

Health Policy Developments
Issue 1/2003

Reinhard Busse, Sophia Schlette (eds.)

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International Trends and Analyses
Issue 1/2003

Bertelsmann Foundation Publishers

Bibliographic information published by Die Deutsche Bibliothek

Die Deutsche Bibliothek lists this publication in the Deutsche Nationalbibliografie; detailed bibliographic data is available on the Internet at <http://dnb.ddb.de>.

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Responsible: *Sophia Schlette*

Copy editor: *Michael Kühlen*

Production editor: *Christiane Raffel*

Cover design: *HTG Werbeagentur, Bielefeld*

Cover illustration: *Aperto AG, Berlin*

Typesetting: *digitron GmbH, Bielefeld*

Print: *Hans Kock Buch- und Offsedruck GmbH, Bielefeld*

ISBN 3-89204-733-2

www.bertelsmann-foundation.de/publications

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Introduction

Comparative research on health care systems and health policy reforms is not a new venture. A number of international bodies, such as the OECD, the WHO, the European Observatory on Health Care Systems and the World Bank, are involved, as are academic institutions. Health system research typically compares and analyzes quantitative data, structures, and system performance between countries, often within a region or a group of countries with common socio-economic or organizational patterns.

Undeniably, health reform issues across countries are similar: Demographics, aging and longevity, modern medicine and new technology, coordination, transparency and efficiency, quality and cost, access to and financing of services are all major challenges every health policy maker needs to address. However, transfer of research and experience into politics and innovative reform lags considerably behind the proper comparative analysis of health policy.

The Bertelsmann Foundation has a tradition of comparative policy research and international benchmarking. In Germany, it has established a reputation for providing advice and innovative problem-solving in the field of economic and social politics.

The International Reform Monitor (www.reformmonitor.org), initiated in 1999 and now in its fifth year, is one example of this benchmark expertise. It primarily covers social and labor market issues. An example of the Foundation's experience in comparative health system analysis is the eight-country-study "Reforming the Health Sector" (Gütersloh 2000).

The success of both projects underpinned the need and the potential demand for timely and regular information on health policy issues in countries with similar socio-economic patterns. To this end, the Foundation established a separate monitoring tool, the International Network for Health Policy and Reform.

The International Network for Health Policy and Reform

Since 2002, the International Network has brought together health policy experts of 16 partner institutions from around the world to report on current health reform issues and health policy developments in their countries. Geared toward implementation, the purpose of the Network is to narrow the gap between research and policy, providing timely information on what works and what does not work in health policy reform.

Participating countries were chosen from a German perspective; we specifically looked at countries with relevant reform experience to enrich the debate in this country. To make this network initiative even more meaningful, it is planned to incorporate more countries in the future.

Partner institutions were selected taking into account their expertise in health policy and management, health economics, or public health. Our network is interdisciplinary; our experts are economists, political scientists, physicians or lawyers. Many of them have considerable experience as policy advisers, others in international comparative research.

Partner institutions

Australia	Centre for Health Economics, Research and Evaluation (CHERE), University of Technology Sydney
Austria	Institute for Advanced Studies (Institut für Höhere Studien; IHS), Vienna
Canada	Canadian Policy Research Networks (CPRN), Ottawa
Denmark	Institute of Public Health, Health Economics, University of Southern Denmark, Odense
Finland	STAKES, National Research and Development Center for Welfare and Health, Helsinki
France	CREDES, Centre de Recherche d' Etude et de Documentation en Economie de la Santé, Paris

Germany	Bertelsmann Foundation, Gütersloh
Japan	National Institute of Population and Social Security Research (IPSS), Tokyo
Netherlands	Institute of Health Policy and Management (iBMG), Erasmus University Rotterdam
New Zealand	Centre for Health Services, Research and Policy, University of Auckland
Singapore	Department of Community, Occupational & Family Medicine, National University of Singapore (NUS)
Spain	Research Centre for Health and Economics (Centre de Recerca en Economia i Salut; CRES), University Pompeu Fabra, Barcelona
Switzerland	Department of Health Economics and Social Policy, Centre for Economic Sciences (Wirtschaftswissenschaftliches Zentrum; WWZ), University of Basel
UK	LSE Health & Social Care, London School of Economics and Political Science (LSE)
USA	The Commonwealth Fund, New York
	Institute for Global Health (IGH), University of California San Francisco/Berkeley

Survey preparation and proceedings

Issues for reporting were determined jointly based on what the network partners identified as the most pressing issues for reform. Subsequently, the issues were arranged into clusters, namely:

- Sustainable financing of health care systems (funding and pooling of funds, remuneration and paying providers)
- Human resources
- Quality issues
- Benefit basket and priority setting
- Access to health care
- Responsiveness and empowerment of patients
- Political context, decentralization and public administration
- Health system organization/integration across sectors
- Long-term care
- Role of private sector
- New technology

If an issue did not fit into one of the clusters, participants could create an additional category to report the topic.

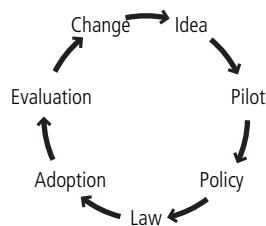
Reporting criteria

For each survey, conducted every six months, partner institutes select health policy issues according to the following criteria:

- Relevance and scope
- Impact on status quo
- Degree of innovation (based against national and international standards)
- Media coverage/public attention

Partner institutions fill out a questionnaire aimed at describing and analyzing the dynamics or processes of each idea or policy under review.¹ At the end of the questionnaire, our correspondents give their expert opinion regarding the expected outcome of the reported policy. Finally, they also rate the policy in terms of system dependency/transferability of a reform approach.

The process stage of a health policy development is illustrated with a small circle showing the phase(s) a reform is in. A policy or idea does not necessarily have to evolve step-by-step. Also, depending on the dynamics of discussion in a given situation, a health policy issue may well pass through several stages during the time observed:



- *Idea* refers to new and newly raised approaches voiced or discussed in different fora. Idea could also mean “early stage”: any idea floating but not anywhere near formal inception.² That way, a “stock of health policy ideas-in-development” is established, permitting the observation of ideas appearing and disap-

1 Detailed definitions of health policy issues, criteria for selection and rating, process stages and groups of actors form part of the questionnaire included in the annex.

2 For the first survey, this notion has been widened to capture (1) ideas that have only recently surfaced and (2) ideas that have been in the pipeline for more than six months (retrospective view).

pearing through time and “space” (i.e., medical savings accounts in the Australian health policy debate; Primary Care Trusts in England).

- *Pilot* characterizes any innovation or model experiment implemented at a local or institutional level (i.e. integrated care in Catalonia).
- *Policy* means any formal written statement or policy paper short of a draft bill. Included under this heading is also a growing degree of acceptance of an idea within a relevant professional community.
- *Law* covers all steps of the legislative process from the formal introduction of a bill/draft piece of legislation through parliamentary hearings, driving forces, the influence of professional lobbyists in the process, up to the effective enactment or rejection of the proposal.
- *Adoption*: This stage is about all measures taken towards legal and professional implementation. Adoption does not necessarily result from legislation; it may also follow the evidence of best practice tried out in model or pilot projects.
- *Evaluation* refers to all health policy issues scrutinized for their impact during the period observed. Any review mechanism, internal or external, mid-term or final, is reported under this heading.
- *Change* may be a result of evaluation or abandonment of development.

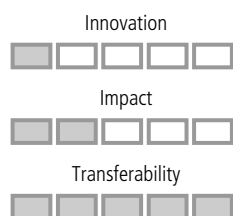
Policy ratings

A second figure is used to give the reader an indication of the character of the policy. For this purpose, three criteria are shown: innovation, impact and transferability.

- *Innovation* is an indicator to assess the idea or policy described against the country’s current situation and background. A policy may or may not be entirely new or adapted from elsewhere. The innovation scale ranges from “traditional” to “innovative approach.”
- *Impact*: Ranging from “marginal” to “fundamental,” this rating criterion illustrates the structural or systemic scope and relevance of a reform.

- *Transferability*: This rating indicates whether or not a reform approach could be adapted to other health care systems. Our experts assess the degree to which a policy or reform is system neutral (transferable) or strongly context dependent.

The figure below illustrates a policy which follows a traditional approach, has little impact but is highly transferable.



Project management

The Bertelsmann Foundation’s Health Program organizes and implements the half-yearly surveys. The Department of Health Care Management, Berlin University of Technology, assisted with the development of the semi-standardized questionnaire (see Annex) and produced and edited this summarizing report. Thanks are due to Susanne Weinbrenner and Kerstin Lipperheide.

The results from the first biannual survey, covering the period September 2002–March 2003, are presented in this booklet. Out of 77 reported reform issues, 29 were selected. All reforms can be looked up and researched on the network’s Web site, www.healthpolicymonitor.org. Both the detailed description on the Web and this brochure draw upon the partner institutions’ reports and do not necessarily reflect the Bertelsmann Foundation’s point of view.

Thanks go to the authors and experts from our partner institutions: Toni Ashton, Mickael Bech, Ortrud Biersack, Jan Böcken, Terkel Christiansen, Agnès Couffinhal, Cathy Fooks, Tom van der Grinten, Marion Haas, Jane Hall, Jan-Kees Heldermaann, Maria M. Hofmarcher, Nobuyuki Izumida, Jaume Puig i Junoy, Ilmo Keskimäki, Meng Kin Lim, Esther Martínez García, Lisa Maslove, Katsuki Matsumoto, Carol Medlin, Fabienne Midy, Kjeld Møller Pedersen, Robin Osborn, Valérie Paris, Dominique Polton, Kim Put-

ters, Monika Riedel, Ray Robinson, Masayo Sato, Elizabeth Savage, Peter Sawires, Jürg H. Sommer and Karen White.

Special thanks go to all the people who have shared with us their time, their thoughts, and their questions to shape and refine this project conceptually from the very beginning: Orvill Adams, Andreas Esche, Pam Garside, Sheila Leatherman, Rudolf Klein, Julian Le Grand, Antonia Maioni, Kieke Okma, John Wyn Owen and Marc Roberts.

Comments and suggestions on this experimental first report are more than welcome and can be addressed to the editors. Over time, the report will evolve, change and, we hope, improve. That is why any input will be helpful.

Reinhard Busse
Sophia Schlette

Overview

This first issue of “Health Policy Developments” takes a closer look at 29 out of 77 reforms reported over the period September 2002–March 2003. Highlighting current discussions and developments, the reports presented here were organized around five major themes of overarching interest across countries and health systems:

- Funding and reimbursement
- Quality improvement and quality control
- Integrated care
- Public health
- Plans and proposals addressing US coverage gaps

The following pages will highlight developments in the first three areas, the focus of this report. Issues that warrant further explanation in the future are explored at the end of this chapter.

Funding and reimbursement

Health care systems in many industrialized countries are facing sustained financial pressure. How are countries coping with this situation? What are the proposed policy options and solutions? Responses vary from rationing to a different mix of public-private resources and to the call for structural reforms of health care financing (e.g., proposal for a single-payer system, Hawaii).

Switzerland is an excellent case study: Only recently, the entire health care financing system was at stake in the referendum of May

Case study
Switzerland

18, 2003. With little probability for success (only one out of 10 referendum proposals is successful in Switzerland), the voters rejected the Health Initiative of the Social Democrats.

However, Europe's most expensive health care system continues to be challenged from inside and outside of Switzerland. The Swiss financing system based on per-capita premiums with some subsidies for lower-income groups has been criticized for its regressive effects.

It has been argued that per-capita premiums and high copayment rates disproportionately burden the lower tier and slow down demand and overall economic performance. The rejected referendum proposal had proposed a major turn toward an income- and wealth-related financing system more similar to the Bismarckian model.

Elsewhere, opting-out models—a euphemistic way of describing restrictions in the benefits catalogue—are implemented or in preparation, leaving the responsibility for choice of more comprehensive health insurance with the individual. Still other countries are expanding care, nursing or social services covered by their public benefit schemes.

**Decentralization
versus centralization**

Interestingly, many of the reforms on funding highlighted in this report could equally be dealt with from a different angle. These reforms are often about the division of competencies between central and lower levels of public administration or government.

Supporters and opponents of decentralization come from both the regions (more autonomy, higher acceptance, better accountability) and the center (better quality, improved efficiency, more equitable distribution of resources and services). Among others, Denmark, Finland and Spain provide particularly good examples of this debate.

Quality improvement and quality control

With increasing public pressure and concerns about quality improvement and documentation, accountability and public participation have been moving higher on health policy agenda, as have prevention and public health programs.

In the Canadian province of Saskatchewan, the new idea consists of establishing a council for quality improvement in health care, “independent from the government” and made up of representatives of the public, health care providers, health policy experts and government representatives.

In Germany, widespread public concern about quality disparities in health care and a demand for more accountability and transparency in government decisions are driving forces in the process towards an “independent” German Center for Quality in Medicine.

Also, in the draft bill for the Health System Modernization Act, patient entitlements and guaranteed participation, rights and obligations of patients to participate and contribute to the improvement of their health status are explicitly stated.

In many countries, we can observe initiatives aimed at making health policy geared more toward the patient (in terms of quality and needs) and less toward the institutions involved.

Emphasis is placed on the participation of the expert patient. Patient involvement is gaining importance with chronic diseases, quite different from the traditional treatment of acute illness. At the same time, lobbying by powerful interest groups is seen more and more as an obstacle to swift reforms.

In Australia, the South Australia Generational Health Review, a consultation and review process involving the South Australian population, called for more community-based services and a more needs-based health care system.

In the Canadian province of Saskatchewan, the aim is to build an independent, non-politicized institution to accomplish leadership in health care reforms.

In Spain, it is expected that the “National Health System Inter-territorial Council” (NHSIC) will gain more influence on health policy issues through regional government participation. Some fear, however, that this power will remain restricted to basic public health issues. The central government still wants to keep control over areas affecting the national health care system.

