

Options for Healthcare Funding

Health Policy Consensus Group

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INTRODUCTION

The Health Policy Consensus Group is a coalition of organisations and individuals representing various points on the spectrum of opinion. It has set out some guiding principles for reform of the NHS¹, to examine the main options for change, and to select the most promising. However, the group has not set out to recommend a single preferred solution but rather to act as a filter, offering a reasoned justification for ruling out some options and a balanced assessment of those remaining.

This first Health Policy Consensus Group paper examines 11 healthcare funding systems.² We have appraised systems by asking about eight key features by which the important relationships between individuals as potential patients, third-party payers and healthcare providers can be assessed. Definitions of unfamiliar words and phrases can be found in the glossary. We also include an extensive list of references for those seeking more detail.

Does the system exhibit these key features?

1. *Price consciousness*: Can individuals tell whether they are getting good value for money? To answer that question, people need to be able to compare the price and the package of cover.
2. *Social solidarity*: Can individuals tell whether their payment is enabling the poor to enjoy a high standard of care?
3. *Consumer empowerment and patient satisfaction*: Does the method of payment put the consumer in a weak or strong position? For instance, pre-payment may make it harder to escape bad service in the short run, whereas paying an insurer who will then pay any doctor of the customer's choice is empowering.
4. *Quality of care*: What reasons do providers have to offer a high standard of care?
5. *Clinical autonomy*: Does the system impact on the professional duty of clinicians to act in the best interest of patients and does it encourage 'best practice'?
6. *Conflicts of interest with the third party payer*: Any system will partly involve the pooling of risk by a third party payer. But whose interests are served by this third party? Is it a consumer dominated organisation, or is it producer, government, or unduly shareholder dominated?
7. *Responsiveness*: Has the system proved able over time to bring the expectations of individuals into balance with the capacity of providers to treat patients?
8. *Fiscal viability*: Is the burden on public finances affordable?

¹ These guiding principals may be found in the appendix.

² In reality all countries rely on a mixture of funding sources.

Funding systems

We have examined the following eleven funding systems using the criteria above:

1. General taxation (the UK).
2. Local taxation combined with provider management by local councils (Denmark).
3. Social insurance paid by the employer and the employee with multiple non-competing autonomous insurers (France).
4. Social health insurance paid by the employer and the employee, with competing insurers (Germany).
5. Compulsory social insurance paid by individuals with competing insurers and a government-approved insurance plan (Switzerland).
6. Voluntary insurance, with tax subsidies, paid by employers (USA)
7. Voluntary insurance, paid by individuals, with tax subsidies (Australia).
8. Voluntary insurance with either no, or very limited tax subsidy; supplementary insurance (France), substitutive cover (Germany and the Netherlands).
9. Catastrophe insurance plus a tax-protected savings account (Singapore).
10. Compulsory 'exceptional and costly' health insurance with German-style social insurance for acute personal medical services (the Netherlands).
11. Health care purchasing co-operatives (USA).

In the course of our group discussions we have come across many healthcare funding myths that are repeated either in ignorance or in an attempt to stifle debate on change. So before our funding system accounts, we present a brief section on healthcare funding myth busting.

MYTH-BUSTING ON ALTERNATIVE HEALTHCARE FUNDING

- *The NHS is free.* Wrong. The NHS costs the average household **£2400 per year**. That is roughly **£1000 per person**.
- *Health care in the UK is based on need, not ability to pay.* Wrong. In reality, access to care in the UK is influenced by age, gender, education, race, class and wealth. We have a multi-tier system. Almost all developed countries claim that their citizens have access to healthcare on the basis of need, not ability to pay. To continue impliedly asserting that the NHS is different in this respect is dishonest. Many countries can make this claim with more authority than the UK.
- *All social insurance systems are the same.* Wrong. Social insurance systems have four common features: **universality** (compulsory insurance with subsidisation of the sick by the healthy), **price regulation** (to ensure risk solidarity – usually combined with some form of risk compensation for insurers with relatively many high-risk insured), **open enrollment**, and a **defined and regulated benefits package**. Social insurance comes in two main forms: multiple and single third-party-payer models. Each of these has a number of possible varieties. For example, in the multiple payer model, there may or may not be competition between funds.³
- *Social insurance is just another tax.* Wrong. The third party payer in social insurance systems typically represents the interests of employers and patients. In the UK, the Treasury is the third party payer and has interests of its own, which do not coincide with those of healthcare consumers. By the same token, the important difference between national general, and local hypothecated taxation must be noted; the latter is much more like social insurance.
- *Social insurance is a tax on jobs.* Wrong. Swiss social health insurance is not reliant on employer contributions and therefore is not a tax on jobs. Mossialos and Dixon (2002) further challenge this myth by citing studies from the US and Germany which show little or no effect on employment levels of employer health insurance contributions or employer-provided insurance benefits.⁴

³ For further definitions see Normand, C. and Busse, R. 'Social health insurance financing', in Mossialos, E. Dixon A, Fugueras, J and Kutzin, J. (eds) *Funding Health Care: Options for Europe*, European Observatory on Health Care Systems, OUP, 2002. Also see Jacobs, R. and Goddard, M. *Social Health Insurance Systems in European Countries*. University of York Centre for Health Economics, 2000.

⁴ Mossialos and Dixon *et al* (2002), p 287. Citing Gruber J. and Krueger, A.B. (1991), The incidence of mandated employer-provided insurance: lessons from workers' compensation insurance, in D. Bradford (ed.) *Tax Policy and the Economy*. Cambridge, MA: MIT Press. Gruber, J. (1998) *Health Insurance and the Labor Market*, Cambridge, MA: National Bureau of Economic Research, Inc. Bauer, T. and Riphahn, R.T. (1998) *Employment Effects of Payroll Taxes - An Empirical Test for Germany*, Bonn: Institute for the Study of Labor (IZA).

- *Taxation is the most efficient means to pay for health care.* Wrong. Any system can be inefficient.⁵ Although OECD members funded through social insurance have higher average total expenditure on health, tax funding can be as inefficiently spent as any other type of funding. The Netherlands and Germany illustrate that cost control can be effective in insurance systems (Mossialos and Le Grand, 1999). When considering technical efficiency, it is the systems and incentives under which providers, payers and patients operate that are important. Mossialos and Dixon (2002), hypothesise that higher spending could be owing to greater transparency, less political interference, greater connection between contributions and benefits, and the existence of single or multiple insurers in social insurance systems.
- *Fairness / equity in financial contribution is vital.* Wrong. In a modern, publically financed, social welfare system, it is wrong to look at health care in isolation. Many forms of transfer payment can be made to ensure that households retain sufficient income to live. Equity in access to high quality care is what really matters.
- *Co-payments in France weigh heavily on the poor.* Wrong. Although co-payments are a regressive means of financing (Wagstaff and Van Doorslaer, 1993, 1999, 2000), there is a system of exemption for the poor. A similar system of means-tested co-payment may be introduced in Switzerland soon.
- *The UK Private sector is insignificant.* Wrong. The scope of the UK private sector is significantly wider than we are commonly led to believe. According to the Independent Healthcare Association, the UK independent healthcare sector, although small by comparison with the NHS still manages as a whole to have: 220 acute hospitals, 70 acute mental health hospitals, and 15883 residential and nursing homes. It provides more than 430,000 health and social care beds. "It provides more than 80% of all residential long-term care, 33% of medium secure mental healthcare and about 20% of all acute elective (non-urgent) surgery. The NHS and social services actually fund some of this provision, for example the mental healthcare and more than 75% of residential and nursing home places - and this was the situation before the Government's recent announcement of increased partnership between NHS and independent sector provision. Collectively it is one of the country's top ten employers, employing over 750 thousand people. This is no small contributor to the economy."⁶ It should also be noted that more than 3.5 million trade unionists now enjoy the benefits of private health cash and medical insurance schemes. Not all of the beneficiaries of private sector care are insured. In 2001, nearly 250,000 paid out of pocket for acute hospital operations.

