Healthcare reforms in Europe: a snapshot of the changes

Not only non-harmonised and – under EU law – unifiable, the healthcare financing and reimbursement systems of the individual members of the EU are also prone to rapid change. No one system is the best, says Yvonne van Kemenade*, author of Healthcare in Europe 2007, but each tends to be shaped by the experiences and changes seen over the respective country's borders

European governments are seemingly engaged continually in rounds of healthcare reforms in a bid to address rapid growth in expenditure, lengthening queues and wait times, inequities in access to healthcare, payment issues and lack of co-ordination between providers.

The direction of these reforms is generally not uniform, as the different countries of the EU are confronted with problems of varying intensity and widely varying financing, contractual and regulatory arrangements.

The countries also have differing objectives, or face different political pressures from healthcare providers, patients and taxpayers. So reforms have taken different shapes, even for countries with similar problems. And governments have to balance different objectives, for example introducing user charges that conflict with the goal of access to healthcare, or that restrain the revenues of healthcare providers. which will cause waiting lists to increase.

These objectives can be achieved through four different reform strategies:

1 - Efforts to contain costs

Budgetary caps and other top-down (macro) measures to control expenditure were, in general, introduced first as governments grappled with the budgetary consequences of the unremitting rise in health provision. During the 1980s, many European nations put in place health reforms aimed at curbing the rising rate of spending growth.

These reforms have been showing evidence of success, and there is a growing doubt about the capacity of purely macro-based approaches to sustain overall spending control, partly because of the negative effects they may be having on the efficiency of the system.

With the limits and weakness of overall budgetary control becoming clearer, more recent reforms have sought to tackle the various policy objectives in an integrated and consistent manner, which also allows some of the broader influences affecting health to be taken into account.

Therefore, European healthcare policymakers have turned their attention to micro-based measures, and more attention is being paid to increasing the efficiency with which resources are used, extending patient choice, the system's responsiveness to users, and achieving a better balance among primary, secondary and tertiary care.

2 - Improving quality and efficiency

Efforts to improve quality and efficiency of services can be made in different sectors, such as primary care and hospitals:

- Primary care: Primary care physicians act increasingly as gatekeepers to the rest of the system. Patients no longer have direct access to hospitals, specialists and other services without first contacting their primary care physician. There are also initiatives to improve the agency role of ambulatory care doctors, by setting a ceiling on overall ambulatory overall spending, with mechanisms to reduce doctors' income if spending exceeds the target amount, such as in Germany or the UK);
- Hospitals: There is also a tendency towards a greater independence of hospital management and a greater autonomy of hospital decision-making, which can encourage the search for both efficiency gains and lower-cost options for care (Spain and hospitals with Foundation Trust status in the UK);
- Quality of care: Value for money is a moving target. Increasing value requires experimentation and conscientious performance measurement using actionable and specific indicators. Benchmarking within and across countries, and sharing information can help. There is increasing attention to the development of quality standards of care, evaluating the quality of care and by comparison among providers of referral rates or prescribing rates (for example, in Austria, France);
- Waiting lists: In some countries in this study, the reduction of waiting lists of hospital care is a hot political item. Governments in Nordic countries (such as Finland and Sweden) have introduced a waiting list guarantee, and have allocated extra funds for this purpose. In Finland there is a waiting list guarantee for primary (maximum of three days to visit a general practitioner) and secondary care (maximum of two weeks to visit a hospital-based specialist). Instruments applied to reducing waiting lists are allowing patients to go to other districts or regions where the waiting list is under less pressure or allowing them to obtain care in private hospitals;
- Freedom of choice: The desire to increase the choices available to patients and make services more responsive to users has become very common. Patients in Sweden now have freedom to choose their doctor and hospital. The freedom to choose and switch insurance company has been introduced in Germany, the Netherlands and Switzerland.

3 - Shift costs onto patients

All 11 European countries in this study have a guaranteed minimum set of services to which all members of society have access. Some countries have changed the minimum set of services by reducing the number and kind of services, for example dental care is not longer covered and paramedic care is only covered for a limited number of consultations.

There is also a tendency in most countries to extend co-payments by increasing their level and number. Most countries have some degree of consumer cost-sharing or prescription charges, for example for pharmaceuticals, to decrease their use and make consumers more aware of the cost of services. In an increasing number of countries, individuals are also free to purchase supplementary insurance or services. A small but growing private fee-for-service sector operates to serve this market.

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4 - Market related concepts

The assessment of (implemented and proposed) reforms suggests that the key to increasing efficiency lies in improving incentives through improved market structure and contract relationships between payers and providers. The aim has been to combine some market incentives with a framework of rules for guiding competition and the capacity to intervene in tackling market failures. The reforms that are taking place have a greater focus on enhancing activity and/or outcomes-based efficiency, competition and, most recently, choice (either insurers in, for example Germany and the Netherlands, or providers in, for example, England and Wales).