Moving up on the agenda: Accountability, public health

Public participation gaining ground

Integrated care

Regardless of the predominant financing and purchasing system, lack of coordination and integration of health and related services is a widespread problem in many countries. Bottlenecks occur at the interface between inpatient and outpatient sectors (Spain) or inpatient acute care and rehabilitation (Canada).

Other countries report efforts to improve cross-sector coordination of nursing care involving health care and social care pro-

Coordination across social sectors

professionals (France). Comprehensive integration of health care is expected to have a big potential to improve both quality and cost effectiveness.

Outlook

Policy making styles Are more commissions the right answer? How do policy makers address all of these challenges? Often, governments seek expert advice. Ad-hoc or permanent working commissions on health care reform exist in almost every country. Patient and consumer organizations call for independent councils and public participation.

However, “independent” advisory boards are often appointed by the government in charge. Their roles may vary a lot, and so do their chances of influencing politics or voicing consumer concerns. At this point, it is too early to assess the influence of different advisory bodies and/or consumer involvement groups on the actual outcome of a health policy reform process.

Some examples: In November 2002, the newly re-elected German government appointed an ad-hoc commission to develop strategies for making the social security system sustainable. Deeply divided, the 25 advisers from science and civil society presented two essentially incompatible models for health insurance reform in March 2003.

The new Commission for Patient and Public Involvement in the UK has not had a chance to establish its credentials yet. Some fear it may become another bureaucratic organization that may have limited impact on the ways in which services are actually delivered.

Health policy monitoring over time Financing issues, policy-making styles, the debate about the most appropriate level and scope of regionalized health policy competence, accountability, consumerism and public health affairs are all issues that will be investigated regularly in the next biannual reports.

Funding and Reimbursement

The current debate about funding health care is currently mainly concerned with two issues: sustainability and equity. There is, however, a trade-off between the two objectives and policy makers face tough choices. Most conspicuously, many of the available measures for making public health care funding more sustainable have the effect of increasing the private share of funding, which is typically less “fair” in terms of vertical equity.

In making these choices, policy makers have a number of options:

- They can increase the rate of the main funding mechanism, i.e., contribution rate in statutory Social Health Insurance (SHI) systems or tax rate in national health systems (NHS)—as demonstrated by the policy plans in Austria.
- They can widen the funding base, e.g., by charging additional sickness fund contributions on capital income.
- They can introduce or increase copayments, coinsurance rates or deductibles, thus shifting part of the publicly funded care to private funding. Japan’s employees’ health insurance and a general practitioner’s (general practitioner) clinic in New Zealand are good examples of this policy option.
- They can introduce or stimulate, e.g., through tax subsidies, the purchasing of voluntary supplementary or complimentary insurance, thus shifting the public-private funding mix, as the case of Australia exemplifies.
- They can reduce the benefit catalogue, i.e., remove benefits currently covered from public funding, usually with the main effect of shifting funding of those services to the individual. The—re-

cently abandoned—proposal to exclude general practitioner services in the Netherlands is an example of this idea.

Sustainability of health care funding will come under increasing pressure if policy makers pursue the objective of horizontal equity by including new benefits (long-term care in Singapore or Canada; dental care in Finland and Spain) or new population groups to increase access for all those in need. Singapore has chosen to supplement its 3M-system of MediSave, MediShield and MediFund by a new scheme called ElderShield to cover nursing benefits.

In other countries, the whole funding system is under discussion: In Switzerland, the Health Initiative aimed at replacing the current per-capita premiums with income-related contributions like, for example, in Germany; in the United Kingdom, various alternatives to the current funding via general taxes are discussed in some research institutions but not in the political arena.

Austria: Adjustment of health insurance contribution rates

Like many other countries, Austria faces a growing deficit in its health insurance system, predicted to rise from €350 million in 2003 to €900 million in 2005. In order to alleviate the problem, the present government is planning additional funding and is designing a program for the next legislative period.

The government plan includes the following proposals:

- Equal health insurance contribution rate of 7.3 percent for blue- and white-collar workers. Current rates are 7.6 percent for blue-collar and 6.9 percent for white-collar workers. In the Austrian SHI, roughly 80 percent of the population are insured under the General Social Security Act (ASVG). This group mainly includes blue- and white-collar workers. As there are more white- than blue-collar workers, the equalization of the contribution rate will increase total contribution revenue.

The measure is expected to yield €90 million a year.

- An additional contribution rate of 0.1 percent for non-work-accidents (e.g., leisure or household accidents) should be introduced; this applies for all health insured persons, not only blue and white collar workers.

The “leisure levy” is expected to yield €116 million a year. In



contrast to previous suggestions for charges on sports equipment, the proposed leisure insurance scheme would not have the perverse incentive of discouraging healthy lifestyles by making it more expensive to engage in sport. Also, the former schemes did not cover household accidents.

- The pensioners' part of the contribution rate is to be increased from 3.75 percent by 0.25 percentage points annually until 4.75 percentage points are reached in 2006.

The measure is expected to yield €103 million in 2004 and €210 million in 2005. Presumably, the increased rate of pensioner contributions can be seen as a step towards risk-adjusted contributions, which—apart from “historically” different rates between occupational groups (civil servants, the self-employed and the employed)—have no tradition in the Austrian health care system.

Increased pensioners' contribution rate

Since the contribution rate is fixed by law, the General Social Security Act has to be amended accordingly. So far there has been little public discussion or controversy. The chances of implementation therefore seem quite high. However, the government program was launched only in March 2003, so discussion and public pressure might still arise.

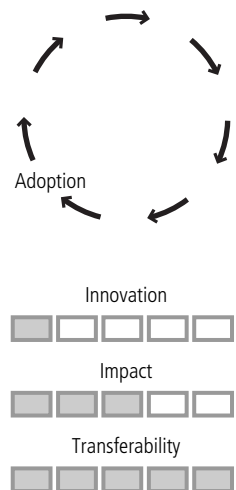
Public debate might still arise

Japan: Increase of copayment rates

As part of their strategy for dealing with Japan's problem of structural stagnation, Prime Minister Koizumi and his cabinet announced a proposal to raise copayment rates in February 2002. The rate for copayments of those insured by the Employees' Health Insurance is to be raised from 20 to 30 percent.

The Japanese health care system is financed mainly through contributions to compulsory health insurance funds, taxes and copayments. There are three types of compulsory health insurance:

- National Health Insurance (NHI) for self-employed and elderly
- Employees' Health Insurance (EHI)
- Insurance for those in specific occupations including civil servants and private school employees



Increased copayment rate for those insured with the EHI became effective in April 2003. Implementation is expected to lead to an

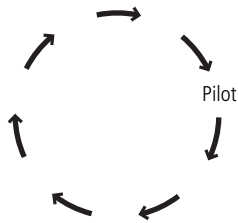
Benefits of copayments:
Equalization of rates

equalization of rates for beneficiaries of both the EHI and the NHI scheme. Copayment rates in the NHI scheme had already been set at 30 percent.

Copayment drawbacks:
Higher out-of-pocket payments

The opposition party in parliament and the Japan Medical Association have criticized the move because it will lead to an increase of out-of-pocket-payments for its beneficiaries.

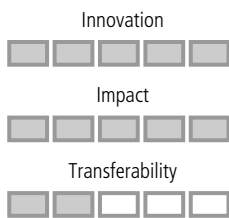
New Zealand: Prepaid general practice fee



In New Zealand, a single general practitioner chose a rather unconventional way of securing additional funding—the one-off idea.

This general practitioner has written to 700 of his patients inviting them to pay an annual fee of €225 in addition to the existing copayments for consultations: Copayments in NZ are set by each individual general practitioner and average around €21.5 per visit. In return for the extra payment, the doctor is offering improved quality of service such as guaranteed appointments, direct cell-phone access, home visits and longer consultations. The general practitioner recognizes he will lose patients but hopes that he will be able to focus his energies on those people who are willing to pay more for his services.

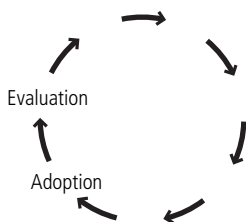
Annual fee for better services



The scheme has attracted criticism from the Minister of Health and from public commentators on the grounds that it is contrary to the national goal of reducing inequality in access to and use of health services. It also runs against the thrust of public policies designed to promote capitation funding of general practice (see p. 55). Still, there is also support for the notion of “let the market decide if this is a winner or not.”

“Let the market decide if this is a winner”

Australia: Private health insurance incentive scheme



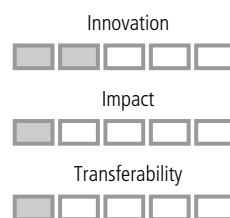
The public/private mix of funding and services is always an important political issue in Australia. The present government strongly supports the private health industry as a potential source of funding and therefore introduced a private health insurance (PHI) incentive scheme.

Even though Prime Minister Howard and his cabinet are committed to the national health insurance scheme, Medicare, a series of

policy changes designed to promote private health insurance have been implemented at the national level since 1997:

- Direct subsidization of private health insurance premiums
- Levy for higher-income groups without private health insurance (individuals with an annual income of more than €28,000 and families with an annual income of €56,000)
- Elimination of out-of-pocket payments for people with private insurance using medical services in private hospitals
- Implementation of an age-related premium differential called Lifetime Health Cover in 2000

Incentives for private health insurance



Prior to July 2000, PHI premiums were community rated. Now a base premium is applied to those purchasing insurance before age 30. This means those who have continuous private health insurance cover from age 30 on continue to pay the base rate. Those joining beyond age 30 pay an age related premium on top of the base premium.

Objectives of the PHI policy reform are:

- To increase the population coverage of private health insurance;
- To encourage people to use private facilities; and
- To provide more people with a choice of doctor and hospital by making private health insurance more widely available.

The changes reflect the assumption by politicians that a strong and viable private health industry, including PHI companies, may relieve pressures on the public system. The PHI industry has developed into a powerful lobby group over many years and is supported by some equally powerful doctor organizations, most of whose members rely on a viable private health industry for their income and some of whom have financial interests in private hospitals. Market-oriented “think tanks” have also been supportive of increased PHI coverage.

PHI to relieve pressures on public system

However, some doctors’ groups and other lobby groups, e.g., the Public Health Association, opposed the ideas. The scheme was always likely to be acceptable to the public as a 30 percent subsidy was available, which lowered the cost of private health insurance.

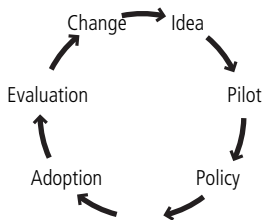
Effects of the new policy on private health insurance:

- An increased proportion of population covered by PHI from 32 to 44 percent
- A large growth in the number of claims for ancillary services (dental, optical, etc.) and therefore an increase in the benefits paid by funds

Policy outcomes

- A reduction of out-of-pocket expenses of the insured
- An increase in costs to government and therefore to the taxpayers of Australia
- No noticeable effect on public hospital waiting lists or other delivery issues; what shift there has been is mostly related to day-surgery
- No reduced pressure on insurance premiums, which have continued to rise

The Netherlands: Rationing benefits



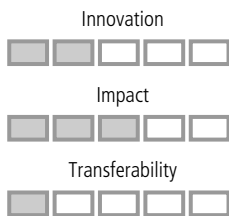
One of the strategies for cost containment pursued in the Netherlands has been to limit the benefit basket. Technical criteria like effectiveness, efficiency and affordability had the upper hand and there was little support for a normative debate.

The recent joint proposal of the Ministries of Health and of Finances dating from February 2003 to remove even more benefits from the basic package is expected to lead to a cost reduction of €930 million by 2007.

Policy making of rationing health care in the Netherlands is linked to the 1991 Dunning Report and its main policy proposals:

- Assessing the basic package
- Admitting (new) technologies
- Stimulating appropriate use of health care
- Regulating the waiting lists

The 1991 Dunning Report



To assess the basic benefit package, the Dunning Committee had outlined a framework of four filters: necessity, effectiveness, efficiency, personal responsibility. The Committee had also raised the question whether everything possible in health care had in fact to be offered and, if so, to what extent these benefits had to be funded publicly.

Principles for removing benefits

The basic principles as outlined in the Dunning Report:

- It is fairer to ensure necessary health care for all than all health care for just a small proportion of population.
- Explicit and publicly accountable choices are better than covert rationing.
- In setting priorities in health care, social values must be combined with professional and expert opinion as to what is valuable medical treatment and what is not.

The appliance of the Dunning Committee criteria have led to the exclusion of several services from the basic package. In 1995, dentistry for adults was excluded, although some services have been covered again since 1997; long-term physiotherapy was dropped and the provision of incontinence pads, colostomy bags and hearing aids was heavily reduced.

Package cuts

Although the February 2003 proposal of the Ministries of Health and of Finances to exclude general practitioner services from the basic package did not stand much of a chance to be accepted, it is remarkable that such an idea was presented in a government policy document.

Exclusion of general practitioner services unlikely

The idea refers implicitly to the current sense of crisis with regard to the position of the general practitioners in the health care system. There is an alarming shortage of general practitioners, alternatives like hospitals that expand their basic care facilities have begun to emerge.

Extending basic services

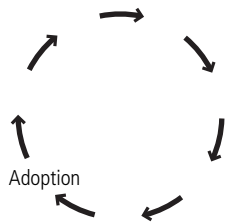
Just like the Netherlands, many countries plan to ration health care services due to an overall economic slowdown. However, some countries have been moving in the opposite direction by extending basic services; for example:

- *Canada*: A proposal to expand universal coverage to cover post-acute home care is on the political agenda (see p. 47).
- *US*: Ever since the 2000 electoral campaign, there has been a major policy discussion about adding prescription drug coverage to Medicare, the national health insurance program for all Americans over 65. The “Triple Option” proposal by the Bush administration, presented in March 2003, met with fierce criticism for its attempt to further privatize Medicare, and for insufficient federal funding provisions in view of the growing drug prescription costs for seniors.
- *Finland*: Since December 2002, the coverage of publicly funded dental care has been extended; basic dental services are provided to the whole population irrespective of the age of patients or their municipal affiliation.
- *Spain*: A bill from March 2003 proposes an extension of the catalogue of minimum services, for instance dental care, mental health and services for the handicapped (see p. 43).

