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CENTRE FOR HEALTH ECONOMICS

Social Health Insurance Systems in European Countries

**The Role of the Insurer in the Health Care System:
A Comparative Study of Four European Countries**

Rowena Jacobs

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Executive Summary

This paper examines the role of social health insurance in four European countries: Germany, Switzerland, France and the Netherlands. It attempts to elucidate the organisational structure, regulation and management of the social insurance schemes, as well as the relationships between the insurers, providers and consumers in the various countries with the aim of uncovering some of the inherent strengths, weaknesses and trade-offs which exist within social insurance systems. The main discussion points and conclusions from each chapter are listed below.

Chapter 1: Introduction

Social health insurance systems share a number of features, although all are not strictly necessary for the system to be described as such:

- Insured persons pay a regular contribution to a health insurance fund based usually on income rather than reflecting their risk of illness.
- Clinical need and not ability to pay determine access to treatments and health care.
- Contributions to the social insurance fund are kept separate from other government mandated taxes and charges.
- Both employers and employees pay contributions.
- Government support for those who are unable to pay goes through the insurance fund.
- There may be more than one social health insurance fund and some choice may be available to citizens.
- Patients have at least some choice in the doctor and other health care providers they use.
- Social health insurance is compulsory for at least some categories of citizens.
- A basic package of health care benefits is defined which may or may not vary across funds.
- Health insurance funds may not turn away applicants for membership.

Services are often delivered by a mix of public and private providers. It is common for contracts to be negotiated between all social health insurance funds together and associations of providers. Because there is no risk-rating (to prevent preferred risk selection and create solidarity), there is usually some sort of system to transfer risk-adjusted funds between insurance companies, so that all insurers can compete. The risk-adjustment mechanism, and the regulation of competition and choice are however complex and expensive and increased diversity can increase inequality. Transaction costs may be high in social insurance systems, especially where there are complex contracting arrangements with competition and choice.

Typically people appear to be most satisfied with social insurance based systems compared to tax funded and private insurance systems. Social insurance systems are often associated with higher levels of funding and the hypothecation of funds makes the system transparent. The problems of the system relate to cost escalation, the excessive reliance on payroll contributions and high transaction and management costs.

Chapter 2: Germany

Associations of providers (physicians and dentists, but not hospitals who contract individually, although this is expected to change in 2000) and associations of autonomous sickness funds represent the statutory health insurance system at the corporatist level where

negotiations take place. The system is highly decentralised with a mix of private and public providers and insurers.

Social insurance is regulated by the Social Code Book which is amended by reform laws and regulates:

- Mandatory and voluntary membership in sickness funds,
- The contents of sickness funds' benefit package,
- The scope of negotiations between sickness funds and providers,
- Risk compensation between funds, and
- The organisational structure of sickness funds and their associations.

The physicians' associations obtain a total prospectively negotiated budget from the sickness funds (negotiated as a capitation per member or per insured person) which they then distribute among their members according to a 'Uniform Value Scale'. This lists all services provided by physicians for remuneration within the health insurance system.

There are around 450 sickness funds and membership is compulsory, except for an 'opt out' scheme for higher income persons. Contributions are based on income with a 50-50 contribution from employer and employee. There is free choice of sickness fund and members may change on a yearly basis. Members receive benefits in kind, cash benefits and health promotion and family members and dependants are also covered. A relatively crude compensation scheme exists between sickness funds to equalise risk structures due to differences in contribution rates (from varying income levels). This is calculated retrospectively from expenditure data.

Privately insured patients usually enjoy better benefits than those covered by statutory health insurance but they generally have to pay providers directly and claim reimbursement. Premiums are risk-rated and separate premiums have to be paid for spouses or children. For those that 'opt out', re-entry into statutory sickness funds is not permitted. Supplementary insurance which covers extra amenities in hospital is a growing market for private health insurers, since sickness funds are not allowed to offer such policies.

Because sickness funds have to offer the same benefits for a similar contribution rate and the range of providers is the same since they are contracted collectively, there is not much competition between sickness funds, although selective contracting is increasing. The problem is to try and maintain a system of equal access.

There is no gate-keeping system in Germany and patients can select any sickness fund affiliated doctor or specialist of their choice. There is a problem of separation between ambulatory care and inpatient care which potentially creates a duplication of services.

Taxes and out-of-pocket payments (which occur mostly for pharmaceuticals) are two other major sources of finance.

Dual financing exists for hospitals where capital costs are financed through individual states and general running costs through sickness funds. Hospitals are reimbursed through prospective case and procedure fees and per diem charges. If the hospital has been reimbursed above the target budget then it has to pay back a certain part of the income.

Sickness funds do not have fixed budgets but have to cover all expenses which means that contribution rates have to be adjusted if income is lower than expenditure. All budgets are on the providers' side and not the payers' side.

Reference prices have been established for pharmaceuticals to establish an upper limit for the costs that are reimbursable by sickness funds.

Cost containment has been the main theme of health care reforms in Germany. Current issues however revolve not around expenditure problems as much but financing problems, since increasing unemployment has caused shrinking financial flows to the social insurance system.

Chapter 3: Switzerland

The health care system is characterised by liberalism with little state intervention although the regulatory powers of federal government have increased considerably. The health insurance system is relatively decentralised and cantons play a large role in the provision and regulation of health care. Most changes in the system entered into force in 1996 with the health insurance law when the statutory health insurance system became compulsory.

There are just over 100 insurance companies offering compulsory insurance. They can also offer supplementary insurance which covers additional benefits such as free choice of hospital doctor and superior accommodation. The insurance companies must accept all applicants and offer the same package of benefits. The premiums are community-rated (the same for each person with a particular company within a canton) whereas supplementary health insurance premiums are risk-rated. Patients have freedom of choice of provider and insurer and can change their health insurance company twice a year.

All insurance companies are members of the Association of Swiss Health Insurance Companies and are in turn monitored by the Federal Office for Social Insurance. Doctors are organised into cantonal medical associations which negotiate fee levels with cantonal associations of health insurance companies. Public and publicly subsidised hospitals are also organised into associations which negotiate fees with the health insurance companies.

Providers are financed by payments from insurance companies or by direct payments from patients. Federal and cantonal subsidies from tax revenues are used to fund hospital capital costs and some of the running costs. Insurance companies usually pay hospitals per diems and higher per diem rates for supplementary insurance. Payments based on a Swiss version of Diagnosis Related Groups (DRGs) are also being implemented in some cantons. Cantons can also impose global budgets for public and publicly subsidised hospitals. Longer stay inpatient care receives federal subsidies which creates an inefficient incentive for insurance providers to favour this treatment since some of the costs are borne by the state.

Services in the ambulatory, outpatient and short-stay inpatient hospital sector are paid under fee-for-service using a Relative Value Scale similar to that in Germany. Negotiations then take place in each canton about the price to assign to the nationally agreed fee schedule and can therefore differ between cantons. Hospital doctors receive a salary and Health Maintenance Organisation (HMO) style insurance models are increasing.

An organisation called Foundation 18 is responsible for meeting the financial obligations of insurance companies in financial difficulty and for the risk adjustment between the insurance companies (making the transfer). The risk-adjustment formula is broadly based on age and sex.

There is no premium fixing by the state, and because of the defined compulsory package of health care benefits, insurance companies compete on the level of the premium as people change insurance companies depending on the premiums offered.

The cantons subsidise compulsory health insurance premiums through tax-financed allocations to reduce the impact of per capita premiums. These subsidies are targeted according to the income of the insured person and can either be phased out at a defined upper limit of income, or used to subsidise individuals or families so that the premiums do not exceed a certain percentage of their total income. For people on very low incomes, the entire premium is paid by the canton.

Aside from the tax subsidies, co-payments and out-of-pocket payments are a major source of financing. Most insurance companies require that people pay a fixed part of the costs in the form of a deductible. Insurance companies are allowed to offer lower premiums for higher deductible rates. There is also a 10 percent co-insurance on all services (whether one item or an episode of care) which has to be paid by patients in the form of a direct payment.

The Federal Department of Home Affairs decides which pharmaceutical products are covered by compulsory health insurance and what price they should be.

Chapter 4: The Netherlands

1987 ushered in some new radical reforms for the Netherlands under the Dekker proposals towards regulated competition. They included a uniform national health insurance scheme and the integration of health care and social services under the scheme with all financing channelled through a single system. In 1995 the new government announced a change from one to two regulatory regimes. For non-catastrophic risks the regulatory regime would follow the Dekker model of regulated competition among insurers and providers to contain costs and improve efficiency. For catastrophic risks (long-term institutional care) there would be direct government regulation.

Everyone is therefore compulsorily covered for catastrophic health care expenditure under the Exceptional Medical Expenses Act (AWBZ) with income-related contributions and additions from employers. Patients have to make a small flat rate payment towards their cost of care.

Those on an annual income below a certain level are also compulsorily insured under the Health Insurance Act (ZFW) for normal non-catastrophic medical risks. Supplementary insurance is also available for higher standards of hospital accommodation. There are about 30 sickness funds and members are charged both an income-related contribution (with additions from employers) and a flat rate premium. Insurers have to quote the same flat rate to all their members.

Insurers' revenues consist of the flat rate premium and a risk-adjusted per capita payment which they receive from the Central Sickness Fund (contributions for AWBZ and ZFW are paid into the Central Sickness Fund). Sickness funds receive partially risk-adjusted capitation payments based on age, gender, region and disability. The sickness funds are responsible for only a small fraction of the difference between their actual and predicted expenses based on these factors (age, gender, region and disability) and the rest is retrospectively reimbursed. The difference between the actual costs and the risk-adjusted payment will not be the same for all insurers and will be reflected in the flat rate premium that competing insurers quote which is one of the main sources of competition between insurers. It is intended that sickness funds will have increasing financial responsibility for the difference between their actual and predicted expenditures (based age, gender, region and disability), and that this will drive premium competition and increased managed care activities.

To obtain benefits, individuals must register with a local sickness fund and a GP (who acts as gate-keeper) with whom the sickness fund has a contract. Enrolment with sickness funds is open (at least every two years). People may therefore choose a contract which offers the free choice of provider, while others may offer a limited provider plan with a lower premium. ZFW provides for a system of benefits in kind. Sickness funds may selectively contract with health care providers and make direct reimbursements to providers.

People with an income above a certain level can opt out of the ZFW and take out private insurance with one of 40 private insurers. Privately insured patients pay providers (usually on a fee-for-service basis) and then seek reimbursement. Private health insurance companies are also increasingly regulated with the introduction of compulsory health insurance for all persons not in sickness funds, open enrolment requirements and premium regulation involving a minimum and maximum premium with premiums below cost for persons over 65. This imposes social insurance conditions on private insurers and increases the financial risk of private insurers, especially for expenditures of persons over 65.

Supplementary insurance is financed by risk-rated premiums which also vary according to the level of deductible chosen and the level of hospital accommodation chosen.

Hospitals receive prospective global budgets. The sickness funds pay GPs by capitation for their members. They pay specialists for each patient referred to them by a GP. Specialists are also paid a fee-for-service for a number of procedures. About half of hospital specialists are salaried. The fees and capitation payments are negotiated between representatives of physicians and insurers, the Central Agency on Health Care Tariffs and the government.

Pharmaceutical coverage falls under the AWBZ.

Chapter 5: France

The French health care system is based on a national universal compulsory insurance system linked to employment and financed by employers and employees (roughly in a 65-35 proportion). Membership to a fund is according to occupation and the schemes also cover spouses and dependants. The funds cover pensions, family benefits and medical care (*Assurance maladie*). The sickness funds do not compete since they are organised along strictly occupational lines. The contribution rates are fixed so that they are the same for all individuals and employers within a fund, but vary between funds. Contribution rates are fixed by negotiation between the state, representatives of employers and employees and the sickness funds.

The social security system forms no part of the national budget, but even though the government provides little direct money, it in effect underwrites the financial stability of the system.

The funds have to be self-supporting (they do not have reserves to prevent deficits), but compensation exists between funds (risk-sharing) in accordance with the principle of the number of beneficiaries per contributor. This in effect means that one large fund, the *Régime Général* which covers 80 percent of the population, supports the other smaller funds.

Patients pay the provider directly and are reimbursed, mostly only partially due to cost-sharing by patients. The state pays co-payments for those whose income falls below a certain level. A large proportion of the population are also members of voluntary, supplementary sickness funds (around 6500 *mutuelles*) or purchase private health insurance through the 80 commercial insurance companies. They charge a flat rate or a proportion of earnings and mostly cover co-payments.

There is total freedom for people to choose private and public health care services without a referral system although in 80 percent of cases GPs are the first contact. Doctors are paid a fee-for-service and can choose to abide by the negotiated fee schedule (in exchange for pension packages and personal health insurance) or set their own fees. This has helped contain the increases in fees, but also had an undesirable effect from an equity point of view. RMOs (treatment guidelines) have been introduced to try and rationalise health care provision and medical records (in the form of a small booklet carried by patients) have been introduced to try and limit redundant prescriptions.

Public hospitals are financed according to global budgets, while private hospitals are still paid on a per diem basis. Staff in public hospitals are salaried. For hospital care, the patient pays a lump sum co-payment which is not reimbursed and the insurance schemes reimburse the hospital directly. Diagnosis Related Groups (DRGs) have been set up and are expected to contribute to the harmonisation of methods of payment between public and private hospitals.

Several planning instruments have been used to rationalise the number of hospital beds and expensive medical equipment and regulate the regional distribution of such services.

Pharmaceutical expenditure is higher than most other European countries. Generic product use is very low and because of complementary insurance, the impact of co-payment is diluted and doctors and patients are desensitised to the cost of medicines. As a result reimbursement rates have been reduced and price and volume agreements have been introduced.

Most reforms have sought to increase revenues to the social security system from new sources, to complement payroll contributions. Any measures which affect the degree of public financing of health care are usually strongly opposed. French public opinion is hostile to subsidising health care from general taxation and the public is strongly attached to the notion of an independent social security system. Ear-marked payroll deductions for health are seen as contributions rather than taxes and are the preferred way of financing health care.

1995 saw the introduction of the Juppé Plan in France, a comprehensive programme of reforms which included some emergency measures to cover social security deficits and longer term reforms to the health care system. These included a progressive widening of finance sources (including a switch from payroll contributions to general tax revenue) and cost control strategies. In addition, it created greater state involvement in the general management of the health care system.

Chapter 6: Conclusions

Most countries in this paper face a similar set of urgent problems. The growth in demand, due to the ageing population, improvements in medical technology and real income growth is outpacing the supply of health care. Health care systems have insufficient incentives for patients or providers to restrain excessive utilisation. There is a general discontent with current methods of financing and delivering health care and no quick fix solution to the challenges.

It is argued by many, that a possible solution for excess demand and constraints on government financing, would be increased information and choice for patients while placing insurers and providers in competition to provide optimal levels of care at competitive prices. This would require putting insurance funds in social insurance based systems on an equal footing to allow them to assume a more commercial role. Most countries have only

rudimentary risk-compensation schemes in place. These market oriented type mechanisms which increase efficiency and choice do however increase transaction costs. Governments will need to set up regulatory frameworks within which such reforms could work.

Systems which allow richer (and often healthier) people to opt out, can also potentially reduce solidarity. These systems usually risk-rate which means they allow for preferred risk selection and even further reduce equity.

In most systems there are growing concerns over the dependence on payroll contributions when the number of people in permanent jobs in large organisations is decreasing. There are also concerns that increasing payroll contributions make firms less competitive, although competitiveness depends on a number of other factors and the link between health insurance costs and competitiveness is not straightforward.

Restricting choice is another method of cost control, introducing gate-keeping to more expensive specialist services as in the Netherlands. This depends on the historical and cultural background of the country as restricting or ending this right could be very controversial.

Most aspects of the social insurance system require careful balancing, as there are definite trade-offs to be made:

- Increased access comes at a higher cost.
- Increased diversity and choice produce higher transaction costs and may lead to greater inequality.
- Higher co-payments have the advantage of raising revenue and may be a valuable tool in reducing excessive utilisation of some services, but they can reduce solidarity if there are no exemptions in place.
- Private 'opt out' schemes may be actuarially fairer for the richer population, but they potentially reduce solidarity and equity.
- Supplementary schemes can also produce inequality and if the complimentary insurance is used to cover co-payments, may diminish the effectiveness of co-payments in reducing utilisation.
- More complex purchasing arrangements that allow for greater choice and competition (as opposed to broader systems of contracting) produce higher transaction costs.
- Managed competition in health care financing could in theory be feasible if a suitable comprehensive risk-adjustment mechanism were in place, but this has been shown to be almost impossible to implement in practice.
- And finally the legal, social and cultural backgrounds and traditions of the country will temper any changes or reform programmes. These norms will affect the role of government and the degree of intervention, the level and degree of bargaining power that the institutional players have, the level of risk sharing between purchasers and providers and the mechanisms to ensure the financial stability of the social insurance system.

1. Introduction

1.1. Introduction and overview

This paper examines in greater detail the health insurance systems in Germany, Switzerland, France and the Netherlands. The paper will examine how institutional factors regulate and constrain health insurers in these European countries. It examines how the insurer is organised and regulated, how premiums and fee schedules are determined and the relationship between the insurer, doctor and hospital.

All the countries in this paper finance their health care primarily through social health insurance contributions. The systems discussed in this paper share a number of common features but also differ in a variety of ways.

1.2. Social health insurance systems

Social health insurance systems share a number of similar features:

- Insured persons pay a regular contribution to a health insurance fund based usually on income rather than reflecting their risk of illness.
- Clinical need and not ability to pay determine access to treatments and health care.
- Contributions to the social insurance fund are kept separate from other government mandated taxes and charges.

Except for the separate management of funds, this simple model of social insurance has much in common with tax finance, especially where taxes are earmarked or 'hypothecated' for use by the health care sector.

There are however a number of other features common to health insurance systems, although these are not strictly necessary for a system to be described as social health insurance. These are:

- Both employers and employees pay contributions.
- Government support for those who are unable to pay goes through the insurance fund.
- Employees and employers may share some responsibility for management of the fund or funds, although that is not always the case.
- There may be more than one social health insurance fund and some choice may be available to citizens.
- Patients have at least some choice in the doctor and other health care providers they use.
- Social health insurance is compulsory for at least some categories of citizens.
- A basic package of health care benefits is defined which may or may not vary across funds.
- Health insurance funds may not turn away applicants for membership.

Where the system contains a choice of social health insurance fund or sickness fund, there is usually a system by which the funds with high cost and low-income members subsidise those with low cost and high-income members. The issues relating to voluntary membership, choice of funds and mechanisms for ensuring equity exist to a greater or lesser extent in the countries discussed in this report.

There is no reason why social health insurance organisations should not own and operate health care providers. However, the normal pattern in social health insurance is for services

to be delivered by a combination of public, private and non-governmental organisations. It is also common for the commissioning of services and the contracts for supply to be done on the basis of negotiation between all social health insurance funds together and associations of providers.

In summary, the key features of social health insurance services are that contributions are usually calculated on the basis of ability to pay, access to care is on the basis of need, and the system provides a separate, transparent system for the flow of funds from the contributions to the fund and on to the providers of services.

1.3. Strengths and weaknesses of social health insurance

The strengths and weaknesses of social health insurance are usually judged against the health policy goals of fairness and efficiency. Some of the objectives might include the following:

- Services should be available for those who are likely to derive significant benefit from them.
- Costs should be minimised for any given level of services.
- People with equal need should have equal access.
- Priority should go to those services that are likely to achieve the greatest health gain from given resources, and
- Users of services should be satisfied with the process and outcome of care.

Development of social health insurance systems have normally been in response to concerns that inadequate resources were mobilised to support access to health services. Since there is no simple answer to the question of how much is the appropriate level of support, the issue of adequacy is best thought of as being a level that is considered appropriate in the country given its total resources, preferences and other development priorities. There are several reasons to suggest that the separation of health care spending from other government mandated spending can be successful in ensuring an appropriate level of funding for health services. When satisfaction with health services is assessed in surveys the typical finding is that people in social health insurance systems are most satisfied. People appear to be less satisfied with tax funded systems and least satisfied with private, risk-adjusted insurance. There is also a tendency to favour the system with which a person is familiar. There are several reasons why this may be the case.

First, social insurance finance is normally associated with higher levels of funding than tax based systems. If people generally believe that too little is spent on health care then it is not surprising if they prefer systems that achieve higher levels of spending. Second, willingness to pay may be higher if the system is transparent. Hypothecation of funds allows people to see that any additional contributions will go to spending on health care and will not be diverted to other government priorities that may be considered to be of lower priority to the contributor. To an extent the separation of health care financing from government financing allows people to take a separate view on the cost to them of higher contributions and better access to services.

The experience of rationing and setting priorities in social health insurance systems is mixed. In many European countries at least in principle there is little explicit rationing of access to care. In other countries with social insurance there are various ways in which access is constrained, either by having a clearly defined benefits package, a preferred set of providers or through a high level of co-payment. There is no popular way in which to develop explicit

rationing in health care. The economists' approach is typically to choose services that maximise health gain for any level of spending (perhaps subject to some equity objective).

Except in cases where resources are sufficient to satisfy all demands, some form of rationing or priority setting is needed. The use of either social health insurance or tax finance does not change this. However it may change who is responsible for choosing which services are provided and may shift blame for constraints (at least in part) away from governments. Formal and explicit rationing systems, however desirable, are rare in both tax funded and social health insurance systems and there is little evidence to suggest that social health insurance is more successful in identifying services for inclusion that are the highest priorities.

Another objective is for services to be provided at minimum cost. Since the normal market mechanisms will work only partially in social health insurance systems, some of the pressures to minimise costs will not be available. Minimising costs allows resources to be used for other beneficial purposes either within or outside the health service. International comparisons show higher expenditure on social health insurance systems when compared to tax financing. The important question is whether this higher spending reflects higher volume of services or simply higher costs of producing care.

Efficiency in production of care depends on structures, skills, motivation and incentives. Structures affect efficiency both through the market power of buyers and sellers and through transaction costs. Where a single social health insurance fund exists and services are purchased by a single buyer, there is a tendency to control costs. If there are multiple funds (as is the case in Germany), but negotiation is between providers and the association of funds then once again there is effectively a single purchaser. However, allowing purchasing of services on the basis of individual contracts with multiple social health insurance funds and service providers may lead to higher costs due to the loss of this monopsony power. Since there are many reasons why cost control in health care tends to be difficult, it may be important to offset some of these effects with the downward pressure on costs of single purchaser arrangements.

A more serious issue in judging the efficiency of different systems of finance is how to keep management and transactions costs to a minimum. Evidence on the relationship of management costs and performance is still poor and transaction costs in health care are difficult to measure. Transaction costs are made up of several different elements. The more complex the transactions the more costly they are likely to be. The important elements of transaction costs are the costs of the processes (such as negotiation and legal costs), costs of information and costs of enforcement. At one extreme these can be minimised with simple agreements covering all insured individuals. At the other, if separate arrangements must be made for each intervention for each patient, there is a large cost of informing, making and enforcing the contracts. In all systems there is a trade-off between more complex purchasing of services, with higher costs, and a broader system of contracting that requires less measurement and processing.

There is evidence that transaction costs in social health insurance are significant. The choice of simple contracting arrangements in Germany is in part a response to the need to keep costs down. One argument for not proceeding with the planned reforms in the Netherlands, which would have introduced choice and competition on both insurance and provision of care, was the need to avoid high transaction costs. One way in which transaction costs can be kept low is for the providers of care to be paid directly by the social health insurance fund. In France, where the system involves the patient paying and then reclaiming some of the costs, the additional costs of operating the social health insurance system are significant.

In all systems of health care finance that provide services free at the point of delivery, there is a tendency for expenditure to rise, since it is not in the short-term interest of either patient or provider to reduce costs. There is no particular reason why social health insurance should involve higher transaction costs than tax finance, and mechanisms can be designed that should encourage efficient production of services. However, as the desire for diversity and choice increases, the tendency to incur high costs and to lose the downward pressure on costs is a major risk.

Social health insurance combines some of the features of private insurance with some that make the system more equitable. Since payments are on the basis of ability to pay (or at least visible earnings) it can achieve the goals of providing care on the basis of need and paying on the basis of income. In the case of Germany there are systems of equalisation, both between richer and poorer funds and between funds with higher morbidity and those whose members are more healthy. In effect there is a subsidy between the former Federal Republic, which is wealthier and healthier and the former Democratic Republic which has higher unemployment, lower income and worse health. The solidarity in the German system is undermined to some degree by the exemption from membership of richer people (opt out scheme) and a similar exemption exists in the Netherlands. Since in general these people are also healthier, allowing richer people to opt out means that they do not share in the subsidy of services for poorer social health insurance fund members. The general issue is that whenever any group and especially richer groups are allowed to opt out of the system, the degree of solidarity and equity is reduced. Other ways in which social health insurance operates can also reduce solidarity. Systems with high levels of co-payments reduce access to service for poorer people unless there is also a system of exemptions. Systems with very limited benefit packages also may reduce the extent to which access to care is on the basis of need.

It is common for there to be a debate in social health insurance systems about the extent to which there should be competing funds. Historically many countries, most obviously Germany, have had multiple funds but not competing funds. This is changing as choice of insurer has been introduced. If a perfect system of risk adjustment and full allowance for differences in incomes is introduced, then it is theoretically possible to have full choice and competition between funds and also full solidarity. However such mechanisms are complex and expensive to run and may be impossible to achieve and there must be a concern that increased diversity and choice also leads to increased inequality in access to care.

Social health insurance systems in Europe have therefore been very successful at meeting particular goals, especially in providing near universal access to care, services that are acceptable to the public and a degree of solidarity. It has already been suggested that social health insurance systems tend to be associated with high levels of satisfaction in the population and therefore are normally successful in that objective too. The successes of social health insurance are clear and there are many advantages of the features the systems offer. The problems are mainly in the risk of cost escalation, excessive reliance on too narrow a contribution base and potentially high costs of management and transactions.

1.4. Lessons for other countries

It is an important principle that one should learn from the experiences of other countries but not try to replicate exactly systems that have developed in particular settings. It is important to consider systems of health care financing in the context of their historical, political and social background. The details of the organisation of funds and provision of care have often arisen as a result of slow evolution and adaptation of institutions to meet new challenges. In the case of social health insurance the evolution of the system, initially in Germany, owed much to the pattern of industrialisation, the growing influence of organised labour and the

development of Germany as a united but decentralised country. To some extent the resulting social health insurance schemes and arrangements are unplanned but have been shown to remain robust and able to prosper both in Germany and other countries.

Countries that are examining these social health insurance systems need to be aware of the trade-offs that exist between costs and access to care, between costs and degree of diversity and choice and between competition and objectives of equity and low management costs. Observing the German system it is important to note the extent to which the apparently diverse and pluralistic system is in many ways a single system in each state. The recent reforms in France, Switzerland and the Netherlands have been grappling with the different objectives of continued universality, concerns to reduce costs of services and of administration, while retaining features of the systems that are valued by users.

There are many variants on the theme of social health insurance and the performance of social health insurance systems may depend significantly on the detail of the chosen characteristics. However, the main arguments in favour of social health insurance systems are the potential to provide universal access to health care, the acceptability to the public, the transparency of financial flows, the potential to allow diversity and choice in provision and the long tradition that has allowed the development of mechanisms for ensuring some control of costs and sound financial management.

The potential problems with social health insurance are the risk of cost escalation, potentially high management and transaction costs (especially when patients have free choice of provider) and the need for good accountability. There is also a risk that social health insurance is too dependent on the payroll for contributions at a time when the proportion of people with permanent jobs in large organisations is falling.

1.5. General conclusions on social health insurance

The fact that social health insurance systems have evolved and survived suggest that this model of semi-independent financing can offer a sustainable model, and one that can adapt to different conditions. Most systems have significant regulation by government and systems vary from those that are close to being hypothecated taxes to those where the funds are independent of government. Many systems have some payments by government and in others there is an element of government guarantee of any debts. Countries with social health insurance typically have higher spending on health than those that use tax finance and this is probably due in part to the greater transparency of financial flows and the acceptability of funding for health care. Competition for provision of services is common, but it is only recently that serious consideration has been given to the development of competition for collecting and managing the funds. It remains to be seen whether market forces can play a useful role in forcing costs down while avoiding problems of inequity and high transaction costs. This paper will examine how these 4 countries have fared in meeting some of the (often competing) objectives of social health insurance systems such as access, choice, solidarity, efficiency and fairness.

1.6. The structure of this report

This report hopes to examine in greater detail the social insurance systems in Germany, Switzerland, the Netherlands and France. In each chapter a different country is described in terms of the organisational structure of the social insurance system, the relationships between the key actors in the health care market, the regulation and management of the insurance system, the financing of and expenditure on health care, benefits available within the social insurance scheme and how rationing is dealt with. The delivery of health care is

briefly discussed as well as any major reforms that have taken place, including general cost containment measures and pharmaceutical expenditures and cost control.

Chapter 2 discusses these relevant issues for Germany, Chapter 3 covers Switzerland, Chapter 4 discusses the Netherlands, while Chapter 5 covers France. Chapter 6 concludes with some of the main problems and issues that arise within social insurance systems (such as the often conflicting objectives of choice, access, solidarity, equity, efficiency, transparency, acceptability, and cost control), how these are observed in the 4 countries and what other countries might learn from these 4 European examples.

2. Germany

2.1 Introduction and overview

The Federal Republic of Germany has a population of 82 million (40 million males and 42 million females). This includes over 7 million foreigners of which just over 2million are Turkish. Most of the population is distributed in the western part of Germany.

Germany is a federal republic and has sixteen states (or Länder) each of which has a constitution which must be consistent with the republican, democratic and social principles embodied in the constitution. The constitutional bodies, which have legislative functions, are the Federal Assembly and the Federal Council (the chambers of parliament). The Federal Assembly's functions include passing laws, electing the Chancellor and controlling the government. The main function of the Federal Council is to approve laws which have been passed by the Federal Assembly. About half of all bills require formal approval of the Federal Council, in other words both the upper and lower chambers, particularly those of vital interest such as financial affairs or administrative powers. Passing laws that need approval from both chambers is often difficult as the political majority in each chamber is typically held by opposing parties in which case compromise is formulated by an arbitration committee.

The President (elected by Parliament) has the role of approving new laws, formally appointing the chancellor and the federal ministers and fulfilling a representative function. The chancellor, who is the head of the government, chooses the ministers and proposes them to the President for appointment. The Chancellor is in a strong position as he also chooses the number of ministers, their responsibilities and the guidelines for government policy. The federal ministers run their departments independently but within the framework of these guidelines.

Certain areas of legislation pertain almost exclusively to the federation such as foreign affairs, defence, monetary policy, air transport, and some elements of taxation, or where necessary to have a uniform law for the whole country. The states can fill in any gaps left by the federal legislation or areas not specified by the constitution. This applies for example in the fields of higher education and culture, nature conservation, landscape management, regional planning, water management, local government and police.

Health is not an area exclusive to federal legislation and specific topics relevant to health are included in the concurrent legislation (as defined by the constitution) such as social benefits, measures pertaining to public health, certification of physicians and other health professionals, pharmaceuticals and drugs and the economic situation of hospitals. Federal law, where it exists in these areas, takes precedence over state legislation, but implicitly, all other aspects of (public) health are the responsibility of the states.

Germany is a member of the G7 leading industrial countries and industry is mainly export oriented. Gross Domestic Product (GDP) amounted to DM 46 100 per capita in 1998 or a total of DM 3784 billion (see Appendix A for national comparisons). Unemployment is the major economic problem at around 10.9 percent in 1998 (20 percent in the eastern states and 8.6 in the western states).

2.2 Health status

The main causes of death in Germany are cardiovascular diseases (50 percent of all deaths in 1998) and malignant tumours (25 percent). Cardiovascular and non-malignant lung disease mortality rates in Germany are well above the European average while infant and

maternal mortality rates are lower (see Appendix A). Standardised death rates for road traffic accidents remain a problem in eastern Germany especially among young males. The incidence of AIDS has been stable since the 1990s and is among the lowest in the EU which is due to a concerted effort towards prevention. Germans also consume more cigarettes and alcohol than the average European.

There is an interesting discrepancy in health status due to political, social and economic influences of an otherwise homogenous population where life expectancy in western Germany since the 1960s has shown continued improvement. Between 1980 and 1990 the gap in life expectancy widened, especially for men, largely due to differences in diet, better living conditions in west Germany, differences in access to high technology care, and better health care at all levels in western Germany. Since unification the gap has rapidly narrowed, especially for women. Likely factors responsible for this trend include:

- The adoption of the western German social welfare system
- The adoption of the western German health care system
- Greater personal freedom (but also higher unemployment)
- A cleaner environment

Current health concerns in the unified Germany are mainly related to diseases associated with the ageing population and related demographic trends. In addition to the increasing share of elderly population, there is a decrease in the relative number of working age population, leading to social security revenue reductions. The change in the structure of the population is also likely to increase the demand for therapy, rehabilitative care and nursing care relative to curative medical care. Other concerns include an increase in the number of one-person households, an increase in long-term chronic degenerative diseases, increasing public expectation with respect to medical care and incentives for the excessive use of health care services.

2.3 A brief history of the German health care system

The rise of Germany's modern health care system dates back to 1883 when parliament made nation-wide health insurance compulsory. Germany has been recognised as the first country which introduced a national social security system. In the following decades the principle of statutory social insurance, called the 'Bismarck system' was also applied to alleviating the risks of work-related accidents and invalidity (1884), old age and disability (1889), unemployment (1927) and the need for long-term nursing care (1994). The prominence and continuity of social insurance is one of the key features of Germany's health care system to the present day.

Motivated by paternalism and the Emperor's charter (1881) which declared social welfare for the poor essential, Chancellor Bismarck suggested a national health service type of system. The resulting legislation of 1883 built upon existing local funds and occupation-based funds (miners, guilds and companies) making health insurance compulsory for workers of certain industries with hourly wages up to a legally fixed income ceiling. They were to pay two-thirds of the contributions while their employers were obliged to pay one third. Members received monetary benefits such as sick pay equivalent to 50 percent of the customary local wage for 13 weeks, maternity pay and death compensation. A minimum number of primary health care services was set as well as medication, while hospital care was left to the discretion of the funds on a case-by-case basis. The funds were non-profit and were initially free to choose private suppliers of health care and to determine contracts with them. National government's role was limited to setting legal standards for the self-administered funds which were to be supervised by provincial governments.

During the 1880s many workers boycotted the self-administered statutory funds and chose self-supporting funds instead which were self-governing and run entirely by the workers (called substitute funds). However this choice became restricted in the early 1890s and national government tried to separate the rising white-collar movements from the blue-collar by introducing a separate set of statutory health insurance for salaried employees in 1901. Because white-collar workers enjoyed greater rights to choose, the existing substitute funds catered almost exclusively for white-collar employees from that time on (until 1995). The substitute funds kept 100 percent worker representation although contributions were eventually shared. The 1911 Imperial Insurance Regulation introduced a common legal framework for social insurance and the regulations covering health insurance remained in force, with a few changes, until 1988.

Over the following decades statutory health insurance coverage grew from 10 percent of the population in 1883 to 88 percent (mandatory and voluntary) of the west German population in 1987 and 100 percent of the east German population in 1949. Social insurance was concentrated in only two large sickness funds in east Germany, one for workers (89 percent) and one for professionals, members of agricultural co-operatives, artists and the self-employed (11 percent). The universal national health insurance scheme of the east German Democratic Republic (GDR) was abandoned after unification in 1990 in favour of the liberal west Federal Republic of Germany (FRG) insurance system. The extension of membership was achieved by either increasing the income ceiling of mandatory membership or by adding new occupational groups to the statutory fund system. Germany also managed to integrate certain social groups into the social health insurance scheme which in several other European countries were financed or cared for by other public agencies, such as the unemployed, family dependants, pensioners (in 1941), students and the disabled.

Contributions and expenditure increased substantially over the 100 or more years of statutory health insurance as a result of the extension of benefits through state intervention, but mainly through the self-administered funds themselves or by joint committees between funds and physicians. While the scheme aimed initially at primarily preventing impoverishment by compensating income in cases of illness, sickness funds increasingly funded services and prescriptions of specialists which was reflected in the falling ratio between monetary and service/product benefits.

