Dalhousie Law Journal

Volume 20 | Issue 2 Article 9

10-1-1997

A Comparative Analysis of the Reforms in EuropeanHealth Care Systems

Thomas Rathwell
Dalhousie University

Thomas Rathwell*

A Comparative Analysis of the Reforms in European Health Care Systems

Most countries in Europe are at various stages in the process of reforming their health care systems. Instead of different and more diverse systems emerging, the health reform process has resulted in a convergence on "managed competition" as the only acceptable means for delivering health care. After briefly describing the historical context, this paper examines the nature and scope of the reform process in Europe. The major features of the reforms are cost-containment and a reduction in the role of the state. There have been few systematic attempts to measure the extent to which expectations are being realized. The paper concludes with an assessment of the likely effects of "reforms" on the health care map of Europe.

La plupart des pays européens se trouvent à des étapes différentes du processus de réforme de leurs systèmes de santé. Au lieu de développer de nouveaux systèmes, le processus de réforme s'est concentré sur la «concurrence dirigée», comme seul moyen acceptable capable de sauver les systèmes de santé. Après une présentation du contexte historique, la nature et la portée de la réforme en Europe sont décrites. Les caractéristiques dominantes des réformes semblent être de limiter les coûts et diminuer le rôle de l'état. Il y a eu peu de tentatives pour mesurer le degré de la réalisation des attentes. En conclusion, l'article présente une étude sur les implications que pourraient avoir de tels changements sur les systèmes de santé en Europe.

Introduction

Health care reform is not just an European phenomenon. Everywhere countries are re-examining and reviewing the underlying objectives of their health care systems with the purpose of creating a different approach capable of delivering efficient and effective health care to all. Within Europe the impetus for health care reforms arises from a variety of factors. They include:

- demographic - a combination of population growth rates, an increasing and aging dependent base (people aged 65 and over) and a shrinking producer base through rising unemployment and/or underemployment;

* Dr. Thomas Rathwell is Director of the School of Health Services Administration, Dalhousie University.

- morbidity - as populations age and medical advances continue a greater proportion of health care resources is being devoted to chronic health care problems;
- economic - a shrinking economy and its effect on the public sector deficit is restricting the ability, and in some cases the will, of governments to maintain expenditure on social welfare programmes, including health care;
- technological developments - greater public awareness and expectations of the benefits of medical care which, along with the health - related aspects of the recession, have given rise to an increase in demand for health care; and
- cost escalation - collectively, the above factors have contributed to an increase in spending on health care. Health sector inflation in most European countries exceeds the average retail price index which, in turn, has led to severe cost escalation.[1]

Thus most governments have reacted by seeking ways to curtail or reduce health services expenditure or both.

In central and eastern Europe there is an additional factor behind the reforms. It is the process of political reformation following the collapse and fragmentation of the old Soviet system under which countries seek to move from a centralized and highly rigid economic and political structure to one that is essentially pluralistic. As a result, governments in central and eastern Europe have embarked on a search for a new and different structural paradigm for their health care systems.

The thesis advanced in this paper is that the health care reform process, rather than leading to greater structural diversity across Europe, has produced the opposite: a propensity for health systems reforms to coalesce around the central tendency of the "health care market" or, more precisely, "managed competition."

This paper begins by describing briefly the historical context which, for the purpose of discussion, is taken to be pre-1989. It then explores, in general terms, the various processes being pursued and their underlying rationale. Finally there is an assessment of the emerging paradigm, managed competition, and its implications for health care in Europe.

---

1. A. Green, *An Introduction to Health Planning in Developing Countries* (Oxford: Oxford University Press, 1992); R. B. Saltman & J. Figueras, eds., *European Health Care Reforms: Analysis of Current Strategies*, European Series No. 72 (Copenhagen: World Health Organization, Regional Office for Europe, 1997) See in particular, chapter 1, "The Pressures for Reform."

I. *A History of Divergence*

The health care systems in Europe have, in many respects, been as varied as the number of countries, though it is possible to group the various country - specific systems according to three general and not mutually exclusive models: Beveridge, Bismarck and Semashko.[2] Table 1 shows the countries of Europe classified according to their type of health care system as of 1989. The main characteristics of each are outlined.

Beveridge - type health care systems or national health systems owe their name to Sir William Beveridge, generally acknowledged as the founder of the British National Health Service. They are financed through taxation, their infrastructure is owned by the state and their operational policies determined by the state. There is universal free access to care. Services are managed and delivered for the most part by state employees, doctors are either salaried employees or paid on the basis of capitation fees, and most hospitals operate with an overall global budget or cash limit.

Bismarck-type health care systems or health/social insurance systems are rooted in late nineteenth century German social legislation introduced by the then Chancellor, Otto von Bismarck. In these systems health care is financed through compulsory contributions by employers and employees. Funds are managed by non-governmental, non-profit agencies established by statute for the purpose, and state regulations set the parameters in which the agencies operate. These agencies, or 'sickness funds' as they are often called, negotiate with hospitals and other providers a 'budget' for services to be provided. The providers (hospitals) are independent with many, but not all, not-for-profit. Health workers are not state employees and most physicians are paid on a fee-for-service basis.

Semashko health care systems or centralized health systems are the dominant model for those countries of central and eastern Europe once under the economic control of the former Soviet Union. This model of health care incorporates the ideas of Semashko, a physician during the early Soviet period who is credited with the development of free medical care operating under tight central control. It has many similarities to the Beveridge model but also has important differences. In essence, the key features of the Semashko model are financing from the state budget, centralized planning and control of all aspects of the health system, and

---

2. B. Majnoni d'Intignano, "Financing of Health Care in Europe" in C. Artundo, C.Sakellarides & H. Vuori, eds., *Health Care Reforms in Europe* (Copenhagen & Madrid: World Health Organization, Regional Office for Europe & Ministry of Health and Consumer Affairs, 1993) [hereinafter *Health Care Reforms in Europe*] at 33-55.

free access for all. Facilities are owned by the state, all employees are salaried, and there is no private health sector.[3] It is these latter two elements in particular which distinguish the Semashko model from the Beveridge.

It should be noted that notwithstanding the features specific to each type, there is much variation between the countries listed under each model heading. For instance, it is not uncommon to find countries which have a health/social insurance system, to have part of the financing of the system come from general taxation, instead of being wholly reliant on income-related contributions.[4] Moreover, even in national heath system countries, user charges or co-payments for services such as dental care and pharmaceuticals are often required for an essentially free service. Nonetheless, despite these variations affecting the 'purity' of the models, they all share a common concern. The perception among politicians and much of the general public is that they have not been successful in creating and maintaining a significantly healthy population.[5] Table 2, drawing on selected health indicators, indicates that there is some variation among the countries of Europe and that this variation exists not only between the health system models but also within each model.