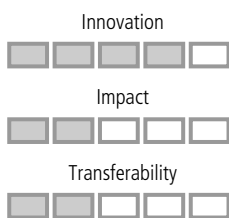
The opposite approach: Expansion instead of reductions

- *Switzerland*: In its first draft of November 1991, health insurance legislation aimed to expand the list of reimbursable services (nursing, home care, prevention, rehabilitation, medical devices, etc.), not to reduce entitlements.

Singapore: ElderShield—supplementary long-term care insurance



3M System



ElderShield: New disability protection scheme

ElderShield auto-cover: no underwriting required

Singapore’s health care financing system is a mixed system, drawing on a combination of taxes, employer benefits, compulsory medical savings, insurance and out-of-pocket payments.

The centerpiece of this system is the 3M system:

- MediSave: compulsory medical savings
- MediShield: a low-cost catastrophic health insurance scheme designed to cover major and prolonged illnesses which MediSave balances are not sufficient to cover
- MediFund: a safety net to help poor patients

ElderShield has now started to complement the 3M-System. The idea of ElderShield as an affordable supplementary insurance scheme for the elderly was first announced by the prime minister in August 2001. ElderShield was designed to provide elderly Singaporeans with basic protection against expenses required in the event of a disability currently not covered by the 3 M’s. Without the need for a special legislation the ElderShield scheme was introduced in June 2002.

Each insurer is obliged to offer similar ElderShield features. Payment of premiums can be made using the policyholder’s own MediSave account, the MediSave account of the policyholder’s relatives or out of pocket.

ElderShield offers two premium plans:

- The Regular Premium Plan, where policyholders pay an age-related premium differential annually, until the age of 65.
- The Single Premium Plan, where policyholders pay a single lump sum premium upon joining the scheme.

The government decided to use an auto-cover approach in combination with an opt-out option for the scheme. “Auto cover” means that no underwriting (a standard insurance feature) is required. An

advantage of the approach is that those enrolled are automatically covered without a medical check-up, even if they have pre-existing conditions, such as diabetes or hypertension, or are already unable to perform two of six basic activities used as disability indicators.

The opt-out option requires an explicit statement of declining coverage. Through the opt-out option the government hoped to include as many people as possible under ElderShield, offering them the benefits of an insurance scheme and keeping the premiums affordable at the same time.

MediShield, too, had been launched in 1990 as an opt-out scheme with the effect that more than 90 percent of the working population is covered under MediShield- or MediSave-approved insurance schemes.

From the time policyholders start paying premiums they can claim payments. Payout is in the form of monthly cash benefits of €154 per month (average costs for a nursing home range from €154 to €257 a month), up to a maximum of 60 months. That is not a large amount of money, but would make a significant difference for many seniors faced with the financial burden of coping with severe disabilities. For lower income groups, the government subsidizes up to 75 percent of the costs if they need nursing home care.

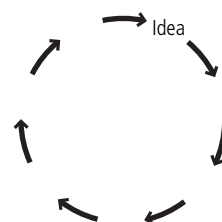
The scheme did not achieve the resounding success the government had hoped for. Citizens were not convinced of the new scheme, and until December 2002 some half a million (i.e., 30 percent of those eligible) decided to opt out. In January 2003, responding to the widespread criticisms received, the Minister of Health said that he was not ruling out the possibility of a review, if necessary.

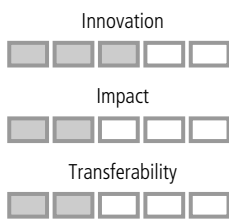
Lifetime coverage

Singapore: MediSave and MediShield withdrawal limits

Currently, the amount of MediSave that a person can withdraw and the amount of MediShield that a person can claim is based on the number of days of hospitalization and the type of procedure the patient undergoes. Above this sum a copayment from patients is required to encourage the prudent use of medical services.

In view of a recent increase in hospital charges there have been claims from the public that the withdrawal limits should be reviewed. The Ministry of Health has signaled that in the coming months the rules governing MediSave and MediShield withdrawals

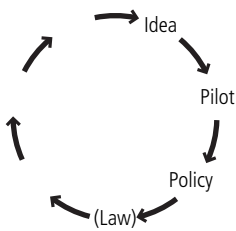




will be changed. It is felt that, in contrast to the per diem basis, a formula based on case-mix would be more flexible and fairer because it takes into account the complexity or severity of a patient’s medical condition.

The case-mix system has been implemented in Singapore’s public sector hospitals since 1999 as a method of reimbursement and to measure the performance of health care provision.

Switzerland: Failed referendum proposal to remove per capita premium health insurance



Health Initiative

Since the revised health insurance law (KVG) came into force in 1996, all permanent residents in Switzerland have had to purchase compulsory health insurance policies. Individuals or their legal representatives purchase insurance policies for which the premiums are community rated. In a referendum on May 18, 2003, Swiss voters rejected a reform proposal aimed at radically changing the system.

The proposal for financing health insurance by income- and wealth-related contributions along with additional earmarked sales taxes had been put forward by the Social Democratic Party in 1999 in the context of the Health Initiative (“Gesundheitsinitiative”).

The social democrats’ proposal would have replaced the present system of mandatory health insurance relying on per-capita premiums and a means-tested subsidy (if premiums exceed a certain percentage of the income), as it would have the sophisticated system of cost-sharing and supplementary health insurance.

**Rejected proposal:
A fairer health
care system ...**

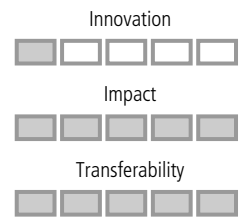
The aim of the initiative was to introduce a fairer and more equitable health care funding system. Contributions of the wealthy would have been redistributed for the benefit of those with few assets or little and average income. The initiators of the proposal referred to other countries as an example for income-related financing (e.g., Germany).

**... or a step
backwards?**

Critics had argued that the proposed new funding system would have been a “step backwards” in the design of the health care system because allocation and distribution goals and requirements would be mixed. Further it was argued that incentives for the insured to be cost-sensitive would have been weakened thus leading to an aggravated problem of moral hazard.

Since contribution rates would have been set by the government under the health initiative’s proposition, competition between insurance funds would also be undermined under the alternative funding system proposed by the Health Initiative. Finally, the effects of redistribution based on solidarity would not be transparent.

The government (“Bundesrat”), conservative parties, the association of the Swiss pharmaceutical companies and the association of health insurance funds (“santésuisse”) opposed the initiative.



England: Alternative methods of health care financing

The English National Health Service (NHS) is mainly funded through general taxation (over 90 percent). Much of the debate surrounding the NHS over the past 25 years has centered on the under-funding of the system. It has been argued that a tax-based funding system seems incapable of producing adequate levels of funding.

Several governments have made marginal changes: increased charges for pharmaceutical prescriptions, ophthalmic and dental services; offering tax incentives for private health insurance premiums for seniors during a period in the 1990’s; user charges for social care at home. Yet, there has been no official support for any far-reaching reform.

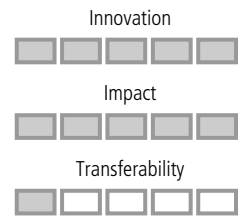
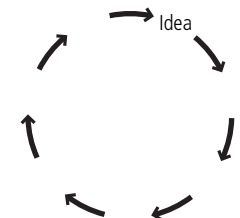
There is currently a flourishing think tank community in the UK covering a wide political spectrum. Many of these organizations have been associated with new ideas or have recycled old ideas on health finance.

Most of these ideas make headlines briefly but have little effect on policy. In short, they fall into four categories:

- Switch to earmarked or hypothecated taxes
- Introduction of different forms of social health insurance
- Greater reliance on user charges
- Extended use of private health insurance

Approximately 11 percent of the English population has some form of supplementary private health insurance. Employment-based private health insurance is the fastest growing sector of this market, and there have been calls for tax incentives to be offered to companies to expand this market further.

The present Chancellor of the Exchequer commissioned a study



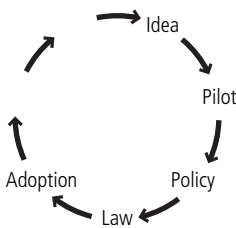
Think tanks with little effect on policy

**Wanless Report:
Tax-based system
efficient and
equitable**

(Wanless Report) on the future funding needs of the NHS. This report rejected alternative methods of funding and claimed that a general tax-based system was the most efficient and equitable way of raising NHS finance.

Opposition parties are considering alternatives but do not at the moment have well-developed policies. Moreover, it is going to be hard to argue against the present system, as the levels of future funding announced by the Chancellor of the Exchequer in his 2002 budget have defused the under-funding argument for the next five years at least. Over this period the NHS budget is due to increase from €93.5 billion in 2003/2004 to €151 billion in 2007/2008.

England: Role of the private sector



Private Finance Initiative

Despite its negative attitude towards private funding the government is promoting greater use of the private sector by the NHS on the supply side. In view of increasing efficiency in health care, the government has supported two main initiatives:

- The Private Finance Initiative should be extended. Under the Initiative, private sector finance and management expertise are drawn upon in order to finance, build, operate and manage NHS capital projects, particularly new hospitals.

In the fiscal year 2003/2004, the Private Finance Initiative is expected to account for 22.2 percent of NHS capital expenditure. The government wants this share to grow and increasingly be extended to investment in primary care facilities.

**Public-private
partnerships**

- Public-private partnerships, whereby the private sector provides services funded through the NHS, are to proliferate.

Since the Secretary of State for Health signed an agreement with the Independent Healthcare Association (IHA) in 2000, initiatives have been announced for placing major NHS contracts with private hospitals.

**Mixed reactions
on both sides**

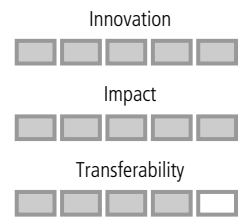
The new Labour government came to power with a commitment to reform public services by creating a “third way” between command and control on the one side and private market systems on the other. Opposition has come from unions representing public sector workers who fear a deterioration in their employment conditions.

NHS managers who have the ultimate responsibility for imple-

menting the strategy have displayed a mixed reaction. The private sector reports major difficulties in working with the NHS. They claim that NHS managers are not used to working with the private sector and that the negotiations about contractual arrangements are very lengthy.

A recent study of public-private partnerships suggested that most NHS managers saw partnerships as a short-term means of increasing capacity rather than as a long-term strategy, as proposed by the government.

Many commentators believe that greater pluralism in the supply of publicly funded health services is desirable and overall general developments in the social and economic sphere suggest that this field will develop in the NHS in the future. A key question is: Will this be confined to the supply side or will greater private funding emerge as well?



Denmark: The search for the right mix of roles

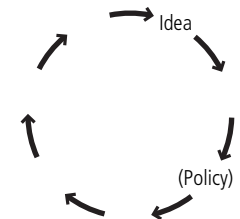
Despite a rather well-functioning health care sector in Denmark, dissatisfaction with waiting time, among other things, has prompted a debate about reforms. In addition, the future role of the counties in general, and their role in health care in particular, is being questioned, i. e., whether or not there will be continuing support for a decentralized public sector.

In late fall 2001, the new government established an Advisory Committee on the Health Care Sector to look into ways of improving efficiency and effectiveness of the health care sector.

In February 2002, the Committee published its first report on possible barriers to more efficient working practices in hospitals, in particular union contracts and rules.

In its second report, the Advisory Committee decided to address the wider question of “the counties and the health care sector.” The second report was the result of visits to Norway, Finland and France as well as of literature surveys and was published at a press meeting hosted by the Minister of Health on January 8, 2003. It addressed the following issues:

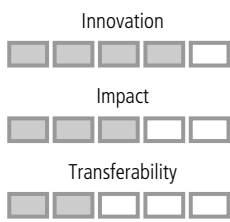
- More autonomy for hospitals in their relationship with county councils, responsible for financing, planning and operating health care in Denmark



Improving efficiency and effectiveness

Barriers: Union contracts and rules

Counties and the health care sector

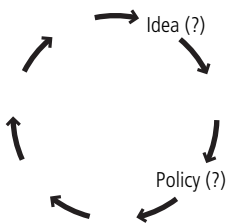


- The possibility of establishing private wings in public hospitals
- A more “relaxed” attitude to the involvement of private hospitals in reducing pressure on publicly financed hospital services
- Compulsory accreditation of hospitals
- Increased use of activity-based reimbursement of hospitals, i.e., less reliance on capped budgets and more reliance on diagnosis-related reimbursement (not to reach 100 percent in order to prevent budget overruns)
- Reduction in the number of counties
- Increased powers for the National Board of Health to ensure a professionally relevant development of the health care sector

To improve effectiveness and efficiency of the hospital sector, the Advisory Committee recommended more autonomy; increased diagnosis-related reimbursement and centralization.

Most of the ideas were well received by the Minister of Health, who declared that apart from the merger of counties he would set in motion initiatives, including legislation, to implement the ideas put forward by the Advisory Committee. The report has been positively received by most political parties and interest groups, too. The issue of merging counties has been relegated to a separate committee, which is expected to publish its report at the end of 2003.

Finland: Plans to reform the hospital billing system



**Unpredictability of
annual hospital
expenditures**

In the context of the 1993 reform of central government subsidies to local governments, municipalities and municipal hospital federations (hospital districts) got larger freedom to make decisions on the arrangements of health services. This resulted in changes in the way hospitals bill the municipalities. Accordingly, pricing systems and prices are not comparable across hospital districts and hospitals any longer. Some districts invoice inpatient somatic care and day surgery using diagnosis-related reimbursement, but most hospital districts use their own service groupings.