Whilst much of the period saw rising expenditures, the pay-as-you-go principle of contributions and expenditure ensured a sound financial basis for health care financing even during two World Wars, hyperinflation in 1923, the economic crisis of 1929 and the introduction of a new currency in 1948. However after the oil crisis (from 1975 onwards) the health care sector suffered dramatic cost increases and 1977 ushered in the era of cost containment in German statutory health insurance with the introduction of the Health Insurance Cost-Containment Act. This ended the period of rapid growth in health care expenditure, particularly in the hospital sector and sickness funds and providers were required to pursue stability in contributions which has remained the main cost containment target in health care ever since. This requirement pegged increases in contribution levels with the rate of increase in contributory income. The basic cost containment principle is therefore one of 'income-oriented expenditure policy'. The drive for cost containment was realised through various measures including:

- Budgets for sectors or individual providers
- Reference price setting for pharmaceuticals
- Restrictions on high cost technology equipment and the number of ambulatory care physicians per geographic planning region

- Increased co-payments (both in terms of size and number of services)
- The exclusion of young people from certain dental benefits between 1997 and 1998

2.4 Organisational structure and relationships of key actors

2.4.1 Federal level

At the federal level the Ministry of Health and the parliament are the key actors. The Ministry of Health is divided into five divisions:

- Administration and international relations
- Pharmaceutical / medical products and long-term care
- Health care and statutory health insurance
- Protecting health and fighting disease
- Consumer protection (mostly food-related) and veterinary medicine

Before 1991, the divisions dealing with statutory health insurance were part of the Ministry of Labour and Social Services while most of the other divisions were part of the Ministries of Youth, Family, Women and Health.

Several subordinate authorities responsible for certain tasks support the Federal Ministry of Health:

- The Federal Institute for Pharmaceuticals and Medical Devices (BfArM) (licensing pharmaceuticals and supervising the safety of medical devices)
- The German Institute for Medical Documentation and Information (DIMDI) (providing the public and professionals in all fields of the life sciences with information and a broad collection of databases)
- The Federal Institute for Communicable and Non-communicable Diseases (Robert-Koch-Institute) (surveillance, detection, prevention and control of diseases)
- The Federal Institute for Sera and Vaccines (Paul-Ehrlich-Institut) (licensing of sera and vaccines)
- The Federal Centre for Health Education (BzgA)
- The Federal Institute for Health Protection of Consumers and Veterinary Medicine (BgVV) (consumer protection in areas of food, chemicals, cosmetics, veterinary pharmaceuticals and diseases, crop protection and pest control)

2.4.2 State level

The federal structure is represented mainly by the 16 state governments. While none has a ministry exclusively dedicated to health, almost all have 'health' combined with Labour and Social Services.

2.4.3 Corporatist level

The statutory health insurance system is represented by the (statutory health insurance-contracted) physicians' and dental physicians' legal associations on the provider side and the sickness funds and their associations on the purchaser side.

Physicians' and dentists' associations exist at the state level (the total number of associations is 23) and at the federal level (The National Association of Statutory Health Insurance Physicians). The associations distinguish between 'ordinary' members, or

physicians in private practice and other members, mainly hospital physicians who are accredited to treat patients on an ambulatory basis.

The hospitals are not represented by any legal corporatist institution but by organisations based on private law, however they are increasingly charged with legal responsibilities as well. The hospital organisations are also both state and federal level organisations.

The payers' side is made up of autonomous sickness funds which are organised on a regional or federal basis. In mid-1999 there were 453 statutory sickness funds with about 72 million insured persons (50.7 million members plus their dependants) and 52 private health insurance companies covering around 7.1 million fully insured people.

Sickness funds can be differentiated into seven different groups:

- 17 general regional funds known as *Allgemeine Ortskrankenkassen* (AOK) – their federal association is based in Bonn
- 13 substitute funds known as *Ersatzkassen* – Siegburg
- 359 company-based funds known as *Betriebskrankenkassen* (BKK) – Essen
- 42 guild funds or *Innungskrankenkassen* (IKK) – Bergisch-Gladbach
- 20 farmers' funds or *Landwirtschaftliche Krankenkassen* (LKK) – Kassel
- 1 miners' fund known as *Bundesknappschaft* – Bochum
- 1 sailors' fund or *See-Krankenkasse* - Hamburg

All funds are run on a not-for-profit basis and are based on the principle of self-government, elected by their members. In most funds the management is made up of an executive board responsible for day-to-day management and an assembly of delegates who decide on bylaws and other regulations of the fund, passing the budget, setting the contribution rate and electing the executive board. Usually the assembly is composed of representatives of the insured and employers who are democratically elected every six years. Many representatives are linked to trade unions or employers' associations.

The total number of sickness funds has decreased steadily since the AOKs and the substitute funds were legally opened to competition for all insurees through the Health Care Structure Act (1992). The first wave of mergers in 1993/4 affected the AOKs as some were very small and merged into single AOKs per state. In 1994/5 the IKKs followed, partly before they opened themselves to outside members. The latest wave of mergers was the BKKs, also often as a prelude to competition. By the beginning of 1999, the open BKKs had more members than those which remained closed (with an exclusive in-company membership).

Table 1: Number of Sickness Funds in Germany 1993-1999

	1993	1994	1995	1996	1997	1999
AOKs	270	93	20	20	18	17
BKKs	845	826	807	651	570	359
IKKs	174	166	122	48	48	42
All other funds	39	39	38	38	37	35
Total	1328	1124	987	757	673	453

Source: WHO (1999a)

By law, sickness funds have the right and the obligation to raise contributions from their members which includes the right to determine what contribution rate is necessary to cover expenditure. The Health Insurance Contribution Exoneration Act of 1996 interfered with this

right by legally lowering the contribution rates of all sickness funds on 1 January 1997 by 0.4 percent.

Other health-related statutory insurance schemes similar to the sickness funds exist as well. These include:

- Accident funds for statutory accident insurance covering curative and rehabilitative care services for work-related accidents and diseases
- Retirement funds for statutory retirement insurance which is responsible for most rehabilitative measures, and
- Since 1995, long-term care funds which were formed by the existing sickness funds

Statutory long-term care insurance was introduced following concerns about the situation of the elderly and concerns about inadequate access and support for nursing care especially in the ambulatory sector. All members of statutory sickness funds (including pensioners and unemployed) as well as people with full cover private health insurance were declared mandatory members, making it the first social insurance with practically population-wide membership. The long-term care scheme is administered by the sickness funds (as an entity separate from the health insurance part but without any separate associations) and by the private health insurers.

Outside the scope of statutory health insurance, legally established professional associations exist for physicians, dentists, pharmacists and veterinarians. By law, all these health care professionals must be a member of their respective associations at state level. The associations are in turn regulated by the laws of the state. They are responsible for secondary training and accreditation (specialist training), and continuing education, setting professional and ethical standards as well as for community relations. To co-ordinate these associations at federal level, there are federal associations which are based on private law and can therefore only pass on recommendations. Professionals organised in associations enjoy certain exclusive rights such as being able to maintain their own pension schemes.

Nurses, midwives, physiotherapists and other groups are not considered to be professionals in the legal sense and are therefore not organised in associations.

2.4.4 Other actors

There are however numerous voluntary organisations outside the above-mentioned legal actors, which can be distinguished along scientific, professional, political lobbying and economic lines of interest. These organisations represent general practitioners, physicians, nurses, physiotherapists, midwives, pharmacists, and the pharmaceutical industry. There is also an organisation representing the providers' side as the head organisation of the six leading non-profit associations which own and manage hospitals, nursing homes, home care agencies and ambulance transportation. On the payers' side, the Association of Private Health Insurance Companies, a powerful lobby group for defending the private health insurance sector, represents the 52 major private health insurance companies. Of the 52 private insurers, 25 are listed on the stock market.

Insurees or patients are not represented by any powerful organisations. There is a small and little known General Patients' Association and a number of disease-specific self-help groups. However the mainly publicly funded Foundation for the Testing of Consumer Goods has recently turned towards the health care sector by investigating hospitals and other providers.

All the above organisations are politically independent and not associated with any particular parties.

2.5 Regulation and management of health insurance

2.5.1 Federal level

Issues of equity, comprehensiveness and the rules for providing and financing social services are regulated at the federal level. All statutory social insurance schemes are regulated through the Social Code Book (SGB), the cornerstone of social insurance legislation, but fall within the authority of different ministries. All parts of the Social Code Book have regulated statutory insurance schemes in the new eastern states since 1991, except for certain transitional regulations. The Social Code Book V (SGB V) which is amended and supplemented by various reform laws, regulates the following issues:

- Mandatory and voluntary membership in sickness funds
- Contents of the sickness funds' benefit package
- Goals and scope of negotiations between sickness funds and providers (most notably physicians' association)
- Organisational structure of sickness funds and their associations
- Financing mechanisms including risk compensation between funds
- Tasks and organisation of medical review boards
- Collection, storage, use and protection of data
- Special regulations for eastern Germany

The most important aspect of the Social Code Book is the self-regulated structure of the statutory health insurance system. It defines what may be self-regulated through joint committees of funds and providers, the level of these negotiations and how the composition of such committees is to be decided. The Federal Ministry of Health is responsible for supervising whether the federal associations of physicians, the sickness funds and the joint committees comply with the SGB V rules.

2.5.2 State level

The state governments are responsible for maintaining hospital infrastructure through funding hospital investments which are paid for independently of ownership of the hospitals according to the priorities of the state government. While the responsibility for major investments (buildings and large-scale medical technology) is undisputed, it is not clear whether the states are responsible for building maintenance and repairs. As such, most states have refused to pay for these since 1993 and the 2nd Statutory Health Insurance Restructuring Act had to introduce an annual flat premium of DM 20 to be paid by all insured people for the restoration and repair of hospitals. This annual fee was however cancelled in 1998.

Otherwise states are responsible for public health services such as supervision and monitoring of health care institutions, diseases, food, pharmaceuticals and drugs, environmental hygiene, counselling and health education and promotion. Furthermore, they are responsible for undergraduate medical, dental and pharmaceutical education.

2.5.3 Corporatist level

The corporatist institutions on the payer side (the sickness funds) have a central position within the statutory health insurance system. The Social Code Book defines their rights and responsibilities such as their obligation to raise contributions from members and the right to determine the contribution rate necessary to cover expenditure. Their responsibilities include negotiating prices, quantities and quality assurance measures with providers on behalf of their members. Services covered by such contracts are usually accessible to all fund members without prior permission from the funds (except in the case of rehabilitative care and short-term nursing care). Where there is doubt, the sickness funds must obtain an expert opinion on the medical necessity of treatment from their Medical Review Board.

A reform to make these benefits (rehabilitative care and short-term nursing care, as well as ambulance transportation and physiotherapy) optional, so as to leave individual sickness funds to decide on their inclusion, failed in 1996 as the sickness funds threatened to remove these benefits altogether as sickness funds without these benefits could offer lower contribution rates and attract a healthier clientele. This would widen the gap in contribution rates and force more generous funds out of the market since expenditure for voluntary benefits would be outside the risk compensation mechanism between the funds.

On the provider side, the physicians' and dental physicians' associations have the 'Corporatist Monopoly and the Mission to Secure Ambulatory Care' which means that legally their monopoly has to provide all personal acute health care services. Hospitals, communities, sickness funds and others do not have the right to offer ambulatory medical care. The legal obligation to guarantee provision of state-wide services in all medical specialties includes the provision of sufficient emergency services within reasonable distances. The physicians' associations obtain a total, prospectively negotiated budget from the sickness funds which they then distribute among their members. In return they must provide a guarantee to the sickness funds that this provision meets the legal and contractual requirements.

The Social Code Book V concentrates mainly on regulating the framework such as the generic categories of benefits, the goals and scope of the negotiations between sickness funds and physicians' and dental physicians' associations, the financing mechanisms and the details of the ambulatory package. As a general rule, the scope of services which can be reimbursed through the sickness funds and the financing mechanisms are tightly regulated, sometimes legally, but mainly through negotiations between providers and sickness funds.

The most important body for the joint negotiations on the scope of benefits is the national-level Federal Committee of Physicians and Sickness Funds established in 1923. It consists of nine representatives from both sides, two neutral members proposed by each side and a neutral chairperson who must be accepted by both sides. This committee has issued 16 guidelines to regulate the prescription of pharmaceuticals, medical aids and care by non-physicians, 'needs-based' planning of the distribution of physicians in private practice and the inclusion of new technologies and procedures in the ambulatory benefits packages.

The 2nd Statutory Health Insurance Restructuring Act gave the Federal Committee new competencies in 1997 such as technology assessment of ambulatory benefits, guidelines on care by non-physicians, as well as decisions concerning the effectiveness of new diagnostic and therapeutic methods.

Due to the absence of corporatist institutions in the hospital sector, hospitals contract directly with the sickness funds. Usually all sickness funds with a more than 5 percent 'market share' in a particular hospital negotiate the contract with that hospital. The conditions regarding the range of services offered and remuneration rates negotiated with the particular hospital are

valid for all sickness funds. After attempts by the Federal Health Ministry to corporatise the hospital organisations failed, a regulation was included in the 2nd Statutory Health Insurance Restructuring Act which widened the hospitals' legal powers by enabling them to negotiate the schedule of prospective case and procedure fees with the sickness funds.

2.5.4 Features of the German health care system

The German health care system is therefore highly decentralised with large amounts of delegation of state power to corporatist actors. Privatisation is another important feature of the German health care system. Some health care sectors are based entirely on private providers, such as office-based ambulatory and dental care sectors and private pharmacies. In other sectors both private (profit and non-profit) and public providers co-exist, such as the hospital sector (with a trends toward privatisation as shown in the table below) and social care sectors. Private insurance companies also co-exist alongside statutory sickness funds.

Table 2: Public-Private Mix in Ownership of General Hospitals, 1990-1997

	Public		Non-profit		Private		Total
	beds	% share	beds	% share	beds	% share	Beds
1990	387 207	62.8	206 936	33.5	22 779	3.7	616 922
1997	304 500	56.3	204 811	37.9	31 603	5.8	540 919
Change	-21%		-1%		+39%		-12%

Source: WHO (1999a)

2.6 Health reform in the 1990s

The 1990s saw a rapid increase in health reform legislation relating to health insurance. These included the Health Care Reform Act (1989), Health Care Structure Act (1992), the Health Insurance Contribution Rate Exoneration Act (1996), the 1st and 2nd Statutory Health Insurance Restructuring Acts (1997) and the Act to Strengthen Solidarity in Statutory Health Insurance (1998).

The Health Care Reform Act renewed the 1911 social insurance legislation with the following changes: new benefits for long-term care, the introduction of 'no claim bonus' models, reference prices for pharmaceuticals, committees to regulate expensive medical technologies and the right for sickness funds to selectively contract with hospitals.

The main elements of the Health Care Structure Act were to increase cost-containment measures through, for example, legally fixed budgets or spending caps and increased competition to enhance efficiency, especially between sickness funds and the hospital sector.

The Health Insurance Contribution Rate Exoneration Act and the 1st and 2nd Statutory Health Insurance Restructuring Acts represented a shift from cost-containment to a possible expansion of private payments. Co-payments were now seen as a way to bring new money into the system. These Acts included the cancellation of the budgets in ambulatory care and the spending caps for pharmaceuticals, and increased co-payments for inpatient care, rehabilitative care, pharmaceuticals, medical aids and transportation. In effect these acts broke several traditional rules of the system such as uniform availability of benefits, contributions being shared equally between employers and employees, financing depending only on income and not on risk or service utilisation and provision of services as benefits-in-

kind. In addition there was an increasing shift of costs onto patients while easing financial pressure on providers.

The abolition of these reforms was taken on as the most important programme of opposition parties. Thus the Act to Strengthen Solidarity in Statutory Health Insurance reversed almost all of the changes again in line with their aim of strengthening some of the basic principles of solidarity in social insurance. In addition, co-payment rates were lowered and budgets or spending caps re-introduced.

2.7 Health care financing

Contributions towards statutory health insurance with the 453 sickness funds constitute the main mechanism for financing health care in Germany. Sickness fund membership is compulsory for employees whose gross income does not exceed a certain level (around 78,000 DM per year) and is voluntary for those above that level. Around 88 percent of the population are covered by the statutory health insurance, 75 percent are mandatory members and their dependants, 13 percent are voluntary members and their dependants, 9 percent are covered by private health insurance, 2 percent by free government health care (police officers, soldiers) and 0.1 percent are not insured.

Contributions are income and not risk-dependant, based on current income only (not savings or assets). The total sum of income of all insured up to the upper level (where they can opt out or become a voluntary member), in other words the contributory income, is a very important policy variable as its growth rate from year to year determines the level of cost containment.

Contributions are shared equally between the insured and their employers, with 50 percent coming from the employee's pre-tax income below the threshold and 50 percent being paid by the employer in addition to wages. In the case of retired and unemployed people, the retirement and unemployment funds take over the financing role of the employer.

The majority of people have had little choice over their sickness fund and were assigned to one based on geographical or job characteristics. This distribution of fund members led to varying contribution rates due to different income and risk profiles. From 1996, the Health Care Structure Act gave almost every insured person the right to choose a sickness fund and to change funds on a yearly basis with three months' notice. All general regional funds and substitute funds were legally opened up to everyone. Only the farmers', miners' and sailors' funds remain with assigned membership, although company-based funds may also choose to remain closed.

To provide all sickness funds with a level playing field for competition, a risk structure scheme to equalise differences in contribution rates (due to varying income levels) and expenditure (due to age and sex differences) was introduced in two steps in 1994 and 1995. The compensatory mechanism requires all sickness funds to provide or receive compensation for the differences in their contributory incomes as well as in average expenditures (calculated retrospectively using actual expenditure data). The sum of the average expenditures (for both sexes for benefits in the uniform, comprehensive package) for all members of a sickness fund determines the fund's 'contribution need'. Actual contributions and 'contribution need' are compared to assess whether funds should receive compensation or make payments into the scheme.

The result of free choice, the risk structure compensation scheme, the actual movement of members between funds and the development of contribution rates and transfers between

funds, has been that funds with higher than average contribution rates tend to lose members while those with lower than average rates gain members. As a result, the AOKs have lost several thousand members in 1997 and 1998, while the BKKs have gained several thousand. The risk compensation scheme has however narrowed contribution rates between funds, but the movement of members between funds has not equalised the different risk structures (which would in turn diminish transfers between funds). The healthier younger and better-earning people move more often and towards cheaper funds which increase the transfer sums. This suggests that a risk compensation mechanism will be needed more permanently until the risk structure has become equal.

2.7.1 Health care benefits and rationing

In the Social Code Book V, the benefits covered in the benefit package include: disease prevention, screening, disease treatment (ambulatory, dental, drugs, physician and non-physician care, medical devices, hospital, nursing and rehabilitative care) and transportation. In addition to these benefits in kind, sickness funds give cash benefits of 80 percent for up to 78 weeks per period of illness. A third type of benefit is health promotion offered directly to members.

All covered procedures are listed in the 'Uniform Value Scale' together with their relative weights for reimbursement. The range of covered procedures, curative and therapeutic, is extremely wide (such as home visits, ante-natal care, care for terminally ill, non-physician care, surgical procedures and laboratory tests and imaging procedures including MRI) and only from 1997 were exclusions possible with the mandate to re-evaluate technologies. The range of services provided in the hospital sector is determined by the negotiations between the sickness funds and each individual hospital. While the state government determines the flow of capital for investments, the negotiations determine whether the costs for running these services are reimbursed by the sickness funds. This dual financing is the result of the 1972 Hospital Financing Act.

Entitlement to benefits in the long-term care sector is given when care is expected to be necessary for at least 6 months. The benefits of long-term care insurance are graded according to the frequency of need for nursing care. Everybody with an entitlement to ambulatory nursing services is given the choice between monetary support for home care delivered by family members or professional ambulatory services as in-kind benefits. In addition, caregivers who care for their family member at home can attend training courses free of charge and are insured against accidents, invalidity and old age. For persons needing institutionalised nursing care, benefits are available for day or night clinics as well as institutional care in old age or special nursing care homes.

There are a number of inconsistencies in the different health care sectors with regard to coverage decisions and the use of health technologies in Germany. In general, the ambulatory sector appears to be much more regulated than the hospital sector. Explicit coverage decisions regarding medical and surgical procedures are currently non-existent for the hospital sector. This is due to the fact that coverage of medical devices and expensive medical equipment falls under budget negotiations at hospital level and hospital plans at state level. Diffusion and distribution of expensive medical equipment for supply to the population is therefore now the task of self-governing corporate bodies to guarantee the efficient use of expensive equipment via remuneration regulations. Closer co-operation between the hospital and ambulatory care sector to ensure adequate coverage is therefore needed.

Even though a number of population surveys have shown blanket rejections of any form of limit setting on health services to a core benefits package of essential services (especially in

the east where the belief in equal treatment opportunities independent of age, income or status is stronger), physicians and health care experts believe rationing is inevitable. Further restrictions and limitations on therapeutic freedom are expected, as well as changes in the coverage of new drugs, supplementary insurance policies (which are currently illegal) and the introduction of a gatekeeper system with bonuses for yearly check-ups.

2.7.2 Other sources of finance

Sickness funds contribute around 60 percent of total expenditure, while retirement, accident and long-term care contribute another 1 to 3 percent each, making up around 68 percent of the total. Three other main sources of finance include taxes, out-of-pocket payments and private health insurance (as shown in the table below). Taxes have more recently overtaken out-of-pocket payments as the major complementary source of financing in the late 1990s. Taxes are used for capital investment costs for hospitals, public health services, free government health care, reimbursement of parts of the private health care bills for permanent public employees and subventions for farmers' funds.

Table 3: Main Sources of Health Care Finance in Germany, as a Percentage of Total Health Expenditure, 1970-1995

Source of finance	1970	1975	1980	1985	1990	1993	1994	1995
Public								
Statutory insurance	58.3	66.7	67.0	66.3	65.4	66.0	67.0	68.2
Taxes	14.5	12.4	11.7	11.2	10.8	11.5	10.6	10.0
Private								
Out-of-pocket	13.9	9.6	10.3	11.2	11.1	11.3	11.3	10.8
Private insurance	7.5	5.8	5.9	6.5	7.2	6.7	6.8	6.6
Other	5.8	5.6	5.1	4.9	5.4	4.4	4.3	4.4

Source: WHO (1999a)

Out-of-pocket co-payments occur mostly for pharmaceuticals and while this grew consistently over the 1990s to around 14 percent of expenditure for prescribed drugs (which meant that more than 20 percent of drugs had to be paid entirely by the patients), the government lowered co-payments through the Act to Strengthen Solidarity in Statutory Health Insurance effective from 1999.

New areas for cost sharing in the 1980s were charges for inpatient days in hospitals, rehabilitative care and ambulance transportation. These were measures of cost containment, shifting spending from sickness funds to patients. The 1989 Health Care Reform Act advocated cost sharing as a means to raise revenue (to reduce dental care expenditure, physiotherapy and transportation and make patients liable for pharmaceutical costs above reference prices) and to reward responsible behaviour (dental treatment). Cost sharing again increased in 1997 when crown and denture treatment were removed from the benefits package (for certain persons), pharmaceutical co-payments were increased and co-payments for spa treatment and rehabilitative care introduced.

Except for crowns and dentures and inpatient care, yearly-cost sharing for each person has an upper limit of around 2 percent of gross income while the unemployed, people with very low incomes and chronic diseases are exempt.

Fully privately insured patients usually enjoy benefits equal to or better than those covered by statutory health insurance. Premiums vary with age, sex and medical history and unlike the statutory schemes, separate premiums have to be paid for spouses and children making

it especially attractive for single or double income couples. Since premiums rise with age and re-entry of privately insured people into statutory sickness funds is not permitted, private insurers are obliged to offer a policy with the same benefits as the statutory scheme at a premium that is not higher at least than the average maximum contribution in the sickness funds. Privately insured people generally have to pay the providers directly and are reimbursed by their insurer. The real fee-for-service reimbursement for privately insured people has led to cost increases which are on average about one half higher than in the statutory health insurance scheme and in some cases as much as twice as high.

There is also a growing market for private health insurers in supplementary insurance, such as covering extra amenities in hospital, since sickness funds are legally not allowed to offer such extra policies.

2.7.3 Health care expenditure

Germany's health care system is expensive by international comparison as expenditure has risen considerably since re-unification (see also Appendix A). The percentage of public expenditure as part of total expenditure has however remained relatively constant since 1975 and is comparable to most other countries with statutory health insurance.

Table 4: Trends in Health Care Expenditure in Germany, 1970-1997

Total health care expenditure	1970	1975	1980	1985	1990	1995	1996	1997
Value in current prices (DM mill)	42356	90380	13012	16963	21210	35972	37308	38050
			8	7	6	3	9	0
Value in constant 1990 prices (DM mill)	10396	15658	18171	18981	21210	30152	30631	-
	7	4	8	4	6	8	3	
Value in current prices, per capita (US \$ PPP)	175	375	649	979	1279	2128	2278	2339
Share of GDP (%)	6.3	8.8	8.8	9.3	8.7	10.4	10.5	10.4
Public as share of total health care expenditure (%)	72.8	79.1	78.7	77.5	76.2	78.2	78.3	77.4

Source: WHO (1999a)

Expenditure on hospital care is low by international comparison, but has risen considerably over the last thirty years. The high increases in hospital expenditure in the early 1970s can be explained both by the introduction of hospital planning to address the shortage of hospital beds and the full cost cover principle. Since 1975 hospital expenditure has been the area that has been least constrained in growth with an increase from 1.9 percent of GDP per capita in 1975 to 2.4 percent in 1995. This accounts for almost two-thirds of the increases in sickness fund expenditure since 1975. Only recently has hospital expenditure been controlled better with major cost-containment legislation.

Dual financing exists for hospitals which means financing of investment or capital costs is done through states (länder) and general running costs through the sickness funds. In order to be eligible for investment or capital costs, hospitals have to be listed in the plans set out by the states which often list the necessary specialties and the number of beds per specialty.

As a cost containment measure, the 1984 Hospital Restructuring Act introduced prospectively negotiated per-diem charges (from retrospective remuneration) which were based on expected costs. Additionally, one could include capital costs in per diem charges if

investments would lower running costs in the medium or long term. Therefore dual financing also meant dual planning with numbers of hospital beds being planned at state level, and staff numbers and hospital day numbers subject to negotiations between hospitals and sickness funds within the framework of negotiating per diem charges at the corporatist level.

2.7.4 Budget setting

Sickness funds do not have fixed pre-determined budgets but have to cover all expenses of their insured members. This means that the contribution rate has to be adjusted if the income does not match the expenditure. The main goal of cost containment policy was to limit expenditure growth to the rate of growth of contributory income in order to keep contribution rates stable. Therefore spending caps were introduced.

All budgets within the statutory health insurance system are on the providers' side and not the payers' side. While some budgets limit expenditure of individual funds (capitation payments to regional physicians' associations for ambulatory care), others do not have that effect (expenditure under a hospital budget or a pharmaceutical spending cap is divided between funds according to actual utilisation of their members).

When the full-cost cover principle was abolished in the Health Care Structure Act (1992) and hospitals were allowed to make both profits and deficits, fixed budgets were calculated for each hospital. Prospective case fees and procedure fees were then introduced from 1996. Fixed budgets were presented as an interim measure until this prospective payment system took effect.

Case fees are supposed to cover all costs during a hospital stay while procedure fees are reimbursed on top of per diem charges. Case fees are based on a combination of a certain diagnosis and a specific intervention. Procedure fees are only based on an intervention and more than one procedure fee may be remunerated per case. Points were set for the case and procedure fees by the Federal Ministry of health while the states negotiated the monetary conversion factor. Points were calculated by comparing costs and length of stay with comparable DRG reimbursements in the USA. The percentage of cases reimbursed through prospective case fees in Germany is less than a quarter, with wide variations between specialties. While no case fees exist for medical, paediatric or psychiatric patients, more than 50 percent of cases in gynaecology and obstetrics and about two-thirds of ophthalmologic cases are reimbursed in this way.

The number of case-fees and procedure-fees is subject to the budget negotiations at hospital level. Case fees, procedure fees and per diem charges are all part of the budget for each particular hospital. These budgets are not budgets in the sense that the hospital will get an amount of money independent of actual activity. Instead, the budgets are targets established through negotiations between the sickness funds and the hospital. The target budget establishes service numbers as well as per diem charges.

If the hospital reaches 100 percent of its target activity then no financial adjustment is made since the sum of all case and procedure fees plus the per diems exactly equals the target budget. If actual activity is higher than the target (the hospital has been reimbursed above the target budget), then it has to pay back a certain part of the extra income. If actual activity is lower than the target then it receives some of the difference.

All budgets in Germany are based on historical expenditure patterns and not according to a needs-based formula. Legislation has aimed mainly to contain increases in expenditure. Therefore budgets or spending caps were introduced which were based on actual expenditure in a previous year and growth rates were legally limited.

2.7.5 Payment of health care professionals

Payment of physicians occurs through two steps, firstly the sickness funds make total payments to the physicians' associations for the remuneration of all social health insurance-affiliated doctors. This releases them from the duty of paying the doctors directly. Total payment is usually negotiated as a capitation per member or per insured person. The capitation which usually varies between substitute and other funds within the state, covers all services by all social health insurance-affiliated physicians of all specialties. The physicians' associations then have to distribute these total payments among their members according to a 'Uniform Value Scale' and additional regulations.

All approved medical procedures are listed in the Uniform Value Scale. While the coverage decision is made by the Federal Committee of Physicians and Sickness Funds, a separate joint committee at the federal level, the Valuation Committee, is responsible for the Uniform Value Scale which lists all services which can be provided by physicians for remuneration within the statutory health insurance system.

At the end of each quarter, every office-based physician invoices their physicians' association for the total number of service points delivered (as attributed in the Uniform Value Scale). The actual reimbursement will depend on a number of factors:

- The number of reimbursable points per patient is limited
- The total budget negotiated with the sickness funds is divided by the total number of delivered and reimbursable points for all services within a regional physicians' association so that the monetary value of each point cannot be predicted as it depends on the total number of points. The monetary value is then used to calculate the physicians' quarterly remuneration.
- The actual reimbursement may further be modified through the 'Remuneration Distribution Scale' which is different for every physicians' association so that minimum or maximum point values for different specialties or service categories are regulated to adjust for large variations between specialties.

There are also control mechanisms to prevent over-utilisation or false claims which are run by utilisation review committees with an equal number of physicians and sickness fund representatives. A physician's level of service provision or hospital referrals per capita may be randomly reviewed and if unjustifiable, financial penalties can be incurred.

2.8 Health care delivery system

A key feature of the German health care delivery system is the clear institutional boundaries between the publicly provided health services, primary and secondary ambulatory care through office-based physicians and hospital care which has traditionally been confined to inpatient care. The separation between the latter two is stricter than in other countries and only the Health Care Structure Act (1992) eroded this separation somewhat by allowing day-surgery in hospitals and a limited amount of ambulatory pre- and post-inpatient care.

All ambulatory care has been organised almost exclusively on the basis of office-based physicians who for the majority have a solo practice and finance their own premises, equipment and personnel. They offer almost all specialties, though around 40 percent are GPs. Of the 287 000 active physicians in 1998, 135 800 worked in hospitals, 124 600 in ambulatory care (112 700 as social health insurance-accredited physicians, 7 800 as salaried physicians and 4 100 purely for private patients), 10 500 in public health services, administration or corporatist bodies and 16 100 in other areas such as the pharmaceutical

industry. Around 5 percent of all office-based physicians have the right to treat patients inside the hospital. All other physicians transfer their patients to hospital physicians for inpatient treatment. Office-based physicians again do post-surgical care. Germany has no gate-keeping system and patients are therefore free to select a sickness fund affiliated doctor of their choice, which means they frequently choose direct office-based specialists. Because of different reimbursement profiles and the lower status of family practice in ambulatory care, the number of office-based specialists has increased more rapidly than numbers of general practitioners. As a result the sickness funds and private health insurers introduced a three-year programme which offers financial incentives to GP-trainees and senior family practitioners during the office-based training period. Physician's associations agreed with the programme despite scepticism about undue intervention in professional autonomy.

German hospitals concentrate on inpatient care and only university hospitals have formal outpatient facilities. Day cases are also new for German hospitals. Around 850 hospitals are publicly owned, another 850 are private non-profit, while 380 are private for-profit, giving around 70.7 beds per 10 000 population with an average occupancy of 80 percent. Until the early 1990s, new beds in preventive and rehabilitative institutions largely compensated for the decreasing number of acute beds. The increasing number of inpatient cases offset the shorter length of stay so that occupancy rates and bed days per capita remained relatively stable. After re-unification, hospitals were faced with a rapidly changing environment of fixed budgets, the possibility of deficits and profits, ambulatory surgery and the introduction of prospective payments from 1996. As a result the hospital sector in Germany today is much less stable and by international comparison, 'hospital' beds (all beds including preventive and rehabilitative), admissions and length of stay are well above average. However, while expenditure per bed and day has risen in the last few years, expenditure per case has actually declined since 1996, meaning that efficiency has increased.

2.9 Pharmaceuticals

Pharmaceutical expenditure has been relatively effectively controlled from the point of view of the statutory sickness funds. Steep increases have always been followed by decreases largely as a result of cost sharing measures, prescription limitation, reference prices introduced in 1989 and the pharmaceutical spending cap from 1993 to 1997 and again since 1999.

The idea behind reference prices was to establish an upper limit for the costs that would be reimbursable by the sickness funds. While the Federal Committee of Physicians and Sickness Funds is responsible for the classification of drugs, the federal associations of sickness funds undertake the price setting. Although the pharmaceutical industry partly compensated for the lower prices of reference price drugs through above average increases for non-reference price drugs, the savings for sickness funds was roughly 9 percent of their pharmaceutical expenditure.

The share of reference priced drugs increased significantly to more than 60 percent by 1997. The result for patients was a general increase in co-payments. For drugs priced below the reference price, there was no co-payment, but if a patient wished to choose a more expensive drug than that covered by the sickness fund, they had to pay the difference. For drugs with no reference price, the patient had to pay a flat-rate co-payment per package of DM 3.

The Act to Strengthen Solidarity in Statutory Health Insurance (1998) set tighter regulations for setting reference prices such that they could not be higher than the highest price in the lowest third of the market which would supposedly bring about lower prices and a large saving. However the reduction was stopped legally when a pharmaceutical company

successfully sued. In 1999, a court argued that price setting by the sickness fund violates EU cartel regulations. Therefore, the health minister plans to put reference prices on a new legal basis by fixing them through ordinance from the Ministry of Health.

The spending cap for pharmaceuticals imposed a real reduction in pharmaceutical expenditure primarily as a result of changes in physician prescribing behaviour. While the regional spending caps were abolished in 1998 and practice-specific soft targets introduced (with doubtful sanctioning mechanisms), the Act to Strengthen Solidarity in Statutory Health Insurance re-introduced spending caps for pharmaceuticals at regional level. Physicians associations were liable for any over-spending up to 105 percent of the cap.

The coverage of drugs by the statutory health insurance schemes is regulated in the pharmaceutical guidelines of the Federal Committee of Physicians and Sickness Funds and forms part of the contract at the federal level. The guidelines which are legally binding, either limit the prescription of certain drugs to certain indications (such as anabolics to cancer patients), specify that they may only be prescribed after non-pharmaceutical treatments were unsuccessful or disallow any prescription at all (such as drugs to quit smoking).

In early 1999, the Federal Committee explicitly stated that licensing is a necessary but not sufficient condition for coverage in the statutory health insurance system. The guidelines list a number of reasons for not including drugs in the benefit package:

- They are not necessary for treating diseases (for example 'Viagra')
- Other pharmaceuticals are more effective and/or cost-effective
- Non-pharmaceutical treatments are more effective and/or cost-effective

The number of drug groups for which prescriptions have been limited or prohibited has grown enormously. The proposed Reform Act of Statutory Health Insurance of 2000 will again likely introduce a positive list of reimbursable pharmaceuticals.

2.10 Conclusions

Since the 1970s, the main goal of sickness funds and providers has been cost containment through maintaining a stable contribution rate. The basic principle behind 'German-style' cost containment has been 'income-oriented expenditure policy to guarantee stable contribution rates. This has been an important objective in a time of economic restructuring and growing international competition, since contributions cover all ambulatory care, pharmaceuticals and all hospital care and are jointly paid by employers and employees. Increases in contribution rates therefore became a question of international competitiveness.