A crude and over-simplistic interpretation of the table suggests that countries with the Bismarck model are marginally better that those with the Beveridge model at protecting and improving the health of their population, but this appears to come at an overall higher cost as measured by gross domestic product (GDP). One of the factors contributing to the higher cost of Bismarck type health care systems is that their pluralistic nature results in greater transaction costs. The table also implies that the efficiency and effectiveness of the Semashko model in improving health status is considerably less than the other two types. This may be due in part to the lower proportion of GDP, on average, that these countries devote to health care costs.[6]

---

3. Although no private sector existed, most people were accustomed to making 'under the table' payments, particularly to physicians, for routine treatment as well as for enhanced care. See V. Borissov & T. Rathwell, "Heath Care Reform in Bulgaria: an initial appraisal" (1995) 42 Soc. Sci. & Med. 1501.

4. OECD, *The Reform of Health Care: A Comparative Analysis of Seven OECD Countries*, Health Policy Study No. 2 (Paris: OECD, 1992).

5. This is the common message emerging from a variety of studies of health reform. See C.J. Ham, R. Robinson & M. Benzeval, *Health Check* (London: King's Fund Institute, 1990); OECD, *The Reform of Health Care Systems: A Review of Seventeen OECD Countries* (Paris: OECD, 1994); *supra* note 4.

6. Space does not permit an in-depth discussion of the various means of financing health care. For a detailed analysis of these from a European context, see Saltman & Figueras, *supra* note 1 at 79-202.

II. *The Road to Reform*

The views of all the countries with Beveridge and Bismarck models of health care is that their particular health systems face persistent problems in the financing and delivery of health care.[7] These problems, it would appear, arise from remedial design flaws in the financing, payment and regulation of the systems, in conjunction with inefficiency and poor performance.[8] Consequently, most governments in western Europe have taken a political decision to reform their respective health care systems. In central and eastern Europe health care reform is but one aspect of the fallout arising from the collapse of state socialism and the desire by the countries concerned to introduce systems designed to emulate those of the established market economies. Dependence on financial support and aid from the World Bank, the European Union and country specific donors inevitably have pushed central and eastern European countries towards a more pluralistic economic approach, and this is especially the case for health sector reforms.[9]

Geographically, health system reform in Europe is a tale of two halves: the countries of western Europe undertaking essentially strategic structural adjustments to established systems; and, the countries of central and eastern Europe carrying out wholesale changes to their health care systems. In short, western European countries are re-modelling their health care systems, whereas the countries of central and eastern Europe are re-designing and re-building theirs. Re-modelling, in this context, means that governments, though generally satisfied with the overall structure, believe that renovations to particular components will yield substantive benefits to the health care system. Re-designing and re-building means a more radical change is in order, with governments seeking ways to create a health care system very different from the one which they inherited.

Among western European nations a variety of measures have or are being introduced, most of which introduce competition into previously centralized systems (Beveridge type) or strengthen the forces of competition in pluralistic systems (Bismarck type.) A common feature of the

---

7. B. Able-Smith, *Cost Containment and New Priorities in Health Care: a Study of the European Community* (Aldershot: Avebury Ashgate, 1992).
8. OECD, *supra* note 4.
9. T. Ensor, "Health System Reform in Former Socialist Countries of Europe" (1993) 8 Int. J. Health Plann. & Management 189; World Bank, *Investing in Health*, World Development Report (New York: World Bank/Oxford University Press, 1993); C. Collins, D. Hunter & A.Green, "The Market and Health Sector Reform" (1994) 8 J. Manag. Med. 42; C. Collins, A.Green & D.Hunter, "International Transfers of National Health Service Reforms: Problems and Issues" (1994) 344 Lancet 755.

reforms taking place in Beveridge - type health care systems is the stated desire to retain the universal, comprehensive, tax - financed base. What has changed is the way in which health care is organized and delivered. Competition is seen as the key to improved efficiency, although the concept of competition varies from country to country.

In many of the Beveridge health care systems, the key to the reform process is the 'purchaser provider split'. There are many variations of this concept, but in essence, it requires the creation of two agencies in which one (the purchaser or budget holder) negotiates a contract with the other (the provider of a service or services). In this approach, the purchaser, usually the health authority (United Kingdom) or the local authority (Nordic countries), is no longer responsible for the direct delivery of health care and instead is given an allocation or operating budget with which to buy health care from a variety of providers. Providers are hospitals and others who compete for funds from purchasers and may be either publicly or privately owned. This form of provider or supply-side competition is at its most advanced in the United Kingdom, but Finland, Italy, Spain and Sweden are experimenting with similar mechanisms.[10]

A fundamental feature of the reforms is the introduction of greater patient choice. This takes a variety of forms ranging from changes to the mechanism for paying general practitioners through increased capitation payments (Denmark, United Kingdom), to performance—related pay (Finland, Sweden), to linking hospital income to the ability to attract patients (Sweden). The common element in all of the schemes is the notion of competition. As Saltman observes, it is the use of "private market incentives to change hospital and physician behaviour to improve productivity, efficiency and responsiveness to patients."[11]

A variety of reforms are taking place in Bismarck health care systems. Although they may appear to be less radical than the reforms in Beveridge and Semashko systems, they are no less fundamental. Bismarck - type systems are concerned with strengthening cost control or cost containment measures or both, through the introduction of tighter or tougher regulations, providing a more visible and central role for government, or

---

10. E. Tragakes & M. Vienonen, "Health Care Reforms on the European Scene" (Paper presented to the joint WHO(EURO) at the IGSF Workshop on Assessment of the Productivity, Efficiency and Quality of Health Care Systems, Kiel, 22-25 November 1994); *Health Care Reforms in Europe, supra* note 2; C. Ham, "The Background" in C. Ham, ed., *Health Care Reform: Learning from International Experience* (Buckingham: Open University Press, 1997) [hereinafter *Health Care Reform*] at 1-20.

11. R. B. Saltman & C. von Otter, *Planned Markets and Public Competition* (Buckingham: Open University Press, 1992) at 123.

enhancing existing competitive measures by improving customer choice. For example, Belgium has concentrated on controlling expenditure through greater government involvement (regulation) and the requirement that insurers now negotiate directly with providers over fees and charges.[12] Germany has attempted to contain costs by replacing the fee for service system with capitation and service level payments and by making it easier for individuals and organizations to change sickness funds.[13] The Netherlands has opened the health care system to greater competition; providers compete for insurance funding, and insurers (both private and public) compete for insurees thus enhancing customer choice.[14]

These changes parallel those occurring in Beveridge health care systems. They differ because they require little or no structural change to implement since many of the reforms are concerned with strengthening regulatory measures. As a result they are less visible than the health sector reforms elsewhere in Europe.

