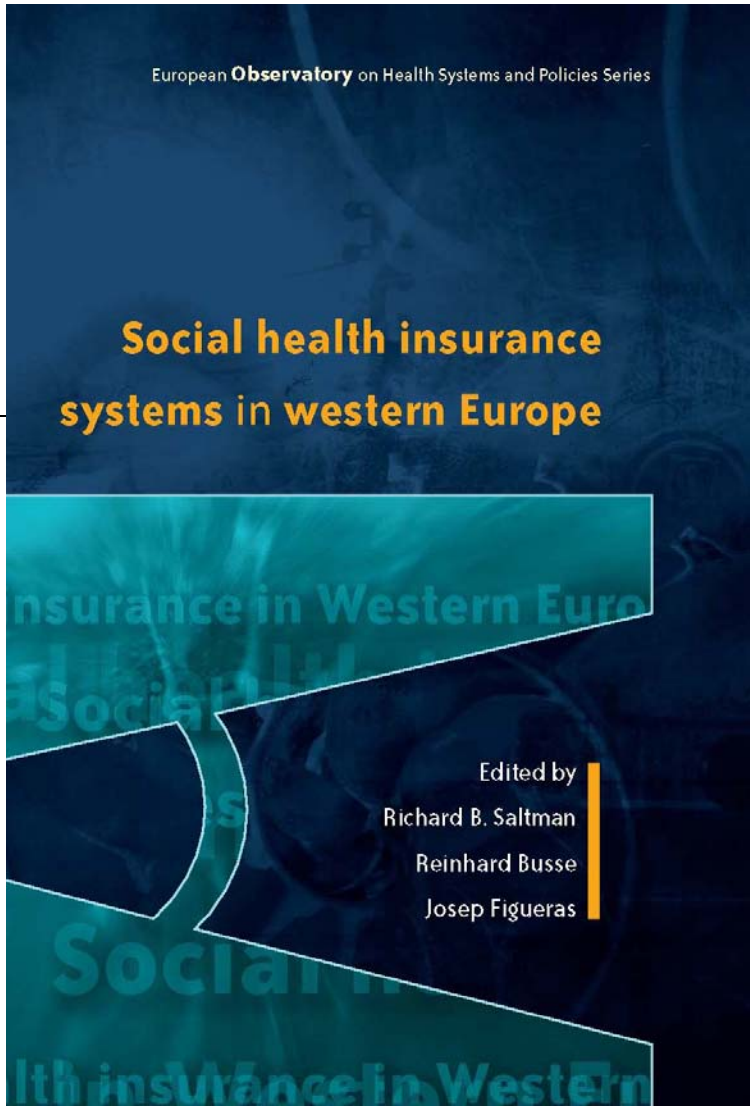
SALTMAN RB, BUSSE R, FIGUERAS J (eds.) Social health insurance systems in western Europe. Open University Press, 2004



chapter three (p. 33-80)

Organization and financing of social health insurance systems – current status and recent policy developments

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This chapter probes more deeply into the complex technical commonalities and variations among the seven SHI countries in western Europe and Israel. Reflecting the 4-level pyramid model introduced in Chapter 1 (Figure 1.2), this chapter details its structural characteristics, respectively from its top, of the funding, organization, and (to a lesser degree) state levels of SHI systems as well as recent developments. Since the funding flows are inextricably linked to the institutions that organize SHI systems, these top two tiers will be reviewed simultaneously, followed by the role of the state. As the four-level pyramid model highlights, these financial and organizational relationships are embedded

within, and heavily steered by, the two lower levels of the pyramid, e.g. the state and, below that, the broader society in which the state sits.

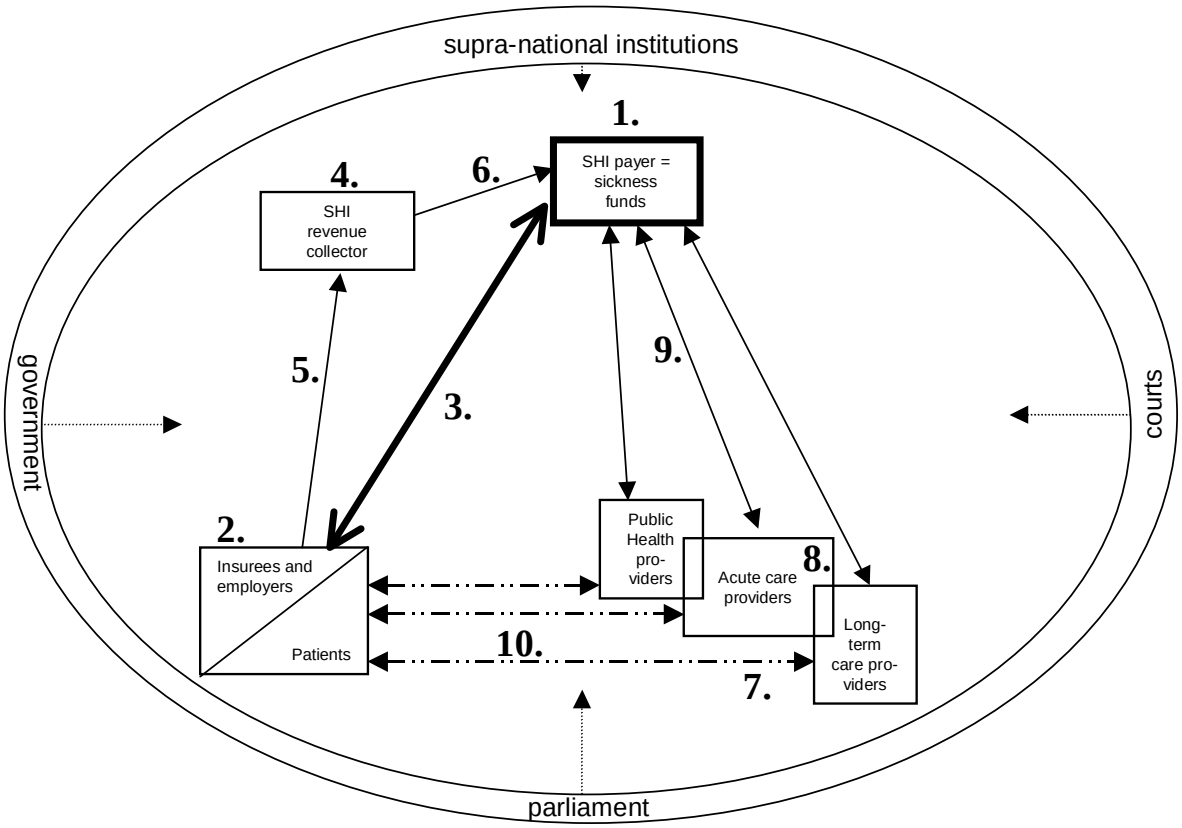
The chapter is organized into three main sections. In the first, the eight SHI systems, as they are currently (2002) configured, are described in relation to ten key structural dimensions. This is followed by a brief review of the role of the state in these systems. In the third section, the main trends of recent policy developments in the eight studied SHI systems are categorised and assessed.

1. The current organizational make-up

One useful way to explore the key organizational and financial components in the eight studied SHI health care systems is a modified version of the classic triangle composed of "insured/ patients", "third-party payers" and "providers" (Figure 3.1). These three main actors – or rather four as the collector of the revenue is considered separately since it is not the same as the actual payer in many countries – are linked by a correlating set of relationships. Using this triangle as a basis, this first section of the chapter explores the following dimensions of these eight SHI systems (the numbers are used to place each dimension in the figure):

1. number, governance and accountability of sickness funds;
2. the extent to which the population is insured;
3. relationship between insurees and sickness funds, especially degree of choice for the insurees;
4. by whom the contributions are collected;
5. how contributions/ premiums are calculated or based;
6. mechanisms and extent of pooling and (re-)allocation of contributions to/ among sickness funds;
7. benefits available under SHI, especially regarding the non-acute sectors of public health/ health promotion and long-term care;
8. forms and organizational set-up of providers;
9. contractual relationships between sickness funds and providers about types of services, reimbursement and quality; and
10. patient access to, as well as gatekeeping by, providers.

Figure 3.1 Actors and relationships in SHI countries with issues explored in this chapter numbered 1 to 10



Issues 1 to 6 concern the sickness funds as well as organizational and financial aspects of the relationships between funds and the insured. Important information and data regarding the issues 1 to 6 are summarized for the eight countries in Table 3.1. Issues 7 to 10, presented subsequently, concern the covered benefits, the providers and the structure of relationships between providers, the sickness funds, and patients.

Table 3.1 Important characteristics of SHI systems relating to organization and financing (unless noted, all data for 2002/2003) (amended and updated from Normand and Busse 2002)

Issue (with number)	**Austria**	**Belgium**	**France**	**Germany**	**Israel**	**Luxembourg**	**Netherlands**	**Switzerland**
1) Number of sickness funds (2002)	24	94 (organised in 7 associations)	17	355	4	9	22 [1]	93
Size of largest fund (% of all insured)	18%	5%	84%	12%	55%	38%	15%	15%
2) SHI coverage (% of pop.)	98	99-100	100	88	100	97-99	AWBZ: 100; ZFW: 63	100
3) % of insured with choice of fund; interval for change	0%	Ca. 99%, 3 months	0%	96%, 18 months	100%, 12 months	0%	100%, 12 months	100%, 6 months
4a) General contribution rate: uniform or varying, % of wage	Varying by profession: 6.4%-9.1%*	Uniform: 7.4%	Uniform: 13.6%	Varying by fund: mean 14.1%	Uniform: 3.1% of income up to the minimum wage and 4.8% above that level	Uniform: 5.1% (+ 0.3-5.0% sick pay)	Uniform: AWBZ 10.25%, ZFW 8.45%; 4.6% for sailors	No
4b) Distribution employer/ employee	Variable*	52/48	94/6	50/50	0/100	50/50	AWBZ 0/100, ZFW 80/20; 50/50 for sailors	0/100
4c) Ceiling on contributory income (in €1,000/ year)	Yes (46)	Generally no (for self-employed 73)	Generally no (for self-employed 146)	Yes (normally 41, higher for miners' fund)	Yes (5x average wage)	Yes (82)	Yes (AWBZ: 29; ZFW: 29/ 20 [self-employed])	Not applicable
4d) Other personal contributions to funds (i.e. excluding co-payments to providers)	No	+ nominal premium per capita (varying by fund)	Social security tax (CSG) 7.5% + social debt tax (CRDS) 0.5%	No	No	No	+ premium per capita (varying by fund), mean 345€/year[2]	Only premium per capita
4e) Contributions for non-wage earners[3]	Pensioners 11% (7.25% of which pension fund)	Pensioners 3.55%	Pensioners 3.95%	Pensioners: same as for employees	Pensioners/ unemployed: flat premium of €32, if on welfare €17/ month	Pensioners: same as for employees but higher lower threshold	ZFW: Pensioners on pension 8.45 %, on other income 6.45%	Might qualify for tax subsidy

[1] January 2003; [2] Ranging between 239.4€ - 390€ (Ministerie van Volksgezondheid, Welzijn en Sport 2003b); almost double the amount of 2002; [3] See Table 3.5 below for more complete information on this issue.