While cost containment measures led to a moderation of health care expenditure growth and stabilised sickness funds' expenditures as a proportion of GDP, the contribution rate has still increased slowly but regularly (from 10.4 percent in 1975 to 13.5 percent in 1999) with cost containment measures having only minor and transient effects. Rising health care expenditure (which rises in line with GDP) is not responsible for an increase in contributions, but the shrinking proportion of GDP used for wages from which all social insurance contributions are financed. Thus larger profits by employers, a higher level of unemployment and wage increases below productivity have caused a relative reduction in the financial flow to the social insurance system since contributions are based only on labour. It is therefore now perceived that there is a financing crisis rather than an expenditure crisis.

However, due to re-unification, health care expenditure as a percentage of GDP has risen substantially and cost-containment will therefore remain on the political agenda. Budgets

have been of varying forms and efficacy but have been generally more successful in containing costs than any of the other supply or demand-side measures which have largely failed. Another focus will be on changes to the reimbursement mechanisms that currently favour unnecessary or excessive treatments such as per diem charges in hospitals being replaced by an all-encompassing case-based system.

In spite of the cost-containment acts that have been passed, the German system places more emphasis on free access, technology and high numbers of providers than cost-effectiveness or cost containment *per se*. The public supports these priorities and waiting lists and explicit rationing are almost unknown. Because all decision-making is through negotiation, any cuts in health care benefits would have to be supported by both the sickness funds and providers which is currently uncommon. There is however a slow shift towards evidence-based medicine, health technology assessment and the support of cuts according to such evidence.

One definite weakness in the German system is the fragmentation and separation between the social health insurance and the social retirement insurance (which covers the majority of rehabilitative care) on the one hand and between ambulatory care and inpatient care on the other hand. There is potential for duplication of services and inappropriate referrals which are made too early or too late. Related to the separation issue is the weak role of primary care and the absence of gatekeepers (GPs). This would require strengthening the role of GPs with respect to office-based specialists and increasing awareness in the population of the ability of GPs to steer patients through the system. Office-based specialists will also increasingly have to face competition with the hospital sector which will be opened for ambulatory treatment.

True competition in the German health care system has not been possible since the sickness funds have to offer almost all the same benefits for a very similar contribution rate and the range of providers is also the same since they are contracted collectively. The funds are therefore increasingly demanding greater flexibility for selective contracting. While policy-makers are cautiously supporting this, they are also keen to retain a system with equal access and service quality for all the insured population. The courts are slowly supporting selective contracting with the reasoning that joint decisions of sickness funds constitute monopoly power and the latest reform act has therefore removed the requirement that funds must get an approval to contract from the respective physicians' association.

The current government introduced the new medium- to long term reform into parliament in June 1999 and it will be effective from 2000 onwards (The Reform Act of Social Health Insurance 2000). This act has tried to pick up many of the system's weaknesses. It includes the removal of ineffective technologies and pharmaceuticals from the sickness funds benefit list and the strengthening of health technology assessment. Decision-making under corporatist arrangements is extended to the hospital sector by establishing a joint committee of hospitals and sickness funds and a positive list of reimbursable drugs is to be approved by the Federal Council. The act allows contracts between sickness funds and providers to cross the line between ambulatory and inpatient care thus increasing co-operation of GPs, ambulatory specialists and hospitals. In ambulatory care, the budget for GPs will be separated from that of specialists.

Global budgets were proposed for sickness funds through which they are legally obliged to spend only as much as they receive through contributions. Additionally the dual financing of hospitals was proposed to be replaced by sickness funds having to cover all costs including capital costs through a case-based fee system covering all patients. In the end, the act did not contain the requirement for global budgets and the proposed change for hospital financing also failed. As far as reimbursement of running costs is concerned, from 2003 a

new payment system based on uniform case fees taking 'complexities and co-morbidities' into account will replace the current mixed system with per diems varying between hospitals alongside uniform case and procedure fees.

3. Switzerland

3.1 Introduction and overview

Switzerland, officially known as the Swiss Confederation, is a federal republic made up of 23 cantons with a population of just over 7 million. There are four principal language communities: Germans account for 65 percent of the population, the French 18 percent, the Italians for 10 percent and the Romansch for 1 percent.

The senior executive body is the Federal Council which consists of seven ministers of equal rank who are elected for a four-year term by parliament. Each year one of the ministers is elected to be President of the Swiss Confederation, which as a position has no additional power except to chair meetings of the Federal Council and to carry out representative duties. Since 1959, the Federal Council consists of two representatives each of the Radical Free Democratic Party, the Christian Democratic People's Party, the Social Democratic Party and one representative of the Democratic Union of the Centre which supports the interests of farmers and the business community.

Executive bodies at all levels of authority are based on a collegial system. Although members are from different political parties, they do not form a coalition and vote according to their convictions, but all members must then uphold decisions collectively.

The parliament consists of two chambers, the National Council represents the population as a whole where members are elected for four years and seats distributed according to the number of votes per party, and the Council of States with 46 members which represent the cantons. Each canton elects two members according to its own electoral system.

Cantons are sovereign in all matters that are not specifically designated the responsibility of the Swiss Confederation by the federal constitution and each have their own constitution and legislative authority. Members of the cantonal executives are directly elected by popular vote.

Like the Federal Council, the individual members of a cantonal executive participate in collective decisions of the cantonal government and take responsibility for one or more administrative departments or directorates. The cantons finance the activities of their administration primarily through income tax and property tax on individuals and corporations. The cantons can allow for referendums on decisions to be approved by popular law and are also responsible for the administration of the judicial system and civil and criminal court matters.

Switzerland has about 2900 municipalities that have rights and duties that are laid down by cantonal laws. The most obvious sign of autonomy is that municipalities are also entitled to levy income tax and property tax on individuals and corporations. They are also free to set the rate of tax. Some municipalities, depending on the rules of the canton, can formulate policies in many areas such as on schools, cultural activities, energy supplies, building regulations, transport, social care, adult education and sport.

The population is involved in the process of political decision-making more directly than in most countries. Through popular petitions the citizens can make changes to the constitution. This requires the signatures of 100 000 voters to be collected within a period of 18 months. Any amendments to the Federal Constitution must be passed by popular ballot of the whole population with support by the majority of valid votes cast in the majority of cantons.

Federal laws are therefore passed by parliament (the National Council and the Council of States) and must then be passed by referendum before they become legislation. The government (Federal Council) passes ordinances, which elaborate laws. Federal decrees also elaborate laws and can be passed by either parliament (in which case they must be approved by referendum) or Federal Council.

Switzerland has attained prosperity mainly through technological expertise and export manufacturing. Tourism and international finance are important sources of income. The economy has grown in recent years with GDP increasing at an annual rate of around 1.6 percent. The unemployment rate was 5.2 percent in 1997, which declined to 3.4 percent in 1999. The dependency ratio (number of people aged 19 and under or 65 and over divided by the number of people 20-64 years of age) was 59.4 in 1995 which is low compared to the rest of the European Union.

3.2 Health status

Life expectancy at birth was 78.8 in 1994 while infant mortality was 5.1 per 1000 live births, better than many other European countries (see Appendix A for national comparisons). The leading causes of death are malignant neoplasms, followed by ischaemic heart disease and cerebrovascular disease.

3.3 A brief history of the Swiss healthcare system

Switzerland has an extremely well developed health care system. In the early 1990s substantial efforts were made to limit excess capacity and co-ordinate health care nationally after it had undergone massive expansion in a largely uncoordinated fashion after the Second World War. Until the early 1970s there were shortages of certain health professionals and in some rural areas health care was inadequate. These shortages have been addressed and today the number of doctors is instead considered to be too high by Swiss policymakers.

The cantons and municipalities were for many years almost exclusively responsible for health and welfare. At its inception in 1848 the Swiss Confederation had practically no legislative powers in this area. This situation changed gradually and in 1877 the qualifying examinations for doctors, pharmacists and veterinarians were standardised throughout Switzerland. From then on several laws were passed regarding public health and safety at federal level.

In 1890 the federal government was given a constitutional mandate to legislate on sickness and accident insurance. An attempt to introduce a system of health insurance in Switzerland was made as early as 1899 with the tabling of a health and accident insurance law. The first proposal was rejected but after changes, was resubmitted and passed by referendum in 1911. The health insurance law required health insurance funds that wished to take advantage of federal subsidies to register with the Federal Office for Social Insurance. The rules of inclusion obligated funds to provide a defined package of benefits which included ambulatory care, drugs and hospital stays of limited duration and to allow people a certain degree of freedom to change funds (such as change of address or change of job). It also imposed a limit of 10 percent on the difference in contribution rates for men and women and prohibited funds from making a profit. The funds were subsidised by the federal government according to the number of people they insured. The law left it to cantons to decide whether the insurance was compulsory. The financial situation of the funds rapidly deteriorated as a result of miscalculations regarding projected demand for services.

Several attempts were made to completely overhaul the system but they all failed at referendum, so from 1958 efforts were restricted to partial reform of the health insurance system. This was completed successfully in 1964 and led primarily to improvements in the financial position of the health insurance funds. The reforms included a revised system of subsidies to the funds based on age and gender and the introduction of compulsory user charges in the statutory health insurance system. The direct charges to patients included a deductible for those over the age of 20 years and a coinsurance for all patients on all services. The subsidies were calculated on the basis of health care expenditure in the previous year and amounted to 10 percent of average total expenditure for men, 35 percent for women and 30 percent for children. The financial problems which began as early as 1911 and continued until the partial reform in 1964 did not result in any funds going formally bankrupt but the number of funds declined significantly.

The main area of concern in the 1970s and 1980s was the sharp rate at which expenditure was rising in the health system. There were several further attempts at reform, including two referenda in 1974 and 1987 but both failed. Both reforms contained a complex mix of proposals relating to cost control, the benefit package, maternity insurance and compulsory insurance. The revised health insurance law, which was passed by the parliament in 1994, was approved by referendum and came into force in 1996. It pursued two fundamental objectives, to strengthen solidarity and to contain costs.

3.4 Organisational structure and relationships of key actors

The health care system in Switzerland is characterised by both liberalism and federalism. The liberal orientation means that state intervention will only occur when private initiative fails to produce satisfactory results, thus it only acts as a safety net or provider of last resort. This explains the relatively major role that actors outside the public sector play. Federalism means that the Swiss Confederation can legislate only when empowered to do so by the constitution. The constitution only grants limited powers to the Confederation over the health care system. The cantons may also delegate tasks to the municipalities.

These principles result in a complicated system in which many different actors are involved. Most of the changes in the system have entered into force with the health insurance law of 1996 and are continually being adjusted by further ordinances and revisions passed by Parliament.

3.4.1 Federal level

The federal constitution lists the legally defined responsibilities of the federal government, which relate to a number of different areas. One area of responsibility is the eradication of communicable or widespread diseases of humans and animals. The Swiss Federal Office handles most of the responsibilities for public health, although the task of implementing these laws is delegated to the cantons. Another area of responsibility is the promotion of exercise and sport through sports facilities, events and research.

Social insurance provision through the health insurance law, the accident insurance law, the disability insurance law and the military insurance law is a further area of responsibility. The Federal Office for Social Insurance is responsible for these except for military insurance, which falls under the Federal Office for Military Insurance. This covers damage to health sustained during service for the federal government such as military service, civil defence duties, emergency relief and peacekeeping duties. The federal government is the sole provider of disability insurance and military insurance. This contrasts with compulsory health insurance and compulsory accident insurance, which are provided by a variety of insurance funds. In 1945 the federal government was given a constitutional mandate to establish a

system of maternity insurance to cover women for loss of pay during pregnancy and childbirth. All attempts to do so have however failed to pass in public referenda (1984, 1987 and 1999).

Regulations governing medical examinations and qualifications of health care professionals are also a federal responsibility. Since 1877 when the federal law on the freedom of medical personnel was enacted, the federal government has been responsible for the accreditation of 'scientific professions' including doctors, dentists, veterinarians and pharmacists. They are required to pass a federal examination to practice anywhere in Switzerland but then also need to apply for a licence to practice from the cantonal authorities. The Swiss Medical Association regulates specialist medical training.

There is a public consensus that federal government should have the main responsibility in the areas of genetic engineering, reproductive medicine, transplant medicine and medical research. The government has had constitutional mandates in several of these areas (reproductive technology and genetic technology in 1992, transplant medicine in 1999) and some laws have subsequently been passed (reproductive medicine in 1998).

The statistics law requires the federal government to compile data on health and the health care system. The health insurance law contains additional regulations that empower the Federal Council to collect statistical data (such as expenditure and utilisation data) necessary to implement the law.

The legislation on labour and the protection of workers empowers the federal government to compel employers to take the necessary measures to protect the health and safety of workers. Responsibilities for environmental protection are embodied in a waterways protection law, environmental protection law, radiation protection law and safety of technical facilities and equipment law.

Finally, the Swiss Federal Office for Public Health collaborates with the World Health Organisation and the Council of Europe as well as the Swiss Conference of the Cantonal Ministers of Public Health to promote international co-operation.

3.4.2 Cantonal level

The health service is one of the areas where the cantons have a declining but still relatively high degree of independence. The cantonal activities involve the regulation of health matters, the provision of health care, disease prevention and health education and the implementation of federal laws.

The regulation of health matters

The cantons determine the conditions under which health professions may receive a licence to practice. They also authorise the opening of a medical practice or a pharmacy. Cantons have established the Intercantonal Union for the Control of Medicines to standardise the registration and control of medicines nationally.

The provision of health care

Most cantons operate their own hospitals and some also subsidise private patients. They provide inpatient care in hospitals and residential nursing homes. There are also private clinics that do not receive any state support. The revised health insurance law requires the cantons to draw up plans for providing hospital care according to need and to produce a list of hospitals and nursing homes that are eligible for reimbursement under compulsory health

insurance. This includes public and publicly subsidised hospitals but can also include private providers. Global budgets for public and publicly subsidised hospitals were introduced in five cantons in 1994 and have since been introduced in others. The exact way in which budgets operate varies between cantons.

The cantons can provide nursing and home care or delegate this responsibility. Most cantons delegate at least some of the tasks to municipalities. The cantons are in any case responsible for licensing providers of nursing and home care services.

The cantonal government endorses the fee schedule negotiated and agreed between service providers and associations of health insurance funds in each canton. If the parties are unable to agree the cantonal government determines the fee schedule.

Cantons are also responsible for emergency, rescue and disaster-aid services including emergency transport and ambulance services.

Basic and specialty medical training is provided at seven cantonal universities and public hospitals and clinics. Training follows the federal regulations on medical examinations and qualifications. The Swiss Medical Association regulates postgraduate training for doctors. The cantons also regulate all major health-related occupations. Training is delegated to the Swiss Red Cross.

Disease prevention and health education

The cantons' activities in these areas vary widely in scope and nature. In 1989 the federal government and the Association of Swiss Health Insurance Companies set up the Swiss Foundation for Health Promotion. In 1996 the Foundation was designated as the national institution responsible for initiating, co-ordinating and evaluating measures designed to promote health and prevent disease in accordance with the health insurance law of 1994. The Federal Office for Social Insurance supervises the Foundation but the management body of the Foundation includes representation from the cantons.

The implementation of federal laws

In most of its areas of responsibility the federal government has delegated powers of implementation to the cantons.

3.4.3 Municipal level

The cantonal health laws confer responsibility for health policy on the municipalities. The responsibility for providing nursing care for certain groups is usually delegated to the municipalities with the emphasis on home care, residential and nursing homes for elderly people and community-based mental health services.

The municipalities in turn have delegated responsibility to independent organisations for most home care services. Larger municipalities and associations of municipalities often run their own residential and nursing homes for elderly. Municipalities run nursing homes and hospitals either alone or in conjunction with other municipalities through hospital associations or are represented on the boards of such facilities. The municipalities are also responsible for supporting and counselling pregnant women and mothers, providing domiciliary obstetrics services and health and dental care in schools.

3.4.4 Health insurance companies

In 1999 there were 109 insurance companies that offered compulsory health insurance in Switzerland compared to 207 companies in 1993 offering statutory health insurance. (Before the health insurance law of 1996, officially authorised statutory health insurance existed, but much of it was voluntary. Since 1996, however, health insurance has been compulsory.) Only those insurance providers who comply with the requirements of the health insurance law and are registered with the Federal Office for Social Insurance may provide compulsory health insurance. These companies which are all non-profit, provide policies for occupational and non-occupational accident insurance, old age and disability and maternity insurance. They also dominate the market for supplementary health insurance policies known as 'private' and 'semi-private' policies, which cover additional benefits not covered by compulsory health insurance, in other words free choice of hospital doctor and superior levels of hospital accommodation. Non-registered insurance companies provide other types of insurance and have a small share of the market for supplementary policies. In 1998 there were 63 registered insurance companies offering supplementary policies compared to 61 non-registered companies.

The registered companies that are allowed to offer compulsory health insurance may be federal, regional, religious or occupational based. They are not allowed to refuse an individual's application for compulsory health insurance coverage. The policies are also uniform and cover the same package of benefits.

The regulation of the funds in relation to administration, accounting and premium calculations intensified substantially in 1996 when the revised health insurance law came into force. Many small funds could no longer participate in this drive for professionalism and withdrew or merged with larger funds. This has not yet resulted in any action on monopolies by the Swiss Competition Commission, as 109 companies were still active in the compulsory health insurance market in 1999.

The health insurance companies have grouped together to form cantonal or intercantonal associations that negotiate fees with service providers. Registered insurance companies can request the canton to set a global budget for financing hospitals and nursing homes as a one-off temporary measure to contain an excessive increase in expenditure although this provision has never been exercised.

All health insurance companies in Switzerland are members of the Association of Swiss Health Insurance Companies. The main functions of the Association are:

- Representing the interests of the members to political bodies including influencing the legislation process, reforming the fee schedule and representing the insurance companies in federal commissions.
- Compiling statistics including collecting data on expenditure and utilisation of members which is used for fee negotiations.
- Negotiating with service providers at the national level on fee schedules, quality assurance and other matters.
- Supporting the cantonal associations when they appeal against the decision of a cantonal government to the Federal Council, and
- Training in areas of health insurance accounting, administration and management.

When the revised health insurance law came into force in 1996 the registered insurance companies established a joint organisation known as Foundation 18. Its responsibilities are to meet the financial obligations of insurance companies in financial difficulty, to be

responsible for risk adjustment between the registered companies and to meet international obligations for reimbursing health care services. At present this concerns, for example, people insured by a sickness fund in Germany who use health care services in Switzerland. The joint organisation pays the service provider and is later reimbursed by the German fund. For people insured in Switzerland using German health care services, the joint organisation reimburses the German funds based on a special agreement between Germany and Switzerland. As soon as the bilateral agreement between the EU and Switzerland comes into force (around 2001), the joint organisation will extend its activities to all 15 EU countries.

3.4.5 Professional associations

Doctors are organised into cantonal medical associations. These negotiate fee levels with the cantonal associations of health insurance companies. Everyone who is a member of the Swiss Medical Association has to be a member of a cantonal association. The Swiss Medical Association regulates and accredits postgraduate medical training for doctors and confers qualifications for training on doctors who are members.

The Swiss Dental Association is also a professional and representative organisation. Part of its function is legal advice, political representation and assistance in establishing and developing dental practices.

Pharmacists are members of the Swiss Pharmacists' Association. Its main functions are similar to the other professional associations and include provision of scientific information for pharmacies.

Other health-related professions are represented by organisations specific to their occupation. These represent the interests of their members in dealing with employers and are involved in drawing up training guidelines issued by the Swiss Red Cross. Various occupational organisations also offer courses of specialist training. Most of the occupational organisations are represented by an umbrella organisation, the Swiss Federation of Healthcare Professional Associations, which represents its members' interests at the national level. It has a seat on the federal government's advisory committee that considers proposals for extending the package of compulsory health insurance benefits.

3.4.6 Hospital associations

The Swiss Association of Hospitals is called 'H+ The Swiss Hospitals'. Its main tasks are to represent the interests of all hospitals, provide in-service training for managers, develop management tools (such as cost accounting) and compile comparative statistics. It collects both administrative statistics such as wage costs and input costs as well as medical statistics about length of stay and service intensity. The private hospitals are also members of the Swiss Association of Private Hospitals. The Association's main functions are legal advice, information provision and political representation.

At the cantonal level, the public and publicly subsidised hospitals have formed hospital associations that negotiate fees with the health insurance companies. Private hospitals are often also members of the cantonal hospital associations.

3.4.7 Other organisations

Patient and consumer organisations work on various committees to represent the interests of the insured population. They have the right to be consulted in the process of negotiating fee schedules between insurance companies and service providers. In general though, they tend to be in a weak position.

3.5 Regulation and management of health care

Switzerland's health care system is a liberal and decentralised system. Providers are free to choose where to locate and patients are free to choose providers within a canton.

Federal and cantonal authorities have no direct planning controls over ambulatory services but have significant controls over hospitals and residential nursing homes. Hospitals and nursing homes can only be reimbursed for services under compulsory health insurance if they are included in the canton's official list of hospitals and nursing homes. These lists are drawn up as part of the canton's planning. In most cantons the criteria are based on bed requirements. The target number of acute beds per 1000 inhabitants varies between cantons, between 2.6 and 3.5 beds per 1000 population for 2005. Planning objectives are also not explicit and may vary between cantons and might include maximising efficiency, containing inpatient expenditure, providing sufficient high quality inpatient care or meeting the needs of the patients. The main aim of planning at the moment is to reduce excess capacity and thus excessive costs. Some cantons might collaborate on planning. Nevertheless a regional or even national consensus about hospital planning does not exist at present.

The cantons' decisions on hospital planning and lists can be challenged at the Federal Council. Appeals are usually lodged by hospitals, which have been excluded from the list, or by an insurance fund that considers the list to be too comprehensive. The Federal Council's decisions have mostly found in favour of the complainant and have thus resulted in extension of the hospital and nursing home lists. The number of complaints regarding the lists is falling, as there is greater convergence between the opinion of the federal state and the cantons. Aside from the lists, some complaints also focused on the fees charged by the hospitals, nursing homes, Spitex organisations (this term is used to describe organisations which provide domiciliary care) and other providers of ambulatory services (such as doctors and midwives). Many of these difficulties are attributed to start-up problems with a new planning instrument.

Law defines the basic benefits package and the services covered by the compulsory health insurance. The insurance provider will reimburse service providers if the services are clinically effective, appropriate and cost-effective. These criteria also apply to pharmaceuticals. Service providers are required to implement methods of assuring quality. The National Association for Promoting Quality in Health Care, an independent network made up of many of the key actors in the health sector, is the main body responsible for developments in quality management and monitoring and co-ordinating work on a national basis.

So far, the criteria that services must be clinically effective, appropriate and cost effective to qualify for reimbursement has only been applied to services being considered to be added to the benefits package. Existing services have not been subjected to these criteria. Quality assurance measures vary greatly between cantons. Outline agreements have been reached between insurance companies and service providers in the hospital sector, but implementing such measures in ambulatory care are only just starting.

Due to the oversupply of doctors in Switzerland, some universities have set an entrance examination for medicine which enables some control over the numbers entering the profession. Neither the health insurance law of 1911 nor the revised law of 1994 has any influence in the ambulatory care sector. Doctors can set up a practice in any location, the only requirement being that they need to fulfil certain criteria such as a minimum period of residence in the canton and postgraduate training so as to obtain cantonal licensing to practice medicine. The lack of regulation results in large variation in the density of doctors

per inhabitant. Similarly, there are no restrictions on pharmacists who want to open a pharmacy.

Dentists, chiropractors and midwives are also reimbursed under the compulsory health insurance scheme (in so far as their services are included in the benefits package). Physiotherapists, nurses, speech therapists and dieticians who are self-employed, also need a recognised qualification and a prescription from a doctor for any services carried out under the compulsory health insurance system.

So-called Spitex organisations (providing domiciliary care) must meet certain requirements as defined in the health insurance law, such as appropriate facilities and personnel with recognised qualifications. They must also be licensed by the canton before they can work under the compulsory health insurance system.

The Federal Department of Home Affairs decides which medicines are covered by compulsory health insurance and what price they should be. It also decides which laboratory tests, investigations or medical devices are covered by the compulsory health insurance. The Federal Department of Home Affairs consults five commissions, four of which are specialist commissions, (for example the Federal Commission for Pharmaceuticals) and the fifth which is the Federal Commission for Fundamental Questions of Health Insurance. This body has greater authority than the other four but is still only advisory. It has 17 members with representatives from each of the four commissions, as well as the Federal Office for Public Health, the Data Protection Agency, the Inter-cantonal Office for the Control of Medicines, the Swiss Competition Commission and the cantons. It attempts to incorporate ethical and practical considerations in defining the benefits package. The other commissions have to comply with the decisions of this commission.

The regulatory powers of the federal government have increased considerably over the past decades, in particular with respect to changes in statutory health insurance, which has fundamentally affected the development of structures for the delivery of health care and how the cantons finance health care services. The health insurance laws compel the cantons to plan hospital provision and to limit the range of providers who will be reimbursed. It also defines the general conditions by which all services will be assessed for reimbursement. In this way there has been some centralisation of power at the federal level.

Reform proposals suggest that this process is intended to continue. The new federal constitution adopted in April 1999 lays down the responsibility of the federal government for the control of medicines and the training of health professionals other than doctors. Further measures for transferring responsibility to the federal government are also under discussion. At the same time, proposals have also been put forward to increase the powers of cantons to intervene and to shift from state regulation to market regulation of health care provision.

3.6 Health care finance and expenditure

Switzerland's health care system is largely financed through the compulsory health insurance premiums. Since the revised health insurance law came into effect in 1996, all permanent residents in Switzerland are legally obliged to purchase compulsory health insurance policies. The premiums are community-rated (in other words they are the same for each person taking out insurance with a particular company within a canton regardless of individual risk rating). Prior to 1996, premiums were risk-rated, with the result that certain individuals who were classed as high risk by the health insurance companies (the elderly and chronically ill), finding health insurance unaffordable.

Persons exempt from compulsory insurance under the new system are:

- Public employees covered by military insurance,
- Non-Swiss citizens residing for more than three months in Switzerland who have insurance equivalent to the Swiss compulsory health insurance through a non-Swiss insurance company or their employer, and who have written exemption.

Non-Swiss citizens are always treated in an emergency, who pays for the service is decided afterwards. The cantons are obliged to inform their residents that they have to purchase compulsory health insurance and they must also enforce this policy. Residents must obtain insurance within three months of their arrival in a canton. If this is not adhered to, a surcharge is calculated based on the premiums for a period twice as long as the time by which the time limit is exceeded. If however the person is eligible for premium subsidies, the municipality or canton will purchase the insurance and no surcharge is imposed. Individuals who refuse to take out compulsory health insurance are forcibly assigned to a health insurance company by the cantonal authority.

Compulsory health insurance can be purchased from a limited number of insurance companies, both public and private, which are in turn monitored by the Federal Office for Social Insurance to whom they must submit their accounts. The entire population is guaranteed a free choice of insurance provider for compulsory health insurance and insurance companies offering compulsory health insurance are not allowed to refuse an individual's application. Individuals can change their compulsory health insurance company twice a year.

Insurance companies compete based on the level of the premium. There is no premium fixing by the state; instead price competition appears to work with many people changing companies on an annual basis depending on the premiums offered. The insurance companies are not allowed to compete on the basis of benefits offered, as a package of health care benefits is defined federally which all companies must offer. Opportunities for competing on the basis of the quality of care are also fairly limited. Managed care and quality competition are allowed under compulsory health insurance but are still not very common.

Compulsory health insurance contributions are community-rated, so that all subscribers to a particular insurance company within a canton or canton sub-region, pay the same rate. The insurance companies calculate their premiums based on estimates of health care expenditure in a canton or sub-region. These premiums are audited annually by the Federal Office for Social Insurance before they are introduced. If the premiums are too high, the federal government can force the insurance company to reduce them before they are introduced. In order to enforce this system of auditing, the cantons have a right to the information held by the insurance companies about the calculations of the premiums. This includes information on the method of calculation and the cost data used.

To reduce the impact of per capita premiums, the Confederation and the cantons subsidise compulsory health insurance premiums through tax-financed allocations. In accordance with the 1996 health insurance law, these public transfers must be used to provide a means-tested subsidy which varies according to the income and wealth of the insured person. Prior to 1996, the transfers were paid directly to the insurance companies, which reduced the level of the premiums for all subscribers rather than targeting the subsidies.

The cantons have some autonomy to define the principles on which premium subsidies are based. They are also free, within certain limits set at federal level, to choose the level at which to fix the total cantonal (and federal) budget available for premium subsidy. In some cantons, the premiums paid by individuals or families cannot exceed a certain percentage of

their total income (such as 10 percent). In other cantons, premium subsidies vary according to income and are phased out at a defined upper limit of income. For people on very low incomes the entire premium, or a cantonal 'reference price', whichever is smaller, is paid directly by the municipal or cantonal authorities.

Compulsory health insurance covers a broad range of services as defined in the health insurance law. Supplementary health insurance cover (or direct payments) can fund the services not covered by compulsory health insurance. Estimates suggest about one in four people in Switzerland have one of the major supplementary health insurance policies known as private or semi-private. In contrast to the community-rated compulsory schemes, supplementary health insurance premiums are usually risk-rated.

Per capita premiums for compulsory health insurance require some risk adjustment between health insurance companies in order that those with high risk subscribers are not penalised. With the revised health insurance law of 1996, new mechanisms for risk adjustment have been created. The formula is based on the age and sex of the insured persons. Some health insurance companies are currently proposing a revised formula that would also take account of the number of hospital treatments in the past year. Foundation 18 is responsible for calculating and making the transfer between insurance companies.

The structure of health care expenditure has changed considerably in the past 20 years as shown in the table below.

Table 5: Main Sources of Health Care Finance in Switzerland, as a Percentage of Total Health Expenditure, 1980 - 1997

Source of finance	1980	1985	1990	1991	1992	1993	1994	1995	1996	1997
Public	65.1	63.3	65.2	65.8	66.3	67.9	57.8	57.4	58.8	59.1
Taxes ¹	31.7	27.4	27.4	28.6	27.7	26.7	25.6	25.2	24.9	24.9
Compulsory health insurance ^{2,6}	33.4	29.7	31.7	31.0	32.0	34.2	25.5	25.5	27.2	27.5
Other statutory insurance schemes ³	-	6.3	6.0	6.2	6.6	7.0	6.7	6.7	6.7	6.7
Private	32.4	33.6	32.4	31.8	31.4	30.4	40.3	40.7	39.5	38.7
Out of pocket ^{4,5}	32.4	33.6	32.4	31.8	30.1	29.1	28.8	28.8	27.4	27.6
Supplementary health insurance										
For profit ⁵	-	-	-	-	1.3	1.3	1.3	1.0	1.2	1.2
Not for profit ⁶	-	-	-	-	-	-	10.2	10.9	10.9	10.0
Other payments⁷	2.5	3.1	2.4	2.4	2.3	1.7	1.8	1.9	1.7	2.1

Note: ¹ Financing from central, regional and local public authorities as subsidies to hospitals, nursing homes and home care, to compulsory (until 1996 statutory) health insurance, military insurance and public health expenditures (such as prevention and administration).

² Compulsory health insurance since 1996, statutory health insurance before 1996.

³ Occupational and non-occupational accident insurance, old age and disability insurance.

⁴ Direct payments from households to health care providers for services not covered by any compulsory or supplementary private health insurance and cost sharing in the compulsory health insurance system.

⁵ Insurance companies (for profit) offering only supplementary private health insurance. Before 1992, data included in Out of pocket.

⁶ Not for profit companies offering supplementary private insurance and also statutory health insurance until 1996 and since 1996 also compulsory insurance. Data not available before 1994.

⁷ Payments from residents of other countries.

Source: WHO (1999b)

- Tax financing has decreased since 1980 from 31.7 percent of total expenditure to 24.9 percent in 1997.
- Health insurance financing (the sum of compulsory and not for profit supplementary health insurance) has increased since 1980 from 33.4 percent of total expenditure to 37.5 percent (27.5 + 10.0) in 1997.
- Direct payments (the sum of cost sharing in the compulsory health insurance and for profit supplementary health insurance) have decreased since 1980 from 32.4 percent of total expenditure to 28.8 percent (27.6 + 1.2) in 1997.

3.6.1 Complementary sources of finance

Federal, cantonal and municipal tax revenues are a major source of financing. These cover:

- Cantonal subsidies to private and public hospitals
- Cantonal and municipal subsidies to nursing homes and home care providers
- Cantonal and federal subsidies for compulsory health insurance premiums
- Premiums for military health insurance paid by the federal government
- Public health expenditures (disease prevention and health care administration)

In 1997, these subsidies paid out of taxation accounted for 24.9 percent of total health care expenditure, whereas compulsory health insurance financed 27.5 percent. Before 1996 this insurance was statutory (but not compulsory) and up to 1994 also included expenditure by supplementary health insurance. Occupational and non-occupational accident insurance, old age and disability insurance financed 6.7 percent of total health care expenditure in 1997. Employers are obliged to insure their employees for compulsory accident insurance or it can be purchased on a supplementary basis by those not in employment and covers ambulatory and inpatient treatment costs and transportation costs as a result of occupational and leisure accidents. Military insurance is paid by the Swiss Confederation (through federal taxes) and covers health care, accident and transportation costs. Employers and employees pay old age and disability insurance and finance pensions and health care costs of the elderly and people handicapped since birth.

The above table shows that direct out-of-pocket payments amounted to 27.6 percent of total health care expenditure in 1997. This resulted from a combination of co-payment under compulsory health insurance (previously statutory health insurance) and direct out-of-pocket payments for services not covered by the benefits package.

Most insurance policies require that people pay a fixed part of the costs in the form of a deductible. This is set annually and varies between compulsory health insurance policies. The minimum is Sw. fr. 230 whereas there is usually no deductible for children up to the age of 18 (and for some insurance companies, 25 years). Insurance companies are allowed to offer higher deductible rates (up to Sw. fr. 1500 for adults and Sw. fr. 375 for children). The individual may then choose the level of deductible they wish to pay, but the premium is higher if a lower level of deductible is chosen.

In addition to the deductible, there is a 10 percent co-insurance on the price of all services covered by compulsory health insurance which has to be paid by patients in the form of a direct payment. The upper limit for co-insurance was Sw. fr. 600 for adults and Sw. fr. 300 for children (in 1999). The co-insurance may apply to a standardised price for one item of service or it may apply to the price of a specified number of treatments (an episode of care). In some cases, part of the cost is only reimbursed if the frequency of utilisation of services is within specified limits, otherwise the full cost of the service will have to be borne by the patient. Co-payments include transportation costs and inpatient hospital treatment. All

services that are excluded from compulsory health insurance cover must be financed by direct payment by the patient (unless covered by supplementary health insurance).

In 1997 supplementary health insurance financed 11.2 percent of total health care. The most popular supplementary health insurance policies are those that allow free choice of doctor and cover for superior inpatient accommodation (private and semi-private cover). Others that are less popular cover treatments and repatriations for people leaving Swiss territory, complementary medicine, dental care and drugs which are not expressly mentioned in the lists of medications and pharmaceutical products.

The insurance companies which provide compulsory health insurance, are also the main providers of supplementary health insurance. There are no tax incentives to encourage people to take out supplementary insurance. The number of people with supplementary insurance is actually declining due to the rising level of premiums and the expansion of the compulsory health insurance benefits package which makes supplementary insurance less attractive.

3.6.2 Health care benefits and rationing

The revised health insurance law defines the basic package of health care services covered by compulsory health insurance. This has been enlarged to now include inpatient and outpatient care for the elderly and physically and mentally handicapped. The other main additions were unlimited stay in nursing homes, home care, unlimited stay in hospitals, accidents (if not covered by accident insurance), diagnostic and therapeutic equipment, transport, limited dental treatment, and disease prevention and health promotion such as mammography, screening for newborn babies and hepatitis vaccination. Since July 1999 the package includes alternative therapy or complementary medicine (provided the latter is offered by doctors). Acupuncture is covered and homeopathy, neural therapy, phytotherapy and Chinese medicine will be covered provisionally until 2005 when a final decision will be made.

The health insurance law also defines which medical aids and devices are covered by compulsory health insurance. The list indicates the maximum price the insurance provider will pay for the aids and devices. The Federal Department of Home Affairs consults the Federal Commission on Medical Aids and Devices and then decides what specific aids and devices are to be covered by compulsory health insurance.

