Arizona Health Care Cost Containment System

International Approaches to a Socialized Insurance System

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I. EXECUTIVE SUMMARY

This paper was developed for the Arizona Health Care Cost Containment System as part of the Arizona State Planning Grant, which is funded by the Health Resources Administration and services. We were asked to provide information regarding international approaches to socialized insurance systems.

We have provided information about many European countries. In the preparation of this paper, we relied upon information that was generally available through the Internet, as well as certain books. As a result, we screened through literally hundreds of Internet articles in order to summarize the information. The number of articles used was numerous and is not included as a bibliography. One of the primary sources of information included reports from the World Health Organization (WHO) concerning the health care delivery system in numerous nations. These reports specifically are Highlights on Health of the various countries, as well as Health Care Systems in Transition. To the extent that these documents are inaccurate or incorrect, our summaries of them may also be inaccurate or incorrect.

A more detailed analysis of this subject was beyond the scope of this paper. The health care delivery systems of the various nations examined in this paper are complex and vary widely. This paper should only be reviewed in its entirety.

Social Insurance – A Description

Many of the European nations have long-standing "social contracts" with their citizens in order to provide health care services. Social contracts are an implied right of the citizens to have health care services provided to them by the government and/or as a result of being employed. Certain characteristics are common to the Socialized Insurance Systems evaluated in this report. These include:

- Solidarity. This forms the basis of the health care delivery systems of many of the European nations. It also means that there is a compact to provide universal care to all citizens, regardless of economic or health status. This means that there is a compact for the working individuals to provide insurance for the poor, the elderly, and the uninsureds.

- Financing. The financing systems vary, but typically rely upon taxation, mandatory insurance coverage financed by the employers and the employees, or a combination of both.

- Regulation. The Socialized Insurance Systems are generally highly regulated. They can take two forms. The first is a single-payor system, such as in Denmark, Norway, and Sweden (additionally in Canada). The second method is a highly regulated, universal multi-payor system such as occurs in Germany and France where Sickness Funds pay providers a uniform rate negotiated annually.

- Prevention. The Socialized Insurance Systems tend to place significant emphasis on health education promotion and prevention. Their emphasis is to move the focus from a curative health care delivery system to a preventive one.

- Out-of-pocket expenses. Many of the Socialized Insurance Systems require copays for physician services, prescription drug services, and for some other benefits.

- Waiting lists. Most countries have some form of wait lists for non-acute surgeries. In some countries, this implies a form of rationing because of the long wait list times. Many countries are attempting to address the issue by implementing a maximum wait list time for procedures.

- Needy populations. There is a general emphasis to provide health care services for the elderly, poor, and uninsureds. This responsibility generally lies with the municipalities of the various European nations. Long-term care is a recognized problem, and is only recently being addressed by these countries. These countries are paying for physician, home health, and prescription drug services for the elderly population.

- Uniformity. A characteristic of the system is a general uniformity of services provided by the state system. Oftentimes, there are different services covered, but they are based upon different income levels or professions. The higher income citizens generally have options to purchase "fill-in" insurance.

Table 1 contains a high level summary of the major countries discussed in this paper. This summary must be used with caution as the various countries have differing details that makes high level summarization difficult. Thus this summary may overlook some of a county's characteristics.

Table 1
High Level Summary of Major Countries

Country	Financing	Employment of Providers	Waiting Lists	Non-Citizen Coverage
Germany	▪ Employer/ Employee Paid Payroll Taxes ▪ User Fees	Private Paid by Sickness Funds	No	Local Social Support Systems
United Kingdom	▪ Payroll Taxes ▪ General Revenue ▪ User Fees	Private and Public	Yes	Same for all Residents
France	▪ General Revenue ▪ Cost Sharing Paid by Mutual Aid Funds	Private and Public	Yes	Limited, Some Charitable Associations
Sweden	▪ Income Tax ▪ User Fees	Mostly Public and Some Private	Yes	Same for all Residents
Spain	▪ General Revenue ▪ Some Private Insurance	Most Public	Yes	Children Under Age 18
Italy	▪ Regional Value Added Tax ▪ Regional Income Tax ▪ User Fees	Private and Public	Yes	Legal Immigrants Covered, Others Limited
Mexico	▪ Employer ▪ Employee ▪ State ▪ User Fees	1/3 Private 2/3 Public	Yes	Emergency Care Only
New Zealand	▪ General Revenue ▪ User Fees	Private and Public	Yes	Yes if Permanent Resident or Have Immigrant Visa

Implications for the United States' System

It would be difficult for the United States (US) to adopt a Socialized Insurance System without a significant change in the US system. Currently, the US has forms of Socialized Insurance Systems for the elderly (Medicare), the poor (Medicaid, CHIP), and the near poor (programs like the Basic Health Plan in the state of Washington) funded entirely or in part by taxes. In addition, most hospitals are required to provide some level of charity care as a result of Federal/state funding.

Massive changes would have to occur within the US system in order to implement the social features of the European systems. This may include many of the following:

- Significant taxes earmarked to cover the uninsureds.
- Mandatory health insurance provided by the employers, but funded by employers and employees.
- More uniformity of benefit coverage.
- Significantly more regulation concerning provider fee levels, especially prescription drug costs.
- A potential loss of patient freedom of choice of providers.
- An income level differentiation concerning taxes and/or benefits (i.e., higher income pay more taxes or have lower benefit levels).

All of these potential changes would have a profound change on the US system. It would require substantial changes that would have to be legislated. It could also involve a new regulatory industry in order to comply with these features.

Implications for a State System

It would also be difficult for a state to implement significant features of the European systems. The current best example of this occurs in the state of Hawaii.

Hawaii's insurance plan predates ERISA and, thus, they were granted an exemption to ERISA requirements. Hawaii has required the employers to provide health insurance coverage to all employees working over twenty hours a week.

It is possible to implement a European model in a state. The state of Washington actually implemented a Clinton health system model in the mid 1990s. The primary features included a mandated benefit plan design, taxes on cigarettes and other sources to fund the uninsureds, and mandatory coverage by the employers. The most significant problem was that ERISA groups (self-insured, mostly large employers) were not subject to the law without an ERISA exemption that needed to be granted by Congress. This exemption appeared to have little

chance of being granted. Within a year of the Washington law passage, almost all features were repealed by the state Legislature.

The most significant issues at a state level are:

- The ERISA exemption need
- The amount and sources of taxes required to expand a health insurance program to the uninsureds
- The cost impact of mandated employer provided coverage for health insurance

Section II provides an overview to the European health care delivery system. It provides a discussion of the general approach, financing, and issues pertaining to the system. There appears to be a near-universal concern over financing, cost, and access to providers.

Section III details ten specific western European countries. It also includes an abbreviated overview of ten other countries in Europe.

Finally, Section IV describes the health care delivery systems for Mexico and New Zealand.

Information concerning the coverage of non-citizen for these countries was quite limited. The general characteristics are that emergency care for non-citizens is almost always covered. Where insurance schemes are available, non-citizens are allowed to purchase insurance in the host nation.

II. HEALTH CARE SYSTEMS OF EUROPEAN NATIONS

General Approaches

Since the late nineteenth century, many European governments have enacted laws requiring specified occupations to join Sickness Funds, levying payroll taxes on their workers and employers, and requiring the Sickness Funds to provide benefits to the workers and their dependents. Additional occupations were successively added to obligatory coverage. Each new occupation was required to pay payroll taxes, and the Sickness Funds steadily grew. The national government administered the agencies for collecting the money and distributing it to the Sickness Funds.

During the late nineteenth and early twentieth centuries, every obligatory Socialized Insurance System began with blue-collar workers in factories, mines, and similar settings. Wives and children were included over time. Later amendments successively added white-collar workers, service workers, farmers, self-employed businessmen, other employees, and their dependents. Finally, pensioners and the unemployed were required to join Sickness Funds.

In several countries, such as France and Belgium, all categories of the population were eventually added, so that coverage is now universal. In others, such as Germany and Holland, persons over a certain income level (regardless of occupation) or persons in certain jobs are not required to join. These persons are free to choose voluntary membership in the official Sickness Funds, purchase private commercial insurance, or self-insure.

Modern health care financing abroad is based on the philosophy and politics of social solidarity, not on the techniques of private insurance, despite the widespread use of the words "health insurance." The details vary among countries, but a common feature is redistributive financing: a large number of people are taxed in order to cover the costs of those who use health care services, even though the high payers are often low users and the high users are often low payers.

Some insurance-like features can be found in Europe. These techniques are used for insuring extra benefits. In a few countries (such as Germany) private insurance methods apply to a small market not covered by the obligatory system, but this formerly common situation is now rare. Once a system of social solidarity and redistributive financing is established for an entire country, it is very difficult to unscramble in favor of voluntary private insurance. Populations become accustomed to thinking of health insurance as part of social security and few want change.

Statutory health insurance is connected to the entire social security system, but the details vary among countries. The health insurance law may administer both, and government may contain the costs of both. The relations between the health insurance carriers and government also vary from country to country. Providers and the managers of the carriers usually try to preserve their autonomy.

General Financing

Social security in general, and statutory health insurance in particular, usually depend on payroll taxes. A proportion is levied on each employee's earnings, and the employer adds a matching or higher percentage. As health insurance costs have risen, the proportions rise-particularly on the employer and the ceiling on taxable wages rises or is eliminated.

Payroll taxes are associated with statutory health insurance. The Government usually enacts specific rates on entire classes of the compulsorily insured. In Germany, an exceptional case, the principle of payroll taxes is obligatory, but each health insurance carrier may fix the rates it wishes in accord with its financial needs and design of benefits. Quoting lower rates may be an instrument of competition for subscribers, although usually carriers compete by offering more generous benefits and customer services.

Rates may vary by economic sector. Some politically influential occupations, such as farmers and the self-employed-may obtain slightly lower rates from Government without loss of benefits. In order to combat deficits, governments recently have begun to impose premiums on the elderly and unemployed. These persons' claims of financial deprivation conflict with the health insurance system's need to cover their costs.

