

*John F. Roatch Global Lecture Series on Social Policy and Practice*

2008

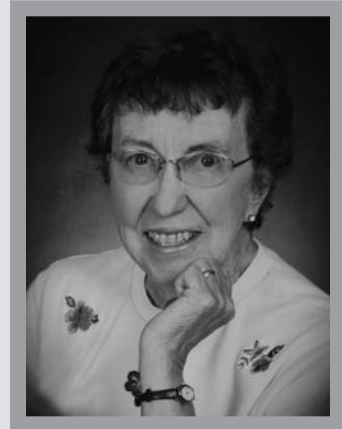
***F**inancing Health Care in Europe:  
Institutional arrangements between solidarity  
and individual responsibility*

Presented by  
Dr. Wolfgang Schulz-Weidner, Brussels/Berlin/Freiburg i.Br.

February 29, 2008



*With gratitude  
to Mary Roatch  
The present*



The John and Mary Roatch Endowment was created by gifts made to the university by John and Mary Roatch. The endowment provides support for the Global Lecture Series, which is organized through the office of the John F. Roatch Distinguished Professor at University College.

John Roatch was born in Ellsworth, Wisconsin, on May 3, 1921 and died in Phoenix, Arizona, on July 2, 1997. Mary was born to missionary parents in Darjeeling, India, and resides in Phoenix. The Roatches have four children: Virginia, Thomas, David, and Joseph. Mary and John met at and graduated from Hamline University in St. Paul, Minnesota. As Phoenix residents, they were also committed to furthering the ability of its citizens to receive timely information on topics in the public interest.

With the 2008 Global Lecture, we wanted to expand our donors' commitment to broaden knowledge for public decision-making. What could be better than adding a presentation about the various European health care systems to our store of global lectures.

Health care management and reform are the topics of the day in this election year, and the U.S. Presidential candidates are offering many varied solutions to the "health care problem." The citizenry demands change, but it is hard for the average layperson or professional to understand the complexities of the issue. Our lecture series joins the conversation by offering an instructive international perspective.

Dr. Schulz-Weidner is in a strategic position to describe types of European systems and Drs. Kirkman-Liff and Lockhart have the background and experience to comment and make sense of this knowledge. Those who attend the lecture will leave, I am sure, enriched by a greater understanding of options that could be used in the U.S. and Arizona.

Once again, we publicly thank the generosity and support of Mary Roatch, her son David, and all the members of her family for helping us keep the tradition of the John F. Roatch lectures. The listing on the back cover illustrates the wide range of topics, the opportune times at which they were discussed, and the result of John F. Roatch's goal of providing a public forum for timely topics.

Emilia E. Martinez-Brawley  
John F. Roatch Distinguished Professor and  
Professor of Social Work



*Celebrating*  
*John F. Roatch's*  
*The memory*  
*Legacy*

*“The evaluation of health care systems in the twenty-seven member states of the European Union cannot be restricted to examining their financial resources, but has to include a scrutiny of their basic benefit performances.”*



*“How much solidarity, how much redistribution should be incorporated in a health care scheme? Who is expected to compromise for the sake of solidarity—and in favor of whom? Is the guiding solidarity principle motivated by the idea of an inclusive residual welfare state, avoiding poverty, and helping the most vulnerable or should everybody have the chance to maintain the former living standard, independent of health status and associated cost?”*

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### **Wolfgang Schulz-Weidner**

German Delegation of the German Social Insurance System to the European Union, Brussels



DR. WOLFGANG SCHULZ-WEIDNER is a member of the permanent delegation of the German Social Insurance System (“Deutsche Sozialversicherung Europavertretung”) to the European Union (EU) in Brussels, representing the Statutory Pension Scheme, now “Deutsche Rentenversicherung Bund.” He is an expert in the fields of early and old-age retirement provision, including invalidity pensions and rehabilitation, the design of reform processes, and comparative studies.

Within the European Union, no longer are the member states alone responsible for the definition of their policies, but big parts of their sovereignty have been shifted to the Union. One of Dr. Schulz-Weidner’s delegation tasks is the preparation and coordination of positions among German stakeholders in the areas of health and sickness pay; old-age, invalidity, and survivor’s pensions; accident insurance; and unemployment benefits. He is also responsible for communicating these positions to relevant European institutions. His personal interest lies in public pensions, including their relationship to private products.

Dr. Schulz-Weidner participates in the activities of the European Social Insurance Platform. In this Commission, public social security authorities from many European member states work together in order to improve understanding and develop common positions in an environment that is often defined in purely economic terms. Obviously the main challenges in this respect are a diplomatic approach and a deep understanding of the principles of social security schemes and their execution in various countries.

He was born in Frankfurt am Main, Germany, where he completed his undergraduate and graduate education. He studied at the Johann-Wolfgang von Goethe University, graduating in 1979. His “first degree” specialisation was labour law. There followed, according to the German system, compulsory training for admission to the bar. In 1986, he completed this training at the Court ‘Frankfurter Oberlandesgericht’, with a specialisation in public law, and he continued doctoral studies in law. His thesis, “Implications of genetic analysis for the legal system and its application to insurance systems,” deals primarily with the consequences of genetic and pre-symptomatic diagnosis for public and private health insurance design.

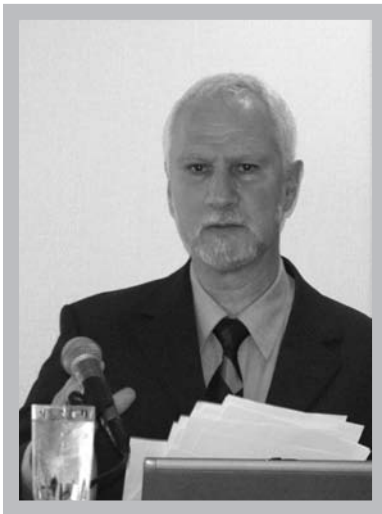
Dr. Schulz-Weidner is in a perfect position to explain to our audience the current bases of economic security and health benefits, not only in the German Republic but also in some representative countries in the EU.

# Scenes from the Lecture



# *Financing Health Care in Europe: Institutional arrangements between solidarity and individual responsibility*

*February 29, 2008*



## INTRODUCTION

Describing financing of health care systems in Europe with its now 27 member states is a challenge that requires the stating of criteria against which the different systems might be evaluated. The evaluation cannot be restricted to examining financial resources, but has to include at least the basic benefit performances of health schemes (plans).

The main countries to be examined here are France, Germany, the Netherlands, Sweden, and—despite the fact that it is not an EU member—Switzerland. These countries represent different types of health systems, but are “relatively” close to each other regarding the level and the quality of care. Occasionally, Spain, Italy, the UK, and some other Scandinavian countries are referred to. In general terms, the UK, Spain, Italy, and the Scandinavian countries can be described as National Health System (NHS)-style schemes with more or less regional characteristics, while the Netherlands, France, Germany, and Switzerland are social security-oriented, with different levels of participation of private insurance.

The following aspects of health care plans will be used to obtain a picture of their financial structures and performances. They are key to any decision on the parameters of health care reforms and should be open to scrutiny.

- Generosity and quality of the health care packages
- Procedural rationing: capacities, budgets, and prioritisation
- Waiting times
- Gatekeeper systems
- Structure of public and statutory financing
- Structured co-payments—statutory user charges
- Other out-of-pocket payments
- Risk structure adjustments
- Choice
- Voluntary private health insurance
- Scale and generosity of protection for older people
- Pooled risk at the employer level
- Regional disparities
- Competition between insurers for clients

It was tempting to use “universality” as a criterion. However, it turned out to be a rather weak indicator, since all European health schemes are de facto “universal” because they no longer distinguish between different groups in society, such as workers, the self-employed, housewives, the industrial sectors, retirees, etc. Therefore, the real challenge is no longer the degree of formal universality or inclusiveness but the financial and social ability to cope with the shortcomings of allegedly “universal” systems that call for additional financing by the patients (out-of-pocket payments, etc). So the question of conceptual “universality” is closely linked with the topic of practical “accessibility”—indeed, one of the most urgent objectives of the official European health strategy. But accessibility turns out to be a very complex phenomenon, since it is determined by many prevailing conditions such as regional and local availability, co-payments, waiting times, etc. These kinds of questions and answers should not be tackled under the vague criterion of “universality” or “accessibility” but in the context of the respective features of a system and its details.

Despite its ever growing influence on national health policy decision making, this presentation will not expound on economic EU law and EU health policy, since it would by far exceed what is feasible in this context.