The following services are not included in the compulsory health insurance package:

- Routine dental care such as check-ups, fillings, extractions or dentures. (Most dental care is funded privately by the patient or through supplementary health insurance).
- Psychotherapy provided by non-medically qualified practitioners and hypnosis.
- Medicines not mentioned in the approved list of medicines and pharmaceutical products.
- Non-essential interventions such as plastic surgery not related to accidents.
- In vitro fertilisation.

The following services are only partly financed by compulsory health insurance according to certain restrictions:

- Spectacles
- Therapies in thermal baths
- Medical aids
- Transportation and emergency rescue services

In general, services covered by compulsory health insurance must meet criteria of clinical effectiveness, appropriateness and cost-effectiveness. The health insurance law states that “for services provided over and above the level that is in the best interest of patients and necessary for treatment, reimbursement may be denied”.

Rationing came under discussion with the use of extremely expensive orphan drugs (developed to treat rare diseases) in university hospitals which had to be financed by some cantons which had university hospitals.

Cost-containment measures undertaken since the introduction of the revised health insurance law include:

- Reducing the number of public and publicly subsidised hospitals and hospital beds
- Merging public and publicly subsidised hospitals
- Global budgeting for cantonal subsidies of hospitals
- Regulating the retail price of drugs (fixed by the Federal Office for Social Insurance) and health services by setting maximum limits
- The introduction of Diagnostic Related Groups (DRGs)
- Managed care policies such as the establishment of health maintenance organisations (HMOs), and
- Referral through general practitioners.

Future cost containment policies are not intended to affect the extent and quality of benefit coverage, they are intended to make the health care system more efficient.

3.6.3 Health care expenditure

Health expenditure as a share of GDP has continued to grow over the last two decades with spending in 1996 reaching just over 10 percent of GDP (as shown in the table below). Only Germany spends more on health care than Switzerland in the European region (see Appendix B). In 1970 Switzerland spent a smaller proportion of GDP on health care than France, Italy and Germany, but by the 1980s and mid 1990s, it outstripped all but Germany. However, when calculated as per capita expenditure in US \$ PPP, Switzerland tops all countries (2547), exceeding even Germany (2339) and Luxembourg (2340), as well as France (2103), the Netherlands (1825) and the United Kingdom (1347) (see Appendix A).

Table 6: Trends in Health Care Expenditure in Switzerland, 1970-1997

Total health care expenditure	1970	1975	1980	1985	1990	1995	1996	1997
Value in current prices (Sw. fr. mill)	4697	9810	12373	18383	26308	35050	36940	37200
Value in constant 1990 prices (Sw. fr. mill)	14651	17537	18445	21196	26308	29039	30033	30024
Value in current prices, per capita (US \$ PPP)	252	483	801	1250	1760	2403	2499	2547
Share of GDP (%)	5.7	7.3	7.3	7.8	8.3	9.6	10.1	10.0
Public as share of total health care expenditure ¹ (%)	-	-	65.1	63.3	65.2	57.4	58.8	-

Note: ¹ Public health expenditures since 1994 exclude supplementary health insurance and cost sharing for compulsory health insurance. From 1994 onwards this includes compulsory health insurance, taxes and other statutory insurance schemes such as accident insurance, old age and disability insurance.

Source: WHO (1999b)

This is most likely a result of the high levels of supply (Switzerland has the highest hospital density, concentration of high technology equipment and one of the highest doctor to population ratios in Europe) and utilisation. Variation of expenditure and consumption within the country is partly a result of cultural differences in utilisation rates with the predominantly French speaking cantons consuming more services. It also relates to the density of providers which is greater in urban areas.

The proportion of total health expenditure from government or public sources is one of the lowest in the European region with 70 percent of total expenditure from public sources (see Appendix A). The proportion of health care expenditure funded through public financing is low relative to other western European countries because a large proportion of health care is financed directly by patients or by supplementary insurance.

Switzerland's health care system consumes significant resources but also offers a broad range of high quality services. Nevertheless, the problem of increasing health expenditure and controlling it is one of the main concerns of government.

The table below shows the proportion of total health expenditure that is spent on different aspects of health care. The proportion spent on pharmaceuticals has slightly decreased from 1975 to 1996. Though this is not particularly significant in policy terms, it is due to several factors:

- The amount spent on inpatient care increased relative to pharmaceuticals.
- Pharmaceuticals were more expensive in 1975 than in 1996 relative to other European countries.
- There was heavy regulation of the pharmaceutical industry by the Federal Office for Social Insurance through the revisions to the drug list and the reduction in retail prices.

Table 7: Health Care Expenditures by Categories in Switzerland (as Percentage of Total Expenditure on Health Care), 1970 - 1996

Total expenditure on	1970	1975	1980	1985	1990	1994	1995	1996
Inpatient care (%)	44.5	47.9	47.9	47.1	48.4	49.6	48.4	48.1
Pharmaceuticals (%)	17.3	12.9	13.6	12.6	11.5	11.0	11.2	11.1
Public investment (%)	-	5.8	3.3	2.6	3.3	3.3	3.2	2.8

Source: WHO (1999b)

3.6.4 Budget setting

Providers are mostly financed by payments from insurance companies or by direct payments from patients (about 75 percent of health expenditure in 1997). Federal, cantonal and municipal subsidies from tax revenue are used to fund hospitals, care for elderly and handicapped people and means-tested premium subsidies for compulsory health insurance (about 25 percent of health expenditure).

The Federal Parliament approves the budget for the contribution to subsidies for compulsory health insurance premiums every four years. It has an annual budget-setting process for federal disease prevention and health promotion activities.

Cantonal parliaments approve budgets annually for the cantonal contribution to compulsory health insurance premium subsidies, prevention programmes and subsidies to public and private hospitals. In some cases budgets are also set for the elderly and handicapped care within the canton.

Similarly municipalities approve budgets for subsidies to inpatient and outpatient care for the elderly and handicapped and for disease prevention and health promotion. All the above budgets are indicative rather than hard budgets.

Services provided in the ambulatory sector and outpatient and short-stay inpatient care in the hospital sector are paid for under a fee-for-service payment system under compulsory health insurance. Payment is based on a relative value scale similar to that used in Germany. The point values are agreed upon annually and appear in a fee schedule. The price attached to the point value is negotiated at cantonal level for compulsory health insurance and at federal level for other types of insurance.

Within each canton negotiations take place between providers and insurance companies about the price to assign to the nationally agreed fee schedule and to determine the fee value and price of other services left to cantonal discretion. As a result, different fee values can be agreed for selected services in different cantons. The cantonal government or the Federal Council must approve the fee schedule for those fees which should be the same in all cantons. If the providers and insurers cannot agree on the terms of a fee schedule, the cantonal government fixes the level of fees.

Insurance companies usually pay hospitals per diems. Financial negotiations take place between insurance companies and hospitals and can vary considerably between cantons. For inpatient services provided under compulsory health insurance the fee charged is a per diem rate (though DRGs are slowly being introduced). For those services covered by supplementary health insurance a higher per diem rate is charged (for hotel costs and itemised charges). Payments based on DRGs are already being implemented in some cantons, although this varies substantially between cantons. A Swiss version of DRGs called AP-DRGs (All Patient Diagnosis Related Groups) released in 1998 lists the categories of DRGs as well as a preliminary version of cost weighting for Switzerland. These are average relative weights that make explicit the cost structure of the DRGs.

Cantons are mainly involved in the financing of capital costs. Public hospitals, which are owned by the cantons or municipalities, and selected private hospitals, which are subsidised by the cantons, come under control of the cantons. The capital investment costs for public hospitals are usually fully financed by cantonal tax revenues. The cantons also finance about a third of the running costs of these hospitals. Since the enactment of the revised health insurance law the cantons finance 50 percent of the recurrent costs of selected private hospitals plus the other costs that are not paid by compulsory health insurance such as capital investment, education and research.

The revised health insurance law also allows the cantons to impose fixed budgets for the subsidies paid to public and publicly subsidised hospitals and nursing homes. Global budgets for public hospitals were introduced in 5 cantons in 1994 and have since been introduced in others. The way in which these budgets operate varies between cantons. In some the deficit will be carried over to the next year. It also depends who runs the hospital or nursing home as to how the budgets operate in practice and how strongly they are applied (for example with or without penalties for exceeding the allocation).

Future financing considerations for hospitals being discussed for future revisions of the health insurance law, include:

- whether cantons should subsidise all Swiss hospitals for inpatient treatment,
- whether cantons should instead channel all tax-financed subsidies towards reducing insurance premiums,

- whether cantons should also subsidise ambulatory and short-stay treatment, and
- whether insurance companies should also pay part of the capital investment required.

3.6.5 Payment of health care professionals

Doctors in ambulatory care itemise services on an invoice after completing an episode of care whereupon third-party payers reimburse the doctor or the patient. Doctors are paid under a fee-for-service system as are most other health care professionals. The fees are determined through a point value system which is usually negotiated annually by associations of insurance funds and professional associations and is set out in a fee schedule. All medical-related professions have such a nationally agreed fee schedule. For accident, military, old age and disability insurance, not only is the fee schedule set nationally but also the actual price attached to the point value. Under compulsory health insurance, the price is negotiated on a cantonal level. Even in the private sector where actors are free to set prices, they are usually based on the nationally agreed fee schedule.

Most hospital doctors are employed by the hospital and receive a salary. These doctors also receive additional payments for services provided to people with supplementary health insurance but have to pay part of this income to the hospitals.

The introduction of health maintenance organisation (HMO) style insurance models similar to those in the USA has changed the payment methods of some ambulatory doctors. The HMOs in Switzerland are mostly still insurance-owned group practices in which the doctors are employed on a salary basis. In doctor-owned HMOs (which are still very new), doctors receive performance-related payments as well as guaranteed minimum income. A global budget (usually based on capitation) is agreed between the doctor-owned HMOs and the insurance company which is then adjusted for age, sex and other characteristics of the insured population.

Under the GP model of ambulatory care provision all the doctors are paid by fee-for-service. Some GPs and insurance companies also negotiate a “risk” payment which is paid by the GPs if the savings target is not met.

3.7 Health care delivery system

3.7.1 Ambulatory care

Doctors in independent practice provide most ambulatory health care. Most doctor contacts take place in office-based practices, most are individual practices, although some group practices exist. Of the 23 679 active doctors in Switzerland in 1998, 13 357 (56 percent) were private office-based doctors, about 36 percent of these were general practitioners and 46 percent specialists. The number of doctors is in line with the EU average but within Switzerland is considered to be very high and is still growing (by 3 percent in 1996-7). Patients are free to choose any doctor, although most have a regular doctor. Patients also have direct access to specialists in an ambulatory care setting, but most are referred to hospital-based specialists. University teaching hospitals often run polyclinics which offer direct access to outpatient services for which patients can register themselves.

Ambulatory care is mostly financed by compulsory health insurance, around two-thirds, with the rest being financed by other statutory insurance schemes (accident, maternity, and so on), supplementary health insurance and direct out-of-pocket payments.

The revised health insurance law allows people to purchase insurance policies that cover benefits from a limited range of suppliers (similar to health maintenance organisations (HMOs) or a general practitioner system). HMOs are group practices that mainly employ general practitioners and specialists in internal medicine, plus other health care personnel such as public health nurses, physiotherapists and practice assistants. A few employ gynaecologists and paediatricians. The doctors in HMOs and general practitioner systems refer patients to specialists and hospitals, but the patient still has a free choice. An estimated 74 doctors are working in HMOs covering about 98 400 insured people and around 3792 doctors are in the general practitioner system covering 350 000 people.

The number of doctors per person varies between regions with a higher density of doctors in urban areas where there is a concentration of them around university hospitals and higher numbers of specialists in ambulatory care where the market for such services is larger.

Switzerland also has the highest number of doctor contacts in western Europe at 11 contacts per person in 1997, above the European average of 7.4 contacts per person (see Appendix A). The following factors contribute to this exceptionally high number of doctor consultations per person:

- A high density of doctors and free choice
- The fee for service payment system
- A relatively limited range of non-doctor providers of primary health care such as nurses
- A culture that emphasises a high level of utilisation of health services, and
- A lack of negative financial incentives for individuals to reduce utilisation.

There is little evidence though that the freedom of choice and high levels of utilisation actually lead to higher levels of satisfaction among the population, as some studies have found no significant differences between those insured by HMOs and those enrolled in traditional policies.

Managed care systems and gatekeeper systems are very much in vogue and people believe they are a good method of controlling costs. Expansion of managed care systems and future primary care provision will largely depend on consumer choice, but it is likely that managed care systems will grow even further as cost control becomes an increasingly important factor.

3.7.2 Secondary and tertiary care

There are public, publicly subsidised and private hospitals. The public hospitals may be operated by the canton, (individual or associations of) municipalities or independent foundations. Private hospitals receive no subsidies and are financed solely by payments from insurance companies and patients. Those private hospitals which are included in the cantons' hospital list can however receive reimbursement for services under compulsory health insurance.

The most recent data indicate that there were 406 hospitals in Switzerland in 1997 of which 272 were public or publicly subsidised. The table below shows the number and type of hospitals in Switzerland.

Table 8: Number and Type of Hospitals in Switzerland, 1997

Type of hospital	Number of hospitals
General hospitals	
University hospitals	5
Non-university hospitals	221
Total	226
Specialist hospitals	
Psychiatric clinics	61
Rehabilitation clinics	46
Surgical clinics	19
Other specialist hospitals	53
Total	179
Total	405

Source: WHO (1999b)

Switzerland has a very well developed infrastructure of hospital care. However, for planning and funding purposes, secondary care can be divided into two parts. The federal government has no planning authority for outpatient and short-stay inpatient care (one night or less) and nor does it provide subsidies for it. Inpatient hospital care (longer stay) on the other hand, is subject to state planning and receives public subsidies.

This results in a system that does not always provide incentives for treatment that is optimal for health and economically efficient. Health insurance providers, for example, will tend to favour inpatient treatment since some of the cost is borne by the state. The incentive structure affecting hospitals and doctors is complex. Their preference for either inpatient or for short-stay or outpatient treatment is determined by many different factors such as capacity and occupancy rates more often than solely health considerations. The Federal Council has proposed revising the health insurance law to attempt to remove the perverse incentives.

Switzerland lies in the upper quartile of countries in western Europe in terms of the duration of hospital stays, even though the duration has dropped continuously since the 1980s from around 25 to 13 days in 1997 (see Appendix A). This above average figure is slightly compensated for by a below average number of hospital admissions, giving a capacity utilisation which lies around the mid range in the ranking of western European countries (see Appendix A). Switzerland has also not followed the trend in bed reduction seen in most other western European countries as a result of the general decline in length of stay in hospital, following technological development and the desire to increase efficiency through a reduction in excessively long stays.

University hospitals, some large cantonal hospitals and private clinics operating with or without subsidies provide highly complex and specialised treatment. This situation has developed over time in a largely uncoordinated way and it is generally agreed that Switzerland will have to reduce excess capacity in high technology medicine and specialised treatments. This will necessitate inter-cantonal and national planning of delivery structures. Two alternatives are being discussed for how this planning should be implemented. In the first instance, the federal government will create the necessary regulation for intervening in the planning of high technology health care and centres of excellence and would ensure that hospital planning is carried out at the federal level. The other option leaves the responsibility for tertiary health care with the cantons, which would then co-ordinate delivery structures throughout the country. The co-ordination would be enforced by a legally defined inter-cantonal agreement.

3.7.3 Social care

The organisation of nursing care outside hospitals is still less developed in some cases. The revised health insurance law has brought about improvements by expanding cover for home nursing care and care in nursing homes (known as “Spitex” services). However, the providers of health insurance are not yet fully obliged to pay in full the cost of home nursing care. Large proportions of people are still looked after by informal carers.

The formal nursing care network provides outpatient, short-term stay and inpatient services. The two main categories of ambulatory care provider are practising doctors and Spitex services. The high density of doctors means the capacity exists to provide home medical care services throughout the country. Coverage by Spitex services is fairly comprehensive although there is regional variation. In most cantons, the municipalities are responsible for nursing homes and often commission private organisations to build and run such facilities. Various indicators suggest the capacity of the available inpatient services is sufficient to meet current needs (with regional variation).

There has been a massive shift towards out-of-hospital care for the elderly, but despite this change, some elderly people requiring nursing care are probably still being admitted to hospital because not enough nursing beds are available. Before the revised health insurance law with extended cover to include reimbursement of nursing care, there was also a financial incentive to hospitalise patients requiring nursing care. In contrast to stays in nursing homes, the health insurance companies paid for hospital stays in full. Now with the extended benefits package of the revised health insurance law (covering Spitex services), insurance companies will pay nursing costs in full as long as a standardised fee schedule is agreed based on submissions of costs by service providers. In recent years, nursing homes and Spitex services are the two areas where expenditure by health insurance companies has risen the most.

However, until health insurance companies pay for these services in full, the balance will continue to be funded by out-of-pocket payments, other social insurance systems, accident insurance, old age and disability insurance, supplementary benefits and if this is not sufficient, by the welfare system. It is the municipalities' responsibility to finance the costs of nursing care that cannot be covered either by the individual or supplementary benefits. (Supplementary benefits make up the shortfall between costs of care of pensioners or state disability recipients and the money they have available). The cantons may also make top-up payments to the welfare system in addition to the supplementary benefits, either alone or in conjunction with municipalities.

3.8 Pharmaceuticals

The Inter-cantonal Office for the Control of Medicines is responsible for registering drug products. Any company wishing to bring a product to market must therefore initiate and pay for the registration procedure. The Federal Office for Social Insurance draws up a positive list of pharmaceuticals for which the compulsory health insurance system will pay (the specialty list). Maximum prices are also set for these products.

The price structure for pharmaceuticals is determined by the “Sanphar” pricing code which governs manufacturers' selling prices, wholesale and retail prices. Sanphar is an association representing manufacturers and wholesalers in the pharmaceutical industry. Pharmacists and dispensing doctors receive a regressive margin determined by the retail price (the higher the price, the smaller the margin).

About 62 percent of medicines are sold through pharmacies, about 20 percent through dispensing doctors, about 12 percent through hospitals and around 6 percent through drugstores. Cantons determine whether doctors are allowed to dispense and many of the cantons have no restrictions over dispensing doctors.

The amount spent on pharmaceuticals as a proportion of total health expenditure has increased from 11.1 in 1996 to 11.6 in 1997 (although it was decreasing prior to that). This is due to the current financial incentives to prescribe a lot of drugs and expensive products. Consideration is therefore being given in the health insurance law to promote the use of generic products. The pharmacists' loss of income will then be replaced by a payment for services rendered (filling a prescription, providing information, advice and patient care). There are also plans to replace the existing Inter-cantonal Office for the Control of Medicines' agreements with a federal law on pharmaceuticals in 2000. This body would then be dissolved and replaced by the Swiss Pharmaceutical Institute which would exist as a separate federal entity. The aim would be to eliminate overlapping areas of responsibility which result from the current combination of regulations that are not clearly defined.

3.9 Conclusions

Switzerland's health care system reflects its political system to a certain extent, characterised by federalism and liberalism. State intervention at the federal level has traditionally been kept to a minimum and much of the responsibility for financing, organising and delivering health care has fallen to other actors such as cantons, municipalities, private insurance companies and private providers. There have been few major reforms, mainly as a result of the political system of referenda which make comprehensive reforms difficult to pass. The system evolved in a largely fragmented and uncoordinated way. However rising health care costs and a lack of solidarity between insurance companies, meant reform became inevitable. 1994 saw the most comprehensive change to the system when the health insurance law made purchasing health insurance compulsory and made significant changes to the systems of subsidies. It expanded the benefits package and changed premiums from risk- to community-rated. It also eliminated cream-skimming by making it a legal obligation for insurance companies to accept anyone applying to them for compulsory health insurance. Problems associated with differential risk pools with some insurance companies attracting higher or lower risks are being dealt with through a solidarity organisation, Foundation 18, which is responsible for risk adjustment and transfers between companies.

As with many other countries the cost explosion in health care has been the subject of concern and debate for some time. In addition there has been a great deal of controversy about the measures that need to be enacted to achieve the aims of reform (particularly relating to containing costs) and the relative roles of government and the market in regulating the provision of health care. Alternatives to the present mixed system of regulation are being put forward but most strongly emphasise the role played by either government or the market.

Despite the many changes there are still some important questions which have to be resolved. These include:

- The relative roles of the state and the market. How should hospitals and other health care services be financed? Should the state withdraw from the planning process?
- The extent of centralisation. Should planning be done at federal level? If not, how can cantons achieve better co-ordination?

- Cost containment versus comprehensive health care benefits. Can a comprehensive benefit package be maintained? How is managed care going to develop? Will rationing be necessary?

Since 1996, the revised health insurance law has set in motion several reforms, however not all have been fully implemented. Some of the barriers include the lack of data and information and the lack of appropriate regulatory bodies (with the necessary power). Some of the reform proposals include an introduction of global budgets for outpatient care (which has been met with enormous resistance), promotion of generic dispensing and an increase in federal subsidies for compulsory health insurance premiums (which are largely unchallenged).

Other proposed changes that would affect hospital funding include a proposal to extend the cantons' responsibility to include subsidising private hospitals on the cantonal hospital list. This would mean considerable extra expense for the cantons. Furthermore, the cantons' responsibility would be extended to cover short-stay inpatient treatment. This would mean that only hospitals on the hospital list would be able to provide short-stay services and be reimbursed under the compulsory health insurance. This would impose the same planning and funding requirements on both inpatient and short-stay care. The intention is to eliminate some of the undesirable incentives in the current system. However the problems that occurred between inpatient and the short-stay sector might just move to the interface with the ambulatory sector, where cantons will not have any planning or funding functions. This proposal will also place a greater financial burden on them.

A further proposal is that hospitals will have to cover capital expenditures from income (and thus take this into account in the process of setting fee levels). This change would reduce the burden on the cantons which currently fund capital investments, but increase the burden on health insurance companies and in turn could lead to increases in premiums.

The federal government's view is that per diems currently used to pay hospitals are not ideal. Instead standardised per case payment (such as DRGs) has been proposed. Future changes in the system include the basis for defining which health services are covered and for agreeing the fee schedule for the reimbursement of services. The revised schedule has to be agreed by 2001. The proposals will attempt to remove some of the perverse incentives which exist and that distort the care settings used, for example patient shifting between short-stay inpatient or outpatient care and long-stay inpatient care which shifts some of the costs from the insurance providers to the cantons. There are also likely to be changes in the payment structures for doctors to improve the relative position of GPs to specialists in ambulatory care.

This legislation has so far been rejected by the cantons on the basis that it places an unacceptable financial burden on them, but the final version of this draft legislation still has to be submitted to Parliament and it cannot be determined what the content of the final version will contain. Several other proposals have been submitted before Parliament as well as a number of popular petitions which will be subject to referenda.

4. The Netherlands

4.1 Introduction and overview

The Netherlands is a constitutional monarchy with a written constitution (last revised in 1983). Executive power lies with the Crown and legislative power rests with both the Crown and the bicameral Parliament. Members of the Provincial States elect the Upper Chamber of Parliament while the Second Chamber is elected by direct universal suffrage with proportional representation. Both Chambers are elected for four years. The Sovereign appoints the Formator, who decides on a majority coalition with the parties in Parliament. The Formator and the parties in the coalition then decide on the appointment of the Prime Minister and Cabinet. The Sovereign has the power to dissolve both Chambers. The Council of State is appointed by the Crown and can be consulted on all legislative matters. The Government and the Second Chamber propose bills which the Upper Chamber can approve or reject but cannot amend.

The Netherlands is a highly decentralised country, with 12 provinces and 646 municipalities. Each province has its own representative body, the Provincial State, whose members are directly entitled to issue ordinances concerning the welfare of the provinces and to raise taxes. Each municipality forms a corporation with its own interests and rights subject to the general law, and is governed by a municipal council directly elected for four years which has the right to issue by-laws concerning municipal welfare and to levy certain taxes. These decentralised levels of government are responsible for most of the organisation of the health care system.

The Netherlands is a founder member of the EU. It has a population of 15.3 million people (in 1997) where 5.1 percent of the population are foreigners. It has a GDP per capita of 46409 guilders (see Appendix A for national comparisons) which has grown at a rate of 4.3 percent on average in the 1990s. However, the country has also seen rising unemployment over the same period.

4.2 Health status

Both infant and maternal mortality have decreased less than for other EU countries and the maternal mortality rate is one of the highest. Cancers and cardiovascular diseases are the most frequent causes of death.

Although the total fertility rate has slightly increased it is still below replacement level with population growth therefore very low (0.53 percent in 1994), despite the flow of immigrants. On the other hand, as a result of increasing longevity, the proportion of the population aged 65 years and over is rising steadily and now accounts for 13 percent of the population. This ageing process is even more pronounced for women and set to continue rising.

4.3 A brief history of the Dutch health care system

In 1986, the then Centre-Right government appointed a committee chaired by Dr. W Dekker to advise on strategies for reforming the structure and financing of the health care system in the Netherlands. The proposals for a market-oriented reform of the health sector as set out in the Dekker Report in March 1987 were widely discussed and debated during that year. While there was general agreement about the need for reform, many individuals and organisations expressed reservations about the feasibility of implementing such radical changes. Moreover, many organisations suggested that the

'willingness to change' was not as widespread as the Dekker Committee implied. As a result, the government organised a series of public hearings at which views and opinions could be expressed. Despite some fears, the main elements of the Dekker proposals were accepted by the Dutch parliament in 1988.

These were probably the most radical health care reforms in any OECD country and included:

- A uniform scheme of national health insurance for all residents in the Netherlands.
- Integration of both health care and related social services under the scheme, and
- A decisive movement away from direct government involvement in the determination of the volume and price of health services towards regulated competition, both in the market for health insurance and in the market for health care itself.

Two years later a new government comprising a Centre-Left coalition replaced the pro-reform Centre-Right coalition, but the main lines of the reforms continued to be accepted. It was noticeable though that the 1990 proposals (known as the Simons Plan) placed far less emphasis on market-based terminology than the earlier Dekker Report. For example, 'competition', 'markets' and 'incentives' was replaced by emphasis on 'shared responsibility between parties', 'consumer choice' and 'decentralisation'. From a political point of view the two key elements of the reforms were well balanced. The compulsory health insurance was attractive for those on the left, while regulated competition was attractive for those on the right. This political balance of the reform proposal explains why both a Centre-Right and Centre-Left coalition cabinet supported the proposal.

According to the 1988 proposals, the reforms were due for completion by 1992. The 1990 proposals extended the implementation period for three years until 1995, however even this was over optimistic. In 1993, Parliament set up an enquiry into the decision-making process in relation to health care reforms. In their 1994 report the Committee concluded that parochial interests and a lack of clear political consensus for restructuring had hampered reforms. As a result, neither of the fundamental proposals relating to basic insurance and regulated competition were realised.

A general election held in May 1994 resulted in a major loss for the two-party Centre-left coalition which was replaced by a three-party coalition comprising the Labour Party, the Liberal Democrats and the Liberal Conservatives. In September 1994 the new coalition presented its programme for the health sector. This departed from the route taken by their predecessors with greater emphasis being placed on centralised regulation and planning. Thus a return to the pre-Dekker policy approach was again signalled and a withdrawal from a market approach.

Prior to the Dekker reform proposals in 1987, the government argued that there were a number of health sector failings which needed to be addressed. These included:

- Unco-ordinated finance
- Few incentives for efficiency
- Unworkable government regulation, and
- Insurance market failures.

Different sources of health finance made it difficult to monitor, co-ordinate and control expenditure. Thus, for example, the compulsory national insurance scheme under the Exceptional Medical Expenses Act (AWBZ) had limited ability to control expenditure and nursing home care when it had no control or leverage over the decisions of individual doctors who placed people in nursing homes. In this way, separate budget

responsibilities hampered attempts to increase efficiency through substitution of different forms of care. Therefore, because there were several funders responsible for the same patient at different points in an episode of illness, and different funders of health and social services, there were barriers to substitution at critical points and a tendency for some providers to try to offload patients on other providers.

Another problem was that the system contained few financial incentives for stimulating efficiency among providers, users and insurers. The fee-for-services system provided no incentive for hospital doctors to review their practice in order to eliminate unnecessary and inappropriate procedures. It in fact encouraged over-supply. The formula through which hospital budgets were set made inpatient treatment more attractive than lower cost day surgery. Most patients had little concern about the appropriateness and costs of their treatment, as their charges were close to being fully met by their insurers. Individual sickness funds received full reimbursement for their expenditures from the Central Sickness Fund and therefore had little incentive to improve their own efficiency or to seek to improve the efficiency among the providers from whom they purchased services. Moreover, they were obliged to contract with any local provider who wished to provide services to their members which meant that they acted as passive funders of care rather than as active cost-effective purchasers of services.

Government regulation had been used extensively in an effort to contain costs with a complex and highly centralised apparatus of regulating prices, volume and quality. This had included efforts to reduce the number of hospital beds, limits on hospital budgets and investments in new facilities, licensing of new technologies for reimbursement purposes and the regulation of doctors' earnings through the negotiation of fee schedules. However during the 1980s, concerns were expressed about the effectiveness of this approach as it was complex, costly and rigid. Regulations were often unable to cope with the complexity of the health sector involving multiple groups often with conflicting interests. Moreover, it often introduced perverse incentives rather than encouraging efficiency, for example cost-increasing avoidance strategies and unintended distortions in resource allocation. Planning and financing decisions were made separately with the result that none of the parties involved were fully responsible for the consequences of their decisions.

Insurance market failures in the Netherlands arose because of adverse risk selection and management inefficiency among the sickness funds. Adverse risk selection occurred because private insurers tended to cater for low risk individuals while sickness funds provided insurance for higher risk groups. A concern with equity meant that a complex system of compensation existed for transferring revenue from the private to the public sector. Management inefficiencies occurred among the sickness funds because they operated as local monopolies with little need to compete for subscribers. There was huge variation in per capita expenses between the lowest and highest cost sickness funds and a widening divergence in premiums in the private market reflecting the differences in risks.

The Dekker health reforms therefore set out to address these sources of market failure.

4.4 Health care reform

The health reform proposals set out in the Dekker Report in 1987 represent some of the most comprehensive and coherent approaches to managed competition in the EU. The main elements in the programme are based upon both demand and supply-side competition within a managed or regulatory framework.

The reform programme which began in 1989 was based on three principles. First, there should be a basic health package available to all funded through social insurance. All existing financing should be channelled through a single system with sickness funds and private insurers competing for enrollees. Second, there should be a shift from government regulation to managed competition as a means of encouraging greater efficiency with appropriate financial incentives offered to users / consumers, insurers and providers. Third, government regulation would still be used to ensure an acceptable quality of care and to meet various equity objectives such as local accessibility and solidarity between social groups.

4.4.1 Health care reform after 1994

Although the then government had announced several major steps to be taken in 1993 and 1994 in order to further implement the proposed reform, in reality the implementation process in these years virtually ceased. At that time there was much confusion as to whether the Simons Plan was dead or not. In May 1995 the new government announced its health care policy for the coming years.

The major change that was announced was that within the compulsory health insurance system there should be two regulatory regimes rather than one as in the Dekker and Simons Plan. The new government stated that it would continue the same Dekker-Simons type of reform but only for the non-catastrophic risks (like hospital care, physician services, drugs and physiotherapy). For the catastrophic risks (like nursing home care and long-term institutional care for mentally and physically handicapped persons) and health care related social welfare (old age homes) there would be direct government regulation with respect to planning, budgeting and prices. For these types of care there would be no role for competing risk-bearing insurers. In order to contain costs and improve efficiency in that sector, the government announced the introduction of a system of personal budgets for certain categories of patients, so that these patients can buy their care out of their own budget. The Dekker-Simons Plan was therefore to be discontinued for catastrophic risks but not for non-catastrophic risks.

For non-catastrophic risks, the dominant regulatory regime would be the Dekker model of regulated competition among insurers as well as providers. The government announced plans to deregulate hospital planning, although they still continue to bear the responsibility with respect to large-scale investments related to hospital building. But for the remainder, the government was of the view that competing risk-bearing insurers would be more able to contain costs and improve efficiency than government. For this reason, government announced a critical competition or anti-trust policy in health care with which it hopes will come commensurate increases in financial responsibility among insurers and sickness funds. Consequently the government will also increase the insurers' tools for improving efficiency by taking away the existing legal regulation concerning hospital budgeting. The government also decided to implement proposals by the Biesheuvel committee, chaired by former Prime Minister Biesheuvel. This committee advised the government to promote the participation of specialists in the management structure of hospitals, to stimulate the integration of specialists and hospitals into one organisation and to replace the fee-for-service payment system with a remuneration system that encourages less over-supply. With respect to the remuneration of GPs, the committee advised the introduction of a flexible system of bonuses related to efficiency and other performance indicators.

As a result of the decision to have two regulatory regimes instead of one, within the compulsory health insurance system, the government also had to choose another

implementation path. During the last seven years the implementation path of the reform has been as follows:

- All non-catastrophic risks (to be included in the compulsory health insurance) should be transferred from the sickness fund insurance and the private health insurance to the AWBZ (Exceptional Medical Expenses) which was intended to become the 'carrier' of the reformed health insurance system.
- The regulatory regime of the AWBZ should be reformed.
- Ultimately all different regulatory regimes for sickness fund insurance and private health insurance would be abolished.
- Sickness fund organisations and private health insurance companies should all become 'care insurers' with the same rights and duties.

Because the new government decided to have two strictly separated regulatory regimes for the catastrophic and the non-catastrophic risks, it no longer made sense to continue the process of transferring non-catastrophic risks to the AWBZ. Instead the government proposed to restrict the AWBZ to only the catastrophic risks, and to transfer all non-catastrophic risks covered under the AWBZ (for example prescription drugs) to the sickness funds and private health insurance. In addition, the government announced a convergence of sickness fund and private health insurance. For the time being the distinction between sickness fund insurance and private health insurance will be maintained but over time the differences between these two types of insurance will disappear.

In the sickness fund sector the government proposed to drastically increase the financial risk for the sickness funds. In 1995 the sickness funds received risk-adjusted capitation payments based on age, gender, region and disability. Currently it is a partial capitation system in the sense that the sickness funds are responsible for only about 3 percent of the difference between their actual expenses and the predicted expenses based on age, gender, region and disability. The remaining 97 percent is retrospectively reimbursed. The new government announced that the 3 percent figure will be increased to 100 percent by 1998 (except for the fixed hospital costs).

In the private health insurance market the government announced the following changes:

- The introduction of a compulsory health insurance for all insured people not in sickness funds,
- Open enrolment requirements, and
- Premium regulation involving a minimum and a maximum premium.

Because the regulatory regime of the AWBZ, despite all the reform proposals since 1988, has not been much affected in the last seven years, in practice the adjustment of the reform proposal does not imply great changes with respect to the AWBZ. Major changes can however be expected in the coming years as a result of the proposed changes within the sickness fund and the private health insurance sector.

4.5 Organisational structure and relationships of key actors

The cultural belief underpinning the Dutch health care system combines a commitment to social solidarity and a simultaneous concern for individualism. The commitment to solidarity results in the belief that health care should be collectively funded on the basis of ability to pay and that access should be based on patient need, while at the same time individualism places an emphasis on discretionary financing. As such, the Dutch health

care system is based on a system of compulsory social insurance and discretionary private insurance.

The key actors in the Dutch health care system form part of a corporatist administrative structure within the Netherlands. There are a number of key characteristics to this structure which influence decision-making and the reform process. First, within Dutch society there is an absence of a legitimised power centre for taking important decisions and implementing them. Second, there is a high degree of professional and organisational autonomy. Third, the administrative system is marked by a high degree of mutual dependency. This means that within the health care sector, the government, providers of care and insurers are all dependent on one another to meet their own objectives. It has been argued that this structure has come under pressure in recent years as individualism and decentralisation have assumed greater importance. There has also been a partial shift in the balance of power towards insurance companies and providers of care.

4.5.1 Social insurance providers

Everyone resident in the Netherlands is covered by a compulsory national insurance scheme for chronic health care risks and for catastrophic health expenditure under the Exceptional Medical Expenses Act (AWBZ) which came into force in 1967. Initially, this Act covered long-term and high cost care, but over the years its scope has been extended. In recent years the services it has covered include long-term hospital care exceeding one year, nursing home care, residential care for people with learning disabilities or mentally and physically handicapped persons, vaccinations, day care in nursing homes, psychiatric outpatient and non-residential care and medicines. Insurance under the Act is compulsory with practically the whole of the population making income-related contributions out of compulsory additions to wages by employers. The self-employed have to make their own contributions. There is a small tax subsidy and patients or relatives have to make a smaller flat rate payment towards their cost of care. Providers are reimbursed directly for services provided in kind. The individual's usual insurer handles the administration of benefits. Negotiations with providers about individual beneficiaries are handled by a designated liaison fund (sickness fund) in each locality. A central payments office makes the payments.