⁵ See Mossialos, Dixon *et al* (2002) p288-90.

⁶ Dr Tim Evans, Executive Director of Public Affairs at the IHA, speaking at an IoD seminar on "The New NHS: Modern, Dependable?", London, 3 May 2000.

FUNDING SYSTEMS

1. General taxation (the UK).

1. *Price consciousness*: It is impossible for taxpayers to make a well-informed judgement about the value for money they are getting because they have no knowledge of the amount being paid, let alone any ability to vary it. Nor is there any clear contract laying down the services their payments entitle them to receive.

2. *Social solidarity*: Similarly, concerned taxpayers are unable to judge whether or not they are paying a suitable amount for the poor.

3. *Consumer empowerment and satisfaction*: Advance payment to the Treasury coupled with inability to influence resource allocation puts consumers in a weak position. The lack of choice of alternative providers results in only very limited ways to express dissatisfaction.

4. *Quality of care*: Under the NHS monopoly GPs, and hospital managers have weakened incentives to provide high quality care.

5. *Clinical autonomy*: Owing to political interference, clinicians in the UK are often not able to act in the best interests of patients by following best practice.

6. *Conflicts of interest with the third party payer*: The Treasury is the third party payer and has interests of its own which do not necessarily coincide with those of consumers.

7. *Responsiveness*: Since 1948, funding health care predominantly from general taxes has proved to be an ineffective way of bringing the expectations of patients into balance with the treatment capacity of the system.

8. *Fiscal viability*: So long as taxpayers are unable to see how much they are paying it is impossible to judge whether the system is affordable.

2. Local taxation combined with provider management by local councils (Denmark).

Price consciousness: In Denmark the vast majority of health care is financed from local taxes raised by 14 county councils, some 81% of all public health care expenditure. Moreover, health care is the dominant responsibility of county councils, comprising 75% of their spending. Some writers argue that this local taxation is more visible to consumers and, therefore, allows them to make a more well-informed decision about the value for money they are getting. In Denmark about 30% of the population choose to purchase private health insurance.

Social solidarity: Unlike the UK, two-tier healthcare is not a major issue in Denmark as access to care is relatively equitable. However, though there are some exemptions for those on low incomes, co-payments are important in Denmark, which seems to contradict the explicit founding principle that care should be based on need, not ability to pay. There is relatively little progressivity in the direct tax system in Denmark, and overall, healthcare funding in Denmark is considered slightly regressive (Wagstaff *et al.* 1999).

Consumer empowerment and patient satisfaction: There is no choice of third party payer and little choice regarding how much to pay for health care; however patients can choose their GP and hospital. The Danish Government publishes waiting times for individual hospitals to enable people to shop around. Danes also pay more out-of-pocket than UK patients. This puts them in a stronger position as consumers. As a government system it is not consumer led, but in practice waiting lists

in Denmark are much shorter than in the UK and political debate has recently focused on guaranteed times for treatment. Local taxation combined with the local electoral accountability of hospitals, a focus on patient rights, and choice of provider may explain the unusually high reported satisfaction scores.

Quality of care: Coupled with the fact that patients can choose and change GP, GPs are encouraged to serve their patients by mix of capitation and fees-per-service. The focus of the system is on cost containment and meeting consumer demand rather than seeking value for money. Since the ‘free choice reform’ of 1992, the Danish government has encouraged choice of hospital, with view to increasing quality of care and reducing waiting lists. Hospitals compete with each other across county boundaries, but only recently was the funding system changed to allow money closely to follow the patient from one county to a hospital department in another.

Clinical autonomy: Studies have shown that the mixed remuneration system has an impact on the professional duty of clinicians to act in the best interest of patients and does encourage ‘best practice’. Payments have encouraged the substitution of primary care for secondary care and therefore result in a more efficient allocation of resources. Payments encouraging GPs to engage in preventive activities also have a positive impact on patients.

Conflicts of interest with the third party: Local taxation and hospital ownership has led to a significant degree of accountability and means that national priorities cannot interfere with local concerns. The third party payer serves the interests of the local community.

7. *Responsiveness:* The Danish healthcare system encourages doctors to serve patients better by allowing patients to visit any GP or specialist in the country, by controlling the supply and location of GPs, through the mixed payment system, and through an effective patient rights and complaints system. One proxy for responsiveness is waiting time. During the 1990s the Danish Government’s efforts to introduce a three-month maximum wait failed, and it resorted to specific targets for serious conditions such as heart failure. Two national waiting times have now been introduced. First, those with certain cancers or life threatening heart conditions have a maximum wait of two weeks for investigation⁷, two weeks for treatment, and a further two weeks for follow-up treatment. Secondly, there is a maximum waiting target of two months for all non-acute care. This is very different from the British Government’s current target of 15 months.

8. *Fiscal viability:* Taxation is higher in Denmark than in all other OECD countries. Health care accounts for 75 per cent of county councils’ spending. Elections are held every four years and health care is always a prominent issue; consumers make decisions about the viability of the health system.

3. Social insurance paid by the employer and the employee with multiple non-competing autonomous insurers (France).

French health care is often categorised as a mixed system in which public and private provision and funding, cohabit. Voluntary private health insurance is more important in France than in any other European country (94 per cent of the population is covered), but still only accounts for 13.4 per cent

⁷ Or three or five weeks for certain heart conditions.

of total expenditure on health. We discuss such private insurance in section 8 below, while here in section 3, we concentrate on the remainder of French healthcare finance.

1. *Price consciousness*: In France employers pay 12.8 per cent of payroll, employees 0.75 per cent, and all residents 7.5% of all income.⁸ This money goes to one of the 18 insurance funds (*Caisses d'Assurance Maladie*) which are independent of the French government.⁹ French people can see on their pay slips how much they are paying and reach a reasonably well informed view about the value for money they are getting. They generally pay ambulatory doctors' bills at point of use, before receiving reimbursement from the insurance agency. This system reinforces price consciousness.

2. *Social solidarity*: Solidarity lies at the heart of French social insurance. Bolstered, since the introduction in 2000 of *Couverture Maladie Universelle* (universal cover on the basis of residency rather than employment), the poor in France enjoy a high standard of care, and rich and poor alike have the power to choose providers.

3. *Consumer empowerment and patient satisfaction*: The French cannot choose their '*caisse*' as membership is according to occupation. However, with free choice of provider, healthcare consumers are in a strong position and often expect to be involved in decision-making regarding their health care. There is direct access to specialists and no compulsory gatekeeper role. With the exception of those on low incomes who are exempt, direct payment for medical services strengthens the position of consumers. Medical tourism is common, and satisfaction is generally high. In 1996 a medical records booklet was introduced in an attempt to limit the number of patient visits and redundant prescriptions. This has had limited success.

4. *Quality of care*: In what is a relatively competitive environment, money follows patients, which gives providers financial incentives to supply a high standard of care.

