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Health Systems and Health Reform in Europe

The organisation of health care differs widely across Europe. Access to services, financing schemes, incentives for better care, and administrative efficiency are challenges that are being dealt with in a variety of ways. Are insurance-based systems the best solution for balancing resources and services or are national health funds preferable? Does the introduction of competition fulfil high hopes for better service at lower costs? What are the relative advantages and drawbacks of central and local management of health care?

Melanie Lisac, Kerstin Blum and Sophia Schlette*

Changing Long-established Structures for More Competition and Stronger Coordination – Health Care Reform in Germany in the New Millennium

In June 2008, the German health insurance system celebrated its 125th anniversary. The oldest mandatory national social insurance scheme in Europe dates back to 1883, when it was introduced by the parliament under Bismarck. With its underlying principles of solidarity and universal access to care, free at the point of use, the Bismarckian system has served as a role model for many European and non-European countries.[1]

However, today Germany is facing the same fundamental challenges as other European nations: for the health sector this means that health expenditures are rising and that health care is suffering from efficiency and quality problems. At the root of it are fragmented financing and obsolete delivery structures that threaten the (financial) sustainability of the system in the medium to long term.

Health reforms since the year 2000[2] are tackling these problems in an effort to render Germany's health system more efficient while adhering to the founding principles of solidarity and equal access.

Following a short overview of the status quo of the German health care system, in this paper we will discuss certain aspects[3] of these reforms – namely measures to promote competition and coordination in health care – and their impact. In the final section we will sum up some general trends that can be identified in Germany's health system reforms of the last eight years and explore in how far developments in Germany are of interest to other European countries.

The German Health Care System – a Snapshot

Germany has a two-tiered health insurance system: statutory health insurance (SHI) covering almost 90% of the total population, and full-coverage private health insurance (PHI) covering the remaining 10%. Since April 2007, all German citizens have been obliged to take out health insurance, either public or private.

Statutory health insurance is based on the pay-as-you-go principle. Contributions are income-related, ranging from 11.5 to 16.5% of gross income, and are equally shared among employers and employees. SHI is compulsory for those earning less than €4,012.50 a month (in 2008), for pensioners, students, the unemployed and disabled individuals. Non-income earning

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[1] For more information on the historical development of the German health care system cf. R. Busse, A. Riesberg: Health Care Systems in Transition: Germany, Copenhagen 2004, WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies.

[2] Health Care Reform Act 2000, Statutory Health Insurance Modernisation Act 2004 (SHI-MA) and the Statutory Health Insurance Competition Strengthening Act 2007 (SHI-CSA).

[3] All of the mentioned reforms have been very comprehensive, introducing changes to many parts of the system. A full description is therefore not possible here. For a more detailed account see eg. M. Lisac: Health care reform in Germany: Not the big bang, in: Health Policy Monitor, November 2006 (http://www.hpm.org/survey/de/b8/2) or R. Busse, A. Riesberg, op. cit.

family members (spouses and children up to the age of 25) are co-insured free of charge. Individuals with an income above the threshold or the self-employed can voluntarily remain in the social system or opt out and purchase risk-rated private health insurance.[4] In this paper we will focus on reforms in the SHI system because it covers the majority of the population.

Statutory health insurance is provided by 212 not-for-profit sickness funds regulated by public law. The sickness funds – the payers – contract with both public and private health care providers. In the decentralised German system where the government only sets the legislative framework, sickness funds and providers are the main actors. Their regional associations constitute the so-called self-governance bodies, responsible for price negotiations and policy implementation at the regional level. At the national level, the Federal Joint Committee – itself one of the products of the 2004 structural reform[5] with even representation from payers and providers and also patient associations – determines which services are included in the SHI benefit basket. The SHI benefit basket is rather comprehensive, embracing preventive, ambulatory and hospital care and rehabilitative services, and is unitary for all sickness funds.

In its decisions the Federal Joint Committee is supported by the Institute for Quality and Efficiency in Health Care (IQWiG), an independent institute responsible for the scientific evaluation of the effects, quality and efficiency of health care services. The establishment of IQWiG in 2004 constitutes a first step towards more evidence-based decision-making in Germany.

For the provision of services included in the SHI benefit basket, providers get directly reimbursed by the sickness funds. Patients can freely choose a health care provider. Care is free at the point of service. However, to reduce moral hazard, co-payments for visits to outpatient care providers have been introduced in 2004: €10 per calendar quarter are payable to the physician visited first in that quarter and to any other physician visited without referral. For hospital care, patients pay €10 per day (maximally €280 per year), for drugs at least €5 and maximally €10 per prescription; for medical devices, rehabilitation, and home care co-payments must not exceed 10% of costs. Children up to the age of 18 are exempt from co-payments and co-payments may not exceed 2% of the annual gross household income (1% for individuals with chronic conditions).

Health Care Reforms since 2000 – Objectives and Results

With structural unemployment and an aging population, both lowering sickness funds' revenues, the German health care system has come under financial strain. While revenues are decreasing, health care expenditures have been rising from 9.6% of GDP in 1992 to 10.6% of GDP in 2006[6] due to medical advancements, growing demand, and an increasing number of patients with higher needs and are now the second highest in the EU after France.

Next to the resource challenge, one of the most pressing problems in the German health care system is due to the fragmentation on the delivery side: a strong ambulatory care sector, including office-based general practitioners and specialists, competes with and exists next to a hospital sector providing inpatient care[7] and still separate institutions that provide rehabilitative care and long-term care. Capacity planning is in the hands of different actors and all sectors are financed by different budgets and partly also by different insurance regimes.[8] This fragmentation and subsequent coordination deficit leads to quality problems and low efficiency.

Reforms prior to 2004 mainly aimed at keeping health expenditure growth at bay through sectoral budget caps and increased cost-sharing by patients. More recently policymakers are focusing their attention on quality issues and on tapping upon efficiency reserves in the system in order to get better value for money spent on health care. More competition among sickness funds and among providers, and better coordination between providers and between the different care sectors are expected to improve quality and efficiency and thus to render the health system more sustainable.

Promoting Competition for better Quality and Efficiency

The SHI Competition Strengthening Act 2007 promotes competition between payers by allowing, and in

[4] Traditionally civil servants are all insured via private health insurance without an option of choosing SHI coverage/staying in the SHI system.

[5] Before 2004, various joint committees for the ambulatory sector, the hospital sector and the coordination committee existed. These were unified into one common committee, the Federal Joint Committee.

[6] OECD: Statistics and Indicators for Thirty Countries, OECD Health Data (CD-ROM), Paris 2008, OECD.

[7] Hospitals still focus on the provision of inpatient care services. However, the 2007 health reform has increased the opportunity for hospitals to provide highly specialised outpatient care services, e.g. for cancer patients.

[8] For example, rehabilitation is partly financed through the pension insurance scheme, long-term care is financed through the long-term care insurance scheme.

some cases even mandating, sickness funds to offer different insurance plans and tariffs. For example, today all sickness funds are required to offer gatekeeping and disease management programmes (DMPs) to their members. Compared to traditional care, these new forms of care are expected to optimise service provision and lead to improved quality and higher efficiency (see below).

Also, funds are free to develop for example deductible health plans where the insured – in return for contribution refunds – pay a certain amount of health care costs out of their own pockets before insurance coverage kicks in. These types of tariffs are supposed to reduce the consumption of inappropriate care, eg. visits to doctors for petty diseases.

The development of new tariffs is attractive for sickness funds, because the SHI-CSA 2007 foresees changes in funding and pooling of health insurance contributions from 2009 on. So far, sickness funds have competed mainly via contribution rates (that is prices to their members), which they have been free to determine. From 2009 on, there will be a unitary contribution rate set by the Government, so price competition will be largely eliminated. The contributions will no longer go to individual sickness funds but will flow into a central pool, the so-called health fund. From this central pool, sickness funds will receive a per capita amount for each insured person as well as additional risk- and age-adjusted payments for old and sick individuals. Sickness funds that do not get along with the money they receive out of the health fund can charge an extra premium from their insured (up to 1% of gross income). Funds that operate efficiently may instead refund part of the contributions to their members.

With price competition limited to the extra premium or the refund, sickness funds now have to compete through the development of new tariffs. It is too early to tell if these new tariffs lead to more efficiency and better quality. However, they can be seen as a first step in the right direction, because payers are now required to develop insurance tariffs that better meet the needs of their members.

Connected to the development of new insurance plans such as DMPs, "selective contracting" between physicians and sickness funds was also introduced. Prior to 2000, self-employed physicians could not directly enter into a contract with a sickness fund. Contracting was and still is to a large degree in the hands of regional physicians' associations that negotiate with the sickness fund in the respective region. The negotiated contract is binding for all members of the physicians' association ("collective contracting"). The 2000 reform changed this process: in theory, single physicians are no longer bound by collective contracts. Instead they can now also selectively sign contracts with insurance funds for DMPs and other new forms of care.

For providers to get a DMP contract (described in more detail below), they must fulfill requirements such as adhering to evidence-based treatment guidelines, quality standards, participation in training programmes, etc. The incentives for providers to join these programmes are extra payments on top of the money they receive through the collective contracts. With these incentives, the quality and effectiveness of care are expected to improve, which in turn will generate greater value for money in the system.[9]

Coordination for Better Care

As mentioned above, health care reform in Germany has increasingly focused on optimising health care delivery. Lack of coordination between health care sectors and providers had been repeatedly identified to be at the root of substantial inefficiencies in the system.[10] The German government has therefore introduced forms of managed care through the Health Care Reform Act 2000 and the Statutory Health Insurance Modernisation Act 2004. These reforms were the major and most impacting structural reforms ever taken since the beginnings of the SHI system in the late 19th century.

Integrated care contracts, gatekeeping arrangements, medical care centres, and disease management programmes (DMPs) are expected to improve both care coordination and quality of care and to control costs by increasing coordination and the efficient use of health care resources. Most recently, the Statutory Health Insurance Competition Strengthening Act 2007 has broadened the possibilities of coordinating care between providers and across sectors.

Integrated Care Contracts

The Health Care Reform Act of 2000 already gave sickness funds and providers the right to enter into integrated care contracts. Under these contracts, care is provided in provider networks that can be managed by independent management organisations. While the uptake of integrated care contracts in 2000 was rather slow (there were just over 600 contracts in early

[9] Note that non-financial incentives play no role in the entire debate in Germany.

[10] Advisory Council on the Assessment of Developments in the German Health care System 2005.

2005)[11] by April 2008 their number had risen to more than 5,000 with about 4 million patients being treated under these contractual arrangements.

Financial incentives for providers played an important part in this development. Since 2004, one percent of the total budget available for ambulatory care and one percent of the hospital budget are redirected to integrated care contracts. In total, start-up financing, scheduled until the end of 2008, today amounts to approximately €800 million.

The SHI Competition Strengthening Act 2007 included some changes regarding integrated care contracts. Providers of long-term care (which is financed not through health insurance but through compulsory long-term care insurance) can now be included in contracts. Non-medical professions (e.g. occupational and physical therapists) can become the main contractual partner of sickness funds, a position that was formerly restricted to physicians. Since 2007, new integrated care contracts are to focus on population-oriented integrated care, although disease- or procedure-oriented contracts continue to constitute most of the contracts signed so far. However, a few projects are developing ambitious models of population-oriented integrated care in Germany on the basis of integrated care contracts[12].

Gatekeeping Models

A second form of care coordination introduced in 2000 is the family physician centred model of primary care, which is also being applied in other countries like France or the Netherlands. In the gatekeeping model, family physicians, that German patients are free to choose, serve as gatekeepers and "navigators" through the health care system. Specialists can only be seen upon referral, although exceptions exist for gynecologists, pediatricians and ophthalmologists. Sickness funds, which since 2007 have been obliged to offer gatekeeper contracts, may offer their insured a financial incentive to join. For patients, participation is voluntary; currently about 5.8 million patients have signed up for the GP model.[13] Family physicians wishing to enter into a gatekeeper contract with a health insurance fund must meet certain criteria: they must participate in quality circles, follow evidence-based treatment guidelines, run a quality management programme in their practice, and participate in training courses in relevant areas like patient-oriented communication, basic treatment and diagnostics of mental disorders, palliative or geriatric care.[14]

Evaluation of the outcomes of gatekeeper contracts has not been mandatory. A patient survey conducted by the Bertelsmann Stiftung between 2004 and 2007 concluded that in their current set-up, German gatekeeping programmes do not achieve their aims of regulating the number of (specialist) interventions and improving health outcomes. Patients enrolled in gatekeeper contracts do not report better health outcomes than patients who are not enrolled, and the number of specialist visits does not seem to be reduced.[15] In future contracts, more incentives for physicians to improve the quality of care seem to be necessary if gatekeeping models are to actually reach their goal of improving quality and efficiency of care.

Medical Care Centres

Medical care centres are another innovation. These centres offer an outpatient care delivery system that brings together general practitioners and specialists under one roof. Larger medical care centres being rare, the average centre employs no more than four physicians – just about the size of a small group practice in other countries. In their organisational form medical care centres resemble the "polyclinics" in the German Democratic Republic, mostly dismantled with reunification. The 2004 reform allowed for the establishment of new medical care centres. These can be part of, or run by, hospitals; legislation also permits the integration of pharmacies and paramedical services (e.g. physiotherapy, ergotherapy).

Since 2004, more than 1,000 medical care centres have been established, with the still tiny number of 4,500 staff physicians (out of 130,000 doctors in outpatient care) working in this type of health care delivery system. Medical care centres offer physicians the possibility to work as salaried employees, an option which did not exist before in the ambulatory sector and is particularly attractive to the rising number of female physicians who look for a new work-life balance. For patients, medical care centres can improve the quality of care using electronic medical records, standardised

[11] For more information see Kerstin Blum: Care coordination gaining momentum in Germany, in: Health Policy Monitor, July 2007. Available at www.hpm.org/survey/de/b9/1.

[12] For examples see, John Weatherly et al.: Leuchtturmprojekte integrierter Versorgung und medizinischer Versorgungszentren. Innovative Modelle der Praxis, Berlin 2007, pp. 129-223.

[13] Federal Ministry of Health 2007.

[14] These criteria were made obligatory in 2007, but had already been applied in some of the earlier gatekeeper contracts. National Association of Statutory Health Insurance Physicians, www.kbv.de.

[15] Jan Böcken et al.: Unterschiede in der Inanspruchnahme von Fachärzten in der hausärztlichen und in der hausarztzentrierten Versorgung. Eine Analyse auf der Grundlage ausgewählter Fragen des Gesundheitsmonitors, to be published in: Das Gesundheitswesen, autumn 2008.

processes, coordinated care according to treatment guidelines, and better access to specialists. Customer orientation is also more pronounced. Better reachability, extended opening hours and speedy diagnosis going hand in hand with reduced anxiety and prompt treatment uptake – these are all polyclinic "one-stop-shop" advantages much appreciated by patients.

Disease Management Programmes – a German Success Story

Disease management programmes were introduced in Germany in 2002. They were a response to the diagnosis of a report made public by the Advisory Council to the Ministry of Health in 2001 on over-, under-, and misuse of the German health care system. DMPs in Germany were also an amendment of an earlier reform: in 1996, free choice of statutory sickness funds in Germany was introduced, accompanied by a risk structure adjustment mechanism (RSA) based on average spending by age and sex. But since the costs of providing care for chronically ill patients had not adequately been taken into account, "cream-skimming" became a growing problem: sickness funds competing for new insurees would run after the healthy. Since 2004, though, patients enrolled in disease management programmes have been treated within a separate risk structure compensation scheme, making them an evenly attractive group to sickness funds: with extra funding, DMP participants no longer generate a deficit.

Sickness funds are responsible for developing and implementing DMPs. They receive an additional lump sum from the risk equalisation scheme for each person enrolled. In 2004, the Statutory Health Insurance Modernisation Act made it compulsory for all sickness funds to offer DMPs. There are six requirements for accreditation by the German Federal Insurance Authority (BVA):

- treatment according to evidence-based guidelines with respect to the relevant sectors of care
- quality assurance measures
- required procedure for enrolment of insured, including duration of participation
- training and information for care providers and patients
- documentation of diagnostic findings, applied therapies and outcomes
- evaluation of clinical outcomes and costs.

