

*Sophia Schlette, Kerstin Blum,
Reinhard Busse (eds.)*

Health Policy Developments 9

Focus on Mental Health,
New Role for Hospitals,
Search for the Right Funding Mix

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Responsible: *Sophia Schlette*

Copy editor: *Celia Bohannon*

Production editor: *Christiane Raffel*

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Introduction

Dear Reader,

Issue nine of *Health Policy Developments* is not so much about big schemes as about pragmatic approaches to overcoming known deficits in health care. A look at health policy around the globe shows a new realism emerging in many places. Instead of debating underlying principles along the traditional lines of ideological conflict, efforts are being made to tackle the objectives that appear achievable, using methods that are feasible—often following the example of other countries’ “beacons of excellence.” After all, the priority objectives are often the same, with the focus on more coordination, more transparency, and more incentives to ensure quality and cost-effectiveness. So why shouldn’t good solutions be exported, adopted by other countries and adapted to their systems?

One area of health care that is benefiting from the new pragmatism and the overcoming of old prejudices is care for the mentally ill. In many countries, mental health care had for a long time suffered from the attached stigma and the fact that it was not properly linked to the rest of the system. Now, numerous countries are restructuring their mental health care and making it patient-centered. The funding provided is currently not sufficient to cover the wide range of mental illnesses, nor are all the reforms based on a coherent strategy. Nonetheless, here too, countries such as Australia and Israel are showing how care can be improved through small but effective changes. Australia, for instance, has recently introduced personal “coordinators” who help integrate the patient into society and ensure they receive appropriate care. Israel trains general practitioners and practice assistants to diagnose mental disorders.

In the area of funding for health systems, a workable balance is being sought between individual and collective responsibility. Irrespective of whether the systems were originally based on high financial risk for individual insurees or a pronounced safety net mentality, the tools being used have become astonishingly similar. They range from co-payments to reimbursements to rewards and penalties. The value-based decisions that originally led to the introduction of one system or another have now become less significant. And so it is only briefly surprising that President George W. Bush is introducing income-dependent premiums for Medicare, while in the Dutch social insurance system community-rated premiums have become much more important since 2006. By contrast, Singapore opted for a mixed system from the outset, combining MediSave (individual savings accounts for acute care), MediShield (insurance for severe and chronic illnesses) and MediFund (a safety net for destitute patients), and makes adjustments whenever undesired side effects occur or false incentives for patients develop.

In line with the pragmatism outlined here, we hope the reports selected for this book will provide input for the health policy debate. As always, information has been drawn from the reports produced by the experts of the International Network for Health Policy and Reform. This issue presents the results of the ninth biannual survey, which covered the period from October 2006 to April 2007. Of the 69 reforms reported, we selected 24 for this publication.

Since issue five of *Health Policy Developments*, we have concentrated on providing a transnational analysis of reform developments. Each chapter deals with a separate subject and begins with an introduction that summarizes common and opposing trends around the world. The reader thus has a better idea of where the reform developments in individual countries reported on in the remainder of the chapter fit into the overall picture.

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Authors: Ain Aaviksoo, Tit Albrecht, Gerard Anderson, Rob Anderson, Toni Ashton, Sylvie Azogui, Gabi Bennun, Shuli Brammli-Greenberg, Elena Conis, Luca Crivelli, Kristina Das, Kees van Gool, Revital Gross, Marion Haas, Maria M. Hofmarcher, Agris Koppel, Hans Maarse, Tom McIntosh, Carol Medlin, Lim Meng Kin, Adam Oliver, Zeynep Or, Tanaz Petigara, Thierry Rochereau, Gerald Röhrling, Lauri Vuorenkoski, Dominik Walch, Erja Wiili-Peltola and Włodzimierz Cezary Włodarczyk.

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Comments and suggestions regarding issue nine of *Health Policy Developments* are very welcome and can be addressed to the editors. We will be glad to receive any suggestions for improvements.

Sophia Schlette, Kerstin Blum, Reinhard Busse

Health policy: More pragmatism, less debate on underlying principles

Around the globe, health care is becoming one of the most important political issues. In the U.S. presidential campaign (with a worldwide audience of onlookers), the only other subject being so hotly debated is the war on Iraq. In Germany, the grand coalition's "health care compromise" has triggered a lively and well-informed response, though the media's reaction has mostly been negative.

The global trend, however, is not one of major, visionary reform or irreversible policy decisions. The nature of the developments—coupled with the familiar political compromises that are often considered unsatisfactory—means that the steps taken seem small and are perceived as ambivalent or even contradictory, and that, at first glance, it is impossible to see the forest for the trees. The revolutionary aspect of the current trend is not that it has led to resounding success, but rather how numerous small steps have accumulated to create a new quality in health care policy.

Although the debates in the United States and Germany, in Canada and New Zealand and even in countries as different as Estonia and Singapore relate to very different circumstances, the goals being pursued all over the world are becoming more and more similar. As they do so, debates on underlying principles are becoming less significant—principles concerning, for instance, whether illness is an individual risk by nature or whether the risk needs to be borne collectively, or whether a health care system can be better financed by insurance contributions or by tax revenues.

Instead, the new discussion on health is characterized by pragmatism and a multiplicity of methods. Under the pressure of the problems confronting them, the different systems are essen-

**Pragmatism and
multiple methods**

tially becoming more similar—a development that is making ideological lines seem less important. Even in the “individualistic” United States, people are realizing that health care services cannot be financed exclusively by private means. Europe, on the other hand, a “collectivist” continent in American eyes, is developing an increasing interest in the coordination and innovation achievements of certain “beacons of excellence” in the U.S. system.

Goal: combine advantages of all systems

This pragmatism and multiplicity of methods should not be confused with indifference or a lack of direction. Today, eagerness is geared to the goals, not the tools. What gives a system legitimacy is not its beauty or consistency, but its efficiency in terms of how it meets the needs of those who pay for it and wish to benefit from it. A country like Germany may well feel vindicated by the U.S. debate and proud that its old, still functioning insurance system is being copied by transition countries and carefully studied by the particularly liberal western states. But those are triumphs of no worth in the new health care debate.

The point is that simply choosing a system is not enough to answer today’s pressing questions—such as “How can we prevent patients from losing their way in a labyrinthine system and consuming services arbitrarily and without any advantage, instead of regaining their health?” or “How can we get competing service providers to work together for the good of the patient?” At the cutting edge will be the system that provides the best combination of the advantages of all the systems: precise allocation of resources and service orientation, medical excellence and wide-scale prevention, fairness and individual freedom of choice.

Initial results of the Dutch health care reform

In 2006, the Netherlands launched a comprehensive reform of the health care system in an attempt to contain health care costs and create incentives for more quality by facilitating more competition both among insurers and service providers. After having been discussed for 30 years before actually being introduced (see *Health Policy Developments 7/8*, p. 23), the implementation of the new health insurance system is now also proceeding at a slower than planned rate. The new coalition that came to power after the change in government in February 2007 is hesitant to carry out the planned steps towards liberalized financing and remuneration and is concerned about the negative impacts that might

occur if the market becomes too free. Nonetheless, the reform has already produced some positive results—in particular, the strengthened position of insurees. The Netherlands appears to have moved one step closer to the goal of patients being active, informed “clients” (see the report from the Netherlands, p. 16).

In the United States, the ever-widening gaps in the insurance system are not only resulting in an ever smaller portion of the population financing a system that has to be shared with an ever larger number of “freeloaders.” The gaps are also pushing up the overall cost of health care to the national economy, since people without insurance tend to wait until the very last moment before consulting a physician and they are not included in many of the prevention programs.

It now seems that there is a universal desire to plug the gaps—though admittedly the dispute about how that is to be done is all the more bitter (see the report on the United States, p. 19). While (most) Republicans maintain that insurance coverage is an individual responsibility and would like to subsidize private insurance, many Democrats advocate an approach whereby the responsibility would be placed on employers. The old lines of ideological conflict can thus still be clearly seen in the current dispute.

On the other hand, the initiatives launched by some U.S. states illustrate the extent to which the problems are forcing them to take action; regional developments are beginning to move faster than the debate. Even in Republican-led California, decreasing numbers of insurees are compelling the state to involve employers in the financing of a health insurance pool for low earners.

The most important problem group (not only in California) is the large number of “working poor.” They earn too little to afford insurance but too much to benefit from state support programs. Employers who offer precarious conditions of employment are not exactly interested in providing health insurance for their employees.

Paradoxically, it is precisely the patchy, fragmented U.S. health-care system—with its private health insurers and state programs (both in the private and the public sector), wide range of commercial providers and federal structure—which is generating new tools that are also of interest for European states with central, hierarchically organized systems that are rationally structured

Coverage gaps in the United States

Insurance coverage: An individual or community responsibility?

And ... action!

Of blemishes and beacons

from start to finish. Where health care is a maze to negotiate, any attempt to tidy it up by making minor adjustments to the system is doomed. The only remedy is to devise unbureaucratic solutions that bring all of the stakeholders to the table to discuss current problems.

Cooperation between various sectors is easier to achieve if none of them can claim the right to provide services for an entire section of the population or throughout an entire area of care. However, if a system has a mandate to ensure universal health care coverage (as is the case in many European countries), it is less than likely to want to cooperate with other systems intended to complement it.

**Austria: More
patient proximity**

In the Austrian system, the majority of hospitals are state-run (and, incidentally, also play a significant role in care), there is a national insurance scheme, and health insurance is provided through almost monopolistic regional health insurance funds. Austria's system is based on a simple, logical concept and, like its kin, displays a surprising lack of interdisciplinary and inter-sector collaboration.

Attempts to establish new forms of cooperation are thus correspondingly sluggish. "Reform pools" are now being set up at the federal-state level (see also *Health Policy Developments* 7/8, p. 32). Shortcomings in health care services, most of them minor, are no longer fixed by perfecting the system but are now seen as a task to be performed jointly by authorities, health insurers and care providers. The federal states, whose populations range between 260,000 and 1.4 million and are therefore no larger than cities in other countries, are appropriately sized units for ensuring patient proximity. Tasks are being redistributed on two fronts: hospital financing is to be centralized and the benefit baskets offered by the federal states' insurance funds are to be harmonized.

**Fixing interface
problems at
federal-state level**

"Think globally, act locally"—the motto of the new health care debate no longer sounds paradoxical, even in a system like Austria's. Outlines of the problems at the federal state level show that, there too, plenty of gaps still urgently need filling. The inter-sector initiatives in Austria are concentrating on the interfaces between the systems; the focus is on inpatient discharges, cooperation between hospitals and providers of care, patient empowerment and integrated care for the chronically ill (see report from Austria, p. 26).

With its extremely federal structure, Canada has de facto 13 different health care systems—one for each of the provinces and territories. Traditionally, Ontario, which includes Toronto and the surrounding area (where 40 percent of the Canadian population lives) has led the way. Consequently, the thorough dialogue between physicians, other health care professionals, health insurers and government representatives which took place there is no less significant than a dialogue at the national level would be.

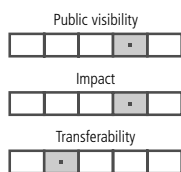
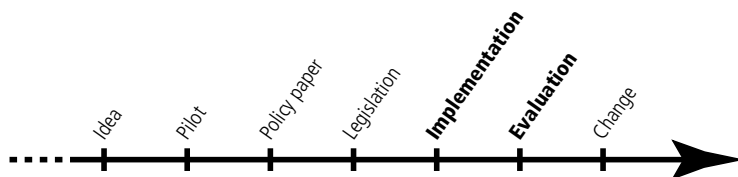
Canada: Dialogue and a patient-centered approach

At the heart of the reform proposals drawn up by the participants was interdisciplinary cooperation. So there is also a softening of rigid system boundaries, represented in Ontario primarily by the controlling and dominating role of physicians. It has become clear that a modern health care system no longer bases decisions purely on the expertise and authority of one professional group. Instead, it is geared to the needs of the patient, the consumer—needs that are often difficult to predict but more important than the system's organizational aspects (see the report from Canada, p. 32).

Health Impact Assessments of the type New Zealand is planning to introduce (the 16th country to do so) are truly paradigmatic of an interdisciplinary approach to health in the society of the future. Health Impact Assessments leave no doubt that health care is a task to be performed jointly by society and the political sphere, no longer assigned to just one specific sector (see the report from New Zealand, p. 34).

New Zealand: Establishing health care as a task for society as a whole

The Netherlands: Health insurance reform 2006—results so far



**More market,
more freedom of
choice, more
negotiating room**

**Reform already
having notable
impact**

**More
“Independent
Treatment Centers”
in hospitals**

The reform of the Netherland health care system was launched in order to improve care by making it more efficient, demand-driven and innovative and by raising quality. The reform sought to achieve these aims by establishing a market and competition, creating more room for direct price negotiations between insurers and providers, giving consumers more freedom of choice and introducing public reporting of hospital rankings. The various stages of this major reform project are described in detail in *Health Policy Developments 7/8*, p. 25.

The reform has indeed had an impact during its first year. By the end of 2006, supported by new platforms providing information on the services and quality of insurers and providers (e.g., www.kiesbeter.nl), 18 percent of the insured had already taken advantage of the new freedom to change insurer. In most cases, they switched from an individual policy to a group policy; the share of insured persons covered by a collective group contract rose from 44 percent in 2006 to 57 percent in 2007. Before the reform, group policies were possible only for employers seeking to insure their employees collectively; but now any grouping, be it a trade union, a pensioners’ organization or a patients’ organization, can take out joint insurance, enabling them to reduce their premiums by an average of 7 percent. However, it is not yet possible to measure how the reform has affected the quality of health care provision.

As intended, more Independent Treatment Centers have been set up in hospitals, particularly for ophthalmology, dermatology, mother and child care, orthopedic surgery and cosmetic surgery. The price of the “diagnosis treatment combinations” (the Dutch equivalent of DRGs), which hospitals use as the basis for billing health insurers, has dropped by 0.8 percent. Waiting times for elective care have decreased significantly.

Despite these positive developments, there have also been a few difficulties. Insurers were quick to leap into the competition ring—and overshot the mark to start with. In 2006, the average income-independent community-rated insurance premium was only €1,028 per year: to compete in the tough price war, insurers were offering premiums which did not cover their costs. As a result, the average premium increased again in 2007 by around 7 percent to €1,103. And, finally, there is a risk that the number of uninsured persons (currently 1.5 percent of the population) will climb now that health insurers are allowed to drop defaulting payers, creating a potential problem for the legal provision of universal coverage.

In other areas, the future of this major reform is again unclear. The health remit *did* remain in the hands of the Christian Democrats (already a coalition partner before) after the change of government in February 2007. Nonetheless, it is expected that the reform will slow down and be altered now that the conservative-liberal VVD has left the government and been replaced by the Labour Party and the Christian Union.

At the same time, criticism of certain provisions in the reform package is beginning to emerge. Some hospitals, for instance, have put major projects on hold or announced plans to do so—for fear of new rules regarding the amortization and depreciation of their investments. Health insurers and the national patients’ association, on the other hand, still fully support the reform, which permits more competition between insurers and between providers.

Many decisions regarding the reform’s implementation have not yet actually been made. For instance, a revision of the hospital payment system is pending. Currently, insurers pay the hospitals for their services on the basis of “diagnosis treatment combinations,” highly differentiated case fees, of which there are almost 30,000. With the payment system considered too complicated, price negotiations between hospitals and health insurers cannot get underway until it has been revised and simplified.

It is also unclear how many hospital services will be negotiable between insurers and hospitals. Right now, 92 percent of diagnosis treatment combinations are still subject to government price regulation; only 8 percent are negotiable. The latter include cataract surgery, orthopedic surgery, hernia/adenoid operations and

Benefits increasingly being sold under value

Change of government delaying implementation of reform

Criticism of reform package beginning to emerge

2008: Decisions on implementation

How many prices are to be negotiable?

tonsillectomies, diabetes care and a number of other services. The previous government intended to expand the share of negotiable diagnosis treatment combinations to 70 percent before the end of 2008. The new government feels that an increase to just 20 percent in the year is plenty.

**More planning
autonomy for
hospitals—but
how much more?**

The previous system of hospital planning, in which the Netherlands government was responsible for planning capacity, was abolished as of 1 January 2007 in order to boost competition in the hospital sector too. A new law defining the framework for contracts between insurers and service providers now grants hospitals considerable autonomy with regard to planning and investment. However, the government still has what might be termed a “right of veto”: if it feels that universal access to adequate hospital care is being jeopardized, it can reclaim the power to make capacity-planning decisions. It also retains the authority to make decisions concerning purchases of high-tech equipment and other particularly large investments. Thus, all in all, it is not yet clear how much planning autonomy hospitals will really have in practice.

**Freedom to take
out loans—
controversial issue**

Whether hospitals should have as much freedom to take out loans as the reform law actually intended is also the subject of controversy. The law stipulated that the extent to which hospitals would be able to take out loans would be turnover-dependent. This would mean new risks both for hospitals and for private investors and banks since, for example, hospitals might go bankrupt. The new government, on the other hand, intends to at least include a safety net; however, there is as yet no clear strategy.

In accordance with the reform law, hospitals would also have been allowed to make a profit as of 2012. This was a core element of the law because hospitals cannot acquire capital from the market if they cannot expect to make a profit. But the new government is in no hurry on this point: first of all, the new billing system has to prove its worth. There is also a fear that capacity created with public money will now be placed in private hands. But, here too, the government’s position remains uncertain.

Eight months after the formation of the new government, the future of the reform was not yet clear. Crucial decisions are expected in 2008.

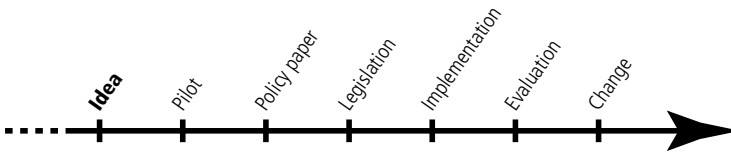
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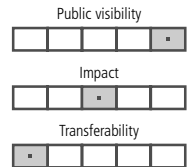
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United States: Filling the gaps—solutions instead of ideology



Though U.S. citizens spend more per capita on health than any other nation, 47 million have no health insurance coverage. It is no longer just politicians from the Democratic Party, but also many conservatives and employers, who feel that these major gaps in the health insurance system are the biggest health care problem confronting the United States.

Most people in the United States *are* covered against the financial risk of illness in some way. U.S. citizens above the age of 65 and disabled persons are covered by the Medicare insurance system, which is half financed by employer contributions and half by employee contributions—like the much older German social insurance system. However, as is typical of a social insurance system, Medicare beneficiaries only gain access if they have paid in for at least 10 years. People under age 65 receive care from a variety of sources. For 61 percent of the population under age 65, this means private health insurance through their employer. An additional 5 percent of Americans are self-insured and 13 percent are covered by one of a variety of public programs. The larg-



Gaps remain despite a range of insurance systems

est and best-known programs administered by the states are the tax-funded Medicaid for the poor and the State Children's Health Insurance Program (S-CHIP). There is also the program run by the Veterans Health Care Administration (VHA).

**Three routes to
universal insurance
coverage**

That leaves the above-mentioned 47 million citizens who have no insurance coverage—a figure which Americans interested in politics can quote by heart. It represents those who have been uninsured for longer than one year. If one includes all people who had either no insurance, sporadic coverage, or insurance coverage that exposed them to high health care costs, the number of uninsured increases to more than 60 million. And since the uninsured are constantly growing in number, fewer and fewer insured persons are paying ever-increasing premiums. The need for action is so evident that even neoliberal economists are proposing solutions. There is little disagreement concerning the need to drastically reduce the figure—the argument is about *how* to do it. Essentially, three potential routes are being contemplated, though they usually appear in combination in the political programs:

**Expansion of
public programs**

– It has been proposed that Medicaid and S-CHIP eligibility be expanded to include more low earners. Another idea put forward is to open up the Medicare program to all Americans so as to create a comprehensive health insurance system akin to the European model (“Medicare for All”). Another option is a private/public partnership—a plan which the then First Lady and now presidential candidate, Hillary Clinton, failed to implement back in 1992/1993.

