Describe the organization and provision of secondary and tertiary health care services, including settings, responsible organizations, nature of providers and functions. Please consider:

- the organization of specialized medical services are provided
- the organization of specialized medical services within a hospital
- the main categories of hospitals and their function and distribution
- types of hospital management (e.g. autonomy)
- briefly discuss the public–private mix of hospital services

Secondary care refers to medical services and typical hospital services, which may include outpatient and inpatient services in higher level facilities. It excludes general long-term care, which is dealt with separately.

Tertiary care refers to medical and related services of high complexity, usually of high cost and provided at university/tertiary/referral hospitals.

Refer to http://www.who.int/management/quality/assurance/QualityCare_B.Def.pdf

Cross-reference to section 2.8.2.

Cross-reference to Fig. 4.1.
Baby-friendly Hospital Initiative

Launched by WHO and UNICEF in 1991, this initiative asks hospitals to ensure that their hospital practices encourage women to breastfeed their babies. 152 countries and 15,000 facilities around the world now implement this initiative. Available tools and materials include a course for maternity staff, and self-appraisal, monitoring and assessment tools. The initiative has measurable and proven impact, increasing the likelihood of babies being exclusively breastfed for the first six months. To be accredited under the scheme hospitals should meet the following criteria:

• Have a written breastfeeding policy communicated to all health care staff.
• Train all health care staff in skills necessary to implement this policy.
• Inform all pregnant women about the benefits and management of breastfeeding.
• Help mothers initiate breastfeeding within one hour of birth.
• Show mothers how to breastfeed and maintain lactation.
• Give newborn infants only breast milk, unless medically indicated.
• Practice rooming in where mothers and infants remain together 24 hours a day.
• Encourage breastfeeding on demand.
• Give no artificial teats or pacifiers to breastfeeding infants.
• Foster breastfeeding support groups and refer mothers to them on discharge.

Discuss the relationship between primary and secondary care. Please consider:

- substitution policies (or plans) to replace inpatient care with less expensive outpatient or home care
- the degree of integration between primary and secondary care providers (outpatient and inpatient)
- referrals both up and down levels of care

Summarize what is known about the quality of inpatient care. Please consider:

- readmission rates
- medical errors/adverse events
- AMR, infection control
- baby friendly hospitals

Describe major changes in recent years, current problems/challenges and reform plans.

5.4.1 Day care/ day hospitals/ day clinics/ surgi-centers

Please describe day care in your country, public or private.

Please note that long-term care options should not be discussed here, but in Section 5.8 Long-term care.

Cross-reference to Fig. 4.2.

Cross-reference 2.8.2 Regulation and governance of providers

Cross-reference to Chapter 6 Principal health reforms.

e.g. medical and paramedical services delivered to patients who are formally admitted for diagnosis, treatment or other types of health care with the intention of discharging the patient the same day
Describe the organization and provision of day-care services, including settings (public or private), responsible organizations, nature of providers and functions. Please consider:

- the location of day care
- the proportion of care provided in special day-care settings (public or private)
- the main medical services provided on a day-care basis
- trends in day-care provision in the last 10 years

5.5 Emergency care

Please provide the definition of emergency care used in your country.

Describe the organization and provision of emergency care, including settings, responsible organizations, nature of providers (e.g. emergency trained providers) and functions. Please consider:

- organizations involved in transporting patients and care given during transit

Comment on the accessibility, adequacy and quality of services.

- bottlenecks that prevent access
- competencies of primary care providers
- intersectoral coordination

Describe major changes in recent years, current problems/challenges and reform plans.