DMPs currently exist for six major chronic conditions: diabetes type 1, diabetes type 2, coronary heart disease, breast cancer, asthma, and chronic obstructive pulmonary disease. In June 2007, 14,000 programmes were being offered by funds across Germany; in June 2008 more than 4.7 million patients were enrolled,[16] the largest share (about 23%) for diabetes type 2.

What is interesting and underlines the non-state imposed character of the German health care system is that DMP participation is voluntary for physicians and patients. Incentives exist for both: physicians receive a lump sum payment for their coordination and documentation activities, while patients are exempted from co-payments and out-patient fees.

A growing number of DMP evaluations show them as successful and meeting expectations.[17] All studies indicate a better care process as well as improved clinical outcomes. Participants experience less complications and emergency hospital admissions; instead the number of cases of early-stage hospitalisation is higher. Compared to non-enrolled control group patients, those patients enrolled in DMPs report a higher quality of life and a better physical and mental health status; their abilities for self-management of their condition are strengthened. A study published in mid-2008 with patients participating in a DMP for coronary heart disease has just reported less relapses, less pain, better results for blood pressure and cholesterol.[18] Among physicians, acceptance is also rising, although initially documentation requirements were perceived as an extra burden.

When developing the framework for disease management programmes, Germany had looked at managed care models in the USA. Since then, with their clearly defined requirements for documentation, evaluation and treatment guidelines, German DMPs have themselves become a model for other countries. One of the next challenges to be solved is how to adapt

[16] German Federal Insurance Authority data of 2007, AOK newsletter prodialog 06/08.

[17] Cf. Joachim Szecsenyi: ELSID, Evaluation of large scale implementation of disease management programs for patients with type 2 diabetes, Heidelberg 2007; T. Elkeles, S. Heinze, R. Eifel: Healthcare by a DMP for Diabetes mellitus Type – Results of a survey of partcipating insurance costumers of a HI company in Germany, in: Journal of Public Health, Vol. 15, No. 6, 2007; T. Elkeles, W. Kirschner, C. Graf, P. Kellermann-Mühlhoff: Versorgungsunterschiede zwischen DMP und Nicht-DMP aus Sicht der Versicherten. Ergebnisse einer vergleichenden Versichertenbefragung von Typ 2-Diabetikern der BARMER, in: Gesundheits- und Sozialpolitik, No. 1, 2008, pp. 10-18; C. Graf, Walter Ullrich, Ursula Marschall: Nutzenbewertung der DMP Diabetes mellitus -- Neue Erkenntnisse aus dem Vergleich von DMP-Teilnehmern und Nichtteilnehmern anhand von GKV-Routinedaten und einer Patientenbefragung, in: Gesundheits- und Sozialpolitik, Vol. 62, No. 1, 2008, pp. 19-30.

[18] AOK Curaplan Koronare Herzkrankheiten der AOK Westfalen-Lippe. Interim report 2/2004–1/2006, July 1, 2008.

DMPs to multimorbidity: most chronically ill patients suffer from several concurrent chronic conditions[19] – a fact not yet taken into account appropriately in disease management. Currently, the German Association of Family Physicians is working on a DMP for patients suffering from multiple chronic illnesses.

Changing Structures to Pave the Way for a Learning System

In its 125 years of existence, the German health insurance system proved to be extremely robust. It "survived" two world wars and a major political transformation process when the German wall fell in 1989. However, robustness came at a price: in its rigid self-governmental structure, providers and payers were powerful and for a long time able to obstruct changes on the organisational and delivery side necessary to keep the system sustainable.

Reforms since 2000 have implemented a number of major changes that are to streamline decision-making, to make the system more evidence-based overall and to limit the autonomy of the self-governing bodies of payers and providers. The amalgamation of the various joint committees into the Federal Joint Committee, and requiring it to consider the advice of an independent scientific institute (IQWIG) are examples of this trend. Moreover, the promotion of competition through selective contracting reduces the influence of physicians' associations and allows high performing and efficient providers to generate extra money next to the payments they receive out of the collective contracting system. Selective contracting also facilitated experimentation with new and better coordinated forms of care such as DMPs.

[19] Cf. Results of the DETECT study group, Technical University of Dresden.

At a time when European countries face similar challenges, a look into other nations' experiences can be valuable. Tools for international knowledge exchange[20] enable us to identify and learn from parallel developments. For example, the Netherlands and the UK are also experimenting with more competition in the health care system (see also the articles on the Netherlands and the UK in this issue). And we believe that in the area of care coordination, the German reform experience could be valuable for the further development of reforms in other European (and non-European) countries.

Recognising the common challenges and the benefits of mutual learning, the European Commission recommended in 2004 to extend the Open Method of Coordination (OMC) to the area of health care. Among the priority areas identified by the Member States are the need to guarantee safe and high-quality care and a more rational use of resources.[21]

Improved care coordination has been identified as one policy strategy that can help both to improve health status and to reduce expenditure growth.

International knowledge exchange – as practised by the European Commission or independent sources like the HealthPolicyMonitor – can support and inform policymakers and other key actors in Germany and elsewhere in their efforts to keep health care systems financially sustainable while providing and ensuring high quality care.

[20] An example is the HealthPolicyMonitor of the Bertelsmann Stiftung (www.hpm.org), a free internet database providing expert reports on health policy developments in 20 industrialised countries since 2002.

[21] European Commission: Joint report on social protection and social inclusion 2007, March 2007.

Hans Maarse* and Yvette Bartholomée**

Course and Impact of Market Reform in Dutch Health Care Uncertain

Presently, Dutch health care holds a remarkable position in Western Europe because of its extensive market reform. The introduction of a new health insurance scheme in 2006, which also drew the attention of US observers,[1] has been its most conspicuous element so far. However, the ongoing reform encompasses many other structural changes including a revision of the legal framework for planning, contracting, price-

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[1] G. Naik: In Holland, Some See Model for U.S. Health-Care System, in: Wall Street Journal, 6 September, 2006, p. A1.

setting and supervision. The main objectives of the reform are to make health care more cost-efficient, innovative and client-oriented. The mantra of the reform is *regulated competition*: competition is regulated to preserve the accessibility, financial affordability and quality of care. These are termed the "public constraints" to competition.[2]

This article gives a brief overview of the current reform. We start with a short discussion of the health insurance reform and its immediate impact on the insurance market. The rest of the article discusses a few other important elements of the reform, whereby we restrict our analysis to hospital care. The implementation of the new health insurance scheme in 2006 was just the first major step in the market reform that is planned as a multi-year process. Various *market-making* decisions are scheduled for the period until 2012. The government has chosen a staging strategy for the market reforms, not only to learn from experience and avoid unforeseen disruptions in health care, but also because of the need for political compromises between differing conceptions on how to restructure health care. The consequences of such a strategy are that the further course of the market reform and its impact are still uncertain and contingent on future decisions and changing political conditions.

Competition in Health Insurance

The new health insurance legislation integrates the former statutory sickness fund scheme that covered about 63% of the population and private health insurance covering the remaining 37% into a single mandatory scheme. Legislation obliges all residents to purchase a basic health plan, but leaves them free to choose their insurer and type of plan. To encourage competition, all residents are permitted to switch to another insurer by the end of each year. Insurers, which may operate for-profit, are expected to compete on premium rates, type of health plan (e.g. a plan with a deductible, a preferred provider network or specific service level agreements). By means of a sophisticated risk equalisation scheme the government intends to safeguard a common level playing field for competition and avoid preferred risk selection. Some parameters in this scheme even make it attractive to develop health plans geared to the needs of specific categories of people with chronic illnesses (e.g. diabetes and COPD).

Legislation contains various regulations to guarantee the social character of the new scheme that, formally speaking, is a private arrangement.[3] To guarantee access to health care and preserve risk solidarity in financing, insurers must accept each applicant and are not permitted to vary their premium rates according to age, sex or pre-existing medical disorders. Another "public constraint" concerns the standard package of health services established by the government. The latter constraint plus the obligation to purchase a basic health plan sets limits to consumer choice in health insurance.[4] To preserve income solidarity the government pays persons on low income an income-adjusted cash benefit to make the purchase of a health plan financially affordable for them.

The new health insurance legislation only regulates the basic health plan. It does not contain regulations on complementary health plans. Consumers are free to take out a complementary plan for health services not covered by their basic plan (e.g. dental care for adults and physiotherapy). Health insurers are free to develop complementary plans and set restrictions to access.

Health insurance reform had a significant impact upon consumer mobility. In 2006 about 18% of the insured switched to another insurer. Most did so to benefit from a lower premium rate. In 2007 consumer mobility dropped to 4.4% and in 2008 even to 3.5%. These figures suggest the high switching rate in 2006 was a once-only effect of the reform.

The reform boosted a notable growth of group plans which previously only existed in private insurance. In 2008, almost 60% of the population was enrolled in a group plan. Health insurance legislation restricts the maximum premium discount for group plans to 10%. Two-thirds of all group contracts are employer-based, but other groups including patient organisations may also contract on a health plan with insurers. So far, the market share of these patient group related plans has remained marginal (less than 1%).

Another effect concerns the uninsured and defaulters. Residents who do not purchase a health plan are no longer insured. The Central Statistics Office recently estimated the number of uninsured residents by the end of 2007 at 1.4% of the population and the

[2] Y. Bartholomée, J. Maarse: Health Insurance Reform in the Netherlands, in: Eurohealth, Vol. 12, No. 2, 2005, pp. 7-9.

[3] J. Maarse, Y. Bartholomée: A public-private analysis of the new Dutch health insurance system, in: The European Journal of Health Economics, Vol. 8, No. 1, 2007, pp. 77 -82.

[4] J. Maarse, R. Ter Meulen: Consumer Choice in Dutch health Insurance After Reform, in: Health Care Analysis, Vol. 14, No. 1, 2006, pp. 37-49.

number of defaulters, defined as subscribers who did not pay their premium over six months or longer, at 1.9%. These figures, though relatively small, are a source of concern.

The new health insurance legislation had marked consequences for health insurers. Many of them reported a deficit in 2006. De Nederlandse Bank estimated the total deficit on basic health plans at €563 million in 2006 and €507 million in 2007. These results indicate that insurers sought to defend and buy market share by loss-making premiums. Premiums are likely to increase in future to offset the deficit.

Health insurance reform was followed by further consolidations in the health insurance market. Consolidations are not new: the number of sickness funds dropped from 48 in 1986 to 22 in 2005 and the number of private insurers from 75 to 35. Due to new consolidations the market share of the five "bigs" climbed to 83 per cent in 2007! Consolidations are motivated by the need for further risk pooling and greater efficiency as well as the notion of building up a strong position in negotiating with providers on the volume, prices and quality of health care. Although the Dutch Health Care Authority recently stated that there were no signs of insurers abusing market power, there is some concern that consolidations will distort competition.

In complementary health insurance insurers voluntarily followed an open enrolment strategy in 2006 and 2007 to increase market share. There are indications, however, that insurers are now becoming more restrictive in accepting new clients, in particular as regards their plans with the broadest coverage. Complementary plans may evolve as a vehicle for risk selection in future, because it will be quite unattractive for subscribers to switch if they are not accepted for complementary health insurance. Note that presently about 92 of the population is enrolled in a complementary plan.

New Provider Entrants

Since 2000, there has been a rapid increase in a new type of provider organisations which, unlike general hospitals, concentrate upon a limited range of medical services such as orthopaedic surgery, cataract surgery, diagnostic services or maternity care. Whereas the number of general hospitals declined from 172 in 1981 to 90 in 2006, the number of specialised centres or "independent treatment centres" (ITCs) rose spectacularly from 31 in 2001 to approximately 160 by the end of 2006. The new entrants often present themselves as a "focused factory" delivering routine elective (non-acute) care and claim significantly higher levels of efficiency. In the 1990s the government did not consider them to be necessary because "there was plenty of capacity". General hospitals accused ITCs of cherry-picking. The "waiting list crisis" at the end of the 1990s and the competition vogue in the 2000s created a more favourable environment for ITCs and led to new regulatory arrangements that now give them a fully fledged position in health care delivery.

The rise of the number of ITCs is somewhat misleading, because in 2006 ITCs took less than 1% of total expenditures for hospital care. The picture varies with the type of medical specialty (e.g. relatively high for dermatology, cosmetic surgery and ophthalmology and very low for ENT, radiodiagnostic services and orthopaedic surgery). Yet, their impact should not be underestimated. General hospitals tend to perceive ITCs as a threat of competition which encourages them to redesign health care delivery to remain competitive. The real impact of ITCs on hospital care may even be more in their influence on the performance (e.g. productivity and quality of care) of general hospitals than in the market share they gain.

For-profit Hospital Care

For-profit medicine has always been a delicate topic in Dutch health care. Health care legislation traditionally contained a formal ban on for-profit hospitals. However, the previous government announced that it would lift the ban as part of its market reform, but not earlier than 2012. An important reason for this cautious strategy was that it did not consider the new hospital payment system by means of case-based payments (see below) to be stable enough to permit for-profit hospital medicine at short notice.

The new government that took office in 2007 has come up with a revised market-making proposal. For-profit hospital care will be permitted by 2010 in order to make it easier for hospitals to attract capital resources for investments. However, there will be restrictions to the extent hospitals can pay their shareholders a return on investment. The basic principle is that profits must be reinvested in hospital care. Furthermore, it is forbidden for the financial reserves of hospitals, particularly in real estate, that were built up in the past in a "protected financial environment" of full cost reimbursement, to leak away to the commercial sector after hospitals have gone for-profit. The new government conceptualises hospitals as a "social enterprise" that differ in various respects from

pure business organisations. Profit maximisation is not considered to be an appropriate goal of hospital medicine and profits made in hospital care should be retained in principle for hospital care.

Policy-making on for-profit hospital care nicely illustrates that the eventual shape of the reform and its impact upon hospital care are contingent upon political conditions. The social enterprise concept obviously limits the scope of for-profit hospital care.

Purchasing

The cornerstone of the market reform is that competition in health insurance encourages insurers to negotiate favourable contracts with health care providers. Purchasing must put an end to the tradition of collective bargaining on hospital tariffs and is expected to generate competition among hospitals because they are (largely) dependent on contracts with insurers.

There are indications that purchasing is only gradually developing. Some insurers negotiated service level agreements on the maximum waiting period for elective care. Contracts may require providers to have a quality accreditation. Yet, it is fair to say that effective purchasing is still in an embryonic phase and that bilateral negotiations between insurers and hospitals have mainly concentrated on prices and much less on the quality of care. The scope for price competition has remained quite limited so far (see below). Insurers have only limited experience with purchasing and often miss critical information on the quality and costs of medical services. Hospitals, too, must learn the new rules of the game. In order to reinforce the negotiating power of insurers, the legal obligation to contract with each hospital has been lifted. However, the impact of this measure should not be overstated. Selective contracting hardly exists yet because of feelings of strong mutual dependencies between insurers and hospitals. Furthermore, insurers fear negative consumer response to selective contracting and preferred provider networks (which require patients to co-pay for health services delivered by other than preferred providers). The presence of a single dominant provider in many regions may also weaken their market power. Given these and other obstacles, it is no surprise that effective purchasing – the most critical part of the market reform – has hardly materialised yet.

How purchasing will further evolve is still uncertain. One scenario is that insurers and providers are still at the beginning of their learning curve. An alternative and more conservative scenario is that the existing market for hospital care proves to be more resistant to change than assumed, so that it may take many years before the market reform will bring about business-like changes in hospital-insurer relationships.

Price Competition

Competition requires the abolition of the system of fixed hospital budgets which was introduced as an instrument for cost control.[5] The system underwent many revisions since its inception in 1982, but these revisions never established a clear and unambiguous link between hospital funding and performance. In order to introduce pay for performance, a system of casemix-based payments, based upon Diagnosis Treatment Combinations (DTCs), was developed. DTCs are to some extent comparable to Diagnosis Related Groups (DRGs) but, unlike DRGs, they cover both inpatient and outpatient hospital care. Presently, there are about 30,000 DTCs.

From 2005 onwards, 1246 DTCs that can be grouped in 24 categories including, among others, cataracts, inguinal hernia, total hip and knee replacement and diabetes care, have been open to price competition. In 2006, they represented about 7.3% of total hospital revenues. The fraction of revenues for which price competition exists in total hospital revenues varies not only by type of hospital (high for some general hospitals but low for academic centres), but also by medical specialty (e.g. high for orthopaedics and ophthalmology and low for ENT and neurology). For the remaining 92.7% of hospital production, DTCs were only used as an administrative tool to calculate a hospital budget. The tariffs of these DTCs are centrally regulated by the Dutch Health care Authority.