**More employer-
sponsored
insurance**

– Other proposals range from providing financial incentives for employers to expand private insurance for their employees, to the creation of group health purchasing initiatives for small companies to increase their negotiating power and risk pool, right through to compulsory contributions to a public fund to be paid by employers who do not insure their employees (“Pay or Play”).

**Subsidization of
individual health
insurance**

– In addition to the above-mentioned conventional, collectivist methods of expanding insurance cover, new insurance strategies are also being devised that emphasize individual responsibility. One idea is that individuals could be given financial support for their private health insurance in the form of tax credits or subsidies (see *Health Policy Developments 1*, p. 61).

Another proposal is tax-free health savings—an approach which involves the individual saving money for treatment he or she might need in the future and being granted tax relief in return.

The question of how the number of insured persons can be permanently increased without increasing health care spending is a cause of dispute between the parties. The legislative proposal put forward by the Bush administration plans a cautious expansion of insurance coverage, driven by incentives and tax credits:

- The Bush administration would like to see small employers form groups in order to be able to take out joint insurance coverage for their employees.
- Premiums for employees insured through their employer would no longer be tax-free.
- Instead, a standard tax deduction would be introduced: Individuals with health insurance would not pay tax on the first \$7,500 of their income and families on the first \$15,000, irrespective of whether the insurance is private or financed by the employer.
- Use of health savings accounts would be promoted.
- The federal government would support states which themselves help individuals purchase private health insurance.

However, the Bush administration has not been able to garner support for its plans in what is now a Democrat-led Congress. The tax-relief strategy is viewed skeptically because it would not provide sufficient resources for most low-income individuals to afford health insurance coverage. The average annual income of a family of four is \$30,000; the average insurance premium for a family of four is \$10,000 and premiums are increasing at a two-digit rate. The tax deduction would be insufficient to cover the cost of health insurance.

The objectives behind the Democrats' ideas go far beyond those behind the Bush administration's proposals. The former senator and (no longer running) presidential candidate John Edwards has suggested, for instance, that employers should be obliged to take out health insurance for their employees or to raise their wages by 6 percent so that they can insure themselves. In addition, he

**Bush proposal:
Unaffordable
for average
earners**

**Democratic
candidate Edwards
looking to put
responsibility on
employers**

has proposed expanding eligibility for Medicaid and S-CHIP. In line with Edwards' plans, regional insurance pools would be created for self-employed persons and small employers with few employees: Companies would form groups in order to offer private insurers a high rate of new business and thus to gain more favorably priced premiums. Other mainstream Democratic candidates have different but similar ideas. Some Democrats have proposed allowing low wage earners and young, uninsured employees to purchase insurance themselves by granting them tax credits or subsidies. Massachusetts has led the way with this approach—in 2006, after years of debate, the state's Democrats and Republicans agreed on a similar combination of group insurance and individual compulsory insurance (see *Health Policy Developments* 7/8, p. 105).

Hundred-year-old debate

The U.S. debate on universal health insurance started one hundred years ago, when the idea was first proposed by President Theodore Roosevelt (1901–1909). New waves of the debate arose in the 1930s (New Deal), the 50s, 70s and, finally, in the early 1990s under Bush's predecessor, Bill Clinton. This universal coverage resurfaced as a result of the rising number of uninsured persons and continuing increases in health care costs in recent years. Polls show that the majority of Americans support universal health insurance coverage. But, in view of the debate's long history, the political players are not particularly free or flexible. Despite the willingness to cross the boundaries between systems, it is not easy to find support for new arguments if they are too similar to the old arguments of the other side.

Between liberalism and "collectivism"

The question of health insurance has long been a divider of opinion in the United States; it is considered an indicator of people's free-market and liberal thinking. The players involved are thus not taking their new pragmatism lightly and are going to great lengths to avoid being accused of espousing "socialized medicine," "collectivist" or "state interventionist" strategies. On the other hand, merely alluding to American values does not make it clear how the problem is supposed to be solved.

Nonetheless, clear lines of conflict have evolved. The current administration (and with it the majority of Republicans) favors tax subsidies and credits for individuals; the Democratic candidates favor expansion of public programs.

Most health care providers are siding with the Republicans in this conflict. They fear that expansion of public programs could lead to a decrease in their market power and an increase in pricing control. Those who finance the health care system—in the U.S., primarily large employers—are intensively lobbying for market-based reforms and against government-centered and tax-funded solutions. And finally, the patients, insured and uninsured persons are poorly organized and have hardly any bargaining power.

Providers fear more government control and less market power

In recent years, four states have taken the initiative and introduced universal health insurance coverage in order to address increasing health care costs and decreasing numbers of insured persons. They are the New England states of Maine, Massachusetts (see *Health Policy Developments* 7/8, p. 100) and Vermont, with their strong Democratic parliamentary majorities, and, in January 2007, Republican-led California (see *Health Policy Developments* 5, p. 16). Hawaii did this years ago (see *Health Policy Developments* 1, p. 49).

The Californian model has caused quite a stir because California has almost 10 percent of the U.S. population and a high percentage of uninsured persons. America's health care problems are particularly blatant in California. In the past six years, health care costs have climbed by a staggering 64 percent. Some 6.5 million people, 18 percent of California's population, have no health insurance. Three quarters of them live in households in which at least one person has employment. They are part of the "working poor." At the heart of Governor Schwarzenegger's proposal is an incremental expansion of health insurance to cover all Californians, including illegal immigrants. This objective is to be achieved by means of employer mandates and easier access to public programs as well as by reducing the high insurance premiums. He faces opposition to his proposal, particularly in his own Republican Party. Schwarzenegger is one of those pragmatists who, in view of new developments, are not afraid of crossing ideological boundaries.

Does California's governor have the solution?

In the Californian model, employers with more than 10 employees are supposed to contribute 4 percent of their payroll either to insurance for their employees or to a state fund, from which the employees could then purchase insurance. This would

Pay or Play: The employer decides

affect one in five Californian enterprises; the others either already offer health insurance or employ fewer than 10 people. Above all, however, the rule would curb employers' tendency to end health insurance.

During his last period of office, Schwarzenegger is also seeking to expand the Californian Medicaid program, Medi-Cal. People whose income puts them under the Federal Poverty Level (FPL) are to be insured at no cost; those who earn up to 2.5 times the FPL are to pay between 3 and 6 percent of their gross income. In California, the FPL for a family of four is \$20,650 per year, i.e. €15,100. Expanding the program will put a major burden on California's budget. With that said, Schwarzenegger's plans do have a populist touch. After various changes in direction and various new advisers, Schwarzenegger, "the people's governor," has now discovered a topic—health care—with which he will enter the annals of history.

**California: Insurers
must spend
85 percent on care**

But the Schwarzenegger package of measures also contains requirements for health insurers, physicians and hospitals. Of each premium dollar they earn, private health insurers would have to spend 85 cents on patient care. Their premiums would be capped and they would no longer be able to turn away high-risk patients. Physicians and hospitals would face a new levy, which the state would use to purchase reasonably priced insurance for the needy.

This model is popular with the public, especially since the governor has combined his structural reform with a wide-ranging prevention program to tackle diabetes, obesity and smoking. In terms of political support, Schwarzenegger's plans have more backing from the opposition Democrats than from the Republicans. The Democrats actually favored a solution that mandated employers to provide insurance. But when it comes to the goal of insuring all Californians, as far as possible, the Democrats agree with the Republican governor.

**Opposition from
insurers; physicians
divided**

In its current form, the model's primary opponents are the insurance companies. They are fighting to prevent capping and the stipulated earmarking of funds for care and to allow high-risk clients to be rejected—although, in principle, they naturally welcome the expansion of compulsory insurance. Representatives of industry fear that the 4 percent levy could be too much for small

employers to cope with. Physicians are divided: emergency doctors, who deal a lot with uninsured people, are particularly happy about the increase in the Medi-Cal reimbursement rates, while specialists in prosperous areas are afraid of the new levy. Finally, trade union representatives and consumer advocates argue that even sponsored health insurance costing \$1,200 per year per family member is still too expensive for the country's working poor.

In the light of new costs and morbidity numbers, it now appears easier to achieve what arguments based on the concept of justice were unable to in the course of 100 years. Republicans are expressing less opposition to the expansion of universal health insurance or are even actively expanding it themselves. "Fiscal conservatives" are becoming increasingly convinced that even if the risk of illness is considered strictly a personal risk for the individual, if it is not given due attention it will develop into a collective risk. The new pragmatism could therefore help bring about a clear political decision, with broad-based support, in favor of universal insurance cover in California.

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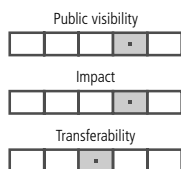
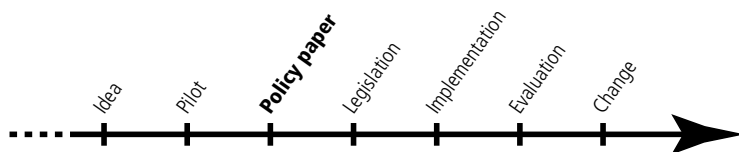
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Austria: More coordination and proximity through federal-state initiatives



Austria's healthcare system has long been fluctuating, as indeed has the entire republic, between a regionalized and a centralized approach. The healthcare program developed by the new federal government (a coalition of the social-democratic SPÖ and the conservative ÖVP) only ventures some cautious adjusting of the balance between the center and the regions. The federal govern-

ment and federal states are to remain key players but their tasks are to be distributed in a more logical way.

In keeping with the tradition of joint decisions, negotiations are to take place concerning a monistic (instead of the current dual) system of hospital financing. In addition, the intention is that health insurers, which mostly operate on a regional basis, should harmonize their benefit baskets. In the past, regional autonomy was always considered an asset because it meant proximity to insurees and contractual freedom for health insurers and providers.

Other powers which, by nature, belong more to the regional level are to be increasingly transferred from the center to the regions. One example is the field of prevention, where the aim is to base activities on the local circumstances in the different areas.

Due to the country's federalist tradition, the financing of its healthcare system is complicated and lacking in transparency. The legal basis for hospital financing is the "Agreement in accordance with Article 15a" (of the Austrian Federal Constitution), which is renegotiated every four years as part of the process of distributing tax revenue between the federal government and the nine federal states. Austria's federal states have hardly any fiscal sovereignty.

The new federal government now wants to introduce centrally coordinated planning and governance of financial flows, to optimize patient care and to evaluate and then harmonize the current resource-allocation structure and the payment and remuneration systems. Integrated healthcare is to be introduced in a legally binding way and may transcend regional and sector boundaries. One example would be outpatient health centers intended to improve specialist care in rural areas—this would be a case of transcending sector boundaries because complex outpatient care is mostly delivered in hospitals in Austria.

In principle, the new government does not wish to change the regional structure of statutory health insurance. Most Austrians are insured with a "Gebietskrankenkasse" (regional health insurance fund), of which there are nine (one for each federal state). Insurance companies for specific professional groups, e.g. farmers or self-employed persons, are rare. There are no plans to grant freedom of choice with regard to one's health insurer, as has

The end of dual hospital financing?

More coordination in financing, patient care and resource allocation

No competition between insurers

been introduced in Germany, the Netherlands and Switzerland. Competition between insurers is thus also not planned. However, the government does intend to simplify the landscape, merge insurers and, above all, harmonize benefit baskets.

The coalition partners have also agreed to realize efficiency gains of €300 million by the end of 2008 and a further €100 million by 2010—with healthcare costs totalling a good €25 billion. As there has been no lack of similar announcements in the past, experts are sceptical. In those cases, there was not even any evaluation of whether such expectations were actually realistic. Combined with cost-containment measures, the efficiency gains are intended to halve the current deficits run up by many insurers. For the other half, premiums are to be raised by 0.15 percentage points.

**Centralized
powers for health
promotion**

While financing and governance take place at the regional level, objectives and intentions are increasingly being formulated at the central level. The Health Promotion Act passed in 1998 (again under a “Grand Coalition”) is also having a centralizing effect. Its aim was to establish prevention, health promotion and public health as the fourth pillar of the healthcare system—alongside curative, rehabilitative and long-term care. In terms of the new “pillar”, the new government now intends to

- issue new rules on smoking in public (see also *Health Policy Developments 7/8*, p. 218),
- develop a nationwide strategy to combat youth drug addiction,
- expand its efforts in the area of public health,
- set up systematic screening programs,
- enhance vaccination programs,
- introduce epidemiology-based prevention and health documentation and
- offer incentives to participate in health programs and have check-ups.

In order to overcome fragmentation, the predecessor government had already created healthcare platforms at the federal-state level, which operate on a “round table” principle, and provided them with a budget (see also *Health Policy Developments 7/8*, p. 32). The aim was that the platforms should initiate projects which, by their nature, required sector boundaries to be transcended. Just two years later, a survey of the federal states showed that the extent to

which this approach is being implemented varies considerably. While a few federal states rapidly identified an entire range of projects, others are not yet past the stage of non-binding discussions.

Styria, for example, was quick to fill its “reform pool” with eight projects and could, if the outcomes are good, prove to be a trailblazer with its project objectives:

Styria developing eight integrated-care projects

- It intends to set up an integrated program for persons with kidney failure. The aim is to ensure that high-risk patients consult a specialist, patients are prepared for renal replacement therapy and that peritoneal dialysis (which is less harmful than other methods) is rolled out Styria-wide.
- Following the lead of numerous programs worldwide, a disease management program is to be developed for type 2 diabetics, which would then be monitored and coordinated by the patient’s general practitioner.
- Integrated care is to be provided for myocardial infarction patients to ensure that heart attacks are diagnosed early and correctly, that there is a smooth transition between acute treatment and rehabilitation, the results of the treatment are documented precisely and that care is checked for controllability and sustainability with feedback given regularly.
- An integrated program for sufferers of coronary heart disease and coronary artery stenosis, in which three Styrian hospitals are involved, aims to increase the survival rate of MI patients.
- Hospital staff and extramural and outpatient services are to work more closely together when inpatients are discharged so as to prevent “revolving door” effects.
- General practitioners and hospital physicians are to be given better possibilities for at-home treatment in rural areas.
- Based on German practice, hypertensives are to be given special patient training.
- In order to relieve the burden on acute care, hospice and palliative care are to be developed and expanded, including help for relatives. The intention is that basic care will be delivered by the existing system and supplemented by mobile teams.

Other federal states are also seeking to improve coordination with general practitioners and outpatient care providers after patients

Better care for MI patients and diabetics	have been discharged from hospital and to integrate care for MI patients and diabetics. In Tyrol, the stakeholders intend to look at access to and financing of particularly expensive medicines. Carinthia wants to ensure easier access to speech therapists, and in Burgenland early diagnosis of intestinal cancer is to be improved.
Long road from knowledge to action	The inter-sector approach is generally welcomed but it has become apparent that a certain amount of lethargy needs to be overcome before it can truly bear fruit. Sceptics fear that if cooperation really does start to occur on a cross-sector basis, the funding set aside for it (2 percent of the health budget) will be insufficient.
No change in relationship between coalition partners	Health policy played a very insignificant role in the protracted coalition negotiations following the election in October 2006. Although it was heavily criticized by the Social Democratic opposition at the time, the coalition partners kept one change introduced by the ÖVP/FPÖ coalition: the old government had considerably curbed the trade unions' influence on self-governed social agencies. On the other hand, the partners agreed (at the request of the Social Democrats) that there would be no additional co-payments for insurees.
Guidelines and consolidation	Many other projects initiated by the new government do not even impinge upon the balance between the center and the periphery; most of them are in line with international trends or a logical continuation of reforms launched in recent years. For instance, the Austrian "box system" (see also <i>Health Policy Developments 2</i> , p. 57) for reimbursements for pharmaceuticals is to be evaluated and reformed. Another aim is to introduce e-prescriptions and e-medication and promote the prescription of generics. Joint hospital and health-insurer committees are planned to draw up guidelines for evaluating and selecting medical products. In the area of residency programs for physicians, general medicine is now to have its status "upgraded" by being defined as a distinct subject, following the lead of the German system. Currently, general practitioners only need three years before they are allowed to set up their own practice but specialists needs six. A new plan is to specify precisely, by means of legislation, which procedures can be carried out by nursing staff and which can only be performed by physicians. The educational curricula for healthcare professions (other than physicians) are to be harmonized and made more flexible to increase mobility.

None of these planned changes are likely to elicit major public attention or considerable resistance. The opposition Greens are calling for an exemption from prescription charges for people whose monthly income is lower than €1,000. And the right-wing populist FPÖ wants measures to combat “insurance fraud”, which, supposedly, is predominantly committed by immigrants. During the election campaign, right-wing extremist politicians demanded a separate social insurance system for “foreigners” so that they can equalize their risks “among themselves.”

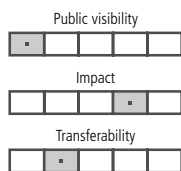
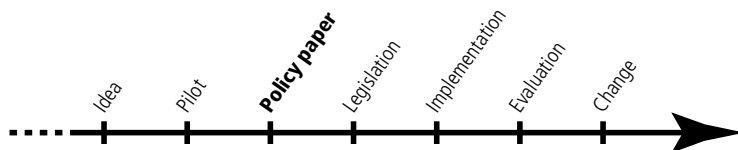
The reallocation of tasks between the center and the periphery in Austria has thus almost gone unnoticed among a variety of individual measures which have caused hardly any dispute. Nobody has yet put it on the political agenda; it is taking place without anybody publicly calling it by its name. Having said that, those who officially meddle with the relationship between the federal government and the federal states are always treading on dangerous ground in Austria.

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Ontario/Canada: Visions for the future of health care



The Ontario Medical Association (OMA), considered by most a conservative organization, caused a great deal of surprise when, in 2006, it invited all health sector stakeholders to take part in a large-scale dialogue on the sector's future. The aim was for policy makers and a range of health care professionals to meet in five half-day meetings in various cities to develop a vision for health care services and delivery in Canada's largest and economically most powerful province in the year 2020.

**More health, more
community-based,
more patient-
centered focus**

Despite their conflicting interests, the participants managed to arrive at a consensus, agreeing that future health care services and delivery must—and will—

- have a stronger focus on the determinants of health,
- concentrate more on the community level and
- attach particular value to patient education and awareness.

Five key changes were defined to help achieve this vision:

- More integration to allow for better use of inter- and multidisciplinary teams who not only work together but are educated together
- More patient navigators
- Better use of evidence when making care-related decisions
- More targeted use of technology
- Better ability to manage change; in other words, a more flexible system of collaboration between decision-makers, researchers and service providers.

The Ontario dialogues will not have any direct legislative impact. Nonetheless, they are still felt to have been important: nothing of the kind had ever taken place before, it could be the start of a new dialogue process and the Medical Association itself is surely the most influential player in Ontario's health care sector.

The fact that it was the Medical Association that commissioned the brainstorming sessions was particularly touchy. When viewed in isolation and when compared with the medical associations in other Canadian provinces, the OMA is perceived as very inflexible in its approach to change and to coordination with other non-physician health professions. Its relations with government and other stakeholders in the province are strained, especially since the physicians strongly resist the partial replacement of fee-for-service payment with other forms of remuneration. The invited stakeholders were therefore initially skeptical about this sudden initiative by the OMA.