## GENEROSITY AND QUALITY OF THE HEALTH CARE PACKAGES

Transparency in the degree of generosity and quality of the health care package is often hampered by the fact that this package is not always clearly defined. In principle, social insurance schemes define, in relatively concrete terms and in advance, the rights and claims of patients in given situations. So, in France, the Netherlands, and Switzerland, the range of covered services is regulated by law or by-law. In Germany, it is defined in a cooperative framework between service providers and sickness funds. In contrast, in NHS-style schemes such as in Sweden and the UK, budgets and prioritisation will decide on the final volume of services and access in individual cases. Especially in the UK, the health administration is charged with the authority to set priorities within a given budget. So, with a view to individual access, state health care systems are often replacing material rights by a fair procedure. In Sweden, there is no officially defined basic health care package. Only three guiding principles are steering coverage decisions: human rights, needs and solidarity, and cost-effectiveness. In fact, equity is also a very important issue.<sup>1</sup> Dental treatments must largely be paid by the patient, while the financial participation of the state in financing dentures is more generous.<sup>2</sup> Off the record, the practice of NHS-style health schemes to not clearly define the package in advance and to accept long waiting lists comes more and more under threat by European Law, since it is regarded as an obstacle in citizens' freedom to obtain services across borders. And, again off the record, this is the reason the British NHS has recently installed permanent representation in Brussels.

In addition, the degree of generosity and quality alone is not sufficiently convincing as long as accessibility is not granted: High scores in quality and generosity can be associated with bad scores in accessibility and waiting times. This is particularly the case for Sweden.<sup>3</sup> In addition to waiting times, the density of supply is regionally very different. In remote areas, it can be very difficult to find a specialist.<sup>4</sup> Budget and prioritisation procedures make the judgement even more difficult.

An older Organization for European Community Development (OECD) statistic about health expenditure in relation to Gross Domestic Product has shown that tax-funded systems in Europe spend less than the European average.<sup>5</sup> It is, however, unclear if this goes hand in hand with a lower generosity of NHS systems or with more efficiency.

## PROCEDURAL RATIONING: CAPACITIES, BUDGETS, AND PRIORITISATION

Rationing of medical resources has drastic implications for the generosity and access of a health care system. Typically, countries with national systems may claim to maintain, in theory, a high quality of medical services with universal access, but at the same time they tend to restrict capacity and so they present, in practice, very poor performance in accessibility. This creates bad scores regarding waiting times. This is true for all Nordic countries as well as the UK, Spain, and Italy.<sup>6</sup> In countries with insurance-based schemes, in contrast, medical service density is relatively high, such as in Belgium, France, Switzerland, Germany, and the Netherlands. Insurance

schemes tend to increase insurance premiums rather than cut or rationalize benefits—a phenomenon easily observable in countries as different as Germany, Switzerland, and the USA. This not only results in good scores for waiting times in those countries, but also in access to in-house care and elective surgery. The U.S. and Germany are reported to provide the most rapid access.<sup>7</sup>

Rationing can be executed directly and explicitly, for instance, by utility assessment. Most common at the international level is the use of cost per Quality Adjusted Life Year (QUALY). So, as a rule of thumb, in the UK for example, cost per QUALY below £20K is accepted by the NHS, but when the cost rises above £30K, treatment is rejected.<sup>8</sup> Rationing can also be an indirect consequence of setting and running budgets, either global or sectoral budgets; per capita payments and even diagnostic related per case payments can have similar rationing effects. All this is typical for NHS-type systems, but can also be found in social insurance schemes such as in the Netherlands and, to a lesser extent, also in Germany. In Germany, former sectoral budgets will be replaced by single service compensation, but modified by deductions when exceeding certain quantity limits; in addition, case-oriented lumps will be introduced. Details are regulated between sickness funds and service provider organisations.

Running budgets often means somewhat opaque prioritisation procedures. But the principles of prioritisation should be clear. In the UK, for instance, priority is given to gains in overall health, cost, and efficiency; fairness and public acceptance are also considered. The principles are executed in a software-supported framework called "program budgeting and marginal analysis", which steers access in individual cases.<sup>9</sup> But even this kind of principle-based prioritisation does not show in advance which kind of treatment will be paid for whom. Exceeding the budgets will often result in unplanned cuts in benefits that otherwise would have to be covered. In the UK, the East Suffolk Health Trust, for instance, after having exceeded its annual budget by several million pounds, decided in the framework of its prioritisation regime to no longer pay for synthetic hip joint or knee joint replacements for overweight patients. Their argument was that, in many cases, the implants would not work. The decision has prompted hard public criticism.<sup>10</sup> In 1997, Sweden passed a priority list. Grade 1 is treatment for people with acute life-threatening conditions; grade 2 is prevention, rehabilitation, and aids for people with restricted faculty of listening or sight; grade 3 is treatment of less important chronic and acute diseases.

The visible outcomes of indirect rationing through budgets are waiting lists. The UK is a good example to study. Here, we can find lengthy waiting lists not only dependent on medical discipline and diagnosis, but also on regional disparities.<sup>11</sup>

Open and transparent procedures of rationing and prioritisation are made up by less transparent decisions, often in individual cases at the clinical level, resulting in waiting times. Even some social security-type health schemes with allegedly no rationing (for example, Germany), have priorities set at the level of the single doctor or hospital. This kind of rationing will be encouraged by lump sum payments to service providers instead of per service fees. In Sweden, for instance, a



family doctor receives a per annum/per capita yearly fee, only adjusted by the age of the patient. Co-payments for visits, however, ease the yearly fee effect to a certain extent.

## WAITING TIMES

Long waiting lists and waiting times are typically the result of scarcity in planned resources or budgets. They are often—but not exclusively—associated with state-run NHS systems. Three-quarters of investigated national health systems make many patients wait more than three weeks for cancer treatment.<sup>12</sup> In particular, the UK suffers extremely high waiting times, even after undergoing improvements, reporting waits of more than one year for non-elective surgery for 8% of people surveyed and more than 6 months for 15%.<sup>13</sup> Finland reports relatively good outcome and generosity, but has waiting list problems.<sup>14</sup> In Norway, long waiting times have been reduced substantially in the last few years. In 2002, there were more than 250.000 cases.<sup>15</sup>

Sweden is one more example of having long waiting times,<sup>16</sup> particularly in cases of specialist and hospital treatments; even refusals are occurring. Long waiting lists in hospitals, especially for surgery are of concern. Waits depend on diagnosis and specialist involvement. But waiting lists exist in ambulatory specialist treatment in hospitals. In local health centres, capacities are scarce. Only half the patients get an appointment for the same day, and more than 20% wait more than one week. It is also difficult to reach the local health centre by phone. Consequently, people make a continuous run on hospital emergency rooms, causing long waiting times and even refusals in emergency wards, sometimes with injurious consequences.<sup>17</sup> After local health centers refer patients to a specialist or to a hospital, one-third of the patients have to wait for more than three months to get an appointment. Following the prioritisation rules, waiting times for heart treatments are the shortest, while less urgent operations such as cataract, knee or hip surgeries have to wait longest.<sup>18</sup> Even out-patient treatments can be associated with waiting times up to one week for the first contact. On average, more than 50.000 people (out of 9 million) wait for treatment for more than one year.<sup>19</sup> Due to scarce medical resources, sometimes patients with urgent need are sent for treatment abroad. Confronted with these shortcomings, the Swedish government formulated some guiding principles for waiting times. In an ideal case, first contact should be granted the same day, an appointment with a general practitioner should be granted within one month, and the first contact with a specialist within three months.

In contrast, the higher density of medical resources in insurance-based countries results in good scores for waiting times, as is the case of Austria, Belgium, France,<sup>20</sup> Germany, and Switzerland. An exception is the Netherlands.<sup>21</sup> Long waiting lists are common in the “compulsory national healthy insurance” scheme (AWBZ). The same applies to the “universal compulsory health insurance” scheme (ZWV): There are long waiting times, depending on the diagnosis and kind of treatment. Waiting times for an ophthalmologist or knee surgery are particularly problematic. The lengthy waiting periods can sometimes be dangerous for the patient.<sup>22</sup> For a long time, such waiting times were not transparent, until norms were introduced to define maximum acceptable waiting

times. In addition, insured people were given access to cross-border treatment, particularly between Belgium and Germany. Many Dutch people have undergone heart surgery in Germany, but with costs approximately 50% higher than they would have been in the Netherlands (2001/2002).

Often, bypass-strategies such as co-payments or supplemental insurance are used in order to avoid waiting times. This raises, however, the question of “equality and fairness” of health care systems. Private provisions to avoid waiting lists will be dealt with later, in “Voluntary Private Health Insurance.”

## GATEKEEPER SYSTEMS

Gatekeeping can, in principle, have two functions. It can be used to assign the patient to the appropriate service provider and thus avoid unnecessary or repeated diagnosis and treatment. But it can also serve as a tool to offer scarce resources to those most “in need”. Unfortunately, both functions are difficult to combine. Thus, gatekeeping procedures are often associated with longer waiting times.<sup>23</sup>

Gatekeeping is not only to be found in NHS-style schemes, but in social insurance schemes as well. Examples are the Netherlands or, to a lesser extent, in Germany. In the Netherlands, a general practitioner acts as a gatekeeper to all other services. In the UK, a family doctor, who is assigned according to the patient’s domicile, refers the patient to a hospital or to a specialist.<sup>24</sup>

Obviously, gatekeeping procedures, as well as other forms of managed care, will diminish or even abolish personal choice. In the UK, for instance, it was not until 2005 that the patient was allowed to choose between four or five local hospitals.<sup>25</sup> Sometimes, the patient has the right to choose between providers. For instance, in France, opting for a gatekeeper model instead of free choice can improve access to so-called sector 2 doctors (specialists), who are not contracted to the “Sécu” in such a binding way as sector 1 doctors (general practitioners). “Improved access” means that co-payments are moderated. But, in exchange, the patient must accept the decision of the gatekeeper and cannot choose freely between specialists.