Provide a patient pathway in an emergency care episode (see the Box for an example).

e.g. in hospitals, ambulatory care or long term care facilities, public or private

Cross-reference to data on day cases as a percentage of total surgery in Section 4.1.2

e.g. medical care provided to patients with life-threatening conditions who require urgent treatment

e.g. the national health service or specialized services such as the Red Cross

Cross-reference to Chapter 6 Principal health reforms.
Example of patient pathway for emergency care

Emergency Care in Myanmar
Thirty nine year old male, a taxi driver, residing in Sipaw township, Shan North, woke up in the middle of the night of 2nd May 2013 with pain in the abdomen and vomiting of sour fluid. He visited to the general clinic opened by the Medical Superintendent (MS) of Sipaw Township Hospital about half mile away from his home by motorcycle carry on the following morning of 3rd May. He was given an injection and three doses of medicine by the doctor. At first, the pain seemed to subside but it became worse on the 4th May with sweating. He visited the same doctor again and was told this was an appendicitis and he should go to hospital immediately.

When he arrived at the OPD, abdominal examination was done and treatment was given at OPD: an IV infusion was given and he was admitted to the surgical unit.

He was operated on the morning of 5th May by spinal analgesia. The operation took half an hour, he did not suffer from pain anymore after operation. He stayed in bed for the whole day of 6th, started to walk on the 8th May. The stitches were out on the 12th and he was discharged from hospital.

He was satisfied with the doctors and staff from the hospital and although estimated 30,000 kyats was spent during his hospitalization he was quite happy.
Source: Myanmar HiT, Vol. 4 No. 3 2014

5.6 Pharmaceutical care

Describe the organization, procurement, manufacturing, method of distribution, and provision of pharmaceuticals to the public. Please consider:

- settings (public/private)
- licensed and unlicensed
- responsible organizations/bodies
- nature of providers and functions
- the pharmaceutical sector’s production capabilities, the number of firms, local production as a percentage of pharmaceutical expenditure
- public and private bodies involved in procurement, manufacturing and distribution
- report on the number of pharmacies
- any innovative ways of providing access to pharmacies, e.g. social marketing

Some of the information in this section will have been provided in previous sections (e.g. Section 2.8.4 Regulation and governance of pharmaceuticals). Instead of repeating it, please cross-reference where appropriate.

e.g. manufacturers, importers, parallel importers, wholesalers and pharmacies

e.g. through supermarkets
Comment on the accessibility, adequacy and quality of services/pharmaceuticals. Please consider:
- whether pharmaceuticals are covered as part of the statutory system
- who has access to publicly subsidized pharmaceuticals
- whether certain groups are exempt from pharmaceutical cost-sharing or pay reduced user charges
- extent of availability, distribution, and consumption of unregulated, out of date or counterfeit drugs

Discuss the nature and levels of consumption of pharmaceuticals. Please consider:
- pharmaceutical expenditure per capita, trends over the past 10 years
- types of prescription written
- the defined daily dose (DDD) consumption rate if possible
- extent of self-prescribing practices
- extent of availability, distribution, and consumption of unregulated, out of date or counterfeit drugs
- inappropriate use of antibiotics (AMR issues, problems of resistance)

Describe major changes in recent years, current problems/challenges and reform plans.

5.7 Rehabilitation/intermediate care
Describe the organization and provision of rehabilitation/intermediate care services, including settings, responsible organizations, nature of providers and functions. Provide information on links between rehabilitative services and health/social care services.

Rehabilitation: care that aims to cure, improve or prevent a worsening of a condition, e.g. physiotherapy after hip replacement surgery or occupational therapy to prevent carpal tunnel syndrome.

Intermediate care: short-term health and social care that aims to facilitate earlier discharge or prevent admission to hospital by providing support at a level between primary and secondary care.
Comment on the availability, accessibility, adequacy and quality of services.

Describe major changes in recent years, current problems/challenges and future reform plans if any.