Furthermore, because of their small average size (median about 5,000 inhabitants) and the decentralized responsibility for health care funding, a major problem for many municipalities in the present hospital funding system is the unpredictability of annual hospital expenditures due to random variations in hospital utilization.

Within the National Project on Safeguarding the Future of Health Care Services, the Ministry of Social Affairs and Health (MSAH) hence appointed two experts to advise on how to develop the hospital billing system in order to attain the following objectives:

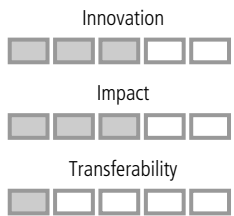
- Support municipalities in gaining more power to steer hospital services structures
- Make health care more efficient

Hospital billing reform

The experts made the following recommendations:

- A new, more effective method for equalizing the large variations in hospital expenditures between municipalities within a given hospital district is to be introduced by 2005, which would require an amendment of the Specialized Medical Care Act.
- Diagnosis-related reimbursement is to be introduced in all hospital districts by 2005 to improve the comparability and transparency of service prices across hospital districts.
- The same criteria are to be applied to hospital billing independent of whether the patient came from one of the district's member municipalities or from another hospital district.
- As an incentive for improving continuity of care, municipalities will be charged fines if they are unable to provide continued care to their residents in the non-specialized sector. The extra charge, to be effective from 2005 in all hospital districts, will go to the municipal hospital federation.
- The treatment costs of certain expensive patient groups are to be shifted from the municipalities to central government.

National Project on Safeguarding the Future of Health Care Services

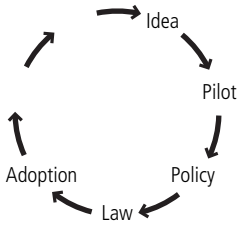


If the MSAH considers the initiatives worth implementing, the adoption of the proposals will ultimately depend on the approval of the hospital districts and their member municipalities. Since the problems of the present hospital funding/billing system are well recognized, the municipalities are likely to be interested in adopting the reform.

Municipalities are key to implementation

However, it is questionable that it will solve a major problem in hospital steering; due to the small size of most municipalities the municipalities often have no resources and expertise to manage hospital services effectively.

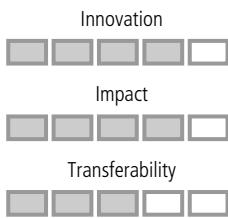
England: NHS Foundation Trusts



NHS foundation trusts: Independent public interest companies

As a component of a major 10-year NHS reform program (main elements are set out in the official documents “NHS Plan,” July 2000, and “Delivering the NHS Plan,” July 2002), the present Labour government has announced a program for the creation of a new form of NHS organization. This new status will apply to NHS hospitals but it is intended that eventually it will be extended to Primary Care Trusts as well.

NHS foundation trusts will be set up as independent public interest companies. They will be within the NHS and subject to NHS inspection, but will be guaranteed, by law, freedom from the Secretary of State’s powers of direction. Specific new operational freedoms will include the ability to retain revenues from land sales, the freedom to determine their own investment plans and to raise capital funds and the discretion to offer additional performance-related bonuses to staff.



New forms of governance through Boards of Governors, to be elected by constituencies of users and the public, and Management Boards are intended to complement accountability to the center with greater accountability to local communities. The line of accountability to the center is through an Independent Regulator.

By placing foundation trusts outside direct line management and control from the center, ministers expect to stimulate local entrepreneurship and innovation, while local accountability will ensure that they pursue public-sector values.

“Earned autonomy” for high performers

The government’s approach embodies the concept of “earned autonomy”: Organizations that have established themselves as high performers are to be given greater freedom to manage their own affairs independent of central control. Thus organizations that achieve a three-star rating in the annual performance ratings carried out by the Department of Health (DoH) are to be given the freedom to apply for foundation trust status.

A comprehensive guide, “A Guide to Foundation Trusts,” was published by the DoH in December 2002. The first set of applicants for NHS Foundation Trust status will be set up in shadow form in July 2003, and will become fully operational following the passage of respective legislation in April 2004.

Various antecedents of the idea for foundation trust status can be traced. For instance, the internal market reforms of 1991 established

NHS Trusts: hospitals and other providers established as freestanding organizations within the NHS. These were to be given many of the same freedoms as NHS foundation trusts in relation to, for example, capital spending and employment contracts. However, these freedoms materialized to a limited extent only because NHS trusts were still accountable to the Secretary of State.

Experiences from Denmark, Sweden and other Nordic countries, where local, democratic ownership of health care organizations is strong, have also played a role in the proposals for foundation trusts.

Furthermore, there may be an influence by the Spanish “fundaciones” hospitals, which—ironically—were one of the Spanish ways of copying the UK hospital trusts.

The policy has supporters and critics both within and outside government. Within the traditional Labour movement there is also opposition on the grounds that it will disadvantage non-foundation trust hospitals, and lead to a two-tier system. For example, it is claimed that foundation trusts will be able to offer better salaries and conditions of service to staff and, in a period of severe nursing shortages, this will have a detrimental effect on hospitals losing staff.

Legislation is necessary for certain parts of the proposal and is currently underway.

There is concern about whether local autonomy will actually be offered in a centralized system that, because it is tax funded, is answerable to parliament through the secretary of state. The existence of political accountability led to excessive intervention in the internal market and may do the same in relation to foundation trusts, despite the planned safeguards. The elaborate mechanisms for local accountability may also stifle local entrepreneurship.

Nordic influence: Local ownership of health care organizations

Reimport from Spain

Quality Improvement and Quality Control

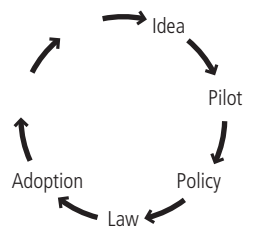
The demand for improving, managing and controlling quality has become increasingly urgent in many countries. The main reasons are growing concerns for patients' rights and safety and the potential for cost containment as a result of improving cost effectiveness.

Some countries are following the example of the United Kingdom by planning or creating an independent institution for quality on the model of the National Institute for Clinical Excellence (NICE), e.g., Germany and Canada (Province of Saskatchewan). Other countries are considering regulation of service provision (up to legally mandatory quality management—Netherlands) or centers of excellence to advance this area (Finland, Spain).

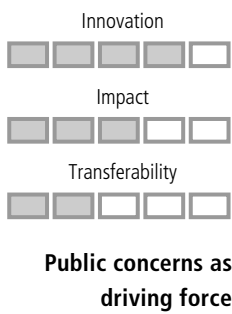
Canada: Independent council for quality improvement

Even though in Canada the public awareness of quality and cost-effectiveness issues has been increasing over time (four regional and two national reports have recommended councils to organize quality management since the year 2000), there were only few efforts to set up an effective system of quality management and quality control.

The Saskatchewan quality council was launched in December 2002, emerging from a pre-existing health service research institute (Health Service Utilization and Research Commission, HSURC). The council has already held its first meeting and is developing a work program.



**Saskatchewan:
Independent council
for quality improvement**

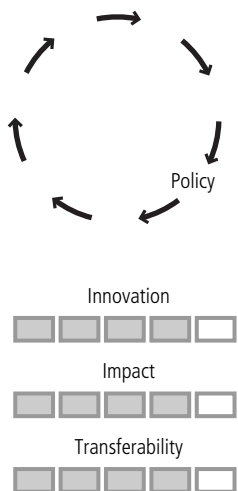


The idea was to establish a quality council in the Province of Saskatchewan, independent of government and made up of representatives of the public, health care providers, health policy experts and government representatives, to accomplish leadership in health care reforms. Increasing public concerns about quality issues in health care and a demand for more accountability and transparency in governmental decisions were driving forces in this process.

The overarching goal of the Saskatchewan quality council is to promote quality improvements in the health care system as a whole. The functions of the council are:

- To develop and compile performance indicators on the finance and delivery of health care;
- To develop and compile indicators of the health status of the Canadian population;
- To formulate evidence-based standards for various services;
- To advise the government on issues with broad implications for the health care system, such as primary care reform and the stewardship of health human resources;
- To report to the public on these performance indicators; and
- To provide a platform for public input.

Germany: Plans for a "Center for Quality in Medicine"



Quality improvement initiatives in Germany have come from a number of different sides. One reason for this rising interest might be the poor performance of the German health care system in the 2000 WHO ranking (rank 25 of WHO overall health system performance assessment).

Other possible reasons are the funding problem of the statutory health insurance system and the findings and recommendations of the 2000/2001 report of the Advisory Council to the Concerted Action in Health Care on over-, under- and misuse of services. In this report, the Advisory Council had raised serious concerns about the quality of the services provided. Consequently, it recommended increased efforts for quality improvement.

The proposal to establish an (independent) public institution to set quality standards for clinical practice by, for instance, establishing evidence-based treatment guidelines, minimum numbers for surgical interventions and the like was first put forward by an advisory

group to the Friedrich Ebert Foundation (FES), affiliated with the Social Democratic Party, in April 2002. Ever since, the quality center proposal has been discussed. It continues to be modified and debated in all relevant political and professional communities.

FES's advisory group had explicitly recommended the establishment of a state institute for quality in medicine to set standard criteria as prerequisite for the medical providers to compete for contracts with the statutory health insurance.

Model: NICE

The advisory group also recommended the creation of a separate state institution to analyze the effectiveness and cost-efficiency of new drugs before including them in the benefit basket. The English "National Institute of Clinical Excellence" (NICE) is explicitly quoted as a model. Support for a German NICE came from prominent health politicians in the social democrats' parliamentary group.

However, the concept of a national, public or state institute—the labels vary—as proposed by FES advisers differed considerably from the one outlined by the Ministry of Health on February 5, 2003. This outline, aimed at presenting milestones for a health system reform, had been prepared by some of the advisers who had already coauthored FES's policy paper.

In the document, the Quality Center is presented as an independent body—quite a difference from the state institution which had been recommended earlier.

Either way, state or independent—medical associations and physician groups fear a loss of therapeutic choices and an imposition of "state medicine." There is little confidence in any new institution proposed by the Ministry. Another argument against the Quality Center is that there are a number of highly qualified institutions already doing what the Center is supposed to do.

Toward "state medicine"?

Physicians are also strongly opposed to any type of compulsory re-certification of practicing physicians, which, according to draft bill, will be one of the tasks of the future Quality Center. However, for the past 10 to 20 years, German physicians have done little to introduce reliable, objective quality management tools except for localized quality circles for peer reviews.

Physicians opposed to benchmarks

Behind the fierce opposition of the medical community, there are many hidden fears. Transparency will reveal poor medical practice, hold physicians accountable for malpractice, inefficiency, poor practice management and waste.

Meanwhile, the plans for the Quality Center have become part of the draft Health System Modernization Act, a bill which comes in the context of reforming the German social security system as a whole and the reorganization of the German health care system in particular.

In the draft dating from March 18, 2003, the Quality Center's key functions are defined as follows:

- To provide information to the insured about services and quality assurance measures and to strengthen patient involvement and responsibility throughout the health care system
- To provide evidence-based information on the best available diagnostic and therapeutic measures, carry out Health Technology Assessments and recommend services for inclusion in the benefit basket, including disease management programs.
- To classify innovative prescription drugs according to their effectiveness (if the effectiveness is equal to pharmaceuticals already on the market, the new product will be immediately incorporated in the reference price system)

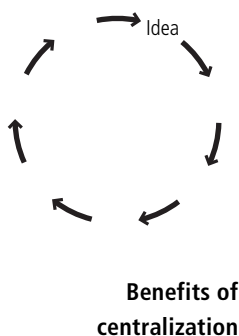
If implemented, the Health System Modernization Act would bring about considerable improvements in quality assurance and it would pave the way toward better continuity of care. Also, aiming to ease contractual relations between insurers and providers and to facilitate “integrated care,” the draft represents another approach to overcome fragmentation in the German health care system. It also contains provisions to improve the quality of services for the chronically ill.

Finland: The debate about the right level of specialized care

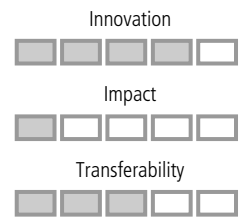
In January 2003, the Finnish Medical Society Duodecim (a scientific medical society) and the Academy of Finland (a national research council) held a consensus meeting on centralization in specialized care as a way to improve quality.

The panel thought that by centralizing certain diagnostic services and treatment of specific patient groups, cost effectiveness and quality of services could be improved in many cases. The panel stated that the benefits of centralization are related to factors such as:

- Concentration of medical excellence



- Improved opportunities to analyze outcomes and to learn from poor results
- Improved access to advanced diagnostic services
- Access to a second opinion



As drawbacks of centralization, the panel listed:

- Longer traveling times for patients
- Loss of quality and continuity of care, as experienced by Finnish patients

Drawbacks of centralization

The meeting did not give any organizational recommendations but gave advice on several topics such as: increase of outcome and cost-effectiveness research, improved recording of patient data and development of practice guidelines and patient transportation/ambulance services.

The panel recommended that the need for centralization be recognized as an issue for research and that the decisions on centralization should primarily be made by negotiations and agreements. The Ministry of Social Affairs and Health had issued a directive on the centralization of highly specialized services in 2001. This directive is not legally binding, and there are no data on its impact yet. Most likely the government will continue to promote centralization by voluntary agreements between municipal hospital federations.

**Centralization:
More research needed**

The organizers of the meeting (Duodecim and the Academy of Finland) represent medical and research excellence and established professionals. In this respect, there may be vested interests involved because of the connections to university hospitals.

Centralization of specialized care is dependent on the decisions of the 20 hospital districts. These districts are independent federations of municipalities. They vary in terms of their population base and the services offered. Accordingly, views about centralization tend to vary among the management of hospital districts. Hospitals are often large employers and a source of tax revenues. Thus centralization threatens the viability of small hospital districts, by decreasing their income and by making it more difficult to hire medical specialists and other expert staff. On the other hand, it offers large district hospitals new options.