In order to bypass reduced choice, one will find in many countries private arrangements that again increase personal choice.

## STRUCTURE OF PUBLIC AND STATUTORY FINANCING

There are several kinds of public or statutory funding of health care: taxes; social contributions and obligatory contributions to private schemes in the form of payroll taxes with or without upper ceilings; per capita contributions; and several sources of private funding. In all EU member states, it is eventually a mix of these sources which makes up the total expenditure, while the composition of the single sources differs considerably.

Compared to financing through social contributions in wages, tax funding can have a progressive redistribution effect and thus result in more solidarity in sharing the burden of financing public health. In addition, levying contributions on wages increases the burden on “labour” and creates negative

employment effects. This might be the reason for OECD in Germany recommending a shift to tax financing of public health schemes.<sup>26</sup> Another way to avoid an increase in the so-called “non-wage-labour costs” is to introduce a per capita fee.

For NHS-style schemes, tax financing for health care out of the general budget is the norm. In Spain, the new financing system adopted in 2001 included, according to Duran, Lara, and van Waveren (2006), the management of the health sector within the general financing model. There is also a new tax-sharing scheme for all regions, which integrate all health funds within a general financing scheme. Consequently, these authors suggest, the co-responsibility between the central state and the regions has increased.

Evidence shows, however, that the Bismarck style in EU member states is starting to readjust the public financial sources of health care. A cautious trend toward tax funding and per capita funding, and away from payroll tax/social contributions, can be observed. It is obvious in Switzerland. In Germany, after the latest reform, only a part—by far the biggest one, however—will be paid in the form of a payroll tax, as a percentage of the wages, while another part comes directly from general taxes. In addition, if both sources are not sufficient for the operation of a sickness fund, it can ask its members for an additional payment in the form of a per capita lump sum. It is worth looking at how it is now as well as how it would be in the future. Both big political parties in Germany want to change the current finance mechanism, but in opposite directions. The conservatives are in favour of a general per capita premium. The Social Democrats, in contrast, want to enlarge the personal basis for assessment of contributions. Not only wages should be considered, but the whole individual income, including return from capital or income from rents. This would cause health care contributions to become a sort of general income tax. Since Christian democrats and social democrats are running the federal government together, no substantial change is to be expected for the next two years. In the Netherlands, a compromise has been found. Half of the health care expenditures by sickness funds is paid by wage-related contributions and the other half by per capita premiums. In Switzerland, the whole contribution to sickness funds is a per capita premium.

It goes without saying that per capita funding indirectly increases the need for tax funding through state subsidies to those who are not able to pay the full contribution. In Switzerland, this results in a respectable amount of contribution subsidies, indirectly paving the way into tax financing of health care. Only two-thirds of premium revenue comes from households; one-third results from general taxes. In addition, investment in hospitals and half of their current expenditures is paid by the federal state or the cantons. This is one of the reasons even Swiss experts are warning against an adoption of the Swiss per capita premium model in other countries.<sup>27</sup>

In France, the contribution rate is about 14% of the salary. There is a bottom limit (560€), but not an upper limit for the basis of assessment. In Germany, the contribution rate on wages—in the future, to be fixed at the federal level—is about 15%, with an upper ceiling of the assessed wages of 3.600€

per month. In addition, general taxes are used to finance a statutory health insurance. The rationale for the tax contribution is to avoid financing “non-insurance-based components,” such as free coverage for children, exclusively by means of charges on wages. In the future, one more source is likely to be tapped: per capita premiums. Those sickness funds that are not able to cope with transfers from public resources are allowed to ask for additional premiums by their members in the form of per capita lump sums. Here will be the place for competition between the sickness funds.

In the Netherlands, tracking the financial resources of health care is tricky. It has to be mentioned, first, that the health scheme is divided into two tiers:

1. AWBZ is a compulsory universal insurance for exceptional health expenditures such as mental care, hospital care exceeding one year, different kinds of long term care, and care for chronic diseases, covering the whole population living in the Netherlands. In practice, it represents 45% of all public (statutory) health expenditures.<sup>28</sup>

2. For other health expenditures, the ZWV universal compulsory health insurance scheme is run by private providers and strictly regulated. It is partly financed by the so-called health care fund. This fund is primarily funded through income-related contributions (all individual income taken into consideration) paid by employers (on salary) and employees (on everything but salary). The contribution rate is fixed by the central government at 6,5%, at the moment, with an upper ceiling for the contribution base of about 30.000€ per year. In addition, the fund is financed by state contributions for people younger than 18 years old. But the money from the fund covers only approximately 50% of the costs. The other 50% is financed through nominal premiums paid by insured individuals. It is a flat rate per capita premium which can be set by the insurance company itself. People who cannot afford the full flat rate contribution are eligible for a state subsidy. People younger than 18 do not have to pay premiums. Summing up: Half of the overall contributions is income related; the other half comes from a lump sum. For each individual, of course, the composition is different.

An overall look at the composition of public finances going into health care shows that, even in social insurance countries, much is financed through general taxes, for several reasons. So in France, only half of public expenses for health treatment stems from contributions; the other half is generated by a diversity of taxes. In the Netherlands, 25% of total health expenditures are said to stem from the general state budget, not the least as a consequence of premium subsidies for those who cannot afford the per capita premium. In some countries, dualistic financing of hospital (investment by state budget, current medical expenditure by sickness funds) can contribute to a higher share of tax financing, such as in Germany. French hospitals however are paid exclusively by health insurance.

## STRUCTURED CO-PAYMENTS—STATUTORY USER CHARGES

In many cases—and independently of the type of the scheme—public health plans do not pay the full cost of treatment, but

oblige the patient to pay for a certain amount or percentage. The installation of co-payments can result in out-of-pocket payments and in obtaining complementary private insurance.

There are two independent reasons for the arrangement of co-payments: The first one is simply the aim to directly reduce costs by requesting that the patient pay fees (shift financial burden from public budget to the sick person). The second one would be to motivate the patient to be more careful with public resources and to ask only for indispensable treatment. In this case, the aim is to avoid unnecessary health care.

Co-payments range from small lump sums to high payments, often as a percentage of total cost, as in most countries patients pay high fees for dentures, medicines, or physiotherapy.

In state NHS-type schemes, out-of-pocket co-payments are often relatively low; such is the case in UK and Sweden,<sup>30</sup> where co-payments make up only about 2% of overall health cost.<sup>31</sup> In Sweden, however, there are some very interesting situations when one takes a closer look at the cost structure of co-payments.<sup>32</sup> Family doctors receive a fee by the patient between 11€ and 16€ for each personal contact. For the specialist, it is between 16 and 33€. For socially disadvantaged people, the co-payments are restricted to 100€ per year. For hospital care, patients have to pay a fee of 9€ each day, the retired and elderly only two-thirds of that. High co-payments have to be paid for dental treatment, increasing from 39% in 1993 up to 61% in 2002. In the case of dentures, however, the co-payment is restricted to 650€ per year; elderly people don't have to pay more than 78€. <sup>33</sup> In addition, the cost for medicines, up to 100€ per year, have to be paid out of pocket; above this threshold, payments are subsidized, and from 200€ upward, the costs are paid by the NHS. There are restrictions on the number of visits people can make without co-payment; only 2,6 medical visits each year, on average, in Sweden compared with, for instance, 6,5 in Germany.<sup>34</sup> The NHS, in Italy, in contrast, assigns extremely high co-payments. The patient has to pay up to 36€ for each personal contact with a doctor.<sup>35</sup> For laboratory work, ultrasounds, and X-ray examinations, the co-payments can easily total up to 100€. <sup>36</sup> In Ireland and Finland, patients' high contributions to in-hospital costs must be mentioned.<sup>37,38</sup> In Finland, co-payments for medicines are as high as 50%.<sup>39</sup>