III. *The Health Care Market*

In many respects the introduction of market mechanisms into the health care systems of Europe stems as much from the prevailing ideology of the 1980s, as it does from perceived inherent weaknesses in their health care systems. This dogmatic approach to social policy development can be traced to the influence of a number of economists, primarily American, who argue that excessive bureaucracy and overtly interventionist government stifle economic development and directly contribute to inefficient and ineffective social policies.[15] The market approach is judged to be a better mechanism for regulating the delivery of health care because of factors such as competition between providers and purchasers, public choice of providers, and individual responsibility.[16] Thus the discipline inherent in market mechanisms is seen as being the preferred prescription for treating the diagnosed ills of national health care systems.[17]

---

12. *Supra* note 7.
13. F. W. Schwartz & R. Busse, "Germany" in *Health Care Reform, supra* note 10 at 104-118.
14. *Health Care Reforms in Europe, supra* note 2; Tragakes & Vienonen, *supra* note 10; A.deRoo, "Contracting and Solidarity: Market-Oriented Changes in Dutch Health Insurance Schemes" in R. B. Saltman & C. von Otter, eds., *Implementing Planned Markets in Health Care* (Buckingham: Open University Press, 1995).
15. M. Friedman & R. Friedman, *Free to Choose* (New York: Harcourt Brace Jovanovich, 1981).
16. Collins, *supra* note 9.
17. A. Enthoven, *Reflections on the Management of the National Health Service* (London: Nuffield Provincial Hospitals' Trust, 1985); A. Enthoven, "Managed Competition in Health Care and the Unfinished Agenda" (1986) Annual Supplement, Health Care Financ. Rev., 105-119.

The acceptance by many politicians of the views of free-marketers such as Friedman, coupled with the necessity of containing public expenditure, led countries such as Britain and the Netherlands, in particular, to introduce elements of competition into their health care systems. The rationale for this radical change was the belief that the discipline associated with having to compete for patients and resources would result in greater efficiency. A form of managed competition was introduced. Managed competition seeks "to appropriate the benefits of increased efficiencies in health care provision emerging from competitive mechanisms, into an altered framework of publicly operated health care systems."[18] While the ownership of the health care system has not changed in western Europe, competition is now used to maximize services and benefits for a given level of resource. In central and eastern Europe a different set of factors has pushed countries towards a more mixed economy of health care facilities, in which competition is a key feature.[19]

Two types of managed competition appear to have emerged: mixed markets, and public competition.[20] In mixed market form of managed competition, both publicly and privately owned institutions (providers) compete for custom. Institutions compete for contracts to provide a specified range or type of service or both. The contracting process is based on "real" prices (the actual cost to the provider of the service), and contracts are subject to monitoring by the purchaser and may be open to re-negotiation. Patients are essentially passive players in this process as services are purchased on their behalf, and providers generally are accountable only through the contract process. Their power remains largely intact and providers are able to exert considerable influence on the contracting process.[21]

There are a number of features of public competition. One is that providers are organized as "public firms": namely, they are publicly or state owned and are able to operate much like a private firm. They can establish their own organizational structures, negotiate salaries and conditions of service for their employees and determine the range and scale of services they wish to provide. The state (in theory) generally plays a minimalist role vis-à-vis these institutions. Patient choice determines the budgets of these "public firms" and, consequently, the salaries paid to employees. The institutions compete for patients but, unlike the

---

18. Tragakes & Vienonen, *supra* note 10 at 19.
19. Saltman & Figueras, *supra* note 1 at 5-38; G. Zarkovic et al., *Reform of the Health Care Systems in Former Socialist Countries: Problems, Options, Scenarios* (Neuherberg: Institut fur Medizinische Informatik und System Forschung, 1994).
20. See Saltman & von Otter, *supra* note 11 for a more complete discussion of these concepts.
21. *Supra* note 11.

mixed market model, money follows the patient. Thus to be successful, "public firms" must pay particular attention to customers' preferences. Failure to do so could lead to severe financial consequences. Another crucial feature of public competition is the role of politicians. Politicians become guardians and facilitators of the system. The responsibility of politicians is threefold: to establish the pricing systems for remunerating providers; to monitor the implementation of the policy through public opinion; and, to retain control over large scale capital investment in the health system.[22]

It is difficult, if not impossible, to characterize the health care reforms in one country or another as either of the mixed market or public competition archetypes. However, developments in Britain[23] and to some extent the Netherlands[24] are said to epitomize the mixed market approach, whereas developments in Denmark and Sweden[25] are more akin to the public competition model.[26] Whatever the version being pursued, it is evident that the changes occurring in health care systems throughout Europe are moving those systems towards a form of managed competition,[27] and thus are an important factor in the apparent convergence of health systems.

IV. *Converging Tendencies - The Development*

Two general trends in health systems reform can be discerned: increasing pluralism allied with the introduction or expansion of market mechanisms; and, the shift from a wholly collectivist and universal tax-based funding of the health system towards a form of health insurance and its associated emphasis on individual entitlement. In western Europe, re-

---

22. *Ibid.*

23. See H. Glennerster, "Internal Markets: Context and Structure" and A. Maynard, "Internal Markets and Health Care: A British Perspective" in M. Jerome-Forget, J. White & J. Wiener, eds., *Health Care Reform Through Internal Markets: Experiences and Proposals* (Montreal & Washington: The Institute for Research on Public Policy and The Brookings Institute, 1995) at 17-25 and 27-47 for an interesting and, at times, contradictory view of health care markets in Britain.

24. W.P.P.M. van de Ven & F. Schut, "The Dutch Experience with Internal Markets" in Jerome-Forget et al, eds., *ibid.* at 95-117.

25. C. Rehnberg, "The Swedish Experience with Internal Markets" in Jerome-Forget et al., eds., *ibid.* at 49-73.

26. C. Ham & C. Brommels, "Health Care Reform in the Netherlands, Sweden and the United Kingdom" (1994) 13 Health Affairs 106-119; A. Anell, "Implementing Planned Markets in Health Care: the Case of Sweden" in Saltman & von Otter, *supra* note 11 at 209-26.