The following table shows the contributions to the AWBZ for 1991 and 1992.

Table 9: Contributions to the Exceptional Medical Expenses Act (AWBZ) in the Netherlands, 1991-2

	Employees & persons on social security benefits (as % of income)	Flat rate: Adult (guilders)	Flat rate: Child ^a (guilders)
1991	5.8	-	-
1992	7.3	133.20	44.40

Note: ^aFor all children under the age of 18 years

Source: Hoffmeyer & McCarthy (1994)

Those people on an annual income below a yearly adjusted specific level (approximately two-thirds of the population) are also compulsorily insured under the Health Insurance Act (ZFW) of 1966, for normal medical risks such as general practitioner services, dental care, specialised medical care, maternity services, hospital services and transport. Compulsorily insured members can also opt for supplementary voluntary insurance for higher standards of hospital accommodation. There are about 30 non-profit sickness funds, which nearly all operate nation-wide. The insured are charged both an income-

related percentage contribution, a part of which is payable by the employer (which covers around 85 percent of the cost of the basic package of care), and a flat-rate contribution (of around 15 percent of the cost), set by the sickness funds. An insurer is obliged to quote the same flat rate premium to all insured people who choose the same insurance contract. The insurers' revenues consist of a risk-adjusted per capita payment from the Central Sickness Fund, supplemented by the flat rate premiums to be paid by insured people. The difference between the actual costs and the risk-adjusted payment will not be the same for all insurers and will be reflected in the flat rate premium that the competing insurers quote. This creates an incentive for insurers to be efficient and represents one of the main sources of competition.

The table below shows the contributions to the Health Insurance Act fund from 1987 to 1992.

Table 10: Contributions to the Health Insurance Act (ZFW) in The Netherlands, 1987-92

	Employees and others (% of income)	Over-65: On benefits from Old Age Pension Act (% of income)	Over-65: On other income (% of income)	Flat rate: Adult (guilders)	Flat rate: Child ^a (guilders)
1987	9.80	2.95	9.80		
1988	10.20	3.10	10.2		
1989	8.10	1.90	8.10		
1990	7.90	1.85	1.90	186.00	93.00
1991	7.80	1.90	7.25	225.60	112.80
1992	6.35	0.75	6.35	198.00	99.00

Note: ^aUp to a maximum of two children

Source: Hoffmeyer & McCarthy (1994)

Contributions for both AWBZ and ZFW are collected from households and enterprises and paid into a Central Sickness Fund. There is also a tax subsidy. Furthermore, the scheme is funded by an annually determined government grant. To obtain benefits, individuals must register with a local sickness fund and a GP with whom the sickness fund has a contract. ZFW provides for a system of benefits in kind. To this end, sickness funds contract with health care providers and make direct reimbursements to the providers for services supplied to their members without any financial involvement on the part of the patient. They may also provide supplementary private insurance for extra services such as higher classes of hospital care.

There is also a statutory medical insurance scheme for local and regional civil servants and corresponding retirees (5 percent of the population) but not for national civil servants. This is also a compulsory scheme with benefits similar to those provided by sickness funds. Contributions are income-related and shared between employers and employees. Dependants are also covered. Like private insurance, these schemes provide indemnity payments rather than benefits in kind.

There is also a separate programme for social care which covers the whole population, including domiciliary care and old people's homes. A mix of sources including AWBZ, general taxation and out-of-pocket payments finances these services.

Contributions made under the AWBZ and Health Insurance Act are administered by the Central Sickness Fund (Ziekenfondsraad) which makes payments to the individual sickness funds on a partially risk-adjusted capitation basis. As well as acting as a central pool for contributions, it receives a government subsidy. The council has 37 members drawn from government, providers of medical care, individual sickness funds, employers

and employees as well as representatives of consumers and patients' associations. Although the government sets contribution rates, payments by the Fund are potentially open-ended. Deficits or surpluses can be carried forward.

The individual sickness funds are non-profit, originally regionally based organisations, often with charitable origins. They may now sell policies on a nation-wide basis rather than being restricted to a single regional area. They are responsible for making payments on behalf of patients to health care providers. Enrolment with sickness funds is open (at least every two years) which reduces the incentive for preferred risk selection. Some people may therefore choose a traditional health insurance contract with free choice of provider, while others may prefer a limited provider plan with a lower premium. Furthermore, the premium paid will reflect the efficiency of the contracted health care providers. It is therefore expected that insured people will be rewarded for choosing efficient insurers and cost-effective providers. Providers are also rewarded for effective and efficient provision of care and insurers, acting as intermediaries, are stimulated to contract efficient providers.

In the late 1980s there were over 40 regional sickness funds but since then they have been subject to rationalisation and amalgamation. Today about 60 percent of the population is enrolled in approximately 25 sickness funds operating nation-wide. It is expected that eventually there will probably be only between 10 and 15 funds remaining.

Since 1994, sickness funds can selectively contract with physicians and pharmacists whereas before (since 1941) they had a legal obligation to contract with each provider in their working area. Thus sickness funds do have an element of competition between them as suggested in the Dekker proposals based on their flat rate premium, quality, and providers with whom they contract. They have therefore made large moves from being administrative bodies to being competitive, risk-bearing enterprises.

Since the early 1990s there has been a reorganisation of the internal structure of sickness funds. Administration-oriented chief executives who go on early retirement are replaced by entrepreneurial, market-oriented managers. The service to members is being improved, such as better opening hours and mobile offices and there have been several other innovative activities. For example, sickness funds have broken the price cartel of providers of some medical devices which brought prices down. Insurers are developing mail order firms as an alternative distribution method of pharmaceuticals and all kinds of electronic data interchange (EDI) projects are being developed, aimed at improved co-operation among providers and a more efficient relationship between providers and insurers.

4.5.2 Private sector

People with an income above a certain eligibility level (approximately one-third of the population) for coverage under the Health Insurance Act, can take out private insurance for acute health care risks with one of the 40 or more private insurers. Supplementary insurance covers items not included in the basic package such as dental care for those over 18 years, physiotherapy and some medicines. Approximately 60 percent of private insurance is in the form of individual contracts, with the remainder on a group contract basis. Private insurance is voluntary and individuals can carry some of the risks for themselves but very few do not insure at all. Privately insured patients have to pay for treatment and then seek reimbursement from their insurers.

Supplementary insurance is financed by fixed premiums set by insurers. Premiums are per individual and vary according to medical risk, the level of deductible chosen and the

desired level of hospital accommodation (first, second or third class). Private insurance premiums are tax deductible only to the extent that they exceed an amount equal to an imputed compulsory contribution to a sickness fund on the income of the individual concerned. Traditionally private insurance premiums were community-rated but this arrangement began to break down in the 1970s. High-risk individuals, especially the elderly were faced with steep rises in premiums. Rather than leaving the sickness funds to act as insurers of last resort, the government has obliged private insurers since 1989 to provide standard cover at set premiums, below cost, for people over 65 who were previously covered by private insurance. A system has been devised to spread the corresponding outgoings among other privately insured persons. In effect, this imposes social insurance conditions on private insurers. This increases the financial risk of private insurers especially for the expenditures of persons over the age of 65. Currently all expenditures for these persons are fully reimbursed retrospectively. Therefore the insurance companies have no financial incentive for efficiency with respect to these costs.

Private insurers are required under the Medical Insurance Act to offer a standard insurance package with statutory regulations partly governing acceptance, the extent of the risk insured and the maximum premium to be charged. Therefore, to ensure financial access to private health insurance for everyone, the government has announced open enrolment and premium regulation (minimum and maximum premiums) in the private health insurance market. In a competitive market with risk-bearing insurers, such regulation has to be supplemented by a risk-equalisation scheme in order to compensate insurers for the predictable losses on high risk insured people, especially when the proportion of high risk insured people varies between insurers as is currently the case in the Netherlands. In practice the implementation of such a risk-equalisation scheme is not only technically complicated but also a very sensitive issue politically.

Although the private insurance industry serves that section of the population not eligible for coverage under the Health Insurance Act, there is a good deal of collaboration with the non-profit sickness funds. In fact the largest private insurance company, Silver Cross, which has over 600,000 subscribers, was originally founded in 1948 following an initiative on the part of the sickness funds. At the time the funds were concerned about the problems facing their members when their incomes rose above the ceiling level making them ineligible for insurance by the funds. In response to this situation, Silver Cross was developed with the aim of offering high quality services at affordable premium levels.

4.6 Regulation and management of health care

In a system based on private institutions and independent practitioners, the determination of the volume and price of services was originally placed on decentralised bargaining between individuals, insurers and providers. However, since the 1970s with the high rate of growth in health care expenditure, the government has become increasingly involved in detailed regulation of prices and volume. The result is that both private and public sectors are now heavily regulated. Since the Dekker reforms however there was a greater move toward managed competition given the difficulties of detailed government regulation.

Although the government does not control the overall health budget, legally, both the compulsory and voluntary insurance schemes remain open-ended, it does intervene in other ways.

- It publishes an annual health expenditure plan which carries considerable weight and has for all practical purposes assumed the role of an indicative budget.
- It closely regulates the two compulsory insurance schemes and has become increasingly involved in regulating private insurers.
- The Government has responsibility for and financial control over most aspects of the health services.
- The Central Agency for Health Care Tariffs, established in 1982, exercises strong control over the fees and charges set by providers for both public and private patients and oversees the setting of hospital budgets. It also tries to regulate doctors' incomes by defining so-called "target incomes".
- There are selected volume controls over the numbers of physicians admitted to training and the numbers of GPs allowed to practice and efforts to reduce hospital capacity. Since 1982 hospitals have not been allowed to expand unless such expansion had been planned by local government and approved by the Ministry.
- There are wage controls for non-medical employees, and
- The government has sought to apply quality controls in health care via medical inspectors and a system of hospital accreditation.

The emphasis of the Dekker reforms was on managed competition, such that consumers would be able to choose the insurer and provider they wished based on the quality of care and service they received. The ability of consumers to express their preferences in this way was expected to act as a signal for the efficient allocation of resources. The emphasis was therefore to shift from regulated quality assurance to consumer demand, although it would still be necessary for government to lay down minimum standards. For example, it was planned to use the Hospitals Facilities Act to provide for the monitoring of large residential institutions. Beyond this, there was also discussion of the need for government to support quality assurance through the development of accreditation schemes and other regulatory initiatives.

The problem is that consumers rarely possess good information about health care services, particularly in relation to quality of care. The absence of well informed consumers places limitations on the efficient regulation of a market system. Furthermore, the fact that prices within the Dutch health care system have been determined by negotiations between providers and insurers and by government regulation means that they have been poorly related to costs. As such, they could not be immediately relied upon to provide the right signals for achieving an efficient allocation of resources. This requires a heavy investment in information technology and costing systems.

A factor complicating the implementation of the reforms was the difficulty of determining a risk-adjusted capitation formula for paying individual insurance funds from the central fund. Because all insurers are obliged to accept all applicants, the risk-related contribution from the Central Sickness Fund would eliminate the incentive for the insurer to compete on the basis of the individual's risk (and therefore they would only compete on the flat-rate levy). Ideally each insurer should receive a premium payment which reflects the risk category of the individual that insures with it. If these categories are set too broadly, as was done by the government, on the basis of age, sex, region and disability, which they believed to explain a reasonable proportion of the variance in health care expenditure, the potential for preferred risk selection or 'cream-skimming' is increased. In 1993 and 1994 sickness funds received only an age-gender adjusted payment, but in 1995 region and disability were added as risk-adjusters. The effective prevention of this 'cream-skimming' (selecting good risks and rejecting poor risks) was necessary for reaping the benefits of competitive health insurance within a regulated premium structure. Unfortunately age, sex, region and disability predict only a small

proportion of the explainable variance in individuals' annual health care expenditure. If the previous year's expenditure incurred by individuals is added to the equation as well as further indicators of health status and background characteristics, the proportion of the explainable variance that can be predicted rises, although it still remains relatively low. This suggests that these variables might be added to the capitation formula although such developments would require substantial investments in data collection and administration which is still some way off in the Dutch health care system. Since the 1990s however there has been a major investment in cost-accounting systems by hospitals and other health care institutions. Knowledge about the nature and real costs of the different services is necessary in a more competitive market to make the necessary risk adjustments. It also prevents providers from selling products below cost and it enables insurers to be prudent purchasers of care and to make appropriate trade-offs between substitute products.

Because of the imperfection of the risk-adjusted capitation payments, sickness funds are responsible for only about 3 percent of the difference between their actual expenditure and the normative expenditure level on which the risk-adjusted capitation payments are based. The remaining 97 percent of their expenses are still reimbursed retrospectively. Therefore the sickness funds' incentive for efficiency and stimulating managed care is still very low. However the proposal by the new government to increase the financial responsibility of the sickness funds from 3 to 100 percent of the difference between their actual expenses and risk-adjusted predicted expenditures (except for fixed hospital costs) will undoubtedly bring new dynamics into the health care sector. It will yield premium competition among sickness funds and also more managed care activities. However, as long as the risk-adjusted capitation payments do not sufficiently reflect an individual's predictable future expenditures, sickness funds might be inclined to cream skim with all its adverse effects. Therefore government needs to strike a balance between increasing the sickness funds' financial risks and simultaneously improving the risk-adjusted mechanism. This will stimulate sickness funds to make long-term investments in managed care.

It appears to be technically feasible to develop a sufficiently risk-adjusted capitation formula for the non-catastrophic risks (like hospital care, physician services and drugs), but the technical possibility of finding a risk-adjusted capitation payment formula for catastrophic risks like long-term nursing care and long-term institutional care for mentally and physically handicapped persons, appears to be much more problematic.

Various other types of regulation could be deployed to discourage 'cream-skimming' including allowing differentiation, within limits, of the voluntary flat-rate part of the basic insurance premium on grounds of risk, risk-sharing between the Central Sickness Fund and the insurers, and the promulgation of ethical codes for insurers. Some combination of these measures could further help combat risk selection.

Another problem which slowed the pace of reforms, is that Dutch health policy is characterised by a diffuse decision-making structure without a clear-cut centre of power. Hence, government cannot impose changes without the consent of major interest groups such as the organisations of physicians, health insurers, employers and employees. The employers opposed the Simons Plan because they were afraid that the government would pay more attention to the compulsory health insurance with a broad benefits package. This would increase total health care costs (because of moral hazard) rather than promote cost containment and improve efficiency. Because the premium is partly paid by the employers, increases in health expenditures would increase their labour costs and therefore affect their competitive position. The insurers opposed the Simons Plan because they strongly opposed a system of risk-adjusted capitation payments from

the Central Sickness Fund and other government regulation that reduces their entrepreneurial freedom. The physicians opposed the Simons Plan because they found the description of the benefits package too general, leaving too much room for competition among providers of care. While labour unions and consumer associations supported the extension of health insurance, they were concerned about the income distribution consequences of the flat rate premium payment component of the scheme and what effect this would have on low income groups and social solidarity. As such these powerful lobbies and interest groups presented strong resistance which delayed implementation and change.

Because of the complexity of the reforms and in order to be politically acceptable, they had to be implemented in a step by step fashion, but this introduced a new complexity. For example the political right, supported by the employers, strongly opposed some steps because in their opinion more emphasis was being placed on the implementation of the compulsory health insurance than on cost containment efforts. Another political problem was that the introduction of compulsory health insurance for the whole population would create negative income-distribution effects for relatively young and healthy middle class people with private health insurance. They would have to subsidise the poor and the unhealthy by paying an income-related premium instead of their current, considerably lower risk-related premium.

The major adjustment from the Dekker-Simons proposals made by the new government, to have two regulatory regimes instead of one, appeared to have broad support in Parliament and in the health care sector. A fundamental discussion can however be expected in the coming years on the advantages and disadvantages of having one or two regulatory regimes within the compulsory health insurance scheme. In the previous seven years the government at the time put forward the following arguments against having two regulatory regimes instead of one:

- Where would one draw the line between types of care for which insurers bear and do not bear financial responsibility?
- How can one prevent insurers from encouraging substitution of expensive care for which they do not bear any financial responsibility for less expensive care for which they do bear financial responsibility?
- How can one prevent closely inter-related forms of care being artificially separated by different financing mechanisms and different regulations?
- How does one deal with the complexity of two regulatory regimes?

Although the new government gave no clear arguments for the two regulatory regimes, there are some compelling reasons for choosing it. Firstly, there is little prospect that in the foreseeable few years a workable system of risk-adjusted capitation payment for catastrophic risks will be in place. Secondly, even if there was a good risk-adjusted mechanism, a major problem would be that competing risk-bearing insurers would have the financial incentive for reducing the quality of certain types of care. Although there are several arguments why a regulated competitive market for health insurance may increase the quality of care (especially in the market of non-catastrophic risks), these arguments may not hold for other categories of care. In particular, this includes care that is regularly used by individuals who do not have the ability to make the trade-off between price and quality of care, about which many people are indifferent regarding quality because of the low probability of needing it in the foreseeable future. Examples include institutional care for people with mental handicaps, long-term institutional care for physically handicapped people, chronic psychiatric care, long-term care for alcohol and drug addiction and long-term nursing care. Most of these can be labelled catastrophic

risks. Therefore, at least for the time being, two regulatory regimes is sensible although decisions about the exact boundaries of the two regimes is needed.

4.7 Health care finance and expenditure

4.7.1 Health care benefits and rationing

When the government in 1988 finally confirmed their intention to proceed along the lines of the Dekker Report towards a system of compulsory health insurance for all the population, its proposed reforms differed slightly from those originally proposed. In particular, it was decided to extend the package of basic insurance to include artificial aids and appliances. The minimum level of care to be provided under basic insurance would be described in legislation.

When the new government took over in 1990 and reconsidered the reforms some important changes were proposed. These were based on policy considerations (the basic insurance was to cover all essential care) but also on legal requirements originating in international treaties (ILO and others) as well as European Community regulations. As a consequence the content of the basic insurance package would be enlarged to cover about 90 to 95 percent of total health care expenditures instead of 85 percent. The content of complementary insurance, which would be privately funded, would be correspondingly restricted.

The current AWBZ benefit package includes cover for long-term hospital care exceeding one year, nursing home care, residential care for people with learning disabilities or mentally and physically handicapped persons, vaccinations, day care in nursing homes, psychiatric outpatient and non-residential care and pharmaceuticals. The Health Insurance Act benefit package covers general practitioner services, basic dental care, specialised medical care, maternity services, hospital services and transport. Supplementary insurance covers items not included in the basic package such as dental care for those over 18 years, physiotherapy and some medicines as well as optional higher quality hospital accommodation.

One of the main problems since the Dekker proposals has in fact been the content and the appropriate definition of the benefits that should be covered by compulsory insurance.

4.7.2 Sources of finance

In 1992, the different sickness funds covered 81 percent of the total health care bill. Compulsory health insurance contributions account for the largest component of health expenditure, although this figure also includes supplementary (voluntary) health insurance premiums. Government subsidies out of general taxation amounted to 10 percent and patients paid 8 percent.

The following table shows the sources of financing in the Netherlands over the period 1987 to 1992.

Table 11: Sources of Health Care Financing in The Netherlands, 1987-92

Sources of finance (as % of total)	1987	1988	1989	1990	1991	1992
Health Insurance Act Fund (ZFW)	35.3	35.3	32.6	32.8	32.9	23.9
Exceptional Medical Expenses Act (AWBZ)	23.8	23.8	30.7	31.3	31.4	45.6
Government	14.1	13.8	10.6	10.6	10.6	10.7
Other sources	26.8	27.1	26.2	25.3	25.0	19.9

Source: Hoffmeyer & McCarthy (1994)

There is some cost-sharing for long-term care facilities which accounts for about 10 percent of the costs. Public health services are managed by municipalities and financed out of taxation. Domiciliary health services are run mainly by "Cross Associations" which are independent foundations set up by private initiative but financed mainly through taxes, the Exceptional Medical Expenses fund and to a small extent by direct payments.

4.7.3 Health care expenditure

In 1997, the Netherlands spent 8.5 percent of its GDP on health which is comparatively lower than several other EU countries. This has also remained relatively stable since the 1980s, as has the share which is spent on ambulatory medical care and hospital care. Within spending categories, a relatively large share of the budget is spent on nursing which is in line with the relatively high number of nursing professionals. On the other hand a relatively lower share of the total expenditure is spent on medications and ambulatory medical care as well as dental care.

The Netherlands has relatively low consultation rates with physicians, a very low prescribing rate, a relatively low acute hospital admission rate and a relatively high average length of stay in acute hospitals. Following the introduction of global budgets for hospitals, there was a sharp fall in the rate of growth of expenditures in hospitals and a pronounced fall in admissions. There was also an increase in waiting lists for elective surgery. The government has had some success in containing the rate of increase of doctors' fees below the rate of inflation, but the effect on overall cost containment has been less pronounced because of increases in the numbers of doctors per capita and in volume of services per doctor, especially for specialists.

4.7.4 Budget setting

Government policy has sought to contain the rate of increase in hospital cost through changes in the financial arrangements governing hospital behaviour. Until 1983, hospitals received full retrospective payment for all of the services they provided. Combined with the fee-for service system through which doctors were paid, this provided a strong incentive to maximise the number of inpatient days. The result was both high admission rates and long lengths of stay (see Appendix A for comparative data).

To remedy this situation a new system of prospective global budgeting was introduced in 1983. Under this arrangement, hospitals received a fixed budget allocation for the financial year ahead. Because any overspends would have to be met from within the hospitals' own resources, it was hoped that this system would offer stronger incentives for cost containment.

Subsequent experience cast doubt on whether this aim was achieved. Many hospital budgets increased rather than being reduced as official policy implied. The policy failure seemed to result from cost-shifting strategies, for example new capital investments

would be undertaken for which additional revenues were automatically approved or off-budget services were developed which were beyond the regulators' control.

4.7.5 Payment of health care professionals

While providers are generally paid directly by private patients, they are paid directly by sickness funds for public patients. The sickness funds pay GPs by capitation for their members. They pay specialists for each patient referred to them by a GP. The patient is given a referral card which entitles him or her to treatment for one month. However, specialists are paid over and above this by fee for service for a long list of specific diagnostic and therapeutic procedures. The various fees and capitation allowances are negotiated in a complex way between representatives of the physicians and of the insurers with the involvement not only of the Central Agency on Health Care Tariffs but also the government. There are separate negotiations over the personal income of physicians and over payments for practice costs. There has been discussion about bringing in global budgets for payments to specialists which would have the effect of reducing automatically fees per item if the volume of services went up more than had been allowed for in the budget.

Traditionally, most hospital specialists worked as independent practitioners and were paid on a fee-for-service basis, however there has been a rapid move towards salaried medical specialists so that they currently represent approximately 50 percent of the profession. Wages for non-medical hospital employees are decided by central bargaining between the representatives of hospitals and labour unions. This process is subject to government directives on the maximum annual growth of labour costs per employee which leaves some scope for bargaining about pay rates, hours of work and fringe benefits.

4.8 Health care delivery system

4.8.1 Primary health care

Primary health care is regarded as an important priority and is constructed around different facilities. General practitioners, the public health services, district nursing, home help and social work can be regarded as the central provisions which are accessible to everybody across the country.

Owing to the ageing population there is an increasing demand for care in the home which is much preferred by patients to care in institutions. Since 1989, home help and district nursing have been jointly financed to increase co-operation between the two services and thereby avoid duplicating care.

The following table shows the number of health care workers and institutions providing health care in the Netherlands in 1986 and 1990 and the number of providers per population.

Table 12: Health Care Providers and Institutions in The Netherlands, 1990

Number of providers	1986	1990		
	Number	Number	Per 100,000 inhabitants	Per 100,000 compulsory insured
Pharmacies	1320	1453	9.7	15.8
GPs with pharmaceutical facilities	826	718	4.8	7.8
GPs	6285	6573	43.8	71.3
Maternity care	5624	5860	39.0	63.6
Home care services	10638	11800	78.6	128.0
Dentists	5057	5206	34.7	56.5
Physiotherapists	9686	9972	66.4	108.2
Speech therapists	2340	2619	17.4	28.4
Medical specialists	7117	8250	55.0	89.5
Ambulatory mental health care	6394	7022	46.8	76.2
Dental specialists				
-oral & maxillary surgery	123	135	0.9	1.5
-orthodontists	207	238	1.6	2.6

Source: Hoffmeyer & McCarthy (1994)

The number of doctors per 1000 population is slightly below the EU average (there is a *numerus clausus* or restricted number of places for medical students in the first year of study). On the other hand, there are large numbers of nurses, reflecting the country's commitment to nursing. At around 9 nurses per 1000 population this is one of the highest rates in the EU (see also Appendix A).

General practitioners

The Netherlands has an extensive system of primary health care based upon approximately 7,000 general practitioners that play a key role, since they provide most of the primary medical care and act as gatekeepers to specialist services. GPs work as independent contractors for the sickness funds and private insurers. Some GPs have licensed dispensaries and a few will deliver babies, especially in the rural areas. GPs are accessible 24 hours a day and they arrange out-of-hours services among themselves. Most GPs are independent contractors, more than half work in single practices, around 40 percent have partnerships and less than 10 percent are in group practices (health centres with community nurses and social workers). Until 1992 GPs needed a license from the municipality to start a practice, but now they are free to open a practice wherever they want. Sickness fund patients must register with a GP contracted to the fund, and cannot change or register with another GP inside a year. The sickness fund pays the GP on a capitation basis and the GP provides free care to the patient.

Recent reforms of the insurance system mean that private patients as well as public employees also have to register with a GP and GP referral is required before access to specialist services. However, in the case of patients covered by private insurance, they generally pay their GPs a fee-for-service per consultation and then claim reimbursement from the insurance fund.

With the trend towards more primary care, the role and functions of GPs, especially their gatekeeping role, are expected to increase. GPs' professional groups have therefore developed a quality control policy with standards for good GP care as the central point, and efforts will be made for better co-operation between GPs and specialists.

Specialists

About one-third of medical consultations are with specialists which is less than many other EU countries. Specialists are usually associated with hospitals, but some have independent practices. Most specialists are paid for their services at fee levels which are controlled by the Central Agency for Health Care Tariffs. This applies to both private and sickness fund patients. Specialists in public and academic hospitals and junior doctors are salaried. Again, for sickness fund patients the bill is paid direct to the specialist by the sickness fund, but privately insured patients have to pay and claim back their fees depending on their insurance cover.

Primary health care nurses and midwives

There are approximately 7,000 community nurses who have to undertake specialist training. The approximately 60 "Cross Associations" are the main employers of nurses. There is no distinction between a district nurse and a health visitor. Community nurses nurse patients at home, do home calls for mothers with babies as well as for the elderly, hold open office / surgery hours and play an important role in health prevention and education. There has been an important effort to substitute home care for hospital care and to integrate the provision of home care services with nurses playing an important role in this change. Care provided in primary or community settings is organised on a national basis through regional organisations and local teams with each local team comprising 10 nurses. These nurses concentrate on child health care and nursing care for the elderly. Patients have direct access to community nursing which is insured under AWBZ. Most midwives work in independent practices and are in partnerships. Some 72 percent have their own practices while 28 percent work in institutions.

Physiotherapy

In 1995, 14 percent of the population consulted physiotherapists. 70 percent of the 11 7000 physiotherapists working in primary care were in private practice. The remainder were in paid employment with other physiotherapists or health centres. Some 40 percent of the 4578 practices were individual, the rest were group practices.

Since 1996, cover for physiotherapy under the Health Insurance Act and the Medical Insurance (Access) Act has been limited to a maximum of nine sessions per indication per year. However, a list of complaints for which a longer course of physiotherapy is necessary has been drawn up, and insured people diagnosed by a doctor or a physiotherapist as suffering from one of these complaints are entitled to the appropriate number of sessions. The insurers' authorisation for these treatments must be given in writing. Many health insurance funds are also offering a complementary policy to cover forms of physiotherapy which have not been reimbursed since 1996.

Physiotherapists are paid a fee per session for patients with statutory health insurance. Other people pay a fee for each treatment according to an agreed schedule. Preventive and patient education activities are supposed to form part of therapy, but they are not valued separately in the schedule of payments.

Primary dental care

Almost all dental care is provided from a general dental practice setting. All dentists are private practitioners who have, in most cases, a contract with the public health care system. Since January 1995 dental cover under the Health Insurance Act has been limited to dental care for children and preventive dental care for adults, plus specialist

surgical treatment and, in certain cases, the fitting of dental implants and related X-rays. This step was taken because it was felt that the Dutch public had become much more aware of the importance of oral hygiene and of individuals' responsibility for the state of their teeth. Regular visits to the dentist are the norm in the Netherlands and as such the cost of dental treatment to the individual is generally affordable. Dental care for children includes preventive maintenance work, fluoride applications, sealing, restorative care (excluding crowns and bridges), periodontic care and surgical treatment. At the age of two years children receive a dental card which is valid for one year at a time. Children over 13 years who have no dental card have to pay 50 percent of the cost of treatment up to a maximum of 500 guilders a year. Adults are entitled to preventive care, provided they go for a check-up at least once a year.

As a result, compared to other European countries, the costs for the provision of dental care are rather low in the Netherlands and oral health is generally very good.

4.8.2 Hospital care

Many social institutions in the Netherlands have been developed on either a religious or a political basis. The hospital sector reflects this emphasis with the majority of the country's hospitals retaining a religious character. All these hospitals are owned and operated on a non-profit basis by private, locally controlled independent boards. Law in fact, prohibits private for-profit hospitals. Very few acute hospitals are public. Hospital associations or organisations, municipalities or provinces maintain hospitals. Local and regional authorities are responsible for ensuring that the health services they provide comply with national standards. The hospital system is well developed comprising a network of general, single specialty acute and university hospitals. Psychiatric hospitals are in a category of their own and are complemented by a wide range of community facilities and services. There are also institutions for the handicapped and nursing homes which provide beds.

The following table shows the number of health care institutions, the number of beds and the number of beds per 1,000 population in 1986 and 1990.

Table 13: Number Of Hospitals and Beds in The Netherlands, 1986 and 1990

	1986			1990		
	No. of institutions	No. of beds	Beds per 1,000	No. of institutions	No. of beds	Beds per 1,000
General hospitals	143	55360	3.79	120	52164	3.50
Specialised hospitals	45	5408	.37	36	4660	0.31
University hospitals	8	7715	.53	9	7292	0.49
Psychiatric hospitals	82	24498	1.68	83	24731	1.66
Institutions for the mentally handicapped	119	30461	2.08	121	31561	2.12
Nursing homes						
-somatic	134	15099	1.03	105	11919	0.80
-psycho-geriatric	81	11692	0.80	72	11212	0.75
-combined	110	22877	1.57	148	28723	1.93
Total		173110	11.84		172262	11.57

Source: Hoffmeyer & McCarthy (1994)

Since 1983 hospitals have had prospective annual global budgets fixed by the government through negotiations with local insurers and approved by the Central Agency

for Health Care Tariffs. Budgets cover both public and private patients and they cover most costs with the exception of fees for specialists. Initially global budgets were based on past activity. They were based on historic costs with additions for inflation, the revenue consequences of approved capital projects and across-the-board deductions of 1 or 2 percent per annum for assumed productivity gains. This tended to penalise the more efficient hospitals. Since 1988 an effort has been made to equalise the costs across acute hospitals.

Now global budgets are based on a formula which includes the catchment population (about 25 percent of costs), the number of specialties and beds (determined by planning) (about 35 percent of costs) and the expected volume of services in various categories (about 40 percent of costs) and prices per item of service. This includes the number of admissions, patient days, day cases and first outpatient attendances (negotiable with the insurers). Certain categories such as interest, depreciation and maintenance, are kept out of the model. Under this formula, money follows the patient to the extent that changes to catchment populations and volume are agreed in the annual negotiations about budgets.

This provides a method of dividing the actual payments to a hospital (which should equal the budget) between the insured population (or their insurers). It also provides a continuing set of price signals in the market. Any surplus or deficit remaining at the end of the year is eliminated in the subsequent year by price adjustments. There is scope for hospitals to negotiate changes to volume between years. If, for example, volume exceeded the planned level for two years running, a hospital might persuade the sickness funds and insurers to adjust the budget accordingly.

Most hospital investment is private and hospitals usually borrow from the banking system to finance acquisitions. Investments are subject to planning approval by provincial government. If planning approval is given, depreciation and interest on new investments can be included in prices and are automatically covered by sickness funds. Initially the government guaranteed hospital investment loans, but this was scrapped with the Dekker proposals. Academic hospitals are public and their investments have been financed by government grants. The Dekker reforms also established capital charges for academic hospitals to put them on the same basis as private hospitals and hospital depreciation was put on a replacement-cost basis.

During the 1980s, government policy encouraged a series of mergers between hospitals in the belief that this would reap economies of scale and lead to reductions in excess capacity. However, this policy was criticised that it was likely to stifle competition and was abandoned in the early 1990s.

4.9 Pharmaceuticals

Pharmacies do not have a monopoly on drugs. Most drugstores can sell general products and have an 85 percent share of this market. The pharmacist or dispensing doctor is reimbursed by the sickness fund for drugs prescribed to sickness fund members. Pharmaceutical coverage falls under the AWBZ.

Drug prices set by manufacturers are not controlled when the drugs first go on sale but subsequent prices are regulated. Pharmacists' profit margins are controlled and their dispensing fees are set through negotiation between representatives of the insurers and the pharmacists and are approved by the Central Agency for Health Care Tariffs.

Drugs dispensed by prescribing GPs or by pharmacies are free to all sickness fund patients. Privately insured patients have to pay and claim reimbursement. The drug reimbursement system aims to replace expensive new drugs with cheaper existing alternatives, through reimbursements up to the level of the cheaper but equally effective generic alternative. This system applies to everybody.

In 1991 a list of reference prices for pharmaceutical ingredients was introduced for the sickness funds and part of the private insurance market. The fixed refund price is based on the average list price for 'therapeutically interchangeable' drugs (within the same group). The manufacturer will remain free to charge higher prices and the doctor will remain free to prescribe a higher priced drug, but the patient will have to pay the difference.

4.10 Conclusions

One of the lessons from the Dutch health care system is that it is very hard to make a realistic time frame for the full realisation of such radical reforms as have been proposed in the Netherlands. Although the implementation of the reforms is far behind schedule, from a historic point of view radical changes have been realised within a relatively short period of time. For example, in the first part of the century there was great disagreement between sickness funds and physicians as to whether sickness funds should have the option to selectively contract with physicians. From 1941 until 1991 physicians won this battle and sickness funds had the legal obligation to contract with each physician established in their area. Creating the opportunity for selective contracting since then represents a fundamental change, although putting it into practice has been problematic.

Given the resistance from interest groups and the technical and political complexity of the reforms, a time schedule for sensitive issues like health care and its financing is hard to realise for a cabinet that is in office for only four years. Had the government announced a more realistic time scale for the reforms, say 10 or 15 years, probably nothing would have changed. And therefore in the shorter time-span, even the credible threat of competition generated a great change in behaviour among parties.

There has been no urgent pressure for quick reform because the reorganisation of the health care system is aimed at anticipating the problems of the next century such as advances in medical technology, an ageing population, and an expected increase in the share of GDP going to health care.

The proposal for market-oriented health care is not a proposal for a free health care market. A free market would yield results that most societies would deem undesirable as low-income people and chronically ill people would not have financial access to all the care they need. The Dutch proposal is for regulated competition. Government regulation will not fade away, but its emphasis will change dramatically. Instead of direct government control over volume, prices and productive capacity, the government will have to create the necessary conditions to prevent the undesired effects of a free market. The emphasis of government regulation will therefore be primarily on compulsory health insurance for everyone, on the risk-adjusted capitation payments to insurers, anti-cartel measures, quality control and disclosure of information.

5. France

5.1 Introduction and overview

France is a republic with a constitution with the latest revision dated October 1958. Elected for seven years by direct universal ballot, the President of the Republic sees that the constitution is respected and ensures the regular functioning of the public authorities as well as the continuity of the State. The President appoints a prime minister and on the latter's advice, appoints and dismisses other members of the government.