Decentralisation: In most countries, there has been a reduction or decentralisation of direct government regulation and more responsibility has been shifted to private (or quasi-private) institutions (providers and insurers) or lower authorities. For example, in Finland and Sweden, where the municipalities and counties have been given more responsibility to organise and provide services and more freedom in setting their own user charges (within certain limits).

Financiers as purchasers: The central requirement for improving micro-efficiency is to clarify and strengthen the role of health financiers (public authorities, sickness funds or private insurers). Financiers were often been relatively passive intermediaries between consumers and providers. Their function was to allocate available funds among, for example, an established group of healthcare institutions, usually using payment methods such as block grants, day payments or fee-for-services systems. These methods paid little attention to issues of value for money and supplier-driven incentives.

There has been a tendency over the past few years towards increased accountability of purchasers for cost control; health financiers are given an overall prospective budget cap and are becoming more responsible for choosing contracting arrangements with providers, including incentives to improve efficiency. More emphasis is placed on negotiations between providers and financiers. In Belgium and the Netherlands the sickness funds/insurers have become financially responsible (for some of the costs) and money is divided among the financiers according to a risk-adjusted formula.

The effectiveness of the change of the role of insurer from funding towards purchasing would be enhanced if there were actual or potential competition between health providers. Such an approach is being used for instance in the UK, where the financiers are no longer restricted to purchasing from local public hospitals, and in Sweden, where consumers now have free choice over hospitals. In the various contract-based approaches for hospital services, more attention is being paid by the financiers to efficiency, and contracts are negotiated between parties regarding the number and type of activities for the coming year.

Other contracting methods will also be used (the role of risk-sharing), such as prospective payment by case systems using DRGs, or similar approaches, to provide a means of sharing risk. The financier recognises and pays for differences in costs across a limited range of diagnostic categories, while the provider bears the risk of variations in treatment costs within these categories.

Purchaser-provider split: In Sweden and the UK, a separation has taken place between purchasers and providers. Sweden and the UK are moving away from integration of responsibility for financing and delivering services in county councils and District Health Authorities (DHA), respectively, to separation of purchaser and provider roles.

In Sweden this involves a separation of responsibilities within the county councils. In, for example, the Netherlands these roles have always been distinct. More active purchasing has also occurred in countries with public contract models (for example, Germany and Belgium). The form of the purchaser has also varied. While most countries have focused on the hospital sector, the UK has experimented with using primary care doctors as purchasers, and general practitioner fundholder policies were reinforced in 1997.

And the extent of the experiments has also varied in countries where healthcare is decentralised (Sweden, Italy and Spain). Purchasers have sometimes also taken on the role of reorganisation and rationalisation of care institutions. In France, the Agences Régionales d'Hospitalisation (ARH) were established in 1996 to organise hospital care by region. While they do not actively purchase care, they can set contracts with providers and allocate budgets to the various hospitals under their jurisdiction. These groups are also actively engaged in the restructuring of hospital supply.

Pooling and purchasing: Whatever health financing arrangement is chosen, a "capitation" approach (see box) is necessary to redistribute pooled resources equitably. If a system intends to establish competition among sickness funds, capitation also has the regulatory function of equalising the chances of success for each fund. The higher the predictive value of the capitation, the fairer is the competition and the more equitable the allocation. Pooling has generally become more centralised, while purchasing has generally become more decentralised. Regional governments in Italy, Spain and Sweden have received more autonomy in both collecting and pooling.

In Sweden, collecting and pooling responsibilities have been strongly decentralised since the 1970s. County councils rely mainly on income taxes, which they collect themselves. In addition, counties receive subsidies from central government on the basis of an allocation formula. In contrast to tax-financed systems, social health insurance systems are increasingly moving away from decentralised pooling organisations.

Many countries, such as Belgium, Germany, the Netherlands, and Switzerland have centralised their pooling organisations in independent organisations at the federal level, such as the federal insurance authority in Germany or the healthcare insurance board in the Netherlands.

Switzerland is a special case, as it pools resources only in each "premium region" (usually on the sub-canton level), so that, for example, the high per capita expenditure in the urban canton of Geneva is not shared with the inhabitants of, say, rural Appenzell, where per capita expenditure is low.

In recent decades most countries have moved toward the application of independent criteria of healthcare needs – frequently referred to as capitation – as the dominant method of allocation. **Capitation** can be defined as a kind of price paid by pooling organisations for each individual covered by purchasing organisations with the necessary health services. The predictive value of risk adjusters for setting capitations varies widely among the countries. Capitation ranges from less sophisticated schemes, such as Switzerland's, which applies only age and sex as risk adjusters, to the very complex, but highly predictive capitation in the Netherlands and Sweden. Sweden for instance applies a very advanced matrix approach, using age, sex, marital status, employment status, occupation, and housing tenure, as well as previous high utilisation, as risk adjusters on an individual level. The Netherlands might be even one step further since 2002, when it introduced a capitation with age, sex, social security and employment status, region of residence, and even diagnostic and pharmaceutical cost groups as risk adjusters (Mills 2002). In some social insurance countries, pooling organisations receive financial resources from tax authorities.