5.8 Long-term care

Describe the organization and provision of long-term care services. Please consider:
- settings: public or private
- home and community
- responsible organizations, nature of providers and functions
- the extent to which health and social services are integrated and any mechanisms to coordinate services
- community-based care: services available and percentage of each client group receiving them
- residential care: percentage of each client group in institutional care and types of residential care facility provided

Comment on the accessibility, adequacy and quality of services. Also consider:
- whether there is a process for assessing eligibility and who carries it out
- whether assessment is based exclusively on a patient’s care needs or if it is also based on the availability of informal care
- national programmes to improve quality
- any data from official quality assurance reports

Describe major changes in recent years, current problems/challenges and reform plans.

Cross-reference to Chapter 6 Principal health reforms.

Long-term care (LTC) is the health care provided to patients with chronic impairments and who require assistance with activities of daily living (ADL, such as eating, washing, and dressing). It includes palliative care and health care provided in LTC institutions, and health and personal care services (for ADL) received at home.

(from the OECD iLibrary http://www.oecd-ilibrary.org/sites/health_glance-2011-en/08/08/index.html;jsessionid=as008die826bn.delta?contentType=&itemId=/content/chapter/health_glance-2011-73-en&containerItemId=/content/serial/19991312&accessItemIds=/content/book/health_glance-2011-en&mimeType=text/html)

Care for acute and chronic mental health disorders should be discussed in Section 5.11.

Cross-reference to Chapter 6 Principal health reforms.
Chapter 5: Provision of services

5.9 Services for family/informal carers

Describe the organization and provision of informal care, including settings, responsible organizations, nature of providers and functions.

Please consider:

- policies (e.g. financial entitlements, training, facilities) that recognize the value of informal care, protect informal carers and provide them with access to support services
- if available, information on estimates of the number of individuals providing informal care
- the accessibility, adequacy and quality of services and facilities
- any major changes in recent years, current problems/challenges and reform plans
- family members, community organizations

Informal care refers to the provision of (formally) unpaid caregiving activities, typically by a family member to an individual who requires help with basic activities of daily living. Examples of individuals with such needs could be people with dementia, people with physical or learning disabilities, the terminally ill and those with mental health problems.

5.10 Palliative care

Describe the organization and provision of palliative care services, including settings (public, NGO, and private), responsible organizations, nature of providers and functions. Please consider:

- the extent to which palliative care services are reliant on volunteers and what level of training/support is provided for these volunteers
- whether patients and their families are explicitly involved in determining palliative care management plans

Palliative care is the continuing active total care of patients and their families at a time when cure is no longer expected. The goal of palliative care is the highest possible quality of life for both patient and family. It may include the following services:

- specialist palliative care teams, including individuals with recognized palliative care accreditation, specialist nurses and care attendants;
- specialist palliative care units, and their location (e.g. within hospitals, hospices, day-care centres);
- palliative care offered in the home;
- bereavement support services for families.

Cross-reference to Chapter 6 Principal health reforms.
• links between specialist palliative care services and other health professionals

Comment on the accessibility, adequacy and quality of services, drugs and facilities. Include any data available (e.g. from surveys) on the quality of palliative care.

Describe major changes in recent years, current problems/challenges and reform plans.

5.11 Mental health care

Describe the organization and provision of mental health services (public, NGO, private), including settings, responsible organizations, nature of providers and functions. Please consider:
• availability of specific services to deal with special problems
• programmes (national or local) and educational initiatives to tackle the discrimination and social exclusion/stigma that those with mental health problems may suffer from
• legal obligations, if any, that families have to provide care for people with mental health problems
• community based mental health sources, including access to psychotropics at PHC level
• provision of mental health sources after emergencies or disasters

e.g. social workers, psychologists, physiotherapists, occupational therapists, complementary therapists, speech therapists, spiritual counselling

Cross-reference to Chapter 6 Principal health reforms.

e.g. opioids

Cross-reference to Section 5.9 Service for informal carers, and Table 1.4.
Comment on the accessibility, adequacy and quality of services and facilities. Please consider:

- availability of specialized mental health professionals
- the balance of psychiatric hospital beds and beds for acute, chronic and long-term care and the reliability of existing data
- indicate whether psychiatric beds are integrated into general hospitals or provided in special psychiatric hospitals

Describe major changes in recent years, current problems/challenges and reform plans.