Legislative responsibility rests with the bicameral Parliament, consisting of the National Assembly and the Senate. The National Assembly is elected by direct ballot and the senate by indirect determination. The Constitutional Council, with nine members appointed for nine years, oversees the fairness of elections and referenda, and the constitutional conformity of the basic laws.

The country is divided into 22 regions comprising 100 *départements* for national development, planning and budgetary policy. The regions, *départements* and municipalities are each governed by local assemblies elected by universal suffrage. Their responsibilities in healthcare are however limited to preventive activities, despite the post-1982 political and administrative decentralisation.

France is a founder member of the EU. It has a population of just over 58 million and a GDP per capita of Fr. fr 138839 (see Appendix A for national comparisons). France has also had a relatively high unemployment rate at 12.5 percent of the labour force in 1994. Young people and women are especially at risk of unemployment and regional variations are considerable.

A comprehensive system of social welfare benefits covers most of the unemployed population, providing family allowances and old age, disability, sickness and maternity benefits. Nevertheless there has been a growing problem of social exclusion in recent years with an alarming increase in the number of people falling through the social security safety net.

5.2 Health status

Female life expectancy at both birth and the age of 65 years is the highest in the EU countries. Male life expectancy at birth is just above the EU average, but at the age of 65 years, is also the highest. The difference between male and female life expectancy which is the widest in western Europe, reflects a high excess mortality among men in the younger age groups.

As in most EU countries, the total fertility rate is below replacement level. As a result, the population growth rate is small: 0.43 percent in 1994. Low fertility and decreasing mortality (particularly among people over aged 65 years) has led to an ageing of the population and forecasts are that the elderly population will continue to rise. This will indeed affect the future costs and organisation of health care.

Cardiovascular diseases and cancers are the most frequent causes of death.

Table 14: Summary of Main Cost Containment Measures Introduced in France, 1975-95

	Revenues of the <i>Sécurité Sociale</i>	Benefits of the <i>Assurance-maladie</i> : reimbursement mechanisms	Fees and charges for medical care	Other forms of management and control
Barre Plan Sep 75	Supplementary source of finance: road tax	Reduction of reimbursement rates for non-essential drugs. Increase of co-payment rates (ancillary services and transport)		
Durafour Plan Dec 75	Removal of ceiling on payroll contributions		Reduction of VAT on drugs from 20 to 7%	
Veil Plans Apr 77-Dec 78	Rise in contributions (salaried agriculture workers and active workforce). Contributions charged on pensions	Reduction of reimbursement rates for non-essential drugs (from 60 to 30%)		Constitution of audit commission for <i>Sécurité Sociale</i>
Barrot Plan Jul 79	One-off contribution of pharmacists		Freeze of doctors' fees and hospital daily rates. Ceilings on hospital expenditure increases	
80 <i>Convention</i>				Doctors: introduction of <i>secteur II</i> with unregulated fees
Questiaux Plan Nov 81	Twofold rise in car insurance. Partial removal of ceiling on payroll contributions			
Beregovoy Plans Jul-Sep 82	Contributions from unemployed	Introduction of hospital co-payment fee		
Mar 83	Tax on pharmaceutical advertising (5%). Taxes on tobacco and alcohol	Reduction of reimbursement rates from 70 to 40% for 1258 drugs		
Delors Plan Mar-Jun 83	One-off 1% levy on taxable income and subsequently on capital			
84				Gradual introduction of global budgets for public hospitals
Dufoix Plan May-Jun 85		Increase of co-payment rates for some services. Reclassification of 379 drugs.		
Seguin Plan Nov 86-87	One-off 0.5% levy on 85-86 incomes. Supplementary 2% tax on tobacco	Extension and revision of list of 254 diseases exempted from co-payment. Limited co-payment exemption. Abolition of reimbursement for vitamins.	Reduction of VAT on drugs from 7 to 5.5%	

	Revenues of the <i>Sécurité Sociale</i>	Benefits of the <i>Assurance-maladie</i> : reimbursement mechanisms	Fees and charges for medical care	Other forms of management and control
Evin Plan Sep 89	Modification of part of restrictive measures of Seguin Plan	Re-establishment of some co-payment exemptions	Reduction of VAT on drugs from 5.5 to 2.1%	
90 <i>Convention</i>				Significant restrictions for <i>secteur II</i> doctors
Dec 90-91	Introduction of <i>Contribution Sociale Generalisée</i> (CGS) fixed at 1.1% for 91. Increase of tax on pharmaceutical advertising	Abolition of reimbursement for 'anti-fatigue' drugs		Global budgets for ambulatory care. Hospital reform law
Bianco Plan Jul 91	Increase of payroll contribution to health insurance by 0.9%	Hospital co-payment fee increased from 33 to 50 FRF. Abolition of reimbursement for drugs containing magnesium or oligo-elements	Revision of nomenclature for radiological procedures	Pharmaceutical industry asked to reduce sales. Reduction of wholesale margins. Changes in therapeutic categories concerning level of reimbursement
92		Regulation agreements with adjustment measures. Ceiling caps introduced for biology 7%, nursing 9.7%, private practices 5.2%		
93				Establishment of pharmaceutical agency
93 Veil Plan and <i>Convention</i>	Increase of the CSG from 1.1 to 2.4%	Reduction of reimbursement rates. Increase of hospital co-payment fee (55 FRF)		Introduction of treatment guidelines (RMOs) and patient medical records. Setting of prospective expenditure target
94				New expenditure targets: doctors 3.4%, physiotherapists 5%, biologists 3.4%, nurses 4.5%, pharmaceuticals 3.2%
Juppé Plan Nov 95	Introduction of a more comprehensive set of measures including structural measures			

Source: Lancy & Sandier (1999)

5.3 A brief history of the French health care system

Since the 1970s, the reduced rate of growth in economic activity and increasing unemployment have led to a fall in social security revenue, particularly of the *Assurance-maladie*, the statutory health insurance which is a part of the social security system. Faced by financing difficulties and the recurrent deficit in public accounts, the government and the *Assurance-maladie* took measures aimed to control health care expenditure. During the last 20 years, rationalisation plans (often named after the ministers who proposed them) have been issued on average every 18 months, with limited effectiveness. These have been aimed at either increasing revenues or reducing expenditure or the public deficit or limiting the growth of the health sector. The table below gives a summary of the main cost containment measures introduced between 1975 and 1995 when the comprehensive reform programme under the Juppé Plan was introduced.

These reforms can be grouped as follows:

- Governments have generally preferred to increase the amount of resources available to the *Assurance-maladie* in order to limit their deficit in the short-term. This strategy is less risky politically than reducing benefits and was achieved by enlarging the salary base of payroll contributions as well as by progressively increasing contribution rates from both employees and employers (for example the Veil Plan, 1977 and the Bianco Plan, 1991). To complement payroll contributions new resources from taxes and other levies on revenues have also been allocated to the *Sécurité Sociale* (for example the Barre Plan, 1975 and the Beregovoy Plan, 1983). These new resources have gradually been adopted as new sources of financing. Salary contributions rose from 1.5 percent to 6.8 percent between 1975 and 1995. During the same period employers' contributions increased from 2.5 percent to 12.8 percent.
- Measures which affect the degree of public financing of health care expenditure are often opposed by public opinion. An overall increase on co-payment rates in 1967 had to be reviewed the following year after public demonstrations of social discontent. After this experience, the government waited 25 years before proceeding with another measure of this kind, establishing a general increase in patients' financial contribution to their health care expenses in 1993. Prior to this reform, the *Assurance-maladie* reduced its obligations to finance certain expenses through partial measures with direct or indirect effects. Those having a direct effect include the limitation of exemptions from co-payment (Seguin Plan, 1986), the introduction of patient charges to cover hospital hotel costs (Beregovoy Plan, 1983) and successive adjustments of pharmaceutical reimbursement rates to a level as low as zero, varying according to the type of drug (for example the Barre Plan, 1977, the Veil Plan, 1977, the Beregovoy Plan, 1983, the 1990 Convention, the Bianco Plan, 1991 and the Veil Plan, 1993). A measure which had an indirect effect on the share of health care expenditure financed by the *Assurance-maladie*, was the creation of a sector of doctors with unregulated fees under the 1980 Convention (office-based *secteur II* doctors).

These restrictive measures have led to a fall in the participation of the *Sécurité Sociale* in financing health expenses. As a result, a growing number of people have resorted to supplementary private insurance. The declining role of the *Sécurité Sociale / Assurance-maladie* has certainly affected the equity of access to health care. The French insurance system linked to occupation means that a number of people are left out of the system.

The estimate of 0.4 percent of the population is certainly below the real figure in view of the unknown number of illegal immigrants.

The current system of payroll deductions has a number of disadvantages. They discriminate against labour-intensive sectors in favour of capital-intensive ones and in this way may affect the international competitiveness of French industry. Their basis is narrow: only a minority of the population pays the full rate. Furthermore, income from investments is not taxed at all. The rates are not progressive and weigh more heavily on the poor. They also take no notice of family size or other responsibilities.

The possibility of extending the range of incomes on which payroll deductions could be charged or of subsidising health care from general taxation has been raised on several occasions. An example was in 1991 when a general tax of 1.1 percent was proposed on all incomes under the Contribution Sociale Generalisée (CGS) to meet the anticipated deficit in the social security budget. This was met with considerable opposition, especially from pensioners, although it was nevertheless imposed. However when employee contributions to the sickness funds was raised by 0.9 percent (Bianco Plan, 1991), this aroused little opposition.

There is general agreement that French public opinion is hostile to taxation *per se* and strongly attached to the independence of the social security system. Payroll deductions for the latter are seen as contributions rather than taxes and arouse less hostility. In political terms the difficulties of moving away from such a system are seen as overwhelming. The French therefore prefer to pay for health care by means of earmarked contributions rather than from general taxation. This is seen as insulating health care spending from other financial pressures.

Controlling costs or at least prices, has been the favoured strategy of French governments both on the left and the right. The most successful initiative in this respect has been the system of global budgets for hospitals. Although crude and not without disadvantages they have undoubtedly reduced the growth of expenditure. Along with the 1970 *Carte sanitaire* to plan hospital beds and the diffusion of high technology equipment, it had a positive effect in restraining the growth of hospital capacity. Although the fee-for-service system still prevails, the only way to control costs has been through the negotiation of the actual fees. In 1991 a bill was introduced to limit the growth in all forms of primary care expenditure to a fixed percentage. If this was exceeded then the increase in standard fees would be reduced in the following year. The system was also to apply to private hospitals. The bill was subsequently withdrawn due to opposition from the medical profession. A somewhat watered-down version was however reintroduced again in 1992 and became law (Bianco Plan).

Controls over medicine prices have been in place for many years, but the competitive position of the pharmaceutical industry has been adversely affected while consumption has continued to rise rapidly. A new approach was unveiled in 1991 which set a global limit on medicine spending by the sickness funds and by negotiation, a limit for each company. There would be a limit on sales and if the company exceeds its target, it would be obliged to refund a proportion of the overshoot. The prices of other products could be adjusted annually provided that permitted total sales were not exceeded. This bill also aroused great opposition and was subsequently shelved.

5.4 Health reform

By 1995 the growth rate of *Assurance-maladie* expenditure was very high (3.2 percent in constant FRF) compared to previous years (2.9 percent in 1993 and 0.4 percent in

1994). The lower growth in 1994 was partly due to a generalised increase of co-payment rates implemented in 1993 and the economic effect of the introduction of treatment guidelines (*RMOs*) in 1994. The higher growth in 1995 again was also because of the upgrading of doctors' fees at the beginning of the year within a pre-election context which was unfavourable to restrictive measures.

As a result, in November 1995, Prime Minister Alain Juppé, aware of the expected deficit, presented the *Assemblée Nationale* with a programme of reforms of the *Sécurité Sociale*, which would affect the three branches of sickness, family benefits and pensions. On the one hand, the Juppé Plan announced emergency measures aimed at covering previous deficits, while on the other, it set out the guidelines for a financial and operational revision of the health care system in the medium term. It was an ambitious reform plan which proved extremely controversial, provoking social turmoil at the end of 1995. Its central proposals were nonetheless preserved and it has been gradually implemented since 1996. The implementation of the measures set out in the Juppé Plan entailed a complex process of legislative reform: first a constitutional reform, then a law authorising the government to pass legislation through decrees, and finally the adoption of 5 decrees between January and April 1996 with other decrees specifying the details of the implementation process thereafter.

The Juppé Plan offered some standard, short-term measures which were aimed at increasing social security revenues or curbing the progression of expenditure in a number of ways:

- Increasing contributions by pensioners, the unemployed and private doctors,
- Reducing coverage rates with an increase in the hospitalisation co-payment rate from FRF55 to 70,
- Imposing an exceptional tax of FRF2.5 billion on the pharmaceutical industry, and
- Targeting the growth rate of hospital and general medical expenditure for 1996-97 to equal general inflation (2.1 percent).

There were also further plans to introduce reinforced control mechanisms. These measures started to be implemented at the beginning of 1996. In 1997 Parliament voted for a cap of 1.7 percent on health care expenditure increases.

As a long-term measure, the Plan instituted an 'exceptional' income tax for a period of 13 years aimed at discharging the debt of the *Sécurité Sociale* (FRF 250 billion). The tax of 0.5 percent of total income was introduced in 1996.

The Plan also aimed to introduce universal coverage by the *Assurance-maladie*, a progressive widening of its sources of finance (including a switch from payroll contributions to general tax revenue) as well as the control of its expenditure. To these ends, a number of structural measures (more innovative but requiring more time to be implemented) related to different areas of the health and social security system. These included the health care system's general management, the financing and management of the *Assurance-maladie* and the organisation of health care delivery. New supervisory and management bodies were set up, operating above and below existing bodies: councils supervising the finances of the *Sécurité Sociale*, the *Agence nationale d'accréditation et d'évaluation en santé (ANAES)*, the *Unions regionales des caisses d'Assurance-maladie*, and the regional hospital agencies (*Agences Regionales de L'Hopitalisation*).

In addition, the French Parliament now participates in the general management of the health care system. It deliberates on the revenue and expenditure trends of compulsory social security regimes by voting laws on the financing of the system. The role of the state has also been strengthened by new measures regulating the management of the *Assurance-maladie*. Trade union representation within the new management boards has been modified in favour of employers' representatives. Mandatory targets have also been set for the activities of the *Assurance-maladie*.

Long-term agreements on objectives and management have been signed between the state and the sickness funds of the *Sécurité Sociale*, accompanied by annual amendments after the publication of the *Sécurité Sociale* finance law. These agreements and their amendments concern first, the instruments and expected results of the internal management of funds, second, long-term government strategies in the field of public health, medical workforce and pharmaceuticals, and finally, the compliance to the cost objectives for general practice. The conditions of implementation of these agreements are examined by the *Conseil de Surveillance*.

The decree referring to the 'medically driven control of health expenditure' presented a long list of measures concerning different aspects of care: access, supply, quality, prices and expenditure. Some measures are ready for implementation while others require further action by the government, the managers of the *Assurance-maladie*, and those who represent the medical profession.

The most important innovation in the field of access to care is the introduction of the *carnet de santé* (medical records in the form of a small booklet) which patients must present when seeking medical attention, and in which doctors should record the information relevant to any follow-up. The introduction of patients' records started in 1996. It is anticipated that this will effectively limit the number of visits and redundant prescriptions.

In an effort to reduce medical staff in the short-run, private doctors are being encouraged to retire early, starting from the age of 56. Another measure with a similar aim is the six month extension of GP training. Continued medical training has now been made compulsory.

Several measures have set criteria for the reimbursement of services provided by private doctors under the *Assurance-maladie*. These include:

- Inclusion of a list of reimbursable services,
- Electronic transmission of information,
- Compliance to treatment guidelines (*RMOs*), and
- Reference to the contractual agreements on the expenditure of the *Assurance-maladie* for determining the volume of activities and prescriptions.

Though the application of global or individual sanctions for non-compliance with the above criteria has been established, the exact nature and details of how these sanctions should be applied have yet to be fixed. Decisions on the application of sanctions will be determined by instruments which will contribute towards enhancing the information available on medical activities, such as the coding of services, prescriptions and diseases.

The Juppé Plan allows for experimental projects on new ways of delivering health care. These projects must be accepted by the sickness funds and, although they may cover a wide variety of plans, only volunteers (doctors and patients) may participate.

Under the Juppé Plan, in the field of hospital care, the issues of quality and cost containment are similar to those in ambulatory care, but the role played by the funds of the *Assurance-maladie* is less important and the state's supervision is more direct. Regional hospital agencies are responsible for the planning of facilities and the allocation of resources to both private and public hospitals under the direct supervision of the ministries in charge for health and social security. The accreditation of hospitals and services, as well as the production of guidelines for good medical practice, are ensured by the *Agence nationale d'accréditation et d'évaluation en santé (ANAES)*, whose president and director are nominated by the health minister. The Juppé Plan emphasises the co-operation between public and private facilities and encourages hospitals to promote alternatives to hospitalisation as well as to develop health care networks with private doctors.

The Juppé Plan also touches on pharmaceutical products. A drug can only be prescribed for the therapeutic purposes for which it was registered in the list of reimbursable products. Prescriptions must comply to treatment guidelines (*RMOs*). However, despite the encouraged use of generic products, there are no clear defined guidelines as to how this should be achieved.

5.5 Organisational structure and relationships of key actors

The French health care system is an attempt to reconcile two conflicting ideologies. The first is social solidarity, the duty to make sure that all citizens are adequately covered against risks such as sickness and medical care. The second is liberal-pluralism, the desire for those who supply health care and those who consume it to retain the maximum amount of independence. Both are deeply entrenched in French life and have profoundly shaped the nature of health care.

5.5.1 Sickness funds

The concept of solidarity underpins the financing of the French health care system, which is based on a national universal and compulsory health insurance system, linked to employment and financed by employers and employees. The population is almost universally covered by statutory health insurance (*Assurance-maladie*), a branch of the social security system *Sécurité Sociale*.

Affiliation to the *Assurance-maladie* is through different schemes according to occupation. Membership to one of the occupational schemes is compulsory and they typically cover not only the subscribers but also their non wage-earning dependants, children, unemployed and pensioners, although details may vary between schemes. There is one general scheme, *Régime Général*, for salaried workers from trade and industry and their families. They make up 80 percent of the population and the scheme is financed mainly by payroll contributions paid by both employees and their employers (respectively 6.8 percent and 12.8 percent of gross salaries). There is also a scheme for farmers, agricultural workers and their families, and one for independent professionals (artisans and so on) which together make up the national health insurance system. Smaller funds cater for specific professions. In turn, each of these funds is divided into several branches, providing pensions (*Assurance Vieillesse*), family benefits (*Branche Famille*) and medical care (*Assurance-maladie*). Those who move from one occupation to another automatically change funds, but otherwise there is no choice. The sickness

funds do not compete with one another since they are organised along strictly occupational lines. They are however under considerable pressure from government to control their spending.

The sickness funds have to be self-supporting (they do not have reserves to draw on to prevent deficits occurring), but there is a system of compensation by which those funds with a lower number of beneficiaries per contributor transfer funds to the others (risk-sharing). In practice this means the *Régime Général*, which accounts for 80 percent of total income, supports the other smaller funds.

Patients initially pay the provider directly and are reimbursed later, but in most cases only partially. The difference is expressed through a patient cost-sharing scheme (*ticket modérateur*) which charges patients different amounts depending on the type of care and treatment necessary. There are however exceptions to these general rules for certain patient groups or types of diseases and treatments which are serious or long-lasting and for certain social and economic reasons. The state provides co-payments for those whose income falls below a certain level. Those who are employed support a large number of the unemployed, children, chronically sick, and pensioners, even though these groups may account for the majority of expenditure. The number of beneficiaries therefore outnumbers the contributors, which is in line with the principle of social solidarity.

The contribution rates however are fixed so that they are the same for all individuals and employers within a regime but vary between regimes. Contribution rates are fixed by negotiation between the state, representatives of employees and employers and the sickness funds themselves.

5.5.2 Private insurance funds

Eighty-seven percent of the population are also members of voluntary, supplementary sickness funds (*mutuelles*) (co-operative non-profit societies), or purchase private insurance through commercial insurance companies offering sickness insurance policies which complement the compulsory insurance and covers to a varying degree the charges that the *Assurance-maladie* does not reimburse. There are currently about 6,500 *mutuelles*, organised by work-place, by occupational group or by geographical area. Like the sickness funds they must balance income and expenditure and adjust premiums accordingly. *Mutuelles* mostly cover co-payments, but also some health-related activities like public clinics. In most cases they charge a flat rate or a proportion of earnings. There is no overt selection of members according to health and no discrimination against the elderly.

In 1990 there were 79 commercial health insurance firms with perhaps 8 million customers. Estimates of the proportion of health care spending that they provide range from 2 to 6 percent, but it is agreed that they are increasing in importance. Most of such insurance is arranged by firms for their employees and covers everyone without discrimination. There is however an incentive to cream-skim as they exploit a growing market. Once again the role of commercial insurance is to supplement provision of the sickness funds and focuses mostly on co-payments.

The profitability of private health insurance is apparently low. There is however some competition between the *mutuelles* and the commercial companies. Because the commercial companies offer company-wide agreements, they very much resemble the *mutuelles* and both therefore have an interest in promoting economy in health care. Thus they favour systematic evaluation of medical procedures, firm controls over rates of

reimbursement and the use of generics. Some also limit the extent to which they will cover patient co-payments. The *mutuelles* wish to avoid raising their contributions unduly, while private insurers want to remain profitable.

5.5.3 Health care providers

The supply and consumption of health care, on the other hand is dominated by the concept of liberal-pluralism. There is almost total freedom for people to choose and use private and public health care services without a referral system. Private practitioners who are subject to relatively few controls provide primary care. Most medicines are supplied by privately-owned retail pharmacies. Public and private hospitals coexist in large numbers and all these categories of providers, although subject to overall health planning, otherwise manage their own affairs to a considerable extent. The supply of health care is therefore in the hands of a large number of independent actors.

The laws concerning the *Sécurité Sociale* are voted by Parliament and government agencies play a major role in deciding the payments for medical treatment through the sickness funds. However the government has little influence over the volume of primary care supplied although its powers over hospitals and their services are more substantial. The practice of medicine is largely outside official control. The ability of the government to regulate expenditure is therefore relatively restricted.

Hospitals

Patients are admitted to hospital on reference from their primary health care physician and although they are free to choose between public or private, if they choose a public hospital they must go to the one in their catchment area. Public hospitals are attached to municipalities or regions and although legally distinct from the localities where they are sited, policy is decided by hospital boards comprising representatives of the sickness funds and medical and administrative staff of the hospital. They are obliged to provide equal treatment for all patients.

Following the introduction of the hospital law in 1991, local hospitals have been given relative autonomy. Hospitals may make their own investments and hospital directors have authority over all staff. The Government has control of development programmes, the creation of new medical posts and the budget. The Minister of Health appoints hospital directors and physicians. Since 1996 they have reported to the regional hospitalisation agencies.

At a local level, the mayor is often president of the hospital's administrative board and thus the biggest employer in the locality. There is therefore a strong local political pressure to keep hospitals running which sometimes conflicts with central government interests and those of the health insurance companies.

Private doctors

The private sector is highly developed in accordance with the basic principles of the health insurance system and patients' freedom of choice. The reforms which have affected private doctors during the last 20 years, have had no effect on the three distinctive features of the French health care system, namely the patient's free choice of doctor, free access to specialists and the direct payment of doctors' services by patients.

GPs have no gatekeeper role and patients can bypass them and go straight to specialists or hospitals, leading to a situation where public hospital outpatient

departments and specialists also provide primary health care. Although patients are free to consult any specialist or out-patient clinic, in practice first contact is mostly with GPs in 80 percent of cases. Private doctors who are paid on a fee for service basis provide most ambulatory care. Their density is high by European standards, 1.5 per 1,000 population (see Appendix A for national comparisons) and there is a good deal of competition between them. Most practice alone and in 1988 only 3 percent of GPs and 9 percent of specialists were members of group practices.

Patients pay first and are then reimbursed by their insurance schemes. However GPs can choose not to contract with the social security system. Only very few choose not to do so. Doctors who contract with the social security system can either:

- Agree to abide by the negotiated fee schedule in exchange for free pension packages and personal health insurance, which in turn guarantees the patient reimbursement at 75 percent (*secteur I*), or
- Set their own fees but not benefit from the pension and health package and by so doing expose patients to extra, non-reimbursed charges (*secteur II*).

A problem of equity of access has now appeared in the big cities where there are very few *secteur I* GPs. The extra charges can be a problem for underprivileged people. To overcome this obstacle increasing use has been made in recent years of public hospitals' outpatient departments in big city centres.

The relationship between private doctors, their patients and the *Assurance-maladie*, is regulated by contracts (*conventions*), the last of which was signed by two doctors' trade unions in 1993, later joined by a third in 1995.

5.5.4 Central government

The central government exercises a powerful though not overwhelming influence on the health care system. It does so primarily through the Ministries of Health and Social Affairs. At times these ministries have been combined and at times they have been separate as at present. The Ministry of Social Affairs has a more direct influence as far as finance is concerned with close links to the Ministry of Finance. The Ministry of Social Affairs is primarily concerned with 'costs' whereas the Ministry of Health is concerned with the location of hospitals, the licensing of pharmaceutical products and public health. There is therefore some tension between the aims of these two ministries. The ministries exert their powers directly and indirectly and are able to act freely but inevitably a decision as to where a hospital will be built or what price a medicine will be, exerts political pressure into the final decisions. Ultimately, the initiative lies with the government. Thus the *Conventions* between sickness funds and private doctors are also in principle freely negotiated but must be approved by the government before they can come into force.

The *Sécurité Sociale* is nominally independent and its income and expenditure are not subject to parliamentary control and form no part of the national budget. However, the Ministry of Social Affairs exerts a powerful influence in so far as it determines the rates of contribution, partly through its legal powers of supervision and partly through its role as arbitrator when there is a disagreement between negotiating parties. Ultimately the Ministry is the master over the financing of all aspects of social security including health care. Even though it provides little direct money, it in effect underwrites the financial stability of the system.

Nevertheless there are limits to the role of government. There is no national health care budget as such. Where hospital expenditure is concerned, the ministries have limited powers. They can regulate such spending on a retrospective basis by engineering increased payroll deductions but they cannot do so on a prospective basis. This is the main source of the financial problems of the French health care sector.

5.6 Health care finance and expenditure

The national health insurance system accounted for 74 percent of all expenditure in 1995, while the smaller insurance companies (*mutuelles*) accounted for around 6 percent. Less than 1 percent of the non-reimbursed costs were paid by the state and the local authorities, although the state pays for part of the training and much of the medical research. In other words, patients (households and their private insurance funds) pay 18.5 percent, one of the highest shares in Europe. The role of the sickness funds is particularly marked in the provision of inpatient care, where it accounts for 89 percent of total spending and in sick pay, of which it is the sole source. It is less overwhelming in the cases of primary care, medicines and spectacles and other prostheses in which it provides respectively 59 percent, 60 percent and 41 percent of expenditure.

The poorest segment of the population can however apply to Medical Aid, which entitles them to free health care. This is mostly financed by the state and earmarked taxes on alcohol. Unemployed people and their families qualify for health care but problems arise when they no longer qualify or have never qualified for unemployment. The RMI (*revenue minimum d'insertion*) was introduced to tackle this problem in 1988. Since 1992, people eligible for the RMI have been entitled to free medical care where the state pays the premiums.

5.6.1 Health care benefits and rationing

The French health care system provides a large range of services, including not only medical and dental care, but medicines, medical appliances and home care and rehabilitation services. In addition a variety of cash benefits are available, notably sick pay, maternity benefit and death benefit.

Table 15: Benefits Offered by the French Sickness Funds

Benefits in kind	Benefits in cash
<ul style="list-style-type: none"> • Prevention • Regular check-ups • Immunisation • Ambulatory services • Medical care • Dental care • Midwives • Physiotherapy • Nursing • Hospital care • Medicines • Medical aids and appliances • Rehabilitation 	<ul style="list-style-type: none"> • Sickness benefit • Maternity benefit • Death benefit

Source: Burstall & Wallerstein (1994)

The services and goods covered by the *Assurance-maladie* must be provided by registered health providers to come under the list of reimbursables. A doctor must prescribe these goods and services. In certain cases, such as eye-glasses and

physiotherapy, prior approval is needed for reimbursement. Under these circumstances there is no limit to the number of services covered. Private doctors can prescribe any treatments or diagnostic tests for their patients.

Table 16: Sources of Financing Different Types of Health Care in France, 1975-95

Percentages	1975	1980	1985	1990	1995
<i>Expenditure for medical goods and services</i>					
Health insurance	73.2	76.5	75.5	74.0	73.9
General and local taxes	4.1	2.9	2.3	1.0	0.8
Supplementary health insurance (mutual funds)	3.8	5.0	5.1	6.1	6.8
Private expenditure	18.9	15.6	17.1	18.8	18.5
- of which direct payments	-	-	-	-	13.9
Total financing	100.0	100.0	100.0	100.0	100.0
<i>Hospital care</i>					
Health insurance	83.0	87.0	87.6	89.3	89.4
General and local taxes	7.0	4.6	3.5	1.4	1.0
Supplementary health insurance (mutual funds)	1.1	1.7	1.9	1.9	2.1
Private expenditure	9.3	7.0	8.5	7.4	7.5
- of which direct payments	-	-	-	-	6.1
Total financing	100.0	100.0	100.0	100.0	100.0
<i>Total ambulatory care</i>					
Health insurance	67.6	66.7	63.9	59.0	57.1
General and local taxes	1.4	0.9	0.9	0.7	0.6
Supplementary health insurance (mutual funds)	6.2	8.9	7.5	9.1	10.8
Private expenditure	24.7	23.5	27.7	31.3	31.5
- of which direct payments	-	-	-	-	23.0
Total financing	100.0	100.0	100.0	100.0	100.0
<i>Services provided by office-based doctors</i>					
Health insurance	75.1	74.3	69.3	61.6	58.7
General and local taxes	1.9	1.3	1.5	1.0	0.9
Supplementary health insurance (mutual funds)	7.4	9.4	7.4	8.6	10.5
Private expenditure	15.7	14.9	21.8	28.8	29.9
- of which direct payments	-	-	-	-	22.4
Total financing	100.0	100.0	100.0	100.0	100.0
<i>Dental services</i>					
Health insurance	50.7	48.5	43.8	36.0	31.5
General and local taxes	0.4	0.4	0.3	0.2	0.2
Supplementary health insurance (mutual funds)	5.2	9.4	7.9	10.4	13.6
Private expenditure	43.7	41.7	48.0	53.4	54.8
- of which direct payments	-	-	-	-	40.1
Total financing	100.0	100.0	100.0	100.0	100.0
<i>Pharmaceuticals</i>					
Health insurance	62.8	63.6	65.0	60.2	60.4
General and local taxes	1.9	1.1	1.1	0.8	0.6
Supplementary health insurance (mutual funds)	6.4	8.5	10.6	12.0	12.4
Private expenditure	28.9	26.8	23.4	27.0	26.6
- of which direct payments	-	-	-	-	19.8
Total financing	100.0	100.0	100.0	100.0	100.0

Source: Lancry & Sandier (1999)

5.6.2 Sources of finance

Since 1980, the modification of the reimbursement scheme has led to an overall decrease in the contribution of compulsory health insurance towards health care expenditure, from 76.5 percent in 1980 to 73.9 percent in 1995. In 1995, health

insurance still contributed up to 90 percent of hospital expenditure, but only about 60 percent towards doctors' fees. An equal percentage was attributed to pharmaceutical expenditure and less than a third to dental care expenditure. On the other hand, supplementary health insurance (*mutuelles*) and the private sector (families and private insurers) play a more important role in financing ambulatory care expenditure and pharmaceutical consumption. Between 1980 and 1995, the component of health care expenditure financed by the *mutuelles* increased from 5 percent to 6.8 percent of overall health care expenditure and from 8.5 to 12.4 percent for pharmaceutical expenditure.

Due to the combined effects of the compulsory and complimentary coverage, different payers contribute differently to financing health care expenditure according to the type of services provided. Where direct payments (by the patient) only cover 13.9 percent of the overall expenditure, the amount rises to 22 percent in the case of physician services, 20 percent for pharmaceutical products and reaches 40 percent for dental treatment, as shown in the table. Patients must pay 22 percent of their GP bill unless they are covered by a voluntary complementary insurance scheme or if because of the severity of their illness they belong to one of the exempted categories covering 10 percent of the people insured. For those patients without complementary insurance (*mutuelles*) who have to make large direct payments, the issue of equity of access to care arises.

However, despite the high levels of co-payment, the consumption of health care is still high. Because only 10 percent of the population are exempt from co-payments (those receiving prolonged or expensive treatment, pensioners, chronic invalids, those unable to work, pregnant women and those living in residential homes), the other 90 percent of the population are still liable for the burden of co-payment (almost half of patients over 80 still have to pay, as do almost all children aged less than 15). However, most people are insured against these payments which amount to approximately 2 percent of household income, either through *mutuelles* or private firms, so they have little effect on demand. The effect of co-payment is to create a second tier of insurance (or source of finance), not to reduce demand. In fact, an attempt in 1980 to limit supplementary cover to 5 percent of the total paid was met with strong opposition from the public and dropped in 1982.

The other reason for the modest impact of co-payment on the level of usage is that the 10 percent who are exempt account for nearly half of spending by the sickness funds.

5.6.3 Health care expenditure

The French health care system is comparatively expensive at 9.6 percent of GDP in 1997 spent on health care, which was third highest among the OECD countries (see Appendix A). In the 1980s this figure showed the highest increase amongst EU countries. In 1995, expenditure for medical goods and services represented 87.2 percent of total expenditure with the remainder consisting of research, training, preventive care and administrative costs. Medical expenditure rose with an average growth rate of 3.2 percent per year at constant 1995 prices between 1980 and 1995, as shown in the table below.

Table 17: Expenditure for Medical Goods and Services and Different Types of Care in France, 1975-95

	1975	1980	1985	1990	1995
<i>Expenditure for medical goods and services</i>					
Total value, current prices (million FRF)	91126	192327	363454	528401	681959
Value per person, constant prices (FRF 1995)	5828	7370	8758	10422	11728
Percentage of GDP	6.2	6.8	7.7	8.1	8.9
<i>Share of different types of health care (%)</i>					
Hospital care	46.7	53.0	51.4	48.4	49.3
Ambulatory care	27.9	26.3	27.4	29.4	27.8
- medical services	13.2	11.9	12.5	13.3	13.1
- dental services	6.6	6.9	6.4	6.6	6.1
Pharmaceuticals	22.2	17.5	17.7	18.2	18.5

Source: Lancry & Sandier (1999)

A number of factors were responsible for this rapid growth in expenditures:

- The health insurance system up to 1996 gave little incentive to reduce the demand for health care.
- The fee for service reimbursement of doctors has provided a powerful incentive for growth in the volume of certain types of care (prescribing, diagnostic tests and so on).
- A combination of the highest prescribing rates with some of the lowest prices of pharmaceuticals, and
- Global budgets for public hospitals where money does not follow the patient, alongside a thriving private sector that has managed to shift towards ambulatory care.

However, in terms of share of expenditure allocated to each sector within healthcare, there is little difference between France and the EU average except for the higher amount spent on hospital care and the lower amount spent on nursing care in France. This could be linked to the medico-social role of hospitals, some of which still care for long-term patients, as well as the failure of alternative care to keep up with the growing needs of an ageing population. In 1987 those aged 60 and over accounted for 41 percent of total expenditure by the sick funds, although they made up only 19 percent of the population. Similarly, those with serious or chronic illnesses make up 11.6 percent of patients, but absorb 46 percent of all sick fund spending. The distribution of expenditure has however changed over time where the proportion spent on hospital care has fallen, while that spent on primary care has risen.

In April 1996 legal regulations were brought in aimed at limiting the growth of health expenditure (public and private hospitals and ambulatory care) reimbursable by the health insurance.