Beginning of a new dialogue process—initiated by physicians

Dialogue participants soon became convinced that the move stemmed from serious intentions. Brainstorming sessions were moderated not by OMA officials but by experts from an independent think tank. In fact, the results pose some serious challenges for the OMA. After all, it was the OMA that had always rejected the idea of multidisciplinary teams and, especially, the introduction of new health care professions: the nurse practitioner (for care) and the physician assistant.

More equality between health care professions

As if they didn't quite trust this new open-mindedness, the invited participants gave their host some very clear messages. First, the OMA had to recognize that physicians were only one of many provider groups; it needed to listen more constructively to other providers. Second, physicians were, admittedly, indispensable in ensuring the health reform was a success; and third, the OMA could consequently play an important role in securing resources for all forms of health care provision.

Fee-for-service scheme on the way out

The physicians' unexpected willingness to engage in dialogue may not only have been caused by their concern about the image of their profession, which had been damaged in the disputes concerning remuneration schemes. The new leadership's more conciliatory approach can be explained by the divisions within its own ranks. Younger physicians, in particular, often had little sympathy for attempts to fiercely defend the fee-for-service system.

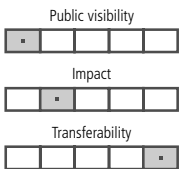
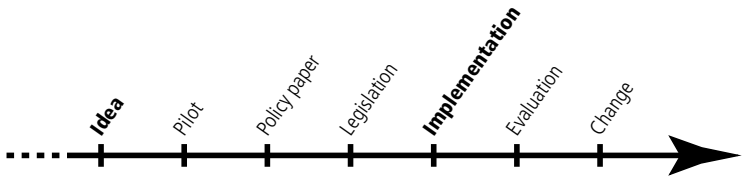
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New Zealand: Toward health impact assessment



New Zealand's government has allocated funding for the introduction of Health Impact Assessments (HIAs). HIAs are formal assessments of the potential health-related consequences of a project in another sector—similar to Environmental Impact Assessments. They can be used to investigate, for example, how housing, transport or environmental projects affect human health. Just as Environmental Impact Assessments forced authorities to rethink their activities from a totally unfamiliar perspective, HIAs can also open up a completely new outlook.

Health Impact Assessments implemented in 15 countries

HIAs are already in place in about 15 countries, including Canada, England, Sweden, the Netherlands and Switzerland (see *Health Policy Developments 4*, p. 24). The European Union's 1997 Treaty of Amsterdam also encourages their use. New Zealand plans to first create a support team to provide agencies with information and expertise. The HIAs are not intended to be compul-

sory; for the time being, the team will merely encourage them. New Zealand's first serious plans to introduce this new tool date back to 1998 and HIAs are already in place at the local level. Support teams of the type soon to be used in New Zealand already operate in Sweden, Wales and the Netherlands.

Other countries' experiences show that government agencies are not particularly inclined to take the initiative when it comes to assessing the health impact of their projects. Information, a little pressure and the fear of actionable compensation claims can help. In addition, some countries (including New Zealand) have seen the HIAs themselves produce unexpected side effects. But they have all been positive, ranging from interdisciplinary cooperation, enhanced relations and more participation in the policy-making process by, for instance, Maori.

Experts in New Zealand do not expect the new tool to conquer the country all by itself. Whether Health Impact Assessments really are implemented will depend on government agencies' willingness to commit to them. Though that willingness can be nurtured, it is still subject to tight financial constraints. Whatever the case, yet another country has now introduced Health Impact Assessments—a tool more suitable than any other to transcend and blur the conventional lines of responsibility and sector boundaries, thus making for another step toward outcome-oriented pragmatism. Still, many countries have not yet begun working on this subject—despite the Finnish EU Council Presidency's focus on “Health in All Policies.”

HIA—Leveraging transparency and cooperation

Government agencies' commitment crucial

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Mental health: Moving into the spotlight

The traditional health care system, with general practitioners navigating patients, has its difficulties coping with the mentally ill. But sufferers tend to avoid the specialized mental health care systems for fear of coercion and ostracism. As a result, many mentally ill people do not get adequate care. However, this area of illness, a taboo subject for far too long, is now shifting more and more into the spotlight—not least due to huge cost pressure. Many countries now see the solution as being to tighten the link between the general health care system and the specialized mental health care system, both in terms of organization and the services delivered.

The gulf between attitudes toward general health care and those toward specialized mental health care is one of the main reasons why mental health only plays an essentially marginal role in industrialized countries' health care systems all over the world.

Given the damage that mental illnesses and disorders cause to national economies, this disparity is particularly stark. One in four people will go through a phase of mental illness at some point in their life. According to an acknowledged rule of thumb, mental disorders and illnesses account for one fifth of the burden of disease in Europe (McDaid, 2005c: 1). In industrialized nations, they cause 35 to 40 percent of all absence from work.

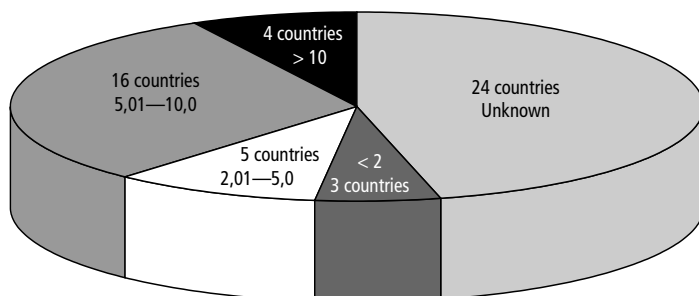
Compared to the costs incurred due to mental illness, the funding provided in this area is low. Only four European states spend more than 10 percent of health care costs on people with mental problems (McDaid, 2005a: 11) (see Figure 1).

But high expenditure figures do not really indicate whether patients actually receive appropriate assistance. Historically speak-

**Mental health care:
Big damage,
little assistance**

**Past failures still
being felt today**

Figure 1: Specified mental health budget as a percentage of total health care expenditure in 52 European countries



Source: McDaid 2005c: 3 (Data: WHO Project Atlas 2001, Mental Health Economics European Network 2004)

ing, mental health care systems were created not to heal the sick but to protect society from them. Despite many corrections, this initial design error is still making its presence felt today and is significantly impeding access. Sustainable care and rehabilitation are still the exception and often not even an objective. A study in England concludes that today's health care professionals still do not believe that mentally ill patients will improve particularly; placing such patients back in work, for example, is not a primary goal in their eyes (McDaid, 2005a: 7). It thus seems that the skepticism toward specialized mental health care systems is still justified.

Reducing beds is not enough

The first—and appropriate—response to the weaknesses of the mental health care system, first in Western Europe and later in Eastern Europe, was to modify its dimensions; major hospitals reduced their bed numbers on a grand scale. But the downscaling of the inpatient sector was not followed by a corresponding increase in outpatient and preventive care. Compared to general health care, there is still an imbalance between what is in any case a small amount of funding divided up among prevention, services and inpatient care. Even now, after 30 years of closures of the old asylums typical of psychiatric care in the period from the 19th century onward, a large chunk of expenditure on mental health in almost all countries goes to institutionalized long-term care (Knapp, 2006: 79). Nowhere do modern, preventive methods play a significant role in mental health budgets.

As has become clear, reforms aimed at deinstitutionalization by no means ensure better care. The days when “liberalization” from such institutions was considered progressive, irrespective of whether they were actually replaced by a different form of care, are gone. Throughout Europe, word has now gotten around that long-term care in a closed institution is expensive but certainly not a satisfactory way of dealing with mental disorders. However, it is not yet common knowledge that community-based care “outside the walls” does not cost any less.

**Adequate care
often not available**

Where the number of psychiatric asylums has been reduced, there has actually tended to be a decline in acceptance for the system. It is seen as the last resort for “hopeless cases.” As a result, people who declare themselves “disturbed” by seeking psychiatric help still risk considerable disadvantages, especially at work. Not only does this stigmatization discriminate against sufferers, it is also a major obstacle to their accessing the mental health care system. There is a tendency for them to think that they have to feel so bad that nothing else helps before they consult a mental health professional.

**Stigmatization an
obstacle to access**

In view of these circumstances, it is now considered a desirable goal to find the ideal balance between community-based, and thus low-threshold, care and treatment in the specialized psychiatric or psychological system for each mentally ill person. Initial contact should be through the patient’s general practitioner. The idea is that if individuals access the mental health care system voluntarily at all, they do so through their GP—a person they can open up to more easily and do not suspect of wanting to do them harm.

**Aiming for access
to psychotherapy
care via GP**

The general health care system, geared to somatic disorders, copes at least as badly with mental disorders. Someone who goes to a GP with a masked depression, for instance, still runs the risk of being treated for a whole range of somatic disorders over a long period before he or—in most cases—she can expect a proper diagnosis.

**But general
practitioners are
poorly equipped**

A study commissioned by the WHO (albeit more than 10 years ago) concluded that while more than one third of patients with mental illnesses in Germany were treated by their GP, established pharmacological and psychotherapeutic treatment strategies were only used in 5 to 10 percent of those cases (Maier,

1996). This professional helplessness is mainly due to deficits in medical training. In the best-case scenario, the result is that the patient is referred to the specialized mental health care system after all—a system that, by nature, cannot do anything itself about the stigmatization that it brings.

**Different payers
a barrier to
integration**

Neglect of mental health complaints in many health care systems is also due to fragmented government budgets. In Israel, mental health care used to be the responsibility of the Ministry of Health and general health care was paid for by the sickness funds. To reduce interface problems, the sickness funds are to be responsible for both in future (see the report from Israel, p. 43).

In other countries mental health care is paid for by the same insurers as general and specialist care. However, in addition to the costs of care, mental illnesses and disorders also create particularly high costs for the national economy. When studies state that mental illnesses cost around 3 to 4 percent of GDP, they are primarily referring to the social consequences (McDaid, 2005c: 2). However, social consequences are addressed, if at all, through social work, daily inclusion work or work therapy. Often the majority of these services are financed by other entities, both public and private.

**Far-reaching
consequences for
family and
working life**

These consequences of mental illness range from diminished performance at work to long periods of absence, to early retirement and unemployment, right through to homelessness, criminal activity and even suicide. Depression is the most common and most expensive mental illness. Schizophrenics' families spend an average of six to nine hours per day looking after them (McDaid, 2005a: 4). Dementia patients often require around-the-clock care, which is also provided by their families. If a 10-year-old child is diagnosed with a behavioral disorder, the complaint can be expected to cost €110,000 before the young person reaches the age of 27 (McDaid, 2005a: 4)—not so much because of expensive therapy but because it is extremely difficult for such patients to enter into employment.

Conversely, social processes influence the incidence of mental illnesses more directly than (and at least as much as) they do the incidence of somatic illnesses. These processes include the rapid social change in Eastern Europe, unstable family relationships, and depopulation of high-unemployment regions, but also rapid

aging of societies, which is causing the number of dementia patients to climb.

In recent years, mental illnesses have finally moved more into the health policy spotlight. In its 2001 Atlas on Mental Health, the WHO made public most of the above-mentioned sobering figures. Four years later, an intergovernmental conference on the topic was held in Helsinki, organized jointly by the WHO, the EU, the Council of Europe and the Finnish government. Also in 2005, the EU Commission published its green paper on “Improving the Mental Health of the Population,” nudging the subject farther into the open.

But there is no consistent reform process in place yet. Most EU countries still lack a comprehensive national action plan. The subject is avoided in the public arena. There are no signs of political movements for mental health, as existed in the 1970s when popular journals denounced conditions in asylums and books on the subject were showcased. In Italy, the psychiatrist Franco Basaglia succeeded at that time, after extensive public discussion, in having the large hospitals shut down. The political sphere’s response is thus haphazard, as illustrated by a package of measures in Great Britain. Though it reflects a will to improve the situation, the package is also characterized by a certain lack of direction (see the report from Great Britain, p. 47).

The other end of the world seems to be much farther ahead than Europe. Following New Zealand (see *Health Policy Developments* 4, p. 23) and Canada (see *Health Policy Developments* 7/8, p. 56), Australia also began implementing a national action plan in 2006. Possibly the most interesting change set out in the five-year plan is that two “coordinators” are to be appointed for each mentally ill patient. One, the Clinical Care Coordinator, will navigate the patient through the complex care system and the second, the Community Care Coordinator, endeavors to ensure that the patient is integrated into society as well as possible (van Gool, 2006).

In making this move, Australia is seeking to address the fact that mental illnesses have a much higher impact on society than somatic illnesses. Not only do their consequences almost always have a detrimental effect on working life and sometimes on law and order; being ostracized and stigmatized also has a huge effect on patients’ chances of recovery.

**WHO Atlas on
Mental Health**

**National action
plans still a rarity**

**Process down
under: Clinical and
social coordinators
for mentally ill in
Australia**

**Mental disease
comes at a high
societal cost**

However, there is another change that is more visible to and has a more far-reaching effect on Australians than the appointment of coordinators: The state health program, Medicare, now pays for specialist treatment of mental illness (see report from Australia, p. 50). Despite substantial public approval, this experiment is not without its risks: GPs now also receive payment from Medicare when treating mentally ill patients, but they are not required—as was originally planned—to complete additional specialized training to be eligible. Whether they are sufficiently qualified for this task remains to be seen.

Israel starting
by giving GPs
additional training

Several countries have designed measures to respond to the fact that mentally ill patients often first seek the help of their GP. In Israel, Clalit, the large sickness fund, has started by offering GPs additional training, therapy guidelines and guidance on the prescription of common psychopharmaceuticals, instead of simply enabling GPs to receive payment for new services and then sending patients to the next GP's practice, as the Australians are doing. Since Clalit introduced these measures, there has been a verifiable increase in physicians' knowledge of depression (see *Health Policy Developments* 7/8, p. 59).

Thus, there are various ways in which general health care and specialized mental health care can be brought closer together. However, the ideal way has evidently not yet been found anywhere.

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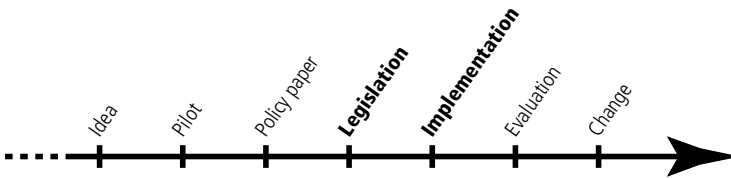
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Israel: Tug-of-war over outpatient mental health clinics



The agreement between the Minister of Health and the Minister of Finance that responsibility for mental health should be moved from the Ministry of Health to the sickness funds (see *Health Policy Developments 7/8*, p. 59) has provoked a major tug-of-war in Israel (see Figure 2). However, the question is not so much whether the shift will take place, but how. The idea of creating a closer link between general and mental health care by having them paid for by one single entity is generally welcomed. The cause of the opposition is the plan to gradually close down the Ministry of Health’s (MoH) outpatient mental health clinics by 2010 in order to cut costs.

Since the 2004 agreement, the reform (first announced in 1996) has already been postponed three times and repeatedly modified

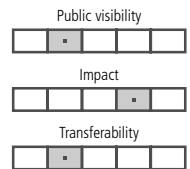
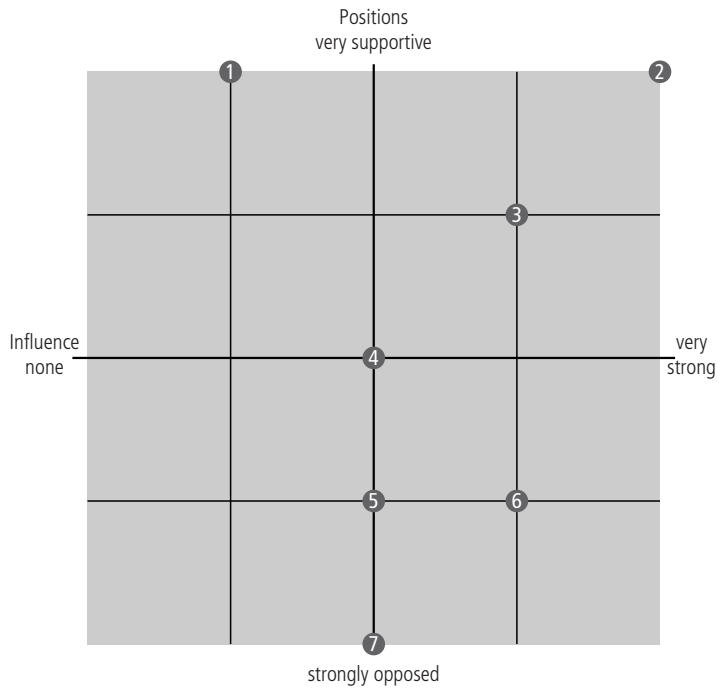


Figure 2: Controversial reform: Positions on the mental healthcare reform planned by Israel's Minister of Finance



- | | |
|---|---|
| ① National council for mental health | ⑤ Mental health professional unions |
| ② Ministry of Finance | ⑥ Israel Medical Association |
| ③ Ministry of Health, Sick Funds | ⑦ Government mental health clinic staff |
| ④ Psychiatric patients' family organization | |

Source: Gross 2007

as a result of the opposition. In principle, the sickness funds are willing to assume responsibility but call for additional funds and changes in the allocation formula. They do not object to the planned closures—unlike the unions and patient organizations who vehemently oppose them. Nonetheless, the protests and delays have had no effect on the finance minister's call for closing the clinics.

The joint bill specifies the precise funding to be allocated to inpatient (61 percent), day (5.2 percent) and outpatient treatment

(33.7 percent). Also, 63 percent of the budget will be allocated on the basis of how many days a sickness fund's members spent in a mental health hospital ward in 2005. The remaining funding will be allocated according to the number of members in two age groups, 25 and over and under-25s. The remuneration system for psychiatric hospitals is still being developed. Currently, the plan is for the sickness funds to pay insurees a fixed amount for a specified number of hospital days and a higher rate if the number of days is exceeded. With regard to rehabilitation, the sickness funds would have to use the 2006 figures as their basis and would be fined if, compared to 2006, they increase the rate of patients referred to rehabilitation by more than 10 percent.

Funding allocated for inpatient and therapy

The finance minister hopes the agreement will help contain costs and his intention in closing the MoH outpatient clinics is to lessen the burden on the government budget. He knows that many stakeholders and the health care research sphere agree with the goal of combining the two systems. The health minister, who had originally pushed for the combined setup, had to accept the agreement with his fellow minister because he needed the latter's approval in order to transfer responsibility to the sickness funds. However, it was not possible to get that approval without closing the MoH outpatient clinics. The health minister is specifically concerned that the sickness funds might not be able to establish alternative facilities. There is also a fear that there might be a number of risks that cannot be covered using the planned case fees, which might lead to cherry-picking. In addition, some are worried that the agreement might not leave sufficient room for quality assurance measures.

Cost savings in mental health at the expense of facilities

The sickness funds are demanding better financial resources, 150 million shekels (€26 million) more, to be precise, and feel that co-payment levels are too low. They expect there to be a lack of funding, particularly for "soft" mental health care (i.e., management of stress and life events). They also argue that future financing should take into account the fact that many of them have yet to actually install structures for mental health care. However, this argument is again opposed by those sickness funds that already have such structures in place, who feel that they might be "punished" for doing the right thing earlier than everybody else.

Sickness funds fear lack of funding for "soft" care

The strongest opposition comes from the staff in the government mental health clinics. Despite the government's assurances

to the contrary, they are afraid that they may lose their jobs and that there may be a general decline in demand for private psychiatric and psychotherapeutic care if it is provided by the sickness funds.