Sickness Funds used to be allowed considerable discretion in fixing their rates. Since the payroll taxes are really acts of government, however, finance officials now play a bigger role in examining the Sickness Funds' accounts and setting the rates. Governments now limit the annual increases in payroll taxes and impose cost containment upon the health insurance carriers and the providers.

Statutory health insurance in most countries was designed to be financially self-supporting and independent of government budgets. But the increase in health care costs and the extension of health insurance to the poor, the unemployed, and pensioners induce government to fill shortfalls with grants to the Sickness Funds. As payroll taxes reach their limits, pressures build for government help.

Subsidy policy takes different forms. As an example, Government has long granted money to Belgian nonprofit carriers in order to support their administration and make public corporations unnecessary. In lieu of normal Socialized Insurance System payroll taxes on employers, the Swiss national government has long made direct grants to all Sickness Funds. Grants to carriers make up for the excess of health costs over premiums by the aged and unemployed in France, in Holland, and in American Medicare.

Some governments grant money to providers in order to reduce the claims charged to health insurance carriers. Examples are capital grants to hospitals in several countries and Swiss cantonal sharing of hospital operating budgets.

Starting subsidies in periods of prosperity is politically popular; but controlling them during recessions touches off great political controversies. The need to limit increases in payroll taxes and public subsidies lead national governments to intervene in the once independent health care market by controlling provider costs.

If a health insurance scheme is universal and unified in one sickness fund, social solidarity is fulfilled. However, if the carriers are separate, different social classes and different medical risks often gravitate to different funds. The carriers may then select risks and vary coverage in order to improve profits and image. As a result, some Sickness Funds are stronger financially than others, and without intervention by regulators the imbalance may worsen.

Instead of reducing the imbalance through subsidies, some governments have insisted that the carriers redistribute their revenue according to need. In other words, the industry is pressed to practice social solidarity rather than competitive preferred-risk selection. Critics of interfund transfers say that some arrangements contradict social solidarity.

Every country has experienced an increase in health care costs that has strained payroll taxes, government budgets, and premiums. The causes are universal and very difficult to control. These causes are the general increase in the cost of services, greater demand for services due to increased affluence, an aging population, and new technologies. All are struggling for ways to eliminate waste and contain costs without depriving their populations of care.

Regulation of capital investment and provider rates have steadily increased in Europe and have reduced the once rapid increase in costs. But, government rate regulation is not possible in all situations, for example where the medical associations insist on negotiations.

In the negotiations with doctors and in rate regulation, payers have tried to limit the annual increases in total costs by reducing the annual increases in physicians' fees and hospital charges. But price control alone has had only partial success, since utilization of doctors and

hospitals can rise, more expensive treatments replace the less expensive, and payers are obligated to cover the hospitals' costs.

Because of the numerous methods of regulation, negotiation, and financial incentives have had mixed results, have elicited protests from providers, and have required constant administration, some payers and governments have resorted to the most direct form of cost containment-that is, requiring providers to give all necessary service within an expenditure cap set in advance.

Global budgets are a common method of paying hospitals in countries with full public financing. This is difficult within a statutory health insurance system since there are multiple payers, autonomous providers, and legislative guarantees of full services on demand. Physician reimbursement in German health insurance has long used fixed annual caps, and some countries have attempted to introduce fixed budgeting. Negotiation with providers must be combined with financial guidelines from government. Several countries have introduced and then steadily tightened the expenditure "targets."

The effects of any cost containment effort depend on how it is administered. The same method may be generous at one time and restrictive at another. The long-term trend in countries with statutory health insurance and national health services is toward tighter limits, forcing health care to function within the country's fiscal capacity.

The hospital sector was the first to be constrained, but controls are now being tightened on physicians' services and pharmaceuticals.

Common features include some copayments by patients. Some countries have copayments for inpatient services. Most have copayments for physician services and almost all require significant copayments for prescription drug services. Oftentimes copayments for the poor or elderly are less or free for basic medical services.

Issues

Statutory health insurance has steadily expanded in coverage and financing. It has enabled entire populations to receive mainstream health care in place of the class-based differentials of the private market. It has developed redistributive methods of financing in place of variations by subscribers' own incomes. "Good" and "bad" health risks are fully covered by the same financing principles.

Statutory health insurance protects the full entitlements of aging populations and covers increasingly expensive clinical methods. It must also operate within society's fiscal capacity, within the constraints of the payroll taxes and public subsidies.

Many countries are concerned about a number of issues. These include:

- Financing and the cost of health care services
- Wait list queues as a form of rationing
- Inequality of the health care systems between urban and rural settings
- Shortages of nurses
- Affordability of the compulsory insurance schemes
- Efficiencies of the hospitals and the physician providers
- Patient rights and access

III. SPECIFIC WESTERN EUROPEAN COUNTRIES

Germany

History

The modern German health care system was pioneered in 1883 by Chancellor Von Bismarck. At that time, the system of health care was developed for individuals under specified income levels. Further social changes and doctors' victories occurred during the Empire and Weimar Republic (1880), the National Socialist period (1933-1945), and the Post-War period, which resulted in the two German states.

In modern times, the re-unified Germany after 1990, created a number of other issues. At the time, the German Democratic Republic (GDR) had a universal national health insurance system. This was abandoned after re-unification in 1990 in favor of the Federal Republic of Germany (FRG) insurance system.

The Federal Government now provides the regulatory framework for health care, but the Länder (i.e., German states) are responsible for providing health care. The Länders are major suppliers of capital investments in hospitals, funding of hospital construction, medical education, and are among the major owners of hospitals.

The providers of health care services and purchasers (mainly the Sickness Funds) are strictly separated.

By 1997, some 75% of the population had mandatory health insurance because their income fell below a fixed level or because they were unemployed. Approximately 13% voluntarily joined statutory Sickness Funds and 10%, primarily civil servants, were covered by their employers. The bulk of the remaining population, which had high incomes, obtained private health insurance. The unemployed are covered by a mandatory health insurance paid by the state. Less than 5% of the population were uninsured at that time.

There are quite a few parallels existing between the United States' and Germany's health care system. Germany has a federal system of government whose constitution describes the responsibility for local, state, and federal government. Additionally, both health care systems are a mix of public and private financing and federal-state responsibility. Employers are directly involved in financing both systems.
The German health care system is neither government owned nor government run. The health care providers and the Sickness Funds are the center of the system.

Financing

Most of the insureds in Germany are mandated by federal law to become members of the Sickness Funds, which are non-profit insurance organizations. Sickness Fund members receive comprehensive coverage of health care services through a voucher system. Members with their Sick Certificate card are entitled to unlimited ambulatory care, which was free until 1996. Since then, there has been a small fee for a number of services such as optician and dental care. Hospital care requires very small copays, 11DM per day up to 150DM for a fortnight (two weeks).

The Sickness Funds collects premiums in the form of employee and employer paid payroll taxes and pay the providers from these revenues. A system of risk equalization based on age/gender and geographical factors operates between the Sickness Funds. The German system is also an "All Payor System" because all Sickness Funds in the same geographic area pay providers the same fee for the same service.

Approximately 1,150 Sickness Funds provide coverage to about 90% of the population. Internet articles have estimated this to range between 88% and 92%.

All physicians and dentists practicing under the Sickness Fund System must join an organization of Sickness Fund Physicians. The Sickness Funds are organized both on a local as well as regional basis. Regional associations of Sickness Funds negotiate with regional organizations of Sickness Fund Physicians to set payment rates for ambulatory medical services.

Contributions to a Sickness Fund are calculated as a percent of the individual's wage or salary. The age/sex and health risk of the insured person is not considered in the contribution level. Contributions are shared equally between the insured and their employers.

The Long-Term Care Insurance System was established January 1995. It was a new and independent branch of the Social Insurance System. Anyone who is insured in the Statutory Health Insurance is automatically a member of the Statutory Long-Term Care Insurance. Individuals who have obtained private insurance coverage (primarily high income individuals) must take out a private Long-Term Care Insurance.

It is estimated that the cost of the health care in Germany in the year 2000 is approximately 600DM billion. The hospital sector has the most expenses. They have had significant cost increases in the 1990s. In 1996 the government introduced a DRG-like system. They established case payments and special payments, which account for about 25% of the total

costs in the hospital sector. 5% of expenses are settled by departmental, basic nursing, and medical rates.

The 1997 Health Insurance Cost Containment Act required Sickness Funds and providers of health care to pursue cost containment goals through a policy of maintaining contribution levels. They have attempted to hold increases in contributions level with the rate of increasing contributory income.

The Cost Containment Acts used various methods to contain costs. These included budgets for sector or individual providers, reference price setting for pharmaceuticals, restrictions on high cost technology equipment, restrictions on the number of ambulatory care physicians, increased copayments, and the exclusion of young people from certain dental benefits in the early years.

Issues

Major health care reform was introduced in 2000. The Health care Reform 2000 re-organized the health insurance system and included multiple objectives. These objectives include:

- The right to high quality care
- Medical care more tailored to suit the needs of the patients
- Improved patient rights and better patient information
- An improvement in health promotion and prevention

Social care (including institutional care, schools for special needs children, and old age homes) is delivered by a broad variety of many private organizations that complement family and lay support for the elderly, the mentally ill, and for physically or mentally handicapped. Funding generally is based upon a priority of private funding (either out-of-pocket or insurance) over public subsistence. Public resources will contribute a share of monetary and service benefits in social care because the recipients are often times not employed and eligible for the Sickness Funds. Most providers of institutional care belong to six welfare organizations, which have established sixty thousand autonomous institutions. The German system puts emphasis on free access, high numbers of providers, and technological equipment. Waiting lists and explicit rationing decisions in other nations' delivery systems are virtually unknown in Germany. The most important topics for current and future reforms are:

- Financing and reimbursement
- Health technology assessment

- The fragmentation of the health care between sectors and payers
- In the integration of the former eastern block with the western block health care delivery system

Expenses for people who have no health insurance (including migrants from various communities) are usually covered by social support systems, which are funded by the cities. Private insurance is possible for individuals with an income over a certain level.