5.12 Dental care

Describe the organization and provision of dental care, including settings, responsible organizations, nature of providers and functions. Please consider:

- any specific policy documents or national strategies on the provision of dental care
- any preventive dental care programmes or activities and their effects
- the public–private mix in financing and delivery

Comment on the accessibility, adequacy and quality of services and facilities. Please consider:

- fees, if any, for dental services, indicating whether prices are regulated and by whom
- whether the quality of dental services is monitored and by whom

Describe major changes in recent years, current problems/challenges and reform plans.

e.g. psychiatrists (distinguish child and old age psychiatrists), psychiatric nurses, psychologists, mental health social workers, neurologists, psychologists, psychiatric social workers and other specialist mental health staff.

Cross-reference to Fig. 4.1.

Cross-reference to Chapter 6 Principal health reforms.

e.g. fluoridation, school education programmes

Cross-reference to Chapter 6 Principal health reforms.
5.13 Complementary and Alternative Medicine (CAM) and Traditional Medicine

Describe the organization and provision of complementary and alternative medicine (CAM), and traditional medicine, including settings, responsible organizations, nature of providers and functions. Please consider:

- any regulations of the provision of CAM and traditional medicine
- the extent to which CAM and traditional medicine is accepted by the mainstream medical profession and provided within the mainstream health system
- the extent to which CAM and traditional medicine is reimbursable by third-party payers
- any data on the use of CAM and traditional medicine
- any licensing/certification procedures for CAM and traditional medicine practitioners
- the accessibility, adequacy and quality of services and facilities
- any major changes in recent years, current problems/challenges and reform plans
- formal training programs

CAM refers to medical practices not typically considered to be orthodox therapies. These might include acupuncture, osteopathy, herbal medicine, massage therapy, and meditation.

Complementary medicine is used in combination with mainstream techniques.

Alternative medicine is used in place of conventional medicine.

Traditional medicine is the sum total of the knowledge, skills, and practices based on the theories, beliefs, and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness.

Cross-reference to Chapter 6 Principal health reforms.

The focus of this section is the delivery of health care to specific population groups who either do not have access to the mainstream health system or have special access to other health services. These might include minority populations, indigenous groups, and social groups such as refugees, asylum seekers, irregular immigrants, internal migrants, homeless people, street children, intravenous drug users and sex workers.

Note: If these groups are treated within the main health system, they should not be discussed here.
Describe the organization and provision of these services, including settings, responsible organizations, nature of providers and functions. Please consider:

- the accessibility, adequacy and quality of services and facilities
- any major changes in recent years, current problems/challenges and reform plans
- internally displaced, vulnerable populations

5.15 Disaster Risk Management for Health (DRM-H)

Describe public health planning and operations to ensure responsiveness and resilience to natural and human-induced hazards, including emerging diseases, epidemics and pandemics. Please consider:

- cross-sectoral engagement in DRM-H and health sector representation on relevant governing bodies;
- health policies, planning, and coordination of DRM-H across preventive, preparedness, response, and recovery phases;
- risk communications as well as procedures for information and knowledge management;
- definition of health services packages for disaster response aligned with hazard and risk profiles;
- strategies for continuity of health service delivery, and implementation of safer hospitals principles;
- skills development for DRM-H at national, subnational, and local levels;
- mechanisms for meeting staffing surge requirements and ensuring risk assessment based minimum stocking for critical supplies and equipment;
- * contingency funding for disasters and dedicate budget allocation for DRM-H

Cross-reference to Chapter 6 Principal health reforms.

Cross-reference to Chapter 6 Principal health reforms.
In this chapter, individual health reforms, policies and organisational changes, some of which may have been discussed earlier, are set within the context of the overall reform programme. The chapter considers major reforms already implemented as well as those which failed or were passed but never implemented. It also provides an overview of future developments.