1.1 The sickness funds

The number of funds, their size and their structure vary widely. Austria, France and Luxembourg have a comparatively small and stable number of funds (Table 3.2) defined on the basis of occupation/al status or, in the case of Austria, by occupational group and/or by region of residence, with no insuree choice among them. In the French system, sickness funds have to be differentiated from the various "regimes". Most notably, the largest sickness fund (*Caisse Nationale de l´Assurance Maladie des Travailleurs Salariés*, CNAMTS, or: *Régime Générale*), operates the General Regime of Social Security covering employees, industrial workers, pensioners, unemployed and their dependants. Eighty-four percent of the population are covered by this fund (2000 data) which has a pyramidal structure, with a national office, 16 regional coordinating funds (*Caisses Régionales d'Assurance-Maladie*) and 129 local "*caisses*" (*Caisses Primaires d'Assurance-Maladie*). Luxembourg has nine sickness funds – one each for manual workers (CMO, the largest), white-collar workers in the private sector, self-employed, the agricultural sector, civil servants of the state, civil servants of local authorities, manual workers at ARBED, white-collar workers at ARBED, and the Luxembourg railways (Kerr 1999).

The other five countries have competing funds with greatly varying numbers. Israel has, with four, the smallest number of competing funds. The Netherlands has 22 funds (January 2003) with several of them forming part of the same holding company. Just after the second World War there were about 250 sickness funds in the Netherlands (Veraghtert and Widdershoven 2002), thus in the Netherlands as well as in Germany and Switzerland, there has been a substantial decrease in the number of separate funds. Each Dutch fund still has a regional stronghold, although these links are weakening (see below; Chapter 4, Table 4.12). The introduction of limited competition in the mid-1990s led to both mergers and new funds. Another Dutch phenomenon is the fact that many sickness funds have merged with private health insurers to form holding companies with both a statutory and a private arm (Den Exter *et al.* 2002).

In Belgium, there are some 100 funds, organised according to religious and/or political affiliation. All are governed by public law, and all but two groups (the Auxiliary Association and the Railway Association) are members of one of the five sickness fund associations (i.e. Christian, Neutral, Socialist, Liberal, Free and Professional). The association of Auxiliary funds is not organized as a mutual society but is rather state-

organized. In addition to those individuals who choose this fund, persons who fail to affiliate themselves with any fund are by law insured by it (Kerr 2000).

In Germany, as a result of competition and the professionalization of fund management (the latter was made mandatory by law from 1993 onwards), the number of funds has been radically reduced from more than 1000 in the early 1990s to 355 in 2002. These have been historically organised on the basis of geographical areas, occupation or employer and are legally classified into seven groups which reflect their origin: 17 general regional funds, 12 substitute funds, 287 company-based funds, 24 guild funds, 13 farmers' funds, 1 miners' fund and 1 sailors' fund.

Table 3.2 Number of sickness funds, 1990-2002

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	Change 1990-2002[2]
Austria	26	26	26	26	26	26	26	26	26	26	26	25	24	-7.7%
Belgium[1]	119	127	127	121	121	114	116	111	109	107	103	95	94	-21.0%
France	18	17	17	17	17	17	17	17	17	17	17	17	17	-5.6%
Germany[2]		1209	1223	1221	1152	960	642	554	482	455	420	396	355	-70.6%
Israel	4	4	4	4	4	4	4	4	4	4	4	4	4	0%
Luxembourg	9	9	9	9	9	9	9	9	9	9	9	9	9	0%
Netherlands[3]	37	31	27	26	26	27	29	30	28	28	27	25	24	-35.1%
Switzerland	220	203	191	207	178	166	145	129	118	109	101	99	93	-57.7%

Notes:
[1] forming part of seven national associations who are financially responsible for the compulsory health insurance system
[2] for Germany: 1991-2002 as 1990 difficult to compare as before German re-unification, data from 1 January of the corresponding year
[3] only counted as one sickness fund if merged; 2002 data take into account the 1 January 2002 merger of Groene Land and PWZ (even though they still had a separate nominal premium during that year)

Sources: Austria: Bundesministerium für Soziale Sicherheit und Generationen und Konsumentenschutz (2003b), Belgium: RIZIV (2003a) and Schokkaert and Van de Voorde (2003), France: Meftah (2003), Germany: Bundesministerium für Gesundheit und Soziale Sicherung (2003a), Israel: Gross and Harrison (2001), Luxembourg: Union des caisses de maladie (2003), Netherlands: Vektis (1996; 1998; 2000; 2002) and CVZ/CTZ (2003), Switzerland: BSV/OFAS/UFAS (2003a)

In Germany (as in Austria, Belgium, France and Luxembourg), all sickness funds are not-for-profit entities under public law. Besides that legal status, they share a management structure with, as a general rule, equal representation of employers and employees – with differences both between countries (e.g. in France, the ratio between employers and employees in boards is 1 : 2) and within countries (e.g. in the case of the German substitute funds which are managed by the employees only). Both the composition of the management and supervision boards as well as the decision-making powers of those boards are

defined by law, for example, whether they include the right/ obligation to determine the contribution rate (see section 2 below). They are also subject to control either directly by the government or by an agency charged with that responsibility; i.e. the relationship between the state and the sickness funds in these countries is a classical example of "enforced self-regulation" (cf. Saltman and Busse 2002).

Since the 1990s, the decision-making powers of these SHI decision-making bodies have, as a general rule, decreased. In France, the national parliament now passes a budget for all sickness funds, which is sub-divided into "envelopes" (i.e. sectoral sub-budgets). In Germany, the governmental aim to exercise more control over the types of services included in the benefit catalogue as well as the way they are delivered has paradoxically led to the creation of new self-governmental committees charged with the implementation and actual running of those legal stipulations. Whether the current government's proposal to create a National Institute for Quality in Medicine marks the end of that development in favor of more direct governmental control, remains to be seen.

In Switzerland, the number of insurers offering compulsory health insurance has declined from almost 1000 in 1965 (Beck *et al*. 2003) to less than 100 in 2001. Compulsory health insurance is offered both by sickness funds and by private insurance companies (which may only make profits from the provision of supplementary insurance). Sickness funds can be incorporated under public or private law in various legal forms, e.g. association, foundation, mutuality or not-for-profit stock company.

In all countries except Germany, the sickness funds are supplemented by a national umbrella organization. In the Netherlands, there is a difference between the voluntary association which also includes the private insurers (Zorgverzekeraars Nederland) and the statutory Health Care Insurance Board (College voor zorgverzekeringen) charged, among others, with the management of the collective resources (Den Exter *et al*. 2002).

1.2 Insured persons

The eight countries use different frameworks to define the group of persons insured. France, Israel, the Netherlands (for their long term-care insurance [AWBZ]) and Switzerland have by law universal coverage for their SHI system. Belgium also has universal coverage but as a two tier-system for the 88 per cent in the 'general regime' (with a comprehensive benefits package) and the 12 per cent in the 'regime for self-employed' (for whom the benefits package covers 'major' risks only) (Nonneman and Van Doorslaer 1994).[1] Austria and Luxembourg have *de-facto* universal coverage though some persons remain uninsured. In Germany, a large proportion of the popu-lation (ca. 74 per cent) has mandatory insurance and a small portion is legally excluded (6 per cent)[2] – leaving a third group (mainly employed people with income above a relatively high threshold[3]) with a choice between statutory and private health insurance. Of the approximately 18 per cent eligible for voluntary SHI membership, about 14 per cent are insured with the sickness funds and 4 per cent privately (Busse and Riesberg 2003). The percentage of voluntary members differs between 2.3 per cent and 37.9 per cent among the 35 largest sickness funds (MedWell Gesundheits-AG 2002).

In the Netherlands, there is a strict legal separation based on an income limit between the mandatory ZFW (statutory health insurance) system and private health insurance, allowing insured persons no choice between the two systems (Den Exter *et al*. 2002). As the income limit is lower than in Germany, the share of the population insured under ZFW is smaller than in Germany. Since 1994 the (even lower) income limit for pensioners for inclusion into ZFW was increased considerably, and since 2000, a similar limit applies to the self-employed who previously were excluded altogether.

[1] Since historically the SHI system is a work-related insurance program, population-wide coverage was not the original intention. While coverage has been gradually expanded to non-working parts of the population in all countries, the achievement of population-wide coverage is only a very recent phenomenon, being introduced in Israel in 1995 (Gross and Harrison 2001), in Switzerland in 1996, in Belgium in 1998 and in France in 2000. As a partial exception here, the Netherlands introduced their AWBZ insurance on a population-wide basis already in 1968.

[2] Self-employed people are excluded from SHI unless they have been a member previously (except those who fall under mandatory SHI cover like farmers), and active and retired permanent public employees such as teachers, university professors, employees in ministries etc. are excluded de-facto as they are reimbursed by the government for most of their private health care bills (they receive private insurance to cover only the remainder). The Reform Act of SHI 2000 widened the group of excluded persons by excluding privately insured persons above 55 years who would, through a falling income e.g. through reduced working hours, fall in the mandatory membership group. This was done to stop these persons from a deliberate return to SHI (Busse and Riesberg 2003).

[3] 41,400€ (2003) to be raised to 46,350€ in 2004.

Table 3.3 Total sickness fund insured (thousands), 1990-2002

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
Austria	7652	7735	7835	7912	7949	7966	7979	7991	7998	8011	8029	8051	8073
Belgium	9690	9724	9960	9930	9945	10040	10055	10084	10030	10070	10100	10130	10166
France	56369	56634	56896	57122	57312	57497	57678	57858	58047	58564	58835	59129	59422
Germany		71281	71975	72165	71710	71886	72132	71601	71373	71283	71257	70948	70815[3]
Israel[4]	4300	4460	4710	4950	5077	5202	5492	5664	5820	5986	6158	6328	6460
Luxembourg	419	429	434	444	455	465	474	486	500	516	535	554	566
Netherlands	9190	9250	9334	9428	9574	9706	9769	9907	9909	9940	10311	10287	10267[1]
Switzerland	6874	6967	7017	7057	7132	7166	7195[2]	7215[2]	7249[2]	7267[2]	7268[2]	7321[2]	7350

Data include nationals living abroad who are insured with a sickness fund
[1] data for January 2001, while rest of the Dutch data are for July
[2] end year values in contrast with the mean values used for 1990-1995
[3] data for 1 January 2002, while other German data are for 1 October
[4] data do not include insured living abroad for more than one year
Sources: Austria: OECD (2003), Belgium: RIZIV (2003a) and OECD (2003), France: Eco-Santé France (2003), Germany: Bundesministerium für Gesundheit und Soziale Sicherung (2003b), Israel: Ben Nun (1999; 2003) and National Insurance Institute of Israel (1995; 1996; 1997; 1998; 1999; 2000; 2001; 2002), Luxembourg: Union des caisses de maladie (2003) and OECD (2003), Netherlands: Vektis (1996; 1998; 2000; 2002), Switzerland: BSV/OFAS/UFAS (2003a); estimation for 2002

1.3 Relationship between insured persons and sickness funds, including degree of choice

A mandatory relationship between insured individuals and third-party payers that administer payments separately from governmental funds is one of the backbones of SHI systems. The requirement for a relationship may include a fixed assignment to a certain sickness fund or there may be choice. The presence of more funds in a country does not necessarily mean more choice, as demonstrated in the case of Germany where membership of most funds was legally assigned until 1995. In Germany[4] as well as in the Netherlands, almost all insurees now have the right to choose a sickness fund (only farmers, miners and sailors are assigned membership to the corresponding funds in Germany and sailors in the Netherlands), with these countries thus joining Belgium, Israel and Switzerland. Four of these five countries (all except Belgium) offer choice as part of a policy to increase efficiency through limited competition for insurees. Choice for insurees (and competition among funds for insurees) does not exist in Austria, France and Luxembourg. In these

[4] Not all sickness funds are open to new applicants, however: company-based sickness funds may choose to remain closed, thus creating a form of risk selection (Buchner and Wasem 2003).

three countries, the assignment is based on two criteria, 1. professional status or employer and 2. place of residence. If a person belongs to a profession or works for an employer which has its own fund or scheme, he or she will be mandatorily insured with that fund. Otherwise, one belongs to a regionally based fund (or a local branch of a fund in the case of France).