United Kingdom

History

Public health programs have a long history in the United Kingdom. In the nineteenth century, landmark legislation was passed to improve water supply, sewage, working and living environments, and personal hygiene. The National Health Service (NHS) came into operation in 1948 following the provisions of the NHS Act of 1946. Freedom from user charges was a key feature of this approach, which placed heavy emphasis on equality of access.

The political consensus for establishing the NHS was built during the war and was consistent with other welfare state initiatives in areas such as social security, education, and housing, which were being developed at this time. Physicians strongly opposed any loss of professional autonomy and compromises were made. General Practitioners (GPs) were able to retain independent contractor status. The consultants (specialists), while becoming salaried employees of the NHS, were given significant control over the conditions of their employment.

Over the years, the NHS has undergone many structural and organizational changes. In the early 1990s it underwent the most important structural reform since its creation: the introduction of market forces into the system which was intended to make it more efficient, effective, and responsive to the needs of patients. The key change of the reform was to separate "purchasing" and "providing."

The recent introduction of Primary Care Groups (PCGs) is an attempt to integrate delivery, finance, and quality improvement into a locally directed care system with a strong sense of community accountability. Primary Care Groups (PCGs) are groups of PCPs that are designed to serve between 50,000 and 250,000 persons. The PCGs will eventually hold the budgets for primary care, specialist, hospital, and community-based services and have the flexibility to reapportion these budgets.

Financing

The NHS is predominately financed through payroll taxes and general government taxation. The remaining 6% of the NHS funding comes from user fees for pharmaceuticals and dental services. In addition, approximately 15% of all health care services come from private out-of-pocket spending for insurance products and complementary care.

During the last decade the private sector has been rapidly developing in all aspects of health care (elective surgery, ambulatory care, dentistry, etc.). Many companies now offer private medical insurance as part of their employment benefits packages and approximately 10% of the population enjoys this coverage.

The tax based funding has contributed significantly to the cost of the NHS remaining among the lowest in Western Europe over time, as a percent of GDP. In 1997, the UK was at 6.7%, with Germany at 10.4% and the EU average at 8.5%. The funding for the NHS has predominately been based on prior year revenues, rather than services based.

Cost containment programs have been facilitated by the GP focus in delivering care. Access to a specialist is generally limited to hospital admissions or with a GP referral. This gatekeeper approach has allowed the NHS to work to contain pharmaceutical scripts and to implement disease management programs.

GPs have four components to their compensation:

- Per patient – incenting them to provide high quality care and retain patients
- Practice allowances – to cover practice costs
- Health promotion payments – for disease management programs, achieving immunization targets, etc.
- Service payments – paid per service

There has been a significant increase in the use of practice nurses by the GPs to help them serve their patient panels.

Issues

Waiting lists are the dominant concern. Pledges were made by the Labor government in 1997 to reduce the waiting lists dramatically. The current goal is to have a three-month maximum admission delay by 2004. However, the number of persons waiting for admission is still over one million persons, as of March 2001. Outpatient waiting times have dropped with 75% of all persons seen within 13 weeks, and only 7% having to wait more than 26

weeks for an appointment. Surveys have shown that, overall, the general population is proud of, and satisfied with, their national health system.

Other forms of rationing and priority setting also exist. There has been a great deal of publicity generated from a 1995 case involving the denial of a second bone marrow transplant for leukemia treatment on the grounds that the child's clinical prognosis was extremely poor. The government has since tried to involve the public in helping to set priorities.

The NHS has a formulary and covers a restricted number of prescription drugs. Drug company profits are also tightly regulated.

Using technology is another current concern for the NHS. Electronic Health Records (EHR) are being used in many test sites to improve the coordination and communication of patient care. The goal is to have cradle to grave information for all persons in one EHR. Increased use of the Internet and intranet has improved the ability to schedule appointments, get lab results, etc. Telephonic help centers are helping to answer questions and triage care to the appropriate setting or even eliminate unnecessary visits.

The NHS, regardless of citizenship, covers all residents. There is also a reciprocal arrangement with many other European countries for visitors.

France

History

The modern health care delivery system started as Mutual Aid Funds in the 19th century. They were numerous at times, and small. The first modern health insurance enactment occurred in 1928. The Mutual Aid Funds were retained as carriers.
A more comprehensive Socialized Insurance System was enacted in 1945. By the 1990s all the carriers for basic coverage of employees and families were corporations (regimes), monitored by the Ministries in the government. All employed persons are required to join a regime. A few industries such as agriculture, the railroads, and mining have their own regimes. The self-employed have a program of their own, administered by a mixture of private health insurance carriers and Mutual Aid Funds.

The health insurance system consists of two levels. The first is a mandatory public plan, and the second is provided by private insurers and
Mutuelles.

France has more cost sharing by patients than any other statutory health funds in Western Europe. If one pays subscription fees to a Mutuelle (renamed Mutual Aid Funds), the fund covers the cost sharing in full. This role is similar to Medicare supplement plans filling in Medicare deductibles, coinsurance, and copays in the United States.

France has a very large private insurance industry. The carriers pay hospitals directly and reimburse the patient for physician claims. The physician cost sharing is 25%, but can be as high as 50% for the self-employed. This presumes the patient does not buy insurance to fill in the cost sharing provisions, as discussed earlier. Additionally, there may be small copayments for hospital services.

Financing

The self-employed pay into the self-employed's health insurance general regime that is tiered, based upon income levels. The French system for other citizens is based upon tax rates paid to the general regime. There is a fairly complex transfer of funds between the general regime and other funds for farm workers, miners, railway men, etc. Certain regimes are seriously under funded and are, thus, subsidized by other regimes.

In France, approximately 85% of the health care system is publicly financed. About 10% is paid for by Mutual Insurers (Mutuelles) through private insurance, with the remaining being paid directly by the patients (primarily upper income).

Public hospitals are funded out of global budgets paid by the health insurance funds. Private clinics and ambulatory care, provided mainly by doctors in private practice, are paid on a fee-for-service basis. The government sets official schedules of reimbursements, which in many cases are billed charges.

The Juppe Plan, enacted in 1996, introduced measures to control health expenditures on the basis of financial and medical criteria. This resulted from the deterioration in the financial situation in France. Changes were made to the way health insurance funds operated. It was felt by many that the financial incentives for health care institutions were inappropriate. For example, public hospitals received global budgets, which were based upon levels of past expenditures with little incentive to improve performance. Private clinics operated on a fee-for-service basis, but were paid using out-of-date fee schedules. Studies have begun to introduce fee schedules using principles similar to those created by William Hsiao for payment to physicians under Medicare in the USA. These studies are not yet completed.

Issues

The World Health Organization rated France's health system #1 in the world. The national health systems are judged by a variety of criteria. On all scales, France is among the world leaders. In overall performance, achievements compared to expenditures, France ranks #1.

The French system is based upon an emphasis on preventive health care. For example, employees are legally required to have a thorough medical check-up every year.

Foreign students must obtain special coverage known as Assurance Personnelle, unless they are entitled to student coverage at their universities.

Foreigners living in France comprise around 6.4% of the population. Access to health care for ethnic minorities, that is culturally and linguistically acceptable, is limited. Illegal immigrants (approximately .4% of the population), in particular, find it difficult to access health care, and follow-up care can be problematic. They can, however, use charitable associations which were originally created to provide for the poorest segment of the French population.

The indigent are able to obtain free health care. The unemployed individuals and their families qualify for health care, but problems arise when they no longer qualify, or have never qualified for employment. Over 2000 health centers provide services primarily to the poorer segments of the population. They are offered free periodic health checks and targeted screening, education, and prevention campaigns.

The population seems to be satisfied with the health care system. It ranks high among European countries in terms of health and mortality indicators.
Critics contend that the health care system encourages doctors to see patients too often and to over-prescribe medications. France has amongst the highest use rate for medicines of any other country. As a result, spending on the government health care program has surged at a real annual rate of more than 5% over the past fifteen years.

In February 2000, the doctors protested rationing in France. Much of this was denouncing the Juppe Legislation, which was created to reduce the growing deficit of the health insurance system. An Internet article suggests that hospital administrators were complaining of a shortage of nurses as well as doctors, and waiting lists have lengthened. It has also been suggested that there is an unequal distribution of resources across France. It has been recommended that the method of payment of hospital services should be reformed, so as to establish an environment that encourages hospital to provide high quality services at an optimal cost. This will only have an impact if hospitals themselves acquire more autonomy of management, allowing them to change.

One Internet article indicates that a very large proportion of citizens' expenditures are funded through the insurance. These individuals tend to consume without attention paid to the prices charged. This is a similar situation to that in the United States where utilization patterns raise as the copayments lower, especially for physician services.

Several reforms are needed in order to curtail the demand for professional services. It is suggested that the benefit plan designs need to change to discourage overuse.

It is also suggested that public health policy needs to place an even greater emphasis on preventive care versus curative care. They are recognized as having a high priority for preventive care. An example would be to expand advertising campaigns concerning the dangers of smoking and drinking, promoting cancer screenings. This might also require more incentives to change behavior.

Sweden

History

As early as the beginning of the 17th century, towns and cities began hiring their own physicians to provide public care. In the 1800s the central government became responsible for hospital care and in 1928 the government mandated that counties provide hospital care. In 1946 the National Health Insurance Act was passed and implemented in 1955, providing universal care for hospital services, physician services, prescription drugs, and sickness compensation.

There are six regions, which coordinate care for 26 county/municipal councils. The county councils are autonomous and use income tax to cover the cost of the health care systems.

Physicians are only able to treat private patients with permission from the county councils or they have to opt out of the social system. Only the largest cities have private physicians and they make up approximately 8% of all physicians. Sweden has only six PCPs per 1,000 population, the lowest in the EU.