Chapter summary

Please provide a summary of the whole chapter (maximum 500 words).

6.1 Analysis of recent major reforms

Please provide a box (Box 6.1) listing major reforms/changes and policy initiatives that have had a substantial impact on the health system in chronological order.

This section focuses on the major reforms/changes that have taken place since the last HiT or in the last five to ten years, sets them in context and explains their impact on health and health service provision.

For more details on older reforms it may be useful to refer readers to the previous HiT profile or cross reference to chapters 1 and 2.

Please consider the distinction between rhetoric and reality. While it is useful to look at the political agenda and priorities in health policy, it is also necessary to look at what is actually implemented.

Where possible, include reports on what is taking place in terms of implementation and comment on the extent to which these reports can be considered impartial.

For each principal reform describe:

1. aims and background
2. the policy process
3. content and implementation.
In doing so, please consider:

- key issues underlying the development of each reform
- how the content of the reforms was developed
- how far objectives have been achieved
- the role of key national actors, interest groups, development partners, international agreements
- the impact of any evaluation, pilots
- any major obstacles (see the Box on the right)
- significant policy proposals and legislation from other fields that have had an impact on the health sector

Please discuss major reforms that have failed to be implemented, noting reasons why they were not implemented, independent evaluations of the reforms and prospects for future implementation.

### 6.2 Future developments

Outline any current political or policy debate around health and the health system.

Note any recently announced reforms including, where appropriate:

- current policy proposals
- ongoing public debates
- political party plans

---

Obstacles to reform can include:

- political resources (e.g. government stability, support of interest groups and/or the population)
- financial resources
- technical/managerial resources (e.g. expertise, administrative skills, information systems)
- the impact of the sociocultural context on policy-making and implementation
- the role of the media
Include potential developments outside the health system that may have an impact on health policies.
- AMR
- climate change
- trade agreements
- rapidly ageing population
- urbanization
- water and food security

List plans/expectations concerning developments in relation to:
- organizational structure or governance of the health system
- financing, including ODA, domestic, and other sources
- services and specific sectors such as mental health, long-term care, social care, palliative care
- emerging health threats
- disaster risk management
- rising rates of NCDs

Cross-reference to the relevant sections in Chapter 5.
Chapter 7: Assessment of the health system

Explanatory Note:
The approach to assessing health system performance adopted by the HiTs is based on that of WHO’s World Health Report 2000.

Assessment should critically analyze all areas of the health system (public and private), with emphasis on performance outcomes, including health services, mental health care, social care and intersectoral approaches towards improving health determinants and health. The selection of appropriate indicators should be assessed and discussed with the editor.

Where appropriate and possible:
- assess the quality of data and indicators used in the analysis;
- draw upon expert opinion and key informants/consumer views;
- use longitudinal (time series) data, since these can usefully illustrate developments in health system performance within a country;
- assess health system performance in your country in comparison with other countries, where it is methodologically sound to do so refer to published studies, include findings from reports evaluating the health system and comment on the extent to which these reports can be considered to be impartial and of a high standard; for example, are they produced by reputable organizations independent from government?

If information and evidence are not available or of questionable quality, please say so.

Chapter summary

Please provide a summary covering the whole chapter (maximum 500 words).

7.1 Stated objectives of the health system

Discuss the stated objectives of the health system and specific reform initiatives. Please consider:
- whether policies have been developed and implemented to meet these objectives
- the extent to which major strategies and laws are actually being implemented
- political commitment to intersectoral approaches and health in all policies

Where there is lack of conclusive evidence on the effects of reforms please note this.

Examples of objectives might include:
- ensuring equal access for equal need
- achieving universal health coverage
- improving population health
- strengthening primary health care
7.2 Financial protection and equity in financing

Financial protection measures the extent to which people are protected from the financial consequences of illness. The need for financial protection arises from three factors: uncertainty about the need for health care (timing and severity of ill health); the high costs of health care (both in absolute and relative terms; even low-cost health care may be expensive for poorer households); and the loss of earnings associated with ill health.

