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Contents

An overview of cost sharing for health services in the European Union

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In the interest of providing a high level of protection from the financial consequences of ill health, as well as promoting equity and efficiency, health systems in Western Europe are predominantly funded from public sources of revenue such as taxation or social health insurance contributions. However, over the last twenty years, levels of private expenditure on health have risen in many EU member states. This is mainly attributed to greater reliance on out-of-pocket payments and, to a lesser degree, increased take-up of private health insurance.

This article presents an overview of a recent report prepared for the European Commission examining cost sharing for health services in the European Union. The authors based their analysis on an extensive literature review undertaken at the EU15 country level.[1]

Cost sharing in health systems

Out-of-pocket payments can take three broad forms (see Table 1). The type and level of cost sharing applied varies considerably between countries (see Table 2).

Table 1: Types of out-of-pocket payment

Form	Definition
Direct payments	Payments for goods or services that are not covered by any form of pre-payment or insurance.
Cost sharing	A provision of most health funding systems that requires the individual who is covered to pay part of the cost of health care received; often referred to as user charges.
Informal payments	Unofficial payments for goods or services that should be fully funded from pooled revenue; sometimes referred to as envelope or under-the-table payments.

Table 2: Direct forms of cost sharing

Form	Definition
Co-payment	The user pays a fixed fee (flat rate) per item or service.
Co-insurance	The user pays a fixed proportion of the total cost, with the insurer paying the remaining proportion.
Deductible	The user bears a fixed quantity of the costs, with any excess borne by the insurer; deductibles can apply to specific cases or a period of time

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Cost sharing arrangements and protection mechanisms

Cost sharing is applied to pharmaceuticals, dental care and some other types of care in all the EU15 health systems. Countries funded through social health insurance tend to apply cost sharing to General Practitioner (GP) and specialist visits and inpatient care, whereas predominantly tax-funded countries tend not to impose charges for those services.

GP and ambulatory specialist care

Cost sharing applied to GP and ambulatory specialist care tends to be in the form of a co-payment or co-insurance with some extra billing for visits to doctors not contracted by sickness funds. Protection mechanisms take the form of exemptions, reduced rates or out-of-pocket maximums. In Greece and Sweden cost sharing and protection mechanisms vary by sickness fund (Greece) or county council (Sweden). In Denmark and Ireland cost sharing only applies to certain population groups – Group 2 in Denmark (those who have opted for free choice of GP) and Category II in Ireland (those with higher incomes).

Inpatient care

Cost sharing applied to inpatient care tends to be in the form of a co-payment per day ranging from about €5–10 per day in Austria, France, Germany, Luxembourg and Sweden to about €26–65 per day in Finland, Ireland (Category II patients) and Belgium. In France this co-payment is accompanied by co-insurance. Sweden is the only member state to impose a co-payment for visits to the accident and emergency department of a hospital.

Protection mechanisms take the form of annual out-of-pocket maximums ranging from about €100 per year in Sweden to about €600 in Finland.

Pharmaceuticals

Co-insurance is the most common form of cost sharing for prescription drugs in the EU15 health systems (Belgium, Denmark, France, Greece, Luxembourg, Portugal and Spain). Flat-rate co-payments per prescription exist in Austria and the United Kingdom. A deductible (a fixed amount) per prescribed item is combined with co-insurance above the deductible in Denmark, Finland and Germany. In Ireland a monthly deductible is imposed on Category II patients. Reference pricing is an indirect form of cost sharing used for certain prescription drugs in Denmark, France, Germany, Italy, the Netherlands, Portugal and Spain.

Protection mechanisms may apply to particular groups of people or to particular types of product – for example, essential drugs or drugs for chronic or life-threatening illnesses.

Reduced rates or exemptions commonly relate to one or more of the following:

Clinical condition – diabetics in Sweden, pregnant women in the United Kingdom and people with specified chronic illnesses in Ireland, Finland, Spain and the United Kingdom;

Level of income – all those with low incomes in Austria, Belgium, Germany, Ireland and the United Kingdom and older people with low incomes in Greece;

Age – older people in Belgium, Ireland, Spain and the United Kingdom; children in Germany and the United Kingdom;

Type of drug – drugs for chronic illnesses in Portugal, drugs for life-threatening illnesses in Belgium, both types of drugs in Greece and effective drugs in France.

Some governments employ out-of-pocket maximums either per prescription or per year. Out-of-pocket maximums apply in Belgium, Denmark, Finland, Germany, Ireland, Italy and Sweden.

Dental care

Most adults requiring dental care are subject to paying the full cost in Italy, the Netherlands, Spain, Portugal and Sweden. In other member states dental care is subject to co-payments or co-insurance. Children are entitled to free dental care in Austria, Denmark, Finland, France, Greece, Ireland, the Netherlands and Sweden.

Arguments for and against cost sharing

Proponents of cost sharing argue that it reduces excess utilization of health services by creating price signals, which deter individuals from consuming unnecessary health care. For this reason cost sharing is thought to improve the efficiency of the health system at a micro level while containing costs at a macro level.

Other arguments in support of cost sharing emphasize its potential to raise revenue to sustain and expand the provision of health care, particularly in countries where public budgets are under pressure or funding health care through other means is politically sensitive. In this case, lower levels of equity in funding can be offset by higher levels of equity in the receipt of benefits – for example, if the additional revenue raised is used to provide services for people.

However, those arguing against cost sharing point to information asymmetries in health care as a major obstacle to achieving efficiency gains. Individuals are not always able to distinguish between effective and ineffective treatment. In practice, most decisions about the use of health services are made by providers on behalf of patients. Excess utilization may be a consequence of supplier-induced demand.