Where insured persons are entitled to switch between funds, there are differences in how often this is possible. When the Netherlands opened their funds to competition for insurees in 1995, they opted for two-year intervals but subsequently changed to an annual option from 1997. In Belgium, a change is possible every three months, in Switzerland every six months and in Israel every 12 months. When competition started in Germany, the interval for changing was annual, with a fixed date (30th September) to decide to revoke existing membership which took effect towards the end of the year. As this fixed date opportunity was felt to encourage too many insurees to switch, the opportunity to do so in 2001 (for 2002) was canceled. Since 2002, change is possible at any time but the interval to remain insured with a particular fund must be 18 months. However, voluntary members, i.e. those earning above the threshold, could always – and still can – move from one fund to another at any time with two months' notice. A decision to leave the SHI system in favor of obtaining private insurance cannot be revoked, however. In the Netherlands – which also has an income threshold for eligibility for statutory membership – high earning individuals whose income subsequently falls below the threshold are again eligible for statutory coverage. Change is also allowed in the Netherlands and elsewhere (except Belgium) within 1 to 2 months after an increase in premiums, and, if in a regional fund, upon moving out of that region (Austria).

Insurees who are unhappy about the treatment they receive from their SHI system must take their case through a special legal process. The structure and organization of these social, labor, or administrative courts vary considerably among the eight studied countries (Table 3.4). This separate system for legal redress reflects both the unique legal standing of SHI institutions as well as the strong link between social health insurance and the broader national systems of social insurance within which they sit.

Table 3.4 Legal Arrangements for Social Health Insurance, 2003[1]

	Potential path through national courts/tribunals for administrative (health insurance) claims[2]	**Potential path through national courts/tribunals for social health insurance claims[3]**
Austria	(Verwaltungsbehörde) ↓ Verwaltungsgerichtshof	Landes Arbeits- und Sozialgericht ↓ Oberlandesgericht ↓ Oberster Gerichtshof
Belgium	Raad van State/Conseil d'Etat	Arbeidsgerecht/Tribunal du Travail ↓ Arbeidshof /Cour du Travail ↓ Hof van Cassatie/Cour de Cassation
France	Tribunal Administratif ↓ Court Administrive d'Appele ↓ Conseil d'Etat	Tribunal des Affaires de Sécurité Sociale ↓ Cour de Cassation (Chambre Sociale)
Germany	Verwaltungsgericht ↓ Oberverwaltungsgericht ↓ Bundesverwaltungsgericht	Sozialgericht ↓ Landessozialgericht ↓ Bundessozialgericht
Israel	Health funds ombuds \ National ombud \ State Comptroller \ Regional Labour Court ↓ National Labour Court ↓ Supreme Court as High Court of Justice	Health funds ombuds \ National ombud \ State Comptroller \ Regional Labour Court ↓ National Labour Court ↓ Supreme Court as High Court of Justice
Luxem-bourg	Tribunal administratif ↓ Cour administrative	Conseil Arbitral des Assurances Sociales ↓ Conseil Supérieur des Assurances Sociales
Nether-lands	Rechtbank (department: bestuursrecht) ↓ Raad van State (department: bestuursrechtspraak)	Rechtbank (department: bestuursrecht) ↓ Centrale Raad van Beroep / Social-economical: College van Beroep voor het bedrijfsleven
Switzer-land	Decision by a cantonal authority ↓ Kantonales Verwaltungsgericht or Besondere Gerichte (e.g. Rekurs-kommissionen,Versicherungsgericht) / Tribunaux spécialisés (e.g. commissions de recours, tribunal des assurances) ↓ Bundesgericht / Tribunal fédéral or Eidgenössisches Versicherungsgericht / Tribunal fédéral des assurances	Decision by a federal authority ↓ Eidgenössische Rekurskommissionen ↓ Bundesgericht/ Tribunal fédéral or Eidgenössisches Versicherungsgericht / Tribunal fédéral des assurances

[1] In general the countries have different courts if the case's argument is based on constitutional law.
[2] The distinction is not perfectly comparable in every country (e.g. the Belgian Raad van State/Conseil d'Etat is very different from the Israeli District Courts) and several of the courts mentioned deal with many more issues than administrative issues.
[3] The distinction is not perfectly comparable in every country (e.g. the German Sozialgericht is not exactly the same as the French Tribunal des Affaires de Sécurité Sociale) and several of the courts mentioned deal with many more issues than social issues.
[4] Only created recently.
Sources: Association of the Councils of State and Supreme Administrative Jurisdictions of the European Union i.n.p.a. (2003), Bundesgericht (2003), Bundesministerium der Justice (2003), Der Österreichische Verfassungsgerichtshof (2003), Gertner Institute for Health Policy (2003), Raad voor de Rechtspraak (2003), Service central de legislation (2003)

1.4 Collecting contributions and other revenue

In the eight studied countries, there is great variety in the relationship between the collection of revenues for health care and the actual payer. The sickness funds are the actual collectors of the contributions only in Austria, Germany and Switzerland. Associations of funds (Luxembourg) or special agencies under government control (Belgium and Israel) or the tax authorities directly (the Netherlands) are other collectors.

In Belgium, most contributions are paid directly to the National Social Security Department (RSZ/ONSS) which in turn redistributes the money to the respective agencies responsible for the administration of different sectors of social security, e.g. unemployment, health, pensions. The agency responsible for health benefits is the National Institute for Sickness and Invalidity Insurance (RIZIV/INAMI). This institution also collects the contributions of self-employed persons.

In France, revenues are also collected for several branches of social security, namely by the *Unions de Recouvrement des Cotisations de Sécurité Sociale et d'Allocations Familiales* at the local level which are managed by the social partners, i.e. employers and employees. The money is passed to a national agency, the *Agence Centrale des Organismes de Sécurité Sociale*, which is in charge of managing and allocating the money to the different social security organisations and their branches. In Israel, the contributions are collected by the National Insurance Institute which also receives the national tax allocation before distributing the money to the sickness funds according to an age-adjusted capitation formula.

1.5 SHI contributions and other revenue

The financial relationship between the individual and the sickness fund varies and has changed in several countries. The main part of the health care revenue is, in all countries except Switzerland[5], mainly raised through wage-related contributions which are shared between employers and employees. Nonetheless, there are important differences relating to: a) the uniformity of the rate, b) the ratio of contributions from employer and employee, c) the existence of an upper contribution ceiling, d) the existence of additional non-wage-related revenues, e) the calculation of contributions for non-waged persons and f) the role of general taxes in funding. These issues are presented in turn.

a) **Uniformity** of the rate. The contribution rate is uniform for all insurees regardless of the sickness fund and membership status in 5 of the 8 countries: Belgium, France, Israel, Luxembourg and the Netherlands. In Austria, rates vary between 6.4 per cent and 9.1 per cent according to employment status but within a given employment status, not between funds. In Germany, on the other hand, the contribution rates differ among funds but not by employment status.[6]

b) Ratio of **contributions from employer and employee**. An almost equal distribution of 50:50 between employer and employee exists in Austria, Belgium, Germany and Luxembourg. In France, the split had been 80:20 in the early 1970s, with adjustments to around 70:30 by the late 1980s/ early 1990s. With the virtual abolition of the employees' contribution in 1999 in favor of a health tax (see below) it is now nominally 94:6. In Israel, contributions were divided almost evenly between the insured and the employers until 1997. The insured continue to pay contributions (termed a "health tax"), however, employers no longer contribute directly to health care (as their share has been replaced by increased funding from general taxation since 1998)[7]. Thus in Israel the ratio of the direct contribution is now 0:100 – constituting the opposite development in comparison to

[5] Since the introduction of compulsory health insurance from 1996, Switzerland has a system of both income- and risk-unrelated per-capita health insurance premiums. These differ between insurers but are community-rated for all insured of a particular insurer in a certain region (usually the canton) (Minder *et al*. 2000).
[6] There are certain exceptions to this rule: The largest group treated differently were pensioners until July 1997 since their contributions were based uniformly on the average contribution rate of all funds. For that purpose, the average rate on each January 1st was used for half a year both retro- and prospectively (i.e. from July 1st of the previous year until June 30th). Since 1999, there is a legal uniform rate of 10% for all workers below a threshold of Euro 325 – a group which was not mandatorily insured before. Students are another exception to the rule as they pay a uniform per-capita premium (Busse and Riesberg 2003).
[7] In 1999, 48% of the national health expenditure came from general taxation, 25% from the "health tax" and 27% from direct payments for services and medicines by patients (Gross and Harrison 2001).

France. In the Netherlands, employers cover the majority of the ZFW but nothing of the AWBZ – taken together, this amounts to 35:65.

c) Existence of an **upper contribution ceiling**. There is a ceiling on contributions in Austria, Germany[8], Israel, Luxembourg and the Netherlands (different between the two insurance schemes) but generally not in Belgium or France (where it was phased out between 1968 and 1983), where it is limited to the regimes for the self-employed. Ceiling definitions vary, with multiples of social security, minimum wage or average wage limits being the most common forms (in France, Luxembourg and Israel respectively). In other countries it is determined independently of such figures, for example in Germany or the Netherlands. In these countries, the contribution limit has to be conceptionally differentiated from the threshold for mandatory membership, even though the latter was the same as the former in Germany until the end of 2002 and is very similar in the Netherlands.

d) Existence of **additional non-wage-related revenues**. There are revenue components in addition to the wage-based contribution in Belgium, France and the Netherlands. In Belgium and the Netherlands, the insured pay a non-income-related per-capita premium (which varies among funds but is currently only nominal in Belgium) on top of their contributions. These differ in the Netherlands, but have mostly remained uniform in Belgium: only one fund lowered its rate from the usual monthly BEF 90 (2.23 Euro) to BEF 50 (1.24 Euro) in 1998 but reverted in 1999 (Schut and Van Doorslaer 1999). Through this mechanism, overall contributions vary between funds even though the baseline contribution rate is uniform. France has effectively substituted the employee's part of the contributions with a General Social Levy Tax that is based also on non-wage income; in addition a Social Debt Tax is charged. For both taxes, a uniform rate is applied to everybody making it a proportional source of financing (Sandier *et al*. 2002a).

The reasons for these complementary financing components differ. While increasing the financial base of the funds was the driving force in France (and rhetorically also in

[8] The only exemption being the ceiling for miners (mandatorily insured in the miners' fund) which is one-third higher than that which applies normally.

Belgium)[9], in the Netherlands it was the introduction of competition among funds which was thought to require some price competition (Normand and Busse 2002).

The opposite of supplementary contributions is also possible. Germany experimented with 'no claim' bonuses – i.e. a partial refund of contributions if no services are used – after 1989 and opened up this option for all funds in 1997, in spite of equity concerns. This was accompanied by the introduction of other market-derived instruments. All sickness fund members were given the right to choose care delivered under the 'reimbursement' rather than the 'benefit-in-kind' principle, thereby enabling them to be treated as 'private' patients. Sickness funds also were given the option to introduce deductibles. These instruments were eliminated by the Social Democratic government that came into power in 1998 on the basis that they were not compatible with the basic solidaristic values of Germany´s SHI system. In Switzerland, no-claim bonuses currently exist. Introduction of a bonus (premium rebate in the following year depending on the expenditure-level in the present year) for CSS (largest sickness fund) insured seems to have been responsible for the lowest growth rate in per capita costs since 1914, except for 1994, when any cost increase was disallowed by the government (Beck 2000).

e) Calculation of contributions for non-waged and low-waged persons. Since contributions rely on wages as a basis, the calculation for non-waged persons causes difficulties. For the largest such group – pensioners – contributions vary between countries, both in terms of how much they pay as well as who actually pays the contribution. In most cases pensioners pay the same percentage rate on their pension as employees pay on their income (or, in the case of Switzerland, the same per-capita premium). This amount may be split between the pensioner and the statutory pension fund (substituting for the employer) as in Germany and Luxembourg or it may be placed entirely on the pensioner as in the Netherlands. The contribution rate also may be lower or higher. The former is the case in Belgium where pensioners pay only the employees' part of 3.55 per cent; the latter is the case in Austria with a contribution rate of more than 11 per cent for pensioners. Since Austrian pensioners themselves pay only the average for working members (3.75 per cent), two thirds of their contributions fall on the statutory pension funds (Table 3.5).