Financial protection is closely linked to health coverage and can be undermined by gaps in the breadth (universality), scope (range of benefits) and depth (user charges) of coverage.

7.2.1 Financial protection

Discuss the degree of financial protection the health system provides, by wealth quintiles or income levels. Please consider:

- evidence of high OOP household spending on health, its distribution across different wealth quintiles or incomes and its structure (e.g. which health services it is spent on)
- longitudinal data showing changes in the extent, distribution across wealth quintiles and incomes, and structure of OOP household spending on health by wealth quintiles or incomes
- survey data on the affordability of health care; evidence of catastrophic expenditures
- whether high OOP health spending by households occurs due to gaps in coverage breadth (universality), scope (range of benefits) or depth (user charges)
- the impact of reforms or initiatives to strengthen financial protection

High OOP household spending on health is often measured as OOP payments above a certain percentage of household capacity to pay (so-called catastrophic expenditure) or as the percentage of households pushed below the World Bank one-or-two dollars poverty line by OOP payments (so-called impoverishing expenditure).

e.g. surveys asking people whether they have foregone care for financial reasons
7.2.2 Equity in financing

In discussing this aspect of equity, please consider:

• whether individual sources of financing are regressive, proportional or progressive
• the progressivity of the financing system as a whole (e.g. quintile analysis)
• whether the financing system results in a redistribution of resources (from whom to whom?)
• changes in the distribution of financing
• the impact of reforms or initiatives to increase equity in financing

7.3 User experience and equity of access to health care

7.3.1 User experience

Discuss different aspects of user experience of the health system (public and private). Please consider:

• data on what happened during people’s actual contact with the health system
• public satisfaction with the health system
• efforts to ensure confidentiality of personal information
• patient involvement in treatment decisions
• waiting times
• the impact of reforms or initiatives to improve user experience

This section focuses on the distribution of the burden of financing the health system.

This section focuses on how well the health system meets people’s legitimate expectations about how they should be treated, independently of any health outcomes – a notion often referred to as “responsiveness” (World Health Report 2000).

Cross-reference to section 2.9 Patient empowerment.

This section focuses on equity in the provision and use of health care. It should indicate the extent to which there are problems or barriers in access to health care (e.g. financial, geographical, cultural, supply-related). Refer to published studies where possible.
7.3.2 Equity of access to health care

In discussing equity of access to health care, please consider:

- whether benefits are the same across the population, gender, age, education, geography, or other relevant characteristics
- the distribution of health workers and facilities across the population
- any evidence to suggest that the use of health services is related to factors other than need
- evidence of barriers to accessing health services
- the extent to which barriers to access affect some population groups more than others
- the impact of reforms or initiatives to increase equity of access to health care

7.4 Health outcomes, health service outcomes and quality of care

7.4.1 Population health

Discuss trends in population health. Please consider:

- data on morbidity and mortality
- risk factors
- obesigenic environment
- natural or human induced hazards

Suggest including a table of utilization of sources (OPD, IPD, and maternal care) by wealth quintile/income.

Make allowances for an acceptable level of inequality; e.g. highly specialized centres are likely to be concentrated in urban centres.

E.g. income level or socioeconomic status

E.g. user charges (formal or informal), insufficient services in remote areas, cultural or language issues, long waiting times

E.g. lower socioeconomic groups, ethnic minorities, older people, (undocumented) migrants, unemployed people

Cross-reference to the relevant sections in Chapter 1, including Tables 1.4, 1.6 and 1.7.