Social care in Sweden includes care for the elderly, the disabled, and psychiatric patients. These include institutional housing and care facilities for the elderly and disabled, home help services, and group living arrangements for special needs individuals. The 288 municipalities are in charge of these programs.

Financing

About 5% of health costs are paid for out-of-pocket. The health care system is funded primarily by a county council income tax. Insurance is compulsory and covers expenditures for prescription drugs and health care services.

Sweden's cost of health care as a percent of GDP is now close to the EU average and has decreased since 1991. In the 1970s and 1980s Sweden's cost as a percent of GDP grew substantially during an "expansion phase." This expansion included hospital building and other infrastructure, while the economy was strong. In the 1990s health care costs as a percent of GDP dropped from approximately 10% to around 8%. The reduction is partly due to changes in the definition of health care expenditures.

Hospitals in the 1960s and 1970s were paid, based upon cost-based annual budgets. During the 1980s, certain cost control mechanisms were implemented whereby some county councils introduced clinical budgets. Clinical departments would carry forward deficits, but a portion of surpluses was used for training. More recently in 1994, fourteen country councils introduced new payment mechanisms, which included DRG features. Outlier reimbursements included additional per diem payments.

While choosing and utilizing a PCP is encouraged, it is not required. There is no gatekeeper, and residents can see any doctor whenever they choose.

Issues

The Swedish system provides coverage for all persons who are resident in Sweden, regardless of nationality. In addition, an exchange program with many EU countries provides emergency coverage for travelers. Emergency coverage is provided in all EU countries, as well as seven other countries.

Sweden, like most European countries, is generally homogeneous racially. This contrasts to countries in the Americas or New Zealand where large native and ethnic populations provide additional challenges to health care delivery.

Cost containment issues and restructuring of the providers, especially hospital services, are at the forefront of discussions. Rationing and admission waiting times are a major concern. Guidelines are still being developed for rationing. Waiting times have dropped in the late 1990s due to increased awareness and the option to go to another county if the wait is longer than three months.

Both the cost and access to prescription drugs is tightly regulated. A formulary has been established with some drugs available at no cost and others that require cost sharing.

Spain

History

Spain's recent economic history is punctuated by a handful of impressive accomplishments and a fair number of truly significant failures. Perhaps the most noteworthy achievement was the country's ability to reinvent itself after the fall of the Franco Regime in 1975. Following the death of General Franco who controlled the country since the 1930s, Spanish leaders embarked on an ambitious reconstruction plan that liberalized all aspects of government, commerce, and private citizenship. First came a new constitution that guaranteed an elected, bi-cameral legislature and complete political freedom. Newly elected lawmakers then set to work vigorously dismantling the repressive government of the fascist state and restructuring or replacing outmoded systems to better serve the needs of the Spanish people.

Spain's health infrastructure and social safety net evolved under Franco. A Socialized Insurance System similar to other European nations was created.

To facilitate trade and economic growth, Spanish institutions adopted a northern European outlook. The reconstruction came at tremendous cost, which has lead to problems that continue today, not least a significant increase in public spending.

In recent years, the nation's health care system has become a showcase for how quality of life has improved since the death of Francisco Franco in 1975. Most analysts agree that the nationalized Spanish health care system in 2000 offers decent service at a reasonable price.

One of the strong points is a well-organized primary-care infrastructure that is publicly financed and offers free services to all. Although a significant weakness is an aging hospital system dominated by multi-bed wards, the toughest challenges for the government are improving patient satisfaction and reducing waiting times for non-emergency procedures. As the standard of living rises, so does the demand for improved quality health care. That puts pressure on the government, but also creates opportunity in the private sector.

The main problems of the Spanish health care system at the start of the transition to democracy (1975) might be summarized as follows. First, the variety of health care networks and the number of different departments to whom the networks were responsible led to poor coordination and inadequate organization. Second, primary health care and preventive care were considerably underdeveloped. Third, there was not universal coverage and, as a result, important inequalities developed among the needy (with restricted access to the charity-based network), the bulk of salaried workers (covered by the Socialized Insurance System), and the upper classes (mostly resorting to the private health care system, especially for primary and preventive care).

The 1978 Constitution highlighted the need to tackle health care reform by establishing a universal right to health care. Since then a National Health Service model has evolved.

The Spanish health care system has been set up as an integrated National Health Service, which is publicly financed and provides nearly universal health care free of charge at the point of use. Provision is mostly publicly owned and managed: this applies to all general practitioners and primary health care centers, to outpatient specialized clinics and physicians, and to 80% of hospital care. Governance of the system is decentralized, with local organization in each of the 17 Autonomous Communities, or regions, which comprise the Spanish state. The general principles of the National Health System as defined by the 1978 Constitution and the 1986 General Health Care Act are:

- Universal coverage with free access to health care for almost all citizens;
- Public financing, mainly through general taxation;

- Integration of different health service networks under the National Health System structure;
- Political devolution to the Autonomous Communities and region-based organization of health services into health areas and basic health zones; and
- Development of a new model of primary health care, emphasizing integration of promotion, prevention and rehabilitation activities at this level.

These principles have resulted in far-reaching change, a process that is not yet complete. The Spanish National Health System presents a complex panorama as it evolves away from its origins as a centralized system rooted in a Socialized Insurance System towards one of universal coverage delivered through 17 Autonomous Communities. Difficulties remain in guaranteeing equal access to deprived social groups, consolidating a stable system of financing, controlling the increase in health expenditure, decentralizing services to all Autonomous Communities and coordinating and integrating the various services within the National Health System.

Financing

Broadly speaking, the Spanish health service is financed out of general taxation, which replaced a more insurance-oriented system. Funding is collected centrally and is allocated on a per capita basis to autonomous communities, which manage these resources with varying degrees of independence.

In theory, the financing of the National Health system is characterized by the principle of solidarity: the population should contribute to the financing of health according to its own level of wealth and should have access to health care according to its own particular needs. In practice, however, recent research has shown that the reality of this system is different, which has mainly occurred through the 1986 reform of the indirect tax system to introduce VAT, after accession to the EU. The progressive, re-distributive income tax-system, after being complemented with indirect and other taxes, gives nearly proportional results in Spain: each citizen contributes to general taxation by a fixed, similar proportion of their income, independent of their total level of wealth.

Currently, 98% of total public health care expenditure (excluding civil servants' mutual funds) is funded through general taxation, while the remaining 2% is generated by care provided for patients with other types of coverage. Most taxes are centrally raised, due to the limited fiscal autonomy of Spanish regional and local governments.

Regarding the financing of civil servants' mutual funds, it is estimated that they are 70% funded by the state (through taxation) and 30% through contributions form the civil servants

to their own mutual fund. The funds protect their members from other social risks, and so the concrete financing scheme for health care services is not known. When members opt to be covered by the National Health System, the mutual funds pay a per capita sum directly to the national system. If, on the other hand, members choose to join the private health care system for civil servants, a sum is paid to private insurance companies in line with the pre-agreed stipulations of the mutual fund. Health care expenditure by these funds represented about 5% of total public health care expenditure in 1996.

Finally, the allocation of resources to the various Autonomous Communities is laid out in the State Budget Act of the Spanish Parliament on an annual basis. The General Health Care Act envisages the progressive transition from a regional allocation system based on historical expenditure to a capitation system for those communities, which have taken on full responsibility for regional health care. The regulation and steering of regional resource allocation during the transition process is made from within the Financial and Fiscal Policy Committee, which includes representatives from the finance departments of the Autonomous Communities and the central state. However, central state authorities retain the constitutional right to make final decisions in this area.

There is no cost sharing for public primary, outpatient or inpatient care in Spain. 40% co-payments for prescription pharmaceuticals only apply to the population under 65 years of age who does not suffer from permanent disability or chronic illness. In 1998, according to the official registration system for pharmaceutical expenditure, total out-of-pocket payments to the public system were estimated to be at around 7.7% of the total public pharmaceutical bill, or 1.5% of total public health care expenditure. In addition, according to the General Household Budget Survey of 1998, total out-of-pocket payments (to the public and private systems), amounted to 16.9% of total health care expenditure.

According to the 1997 National Health Survey, up to 8.9% (that is, some 3.5 million) of the Spanish population had private health coverage through voluntary insurance in 1997, although survey data probably tends to underestimate the size of this group of the population. The private insurance coverage is unevenly concentrated in big cities and is directed towards supplementing services offered by the National Health System (e.g., dental services which are not covered, and preventive gynecological services which are subject to significant problems of effective access), or providing an alternative modality of care. An additional percentage of the population (civil servants and their dependents) is insured through mutual funds, which simultaneously offer other social benefits. Employer purchased health care insurance schemes, according to survey data, covered 1.9% of the Spanish population in 1997.

Issues

The extension of the public network and the transition form a Socialized Insurance System to the National Health Service model initiated in the mid-1980s has reaped particularly successful results, as reflected in the levels of private health expenditure, which are lower than those in other Southern European Countries. In terms of citizen satisfaction, the results are especially remarkable: the percentage of the population declaring that the system works adequately and only needs minor changes increased from 20% to more than 60% between 1991 and 1998, with a concurrent drop in the percentage of those defending the need for a complete restructuring of the health care system from almost 30% to 7%. By level of care, satisfaction with primary care increased substantially, while the evolution in the hospital sector only shows a small increase throughout the period. However, the three areas of care rated the worst in the early 1990s (waiting times, number of persons per hospital room, and administrative procedures required to obtain access to hospital care) suffered net decreases by 1998.

The most urgent future challengers are the development of information gathering resources and managerial autonomy, and expansion of social and community care within the framework of the National Health System.

In addition, there is a pressing need to manage health services with greater efficiency through: transferring responsibilities (and risks) to local budget holders; increasing the autonomy of hospitals and health centers, especially in terms of day-to-day organization; involving health care professionals (particularly physicians) in clinical management; appropriate use of available resources by adopting alternative treatment methods, like major ambulatory surgery; and by promoting the extension of evidence-based medicine into clinical practice.