[9] To ease the financial burden on employers (and not for the sake of competition among funds), Germany also introduced a flat per-capita premium on top of the income-related contributions in 1997. This was abolished after the change of the parliamentary majority in 1998, however.

For persons with low wages, regulations lead to contributions which are often lower but sometimes also higher than for other employees. In the former category, France and Luxembourg exempt persons below a certain threshold income from any contributions and Israel charges a reduced contribution rate. Germany, however, while exempting the employee from any contributions for monthly wages up to €400 and reducing the contribution rate for wages up to €800, does not provide health insurance to these workers (assuming they are either having a second job, that they are covered via other family-related arrangements or are insured via communal arrangements). Employers pay an increased share for wages up to €400. Austria, Belgium and the Netherlands all charge a certain minimum contribution, which in effect raises the actual percentage for persons with low incomes (Table 3.5).

Table 3.5 Sickness fund contributions for unemployed, pensioners and persons with low wages (2003)

	Unemployed	Pensioners	Persons with low wages
Austria	6.8% of unemployment benefit. For unemployed without social benefits (including asylum seekers who are recognized as such by the federal state) the government pays.	Contribution of 3.75%. The rest is paid by the social insurance fund that pays the pension. [9]	Below 309.38€/month: no compulsory contribution (only accident insurance is compulsory). Voluntary assurance is possible at About 14€/month for their illness insurance.
Belgium	Unemployed with and without benefits do not pay, but are covered by the sickness fund of choice. The sickness fund pays.	If worked for more than 15 years: no premiums; if less than 15 years: fixed amount of premiums 17.02 € (with dependents: 25.57 €) / 3 months, supplemented by a government subsidy.	Minimum contribution to be insured is based on an income of 4,652.08€/year for employees of 21 years[7] and older.[5]
France	General social contribution (CSG) 3.95% of benefits.[1] For those without benefits, expenditure will pooled and shared among funds.	General social contribution (CSG) 3.95% of benefits.[1]	No contribution if taxable income lower than 6,600€/year. Lower contribution rate for low wages (for self-employed: 0.6% until social security limit of 29,184€/year; after that 5.9%).
Germany	Unemployment funds pays fully; contribution is based on 80% of pre-unemploy-ment salary.	Retirement funds pays in place of employer, i.e. pensioner pays half out of pension	Wages below 400€/month[4] employers pay 11% and employees: 0% for 0-400€/month.[8] (No health insurance provided.) For 400.01-800€/month reduced fee.

Israel	Unemployed with welfare pay 3.1% on wages up to half the average national wage, and 4.8% on income beyond that level. Unemployed without welfare pay the minimum health tax of NIS84/month.	Pensioners who are on welfare pay the minimum health tax of NIS84/month. Pensioners not on welfare pay NIS157/month (NIS227 for pensioner couples).	Individuals pay 3.1% on wages up to half the average national wage, and 4.8% on income beyond that level.
Luxembourg	No state benefits: no compulsory coverage. Voluntary assurance is possible at same contribution level as minimum guaranteed income (1,369€/month).	Same rate as employed, but minimum cut-off point is 30% higher than social minimum wage (1,779€/month).	Below minimum guaranteed income (1,369€/month): no compulsory contribution. Voluntary assurance is possible at same contribution level as minimum guaranteed income.
Netherlands	Nominal contribution independent of income. Social benefit treated as wage (1.7% for employee, 6.75% for employer). No premium-discount for unemployed. Unemployed without any benefits have to buy private insurance.	8.45% (same as the sum of regular employer and employee contribution) of general old-age pension (additional funds, when older than 65: 6.45%).	Nominal contribution independent of income and no premium-discount for low-wages.
Switzerland	Premium payment independent on income, but subsidies are available in case of inability to pay.[6]	Premium payment independent on income, but subsidies are available in case of inability to pay.[6]	Premium payment independent on income, but subsidies are available in case of inability to pay.[6]

[1] While 5.25 per cent on earned income, capital gains and winnings from gambling; [2] Amount for 2002; [4] Since April 2003; [5] Contributions for widows, some pensioners, some students, and persons registered in the *rijksregister* (government register): 542.88 € / 3 months when income > 26,832.59 €/year, 271.44 € / 3 months when income between 26,832.59 and 12,482.92 €/year, 46.02 € / 3 months when income lies between 12,482.92 and 9,338.52 €/year and no contribution if income < 9,338.52 €/year; [6] A person who is not able to pay his premium has to ask the social administration for help. The amount of financial help and the threshold under which one is entitled to be helped varies from one canton to another (no range is available currently, but as a general, not always valid, rule subsidies target to limit sickness fund contributions for a family to 6 per cent of income). Half of the funding comes from the state and the other half from the canton; [7] 3,489.06 € / year for persons under 21; [8] Most already have a sickness insurance through a second job or through their family. Otherwise the same applies as to the unemployed; [9] By the year 2004 pensioners will pay 4.25 per cent and by 2005 they pay 4.85 per cent (pension reform 2003).
Sources: HiTs. Additional sources: Austria: Bundesministerium für Soziale Sicherheit und Generationen und Konsumentenschutz (2003a; 2003c; 2003d); Belgium: Belgian Federal Ministry of Social Affairs, Public Health and Environment (2003), RIZIV (2003b); France: Sandier *et al*. (2002a ; 2002b); Germany: Bundesknappschaft (2003), Minijobzentrale (2003); Israel: Bassan (2003), Chinitz (2003), Rosen (2003); Luxembourg: Ministère de la Securité Sociale du Grand-Duche de Luxembourg (2003); Netherlands: Ministerie van Volksgezondheid, Welzijn en Sport (2003d); Switzerland: Santé Suisse (2003)

f) Role of **general taxes in funding**. The common assumption is that SHI countries rely predominantly on wage-related contributions to fund their health systems. In international statistics on sources of health care funding, however, it is often unclear whether expenditure through taxation includes tax subsidies to sickness funds or whether these are included as SHI expenditure. Austria and Switzerland finance a substantial part of hospital care directly through taxation (and therefore have relatively low figures for the expenditure share covered by SHI) while in other countries, e.g. the Netherlands, hospital care is

financed exclusively by the sickness funds which in turn receive substantial subsidies from general taxation (Hofmarcher and Durand-Zaleski, Part Two, Chapter Nine). In Austria, on the other hand, as in Germany, sickness funds receive no tax subsidies (with the exception of the farmers' funds in both countries) although in Germany the 16 *Länder* governments pay for all major capital investments. Besides the Netherlands, tax subsidies – which are paid to the joint sickness funds' institutions – are substantial in Belgium, Israel and Luxembourg. The high Belgian tax component is the result of a deliberate policy change in 1981 when social security contributions were lowered by 6.17 percentage points and VAT was increased in an attempt to become internationally more competitive. Similarly, as mentioned, Israel has replaced employers' contributions by general tax-funding since 1997.

France has a mixed approach in this respect. While its subsidies from general taxes are rather low (and limited to funds with low income/ high need members such as the farmers fund), it has allowed the funds to accumulate sizeable deficits which were covered by the state and are now being paid off through a special social debt tax – a mechanism through which SHI financing is retrospectively changed into tax-financing. To estimate the degree to which countries rely on SHI contributions *per se*, based on wages, two factors have to be combined: the percentage of SHI income generated through wage-based contributions and the percentage of overall health expenditure covered through SHI. Based on such a calculation, Germany and the Netherlands are the only countries that cover more than 60 per cent of total health care expenditure through wage-related contributions. Until 1997, France was the country that relied most heavily on such contributions but, since its shift to a wider base for contributions, the share is now below 60 per cent. Austria and Luxembourg finance a little less than 50 per cent and Belgium even less than 40 per cent of total health care expenditure through wage-related contributions (Normand and Busse 2002). Among the eight countries, the percentage is lowest in Israel (25 per cent).

1.6 Pooling and (re)allocating revenue to/ among sickness funds

The (re)allocation of resources for health care between the collector and the payer does not occur at all in Austria, since individual sickness-funds are both collector and payer (although funds in financial difficulties may apply to the association of social insurance funds for financial aid.) The situation is similar in France, even though there is a compensation scheme among the local branches of the National Sickness Fund and the

smaller funds (with lower-paid insured persons) get support from the National Sickness Fund as well as through taxes.

In Belgium, Luxembourg and the Netherlands, the complete national pooling of contributions and a *de-facto* joint expenditure (i.e. *ex-post* allocation of contributions according to actual expenditure) was the customary approach before reforms in the mid 1990s. Reforms in Belgium and the Netherlands have led to the gradual introduction of per capita risk-adjusted allocations to the sickness-funds. Currently, however, the funds are financially responsible for only a fraction of total expenditure.[10] In Luxembourg, the Union of Sickness Funds directly covers the expenses for services delivered on a contract basis (e.g. hospital care), therefore the *ex-post* approach is used only for services requiring patient reimbursement such as physicians' services.

From 1989 to 1994/95, Germany had a mixed system whereby expenditure for pensioners was covered jointly by all funds while for all other insurees there was no re-allocation at all. The introduction of competition between funds in 1996 was preceded by the introduction of a risk-adjustment mechanism equalizing both income of insurees and (average) expenditure by age, sex and disability (Busse and Riesberg 2003). With this mechanism, sickness funds have to cover all (actual) expenditures with the re-distributed money. Switzerland employs a similar mechanism, with the main difference that the equalization mechanism is limited to each canton, i.e. the high *per-capita* expenditure in Geneva is not shared with the inhabitants of Appenzell with a low *per-capita* expenditure. In both countries, all expenditure needed to cover the uniform benefits basket – i.e. more than 90 per cent of all income – is in theory liable to re-distribution. The risk-structure compensation is carried out by the Federal Insurance Office in Germany and the joint organization of insurers offering compulsory health insurance (known as Foundation 18 after the relevant paragraph in the health insurance law) in Switzerland. In Israel, sickness funds receive a capitated amount for each covered individual from the national pool that has been adjusted only for age but there are also special payments for each member with

[10] In Belgium, the prospective allocation amounted to 10% of the total health care budget for 1995-97 and was raised to 20% for 1998-2000 and 30% since 2001. Since the funds are, however, only financially responsible for 15%, 20% and 25% of that allocation in the respective years, the actual percentages 'at risk' amounted to only 1.5%, 4% and 7.5%. In the end, however, sickness funds are responsible for only 25% of, maximally, the first 2% of over-spending (Hermesse and Beckmans 1998; Breda 2003). The Netherlands went ahead more rapidly, from 3% in 1993-95 to 15% in 1996, 27% in 1997, 29% in 1998 and 35% in 2000 – but a special provision that expenses for extremely expensive patients are shared provides a 'safety net' for the funds (Den Exter *et al.* 2002).

one of five major illnesses (Table 3.6). Age is the only risk-adjuster used in all five countries, with the number of age-subgroups ranging from less than 10 (Belgium and Israel) to 92 (Germany). (Van de Ven *et al*. 2003)

Table 3.6 Risk adjusters in the capitation formulas for (re-)distribution of funds among sickness funds

Country	**Year of implementation**	**Risk-adjusters[4]**
Austria	None	
Belgium	1995	-Age, sex, social insurance status, employment status, mortality, income
France	None	
Germany	1994/1995[1] 2002	-Age, sex, disability pension status -Age, sex, disability pension status, inscription into a disease management programme
Israel[2]	1995	-Age
Luxembourg	None	
Netherlands[3]	1993 1996 1999 2002	-Age, sex -Age, sex, region, disability status -Age, sex, social security/ employment status, region of residence -Age, sex, social security/ employment status, region of residence, pharmaceutical cost groups
Switzerland (within canton)	1994	-Age, sex

[1] Risk adjustment was implemented in 1994 for the non-retired sickness fund members and in for the 1995 retired members too. In the first 5 years, the risk adjustment system was separate for East and West Germany.
[2] And supplements if insured has one of 5 major illnesses.
[3] 90 Per cent of the cost of out-patient and production-dependent hospital care of an individual enrollee in excess of 7500 € (2003; up from 2042.01€ when introduced in 1997) is reimbursed afterwards from an outlier pool.
[4] The precise design of the formulas varies largely among the five countries.
Sources: Hermesse and Beeckmans (1998); Schut and Van Doorslaer (1999); Beck (2000); Busse (2001); Buchner and Wasem (2003); Chinitz (2003); Ministerie van Volksgezondheid, Welzijn en Sport (2003c)

Germany, Israel and Switzerland have made the most systematic moves in this realm, as sickness funds have to cover actual expenditure with the risk-adjusted resources that they receive or alternatively increase their contribution rate (Germany) or *per-capita* premium (Switzerland) – or run into deficit as in the case of Israel.