5.6.4 Payment of hospitals

Public hospitals have been financed according to a global budget since 1984 and were the first sector where they were introduced, while private hospitals are still paid on a per diem basis within a framework where expenditure targets are set. In principle most patients are required to pay for public hospital care and to seek reimbursement but since a new system was introduced in 1996, the *Sécurité Sociale* reimburses the hospital directly (*tiers payant*). The patient provides only the co-payment which in practice is often

a lump sum (*forfait hospitalier*) that is not reimbursed. The reason is that hospital bills are infrequent but large. In public hospitals patients pay FRF 30 per day (1990) towards their hotel costs. In addition, for a stay of less than 30 days, the large majority, and for certain minor operations they are liable to a co-payment of 20 percent of the total cost from which the day payment is deducted. In private hospitals patients are also charged a co-payment of 20 percent of the standard charges for medical treatment. In addition they have to find the balance of the other costs. Due to the high proportion of hospital spending that is accounted for by people who are exempt, co-payments account for only 9 percent of expenditure in public hospitals and 12 percent in private hospitals (a much lower proportion than in the case of primary care or pharmaceuticals).

All publicly financed hospitals are therefore no longer paid on a per diem basis (a method deemed to generate inflation) but are allocated a global budget aimed at covering most of their costs. They are allowed to spend this predetermined sum of money to within a 2 percent margin. The budget is calculated on the basis of past expenditure, allowing for a rate of growth set at the start of the financial year (11.8 percent in 1980, 5.7 percent in 1985, 4.2 percent in 1990 and 2.1 percent in 1996). The possibility of introducing a complementary budget for those expenses which cannot be predicted at the start of the financial year (such as salary rises or new treatments) has yet to be explored. Capital payments are met by the sickness funds.

It seems that while global budgets played a significant part in the decrease of hospital expenses, since the growth rate had already slowed prior to their introduction, other factors must also have had an effect. The annual growth rate in the volume of care provided by public hospitals dropped from 7.4 percent (on average) between 1975 and 1980 to 2.2 percent between 1980 and 1982. Other factors also influenced this trend, but the most important was the reduction in general inflation rates. Certain technical advances and new pharmaceutical treatments, as well as the high number of private doctors, contributed to the practice of shortened hospital stay, strengthening primary and home care.

Between 1982 and 1995 the hospital share of expenditure for medical goods and services fell from 53 to 48 percent. Despite this, after ten years of experience, global budgets were judged unsatisfactory. Hospital expenditure and its contribution to total expenditure decreased, but the allocation of resources according to a uniform rate of growth did not reduce the disparities between hospitals. This measure failed to take into account the volume and quality of the output produced. Combined with this, a low allocation of resources can act as a brake on the introduction of new technologies and constitute an incentive to the selection of patients. Thus global budgets have led to allegations of shortages of resources, rationing and even corruption, with certain patients getting preferential treatment.

A new system (*Programme de Medicalisation de Systemes d'Information PMSI*), aimed at enhancing the medical component of information systems and outcomes, based on the US DRGs (Diagnostic Related Groups), was set up in order to measure hospital outputs. The information collected is used as a basis for hospital planning, where the notion of output replaces the administrative notion of hospital bed. This new system is expected to contribute to the harmonisation of methods of payment between private and public hospitals.

Private hospitals which have assumed the same responsibilities as the public hospitals, also receive an overall budget. Those who have not done so may nevertheless be supported by the sickness funds. Almost all of them have signed the national agreement (*Convention*) which allows their medical staff to be paid by fee-for-service. Other costs

are reimbursed on a per diem basis with fees which reflect the general standard of services and accommodation offered by the hospital. These are also set by the Ministry of Health and the medical associations.

5.6.5 Payment of health care professionals

GPs are paid on a fee-for-service basis and patients are later reimbursed by their insurance company. They are paid according to a negotiated fee schedule. One of the main reforms was the introduction of *secteur II* doctors in the 1980 *Convention*. This gave about 30 percent of doctors (*secteur II*) the opportunity to exceed these negotiated fees, in exchange for reduced benefits (sickness benefits, pensions) and made patients or their private insurers liable to pay the difference between actual and negotiated fees which is on average about 9 percent higher. The advantages to the *Assurance-maladie* were that it created divisions amongst doctors making them less aggressive during fee negotiations, since those belonging to *secteur II* could increase their prices beyond the negotiated fees, and the expenses of the *Assurance-maladie* would only be partly affected by real price increases. In 1980 the *Assurance-maladie* defended itself from the critics of a 'two-tier health care system' saying that in a context of excess supply, market mechanisms would limit the number of doctors in the *secteur II*, as well as the price increases.

It is true that since it was introduced, *secteur II* has contributed to containing the increase in doctors' fees, keeping growth rates between 1980 and 1995 at an average of 0.24 percent per year in constant 1995 FRF. However, the development of *secteur II* has posed a threat to the principle of equal access to care. The difference between actual and negotiated fees has widened from 5 to 10 percent of negotiated fees over the same period. Hence the 1990 *Convention* attempted to limit the development of *secteur II*, which had proven undesirable from an equity point of view and ineffective in decreasing the amount of services provided. As a result restrictive measures were introduced regulating access to *secteur II*. In 1994 the proportion of doctors in this sector had dropped to 28.5 percent (19 percent of GPs and 39.5 percent of specialists).

In 1995, expenditure on private office-based doctors accounted for approximately 14 percent of spending on medical goods and services. However, their prescriptions for treatments and diagnostic procedures provided by other professionals, affect virtually all health care expenditure.

5.7 Health care delivery system

The compulsory insurance system finances a large private sector which provides most of the ambulatory care services. However, despite the numerous private hospitals contracted by the sickness funds, most hospital care is also still in the public sector.

5.7.1 Ambulatory care

As far as ambulatory care is concerned, health professionals and health care facilities are mainly in the private sector.

General practitioners and specialists

The number of physicians per 1000 population is high compared to the European average at 1.5 but there are important regional variations, raising issues of geographical equity of access to health services.

Private general practitioners (GPs) provide the largest share of ambulatory care and house calls. There were 57,700 GPs compared to 48,000 specialists in 1990. The introduction of a *numerus clausus* (restriction on number of places) has been successful in reducing the number of students graduating every year from medical faculties. The growth rate of the medical workforce has declined from 5 percent in 1988 to 0.7 percent in 1995. However, this has also had a serious drawback in reducing the number of junior doctors available for hospital work and there are concerns about their working conditions. Currently the number of private doctors is stagnant, whereas the proportion of specialists is growing (44 percent in 1975 and 47 percent in 1995).

GPs carry out only a limited range of procedures. They visit their patients, they consult, diagnose and prescribe, but do little else. In 1990 the average GP was paid for 4500 consultations and visits and for only 250 other items of activity. Unlike their German counterparts, they do not do much minor surgery as the tariffs for doing so are not attractive. Specialists receive fewer callers but carry out a wide range of more technical and highly paid activities, including more elaborate forms of investigation, diagnosis and treatment.

Although the total consumption of primary care by patients in France has risen quite considerably since the 1980s, the GPs are under some financial pressure. Their numbers have increased, to an increasing extent their activity consists of less well-paid duties and their per capita rates of activity actually fell between 1980 and 1990 by about 4 percent. At the same time their density rose and specialists took an increasing share of the market. As a result their gross incomes have remained almost static in real terms with 1990 incomes below 1970 levels.

Competition is therefore on the basis of quality of service and relationship with the patient. The patient is often in a buyer's market where time spent waiting and time spent during the consultation are important. As a result, 30 percent of the contacts between GPs and patients take the form of house calls and doctors prescribe freely and heavily. In the absence of higher fees, GPs can only improve their position by seeing patients as often as possible and treating them as intensively as possible.

In contrast, in recent years, patients have increasingly preferred to visit specialists rather than GPs. Specialists benefit from the higher fees and their numbers have increased more rapidly than those of GPs. Their per capita activity rose between 1980 and 1990 and their average real income also increased during this period.

Several reforms made explicit reference to the activity of doctors and a number of new concepts were introduced from the 1980s onwards. These included statistical tables of doctors' activities, including average prescription patterns, cost containment, appropriate use of services, and global budgets for health services in 1990. However these measures did not have sanctions and were rather vague with the result that they had only a limited impact on regulating the volume of medical activities.

In 1993, three measures were introduced to rationalise the provision of health care. These also had the effect of challenging doctors' professional autonomy by introducing controls:

- The possibility of forcing doctors to prescribe the most appropriate services, without duplication, according to treatment guidelines (*Références Médicales Opposables – RMOs*) produced with reference to treatments and interventions. Sixty five *RMOs* were produced in 1994 and 147 in 1995. These are expected to cover, progressively, all sectors of medical care. Doctors who do not abide by the guidelines are, in

principle, subject to financial sanctions varying according to the frequency and gravity of negligence. However, controls by the *Assurance-maladie* are still limited and there are several ways of appealing against a sanction.

- The introduction of '*carnet de santé*' (medical records in the form of a small booklet carried by patients) aimed at limiting the access to multiple doctors and avoiding conflicting and redundant prescriptions.
- The setting of a prospective target growth rate (3.4 percent in 1994) for private doctors' fees and prescriptions expenses.

During the first few months of their introduction, *RMOs* appeared to be an effective measure in curbing the expenditure of the *Assurance-maladie* and did indeed influence pharmaceutical prescriptions, however a subsequent acceleration in the rate of growth of health care expenditure proved its effectiveness was temporary. Medical records have also had a limited effect. During the first phase of their introduction they were targeted at 4 million people aged over 70 who suffered from more than one disease. In fact medical records were given to only 45,000 people before this measure was suspended with the introduction of the Juppé Plan in November 1995. It was reintroduced as part of the Juppé Plan in autumn of 1996. There is however no evaluation of the impact of medical records on health outcomes or medical practices.

Over 2000 health centres with salaried doctors provide services mainly for the poorer segment of the population. The "priority population" (unemployed people and their dependants, as well as pensioners) are offered free periodic health checks. Moreover, they are the target population of screening, health education and prevention campaigns. The health clinics are operated by municipalities, voluntary bodies such as the *mutuelles*, or by humanitarian organisations and are remunerated on a fee-for-service basis.

Various programmes such as mother and infant protection and national school health services are also available.

Primary dental care

Private dentists are the main providers of primary dental care. Their reimbursement from the sickness funds is normal for specified services with standard fees being set by agreement between payers and suppliers and co-payments imposed on patients. The scope of such agreements has steadily been extended over the years. For dentists there is more scope for providing services at a higher price than that reimbursed by the sickness funds.

Nursing care

There is a shortage of nurses in hospitals, despite improvements in working conditions and pay following action taken by the unions in the late 1980s. Nursing care includes preventive, curative and palliative care. At the primary care level, nurses can work in a municipal health centre, with a private association of health professionals (doctors, physiotherapists and nurses), or be self-employed. Some 12 percent of nurses are self-employed and they only work according to a doctor's guidance. In addition there are around 5000 occupational health nurses with preventive, clinical administrative and social duties, as well as school nurses. Community psychiatric nurses care for the mentally ill in a specific geographic area (defined by the number of inhabitants) in close co-operation with the specialised service of the area. Other primary care nurses include those working in HIV service, drug addiction and alcohol dependence services.

Pharmacists

Most pharmacies are privately owned although a few are operated by non-profit organisations. Approximately 90 percent of medicines by value are supplied through retail pharmacies. Qualified pharmacists have a legal monopoly for selling products and there is a legal restriction on the number of retail pharmacies in each area (one pharmacy for 2,500 inhabitants). Currently there are 22,150. Of the total amount of medicines sold, doctors working in the primary sector prescribed 80 percent and 7 percent were bought over the counter (OTC). The remaining 13 percent were prescribed in hospitals. Under pressure from patients, doctors may add what should be OTC products to their prescriptions. Medicine prices are strictly controlled and low by European standards, but there are few restrictions on what may be prescribed and per capita consumption is high.

5.7.2 Secondary and tertiary care

Hospital care accounts for approximately half of total health care expenditure. In the field of hospital care, the public sector dominates.

Inpatient care is provided by both public and private hospitals (with public hospitals having three quarters of hospital beds and the remaining quarter in the private sector). Hospital provision is generous. In 1990, there were 559,000 beds or 9.9 beds per 1,000 population. Public sector hospitals are considerably larger (and generally better equipped) than those in the private sector, on average they contain 350 beds as opposed to 70 in both non-profit and for-profit private hospitals. They have a much higher proportion of medium and long-stay and psychiatric patients, but also lower occupancy rates. They also carry out a larger proportion of major surgical interventions and high-technology treatments. This is reflected in the higher costs per patient day. Private hospitals tend to specialise in minor and elective surgery.

Table 18: Changes in Utilisation of Hospital Facilities in France, 1984-1990

	1984	1986	1988	1990
<i>Beds, 000</i>				
- public	388	378	371	363
- private, non-profit	112	95	91	88
- private, for-profit	94	107	108	108
<i>Admissions, 000</i>				
- public	6418	6953	7120	7534
- private, non-profit	1754	1335	1295	1353
- private, for-profit	2709	3332	3655	3972
<i>Patient days, m</i>				
- public	110	109	105	103
- private, non-profit	31	29	27	26
- private, for-profit	33	36	36	36
<i>Expenditure, 1990 FRF</i>				
- public	165411	170437	176665	188670
- all private	49425	51353	54086	59385
<i>Cost/patient day, 1990 FRF</i>				
- public	1504	1564	1683	1832
- all private	741	790	859	973

Source: Burstall & Wallerstein (1994)

Although medical staff in public hospitals are salaried and do not have the same incentives as private hospital doctors under the fee-for-service system to offer the maximum amount of treatment, they are not motivated towards economy. The medical

audit has developed only slowly and cost-effectiveness and cost benefit studies are only few. French hospitals carry out a large number of probably unnecessary operations. The appendectomy rate is five times higher than anywhere else in Europe and the number of X-rays and biological tests is also large.

A planning instrument, the *Carte Sanitaire*, was introduced in 1970, based on the assumption that the availability of hospital beds induces greater demand (as doctors have a tendency to fill beds if available). As a consequence, the step taken for containing hospital expenditure was the rationalisation of hospital capacity. Changes in the number of beds or hospital equipment must abide by the *Carte Sanitaire*. It defines the regions into which the health care system is divided, as well as the nature and role of the facilities available to the population. It also defines standard ratios of hospital beds or inpatient capacity and medical equipment to local populations (per capita) and broad specialties (medicine, surgery, obstetrics, and so on) for both the private and public hospital sectors. It also defines the norms regulating the use of costly medical equipment and the geographical distribution of medical equipment and activities within each region.

On the one hand, the *Carte Sanitaire* has effectively contributed to limiting the growth of hospital beds. However, beds are only one of the factors in hospital supply. Thus it did not prevent the rapid increase of hospital expenditure which took place before the 1980s due to staff and salary increases which are approximately 70 percent of hospital costs. It has however been successful as a good planning tool. Many beds, especially in psychiatric hospitals were shut down, although the total number of beds today still remains comparatively high.

In 1991, a new law introduced a complementary planning instrument called the *Schéma Régional d'Organisation Sanitaire (SROS)*, which regulates the geographical distribution of equipment and activities at a regional level. The *SROS* tasks include reorganisation of the emergency services, networking health care facilities, and reducing or converting the use of hospital beds. A law, approved in July 1994, allowed for the closure of hospital services with limited activity. This measure is however often opposed by local political interests because of the sensitivity about the issue of access to health care and the effects on local economic and employment levels.

Public hospitals have three functions: preventive and curative care and rehabilitation. Medium and long-stay hospitals are devoted to follow-up treatment and also look after patients who can no longer live alone. However, as in most European countries, despite a major effort to develop alternative solutions to long-term hospital stays, general hospitals still have an important, if ill measured, medico-social function. Public hospitals have a duty to provide emergency treatment. There are 29 regional hospital centres (teaching hospitals) with medical equipment of a very high standard. Specialised hospitals include psychiatric hospitals (the vast majority of them) and rehabilitation centres.

Private hospitals represent 25 percent of hospital beds. 60 percent of these are in for-profit hospitals and are principally dedicated to elective, short-term stay. Patients are partly reimbursed by the national social security scheme according to the fee schedule. The hospitals have ad hoc agreements with the sickness funds based on fee-for-services supplied and per diem charges for the stay. They are largely staffed by private doctors.

Non-profit private hospitals represent the other 40 percent of the total number of private beds. Most private hospitals are reimbursed on a per diem basis for inpatient care, with separate fees for physicians' services under the same agreement applying to ambulatory care.

In contrast to primary health care, hospitals are subject to a good deal of official regulation. All hospitals require accreditation by the Ministry of Health which places them in a certain category and determines the types of reimbursable treatment they may give. Their standards are periodically checked by the medical inspectorate while another body of inspectors maintains control over reimbursement for unusually costly treatments.

5.8 Pharmaceuticals

Pharmaceutical expenditure for both prescription and over the counter drugs represents 18.4 percent of the total expenditure for medical goods and services in France. This percentage is clearly higher than in most other European countries. It would seem that doctors in France and GPs in particular prescribe more drugs per visit (3.2 items) than their counterparts in other countries. The consumption of certain types of drugs is also higher in France than in other countries (anti-depressants, vasodilators, antibiotics). The frequent use of new products and the virtual absence of generics makes the average cost of drugs consumed higher when compared with other countries.

Generic products have only 2-3 percent of the market which is mostly in hospitals. Generic competition is limited because prices of older products are too low to make it commercially attractive. Because retail pharmacists are paid by a mark-up on wholesale prices, they have always strongly opposed generic products and have even boycotted them. Because prices are low and volume is high, the pharmaceutical industry competes by innovation on the one hand and marketing on the other hand.

Reimbursable drugs which represent about 90 percent of the pharmaceutical market, appear in a list which indicates their price and reimbursement rate as set at ministerial level. Patients pay for drugs prescribed by a doctor and claim reimbursement. A percentage of the standardised cost of prescriptions is excluded from the cost-sharing arrangement with the insurance companies (*ticket modérateur*). However, direct billing of the insurance companies by pharmacists (*tiers payant*) with patients paying only the non-reimbursable share (*ticket modérateur*) is becoming more usual and available upon request. The complementary insurance schemes usually compensate fully for the excluded charge while 10 percent of the people insured are exempt from making any payment because of the type of their illness. Because of complementary insurance, the impact of co-payments is diluted and doctors and patients are desensitised to the cost of medicines. *Mutuelles* have however more actively promoted the use of medicines which are cheaper equivalents of popular branded products.

Expense coverage by the *Assurance-maladie* ranges from 40 percent for non-essential drugs to 100 percent for essential or expensive drugs (which make up approximately 44 percent by value of the reimbursable class). The sickness funds pay 71 percent of the overall bill for medicines prescribed outside the hospitals and for all those used inside hospitals. An increasing proportion of prescription medicines are not reimbursed (such as most vitamins). Medicines bought over the counter are also strictly speaking excluded.

The control of expenditure has meant acting on two components of pharmaceutical costs for the *Assurance-maladie*, namely prices and reimbursement rates. In addition to setting a specific pricing method at the production level, there have also been several reductions of VAT on drugs (1976, 1987, 1990) as well as reductions in wholesale and pharmacy distribution margins. Since 1976, reimbursement rates have fallen from 70 percent to 40 percent for certain non-essential drugs. The reduction of reimbursement rates and in some cases, exclusion from any reimbursement at all for specific categories of products, has been one of the most frequently used measures (1978, 1982, 1985, 1987, 1991). In

addition, all products were affected by a general rise in patient contributions to pharmaceutical expenditure in 1993 (Veil Plan).

In 1994, the combination of prices and volumes became the subject of an agreement between pharmaceutical companies and the state. According to the agreement, from 1995 onwards companies must commit themselves to promoting an appropriate use of drugs, within the framework of a national expenditure target. Sanctions in the form of price reductions can be applied when consumption exceeds targets. In 1994, the growth rate was much lower than the target set at 3.2 percent (0.7 percent for the expenditure financed by the *Sécurité Sociale* and 2.1 percent for total pharmaceutical expenditure). However in 1995 the share of pharmaceutical consumption financed by the *Sécurité Sociale* increased by 6.9 percent. It appears that until now there have been no price reductions as provided for in the above agreement. *RMOs* (treatment guidelines) concerning prescriptions also represent an indirect mechanism for controlling pharmaceutical expenditure and in some treatment categories, seem to have been effective in leading to overall savings.

It would seem that French patients have an unusually positive attitude towards the benefits of medicine and tend to expect to be given prescriptions when receiving medical treatment. These expectations are a significant factor when considering changes in the health care system.

5.9 Conclusions

The present French health care system is relatively equitable but inefficient. Almost the entire population is covered by the sickness funds which provide most kinds of medical care. The differences between the sickness funds are marginal. In terms of equity a possible problem is the high level of co-payments which adversely affect the poor. Although help is available through the Medical Aid this may not reach all who need it. The delivery of health care is also reasonably equitable, although a further possible problem could be the uneven distribution of primary care doctors who have a disproportionately higher density in the south and low numbers in rural areas. This is particularly true of specialists. Access and choice are hereby reduced. Because of the *Carte Sanitaire*, hospital beds and high technology equipment is more equitably distributed.

The finance system does not however encourage efficiency. Membership of a sickness fund is compulsory and because a patient cannot opt for a scheme which charges less for the same benefits, they are motivated to consume as much health care as they can. In the primary care sector, physicians also have good reason to overtreat and patients reinforce this because they appear to equate receiving prescriptions with quality of service. The fragmentation of primary care means that patient records are often erratic and treatments repeated unnecessarily.

There have been numerous attempts to control the soaring health care costs, including the introduction of and subsequent increase in patients' contributions, especially for pharmaceuticals which have resulted in higher patient charges than in most OECD countries. Cost containment measures have targeted the *Assurance-maladie*, rather than considering health care expenditure as a whole. Some of these measures, such as the increase in payroll contributions or the increase in co-payments, or the reduction in services provided, have achieved their objective of improving the *Assurance-maladie's* finances in the short-run. On several occasions, the growth of expenditure related to services covered by the *Assurance-maladie* and overall health care has slowed significantly. This has sometimes occurred in the interval between the announcement

and the implementation of the new measures and is more the result of psychological influences on people's behaviour than the measures' effectiveness.

The cost containment measures have however had an effect over the long run with a slow but certain deceleration in the growth rate of health care expenditure increases.

Between 1975 and 1995 the most frequently used cost containment measure was increases in cost-sharing. Another aim of these increases was to increase the revenue of the *Assurance-maladie*. This may be very effective in the short-term, but the reduction of reimbursement rates which has been widely used for pharmaceuticals seems to have been abandoned due to its unpopularity, its discretionary application and its minimal long-term effectiveness. The resulting increase in prices to the consumer did not contribute to reducing consumption, but on the contrary, led to the development of complementary insurance (*mutuelles*). The subsequent introduction of global budgets has proved more effective in controlling the expenditure of the *Assurance-maladie*, but has had no influence on the delivery of care or equity. This measure was maintained by the Juppé Plan and is now accompanied by other measures aimed at improving the quality of care.

1996 saw the commencement of the implementation of the Juppé Plan. Emergency financial measures came into force and most of the administrative framework was set up. In December 1996, the *Loi de Financement de la Sécurité Sociale* was passed and 1997 saw for the first time a cap on the growth of health expenses.

In June 1997 a new left-wing administration unseated the right-wing government. In spite of this major political change there has been no significant change in health policy to date. Even though the Juppé Plan contributed to the fall of the previous administration, the newly elected government has continued to implement most of the measures based on the existing legislation.

In 1998, the deficit of the *Sécurité Sociale* as a whole (health, family benefits, pensions) again exceeded the target envisaged when Prime Minister Juppé presented his plan (1996 forecast: FRF 17 billion deficit, actual: FRF 52 billion; 1997 forecast: FRF 12 billion surplus, actual: FRF 47 billion deficit). The gap between forecast and actual deficit is due mainly to a lack of revenue rather than to an increase in expenditure. To address this issue, the Jospin government has decided to extend the period of the 'exceptional' 0.5 percent income tax from 13 to 18 years.

The second *Loi de Financement de la Sécurité Sociale* was more generous than the first. The rate of increase allowed in 1998 was higher than in 1997, at 2.2 percent (as opposed to 1.7 percent in 1997) for total reimbursed expenses. The breakdown by type of care was 2.1 percent for ambulatory care (2 percent in 1997) and 2.2 percent for hospital care (1.4 percent in 1997). The rates, which have legal force at national level, are divided at regional level according to rules based on the age of the population for ambulatory care. The allocation formula for the hospital sector, adjusts for discrepancies in the cost of the provision of care in different regions.

A two-tier *Convention* between the doctors' union and the sickness funds was signed in March 1997. The agreement includes provisions applicable to GPs and specialists both jointly and separately. The GPs' *Convention* allows doctors to become *médecin référent*, a kind of gatekeeper to the system. This is voluntary for both doctors and patients. Under this system GPs must keep a detailed record for their patients and 10 percent of their prescriptions must be for generic drugs. There are financial incentives to join the scheme for both patients and doctors. Normally the patient has to pay the provider directly and

then has to wait for reimbursement. Under the *médecin référent* scheme the direct payment is only 30 percent and if the patient has a complementary insurance (such as a *mutuelle* or private insurance) it is possible that no charges are asked of the patient. By the end of 1997, only 12.5 percent of GPs had joined the scheme as many are concerned about the risk of increased control by sickness funds.

There has therefore been continuity in the French health care system under Juppé and now Jospin. Similar economic constraints have driven the health policy decisions of both governments which is one of the possible reasons why a popular measure such as universal coverage based on residence, announced by Juppé, has not yet been implemented. Measures to enhance public health can be expected but it is unlikely that major changes regarding the financing and delivery of health services will be recommended in the near future.

One further constraint on any major reforms is that the large majority of French people are broadly satisfied with their health service. The system is good even if it is expensive and none too efficient. There is rising disquiet over the cost and volume of treatment, but this has not yet reached acute levels and is not widely shared. In contrast to other countries like Germany, health care reform has not emerged as a major theme of political controversy in France. In the eyes of the average French person, the present system reconciles a number of important objectives of social solidarity and liberal-pluralism, albeit at a high price which until so far has been bearable.

6. Conclusions

6.1 Common concerns in social insurance systems

No country seems to have it quite right. While none of the health care systems in the countries in this report are on the verge of collapse, all face the same set of urgent problems. These problems threaten to reduce the quality of care now being delivered or drain the public coffers. In short, demand for health care is outpacing the ability to supply it in all these industrialised nations.

The main factors which propel the growth in demand, appear to be the ageing population, improvements in medical technology and real income growth. All of these are in many ways very positive developments. Ageing occurs because the health care system has been able to increase life-spans, and medical technology, while expensive, save lives and often relieves pain and suffering and widens the range of potentially beneficial treatments. Rising income is the result of gains in economic productivity which is in turn often spent on health. These demands for better care are not adequately offset by incentives for patients or providers to restrain excessive utilisation.

The problem therefore must lie in the way that health care is financed and delivered. Almost everywhere there is dissatisfaction with existing methods of financing and delivery and a search for new policy instruments. At the same time there is the recognition that there is no quick fix solution to the challenges faced by the health care system. The health care markets in this report are all dominated by insurance, whether publicly or privately provided. This is necessary because illnesses are unpredictable and the consequences of these illnesses may be financially catastrophic and the risks may also be shared between the healthy and the unhealthy. However it is also well established that patients and providers behave very differently when an insurer is paying the bill. In some countries, the major insurer is the government, mainly to ensure the equitable distribution of care. Thus the insurance problem becomes compounded by also being a budgetary problem. The key to reorganising health care systems in most of these countries requires finding an acceptable balance between the efficiency with which care is financed and delivered and the equity or social solidarity of the system.

Health sectors in all OECD countries are noticeable for their high levels of government intervention, involving different mixes of finance, direct ownership and regulation. Throughout the 1980s the belief that a market-based competitive environment produces the necessary incentive scheme for greater efficiency provided the rationale for reformers to introduce market-based reforms in the health sector.

Unlike other sectors of the economy however, there is little empirical or theoretical evidence to suggest that purely market solutions would result in greater efficiency within the health care sector. There are many well-documented market failures that are endemic to the health sector. Moreover, as far as empirical evidence is concerned, the United States which has relied on market-based systems in health care to a far greater extent than any other OECD country, has been conspicuous for its failure to contain aggregate costs and has also experienced difficulties in achieving efficient solutions to the provision and funding of health care services.

The political dominance of the argument for market-based systems in health care has therefore been tempered since the late 1980s. However, policymakers might argue that in fact excess capacity and perverse incentives, and not reliance on the market, are what lie behind the high costs of the US system today. It is argued by many that the best

solution to excess demand and the constraints on government financing, would be to actually make the market work more effectively by increasing information and choice for patients while placing insurers and providers in competition to provide optimal levels of care at competitive prices. Each country is however different from all others and thus competition is not the simple answer unless reform is carefully tailored to each country's particular social and political setting.

In order to encourage competition in a social-insurance based health care system, insurance funds would have to be put on an equal footing in order to allow them to assume a more commercial role as insurers, eventually leading to competition. However, health insurance in a social insurance based system needs to be mandatory (at least for part of the population), with a means for subsidising the health insurance premiums of low-income households. Government plays a large role in setting institutional priorities for subsidising the poor and the sick. Citizens should have access to basic health care services irrespective of ability to pay. In other words, in an ideal scenario of social health insurance, government collects income-related premiums and an independent central fund divides the pool among private insurers in relation to the risks they bear. When consumers shop around for insurance, insurers compete on the basis of providing the best coverage at the lowest cost. This produces an essential source of efficiency in competitive health care systems. Governments would need to set up a regulatory framework within which these health care markets can work, define a guaranteed health care package to which all citizens are entitled and assume responsibility for collecting the income-related portion of all citizen's health care payments such that the system is equitable. The government also has a continuing role in assuring safety, quality and fairness.

In a regulated market for health care insurance, premiums are based on average expected costs of a group of individuals. Insurance companies have the incentive to pick the good risks within that group or the healthier individuals in that group who will have lower average health care costs. At the same time these individuals may choose to opt out of such social insurance schemes altogether which would leave only the sick and would tend to further disadvantage those left in the scheme as they are often also the poor. Governments tend to address these adverse effects of regulated markets :

- Obliging insurance companies to accept all individuals regardless of risk at a common premium (which may be income-related), and
- Obliging all individuals to take out insurance, even if the premium they contribute is higher than their expected health care costs.

It is possible that mandatory insurance pools restrict the degree of competition for the financing of health care, because insurers may be obliged to charge the same premiums to all subscribers and accept all individuals. Similarly, if consumers are obliged to take out insurance at a flat rate premium, irrespective of their risk, they may have limited scope to express their preferences which curtails the ability of a market-response to consumer demands to achieve economic efficiency. The problem is therefore to find a reasonable balance between efficiency and social solidarity.

In the social insurance-based systems considered in this study, some competition exists between funds where membership is open to all, while little or no competition exists where membership is restricted. In Germany, everyone in the same fund pays the same percentage of income, regardless of their individual risk. However, premiums across funds vary so that some charge higher percentages of income than others. There is free choice of sickness fund and members may change on a yearly basis. A different approach which is broadly that followed in France and Switzerland, is to compensate

individual funds for the risk profile they actually face so that members of all funds can be charged the same premiums. In France the contribution rates are fixed so that they are the same for all individuals within a fund but vary between funds. The sickness funds do not typically compete since they are organised along occupational lines and membership is therefore restricted. In Switzerland, compulsory health insurance contributions are community-rated, so that all subscribers to a particular insurance company within a canton or canton sub-region pay the same rate. Because the insurance companies have to offer a standard benefits package and because managed care and quality competition are not common, insurance companies compete on the level of the premium. Price competition appears to work because many people change companies on an annual basis depending on the premiums offered. In the Netherlands, insurers charge both an income-related percentage contribution and a flat-rate contribution. The insurer is obliged to quote the same flat rate premium to all insured people. Because the insurers' revenues consist of risk-adjusted payments from the Central Sickness Fund, supplemented by the flat rate premiums, the difference between actual costs and revenue will be reflected in the flat rate premium which becomes the major source of competition between insurers.

Often a compensation mechanism exists between funds (through transfers) to encourage the development of decentralised, independent and commercially oriented funds with opportunities for increased competition. Most social insurance-based systems usually have some sort of risk-compensating mechanism in place between funds, albeit that some are not very comprehensive. Premiums typically differ (sometimes substantially) between funds. This reflects the differences in the risk structure of the funds' members, as well as the imperfect nature of the risk-adjustment. France relies on a central risk adjustment mechanism to balance premiums across funds which in effect means the larger funds compensate the smaller funds (with higher number of beneficiaries per contributor). The Netherlands has experienced profound difficulties in determining a risk-adjusted capitation formula with which to pay individual insurance funds from the Central Fund. Currently age, sex, region and disability are used in the formula but these predict only a small part of the variance in health care expenditure. Germany has a (rather crude) compensation mechanism to equalise differences in contribution rates and expenditure so that all sickness funds provide or receive compensation for the differences in their contributory incomes and average expenditures, while Switzerland has set up an organisation called Foundation 18 which is responsible for the risk adjustment between registered insurance companies.

The existence of competing insurers does however tend to increase administrative costs. These market oriented type reforms to increase efficiency, choice and responsiveness increase transaction costs. They also make it difficult to achieve other objectives of access and equity and equally increase the incentive for the insurer to compete on the basis of the individual's risk, thus increasing the potential for preferred risk selection or 'cream-skimming'. The effective prevention of this 'cream-skimming' is essential for reaping the benefits of competitive health insurance within a regulated premium structure. There are therefore always trade-offs in any reform program.

It is important to recognise that reforms should proceed in a pragmatic fashion. Successful policies are piecemeal. The puzzle is how to best regulate the healthcare market to combine the anticipated benefits of competitive strategies with the need for effective planning, co-ordination and equity considerations. Most policymakers have not abandoned planning and regulation but rather sought to combine some market incentives with a framework of rules to guide competition and the capacity to intervene to tackle problems when they arise. The reforms in most cases therefore lead to managed or regulated markets.

Reforms have been attempted in all these countries and some important changes are still taking place, for example in Germany and Switzerland. It is interesting to note which of the Dutch reforms have been implemented and which have not. The initial plan to introduce competition into the financing system has not been implemented completely, largely because of resistance from political interest groups and because of the complexity of the reforms. This illustrates the difficulty in implementing these changes without risking high transaction costs.

There are often several impediments to rapid reform in any health care system. Especially in countries where there is broad support for the existing health care system, such as France, the reform process is harder. A move towards more competitive market arrangements would require a change of culture for both providers and insurance funds. Currently, the allocation of resources is decided by very powerful interest groups. Change would require that in a sector which has been dominated by medical experts, management decisions will need to be made regarding tougher economic and commercial issues.

6.2 Health insurance in practice

In Germany and the Netherlands there is a long tradition of government regulation and participation in the development of the systems, whilst in France and Switzerland the degree of government control has historically been less. France accepted a complex set of structures to ensure universal cover, a degree of equity and a large amount of choice for patients. The main system does not cover the full cost of treatments, so supplementary arrangements are available for most people to meet the remaining part.

Inclusion of other family members in addition to employed persons is common in most social health insurance. This may involve an additional fee or may come without charge. Such schemes that cover employed persons' family members do well in terms of coverage and universality but may have slightly higher contributions. The schemes in this report all provide for non-working dependants as well as for the employed persons.

There is some variation in the ways in which contributions are paid to provide for retired and unemployed persons. There are two kinds of methods that are used. In some cases membership contributions are paid by government on behalf of those who are not earning. This may be the most feasible method since it is difficult to cross-subsidise from working people to non-workers. A second option is for membership to continue after retirement (or loss of job) with working members paying to subsidise non-earners (who pay nothing or reduced contributions). If the costs of services for non-workers are paid directly by existing workers, then the percentage contributions have to be higher to pay for this subsidy. However it has the advantage that the whole of the social health insurance scheme can be kept separate from other government services.

The system in France is effectively universal although a small proportion of the population slip through the social security net and fail to be covered. In the Netherlands and Germany the systems allow richer people to opt out of the social health insurance system and this potentially reduces solidarity. In practice, the level of opting out in Germany is quite small. A possible reason for this is that the low transaction costs associated with the main social health insurance system mean that the savings for richer people opting for private insurance are small in many cases (as the premiums have to be higher to cover transaction costs) and there is not much difference in terms of the quality of services offered. The argument is that richer (and healthier) people can benefit from opting out since the social health insurance schemes are actuarially unfair (they involve people paying contributions that are higher than the expected cost of their services).

However if transaction costs are higher for private insurance, then it is likely that for some people the premiums paid for their social health insurance will be lower. In the Netherlands and Germany private 'opt out' schemes all offer risk-related instead of community rated premiums, making it much more attractive for healthier and wealthier people to opt out. However these are counter-balanced by disadvantages such as the lack of ability to re-enter the social insurance scheme in Germany and the additional premium payments for dependants of insurees.