In social insurance-type countries, high co-payments are the current norm. The most extreme example is certainly France. Statutory co-payments range between roughly 20% in the hospital sector and 30% for outpatient treatment, and even more for medicines and dental treatments. In Switzerland, co-payments are relatively high not only for particular medicines and dental treatments, but also for normal visits with a doctor. Many different individual options for co-payment, (franchises, etc.) are available. In Germany, for all services prescribed by a doctor the statutory co-payment is 10% of the cost, but with a cap of 10€. In hospitals, co-payment is 10€ each day, but for 28 days maximum. In addition, 10€ have to be paid per quarter year if medical services have been retained. Despite the relatively modest extent of statutory co-payments in Germany, 20% of chronically ill adults reported they had skipped medications, not seen a doctor, or had foregone recommended care

because of costs.<sup>40</sup> In the Netherlands, in the AWBZ scheme for cost-intensive health care, the patient has to bear income-related co-payments, normally at least 10%. In the ZVW, for "normal" health expenditures, co-payment for transportation is 10%, for dentures 30%, and for medicines 100% for the amount exceeding the fixed price. Astonishingly enough, in the Netherlands only 5% of chronically ill adults reported they had skipped medications, not seen a doctor, or foregone recommended care because of costs.<sup>41</sup> In Switzerland, patients are sharing the cost of treatment with a payment of 300SFr per year and, above that, they will pay 10% of costs up to an upper ceiling of 700SFr (2005). In case of hospital treatment, 10SFr per day must be paid in addition to the shared costs. Eventually, co-payments for medicines have to be borne at a level of 10%. If generics exist and the patient insists in consuming the name brand, their share will be 20%. This strategy was very successful; the market for originals has dropped in Switzerland.<sup>42</sup>

The fraction of non-insurance-covered statutory co-payments on total health expenditure comes, on average, to 5% in Germany,<sup>43</sup> 9% in France<sup>44</sup> (despite wide-spread complementary insurance), 14% in Switzerland,<sup>45</sup> 8.4% in Denmark<sup>46</sup> and 4.1% in the Netherlands.<sup>47</sup>

In any case, the decision to ask for co-payments will almost automatically be linked to exceptions for those who are not able to pay, for vulnerable groups, or for severe medical conditions.<sup>48</sup> France is a good example for exempting low income groups (below 500€) from co-payments with its programme "Couverture Maladie Universelle Complémentaire", which was introduced in 2000, in addition to its allegedly universal "Sécu Sociale – Health Insurance". This programme helps those who are not able to pay premiums for complementary private insurance. About two million people are affected.<sup>49</sup> In addition, the "Couverture Maladie Universelle" eases co-payments for certain groups of chronic illnesses. Switzerland eases or eradicates completely the co-payments for long term illnesses and for children. Low-income earners contribute with lower or no co-payments. Sweden and the UK eliminates co-payments for children. Sweden applies an upper limit (291€) for co-payments by the elderly. In Germany, hardship clauses are foreseen for vulnerable groups.

Such exceptions not only create enormous bureaucratic workloads and red tape, but reduce the expected steering effects—if there are any. One more problem lies with the possibility of covering statutory co-payments by private insurance, thereby counteracting politically intended steering effects. This is the reason why in Switzerland it is forbidden to cover the relatively high statutory co-payments with voluntary, private insurance.

Critics of co-payments, even at high international levels, deny any meaningful effect of statutory co-payments, including the alleged steering effect. The EU commission states that evidence in many member states shows that "co-payments, though raising some revenue, have not been able to restrict unnecessary care consumption, and they may have hindered access for vulnerable groups. Hence, a co-payment system requires the development of a whole set of exemptions so as

to ensure that equity of access is maintained. Moreover, co-payment systems imply important administrative costs which need to be balanced with the savings generated from deterring unnecessary care use. Critics say that they will reduce health care access by people who most need it.<sup>50</sup> Other studies from international organisations active in the field, (for instance, the International Social Security Association), are showing that co-payments regularly diminish public expenditures, but act in a very unspecific way and cannot efficiently counteract wrong use of medical resources. It is only the “first contact” that will be avoided or delayed, but then it is the doctor who decides, in most cases, on the next steps.<sup>51</sup>

## OTHER OUT-OF-POCKET PAYMENTS

Out-of-pocket payments can be the result of planned co-payments. In addition, they can be the indirect consequence of poor benefit packages in the public scheme—or even worse—informal over-the-counter payments. The latter is a normal feature in most new EU member states in Middle and Eastern Europe. In some cases, health care is purchased completely outside the public health care scheme. NHS-guided countries in Southern Europe, in particular, appear to provide relatively good health care services, but are dependent on the patient’s ability to afford private health care as a supplement to public health care.<sup>52</sup>

In Germany, unplanned out-of-pocket payments are mostly the result of the ambition of contracted doctors to gain more money. They are not allowed to do that within the public health care package but they are allowed to “offer” additional services, not paid by the statutory health funds. A list of additional services was established at the end of the 1990s by recommendation of the contracted doctors’ federal organisation *Kassenärztliche Bundesvereinigung*. It contains so-called “*Individuelle Gesundheitsleistungen*” (individual health) that must be paid exclusively by the patient. The medical necessity is, however, contested. The volume of these services delivered in practice is not transparent. Polls suggest that one-fourth of patients were confronted with relevant offers by their doctor(s), which often were hard to reject. The main services were additional diagnostics of intra-ocular pressure, ultrasound examinations, and additional preventive examinations for cancer.<sup>53</sup>

In reality, the fraction of out-of-pocket payments is much bigger than only the statutory co-payments. In Switzerland, setting aside purely privately purchased health care, out-of-pocket payments (co-payments, franchise, medicines, dental care, and other treatments not covered) amount to 33%.<sup>54</sup> Other sources report 29%,<sup>55</sup> but, including expenses paid by private supplemental or complementary insurance, they total almost 44%.<sup>56</sup> In the Netherlands, out-of-pocket payments are 27%;<sup>57</sup> in Germany 21,5%;<sup>58</sup> in Finland 22%; in the UK 16,5%<sup>59</sup> and in Sweden 15%.<sup>60</sup> It is difficult to obtain a clear picture for France. According to an interview survey, out-of-pocket household spending without complementary insurance is estimated to be about 14% of all health costs or 750€ per year.<sup>61</sup> Other sources report 24% (apparently without payments covered by complementary insurance)<sup>62</sup> or 45% (including payments covered by complimentary insurance).<sup>63</sup> However, despite private

complementary insurance, the high out-of-pocket payments makes one-third of French patients complain about an ever-deteriorating access.<sup>64</sup> In Italy, household spending on health care accounts for close to 30%, giving Italy one of the highest levels of out-of-pocket payments.<sup>65</sup>

It is estimated, that all over Europe, on average, one-quarter of all health expenditure is borne by private households.<sup>66</sup>

## RISK STRUCTURE ADJUSTMENT<sup>67</sup>

In a statutory universal health scheme with multiple health funds, risk structure compensation is an important tool to maintain national solidarity. Compensation becomes almost indispensable in statutory schemes where sickness funds have to compete for clients. It is a precondition for a fair competition on efficiency and quality. Only schemes with one single sickness fund, one single NHS scheme with a central (and not regional) budget, or voluntary schemes based on risk-adjusted premiums will not rely at all on risk structure compensation.

The main goal of such compensation is to avoid risk selection, competition for good risks instead of quality. Even the legal obligation to contract and the prohibition of discriminatory practices do not eliminate incentives for skimming. For instance, quality-distortion problems can occur when plans compete on the basis of medical service quality. It is tempting to under-provide some services associated with bad risk users and over-provide others. In addition, elements of choice for the insured such as co-payments, voluntary enrollment in managed care programs, etc. are creating gateways and opportunities for indirect discrimination. In addition, service negligence could be applied to bad risk clients; the offices and contacts which sick people rely on could be reduced, while marketing could be targeted to the healthy and wealthy.

In Germany, the risk structure equalization will be organized in the future by the so-called “*Gesundheitsfonds*” (global health funds). It will be fed by payroll taxes of about 15% of wages and a state contribution. The global health fund allocates for each insured person certain payments to the responsible sickness fund. This allocation is comprised of a uniform per capita sum and a risk adjusted supplement. The supplement is calculated upon age, sex, and status as a recipient of an invalidity pension or not. In addition, starting next year, morbidity will be taken into consideration. This will be extremely difficult—between 50 and 80 sicknesses or health conditions are under discussion. The Ministry for Health will set up an extra scientific committee (*wissenschaftlicher Beirat*), charged with the development and maintenance of a classification system for the morbidity equalization.

In the Netherlands, the risk equalisation scheme will involve payments to health insurers, which compensates for public service obligations and which intends to neutralise the different risk profiles of the health insurers. The compensation is financed from the “*Zorgverzekeringsfonds*” (health care fund), which is administered by the Health Care Insurance Board (CVZ) and financed by income-related contributions and subsidies financed out of the general budget. Risks compensated for are: age, gender, morbidity by diagnosis cost groups, morbidity by pharmaceutical cost groups, the kind of

income (kind of employment, social benefits such as disability benefits), and the region.<sup>68</sup> The nine diagnostic cost groups reflect in-house expenditure; the 17 pharmaceutical cost group risk adjusters identify individuals who show indications of chronic health conditions. These groups are an outpatient morbidity measure, using selected drugs. In addition, for very severe cases (expenditure above 12.500€ per year) an ex post facto payment or “retro perspective equalisation” scheme is used.<sup>69</sup>

In Switzerland, a risk structure compensation has been introduced for age, sex, and region within a canton (state), but not for the health condition. In addition, there is no risk compensation across cantons. At the moment, there is no risk compensation for morbidity, but a change can be expected for the near future. Hospitalisation dating back one year is likely to be used.