27. Tragakes & Vienonen, *supra* note 10.

forms largely embrace the first trend, whereas in central and eastern Europe both trends are key features of health sector reform.[28]

Table 3 outlines the main characteristics of the reforms being introduced into Beveridge -type health care systems. Although a wide variety of measures are evident, a common pattern can be detected: the market oriented nature of the reforms. In Denmark, for example, the key elements of health system reform are decentralization, competition, and public choice. In other words, the introduction of specific market mechanisms into the health care system. Indeed, in one form or another, this is feature of the health reforms in Finland, Greece, Italy, Portugal, Spain, Sweden and the United Kingdom. Two exceptions to the trend appear to be Ireland and Norway, both of whom have tightened rather than relaxed central control. [29]

Few Beveridge - type countries have sought to widen the financial base for health care. In the past, prior to health care reforms, Ireland and Portugal encouraged their citizens to take out private health insurance as an alternative or supplement to the state - funded health system. Other countries have been reluctant to shift the cost of health care more directly onto the individual. Recently though, Ireland has sought to transfer part of the responsibility for health care onto the individual through an increase in user charges or fees. The increase in user fees, however, has been counter-balanced with an extension in coverage by the national health system, thus lessening the dependency of the individual on voluntary private health insurance. The issue of user fees and co-payments is returned to below.

It is evident from Table 3 that different aspects of the market are being applied in different countries, with many increasing or enhancing the pluralistic nature of the health care system. This trend is being pursued in Greece, Italy, Ireland, Portugal, Spain and the United Kingdom. In the remaining countries, Denmark, Finland, Norway and Sweden, the agencies providing health care are solely located in or financed by the public sector. A feature that is common to most of the countries in Table 3 is the introduction of policies and mechanisms to promote patient choice and competition between providers. The preferred procedure in the United

---

28. T. Ensor, *supra* note 9; G. Zarkovic et al., *supra* note 19.

29. There is considerable debate in the literature about whether or not market mechanisms have led to greater decentralization or re-centralization of the health care system. See R. B. Saltman, "Patient Choice and Patient Empowerment in Northern European Health Systems: a Conceptual Framework" (1994) 24 Int. J. Health Serv. 201-229 [hereinafter "Patient Choice"]; see also "Reorganizing the System: Decentralization, Re-centralization and Privatization" in Saltman & Figueras, eds., *supra* note 1 at 43-58 for an informed discussion of the issues.

Kingdom is the introduction of competition between service suppliers for health sector funds—the ubiquitous purchaser provider split.[30]

Sweden is the country most associated with public competition, whereas the United Kingdom is the vanguard for the mixed market. While there have been a number of experiments in contracting out elements of the public health services to private providers in Sweden,[31] it is the transformation of hospitals into public firms which has generated particular interest. The hospitals remain publicly owned but instead of receiving an annual budget from a county council they earn their revenue through contracts with primary care providers (who have been given responsibility for purchasing hospital services for their patients), and from patients exercising their preferences. Patients can determine the hospital to which they will be referred and these referrals directly affect the hospital's operating budget, since the budget is directly tied to the number of patients they treat. [32]

The health care reform processes implemented in Bismarck - type health systems complement those in the Beveridge type systems. The changes in the Bismarck systems (Table 4) are primarily designed to enhance the pluralistic nature of the systems and to strengthen existing competition between suppliers. An interesting feature of these reforms is the tendency to introduce a variety of regulatory procedures or mechanisms designed to control or curtail some of the adverse aspects of competition. Many of the new measures are directed at cost containment with governments assuming a greater degree of control or influence than previously.

An example of new cost containment measures is fixed national budgets for hospitals in Belgium along with efficiency measures which penalize hospitals for the under-utilization of specialist services.[33] In Germany, hospitals now receive a negotiated budget based on the previous year's activity. In 1995 this negotiated budget was replaced by a system of payment by diagnosis. The government's aim is to have strong sickness funds competing for members, and it is providing incentives to encourage the funds to amalgamate.[34] The move to paying

30. C. Ham, "The United Kingdom" in *Health Care Reform*, *supra* note 10.
31. *Supra* note 11.
32. R. B. Saltman, "Competition and Reform in the Swedish Health System" (1990) 68 Milbank 597-618; "Patient Choice", *supra* note 29; C. Rehnberg, "Sweden" in *Health Care Reform*, *supra* note 10.
33. B. Able-Smith & E. Mossialos, "Cost Containment and Health Care Reform: a Study of the European Union" (1994) 28 Health Policy 89-132.
34. *Ibid.*

hospitals by diagnosis and the introduction in 1996 of an annual free market between sick funds suggests that in Germany, competition is seen as the best mechanism for constraining health care expenditure.[35]

France has pursued a strategy of cash - limited budgets for public hospitals, introduction of budget caps for certain expenditures in private hospitals, the closure of under utilized beds in both public and private hospitals, and an increase in the contribution paid by the public for health care services.[36] The French health care system, of all the Bismarck types, probably is the most liberal and market - oriented as patients have freedom of choice of a general practitioner. There are few restrictions on where a doctor can set up practice, and the majority work in private practice. There is also strong competition for patients between the public and private hospital sectors.[37] The French reforms have concentrated on improving hospital efficiency, containing expenditure on health care, and rationalizing the provision of public and private services. The French, unlike some of their European counterparts, have not chosen to address some of the inherent operational and managerial issues associated with leaving the liberal and pluralist aspects of the system unchecked.[38]

Regulatory cost containment measures introduced over the years by successive governments in the Netherlands have not been very effective. The Dekker Committee, set up to review the Dutch health care system, attributed the failure of such measures to the existence of few incentives to improve the efficiency of the services, a fragmented financing system for health care, and very poor coordination between providers and purchasers.[39] Thus with the publication of the Dekker Committee report, and the subsequent report by the Dunning Committee,[40] the Dutch government began to explore ways of restructuring the health care system.