A recent study of this agency reported that the real prices of DTCs for which price competition exists decreased by 2.7% over the period 2005-2007. Insurers with a large market share in a region managed to negotiate lower prices than insurers with only a small market share. The prices of ITCs are on average 19.7% less than the average prices charged by general hospitals and academic centres. Nevertheless, there are many unanswered questions. For instance, are lower prices a temporary or lasting effect of competition? Another question is to what extent lower prices for specific medical procedures will be offset by higher prices of other procedures or other forms of cost-shifting.

[5] J. Maarse: Fixed budgets in the inpatient sector: the case of the Netherlands, in: F. Schwartz, H. Glennester, R. Saltman (eds.): Fixing health budgets: experience from Europe and North America, Chichester/New York 1995, John Wiley & Sons, pp. 75-92.

The scope of price competition has been extended to 20% of hospital revenues in 2008 and will be further extended to 34% in 2009. Yet, the latter percentage is still significantly less than the 70% the government had in mind at the introduction of price competition. The main reason for this incremental implementation strategy is that there are still many unresolved flaws in the system of casemix-based payments. Because it is considered to be too complicated, there is a strongly felt need for simplification. Instructions to classify patients are ambiguous and may elicit gaming of the system causing higher costs.

The ultimate scope of price competition in hospital care is still a topic of debate. The government considers price competition to be inappropriate for certain parts of hospital care including emergency care and top-clinical care. For those forms of care hospitals will continue to receive a budget, but a still unresolved problem is how to build effective incentives into the budget to encourage efficiency. Another big issue is how the government will respond to cost inflation in hospital care if competition does not work properly.

Hospital Planning and Capital Investments

Centralist hospital planning has always been a cornerstone of Dutch health care policymaking. Planning the number of hospital beds, medical specialist units and facilities for high-cost medical treatments was considered a prerequisite of effective cost control. Hospitals were also required to acquire a government license for major capacity planning decisions.

Centralist hospital planning is at odds with competition. Competition assumes hospitals to be self-responsible for planning and investments. For this reason the Hospital Planning Act (1971), the legal base of hospital planning, has been abolished and replaced with a new regulatory regime that came into force by January 2006. The new regime requires hospitals to acquire a license, but that license is no longer intended as a tool for planning but as a tool for safeguarding the quality of hospital care and hospital governance. It makes hospitals self-responsible for planning and capital investments. However, the new legislation does not fully eliminate the role of the government in hospital capacity planning. It retains its planning power in a few specialist areas and is also authorised to intervene when it considers access to hospital care to be at risk. What these "public constraints" will practically mean is uncertain.

The market reform also includes a major revision of the arrangement for the financing of capital investments. Under the previous arrangement, the costs of rent and depreciation were covered by a mark-up to the inpatient per diem rate over a 40-year period after the government had given its approval to these investments. As a consequence, neither hospitals nor financial agents providing long-term loans to finance hospital investments did incur a financial risk. This arrangement is considered to be incompatible with competition. Competition not only requires hospitals to make their own investment decisions, but also to make them self-responsible for financing these investments. For that purpose they will be paid a centrally regulated "investment" mark-up on the DBC-rate. In this new model, the hospital's room for capital investments is contingent on hospital revenues. Policymakers expect that the new model will encourage all stakeholders to become more critical on capital investments and financing arrangements. Hospital investments are no longer a risk-free activity for hospitals and financing agencies.

The introduction of the new arrangement for capital investments will be phased in from 2009 during a four-year period. A cautious implementation strategy is held necessary to avoid disruptive effects upon hospital care. Some hospitals are warning of bankruptcies if the payment of rent and depreciation is no longer guaranteed. The Minister of Health recently repeated that tailor-made interventions will be worked out to avoid hospital bankruptcy.

Performance Rating

A key element of the ongoing reform is to collect and disseminate information on the performance of hospitals. Such information is seen not only as an instrument to inform the general public and other stakeholders so that they can make informed choices, but also as a tool for improving the efficiency and quality of hospital care. Information can be considered a precondition for competition and fits into the wider call for greater transparency on the quality and costs of hospital care.

In order to fill the information gap the number of initiatives to compile quantitative, standardised and comparative information on hospital performance is rapidly increasing. One may speak of an unprecedented rise of an "information industry". The Health Care Inspectorate and the National Institute for Public Health and Environmental Hygiene are investing in information systems to inform hospitals, insurers and the general public on the performance of each hospital. Private agencies are also active. Some media

publish an annual hospital ranking which informs the reader about the "best" and "worst" hospitals. Some rankings are not only based upon structure and process indicators, but also include clinical outcome indicators.

There is little information available yet on the impact of performance information on the market behaviour of hospitals, insurers and the general public in the Netherlands. The impression is that particularly hospitals have become more sensitive to their scores in the rankings and that managers are increasingly using this information for initiatives to reinforce the market profile of their hospital, for instance by shortening waiting times or establishing specialised clinics. The Health Care Inspectorate recently issued instructions that forbid hospitals to carry out specific surgical procedures if the annual volume of these procedures is under a critical level.

The Politics of Health Care Reform

This article discussed the ongoing market reforms in the Netherlands. It demonstrated that the 2006 health insurance reform was only part – though an important part – of the reform. Other market reforms include, among others, the introduction of a friendly regulatory regime for ITCs, the introduction of some room for price competition as well as the significant changes in the hospital planning system and the regulatory regime for capital investments.

Within a European context the Dutch market reform may be described as rather comprehensive. It affects not only health insurance but also health care purchasing and health care delivery. The scope of market reforms in other European countries tends to be more restricted. For instance, current market reforms in Germany and Switzerland have important consequences for health insurance but have left the other aspects of health care largely unaffected. There is little or no room for price competition and selective contracting in these countries. Centralist hospital planning is continued and the arrangements for financing capital investments are not adapted to a competitive environment. In the UK competition has also remained limited in scope so far. Competition in health care financing is absent and the tariffs of the health resources groups for paying hospitals are centrally regulated.

However, it would be erroneous to argue that Dutch health care is unambiguously moving towards a pure market model. The current legislation contains many "public constraints" to competition and in some areas the government retains formal competences to intervene or to limit the domain of competition. The essence of regulated competition is to design a market model that on the one hand encourages efficiency but on the other hand "respects" the traditional values of universal access, solidarity in health care financing and equal treatment in health care. It is too early yet to conclude whether this effort to reconcile competition with public values will succeed in practice.

Our overview demonstrates the cautious character of the market reform. With the exception of health insurance reform, the reforms are not implemented as a "one-shot" operation but, instead, as a stepwise process evolving over time. Various market-making decisions, for instance concerning the domain of price competition, the introduction of for-profit hospital care, and the decentralisation of hospital planning from the centralist level to the level of the market players, have been planned for the next two or three years. Policy measures are often phased in gradually and safety nets are frequently used to avoid disruptive effects. One may speak of a deliberate learning-by-doing strategy.[6]

It would be too simple, however, to explain the cautious character of the market reform by referring only to risk avoidance and lack of information. These are certainly important explanatory factors, but there is another explanation too. Competition in health care has always been a contested issue in Dutch politics, although one may argue that the political debate is gradually moving away from a "yes-or no" debate to a debate on the proper domain of competition and on how it should be regulated. From this perspective, market-making decisions can be interpreted as a political compromise between different conceptions of market reform. The revision of the concept of for-profit hospital care clearly illustrates that the ongoing market reform is contingent upon the political composition of the coalition government.

In summary, there is no end yet to the politics of the ongoing market reform in the Netherlands. There are still many uncertainties. Its ultimate course and impact depend upon many policy decisions yet to be taken over the next five years in a volatile political environment. Hence, foreign observers should be careful when drawing conclusions on the success and failure of market reform in the Netherlands.

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[6] J. Helderman, F. Schut, T. van der Grinten, W. van de Ven: Market-oriented health care reforms and policy learning in the Netherlands, in: Journal of Health Politics, Policy and Law, Vol. 30, Nos. 1-2, 2005, pp. 189-208.

David McDaid* and Adam Oliver**

A Comparative Analysis of Health System Reform across England and Scotland

The health policy landscape in the United Kingdom has changed substantially since major constitutional reform in 1999 saw the establishment of devolved administrations for Scotland, Wales and Northern Ireland.[1] Prior to this, health policy had largely been determined at a UK-wide level, albeit with some (generally modest) differences in the way in which policy had been implemented across the four countries due to different administrative structures.

Devolution has allowed each of the four countries of the UK the freedom to pursue different approaches to reforming the National Health Service (NHS) that still dominates health care provision and is more than 90% publicly financed. An evaluation of the success or failure of what might be viewed as a natural experiment, by comparing and contrasting different approaches to reform across at least some of the four "home" nations, may provide valuable lessons for health policy makers in tax or social insurance funded health systems in Europe and beyond.

Interestingly, when devolution was first mooted, the UK government took the view that such a major constitutional change, which included the transfer of most responsibility for health services to the devolved administrations, would merely allow some additional flexibility for differences to emerge in approaches to policy and reform at the margins.[2] The reality has been rather different, if somewhat complex to understand. Political autonomy, coupled with accountability to national rather than a UK-wide electorate, have clearly led to increasing differences in the direction of health policy implemented by the Department of Health in England and her sister departments in the devolved structures of the other three countries.[3] These differences not only cover aspects of health system financing such as the extent to which individuals have to make co-payments for some health and social care services, but also reflect changing values within the health systems of the UK, expressed through differences in institutional structures and interactions between different stakeholders and in the role to be played by the private sector in the delivery of what remain publicly funded health care services.[4]

This paper reflects on some of these issues by providing a brief overview of the direction of health policy and key reforms in both England, the largest of the four countries with approximately 51 million inhabitants, and Scotland, with a population of just over 5 million. We have chosen to focus our comparison on England and Scotland because the latter enjoys the greatest level of autonomy post devolution, with the Scottish Government's Minister for Health and Wellbeing now being accountable to a fully fledged Scottish Parliament (with some tax raising powers) in Edinburgh for almost all aspects of health policy.

Reforms in the English NHS

Until the mid 1980s, the system prevailing in the English (then still UK) NHS was, and had always been, widely cited as one of "command and control".[5] Primary care doctors and dentists were self-employed but predominantly contracted to the NHS, but most other employees within the system were salaried and most hospitals were owned and managed by the state.

The Department of Health was allocated funds from central government, and in turn allocated budgets, weighted by demographic and mortality data, to 14 regional health authorities. These were responsible for

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[1] S. L. Greer, A. Trech: Health and intergovernmental relations in the devolved United Kingdom, London 2008, Nuffield Trust.

[2] T. Smith, E. Babbington: Devolution: a map of divergence in the NHS, London 2006, British Medical Association.

[3] S. L. Greer: Four way bet: how devolution has led to four different models for the NHS, Constitution Unit, London 2004, University College London; S. L. Greer, A. Trech, op. cit.

[4] R. Klein: Values talk in the (English) NHS, in: S. L. Greer, D. Rowland (eds.): Devolving policy, diverging values?, London 2008, Nuffield Trust.

[5] A. Oliver: The English National Health Service: 1979-2005, in: Health Economics, Vol. 14, 2005, pp. S75-S99.

the strategic management of health care services in a geographically defined area, and were collectively supported in this by a total of 192 district health authorities.

Over the past twenty years, efficiency concerns have been at the core of the reforms in England, together with measures to promote greater consumer empowerment.[6] Under the Conservative government in 1991 a so-called "internal market", where purchasers would agree contracts with competing providers, was introduced. It was thought that the competitive nature of this market would provide the necessary incentives for the providers to provide a better service, and thus improve efficiency.[7] The purchasers in the internal market were the district health authorities, which were allocated budgets to purchase hospital care services, and general practitioner "fundholders", who held budgets to provide primary health care and purchase some hospital care services for their patient list members.

1997 saw the election of a Labour government that had campaigned hard on the slogan of saving the NHS; the new government proceeded to embark on a number of major system reforms.[8] These included the replacement of fundholding GPs with 303 (and subsequently 152) Primary Care Trusts (PCTs), which provided primary care and commissioned most secondary care. Becoming fully operational in April 2004, they are financed by weighted capitation and comprise GPs located in a particular area, supported by nurses, midwives, health visitors, social services and other stakeholders. District health authorities were also replaced by 99 health authorities, later merged into 28 and later still just 10 Strategic Health Authorities (SHAs). Since PCTs are now the principal purchasers of secondary care, other than retaining commissioning responsibilities for highly specialised health services, the role of the SHAs is merely one of monitoring the performance of PCTs and hospitals.

Despite their part opposition to the internal market, the Labour government arguably moved to create an even more radical version of this system in the early part of the new millennium. Key to this was the creation of NHS Foundation Trusts (FTs) in 2004, with a long-term goal of transforming all NHS hospitals into FTs; by August 2008 103 Acute and Mental Health FTs were in operation in England.[9] FTs are independent hospitals (but still part of the NHS) that have greater autonomy in the way that they run and deliver services, competing with other hospitals for business from the PCTs. No longer directly accountable to the Minister for Health they have some additional freedom to borrow and raise money to invest in services to improve their performance.

Local citizens are intended to have a direct say in how FTs operate by registering as members who can then elect governors.[10] Experience to date in increasing local involvement in decision making has been mixed, with very few members of the public becoming members in some trusts. Qualitative evidence from one trust where governors were observed over a one year period suggested that they had made "little tangible impact" on the running of the hospital and "in this regard, the new governance arrangements had so far failed to deliver the government's objectives of 'social ownership' where members influence the management of the Trust".[11]

Increased Private Sector Involvement

The private sector has become an important source of investment in the NHS. Much recent capital investment in NHS hospital trusts has also been directed through a private finance initiative (PFI), where firms have been contracted to build facilities and operate non-clinical ancillary services.[12] Although this reduced the immediate outlay on new hospitals to the exchequer, PFI has continued to attract criticism amid reports of profiteering by private consortia,[13] and arguments that binding long-term contracts for hospital services with punitive penalties for change are not prudent in a rapidly changing health system. Moreover, borrowing from the private sector may ultimately prove more costly than public sector borrowing.[14]

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[6] A. Oliver: Inconsistent objectives – reflections on some selective health care policy developments in Europe, in: Health Economics, Policy and Law, Vol. 2, 2007, pp. 93-106.

[7] Department of Health: Working for patients, Norwich 1989, HMSO.

[8] Department of Health: The new NHS: modern, dependable, Norwich 1998, Stationery Office.

[9] Monitor: Annual report and accounts 2007-2008, London 2008.

[10] Department of Health: A short guide to NHS Foundation Trusts, London 2005, Department of Health.

[11] R. Lewis, L. Hinton: Citizen and staff involvement in health service decision-making: have National Health Service foundation trusts in England given stakeholders a louder voice?, in: Journal of Health Services Research & Policy, Vol. 13, 2008, pp. 19-25.

[12] J. Le Grand: Further tales from the British National Health Service, in: Health Affairs, Vol. 21, 2002, pp. 116-128.

[13] National Audit Office: The refinancing of the Norwich and Norfolk PFI hospital, London 2005.

[14] R. Atun, M. McKee: Is the private finance initiative dead?, in: British Medical Journal, Vol. 331, 2005, pp. 792-793.

Another key element of the development of the new internal market has been an acceptance that a public sector monopoly of secondary care services in England is no longer necessary; the private and voluntary sectors might also compete with the public sector to deliver some services. A concordat with the private sector[15] allowed the purchasers of health care to enter into contracts with private sector facilities in order to reduce waiting times for elective surgery. Additionally, privately run independent treatment centres, intended to provide extra capacity to the NHS and reducing waiting times for elective surgery, have been rolled out. The first wave, in 2003, was contracted to deliver up to 170,000 finished consultant episodes per annum over five years, at a cost of £1.6bn. The second wave, launched in 2005, was to provide up to 250,000 additional elective and two million extra diagnostic procedures annually, over five years, at an estimated cost of around £4bn. Again these centres have been criticised, firstly for providing insufficient information to judge their performance and value for money, and secondly for potentially having a detrimental impact on capacity within the NHS by reducing the opportunities for routine medical practice that can help provide training for new NHS professionals.[16]

Competition and Choice

Linked to the drive for a greater degree of efficiency in the English NHS have been measures to promote greater patient choice. In January 2006, GPs for the first time were required to offer patients requiring elective surgery a choice of four or five hospital providers at the point of referral.[17] An electronic "choose and book" system now allows patients to decide the date and time of their first outpatient clinic appointment, while the NHS Choices website provides the public the opportunity to compare hospitals, doctor profiles and performance. In April 2008 the choice programme was extended so that individuals can now choose any hospital, public or private, that meets standards set out by the NHS.[18] Only emergencies, mental health and maternity care are not covered by this policy.