Risk equalisation schemes exist even in voluntary supplemental schemes, but only in rare cases (Ireland<sup>70</sup>).

## CHOICE

At the center of this topic is certainly the right to choose between medical service providers. The degree of consumer choice varies considerably—from direct assignment to a given provider without any choice in certain NHS schemes or managed care schemes to almost free choice. In many cases however, completely free choice has to be paid for by additional contributions, fees (out-of-pocket payments), or supplemental insurance.

In NHS schemes, one should not expect too many individual rights and choices, but—with exception of the UK—it exists. In Italy, those who accept high co-payments have more choice between service providers. In Denmark’s public NHS, people can choose between an almost “for free” basic scheme (group 1) and a more liberal scheme with their choice of doctor (group 2). The overwhelming majority has chosen group 1. It is associated with enrollment with a general practitioner as a gatekeeper for special care. The more liberal group 2 scheme offers choice of doctors, without any gatekeeping procedure. In exchange for this freedom, group 2 patients must pay a part of the expenses themselves, for both the general practitioner and specialist. The co-payment amounts to the share exceeding the amount covered in the basic scheme. Danish patients can also choose between three kinds of hospitals. Access to public hospitals is free. Using a privately contracted hospital requires the patient to bear the cost exceeding the public tariff. Using a non-contracted private hospital means the patient must pay all costs. For Norway, the patients’ free choices of (public and contracted) hospitals is remarkable. In Sweden, for ambulatory care, most patients can choose between local health centres and hospital outpatient departments, but the latter case is linked to higher co-payments. Alternatively, since 1994, citizens can freely choose a contracted family doctor; this decision is binding for one year.

In contrast to state-run health systems, insurance-based schemes have the tendency to contract a wide range of service providers not employed with the national health system, giving patients many opportunities to decide for themselves whom to trust. Some health schemes are even going as far as giving its insured people complete freedom to choose between all

licensed service providers, without restriction. The Swiss scheme gives its insured people complete choice between service providers, only restricting patients to hospitals situated in the relevant canton. In Austria and France, the decision to consult a non-contracted provider means the patient must pay higher co-payments. In Germany, sickness funds may offer a cost-reimbursement tariff instead of the normal direct clearing procedure between the health fund and service provider (benefit-in-kind principle). This gives the patient access to non-contracted doctors, but is regularly linked to higher co-payments.

The problem with this kind of choice between contracted and non-contracted doctors is the emergence of a “double” or “parallel” structure on the supply side. Some doctors commit themselves to treat patients for fixed tariffs in the public health scheme. Other doctors are also approved to treat members of the social health insurance but are, in principle, free to create their own tariffs—with the consequence of additional out-of-pocket payments by the patients. In France, there exists, side-by-side, sector 1 and sector 2 doctors. Sector 1 doctors work for contracted tariffs and fees; sector 2 doctors are completely free to charge their clients their own (but, in theory, transparent) tariffs. All this is not a problem as long as there are enough doctors in sector 1. But, depending on the specialist discipline and region, it can be almost impossible to find a sector 1 doctor in a timely fashion. This results in the necessity of going to a sector 2 doctor and accepting high co-payments, often not even covered by the private complementary insurance. Is this compatible with the principle of universal access? A similar situation can be observed in Austria. Insured people can use contracted and non-contracted doctors. But the use of non-contracted doctors is associated with additional out-of-pocket payments of at least 20%, if not more. And again, in some regions, it can be hard to find the required specialist.

This kind of problematic trend is not restricted to insurance-based schemes, but exists also in NHS-type schemes. One cannot only find parallel structures of public or private care, but in many cases, the same institution or doctor offers both features, according to the willingness of the patient to accept high out-of-pocket payments.<sup>71</sup>

Longer waiting times are often associated with the need for choice. So the often very long waiting lists in Italy—dependent on region and discipline—can drastically be shortened by using the medical parallel structure mentioned above—with drastic out-of-pocket payments, leading to a sort of two classes of medicine.<sup>72</sup> In France, many people prefer to look for a sector 2 doctor, even if this is associated with higher co-payments. As far as this is discussed in the public, those doctors do not provide better quality, but faster access and more choice in setting a date for an appointment.

Choice does not always mean increased or better access to medical services, but rather the freedom to choose the provider. So, in Germany, sickness funds are obliged to offer their insureds different managed care programs; for instance, associated with binding on a restricted group of providers; participation in disease management programs. Patients choosing a managed care program might be rewarded by

rebates up to two monthly premiums or 600€ maximum. Likewise, in the Netherlands, the system creates many opportunities for health insurers to offer preferred provider arrangements and managed care. But there is little evidence, until now, that the “Hausarzt Model”, family doctor-oriented care introduced at the end of 2004, has measurable results. Six million insured are enrolled in such a programme, but patients’ compliance with the directive not to see a specialist directly is low.<sup>73</sup> In addition, the model could neither prove a significant amelioration of the health status of enrolled patients nor economies in cost. This is put down to too few incentives for both patients and doctors to use the program in an efficient way.<sup>74</sup> In Switzerland, the insured can opt for an HMO-like family doctor model with restricted choice. This option is rewarded with a premium rebate. An alternative would be to enroll in a “Telmed” model; here, the insured is obliged to consult a medical call centre before consulting a doctor. This option is also rewarded with a rebate. Sixteen percent of new entrants decide in favour of one of these programs.<sup>75</sup>

In a few cases, there is choice in the range of the benefit package. German sickness funds may offer their insureds a special additional tariff for certain expensive medicines, such as for homeopathic treatments.

In addition, insurance-based schemes may offer special tariffs linked to out-of-pocket payments, refund arrangements in case of non-use of the insurance, etc. Such tariffs intend to induce a responsible consumption of medical services and to follow a healthy lifestyle. In Switzerland, the insured might choose—in return for a premium reduction—an increased franchise up to 2.500 SFr per year; 40% of insured people opt for this program.<sup>76</sup> Alternatively, the insured can opt for a “bonus insurance”; in case of non-utilization of the insurance, the insured person receives a premium reduction, increasing with each year of non-utilization. After the recent reform of the German health system, the sickness funds are allowed to offer a “premium refund tariff” that refunds two monthly premiums, or up to 600€ maximum, in case of non-use of medical services. In addition, the sickness fund may offer a franchise tariff with a patient’s participation on occurred cost until a contracted upper ceiling. The rebate offered to the insured must not be higher than one monthly premium. In the Netherlands, the health insurers offer franchise tariffs combined with premium rebates (co-payments between 100€ and 500€ per year). But only 5% of all insured make use of this offer (2006).<sup>77</sup> In addition, one can choose between cost reimbursement and direct clearing between health insurer and service provider.

Summing up, it’s clear that NHS- and insurance-based schemes do not automatically curtail the degree of freedom, choice, or sovereignty they grant their members. Many NHS-type schemes readily allow for an upgrade in individual choice—for an additional charge. On the flip side, insurance-based schemes often offer premium rebates as a compensation for an in-advance contracted downgrade in choice. It is noteworthy, however, to look at the UK. In this country, the only choice is to stay in the state NHS under preset conditions or to leave the system completely for a given treatment and pay the whole bill out of pocket. There are no other options.

## VOLUNTARY PRIVATE HEALTH INSURANCE

In general, there are three different classifications.<sup>78</sup> Substitutive insurance is private insurance that replaces coverage otherwise available through the state or social insurance. Complementary insurance provides coverage for services excluded or not fully covered by the public schemes (statutory user charges). Supplementary (or supplemental) insurance coverage offers faster access and increased choice, typically in countries with reasonable waiting times and strict gatekeeper provisions.

Substitutive insurance plays a minor role all over Europe, with the exception of Germany, where it covers 10% of population. In the future, German private health insurers are obliged to offer a basic tariff for all those not obliged to join the Public Statutory Health Insurance. In that case, a private health insurer is obliged to contract without any risk testing or exclusion of benefits. The private contract has to cover all benefits that are obligatorily covered by the public scheme and must not exceed the maximum premium applicable in the public scheme, i.e., an amount of roughly 550€ per month. In case of low income, the premium has to be lowered to 75% of the maximum; beyond that, the state subsidizes the premium. In practice, it exists as competition between the public sickness fund and private health insurers for self-employed clients and higher-earning people (more than 3.600€ per month, for three consecutive years).

Complementary private insurance is not prevalent, except in the Netherlands, Denmark and, particularly, France. In France, the statutory basic social health insurance only covers roughly between 70% and 80% of the real cost of contracted service providers. The rest has to be paid by the patient. However, the patient can draw on additional insurance that covers at least part of the rest. More than 90% of the population possess such a contract. About 14% of health expenditures is paid by voluntary health insurance.<sup>79</sup> In Switzerland, the basic benefit package is relatively low<sup>80</sup> so there is a lot of room for complementary insurance. Complementary insurance covers dental care, glasses, insurance abroad, medicines not paid by the basic insurance, among other things. It is interesting to see that complementary insurance does not only exist in insurance-based but also in NHS-style countries. In Denmark, three commercial insurance companies cover the additional cost of using private hospitals. However, since 1986, premiums to this insurance are no longer tax deductible.