**Pills instead of
psychotherapy**

Unlike the sickness funds, the staff are also fundamentally critical of the plan to transfer responsibility for ensuring care to the sickness funds. They worry that emphasizing the cost factor, making payments too low and downscaling the range of services might lower the quality of care. Another fear is that this could lead to unnecessary medicalization of mental health care. In their opinion, more psychotherapeutic treatment should be applied instead of prescribing more and more drugs.

The staff consider the present level of care to be good. They do not feel that the urgent problems, stigmatization of mental health patients, and long waiting times would change once sickness funds assume responsibility for mental health. Promises of improved care are, in their opinion, misleading. Their suggestion is that an expert team should analyze patient needs first and then put forward a proposal for a reform that is needs-oriented.

**Physicians consider
co-payments
too high**

The Medical Association's criticism does not go so far as to reject the structural reform altogether. However, it too opposes the closure of outpatient clinics, cuts in the benefit basket and what it believes are excessive co-payment levels. In the Association's opinion, chronically ill and elderly mental health patients are particularly at risk since the ministers' agreement does not deal with their special needs.

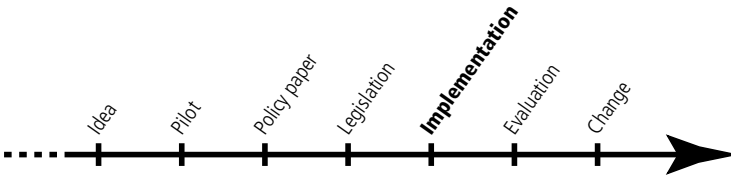
In contrast with clinic staff, the families of mentally ill persons and the associations that represent them do indeed hope that the reform will mean less stigmatization. On the other hand, however, they share the concerns regarding the closure of outpatient clinics. They also feel that the payment system puts seriously ill patients at a disadvantage and does not give sickness funds an incentive to refer their clients to rehabilitation.

As the Israeli example shows, combining mental and general health care systems takes more than a simple stroke of the pen. Even if everyone involved agrees on the goal, how it is to be achieved can raise major questions.

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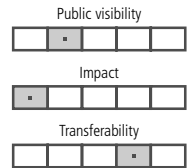
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England and Wales: Pick and mix for the mentally ill



England and Wales have introduced a series of policy developments in the field of mental health. The National Service Framework on mental health focuses on prevention, health promotion and common mental health problems such as depression and anxiety disorders. Other recent developments are concerned with initiatives to help maintain employment or reintegrate people suffering from mental health problems into employment, and actions to tackle stigma and discrimination, as well as initiatives for black and minority ethnic communities. Furthermore, there are policy developments aimed at

- more freedom of choice in mental health care
- a new Mental Health Act
- improved means for the National Health Service (NHS) to provide treatment for patients suffering from both mental illness and addiction
- increased protection against sexual abuse for mental health inpatients



The policy developments are being implemented within the framework of the government’s health policy agenda. As in all countries, mental health care in England and Wales is underfinanced compared to somatic care. However, in recent months, this neglected

**Calling for help—
but not just
out of sympathy**

sector has shifted more into the public focus—partly out of concern for the mentally ill but also due to fear of them. It would seem that these confused motives have resulted in a package of measures that are not always logically linked to each other or to their own objectives.

In accordance with the new Mental Health Act, passed in 2007, patients in community care must be supervised to ensure that they do adhere to the treatments prescribed for them. The aim is to prevent revolving-door effects, thereby improving public safety at the same time. Safeguards are to be introduced for around 5,000 people with serious mental health problems who were previously not covered by legislation. The safeguards include the use of independent examinations to decide whether individuals are involuntarily detained and whether they have a right to appeal. The legislation would therefore offer more protection against unwarranted detention.

**More freedom of
choice for patients**

A further objective is to give patients more freedom of choice as to when and where they receive which treatment. For the time being, information is to be provided on a dedicated website (www.mhchoice.org.uk), which individuals can use to find the therapy best suited to their lifestyle.

**High-risk group:
Mentally ill with
addiction problems**

Finally, patients diagnosed as being both mentally ill and substance abusers have been defined as a special risk group. According to statistics, they commit suicide more often, get into trouble with the law more often, are more quickly hospitalized and take their medications less frequently than mentally ill persons who do not have addiction problems. Medical staff are to be better trained to deal with such patients, and care for patients with addictions and mental health problems is to be better integrated. The plans also involve making the patients more aware of their own specific risks.

**Better protection
against abuse**

The government wants to invest £30 million (€44 million) in safety for mental health patients, particularly female patients, following a series of rapes of female inpatients in the summer of 2006. A total of 19 cases were reported and, even if not all of them were considered credible, the government has taken steps to address the problem. As well as making it easier for patients to report abuse, the aim is to provide clinic staff with guidance on how to deal with incidents and reports more efficiently.

After much controversy and many years in the making, when the Mental Health Act was passed all stakeholders seemed to support it. In fact, self-help groups for the mentally ill have explicitly welcomed it. But none of the policy developments are designed to address the fundamental flaws in the care system. Cautious critics wonder whether the various changes are actually based on a consistent awareness of the problems at all. The plan to give patients more freedom of choice, for instance, quite clearly conflicts with the aim of stricter monitoring of their compliance with prescribed treatments.

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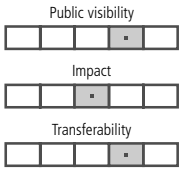
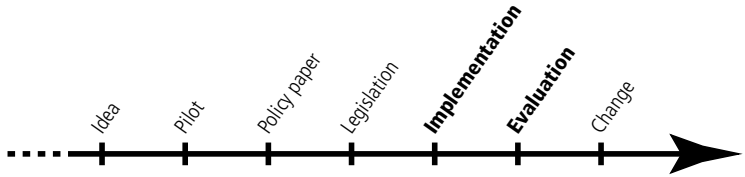
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Australia: Payments for psychotherapy services



Australia's state health program, Medicare, has added a number of new mental health items to its benefit basket, including, for the first time, consultations provided by psychologists, occupational therapists and social workers. The move opens up Medicare's fee scheme to several new groups of professionals. Psychological treatment by general practitioners who already had contracts with Medicare will also be covered. The results to date show that demand is likely to be huge, indicating that a large amount of demand had previously gone unmet. The costs of the reform will therefore probably be significantly higher than originally estimated. It is not yet clear whether this expansion of the benefit basket actually will achieve its objective of improving health care.

GPs earn less than psychologists

The new system has been widely welcomed in Australia; there is no fundamental criticism to be heard anywhere. However, the reform was preceded by a fight for a fair piece of the pie. General practitioners, in particular, felt they were being cheated to the advantage of the new professional groups. The Australian Medical Association complained that general practitioners were receiving less money than psychologists for the same services and that they had to negotiate some difficult obstacles to be able to bill Medicare for psychological services at all. It is true that a GP receives A\$66 (€40) for a 20-minute psychological consultation (a little more than for a general consultation) while psychologists earn between A\$88 and A\$129 (€54 to €80) for the initial consultation, which, however, must last at least 50 minutes.

Protest effective: additional training not required

The government did pay heed to some of the physicians' objections. It abandoned, for instance, the plan to make GPs complete special training before being able to bill for psychological services. This gave GPs an incentive to venture into the un-

known territory of mental health care but also harbored the risk that they might not be able to cope due to their lack of expertise in the field.

Four months later, Medicare's initial assessment of the situation produced positive results, particularly for the GPs. The figures showed that 56 percent of the new subsidized services had been provided by GPs, 38 percent by psychologists and 6 percent by psychiatrists. At 400,000, the number of services provided exceeded the already high expectations. Of the A\$42 million (€26 million) paid for those services, 60 percent went to GPs, 30 percent to psychologists and 10 percent to psychiatrists. There is now a fear that an urban/rural divide will develop since towns and cities are better equipped with psychologists.

The subsidies for these new services are part of the National Mental Health Action Plan, designed to reduce the incidence and severity of mental illness in Australia. To this end, the aim is to ensure that a larger share of persons with an emerging or established mental illness gains access to the right treatment at the right time, with a focus on early intervention. The Australian Senate has announced its intention to have the Action Plan monitored and evaluated on a constant basis, giving particular attention to the following:

- The extent to which the Action Plan assists in achieving the objectives of the National Mental Health Strategy
- Whether it helps create an infrastructure for community-based care
- Whether it promotes the implementation of recommendations made by the Select Committee on Mental Health
- Its shortfalls and shortcomings with regard to financing and the benefit basket.

Action plan promotes early treatment

Medicare is a fee-for-service program, financed through 1.5 percent of contributors' monthly gross wage. Persons who do not have an income or who receive unemployment or welfare benefits are insured free of charge. Medicare pays 85 percent of the costs of outpatient services, calculated in accordance with a fixed schedule of fees. The remainder is covered by co-payments up to A\$253 (€156) per year. Inpatient treatment is paid for in full. There is consequently a fear that the Action Plan will merely result in a

What Medicare pays

shift from the inpatient to the outpatient sector and that access to the system will not improve.

No more than a boom for “mother’s little helpers”?

It also remains unclear whether the high take-up of psychiatric and psychotherapeutic services offered by general practitioners really pays off for patients. Will GPs, having fended off the “impudent” requirement that they complete additional training, really be able to play a navigating role? Are they cooperating properly with psychiatrists and psychologists? Or are they simply living off their reputation as an easier source of “happy pills” and “mother’s little helpers” without having to undergo embarrassing and reputation-damaging therapy?

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Hospitals in search of a new role

The status attributed to the hospitals in a health care system is often an indication of the system's efficiency and quality. Over the course of many years, the inpatient sector in a number of countries became a kind of "retention basin" for all of the problems with which other societal support systems were unable to cope. Not only did hospitals take in everyone whom the primary care system was unable to help, they also had to take on social problems—from loneliness and poverty among elderly people to homelessness through to the banishing of death from the public consciousness.

It was inevitable that hospital status would decline as efforts to find suitable solutions for each of these problems increased. The better the flow upstream, the less the retention basin has to retain. Today, well-working primary care systems, social services and visiting social workers, domestic care and hospices in place in many countries bear testimony to the progress that has been made.

The old-style hospital will not be sorely missed. Although those hospitals swallowed up an ever larger share of the resources available, they were not able to perform their various functions properly and tended to heed their own laws and the interests of local politicians rather than patient needs.

Hospitals often created a specific culture that can even be described as detrimental to health. A strict hierarchy and imposing architecture led to demonstrations of medical power and patient intimidation; hospitals demonstratively closed themselves off to all external influences, with the result that patients had to undergo ritual-like admission procedures and were then treated as if they were the hospital's own product.

**"Retention basin"
for a whole range
of problems**

**Monuments to
medical might**

Emergency departments and other outpatient departments through which hospitals were involved in primary care often developed into admission wards and directed those seeking help straight to empty beds regardless of whether they really needed inpatient care.

**Hospital infections
provoke aversion**

Finally, as if things were not already bad enough, hospitals were shown to be dangerous places where medical errors and infections with resistant pathogens occurred. In numerous countries, these findings led to the boundaries between inpatient and outpatient care being redrawn and the two areas being repositioned in what had previously largely been the hospitals' turf. However, hospitals did not relinquish their functions of their own accord, on the contrary. Being the largest and economically most powerful entities in the health care system, hospitals tend by nature to isolate themselves from other providers and to try to grab other providers' functions for themselves.

**Blurring the
boundaries**

As it turned out, it was therefore not enough to strengthen other sectors (such as primary care) in order to reform an overly hospital-focused health care system. A number of countries have been tackling this issue for a long time by making access to hospitals more difficult, shortening stays and reducing the number of beds.

The boundary line and distribution of resources between acute and long-term care beds also had to be redrawn. This time, the challenge stemmed predominantly from demographic change; as the population's age structure has changed, so have the prevalent illnesses and care needs.

**Cuts plunge
hospitals into crisis**

The wide range of reform strategies was bound to plunge hospitals into a deep crisis, for the reforms were often more the result of alarming spiraling budgets than of visions of a more appropriate and more "human" health care system.

Faced with enormous cost pressure, it is tempting to address the largest cost factor and start making sweeping cuts without analyzing the situation in depth. As Table 1 shows, that largest cost factor is generally the hospital sector.

However, a reduction in beds without an expansion in other facilities would understandably be seen as deterioration by those affected and therefore meet with resistance. Only in a second step can calls for better health care be expected to focus on patient-centered solutions rather than on maintaining hospitals.

Table 1: Expenditure on inpatient and outpatient care

	Inpatient: Total expenditure on curative und rehabilitative inpatient care in percent of total expenditure on health (percent TEH)	Outpatient: Total expenditure on outpatient physician services in percent of TEH (dental services excluded)
Australia	31.4*	16.4*
Austria	34.5	17.9
Canada	16.6	10.1
Denmark	29.7 e	17.5 e
Finland	30.2	27.5
France	35.1	11.0
Germany	27.3	11.7
Japan	22.6* e	25.7* e
Korea	24.0	27.2
New Zealand	22.4 e	17.0 e
Poland	28.3 e	12.7 e
Switzerland	28.2	22.4
Spain	20.9 e	25.6 e
USA	20.1	22.2

Data of 2005, Data marked * of 2004; e: estimate
Source: OECD Health Data 2007

With that said, the new forms of care must first be established before demand for them can develop. Many transition countries in Central and Eastern Europe, such as Poland (see the report from Poland, p. 59), are currently in the critical phase between the downsizing of an oversized inpatient sector and a standstill in the remaining sectors. In some of the former socialist states, the health budget decreased to one-third of its previous level and came to less than 3 percent of the gross domestic product (Healy and McKee 2001).

But even in Western countries, especially Great Britain and the United States, the opinion is gaining ground that the reduction of the inpatient sector has gone too far. Instead of hospitals

From reductions in beds to creation of outpatient facilities

Have bed reductions gone too far?

being reformed from the inside and relieved of tasks that can be delegated to others, the only outcome has been increased pressure on hospital staff, critics say—and they add that quality of care has generally deteriorated as a result. Studies in Canada, the United States and Great Britain confirmed that fewer beds and shorter stays have raised costs per patient and devoured a large part of the potential savings (WHO 2003).

The first step, reducing the number of hospitals and beds, is not necessarily always based on a consistent strategy. In 1998, there were 9.5 hospital beds per 1,000 inhabitants in Central and Eastern Europe (CEE), but just 6.7 in Western Europe (Healy and McKee 2001, p. 3); it would seem clear which way the reform should be headed. By way of comparison, Table 2 shows the latest data from the WHO relating to the number of hospital beds in the CEE states and the EU-15.

**Not all hospitals
are the same**

However, hospitals are so different that merely counting them is of little use. They range from 10-bed facilities to huge complexes with state-of-the-art equipment. Many hospitals also present themselves as centers for outpatient services and open their medical facilities to everyone; some don't. Others offer rehabilitation and post-operative care. In Eastern Europe, hospitals were explicitly encouraged to assume social functions. A hospital's walls are not always identical to the boundary line between inpatient and outpatient care, as projects with names such as "Hospital without walls" or "Hospital at home" illustrate. They combine hospital care with services that patients can use at home, particularly rehabilitation and post-operative care (McKee and Healy 2002, pp. 6, 93).

**Hospitals the pawn
of (local) politics**

In the second phase of reform, moving away from reducing hospital capacity and beds, hospitals are now looking for a new role. However, hospital staff are not being granted much degree of autonomy when it comes to redimensioning and redefining their institutions. As is the case in Estonia, politicians often "prune back" hospitals in line with the old bed ideology, even during the reform process, and make them the subject of regional struggles over the funding pie that have little to do with health policy.

**Specialization an
opportunity**

Hospitals that successfully transitioned into new roles can primarily be found at the interface with medical advancements and thus in specialization. These two factors guarantee access to spe-

Table 2: Hospital beds per 1,000 inhabitants

Central and East European states				EU-15 states			
Country	Beds (acute + long-term beds)/ 1,000 inhabitants	Of which, acute beds/ 1,000 inhabitants	Year	Country	Beds (acute + long-term beds)/ 1,000 inhabitants	Of which, acute beds/ 1,000 inhabitants	Year
Bulgaria	6.4	3.6	2005	Austria	7.7	6.0	2005/ 2003
Czech Republic	8.4	6.2	2005	Belgium	5.3	4.7	2006
Croatia	5.5	3.5	2005	Denmark	3.8	3.1	2004
Estonia	5.8	4.3	2004	Finland	7.0	2.5	2005
Hungary	7.9	5.9	2005	France	7.5	3.7	2004
Latvia	7.7	5.3	2005	Germany	8.4	6.3	2005
Lithuania	8.1	5.3	2005	Greece	4.7	3.8	2004
Poland	5.3	No data	2004	Ireland	5.7	2.9	2004
Romania	6.6	4.7	2005	Italy	4.0	3.5	2004
Slovakia	6.9	6.2	2005	Luxembourg	6.3	5.0	2004
Slovenia	4.8	3.9	2005	Netherlands	5.0	3.1	2003/ 2004
				Portugal	3.7	3.1	2004
				Spain	3.5	2.6	2003
				Sweden	5.2	2.8	1997/ 2005
				U.K.	3.9	No data	2004
CEE average	6.7	4.9		EU-15 average	5.4	3.8	

Source: WHO Health Statistics 2007; European Health for All Database (HFA-DB), WHO Regional Office for Europe, last update June 2007. Latest data available in each case.

cialized care, put into practice the latest technological and pharmacological developments and also offer an organizational structure that facilitates a professional approach.

With specialization, hospital catchment areas are growing correspondingly—a development that is not perceived as critical, given today’s mobility. The new role for hospitals can be examined in Switzerland, where the cantons’ powers concerning the provision of health care for their own populations appear now finally falling apart (see report from Switzerland, p. 63).

Participation of hospitals is also an indication of how the inpatient sector is changing. Like other providers, the hospital of the future will deliver solutions for specific, clearly defined problems. If hospitals stop merely being “retention basins” for all kinds of health and social problems, they no longer need, in principle, to be treated as if they were a universally accessible public resource. Another way of sparing the ambulatory sector competition from hospitals (with their focus on inpatient care) can actually be to merge outpatient and inpatient facilities under one roof—as in Finland (see report from Finland, p. 66).

**Trend toward
monistic financing
and case fees**

Finally, many countries are experimenting with hospital-financing methods. The trend goes from dual to monistic financing. Where investment is publicly funded and the operating costs are taken on by the hospitals, there are distortions and disparities that are hard to predict and thus make planning difficult. Where public funding for investments is too generous, subsequent running costs explode just as much as where lack of funding prevents necessary investments for too long. This can be seen in the French example, where billions in public funding had to be spent on modernization before the financing system could be changed to a monistic model. The result of that modernization is now again leading to a fear that the subsequent costs will be unpredictable (see report from France, p. 68).

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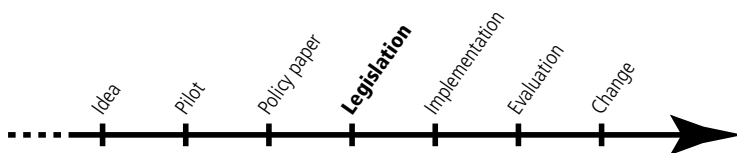
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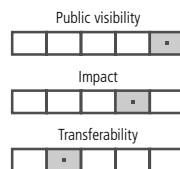
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Poland: 200 hospitals to go



After several false starts, the Polish government is now taking radical steps to reduce the number of hospital beds. According to a “hospital network” legislative proposal put forward by the Ministry of Health, roughly one in four of the country’s hospitals will be closed down; elsewhere, the number of beds will be reduced and acute beds converted into long-term beds. Although hospitals are formally autonomous, they depend on payments from the



National Health Fund. The government is now seeking to stipulate the conditions under which the National Health Fund pays for hospital services. Following the first round of debate, the bill was revised but it is still a work in progress.