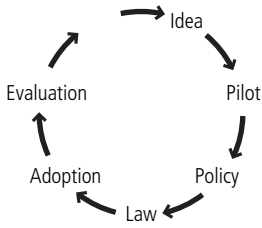
**Centralization
threatens small
hospital districts**

If the centralization of highly specialized care were accomplished, quality of care would probably improve. In some cases, the cost-effectiveness of the services would also improve. On the other hand,

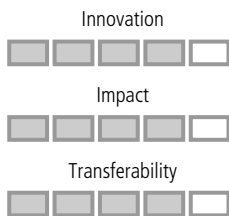
**Challenge:
Balancing quality
and regional equity**

access to centralized services may deteriorate in some regions distant from the large hospital centers.

The Netherlands: Compulsory quality improvement



Compulsory quality improvement



Quality assurance has been one of the main strands in the debate about health care system reforms in the Netherlands at least since the late 1980's. All the same there is still no comprehensive system of quality assurance.

In December 2002, the Minister of Health announced in a letter to parliament that in future health care providers would be required to systematically measure, improve or redesign and control the quality of patient care. This task was to be achieved by implementing a structured quality system now compulsory for every health care institution in the Netherlands. Previously, this system had been voluntary.

This initiative traces back to the 1996 Health Care Quality Law for Health Care Institutions. An evaluation of this law had shown that there had been only little progress in the implementation of systematic quality schemes. Accordingly, the Dutch Government decided to take control of this process.

Control over implementation is to be carried out by the Dutch Inspectorate of Health Care, an institution independent of the Minister of Health, which supervises quality and accessibility in the Dutch health care system. The government move was not an entirely new policy approach, as the Health Quality Act is still the framework, but it is now being applied differently.

The main actor is the Minister of Health, who acted under pressure of parliament, patient organizations and the media. The interest of the media in the quality issue of health care was, and is, overwhelming, but it is difficult to pinpoint the exact influence on policymaking.

Some hospitals have already developed promising quality systems. They include the development and use of certification and accreditation systems as well as the public reporting of their performance. They may act as role models for the dissemination of innovation.

Initially, the reaction of the national associations of service organizations and professionals was defensive. Now the idea is accepted by the main stakeholders. These stakeholders will not only be affected by the policy change but will also have to implement it.

Media interest in quality issues

Hospital quality schemes

Professional associations: From scepticism to acceptance

Notwithstanding the search for well-defined responsibilities of public and private actors in health care, the government is still heavily dependent on the cooperation of (private) health care institutions. Other stakeholders are the scientific organizations of health care professionals, health care insurers, patient organizations and the Health Care Inspectorate.

There are still substantial obstacles for the implementation of this policy. These obstacles are a combination of severe technical problems, e.g., the ability of service organizations to improve or redesign their care processes is still weak; quality assurance systems still have to be developed; the system is only at the beginning of producing reliable and usable performance indicators.

The Health Care Inspectorate will have the lead in supervising compliance with the law with the help of research institutions inside and outside the government. There is general agreement about the need for health care institutions to implement systems in order to improve, redesign, measure and control the quality of patient care. Nevertheless it is difficult to predict the outcome of that policy more precisely, as its impact on costs, equity and quality of health care is not known.

Service providers lack planning and management skills

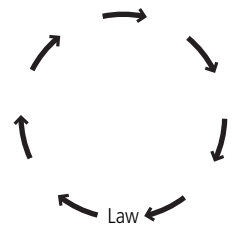
Need for quality management systems widely recognized

Spain: National Health System Act—The debate about decentralization, cohesion and quality of care

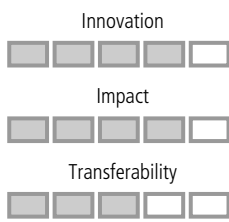
In Spain, the debate about quality has taken place in the context of larger changes in the roles of central and regional governments and in the health care system. Besides being a quality issue, the debate is about a national minimum benefit basket and equal access to the health care system all over Spain.

The National Health System Act bill was debated in parliament in March 2003. It is a central government piece of legislation, within the context of decentralization of health management responsibilities to ten Spanish regional authorities (comunidades autónomas) in 2002. Seven autonomous regions had received such decentralized responsibilities earlier. The responsibility of financing of regional health services was also passed onto the regional governments' system of finance. The main objectives of the bill were:

- To coordinate and standardize the services provided by the public health system among all regions;



Decentralization of health management responsibilities



- To improve quality (second opinion, guaranteed minimum benefit catalogue, guaranteed maximum waiting time across the regions, integration of information, continuing education for health professionals);
- To guarantee equal access to health services across regions; and
- To provide a mandatory list of services by the regional health authorities, which can be extended.

Cross-regional treatment fund

The central government will finance a fund to pay for health treatment of individuals across regions. Coordination of the national health system will be mainly through an existing organization, the “National Health System Inter-territorial Council.” All regional health authorities are represented on this council, as well as the central government health authority.

Central level holding onto overall control

It is expected that the Council will gain in power, which means more regional government participation in health policy issues. But there are some concerns that this power will be limited to basic public health issues. The central government still wants to keep control on areas affecting the national health care system.

Regional governments are especially affected by the planned legislation. Many of them are reluctant because the law is regarded as a potential way of centralizing health responsibilities. Furthermore regional governments want the central government to issue more guarantees for the funding of new services they now have to include and provide within their health service.

California: Pay for Performance

Improving quality at the physician-group level

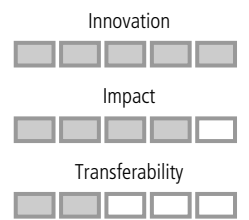
The health insurance system in the United States is far more fragmented than in Europe due to the many funding and purchasing sources. Nevertheless quality aspects attracted interest early. As early as 1989, the Agency for Health Care Policy and Research was founded. This federal authority was explicitly mandated to develop guidelines, including recommendations for their implementation and evaluation.

This reform is a California state-wide collaboration designed to create financial and non-financial incentives to improve quality at the physician-group level. The goal is to reward physician groups for performance in clinical care and patient experience by providing a

clear set of health plan expectations, use of common metrics and public reporting.

The reform is based on two main principles:

- Common performance measures for physician groups, developed collaboratively by health plans and physician group medical directors, researchers, and other industry experts
- Significant health plan financial payments based on that performance, with each plan independently deciding the source, amount and payment method for its incentive program



**Performance measures
Payment follows
performance**

On January 15, 2002, six California health plans (covering more than eight million Californians) agreed to launch the collaborative initiative. In October 2002, the Integrated Healthcare Association (IHA) unveiled the measures that will be used to evaluate physician groups. The first full year for Pay for Performance will involve 2003 data with health plan payments in mid-2004.

The performance measures selected represent a balance of three key areas: clinical quality, patient satisfaction and investment in information technology.

- *Clinical measures* account for 50 percent of the total physician group score. Performance is measured in the management of three chronic conditions: asthma, diabetes and coronary artery disease. Also included are three preventive health measures: childhood immunizations, breast cancer screening and cervical cancer screening.
- *Patient Satisfaction* accounts for 40 percent of the total score. Overall performance is based on individual patient satisfaction in four, equally weighted areas:
 - Communication with the doctor
 - Specialty care received
 - Timely care and service
 - Overall rating of care
- *IT investment* accounts for the final 10 percent of the score. This measure evaluates a physician group's ability to integrate data at the group level or to provide physicians with data at the point of care.

Performance measures

The plans for this reform are mainly driven by the private sector, which means health plans and physician groups. They wanted to take advantage of the fact that health plan premium increases in high single digits or more are expected for another three years in Califor-

**High premium
increases to fund
pay-for-performance
system**

nia. This created a window of opportunity to build a pay-for-performance system that could be funded in part out of these coming increases.

Private sector initiative

The idea was generated by the IHA, a leadership group of California health plans, physician groups and health care systems with at large academic, purchaser, consumer and pharmaceutical representatives. IHA's mission is to promote the continuing evolution of integrated health care, supported by financial mechanisms that align the incentives of purchasers, plans, providers and consumers, as the best means to achieve positive outcomes for the patient and the general public.

There are no precedents for this initiative.

Burden for smaller physician groups

Opponents argue that through pay-for-performance the remuneration increase they would have seen in any case is now at jeopardy. In addition, the burden of data collection and IT investment will disproportionately affect smaller and less financially stable physician groups.

Concerns about publishing results

Each year the performance results will be presented in a consolidated scorecard that will be made public and widely disseminated.

However, there was reservation on the part of many physician groups about making information on outcomes and patient satisfaction public. Health plans will be the primary source of the audited, administrative data. Physician groups may also send audited clinical data and information about meeting the IT measures.

The state-wide company managing the Consumer Assessment Survey process will provide the patient satisfaction data.

Evaluation by Rand

The evaluation of the program will be conducted by independent researchers from the Rand Corporation, a non-profit public policy research organization, and the University of California, Berkeley.

Integrated Care

This chapter deals with the issue of integrating health care. Lack of coordination and/or continuity of care is widespread in the health care systems of many countries regardless of the predominant financing and purchasing system. Many problems occur at the interfaces between inpatient and outpatient sector or inpatient acute care and rehabilitation, respectively. Hence the integration of health care is considered to have a big potential for improving quality and cost effectiveness.

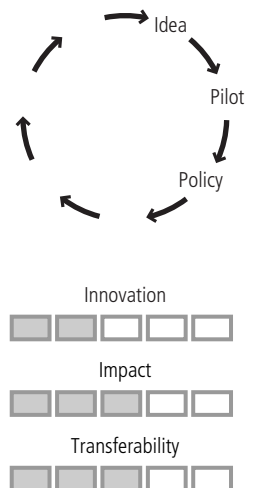
Canada: Public insurance to cover post-acute home care

There are two dimensions to the drive in Canada to improve the integration of post-acute care: the integration of different care sectors and the expansion of insurance coverage on home care.

In November 2002, the Commission on the Future of Health Care in Canada recommended amending the Canada Health Act to include coverage of acute home care provided after a stay in hospital. Due to technological changes in health care, hospital stays have shortened and the numbers of day-case procedures have increased.

The act specifies conditions to be satisfied by provincial insurance plans in order to get their full share of federal funding. Home care coverage is currently not required under this act. Thus shifting of some services from hospital to home has led to effective de-listing (de-insurance) of these services.

At their meeting in February 2003 (Health Accord), the provincial



First-dollar coverage

and federal governments agreed to the general goal of providing first-dollar-coverage rather than legislative reform to bring post-acute home care under universal public insurance. All provincial plans currently cover at least some home care services. But at present, there is wide variation as to what types of services are covered and for what kind of patients. So, in February the federal budget allocated funds to the provinces in order to pursue this and other health reforms.

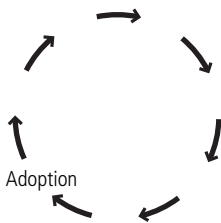
While the federal government has targeted funds to be transferred to the provinces over the next five years to cover home care, the provinces have considerable leeway in deciding how to spend these funds. In practice, these may therefore not turn out to be particularly strong incentives.

**Driving forces:
Public discontent**

Driving forces were a public who increasingly see home care as being an important part of health care and are frustrated with the patchwork of home care services provided across the country. At the same time, there is a growing body of evidence of the cost-effectiveness of post-acute home care as a substitute for in-patient care.

The next step for the health ministers (federal and provincial) is to determine a minimum basket of services by September 30, 2003. The issue will be whether the provinces think that the agreement provides sufficient flexibility for them to pursue their own priorities or whether they will engage in negotiations about what should be in the minimum basket, how compliance will be measured and by whom.

France: Toward a nursing care plan for the disabled



**Strengthening the
nurse's role in patient
management**

One example of the push for integrated care in France is the policy for introducing a nursing care plan for disabled people, integrating not only health but also social care.

The core idea of the nursing care plan is to reinforce the self-employed nurse's role in the management and coordination of the care for dependent patients.

Once the physician has prescribed a nursing care plan (DSI, Démarche de Soins Infirmier), the nurse assesses the patient's health and social needs and defines care objectives. The nurse decides how the objectives should be achieved using a combination of nursing care, personal and social care provided by herself or others. After the

plan is approved by the physician, it is subsequently implemented by the nurse. There are about 350,000 disabled patients who stand to benefit from such plans.

For nurses, the main objectives are to concentrate their activities on clinical aspects, and to delegate and supervise other aspects of care. This, it is hoped, will encourage the development of home care and limit the consequences of the shortage of nurses by inducing them to focus on the clinical and technical part of their activity and to delegate personal and social care. Furthermore, the aim is to improve the care provided by reinforcing coordination between various professionals, in particular those working in health and social services.

Services provided within a DSI are explicitly included in the “nomenclature” (benefit basket/fees). In 2002, the DSI became part of the Nurses National Agreement (“conventions”: fees and commitments on organization of care and adherence to guidelines) as an AcBUS (Accord de Bon Usage des Soins: optional, targeted agreements on best practice).

In the negotiation process substantial increases of all nursing fees were conceded, and in February 2003 the appendix was redrafted to include the new convention tools (AcBUS and Professional Practice Contract). If, within the framework of their National Agreement, nurses choose to join the Professional Practice Contracts (additional contracts pertaining practice improvement methods) they receive a flat-fee payment of €600 per year.

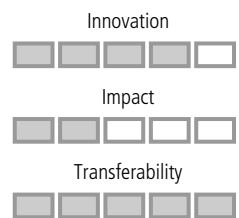
Some professionals argue that their income will decrease and their role in home care will become less important. They also criticize increased control through physicians and additional workload by administrative procedures. The départements’ councils (territorial communities with an elected assembly, which has authority in the areas of health and social care) assisting in the financing of social care are also likely to be concerned about the increase in their expenditure implied by the DSI.