The Dekker report had at its core the twin objectives of encouraging and enhancing competition between and within the insurance and provider markets. The proposal for one basic health insurance package for everyone, paid for by income-related premiums, was central to the

---

35. F. W. Schwartz & R. Busse, "Germany" in *Health Care Reform, supra* note 10.
36. *Supra* note 33; S. Bach, "Health Care Reforms in the French Hospital System" (1993) 8Int. J. Health Plann. & Management 169-87.
37. Bach, *supra* note 36.
38. *Ibid.*
39. The Dekker Committee, *Changing Health Care in the Netherlands* (Netherlands: Ministry of Welfare, Health and Cultural Affairs, 1988).
40. The Dunning Committee, *Choices in Health Care: A Report by the Government Committee on Choices in Health Care* (The Hague: Ministry of Welfare, Health and Culture, 1992).

achievement of these objectives. Coverage for health care outside the basic package could be obtained through voluntary supplementary insurance. These and the other reforms outlined by the Dekker Committee encountered strong political opposition as the government pursued their implementation. In response the government established the Dunning Committee which published its report in 1992.[41] The Dunning Committee, in essence, endorsed the market - oriented approach outlined in the Dekker Report, but went further by articulating a set of criteria which would govern which services would be classified as being part of the basic package and which would not. At the present time the reforms described by both the Dekker and Dunning Committees are bogged down in the labyrinthine Dutch policymaking process with no clear indication of the tone or nature of the outcome.[42]

The reasons underlying the health care reforms being pursued by the old Semashko countries are similar to those in the other types of health care systems in Europe (Table 5). The countries of central and eastern Europe differ from those of western Europe in that they are going through the painful (both economically and socially) process of redefining the role of the state in the aftermath of the collapse of state-socialism,[43] and the nearly wholesale dismantling of all manifestations of the now discredited previous system.[44] They are also under pressure from Western governments, donor agencies and global organizations such as the World Bank to introduce market economies and decentralize the public sector.[45]

The nature, speed and implementation of the reform of the health care system in central and eastern Europe varies from county to country, a legacy of each country's different and, in some cases, faltering approach to the transition from state socialism.[46] A further fundamental factor which has inhibited the reform process in some countries and distorted it in others is the economic crisis which has accompanied and often

---

41. *Ibid.*

42. C. van Etten & G. Okma, "Health Care Reforms in the Netherlands" in Artundo et. al. eds., *supra* note 15; W.P.P.M. van de Ven, "The Netherlands", in Ham, ed., *supra* note 10.

43. A. Preker & R. Feacham, *Searching for the Silver Bullet: Market Mechanisms and the Health Sector in Central and Eastern Europe* (Washington: The World Bank, 1995).

44. G. Moon, "The Territorial Restructuring of State Socialist Health Care Systems: The Case of the Czech Republic" (Paper presented to the Sixth International Symposium on Medical Geography, 1994) [unpublished].

45. P. Musgrove, "Investing in Health: The 1993 World Development Report of the World Bank" (1993) 27 *Bulletin of the Pan American Health Organization* 284; Collins et al., *supra* note 9.

46. Zarkovic et al., *supra* note 19.

undermined the transition.[47] In spite of the differences in progress between countries, two clear trends can be discerned: first, a shift from comprehensive, universal, state - owned and state - financed health care towards a decentralized social/health insurance system based on a payroll tax and individual entitlements; and second, a move towards pluralistic and market - oriented replacement structure.[48] Table 5 outlines the main features of the health sector reforms being proposed or implemented in selected central and eastern European countries. The table clearly confirms the trends documented by Ensor,[49] although they are by no means universal, except for the introduction of varying forms of insurance - based funding measures. Thus, the health system model which most countries are considering or in the process of implementing is primarily Bismarck in construction.[50]

These general trends apart, there are some significant differences in the various models of health care being developed in central and eastern Europe. Some countries such as Belarus are following the model pioneered in St Petersburg which gives a global budget based on capitation to the polyclinics[51] who operate much like fundholders[52] in Britain whereby they pay the hospitals for treating those patients which they refer. It appears that few countries are adopting the St Petersburg model; indeed, developments in St Petersburg indicate that the polyclinics will no longer be purchasers of hospital care.[53] Polyclinics, which were an important feature of the Semashko model, are now not regarded as being a particularly useful form of providing primary care. Several countries such as Bulgaria, Latvia, Romania and Russia are seeking to introduce a British style of general practice where people register with a particular doctor who is remunerated partly by capitation fee and partly by fee-for-service payments. The objective is to encourage the establishment of family-style medicine where the doctor knows the patients and the patients know the doctor. In Russia, for example, polyclinics were paid

47. "Rejoined: A Survey of Eastern Europe" *The Economist* (13 March 1993) 11.
48. Ensor, *supra* note 9.
49. *Ibid.*
50. Zarkovic et al, *supra* note 19.
51. J. Roberts, "Winter in Leningrad" 100 Health Serv. J. 18 at 19.
52. "Fundholders" is the term used in Britain to describe those general practitioners who have applied for and received practice budgets with which to purchase non-emergency secondary and tertiary care services for those patients registered with the practice. For a detailed discussion of Fundholding, see H. Glennerster, H. Matsaganis & P. Owens, *Wild Card or Winning Hand? Implementing Fundholding* (Milton Keynes: Open University Press, 1994).
53. S. Curtis, N. Petukhova & A. Taket, "Health Care Reforms in Russia: The Example of St.Petersburg" (1995) 40 Soc. Sci. and Med. 755 at 765.

on the basis of their potential capacity, physicians were salaried, and tended to refer patients to the hospitals instead of treating them in the polyclinics. The doctors in the polyclinics were specialists, not generalists in the tradition of western general practitioners. Thus the treatment given and the care offered was often off-hand and impersonal, the opposite of the general practitioners model.[54]

Co-payments or user fees are a major feature of the new health care systems. This may in part be in response to the dire economic situation in central and eastern Europe. It may also be a recognition that 'baksheesh' — under the table payment to facilitate treatment — is common place in most countries of central and eastern Europe. Introducing user changes is just making legitimate what was previously illegal.

A further interesting feature of the health systems reforms in central and eastern Europe is that with few exceptions, the changes are either indicative of the mixed market model or the public competition model. Albania, Belarus, the Czech Republic, Latvia, Poland and Romania are introducing reform measures that seek to introduce supply-side competition. The reforms taking place in Bulgaria, Macedonia and Slovenia seem to emulate aspects of the public competition model, especially the emphasis on competition for patients. There are a few countries such as Estonia, Hungary and Russia which appear to be introducing elements of both forms of managed competition.

V. *Converging Tendencies - The Implications*

A common feature of the health systems reforms in Europe is the introduction or strengthening of competition. A basic premise of the managed competition approach is that it will deliver more efficient and effective health care. Increased competition between hospitals or insurers for patients or customers, it is argued, will force them to become more efficient and also to improve quality by paying greater attention to patient needs. There are two inter-related aspects of the move towards demand-driven reforms which have major implications for health care. These are the move from prospective funding in the form of global budgets and capitation fees, to retrospective remuneration through competition based, fee-for-service payments, and the resulting impact that such changes will have on equity.[55]

---

54. A. Telyukov & D. Rowland, "A Soviet Health Care from Two Perspectives" (1991) 70 Health Aff. 71 at 86.

55. J. Ovreteit, "Values in European Health Care Markets: Choice, Equity and Competition" (1994) 4 Eur. J. Pub. Health, 294 at 300.