Possible data source: The Global Burden of Disease study

E.g. rates of tobacco and alcohol use, obesity
Discuss improvements in population health that may be attributed to the health system. Please consider:

- mortality amenable to medical intervention
- maternal mortality
- five-year cancer survival rates for breast, cervical and colorectal cancers
- the factors that have contributed to changes in population health
- whether these factors are related to health care/public health/health policy/lifestyle/other
- any studies showing whether health improvement occurred as a result of health policy or health care interventions

Although it is difficult to disentangle the contribution that health care makes to improving population health, it would be good to have an estimate of any improvement in health status that may be attributed to the health system (including intersectoral action and public health measures).

Amenable mortality refers to death from causes where death should not occur if people have access to timely and effective health care. It seeks to capture mortality that is (at least to some extent) within the control of the health system. Refer to Ellen Nolte and Martin McKee, “Measuring the health of nations: analysis of mortality amenable to health care” BMJ. 2003 Nov 15; 327(7424): 1129. E. Nolte and M. McKee, “Variations in Amenable Mortality—Trends in 16 High-Income Nations,” Health Policy, Volume 103, Issue 1, November 2011, Pages 47–52

Data for OECD countries are available at: http://www.oecd.org/health/hcqi, International Agency Research Center (IARC), Lyon; WHO

7.4.2 Health service outcomes and quality of care

OECD (2013) ’Health at a Glance 2013 ’OECD Indicators’ lists data against which to compare the performance of health systems across countries, including on the quality of care. While many measures of health care quality have been proposed, this OECD list restricts itself to 14 indicators found to be measurable, where data were collected, and where data were comparable across countries. Further, these are areas where intervention and implementation are effective and thus where substantial improvements can be expected. Four such indicators from the list of 14 include avoidable hospital admissions for certain conditions such as asthma, COPD and diabetes; mortality from heart attacks within 30 days of hospital admission among adults aged 45 years and over; number of maternity cases involving obstetrics trauma; percentage of children protected through childhood vaccination programs.

Discuss quality in the delivery of health services. Please consider use of the following dimensions and indicators:

- quality of preventive care: rates of (child) vaccination for measles, and diphtheria, tetanus and pertussis (DTP) and rates of influenza vaccination for older people
- quality of care for chronic conditions: avoidable hospital admission rates for asthma, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), hypertension and diabetes-related complications
- quality of care for acute exacerbations of chronic conditions: in-hospital mortality rates (deaths within 30 days of admission) for admissions following acute myocardial infarction, haemorrhagic stroke and ischemic stroke
- appropriateness of care, e.g. use of clinical protocols
- the impact of reforms and initiatives to improve quality in health service delivery

Although these are process rather than outcome indicators, they have the advantage of being readily available and may indicate areas for improvement. High admission rates for these conditions may indicate poor quality because these admissions could be prevented by timely access to primary/ambulatory care.

These are regarded as good outcome measures of acute care quality.

Comment on whether patient safety solutions to avoid medical errors/adverse incidents are being implemented in health facilities, such as the following:

- avoid look-alike, sound-alike medication names.
- implement patient identification procedures.
- improve communication during patient hand-overs.
- implement protocol on performance of correct procedure at correct body site.
- control the labelling and administration of concentrated electrolyte solutions.
- assure medication accuracy at transitions in care.
- avoid catheter and tubing mis-connections.
- ensure single use of injection devices.
- improve hand hygiene to prevent health care-associated infections.


Also see WHO Patient Safety guidelines, campaigns and checklists intended to save patient lives and reduce serious harm.
7.4.3 Equity of outcomes

Discuss how health and health service outcomes differ across different population groups. Please consider:

- economic groups (wealth quintile/income)
- geographical regions
- gender differences
- education
- ethnicity
- the impact of reforms or initiatives to address unacceptable variation in outcomes and health inequalities

7.4.4 Disaster Risk Management for Health (DRM-H)

Discuss Health Sector DRM planning and actions implemented. Please consider:

- governance, policy, planning and coordination
- information and knowledge management
- health and related services in disasters
- financial, human and physical resources allocated for DRM-H

Note: Select a range of health outcomes that include both primary care and hospital services.