In addition to 'opt out' options, some countries allow patients to supplement their social health insurance with additional cover for added benefits. Again, these premiums are usually risk-rated. Supplementary insurance in Germany which covers extra amenities in hospital is a growing market for private health insurers, since sickness funds are not allowed to offer such policies. In Switzerland the supplementary insurance is offered by the same companies offering compulsory insurance and covers additional benefits such as superior hospital accommodation and a free choice of hospital doctor. In the Netherlands supplementary insurance is financed by risk-rated premiums which also vary according to the level of deductible and the level of hospital accommodation chosen. France's level of voluntary, supplementary insurance is relatively high and mostly covers patients' co-payments. While these complementary insurance policies may offer patients greater choice, they do allow for preferred risk selection and because some proportions of the population will be unable to obtain these supplementary policies, raise the issue of equity.

In France the social health insurance system involves more visible payments and a significant contribution from patients or supplementary insurance. There may be some advantages in an element of co-payment, since it can discourage excessive use of services, although the evidence does not show that deterrent effects can work equally for all services. Because supplementary insurance often covers co-payments, patients are largely blunted to the effect that co-payments would otherwise have in reducing utilisation. While co-payments are an important source of revenue in many countries, they can also have the effect of reducing solidarity unless there is a system of exemptions for those below a certain income level as in France.

Most countries have concerns over the growing costs of the system. In France there have been efforts both to control costs and to pay off accumulated deficits in the social insurance system, most of which are related to health expenditure. Since in each case the main source of funding is the payroll, there is concern that this may make firms less competitive. To some extent this argument is flawed. Competitiveness depends on a number of factors, including the total cost of staff payments, productive efficiency and the exchange rate of the currency. Since most EU countries now effectively have a single currency it is not as easy to gain competitiveness through devaluation of the currency, but nevertheless the link between health insurance costs and competitiveness is not straightforward. It is interesting to note that in France the reforms of social security have been specifically aimed at addressing the issue of the dependence on payroll income. The new taxes and charges cover other sources of income and aim to raise revenue on the basis of ability to pay. Germany has similar concerns, since rising health care expenditure is not responsible for an increase in contributions, but the shrinking proportion of GDP used for wages from which all social insurance contributions are financed. Thus large profits by employers, increasing unemployment and wage increases below productivity have caused a relative reduction in the financial flow to the social insurance system since contributions are based only on labour. The dependence on payroll contributions is therefore of increasing importance given the decline in the number of permanent jobs in large organisations and new sources of finance will for the health insurance system, grow in importance.

The levels of expenditure for health in each of these countries are a little above the EU average when considered as a proportion of GDP. However, it is interesting that in the Netherlands a significant reason for the high health care costs relative to GDP is the relatively large private insurance sector. Rationing of access to care and the associated signs such as long waiting times and more explicit controls on access to care are not significant features in these countries. This does not mean that all services that potentially produce health gain are provided, but that the extent of the need for rationing is less than in some other countries.

In France, Switzerland and Germany, access to specialist care is available without referral from primary care. The right to visit a specialist directly is valued highly in France, but this does reduce the scope for gate-keeping to more expensive specialist services. Ideas for controlling costs in France include the possibility of reducing this right of direct access to the provider of choice. It is not clear that any such system of controls could easily be put in place given the historical and cultural backgrounds of France and Germany, although the gate-keeping principle is very much in vogue with Swiss policymakers. A feature of social health insurance is the typical emphasis on choice of provider. Restricting or ending this right is very controversial and increased choice is a feature of attempts to modernise government funded health care systems. It is not clear that it is choice *per se* that is valued but rather the ability to take action to ensure appropriate and good quality care. In practical terms, exercising choice is only possible in some circumstances and the costs associated with extensive choice may be high where alternative mechanisms for improving quality are available.

Efforts to put in place measures to control costs are likely to concentrate on using some market mechanisms, direct caps on expenditure and other financing measures. There are many possible mechanisms for cost control, including measures to restrict supply, controls on access to care and better education and information. However, one of the most effective ways to control total expenditure on health services is through constraints on funding in a culture of adherence to budget constraints. In France this is partially controlled through the restrictions on contribution rates. The trend in Germany is different with more efforts to use competition amongst insurers to control cost. This is also the trend in the Netherlands.

Controlling costs or prices has been the favoured strategy of French government. There is general acknowledgement that the French public are hostile to general taxation and measures which affect the degree of public financing of health care. They are strongly attached to hypothecated taxes where payroll deductions are seen as contributions rather than taxes *per se* and arouse less hostility. The independence of the social security system as insulating health care spending from other financial pressures is seen as paramount.

A growing concern in all publicly funded services is to ensure that funds are managed properly and are put to the purposes for which they have been collected. The greater the degree of decentralisation and devolution of power, the more important it is to have good systems of accountability and audit. Comparing the social insurance systems offers some useful insights. In Germany it is significant that traditions and understanding of unwritten codes play an important part in the regulation of social health insurance. In France there is no official state subsidy to the social health insurance system but the funds have gone into deficit with growing pressure on expenditure and controls on contributions. This has been possible in part because there is an element of guarantee by government of the debts, but it does illustrate the need for good systems of governance and close links between setting service entitlements and contribution rates.

An important element relating to this is what mechanisms are in place to deal with over or under-spends of the social security system, which in part will be determined by the legal and cultural background of the country. In Germany, sickness funds do not have fixed budgets but have to cover all expenses which means that contribution rates have to be adjusted if income is lower than expenditure. All budgets are on the providers' side rather than the payers' side and any moves to shift this balance of power have been met with fierce resistance. In Switzerland, an organisation called Foundation 18 is responsible for meeting the financial obligations of insurance companies in financial difficulty, while in France the sickness funds have to be self-supporting (they do not have reserves to prevent deficits). Either insurance funds use such reserves when their contributory income is less than their expenditure, or they need to adjust premiums. Alternatively, funds may need to adjust the benefit package and ration care or adjust provider payments, if they are not bailed out by a government which underwrites the system. For the financial stability of the system, one or more of these mechanisms needs to be in place and depending which is used, will have various effects on the system. Limiting the benefit package may reduce equity and access to care while adjustments to the premiums may have a similar effect. The number and size of the funds may also impact on their financial stability.

Control of costs has therefore been an increasing feature of policy in countries with social health insurance funding. Systems also appear to be in a perpetual state of reform and change. This is also common in systems that rely mainly on tax funding. It is clear that in all these countries there is a continuing search for the combination of universal access, cost control, high quality of care and efficient provision of services.

6.3 Performance of health care systems

No reliable measure exists with which one could compare and evaluate different countries' health care systems. The following table lists some of the important measures that are often used to examine the performance of health care systems. These include health care expenditure, both per capita and as a percentage of GDP. This has risen substantially in France. Systems where the patient pays a private provider and then claims reimbursement (as in France) and where there is no overall contract between insurers and providers, seem to be less successful in containing costs than contract systems (like Germany) where there is an overall contract between sickness funds and physicians' associations on behalf of their members. Health care expenditure is influenced by the macro-economic efficiency of the health care system. Micro-economic efficiency can be evaluated by a measure such as physician visits per person per year. This has been much higher in Germany and a possible explanation is that GP visits attract no co-payments by the patient. This may also be due to historical and cultural backgrounds and national preferences. The percentage of the population covered by public schemes is a proxy for performance in terms of social solidarity. Most of the countries score highly in this regard. The lower figures in Germany and the Netherlands indicate the availability of voluntary opt-out schemes. The aggregate health status of the population can be measured by potential years of life lost. Satisfaction with the health care system indicates the results of a widely quoted survey and is sometimes used as a proxy for the outcome of the health care system. There are however reservations about the interpretation of these results as people in different countries are likely to have a widely varying degree of awareness of the cost to them of the services they are getting.

Table 19: Performance of Health Care Systems

	Macro-performance			Micro-performance	Social solidarity	Health status		Satisfaction
	Health care expenditure as % of GDP (1980)	Health care expenditure as % of GDP (1990)	Health care expenditure, per capita PPP US\$ (190)	Physician visits per head per year (various years)	Percentage covered by public schemes (various years)	Potential life years lost (various years)	Perinatal mortality (various years)	Percentage of population generally satisfied
France	7.6	8.9	1379	7.2	99	4434	8.9	41
Germany	8.4	8.1	1287	11.5	92	4039	6.4	41
Netherlands	8.0	8.1	1182	5.5	69	3499	9.7	47
Switzerland	7.3	7.8	1640	6.0	100	3718	7.1	n/a
United Kingdom	5.6	6.1	909	5.7	100	4060	9.0	27

Note: n/a not available

Source: Hoffmeyer & McCarthy (1994)

6.4 What other countries might learn from these experiences

Many of the European countries like Germany and others in this paper have lessons to offer as highly regulated, multiple payer financing systems. Ideas for health care reform in other countries can draw on many of these ideas such as moves to managed care organisations, methods of risk adjustment, evidence-based medicine and various ways to encourage market mechanisms.

Some of the key messages from this paper are that there are no obvious quick fix solutions to the challenges faced in these countries. Most aspects of the social insurance system require careful balancing, as there are definite trade-offs to be made:

- Increased access comes at a higher cost.
- Increased diversity and choice produce higher transaction costs and may lead to greater inequality.
- Higher co-payments have the advantage of raising revenue and may be a valuable tool in reducing excessive utilisation of some services, but they can reduce solidarity if there are no exemptions in place.
- Private 'opt out' schemes may be actuarially fairer for the richer population, but they potentially reduce solidarity and equity.
- Supplementary schemes can also produce inequality and if the complimentary insurance is used to cover co-payments, may diminish the effectiveness of co-payments in reducing utilisation.
- More complex purchasing arrangements that allow for greater choice and competition (as opposed to broader systems of contracting) produce higher transaction costs.
- Managed competition in health care financing could in theory be feasible if a suitable comprehensive risk-adjustment mechanism were in place, but this has been shown to be almost impossible to implement in practice.
- And finally the legal, social and cultural backgrounds and traditions of the country will temper any changes or reform programmes. These norms will affect the role of government and the degree of intervention, the level and degree of bargaining power that the institutional players have, the level of risk sharing between purchasers and providers and the mechanisms to ensure the financial stability of the social insurance system.

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8. Appendix A: Comparative data

8.1 Demographics

Table 20: Total Population, Thousands of Persons

	1990	1991	1992	1993	1994	1995	1996	1997
France	56735	57055	57374	57654	57900	58143	58380	58608
Germany	63254	79984	80594	81179	81422	81661	81895	82061
Netherlands	14947	15070	15184	15290	15383	15459	15494	15277
Switzerland	6796	6800	6875	6938	7019	7041	7072	7087
United Kingdom	57561	57808	58006	58191	58395	58606	58801	59009

Source: OECD (1999)

Table 21: Births, Crude Rate per 1000 Population

	1990	1991	1992	1993	1994	1995	1996
France	13.5	13.3	12.9	12.3	12.3	12.5	12.6
Germany	11.5	10.4	10.0	9.8	9.5	9.4	9.7
Netherlands	13.2	13.2	13.0	12.8	12.7	12.3	12.1
Switzerland	12.5	12.7	12.6	12.1	11.9	11.7	11.7
United Kingdom	13.9	13.8	13.5	13.1	12.9	12.5	13.0

Source: OECD (1999)

Table 22: Total Unemployment as Percentage of Labour Force

	1990	1991	1992	1993	1994	1995	1996	1997
France	9.3	9.1	10.1		12.5			
Germany	6.2	5.6	6.7	8.1	8.6	8.3	9.1	10.1
Netherlands	8.9	8.5	6.6	8.2	6.8			
Switzerland	0.5	1.9	3.1	4.3				5.2
United Kingdom	6.8	8.4	9.8	10.4	9.8			

Source: OECD (1999)

8.2 Economics

Table 23: GDP Per Capita, US\$ PPP

	1990	1991	1992	1993	1994	1995	1996	1997
Germany	18351	17070	18454	18558	19747	20871	21194	22081
France	17358	18244	19003	18684	19279	20306	20523	21294
Netherlands	15926	16515	17422	17854	18836	20283	21073	22639
Switzerland	21223	22003	23055	23670	24251	25557	25160	26007
United Kingdom	15907	15512	16600	16881	17558	18136	19644	20430

Source: OECD (1999)

8.3 Health status

8.3.1 Life expectancy

Table 24: Life Expectancy, Females at Birth

	1990	1991	1992	1993	1994	1995	1996	1997
France	80.9	81.1	81.4	81.4	81.8	81.9	82.0	82.3
Germany	79.0	78.7	79.1	79.2	79.5	79.8	79.9	80.3
Netherlands	80.1	80.2	80.3	80.0	80.3	80.4	80.4	80.6
Switzerland	80.9	80.9	81.2	81.4	81.6	81.7	81.9	
United Kingdom	78.5	78.8	78.9	79.1	79.2	79.4	79.5	

Source: OECD (1999)

Table 25: Life Expectancy, Males at Birth

	1990	1991	1992	1993	1994	1995	1996	1997
France	72.7	72.9	73.2	73.3	73.7	73.9	74.2	74.6
Germany	72.7	72.2	72.6	72.7	73.0	73.3	73.6	74.1
Netherlands	73.8	74.1	74.3	74	74.6	74.6	74.7	75.2
Switzerland	74.0	74.1	74.3	74.7	75.1	75.3	75.7	
United Kingdom	72.9	73.2	73.4	73.7	73.9	74.1	74.3	

Source: OECD (1999)

8.3.2 Mortality

Table 26: All Causes, Deaths per 100 000 Population

	1990	1991	1992	1993	1994	1995	1996	1997
France	649.97	640.12	626.44	625.55	601.51	599.77		
Germany	766.77	789.89	759.43	759.63	738.56	724.63	712.32	687.48
Netherlands	714.88	707.54	695.01	722.68	690.47	690.15		
Switzerland	673.54	652.28	635.88	624.00	607.20			
United Kingdom	786.87	777.04	753.76	770.59	731.44	738.74	720.58	706.13

Source: OECD (1999)

Table 27: Infant Mortality, Deaths per 1000 Live Births

	1990	1991	1992	1993	1994	1995	1996	1997
France	7.3	7.3	6.8	6.5	5.9	4.9	4.8	4.8
Germany	7.0	6.9	6.2	5.8	5.6	5.3	5.0	4.8
Netherlands	7.1	6.5	6.3	6.3	5.7	5.5	5.7	
Switzerland	6.8	6.2	6.4	5.6	5.1	5.0	4.7	
United Kingdom	7.9	7.4	6.6	6.4	6.2	6.0	6.1	5.9

Source: OECD (1999)

Table 28: Maternal Mortality, Deaths per 100 000 Live Births

	1990	1991	1992	1993	1994	1995	1996	1997
France	10.4	11.9	12.9	9.3	11.7	9.5	12.0	
Germany	7.3	8.7	6.7	5.5	5.2	5.4	6.4	6.0
Netherlands	7.6	6.0	7.1	8.2	6.1	7.4	13.2	
Switzerland	6.0	1.2	4.6	6.0	3.6	8.5		
United Kingdom	8.0	7.0	7.0	6.0	8.0	7.0	7.0	6.0

Source: OECD (1999)

Table 29: Potential Years of Life Lost, All Causes, Under 70 Years per 100 000 Population

	1990	1991	1992	1993	1994	1995	1996	1997
France	5142	5143	4987	4905	4742	4580		
Germany	4790	5027	4775	4671	4537	4441	4316	4164
Netherlands	4178	4066	3976	4001	3802	3757		
Switzerland	4644	4661	4480	4256	4179			
United Kingdom	4709	4557	4306	4261	4109	4110	4053	3951

Source: OECD (1999)

8.3.3 Morbidity

Table 30: Low Birthweight, Percentage of Total Live Births

	1990	1991	1992	1993	1994	1995	1996	1997
France	5.3	5.7	5.8	5.8	5.9	5.8	5.8	6.2
Germany	5.7	5.8	5.8	5.8	6.0	6.1	6.1	6.2
Netherlands	4.9	4.9	4.9					
Switzerland	5.1	5.2	5.2	5.3	5.2	5.5	5.7	
United Kingdom	6.7	6.8	6.7	6.8	6.9	7.2	7.2	7.4

Source: OECD (1999)

Table 31: Down's Syndrome, Rate per 10 000 Births

	1990	1991	1992	1993	1994	1995	1996	1997
France	13.4	13.5	10.1	10.3	9.6	7.0	10.4	
Germany					7.9	7.4	7.2	
Netherlands	11.2	13.1	13.1	11.3	10.4	16.7	18.0	
Switzerland	13.0	8.4	12.2	14.9	12.5			
United Kingdom	5.9	6.3	5.7	4.6	4.7	4.8	4.9	4.4

Source: OECD (1999)

Table 32: Aids Incidence per Million Population

	1990	1991	1992	1993	1994	1995	1996	1997
France	74.2	79.5	88.2	93.4	96.7	88.2	66.4	37.6
Germany	23.0	21.0	22.5	23.5	23.5	20.8	17.1	10.6
Netherlands	28.0	29.6	33.7	31.0	31.1	33.9	28.2	20.9
Switzerland	97.0	85.4	101.7	93.7	95.1	81.6	71.4	52.6
United Kingdom	22.0	24.0	27.2	30.7	31.7	29.9	24.1	18.7

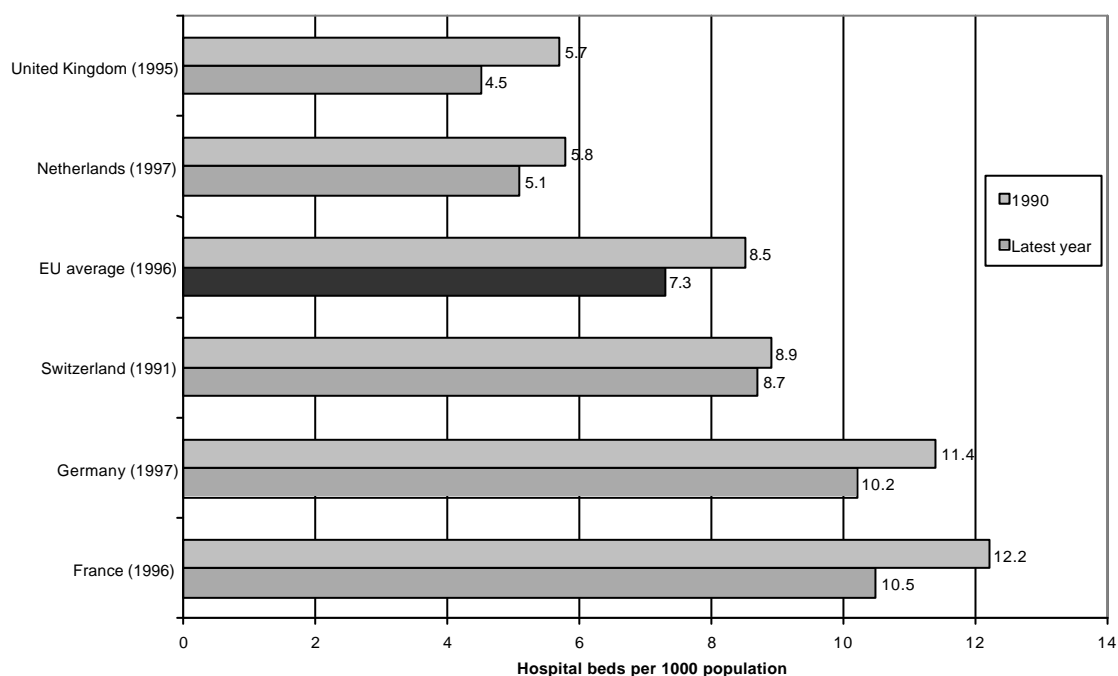
Source: OECD (1999)

Table 33: Road Traffic Accidents, Injured Per Million Population

	1990	1991	1992	1993	1994	1995	1996	1997
France	3981	3610	3463	3286	3116	3120	3058	3024
Germany	7085	6320	6412	6228	6342	6281	6028	6110
Netherlands	3572	3230	3267	3193	3279	3383	3193	3143
Switzerland	4303	4109	4131	4036	4268	4170	3835	
United Kingdom	6125	5558	5546	5446	5767	5658	5826	5934

Source: OECD (1999)

8.4 Healthcare resources

Figure 1: Hospital Beds per 1000 Population, 1990 and Latest Available Year

Source: WHO (1999b)

Table 34: Inpatient Care Beds per 1000 Population

	1990	1991	1992	1993	1994	1995	1996	1997
France	9.7	9.6	9.4	9.2	9.0	8.9	8.7	8.5
Germany	10.4	10.1	9.9	9.7	9.7	9.7	9.6	9.4
Netherlands	11.5	11.4	11.4	11.3	11.3	11.3	11.3	11.5
Switzerland		20.8						
United Kingdom	5.9	5.6	5.4	5.1	4.9	4.7	4.5	

Source: OECD (1999)

Table 35: Magnetic Resonance Imaging Units per Million Population

	1990	1991	1992	1993	1994	1995	1996	1997
France	0.8	1.1	1.2	1.4	1.9	2.1	2.3	2.5
Germany	1.9	2.0	2.6	3.6	4.1	4.8	5.7	6.2
Netherlands	0.9	1.3	1.8	2.5		3.9		
Switzerland	3.8			7.5				
United Kingdom	1.0	1.1	1.4	2.3		3.4		

Source: OECD (1999)

Table 36: General Practitioners per 1000 Population

	1990	1991	1992	1993	1994	1995	1996	1997
France	1.4	1.4	1.4	1.4	1.4	1.5	1.5	1.5
Germany	1.2	1.1	1.1	1.1	1.1	1.1	1.1	1.0
Netherlands	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.5
Switzerland	0.6	0.6	0.6	0.6	0.6			
United Kingdom	0.6	0.6	0.6	0.6	0.6	0.6	0.6	

Source: OECD (1999)

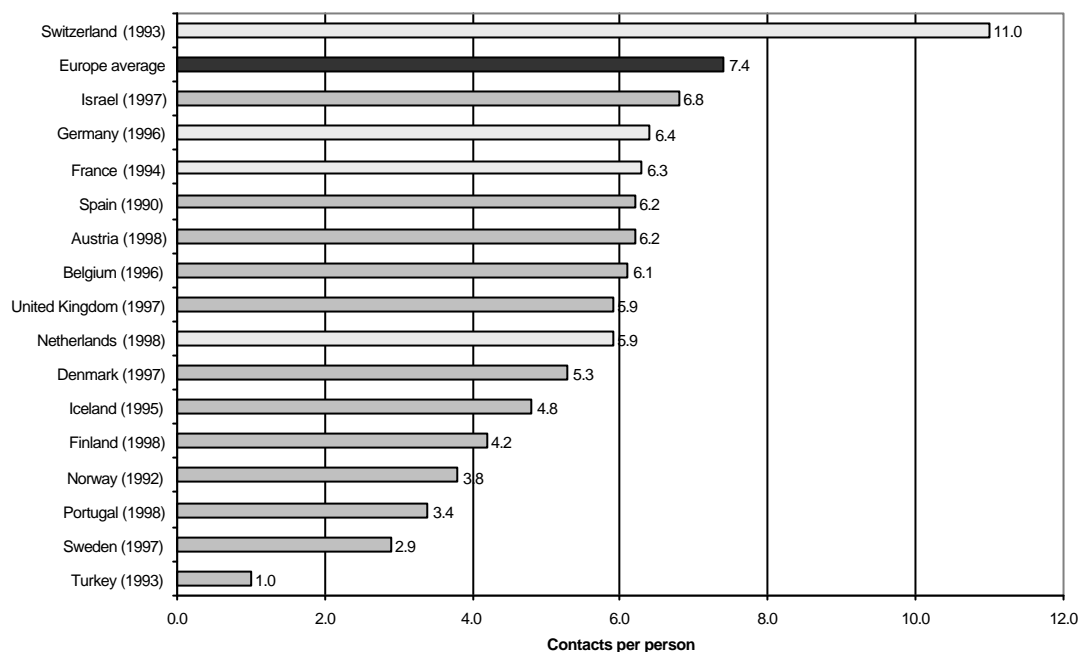
Table 37: Certified Registered and Practising Nurses per 1000 Population

	1990	1991	1992	1993	1994	1995	1996	1997
France	5.4	5.4	5.5	5.7	5.8	5.9	5.9	5.9
Germany		8.9		8.7		9.0	9.5	9.5
Netherlands								9.0
Switzerland	13.8							
United Kingdom	5.2	5.2	5.2	5.1	5.0	5.0	4.5	

Source: OECD (1999)

8.5 Healthcare utilisation

Figure 2: Physicians' Contacts per Person in the WHO European Region, Latest Available Year



Source: WHO (1999b)

Table 38: Average Length of Stay Inpatient Care, Days

	1990	1991	1992	1993	1994	1995	1996	1997
France	13	12	12	12	12	11	11	11
Germany	17	16	16		15	14	14	13
Netherlands	34	34	34	33	33	33	33	32
Switzerland	20				17	17	-	13
United Kingdom	16	14	12	10	10	10	10	

Source: OECD (1999)

Table 39: Average Length of Stay Acute Care, Days

	1990	1991	1992	1993	1994	1995	1996	1997
France	7	7	7	6	6	6	6	6
Germany	14	13	13	12	12	11	11	10
Netherlands	11	11	11	10	10	10	10	9
Switzerland	13	13	12	12	12	12	12	
United Kingdom	6	5	5	5	5	5	5	

Source: OECD (1999)

Table 40: Inpatient Utilisation in the WHO European Region, 1997 or Latest Available Year

	Hospital beds per 1000 population	Admissions per 100 population	Average length of stay (days)	Occupancy rate (%)
Austria	9.2 ^a	25.1 ^a	10.5 ^a	75.1 ^a
Belgium	7.3 ^a	20.0 ^a	11.3 ^a	81.4 ^b
Denmark	4.7 ^a	19.8 ^b	7.3 ^a	79.1 ^b
Finland	9.3 ^b	26.7	11.0	74.0
France	10.5 ^a	22.8 ^b	11.2 ^a	75.0
Germany	10.2	-	14.3 ^a	79.8 ^a
Greece	5.5 ^a	15.0 ^b	8.2 ^a	-
Iceland	10.8 ^d	28.0 ^c	16.8 ^d	70.3 ^f
Ireland	3.7 ^a	15.1 ^a	7.5 ^a	82.3 ^a
Israel	6.1	19.0	13.0	93.0
Italy	6.1 ^a	17.5 ^a	9.4 ^a	77.4 ^a
Luxembourg	11.0 ^c	19.4 ^c	15.3 ^a	74.3 ^c
Netherlands	5.1	9.8	13.8	64.4
Norway	13.5 ^c	15.3 ^a	9.9 ^a	81.1 ^a
Portugal	4.1	11.8	9.3	70.1
Spain	4.3 ^a	10.0 ^a	11.0 ^a	73.9 ^c
Sweden	5.6 ^a	18.0 ^a	7.5 ^a	81.9 ^a
Switzerland	8.7 ^e	15.0 ^c	24.5 ^f	77.7 ^c
Turkey	2.5	6.9	6.1	57.7
United Kingdom	4.5 ^b	23.1 ^a	9.8 ^a	76.2 ^g

Note: ^a1996, ^b1995, ^c1994, ^d1992, ^e1991, ^f1989, ^g1986.

Source: WHO (1999b)

8.6 Expenditure on health

Table 41: Total Expenditure on Health as Percentage of GDP

	1990	1991	1992	1993	1994	1995	1996	1997
France	8.9	9.1	9.4	9.8	9.7	9.8	9.8	9.6
Germany	8.7	9.4	9.9	9.9	10.0	10.4	10.8	10.7
Netherlands	8.3	8.6	8.8	9.0	8.8	8.8	8.7	8.5
Switzerland	8.3	8.9	9.3	9.4	9.5	9.6	10.1	10.0
United Kingdom	6.0	6.5	6.9	6.9	6.9	6.9	6.9	6.8

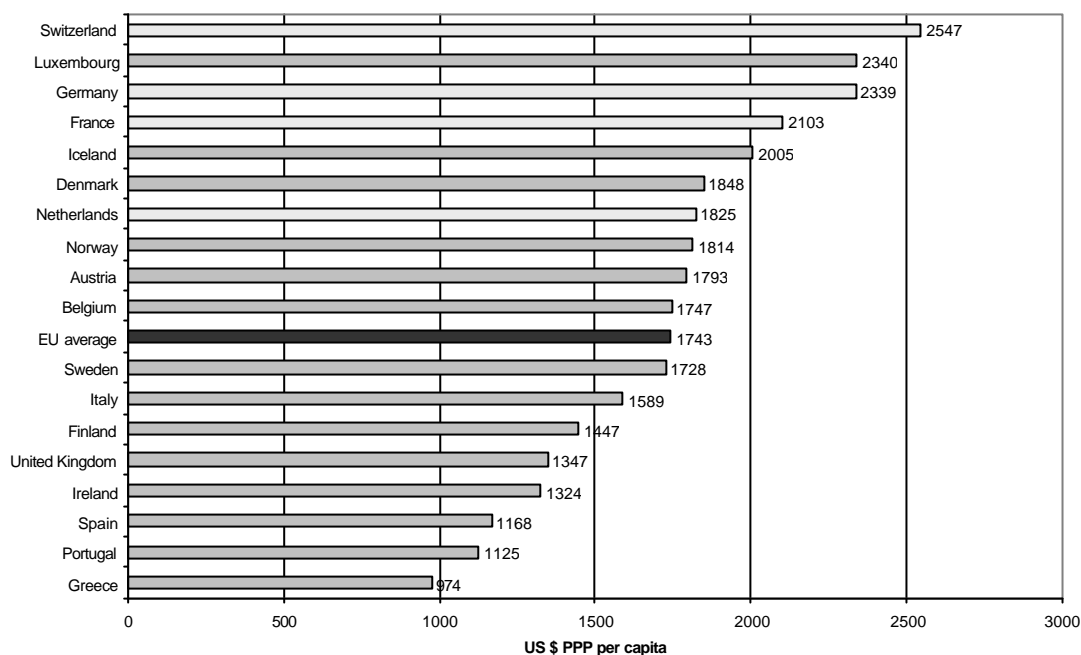
Source: OECD (1999)

Table 42: Public Expenditure on Health Per Capita, US\$ PPP

	1990	1991	1992	1993	1994	1995	1996	1997
France	1146	1234	1333	1365	1384	1474	1491	1520
Germany	1221	1250	1434	1424	1529	1701	1792	1822
Netherlands	964	1050	1189	1252	1282	1366	1310	1404
Switzerland	1204	1344	1498	1589	1653	1781	1783	1825
United Kingdom	804	842	973	987	1021	1057	1148	1177

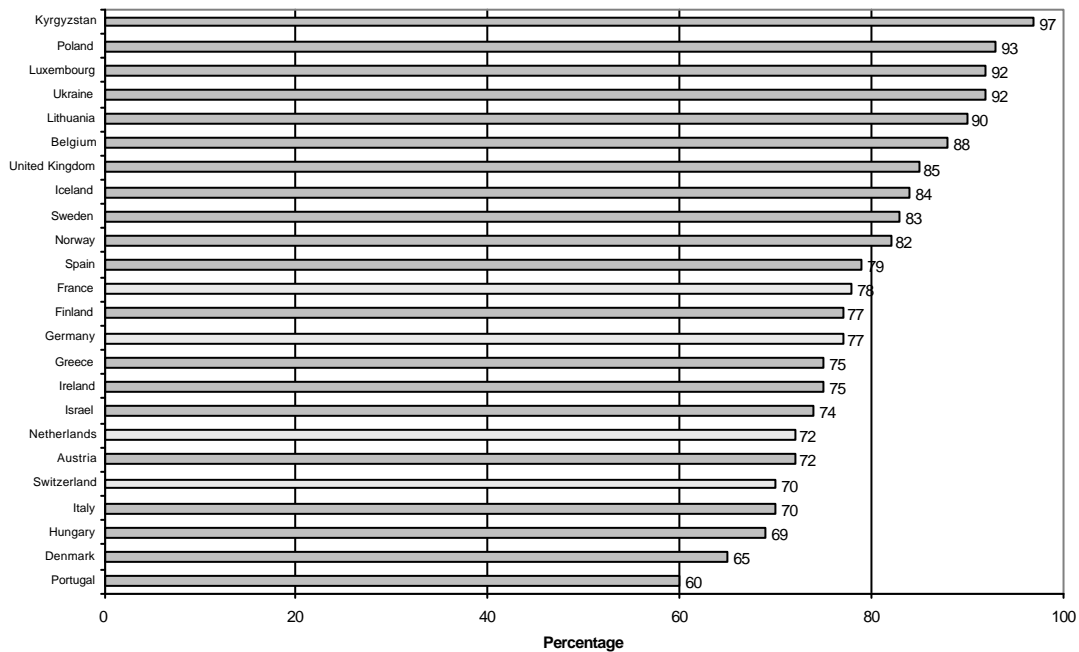
Source: OECD (1999)

Figure 3: Health Care Expenditure in US\$ PPP Per Capita In the WHO European Region, 1997



Source: WHO (1999b)

FIGURE 4: PUBLIC HEALTH EXPENDITURE AS PERCENTAGE OF TOTAL HEALTH EXPENDITURE IN WHO EUROPEAN REGION, 1997



Source: WHO (1999b)

8.7 Financing

Table 43: Private for Profit Insurance Payments, Million US\$ PPP

	1990	1991	1992	1993	1994	1995	1996
France	2148	2412	2757	2892	3066	3112	3288
Germany	7321	8263	9412	10026	10922	11837	12759
Netherlands	2542					3922	
Switzerland	216	165	192	202	209	174	171
United Kingdom	1833	1986	2339	2392	2475	2577	

Source: OECD (1999)

Table 44: Out of Pocket Payments, Million US\$ PPP

	1990	1991	1992	1993	1994	1995	1996	1997
France			13418	14058	13982	14606	14709	
Germany	11278	13823	15806	16983	18303	19270		
Netherlands								
Switzerland	3479	3865			4851	5179		
United Kingdom	1890	1944	2134	2106	2089	1964		

Source: OECD (1999)

Table 45: Territorial Government Financing, Million US\$ PPP

	1990	1991	1992	1993	1994	1995	1996
France	3532	3698	3967	4017	4173	4489	4562
Germany	10955	14444	16605	17275	17096	17778	
Switzerland			2712	2640	2596	2744	2764
United Kingdom	43447	45921	54767	56248	58098	61688	

Source: OECD (1999)

8.8 Social protection

Table 46: Public Expenditure on Sickness Benefit, Per Capita, US\$ PPP

	1990	1991	1992	1993	1994	1995	1996
France	96	103	111	110	109	110	
Germany	73	73	82	83	92	102	
Netherlands	480	474	488	493	395	404	411
Switzerland	53	58	62	63	67	72	
United Kingdom	59	35	43	42	34	35	

Source: OECD (1999)

Table 47: Social Expenditure on Housing Benefits, Per Capita US\$ PPP

	1990	1991	1992	1993	1994	1995	1996
France	131	140	152	166	175	186	
Germany	26	25	36	34	31	32	
Netherlands	54	59	59	59	59	66	71
Switzerland	18	18	24	25	24	24	
United Kingdom	209	197	269	305	329	341	

Source: OECD (1999)

Table 48: Social Expenditure on Unemployment, per Capita US \$ PPP

	1990	1991	1992	1993	1994	1995	1996
France	324	353	382	394	376	363	
Germany	202	307	361	478	497	497	
Netherlands	406	417	455	527	605	620	610
Switzerland	28	78	215	382	341	294	
United Kingdom	107	163	217	207	185	164	

Source: OECD (1999)

Table 49: Disability Cash Benefits, Per Capita US\$ PPP

	1990	1991	1992	1993	1994	1995	1996
France	183	192	204	205	207	218	
Germany	150	148	167	182	198	228	
Netherlands	768	802	843	843	803	821	775
Switzerland	193	209	238	273	295	329	
United Kingdom	264	308	387	451	481	486	

Source: OECD (1999)

Table 50: Cost Sharing Total Health Care, Billing Mean Co-Payment, Percentage

	1990	1991	1992	1993	1994	1995	1996	1997
France	75	75	74	74	74	74	73	73
Germany	92	92	91	91	91	91	91	91
Netherlands	73	74	77	78	77	77	72	76
Switzerland	91	91	90	90	90	90	90	90
United Kingdom	93	93	93	93	93	93	93	93

Source: OECD (1999)