Ensuring an equitable financial basis in countries where individual funds are the contribution collectors is difficult. Money needs not only to be allocated according to some criteria but, actually, needs to be re-allocated, i.e. the money necessary for compensating one sickness fund has to be taken from another fund. However the better-off funds tend to regard their contributions as 'theirs', so that the issue becomes politically contentious. A

second reason is of a more technical nature: the re-allocation has not only to take 'need' factors (or other factors determining utilisation and expenditure) into account but also the different contribution bases of the funds. Not surprisingly, the topic of 'risk-structure compensation' is discussed fiercely in Germany and Switzerland (though there is more scientific literature on the Netherlands e.g. Van Barneveld *et al*. 1998; Van de Ven 2001).

1.7 Benefit catalogue

One of the central characteristics of SHI systems is the existence of defined benefits to which the insurees are entitled (see Gibis *et al*., Part Two, Chapter Eight). This characteristic was recently reinforced in 2001 in the Netherlands when a court ruled that entitlements (in this case, in AWBZ) had to be guaranteed independent of the costs associated to them. The actual contents of the benefit baskets as well as the processes applied to define them vary between the countries, however, ranging from a list of benefits by law (as in Israel) via decrees (as in the Netherlands) to negotiations between sickness funds and providers (as in Germany). Among the notable difference in the contents is the inclusion of benefits outside acute curative care, especially regarding health promotive measures and long-term care. The Netherlands and Germany have separate social insurance schemes to cover the latter.

1.8 Providers

In all eight countries, providers are a mix of public, private not-for-profit and private commercial in status – but almost all are separated from the payers (with the notable exception of Israel). This cannot be considered a necessary characteristic of SHI, however, since many funds originally started as institutions which combined the role of payers and providers. Visible reminders of this are the sickness fund-owned policlinics and hospitals in Austria as well as hospitals in Belgium and Germany (due to its special status, by the miners‘ fund only) – in addition to the provider network owned and operated by Israel’s largest fund, *Kupat Holim Chalit*. In the late 1990s, this integrated approach was sometimes re-advocated as “managed care“. Accordingly, so-called HMOs were established in Switzerland. Somewhat similarly, Dutch sickness funds have been allowed to operate their own pharmacies since 1999 (Van de Ven *et al*. 2003).

Hospitals in Austria, Belgium and Germany are mainly public (with ca. 70 per cent, 60 per cent and 55 per cent of beds respectively) with private not-for-profits in second place (ca. 25 per cent, 40 per cent and 40 per cent)[11] and a small, but growing private for-profit sector (ca. 5 per cent) in Austria and Germany. France also has mainly public hospital beds (65 per cent) but private for-profits are in second place (20 per cent) with private not-for-profits only in third (15 per cent). Hospitals in Luxembourg are equally divided between public and private not-for-profit. Israel has the most pronounced public-private mix: While 33 per cent of beds are government-owned, 16 per cent are owned by the four sickness funds, 26 per cent by (other) not-for-profit organisations and 26 per cent are private for-profit. In the Netherlands, all hospitals are legally private not-for-profit entities; vertical mergers (e.g. hospitals with nursing homes) happen increasingly. These percentages of different types of hospitals have been determined in all countries by historical developments and have not changed recently as a result of deliberate reform attempts – with the exception of the Netherlands where in 1998 the last public hospitals were transformed into independent not-for-profit entities under private law. [NB: Due to a new data collection system, no data are currently available on this issue for Switzerland.]

In all countries except Israel and the Netherlands, both primary and secondary ambulatory care is provided by physicians in private practice – with Belgian physicians directly competing with the out-patient departments of hospitals. In the Netherlands, only GPs are in private practice while specialists are mainly hospital-based (but not hospital-employed). In Switzerland, a limited number of physicians (ca. 1 per cent of all ambulatory care physicians) are directly employed by the new HMO-like companies. Physicians are often employees of sickness funds in Israel. Ambulatory care physicians work either on a salary or a contract basis for (one of) the sickness funds, while a minority are employed by hospitals. Many otherwise hospital-employed specialists (for in-patient care) also have private practices, or are employed by private hospitals or other private institutes to provide ambulatory care services.

1.9 Relationships between payers and providers

Due to the customary payer-provider split that is a key structural characteristic of all SHI systems – with the partial exception of Israel - contracts have been a standard feature of

[11] These numbers include the hospitals which are owned and managed by the sickness funds (ca. 8% in Austria and 5% in Belgium).

SHI systems. Traditionally, however, contracting established a fixed and static relationship between sickness funds and providers – it was not intended to be a means of instilling competition.

The changing nature of contracting over the 1990s in some SHI systems thus becomes of particular interest. Such changes build on a varied inheritance both regarding the contract partners and the contract contents (see Hofmarcher and Durand-Zaleski, Part Two, Chapter Nine). In Belgium, France, Israel and Luxembourg, specific benefits are defined by the government, leaving volume and prices to the contract partners (who often do not fix numbers, however). In Germany, a detailed benefits package is negotiated and put into the form of a contract (on the federal level) as well as reimbursement levels or the size of total reimbursement in a given region (except from 1993 to 1995 when total reimbursement levels were set by the government). In 1997 there was a move towards pro-market policies which abolished total reimbursement levels and returned to a pattern of fee for service with negotiated prices. However, this was in turn stopped in 1998 by the then new Social Democratic government (Busse and Riesberg 2003).

In all countries except in Israel and the Netherlands, collective contracts are the prevailing model for non-hospital-services (see Hofmarcher and Durand-Zaleski, Part Two, Chapter Nine). However, collective contracting in one country does not equal collective contracting in another country. First, the term is used ambiguously - both for bilaterally collective contracts between all funds and provider associations as well as for unilaterally collective contracts (as usually in ambulatory care), and between all funds and individual providers (as usually for hospitals). Second, collective contracts may be final and binding (as those between funds and physicians associations in Germany where individual physicians have no contractual relationship with funds), or may require additional unilaterally collective contracts (as between all funds and individual physicians in Austria) or may require the approval of individual providers to be binding (as in Belgium where physicians may reject a bilaterally collective contract). In Israel, since 2001 the four funds must legally negotiate collectively with health care providers; similarly, in the Netherlands, sickness funds still retain collective contracts with general practitioners.

Collective contracting between all funds and all providers have been the norm in SHI countries, often as a result of governmental efforts to standardise conditions of health care benefits and delivery. In most countries selective contracts are therefore illegal, although

Germany has allowed selective contracting under certain conditions since 1997. In the Netherlands, on the other hand, selective contracting has been encouraged since 1992. According to the Anti-Cartel Act of 22 May 1997, collective contracting in health care will – after a period of five years – be per se illegal (Den Exter *et al*. 2002). While hospitals were exempted from this regulation during that period, the Anti-Cartel Authority announced after the five years were over that it would in future sue sickness funds that did not contract acute care providers selectively (De Roo 2003).

Regarding the contents of contracts, payment issues receive the most attention. These are, however, the result of a combination of legal or governmental regulations and decision-making by funds and providers through negotiations. Recent changes have included limitations on growth rates of overall expenditure, the introduction of budgets or spending caps for all types of physicians, the integration of service definitions for the purposes of reimbursement (to replace individual item reimbursement), and the inclusion of physician services in hospital budgets. In the hospital arena, new measures have included the introduction of explicit budgets and/or the introduction of Diagnosis Related Groups-like forms of payment.[12] The principal area of contracting between funds and providers (both physicians and hospitals) in all countries has, therefore, been less on the structure of payments but rather on the details of the structure and, more importantly, the amount of the reimbursement, be they in the form of fee-for-service payments or budgets. Especially in the case of hospitals, the (financing) relationship between sickness funds may be supplemented through direct payments for services from taxes – most visibly in Switzerland where cantons cover 50 per cent of ordinary hospitalization bills (Minder *et al*. 2000).

Capital funding (especially of hospitals) is usually separated from payments for operating costs. Separate payments do not necessarily mean separate payers, however (as capital costs may still be provided by the sickness funds as in the Netherlands). Other countries have mixed systems – such as Belgium where 60 per cent is provided by the regions directly and 40 per cent by the federal government via per-diem fees (Kerr 2000) – or place

[12] These policy requirements may still leave some room for negotiations and contracts between funds and providers, though. For example, in December 1999, German legislators decided in the new law of SHI 2000 that hospital reimbursement has to be DRG-based from 2003. The only requirement the law made was that the DRG system chosen should already be established somewhere while the decision on the actual system was left to the contracting partners (hospital organization and sickness fund associations). On 30 June 2000, they decided to adopt the Australian Refined DRGs. This contrasts with the Austrian and the French experience where DRG-type systems were developed inside the countries.

the requirement for capital funding entirely on the public purse (the 16 *Länder* in Germany). There are – not always successful – tendencies in most SHI countries to include at least part of capital investments in operating payments.

In the field of pharmaceuticals, government-led reforms (and not contracts) have primarily included the introduction of reference prices and overall spending caps, as well as the tendency to lower drug prices to the international average. (Mossialos 1998; Mossialos *et al*. 2004 forthcoming).

1.10 Patient access to providers

There is no 'gate keeping system' in these SHI countries except in The Netherlands. As a result, patients are free to go to the provider of their choice (Table 3.7). This choice is, however, often restricted by the fact that it is limited to contracted providers. This arrangement ensures that the patient receives a service in kind (as the provider is directly reimbursed by the sickness fund, or through the respective physicians' association in the case of ambulatory care in Germany). While this is the usual situation for inpatient care, only Austria, Germany, Israel and the Netherlands operate this type of system for ambulatory care. Belgium, France, Luxembourg and Switzerland have a patient reimbursement system for ambulatory care, i.e. the patient is invoiced by the physician and reclaims the amount from the sickness fund. Two factors limit the reimbursable amount. First, the physician may have charged above the fees set by the sickness fund in its fee schedule or those agreed upon with representatives of physicians' organizations. Second, from the set fee a certain percentage might be a co-insurance (see below). Austria has a system of contracted ambulatory care providers but allows free access to other providers as well.