Complementary private insurance can become counter-productive in cases where public health policy has introduced cost-sharing and co-payments in order to steer the consumption behaviour of the patient. Some countries even forbid enrollments in private complementary health insurance plans. In Switzerland, it is forbidden to cover co-payments stipulated by law or chosen in the form of a contract variant within the statutory health insurance. Totally different is the situation in France. There, taking voluntary complementary insurance is politically welcome and associated with tax subsidies. Supplemental insurance can be found in many countries.<sup>81</sup> In Ireland, despite universal access to the public health care system, 50% of the population have taken supplemental

insurance. It covers mostly more comfort in hospitals.<sup>82</sup> In Italy, 10% of the population has supplemental health insurance (other sources suggest it is 33%, but without specifying what the insurance covers<sup>83</sup>). Insurance often takes the form of lump sum payments in case of hospital treatment; in addition, it gives better access to private doctors or increased comfort in hospitals.<sup>84</sup> In Denmark, mutual insurance institutions cover benefits otherwise not or only poorly provided by the basic NHS, i.e., medicines and dental treatment. Twenty-eight percent of the Danish population is thus insured. However, since 1986, premiums to this insurance are no longer tax deductible. All together, financing through private complementary and supplemental insurance accounts for 20% of overall health cost, leaving 80% to the state budget. In Austria, 38% of households are covered by a private complementary or supplemental insurance.<sup>85</sup> In the UK, 15% of the population is covered by supplemental private insurance.<sup>86</sup> It covers easier access to specialists, and gives fast access to treatment otherwise delayed by long waiting lists, particularly for non-elective surgery. In the Netherlands, 93% of insureds are in possession of a voluntary supplemental health insurance contract.<sup>87</sup> It is particularly important to have this in order to cover some services almost completely excluded from the basic package, such as dental care and physiotherapy. In theory, there is no binding link between the basic contract (obligatory package) and the supplemental contract. By law, insurers may not terminate a supplemental contract when the insured decides to switch the basic contract. But in practice, not all insurers comply.<sup>88</sup> In Sweden, voluntary private health insurance plays only a minor role; 150,000 people are covered. Insurers promote this product by addressing the chance to bypass waiting lists and use private hospitals. In Switzerland, supplemental insurance covers certain treatment in hospitals such as that by the medical superintendent; free choice of the hospital beyond the borders of the canton; avoidance of waiting lists; consumer-friendly visits (including the ambulatory sector); and continuity of the personal doctor. Thirty percent of insured are contracted in a complementary or supplemental insurance. Supplemental and complementary private insurance together account for 10.5% of overall health costs.<sup>89</sup>

In general, voluntary insurance does similar things as out-of-pocket payments: It improves choice, quality, and access for those who can pay and can diminish access, at the same time, for those who cannot pay or who exhibit poor health conditions. In addition, in most countries, private, voluntary insurance is loosely regulated, linked to medical risk testing and the exclusion of pre-existing conditions, and the insurer can easily terminate it. There are only a few exceptions. In Germany, substitutive private insurance has to provide a standard contract without risk testing. In Ireland, risk testing is forbidden by law. In Italy and France, tax deductibility is dependent on the absence of risk-adjusted premiums.<sup>90</sup> In the Netherlands, health insurers committed themselves by their umbrella organisation not to introduce risk selection in supplemental health care insurance. This self-commitment is observed by most, but not all.<sup>91</sup> The problem is that insurers are not legally obliged to accept an applicant. But normally, in the absence of strict regulation, there is no community rating in voluntary health insurance. So, in the worst case, it

contributes to health inequalities instead of easing them. One more problem with private health insurance is high administrative cost, up to 25%.<sup>92</sup>

## SCALE, GENEROSITY, AND FINANCIAL BURDEN OF PROTECTION FOR OLDER PEOPLE

Even generous health systems are challenged with serious shortcomings regarding the needs of older people. This could be the result of open and transparent targeting of scarce resources to the active population. In many cases, medical resources are withheld depending on age. Rules for these restrictions are often not written, but can be found at the clinical level, (e.g., the UK).<sup>93</sup>

Beyond direct discrimination, there might be a lot of hidden and indirect access constraints that will hit older people in particular, starting with a generalized system of high co-payment or out-of-pocket payments.

In Switzerland, three factors are indirectly burdensome for the elderly.<sup>94</sup> The per-capita premium to the health fund is putting pressure on older people's incomes since pensions are normally lower than earned income. In a similar way, high co-payments in the Swiss system hit older people more than younger.

Reliance on voluntary, private insurance, as well, puts older people at risk. Since 1996, in Switzerland, where voluntary private complementary and supplemental insurance play a high role, insurers are obliged to calculate risk-based premiums, typically more expensive for older people. So it is this group who cannot afford this kind of insurance any longer. Similar problems exist for the elderly in the UK, who have problems paying the premiums for private supplemental health insurance—since the premium is, among other things, linked to age. In Denmark, complementary insurance covering expenditures for private hospital use automatically stops at age 67.

Generally, any company-based organization of basic or additional health insurance turns out to be risky for the elderly and pensioners. Even in France, complementary protection is often organized at the company level in the form of group contracts with obligatory adhesion by all workers, but such contracts will expire when a worker retires and leaves the company. The insured might have the right to continue the contract on an individual basis, but the insurer is allowed to ask for a substantial increase of contributions, up to 50% or more.<sup>95</sup> This puts the insured in a rather weak position and creates serious problems from an international accounting standards perspective, since they oblige the insurer to finance and fund this lifelong protection in advance.

Generally, co-payments burden the chronically ill and particularly the elderly. Even in Germany, where structured co-payments (dental care excepted) are relatively moderate, more than 40% of older people feel particularly burdened by the per-capita family doctor enrollment fee and other co-payments, saying they have to economize elsewhere in order to be able to pay their additional fees.<sup>96</sup> The particular burden co-payments represent to elderly people gives rise for

subsidies targeted to this group. Sweden is a good example: Older people's statutory co-payments to hospital care and dentures are reduced in relation to younger people.

Discrimination at the clinical, provider, or administrative level is common and hard to detect. It is often hidden in allegedly purely medical considerations. This can occur, for instance, even in Germany where open prioritisation regimes do not exist. Occasionally, the sickness fund refuses treatment with the argument that the treatment isn't suitable, as for an older patient, for instance. This is quite justified with medical and scientific recommendations, even by international expert organizations. So in one case, the competent sickness fund rejected a bone marrow transplant for a 64-year old person, saying that he would be too old for this kind of treatment. Doing this, the fund followed a recommendation by the European Blood and Marrow Transplantation Group, which, in some cases, defines the age limit as 55 for donations between brothers and sisters.<sup>97</sup> In Sweden, apparently as a consequence of budgeting, it's hard for the elderly to obtain certain types of treatment such as the after-care of a heart attack or to have cataract surgery.<sup>98</sup> A certain province or region had, in order to cope with prioritisation requirements, abolished surgery related to gastro-intestinal diseases by elderly, multi-diseased patients; now, they have to pay the whole treatment by themselves.<sup>99</sup>

In order to ease the burdens of elderly people, targeted (or indirect) "rebates" (as well as targeted tax advantages) can be granted. In France, for example, health care-related social contributions and taxes on pensions are lower than the related deductions on salary.

### POOLED RISK AT THE EMPLOYER LEVEL

Up until now, the company or industry-wide organisation played only a minor role in the organisation of sickness insurance and is almost exclusively restricted to complementary or supplemental insurance. This is of interest to the predominantly employer-based system in the U.S.

In France, 50% of private complimentary health insurance contracts are collective contracts, agreed by social partners at the company level<sup>100</sup> and purchased through employers, who often pay a part of the premium. The advantage, besides special tax breaks, is the cheaper cost structure and community rating—instead of the complicated premium differentiation for individual contracts. In addition, these group contracts tend to be more generous than individual contracts.<sup>101</sup> The consequences of retirement for those collective contracts are not easily understood. Retirement alone must not be a reason to terminate the contract, but the premium will be recalculated on an individual basis, since after retirement the age will be taken into consideration. In Italy, similar group contracts exist at the company level. This gives access to more comfort in hospitals and faster access to specialized care.<sup>102</sup>

One more country with group contracts is the Netherlands, with its ZVW scheme for normal medical treatment. These contracts are agreed upon, for example, between employers and trade unions. Patient federations or groups are also active in group health insurance contracting. In any case, people cannot be forced to join such contracts, even when such a contract exists in their firm. Health insurers are allowed to offer rebates up to 10% on the flat rate part of the premium. In practice, 46% of insureds are enrolled in a group contract, 67% of them in a contract negotiated by the employer.<sup>103</sup> The average rebate in the mandatory insurance package is 6,8%; in voluntary insurance it is 8%.<sup>104</sup> In Switzerland, company-wide group insurance exists in the voluntary sector. Whole staffs are insured for a unique community rate that reflects the average age of the employees.