Implementing successful reforms

The reforms in most European countries can be seen as small changes to parts of the system. Structural reforms of the overall system are very complex, and require relatively rapid action over a single period of government. When such action is not feasible and reform must take place over several governments, incremental and organisational reforms must take the lead (Krikman-Liff 1997).

The reforms debate is focusing more on those contextual and process factors that enable or obstruct change. Understanding the context is fundamental. A key lesson for the implementation of reforms is the importance of mapping and appreciating the impact of the social, political, cultural and economic context within which the reforms take place.

The historical experience of countries, their national culture and popular customs all help shape expectations of the healthcare system and responses to proposed reforms.

Ensuring the political willingness to support the reform will be the key to success.

A lack of political will has posed a major obstacle to reform in several countries, and explains some of the slowness in introducing change. Frequent political changes, not only of governments and ministers, but also of high-level officials within the relevant ministries, have often led to multiple overlapping or competing reform proposals and overall inaction. Furthermore, setting strategic alliances with the key health sector actors is central to implementation efforts.

There are numerous examples of pivotal stakeholders, such as the medical profession, having blocked or enabled reforms. Nonetheless, every attempt at reform needs to be preceded by a political mapping of key stakeholder interests and to include the development of alliances, and, if possible, the cultivation of policy champions if implementation and sustainability are to be secured.

Public support

Public support of reform is becoming increasingly important. Many new reform strategies give the public, ie consumer groups, a major role in reform areas.

Steering the process or the design and the management of the implementation process itself is also crucial. Building institutional, human and management capacity is also crucial to the success of reform implementation. The absence of these preconditions helps to explain the minimal progress achieved with some reforms strategies in a number of countries.

In reviewing these countries' reforms, it is clear that no one healthcare system can be singled out as "best", and that one system is not necessarily superior to another. Co-operation between the systems is important in respect to mutual learning. And ever more similar or comparable experiences abroad are taken into account and discussed in preparation of new legislation and reforms at home.

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UK Medilink strengthens Chinese medtech ties

UK regional medical technology development association MediLink Yorkshire & Humber is taking a mission to China this month, with a view to strengthening its collaboration agreement with the China Association for Medical Devices Industry (CAMDI). The mission will profile regional developments, notably in the areas of wound management and orthopaedics, a spokesperson at the Sheffield-based association told *Clinica*. Also, Beijing University is to host a visit by Medilink Y&H members with a view to "exploring collaborative opportunities".

A central event of the mission will be the China International Medical Equipment Fair (CMEF) 2008 (Shenzhen, April 18-21 – see this issue, page 14), where it will be part of a UK pavilion led by the Association of British Healthcare Industries (ABHI). Medilink Y&H signed a memorandum of understanding with CAMDI in April 2007 and hosted an inward, CAMDI-led mission last year to consolidate the agreement.

UK Sport courts biophysical sciences innovations in rolling R&D programme

Biophysical science innovations resulting from research conducted on the fringe of healthcare R&D are being engaged by UK Sport to support athletic performance. Eight "innovation partner" industry and university sector organisations – examples of "expertise in the fields of engineering, technology and human sciences" – have been chosen to collaborate with its Research and Innovation department, in a rolling development programme. Projects include: active and passive methods of body cooling (the University of Portsmouth's department of sport and exercise science is said to be a leader in thermal science research); optimal hydration; and biochemical recovery strategies. UK Sport is the government's leading sports development body.

German industry wants say in reimbursement decisions

Germany's BVMed industry association says its knowledge and expertise should be used by the health ministry's reimbursement bodies when it comes to decision-making on healthcare products. In a recent position paper (see www.bvmed and go to Publikationen-Stellungnahme), the Berlin association said its practical, industry-relevant insight would be valuable to the joint federal committee (G-BA) and its executive arm, IQWiG, in bringing cost-effective, innovative advanced medical technologies into circulation. BVMed director Joachim Schmitt has long campaigned for industry to be better consulted on technical medtech issues, on cost-benefit grounds and for the benefit of German patients (see *Clinica* No 1157, p 8).

German patients warm to co-payments, rate price far below quality

Up to two-thirds of German patients and handicapped people said that they would pay 50% or more of the cost of the standard products used in their treatment. This was one of the findings of a survey carried out by industry association Spectaris and consultancy company sa.font (Lünen), and reported by *MTD-Verlag*. Selection of products, functionality and level of service rendered were rated higher than price. Some two-thirds of wholesalers of these products considered that the co-payment element would rise considerably in the coming 2-5 years. In view of these findings, Spectaris saw the medtech aids quality association (QVH) playing an increasing role in overseeing the delivery of quality products in the future.

Our article that mentioned companies that are set to benefit from new NICE guidelines on prostate cancer ("Radical treatment not the only way" - *Clinica* No 1298, page 7), should have included Oncura Ltd (Amersham, UK), a spokesperson has asked us to point out.