**Small hospitals
have no chance
of survival**

Hospitals not included in the hospital plan are unlikely to survive. In particular, the government has announced its intention to axe small hospitals with less than 150 beds. Councils are to be created at the provincial (voivodeship) and national levels, predominantly appointed by the government, for the specific purpose of evaluating the hospitals; the final decision will then be made by the minister of health. In addition, hospital management is to be improved, especially in remote areas.

**Protests in under-
privileged regions**

The project is provoking opposition from the staff of the hospitals concerned and the local population. Small hospitals, now facing possible closure, are mostly situated in underprivileged regions. Often, they are the largest and sometimes the only employer there. Independent critics doubt that merely reducing the number of beds will bring about an increase in efficiency.

**No valid data
to support bed
reductions**

All of the decision-makers have long known that Poland has far too many hospital beds. Former governments of every hue have repeatedly attempted to “rationalize” the hospital landscape, in other words, to reduce beds. But rather than going to the effort of carefully analyzing the situation, it was often felt sufficient to simply look at international statistics in order to arrive at the diagnosis. Waiting times were not taken into consideration, nor was the fact that international statistics usually count acute beds—a category for which there is no direct equivalent in Polish statistics.

The new plan entails raising the number of long-term beds—an aim welcomed by experts since it meets the needs of the population. However, the problem is that it can only be achieved via the other aim, i.e., reducing the total number of beds and closing hospitals. Only if this first aim is achieved can long-term capacity be expanded. Consequently, staff in small hospitals and local politicians in rural areas, who welcome the creation of long-term beds in principle, are currently busy defending their acute beds. Their logic is that where there is nothing, nothing can be converted.

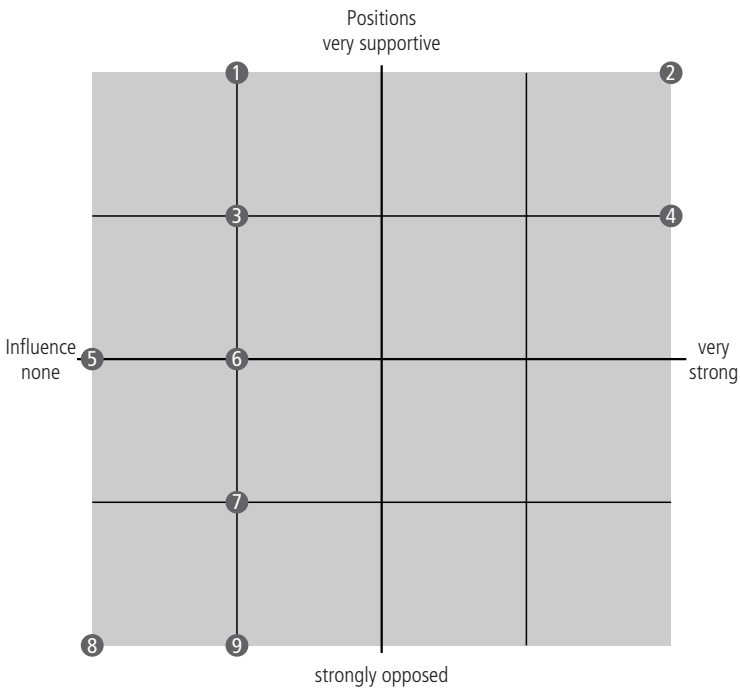
**Earlier attempts
sluggish**

Various measures taken to reduce capacity between 2000 and 2006 led to a marginal decline in the number of beds here and there; at the same time, some physicians and nurses moved to

the private sector. But there was no breakthrough. Nobody dared to make bigger cuts for fear of the opposition they would cause. The topic was also always treated very cautiously in the last election campaign (2005). As a result, the old structures have become rigid.

The hospital network plan is still extremely contentious and looks set to influence public debate for some time to come. The players can be divided into the following camps:

Figure 3: Polish players' positions regarding the government's hospital network plan



- ① Ministry of Health
- ② Ministry of Finance, National Health Fund
- ③ employees of other health institutions
- ④ government coalition
- ⑤ patients not likely to be affected
- ⑥ primary health care providers
- ⑦ opposition
- ⑧ patients possibly affected
- ⑨ employees of small hospitals, local governments

Source: Włodarczyk 2007a

It is difficult to predict how the dispute will end. Of Poland's 881 hospitals, 324 have fewer than 150 beds, which means that they would be closed. The Ministry considers 200 hospital closures possible, with the hardship cases deducted. Acute beds are being converted into long-term beds anyway, without the disputed "hospital network," even if it is a slow and intermittent process. From 2001 to 2005, the number of long-term beds rose from 14,200 to 17,300. In the following year, it fell again by 2.4 percent.

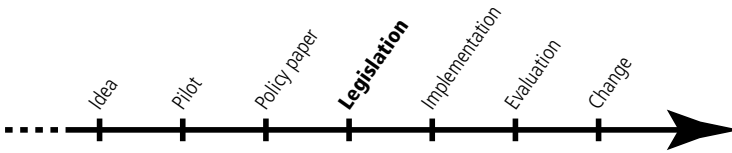
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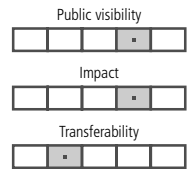
Switzerland: Headed for a national hospital system



The plan to merge Switzerland's 26 cantonal hospital systems into one national system is making visible progress. The Council of States, as well as the National Council (the two chambers of the Federal Assembly, i.e. the Swiss Parliament), now seems willing to grant all Swiss access to all of the country's hospitals no matter which canton they live in.

Currently, patients must obtain the consent of the cantonal physician in their canton of residence in order to use a hospital in another canton under the compulsory health insurance scheme. This is the only way to gain approval for cantonal contributions to inpatient treatment costs (contributions provided for by law) outside of the canton of residence. Treatment in another canton is only authorized if the service being sought is not available in the patient's own canton. However, many Swiss already use hospital services outside of their own canton. In the small, central Swiss cantons of Schwyz, Obwalden and Nidwalden, which are unable to provide many services using their own resources, the figure is already higher than 50 percent; in Zurich, it is already 10 percent. Sometimes, small cantons incorporate hospitals in the neighboring canton into their hospital plans and pay them, too, but often these "external" services are paid for by private insurers.

The new system planned in the bill will provide freedom of choice in accordance with the "Cassis de Dijon" principle. In other words, if a canton builds a hospital for its own population's needs, it will also open it up to all other cantons. The costs will be partly borne by the health insurer and partly by the patient's canton of origin. The name "Cassis de Dijon" stems from a ruling by the European Court of Justice concerning imports of the French black-currant liqueur to Germany. The Court of Justice found that the concept of freedom of the market superseded national



Access to another canton's hospitals requires cantonal physician's OK

"Cassis de Dijon"

regulations and that both national regulations and similar regulations in the neighboring country had to be observed.

In Switzerland's case, this means that cantons can continue to build their own hospitals in accordance with their own criteria but cannot refuse patient "imports."

**National per-case
payment scheme**

A bill drafted by the Federal Council (i.e., the government) in 2004 and amended by the Council of States in March 2006 provides for one single, full-cost per-case funding scheme for hospitals, in line with these plans. Neither cantonal borders nor ownership status would play a significant role. In addition, the costs would be redistributed between compulsory health insurance, cantonal governments and supplementary private health insurance.

A more radical bill originally planned a monistic financing system, in which each cantonal government would have paid a flat contribution—30 percent of its population's total basic health care—to the health insurers. If the system had been introduced, it would have completely removed control of hospital expenditure from the cantons' hands and left hospitals with the task of managing a large amount of public, tax-financed money.

**Confederation
stronger than
cantons**

By Swiss standards, even the proposed system is revolutionary, since it breaks with the venerable principle of cantonal territoriality and gives the confederation supremacy over the cantons. National Council members of all parties agree on this issue; the argument is not about the necessity for one single system, but rather about opening up the health care system to market logic or regulation and planning by the state. Initial caution gave way to a more resolute line of reform after a crushing assessment of the expensive duplicate structures in the Swiss system in an October 2006 OECD report.

If the costs for "outside patients" are to be borne jointly by statutory health insurers and the taxpayers in the cantons and no longer have to be paid for privately, the outcome will be that costs are shifted from the private to the publicly financed sector. This shift will be at the cantons' expense, which is the main reason why they are opposed to the planned freedom of choice beyond cantonal borders.

**Dispute concerning
distribution key**

The National Council has proposed that health insurers should pay 45 percent and the cantons 55 percent of the costs per case. If this distribution key is confirmed, a referendum might be required.

However, the cantons would accept a scenario in which they pay part of the costs for treatment of outside patients. They would determine the amount themselves and it would be somewhere between 45 and 55 percent.

Santésuisse, the health insurers' association, which is otherwise so enthusiastic about competition and market deregulation, is keeping surprisingly mum about the issue of freedom of choice. After all, if treatment of outside patients is covered by public funding, one of the key reasons for additional private insurance will disappear.

The advantages of freedom of choice include the competition it creates and the quality benchmarking, targeted cost-cutting and necessary specializations that it makes possible and that many small cantons cannot provide. There will be no huge amount of patient migration, if only because nobody likes to be treated a long way from home. At most, the likelihood is that there will be an increase in patients from remote regions seeking treatment in large centers.

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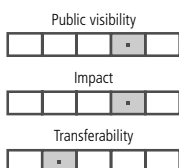
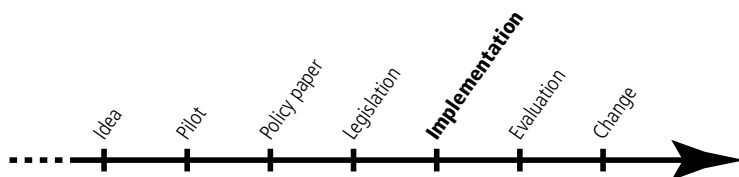
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Finland: Municipal federations to provide primary care



There is a trend in Finland toward greater integration of primary and secondary care. Although both types of care are already provided at the local level, it is only for primary care that municipalities have their own organizations. Secondary care services are provided by municipal federations (also called “hospital districts”). As a result, although responsibility for both forms of care is at the local level, there are two parallel structures that are subject to different laws and often clash in practice.

**Hospital operators
to assume
responsibility for
primary care**

Local reforms, initiated by the municipalities and supported by the government in the form of financial incentives, aim to transfer responsibility for primary care to the federations as well. This move would, in any case, reflect a trend that has been evolving for some time.

By contrast, transferring responsibility for both forms of care to the individual municipalities is not feasible in such an expansive yet thinly populated country. Of Finland’s 416 municipalities, 76 percent have fewer than 10,000 inhabitants and 17 percent even fewer than 2,000—too small to run their own hospitals. Although the country has already reduced the number of municipalities by 7 percent in the last five years, the ongoing merger process has not kept up with the need for health care concentration. The goal is to transfer responsibility for primary care to organizations with at least 20,000 inhabitants.

There have already been many reform initiatives at the local level in the past ten years, one example being the reform pursued in the Kainuu region in the north east (see *Health Policy Developments 3*, pp. 44–45). In most cases, they were born of a desire to improve integration of primary and secondary care. But further objectives were to improve collaboration between small neighboring municipalities and to create a better structural basis for financing. In two small regions, the former hospital districts of Itä-Savo and Päijät-Häme, new organizations have been set up to provide both primary and secondary care. In both cases, the new organizations are municipal federations governed by the member municipalities.

**Purchasing groups
in pioneering
regions**

The Itä-Savo region, with a total population of 60,000, is located in the east of the country and comprises eight rural municipalities and a small city. The reform permits the municipalities to decide how closely they wish to cooperate with the other municipalities. All nine municipalities purchase hospital services from the federation, but only seven of them also buy primary care. Three of the nine municipalities, making up 62 percent of the region's population, also purchase certain social services from their federation, namely elderly care and services for alcohol and drug abusers. The district has a total of eight health care centers and one hospital.

**A la carte health
care services**

The Päijät-Häme region in the south is concentrated around Lahti, the country's seventh largest city. The region covers 15 municipalities and has a total of 210,000 inhabitants. In Päijät-Häme, as in the former hospital district, all municipalities purchase their secondary care from the federation but only eight of the smaller ones, corresponding to one quarter of the region's population, also purchase their primary care from it.

The reform is urgent because municipalities are increasingly unable to provide adequate care services for the rapidly aging population. One reason is a chronic lack of skilled staff. The smallest health centers, in particular, find it difficult to acquire suitable staff and to provide funding for care. Despite mandatory risk-pooling arrangements in the hospital districts, small municipalities find the risk of running their own hospitals unbearably high. From the clinical perspective too, there is a need for reform. Exchanging patient reports is difficult, for instance. Finally, the

**Main problem is
lack of skilled staff**

primary sector, which is divided up into small units, often has a disadvantage compared to the more concentrated secondary sector when it comes to acquiring resources.

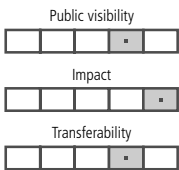
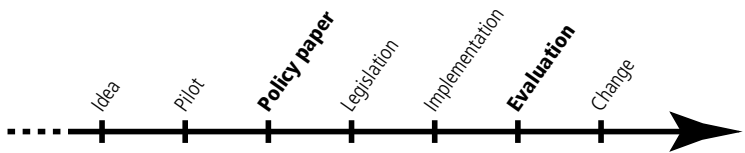
**Conflicting aims:
Lower costs and
more prestige**

The Finnish government’s financial incentive aimed at promoting integration of the municipal services is important, because it is sometimes difficult to expand the federations’ remit to cover primary care. Municipal politicians fear that the municipalities might lose control of care provision and that disadvantageous structural policy decisions might be taken—for example, a decision to relocate a health center to a neighboring municipality. In addition, the municipalities will lose importance as local employers. The key drivers behind the reform, on the other hand, include the directors of the hospital districts. As for the direction the reform should take, there is no doubt among the stakeholders that integrating the various care providers is the way to go.

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France: Hospital reform with side effects



The major French hospital reform (see *Health Policy Developments* 5, p. 27) is now in its final phase. A new governance structure has been put into place for hospitals, giving medical staff more autonomy over managerial decisions. In addition, the government is negotiating with providers to ensure that neither the range of services nor the prices explode as a result of the new form of hospital financing.

The core component of the Hôpital 2007 program, adopted in 2003, was a financing reform for hospitals. Previously, public and not-for-profit hospitals had been financed by global budgets on the basis of historical costs.

**Activity-based
payment for all
hospitals**

For the public sector, a system came into effect in 2004 in which public hospitals receive flat fees for diagnosis-related groups (Groupes Homogènes de Séjour, GHS). Initially, these fees only covered part of their expenditure. The activity-based share of hospital financing rose from 10 percent at the beginning (2004) to 25 percent in 2005 and 35 percent in 2006; the aim is that it will cover costs completely by 2012.

Private hospitals have been paid by the new activity-based system since March 2005. However, in a transition period “national prices” have been adjusted, first taking into account the prices for the private sector, and second using a transition coefficient for each provider based on its own historical costs/prices. The objective is to harmonize the prices for all providers (public and private) by 2012.

The hospital reform was preceded by major investment and decentralization. France spent €6 billion of tax money on modernization and repayment of debts. The sanitary chart, an index of local health needs which had been used to control the number of beds and medical equipment for every hospital in the country, was replaced by regional plans that give more consideration to demographic and epidemiological criteria. The schémas régionaux d’organisation sanitaire (SROS) are now the only hospital-planning tool.

**Regional
morbidity—
adjusted plans**

Hospitals are now governed more on the basis of medical needs, rather than pure accounting, allowing them to participate more in strategic planning and to react flexibly to the requirements of the new billing system. A board of directors, consisting of representatives from local and regional governments, employee representatives and qualified individuals, is responsible for strategic governance, assessment and control. The intention is that hospitals should create large physician-led departments, which will mainly act autonomously on the basis of an internal contract with the hospital management.

However, their autonomy remains limited in many ways. The boards and executives of hospitals are still under the control of

the Ministry of Health and the regional health agencies (ARHs). Resource allocation still results from a mixture of predefined rules and bureaucratic negotiations. Most of the management rules concerning recruitment, investment strategy and the use of new interventions are also set through this administration. One striking example of this is that hospital managers still do not have the power to lay off staff.

Hospitals quickly outmoded in previous system

The reform is intended to remedy a serious problem. The old financing system swallowed a disproportionately large part of the health budget (almost half) but did not enable hospitals to keep up with the state of the art. At the end of 2001, the obsolescence rate (accumulated depreciation divided by gross assets) was 55 percent, and 60 percent of university hospitals did not meet the safety requirements. Stricter safety rules and competition from the private sector meant that modernization could be delayed no longer.

Nobody disputed the need for reform or its underlying principles, such as equal treatment for private and public hospitals. However, some skepticism has crept in over the years with implementation.

Concerns about sustainability and subsequent costs

Initially, the urgently needed investments were universally welcomed, and they had the intended effect. Throughout the country, there have been several hundred regroupings (mostly small facilities) or mergers of activities. Between 2003 and 2005, investment expenditure doubled; the investment rate rose to 8 percent. Weak private hospitals disappeared from the market or joined stronger ones. However, there are now doubts about the sustainability of these investments. Larger hospitals require more coordination effort. The new buildings are more demanding and need new technical equipment and information systems—costs that had not always been sufficiently taken into account.

The risks posed by the new billing system have also not been averted. The system could cause an excessive expansion in the range of services offered as well as pushing up prices. The state has therefore reserved the right to control both the volume of services and prices. The ARHs have the authority to grant licenses to hospitals and other providers but also to revoke or suspend them. In addition, the agencies have to set quantified objectives determining the location of services and costly equipment

as well as a framework of activity including length of stays and surgical procedures. The objectives are part of multiyear contracts; the hospitals receive the agreed funding only if they adhere to the contractual agreements.

It is not yet clear how hospitals will deal with the new restrictions. It is not expected that they will refrain from conducting necessary procedures for cost reasons. But it is possible that they might limit the number of non-priority medical procedures and operations.

In 2005, both the public and the private hospital sectors exceeded their financial targets by 3.5 percent. The government responded by reducing the GHS prices for hospitals by 1 percent, a move that has made it difficult for hospitals to plan their revenues reliably. There is some doubt that the reform really will create a level playing field for public and private hospitals. As mentioned above, the new, autonomous hospital-management structures in public hospitals are bound by a variety of regulations and control mechanisms; under France's strict public sector employment legislation, they do not even have the power to dismiss staff.

**Less maneuver
room for hospitals**

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Dental health care: Inclusion or exclusion? That is the question

A longtime trend in dental care appears to be gradually coming to an end. Many countries still consider removing dental services from the benefit basket a step toward perceived overdue modernization. But others (not only the very progressive Spain and Australia) are already going the other way, bringing previously excluded services back into the benefit basket. Finland too is moving in this direction, having abolished the age restriction on access to public dental care in 2000; Finnish municipalities now have to ensure basic dental care for all inhabitants (see *Health Policy Developments* 7/8, p. 75).

Fairness was the very reason given in recent years, in many places, and over a long time period for removing dental medicine from benefit baskets. For some time now, health economists have thought it inefficient to maintain a universal dental health care system, arguing that it was, in the final analysis, a luxury that only benefited an already privileged section of the population. But that is not the only concept of fairness that one can consider when considering the dimensions of dental care. A very different, older concept leads in the opposite direction: the question of barrier-free access and appropriate care for all age sections of the population (for more on the topic of “Access,” see also *Health Policy Developments* 4, pp. 26–42).