### REGIONAL DISPARITIES

The degree of autonomous regional organisation and financing of health insurance and health care is directly linked to the question of how much national solidarity will be needed or accepted. In Europe, this is not a big topic for discussion, even if the phenomenon of regional disparities exists. Therefore, the topic requires only a brief mention, but regional issues might become an important subject in US health care reform.

In Italy, the NHS (Servizio Sanitario Nazionale e Regionale) is largely financed through regional taxes or tax-like contributions with very complicated features. At the national level, an essential benefit package has been defined and a fiscal equalisation mechanism (National Solidarity Fund) has been developed to transfer funds to those regions unable to raise sufficient resources. However, coverage differs between regions.<sup>105</sup> The regionalization is associated with unequal geographical spread of medical standards, including extremely different waiting times.<sup>106</sup> In the UK, regionalized budgets often result in regionally different waiting lists and even priority decisions.<sup>107</sup> In Switzerland, the basic health care benefit package as well as tariffs can be different from canton to canton; even tariff zones between cantons are allowed.

### COMPETITION BETWEEN INSURERS FOR CLIENTS

Competition between sickness funds and private health insurers for clients for basic coverage is rather an exception in Europe. For decades, in Germany, there was competition between public sickness funds and—in the case of substitutive insurance—also between public sickness funds and private health insurers.

In Switzerland, all citizens are obliged to subscribe to a private health insurer contract for a basic basket of health care. For those who fail to select an insurance, the government assigns the citizen to a health insurer. But insurers have to comply with many legal demands and restrictions. The system is financed by a pay-as-you-go-principle, without capital reserves: A basic health care benefit package has to be provided, including hospital care and a prescribed list of medicines; dental care is largely excluded. The basic package can be



different from canton to canton. The obligation for the insurer to contract is stipulated by the law, regardless of individual risk. The premium is calculated as a uniform per capita fee. In principle, the amount of this fee is the decisive competition parameter. But since competition does not exist beyond canton borders and additional regionalization is possible, competition on price is limited.

For people with low incomes and for families, the premiums are subsidized by the Swiss Confederation and the cantons. The idea is—very roughly—that the amount of the premium does not exceed 8% of family income. Thirty-three percent of the insured people were eligible for premium subsidies. In principle, an insurer must apply one single tariff to everyone. However, differentiation is allowed between the different cantons, and even tariff zones within a canton are possible. In addition, premiums can be differentiated by three age groups: 0-18, 18-25, above 25. No further discrimination is allowed. Every insured has the opportunity to change insurers at any time, but only among the supply given in the region.

Premiums charged to the insured for the obligatory, basic part of the health insurance are not allowed to be used for other purposes than exclusively for financing medical care defined by the basic package. That means statutory contributions by the insured must not be used for distribution of profits in favour of the investors of the health insurance company. A risk structure compensation has been introduced for age, sex, and region within a state, but not for health conditions. In addition, there is no risk compensation beyond canton borders. There is only a little competition between health insurers for efficient purchasing of health care services.

All doctors licensed to practice are automatically allowed to treat the insured in the basic scheme. The decision to give a license is, among other things, guided by capacity planning and restricting, but it is the cantons and not the health insurers who decide. Remuneration of hospitals is contracted between insurers and hospitals, both acting individually as well as collectively; there are 100 such contracts, but they are strictly controlled by the cantons and the federal level and have to be approved by both. The only way to gain some autonomy is the possibility for insurers to reach an agreement with single or participating doctors on managed care arrangements and model disease management and case management.

Today, nearly 100 health insurers are licensed with the obligatory health insurance scheme. A diversity of insurers are approved, among them for-profit and not-for-profit organizations, HMOs, owned by insurers or other private investors. It is noteworthy that administrative costs in the obligatory sector created by commercial insurers are four times as high as administrative costs by not-for-profit organizations.<sup>108</sup> The problem with the Swiss health insurance is the steep increase in costs by 4% to 6% each year, 10% alone in 2000.<sup>109</sup> This makes the scheme the second most expensive in the world, after USA.<sup>110</sup> The introduction of competition between health insurers in 1996 did not bring economies. Critics say that competition is incomplete as long as the obligation for health insurers to contract with all existing

service providers is not abolished and as long as there is no public requirement planning, restricting the offer of health services. In addition, the principle of fee-for-service payment is held responsible for driving costs upwards. Last, but not least, shortcomings are identified in the construction of the risk adjustment scheme (without compensation for morbidity), since it gives more incentives to compete for healthy consumers instead of competing for management of service and administration cost. Apparently, the incentives for skimming and discriminating against bad risks were so tempting that the insurers couldn't resist.<sup>111</sup>

Special attention should be given to the Netherlands. Since the reform of 2004, coming into force in 2006, a universal general health insurance system (ZVW, in addition to the AWBZ system) covers the whole population, independently of the individual status as a worker or of individual income. For statutory, basic health insurance, there is one marked for private health insurers (including old sickness funds that had to change status). All licensed insurers are required to comply with both general legislation covering the private insurance sector and with specific provisions of the Health Insurance Act. In order to maintain solidarity, important restrictions are imposed upon health insurers.

The government determines the risks which have to be covered and the medical services to be delivered by a compulsory standard insurance package. The insurer must offer this package nationwide, with obligation to contract, open enrollment, and with community-rated premiums. A risk equalisation scheme will hamper competition on the basis of risk selection. A no-claim reimbursement is obligatory. It is prohibited to differentiate the premiums according to individual health risk. Insured people can change to another insurer once a year. At least in theory, every single health insurer will purchase services by health care providers. But in practice, the competition between insurers for the best supply of contracts has not yet occurred.<sup>112</sup> In practice, 14 insurers are active in the relevant market, the four biggest among them insuring 80% to 90% of all insured people.<sup>113</sup>

As a consequence of strict legal requirements, risk management as a source of competition and return for investors in insurance is reduced. This appears to make obligatory insurance not so interesting for the commercial financial industry and gives reason for legal complaints.

## OUTLOOK

Summing up, after this lengthy discussion of the strengths and weaknesses of the public health schemes and arrangements in different countries, are there some lessons to draw for American health care reform? What could America do better and what should it better abstain from? The answer will depend largely on the analysis of what is wrong with the American scheme. And this is not only a question to be answered by experts, but a question deeply rooted in political preferences and priorities. Is it the rising costs that are regarded to be the main problem? Is it failing access for the poor? If the measure challenge is the latter, the introduction of

a state-run NHS with strict budgets and prioritisation rules could be the solution. But are the consequences fully acceptable? Such a move would result in a budget-based health system instead of a needs-based one.

If it turns out that the employers are no longer willing to pay increasing health care premiums for their workers, maybe the introduction of a general obligation to buy coverage could help. This solution would bring to an end the “45 million Americans without coverage” phenomenon and could do away with frequently reported “unwanted Medicare and Medicaid.” If the premiums were calculated as a per capita lump sum instead of a percentage of wages, separation of health care provisions from labour market participation would be complete. However, a comprehensive legal and supervisory environment would have to be created to steer the competition between health insurers. There will also be a need for a complicated regime of premium subsidies, with their concomitant political debates.

This leads directly to the question of how much solidarity and how much redistribution there should be in any scheme? Who will be expected to “give” or compromise for the sake of solidarity and in favor of whom? Would the guiding solidarity principle be motivated by the idea of an inclusive welfare state, capable of avoiding poverty and helping the most vulnerable? Would a lesser degree of solidarity be based on citizens’ wanting to have the chance to maintain the former living standard, independent of the health status of the nation? From the perspective of the insured and the patients, decisions must be made on the meaning of competition and choice and on the extent of a basic healthcare package. In short, many problems that have been deceptively buried will be resurrected if America undertakes fundamental changes in the health care system.

I have tried to offer a broad menu of experiences from European countries, being as forthright as possible in my descriptions. Change, even when desperately needed, carries many consequences. It is best to be aware of them without being discouraged by them.



## NOTES

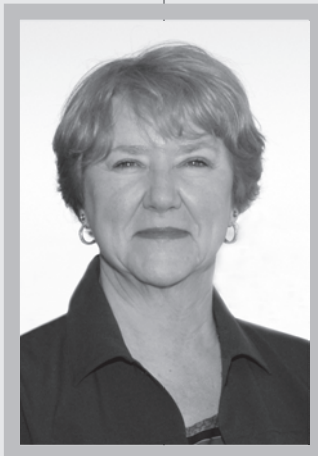
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## Respondent Carol Ann Lockhart, Ph.D.