Underlying this choice initiative and the functioning of the "new" internal market is a system of hospital payments introduced in September 2004, termed Health Care Resource Groups (HRGs).[19] Operating in a similar fashion to diagnostic resource groups seen elsewhere, hospitals are offered a set, national tariff per procedure defined by the HRG system and therefore are no longer able to compete for patients on the basis of price. Instead, it is hoped quality will influence demand for services. In 2006/07 over £22 billion of services were delivered under the system, representing around 35% of PCT revenue allocations, or over 60% of acute hospital income.

A quality and outcomes framework (QOF), introduced in 2005, provides additional financial rewards for aspects of the quality of care that GPs provide. This QOF programme is applied across the whole of the UK, being part of a new contract for general practitioners negotiated with the British Medical Association. While participation is voluntary almost all GPs have now signed up.[20]

Regulatory Reform

Major developments in the regulatory landscape have included the establishment in 1999 of what is now known as the National Institute for Health and Clinical Excellence (NICE) in England. NICE has, among other duties, a remit to assess new and existing interventions for their clinical and cost-effectiveness and to decide whether an assessed intervention ought to be made available within the NHS. In 2005 this remit was extended further to include health promoting and public health interventions delivered outside the health care system. Another development was the creation of a Commission for Health Improvement (now called the Healthcare Commission) to monitor NHS quality, performance and adherence to NICE recommendations and guidance on care set out in a series of National Service Frameworks for conditions such as cardiovascular disease, mental health problems and cancer. Performance ratings can influence both funding levels, the possibility of applying for FT status and in the case of very poorly performing trusts could lead to the replacement of the local management team.

Going Forward

Health Minister Lord Darzi recently published a review setting out plans for the next ten years of the

[15] Department of Health: For the benefit of patients. A concordat with the private and voluntary health care provider sector, London 2000, Department of Health.

[16] A. Pollock, S. Godden: Independent sector treatment centres: evidence so far, in: British Medical Journal, Vol. 336, 2008, pp. 421-424.

[17] Department of Health: Choice matters: increasing choice improves patients' experiences, London 2006, Department of Health.

[18] Department of Health: Choice at Referral – Supporting Information for 2008/09, London 2008, Department of Health.

[19] S. Boyle: Payment by results in England, in: Eurohealth, Vol. 13, 2007, pp. 12-16.

[20] The Information Centre: National Quality and Outcomes Framework Statistics for England 2006/07, London 2007.

English NHS.[21] This further emphasises the need to personalise services and proposes that the concept of patient choice be enshrined as a right in a new NHS Constitution. Choice will be expanded further within primary care: catchment areas for GPs' practices will be expanded while patients will also be able to express a preference to be seen by a GP within specific practices. Patients with long-term care problems will also receive individualised care plans and personal budgets, again promoting the notion that patients can be empowered to purchase services that best meet their needs. This policy direction is of course based on the assumption that patients are able and willing to choose their services effectively, an assumption that is not immune from criticism, but only time will tell whether the policy will prove a fruitful path to follow.

Post-devolution Reform of the NHS in Scotland

Other than a few limited functions which remain at a UK-wide level, including pharmaceutical pricing negotiations, professional regulation and rules governing abortion, all responsibility for the health system has been fully devolved to the Scottish government. The Minister for Health and Wellbeing is fully accountable to the Scottish rather than the UK Parliament. The Scottish Parliament has the power to call to account the Chief Executive of the Scottish NHS and the 15 Local NHS Health Boards that manage services.

The Scottish government is also under no obligation to spend the same share of its overall budget on health as England. The health care budget is taken from a non-earmarked global budget for public services transferred annually from the UK government using a specific (non-needs based) mechanism known as the Barnet formula. This ensures that the public expenditure budget grows relative to expenditure on public services in England. Thus, while health spending in Scotland has grown at a slower rate than that in England since devolution, historically higher levels of spending when the Barnet formula was established in the 1970s mean that it still outstrips spending in England. In 2005/06 total identifiable health spending per head was £1,643 (20% of total public spending) in Scotland compared with £1,437 (21% of total public spending) in England.[22] This is one reason why the Scottish government was able to provide free personal care for older people, adopting the recommendations of the UK-wide Royal Commission on Long Term Care chaired by Lord Sutherland that had previously been rejected by the UK government.[23]

Abolition of the Internal Market

It is not just budgetary arrangements that differ in Scotland. Post devolution, much reform has moved in a very different direction to that observed in England. Market orientated reforms have been sidelined with the last vestiges of the internal market introduced under the UK Conservative government in 1991 removed in 2004, when all NHS Trusts were abolished. Local NHS Health Boards are now the single tier of governance and accountability. Foundation trusts have no place in the Scottish health policy landscape; instead of the purchaser-provider split, the Scottish NHS emphasises partnership and cooperation between different stakeholders. At a local level the NHS Health Boards allocate funds, develop local health plans (in association with local health board hospitals, GPs and other NHS bodies) and take part in regional and national planning.

Kerr (the principal architect of recent reform proposals in Scotland) and Feeley recently argued that this direction of travel was not the result of explicit governmental policy, but rather came about because of the strong expression of values by the general public and other stakeholders within the Scottish NHS.[24] The blueprint for the future development of the NHS in Scotland was being developed at a time when the health system was the subject of much scrutiny and criticism: more than 250,000 people (approximately 5% of Scotland's population) had been active in public demonstrations or had signed public petitions.

In response a series of "town hall" meetings between the report's advisory group chaired by David Kerr and both the public and NHS staff were undertaken in an attempt to secure "buy in" for a shared future vision of the NHS. One consequence of these meetings was the supremacy of values (shared by both the public and health care professionals) such as collaboration, partnership and collectivism over notions of choice and consumerism. Kerr and Feeley now state that the "level of debate was high and was characterised by a strong degree of antipathy towards the 'market-driven' health reforms which appeared to dominate England's NHS". The model of foundation trust hospitals competing with each other for patients

[21] A. Darzi: High quality care for all: NHS next stage review final report, London 2008, Department of Health.

[22] Office for National Statistics: Public expenditure statistical analyses, London 2007.

[23] D. Bell, A. Bowes, A. Dawson: Free personal care in Scotland: recent developments. York 2007, Joseph Rowntree Foundation.

[24] D. Kerr, D. Feeley: Collectivism and collaboration in Scotland, in: S. L. Greer. D. Rowland (eds.): Devolving policy, diverging values?, London 2008, Nuffield Trust.

was "roundly rejected in open debate by the citizens of Scotland".[25]

These values were subsequently encompassed in the 2005 publication of the National Framework for service change, "Building a Health Service: Fit for the Future"[26] and the action programme, "Delivering for Health"[27], set up to implement these changes. The Framework called on people to take more responsibility for their own health, view the NHS as a service delivered mainly in local communities rather than hospitals, and anticipate and prevent rather than react. This did not mean that there would be no moves to promote choice, but the potential care package would be discussed collaboratively between patients and their doctors.

Reorganisation of health care services has seen the rationalisation and centralisation of some specialist services, whilst Community Health Partnerships have also been established with resources and decision making power to work with Health Boards and involve patients and a broader range of staff in their work. The underlying aim is to expand community based and primary care services as part of a move towards more integrated care pathways.

The use of the private sector to provide additional capacity for acute care and reduce waiting lists has also been seen merely as a temporary measure while system reorganisation takes place. The new Scottish National Party government has now put a block on the expansion of private sector involvement.[28]

Regulatory Reform

Notably Scotland also developed its own approach to the assessment of new technologies, the Scottish Medicines Consortium (SMC). In some cases this has led to situations where drugs may be recommended as appropriate for some population groups in Scotland, whilst being unavailable in England.[29] This has led to accusations by the tabloid press of a medical apartheid for English patients compared to their Scottish counterparts.[30] In fact, in the long term decisions on access to treatments are nearly always identical between the SMC and NICE; the principal difference has been that the SMC has assessed medical technologies using a more rapid appraisal process than that used by NICE leading to recommendations many months earlier on the use of treatments. This adverse media coverage in England was one contributory factor to NICE's decision to subsequently adopt its own rapid technology appraisal process.[31]

Going Forward

In late 2007, under the new Scottish National Party government, the action plan "Better Health, Better Care" was launched.[32] The Minister for Health and Wellbeing, Nicola Sturgeon, said that it presented a vision "based on a shift from the current position where we see people as 'patients' or 'service users', to a new ethos for health in Scotland that sees the Scottish people and the staff of the NHS as partners, or co-owners, in the NHS".

In some respects this move towards a "mutual NHS" has echoes of the case made in England for promoting local accountability and input through the creation of Foundation Trusts, but importantly it involves no changes to the financial rules under which hospitals run, nor does it create opportunities for private sector investment. Instead the emphasis is on quality enhancement through improved patient experience, clearer patient rights and enhanced local democracy through direct elections to health boards. The document explicitly outlines a shift away from viewing people as consumers – with rights – to viewing them as owners with both rights and responsibilities. The overall strategic objective is to help people to sustain and improve their health, especially in disadvantaged communities, ensuring better and faster access to health care. Similar to developments in England, a Patient Bill of Rights is being developed.

Divergence and Difference

Why has there been such a divergence in health policy and system reform between the two countries? In part, of course, this will reflect differences in population needs, but it may also be influenced by differ-

[25] Ibid.

[26] D. Kerr (ed.): Building a health service: fit for the future, Edinburgh 2005, Scottish Executive.

[27] Scottish Executive: Delivering for Health, Edinburgh 2005.

[28] BBC NEWS: Plans to end private cash for the NHS, London, 21 June 2007.

[29] G. Watts: Are the Scots getting a better deal on prescribed drugs than the English?, in: British Medical Journal, Vol. 333, 2006, p. 875.

[30] T. Shipman: Medical apartheid as English cancer patients are denied life-extending drug, in: Daily Mail, 20 October 2006, London.

[31] D. J. Webb, K. R. Patterson, A. Timoney, A. Walker: Scotland v England deal on prescribed drugs: Scottish Medicines Consortium responds, in: British Medical Journal, Vol. 333, 2006, p. 1073; author reply p. 1073; J. Cairns: Providing guidance to the NHS: The Scottish Medicines Consortium and the National Institute for Clinical Excellence compared, in: Health Policy, Vol. 76, 2006, pp. 134-143.

[32] Scottish Government: Better Health, Better Care: Action Plan, Edinburgh 2007.

ences in the political climate in the two countries.[33] Parliamentary democracy in England is adversarial in nature reducing the opportunities for collaboration on the political hot potato of health policy; moreover national politics, certainly since the time of Margaret Thatcher, has been dominated by discussions over curtailing the power of the state and promoting choice and competition through private and voluntary sector alternatives. The situation in Scotland is somewhat different. The new Parliament is elected by proportional representation, meaning that no political party is ever likely to win an overwhelming majority; indeed in the current situation the country is governed by a minority Scottish National Party administration. This makes the need to build a consensus between the political parties over key policy issues essential; moreover, Scottish politics has never been dominated by differences in left-right politics, and this may explain why there has been much less enthusiasm and interest in market orientated reforms.

It has also been contended that much value in developing health policy has been placed on the (broadly similar) views of the small number of health professional groups and leading academic institutions in Scotland, compared with the situation in England where a plethora of diverse institutions and think-tanks put forward opposing views on the direction of health care reform.[34] This may be evidenced by the fact that professional groups such as the British Medical Association and the Royal Colleges in Scotland have supported the direction of reform in the country; reforms which view health care professionals as equal partners who have a desire to improve quality within the health system.

An Ongoing Natural Experiment

It is still too early to make a judgement as to whether the English or Scottish approaches to health system reform are more effective in promoting efficiency and quality. Certainly in both countries patient surveys indicate that more than 90% of the population are very or fairly satisfied with the care that they receive.[35]

Some evaluations of the internal market reforms in England suggest that they may only have had a short-term effect on productive efficiency, moving the system to a slightly higher baseline, raising questions as to the merits of investing in this policy direction.[36] But few direct comparisons of performance between the non-market orientated system in Scotland and the market driven approach in England have been made: indeed one of the challenges in respect of meaningful comparisons is the need for appropriate and common indicators and performance measures to be put in place. The lack of such common indicators has curtailed some of the initial attempts at inter-UK country comparisons.[37] A rigorous evaluation of quality improvement in both countries still needs to be undertaken.[38]

One comparison of performance and activity indicators in England and Scotland in 1996 and in 2002 suggested that the higher levels of spending and health care resources in Scotland did not lead to greater improvements in population health or in hospital activity rates.[39] Another more recent comparative analysis between the two countries looked at waiting times for elective treatments. This suggests that the more aggressive approach adopted in England, where the Healthcare Commission had as one of its performance targets a reduction in waiting times, led to a significant decrease in overall waiting time compared to the situation in Scotland where a softer more consensual approach was employed.[40]

What is increasingly clear is that the direction of health reform in England, at least in the popular press, is now being compared and contrasted with different approaches seen not only in Scotland, but also in Wales (where free drug prescriptions for all have been introduced) and Northern Ireland (where health and social care services have long been relatively integrated). It is vital that academics and policy makers build up an evidence informed picture of just how different approaches to policy and reform can impact on goals such as equity, efficiency and quality across all four countries of the UK.

[33] S. L. Greer, A. Trech, op. cit.

[34] T. Smith, E. Babbington, op. cit.

[35] N. Rose, R. Glendinning, R. Carr-Hill: Public attitudes to the National Health Service in Scotland – 2004 Survey, Edinburgh 2004, Scottish Executive Social Research; Healthcare Commission: National survey of adult inpatients 2007, London 2008.

[36] A. Oliver, 2007, op. cit.

[37] A. Alvarez-Rosete, G. Bevan, N. Mays, J. Dixon: Effect of diverging policy across the NHS, in: British Medical Journal, Vol. 331, 2005, pp. 946-950.

[38] S. Leatherman, K. Sutherland: The quest for quality: refining the NHS reforms, London 2008, Nuffield Trust.

[39] A. Alvarez-Rosete, G. Bevan, N. Mays, J. Dixon, op. cit.

[40] C. Propper, M. Sutton, C. Whitnall, F. Windmeijer: Did 'targets and terror' reduce waiting times in England for hospital care?, in: The B. E. Journal of Economic Analysis and Policy, Vol. 8, 2008.

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Health Care Reforms in Spain – Achievements and Challenges

Halfway through the 1980s, the Spanish health care system began a change from a social security system to a national health care system (NHCS) with universal coverage and tax funding. This great change was a result of the Health Care General Law (1986). The second great transformation was the decentralisation of the national health care system, creating seventeen regional health care systems. This process took more than 20 years: from 1981, when Catalonia took over the management of its health care system, to 2002, when the health services were devolved to the last ten autonomous communities depending on the central government. The autonomous communities are very different in size and in population, ranging from 300,000 inhabitants in La Rioja to more than eight million inhabitants in Andalucia. All of them have complete authority to regulate, plan, organise and manage the provision of health care services. In fact, the central government has only residual power and its main function is to coordinate and to manage processes involving the state as a whole.

Health indicators in Spain are good (life expectancy is 81 years, Spain ranks number 6 in the world[1]) and health expenditure is lower than expected considering its income level.

In general, the population is satisfied, except with the waiting lists.[2] 20% considers that the health care system works quite well, 47% thinks that it works well, but some changes are needed, and 27% thinks that it needs deep changes. In December 2007, there were 376,000 patients on the waiting lists in the national health care system.[3] The average waiting time for surgery is 74 days, and the percentage of patients waiting more than six months for surgery is 7.3%. 11% of the population thinks that the waiting list problem has worsened, 24% thinks it has improved and 50% thinks that it is still the same. The situation is even worse regarding the waiting lists for medical services. The average waiting time is two months, and the percentage of patients waiting more than two months is 37%. Citizens consider that the waiting time to be seen by a specialised doctor is unsatisfactory; they grade this time as 4.7 (on a scale from 1 to 10, with 1 being the worst); this rating is the same for the waiting lists for diagnostic tests.