5. *Clinical autonomy*: '*La médecine liberale*' is a cultural banner of French health care. Physicians fiercely protect their freedom to prescribe and freedom to establish practices. Nevertheless, the introduction in 1994 of RMO's (treatment guidelines with financial sanctions / incentives) as both a cost containment measure and in order to encourage best practice, has led to some restriction of professional autonomy. Patients often have to seek approval from the insurer before commencing treatment.

6. *Conflicts of interest with the third party payer*: While the French have no choice of main third party payer,¹⁰ that payer is not run by the government, but by a board representing employers and employees. The system does not permit the third party payers actively to pursue selective purchasing strategies as there is an all-willing provider policy. Top-up insurers have no selective purchasing policy either.

7. *Responsiveness*: Treatment capacity is high and has kept pace with public expectations, partly because of supplementary insurance. As a result, waiting lists are rare, although medical

⁸ This latter figure represents the recently introduced hypothecated tax (*Contribution Sociale Generalisee* - CSG). Rates of 6.2% and 3.8% apply to certain types of income.

⁹ Three '*Caisses*' cover roughly 96% of the population.

¹⁰ The French do have choice of top-up insurer - see pages 13-14.

demography is uneven. Historically, there is a curative focus, though preventive services are receiving greater attention.

8. *Fiscal viability*: Value for money is not the strong point of the French healthcare. The system was established at a time when the prevailing philosophy held that medical care was a need which should always be met. Costs are constrained by increased cost sharing and limiting the extent of the benefits package. However, while the social security system as a whole is now in balance, the healthcare system element remains in deficit.

4. Social health insurance paid by the employer and the employee, with competing insurers (Germany).

The German statutory healthcare system is not universal. Rather, the population is divided into three: 74 per cent are mandatorily insured under the statutory system, a small number including many self employed and certain civil servants are excluded and usually choose to purchase private insurance, and a third group earning above an income threshold may choose between statutory insurance and private health insurance. We discuss German private insurance in section 8 and statutory insurance here in section 4.

1. *Price consciousness*: In Germany, the cost is also expressed as a percentage of income, and employers and employees pay half each. The average cost is 13.5 per cent of income. The money does not go to the German government, but to the c.450 independent sickness funds who pay for the care chosen by their members. There is some concern that social insurance patients consume too much health care, because, with the exception of pharmaceuticals which are subject to co-payment and much dental care for which they receive a bill, after they have paid their premium, patients are not aware of the cost of treatment.¹¹

2. *Social solidarity*: The poor are very well cared for. In most cases the unemployed have their insurance premium paid by the government. However, in what is an openly two or three tier system, there is a concern in some quarters regarding stigmatisation of the poor.

3. *Consumer empowerment and patient satisfaction*: Individuals may choose their insurer and increasingly do so based on price. Patients may choose providers and have a particularly wide range of ambulatory specialists to choose from. The gatekeeping function is weak in Germany, though it is likely to be strengthened in forthcoming reforms. Patient satisfaction is high, but has fallen in recent years, perhaps owing to rises in insurance premiums.

4. *Quality of care*: Germans receive some of the best quality care in the world. Competing providers usually treat all patients but have an incentive to attract the high paying privately insured. This has a 'levelling up' effect on the quality of care available to all.

5. *Clinical autonomy*: Key features of corporatism and subsidiarity dominate German health care. Accordingly, regional physicians' associations and sickness fund associations determine the level of treatment budgets. A series of Federal Acts have focused on cost containment since 1977. Pharmaceuticals are controlled by a short negative list, and reference prices. The pharmaceutical spending cap was abolished in 2002. There is increasing concern among doctors that new medical

¹¹ The Federal government recently announced a pilot scheme in which patients will receive a detailed statement of all treatment received.

technologies are not being made available to those who may benefit from them. There is geographical restriction over the freedom to set up a practice.

6. *Conflicts of interest with the third party payer:* Most of the independent sickness funds are run by boards representing employers and employees. However, a major weakness of the German system is that sickness funds (third party payers) have to contract with all doctors and hospitals. That is, they have to pay ‘all willing providers’ (AWPs) which prevents them from selecting approved lists of cost-effective, safe, or consumer-friendly doctors or hospitals. This is likely to change in the near future, with a shift towards greater freedom to contract. Insurers must also offer the same extensive package of benefits – further weakening their position.

7. *Responsiveness:* Supply of physicians is high, and waiting lists are almost unheard of in Germany. Hospital treatment capacity is high, partly because German regional governments provide for capital investment. There are concerns, however, that current cost control measures will limit the capacity of the system to adapt to future needs.

8. *Fiscal viability:* Like France, value for money is not the strong point of the German system. It was established when the prevailing ethos was that everything that medically can be done should be done. In recent years the main thrust of public policy has been to increase more competition to encourage the search for cost-effectiveness. Employers are worried about the social costs they bear and believe that their ability to compete in world markets is being diminished.

5. Compulsory social insurance paid by individuals with competing insurers and a government-approved insurance plan (Switzerland).

1. *Price consciousness:* In Switzerland, it is compulsory to pay for a basic insurance plan defined by law. About 100 non-profit private insurers compete for customers, offering a mandatory and comprehensive package which is set at the national level. Premiums vary considerably and a variety of deductibles, managed care options, and co-payment for ambulatory care, serve to increase price consciousness.

2. *Social solidarity:* In order to guarantee that economic burden does not fall disproportionately on the sick, old and poor, premiums are community rated, there is open enrolment, and there is a risk adjustment mechanism between insurers. A third of the Swiss receive premium subsidies. There are 23 cantons and three demi-cantons in Switzerland, each with a slightly different policy towards subsidisation. One approach is to cap the premium if it exceeds 10 per cent of taxable income; another is to pay on a sliding scale based on income. A forthcoming law is likely to cap premiums at 8 per cent of household income. The very poor effectively have the full premium paid for them so that everyone is an insured customer.

Small fees are required for visits to the doctor, up to an annual maximum. Critics feel that these charges weigh too heavily on the poor. For this reason the government is planning to introduce an exemption system similar to that used for premium subsidisation.

3. *Consumer empowerment and patient satisfaction:* With wide choice of insurers and providers, it is said that Swiss consumer preferences are respected to a degree only matched in the US. People who want to pay for extras, over and above the basic plan can do so. But all have a stake in the standard package guaranteed for everyone. Through their system of decentralised direct democracy,

the Swiss also have a notable influence over the design of the healthcare system. Patient satisfaction in Switzerland is high.

4. *Quality of care*: Competing Swiss physicians, paid fee-for-service, have a financial incentive to offer high quality care. There is a point value schedule (TARMED), similar to that in Germany. While there is an increasingly important GP network scheme, the vast majority of the population prefer freedom of choice over which provider to use. Swiss healthcare outcomes are generally high.

5. *Clinical autonomy*: The clinical autonomy of independent Swiss clinicians (*libre praticiens*) is subject to increasing regulation. For example, there is a condition that insurers will only reimburse providers if services are clinically effective, appropriate and cost-effective. Measures to promote quality assurance, vary greatly between cantons. Providers have freedom to set up practice.

6. *Conflicts of interest with the third party payer*: A major weakness of the Swiss system is that the sickness funds have to contract with all hospitals, which prevents them from selecting approved lists of cost-effective or safe, or consumer-friendly doctors or hospitals. As in Germany, this is likely to change, with a shift in the near future towards greater freedom to contract. In addition, a variety of managed care schemes have been introduced over the last decade. In return for lower premiums, the nature of the relationship between third party payer and provider is altered in such schemes. Those choosing to leave managed care schemes often cite lack of choice as their main reason.