**Carol Ann Lockhart, Ph.D.**

*President, C. Lockhart Associates*

Carol Lockhart is president of C. Lockhart Associates, a health systems relations and policy consulting firm. Lockhart Associates provides assistance to local, national and international organizations planning and implementing health and public health policy and program change. Dr. Lockhart is also a professor at the University of Tennessee Health Science Center, College of Nursing in Memphis where she teaches health economics and health policy in the Doctor of Nursing Practice distance learning program.

She has held local and state public health positions, including director positions in the Arizona Department of Health Services. While there, she was the first director of the Arizona Health Care Cost Containment System (AHCCCS), the nation's first (1981) statewide capitated Medicaid system. Dr. Lockhart was also one of the original 13 commissioners appointed to the Physician Payment Review Commission (PPRC) to advise Congress on payments to physicians under Medicare. She served two terms (1986-1991).

Co-author of two books on labor relations in health care plus articles and chapters on health care management and nursing, Dr. Lockhart has taught in baccalaureate and masters program in schools of public health, health administration, and nursing. Her doctoral studies in health policy were done at the Heller School at Brandeis University as a Pew Health Policy Fellow. Her bachelor of science degree was granted from Case Western University, Bolton School of Nursing and her master of science from the University of California at San Francisco.



*Let me say at the outset that I have a bias toward efforts to expand access to health care for our population. That bias is reflected in the fact that I have been involved for many years in multiple state and local efforts to expand care in Arizona. I remain committed to that idea and welcome the exploration of options that might make that a concrete reality sooner rather than later.*

*One could say that I was predisposed to find hope in Dr. Schultz-Weidner's presentation. He describes universal health care systems that are not incompatible with the values in the United States and our insurance-based approach to care. The countries described in his lecture provide examples of what might be possible, practical, and compatible with U.S. health care, yet allow universality.*

*In the United States, "socialized" is usually the word thrown at anyone suggesting some universal approach to health care, and it is not meant as a compliment. Dr. Schultz-Weidner specifically separates his descriptions of universal health systems between: 1) national health systems such as in the United Kingdom; and, 2) social security systems with different levels of private insurance participation (social insurance schemes) such as in the Netherlands, Switzerland, and Germany, systems that are much like our own Medicare system. He clearly demonstrates that a universal health care system can involve private insurance groups, and the paper explains and explores the approaches very fully.*

*Consensus for change to a universal health care policy will not come easily in the U.S., with our very large and diverse population and interests. If change occurs, it will most likely be instituted in incremental steps over a number of years. But, system-wide changes are occurring at the state level. States are reaching consensus on health care changes that provide universal access to a basic level of care within a state.*



*Whether you liked the Clinton health plan in the early 1990s or not, the effort stimulated some of the first serious discussions on all sides of the debate about what care should be offered and what a "basic" health plan might look like. Before that time, we tried to avoid the idea that there might be differences in what people could be assured and that money might mean you are able to buy more than your neighbor. What this presentation shows is that there can be some agreed upon definition of basic care and that the definition varies between nations and states; however, the lecture also shows that there is universal health care of some type in these nations and states.*

## Respondent Bradford L. Kirkman-Liff, Dr.P.H.

*In the early 1980s, Arizona moved to a state-wide rather than county-specific system of care for the indigent partially because the counties differed so much in what care they offered. Our newly adopted Medicaid system, the AHCCCS, was unique in the country. It was the first pre-paid capitated state-wide Medicaid program.*

*Offsetting the escalating cost for indigent health care with millions of Medicaid dollars was a driving factor in the move to that system, but so was a desire for consistent services across the state and an effort to move the indigent to private providers of care and away from county run systems.*

*How did that happen? It happened because we had leaders on both sides of the aisle that wanted Arizona to be a better place to live. They found a way to talk, push, and cajole. Those were leaders who had a vision and worked together to make it real. Arizona has done it before. Other states are moving to some sort of universal program. It is not unlikely Arizona could craft another innovative yet universal health care program.*

*The presentation today outlined some of the struggles universal insurance systems face, and the list of 14 criteria for the analysis presented is the same list of problems, questions, and struggles we already face in our country with our existing system. What this tells us is there is no "perfect" policy, system, or solution. No matter how we craft it, we will face the same issues, and policies will need to change as the population grows, ages, and diversifies, as economies boom and struggle and as technology brings innovation. The difference will be whether we are struggling to assure everyone gets something through some rational approach or whether we shift people and costs in an ongoing chess game where some people are completely left out or going into bankruptcy to care for themselves and their families.*

*The systems described do not provide access to everything at all times. There are limits/differences within these systems and between nations and even within them between states in nations. There are limits in funding, resources, and services. But, people have access to basic care, however it is defined. As a person with a long history in public health, that, for me, is the bottom line: Is there access to care that can help ensure a good health status for Arizona's citizens? There is room for solidarity and individual responsibility in that vision, and the presentation today offers insight into how that might take place.*

### **Bradford L. Kirkman-Liff, Dr.P.H.**

*Professor, School of Health Management and Policy  
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Bradford Kirkman-Liff has been a faculty member in the School of Health Administration and Policy, W. P. Carey School of Business, Arizona State

University since 1981. He has also taught at the Centre for Public Policy and Management, Manchester Business School, University of Manchester, and the Centre for Health Care Planning and Management, Keele University, in England and the Institute of Health Care Policy and Management, Erasmus University, in Rotterdam, The Netherlands.

Dr. Kirkman-Liff currently teaches on the global pharmaceutical and biotechnology industries, biotechnology entrepreneurship, health management and health policy in the ASU Masters of Health Sector Management program. He has previously taught courses on managed care, health insurance, health reform in industrialized nations, and health information management. His current research is focused on collaborative networks and knowledge management and their application in health care. His comparative policy research is focused on the Netherlands, Germany, and England, examining health care reform and physician payment.

Professor Kirkman-Liff has published more than 50 papers in such journals as the *Journal of the American Medical Association*; *American Journal of Public Health*; *Hospitals and Health Services Administration*; *Health Policy*; *Journal of Health Politics*; *Policy and Law*; *Health Affairs*; and *Health Research*. He has been a World Health Organization Fellow and has served as a consultant to governments (including the U.S. Congressional Budget Office the U.S. General Accounting Office), foundations, hospitals, physician group practices, health care trade associations, biotechnology businesses, and insurers in the U.S., Canada, England, Belgium, Ireland, and the Netherlands. He received his bachelor and master of science degrees from Carnegie-Mellon University and his doctor of public health degree from the University of North Carolina at Chapel Hill.



## Respondent Bradford L. Kirkman-Liff, Dr.P.H.



*LESSONS FOR THE UNITED STATES. There seem to be some resonances between the values in the health care systems of the Netherlands, Switzerland, and Germany and traditional American values. Most American physicians and health care executives would state that patients and their insurers should be obligated to pay for the costs of their treatment. Most of the American public would state that physicians and hospitals are obligated to serve all people who need care. In my view in 2008, most employers would prefer to pay taxes to subsidize low-income individual and household purchase of health insurance than to have to continue to arrange and pay for health coverage. Most large American employers and their employees expect that insurers will cover all of the employees of an organization, without medical underwriting or exclusions for preexisting conditions. Insurers expect that providers will enter into good faith bargaining and negotiation over fees and charges. Overall, there are many parallels between the values described in these system and values currently held by the various parties in the American system.*



*The health care systems of these European nations provide American policymakers with some models that are close to our own current structure and our traditional values. In these nations, it is the private sector competing in the marketplace that is responsible for assuring universal coverage for preventive and curative medical care, not the government operating a single-payer agency. Fees and budgets are not dictated to providers, but arrived at through negotiation between private parties with increasing use of "pay for performance" incentives. Determination of health policy is shared by the national government and autonomous interest group associations. Such a system seems closer to American traditions than one involving government-provided insurance.*

*These systems have five lessons that can guide future policy:*

*1. Explicit public discussion about the underlying values is essential if a consensus is to be reached on the strategy to achieve universal coverage, sustainable costs, and choices for clinicians and patients,*

*2. Mandated coverage and mandated offering are both essential to achieve universal coverage through a private sector approach. No individuals—be they part-time, seasonal, temporarily employed or unemployed—should be excluded from insurance coverage. There must be no gaps or options for coverage. The unemployed and chronically ill as well as the young who might feel invulnerable, all have a responsibility to continue their insurance.*

*3. There is a danger that in a competitive market there will be favorable and adverse risk selection. There needs to be a strong mechanism to provide risk equalization among insurers. Those plans that attract a disproportionate number of patients with more complex and chronic health care needs and so have to contract with clinicians and institutions to meet those needs must have the financial resources to meet those patients' needs.*

*4. Choice can be assured in a system that provides universal coverage. HMOs, PPOs, and consumer-directed health plans with health savings accounts can all be made available. Some form of refundable tax credits in advance will be necessary.*

*5. Separating catastrophic risks from conventional risk is one feasible approach to make mandated coverage affordable. The approach in the Netherlands of covering long-term care, mental retardation, developmental disabilities, maternal and child health, and public health separately works well.*