Changing to a form of remuneration which is grounded in competition, as already indicated, has certain attractions for governments; among these are greater consumer choice and a more efficient use of resources. However, this approach often leads to financial and geographical inequality and economic inefficiency.[56] Competition - based remuneration can have a number of negative and positive consequences. The benefits of competition have been discussed earlier. The difficulties include matters such as provider - induced demand which could result in unnecessary diagnostic and therapeutic procedures; adverse selection or "cream skimming" whereby insurers or providers or both continue to exclude high risk, high demand patients in order to minimize risks and maximize earnings or profits; the monopolistic tendency for providers to form strategic alliances or to merge, thus potentially benefiting from economies of scale while maintaining or increasing prices; the high cost of managing a more fragmented system; and the marketing costs associated with operating in a competitive environment.[57]

An even more fundamental flaw is that, in the health care market, the concept of consumer choice—the essence of competition—is unworkable. Consumers' knowledge of health and health care issues, it is generally agreed, is insufficient to enable them to make informed decisions.[58] Thus health care consumers are largely reliant on varied vested interests when it comes to making important decisions about health or medical care. Given this, and taking into consideration the constraints outlined above, there is a strong argument for governments to retain a major role in policy making. Introducing competition into health care does not absolve governments from the responsibility for regulating health and medical care practices and monitoring the quality of care available.[59] This issue will be returned to below.

Changing the basis of remuneration through competition also impinges upon equity. One of the most significant design features of both the Beveridge and Semashko health care systems was that both were comprehensive in coverage, universal in enrolment, and free at the point of delivery. Few Bismarck type health care systems are able to make this

---

56. *The Reform of Health Care, supra* note 6; S. Banoob, "Private and Private Financing-Health Care Reform in Eastern and Central Europe" (1994) 15 World Health Forum 329 at 334.
57. R. B. Saltman, "Thinking About Planned Markets and Fixed Budgets" in F. W. Schwartz, H. Glennerster & R. B. Saltman eds., *Fixing Health Budgets: Experience from Europe and North America* (London: J. Wiley, 1996).
58. Banoob, *supra* note 56; P. Shackley & A. Healey, "Creating a Market: An Economic Analysis of the Purchaser-Provider Model" (1993) 25 Health Policy 153 at 168.
59. Banoob, *supra* note 56; H. Maarse, State Intervention in Health Care: Aspects, Effects and Prospects [unpublished].

claim.[60] As health care systems become more pluralistic in nature and competitive processes determine service provision, the implications for equity could be profound.

As member states of the European Regional Office of the World Health Organization, all the countries of Europe have endorsed the principles of Health for All and, through an acceptance of the Regional Office's 38 targets, have agreed to be accountable for their performance.[61] Health for All is predicated on two core concepts: equity and health gain. Equity is defined in terms of reducing inequities within and between member states and is held to be a fundamental component of any health care system. Health gain, in the WHO context, is about adding life to years, adding years to life, and adding health to life.

Competition and cost-containment, or more precisely cost-shifting measures, threaten to undermine the Health for All concept. A feature of many health systems reform measures is to shift some of the cost of health care onto the consumer. A favourite is the introduction of, or increase in, co-payment or user charges. While it is true that such contributions do lead to improved cost-consciousness among the public, they do have a highly inequitable distributive impact.[62] So too do measures which seek to encourage health care customers to supplement through voluntary private insurance the package of benefits available from the compulsory or state - controlled scheme. Such measures are regressive as they discriminate mainly against those in greatest need. Moreover, as Tragakes and Vienonen note, "the growing use of voluntary insurance contributes to the risk of developing a two-tier health care system, particularly in situations where legislation does not clearly delineate the respective responsibilities and obligations of compulsory and voluntary health insurance."[63]

A further feature of the insurance - based health reforms in central and eastern Europe is that the new health care package often is no longer comprehensive in scope nor universal in coverage. The irony for many people in these countries is that benefits of the new system, unlike the old, are not available to all; people are excluded on the grounds of cost, eligibility and geography. In short, the new is far more inequitable than

---

60. Tragakes & Vienonen, *supra* note 10.

61. Regional Office for Europe, *Targets for Health For All: Targets in Support of the European Strategy for Health for All* (Copenhagen: World Health Organization, 1985); *Regional Office for Europe, Targets for Health for All The Health Policy for Europe* (Copenhagen: World Health Organization, 1992).

62. R. Evans, M. Barer & G. Stoddart, "The Truth About User Fees" (1993) 14 Policy Options 4; Tragakes & Vienonen, *supra* note 10.

63. *Ibid.* at 27.

the old ever was. The healthy benefit to the detriment of the sick, the wealthy are advantaged relative to the poor, with the consequence that the sick, if poor, are in double jeopardy.[64]

None of this instills great confidence that the reform process will lead to significant health gain (enhanced health status) for the population. This raises the fundamental question about the purpose of health systems reforms in Europe. The rationale for reform is not uniform for all countries but, the reforms seemed to have two key features: improved efficiency in the use of resources and greater customer choice of services, with competition regarded as the best vehicle for achieving these aims. The truism that the "proof of the pudding is in the eating," is very apposite with regard to the reforms. Tragakes and Vienonen[65] fear that the common overriding concern to control costs—focusing on "means"—inevitably has caused policy makers to lose sight of the real goal, the achievement of health gain. The end result may well be leaner, fitter and more efficient health care systems which, while greatly improving the health status of some—the affluent and the healthier members of society—nevertheless exacerbate inequities and diminish the health status of the rest of the population.[66]

Many of the health systems reforms taking place in Europe are founded on a minimalist role for the state. Certainly the reforms in Britain have been driven in part by an ideology that questions the effectiveness of state intervention.[67] It is a pattern which is being repeated throughout Europe as countries "reconsider the optimal public/private mix in health care."[68] The broad consensus in Europe that social justice linked with economic growth equalled prosperity, which gave rise to the welfare state, has been all but shattered by the recent economic slowdown. This has resulted in an increasingly strident political debate between those who advocate a rolling back of public responsibilities and those who argue for continuing high levels of social protection.[69] Many European countries currently have governments which are converts to the gospel of the market. They are advocates either on ideological grounds, or in the case of some central and eastern European countries, dependent upon international financial

64. *Ibid.*
65. *Ibid.*
66. For a detailed discussion on and related issues, see chapter 5 "Allocating Resources Effectively" in Saltman & Figueras, *supra* note 1.
67. M. Goldsmith & D. Willetts, *Managed Health Care: A New System For a Better Health Service* (London: Centre for Policy Studies, 1988).
68. J. Frenk, "Dimensions of Health System Reform" (1994) 27 Health Policy 19.
69. Tragakes and Vienonen, *supra* note 10.