The National Health System currently provides limited social and community care benefits. These services include long-term care for the elderly and handicapped. Home health care is only partially covered and access is severely restricted. Only mental care has been integrated into the public health care system and subjected to major reform. In contrast, long-term care for the elderly and handicapped is still underdeveloped and managed within a different organizational structure.

Other challenges facing the health sector are to continue implementation of the reforms and to consolidate progress made to date. Specifically, this will be to:

- Extend universal coverage to 100% of the population;
- Guarantee improved levels of accessibility, equity and quality of the public health care network;

- Make effective the formal goal of tipping the balance of the health care system toward the primary care level;
- Complete the decentralization process in 10 of the 17 Autonomous Communities (covering 38% of the population) which have not as yet assumed full responsibilities for health care management;
- Build on the regional resource allocation agreement covering 1998 through 2001 to agree on a definitive model to finance the system, adjusting simple capitation targets by age and needs, and ensuring that regional health service administrations continue to bear the risk of any debt generated;
- Reinforce the key role of the Ministry of Health as an impartial coordinating and regulatory body for the National Health System, (particularly after completion of the decentralization process; and
- Enhance legitimacy by increasing both user satisfaction and the participation of the population by encouraging a people-centered approach with fewer bureaucratic barriers and better staff-patient relationships. This implies, as first steps, maintaining the initiatives to decrease waiting times for both inpatient and specialized outpatient care, and introducing greater choice of provider.

Coverage is almost universal for Spanish citizens and guarantees a fairly comprehensive package of benefits to all citizens regardless of personal wealth. If individuals are not covered by the national scheme, this is usually on the grounds of membership in an alternative, employment-linked insurance program and not on the basis of an inability to contribute. The option of purchasing additional private insurance is also open to all citizens.

In 1990, the Children's Rights Act gave all immigrant children under the age of 18 years full rights of coverage and access to the public health care system. However, this provision of the Act was never implemented. During 1999 and after significant public debate, immigrant children's rights were made effective through development of the necessary implementation measures. In addition, the extension of full health care rights to the adult immigrant population was included within the first draft of the Immigrants Act, which was approved by all the main opposition parties in parliament in 1999, but rejected by the party in office. Accordingly, government declarations during parliamentary discussions posed doubts as to the likelihood of effective implementation.

Italy

History

During the period between national Unification (1861) and the fascist regime in the 1920s, health care provision in Italy was highly fragmented and relied on several different

structures. Some of them were health care centers sponsored by the Catholic Church, while others were old charitable institutions nationalized by the state. There was also a provincial network for preventive medicine and public health, municipal provisions for economic and social assistance to the disabled and the needy, artisans and workers' autonomous mutual aid associations, and independent not-for-profit structures.

During the fascist regime (1922–1943), several changes in the Italian health care system were pushed forward. Through the 1923 Royal Decree, the right to hospital care for the indigent population was guaranteed for the first time. Several initiatives targeting diseases of perceived social relevance were launched. Some steps towards compulsory health care insurance for workers were also made. In 1925, the INADEL (Istituto Nazional di Assistenza per I Dipendenti degli Enti Locali) was instituted as the national body in charge of providing health care for local authorities' employees. The regulatory framework of the trade union system issued during 1926–1928 included mandatory health care provisions for workers as a prerequisite for collective agreements becoming effective. Compulsory insurance for occupational disease was introduced in 1929.

During the 1930s, health insurance funds became responsible for covering not only workers, but also their dependents. During the 1950s, financial solidarity among workers was extended to cover retired people in the same work category. In 1958, an independent Ministry of Health was established for the first time, and in 1968, public institutions providing hospital care were established as autonomous entities.

In the early 1970s, as a result of these historical developments, there were nearly 100 health insurance funds in Italy. Each fund had its own regulations and procedures, with some providing direct care (through their own facilities) and others providing indirect care (with reimbursement to patients for costs of care delivered by private physicians and facilities). Coverage was not only segmented across largely diverse funds, but also characterized by important limitations. Some 7% of the population was not covered by insurance in the mid 1970s, including a sizable share of the unemployed. In addition, the self-employed were only entitled to use the hospital services.

More generally, the health care system was affected by serious structural problems, such as organizational fragmentation, compartmentalization across levels of care, unnecessary duplication of services, bureaucratization, and rapid growth of expenditure. In addition, owing to the large deficits of the insurance funds, a financial crisis took place, which prompted the government to intervene. In 1974 and 1975, the responsibility for hospital management was transferred to the regions. Health insurance funds were abolished and the National Health Service (NHS) was set up.

The 1978 reform, which created the NHS, introduced universal coverage to Italian citizens, and established human dignity, health need and solidarity as the guiding principles of the NHS. The main goals of the 1978 reform were to guarantee all citizens equal access to uniform levels of health care, irrespective of income or geographical location, to develop disease prevention schemes, to reduce inequalities in the geographical distribution of health care, to control health expenditure growth, and to guarantee public democratic control (exerted by political parties) over the management of the whole system. A mixed financing scheme was established, which combined general taxation and statutory health contributions. The main goal was to move progressively to a fully tax-based system.

The new Italian health system was based on a decentralized organizational structure made of three levels of administration: national, regional, and local. The central government had the responsibility for determining the amount of public resources devoted to health care and for planning. Regional authorities were responsible for local planning (according to health goals specified at National level), for organizing and managing the provision of health services, and for allocating resources to the third tier of the system, local health units (LHUs). LHUs were operative agencies responsible for providing services through their own facilities or through contracts with private providers.

Clear divisions of responsibility and a coherent planning of health care at national and regional level were missing. Regional governments judged the resources they received from the central government as insufficient for satisfying the health care needs of their populations. As a result, regional public deficits mounted, with the central government having to cover the accumulated regional debts. The central government tried to contain cost escalation by setting budget caps, which were regularly overpassed; and by introducing user copayments.

Faced with widespread problems, the government attempted to reform the health care system.

Dissatisfaction with the effects of the 1992/93 reforms prompted parliament to confer, in 1998, legislative power to the government regarding the complete reorganization of the National Health Service in terms of the relationships between levels of responsibility and management, the roles played by different actors (managers, physicians, local institutions, etc.), the balance between economic constraints and the principles of universalism, and equity of access. The resulting reform extended the regionalization process and strengthened the role of municipalities, with a clearer division of responsibilities among levels of government.

Financing

The 1978 reforms, which established the Italian NHS, envisaged universal coverage, a fully tax-based public health care system, and an increasingly marginal role for private financing. While the former aim was rapidly implemented, the latter two political goals were redefined during the 1980s and 1990s. As a result, the Italian National Health Service is currently financed out of Socialized Insurance System contributions, general taxation collected at central level, and a mix of regional taxes and patients' co-payments. In addition, private sources of financing account for more than 30% of total health care expenditure. This has resulted from increased co-payments to the public system, growing utilization of private providers under direct out-of-pocket payments, and raised numbers of private insurees.

During the late 1990s, following a general transformation of the Italian First Republic into a federal state, several reform packages were passed, which will considerably modify the architecture of health care financing in the country. Given the progressive move towards fiscal federalism, which started in 1997, regional taxes should finance a larger share of health care expenditures, with general taxation playing a complementary role. In fact, central funding should be used primarily to redistribute resources to those regions with a narrower tax base, in order to grant all residents adequate levels of care.

Following a series of measures passed in 2000, the move towards fiscal federalism will be completed in 2001 and accompanied by a shift in central financing from general revenues to indirect taxes, which the state will transfer to the regions.

Over the years, the financing of the Italian Health care system has undergone important changes. Although the stated aim of shifting to a tax-based system has not been achieved, the 1978 reforms fostered an increase of the percentage of public expenditure financed out of general taxation versus Socialized Insurance System contributions, which however still represented over 50% of total public financing throughout the 1990s. There has been a significant increase in out-of-pocket payments to the public system during the 1980s and 1990s. In 1999, private health care spending represented approximately 32% of total health expenditure, while in 1980 it stood at only 20% of the total.

Over the years, these various sources of funding have been both transformed and simplified. In 1997, before the latest fiscal reforms, the main sources were:

- Payroll tax from employees in the public and private sector and from self-employed workers. The tax had a regressive structure with rates starting at 10.6% and 6.6% of gross income for employees and self-employed workers, respectively, and decreasing to 4.6% for both types of workers;
- Local Health Units income, made up of co-payments for pharmaceuticals, diagnostic procedures and specialist visits;

- Contributions from special statute regions – from 1990, special statute regions contribute to the financing of their own health care system by using part of their own budget, as they receive higher overall funding than average.

In 1992, Legislative Decree stating that regions incurring budget deficits could not rely on general taxation, but had to raise the extra resources either through higher co-payment levels or higher regional taxes. The 1997 fiscal reform, in turn, aimed at eliminating disparities in payroll tax contributions rates, reducing negative incentives on employment, and introducing elements of fiscal decentralization. Accordingly, a few local duties and the payroll tax were replaced with:

- A regional tax on productive activities applied on the firms' value added and on the salaries paid to workers of the public sector.
- A piggyback regional tax on the national income tax.

Between Regions, extreme differences in fiscal autonomy co-exist with important territorial imbalances in per capita expenditure, which will require that fiscal devolution be complemented by substantial redistribution of funds through central transfers. To address this problem, a fiscal equalization mechanism has been developed to transfer funds to those Regions unable to raise sufficient resources. The Fund will be allocated to the regions first based on historical expenditure, and later on, according to weighted capitation targets aimed at guaranteeing interterritorial equity in access to public health care services.

In Italy, there are mainly two types of out-of-pocket payments. The first is represented by demand-side cost sharing, namely a co-payment for diagnostic procedures, pharmaceuticals and specialist visits. The second is payment directly made by patients for the purchase of private medical services and over-the-counter drugs. Co-payments for pharmaceuticals and specialist visits were introduced in 1978 and 1982 respectively, and are regulated by national legislation. In 1993, a drastic reform classified pharmaceuticals and associated copays into three categories according to a combination of their relevance in terms of effectiveness and cost.