In Belgium, France and Luxembourg the system of reimbursement generally leaves patients with a co-insurance of 30 per cent for ambulatory care. Swiss insurees generally have a co-insurance of 10 per cent and a deductible of 157 € (and up to 1026 € on a voluntary basis). One fifth of the population in Austria generally pays a co-insurance of 20 per cent for ambulatory care. Additionally, if an Austrian patient chooses a non-contracted provider, the reimbursement is limited to 80 per cent of that paid to contracted ones for the same service. In Germany, the patient reimbursement system was an option for voluntary members until 1997 when it became an option for all members. Since 1999, the option is

again restricted to voluntary members. If they choose this option, patients pay both the difference between the reimbursement of patients (at the level of agreed contract payments) and their actual costs as "private" patients *and* a percentage between 1.5 per cent and 7.5 per cent (differs from fund to fund) of the contract payment which the sickness funds deduct to cover their higher administrative costs. Otherwise, cost-sharing for ambulatory medical care currently does not exist in Germany (but is proposed by the government at the time of writing for introduction from 2004). The Netherlands is the only other country without cost-sharing in ambulatory care, as the charges introduced from 1997 were abandoned after only two years.

In the Netherlands, insurees register with a GP who is partly freely chosen but who then acts as a gatekeeper to specialists and to in-patient care. Upon referral, the patient has free choice for the respective type of provider. Of particular interest is the tension between the traditional free access and the recent trends towards managed-care-type arrangements, most explicitly in Switzerland, or instruments such as clinical pathways and guidelines or the option for insurees to register on a voluntary basis for GP gate-keeping in Germany since 2000. In Israel, the power to introduce gate-keeping lies with the sickness fund; currently the largest fund limits direct access to specialists to some specialties while the other three funds allow free access.

Table 3.7 Choice of provider and insurer in eight SHI countries in 2003

	Austria	**Belgium**	**France**	**Germany**	**Israel**	**Luxem-bourg**	**Nether-lands**	**Switzer-land**
GP	YES[1]	YES	YES	YES	PARTLY YES[2]	YES	PARTLY YES[2]	PARTLY YES[3,4]
Ambulatory specialist care	YES[1]	YES	YES	YES[5]	PARTLY YES[2,6]	YES	PARTLY YES[2,7]	PARTLY YES[3,4]
Hospital (inpatient care)[7]	YES	YES	YES	YES	YES	YES	PARTLY YES[2]	PARTLY YES[3,8]
Nursing home[7]	YES	YES	YES	YES	YES	YES	PARTLY YES[2]	PARTLY YES[3,8]
Sickness fund	NO (geographical /occupational)	YES[9] 1x/3 months	NO (occupational)	YES[10] 18 month interval	YES 1x/12 months	NO (occupational)	YES 1 year interval	YES[8] 1x/6 months

Notes: Referring physicians (especially in the Netherlands) have an important say in which specialist/hospital a patient goes to. Also there is a small number of private hospitals/clinics/departments that are limited to usage by people with a private (co-)insurance (in e.g. the Netherlands and Switzerland). In addition (e.g. in Austria and Germany) there may be

minimum periods of time during which you can't change GP (sometimes consent of the sickness fund is needed as in Austria and of the GPs in the Netherlands).

[1] = by choosing a physician who is not under contract to the scheme, reimbursement is 80% of the fee of a contracted physician;
[2] = if the physicians/hospitals have a contract with the sickness fund (in the Netherlands only privately insured and civil servants with public sickness fund arrangements have real free choice)
[3] = 35% of the potential patients can choose for a HMO or PPO (preferred provider organization) that restricts the patient's choice of physician/hospital (HMOs and PPOs are not offered in every canton). About 8% of the Swiss formed part of a HMO or PPO. (2000 data)
[4] = people do not have free access to physicians outside their canton of residence (exceptions: people working outside your canton you have access to physicians at the place where you work, and in case of urgency, you have free access to all physicians also outside your canton)
[5] = since 2000 insurees have the option to register on voluntary basis for GP gate-keeping; but no sickness fund implemented this possibility as of yet in 2003
[6] = the largest sickness fund limits access to specialists to five specialities, while the other three Israeli sickness funds guarantee free access
[7] = referral necessary if no emergency
[8] = only within the canton; there is a limited cantonal list of hospitals and nursing homes for which cost are reimbursed; only in emergency cases and when permission is obtained before treatment, patients can get care in hospitals not on the cantonal list of their home-canton.
[9] = except for railway employees
[10] = except for of farmers, miners and sailors
Sources: European Observatory's Health Care in Transition reports, Weber (2000), Österreichische Sozialversicherung (2002), Beck (2003), Belgian Federal Ministry of Social Affairs, Public Health and Environment (2003), Bundesministerium für Soziale Sicherheit und Generationen und Konsumentenschutz (2003a), Chinitz (2003), Lamers *et* al. (2003), Ministère de la sécurité sociale du Gran-Duche de Luxembourg (2003), Ministerie van Volksgezondheid, Welzijn en Sport (2003a; 2003d), BSV/OFAS/UFAS (2003b)

In-patient hospital care in all countries is covered through contract payments by either the individual funds or – in Austria and Luxembourg – joint institutions. Patient cost-sharing in the form of co-payments exists in all countries (between ca. 4 and 10 €/ day except in Belgium for the first day [35 €]). These payments have been introduced or raised during the last 10 years (Mossialos and Le Grand 1999). The same is true for pharmaceuticals; in addition, the removal of certain drugs from the benefits package has led to 100 per cent patient cost "sharing" for a growing number of drugs.

2. The role of the state

The role of the state in SHI systems is often misunderstood. Commentators outside these countries often consider it to be weak while inside these countries the state influence is seen as a dominating factor. Utilising the 10-dimension list above, one can see that decision-making on many key points lies with the state: the make-up of the decision-making boards as well as their competencies (no. 1), the decision to introduce universal compulsory health insurance or to define groups of the population with mandatory membership (no. 2), whether sickness funds have defined membership or operate in a competitive environment (though the state may leave the decision to define their actual clientele to the funds) (no. 3), how contributions are calculated (no. 4), who collects the

contributions (no. 5), whether resources will be pooled and (re-)allocated to the individual funds using a particular formula – or whether expenditure will effectively be done jointly (no. 6), how extensive the benefit catalogue is, whether it's uniform for all funds and who has the actual power to decide on the inclusion of particular services (no. 7), which providers have to be or may be included in the contracts by the sickness funds (no. 8), whether contracting of the providers by the sickness funds will be done collectively or selectively and which rules apply for contracting (e.g. observing global or sectoral budgets or maximum/ reference process) (no. 9) and the conditions for accessing providers in terms of gate-keeping and copayments/ co-insurance rates/ deductibles etc.(no. 10).

This is not to say that sickness funds have no decision-making powers – but their degrees of discretion depend on the central framework established by the state. When it comes to setting the contribution rate(s), for example, the national government and/ or parliament have a decisive influence in most countries. In France, contribution rates are negotiated between the government, representatives of employees and employers and the social security organisations themselves, but ultimately it is the government that decides. In the Netherlands, the Supervising Board for Health Care Insurance, which runs the Central Funds of ZFW and AWBZ, recommends contribution rates for the following year to the Ministry of Health which has the authority to set the rates. In Austria and Israel, changes in contribution rates must be approved by parliament. Only Germany and Luxembourg have (still) delegated the power to decide upon contribution rates to self-governing bodies[13] – in Germany to the individual funds and in Luxembourg to the Union of Sickness Funds. Their decision is, however, subject to governmental approval. Similarly, Swiss insurers are, under supervision of the Federal Office for Social Insurance, allowed to set their own community-based premiums. The contribution ceilings are amended annually by the government in all countries, taking into account changes in wages. The Belgian and Dutch sickness funds can only set their own per-capita premiums.

The executive or legislative branches have good but often competing reasons for their regulations of the SHI organization and financing. Most notably, governments in their stewardship role pursue objectives such as ensuring access, making funding sustainable, ensuring high quality and maintaining social cohesion or solidarity. These four objectives lead to a set of regulated requirements (Table 3.8, left column).

[13] In Belgium, decision-making by the sickness funds on the contribution rates was replaced by governmental decision-making in 1963.

Table 3.8 Objectives and instruments to regulate sickness funds (modified/ amended from Saltman and Busse 2002)

Regulation to ensure achieving social objectives of access (A), sustainable funding (F), quality (Q) or social cohesion/ solidarity (S)	**Regulation to facilitate sustainable competitive markets for sickness funds**	**Regulation that stimulates entrepreneurial opportunities of sickness funds**
A: Require contracts between sickness funds and all willing providers	Pool contributions of all sickness funds or install risk-related adjustments of contributions between sickness funds (to lessen market distortion due to risk selection)	Allow the insured choice of sickness fund
A, F & S: Require collective contracts (to ensure equal access and to lower transaction costs)	Require payers to accept all applicants (to lower chance of market distortion due to risk selection)	Allow additional services to be included in benefit catalogue
F: Regulate maximum expenditure for administrative/ overhead costs	Mandate annual open enrolment period	Allow differing levels of contributions, per-capita premiums, copayments, co-insurance or deductibles
F: Impose actuarial controls, i.e. regulate minimum and/ or maximum reserves and types of acceptable investments	Restrict or define conditions for (horizontal) mergers between sickness funds	Require financial responsibility of sickness fund (i.e. no retrospective cost cover by government or association of funds)
Q: Mandate the evaluation of (new) services before inclusion in the benefit catalogue (health technology assessment)	Restrict (vertical) mergers, acquisitions and running of other health care institutions	Allow/mandate selective contracting
Q & S: Set uniform benefit catalogue/ mandate the setting of a uniform benefit catalogue through self-regulatory bodies	Install supervisory agency(ies) to approve contracts/supervise financial behaviour and stability	
S: Require sickness funds to accept all applicants (to enforce right to health insurance)		
S: Mandate community rating or income-related contributions (i.e. not risk-related)		
S: Mandate lower, not cost covering contributions for poor		

Depending on the assessment of the various options, governments may, however, choose contradictory instruments to pursue the same objectives: to make funding sustainable, collective contracting may be mandated to avoid high transaction costs in one country, while selective contracting to improve efficiency may be chosen in another so as to stimulate sickness funds to behave entrepreneurially. Consequently, various governments – most notably in the Netherlands and Switzerland, and more recently, but so far less consequently in Germany – have chosen to base part of their regulatory instrumentarium on market-derived instruments (Table 3.8, middle and right column) as a vehicle to improve quality and efficiency, even though this often clashes with ensuring objectives such as maintaining solidarity (cf. De Roo *et al*., Part Two, Chapter Thirteen).

3. Recent policy developments

As discussed in section 1 of this chapter, the eight countries have changed various dimensions of their organizational and financial arrangements during the 1990s. Table 3.9 summarizes the most prominent reforms by issue, while Table 3.10 lists the main reforms, their contents and the issue concerned, by country over time. This section does not review developments issue by issue or country by country but rather seeks to identify underlying patterns and trends.