The Hyogo Framework for Action (2005-2015) proposed a set of core indicators for DRM. Indicators for the Sendai Framework for Disaster Risk Reduction (2015-2030) are under negotiation, however a proposed monitoring framework across input, output and outcome indicators is available.


7.5 Health system efficiency

7.5.1 Allocative efficiency

In discussing allocative efficiency, please consider:

- correspondence between the burden of diseases and service provision

Allocative efficiency indicates the extent to which limited funds are directed towards purchasing an appropriate mix of health services.
Chapter 7: Assessment of the health system

• mechanisms for setting priorities and the use of evidence about effectiveness and cost–effectiveness
• the use and quality of risk-adjusted resource allocation formulas
• trends in the balance of allocation between different sectors
• influence of ODA and mechanisms of Aid Effectiveness

7.5.2 Technical efficiency

Discuss the efficiency with which the health system’s outputs are produced, commenting on whether they cost more than they should or could. Suitable indicators might include the following, but please consider any other indicators of wasteful use of resources in the system:

• hospital care: trends in average length of inpatient stay, day case surgery rates, preoperative bed days, variation in surgical thresholds, variation in emergency admissions, variation in outpatient appointments
• pharmaceutical care: impact of policies to increase take-up of generic pharmaceutical products, low-cost statin prescribing
• human resources: the impact of policies to change the skill mix, staff turnover, sickness absence rates, agency costs, specialist productivity,
• adherence to cost-effectiveness guidelines

Technical efficiency indicates the extent to which a health system is securing the minimum levels of inputs for a given output (or the maximum level of output in relation to its given inputs].

Note that these data do not necessarily indicate the efficiency of the sector concerned, but they may highlight priorities for reform.

Cross-reference to Fig. 4.2 and other parts of the HiT report where relevant.

Note: Consider use of a Pabon Lasso figure, reference Myanmar HiT Figure 7.5.3.
Chapter 7: Assessment of the health system

7.6 Transparency and accountability

Discuss how transparent the health system is. Please consider:

- health policy development and implementation
- public participation
- patient empowerment
- the extent of how people are aware of the health benefits to which they are entitled
- the extent to which government statistics are in the public domain, including health budget disbursements
- public reporting of hospital performance measures
- issues around procurement, false claims, leakage, wastage, financing mechanisms
- the impact of reforms and initiatives to enhance transparency

Possible data source: Transparency International data

Cross reference to Section 2.9.

e.g. the existence of informal payments and tax/contribution evasion

Discuss how accountable the health system is. Please consider:

- how priorities are set for improving health system actions and standards
- how health system performance is monitored
- approaches to ensuring accountability in the health system, their effectiveness and the extent to which they are aligned with the country’s broader governance structures
- how the health system creates capacity for performance monitoring and strengthening accountability
- the impact of reforms and initiatives to increase accountability
- conflict of interest and industry interference

e.g. lines of accountability of providers to their funders and the public (including patients)
Chapter 8: Conclusions

This chapter should strive to develop a narrative framework that avoids repetition of previous chapters.

The aim of this chapter is to:
- identify five key findings
- highlight the lessons learned from health system changes
- summarize remaining challenges
- identify future prospects.

It should be prepared in collaboration with the editor, once the other sections have been completed.
Chapter 9: Appendices

9.1 References

Include key references to relevant academic publications which were used as sources of information within the HiT.

9.2 Further reading

This can be provided after the References section, suggesting any other useful material that is not actually cited in the text of the profile.

9.3 Useful web sites

Provide a list of the most important web sites that were referred to in the HiT, or would provide further information for readers.

9.4 HiT methodology and production process

A standard text describing the HiT process

9.5 About the authors

Each HiT author should provide a short (2–3 sentences) biography.

Bibliographical references should be presented in the Harvard (also known as author-date) system. See the Section Bibliographical references on p. 2.

Please cite the complete organization name, and the website.

Text will be supplied by APO.