Regarding outpatient care, patients paid, until 1993, a proportion (from 15% in 1982 to 50% in 1991) of the total cost up to a certain amount fixed by law. Since 1993, patients pay for the total cost, but always up to a maximum determined by law. The upper limit has been changed several times, going from US $20 in 1982 to US $49 in 1993 and back to the current US $34. Inpatient care and primary care are free at the point of consumption. Patients with chronic or rare diseases, the disabled, as well as pregnant women enjoy specific types of exemptions. Other criteria for exclusion, mainly based on income, were set in 1981, and modified several times since then.

Contrary to what happens in other EU countries, such as Germany and the Netherlands, the private insurance sector is scarcely integrated with the public sector. As a consequence of this, private health insurance companies supply mainly services that are substitutive, rather than complementary, to those supplied by the NHS.

Issues

Italians are extremely dissatisfied with the efficiency and quality of their public health care. This has resulted in an increase in the private health insurance market.

The period 1997–2000, witnessed a series of radical, innovative changes in state institutions and health care regulation. First, political devolution of health care powers to the regions was pushed forward, and the transition towards fiscal federalism started. On the positive side, the new regional taxes designed to replace pay-roll contributions are neutral with respect to factor mix and financing structure, and therefore unbiased against employment. Furthermore, the tax base is widened up, as it is paid by all businesses, while it was previously restricted to income earners. On the negative side, the main problems are as follows. First and foremost, as the tax base is unevenly distributed across the country, a need for large equalization transfers will arise, which might reduce the effective political autonomy of different regions unevenly. In addition to that, poorer regions will have flexibility to increase health care expenditure. An even more serious drawback from the system derives from the fact that, to obtain an equivalent case increase, poorer regions will have to raise tax rates more than wealthier regions, which will introduce negative incentives for business location, and might accordingly hinder economic development prospect in the more disadvantaged regions.

Second, in 1998, the Parliament asked the central government to launch new reform legislation to accommodate the new federalist framework and further regulate the health care sector. As a result, the third reform of the NHS was approved in 1999, which represents one of the more ambitious attempts made in Europe at producing a detailed regulatory framework which could guarantee adequate levels of health care quality, efficiency, and equity without curtailing the political and managerial freedoms transferred to local actors.

Among the various components of the 1999 reforms, three of them merit special mention, namely: the first steps towards defining a core benefits' package which all regions should guarantee, as well as the system designed to monitor its effective accomplishment at the regional level; the regulation of the steps to be followed by regions and LHUs in order to guarantee institutional accreditation to their preferred public and private providers; and the exhaustive provisions aimed at promoting and monitoring quality. Finally, the 1999 reforms

also envisaged an eventual abolishment of most co-payments from 2001 onwards, and a set of parallel measures to guarantee fair competition between publicly funded providers and private ones.

Up to the late 1970s, 93% of the population was covered by public health insurance, although under markedly varying conditions. The 1978 reform changed the principle upon which health care financing was based: solidarity within professional categories was discarded in favor of intergenerational solidarity, what backed the introduction of universal, free coverage for all Italian citizens.

Immigrants were lately covered in 1998. Legal immigrants have the same rights as Italian citizens, while illegal immigrants have only access to a limited range of health care services, in particular treatments for infectious diseases and health care schemes for babies and pregnant women.

Other European Nations – Overview

History

Denmark

Denmark has a long tradition of public welfare and decentralized administration of the health care services system. Initially, landowners and artisan masters primarily funded it. In the 18th and 19th centuries, responsibility passed to cities and counties. In the second half of the 19th century, workers' guilds established health insurance funds. These funds were essentially abolished in 1973 and replaced with a single-payer system. Access to health care is independent of the ability to pay.

Taxes are raised at the parish, town, and county level. Health care is funded by patients or voluntary insurance, in addition to taxes.

Health coverage is fairly universal in Denmark. Recent reforms have been enacted to give patients more choices of hospital coverage. Patient rights have also been strengthened. Issues of waiting lists are prevalent. Recent enactments have guaranteed a maximum three-month wait for non-acute surgery.

Finland

In Finland, health care has long been considered the public responsibility. Municipalities are responsible for the basic health care units. The hospital system was developed in the 1950s. The states originally owned the hospitals, but quickly passed responsibility of hospitals to the municipalities. The Private Health care Act of 1972 was a national health plan for providing health care services. It developed health care centers, which were essentially a fragmented system prior to this. The state is responsible for the State Sickness Insurance Schemes.

Everyone in Finland has the right to health services, regardless of the ability to pay. It is a primarily tax-based system. Both the state and municipalities have taxing capacity. 33% of the taxes are raised by the municipalities, 29% by the state, 13% through Sickness Funds, and the remainder through private insurance. Patients are charged an annual fee to use a health center. Children are free. Copays are also charged for outpatient visits.

Finland's covered services are fairly universal, also. They do exclude coverage for some dental, eyeglasses, and examinations. The Socialized Insurance System services are the responsibility of the municipalities. Waiting time for primary care physicians have increased prior to the 1980s. Since then, a personal doctor system has been introduced. There is an

issue related to inequitable costs between the various municipalities. Some municipalities are very small, whereas others are very large. There are forms of reinsurance that have been created to equalize revenues between the municipalities. Waiting time guarantees are currently being examined for a wide variety of services.

Ireland

Since 1994, the modern health care system in Ireland has been a deregulated health insurance market. Premiums are community rated and everyone is entitled to health insurance. All citizens have access to public health, based upon a means test. There are two income categories. Below a certain income level, the Category I members receive a large number of services. This covers approximately 36% of the population. The remainder are eligible for Category II services. There is a well-developed private sector. The Category II citizens have resource to voluntary insurance services managed through three programs. Theses are the Community Care, General Hospitals, and Specialty Hospitals. Voluntary premiums paid by the patients are tax deductible.

Ireland is funded by a tax system. Essentially, it is a two-tiered health care delivery system with Category I and Category II enrollees. Category I enrollees are below a certain income level, and are provided a wide range of free services including GP services. Category II is also funded through taxes, but more complementary private insurance is used to fund GP and other services not covered by the Category II program. Additionally, premiums paid by individuals are tax-deductible.

In 1989 a capitation payment methodology for GPs was introduced for Category I members. These were introduced to prevent what was perceived to be over-utilization of doctors and over-prescribing of prescription drugs. The reasons are quite similar to those that are stated for capitation payment methodologies in the United States for managed care plans. Health promotion was established as a priority. There is a difference of wait times between the private and the public systems. The equalization of these wait times is a recent goal. There is a concern about community rating. There is no equalization process between insurers. It is perceived, by certain of the insurers, that they have obtained an adverse population. Some younger members, who are under 35, are currently not purchasing health insurance. Because of the community rating aspect, the younger members subsidize the older members. Thus, some of the inner generational subsidies are not occurring. There are discussions being raised to penalize the members who originally dd not signed up for insurance, who are under 35 and as they approach 35, wish to sign up with an insurance scheme.

Switzerland

As with many of the European countries, the first modern health insurance started as a Socialized Insurance System for servicemen who had lost their ability to work after World War II. In the first half of the 1900s, prevention was the focus of the health care system. The cantons and municipalities were originally responsible for health for inpatient services. Municipalities, generally, are responsible for the vulnerable population requiring home health, nursing home care, and the care of the elderly. In 1995, a compulsory health insurance system was created. Equal access was required, regardless of income. This was funded by a tiered tax rate.

Switzerland's primary payment mode is through tax rates, based upon income. The tax rates are tiered (increasing as income increases). Premiums for insurance are compulsory. Additionally, it is community rated without adjustments for age or sex. The patients fund out-of-pocket costs. Cost containment in recent time includes reduction of inpatient beds, merging of public/private hospitals, global budgeting of hospitals, and regulating retail prescription drug costs.

Switzerland has a compulsory health insurance scheme. In recent times, they have had huge increases in premiums. There are current fears among the general population of not being able to afford health insurance. Non-Swiss individuals are always treated in an emergency. Follow up care may be problematical. Rationing is currently an issue. There are four primary areas of concern in the system. These include patients' choice, the need for lower hospital prices, the need for lower Rx costs including more generic options, and the affordability of health insurance.

Netherlands

The Netherlands' system is a system of public and private insurance. It is a compulsory national insurance scheme. Everyone is covered for chronic and catastrophic expenditures. Below a certain income level (60% of the population), the compulsory insurance covers additional medical services such as for the GP, dentist, specialty, maternity, and hospital services. Individuals above the income level may buy supplemental insurance.

As is the case with many European countries, the Netherlands has a program which is paid by the employer, employee, as well as taxes. Insureds are charged both a percentage of income contribution, as well as a flat rate contribution. Incomes over a certain level can also buy health insurance. Premium rates are regulated by the state.

There is a current attempt to tie the chronic/catastrophic insurance coverage, the Public Servants Schemes, and the private medical insurance in one overall system. There are issues related to the aging population. New technologies and payments for those technologies are

an issue. The system is attempting to move its focus from a curative to a preventive nature. PCPs receive capitations and are perceived as not being penalized for inefficient practice patterns. This appears to be the opposite of the Ireland focus, which is moving towards capitations. There are long waiting lists for certain hospital admissions.

Portugal

Prior to the 18th century, health care was provided by hospitals of religious charities. The state began to establish hospitals to support the charities. Public health began in 1901 and was expanded in 1945 to cover maternity and child services. In 1946, a German Bismarck-style model was created. Since 1979, the national Network of Hospitals and Health Services were established under the National Health Service (SNS). The SNS provided free primary and hospital care. There is a separate system for Civil Servants under the SNS.

The SNS is financed by taxes. Civil Servants have a separate government scheme, which is funded partially by a flat 2.5% rate of the employees' salaries. Similar contribution schemes cover people in certain industries like banking, insurance, and some public enterprises. There is some private insurance, which covers approximately 10% of the population. The sources of financing include taxes, out-of-pocket expenses, costs for social insurance, and voluntary insurance.