The current main reforms and the challenges in the Spanish health care system have to do with its coordination and funding, and with the search for new management models to improve efficiency. We deal with these three issues below.

Coordinating an NHCS Involving Seventeen Health Care Systems

In Spain, the decentralisation of the health care system has been a secondary effect of the political will to create an Estado de las Autonomías (State of the Autonomies), rather than the result of the search for a specific model for the health care system or a tool for achieving certain aims in the field of health care.

Some problems regarding centralism and decentralisation remain unsolved in the NHCS. The role of the Ministry of Health Care and Consumption has been reduced to a residual function. Governability[4] is questioned, since the organisation in charge of coordinating both the whole system and the reforms involving the whole country is an Inter-territorial Council of the SNS (Sistema Nacional de Salud, National Health System), which is composed of the seventeen Communities and has no executive power. It is difficult to undertake changes, as decisions are taken by general consensus, avoiding any voting.

Decentralisation has unquestionable advantages.[5] There are both technical and political reasons: to im-

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[1] WHO: World Health Statistics 2008, http://www.who.int/whosis/whostat/2008/en/index.html.

[2] Sociological Research Centre Sociológicas and Ministry of Health Service and Consumption: Barometer of the Sociological Research Center-2007, Ministry of Health Service and Consumption, 2008.1

[3] Ministry of Health Service and Consumption: Waiting Lists in the National Health System, 31 December 2007.

[4] J. R. Repullo, J. M. Freire: Gobernabilidad del SNS: mejorando el balance entre los beneficios y los costes de la descentralización, in: Gaceta Sanitaria, Vol. 22, No. Suppl. 1, April 2008, pp. 118-125.

[5] B. González López-Valcárcel, P. Barber Pérez: Desigualdades territoriales en el Sistema Nacional de Salud (SNS) de España, Fundación Alternativas, working document 90/2006.

prove efficiency by a more efficient use of local information, proximity to the decision centre, adapting the negotiation to the conditions of the local markets; to achieve a certain degree of "legitimate" diversity in the objectives of the regional health care systems, in the social priorities and assessments; and to move towards democracy in depth. Diversity gives rise to competition by comparison, which is another main theoretical advantage of decentralisation.

However, decentralisation also has disadvantages: sharing and coordination become more difficult, the size of markets does not favour economies of scale or economies of information and network externalities are less pronounced. Former heads of the Health System fear the breakdown of the territorial equity and, in time, the increase in territorial disparities regarding management, public coverage and quality levels.[6] Health decentralisation has boosted territorial differences in public insurance policy — citizens' rights, social security benefits, guarantee of access — and in the use of resources and procedures. At the moment, these differences are not too significant as, in practice, in the autonomous communities there are emulation mechanisms, trying to offer a maximum of public insurance coverage. In addition, the information system has broken down and does not allow easy comparisons of the situation in different areas.

There are three fields in which coordination and decision-making for the health system are especially necessary: the public insurance coverage — which new treatments are to be included, with what particular medical indication etc. — human resources policies and information systems.

Coverage of New Treatments and Technologies in the Public Insurance Scheme

The public health care system has a large portfolio of services (one of the largest in the world) laid down in the Royal Decree 1030 of 15 September 2006. Co-payments are lower than in other European countries.[7] Hospital medicines are free for patients, as are consultation and hospitalisation.

Retired people do not pay for ambulatory medicines; workers pay 40% of the retail price; there are lists of drugs with limited contributions and exceptions, so that users contribute hardly 6% of the total expenses of the ambulatory prescriptions of the national health system. Maybe that is the reason why in 2007 there have been nearly nineteen prescriptions per inhabitant in the Spanish ambulatory system. The system is also generous with immigrants, who have health care coverage, even if they are not legal residents of Spain. Low co-payments help the equity of access, but they also give rise to moral hazard.

In Spain, the decision whether to include new medicines in the national health care system on the basis of cost-effectiveness and equity faces methodological and institutional difficulties. Decisions are fragmented and there is a lack of coordination at the macro, meso and micro levels of management. New medicines are authorised at the State or European level (by the European Agency, EMEA). The State fixes prices and decides on the funding and public coverage, which may be increased by the autonomous communities. All these decisions are taken by politicians who may succumb to short-term temptations.

There is no agency for health technology assessment to prepare clinical guides with the moral and legal authority to establish national standards and to decide on the conditions of public funding. Unlike other countries, there is no explicit "fourth hurdle" demanding a cost-effectiveness threshold for a new technology to be included in the national health insurance policy.

There are several local agencies for health technology assessment, without any decision-making capacity, that work together voluntarily. Medicines are chosen at the meso level, in the hospital pharmacy (the hospital's and department's pharmaco-therapeutic guides). The criteria for use are established by the Pharmacy and Therapeutic Committee. And the guides to clinical practice are established by the clinical services and the quality commissions. Finally, doctors make the specific clinical decision for their patients, on the basis of the guides or otherwise, and select the drugs authorised in the Centre's lists.

Though slowly, progress is being made in some areas, such as the standardisation by consensus of the methodology of economic evaluation,[8] and the diffusion and dissemination of scientific evidence, working in national and international projects and networks.

Rising tensions in health expenditure due to demographic expansion (more than five million people in the last ten years), population aging (a recent United Na-

[6] J. Artells: Desarrollo y sostenibilidad del Sistema Nacional de Salud descentralizado, Fundación Salud Innovación y Sociedad, 2005.

[7] A. Tur, I. Planas Miret: Un panorama de la contribución financiera del usuario sanitario en Europa, in: Jaume Puig (ed.): La corresponsabilidad individual en la financiación pública de la atención sanitaria, in: Informes FRC, No. 1, 2007, pp. 57-78.

[8] J. Lopez Bastida, J. Oliva: Propuesta de estandarización de métodos para la evaluación económica aplicada a las tecnologías sanitarias, mimeo 2008, www.fgcasal.org/fgcasal/database/documentos/JornadaFenin-Juan_Oliva.pdf.

tions report shows that in 2050 Spain will have the oldest population in the world: 44% will be over 60 and the median age will be 55 as compared to the world median of 36[9]) and new technologies put system sustainability at risk, due to accumulating deficits.

Up to now, co-payments have been a taboo subject. As a consequence, users are leaving the public health system to avoid long waiting lists, by using private services out-of-pocket. In fact, according to the OECD data base, in Spain the private share in health expenditure increased more than in other countries between 1994 and 2002, except for those in Eastern Europe.

Health Professional Policies

Health professional policies and human resources for health policies, involve questions such as how to manage deficits and surpluses, how to avoid spiralling personnel costs, how to pay doctors and nurses. Numerus clausus is regulated by the central government. Payments, employment and training policies depend on the autonomous commmunities.

Nowadays, there is a considerable shortage of doctors in some specialities and fields, due to three reasons: the demand pull of both private services and foreign markets (United Kingdom, Portugal, France), and "crash" infrastructure plans to open new centres and hospitals in those autonomus communities to which health care competences were transferred in 2002. For instance, Castilla-La Mancha, a Spanish autonomus community, increased its staff by 57% from 2002 to 2008.

Mobility incentives in the country are extremely weak, since decentralisation has segmented labour markets geographically. An especially serious and urgent challenge is to recover the national dimension of labour markets which have been segmented geographically and professionally. Their narrowness makes it difficult to achieve a balance and causes excessive inflexibility in supply.[10]

Besides, as doctors are civil servants with salaries which are independent of market equilibrium wages, imbalances are not easy to solve. In the short term, the immigration of doctors plays a major balancing role, though with a certain time constraint — due to the period for the official recognition of foreign degrees in medical specialities — as most immigrants come from Spanish-speaking countries in Latin America.

Dissatisfaction with work, particularly high in primary care, and the rising pressure on medical remuneration due to staff shortages have led to expectations of medical careers as a mechanism for professional and economic improvement, linked to excellence and effort throughout the doctors' professional life. However, in practice, what is happening is that there is a general increase in payments depending merely on seniority. There are some promising attempts to change the professional payment formula, which have been defined mainly in Catalonia (General Council of the Medical Profession).

Since physicians working in public centres are civil servants, it is difficult to define incentive payments according to objectives such as the improvement in quality and productivity. Peonadas (day's work) have been a bad idea. Surgeons and clinicians are paid on a fee-for-service basis out of their regular scheduled working hours to alleviate waiting lists. Two consequences have emerged: evening productivity is more than double the regular working hours (morning) productivity and waiting lists do not decrease, as doctors have strong incentives to keep them long.

Nursing specialities have been extended recently, in the Royal Decree 450 of 22 April 2005, and there is an on-going project to upgrade nursing to a bachelor university degree. Granting nurses permission to write prescriptions has been discussed, with some opposition from physician sectors. The ratio nurses/physicians in Spain is one of the lowest in Europe (about 1/1 in primary care centers and 1.8/1 in hospitals). One of the challenges for the Spanish Health System is to redefine the role of nursing in the public health care system. Innovative solutions are being put into practice — for instance, the liason nurses, who improve health service continuity, and combine medical and social assistance as well as primary and specialised care. Significant progress is being made in this field in some autonomus communities, e.g. Andalucia.

Information Systems

Electronic clinical records, medical ID-cards, and electronic prescriptions are slow projects, in which each Community searches for its own solution without any coordination with the others.

The lack of interoperability among the Communities' data and the deficiencies of the health information system have been two of the most tangible costs of decentralisation. The foundations for a system of

[9] United Nations, Population Division: World Population Ageing 1950-2050, 2002, available at www.who.int.

[10] B. González López-Valcárcel, P. Barber Pérez: Oferta y necesidad de especialistas en España 2007-2030, Madrid 2007, Ministry of Health Service and Consumption.

common indicators for health and health care services are being laid, but there are some difficulties regarding political rules and system governability. Autonomous communities are obliged to report the waiting list data (which are published twice a year as a result of a report by the Ombudsman in 2002) according to a common methodology. One of the main challenges is to achieve an integrated information system in the Spanish national health system, as this is a necessary, but not the only, condition for a cohesive health care system. Such an information system needs guidelines, standards and common operative definitions to make comparability possible. This task requires technical and executive leadership by the central government. The information system is the cornerstone of the national health system. Cohesion in the health system is impossible without comparable information about health, resources, access, uses and costs.

Regional Funding and Territorial Equity

A short-term challenge is how to change the formula for allocating funds to the regions. The Territorial Funding Law 21/2001 integrated health care expenditures into general public expenditures. Previously, the health system was financed differently. The change in the model of territorial funding coincided with the transfer of health care competences to the last ten autonomous communities in January 2002.

The public health care system has chronic problems of financial shortage which have been resolved by injecting extra funds from time to time to defray later deficits. Between 1999 and 2005, total public health expenditure increased at a cumulative annual rate of 8.53%,[11] much higher than inflation. The last extraordinary fund injection took place in 2005.

There are two problems in the territorial health funding: first, the amount of funds to share out, and second, how the autonomous communities distribute these funds among themselves. The current method of distribution is based on population, with some adjustments due to the insularity and demographic structures.

From a dynamic point of view, there are some allocations to counterbalance population growth where this is three points higher than the average population growth (such deviations from the average have not taken place so far in any autonomous community). The autonomous communities' responsibility for incomes is a question of law open to reform. So far, decentralisation has been much more focused on expenditure than on incomes. The trend is to entitle the communities to collect and regulate taxes. Nowadays, public funds are redistributed from the richest communities to the poorest. The dispersion of public health expenses per capita, in euro, is somewhat reduced. In 2005, the minimum was €1,020 (Andalusia) and the maximum €1,331 (Cantabria). The ratio maximum-minimum is 1.3.[12] However, as a percentage of regional GDP, dispersion is much higher. In 2005, the autonomous community of Madrid spent 3.5% of its GDP on health care, whereas Extremadura spent 8.05%.[13] The increase in competences in health services management should also be accompanied by a joint responsibility of the State and the Communities so that the Communities have to share the burden of tax collection and of declining tax revenues in times of economic crisis. To combine this objective with solidarity, cohesion and equity is a hard, but necessary, task because, having decentralised expenses, not incomes, it is hardly surprising that the autonomous communities keep putting pressure on the central government, demanding more funds for health care, without any payments.

Equity Concerns

Equity is one of the most important principles in both the Health Care General Law of 1986 and the Law of Cohesion and Quality in the National Health System of 2003, in that they try to guarantee that access to the health system and health care provision are carried out on effectively equal terms, and that health policies and the coordination and cooperation among public administrations are designed to eliminate geographical and social imbalances in health.

In general, with respect to the use of health care services, we can find that people of a low socioeconomic level visit the general practioner (GP) more often, whilst people of a higher socioeconomic level tend to visit specialised doctors and to be hospitalised more often (the latter two are health care services in which the GP plays an essential role). Geographically there are no significant differences in the use of hospital servcies, although there are some differences in primary care and specialised services. These differences may have to do with the effect of decentralisation on the way health care services are provided. Regarding access, there seem to be no differences in the waiting time for primary and specialised care amongst income groups. However, people from lower income groups

[11] Department of Health, Group for the Analysis of Health Expenses, 2007, http://www.msc.es/estadEstudios/estadisticas/sisInfSanSNS/finGastoSanit.htm.

[12] Ibid., Table V3.3.

[13] Ibid., Table V.2.4.

wait longer to be hospitalised by ordinary admission (not emergency admission).[14]

Between efficiency and equity, the Spanish public health system clearly tends to equity. Maybe this fact captures the opinion of the general Spanish population, who consider that equity in the health system is a more important cause for concern than efficency, to the point that they are willing to forego overall health to achieve a more equitable distribution of health.[15]

Management and Organisational Reforms

It is well-known that efficiency in management is a big challenge for the public health care system, but the experiences of change are limited and, above all, there is a lack of evaluation.

Except for Catalonia, which has a wide private health care network used by the public system, regional health care systems provide health care in the public health care network. They just purchase services from the private network when they need them, as complementary health care. In Spain, 56% of the 146,202 hospital beds belong to the National Health System.[16]

Public hospitals have the expected problems of public bureaucracies, i.e. a lack of incentives to change. In recent decades, there has been a series of reforms to improve efficiency in management and health care quality in public hospitals. In the 1990s, following the reforms in the United Kingdom, Spain tried to split the roles of public financer, purchaser and provider. But it was a formal change rather than an actual one. In 1997 a national law was passed to promote the role of public organisations governed by private law, foundations and public companies, with the aim of gaining automomy in hospital administration. This strategy has not worked, and some communities, for example Galicia, have already admitted that it has to be rescinded. A more innovative model is that of a complete arrangement between regional public primary care and a private company, on an adjusted per capita funding basis. This is the "Alcira" model, which is being applied in some areas. These experiences have not been assessed scientifically. Madrid is testing other ways of privatising the provision of health care, with administrative concessions to build and privately run new public hospitals.

There are other promising experiences with regard to precise improvements in management, such as clinical management, process management and the integration of primary and specialised health care. However, these experiences have not been sufficiently evaluated.

[14] R. Urbanos, R. Meneu: La investigación sobre desigualdades en utilización de servicios sanitarios y sus distintos abordajes, in: M. Rodríguez y R. Urbanos: Desigualdades Sociales en Salud, Barcelona 2008, Elsevier Masson.

[15] I. Abásolo, A. Tsuchiya: Exploring social welfare functions and violation of monotonicity: an example from inequalities in health, in: Journal of Health Economics, Vol. 23, pp. 313-329.

[16] Hospital Survey in 2006, on the web page of the Ministry of Health Service and Consumption, http://www.msc.es/estadEstudios/estadisticas/estHospiInternado/inforAnual/tabEst2006.htm.

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Health Systems and Health Reforms in Europe: the Case of Italy

National Health Service systems are based on the principle of ensuring equal opportunities of access to services with the guarantee of equal standards for equal need, irrespective of the socio-economic circumstances of the individuals and of where they live. In recent years, many NHS countries, such as Italy, the United Kingdom and Spain have been shifting the provision of health services to sub-national entities (e.g. regions, provinces), defending the equity principle through the introduction of qualitative and quantitative standards set by national legislation and centrally monitored.