7. *Responsiveness*: One of the three pillars of the recent health insurance law was access to high quality treatment. The Federal government considers this has been achieved. Treatment capacity is high, partly because the cantons invest in hospitals. The number of physicians is growing. The Swiss system appears to be able to meet patient expectations and to adapt to changes in expectations more quickly than other health systems.

8. *Fiscal viability*: The Swiss system is very expensive and since 1996, has experienced steep increases in premiums. Taxation and match-funding also play an important role in health care, and there is concern that a number of perverse financial incentives serve to exacerbate spiralling expenditure. Pharmaceutical expenditure is very high (owing to domestic industrial policy which prohibits parallel imports), and there is a continual debate about how best to encourage more competition on the supply side.

6. Voluntary insurance, with tax subsidies, paid by employers (USA).

The health sector in the United States is diverse and is characterised by a mix of public (45 per cent) and private (55 per cent) funding. Seventy two percent, or 200 million people, have private insurance. Of those, 177 million received their coverage through the workplace.

1. *Price consciousness*: Employers usually pay for most of an employee's health insurance, so apart from their co-payments and deductibles, individuals have little incentive to economise. In recent years employers have become concerned about the high cost of health benefits and tried to reduce expenditure by introducing managed care. A number of recent innovations (e.g. Defined Contributions Plans and Medical Savings Accounts), aim to engage consumers in the decision-making process about their health coverage, and to provide incentives for them to use services wisely.

2. *Social solidarity*: The US health system is inequitable. Those who receive health insurance at work receive a generous tax break worth more than \$130 billion a year. Meanwhile, many, usually low-paid workers, find it difficult to obtain affordable cover because their employer does not include health insurance as a workplace benefit. In 2000, some 38 million Americans did not have health insurance. However, a strong safety net guarantees access to hospital care regardless of ability to pay. Private, not-for-profit community-based health centres provide high quality, cost-effective and comprehensive primary and preventative care to the uninsured and medically underserved. More than 11 million patients utilise these programs. Federal grants, Medicaid and Medicare payments, state and local grants, private insurance payments, patient fees, foundation grants, and private donations fund community health centres. Patient cost-sharing is means-tested on a sliding fee scale according to income. Despite the safety net described above, it is clear that the uninsured often wait until the later stages of illness to get the care they need. There is now widespread support for the introduction of an individual tax credit to replace the employer-based system.

There are separate tax-payer supported systems for lower-income children (SCHIP), the poor (Medicaid), and the elderly (Medicare). Recipients are entitled to outpatient medical care from physicians and to receive hospital care from the same medical professionals who provide health care to those with private health insurance.

3. *Consumer empowerment and patient satisfaction*: In practice, many consumers are unable actively to shop around for plans, as employers may only offer one plan (60% of employers offer a choice, usually 3-5 plans). Patient satisfaction varies across states and plans. Although satisfaction with quality of care is high, there is much dissatisfaction with managed care. While employers instituted managed care to control rising health costs, many Americans have become frustrated with a system that essentially places barriers between them and the medical care they want and/or need. But they are limited in their options for action. If they do not like the health insurance and restrictions offered by their employers, they face adverse tax consequences if they want to buy health insurance on their own outside the workplace.

4. *Quality of care*: Providers in both the public and private sectors generally offer a high standard of care, as they are subject to selection by insurers. Waiting lists are very short in the USA. The American health care sector does not have a single quality performance department, but instead relies on a mix of private and public entities such as the National Committee for Quality Assurance, the Agency for Healthcare Research and Quality, and the Joint Commission on Accreditation of Healthcare Organizations.

It has been estimated that 30 per cent of all direct U.S. health care outlays – \$390 billion – are the result of “poor quality care, consisting primarily of overuse, misuse and waste.”¹² Much of this is caused by providers performing unnecessary or unnecessarily expensive procedures because they profit from them, and consumers have little reason to question the costs.

¹² *Reducing The Costs Of Poor-Quality health Care Through Responsible Purchasing Leadership*, Midwest Business Group on Health, June 11, 2002

5. *Clinical autonomy*: Physicians are sometimes required to obtain prior authorisation from insurers before performing procedures or tests. However, new legislation being considered by Congress may give physicians more power by allowing them to form unions and bargain collectively.

6. *Conflicts of interest with the third party payer*: Insurers, driven by stakeholders ranging from employers, to providers, to patients, generally serve the needs of their covered population.

Managed care, in which third party payer and provider are integrated, clearly alters the patient-provider relationship.

7. *Responsiveness*: Treatment capacity is high and most hospitals are private (87% non-profit), but there is some government funding of hospitals and a great deal of regulation of hospital prices and capacity in most states. However, because the majority of health care in the United States is delivered through private-sector programmes, the system overall is better than most in encouraging continual innovation and new technology. For example, the strength of the U.S. health sector is evident through pharmaceutical innovation and new medical techniques and technologies, rewarded by policies that, for the most part, value and pay for these advances.

8. *Fiscal viability*: US health care is the most expensive in the world, and there are widespread concerns about its viability, especially as so many remain uninsured. Many are coming to realise that pouring millions more dollars into malfunctioning systems only perpetuates their problems.¹

7. Voluntary insurance paid by individuals with tax subsidies (Australia).

Australia has a government-funded universal public healthcare system (Medicare), partly (27 per cent) financed by a hypothecated tax (the Medicare levy). However, Australia encourages private supplementary insurance for hospital care and ‘extras’, through the tax system. Such insurance now accounts for eight per cent of total expenditure on health.

1. *Price consciousness*: 45 per cent of Australians purchase private insurance from one of about 40 insurers. They do so, bearing in mind carrot and stick tax incentives, in order to obtain greater comfort, to be treated by a doctor of their choice, or to cover co-payments. The privately insured also benefit from shorter waiting times, and can receive assistance with meeting the costs of services which are not covered by Medicare – such as dental, optical, and physiotherapy services.

2. *Social solidarity*: Insurance premiums do not vary according to health risk. Australia encourages private supplementary insurance by tax measures, one such being the 30% tax rebate. The use of the tax system since 1997-98 to provide subsidies to the health insurance industry directly contradicts the thrust (increased progressivity) of the Government’s tax reform agenda. Subsidies will soon cost around \$3 billion and are skewed heavily towards the affluent – half the subsidy goes to the top 20% of tax-payers, and nearly three quarters goes to the top 40%. Some of the subsidy goes towards ancillaries – non-hospital care costs – including insurer administration. Furthermore, a recent study of private insurance purchasing trends shows that the rebate has failed to reduce public sector spending or significantly increase membership of private funds. The sharp increase in

¹ Johan Hjertqvist. *Blair Repeats the Stockholm Sea Change*, Fact Sheet. The Timbro Health Unit. Stockholm, Sweden, May 2002.

membership was not due to cash incentives but from deregulation of health funds and the introduction of life-time cover rules.²

3. *Consumer empowerment and patient satisfaction*: Privately insured patients have greater choice of hospital provider (public and private), and of doctor. In general, Australian patient satisfaction has fallen recently, in light of longer waiting lists and consumer costs, but these elements are less pressing on the privately insured.

4. *Quality of care*: As private patients are free to choose and change their doctors, those treating the privately insured have a financial incentive to provide high quality care. For example, salaried specialist doctors in public hospitals often have rights to treat some patients in those hospitals as private patients, charging fees and usually contributing some of that fee income to the hospital.