In 1993 Portugal established certain reforms. There are now five health regions with autonomy as to the provision of health services. Salaried MDs can provide private services, as long as the services they are responsible for through their salaries are covered. A number of problems include an inequitable distribution of health resources, the lack of PCP access, and a weak reputation of public PCPs. There is a movement away from public provision of health services to private insurance. Rationing is also an issue because of long wait lists.

Norway

Norway has an integrated system built upon different responsibilities provided by the state, counties, and municipalities. The states' responsibility is primarily providing providers and financing. The state owns some hospitals. The county's responsibilities include hospitals and specialists. The municipalities responsibilities are for GPs and preventive services. Certain elderly care and most social care is primarily the responsibility of the municipalities.

General taxes are the primary source of funding for the Health care Delivery System. The county and municipalities have taxing ability. The state also subsidizes the National Insurance Scheme. There are compulsory fees for employers and employees. Additionally, there are user charges (i.e., copays) for various services.

The Norway health care delivery system is perceived as providing good service. There are issues relating to equity between geographic regions. There is increased demand for technological services, which are sometimes not covered. Efficiencies are being implemented within the health care system. Waiting periods are guaranteed. There is a patient bill of rights. There is an emphasis on preventive health promotion, and initiatives designed around those promotions.

Austria

In the early 1800s, employers were mandated to provide services for hospital and for sick employees. In 1867 the Associations Act established health funds. In the late 1800s a German-style Bismarck-like health insurance scheme was introduced. A Socialized Insurance System became a feature after World War II. Presently, most medical services are free, or nearly free. Participation in the Public Insurance Scheme is essentially mandatory. Insurance costs are shared between employers and employees. Hospital budget shortfalls are funded by the state. In 1997, hospital financing was reformed.

Austria's funding comes from public sources primarily raised through taxes, as well as employer and employee contributions. Supplemental insurance can be purchased, this is primarily used to obtain better inpatient accommodations and improve access to doctors. 50% of the total funding comes from Socialized Insurance System, 20% from general taxes, with the remaining 25+% from private households through contributions and copays.

In 1997, reform was established to provide equal access, financing, and public delivery of health services. It also included an emphasis on health promotion. The re-organization of financing has caused some structural shock. Prior to the health care reform, the emergency room outpatient physicians provided many of the primary services. Because there is a

current lack of integration of the emergency room outpatient with a shift to PCPs, there is concern about a lack of funding and an inequity between the emergency room and the PCP systems. Technology coverage is expected by the population, but has become a growing problem. The rationing in the health care delivery system is minimal.

Belgium

In the early 19th century, health insurance associations were created (Mutualities). These were formed around professions, rather than income levels. In the early 1900s, many of the Mutualities began to merge. After World War II, there was creation of a public compulsory system. The modern Belgium system has a feature of compulsory health insurance, coupled with independent medical practitioners. Individuals also have free choice of provider and are subject to fee-for-service payments. The current system also covers the poor and retired. It has many of the same features as France.

As with many European countries, Belgium uses a combination of employer/employee contributions, as well as state taxes. Approximately 68% of funding comes through insurance with the remaining 32% from taxes. Ambulatory care is covered primarily through the private sector. There are two insurance schemes. The General Insurance Scheme covers major risks and minor risks for the whole population. Self-employed Schemes only cover major risks. Solidarity movements (i.e., the thrust for a Socialized Insurance System covering all members) assure that the working pay for unemployed and retired persons. Copayments are also used throughout the Health care Delivery System.

In Belgium, hospital reforms in 1982 were created to make the hospitals more efficient. This included global budgeting, attempts to cut lab test costs, quality requirements, and a requirement for a higher ratio of staff to inpatient beds. There is currently a national fee schedule. Rationing occurs because services not covered by the national fee schedule are not reimbursed through the public systems. Social care is covered by a diverse network of different providers in both the private and public center. Access is good. There is a continuing emphasis on prescription drug reform to contain costs in that sector.

Greece

The modern Greece health care system came into being after World War II with impetus from the Marsall Plan. Greece crafted a National Health Services System in 1983. It was the first effort to provide expanded services to the population. It had poor performance and essentially, they relaxed the rules related to coverage in 1990. This allowed new private hospitals and clinics to be built. There are four major insurance organizations, which cover approximately 90% of the population. These Sickness Funds purchase hospital care on behalf of their members.

Greece uses a mandatory contribution from employers and employees. Government subsidies are funded based upon occupation, rather than income. These are raised through general taxes. Copayments are quite prevalent being as high as 25% for prescription drug, except for certain categories of patients. Rationing and unofficial payments from members to their providers is rampant. These unofficial payments allow people to jump places in the queues, and allow faster access to health care services.

There is an uneven distribution of the health care delivery system. There is a lack of hospital beds throughout the country. There are problems of access related to rural versus urban. There are fewer resources in the rural communities as to proportion of their population. Greece is currently in a transitional stage in regard to the administration of private and public health care centers. There is a lack of GPs throughout the whole system. Medical graduates are required to do one year of rural services. It is perceived that they are unmotivated and inexperienced. There is also a perceived lack of confidence in the competence of these doctors by the population. There is a nurse shortage throughout the whole system. The poor are entitled to free outpatient and inpatient care. There is an issue with queues. There is an unofficial payment scheme, which pays providers in order for individuals to jump places in the queues, as well as obtain faster access to providers. There are elderly centers, which have been created to provide preventive care and prescription drugs for the senior population. Currently, Greece has no policy to provide universal coverage throughout the country.

IV. OTHER COUNTRIES

Mexico

History

The role of the state and its institutions in guaranteeing social rights is enshrined in the Constitution of 1917. But, although Article 3 on the right to education and Article 123 on labor relations apply to the entire populations, access to social benefits depends to a large extent on an individual's place in the labor market. This is particularly so in the case of access to health care services, because the population is divided into two groups: those who are insured by virtue of being employed in the formal sector, and those who are not insured because they are self-employed or work in the informal sector. The origin of this situation goes back to the 1950s when the foundations of the privileges accorded to the most powerful groups, such as the military, the public service and some sectors of the working class, were laid.

Health care policy from 1917 up until the end of the 1970s can generally be considered to have responded to the needs of the "corporate pact." Under this pact, the institutional mechanisms for providing Socialized Insurance System benefits served as an efficient means to channel the demands of certain sections of the workforce, but at the same time, to co-opt them for the government's purposes. The result of this process was the appearance and consolidation of a fragmented public assistance system that failed to cover the entire population. It did, however, improve the lives of some workers and of other segments of the population, as coverage by the social security system grew at a yearly rate of 10% between 1960 and 1970 (Laurell 1996).

As in many other Latin American countries, the Mexican Sistema Nacional de Salud (SNS, national health system) has undergone considerable change over the last two decades. The reasons for the change were both internal and external, and mostly of an economic nature.

Beginning in 1981, a free fall in oil prices, the consequent decrease in foreign earnings, and rising interest rates made it impossible for Mexico to continue servicing the national debt. The gravity of the crisis was reflected in a general deterioration in all indicators of economic growth. Since 1995, there has been some improvement in the economy, although the effects of 15 years of continuous economic recession have decisively eroded the "social contract." The social contract arose out of the Mexican Revolution and is considered by many to be the basis of social stability in the country over the last few decades.

Several attempts to increase benefits, including health care coverage, proved fruitless as the economic crisis deepened and the international creditors started putting pressure on the government to reduce unemployment and welfare benefits. The failure of the state to honor its obligations and the relative expansion of the informal sector reduced the government's credibility and hence its legitimacy. Since the early 1990s, there has been a profound questioning of the corporate pact between the state and various interest groups. The economic and social reforms that are now taking place, including health care reform, thus form an integral part of the process of redefining the roles and responsibilities of the state and the citizens and their representatives.

While political and economic changes have been the most compelling reasons for reforming the health sector, one cannot discount the impact of the profound epidemiological and demographic transition that Mexico has undergone in the last few decades, or the growing recognition of the need to improve equity and quality in health care.

Two key periods may be considered as the precursors of health care reform in Mexico. The first began in 1983 with the proposed additions and amendments to Article 4 of the Constitution that effectively raised the right to health protection to the constitutional level. The second period began in 1995 with modifications to the Ley del Seguro Social (social security law) and the adoption of the Programma de Reforma del Sector Salud 1995 through 2000 (PRSS, health sector reform program 1995 through 2000).

The reform proposed in 1983 intended to radically transform health care services, and clearly establish the strategies to do this. Its success was limited, however, by resistance on the part of various interested parties, as well as a lack of citizen participation. On the other hand, the changes initiated in 1994 originated within a context of changing political process and occurred in response to pressure from various interest groups. These changes aimed to produce a profound transformation in the health care services and involved modifying the regulatory framework that governed them. The involvement of different interest groups and their diverging political agendas in the process has generated contradictions and tensions, however. The way in which these are reconciled will affect the future direction of reform.

At present, the compulsory social security system covers little over 50% of the population and includes formally employed workers, members of production cooperatives, and various organized groups of small landowners and agricultural workers.

The rest of the population that is not covered by the Socialized Insurance System security is covered by the Secretaria de Salubridad y Asistencia (SSA, department of health). This population is a complete mosaic, because it includes people from all strata of society, from the wealthiest self-employed professionals to the poorest rural workers and indigenous

groups. None of the following are included in the social security system: people who work in family businesses; self-employed professionals, craftsmen, and traders; small landowners and agricultural workers who are not organized into associations or credit unions; and individuals (not businesses) who employ insured workers. These people have the option of voluntarily insuring with the Instituto Mexicano del Seguro Social (IMSS, Mexican institute for social security), but the cost and requirements for doing so, as well as the lack of publicity concerning this options, have made it an insignificant one.