Italy has a national health service which was established in 1978 to replace its Bismarckian social insurance health care system with a Beveridgian model based on the principles of universalism, comprehensiveness and equity, that was modelled on the Brit-

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ish NHS.[1] Public health expenditure is relatively low in comparison with international standards: public expenditure on the NHS was 6.9% of GDP in 2006, whereas total health expenditure was 9% of GDP, slightly above the average of 8.9% in OECD countries.[2] Despite relatively low public health spending, the existence of the largest public debt in the European Union has forced Italy to change its NHS over time in order to reinforce incentives to contain costs.

After 1978, the major changes experienced by the Italian NHS involved a process of progressive regionalisation, including the introduction of fiscal federalism. This evolution gave the 20 Italian regions political, administrative and financial responsibility regarding the organisation and provision of publicly financed health care. In 2001 an amendment to the Italian Constitution further consolidated the power of the regions in a context where they differ widely in terms of demography and economic development with the persistence of a substantial north-south divide.[3] The central state retains the power to set and assure uniform and essential levels of health services (LEAs) to be guaranteed within the national borders. It can replace the regions in the case of their inability to provide health care at the desired levels. However, these health standards are specified only in terms of general principles, making it very difficult for the central government to use them as a tool to enforce greater uniformity in the provision of health care services at the regional level. At the same time, the regions are free to deliver additional services for which they are financially responsible. Indeed, the most efficient regions, which are able to meet the required standards at a lower cost, may employ the resources they save to finance other expenditure programmes according to the needs and preferences of their constituencies. "The greater independence given to the regions has accelerated the fragmentation of the system in terms of organisation of the regional services and funding of providers".[4] Hence, the devolution of powers to regional authorities has relevant implications for equity.

The aim of this paper is to provide a review of recent developments in the Italian federal health care system and to briefly discuss the main issues raised by this evolution. According to public choice theory, in unitary states decentralisation and vertical competition can generate stable outcomes, induce policy innovation, reduce information asymmetries and develop local democracy.[5] Nonetheless, decentralisation makes it more difficult to enforce an acceptable level of uniformity even when constitutional rules would require it, and it may increase regional inequalities. Moreover, centralised systems provide an institutional setting that facilitates the design and the enforcement of redistributive policies in favour of poorer areas, while greater financial autonomy at the regional or local level – even in a framework that allows for horizontal transfers between regions – makes it politically more costly to address equity issues.

The discussion is organised as follows. First we summarise the reform processes developed in the last thirty years within the Italian NHS, then we focus on more recent developments with particular reference to the enlargement of the fiscal autonomy of sub-national governments and the design of equalising transfers. From this point of view, the Italian case is "illustrative of the economic and political difficulties in implementing the insights provided by the theory of fiscal federalism in a country marked by stark territorial disparities".[6]

Reforms in the Italian Health Care System

In 1978 the health insurance system was replaced by a public integrated model of national health service. The system was deeply decentralised. It is now governed by a three-tier system with the central state (providing national planning and the aggregate budget – National Health Fund), the regions (providing more detailed planning and receiving central transfers to manage health services for their population) and the local health authorities (USLs). The latter were vertically integrated organisations funded by the regions through a capitated budget, administered by local governments and directly responsible for service provision in their geographical area. On the provision side, the private sector played only a complementary role to the NHS, contracted out to provide publicly financed services only when the public providers were unable to supply the complete array of services. As a result of this reform, benefits were standardised, universal access to comprehensive care was introduced

[1] G. France, F. Taroni: The evolution of health-policy making in Italy, in: Journal of Health Politics, Policy and Law, Vol. 3, 2005, pp. 169-87.

[2] OECD: Health Data 2008, Paris 2008.

[3] G. France, F. Taroni, A. Donatini: The Italian health-care system, in: Health Economics, Vol. 14, 2005, pp. S187-S202.

[4] Ibid., p. S190.

[5] A. Breton, A. Fraschini: Vertical competition in unitary states: The case of Italy, in: Public Choice, Vol. 114, 2003, pp. 57-77.

[6] G. Arachi, A. Zanardi: Designing Intergovernmental Fiscal relations: some insights from the recent Italian Reform, in: Fiscal Studies, Vol. 25, No. 3, 2004, pp. 325-65, here p. 326.

and large regional variations were reduced.[7] Meanwhile, the NHS was criticised for problems of reform implementation, for its poor economic and clinical performance, its inefficiencies and bureaucratic sclerosis. One of the major flaws of the 1978 reform was that "virtually the entire responsibility for financing the NHS lay with the central government, which, however, had limited power over how the USLs – legally creatures of the regions and run by the municipal governments – spent these funds. The central government's response to the disconnection between funding responsibility and spending power created a situation of permanent financial crisis"[8] that produced chronic regional deficits always made good by the central government that was unable to enforce a system of hard budget constraints.

In the early 1990s the Italian macro-economic situation was critical and the public budget went progressively out of control. Moreover, the Italian political party system lost its legitimacy because of corruption scandals. This critical juncture in 1992-93 opened up the opportunity for passing an extensive reform of the NHS in line with the principles of managerialism and of managed competition. The reform greatly increased the power of regions by transferring several functions from the state and by significantly reducing the role and political control of municipalities. In exchange for this greater power, the regions had to accept harder budget constraints for the financing of health care services. Financial resources from the National Health Fund could be topped up with additional resources collected by the regions. The state retained exclusive power to assure uniform and essential levels of health services (LEAs) and regions were accountable to provide LEAs, covering any deficit incurred with their own revenues.[9] Regions had control over USLs, transformed into Local Health Care Enterprises (ASLs) endowed with considerable operating independence and managed by a chief executive officer appointed by the region. Major hospitals were hived off from the ASLs and transformed into public hospitals (AOs) acquiring a status similar to the British Trusts, whereas prospective payments (DRGs) were introduced to finance public and contracted private hospitals. Compared with the UK, the degree of purchaser-provider separation was not complete in the hospital sector and no experience of GPs fundholding was introduced. Nonetheless, the 1992-1993 reform introduced incentives for cost-containment and efficiency improvements at the regional level and opened up to regions the possibility of adopting considerably different models of planning and/or quasi-markets in health care.[10] During the 1990s most regions organised their systems around the "ASL-centred model", according to which ASLs were financed by the region on a capitation basis and were expected to provide their residents with a complete range of services, negotiating agreements with accredited public and private providers. A few regions in northern and central Italy, characterised by smaller than average size, implemented a "region-centred model", with ASLs acting mostly as providers and the region playing the purchaser's role. The region of Lombardy (the largest in the country) opted for a "purchaser-provider split model" in which almost all hospitals were hived off from ASL control and transformed in AOs. ASLs acted mainly as third-party payers in a system where public-private competition and patient freedom of choice were encouraged. Finally, several central and southern regions neither implemented quasi-market mechanisms nor refined their planning strategies, but limited themselves to covering the actual expenditures of their providers.

In 1999, the Parliament approved a new reform that organised the NHS along the lines of what is termed "managed planning", i.e. a return to a more centrally controlled environment in which the competitive internal market scheme was replaced with a more collaborative system based on partnership. In line with the English White Paper of 1997, the Italian reform revised the 1992 market-oriented approach, giving more emphasis to planning and cooperation and increasing central government control to guarantee greater uniformity both across and within regions. According to France and Taroni[11] "the 1999 reform ... was an act of political will, made in the belief that the new public management model had gone too far" and was potentially jeopardising the basic principles of a national health service. As the possibility of purchaser/provider separation introduced in 1992-1993 was maintained, contracts were still necessary but had to be based more on cooperation between public and private providers rather than on competition. In this

[7] V. Mapelli: The origins of the Health Sector Deficit (in Italian), in: E. Gerelli, A. Majocchi (ed.): The public deficit: origins and problems, Milan 1984, Franco Angeli, pp. 505-571.

[8] G. France, F. Taroni, op. cit., p. 174.

[9] G. Fattore: Clarifying the scope of Italian NHS coverage. Is it feasible? Is it desirable?, in: Health policy, Vol. 50, 1999, pp. 123-42.

[10] G. France: Constrained governance and the evolution of the Italian national health service since 1980. Paper presented at the ECPR workshop on beyond the health care stat, Oslo 1996.

[11] G. France, F. Taroni, op. cit., p. 183.

context, the negotiation of volumes of services was, first, a means of controlling costs and decreasing the supply of unnecessary services. In any case, only a few elements of this reform were implemented as Italy began a process of further decentralisation and of fiscal federalism in early 2000.

In 2001, an amendment to the Constitution gave the regions legislative power, concurrently with the state, in many sectors and especially in health care, which accounts on average for two-thirds of the regional budgets. This was the most relevant achievement of an intense process of decentralisation of Italian institutions that, in less than ten years, deeply changed the relations between different layers of government, moving the country from a rigidly centralised to a highly decentralised structure.[12] As the possibility of improving the performance of the health care sector by increasing competition was highly disputed, a move towards greater decentralisation was perceived as an alternative strategy for raising the average quality of health care services across regions and for containing costs.

Some fundamental policy issues were expected to be addressed through a strong shift towards a federally oriented health care system. In particular the reform was expected to ensure:

- a higher capacity to control health care expenditure
- a higher efficiency in the provision of services
- the containment of free-riding incentives for local authorities facing soft budget constraints.

Despite the relevance of each of the above objectives, it has been remarked[13] that there is no clear empirical evidence that they can be pursued more effectively in a decentralised context.

As a matter of fact, major improvements can be achieved on different dimensions for which a decentralised organisation offers a potentially effective solution such as the capacity to provide services that more closely reflect local needs and to make political institutions more clearly accountable for the performance of their local health care systems. Decentralisation of health care is deemed to ensure greater adjustment to local preferences with the result of increasing the effectiveness in service delivery and allowing experimentation. At the same time, from a political point of view, decentralisation makes local politicians and managers more responsible for the use of their financial resources and the results they achieve.[14] Indeed, following the 1992-93 and 1999 reforms, the 20 Italian regions have now developed different organisational models that are in some cases also innovative, combining competition and planning in a complex mix of policy instruments.

We argue here that part of the difficulties currently observed in governing the regional health services comes from the poor match between the wide set of policy objectives that the regions in the new federalist system were expected to pursue and the limited opportunities to achieve them with the devolution of financial responsibilities from the national to the regional level. Further conditions should be met such as a broad sharing of the objectives of the reform between the different levels of government, together with measures aimed at improving the governance of the system and at providing incentives for the regions to cooperate, especially in meeting their budget constraints.

To safeguard the "right to health" that the Constitution recognises for each citizen, irrespective of his/her area of residence, at the national level the amendment of 2001 constitutionalised the guarantee for all residents to uniform "essential levels of care" (LEAs), while the regions received exclusive responsibility for the organisation and administration of publicly financed health care. The LEAs were defined in terms of a positive list containing the services that each region has to provide uniformly to its citizens through the regional health care system and a negative list of services excluded on the basis of effectiveness, appropriateness and efficiency criteria. Legislative Decree 56 in 2000 formally abolished the National Health Fund, which had been the main source of financing since the NHS was established. In the current organisation, regions rely mainly on the regional tax on production (IRAP) and on a regional surtax on the national progressive income tax (IRPEF).[15] IRAP is a value-added tax levied on basically all business with the yield accrued to the region where the value added is produced. As regards the IRAP tax base, there are large interregional differences. "In 2002, the two richest regions, Trentino-Alto-Adige and Lombardia, recorded, respectively, 130

[12] M. Bordignon, V. Mapelli, G. Turati: Fiscal federalism and national health service in the Italian system of governments, in: ISAE: Report on Monitoring Italy, Rome 2002.

[13] P. Liberati: Fiscal federalism and national health standards in Italy: implications for redistribution, Working paper SIEP 2002.

[14] I. Mosca: Is decentralisation the real solution? A three country study, in: Health Policy, Vol. 77, 2006, pp. 113-120.

[15] The standard rate of IRAP is 4.25%, while the rate of IRPEF surtax is 0.50%, both defined uniformly by national law.

and 128% of national GDP per head (with Italy equal to 100), while the two poorest regions, Calabria and Campania, reported 63 and 65%. Finally, IRAP's base is unstable: between 1998 and 2001 the contribution to this tax to total NHS funding fell from 44 to 37%".[16] There are also considerable interregional variations in the relevance of regional own-source tax revenues, with the southern regions reporting a value of 25% in 2003, and those in the north one of 56.3%.[17] For these reasons, the regional own-source tax revenues are supplemented for about one-third (on average) of the funding by an equalisation transfer grant fed by general national taxation – called the National Equalisation Fund – financed by a share of value-added tax (VAT) and petrol tax, the amount of which is set annually by the state with the aim of ensuring adequate financial resources for all regions to provide LEAs. In particular the reform provided for a long transition period from the present system of equalising transfers (which basically redistributes the regional VAT in order to meet historical expenditure in each region) to a new system in 2013 in which the transfers are determined according to a formula which takes into account the fiscal capacity, health need and economies of scale in the provision of public services. In practice, this equalisation mechanism is horizontal in the sense that rich regions give up some of their revenues to finance poor regions and regional revenues depend on the dynamics of their tax bases and on the equalising formula.

One of the ultimate aims of the fiscal reform is to ensure that, differently from the past, when regional deficits were systematically bailed out as a consequence of political bargaining, regions are faced with a hard budget constraint. This should reintroduce adequate incentives for cost containment and avoid the previous perverse spiral in which the most negligent regions benefited most. In this respect the (expected progressive) abolition of discretionary transfers should act as a tool to induce regions to become more responsible on the expenditure side. This effect should be reinforced by the fact that the institutional constraints on the use of regional revenues has been removed and the additional taxes can be spent in any programme the regional government decides to support.[18] From this point of view, the equity principle is partly compromised to the extent that regions have an independent source of funding, raising extra revenues,[19] even if only at the margins.

Regionalisation of the Italian National Health Service

As we have seen, organisational issues are no longer addressed at the national level, as it has become generally accepted that the organisation and administration of health care is a regional responsibility. Against this background, the persistent regional divide in terms of demography and economic development is raising major political concern as it may hinder the possibility of providing uniform coverage nationwide. In particular, North and South differ substantially in the age structure of the population, with southern regions being substantially younger than northern ones, whereas GDP in per capita terms reduces to half when moving from northern to southern regions.[20] It has been estimated that, as a consequence of this economic divide, only 7 regions out of 20 will be capable of autonomously raising sufficient resources to contribute to the National Equalisation Fund implemented to transfer resources from richer to poorer regions within the country. All northern regions, with tax bases larger than average, must give up some of their revenue, while all southern regions receive a positive input to their own resources. At the same time, by introducing LEAs the reform has strongly confirmed the principle of the uniformity of health services provision throughout the national territory. It is clear that the latter principle has rapidly begun to be at odds with the new system of regional financing owing to the sharp economic dualism between the North and the South of the country.

In the last few years an interesting pattern in state-region relationships has emerged. Given that a substantial number of regions currently incurs high deficits, the central administration is increasingly conditioning regional access to special funds for covering them to the adhesion to state-region agreements aimed at improving the governance of the health care systems at the regional level and at imposing financial discipline on the regions. On the one hand, this is achieved through the introduction of criteria at the

[16] G. France, F. Taroni, A. Donatini, op. cit., p. S193. By the way, the European Court examined the legality of IRAP in light of European Union rules on VAT harmonisation and in 2006 ruled in Italy's favour despite the adverse opinion of its own legal counsel.

[17] G. France, F. Taroni, A. Donatini, op. cit.

[18] G. Arachi, A. Zanardi, op.cit.

[19] Starting from 2001, each region will be able to raise the rate of IRAP by 1% and the rate of IRPEF surtax up to 1%. Hoping to force lower health spending, such tax rate autonomy was frozen by the central government in the 2003 Budget and freed again in the 2006 Budget. In 2007, the central government envisaged a further increase in the tax rate for regions that fail to get their health spending under control.

[20] G. Arachi, A. Zanardi, op.cit.

state level to improve efficiency in the public supply and to monitor more strictly the major sources of health care expenses (e.g. specific caps on pharmaceutical expenditure). On the other hand, regions experiencing more serious deficits lose their autonomy in fixing the regional income surtax rate that must be set at the highest possible level. In this respect, the central state reduces the incentive of regions to free-ride on the contributions obtained from citizens living in other areas of the country, as extra resources must be matched with a higher fiscal effort at the local level, too.