It is true that the figures immediately suggest a glaring lack of proportion. Treatment of just two illnesses in one single organ— tooth decay and periodontitis—swallows up between 3 and 13 percent of health expenditure in EU member states (Tsakos 2005). Oral diseases rank fourth among the most expensive illnesses to treat (World Health Report 2003: 9).

However, epidemiological data do not seem to provide any justification for dental health care’s high ranking. Dental problems

Is privatization of dental care fair?

The better the teeth ...

have decreased significantly in the past 30 years (see Table 3) and experts believe that only a small part of this improvement is attributable to the universal care system (Sheiham 2005: 1).

It is easy to measure dental health—the DMFT (decayed, missing, and filled teeth) index gives a very clear indication of progress. In the past few decades, it has tumbled in industrialized countries; in Norway, for example, from 10 in 1970 to 1 today; 17 percent of people were toothless in 1970, compared to as few as 4 percent in 2004. In Great Britain, 83 percent of today’s 16- to 24-year-olds have more than 18 healthy teeth, compared to just 44 percent 20 years earlier. Each new birth year cohort has lower tooth decay rates than the previous one (Sheiham 2005: 5).

Table 3: International dental health 1990–2005: Number of decayed, missing, and filled teeth in 12-year-olds (DMFT index)

	1990	2000	2005
Australia	1.4	0.8	
Denmark	1.3*	1.0	0.8
France	3.0		1.2**
Germany	4.1	1.2	0.7
The Netherlands	1.5	1.1	1.1
New Zealand	2.0	1.6	1.7
Poland	5.1*	3.8	
Sweden	2.0	1.0	1.0

(* Value for 1991 ** Value for 2006)

Source: OECD Health Data 2007, July 2007

**... the more
expensive the care**

But the decrease in dental problems has hardly anything to do with the services provided by this expensive dental care system. For instance, a mere 3 percent of the reduction in the incidence of decayed teeth among 12-year-olds is attributed to the care system, while 65 percent is attributed to “socioeconomic factors” (Sheiham 2005: 1).

The strongest effect has come from the rise in living standards and the ensuing change in eating habits, followed by regular, proper cleaning of teeth, and fluoridation of toothpastes and,

in some cases, drinking water, salt, milk, and mouthwashes. Finally, the decline in periodontitis is attributed to the lower number of smokers.

In Europe, it became clear, very slowly, that primary prevention makes a disproportionately higher contribution to dental health than treatment or dentures. As a result, a variety of services, particularly curative and prosthetic services, were removed, at least in part, from the benefit baskets all over the continent.

Prevention disproportionately more efficient than treatment and dentures

The decision to do so was driven by cost pressure but also, certainly, by an attempt to ensure fairness. For the most part, it is health-conscious, forward-looking patients who go to the dentist, that is to say people with characteristics that correlate strongly with a higher social status and corresponding income. A solution for the real problem cases in the poorer social strata has not yet been found, even if the system pays for treatment—a further argument for focusing much more on prevention instead of having public funds pick up expensive treatment and costs.

As the level of dental health changed, so did the range of services performed by dentists, providing yet another reason to reduce the oversupply of dental care. To take Norway as an example again, 31 percent of patients who went to a dentist's surgery in 1983 only needed to have tartar removed, a service that can also be carried out by a hygienist, and 10 years later the figure was already 55 percent (Sheiham 2005). When it came to education and prevention, teachers, schools and kindergartens were felt to have more influence and make more efficient use of funding than dentists who, after all, only ever reach a certain portion of the population.

Removing tartar is all dentists do nowadays

Even the painstakingly established myth that regular visits to a dentist are crucial to ensure oral health was dispelled when an evaluation of 29 studies showed that there was no significant difference between patients who had regular check-ups and those who did not (WHO Europe 2007).

Many countries systematically and radically downsized dental care as a result of such findings. In Great Britain, the Demos think tank even came to the conclusion that the entire dental industry could shrink to a core of dental hygienists, supported by a small number of specialists for injuries, cosmetic dental care and orthodontics (Sheiham 2005: 2). The government plans to

Should dental hygienists take over?

have dentists sign contracts with *primary care trusts*, which operate on the local level and have a better idea of the region's needs, instead of with the National Health Service. The idea that the entire population needs dental care is already history in Great Britain (Batchelor 2005). At the same time, however, there have been attempts to improve dental health care (cf. *Health Policy Developments 4*, p. 40 and *Health Policy Developments 7/8*, p. 169).

It is only recently that the extreme form of this trend toward excluding dental services appears to be subsiding. In some places, dental health is beginning to deteriorate again; Australia has already started to reintegrate previously excluded services into the public care system (see the report from Australia, p. 79).

**France: Prevention
no less selective
than treatment**

Another form of inequality in dental care stems from eating habits, which vary considerably depending on social status, and from the gap in care that is created when people who have not undertaken prevention for a large part of their lives are faced with a complete shift in the system concept from cure to prevention.

It has become clear that prevention in dental care is no less selective than treatment. Prevention and screening programs cannot balance out social disparities in care even if they systematically address socially weaker groups. This assumption has been confirmed in France, where it was primarily socially advantaged young people who had themselves examined, instructed on oral care techniques and treated for free at the dentist's (see the report from France, p. 81).

**Tooth decay still
very widespread**

It may not be as easy to do without dental care as many people think. Dental and oral health problems still abound. In fact, according to the World Health Organization (WHO):

- tooth decay can still be found among 60 to 90 percent of all the world's schoolchildren;
- 5 to 20 percent of the middle-aged population, depending on the region, suffer from severe periodontitis, which can result in tooth loss;
- in most countries, cancer of the mouth develops in 1 to 10 people in every 100,000;
- 1 in 500 to 700 children is born with a cleft lip, jaw or palate; and
- almost half of HIV-positive people suffer from fungal, bacterial or virus infections in the mouth soon after contracting HIV (WHO 2007).

Once they have become manifest, all of these illnesses require dental treatment.

Furthermore, downsizing of the dental care system has resulted in the return of problems that were thought long gone. Following the removal of dental services from the National Health Service's remit, the share of toothless people among Great Britain's over-65-year-olds is 46 percent and thus higher than in Slovakia. Even in Germany, where reimbursements for prosthetic services, in particular, have been made dependent on preventive check-ups in recent decades, the infamous gaps can be seen again in elderly and socially disadvantaged persons' smiles.

The situation is much worse in many transition countries in Central and Eastern Europe where there is a combination of shortages, unhealthy eating habits and poor care. While Slovenia and Lithuania have already achieved extremely low rates of toothlessness among the over-65-year-olds, at just 16 and 14 percent respectively, Albania's 69 percent, Bosnia-Herzegovina's 78 percent and the 53 percent in the EU member state of Bulgaria rank behind the Third World (World Health Report 2003: 5).

In Estonia, the privatization of dental health care, which was gradual and initially not intended by the system, has resulted in improved quality but has also led to a drastic reduction in access (see the report from Estonia, p. 84).

Germany, Denmark, Scotland, Central and Eastern Europe, and, to a smaller extent, Australia, New Zealand and the United States all report a marked rise in cases of cancer of the mouth and the larynx. These diseases mostly occur in men and are the eighth most common type of cancer worldwide (World Health Report 2003: 6). It is also worth noting that it is difficult to isolate dental problems from a persons' general state of health. A suppurative focus can attack the lungs and endocardium (Bundeszahnärztekammer 2000); periodontitis can result in vascular sclerosis due to infection, with a high risk of cardiovascular disease (Grimm 2005); severe periodontal disease is associated with diabetes (WHO 2003: 3); and damaged teeth themselves have a negative impact on food intake.

A mechanism that guarantees quality of care plus more open access for disadvantaged persons, and thus particularly vulnerable sections of the population, has not yet been found.

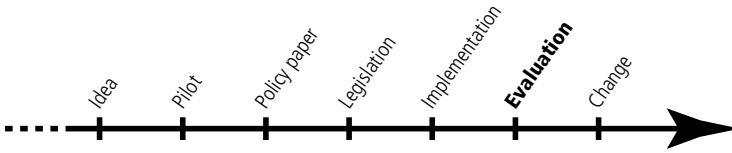
**The toothless
are back**

**Buccal cancer
rising everywhere**

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Australia: Return to public financing for dental care

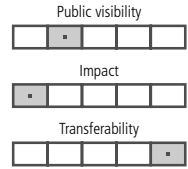


In 1997, following a marked improvement in oral and dental health between 1960 and 1990, Australia privatized its entire dental health care system. The public system was replaced by subsidies for private insurance, which pays part of the costs incurred by insurees for dentist services.

As a study by the Australian Health Policy Institute in 2004 showed, the result was that the dental health of disadvantaged groups deteriorated immediately and, in some cases, dramatically. Now, a return to publicly financed care is being discussed, along with nationwide water fluoridation, health promotion, revitalization of school dental health services, targeted management of public funding, quality control and the establishment of advisory committees on dentistry.

In 1997, the Australian government had completely withdrawn its funding (roughly A\$100 million or €60 million per year) for public dental health care. To compensate for this move, the subsidies for private insurance for dental services were increased to A\$430 million (€257 million) per year. The states were left to step in and provide public care for disadvantaged groups. Some of them did so; some, including the largest state, New South Wales, did not. In addition, school-based dentists began asking for co-payments.

The intention had been for private insurance policies to cover the lion's share of care—but as it turned out, only wealthier Australians took this option. The private care system, which both patients and dentists had always found more appealing than the poorer public system, grew rapidly. Today, around 85 percent of dental medicine employees work in private practices. The range of services there is wider. A private dentist earns two to five times as much as a dentist in the public system. At the few remaining public facilities for disadvantaged persons, waiting lists have grown by 20 percent per year.



Dramatic deterioration in state of disadvantaged groups' teeth

Privatization leads to gaps in smiles and in care

The debate surrounding the deterioration in the state of Australian teeth quickly became public; the popular press reported on the decline in dental health and the unfairness in the care system. It was argued that even a moderate amount of funding would not only result in less pain, fewer extractions and fewer prosthetics, but could also satisfy truly basic needs of socially disadvantaged persons, such as the ability to eat, to speak without embarrassment and to communicate.

National government keeps a low profile

Canberra is still keeping a low profile on this issue. It continues to remind the state governments of their responsibility and also points to the considerable subsidies for private health insurance, which cover approximately 30 percent of the premiums.

Moving back to more public care will probably be no easy matter. Poor pay means that staff are unlikely to change from the private to the public sector. In addition, there is a dearth of new dental talent. The school of dentistry in New South Wales, for instance, has halved the number of places available for students due to funding cuts.

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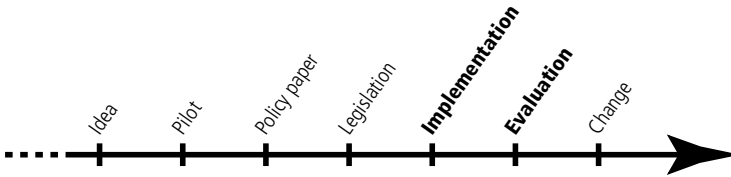
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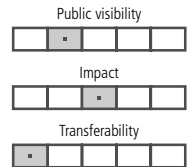
France: Young people difficult to reach even with free care



France is also familiar with the risk of a social divide in dental care, with young people particularly affected. Uptake both of treatment and prevention services differs according to age and social status—a finding that dampens hopes that moving funding from treatment to prevention will eliminate the social imbalance in how funds are employed.

The results of a French prevention program for young people, which has been running for 10 years, suggests that special invitations and promises of free services do not encourage throngs of young people to visit a dentist and that reimbursements do not work well as an incentive—especially for those who are in most urgent need of treatment and guidance on prevention. Nonetheless, the program has not been deemed a failure, since it reached the 12,000 young people who did take part.

Before its latest enlargement, the program, entitled Bilan Bucco-Dentaire (oral check-up), offered all 13- to 18-year-olds the chance to visit the dentist for free once a year and to receive the treatment during that visit free of charge too. Those who are not covered by the program, adults for instance, pay an average personal contribution of around 30 percent for dental treatment.



Young people avoid dentists despite free treatment

Those who do go usually require treatment	<p>A program study conducted by the Paris Institut de Recherches et Documentation en Economie de la Santé (IRDES) showed that more than half of the young people who accepted the invitation to an oral check-up really did need treatment. But fewer than 20 percent actually took part in some form, and only 7 percent participated to the full extent; that is to say, they visited a dentist every year, as intended, and actually did undergo the prescribed treatments.</p>
Significant social differences in state of dental health	<p>There were considerable social differences in take-up. Those who already go to a dentist once a year anyway are more likely to take part in the program. Free services sometimes convince working-class children to participate, but the same does not apply to children of unemployed persons and those from the poorest social strata.</p>
Agreement between health insurers and dentists	<p>But it was precisely the concern about social differences that had led to the introduction of oral check-ups for young people in the 1990s. The differences were also reflected in the state of dental health. Although France's DMFT (decayed, missing or filled teeth) index improved from 4.2 to 1.9 in the decade before 1997, working-class children still had an average of almost 2.5 decayed, missing or filled teeth, while the figure for executives' children was less than 1.5. France's DMFT index was poor by international standards, too.</p>
Birthday card	<p>The Bilan Bucco-Dentaire is based on an agreement concluded between the major health insurance funds and dentists' unions in 1997. Designed to create "incentive actions for oral prevention and screening," it was the first prevention program in the form of a contract between French insurance funds and health care providers. The target group was 15- to 18-year-olds, who tend to try to break free of the rules that apply to them at home. Negligence of dental health as a young person often results in expensive treatment as an adult. In 2003, eligibility was expanded to include 13- and 14-year-olds, and, since January 2007, the program has been offering check-ups and treatment at three-year intervals for all children and young people between the ages of 6 and 18. Screenings are compulsory for the 6- and 12-year-olds. For the 9-, 15- and 18-year-olds, it is voluntary but free of charge.</p>
	<p>For the 13- to 18-year-olds, the invitation to the dentist came with a birthday letter from the health insurance fund. The cam-</p>

paigned was backed up by posters and TV and radio commercials. Those who accepted the invitation and went to a dentist of their choice within three months of their birthday not only got a free check-up but were also eligible for free treatment for the following six months, including crown and denture treatment and orthodontic treatment. All of the costs were borne by the insurance fund.

Nonetheless, many dentists did not cooperate properly. Often, they refused to provide free treatment; sometimes they even rejected young people who wanted a check-up within the framework of the program. More than 40 percent of the treatment forms evaluated showed that the treatment had not been completed. In addition to general indifference, the program's low acceptance among dentists is thought to be due to red tape and delayed payments from the insurance funds.

The new program aims to improve the way in which young people are addressed, with better letters, flyers and TV commercials. Prevention experts now visit every school and give a lesson. Whether these measures will get more teenagers to the dentist remains to be seen.

Dentists not cooperating as much as they could

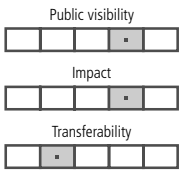
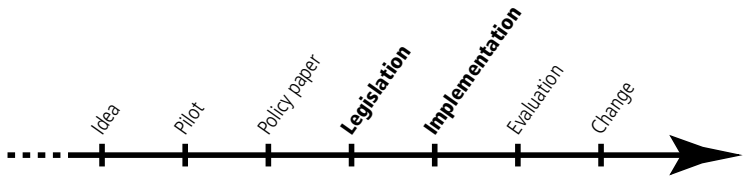
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Estonia: Dental tourism and EU taxes pushing up dental care prices



Since it introduced social health insurance in 1991, Estonia has had its difficulties with dental health care. Although the original system of cost coverage was replaced in 2001 by a system of fixed reimbursements, the situation did not improve significantly. The fixed reimbursements have now been doubled. However, experts doubt that this move will really help improve Estonians' worsening oral health.

Dental treatment still free for everyone after 1991—at least on paper

After 1991, dental care remained free of charge, in principle, for all insured persons. However, as funding was very limited, free care usually only existed on paper. The waiting lists for SHI dentists grew quickly, and patients opted for private dentists, who were able to offer much better care. However, this route was really only possible for high earners. Between 1999 and 2002 alone, the share of Estonians who had seen a dentist in the previous year fell from 51 to 31 percent.

Price increases ousting public care

The sharp decline in access to dental care was primarily caused by price developments. Private dentists rapidly upgraded both their training and their technical equipment, which meant that they were increasingly able to profit from the growing purchasing power of wealthier Estonians. Dental tourists from western countries also pushed prices up. On top of this, the parliament had to raise the reduced VAT rate of 5 percent for medical services to the 18 percent that applies for other products and services when the country became an EU member in 2004. As a result, an ever larger part of the population did not benefit from advances in Estonian dental medicine.

The 2001 health reform had already attempted to address this issue. As a result of the reform, only children and young people receive free care. Adults receive fixed reimbursements upon presentation of an invoice, whether they had consulted an SHI den-

tist or a private dentist. Reimbursements vary based on assumptions concerning patient needs for dental care. The highest reimbursements are paid to pensioners, followed by pregnant women and mothers of infants, “patients with higher dental care needs” and then, finally, other adults.

It became clear, however, that reimbursements were too low to reopen access to dental care for many Estonians. Price developments swiftly offset the financial advantage. The government was thus forced to double reimbursement rates for adults.

Pensioners receive their fixed allowance for dentures (€255.60) every three years; all other fixed reimbursements (€19.20 for adults, €28.80 for patients with higher dental care needs, mothers and pregnant women) are paid on a one-year basis. Although these amounts may seem very low at first glance, the government has calculated that they cover around 43 percent of the actual costs of dental care.

All dentists in Estonia now receive a fee from the health insurance fund for free care provided to children and young people. However, the fee is so low that most dentists refuse to actually perform the service. So, once again, cost coverage only exists on paper. Thus, the new system has evidently not solved the basic dilemma, which is that reimbursements are not in line with cost developments.

The same lack of correlation between reimbursements and prices is also having an impact, though of a different nature, on care for adults. Private dentists are increasingly offering their less affluent patients a few elementary services at a price equal to the fixed allowance, whether those services will actually help them or not.

It can therefore be concluded that by moving to fixed reimbursements, Estonia has swapped one inequality problem for another. In the old system, whether individuals received appropriate care probably depended on luck, contacts or where they happened to live. Today, even after the latest reform, income has increasingly become the determining factor. The price-hiking effects of the private care system, the EU internal market, and the resulting misguided control strategies cannot be restricted by means of allowances.

**From 2001 onward:
Fixed reimburse-
ments for everyone
and free treatment
for children**

**Dentists do not
want to work for
health insurance
rates**

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Funding moves toward more cost-splitting

The general trend in health care funding continues to move toward a readjustment of the balance between individual responsibility and social solidarity (see *Health Policy Developments 5*, pp. 15–32), with the former increasing and the latter decreasing. In Europe, the system of co-payments and user charges, which initially applied mainly to pharmaceuticals and dental care, is being expanded to include ambulatory and hospital care. To avoid hardship and misguided health policies, particularly disadvantaged sections of the population are often exempted from user charges.

The way a society funds its health services is never a purely budgetary matter; the method chosen ultimately has an impact on the health of the population, on the quality of services and even on research in the areas of medicine, medical devices and pharmaceuticals. This is true across the board—when individuals cover most of the risk of illness themselves and choose a form of insurance that suits their income; when the entire population or a more or less large part of it is covered by compulsory insurance; and when income-dependent contributions or tax-financed service providers provide a major part of health services for everyone.