Table 3.9 Main changes regarding the ten issues in the eight countries since 1990

	Issue	**Main changes**
1	Sickness funds	D: requirement for professional management NL: supervision mechanisms restructured
2	Insured population	B, F, ISR, CH: establishment of universal coverage NL: low-income self-employed included in SHI
3	Choice of fund	D, NL: choice of fund newly introduced ISR, CH: choice of fund component of new pop.-wide insurance
4	Contribution collection	ISR: centralisation of contribution collection
5	Calculation/ base for contributions and other revenue	F, ISR: revenue base widened (tax instead of wage-based contr.) B, D, F etc.: limitations in contribution/ expenditure growth rates B, NL: sickness funds received right to determine per-capita premium (on top of wage-based contribution) F: additional forms of revenue introduced

6	Pooling of & allocating to funds	B, NL: less pooling (from full pooling) through introduction of (partial) prospective payments to funds D, CH, ISR: more pooling (from no/ little pooling) through introduction of risk structure compensation mechanism
7	Benefits	A, D, L: introduction of long-term care benefits/ insurance A, D: introduction of health promotion (partly re-abolished) CH, D, NL: benefits made dependent on evaluation (HTA) ISR: legal fixing of benefits
8	Providers	F: accreditation of hospitals introduced NL: transformation of public hospitals into foundations completed Otherwise little deliberate change (except that long-term care benefits/ insurance led to incorporation of new provider types)
9	Payers-providers	Budgets for all sectors or certain important sectors D, NL etc.: quality assurance mechanisms made mandatory NL: replacement of collective by selective contracts (not in in-patient care) L: individual contracts by funds replaced by common contracts
10	Patient access	A, B, D, NL, CH: introduction or increase of co-payments, esp. for in-patient care and pharmaceuticals (re-abolished in NL)

Table 3.10 Major health insurance reforms that came into force between 1990 and 2002

COUN-TRY	YEAR	LAW / ACT / MEASURE	CONTENT	ISSUE NO.
Austria	1990	Co-payment for inpatient stays	The first 28 days- about €6 per day	10
	1992	Price Act	Federal Ministry for Social Security and Generations has been entitled to fix an 'economically justified maximum price' for medicines	9
	1993	Reorganization of funding for long-term care	A new and comprehensive system of long-term care benefits. Entitlement is independent of income, personal wealth or the cause of disability (in 1995 and 1996 a stepwise long-term-care insurance was introduced)	7
	1997	Copayment for primary care doctor visits	€3.6 per voucher	10
	1997	Overall budgeting on states level	Introduction of a dynamic budget for the health insurance expenses (i.e. inpatient care expenses increase only with the same rate as health insurance revenues)	9
	1997	Reform of Health Care system and Hospital Financing	-Development of hospital plans into health plan incl. high-technology and eventually ambulatory care -Introduction of a performance-based, DRG-like reimbursement system for hospitals	8, 9

	1998	Expanding the number of insured persons	Part-time workers (with a monthly income of up to €278.40) may make voluntary social insurance contributions in order to establish their entitlements to health insurance and retirement benefits. In addition, insurance coverage is provided for self-employed business people who do not have a licence issued by a professional body (called *Gewerbeschein*) and whose annual income is above a defined level.	2
	1998	Health Promotion Act	€ 7 million per year will be allocated to health promotion	7, 9
	2001	Flat co-payment for outpatient treatment in hospitals	A flat co-payment of €18.17 per visit in an outpatient department is charged €10.90 if referred by GP or specialist), with an upper limit of €72.67 per person per year	10
Bel-gium	1990	Law with social provisions	Fixed budget within the health insurance system for each sub-sector of health care, as well as a global budget for the health insurance, activated correction mechanisms if these budget limits were surpassed, increased central government powers of supervision to oversee the new system	9
	1992	Reduction reimbursement	The level of reimbursement for several categories of pharmaceuticals was reduced	9
	1993, 1994	Health financing	-Increased fees-for-service -Strict maximum limit of 1.5% on the real growth of health care spending from year to year -Reductions in coverage of health care services by statutory insurance -Increased co-payments and co-insurance	7, 9, 10
	1993-1997	Co-payment increase	16 Increases in out-of-pocket amounts	10
	1994	Bar code introduction	Bar codes on prescriptions, which automatically identify each doctor's prescribing behaviour to detect and control pharmaceutical over-use	9
	1994	System of social and fiscal deductibles	Payment exemptions which established a limit (varying according to patient income) above which health care services were fully reimbursed to redress the inequitable effects of the 1993-1994 reductions in health care service reimbursement	10
	1995	Financial responsibility of sickness funds by risk-based capitation formula	Mutualities receive a prospective budget to finance the health care costs of their members, and they would be responsible for a (increasing) proportion of any discrepancy between this budget and their actual spending	6
	1997	Restructuring health promotion	Decentralisation and target setting	7
	1998	Extension coverage	Residence in Belgium is sufficient basis to have the right to reimbursement for health care within the insurance system	2
France	1993	Mandatory Medical References	Physicians and health funds agreed on a list of practical mandatory guidelines that doctors have to fulfil in ordinary practice. They are not systematically checked by sickness funds. Nevertheless, they had a great impact as it was the first time physicians and health funds had discussion about medical practice and quality of care and not only about prices.	9

	1996	Plan Juppé	A comprehensive attempt to grasp all the aspects of health care (ambulatory care, hospital care and sickness funds organisation) at a time when health insurance experiences a huge financial deficit: - a global budget for reimbursed health care is voted annually by the Parliament; the government divides this in separate budgets for the different actors - regional hospitalization agencies are created in order to better organize the supply of hospitals beds at the local level -an accreditation policy for hospitals is set up under the auspices of the ANAES (quality of care national agency) -some experiments of doctors' networks are launched (cooperative structure between GPs and specialists in order to coordinate health care in some chronic pathologies) -the respective role of the state and of sickness funds is clarified (at the expense of the latter); the government directly manages contracts re hospitals (private as well as public), pharmaceuticals and medical devices; only negotiations with health care professionals (about their fees) remain in the competency of sickness funds.	8, 9
	1998	Law on health care financing	Part of the financing of public health insurance is shifted from salary based social contribution to a sort a generalized income tax, the base of which is constituted of all income sources (salary, financial income, real estate income). This tax named Generalized Social Contribution (CSG) was created in 1990. The rate is a flat rate which was consequently raised from 2.4% to 7.5%. This raise was compensated (for salaried people) by the suppression of social contribution).	3
	2000	Universal Healthcare Coverage	-Health insurance is no longer obtained through the professional status but through residence in France. Therefore about 250,000 people who were still not protected or badly protected (for instance non working divorced women) benefited from health insurance. -A free complementary health insurance is provided to the poorest part of the population (about 4.5 million people). Consequently are presently covered: 100% of the residential population for public mandatory health insurance 92% of the residential population forth the optional private complementary insurance.	2, 3
	2000	Law on the financing of social security	-General health insurance scheme is entrusted with the management of ambulatory care expenditure. The pricing negotiation for fee-for-service lists for general practitioners, specialists, dentists, physiotherapists, etc. will no longer be the responsibility of the Ministry. To meet cost containment objectives, the general health insurance scheme will be entitled to lower if necessary the price of health care services -Health insurance medical staff may call in patients whose medical consumption is particularly high and suggest a more suitable health care plan to the patient and practitioner	9
Ger-many[1]	1991	Unification treaty	-(West) German SHI system with structures system of sickness funds, corporatist provider organizations, monopoly of ambulatory care for physicians' associations, collective contracting etc. extended to East Germany	1, 2, 5, 7, 8, 9

	1993	Health Care Structure Act	-Freedom to choose sickness fund for most of the insured population (from 1996) -Risk compensation scheme to redistribute contributions among sickness funds (from 1996) -Abolition of the full cost cover principle for hospitals -Increased co-payments -Introduction of a positive list of pharmaceuticals (from 1996; but regulation abolished in 1995) -Introduction of reimbursement claims auditing of ambulatory care physicians at random -New health promotion benefits	3, 6, 7, 9
	1996	Statutory Long-term Care Insurance (SLTCI)	-SLTCI established as fifth pillar of social insurance, separate from SHI but managed by the sickness funds	7
	1997	Health Insurance Contribution Rate Exoneration Act	-Exclusion of operative dental treatment and dentures from the benefits catalogue for persons born after 1978 (subsequently abolished from 1999) -Reduction of all contribution rates by 0.4 percentage points on 1 January 1997 -Reduction of benefits for rehabilitative care -Increased co-payments for pharmaceuticals and rehabilitative care -Reduction of health promotion benefits	3, 7, 10
	1997/8	1st and 2nd Statutory Health Insurance Restructuring Act	-Establishment of a link between an increase in the contribution rate of a sickness fund to an increase in the co-payments for the insured of that fund* -Option for sickness funds to introduce 'no claim' bonus, deductibles and higher co-payments* -The option of all insured to choose 'private' treatment with reimbursement by sickness fund at contract rate* -Increased co-payments for inpatient care, pharmaceuticals, medical aids, ambulance transportation and dentures (for those still covered)*(partly) -Increased possibilities for non-collective contracts between sickness funds and providers -Transfer of the responsibility for maintaining and further developing the catalogue of prospective payments from the Ministry of Health to self-government (sickness funds and hospital organisations) -Abolition of public committees for expensive medical technology -New requirements for HTA in ambulatory care -New hospice care benefit -Annual amount of €10.23 per insured (not shared with employers) for restoration and repair of hospitals* -For operative dental treatment/dentures a privatisation of relationship between patient and dentist, i.e. patients have to negotiate services and ultimate prices with the dentist, i.e. patients have to negotiate services and ultimate prices with the dentists and receive only a flat rate from their sickness fund (from 1998)* -Cancellation of the budgets in ambulatory care and the spending caps for pharmaceuticals (from 1998)*	5, 7, 9, 10

	1999	Act to Strengthen Solidarity in Statutory Health Insurance	-Several reforms (ones with *) of the 1st and 2nd statutory health insurance restructuring act were reversed by the new government in power -Co-payment rates for pharmaceuticals and dentures were lowered -Budgets or spending caps were reintroduced for the relevant sectors of health care and in case of dental care more strictly than ever before	5, 9, 10
	1999	Health insurance contribution on low incomes	Introduction of 10% employers' contribution for incomes below € 322 per month (employees continued to be exempted)	5
	2000	Reform Act of Statutory Health Insurance	-Removal of ineffective or disputed technologies and pharmaceuticals from the sickness funds benefits catalogue -Improvements to the cooperation of general practitioners, ambulatory specialists and hospitals -New corporatist structures created to decide on benefits in hospitals, guidelines etc. -Diagnosis-related groups payment in hospitals (from 2003)	7, 9
Israel	1991	Diagnosis related payment	Government instituted a prospective diagnosis related group (DRG)-type payment for 15 major procedures	9
	1995	National Health Insurance Law	-Compulsory universal coverage for all Israeli residents in 4 sickness fund of their choice (rejection of applicants and risk selection became illegal) -Other key components of the law includes: central collection of contributions, institution of risk-adjusted formula for per-capita allocations to funds, legal entitlement to a defined benefit package -Budgetary ceilings on sickness funds (growth additional to increases in the index of Health Costs limited to 2% per year; from 1998 on an additional increase of 1%per year was allowed for a new technology) and state hospitals	2, 4, 6, 7, 9
	1997	Health insurance tax restructured	The employers tax for health insurance of their employees was abolished	5
	1997	Restriction means of competition	Restriction registration for sickness fund membership to post offices and a ban on advertising	3
Luxem-bourg	1992	Reform of the sickness insurance system	-Sickness fund are tax-subsidised at a far higher rate for pensioners than for the currently employed -Tasks of sickness funds limited to direct contact with insured. All other responsibilities (a.o. direct reimbursement to providers) were transferred to the Union of Sickness Funds -Definition nomenclature of all medical and nursing acts, and hospital budgeting (abolishment of per diem payment system)	5, 9
	1998	Insurance to cover the cost of long-term care	Insurance was introduced covering home and institutional nursing care, rehabilitation, home aid, nursing appliances, counselling and other support for the elderly and the mentally and physically handicapped	7
Nether-lands	1991	Health Insurance System First Phase Amendment Act (passed 1989)	Sickness funds free to set per-capita premium	5
	1991	Price system	Reference price system for pharmaceuticals	9
	1992	Health Insurance System First Phase Amendment Act	-Free choice of sickness fund for insured -End of mandatory contracting of self-employed health professionals by sickness funds -Shifting of benefits (e.g. pharmaceuticals) from Sickness Fund Act to Exceptional Medical Expenses Act (AWBZ)	3, 7, 9
	1994	Van Otterloo Act	Extending access to the Sickness Fund Act scheme for low income elderly	2