Overall, this shows that, although decentralisation is often seen as a possible solution for increasing the fiscal responsibility of public authorities, regional autonomy may not in itself be an effective tool for cost containment as it makes it difficult to enforce a hard budget constraint at the national level.

Moreover, regional autonomy may also be at odds with uniformity of service provision. This is explicitly recognised at the political level for all services exceeding the LEAs, which each region may freely decide to finance by raising regional taxes. Yet, given the potential ambiguities associated with any general definition of health care services that entail several quality dimensions, it is possible that some regions may end up reducing the (comparative) quality of essential services, especially if the divergence in local tax bases increases over time. In this respect, an international comparison shows that in the long run decentralisation allows greater regional disparities to emerge[21] and this is more likely in countries like Italy which are characterised by large territorial disparities.

First, the Italian health federalism will potentially create tensions between the state and the regions with respect to the financial resources necessary to guarantee the standards set as LEAs. In 2001, the VAT sharing rate was chosen in order to guarantee sufficient resources to finance the sum of all regions' needs. It is possible that in the future further difficulties will arise if regional tax bases grow less than health needs so that regional revenues will be no longer sufficient to meet the LEAs. In this case central government will face a compelling trade-off. Either it will be forced to increase the total resources granted to the regions by raising various tax rates or it can decide to reduce the LEAs granted by the NHS. However, both strategies have serious shortcomings. First, the possibility of a periodic revision of the VAT sharing rate brings back the problem of the soft budget constraint as it fosters the opportunistic behaviour of regional policy-makers. As the funding of the system is only partly decentralised, while the delivery of health care services is fully decentralised, the regions have a strong incentive not to do all they can to contain costs, claiming that this is due to the growth of health needs. Indeed, such a claim could be made simply to prevent the consequences of similar opportunistic behaviour of other regions' leading to a prisoners' dilemma setting. Second, the alternative strategy at the government's disposal – a reduction of the health standards granted all over the national territory – does not seem to be politically feasible. Hence, the regions that value health care most and want to keep high standards of public services will be forced to raise their tax rates to get additional revenue or to reduce expenditure in other programmes, with the risk of an increasing fragmentation of the various regional systems.[22]

Second, richer regions will be able to devote more resources than poorer regions not only to health care, but also to other expenditure programmes, whereas poorer regions depending on the resource equalisation mechanism will need larger transfers. Alternatively, to obtain an equivalent cash increase, poorer regions will have to raise tax rates more than richer regions, introducing further negative incentives for economic developments. Because of this, northern regions may have incentives to actively manage their tax revenues, while the southern regions may find it convenient to rely passively on grants. In addition, the impact of regionalisation on equity also depends on the rules governing cross-border traffic, i.e. large inter-regional differences in health standards will foster a high mobility of patients from poorer to richer regions. Therefore, the methods used to calculate the bill for the exporting regions, by influencing these cross-boundary flows, have a significant impact on the territorial equity. Under these circumstances, some regions will be strongly encouraged to restrict mobility for health reasons.[23]

Finally, even if the 2001 constitutional reform defines the broad framework for a coherent federalism, in the seven years since its enactment, its implementation is still very preliminary. Institutional conflicts have been widespread involving a large number of

[21] C. Lessmann: Fiscal Decentralization and Regional Disparity: A Panel Data Approach for OECD Countries, October 2006, available at SSRN: http://ssrn.com/abstract=936874.

[22] G. Arachi, A. Zanardi, op. cit.

[23] A. Petretto: On the cost-benefit of the regionalisation of the National Health Service, in: Economics of Governance, Vol. 1, 2000, pp. 231-32.

state-region disputes over conflicting competencies. Even more important for the issue at stake have been the frictions between regions. As long as all regions face more binding budget constraints, richer (or more efficient) regions have a strong incentive to keep a larger share of local revenues, increasing the political costs of horizontal transfers. At the same time, the devolution process potentially increases the financial vulnerability of poorer (and/or less efficient) regions, raising serious concerns over their capacity to sustain part of their welfare systems, and thus generating a demand for more intense redistributive policies. As a consequence of this duality, it comes as no surprise that during this transition, regions are experiencing serious difficulties in agreeing over how to address the equity/allocative trade-off, with the consequences of slowing down the political process and of producing some policy incoherence.[24]

The major obstacles to achieving such equilibrium come from the difficulties for Italian regions to fully accept the principle of the incomplete central financing of health care costs, which resulted from the application of the tax capacity equalisation criterion meant to make interregional transfers from high income to low income regions more explicit. The bargaining mechanism used in the transition period resulted in soft lower level budget constraints. Many regions incurred large health spending overshoots that had been covered by growing suppliers' credits, the securitisation of such credits and, finally, *ex post* state transfers under periodic clean-up operations. In this situation, indebted regions blamed health deficits on the need to satisfy high national standards on health and demanded more *ex post* transfers from the state, exacerbating conflicts with the regions able to achieve the health care break-even point. From this point of view, the problem of inter-regional equalisation is one of the most important political problems for the future of Italian federalism.

A High Commission on Fiscal Federalism, formed in 2003 by a centre-right government to draw up a set of legislative proposals, presented its report in late 2005, but was abolished in 2007 by the subsequent centre-left government that proceeded to put two draft laws before Parliament to clarify spending assignments and to implement fiscal federalism as a future reform priority. In the same period, the Lombardia region advanced a proposal to avail itself of a sort of "multi-speed" federalism, wishing to go ahead with greater spending and tax autonomy before the other regions. The first challenge for the new Italian government that won the election in April 2008 concerns fiscal federalism. One of the movements gathered in the new government, the Northern League, calls for fiscal federalism preventing public money from going south, and the government recently endorsed the bill voted by the Lombardia Region concerning the request of asymmetric federalism.

Conclusions

Italy, as well as other European countries, has undergone a process of fiscal decentralisation that is still under way and the health care sector has experienced the most intense devolution of organisational and expenditure responsibilities from central to regional authorities since the early 1990s. In the last decade this has led to the development of increasingly different regional models for the organisation and supply of health care services. In the same period, the most critical issue concerning health care financing has been the systematic divergence between the *ex ante* assignment of resources defined at the national level and the *ex post* level of expenditure incurred by regions. Over the years this has produced substantial cumulated deficits that have exacerbated the institutional conflict between central and local governments. The expectation that measures aimed at bailing out unrestrained regional deficits[25] would be unavoidable, further reduced the incentives for limiting health expenditure at the local level. Moreover, since per capita deficits, although involving all regions, were distributed unevenly across the country, these measures generated a perverse spiral according to which the least disciplined regions benefited more from the bailing out. This raised a widespread demand for a devolution of responsibilities to regions not only on the delivery but also on the financing side. An attitude that added up to a more general political stance in favour of a federal transformation of the state that, starting in the northern regions, was gaining increasing consensus throughout the country.

The equity issues inherently linked to the federalist process have been addressed through the definition of the essential levels of care (LEAs) that each region has to uniformly guarantee to its citizens. Within this context, the LEAs worked both as a tool for ensuring the uniformity of essential services across the country, a constitutionally protected right, and as a tool to

[24] A. Bibbee: Making federalism work in Italy, OECD, Economics Department Working Paper 590, 2007.

[25] M. Bordignon, V. Mapelli, G. Turati, op.cit.

assess roughly the amount of financial resources that the public decision-maker plans to devote to health.

The implementation of a truly federal health care system has been seen as a possible solution to address a wide range of problems affecting both the provision and the financing of health care. Although for some of these problems, such as the capacity to respond to differences in local needs, sub-national governments can represent a dominant solution, for others, such as the capacity to increase efficiency in the organisation and the provision of care, it is by no means clear that a decentralised setting ensures substantial advantages.

The main purpose of the reform process was to give up progressively discretionary transfers from the state and to move towards a system in which, once adequate compensation for regional differences in the tax base and health needs had been guaranteed, no constraints on resource allocation was imposed. A transparent system of equalising transfers was expected to make regions more clearly accountable for their expenditures and the quality of services provided according to LEAs. Still, the major point to be addressed is the credibility of a process that aims at transforming soft into hard budget constraints. It must be recognised that at the moment the evolution towards a federal system displays substantial weaknesses that are threatening the future sustainability of the process.

The source of most of the problems currently experienced is probably twofold. On the one hand, until now some regions have not been ready to fully take up the responsibilities that a federal system implies. On the other hand, the implications of some of the initial conditions faced by the country – such as the wide differences in the regional tax bases – had initially been overlooked. This implies that, for several regions, the opportunity to cover budget imbalances with local revenues is extremely limited. This limitation, added to the fact that richer regions have become more and more reluctant to give up their own financial resources because they are facing more binding financial constraints themselves, suggests that a fully fledged form of fiscal federalism still requires many institutional and political steps to be successfully implemented. In this respect, recent measures according to which the central government has conditioned extra financial transfers to the regions with larger deficits on the adoption of severe measures for cost containment (agreed with the national government), seems a first response to improve the enforceability of the new set of rules. Overall, however, the ongoing political and institutional conflicts among regions and between them and the state confirm that "federalism is still very much work in progress in Italy".[26]

[26] A. Bibbee, op.cit., p.6.

Eszter Sinkó*

Hungarian Case Study – Lessons from Eastern Europe for New Members of the European Union

This short analysis adresses the transformation of the Hungarian health system during the 2006-2008 period. It is focussed mainly on the attempts to reform the social health insurance scheme because the author of this article is of the opinion that this may contain the most important lessons for other European countries, especially the new member states of the EU.

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Hungary organised its health care system on three basic principles after World War II: (1) universal coverage; (2) offering comprehensive services; (3) which are free of direct charge at the point of use. The health system was based almost exclusively on the state which, as the main actor in health care, accumulated all the important roles, including the provision (through owning facilities), control and financing of health services. These all meant that before 1990 Hungary had typical state-run schemes, as a consequence of the

fact that "the state" fulfilled every important function related to the running of the system.

Main Changes after 1990

In 1990, the new, freely elected government started the process of reducing the roles of government as well as beginning systematically to implement a new health care structure. The measures taken were as follows:

- In 1989, the National Health Insurance Fund (HIF) became independent of the treasury. Since 1990 the HIF has covered all recurrent costs of health services.
- The employees and their employers have had to pay contributions (premiums) to the HIF in order to receive services (compulsory social health insurance scheme).
- At the beginning, all Hungarian citizens were entitled to use services without direct payment at the point of use. There were two main exemptions: dental services and medicines bought in pharmacies. In 1992, entitlement to services was shifted from citizenship to payment of contributions, because the government did not wish to support those working in the black or grey markets who did not pay contributions.
- Local governments became the owners of the bulk of health care facilities. They received the buildings free of charge. They were supposed to be responsible for the maintenance of all facilities as a consequence.
- The financing of the costs of health services was split in two: the recurrent cost was financed by the HIF, while the responsibility for financing the capital cost was transferred to the owners of health care facilities, mainly local governments.
- Health services were paid for on the basis of performance instead of the historical budget of the Semashko system. In the case of acute inpatient care Diagnoses Related Groups (DRGs) became the basis of payment, while outpatient specialist care was paid by a fee-for-service system. GPs were paid according to the numbers of patients registered.

Main Characteristics of the Health Insurance System

The Hungarian health insurance system is a single-payer system which is compulsory for all (there is no possibility to opt out for high income persons), offers universal coverage over the whole range of health services with very few exceptions, is administered by a central organisation, the National Health Insurance Fund Administration (NHIFA), which has 19 county branches responsible for the administration of contracting and payment. These agencies have no autonomy in purchasing, that is to select suppliers with whom they contract, to decide on services for which they contract, or to decide on the price of services.

Contributions from employers and employees amount to 70% of the revenue of the HIF, while the central government budget pays contributions for pensioners, students and those under 18.

General Election in 2006 – New Government

The MSZP (Hungarian Socialist Party – the successor of the communist party) and the SZDSZ (Alliance of Free Democrats Hungarian Liberal Party) won the elections in 2006. In the coalition government the Ministry of Health (MOH) was acquired by the Free Democrats – for the first time in the history of the Hungarian health care system since 1990. The SZDSZ, as unconditional partisans of the free market, emphasised first of all the transformation of the health insurance scheme, assuming that all the major problems of the Hungarian health care system would be resolved as soon as the health financing scheme was privatised to as large an extent as possible.

The health policy of the government went beyond the vision outlined in the election programme of the SZDSZ. The Ministry intended not only to transform the social health insurance system, but wanted to intervene in the service delivery side and to improve the inefficient resource allocation among sectors, too.

Diagnosis by the Government

The government published a Green Paper to popularise its health programme and open it to public discussion. The document contained the following main critical statements to substantiate the necessity of reforms:[1]

- The health status of the Hungarian population is much worse than the level corresponding to the economic development of the country. In respect of the main health indicators Hungary falls behind not only the developed countries, but countries in a similar process of changing their economic and political system and having a similar endowment. (Life expectancy is 6 years less than the EU average.)

[1] I. Csaba: A magyar egészségügy Zöld könyve – 2006 Áttekintés és kommentár, Kézirat, manuscript, August 2006.

- The unfavourable health status of the population may be explained, first, by unhealthy life styles and second, by the low efficiency of health care.
- According to the government the main problem was not the low level of health expenditure (as in fact its proportion of GDP is comparable to that of most developed countries), but that demand and supply were not sufficiently limited (health expenditures as a percentage of GDP was 7.9% in 2004). This has resulted in a quantitative expansion of patient-doctor encounters, so the amount of resources per encounter diminished, making the quality of care worse. At the same time, this problem creates the impression of underfinancing, the most important complaint of health care providers.
- The structure of the health service delivery system is neither in harmony with technological innovation nor with needs, and the system generates geographical inequalities in access to care.
- The health care system is characterised by a lack of clear-cut responsibilities, accountability and transparency. Among other things, this is manifested in the irregularities of insurance status, inequities in financing and in wide-spread informal payments.
- Citizens hold the government responsible for the unsatisfactory functioning of the health care system, which enforces a defensive attitude on the part of the government.

According to the government, the single payer social health insurance system is ripe for transformation, because the NHIFA functions in a bureaucratic, clumsy way, much rather like a public authority than a real insurer. It does not have an adequate registration system for citizens' insurance status, which implies that the state is unable to establish such a system, it is not responsive to the differentiated wants of the citizens when it contracts with providers, and it does not enforce a hard budget constraint in the management of expenditure, that is it allows a continuous reproduction of the deficit of the HIF.

Main Objectives of Transformation

The government believes that the main problem with the Hungarian health care system is that citizens continue to treat health care on the basis of values to which they were accustomed in the socialist period and have not yet realised that health care is no longer "free" ("there is no such thing as a free lunch"). Taking all this into account, the declaration of a new value orientation has also been placed on the agenda. The new objectives have been set in this context. The first objective is to make the spirit of self-responsibility stronger among citizens, to support a change in attitudes to the utilisation of health services that stimulates more responsible behaviour. The second is to limit access to care in a rational way by taking steps to reduce demand, since according to government estimations 20-30% of patients utilise the services unnecessarily. Restrictions on the supply side are meant to act against the unnecessary utilisation of care and make a more efficient utilisation of capacities possible. The third is to implement measures that transform citizens into cost-conscious customers and provide a more efficient protection of their interests, applying methods in wide-spread use in the EU. The fourth is to increase the efficiency of the everyday operation of the social health insurance system, which could produce more satisfaction and better quality for the patients.

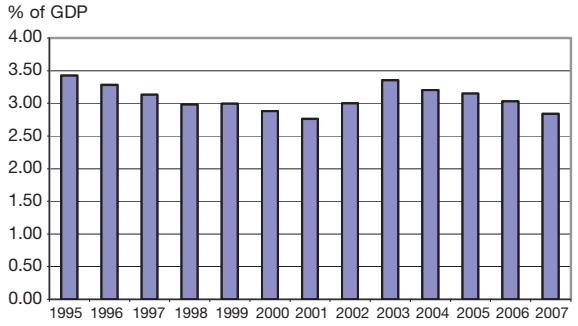
Means Chosen

The government hoped to attain two goals at once by introducing new forms of user charges (a visit fee for each patient-doctor encounter and a hospital *per diem* for inpatient stay, both approx. €1.25): first, to strengthen the spirit of self-responsibility and second, to reduce the unnecessary utilisation of services. It hoped, moreover, that these user charges would decrease informal payments, which is a major problem in Hungary.