Private health care provision has developed at the fringe of official policies, and now accounts for 50% of total expenditure on health. The private sector owns about 30% of hospital beds, employs 34% of doctors, and provides about 32% of medical consultations. Private medical care is very important among those with the fewest resources, covering up to 41% of all contacts with doctors. Private medical insurance coverage, however, is very limited (2%) and the use of managed insurance schemes is even more so. In spite of this wide range of services, there are still about 10 million inhabitants in the country without access of any kind to formal health care services.

Different social groups are segregated into separate subsystems. This means that each institutional group (social security, public sector, or private sector) functions separately. The SSA is responsible for the administration of personal health care services for the poor.

Many problems arise from this structure, among which are duplication of effort, waste of resources, and the creation of monopolies serving different sections of the population. Perhaps the most serious problem is the overlap in demand, because a high proportion of those who are covered by the Socialized Insurance System security also use private sector services or those of the SSA. In these cases, the patient pays twice or even three times - a situation that has been described as multiple contribution. Despite many and repeated efforts to encourage decentralization, the system still suffers from the inertia generated by many years of centralization.

Financing

At present, the integrated public Socialized Insurance System subsystem covers about 51% of the population of Mexico, both those directly insured and their dependents. Financing is tripartite with contributions from employers, the state, and workers. The analysis of spending by source shows that households contribute the most, accounting for 49% of total health spending for 1992 to 1996, as compared to employers (29%) and the federal government (22%). It should be pointed out that, in the case of the Instituto Mexicano del Seguro Social (IMSS, Mexican institute for social security), workers' and employers' contributions cover most of the financing, whereas in the Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado (ISSSTE, social security institute for civil servants), a greater proportion of the contributions come from public bodies (54.5% versus 37.2% from workers and employers). Access is determined by affiliation, which in turn depends on being part of the labor market, for the most part in industrial activities, although some groups of workers from state-supported organizations are also affiliated. Medical benefits are also provided to workers' families.

The subsystem is geographically divided according to users' place of residence. Nearly all institutions of this type provide additional benefits such as prescription medicines, child-care centers, retirement pensions, recreational facilities, and insurance against occupational hazards.

The family doctor is the gatekeeper to the subsystem, with the power of referral to secondary or tertiary levels as necessary. Patients cannot choose their doctor, who is assigned by the institution.

There is no out-of-pocket payment for visits to the primary care physician. Nevertheless, the lack of medical supplies means that patients often have to buy their own. The social security institutions, especially the IMSS, are still in the forefront of medical and hospital technology, although specialized services are being used to full capacity, so access to complex technology is not easy.

The integrated public subsystem for the population provide ambulatory and hospital care.

Initial contact with the system is through a general practitioner, who may refer the patient to secondary or tertiary level. There are no mechanisms in these institutions either, for the patient to choose his or her doctor. An out-of-pocket co-payment is usually charged for walk-in consultations at the secondary or tertiary level. Although this is generally quite small, it has been increasing since the mid-1980s. This co-payment is not regulated in any

way, and each institution fixes the charges and the way in which they are set. The amount of co-payment for hospitalization is based on a socioeconomic evaluation of each user.

Issues

As a whole, the integrated public system has been characterized by the impossibility for the user to choose a particular provider. This, together with various deficiencies in the quality of services provided, has justified a tendency to lay blame for the deterioration in services on the professionals and to call for the introduction of user choice of provider. This evaluation does not take into consideration, however, the role that serious under-financing has played in the deterioration of public institutions. Given the prevailing economic conditions, it is doubtful that the free choice of doctor would result from need, but rather would depend on the purchasing power of the individual. Access would be differentiated on the basis of wealth.

Theoretically, all those who are not covered by social security, mainly low-income people who are not involved in the formal labor market, have access to institutions in the integrated public subsystem for the general population. Charges are paid out-of-pocket and the cost is based on a socioeconomic evaluation of the user, although it can be similar to the most expensive of private services.

The right to free emergency medical attention in any of the government hospitals or clinics applies to Mexican citizens and foreigners alike.

In short, the health care system features incomplete coverage, stratification by population group, and excessive centralization, as well as serious problems of duplication, poor quality, and inefficiency. These issues have been used from the beginning of the 1980s in official arguments to justify the need for health sector reform, and they are still being used today.

From 1994 to the present, the state has been actively participating in changes to the health care sector. In 1995, President Ernesto Zedillo set out the objectives of the proposed health care reform for discussion in the national development plan (Secretaria de Hacienda y Credito Publico 1995). This document describes the Sistema Nacional de Salud (SNS, national health system) as increasingly expensive and difficult to operate because of its segmentation, centralization, poor coordination, and unclear assignment of responsibility. As an answer to these problems, it was proposed to diversify health care services and financing schemes. The changes are aimed at allowing the user some choice of health care provider and opening up the medical service market.
The Programa de Reforma del Sector Salud 1995 to 2000 (PRSS, health sector reform program 1995 to 2000), although it touches on the general aspects of the system, is

specifically concerned with changes that will affect the uninsured population. According to PRSS' diagnosis, the main problems associated with the current health care system are poor quality, limited efficiency, segmentation of the populations, little coordination, excessive centralization, and insufficient coverage. The proposed changes include decentralization of public health care resources, municipal participation, extension of coverage through a basic health care package, a reorganized structure, and the introduction of mechanisms to increase the quality and efficiency of services.

Federal resources intended for the public health care system will be channeled through the SSA and IMSS-Solidaridad (IMSS solidarity) in coordination with state health care programs. The intention in the medium term is to concentrate state-level public health care services in the areas of greatest poverty, both rural and urban, and thereby avoid duplication.

Municipalities will participate in health care through the program, *Municipio Saludable* (Healthy Municipalities). This program involves community participation in the definition of priorities and the design and evaluation of local health care programs.

The latest version of reform envisions a new model of health care system will divide the population into three groups: those with private insurance, including new forms of insurance plans; those with extended social security; and those with access to state-level public health care systems comprising services form the SSA and IMSS-Solidaridad. The last is expected to extend coverage to the 10 million people currently without it. Under the new model, the SSA will take on the regulating and standard-setting role for the health care sector.

From the government's standpoint, integrating and decentralizing the public health care services and extending these services through a basic package will promote greater efficiency and a specific focus on efforts aimed at reducing poverty. Also, the separation between formal and informal workers will be less marked.

And finally, the reform calls for the promotion of mechanisms that result in increased quality, efficiency, and cost-containment and the introduction of a system of incentives based on user choice. These mechanisms will be incorporated into urban social security services in particular, where the segment of the population with the most supply options is located. Unfortunately, however, the introduction of user choice threatens the unified character of social security. This is because the mechanism will allow the low-risk, high –contributing population to transfer to private insurance plans, while the high-risk, low-contributing population remains with the public institutions.

New Zealand

History

The New Zealand health system has evolved during the past 50 years into a mixed public/private system. The development of New Zealand's health system, pre- and post-World War II governments, created the welfare state system in the face of widespread disillusion with the free market. However, cost increases and system concerns have resulted in significant growth in the private insurance market over the last 20 years.

In the 1960s, the first health care insurance was established by Southern Cross. This provided supplemental insurance filling in the gaps not covered by the Governmental Programs. It also represented billed fee reimbursement for physicians, consistent with private sector charges.

Financing

With only 3.8 million persons in New Zealand, total health care costs are only approximately $6 billion annually. General taxes support the public system with the exception of limited user fees. General practitioner visits are paid, out-of-pocket, a mandated flat amount for all visits. Children's GP visits are covered by the government and poor individuals are eligible for subsidies. The private insurance system and private provider services are a significant portion of the delivery system, as a result of waiting times in the public system. Private hospitals are often established near public facilities and perform many services that would require waiting in the public system. Specialists are allowed to work part time in private facilities to supplement their income.

In the 1990s the ministry of health worked to improve primary care services. Historically there has been a common perception that PCPs were inferior to specialists. Incomes were significantly lower for PCPs, and the medical educational system forced the lower tier students to stop at the PCP level rather than becoming specialists. For many years, primary care was reimbursed a very low flat amount for all office visits. This resulted in PCPs performing short office visits with many quick referrals or drug prescriptions. Recent actions by the ministry of health are working to improve public perceptions of PCPs, improve their training, and better utilize them to manage the health of their constituent populations.

Issues

Coverage of "disadvantaged" and underserved populations appears to be the biggest concern at this time. Many special programs have been developed for Maori (native population) and Pacific peoples. The health status of these populations is significantly worse than the general population.

Rationing became a much larger concern in the late 1990s as two well-publicized cases generated considerable criticism inside and outside of New Zealand. A 42-year-old man died while waiting for an urgently needed coronary bypass operation. He had already waited three months and had another month until his scheduled surgery, despite suffering multiple angina attacks daily.

The other highly visible case was a Maori man that was refused dialysis treatment and died within hours of the court decision. There have been numerous other cases that were less publicized but are contributing to the growing public cry for reform in the health care system.

One author suggests that New Zealanders lack specific knowledge of what medical services they are eligible for. They often learn about coverage when access is required, granted, or denied.

The minister of health has published a number of white papers on reforming the system. The following are the New Zealand Health Strategy Objectives for immediate action:

- To address the health disparities between Mäori, Pacific peoples, and other New Zealanders
- To reduce smoking
- To improve nutrition and reduce obesity
- To increase the level of physical activity
- To reduce the rate of suicides and suicide attempts
- To minimize harm caused by alcohol, illicit and other drug use to both individuals and the community
- To reduce the incidence and impact of cancer
- To reduce the incidence and impact of cardiovascular disease
- To reduce the incidence and impact of diabetes
- To improve oral health
- To reduce violence in interpersonal relationships, families, schools, and communities
- To ensure appropriate child health care and immunization services.

The goals include reducing wait times in an inpatient setting for elective services. Other issues include improving the response for mental health services and access in rural areas.

The ministry of health provides coverage to non-citizens if they are permanent residents or have had an immigrant permit for two years. If individuals are unlawfully in New Zealand, they are not eligible for coverage.