5. *Clinical autonomy*: The foundation of the debate about public/private financing is the constitutional amendment of 1946 which protects the right of private practice. This states that the Commonwealth may provide "pharmaceutical, sickness and hospital benefits, medical and dental services (but not so as to authorise any form of civil conscription)". In effect, this means that doctors cannot be coerced by the Commonwealth into providing particular services, accepting salary rather than fee-for-service payments, or even writing prescriptions on government-supplied forms. Therefore, private medical practice in Australia is legally secure, with public control of private practice constrained.

6. *Conflicts of interest with the third party payer*: Australian private insurance is largely non-profit, however, there has been a recent shift towards the for-profit sector (now 15%). The latter operate under a different set of incentives.

7. *Responsiveness*: The private insurance sector appears to meet demand, particularly by enabling the insured to jump waiting lists, by being able to choose when, where and from whom to receive treatment.

8. *Fiscal viability*: The open-ended subsidy encourages wasteful spending. Australian private insurers pay for treatment in public and private hospitals and have not adopted managed care style contracting as in the US, though since 1995 insurers have been allowed to contract with hospitals and individual providers. It is hoped that the 'Lifetime Health Cover' community rating system will improve the risk pool of insurers and therefore limit premium increases.

8. Voluntary private insurance with either no, or very limited tax subsidy.³ Supplementary insurance (France), substitutive cover (Germany and the Netherlands).⁴

In France, supplementary insurance has allowed healthcare resources to increase despite the efforts of the French government to curtail spending. Those earning above an income threshold in Germany may choose to opt out of the social insurance system – c7.4 million do so. About one-

² For details see Butler, J. 'Policy change and private health insurance: Did the cheapest policy do the trick?' National Centre for Epidemiology and population Health. The Australian National University, 2001.

³ Tax incentives are considered weak in the Netherlands and Germany. French employees with employer-paid VHI (48% of households) may deduct the premium amount from taxable income. French employers purchasing commercial VHI pay a seven per cent insurance premium tax. This does not apply to employers purchasing mutual insurance. For details see Mossialos and Thomson (2002).

⁴ There are also small, supplementary insurance markets in Germany and the Netherlands mainly covering treatments that are excluded from statutory packages, dental care being the most common. In the Netherlands, although 93% of the ZFW insured population purchase supplementary insurance, the sector only accounted for just over 2% of THE in 1999.

third of the Dutch population (those above the upper national insurance threshold) are excluded from ZFW insurance – nearly all choose to purchase private insurance.

1. Price consciousness: Many argue that in a fee-for-service system with co-payments, the case in France, supplementary insurance hides the cost of care. In Germany and the Netherlands private insurers compete for people who are above the national insurance threshold. Privately insured patients receive a bill detailing medical expenses incurred. This serves to increase price consciousness, but insurers report that this has little effect on consumer behaviour.

2. Social solidarity: In France, as the national health insurance benefits package has been cut over the past 20 years, supplementary private insurance has been purchased by individuals (commonly risk-rated) or employers (group-rated), to plug the gap. Studies show that use of medical services is higher among those with supplementary insurance. The poorest could not afford this insurance, so amid real concerns about the effect of co-payments on the decision whether or not to seek medical treatment, a means-tested system of free supplementary insurance was introduced in 2000. Ninety-four per cent of the population has now supplementary cover. Meanwhile in Germany (with c.8.9 per cent coverage), social solidarity concern within the substitutive insurance system, led the government to intervene to ensure that those on lower incomes, those with pre-existing conditions and the elderly have access to affordable and adequate insurance coverage (Mossialos and Thomson, 2002). Looking at the healthcare system as a whole, many consider that the existence of a private insurance sector for the well off is unfair, as their higher income and lower health risk could change the risk pool of statutory insurance and reduce premiums.⁵ The privately insured in the Netherlands (c.28.9 per cent of the population), cross-subsidize the statutory sickness funds which have an over-representation of the elderly.⁶ Nevertheless, in the Netherlands too, there is real concern over the fairness of their two-tier system.

3. Consumer empowerment and patient satisfaction: The level of French supplementary insurance coverage varies significantly. Nevertheless, insurance covering co-payments and excluded benefits increases the power of consumers in relation to providers. It is common for those with supplementary insurance to use the private sector and 'secteur 2' specialists.⁷ Depending on level of cover, the privately insured in Germany may expect to be treated by chief physicians and receive care in comfort, but they do complain about the level of premiums, particularly in old age.

Changing insurer is effectively deterred in Germany and the Netherlands, because those who do so face higher premiums. Dutch privately insured benefit from weak gatekeeping in comparison to the rest of the population. Despite this, patient satisfaction in the Netherlands for publically and privately insured alike has been affected by supply-side controls resulting in lengthy waiting lists.

4. Quality of care: Owing to clear financial incentives, the quality of care provided to the privately insured tends to be high. Better amenities may be available and waiting lists avoided. Knowing that the supplementary insurance system in France hides the real cost from patients, there is an increased risk of supplier-induced demand and excess inappropriate use, which is arguably not in

⁵ For this reason, the German health minister recently announced a significant increase in the income threshold for access to private insurance.

⁶ This is known as the MOOZ scheme. VHI insured also cross-subsidise the WTZ scheme for high-risk privately insured.

⁷ Secteur 2 specialists may charge above the negotiated fee for treatment. Supplementary insurance policies may cover these extra charges.

the best interests of patients. Therefore, although the quantity of care may rise, the quality may not. The same does not apply to the same degree in the Netherlands and Germany where cover is substitutive and patients receive bills for treatments. Nevertheless, the asymmetry of information between patients and providers exposes the privately insured to such physician behaviour.

5. *Clinical autonomy*: Voluntary private insurance may enable physicians to practice with greater clinical autonomy than they experience when working under statutory schemes. For example, privately insured patients may receive more expensive, and more medically advanced treatment than those without such insurance.

The asymmetry of information between patient and provider can also encourage supplier-led demand if a provider knows that a patient has supplementary insurance, though this would be obviated (in France) if supplementary insurers were allowed to pursue proactive purchasing strategies.

6. *Conflicts of interest with the third party payer*: Competing insurers may reduce costs and/or maximise profits by exploiting any asymmetry of information between themselves and customers and by engaging in risk selection. This behaviour depends in part on the nature of the supplementary insurer, profit or non-profit. German and Dutch private insurers are largely run on a for-profit basis, while the majority of French supplementary insurers are non-profit. Individuals with low health risk may engage in adverse selection.

Risk and adverse selection can be at least partially overcome through regulation, such as an obligation to provide full comparable information, open enrolment policies, the limitation of exclusions for pre-existing conditions, and by making health insurance compulsory. Effective risk adjustment mechanisms may act as a disincentive to select on the basis of risk. Nevertheless, experience in Germany and the Netherlands shows that substantial risk selection takes place.

7. *Responsiveness*: The French and German systems have proved able to bring expectations of individuals into balance with the capacity of providers to treat patients. The same cannot be said in the Netherlands, where supply-side controls are strong. The Dutch privately insured often have to wait for treatment – though not as long as the statutorily insured.

8. *Fiscal viability*: With the exception of the recent introduction of free supplementary cover for the poor, the burden on public finances is arguably not relevant in relation to French private insurance – quite the opposite was the intention of successive governments. French supplementary insurance is an integral part of the healthcare system. But as mentioned above, insurance may lead to costly irresponsible use and provision of medical services. This is in contrast to Switzerland where the purchase of insurance to cover co-payments is no longer permitted. In Germany, it is argued that premiums might fall if everybody was part of the statutory sickness system. In that sense the burden on public finances is significant. The position, though less clear in the Netherlands where transfers apply, is likely to be the same.