support from agencies such as the World Bank to help them turn around their largely bankrupt infrastructure. They are therefore forced by necessity to follow a pre-determined path.[70]

Maarse in a review of the effects of state intervention on health care considers the likely impact of health sector reforms on the role of the state. His analysis leads him to conclude that it would be an "error to argue that health care reform is generally aimed at less government."[71] He cites two principal reasons in support of his position. The first is based on the assumption that a crucial if not the prime purpose of the reforms is to contain costs. In Maarse's view only through strong state intervention can the goal of cost containment be realized. Empirical findings clearly indicate that as the share of public expenditure on health care rises, per capital expenditure on health care declines,[72] and that efforts to reduce supply are more effective than those designed to curtail demand.[73] Secondly, the empirical evidence suggests that market forces are ineffective in containing costs. As Maarse asserts, in the marketplace sustained growth is what counts and not cost containment. Thus he concludes that the state has a fundamental role to play in health care and that the reform process should result not in *less* government but in *better* government.[74]

Maarse's argument is that the state must determine the policy dimensions within which the reform of the health care system takes place, a view endorsed by Saltman.[75] The overriding objectives of the reforms must be those which "protect solidarity and equity, and link the development of organizational and financial mechanisms to improvements in overall health status."[76] If the state is not prepared to make these a priority, it is most unlikely that the other important players in the health care system will step into the breach. One need look no further than the United States health care system for an example of this type of negative role model.[77]

Many of the health care reforms being introduced are based on an almost blind faith that the new approach will work.[78] Wholesale changes are undertaken without any attempt to set up procedures to monitor the effects, so absolute is this belief in the paradigm. There are very real

---

70. Collins, *et al.*, *supra* note 9.
71. Maarse, *supra* note 59.
72. U. Gerdtham, et al., "An Econometric Analysis of Health Care Expenditure: A Cross-Sectional Study of OECD Countries" (1992) 11 J. Health Econ. 63.
73. Able-Smith, *supra* note 7.
74. Maarse, *supra* note 59.
75. R. B. Saltman, "Balancing State and Market in Health System Reform" (1997) 7 Eur. J. Pub. Health 119 at 120.
76. Tragakes & Vienonen, *supra* note 10.
77. B. Kirkman-Liff, "The United States" in Ham, eds., *supra* note 10.
78. Collins et al., *supra* note 9.

dangers in such myopic policy making. All the available evidence which might suggest that the new reforms are either flawed or based on false premises, is, at best, ignored or, at worst, attacked as being irrelevant. In consequence, policies may be implemented which will do more harm than good. Whitehead, for example, argues that some of the policy changes designed to engender competition in the British National Health Service have been successful but only at a considerable cost in terms of both access and equity.[79]

Another consequence of adopting reform measures without careful evaluation is the replacement of the perverse incentives (said to be a feature of the old system) with a new set of such incentives. Collins et al.[80] cite contracts based on process targets, rather than on outcome targets. Another concern is that the focus of the health care system will shift towards efficient service delivery and away from the pursuit of health itself.

Perhaps the most disturbing feature of the ideology that has driven much of the reform, especially of Beveridge health systems, is the discounting of the high transaction costs associated with the reforms. In the Bismarck systems associated transaction costs may or may not be so great a factor. It appears, however, that few systematic attempts are being made to measure the extent to which expectations fit with reality.[81]

Conclusion

There are both advantages and disadvantages associated with the health systems reform measures. Many of the reforms are predicated on the grounds that what is being implemented will be better than what it replaces. Few procedures are being put in place to test whether or not this is true. In some of the central and eastern European countries, in particular the Czech Republic and Hungary, the financial impact has been particularly severe as a result of the switch from a centrally controlled and funded health care system to one based on health insurance founded on the notion of managed competition.[82]

---

79. M. Whitehead, "Who Cares About Equity in the NHS?" (1994) 308 Br. Med. J., 1284 at 1284-287.

80. Collins et al., *supra* note 9.

81. The debate about the progress of implementation and the effects of the health system reform process is addressed in some detail in chapters 7 and 8 of Saltman & Figueras, *supra* note 1.

82. Banoob, *supra* note 56.

The convergence of health systems reforms in Europe towards managed competition is predicated on the assumption that competition is the best vehicle for delivering efficient, high quality health care. Unfortunately, the market is not the perfect mechanism that economic theory suggests. Otherwise there would be no need for governments and other agencies to intervene through regulations to curb unacceptable aspects and practices. As Maarse eloquently argues, health reform should not be about reducing the role of the state but about changing the role of the state for the better.[83] There is limited evidence that this may be one feature of the health system reforms in western Europe,[84] though Collins and colleagues have their doubts.[85] The prime objective of the changes taking place in central and eastern Europe would seem to be lesser government, not better government involvement in health care. There is a very real danger that the drive towards deregulation, privatization and increased individual responsibility will not lead to better health care for all, but to a widening disparity between the affluent and the poor. Under managed competition, it seems that equity is being sacrificed for efficiency.

The hypothesis of this paper was that the various health system reforms being implemented in Europe are leading towards convergence in the form of managed competition. Ham undoubtedly is correct to state that one should not "exaggerate the extent of convergence,"[86] nevertheless, the wholesale embrace of managed competition as the only solution to the universal problem of Europe's under-achieving health care systems, may not produce the hoped -for panacea. Health care reform is too important to be subjected to the whims of ideological dogma.[87] If this short - sighted approach persists, the consequences could be tragic for health systems reforms.

---

83. Maarse, *supra* note 59.
84. Saltman, *supra* note 75.
85. Collins, *supra* note 9.
86. Ham, *supra* note 10 at 12.
87. In the World Health Organization publication, *European Health Care Reform* (1997), *supra* note 1, the penultimate chapter describes a model for effective implementation which, if followed, could assist countries in avoiding many of the pitfalls that hitherto have plagued health system reforms.