Every funding system has its own specific strengths and weaknesses. All over the world, adjustments made over time with the aim of compensating for system flaws have mitigated or even completely eradicated the typical “symptoms” of this or that method of funding.

Many societies opted for a mixture right from the outset in order to combine the advantages of various funding systems and eliminate their disadvantages. A truly new idea devised in recent decades is the health savings account, which has been introduced in Singapore (see *Health Policy Developments 7/8*, p. 109) and tested

Funding method has far-reaching impact—even affecting research

Decision based on historical and cultural values

in pilots in countries such as South Africa, China and the United States (see *Health Policy Developments* 7/8, p. 86). Singapore's government is currently fine-tuning its Medisave system as false incentives for patients have caused unwanted side effects (see the report from Singapore, p. 93).

**Two extremes—
neither perfect**

Neither of the two extremes—individual responsibility or social solidarity—exists in its pure form in any of the world's industrialized countries. Even in very liberal societies, health costs are predominantly borne by the public purse or insurers, since they are so unevenly distributed and so difficult to calculate over an individual's lifetime. On the other hand, state-financed systems of comprehensive insurance without user fees (of the type that used to be customary particularly in the socialist states) have led to corruption and thus to new inequalities due to the notorious lack of material resources and incentives.

**Privatization of
health-risk
coverage is good
for providers**

Where individuals have to assume a substantial amount of the financial risk of illness, as is the case in the United States, the health sector evolves into a competition-oriented, dynamic and extremely innovative industry. As long as clients have purchasing power and their complaints are not too difficult to deal with, the demands they articulate are met reliably and quickly. According to the neoliberal theory, patients in such a system are more likely to develop into autonomous, responsible health care partners than in systems in which a large share of the funding comes from an external source.

And yet, those articulated demands by no means always reflect the actual needs. The health services market is extremely provider-oriented; even in free market structures, when things get serious, only very few people feel able to decide between this or that form of care and thus prefer to leave the decision to their physician. Consequently, competition does generate new services and higher costs but not necessarily more health.

**Private care
backed by public
funding**

By their nature, systems in which individuals assume a large part of the risk of illness themselves spawn inequality in health care. Only those who earn enough money to insure themselves and can reliably predict their future finances can expect to get good care. Private forms of funding are therefore being supplemented, as has been the case in the United States for many decades, by tax-funded programs for people on a low income, free

emergency care or subsidized insurance for illness in old age. If all of the public expenditure on insurance programs and subsidies (particularly in the shape of tax-deductible insurance premiums) is added together, the total in the United States currently exceeds private expenditure on health. The gap between the two funding systems can result in sick people not going to a physician until their health has deteriorated drastically.

U.S. health policy experts have spent decades analyzing how the considerable gaps in this fragmented system could be plugged and misguided strategies corrected. Following two false starts under the Democratic Clinton administration, President George W. Bush has now introduced partly income-dependent premiums for the Medicare health insurance plan for the elderly—a step toward a European-style social insurance system (see the report from the United States, p. 96).

Finally, health care systems based on a high risk for the individual consume a larger share of gross domestic product than collectively financed systems, precisely due to what are often supply-induced price developments. However, the political sphere only considers this a problem if health expenditure becomes a key cost factor for a particular player, for example, a major client. In the United States, this is the case, for instance, with those employers who pay their employees' private health insurance.

Compulsory insurance funds are the most important source of health care funding in Germany, France, the Netherlands, Austria, Luxembourg and some of the Central European countries, namely the Czech Republic, Croatia, Estonia, Hungary, Slovakia and Slovenia (WHO 2005: 8). Slovenia is also about to add statutory long-term care insurance to its social insurance system in line with German practice (see the report from Slovenia, p. 98). In Europe, there are only four countries (Greece, Italy, Portugal and Switzerland) where patients pay more than 30 percent of their health costs directly out of their own pocket (WHO 2005: 8).

The concepts behind compulsory insurance systems make them more compatible with the goal of equity as they ensure easy access to health services for a large portion of the population and are conducive to contributions staggered in accordance with individuals' ability to pay.

Large share of GDP—what's in a number?

Compulsory insurance—easier access makes for more equality

In principle, such systems are also better equipped to tackle rising costs. Compared to private insurers, compulsory insurance funds have sizable market power unless the government imposes rules that significantly restrict their ability to exercise that power. However, if unrestricted, they tend to crush competition between providers by means of price regulation. In countries with compulsory insurance systems, health policy is mainly about attempting to maintain a balance between these extremes.

In some countries, such as Germany, the majority of the workforce has compulsory insurance; in others, France for instance, the whole population has compulsory insurance. In the German scenario, private health insurers are a source of fresh impetus for the compulsory insurance funds, but also for unfair competition and freeloading. In the French scenario, the compulsory insurance funds create space for competition on the private market by limiting the scope of their own benefit baskets.

**Tax-based funding
often lacking
dynamism**

Then there are tax-financed systems, of the type found in the British Isles, Scandinavia and on the Iberian peninsula (WHO 2005: 8), which essentially have to struggle with similar problems to those faced by a compulsory insurance system if the supply side is mostly privately organized. However, where state health services run hospitals and primary care facilities, physicians often receive a fixed salary from the state. Where even pharmaceutical manufacturers are publicly owned, efforts to plan access to the system, funding allocation and progress in care are purely administrative in nature. This curbs dynamism and places too much of a strain on administrative resources. In extreme cases, the result is poor motivation and poor performance on the part of employees, leading to long waiting times, which might then be shortened by money changing hands on the sly.

**Control
mechanisms and
problems similar
in all systems**

A comparison of the instruments with which legislators in countries with quite different funding systems attempt to strike a balance between individual risk and collective coverage reveals many similarities. Time and again, fixed and percentage-based co-payments, upper limits, rewards and penalties are put in place. The value-based decisions that originally led to the introduction of a specific system hardly play a role anymore.

The findings of a major empirical study by the American Rand Corporation at the end of the 1970s and beginning of the 1980s

(Keeler 1992) made it clear that upper limits on co-payments and percentage-based user charges can control uptake of health services to a significant extent. The precise effect of such mechanisms on population health and on cost development depends on their specific configuration.

Today, all 15 “old” EU states split costs in one of the ways described above, at least for pharmaceuticals and dental care and increasingly for GP, specialist and even inpatient services, no matter what their country’s predominant form of funding.

In Greece, the user charges depend on the health insurance fund chosen; in Sweden, they depend on the place of residence; in Denmark, the determining factor is the tariff selected, and in Ireland, it is the person’s income (Jemiai, Thomson and Mossialos 2004: 2). In Austria, France, Germany and Luxembourg, hospital patients have to pay a low per diem; in Finland, Ireland and Belgium, the amount has more of an impact on the pocket. In France, there are also percentage-based co-payments for inpatients, and in Sweden, a co-payment is also charged for emergency patients. Usually, there is an annual maximum for these additional payments, ranging from €100 in Sweden to €600 in Finland (Jemiai, Thomson and Mossialos 2004: 2).

Percentage-based co-payments are the most common form for pharmaceuticals and are in place in Denmark, France, Greece, Luxembourg, Portugal and Spain. In Austria, Germany and the United Kingdom, a fixed fee is applied per prescription. In many countries, certain groups pay less or nothing at all for medicines. This applies to diabetics in Sweden, pregnant women in the United Kingdom, and the chronically ill in Finland, Sweden, Spain and, again, the United Kingdom. In Belgium, Ireland and Spain, the elderly are exempt from user charges; in Germany, children are exempt, and in the United Kingdom, both groups are. In some countries, user charges are applicable only for certain drugs. Portugal exempts drugs for the chronically ill from user charges, Belgium exempts drugs for life-threatening diseases, Greece exempts both, and France exempts particularly effective medicines from co-payments (Jemiai, Thomson and Mossialos 2004: 2).

The numerous user charges and co-payments are usually too low to significantly relieve the burden on public health budgets. Their primary aim is to control use, not to reduce the burden.

Mixed funding is the current trend

Percentage-based co-payments most common for pharmaceuticals

But it is often difficult to measure how the many financial control mechanisms affect consumers' behavior. It is difficult to separate them from other stimuli, and they change so quickly that it is not possible to arrive at accurate conclusions by observing them.

**Australia: Carrots
and sticks for
state and territory
governments**

It is well known that financial incentives influence consumer demand for health services. However, highly complex administrative entities might also be influenced by such incentives, as the example of Australia shows. This is rather surprising, since elected bodies are driven by completely different motives than individual consumers. Councils and committees of political representatives work with funding provided by others, not with their own money, and tend to deny the motives behind their own spending, referring to laws and constraints that supposedly leave them no other choice. If it is possible, as in Australia, to prove that their actions are a response to incentives earmarked for specific purposes, new funding opportunities can be opened up (see the report from Australia, p. 101).

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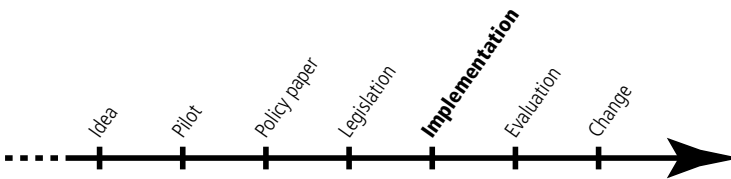
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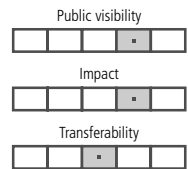
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Singapore: Medisave gets some fine-tuning



Following a recent government policy decision, the inhabitants of the city-state of Singapore are now allowed to withdraw larger amounts from their Medisave savings accounts to pay for certain treatments and diagnostic procedures. Fine-tuning of this nature is necessary in a financing system that endeavors to combine individual responsibility and universal coverage in an innovative fashion (see *Health Policy Developments* 7/8, p. 109).

In Singapore, people with an income from work must put 6 to 8 percent of that income into a publicly administered health savings account, depending on their age; the amount is invested on the international capital market and earns the commercial interest rates. The account is used to pay all of the larger health bills, excluding visits to the doctor and pharmaceuticals for petty ailments.



Every employee has a savings account to cover the risk of illness

But even beyond those exclusions, the account holders are not free to choose how much they wish to spend on this or that treatment. To keep costs under control, the government imposes restrictions on withdrawals, allowing them only for a precisely defined benefit basket. If an invoice exceeds the limit or if too many invoices are submitted for one particular service within a specific period of time, the patient must pay the excess amount out of pocket.

“Steering” in unintended directions

As everyone attempts to avoid out of pocket payments, demand for health services sometimes develops in an unintended direction. For instance, since use of day surgeries was restricted by the Medisave benefit basket, many patients had themselves treated as inpatients. Although this made treatment more expensive overall, the cost was easier for the individual patient to bear because the costs could be debited from the Medisave account. Now, in order to steer things back on course, the limit for day surgeries has been increased by 50 percent in one go; instead of S\$200 (€97), S\$300 (€146) can now be withdrawn from the patient’s Medisave account. Previously, 77 percent of all day surgery treatments were paid out of Medisave accounts; in future, the figure is expected to increase to 84 percent.

Medisave benefit basket expanded

To the delight of wealthier insurees and their physicians, the day limits for inpatient treatment have also been increased. Patients may now withdraw S\$450 (€218) instead of the previous S\$400 (€194). In particular, this move accommodates those who wish to stay in higher class wards.

The Ministry of Health has also added computer tomography (CT) and magnetic resonance imaging (MRI) scans, two expensive diagnosis procedures, to the benefit basket for cancer patients. Previously, it was feared that there would be an excessive increase in these screenings. Today, they are an indispensable component in treatment plans.

Treatment ended when account emptied

Another undesired consequence of the savings incentive in the Medisave system is that psychiatric patients terminate their regular treatment when the Medisave amount earmarked for such treatment has been used up. It was for this reason that there was also a major increase in the limits for psychiatric treatment, from S\$3,500 (€1,700) to S\$5,000 (€2,425). It is not clear whether this increase will ensure that psychiatric patients actually do undergo treatment on a more regular basis.

Medisave, the world's oldest system of its kind, combines measures to control health services utilization with measures to accumulate capital. When the credit in a Medisave account exceeds S\$ 33,500 (€16,250) the excess amount is transferred to the individual's retirement savings account. Those who, for example due to chronic illness, exhaust their Medisave balance can build up debts or pay out of pocket. The Medisave contributions can also be used to pay for the premiums of an insurance policy for major illnesses (Medishield). Those who really have been unable to pay into a savings account must rely on payments from the subsidiary Medifund, which is financed through tax money.

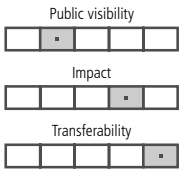
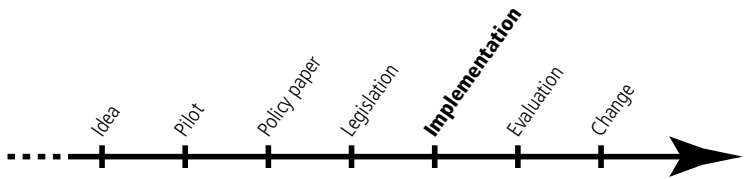
Economists have expressed doubt whether the assumption behind the Medisave model—that demand for health services can be controlled in a similar way as for consumer goods—is correct. In practice, the system does not seem to work quite as perfectly as in theory, as the experience in Singapore has shown. Evidently, insurees do make a very clear distinction between money that they have to pay out of their own purse and money withdrawn from their Medisave account. It looks as though their account balance may have a correspondingly low impact on their behavior.

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United States: Medicare premiums now income-dependent



An important change has been made to Medicare, the U.S. health insurance plan for people over 65, the disabled and people with end stage renal disease. In an effort to ease its precarious financial situation, high-income Medicare beneficiaries have had to pay a larger share of their premium for services beginning in 2007. Critics have two concerns: First, it undermines the solidarity of the Medicare program; second, it will not have much of an impact on Medicare's resources.

Services more expensive for high-income beneficiaries

Medicare is divided into four parts—Part A, institutional care; Part B, outpatient care; Part C, managed care; and Part D, pharmaceutical care.

Part B of the system, the only part to which the change applies, covers services—physician and hospital visits, diagnostic tests, and ambulance services. Currently, 75 percent of the Part B premium is financed through general tax revenues and 25 percent is paid by the Medicare beneficiaries themselves. The increase in the personal contribution will affect the 4 percent of beneficiaries with an individual income of \$80,000 or a joint income of \$160,000 or more per year (€59,500 and €119,000 respectively). The Congressional Budget Office estimates that the increase of the personal contribution for high income earners will increase Medicare revenues by \$13.3 billion over a ten-year period. A particular source of pressure on the system has been the introduction of prescription drug benefits (Part D) (see also *Health Policy Developments* 7/8, p. 179).

Will Medicare turn into a welfare program?

The strongest proponents of the new income-dependent system are to be found among conservative Republicans, who want to limit public Medicare spending. Most Democrats are opposed, fearing that the new approach could turn the insurance system into a welfare program. A few Democrats hope means-testing will bring about greater social equality and help overcome Medicare's financial crisis without the need for benefit cuts.

However, it is difficult to estimate the impact of this premium rise, because high-income beneficiaries can opt out of the system—which is what they probably will do if their Medicare premium reaches the same level as a private insurance premium. Moreover, many employers pay their employees' Medicare premiums. If they have to pay more for their high-earning employees, they might choose to stop doing so.

The new approach is unlikely to result in a marked change in uptake of Medicare services, though it may well alter overall acceptance for the system. It is not yet clear whether the saving targets will be achieved or whether a loss of confidence will lead to the introduction of a misguided long-term control strategy.

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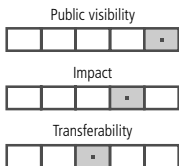
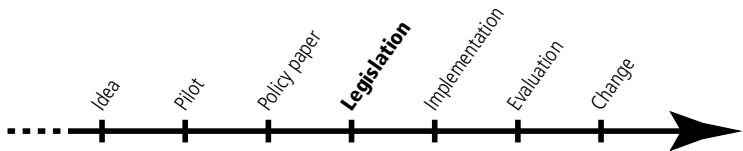
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Social Security Administration. Medicare Part B Premiums: New Rules for Beneficiaries with Higher Incomes.

Slovenia: Long-term care insurance on the horizon



Following various false starts, the governing majority in the Slovenian parliament is now seeking to introduce compulsory long-term care insurance before the 2008 election. It will largely be based on the German long-term care insurance system, combined with components from Luxembourg's and Austria's systems. The new financing mechanism is to be the third pillar alongside health and pension insurance—one of the elements adopted from German long-term care insurance. Other aspects borrowed from the German system include the combination of cash benefits and in-kind services; classification of long-term care patients in care categories based on a medical assessment; and staggered services for those patients, from home care to temporary inpatient care and rehabilitation, right through to full-time institutional care. In the Austrian care system, Slovenia considered the regular monitoring of the system and the involvement of patient representatives in all decisions to be best practice, while Luxembourg served as a good example due to the mixed funding it introduced in 1999. In Luxembourg, 40 percent of long-term care costs are covered by government funding; the rest is financed through a special levy on electricity tax revenue and through long-term care insurance (with contributions corresponding to 1 percent of the insuree's total income). In addition, Slovenia looked to Luxembourg for ideas on coordination of long-

term care; in that system, a multi-professional team of care coordinators regularly assesses the patient's care needs and steers the patient through the system.

Of Slovenia's 2 million inhabitants, 67,000 currently receive publicly funded long-term care services through health and pension insurance funds and the municipalities. In the long run, however, the present system will not be able to cope with the challenges posed by demographic change. The general opinion is that its diverse, often unclear funding structures have led to numerous social disparities and have not provided a satisfactory level of long-term care for those seeking it.

Current system is convoluted and complacent

And yet, the shortcomings of the old, convoluted financing system probably had a not completely undesired controlling effect, since elderly long-term care patients, in particular, are mostly cared for at home. The fact that residents in long-term care institutions or their relatives pay more than 40 percent of the costs themselves is also likely to play a role in this phenomenon.

Controlling demand is not the objective of the new long-term care insurance system. Rather, the new concept represents the government's and parliamentary parties' attempt to react to Slovenia's rapidly aging society. Having gone up 50 percent in the past 20 years, the number of elderly people is expected to climb considerably again over the next 15 years, as is their level of dependency. Slovenia's baby boomers, born between 1950 and 1955, will all be of pension age by 2020 at the latest.

Families and pension insurance fund pay most

At the moment, the pension insurance fund (which also provides coverage for disabled persons) still pays the second largest share of costs for long-term care services; private households pay the largest share. A further 11 percent is contributed by the municipalities, and this figure is on the increase. Service providers are also overstretched: Home care, if not provided by relatives, is almost exclusively performed by district nurses who also have numerous other tasks. Care for elderly people over the age of 70 takes up more than 45 percent of their time.

One particular shortcoming in the present system is considered to be the fact that younger adults with long-term care needs have no suitable financial support before they receive an old age or disability pension. In the new system, they too will benefit from long-term care insurance.

Care according to individual needs

The new system of insurance is intended to cover the costs of both home and institutional care services and can also involve care allowances paid to the beneficiaries. It will cover medical assistance and small-scale home conversions that allow the insuree to stay longer at home. The plan is that insurees will be able to choose between direct transfer payments and specific long-term care services. When choosing the cash option, beneficiaries may buy care on the market themselves; providers will not have to conclude contracts with the insurance fund. The care would be incremental, starting with the provision of home care or the monetary equivalent thereof.

The insurance is intended to cover all adults who have paid into the system before requiring care. In addition to compulsory insurance, it will be possible to upgrade coverage on a voluntary basis.