The main actors involved in the implementation of the project are the nurses, their unions and public health insurance funds, which will monitor the overall impact as well as the compliance of the nurses who sign the Professional Practice Contract.

One of the main obstacles of this reform is the fact that it was conceived through negotiations within the health sector only. The social sector, which is already understaffed, may not be able to pro-

Addressing the shortage of nursing personnel

Expanded benefit basket to include nursing services

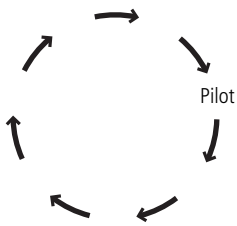


Decreasing income, increasing bureaucracy?

Lack of intersectoral preparation

vide the expected services. Thus it is difficult to predict the degree of success the DSI will have, and whether the financial incentives will be sufficient to modify nursing practices.

Spain: A pilot project for integrated care in Catalonia



Catalonia, one of Spain’s Autonomous Communities, is pioneering new organizational and managerial structures within the Spanish health care system.

The main objective of this policy is to establish a public purchasing system with integrated and coordinated health care. The pilot project is to be tried out in five parts of Catalonia, with a total population of 450,000 people. The integrated health services have to include at least primary care and hospital care. In all the participating areas there are several providers with different ownership (public, non-profit and private for-profit).

Services from integrated health care providers

Contracting issues

The public financing agency (Catalan Health Service) has signed an annual contract of coordination with the different providers in each area. This contract has to specify the following items: services included, providers involved in the contract, population covered, goals related to the coordination of health services and the reimbursement to be paid by the public sector.

Capitation payment scheme

The payment system is based on capitation. The rates are calculated according to the number of residents in the area and reimbursement per person based on the adjusted average public expenditure per person in Catalonia.

Incentive: Shared regional budget

Increasing the integration and coordination between providers in primary care and hospitals which belong to different organizations is one of the main objectives.

The main incentive for coordination and clinical integration is that different providers will have to share and redistribute an overall public budget covering all health care costs of the resident population.

The idea was generated and brought forward in the public health care system of Catalonia. It was first presented by the Health Department of Catalonia and a very powerful association of public health care providers (“Consorti Hospitalari de Catalunya”). Other public providers (“Institut Català de la Salut”) as well as some influential non-profit and private hospitals are less enthusiastic.

There is no policy paper stating the objectives and processes for this policy nor is there a commitment to diffuse this policy to all parts of Catalonia. All the same, a formal piece of legislation passed in May 2002, albeit as pilot project.

In the initial phase of implementation, considerable investments in coordination of different and fragmented health information systems are needed.

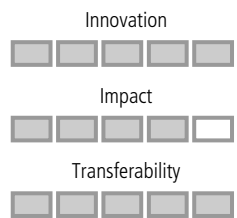
However, a lack of investment in this and other critical areas is evident. Moreover, financial incentives to integrate services are marginal, given that the government continues to allocate financial resources in a markedly retrospective way, allocating a separate budget to each provider in the area.

The pilot project includes provisions for a mechanism to review the impact of this policy. However, the evaluation method has been poorly defined and no evaluation results are available as of yet.

The policy is well intentioned and tries to reduce inefficiency through more integrated care and through financial incentives according to the size of the population covered. It is expected that in the year 2003 the financial allocation system will be more prospective, based on adjusted population, and allocated to the alliance of providers that serve a geographical area included in the pilot project.

Considerable upfront investments required

Lack of financial incentives



Population Health

There are growing efforts based on community health activities to advance public health. This goal requires influencing a wide range of policies: e.g., children’s health, access to care, environmental health, managed care, public health infrastructure, disease control, health disparities, international health, control over addictive substances, and measures to protect civilians and military personnel against bio-terrorism.

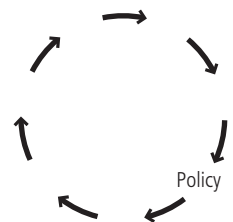
France has taken a broad approach by planning a comprehensive public health law, whereas the emphasis in New Zealand’s effort is on equal access to primary health care and the reorganization of primary health services to encourage a population-health focus.

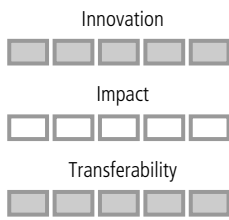
In December 2002 and January 2003, the US government announced programs to protect military personnel, health care workers, and civilians against bioterrorism and biological agents (smallpox vaccination program and “Project Bioshield”).

France: Draft five-year public health plan

The French health care system has historically stressed curative care rather than preventive care. Since the beginning of the 1990’s, however, efforts have been made to improve public health policy.

The High-Level Committee on Public Health (Haute Comité de Santé Publique, HCSP), created in 1991, undertakes regular overviews of the population’s health status, provides guidance and assists in decision-making regarding public health problems. Its first publication, in 1994, identified a set of priorities for France.





**Most effective tool:
Regional Health Plans**

Since 1996, based on the HCSP’s annual report and reports from Regional Health Conferences, a National Health Conference (Conference Nationale de Santé, CNS) takes place every year to make policy suggestions to government and parliament.

The CNS proposals are taken into account in the yearly Social Security Funding Act in an appendix on “orientations of health and social security policy.” So far the impact of these procedures on national public health policies has been relatively small.

Until now, the most effective tools for public health policy have been the Regional Health Plans, which define priorities at a regional level and strategies to implement them over several years, and Public Health Plans drafted by the Ministry of Health (16 plans in 2001–2002, related to asthma, diabetes, use of antibiotics, nutrition, Alzheimer disease, breast cancer, etc.).

Overall prevention and health promotion suffer from the many financing sources, the dilution of responsibilities and the fragmentation of actors, which impairs their global efficacy.

In October 2002, a national technical group of about 80 experts was set up to assist the General Director of Health. The mission of this group was to propose alternative strategies and criteria for choosing health priorities. The groups suggested the following:

- to identify the determinants of ill health;
- to set out the options for interventions for each possible priority;
- to recommend operational quantified goals to achieve, interventions and indicators to evaluate them periodically; and
- to identify stakeholders that should be mobilized, as well as possible risk factors.

The group was composed of representatives from government services, of health sector agencies, of research and statistical institutes and of experts. In March 2003, the group submitted a draft version of its report to the General Director of Health.

**Public health
objectives for the next
five years**

The government now wants to present a bill to parliament in June 2003 to define public health objectives for the next five years. A set of health-related issues will be identified as priorities to improve the health status of the population. For each of these health issues, the bill will set clear and realistic goals to be attained within five years, the public health strategies required to achieve them and a set of indicators to evaluate the achievements annually.

The law is also expected to clarify the missions of the many insti-

tutions which are responsible for public health (national vs. regional level, state versus non-governmental organizations, e.g. health insurance funds).

All public health actors have been supporting and promoting this project. The General Directorate of Health will certainly play a central role in the implementation of the law.

New Zealand: Primary Health Organizations

The reported policy is part of the overall health policy of the current New Zealand Government. The key objective of this policy is to improve access to primary care by reducing the level of copayments. The emphasis of the strategy appears to be on prevention and on alternatives to traditional general practice, with nurses in particular being a given a much higher profile.

The Primary Health Care Strategy of the Minister of Health was released in February 2001 after a phase of public discussion and submissions.

The 21 District Health Boards will implement the national Primary Health Care Strategy through Primary Health Organizations (PHO's).

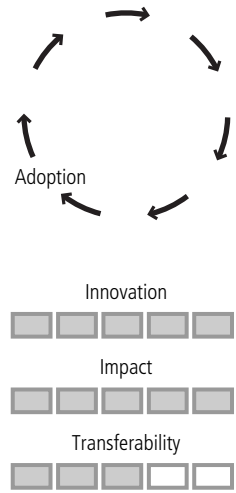
Essential features of PHO's:

- Population-based preventive services
- Personal first-line general practice services
- Lower copayments
- Working primarily with under-privileged population groups
- Ensuring cooperation between the different providers

These tasks are supposed to be achieved by a team approach, coordination around the population needs and flexible use of the professions (e.g., using a nurse instead of a physician).

The PHO's are funded on a population-based formula. They have to be non-profit bodies, responsive to their communities and accountable for the use of public funds. Between July 2002 and January 2003, eight PHO's were established. These local provider organizations comprise general practitioners, nurses and a range of other primary care providers.

Enrollment by patients in PHO's is not compulsory. However, lower copayments provide a strong incentive to enroll. Incentives for



Primary Health Organizations

Participatory and interdisciplinary approach

Population-based funding of PHO's

Low copayments

PHO's are to encourage people to enroll into their organization, as they are funded on a capitation base.

One problem that may arise from capitation funding together with lower copayments (and hence increased demand) is that it may encourage shorter consultations.

Priority: Maori and Pacific Islanders

During the initial phase, priority is given to organizations with members from underprivileged parts of the population. The key groups who will initially have access to PHO's will be Maori, Pacific Islanders and low-income groups who live in an area where a PHO has been established. Eventually the whole population will be affected in the sense that their primary care will be delivered by a different type of organization.

General practitioners who continue to provide services outside of PHO's are concerned that patients might move to cheaper PHO's. General practitioners and their umbrella organizations fear that they might lose patients and therefore be forced to go out of business.

Regressive effects

The policy could be regarded as unfair (at least during the establishment phase) because it directs additional funding to all members of PHO's. Therefore wealthier people using a PHO will receive higher subsidies than poorer, needier people attending traditional general practitioners.

Higher subsidies for needy patients

The government is now trying an alternative formula proposed by the Independent Practitioner Association Council in three of the new PHO's: higher subsidies for individual needy patients within PHO's.

No special legislation was required, and the overall model remains as initially proposed. The Ministry of Health has contracted for the evaluation of the formation and the outcomes of PHO's: their impact on utilization rates by ethnicity and age, services provided, population covered and reported incidence of diseases.

High government spending required

The government has committed €186 million additional funds over a three-year period for the establishment of PHO's. This money is expected to cover both the increase in patient subsidies and establishment costs. As the higher subsidies will require a significant amount of extra government funding, full coverage of the country by PHO's is likely to take three to five years. If the allocated funds are inadequate, the deficit is likely to be shifted back to the patient, so that copayments may not be reduced as much as expected.

Special Issue: Addressing Coverage Gaps in the US

The health care funding system of the USA consists predominantly of voluntary employer-based private insurance (approximately 57 percent of the population are covered by this type of insurance), private insurance purchased by individuals and public insurance coverage for the elderly, disabled or poor. Public and private health insurance cover 85 percent of the population. While it is predominantly an employer-based insurance system, not all employers offer health insurance. Not all low-income workers can afford insurance, and there are 41 million uninsured Americans.

People over 65 years and many of the disabled (a total of 13 percent of the population) are covered by Medicare, an insurance scheme that provides basic services with deductibles and/or co-payments.

14 percent of the population are covered by Medicaid, a program jointly funded by federal and state governments, which provides medical and health-related services to low income or disabled persons meeting defined eligibility criteria. Within broad national guidelines set by the federal government, both service standards and eligibility criteria are at the administrative discretion of the states. In addition, there are special eligibility levels for children and pregnant women.

The rest of the population is insured through their employer or expected to purchase insurance on their own. This is often hard to afford for a considerable part of the population. Uninsured people account, it is estimated, for about 15 percent of the population.

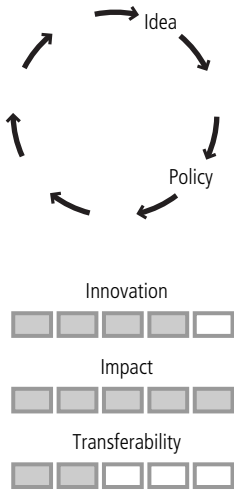
The spectrum of reform proposals ranges from expansive Medicaid system reform, reforms of existing modes of funding (like

**15 percent of
population uninsured**

**Wide spectrum of
reform proposals**

SCHIP, a program for children), new funding options like tax credits for uninsured people or employer-based universal health coverage (diverse private and public payers) to the proposal of universal health coverage in Hawaii (single-payer system).

Proposal for Medicaid Reform



Medicaid became law in 1965 as a jointly funded venture between the federal and state governments to assist states in the provision of adequate medical care to eligible low-income and needy persons. Medicaid is the largest program providing medical and health-related services to America’s poorest people serving approximately 40 million people.

The program has essentially been a state/federal funds match in which state dollars (approximately 43 percent, proportion varies by state) spent for Medicaid beneficiaries are matched by the federal government (approximately 57 percent). Within the broad national guidelines which the federal government provides, each of the states establishes its own eligibility standards; determines the type, amount, duration, and scope of services; sets the rate of payment for services; and administers its own program.

A state’s Medicaid program, however, must provide coverage for basic services, including inpatient and outpatient hospital services, physician services, prenatal care, vaccines for children, home health care for persons needing skilled nursing services, etc.

“State Health Partnership Allotments”

On January 31, 2003, a proposal was issued by the Bush administration that would give states the option to continue operating their Medicaid and State Children’s Health Insurance Program (SCHIP) under current rules as open-ended funding or as block grants, termed “State Health Partnership Allotments.” In states that opt for a block grant, current Medicaid and SCHIP funding would be replaced by two allotments, one for acute care and one for long-term care. The aim of the proposal is to give states fiscal relief flexibility to reduce or tailor benefits to meet their needs, and to encourage innovation and expansion of coverage to new parts of the population.

Allotments for acute care and for long-term care

Accordingly, these states would receive increased federal payments of €3 billion in 2004 to fund new programs and €12 billion over seven years thereafter. For the three years after that, federal funding would decrease to offset the additional up-front payments, so that

the program would be cost-neutral to the federal government over ten years.

States would no longer have to put up matching funds, but instead would be subject to “Maintenance of Effort” spending requirements which would be pegged to their Medicaid spending in 2002 and adjusted yearly to the Medical Consumer Price Index (as the Medical Consumer Price Index increased at an average of 4 percent per year between 1995–2002 while Medicaid expenses grew at 7.5 percent, the lower growth rate would allow states to lower their commitment).