The limited tax incentives to purchase insurance in France, Germany and the Netherlands should be regarded as a further fiscal burden.

9. Catastrophe insurance plus a tax-protected savings account. (Singapore)⁸

For fifteen years Singapore has trodden a middle-way between a laissez-faire system and a government-regulated national health service. The government intervenes only to regulate the provision of facilities, medical manpower and the flow of funds. Singapore provided the inspiration for medical savings accounts. The idea was developed further by some American think tanks, and in 1996, the US Government introduced a limited pilot scheme involving about 100,000 small employers and self-employed people. In South Africa similar schemes have captured more than half the market for private health insurance.

1. Price consciousness: MSAs make patients fully aware of the costs of health care. They are not a single funding method, but rather work in conjunction with ‘catastrophe’ insurance policies which cover people for all medical expenses above, say, £500 a year (like an excess in motor insurance). Individuals can pay the excess out of the medical savings account. This combination keeps insurance costs down and discourages the over-use of services without penalising the poorest people. It is a savings scheme, not an insurance scheme – funds are not pooled – thus personal responsibility is at the heart of the system. Consumers control their own health care dollars and pay providers just as they do for any other good. Patients, who make trade-offs between money, healthcare and other goods, become more price conscious, and therefore frivolous use is limited. Medisave funds cannot be used for primary care. Patients pay the full cost to private physicians, while the government subsidises polyclinic care. Co-payments and deductibles are also at the heart of the system, leading to greater cost-consciousness – money coming from personal savings rather than tax or social insurance.

2. Social solidarity: High quality care for all is guaranteed through the ‘three M system’: Medisave, Medishield, and Medifund. Together they ensure that no citizen is deprived of basic medical care.

Medisave: Instead of taxing an individual’s money and then providing health care, the government requires all workers to put a proportion of their earnings (six to eight per cent) into a special account dedicated to medical needs (hospital care only). The contribution of workers is matched by employers. Contributions are tax exempt and accumulate, earning interest, over a lifetime – building up a reserve for use in old age. **MediShield:** Offers insurance protection against the costs of long-term and catastrophic illness. Premiums can be deducted from Medisave accounts.

Medifund: Since 1993 has been a means-tested safety net of last resort for truly indigent people who are unable to meet medical expenses.

There is a very obvious multi-tiered hospital accommodation system, which would be unpalatable to some, though the standard of care is the same for all types of accommodation.⁹ There are heavy subsidies for 79 per cent of public hospital beds, the remaining 21 per cent are private or semi-private. In the highest category, with choice and so forth, there is no government subsidy, so patients pay full costs from Medisave accounts. With less privacy the subsidies increase. Those who cannot afford to pay still receive care, but in 20-bed, non-air conditioned wards, and they cannot choose their own physician.

Health services for the elderly are provided by voluntary welfare organisations (VWO) which receive government funding. A three-tier means-tested subsidy framework applies to patients

⁸ Much of this section is based on information from the Ministry of Health website.

⁹ There are 9 classes of ward at the public Singapore General Hospital.

receiving care in VWO community hospitals. The recently introduced Primary Care Partnership Scheme (PCPS) is designed to enable easy access to affordable, integrated health care for the elderly. Under the scheme, the public polyclinics sign contracts with private GPs and dentists to engage them to provide common outpatient medical services for simple medical conditions to low-income elderly. The Ministry of Health provides a subsidy to private practitioners for each needy elderly person treated, while the recipients of care only pay polyclinic fees (\$4).¹⁰

3. *Consumer empowerment and patient satisfaction*: Personal responsibility is at the core of the system. There is no choice about whether to pay for healthcare, but there is choice regarding how much to pay and where to obtain care. Patients choose between 17 government one-stop-shop polyclinics (20 per cent of services) and private primary care physicians (80 per cent of services). For inpatient hospital care the situation is reversed; the public sector provides 80 per cent (eight hospitals and six specialty centres) and the private sector, 20 per cent (13 hospitals). Although rationing is accepted as inevitable, Singaporeans receive prompt, universal access to high quality medical care. The basic medical package is defined in broad terms and provides ‘good up-to-date medical practice, which is cost effective and of proven value’.

4. *Quality of care*: Providers (who as a result like MSAs) can practise medicine as agents of patients rather than agents of employers or insurance companies. Competing providers offer better services and drive for efficiency.

5. *Clinical autonomy*: In what is a dual system of health delivery, the government and private sector work alongside each other. Government regulation extends to delivery – number of doctors and the degree of specialisation, number of hospital beds, and provision of specialist facilities. The government also controls hospital prices and levels of patient co-payments. However, there is still a problem of supplier-induced demand.

6. *Conflicts of interest with the third party payer*: There is no traditional third party payer under Medisave. The system separates purchasers (individuals) from providers. Competition between providers allows doctor shopping, but keeps charges down – around s\$10-15 per visit in 2001.

7. *Responsiveness*: Although rationing is accepted, Singapore experiences very short / non-existent waiting lists – two to four weeks for elective surgery.

8. *Fiscal viability*: Singapore’s healthcare inflation is high – 13 per cent, which is above the 10 per cent inflation of the economy as a whole – some put blame on the rapidly rising private sector salaries pushing up salary costs in the public sector. The government heavily subsidises 79 per cent of public hospital beds through general taxation.

10. Compulsory ‘exceptional and costly’ health insurance with German-style social insurance for acute personal medical services (the Netherlands).¹¹

In the Netherlands everyone is required to contribute to an insurance policy covering exceptional medical costs and long-term care – so-called ‘*First compartment*’ or AWBZ insurance. There is a

¹⁰ Conversion rate: £1 = S\$ 2.69, July 5.

¹¹ Germany introduced compulsory long-term care insurance (*Pflegeversicherung*) in 1995. Each statutory insurance fund has established a separate long-term care insurance fund which grants benefits to those members in need of long term care. It is funded by equal contributions from employers and employees. The privately insured must conclude contracts with private insurers. See MISSOC, 2000.

separate system for acute medical services with contributions paid partly by employers and employees – the ‘*Second compartment*’. As discussed in section 8 above, this second compartment is divided in two. Two-thirds of the population are compulsorily covered by traditional style social insurance or ZFW insurance. The remaining third of the population earn above an income threshold and are excluded from ZFW insurance. The vast majority of them choose to purchase private cover.

1. Price consciousness: AWBZ payments are income related. There are multiple geographically defined insurers; there is no competition. Premiums (10.25 per cent in 2000 on the first taxable income bracket) are paid by employees, not employers, and are set annually by the government. Healthcare benefits are provided in kind, and there are no co-payments. ZFW insurance primarily relies on income-related premiums which are set by the government - at 8.1 per cent (2000), employers paying 6.35 per cent and employees, 1.75 per cent. There is choice of insurer, but insurers compete only on the level of an additional flat rate charge levied on all subscribers. The average flat-rate charge in 2000 was 188 Euros (£120). The Dutch are conscious that the price they pay for health care does not provide good value for money.

2. Social solidarity: The health ministry proclaims the guiding principle that if people become able to pay for themselves they should. AWBZ contributions are income related – ensuring that the poor pay less than the rich, however, premium payments are subject to annual maximums. The government pays on behalf of the unemployed. Healthcare services are provided in kind, and there are no co-payments (with exception of certain hotel-type expenses). This ensures the poor are able to access AWBZ care. The ZFW insurers have an obligation to accept applicants. A risk adjustment mechanism operates to avoid incentives to “cream-skim” which would cause the flat-rate premium to increase. Many conclude that the Dutch healthcare system is divisive, because one third of the population have private insurance. Health inequalities are serious in the Netherlands, and there is no exit strategy for the less-well-off. The results of the ECuity study found the AWBZ insurance to be marginally progressive; however, including the ‘Second Compartment’ (under which 31% of the population are excluded, and there is a ceiling on contributions), Dutch social insurance funding is found to be regressive overall (Wagstaff and van Doorslaer, 1993, 1999, 2000). Wagstaff and Van Doorslaer (2000) found access to GP and inpatient care to be pro-poor, yet the delivery of specialist care favoured the rich.