Political parties agree on the fundamentals

All political parties agree that Slovenia needs a new system of funding long-term care, but it is not yet clear how to shape it. The idea of an entirely socialized insurance system, a solution proposed by a Conservative government, has not caused any objection in the post-socialist country. The only concerns are to be heard in municipalities where lay informal care is currently common practice. Local politicians are afraid that they will soon have to professionalize this care and this it will be a costly undertaking.

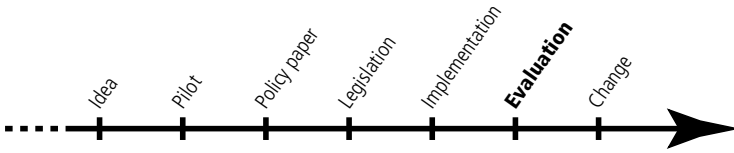
Towards professional modern LTC

If the new financing system steers developments at all, it really will be in the direction of professionalization and modernization of care. The questions of what form private contributions should take, what needs they should cover and whether and how they should have a “steering effect” are still being discussed.

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Australia: States willingly pay for public health

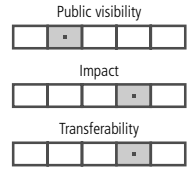


Australia’s states and territories have reacted in a remarkably favorable fashion to centrally provided funding for public health programs. Although not obliged to do so, the states regularly top up the funding provided by the federal government for certain programs with their own money. The amount spent increases by an average of 4.8 percent per year. The reason for this public display of generosity is thought to be that the states and territories can design the programs themselves and thus earn themselves a good reputation with the electorate. Since Canberra handed down more responsibility to regional governments, numerous defined health objectives have actually been achieved on this basis.

Public health is one of the poor cousins of Australia’s health funding. Although investments in public health do pay off, they are not well positioned to compete with the curative sector. Quite simply, a real life is always valued more highly than a statistical one.

The states and territories on the fifth continent have only very limited tax autonomy and primarily manage centrally raised tax funds. In Australia, public health is a governmental task. Up until ten years ago, the federal government designed, financed and controlled all of the country’s public health programs itself. Payments to the states were strictly assigned to specific purposes. The state and territorial governments were responsible for employing, administering and keeping an account of the provided funding. As in other sectors, the federal government always endeavored to exercise as much control as possible over “its” money. Meanwhile the states and territories—each with its own parliament and different political majority—sought as much flexibility as possible in how they used earmarked funds.

This form of funding distribution was abandoned a decade ago. In 1996, Canberra started concluding “Public Health Outcome and Funding Agreements” (PHOFAs) with the states and



**Public health—
the poor cousin of
health policy**

**States motivated
to get involved**

territories. The first agreement came into effect in 1997; the third runs from 2004 to 2009.

Everything happened so quickly, given that the change initially was a mere administrative procedure and the existing programs continued to run. The only difference was in funding administration. What began as an advantage is now considered a disadvantage. A relatively recent evaluation revealed that the new programs, designed by the states and territories themselves, are more successful than the old programs.

**Agreements
on specific health
outcomes**

In the PHOFAs, the federal government and the states and territories agree on specific health outcomes but not on how they are to be achieved or measured. The current agreements relate to communicable diseases (focusing on HIV/AIDS), cancer screening (particularly for breast and cervical cancer), women's health, sexual and reproductive health and certain risk factors, such as alcohol and tobacco use. The idea behind the PHOFAs was that the states and territories would put the funding to better use since they are more familiar with the local situation. It was not anticipated that they would also top up the funding.

In addition to defining health objectives, the PHOFAs also specify the level and distribution of funding provided by the federal government, some key principles, values and general processes for public health services and programs, and the roles and responsibilities for each level of government. The federal government then gives A\$812 million in funding (roughly €500 million for a population of little more than 20 million people) over a period of five years. As well as signing the agreement, the states and territories have to comply with a few other conditions in order to receive the funding. However, the conditions have little to do with achieving the objectives; they are more concerned with reporting duties.

**Cross-country
public health
partnership**

Although Canberra had initiated the idea, the next step of defining the framework for the future PHOFAs was taken by the Australian Health Ministers' Council. It set up a National Public Health Partnership between the federal, state and territory governments, which then worked together to develop ideas on how to modernize access to prevention.

Since the introduction of PHOFAs, several Australian public health programs have become extraordinarily successful, although

it is not possible to say for certain whether the more flexible financing led to that success. Progress has been made in the following areas:

- The mortality rate in the target age group for the BreastScreen Australia Program (50-69 years) declined from 71 per 100,000 in 1993 to 53 per 100,000 in 2001.
- The age-standardized cervical cancer death rate for the entire female population fell from 3.4 to 2.2 per 100,000 women.

The results for other health objectives were not quite as impressive, although it is never possible to say how the figures would have developed had the public health programs not taken place:

- Needle and syringe programs for drug addicts proved unable to reduce what, at 53 percent, is a very high rate of hepatitis C patients.
- HIV infection rates are rising in the three eastern states of Australia.
- Smoking rates are declining overall, although there are indications that young people, particularly females, are taking up smoking at higher rates.
- Use of ecstasy and designer drugs among those aged 14 and over increased by one-fifth, from 2.4 percent in 1998 to 2.9 percent in 2001.

Although critics praise the idea of PHOFAs, they find fault with key elements of their design. For instance, an evaluation of the second phase in 2003 indicated that the reporting duties placed too great an administrative burden on the states and territories, the mechanism of responding to new challenges with new priorities was too rigid, and the federal government was still funding public health programs directly, thus bypassing the states and territories. Other points raised were a lack of flexibility to allocate funding according to local needs, the lack of a mechanism to set new national priorities to guide local investment and, finally, too much focus on performance indicators, resulting in ongoing historical levels of funding for each program.

**Too much
bureaucracy,
too little
momentum**

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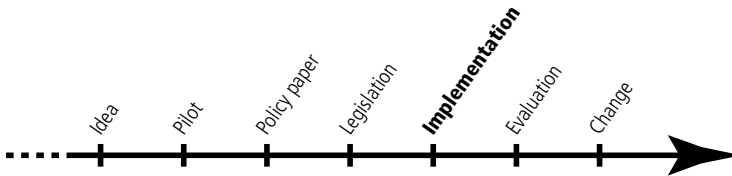
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Newsflash

Finland: Patients stay in charge of their data

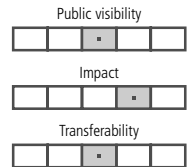


Finland has found a solution to the issue of accessing personal health data. The idea is that all health service providers, public or private, will store their patient records in a central archive. But only the provider who stored the data will have free access to it. Those who wish to view another provider's data must first obtain the consent of the patient concerned. The central archive will be managed by the Social Insurance Institution (SII).

The changes are set out in an act passed by the Finnish Parliament in preparation for the nationwide rollout of electronic patients' records in 2011.

In principle, every provider will keep its own electronic archive but organize it using a standardized structure to avoid technical problems that prevent authorized parties from accessing the data. A specially developed search engine will collect all of the data stored in the archive system relating to a certain patient. The search engine will also enable patients to view their own data as well as to see who has accessed the data and when.

Finland's introduction of electronic prescriptions has also moved in that direction. Again by 2011, all providers will have to enter their prescriptions into a system to which pharmacies will



Standardized EMR archive

Electronic prescriptions by 2011

have access. However, patients will have the right to refuse electronic prescriptions and to request paper prescriptions instead.

**Government funds
introduction of
e-prescription**

Electronic prescriptions are rolled out on the basis of a decision made in 2001. The decision to establish a central electronic archive for patient data came the following year. Between 2003 and 2006, electronic prescriptions were tested in a pilot project. In the four-year transition period up until 2011, which has just begun, the government will pay all of the costs. Later, the costs are to be shared between service providers and pharmacies.

**Concerns regarding
sensitive data**

There is no political dispute about the need for a central archive in Finland. The concerns voiced focused on security for the sensitive information to be contained in such an archive. The general opinion is that the solution arrived at provides the fairest form of access to information for providers and patients.

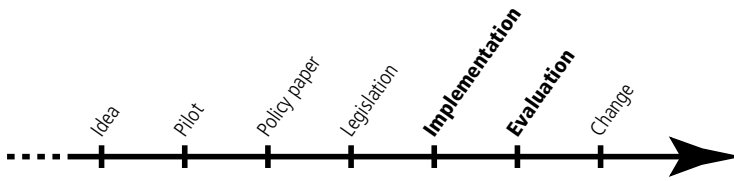
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Israel: Demand-driven Palliative Care Training Program

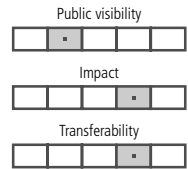


A successful training program on palliative care in Israel aims to teach physicians, nurses and social workers about the care of terminally ill patients and to improve the awareness, attitude and knowledge of health care professionals with regard to the principles of palliative care. Experienced palliative care specialists designed courses that have since been successfully completed by many participants. Limited funding has made the future of the program uncertain. Nonetheless, since feedback on the program has been extremely positive, this report outlines the factors that have made it a success.

The first step was to train the trainers. Professionals who were already working with the terminally ill developed an interdisciplinary syllabus for trainers and the course-specific subjects and outlines. In this first phase, experienced palliative care professionals (i.e., the future trainers) came together for six seven-hour days, a total of 42 hours, over a two-month period. This arrangement enabled learning groups to be formed and the participants to build personal relationships.

In the second step, physicians, nurses and social workers from general hospitals, community services and nursing homes were invited to apply for the program. A committee then selected the participants, taking into account the extent to which the applicants dealt with terminally ill patients in their everyday work, their motivation and their willingness to contribute to it.

In the third step, the trainers trained in phase 1 conducted ten courses all over the country. In 2006, approximately 250 people took part. A further ten courses were scheduled for 2007 with quickly filling waiting lists. About 80 percent of the participants were nurses; it proved considerably more difficult to convince physicians to take part. There were no financial incentives to participate, but plenty of non-financial incentives. Those who took



First step: Training the trainers

Second step: Selecting the participants

Third step: Nationwide rollout based on snowball effect

the courses were satisfied with the acquired skills, as were the sickness funds, which proudly recognized the investment in their workers.

The study that supported the program bears testimony to its success. Each participant was interviewed using a semi-structured questionnaire, once before the course got underway and then again six months later. In the first interview, the questions related to participant expectations; the second dealt with their thoughts on the structuring, subject matter and level of teaching. In addition, the evaluation examined the participants' perceived ability and opportunities to apply what they had learned.

**Participants
in favor of
continuation**

The replies showed that the participants felt they had acquired knowledge in palliative care; in particular, they stressed the physical aspects such as pain medication, treating nausea and other physical problems. They also felt better equipped to deal with emotional problems such as being the carrier of bad news and telling the truth. Many of the participants would have liked more help with difficulties in communicating with patients.

Interestingly, a number of participants formed informal support groups; many of them work alone and do not have colleagues with whom they can discuss problems and experiences. Most of them would like to learn more and to maintain these contacts.

**Palliative care part
of benefit basket**

The program provided the first opportunity for a large number of health care professionals to discover more about the idea and principles of hospice care and to gain theoretical and applied knowledge. This was all the more important since a 2005 committee nominated by the director general of the Ministry of Health recommended the inclusion of palliative care in the services supplied by the health insurance funds. The committee recommended that if two physicians diagnose a patient as having less than six months to live, the patient should be able to use the services of a specialized palliative team of physicians and caregivers (see *Health Policy Developments 5*, p. 82).

**Families and
providers all
satisfied**

The program benefits the terminally ill and their families, primary care workers, and specialists in palliative care. Families receive emotional support; their burden of care decreases. Primary care providers feel more confident and know where to turn when difficult issues arise. Finally, the status of palliative care special-

ists is strengthened. Despite the high numbers of participants and their extremely satisfied reaction, the program and the courses did not receive enough publicity.

The program was initiated and developed by the Jewish Federation of New York, the Association for the Planning and Development of Services for the Aged in Israel (ESHTEL) and the Department of Community Medicine at Ben Gurion University. It received a three-year grant from the Jewish Federation of New York, which has a longstanding interest in improving the quality of care of the terminally ill and supports various related programs in Israel. However, all three stakeholders have no budgetary resources to fund the courses beyond the initial funding.

A new source of funds is currently being sought. The Ministry of Health warmly welcomed the program although it was not involved in its development and running. It too lacks the financial resources to continue the program. Medical and nursing schools have displayed an interest in integrating parts of the courses into their programs. But palliative care is in competition with other subjects in the curriculum, so it is difficult to persuade deans to take it on.

Demand-driven, innovative training for medical professionals is currently a developing phenomenon in Israel. There are other exemplary training programs run by the largest health insurance fund, Clalit. One, provided in an electronic format, focuses on women's health (see *Health Policy Developments 7/8*, p. 63); another Clalit training pilot is for primary care workers on the treatment of mentally ill patients (see *Health Policy Developments 7/8*, p. 69). Israel's experience with palliative care training is instructive in two ways. It shows how to design, plan and conduct such training properly and how to ensure a high level of acceptance among staff and patients. But it also highlights the risks of external project funding that is limited to a specific period. The moral of the story is that it is not enough just to design good programs—sustainable financing and public support are of the essence.

Sustainable financing and political backing required

Search for new source of funds

Pioneering training

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The International Network for Health Policy and Reform

Since 2002, the International Network for Health Policy and Reform has brought together health policy experts from 20 countries around the world to report on current health reform issues and health policy developments in their respective countries. Geared toward implementation, the Network aims to narrow the gap between research and policy, providing timely information on what does and what does not work in health policy reform.

Participating countries were chosen from a German perspective. We specifically looked for countries with reform experience relevant for Germany. Partner institutions were selected taking into account their expertise in health policy and management, health economics or public health. Our network is interdisciplinary; our experts are economists, political scientists, physicians or lawyers. Many of them have considerable experience as policy advisers, others in international comparative research.

Australia	Centre for Health Economics Research and Evaluation (CHERE), University of Technology, Sydney
Austria	Institute for Advanced Studies (IHS), Vienna
Canada	Canadian Policy Research Networks (CPRN), Ottawa
Denmark	Institute of Public Health, Health Economics, University of Southern Denmark, Odense
Estonia	PRAXIS, Center for Policy Studies, Tallinn
Finland	STAKES, National Research and Development Center for Welfare and Health, Helsinki
France	IRDES, Institut de Recherche et de Documentation en Economie de la Santé, Paris
Germany	Bertelsmann Stiftung, Gütersloh Department of Health Care Management, Berlin University of Technology (TUB)
Israel	The Myers-JDC-Brookdale Institute, Smokler Center for Health Policy Research, Jerusalem
Japan	Kinugasa Research Organization, Ritsumeikan University, Kyoto
Netherlands	Department of Health Organization, Policy and Economics (BEOZ), Faculty of Health Sciences, University of Maastricht
New Zealand	Centre for Health Services Research and Policy (CHSRP), University of Auckland
Poland	Institute of Public Health, Jagiellonian University, Krakow
Singapore	Department of Community, Occupational and Family Medicine, National University of Singapore (NUS)
Slovenia	Institute of Public Health of the Republic of Slovenia, Ljubljana
South Korea	School of Public Health, Seoul National University
Spain	Research Centre for Economy and Health (Centre de Recerca en Economia i Salut, CRES), University Pompeu Fabra, Barcelona
Switzerland	Institute of Microeconomics and Public Finance (MecoP), Università della Svizzera Italiana, Lugano
United Kingdom	LSE Health & Social Care, London School of Economics and Political Science (LSE)
United States	Institute for Global Health (IGH), University of California Berkeley/San Francisco; Department of Health Policy and Management, Johns Hopkins Bloomberg School of Public Health, Baltimore

Survey preparation and proceedings

Issues were jointly selected for reporting based on what the network partners identified as the most pressing issues for reform. Subsequently, the issues were arranged into clusters:

- Sustainable financing of health care systems (funding and pooling of funds, remuneration and paying providers)
- Human resources
- Quality issues
- Benefit basket and priority setting
- Access
- Responsiveness and empowerment of patients
- Political context, decentralization and public administration
- Health system organization/integration across sectors
- Long-term care
- Role of private sector
- New technology
- Pharmaceutical policy
- Prevention
- Public health

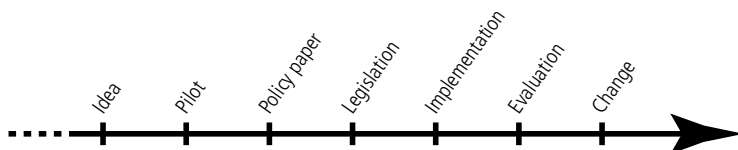
Reporting criteria

For each survey, partner institutes select up to five health policy issues according to the following criteria:

- Relevance and scope
- Impact on status quo
- Degree of innovation (measured against national and international standards)
- Media coverage/public attention

For each issue, partner institutions fill out a questionnaire aimed at describing and analyzing the dynamics or processes of the idea or policy under review. At the end of the questionnaire, our correspondents give their opinion regarding the expected outcome of the reported policy. Finally, they rate the policy in terms of system dependency/transferability of a reform approach.

The process stage of a health policy development is illustrated with an arrow showing the phase(s) a reform is in. A policy or idea does not necessarily have to evolve step by step. Also, depending on the dynamics of discussion in a given situation, a health policy issue may well pass through several stages during the time observed:



Idea refers to new and newly raised approaches voiced or discussed in different forums. Idea could also mean “early stage”: any idea present but not anywhere near formal inception. In this way, a “stock of health policy ideas in development” is established, permitting the observation of ideas appearing and disappearing through time and “space.”

Pilot characterizes any innovation or model experiment implemented at a local or institutional level.

Policy Paper means any formal written statement or policy paper short of a draft bill. Included under this heading is also the growing acceptance of an idea within a relevant professional community.

Legislation covers all steps of the legislative process, from the formal introduction of a bill to parliamentary hearings, the activities of driving forces, the influence of professional lobbyists and the effective enactment or rejection of the proposal.

Implementation: This stage is about all measures taken towards legal and professional implementation and adoption of a policy. Implementation does not necessarily result from legislation; it may also follow the evidence of best practices tried out in pilot projects.

Evaluation refers to all health policy issues scrutinized for their impact during the period observed. Any review mechanism, internal or external, mid-term or final, is reported under this heading.

Change may be a result of evaluation or abandonment of development.

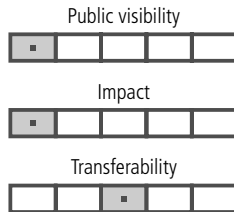
Policy ratings

A second figure gives the reader an indication of the character of the policy by showing three criteria: public visibility, impact and transferability.

Public Visibility refers to the public awareness and discussion of the reform, as demonstrated by media coverage or public hearings. The ratings range from “very low” (on the left) to “very high” (on the right).

Impact: Ranging from “marginal” (on the left) to “fundamental” (on the right), this rating criterion illustrates the structural or systemic scope and relevance of a reform given the country’s current health care system.

Transferability: This rating indicates whether a reform approach could be adapted to other health care systems. Our experts assess the degree to which a policy or reform is strongly context-dependent (on the left) to neutral with regard to a specific system, i.e., transferable (on the right). The figure below illustrates a policy that scores low on visibility and impact but average on transferability.



Project management

The Bertelsmann Stiftung’s Health Program organizes and implements the half-yearly surveys. The Department of Health Care Management, Berlin University of Technology (TU Berlin), assisted with the development of the semi-standardized questionnaire.

Reports from the previous eight and the ninth survey round can be looked up and researched on the network’s Web site, www.healthpolicymonitor.org. Both these reports and this publication draw upon the partner institutions’ reports and do not necessarily reflect the Bertelsmann Stiftung’s point of view.

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