The proposed new block-grant scheme would allow states to change eligibility requirements and alter or “tailor” benefits that are currently extended to “optional or non-mandatory beneficiaries,” who represent one-third of Medicaid beneficiaries and many of the sickest and poorest.

Congressional Democrats, consumer and family advocacy organizations have opposed the proposal, claiming it would eliminate the Medicaid entitlement and benefits for nearly 12 million “optional beneficiaries,” including five million children enrolled in SCHIP. In response, a Democratic alternative, the “Family Improvement Act” has also been put forward.

If implemented, the Medicaid reform would achieve a cost-neutral federal expenditure on Medicaid services and provide short-term fiscal relief and increased flexibility for the states, but would likely reduce flexibility as expenditures shrink in later years.

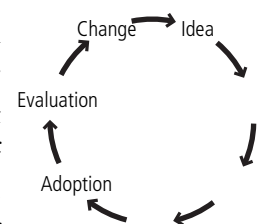
It also may not achieve the objectives of extending coverage to more uninsured individuals or of ensuring the long-term survival of Medicaid if states continue to face increasing budget crises and use the block grant flexibility to cut coverage for “optional beneficiaries.”

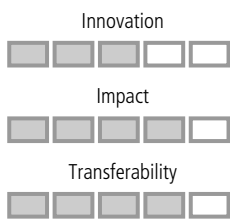
Optional Medicaid populations at risk

Medicaid reform: Short-term flexibility at the expense of quality, coverage and equity

Proposal for SCHIP Reform

In 1997, more than 10 million children were uninsured (one-fourth of all the uninsured and 14 percent of all children), including over three million eligible for Medicaid. This number marked a significant increase over the 8.2 million uninsured children in 1987. Many of these children lived in families whose incomes were too high to qualify for Medicaid but too low to afford private coverage. The lack of coverage disproportionately affected minority children.





Program to cover uninsured children

In response, the State Child Health Insurance Program (SCHIP) was enacted in 1997. SCHIP is designed to provide health insurance coverage to children in families who are unable to afford private health insurance coverage, but make too much money to qualify for Medicaid. SCHIP provided €44 billion for a period of ten years, the largest health care investment in children since the creation of the Medicaid program. States were required to provide matching funds and were given broad flexibility to tailor programs to their own circumstances.

As an incentive to participate, the federal government matches state funds at a rate 30 percent higher than the state's Federal Medical Assistance Percentage, which determines the portion of Medicaid expenses the federal government contributes (maximum match is about 85 percent). SCHIP was targeted at 200 percent of Federal Poverty Level, but if a state had already expanded Medicaid to that level, it could go higher.

In 2001, states were given the opportunity to expand SCHIP coverage to low income parents, and in 2002, states were allowed to offer health care coverage to low-income expectant mothers for prenatal care and delivery, regardless of the mother's immigration status. An additional 5.3 million children from low-income families have been covered (the percentage has dropped from almost 14 percent of all children in 1997 to 11 percent in 2001, but continued efforts are vitally important, given that low income children still constitute over 60 percent of uninsured children.

One study showed that after enrolment in SCHIP for one year, the percentage of children reporting an unmet health care condition was reduced by more than half, to just 16 percent, a finding that suggests both cost benefits and important gains in quality of care. Although participation in SCHIP is voluntary, the program is operating in all 50 states and the District of Columbia.

By expanding health insurance coverage to 5.3 million uninsured children, SCHIP has demonstrated itself to be a creative policy initiative for incrementally improving access to health care for low income children.

SCHIP—achievement at stake

For states opting to take up the proposed new block grant offered as a part of the proposed Medicaid reforms described above, SCHIP would be effectively eliminated, as the dedicated funds and enhanced match would no longer apply and the block grants could be used for other purposes. With states facing the biggest shortfalls in their

budgets since World War II and under tremendous pressure to reduce costs, including those for health care programs, they may have no choice but to make budget cuts that will result in low income children losing coverage.

Tax credits for the uninsured to purchase health insurance

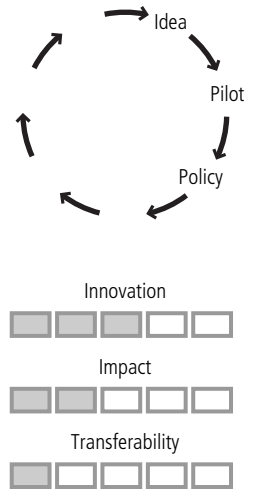
In January 2002, the Bush Administration proposed a plan to provide more coverage to the uninsured which included tax credits for uninsured individuals and families who do not participate in public programs such as Medicaid. The tax credit plan will use €81 billion over 10 years to provide refundable tax credits for workers who do not have employer-sponsored health coverage to purchase individual health insurance policies. The plan hopes to allow up to six million out of about 41 million uninsured Americans to gain coverage through the purchase of individual health insurance policies.

It is intended to address the coverage problem without expanding the current insurance programs Medicaid and Medicare. The uninsured would be given small, non risk-adjusted tax credits to purchase insurance. Given that the size of the credit is small, it is not clear how many low-income families would actually use the program. The General Accounting Office reported that a mid-level family annual health insurance premium was €6,700 in 1998, while the credit would only provide up to €2,700 for the poorest families.

While it is a new approach to offer tax credits to the uninsured, encouraging them to purchase individual (non-group) health coverage, the idea of tax credits or rebates for health services is not new. For example, flexible benefit programs allow workers to set aside pre-tax income for certain health care services.

While healthy young men may be able to purchase individual health insurance policies for €1,000, most women, older people, families, and people with health problems, face much higher premiums which would not be covered by these modest tax credits.

Similarly, premiums would likely be unaffordable for many people with incomes under €13,500. Under the proposal, young healthy males might opt out of employer-based insurance plans where they are required to pay a share of the premium, if they could buy individual insurance with lower premiums using the tax credit.



No expansion of Medicaid and Medicare; small non risk-adjusted tax credits for the uninsured

This would drive up rates for employer groups, as they would have higher proportions of sicker, older workers and could potentially lead more younger employees to opt out, further raising premiums and businesses to drop coverage as it became cost-prohibitive.

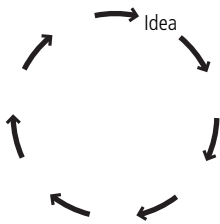
States could also use the opportunity to scale back Medicaid and child health insurance plans since they are in serious fiscal crisis which might end up increasing the number of uninsured instead of reducing it.

Opposition favors risk pooling over individual insurance

Opponents (e.g., Democrats, consumer and family advocacy organizations and a number of health policy think tanks) would like to see any tax credit plan be focused on the uninsured joining group markets which pool risk, as opposed to the individual insurance market, in order to avoid some of the potential pricing and selection problems described above.

Consumer advocacy groups are also calling the proposal far too modest to actually help. While many other proposals using tax-credits in some form to provide coverage to the uninsured have been introduced or discussed, the Administration’s proposal remains largely unchanged.

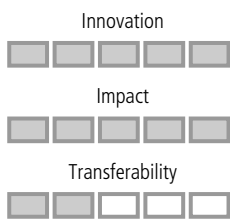
California: Blue Shield proposal for universal health insurance



The Chief Executive Officer of Blue Shield of California (a not-for-profit health plan with over two million members) recently unveiled a proposal to offer a minimum benefit package to all Californians regardless of their employment status. The proposal is to link the private and public health insurance systems to extend benefits to the six million uninsured Californians.

Employers (except very small companies) would be required to offer coverage or contribute the financial equivalent toward an essential benefit package for all their employees. Employees would have the option to opt out and purchase coverage individually. The state government and the private sector would work together to enroll Californians participating in state welfare programs.

Coverage would be bought on a “guaranteed issue” basis. Subsidies would be given to those who cannot afford the full payment. An essential benefits package defined by independent medical professionals would specify the minimum level of coverage. All plans would be required to offer this minimum package of services.



Financing methods may include a broad-based tax, personal income tax, sales tax, a health insurance premium tax, a health care provider fee or a reasonable combination. This Universal Coverage idea is innovative in that it is the first time a health plan has taken charge of presenting a solution to the problem, though various solutions have been proposed previously.

Private health plan taking the lead

The plan requires considerable coordination and cooperation between the private and public sectors of the health care system.

Considerable public-private cooperation required

The idea affects several different groups and actors: private insurance executives of health management organizations, uninsured people, employers and employees, California's taxpayers and residents, government officials and agencies, and health care providers.

The idea has been accepted by some actors like health insurers and representatives of the uninsured. But there are also significant sources of resistance among businesses and employers. Furthermore, individuals who are uninsured either by choice or unintentionally may also resist the mandate to buy coverage on their own. In addition, tax increases as a source of funding for this program might meet opposition as well.

Resistance among businesses and employers

The implementation of the plan will require formal legislation, to be presented and passed by the two Houses of State Legislature as well as approval of the Governor of California. It will also require cooperation and action by all California health plans, employers and health care providers to negotiate rates and accept members in need of the essential benefits package.

Government agencies will need to dedicate resources and may not currently have such personnel or systems in place. Also, the increase in enrollment for state-funded coverage may strain the health care system in that there are very few physicians who currently accept Medi-Cal (California's Medicaid plan).

Universal coverage has received widespread support, but bills proposing a single-payer system have thus far been rejected. Unlike a single-payer system, the new idea spreads the burden of health care costs across public and private segments in California, so it may be more acceptable to consumers and politicians.

Burden of health costs spread across the board

The key incentive is that insuring the uninsured would decrease health care costs across the board because insurance risk would be spread throughout a more diverse population and expensive emergency room treatments for the uninsured would be eliminated.

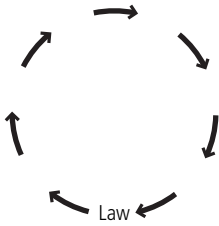
Shared public-private burden + spread of risks = reduced health care cost

Undesirable effects may be increased taxes and costs for those

Likely drawbacks:
increased taxes,
decreased hiring,
moral hazard

with higher incomes, employer resistance to providing insurance and decreased hiring, moral hazard of services provided at a low cost, or providers refusing to serve members of low-cost health insurance.

Hawaii: New legislative move toward universal health insurance



On January 24, 2003, a universal health care coverage bill was introduced in the Hawaii State Legislature. On February 4, the bill (HB 1617) was passed with amendments by the House Human Services and Housing Committee and without amendment by the House Health Committee. The bill was then referred to the House Labor and Public Employment Committee, which, on February 12, 2003 deferred the bill, thus essentially killing it.

Highly contentious, the bill raised the attention of many people. It represented one of the more ambitious bids for universal coverage in the United States. Hawaii's unique location—an island with a small population and few players—makes it an interesting testing ground for universal coverage in the United States as well as a useful tool for examining the stakeholder positions concerning universal coverage.

Significance beyond Hawaii: Test case for universal coverage

The Universal Coverage effort behind HB 1617 was led by a Hawaiian woman, Ah Quon McElrath, a well-known social activist. McElrath worked with the Chairman of the House Health Committee, Dennis Arakaki (Democrat), to develop the bill.

Single-payer system: Insurance plans combined under state health authority

The proposed bill would have replaced the existing system with a single payer one, by establishing a State Health Authority to provide universal health coverage to all residents and a State Health Authority Commission to determine the costs and financing of the system. More specifically, all insurance plans (public and private) would have been combined under the state health authority, which in turn would have collected money from all sources.

The bill intended:

- To distribute health resources more equitably;
- To extend health insurance coverage to the uninsured; and
- To stabilize health care costs.

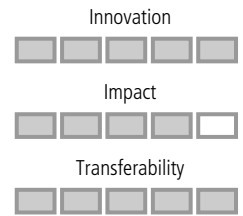
Hawaii, like other states, has seen an increase in the number of uninsured. Currently, 10 percent of Hawaiians are uninsured, which means an increase of about six percentage points since 1994. Hawaii has also seen an increase in health care costs. The authors of the bill

cite the increasing costs as the main reason for Hawaii’s need for a new approach to health care.

HB 1617 was a mandatory program that would have affected the entire health system in Hawaii. Health insurance companies, in particular, would have been significantly affected by this bill because it would either have eliminated the need for private insurance companies or would have set up an arrangement where the insurance companies have to contract with the state.

Health care providers such as hospitals and physicians would also have been affected because they would have had to negotiate rates with the state authority. Individuals would have felt the change in ways that would be positive for some and potentially negative for others.

It is likely that universal coverage advocates will continue their efforts and will try to have a similar piece of legislation introduced in future legislative sessions.



International Monitor on Health Policy Developments¹

Questionnaire (March 2003)

The approach

Overall goals

Does health policy reform work? How and why? This is what this questionnaire intends to explore. The focus of this survey is therefore on:

- The analysis of the common features of health policy and health care reform across industrialized countries; and on
- The sequential analysis of health policy ideas, change processes and change management in health policy. Particular attention will be paid to key players, their interactions and on stewardship in health policy as a factor of change.

Network objectives

- To obtain and analyze information on changes and developments in health sector reform on a regular basis and over time
- To scout, monitor and follow a (new) health policy idea or approach from its inception stage through the policy and law-making process to implementation
- To describe and analyze the formal and informal interactions of all players and stakeholders at each stage in the decision-making process
- To capture best practice models already established

1 The term “Health Policy Development” has been chosen to capture both active reform processes (e.g., laws and acts) as well as technological and/or organizational changes with their implications for health policy. Similarly, the term “development” encompasses the various stages of a “health policy idea” from its inception or appearance via acceptance, adoption and implementation to decay, abandonment or change.