3. Consumer empowerment and patient satisfaction: For AWBZ care, there is no choice of insurer, but under AWBZ and ZFW there is choice of ambulatory provider, though the Dutch must register with a GP. Gatekeeping plays a strong role into the secondary sector, where there is also choice of provider. ZFW insured choose between 30 competing insurers. Although there is freedom to contract, insurers tend to contract with all providers. Uniform supply means there is no effective choice for patients, and it chokes innovation by providers. Patient satisfaction is above average in the Netherlands, but is increasingly adversely affected by long waiting lists and standard of service that the Dutch consider inappropriate for a developed country with a thriving economy.

4. Quality of care: Supply-side controls mean that providers are frustrated. Under AWBZ, every provider must contract with a monopoly insurer, while under ZFW, providers tend to contract with every insurer.¹² Quality of care has deteriorated because there is very limited choice. Payments for services are made retrospectively on a fee-for-services basis. Thus, insurers are reimbursed by the

¹² Since 1994, sickness funds have been able to selectively contract with independent physicians.

General Fund for actual costs incurred – in order to limit expenditure, provider charges are based on set tariffs. This means of financing is often regarded as offering strong incentives for inefficiency (Bramley-Harker et al, 2001).

5. *Clinical autonomy*: Although there has been a long tradition of privately supplied health care, most hospitals being run on a private, non-profit basis, AWBZ and ZFW care is strongly and centrally controlled. A top-down model, the focus is on the regulation of health insurance, price setting and volume planning. Providers have little freedom. Specialist care is almost exclusively organised by hospitals, with specialists being paid by a combination of capitation and fees-for-service. It is suggested that efforts to cut specialist fees have been negated by provider-led increases in services provided. Draft budgets are set annually for each department. Once reached, specialists cannot continue to treat, and so waiting lists grow.

6. *Conflicts of interest with the third party payer*: ZFW funds are independent, non-profit, legal entities with self appointed boards. These ZFW funds act as ‘executive agent’ for AWBZ care.¹³ However, the government decides on ZFW and AWBZ contribution rates following recommendation by the Health Care Insurance Board¹⁴. Though based on private provision, the Dutch system serves its own/the government’s interests. It is said that the focus is on the system rather than the patient. Providers and patients are frustrated by financial limits.

7. *Responsiveness*: In an environment of extensive government regulation of prices, volume and quality, supply does not meet demand. Waiting lists are a problem in the Netherlands. Institutions must stay within estimates of necessary capacity. There is a shortage of labour (because annual limits are set and because qualified personnel leave health care). The result for providers is a complete lack of freedom.

8. *Fiscal viability*: Dutch health care is relatively expensive, but cannot cope with existing demand. The system encourages waste and inefficiency by insurers, providers and users. Increasing costs are exacerbated by greater inefficiency.

11. Health care purchasing co-operatives (USA).

Health care purchasing co-operatives are public or private organisations which secure health insurance coverage for individuals. The goal of these organisations is to consolidate purchasing responsibilities to obtain greater bargaining clout with health insurers, plans and providers, and to reduce the administrative costs of buying, selling and managing insurance policies. Some private co-operatives are voluntary associations of employers in a similar geographic region who band together to purchase insurance for their employees. Public co-operatives have been established by state governments to purchase insurance for public employees, Medicaid beneficiaries, and other designated populations.¹⁵

The Federal Employees Health Benefits Program (FEHBP) began operation in 1960 and today offers nearly 400 insurance plans to some four million civilian employees of the US federal government. Including dependents, about nine million people in total are covered. Every year in

¹³ Details may be found in Ministry of Health, Welfare and Sport, *Health Insurance in the Netherlands*, 2000.

¹⁴ The board is comprised of 9 independent experts appointed by the Minister. ZFW insurers also set and compete on the basis of a nominal contribution. In 2002 these payments range from Euro 114 to Euro 238.

¹⁵ This short description is from Pam Pohly’s Netguide. For details of other managed care terminology see http://www.pohly.com/terms_h.htm

November/December there is a month-long ‘open season’ when people choose their insurer for the next year; workers generally have a choice of about 20 health plans in any region of the country. They receive an official guide, and a consumer group also publishes a private guide. Each year only about five per cent of policies change hands, but the impact on individual insurers can be substantial, with some losing half or more of their subscribers.

1. *Price consciousness*: The US federal government typically pays 75 per cent of the actual premium of each person’s chosen plan. Employees pay the difference. Two types of cover are offered: ‘self only’ and ‘self and family’. Premiums, coupled with a range of deductibles and co-payments, serve to make healthcare purchasing cooperative members price conscious consumers.

2. *Social solidarity*: All insurers must community rate — literally, this means that a retired person pays the same as an 18-year old trainee. Insurers must also accept all applicants regardless of pre-existing conditions.

3. *Consumer empowerment and patient satisfaction*: Plans are rated for consumers by the 5-star system according to categories including access and service, and qualified providers. This provides consumers with the information to make an informed choice. Because choice and competition are hallmarks of the programme, the FEHBP reports one of the highest levels of satisfaction of any health care programme in the country.¹⁶

4. *Quality of care*: To meet the minimum standard to be accredited, plans must fulfil criteria such as access to patients, coordination of care, and medical decision making which adheres to acceptable standards of practice.

5. *Clinical autonomy*: Plans must provide evidence that qualified health professionals are making decisions about medical treatments and services to receive accreditation.

6. *Conflicts of interest with the third party payer*: Insurers must focus on quality and serving patients to retain their covered populations.

7. *Responsiveness*: Risk of losing enrollees forces insurers to be responsive to consumer demand.

8. *Fiscal viability*: 9 million enrollees cost the federal government \$20 billion, compared to 40 million Medicare recipients costing \$246 billion. However, the 75% government contribution reduces the incentive for enrollees to choose low cost plans.

¹⁶ *A Blueprint For New Beginnings: A Responsible Budget for America's Priorities*. U.S. Government Printing Office. Washington 2001. <http://www.whitehouse.gov/news/usbudget/blueprint/bud13.html>

Glossary

Age-adjusted

Community rating: Found in Australia, this is a partial conflation of risk-rating and community rating. A ‘carrot and stick’ policy, all those taking out a private insurance policy before the age of thirty pay lower premiums. Premiums subsequently rise by two per cent for every year of delay before an individual signs up.

Community rating: The opposite of risk rating, community rating means that all members of an insurance pool pay the same premium regardless of individual risk. Thus, risk is pooled across the whole community. In Switzerland, everyone insured with a given insurer in a given geographical area, pays the same amount – a ‘flat-rate’.

Co-payment: See user charges.

Core package: The phrase core package is used to denote a bundle of medical benefits that are usually deemed medically necessary and that would be guaranteed by the government.

Gatekeeping: A system whereby access to specialist and or hospital care is controlled by GPs or ‘family’ doctors. Such a system has two main aims: cost control and guidance to appropriate care providers.

Group rating: Common in the US, group rating is related to community rating and means risk is pooled across, for example, the whole staff of a company or membership of a trade union.