	1996	Pharmaceuticals Pricing Act	Government employs a reimbursement system for pharmaceuticals, which is included in the public sickness fund insurance package and which sets maximum prices	9
	1996	Directive on Sickness Fund Insurance Provisions	-Shifting of benefits (e.g. pharmaceuticals, medical aids, rehabilitation) from AWBZ to Sickness Fund Act -Abolition of flat-rate contribution for AWBZ	5, 7
	1997	AWBZ	Retirement homes funded under AWBZ	7
	1997	General Co-Insurance Scheme	Sickness fund insured had to pay 20% of the cost of services received (except for costs related to GP care, dentistry and obstetrics). For each day in hospital 4 Euros had to be paid. But an out-of-pocket maximum was set for this new cost sharing. Abolished after two years.	10
	1998	Restructuring Sickness Fund Act	After reaching the age of 65 years, people that were privately insured could opt for a sickness fund, while the ones with a sickness fund insurance could continue to be insured under the sickness fund act	2
	2000	27 March 1999 Act	Self-employed people up to the age of 65 years who were insured under the Incapacity Insurance (Self-employed Persons) Act and whose gross income is less than € 19 650 are insured mandatorily under the Sickness Fund Act	2
	2001	Act amending the 27 March Act	Amended the role, composition and procedures of the administrative bodies governed by the sickness fund act; Supervisory board for health care insurance established	1
Switzerland	1996	Revised Federal Law on Health Insurance	-Legal obligation permanent residents to purchase compulsory health insurance -Premiums have to be uniform in one region within one sickness fund/ insurer (children and trainees pay lower premiums) -Risk structure compensation among funds/ insurers in each region -Binding catalogue of services which have to be offered within the basic insurance scheme; addition of new services dependent on evaluation -Mandatory deductible with an annual maximum	2, 5, 6, 7, 10
	2001	First partial revision Federal Law on Health Insurance	-Modifications aiming for more uniform implementation of premium reductions for the less-well-off -Pharmacists should opt for non-brand name drug, if not explicitly demanded by the prescription	5, 9

[1]If parts of the law are implemented later, this is explicitly mentioned.

Much of the political and scientific attention has focused on “financial” aspects, driven by the concern for cost-containment and, though often to a lesser degree, increased efficiency. At the same time, these systems were also quite substantially reformed in pursuit of other, non-financial and/or solidarity-related objectives such as widening coverage and comprehensiveness in order to increase both access and equity.

Most notably, Israel, in 1995, and Switzerland, in 1996, introduced mandatory 100 per cent population coverage by their SHI systems, thereby surpassing countries with a long and established SHI tradition. Belgium (1998) and France (2000) followed by extending their SHI systems to those parts of the population which were still uninsured due to the

prevailing principle of actual or past professional status as the basis for sickness fund enrolment. The Netherlands did not expand their ZFW scheme to the whole population but included low income elderly (1994) and low income self-employed (2000).

The most important expansion of coverage occurred with regard to long-term care. At least three of the eight studied SHI countries either established separate insurance programmes to fund long-term care or included such benefits in the sickness funds' benefit catalogue: Austria in 1993; Germany in 1996, and Luxembourg in 1998. Two other SHI countries, the Netherlands[14] and France, expanded funding for their previously established elderly care programmes. Thus, with regard to long-term care, the issue of financial sustainability was subordinated to the clearly perceived need to expand publicly financed services to a growing segment of the population – i.e. the elderly. This was true (as De Roo *et al*. note in Part Two, Chapter Thirteen) despite the difficulty SHI systems are having in identifying and implementing a consistent, integrated approach to the production and delivery of long-term care services.

Typically for SHI systems, the concern about costs is not primarily about health care costs per se, e.g. measured as a percentage of GDP or in absolute terms per capita, but the percentage of the funding base needed to fund health care. As the major component of funding health care in the eight countries at the beginning of the 1990s was wages, the contribution rate became a politically sensitive indicator. To prevent this rate from increasing, policy-makers employed various options (beyond allowing the SHI system to run into deficit as in France), such as widening the base for SHI revenue, limiting SHI expenditure and increasing patient cost-sharing.

The widening of the SHI revenue base was most notably pursued in France and Israel. In France contributions are, since 1999, based not only on wages but on all income, i.e. including earnings from rent and capital investments, which in effect changed contributi-ons into a tax. A similar development had taken place two years earlier in Israel where the employers' part of contributions was substituted by funding from general taxation. France also introduced specific taxes on other products and services, e.g. pharmaceuti-cal advertisement and tobacco.

[14] This reflects a 2001 court judgment that care within the AWBZ had to be guaranteed, no matter the costs. Since then human resources has been the main restriction rather than finances.

Limiting SHI expenditure was on the agenda in almost all of the studied countries. The introduction of global, sectoral and/or institutional fixed budgets or spending caps were introduced or conditions on their application strengthened (i.e. “soft” budgets were transformed into “hard” ones). While these instruments varied in structure as well as their intended focus, they serve as eloquent testimony to the desire of national SHI policymakers to contain aggregate health expenditures. Moreover, as noted in Chapter One, they also indicate the growing willingness of the state to override the formally self-regulatory character of traditional SHI systems when major national priorities are placed at financial risk. This increasing intervention of the state in the operation of SHI systems raises fundamental questions about the sustainability of these self-managing arrangements in the current period of economic volatility. In addition to the introduction of budgets, the collectivization of contracts between sickness funds and providers was extended, partly to make budgeting more effective, partly to save transaction costs. Luxembourg in 1992 removed all reimbursement of providers from its sickness funds and centralized this responsibility in the Union of Sickness Funds. Similarly, Austria introduced regional pooled funds for hospital care in 1997. Also in Switzerland, there was serious discussion about giving up competition and replacing all sickness funds by only one state-owned and centralized sickness fund (Beck *et al*. 2003).

In contrast – some would say contradiction – to the above-described state regulatory measures, national governments also introduced a number of market-derived changes that were intended to increase competition among sickness funds in the belief that this would increase both efficiency and quality. Choice of sickness fund for the insured (in Germany, Israel, the Netherlands and Switzerland) was introduced and the degree of “risk-bearing” for the individual sickness funds increased. In the Netherlands, for example, funds have been made responsible for an increasing (from 3 per cent in 1993-1995 to 35 per cent since 1999) if still relatively small proportion of their total operating revenues (Schut and Van Doorslaer 1999; Okma and Poelert 2001). This is intended to increase internal pressures on sickness funds to use existing revenues more efficiently. Both Israel and Switzerland also incorporated risk-related pressures on their sickness funds when they established their national SHI structures respectively in 1995 and 1996. However, in order to avoid the danger of cream-skimming potential members under such circumstances, complex mechanisms of adjusting revenues available to each sick-ness fund were needed. In Germany, for example, a complex risk adjustment formula with over 700 categories is used

to re-allocate a portion of revenues retrospectively at the end of the budget year from those sickness funds with low illness rates to those with higher rates (Busse 2001). These risk-adjustment efforts (see table 3.5), increasingly prevalent in the SHI countries examined, are designed to mitigate some of the inequalities, caused by cream skimming, that potentially might emerge along with the introduction of sick-fund-based risk-bearing responsibility.

A particular common concern about financial sustainability concerned pharmaceuticals. Here, policy was complicated and occasionally tentative due to the presence of large pharmaceutical firms in several of these countries (particularly Germany and Switzer-land) and the consequent need for national policymakers to balance health-related financial concerns with industrial policy objectives to retain and expand pharmaceutical research and production facilities within their national borders. Nonetheless, rapidly growing pharmaceutical expenses have led most SHI countries to adopt a variety of restrictive measures such as reference pricing, positive lists (Mossialos *et al*. 2004 forthcoming) and promoting generic drug prescription.

The final financial pattern concerns increased reliance on out-of-pocket co-payments by patients at the point of service. Although such payments are highly regressive as reve-nue raising mechanisms (Barer *et al*. 1998; Evans 2002) and are not considered to be clinically appropriate tools of demand moderation (Kutzin 1998; Robinson 2002), they continue to grow as national policymakers search for short-term financial solutions. Germany increased co-payments in 1993 and 1997 (although several were subsequently lowered in 1998). Switzerland, in 1996, introduced mandatory co-payments with a legal maximum. Belgium increased out-of-pocket amounts 16 times between October 1993 and April 1997 (Peers 1999 as in Louckx 2002) (although subsequently reduced them for certain groups in 1994). Austria, in 2001, required outpatient hospital co-payments with an annual maximum. In the Netherlands, in 1997, out of pocket payment (co-payments for hospital stay and specialist care; with a maximum) was increased – but abolished only two years later (Louckx 2002). Also in Israel the 1998 legislation allowed co-payments to be introduced and to increase at a controlled rate.

Looking at these varying instruments, two opposing trends become visible: On the one hand, SHI systems pursued greater financial stability through an increased role for the state, typically via increased intervention in the heretofore relatively separate corporatist

process of SHI self-regulation. An extreme example of this intervention, in operating matters, could be seen in Belgium, where, in response, the employers in 2002 stopped participating in the annual budget negotiations, believing that such traditional corporatist activity had been superceded by the state. Other forms of strong intervention could be seen in France and, to a lesser degree, in Germany and the Netherlands. In Israel and Switzerland, the state stepped in to fundamentally re-structure the funding system through new national legislation.

On the other hand, a number of the studied countries sought to introduce or strengthen more explicitly market-oriented forms of incentives and, in some instances, market-oriented structures. This appeared to be influenced by a school of economic thought which argued that traditional administrative arrangements generated more expensive system and/or patient behaviour than would a more market-oriented approach. Examples here include the adoption of "no use rebates" on premiums in Switzerland and (although subsequently dropped) in Germany, as well as continued efforts in the Netherlands to increase the percentage of total funding for which sickness funds were "at risk". These were accompanied by expansions of choice among sickness funds in the Netherlands (1992) and Germany (1996), as well as efforts to introduce limited forms of selective (rather than comprehensive) contracting of provider such as hospitals. In the Netherlands, market-driven efforts to open funds to competition led to the introduction of a per-capita premium – which differs between funds – on top of the income-related contribution, which created the potential for contribution differences between sick funds. In Germany, on the other hand, the introduction of a 'risk structure compensation mechanism' to ensure equal market conditions for all funds before opening them to competition – and not competition between funds per se - has narrowed traditional differences in contributions by individuals to funds.

The overall picture that emerges from the multiple measures examined in this chapter is both multi-faceted and complex. The eight studied SHI countries vary considerably along specific dimensions, reflecting diverse histories and quite different national norms and values that serve to underpin the organization of their health funding and delivery arrangements. As Chapter 2 suggests, this is not surprising given the range of countries reviewed, and speaks to the broadly diverse character of social health insurance as a conceptual model. Perhaps even more so than with tax-funded systems, there are numerous

ways to construct an SHI system, and, as a result, observations about the "average" or "typical" SHI configuration often require substantial oversimplification.

Underneath these different national configurations, however, there are nonetheless certain clear patterns. One such pattern, as discussed in Chapter Two, is a common commitment (even if variously interpreted) to the concept of solidarity, and, more fundamentally, a grounding of these different health systems in its resilience and long-term survival. One visible symbol of this commitment was the "export" of the West German SHI organizational and financial arrangements into East Germany upon reunification (Busse and Nolte 2003).

In this chapter, beyond all the particularities, there are specific patterns that emerge from assessing the policy experience for these eight systems over the 1990s. However, the application of both stronger-state and stronger-market measures suggest an overall policy ambivalence about how best to proceed. Much as in tax-funded systems (Saltman and Figueras 1997; Le Grand *et al*. 1998), one can see an effort by national policy makers to step carefully as they moved forward in what they perceived to be uncharted territory.

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