What we want to do with it

- To establish an effective tool for monitoring innovative ideas as they evolve and travel within and across health care systems
- To systematically analyze decision-making processes leading to health sector reforms or facilitating change in health policy
- To review and disseminate that information in an efficient, straightforward and rapid manner among all network partners (half-yearly reports, Internet platform)
- To organize the transfer of findings and results into the process of German health policy making (consultations, advisory activities)

A word of caution

We do not seek to provide health system descriptions for the countries participating in this network. For most network countries, comprehensive health system descriptions already exist. We particularly recognize the country studies developed and published by the European Observatory on Health Care Systems, the “Health Care Systems in Transition” (HiT) profiles. HiTs exist for 12 out of currently 15 network countries (for Canada, the report is from 1996). For Japan, the OECD Labour Market and Social Policy Occasional Paper 56 is similarly comprehensive. For Singapore and the US, comprehensive documents still need to be identified.²

Structure of this survey

In each survey phase covering six months, we will ask you to provide information on the progress of a health policy idea, approach or instrument from the early stage of inception towards implementation over time.

For every six-month period, you will be asked to describe five or more such key health policy developments, selected according to the four criteria mentioned below. We are interested in comparing the background/context of a key health policy issue, its players/process interactions, and, with a view to implementation, its potential impact.

² These documents will be accessible via the Network Web site in spring 2003.

The criteria for selection of a health policy development are:

- Relevance and scope
- Impact on status quo
- Degree of innovation (compared with national and international standards)
- Media coverage/Public attention

We are particularly interested in those reforms with significant impact on the overall structure and organization of your country's health system.

The questionnaire starts with a two-dimensional matrix, picturing key issues (12 categories) and their development over time (seven process stages). For each of the selected key health policy issues, we will ask you to provide a more detailed analysis of stakeholders and their interests and interactions along the stages of the process. The matrix will allow you to categorize both the issue addressed and the current stage of the process.

It is possible that some ideas evolve very fast from one stage to the next. You may also observe that others do not necessarily follow the process, "surfacing" in at stage two and/or "jumping" across various stages during the period observed.

Matrix—First dimension: Issue clusters³

1. Sustainable financing of health care systems:

This cluster has been divided into "funding and pooling of funds" and "remuneration and paying providers," i.e., the relationship between population/patients and payers on the one side and between payers/purchasers and providers on the other. The first sub-section includes generation and collection of funds for health care (i.e., taxes, social insurance contributions or copayments) as well as their pooling and (re-)distribution to the payers (sickness funds or health authorities, including risk structure compensation). Important considerations relate to efficiency and equity. The second sub-section includes budgeting, diagnostic-related group (DRG) systems, drug pricing policy, etc.

2. Human resources:

Education and training, numbers and planning, projected shortages of qualified medical and non-medical personnel, etc.

3. Quality issues:

This should include tools such as guidelines, evidence-based medicine, peer reviews, re-certification of physicians, outcome measurements as well as measures to make them work (e.g., purchaser-provider contracts, financial/non-financial incentives), patient

3 The issue clusters in this matrix are a result of the kick-off meeting of the network participants in Germany in September 2002. In a brain-storming exercise, participants were asked to identify the current five major health policy challenges in their countries. The brain-storming was followed by a factor analysis grouping all issues raised in clusters/categories. The categories were completed during discussions and reorganized for survey purposes.

safety and medical errors/malpractice, public disclosure of provider performance data, benchmarks, best-practice.

4. *Benefit basket and priority setting:*

This cluster includes both the decision-making process on (new) technologies and services, e.g., the question of whether health technology assessment becomes mandatory, as well as actual changes in the benefits covered, e.g., the exclusion of dental care.

5. *Access:*

In contrast to the previous cluster, which deals with technologies and services, this cluster is about de facto access by individuals to health care, including problems such as rationing, waiting lists (equity concerns!), strategies for solving these restrictions and for reducing disparities in care.

6. *Responsiveness and empowerment:*

Responsiveness of the health care system and of health policy to patients, payers'⁴ expectations, patient rights and patient charters.

7. *Political context and public administration:*

Refers to levels of competency (including EU), centralized vs. decentralized responsibilities, policy-making styles, stewardship role, etc.⁵

8. *Organization/integration of care across sectors:*

This cluster incorporates developments which aim at the reconfiguration of health care providers, especially to overcome institutional and sectoral boundaries in order to provide disease management and other forms of integrated care.

9. *Long-term care:*

Long-term care and care for the elderly (aiming particularly at this group even if it also fits into one of the dimensions above).

10. *Role of private sector:*

This cluster deals with developments that specifically aim at changing (regulating, deregulating) the role of the private sector in funding and/or delivery of health care. Depending on your country, it may be useful to make a distinction between private for-profit and private non-profit health facilities. You may also want to report a development that occurred within the private sector (mergers, concentrations of payers and/or providers, i.e., HMOs/PPOs, health insurances, hospital chains, group practi-

4 The term “payer” is used of health care in both (social) health insurance systems (the insured) and state/public health care systems (tax payers). In a larger sense, payers can also be purchasers of health services (public or private insurers, social services institutions covering determined population groups), employers contributing to health insurance funds and patients paying out of pocket.

5 Political context: Here we would like to know more about changes affecting health policy competencies (mix/split) at the government level (ministry of health, ministry of labor/social security, ministry of consumer protection, ministry of the environment), shifting competencies and/or responsibilities in the organization of the health care system (funding, remuneration and service delivery). Key words may be: decentralization (devolution, delegation) or centralization trends; role of corporatism and interest group lobbying in policy making; fragmented levels of responsibility for service delivery (in-patient vs. out-patient services); (changing) role of local government vs. central government in health planning, facility management, etc.; mechanisms of civil society participation in health care issues.

ces). However, the invention of a breakthrough technology should be categorized in the next cluster and not here.

11. *New technology:*

While we are not interested in all new technologies, this cluster has been included to report and assess technological innovations expected to have a major impact on the effectiveness, quality, costs or the organization of the system (genetic testing, chip card, electronic patient records; teleconsultations, etc.).

12. *Others:*

If you feel that the health policy development you wish to describe does not fit in any of the clusters, you may create an additional one.

Matrix—Second dimension: Time line/How ideas travel/Process stages

1. Ideas for reform voiced, discussed in different forums (e.g., think tanks, professional/providers' groups, advisory councils, consumer organizations, supra-national agencies)—even at an early stage, possibly far from a larger expert audience and/or the political arena
2. Innovations or putting into practice of ideas voiced previously (e.g., at the local level, within institutions, as pilot projects)
3. Acceptance of ideas within relevant professional community and/or (governmental) policy papers at a central or regional level
4. Legislative process: This is perhaps the most complex and interesting stage of all, critical for the success or failure of a reform proposal. Please tick here for any legislative proceedings—from the moment a bill is proposed through hearings and lobbying until the effective enactment or rejection of the proposal.
5. Adoption: Measures to facilitate the implementation of a policy at the regulatory and professional level.⁶
6. Evaluation of change—acceptance or failure?
7. Abandonment or further change

The subsequent questions center around the causes and determinants of a particular health policy issue and around the steering and regulatory aspects of this issue.

While we ask you to take into consideration the criteria for the selection of a health policy development (i.e., relevance and scope, impact on status quo, degree of innovation and media coverage/public attention), the choice of what health policy development is worth reporting and commenting on in any given round will obviously depend on your expert judgement.

6 Adoption should include: formulation of accreditation requirements, standards of professional organizations, influence of private sector/market/industry in the adoption process. Note that this step may follow process stage 2 or 3 directly if no legislation was enacted.

Please note that the answers to the questions can be brief: Ten to 40 lines per item, or a maximum of three to four pages per policy should do.

We would like to encourage you to structure your responses according to the guiding questions at the beginning of each sub-set, for two reasons: One, the sub-questions under (5) follow the rationale of the time line in the matrix. Two, evaluation and overall reporting will be easier for us when we receive step-by-step answers.

Finally, it would be helpful if you could give references for your information or indicate Web sites for more detailed information on a given policy.

Please photocopy and fill out the following questionnaire for each of the selected health policy issues!

*Health Policy Network Questionnaire—Survey # 1
Period covered: September 2002—February 2003*

Policy development #___

1. Title of health policy development reported

Has this policy been reported in previous surveys?

Yes, in survey _____, date: _____

No

2. Anchoring the selected health policy issue in the matrix

Please go through the categories of health policy issues listed in the matrix below and tick where appropriate:

- This may be a mark in one box only or a horizontal line if a health policy development has progressed through several columns (stages) during the six months.
- If a policy clearly relates to more than one category (e.g., the introduction of a new remuneration system to facilitate integrated care), then all the appropriate boxes/lines should be marked accordingly.

		Process stages						
Issue categories	"Idea" ⁷	Local or institutional innovation	Acceptance/ Policy paper ⁸	Legislative process ⁹	Adoption and implementation ¹⁰	Evaluation	Abandonment/ Change	
1.1	Sustainable financing I: Funding and pooling of funds							
1.2	Sustainable financing II: Remuneration/ Paying providers							
2	Human resources— training and capacity issues							
3	Quality improvement and assurance							
4	Benefit basket, priority setting							
5	Access to health care (rationing, waiting lists etc.)							
6	Responsiveness to and empowerment of patients							

- 7 This first section refers to any idea floating but not anywhere near a more formal inception stage. Under this heading, you should list ideas that have surfaced only recently and ideas which have been in the pipeline for some time (retrospective view). This means that the reporting period for this column is not restricted to the past six months. That way, we will establish a “stock of health policy ideas-in-development.” Over time, we should be able to observe ideas (re-)appearing a few years down the road (e.g., medical savings accounts in the Australian health policy debate, primary care trusts in the UK).
- 8 This refers to any formal written document short of a bill: Tick here for any health policy paper or program, health plan or similar paper issued for the policy described here over the past six months.
- 9 We renamed this column (previous title: Enactment) to explicitly cover all aspects of the legislative process: from the formal introduction of a bill legislation to parliamentary hearings, lobbying by interest groups and industry and the success (legislation passed) or failure of a proposal.
- 10 Please use this column for any steps taken towards adoption and implementation at both legal and professional levels: e.g., secondary legislation/regulations, accreditation requirements, organizational standards, etc. That way, the distinction between the legislative process and the adoption phase should become clear.

7	Political context, e.g. centralized vs. decentralized policy making							
8	Organization/ integration of care across sectors							
9	Long-term care, care for the elderly							
10	Role of private sector							
11	New technology							

3. Content of idea or health policy

Please describe the main objectives, characteristics and expected outcomes of the policy (idea), approach or instrument. What type of incentives (financial, non-financial) are built into or related to this policy? Whom do they affect and how?

Structured summary Q 3 (optional)

– Main objectives/characteristics of instrument:

– Type of incentives (financial, non-financial)

– Group(s) affected

1) _____

2) _____

3) _____

4. Overall political and economic background of policy development

Was there a change in Government or political direction? Was there a need or pressure to comply with EU legislation (if applicable) or with WTO/GATS regulations?

Has this health policy been derived from or does it aim at attaining a goal formulated in an overall national (or regional) health policy statement such as health policy program, health plan, health goals? If yes—which one?

Structured summary Q 4 (optional)

- Change of government—comment: _____
- Need to comply with EU regulation—comment: _____
- Need to comply with WTO/GATS—comment: _____
- Need to comply with something else—comment: _____
- Change based on an overall national health policy statement (title) _____

5. Process

5.1 Where, when, and by whom was the *idea* generated? Who were or are the driving forces behind this idea and why?¹¹ Is it an entirely new approach, does it follow earlier discussions, has it been borrowed from elsewhere? Is it aimed at amending/ updating a prior enactment (“reforming the reform”), and why would it have been passed? Who were the main actors? Are there small-scale examples for this *innovation* (e.g., at local level, within a single institution, as pilot projects)?

11 Driving forces/causes could be: Failure or poor performance of a previous approach (which one?), pressure by interest groups (which one[s]?), socio-economic conditions, budget constraints or the media. Also, new ideas may have been initially developed from within single institutions (bottom-up initiatives rather than top-down policy initiatives or legislative motions).

5.2 How were or are other stakeholders/affected groups involved? Who opposes/opposed this idea or policy and why? Has the idea or policy been accepted by relevant actors; or was it abandoned? Was a policy paper formulated? By whom? Who held the leadership role in bringing forward this idea or policy? Were there alliances between stakeholders in support of the idea or new policy? Who mediated conflicts of interest between stakeholders?

5.3 Did or will the development of this idea or health policy lead to a formal piece of *legislation*? How far has the original proposal been changed or modified in the process?

5.4 Which actors and stakeholders were, are or will be involved in the *adoption* process towards *implementation*? Which means are necessary? Who moderates the process? Were or are these actors and stakeholders actively participating in the process? If not, why? Who else is or will be directly or indirectly affected by implementation? Why and how? How successful was implementation or, in your opinion, what are the *chances* of implementation? Where were or are the obstacles? What incentives would facilitate the implementation of this policy, in addition to, or instead of the incentives provided? What was done to convince, or promised to appease, the opponents to this policy?

5.5 Does this policy foresee a mechanism for regularly reviewing the implementation process, the impact, the overall appropriateness of its objectives and its consistency with your national health policy (where applicable)? If yes, please elaborate. Have precautions been taken to minimize the undesirable effects of the reform? If *evaluation* has already taken place, please provide results. Did evaluation lead to change or abandonment?

6. Expected outcome/overall assessment of policy

Looking at the intended objectives and effects of the health policy assessed: Will the policy achieve its objectives? What might be its unexpected or undesirable effects? What are or will be the effects on costs, quality, equity, etc.?

7. Rating this policy

Please tick the appropriate box:

1. How innovative is the policy in your country's present situation?	<input type="checkbox"/> traditional approach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> innovative approach
2. Was/is the policy process comparatively ...	<input type="checkbox"/> consensual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> highly controversial
3. Actual or expected impact on status-quo	<input type="checkbox"/> marginal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> fundamental
4. Visibility in public discussion (media coverage)	<input type="checkbox"/> very low	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> very high
5. Transferability	<input type="checkbox"/> strongly system/context-dependent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> transferable system-neutral

Thank you for your cooperation!