In order to attain restrictions on the supply side – to reduce "supplier-induced demand" – the government wanted to radically downsize acute inpatient care capacities (i. e. the number of hospital beds). The thinking behind this idea is that the Hungarian health care system is hospital-centred in the provision of care, which generates unjustified utilisation and expenditure. International comparisons also verified the standpoint of the government in relation to the high number of beds (60/10,000 population in Hungary versus 40/10,000 population on EU average in acute care).

Analysing the Hungarian health expenditure pattern, it has long been obvious that the share of pharmaceutical expenditure is too high (cf. Figure 2 below). Moreover, pharmaceutical expenditure grew at a faster rate than GDP, leaving an ever narrower room for other public expenditure on health. Figure 1 demonstrates a continuous decrease of the proportion of the health expenditures (pharmaceutical cost excluded) as a percentage of GDP. The increase in

Figure 1
Health Care Expenditure without Pharmaceuticals



2002 and 2003 was the result of an average 50% increase in the salary of public employees, which was one of the election promises of the MSZP in the 2002 general election, and which later became one of the sources of the extremely high budget deficit in 2006.

Former governmental interventions (three-year price agreements, volume restrictions) turned out to be insufficient to reduce pharmaceutical expenditure, so the government determined to take more radical steps. It levied a special annual fee per medical representative of pharmaceutical companies, enforced pharmaceutical firms to grant rebates on drugs subsidised by the social health insurance scheme and capped the drug subsidy sub-budget in the HIF, above which the deficit should be financed from payments by pharmaceutical companies.

In addition, the government made it mandatory for medical doctors (especially general practitioners) to use a software to modify their drug prescription habits. Doctors are obliged to prescribe the cheapest drug in a therapeutic group (ATC) unless the patient insists on his/her usual brand. The NHIFA monitored the prescriptions of each doctor individually.

It was considered to be important for the protection of citizens' interests to establish a Health Insurance Supervisory Authority which, as a governmental agency, provides help to citizens in disputes with providers or represents their interests against insurers.

To improve the efficiency of the health insurance system, after long and heated debates a social health insurance scheme was proposed, which had several insurance funds (companies). These funds compete with one another for insurees, and in all insurance companies the state is the majority owner (51%). Private investors, at least initially, would be allowed to have only a minority share (49%).

At the beginning of the debates, SZDSZ would have liked to have privately owned funds, so that the NHIFA would join them as an optional, publicly owned fund. They believed that this solution provided an ideal health policy means for all the financing problems they identified. The scheme was said to be most similar to the Dutch system with some Slovakian influence.

After long disputes the MSZP finally refused to support this model, and instead accepted the aforementioned mixed ownership model as a compromise.

Six New Laws in One and a Half Years

To implement the government's target model, the parliament passed six new laws on health care up to December, 2007.[2] First, a Health Insurance Supervisory Authority was established, which started its activities with 60 employees in 2007. Second, the legal status of the chambers of health professionals has been transformed, obligatory membership abolished and their sphere of authority changed, all this in order to lessen their political influence. Third, the number of hospital beds admitted into public financing was fixed. 26% of acute care beds were eliminated (from 60 000 to 44 000), while the number of chronic long-term care and rehabilitation beds has been increased by 7 500. In April 2007 a distinction was introduced between priority and non-priority hospitals, as an appreciation of their different roles in health care, and each hospital was ranged one by one among categories. Third, in the frame of the act on drug cost containment a special tax has been levied on pharmaceutical companies, amounting to a 12% social insurance rebate, and a sum of HUF 5 million (USD 33 333) capitation fee must be paid for each medical visitor.[3] A special software supporting drug prescription has been distributed in order to change the prescription habits of doctors. Price competition among suppliers of generics has been initiated. The drug retail trade has been liberalised, some non-prescription drugs have become accessible outside of pharmacies and the requirements for establishing pharmacies have loosened. Fourth, to link entitlements to payments of social insurance contributions, and to clarify the insur-

[2] The six Acts: 1. Act CXXXII of 2006 on developing the health care system; 2. Act XCVIII of 2006 on safety and efficient supply of pharmaceuticals and medical devices as well as on the general rules of pharmaceuticals distribution; 3. Act XCVII of 2006 on professional chambers functioning in the health sector; 4. Act CXVI of 2006 on tasks of the Health Insurance Supervisory Authority; 5. Act CXV of 2006 on modification of certain health-related acts; 6. Act I of 2008 on Health Insurance Management Funds.

[3] The Constitutional Court recently abolished this type of rate.

ance status of citizens and the benefits covered, the government withdrew entitlement from persons pertaining to the category of dependants as of January, 2007. The amount of the two forms of co-payment introduced from 15 February 2007 has been set equally at HUF 300 (USD 2). The visit fee has also been levied in primary care (GP), i.e. for the first doctor-patient encounter. Hospital waiting lists have to be made public, which became necessary because a volume limit was introduced for reimbursable performance in specialist inpatient and outpatient care. Fifth, the competing multi-insurer model was planned to start with 6-7 funds in 2009. According to the plans, the funds would have been organised on a regional basis, competition would have emerged mostly in the capital and its vicinities. Each of these funds was planned to be set up by the government as a for-profit joint-stock company and sold 49% of their shares to private investors. Management of the funds was planned to be concentrated in the hands of private investors. Citizens would have been allowed to choose funds freely.[4]

Results, Effects, Consequences

It is difficult to evaluate the impact of government refoms after such a short time since they exercise their full effects in the long run, not in a year. Nevertheless, we shall consider the available partial evidence to inspire further research.

With regard to direct financial effects, the NHIFA showed approximately HUF 14 billion in surplus revenue between 15 February and 31 December 2007 in inpatient and outpatient care together. Health facilities used this sum to increase the wages of their employees or to purchase machines and equipment. To give an impression of the importance of this co-payment, in the case of general practitioners this represented 10-25 % of their total income, in outpatient specialty care it amounted to 8-9%, and in the hospitals 1-3% of their revenue.

Beyond the above-mentioned sums, the government also made some other financial savings as a result of a spectacular reduction in utilisation. (In outpatient specialist care and in hospital inpatient care there is performance-based payment, while primary care is capitated.) Surprisingly, a more than 25% reduction in visits was registered in primary care, while there was a somewhat less dramatic fall in outpatient specialist care, although this also exceeded 20% in some cases. In hospitals there was no perceptible reduction as a consequence of the *per diem*. Savings from the reductions in drug consumption and care utilisation amounted to HUF 42 billion according to the government, but in all probability this balance sums up effects of other governmental measures as well.[5] (N.b.: Unfortunately we have no means of controlling the governmental statements because pertinent data are not accessible to the public.)

Only a few not very sophisticated surveys have served the analysis of the impact on patient behaviour in the past year. According to the viewpoint of the government the new user charges prevented only unnecessary utilisation, but some surveys made in the summer of 2007 indicate otherwise. According to a survey made in July 2007 by GfK Hungaria 26% of the income group below HUF 90,000 (USD 600) said that the visit fee influenced their decision to go to the doctor, while this rate was only 6% among those with an income over HUF 150,000 (USD 1000). To the question "Did you postpone any visit because you would have had to pay a user fee?", 21% of those with low incomes replied with "yes", while in the higher-income group "only" 9% answered affirmatively.[6]

Another survey made by a Hungarian market research company (Szinapszis) in August 2007 revealed that doctors deemed only 47% of the drop in visits to be meaningful while 53% was deemed harmful.[7] This latter is only "soft" evidence, but indicates that more thorough surveys are necessary.

Consequence of Re-tailoring Hospital Capacities

A 26% reduction in the number of acute beds, a significant (35%) increase in chronic and rehabilitation beds and the manner in which these measures were implemented resulted in total confusion in health care provision. On the instructions of the Prime Minister, this cut-down and enlargement was executed in a single step, within a three-month period. As a consequence, previous patient pathways have been disarranged, the former order of patient referral has disintegrated, and access time to care has increased. Patient needs have not been surveyed and capacities have not been adjusted to them. Up to now, the delivery system has not yet recovered from the transformation shock.

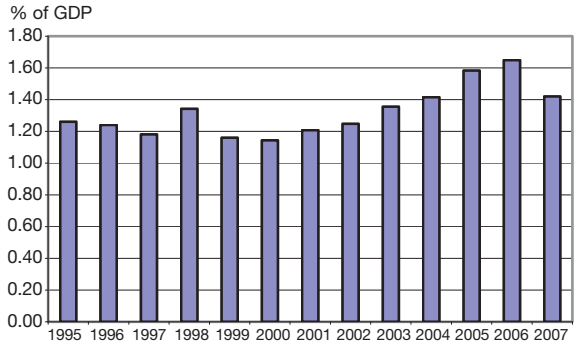
[4] The Act passed on 17 December 2007 was sent back by the President to the parliament for consideration, and thus, after some modification, according to the rules of the Hungarian legislation it was voted in the final form on 11 February 2007.

[5] Notice of the Ministry of Health, 30 November 2007.

[6] GfK Hungaria, July 2007.

[7] Szinapszis Piackutató és Tanácsadó Kft, August-September 2007.

Figure 2
Pharmaceutical Expenditure



Restructuring yielded only a minimal financial saving (HUF 2 billion), because only 5 hospitals were closed, 6 state facilities were amalgamated into one and the entitlement to provide acute beds was withdrawn from only 11 hospitals among the 165.

Drug Cost Containment

Manifold consequences of the Act of Drug Cost Containment can be mentioned here, because the law initiated fundamental changes in several ways. First, the law has succeeded in containing the seemingly uncontrollable growth in drug expenditure. This is shown in Figure 2 by the decrease in the proportion in GDP. Drug expenditure fell by approximately 20% in 2007 as compared to 2006 (from HUF 388 billion to 323 billion).

Second, as a consequence of the prescribed price competition and bidding, a reduction of 23% was registered by authorities in the case of roughly a thousand pharmaceuticals. Third, payments by pharmaceutical producers in the form of a 12% rebate yielded HUF 16 billion, while the payment for visiting medical representatives yielded HUF 7 billion. Fourth, the government intended to introduce clear-cut sanctions in the case of low compliance by doctors, but it has abandoned the application of financial sanctions due to the indignation generated by the detailed regulation, the "whip decree". However, by and large, the drug prescription habits of general practitioners have fundamentally changed, the proportion of generics in drug consumption has increased, which – together with the decreasing number of visits to doctors – yielded a total saving of roughly HUF 15 billion for the HIF.

National Referendum

The largest opposition party (FIDESZ) initiated a referendum on the newly introduced user charges (the visit fee and the hospital *per diem*). There was some polemic as to whether a referendum could be initiated on this issue, but the Constitutional Court finally answered in the affirmative. The referendum took place on 9 March 2008. More than 50% of the electors participated and 85% voted for the withdrawal of the two fees. The government therefore abolished the user charges as of 1 April, 2008. However, so far only family doctors have been partially compensated for the loss of user fee revenues.

The referendum had an unexpected additional result. The government, realising the mood of the population and the threat of another referendum in autumn on the transformation of the insurance system, withdrew the bill on the functional privatisation of the social health insurance system. The SZDSZ left the coalition, so that currently the MSZP forms a minority government.

Lessons for New EU Members

The publicly financed health insurance package is not exactly defined, although the main categories of health care are determined by the law. (Hungary is not the only country in which this issue is not settled appropriately.) It follows that the payers and/or providers have some discretion to interpret rather freely the content of insurance packages within certain limits. (This fact, among others, lays the ground for the defencelessness of patients.) This problem gains in importance in the case of schemes in which profit-oriented investor-type private owners have been given a public financing role.

The danger is not less even if private capital has only a minority participation in the insurer or in the fund, because in all probability it may be expected that the state as majority owner will behave in a way very much like the private owner. (The state, when programmes are targeted at curtailing budget expenditures, is interested in eliminating the health budget's deficit. So, in the case of the Hungarian model, the representatives of the state would vote for all measures which result in a reduction in expenditure. The state would, in any case, not be the holder of the position of general director, which is important for the exercise of management authority. Thus the possibility for representatives of the state to oversee everyday matters was restricted from the start.)

Legal requirements concerning the content of the health care package may in many cases provide real protection for citizens, so one of the strategic chal-

lenges facing any private organisation that participates in public financing schemes, over and above the interpretation of the package, is to move proposals at the legislative level with the aim of narrowing the content as much as possible. It is difficult to develop an organisational scheme in which the private financer would be prevented from exerting pressure on decision-makers to reduce the health care package. (In the government's model a Pricing Committee would have been authorised to continuously revise the content of the care package. Government delegates would have a majority in the Pricing Committee (3:2), but the representative delegated by the MOH could be outvoted by the other four members. The delegate from the ministry that supervises state finances would reasonably defend the interests of the state budget, not those of patients, as the finance ministry has always done during the last one and half decades.)

Capitation-type financing assures fixed definitive revenues for each fund, which is difficult to change in the short run. The SZDSZ can claim this is good, as at least the budget constraint will be harder in this scheme. However, thinking over everything which has to be paid in exchange for it, it has to be realised that the price is too high. On the one hand, financing organisations have to earmark funds from their revenues for operation expenses (in the Hungarian model this amount was 3.5% at maximum, similarly to the Slovakian model), for dividends (2% in the model), for different types of reserves and for marketing activities, and only the remaining part may serve for financing health services. On the other hand, significant excess expenses can emerge in the multi-fund model for the providers, since contracting with multiple funds and different report obligations mean an extra workload for them. Summing up all these items, more than 15% of the revenues would be spent on administration instead of health services.

It is a well-known fact that health care expenditures are highly concentrated on a few individuals and high risk groups. A small number of patients generates extremely high expenses: 10% of patients account for 60% of expenditure or, according to another survey, 20% account for 80% of expenditure.[8] In the Hungarian model, private insurers, when entering the domain of public financing would have been faced with the fact that the government delegates tasks to them which they have not previously implemented. What is more, they would often be obliged to solve problems which have never been settled with success by anybody else. Neither general ready-made panels nor existing know-how are available to them. They face great difficulties in finding experts to implement this task, because it is a rather complex and sophisticated activity. Moreover the coordination of care provision, which would be an activity expected of them, would often result first in a cost increase instead of a cost reduction, simply because of the widened sphere of preventive activities. (However, these organisations have always been aware that restraining the access to care provision, especially for the particularly cost-consuming patients, would result in short-run savings). Pressure to produce profits leads the management of private funds and private insurers to constrain access to care for chronically ill patients. International experience clearly supports these concerns, and even the ever-cautious OECD indicates similar worries.[9] (The Hungarian model puts its trust in control by the Health Insurance Supervisory Authority as a counterbalance, but the mere existence of such an authority would make only extremely weak interventions possible.)

Incentives for patient selection and cream skimming are fundamentally generated by a capitation scheme that does not function adequately. Adjusted capitation-type resource allocation can account for only 30% of individiual risk inhomogeneity. Risk selection remaining after adjustment may be eliminated only by taking into account the actual expenses.[10] Effective prevention of selection is difficult to implement and extremely expensive, everywhere in the world.[11]

The repeal of the Act on the multi-insurer scheme was partly a result of such considerations, but mainly due to the fact that the new value orientation offered by the SZDSZ was rejected by members of society.

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[9] R. Kuttner: Market-Based Failure – Second Opinion On US Health care, in: The New England Journal of Medicine, 7 February 2008; M. E. Porter, E. O. Teisberg: Redefining Health Care – Creating Value-Based Competition on Result, in: Harvard Business School Press, 2006; Private Health Insurance in OECD Countries: The Benefits and Costs for Individuals and Health Systems, 2004; Y. Bartholomée, H. Maarse: Health insurance reform in the Netherlands, in: Eurohealth, Vol. 12, 2006, No. 2, pp. 7-9.

[10] P. Gaál: Egészségbiztosítási reform: innováció vagy ócsítás, in: Orvostovábbképző Szemle, January 2008.

[11] W. Van de Ven et al.: Risk adjustment and risk selection on the sickness fund insurance market in five European countries, in: Health Policy, Vol. 65, 2003; S. Gress: Competition in Social Health Insurance: A Three-Country Comparison, Diskussionsbeiträge aus dem Fachbereich Wirtschaftswissenschaften, University of Duisburg-Essen Campus Essen, No. 135, July 2004.