Income related premiums:

Common in social insurance systems, and usually referring to earned income, premiums are expressed as a percentage of income rather than as a fixed monetary amount. For example in Germany premiums average c. 13.5, paid 50/50 by employer and employee. See ‘proportional’.

Information

Asymmetry: The situation when parties to a transaction (for example, doctor and patient), have different amounts of relevant information.

MOOZ The Dutch Health Insurance Funds Act (1986). This scheme compensates the ZFW scheme, which insures a disproportionately high number of the elderly.

Open enrollment Under open enrollment, the insured are able to leave one insurer and to join another. Certain time restrictions usually apply.

Obligation to contract:

Insurers must accept all applicants.

Payroll taxes: The term used to describe mandatory social insurance contributions that apply to employer and employee.

Progressive: In a progressive system, the rich pay a larger fraction of their income than the poor. Opposite of regressive.

Proportional: System such as that in France where premiums are expressed as a proportion of income and are not subject to a contribution ceiling.

Regressive: Term used in relation to funding mechanisms to describe a system that weighs more heavily on the poor than the rich. That is, the poor pay proportionately more of their income on health care than do the rich. (See ‘proportional’, ‘progressive’, and ‘user charges’).

Risk Adjustment Mechanism:

In a competitive and regulated insurance market, RAMs are used to prevent insurers engaging in cream-skimming/risk selection. Age, sex, and geographical location are generally used in the adjustment formula. There is

	a continuing debate about how to improve the performance of the RAM formula. Previous medical expenditure or death are often suggested.
Risk rating:	The calculation of insurance premiums according to the risk profile of an individual – taking into account, age, gender, medical conditions and so forth.
Social insurance:	First introduced by Bismarck in the 1880s, social insurance is a social security system model under which insurance funds may be independent from government. Normand and Busse (2002) note that social health insurance has two crucial characteristics. Firstly, the insured pay regular, usually wage-based (i.e not related to risk) contributions. Secondly, independent quasi-public bodies act as the main managers of the system and as third party payer. Beyond those two characteristics, several other features are commonly found in social health insurance systems. For more details see Normand and Busse (2002).
Third party payer:	A public or private body that receives taxes or social insurance contributions and transfers them to healthcare providers. The patient is the first party payer while providers are the second party payers.
User charges	Otherwise known as cost sharing or out-of-pocket payments. These payments are highly regressive, and are usually designed to regulate the behaviour of patients. Rubin and Mendelson, ¹ distinguish between <i>direct</i> cost-sharing and <i>indirect</i> cost-sharing). Direct cost-sharing includes co-payment (a flat fee or charge per services), co-insurance (a percentage of the total charge), deductible (a payment covering the first X currency units before insurance coverage applies) and balance billing (an additional fee the provider levies in addition to the payment received from the third party payer). Indirect cost-sharing refers to policies that can result in out-of-pocket payment by patients even though charges are not directly imposed. Rubin and Mendelson include excluded treatments, generic substitution and positive/negative lists in this category.
VHI	Voluntary Health Insurance. Private health insurance terminology is not standardised. This can cause much confusion when discussing the various forms of VHI. Mossialos and Thomson (2002) use the following definitions. Substitutive VHI substitutes for cover that would otherwise be available from the state (eg Germany, Belgium and the Netherlands). Complementary VHI provides cover for services excluded or not fully covered by the state, including cover for co-payments imposed by the statutory health system (eg. France). Supplementary VHI cover provides faster access and increased consumer choice. Though convenient distinctions, there are often grey areas and overlaps between forms of VHI. For this reason, we use only two terms: substitutive VHI , and supplementary VHI .
WTZ	<i>Wet op de Toegang tot Ziektekostenverzekeringen</i> . Dutch scheme to ensure that those excluded from ZFW insurance are able to purchase a similar level of substitutive cover.
ZFW	<i>Ziekenfondswet</i> . The social insurance element of the so-called second compartment of the Dutch health insurance system. It applies to acute medical care and is mandatory for those earning below an income threshold.

¹ Rubin, R. and Mendelson, D. (1995) A framework for cost sharing policy analysis, in N. Mattison (ed.) *Sharing the Costs of health: A Multi-county Perspective*. Basle: Pharmaceutical Partners for Better Health.

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APPENDIX

HEALTH POLICY CONSENSUS GROUP DRAFT CONSENSUS STATEMENT

As the NHS Plan begins: “The NHS is the public service most valued by the British people”. But as it goes on: “Despite its many achievements, the NHS has failed to keep pace with changes in our society”. The public now clearly feels that the NHS does not live up to its expectations — a truth that politicians recognise across the political spectrum, but which they refuse to acknowledge publicly.

Rationing, waiting times, delays in introducing innovative technologies, the poor state of many facilities, shortages of doctors, nurses and equipment and a lack of choice all combine to mean that the NHS fails to provide its most basic requirement - universal access to a standard of care that is taken for granted in other comparable countries.

But although there is now widespread agreement about the NHS’s deficiencies, there is no corresponding consensus about the changes necessary to improve health care in Britain. Thoughtful debate on health policy in the UK is paralysed by party politics. The purpose of the Health Policy Consensus Group is to encourage a new cross-party consensus by suggesting a series of guiding principles that will assist policymakers and members of the public in considering how to move towards a responsive, consumer-driven and high quality healthcare service.

GUIDING PRINCIPLES

The key to reform is to put the patient first. All else stems from this concern.

1. ACCESS FOR ALL

The basic building block of any reform must be ready access for all patients to a government guaranteed high standard of care. Every country is wrestling with how to achieve this end and many have discovered alternative methods which have secured a more responsive and demonstrably higher quality service than that provided through the NHS. None provide a ready-made blueprint but we should be willing to learn from their experiences.

The success of any alternative model will depend on its ability to deliver a standard of care to everyone that is markedly superior to that available today through the NHS.

2. CHOICE & DIVERSITY

Public sector monopolies make it hard even for well-motivated staff to put patients first. As the NHS Plan puts it: “The relationship between service and patient is too hierarchical and paternalistic. It reflects the values of 1940s public services.....The patient’s voice does not sufficiently influence the provision of services”. Staff frequently find that they cannot provide the service they would like. As in almost every walk of life, consumer choice is an essential tool for improving standards of healthcare, the relationship between clinician and patient, and professional autonomy.

A system based upon genuine consumer choice would generate a more attractive range of options for health coverage, available to a wider range of people. Diversity is, of itself, a spur to innovation and improvements in standards. If the existing public sector near-monopoly of healthcare provision were to be ended, a diverse mix of government, private not-for-profit and for-profit healthcare services would be generated, reinvigorating the under-developed health sector of civil society. Health policy should leave communities free to experiment with different funding solutions and public-private partnerships for providing health care, utilising local resources to solve unique community problems.

In order to develop a more responsive service, government policy should be to expand, without dictation or distortion, the opportunities for everyone to make responsible choices in both the financing and provision of their medical care.

3. FUNDING

The NHS is funded predominantly from general taxes. Typical overseas systems rely on a mix of social or private insurance, out-of-pocket payment and general, local or hypothecated taxes. We should be open-minded and willing to examine other systems to see what we can learn from them.

We take it as axiomatic that all members of society should enjoy access to a higher standard of care than is generally provided by the NHS and that, consequently, a guaranteed package must be defined and made available to everyone from taxes. But health care should not be funded by taxation alone. For care over and above the state-guaranteed package, individuals should be free to spend their own earnings as they believe best.