TABLE 1

TYPES OF HEALTH CARE SYSTEMS
(PRE-1989)

BEVERIDGE	**BISMARCKIAN**	**SEMASHKO**
'National health system'	'Social/health/insurance system'	'Centralized health system'
DENMARK	AUSTRIA	ALBANIA
FINLAND	BELGIUM	BULGARIA
GREECE	FRANCE	CZECHOSLOVAKIA
IRELAND	GERMANY	HUNGRY
ITALY	NETHERLANDS	POLAND
NORWAY	SWITZERLAND	ROMANIA
PORTUGAL		USSR
SPAIN		YUGOSLAVIA
SWEDEN		
UNITED KINGDOM		

TABLE 2

PERFORMANCE OF EUROPEAN HEALTH SYSTEMS SELECTED HEALTH INDICATORS

MODEL	POP PER PHYSICIAN[1]	HEALTH SPENDING[2] (% GNP)[3]	LIFE EXPECTANCY AT BIRTH[4a]	INFANT MORTALITY[4a]
BEVERIDGE				
DENMARK	358	6.30	76	7
FINLAND	380	7.82	76	5
GREECE	259	5.39	78	9
IRELAND	588	7.72	76	7
ICELAND	353	8.34		
ITALY	193	7.54	78	7
NORWAY	298	7.35	77	7
PORTUGAL	403	6.99	75	9
SPAIN	246	6.59	78	7
SWEDEN	393	8.79	79	5
UNITED KING.	667	6.11	77	5
BISMARCKIAN				
AUSTRIA	307	8.38	77	6
BELGIUM	267	7.50	77	6
FRANCE	387	9.40	77	7
GERMANY	312	8.73	77	6
NETHERLANDS	391	8.03	78	6
SWITZERLAND	299	7.52	78	6
SEMASHKO				
ALBANIA	729	4.0	73	27
BULGARIA	298	5.36	71	14
HUNGARY	248	5.95	69	16
POLAND	440	5.07	71	13
ROMANIA	531	3.87	70	23
RUSSIAN FED	241	1.41	68	20
CROATIA	486	_	72	9
SLOVENA	489	_	73	7
CZECH REPUB	324	5.94	71	7
SLOVAKIA	336	—	71	12
MACEDONIA	458	—	72	24
ESTONIA	319	3.62	69	16
LATVIA	330	3.87	69	7
LITHUANIA	255	3.58	70	7

1. Data is from 1994-1995; source: World Health Statistics annual as featured in G.T. Kurian, *The Illustrated Book of World Rankings* (Armonk, N.Y.: Sharpe, 1997).
2. Public health expenditures.
3. Data is from 1994-1995; source: Human Development Report as featured in Kurian, note 1.
4. Source: *World Health Report 1997: Conquering Suffering and Enriching Humanity: Report of the Director General* (Geneva: WHO, 1997).
4a. 1996 Data.

TABLE 3

HEALTH SYSTEM REFORM IN SELECTED BEVERIDGE-TYPE COUNTRIES MAIN FEATURES

DENMARK	➢ open competition between public hospitals ➢ patient choice of hospital via general practitioner referrals ➢ considering giving general practitioners budgets for purchasing non-emergency hospital services
FINLAND	➢ capitation based funding for local authorities ➢ detailed 5 year plans abolished ➢ competition between providers likely ➢ greater freedom of choice of personal general practitioner
GREECE	➢ restrictions on private hospitals removed ➢ governmental committee established to plan reform of health system
IRELAND	➢ income-related extended coverage of national health system ➢ increase in user fees/co-payments ➢ capitation payments replace fee-for-service
ITALY	➢ general managers and self-governing hospitals ➢ private hospitals reimbursed on fee basis from public funds ➢ teaching and specialist hospitals part funded by fees ➢ limited competition between hospitals
NORWAY	➢ pilot of DRG based funding for hospitals ➢ resource allocations to countries related to hospital performance ➢ greater central control over resources
SPAIN	➢ patient choice of general practitioner ➢ proposal for health areas to become purchasers ➢ public health units to become self-governing (autonomous) ➢ contracts with both public and private health sectors
SWEDEN	➢ experiments with productivity incentives for general practitioners ➢ experiments with productivity related and patient preferential funding for hospitals ➢ capitation funding for health centres
UNITED KINGDOM	➢ purchaser/provider split - contractual relationship ➢ competition among providers, public and private for needs based contracts ➢ general practice fundholders as purchasers of secondary care ➢ competition among general practitioners for patients ➢ re-imbursement via capitation, plus fee-for-service

TABLE 4

HEALTH SYSTEM REFORM IN BISMARCKIAN-TYPE COUNTRIES MAIN FEATURES

AUSTRIA	➢ focus on cost-containment and quality ➢ encourage growth of non-profit sector ➢ integration of health and social care areas
BELGIUM	➢ fixed national (global) budgets for hospitals ➢ stronger role for government in controlling expenditure ➢ insurers (mutualites) negotiate fees and charges with providers and share burden of cost-containment
FRANCE	➢ introduction of private insurance ➢ increase in user fees/co-payments ➢ hospital reform to give public hospitals similar benefits to private hospitals and subject latter to similar cost controls affecting former
GERMANY	➢ doctors to be paid by capitation and 'service complex' payment instead of fee-for-service ➢ sick funds allowed to pool risks to narrow differences in contribution rates ➢ incentives for sick funds to amalgamate ➢ annual competition for members
NETHERLANDS	➢ basic (national) compulsory universal insurance ➢ competition between private insurers and sickness funds ➢ central (government) control of contributors ➢ insurer led competition among providers ➢ risk-adjustment payments to insurers to reduce adverse selection
SWITZERLAND	➢ mandatory risk compensation payments among insurance companies ➢ capped increases in annual insurance premiums ➢ per diem charge for hospitalization ➢ move towards fixed annual budgets

TABLE 5

HEALTH SYSTEM REFORM IN SELECTED COUNTRIES IN CENTRAL AND EASTERN EUROPE MAIN FEATURES

ALBANIA	➢ right to free health care abolished - certain user charges allowed ➢ law on health insurance in preparation ➢ private health sector permitted
BELARUS	➢ national health insurance fund proposal ➢ per capita funding of polyclinics who pay hospitals for referrals ➢ fund holding general practitioners being considered
BULGARIA	➢ compulsory national health insurance fund - primarily payroll tax funded ➢ hospitals compete for patients and for contracts from insurance fund ➢ general practitioners paid by capitation and fee-for-service ➢ private health sector permitted
CZECH REPUBLIC	➢ general health insurance scheme funded by part taxation, part contribution ➢ privatization of most health care institutions ➢ fee-for-service and 'point scheme' re-imbursement ➢ free choice of physician and health care facility ➢ necessary care (undefined) covered by insurance scheme
ESTONIA	➢ regional sickness funds - payroll tax based ➢ universal entitlement with some co-payments ➢ local competition between providers ➢ national fee schedule
RUSSIA	➢ regional sickness funds (some support from centre) funded by payroll tax ➢ competition between hospitals, polyclinics ➢ mainly comprehensive with some restrictions (eg dental care)
SLOVENIA	➢ compulsory health insurance for basic services, payroll tax funded ➢ voluntary insurance for non-basic services ➢ private health sector encouraged ➢ competition for patients