Since health care spending is primarily driven by supply-side factors, cost sharing is unlikely to contain costs in the long-term. The revenue-raising potential of cost sharing may also be limited by the existence of protection mechanisms, high transaction costs, fraud or providers' reluctance to enforce user charges.

Finally, by shifting the financial burden away from population-based risk sharing arrangements towards out-of-pocket payments by individuals, cost sharing erodes the third party payer principle and reduces equity in funding health care. Those with low incomes are most likely to be discouraged from using health services, while those in poor health will suffer most from lower levels of use.

The impact of cost sharing: a review of the literature

Literature on the impact of cost sharing in EU15 health systems varies across countries in terms of quality and quantity. Most of the studies reviewed are observational in design, rather than fully or quasi experimental, and therefore provide relatively weak evidence.

There are several possible reasons for the lack of clear evidence in this area:

- while cost sharing is applied in every member state, it remains a marginal source of funding for health care, at least in comparison to public sources of funding such as taxation or social health insurance contributions. Research therefore has been hindered by a paucity of relevant data and many studies have had to rely on aggregate rather than individual level data;
- in some countries cost sharing policies have changed frequently, making it difficult to study the impact of a particular policy;
- similarly, studies have found it difficult to separate the effect of cost sharing policies from the effect of other policies and regulatory interventions, making it different to attribute changes in demand to changes in cost sharing alone; inability to distinguish between provider and user responses to changes in cost sharing is particularly important in this regard.

Nevertheless, the review attempted to identify studies that address policy questions about the impact of cost sharing on efficiency, equity and health care expenditure. Of the literature reviewed, studies focusing on the impact of cost sharing on demand and utilization are the most common, followed by studies that use survey data to ascertain the extent to which costs sharing presents financial barriers to accessing health care.

Summary of literature review findings

As expected, most studies examining changes in utilization after a change in cost sharing policy in the EU15 health systems show that people are sensitive to the price of health care and that utilization falls in response to increases in price. Studies undertaken in Belgium, Denmark and Sweden show that the introduction or increase in co-payments for ambulatory care without referral resulted in a decline in demand for GP services. In the Netherlands, an increase in the co-insurance rate of the inpatient per diem rate led to a proportionally higher decrease in the number of inpatient days. There is limited evidence to suggest that some people substitute free services such as accident and emergency care for services subject to cost sharing. French research shows greater variation by socioeconomic status in the use of doctor visits and pharmaceuticals than in the use of hospital care, which may be explained by the fact that hospital care is fully reimbursed by the statutory health care system, whereas the other types of care are not.

Most studies that compare levels of utilization among those with and without complementary private health insurance covering cost sharing find that the former group use significantly more health care than the latter group. In France, individuals with private health insurance are more likely to use services that result in extra-billing. In the Netherlands and Denmark similar findings indicate a correlation between complementary private health insurance and demand for health services subject to cost sharing.

It is more difficult to assess the likely impact of reduced utilization due to cost sharing on levels of health system efficiency. Whether or not cost sharing affects efficiency can be judged according to the extent to which it (i) reduces the use of ineffective rather than effective health care; (ii) results in substitution of cheaper or more effective non-cost sharing services; and (iii) reduces utilization or changes patterns of utilization affecting health status.

EU15 evidence regarding the ability of cost sharing to discriminate between effective and ineffective health services is inconclusive. In Sweden a hypothetical examination of prescription charges on the use of drugs among different socio-economic groups showed that increased charges would result in greater relative reduction in the consumption of discretionary drugs rather than essential drugs. A Danish study indicated that the impact of cost sharing was high for a broad spectrum of antibiotics. Dutch researchers found that cost sharing did not normally influence GPs' prescribing, partly because GPs did not consider any type of out-of-pocket payment to be problematic for patients or to influence demand.

However, there is strong evidence from North America to show that cost sharing reduces the use of effective and ineffective health care. It is possible to conclude that cost sharing may therefore have some impact on health status, particularly when applied to health services initiated by individuals (such as ambulatory care without referral) rather than clinicians (for example, specialist care requiring referral and inpatient care). In this respect it is worth noting that the consumption of prescription drugs is found to be consistently sensitive to price. Western European studies find that cost sharing reduces the utilization of prescription drugs, although there is some variation in estimates of own-price elasticity. Evidence in the United Kingdom suggests that there is both a real price effect and a cross-price effect in prescription charging. The relatively low sensitivity to price found in Spain may partly be explained by the effect of substitution between groups, with those that are exempt from co-payments obtaining drugs on behalf of other family members.

There were no EU15 studies examining the likely impact of reduced utilization on health status. A few studies focusing on preventive care provide evidence to suggest that cost sharing reduces the use of preventive services, particularly among more vulnerable groups of people such as those at risk of heart disease or glaucoma, and amongst elderly people.

Cost sharing is likely to have worrying implications for equity in the EU15 health systems. Out-of-pocket payments are shown to be highly regressive and there is significant evidence to suggest that many people find them to be a barrier to accessing health care. At the same

time, it is worth noting that non-financial barriers to access are also likely to be present. Therefore, the removal of financial barriers may not be sufficient to ensure equal access for equal need. While protection mechanisms such as out-of-pocket maximums may limit the extent to which cost sharing reduces levels of financial protection, other types of protection mechanism such as complementary private health insurance appear to breach equity principles since they tend to be taken up by people with higher incomes.

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User charges in The Netherlands

Hans Maarse

International statistics suggest that The Netherlands has the lowest level of private payments in health care funding in the European Union.[1] For 2002, the Dutch government estimated it at 'only' 8%. However, this percentage is an underestimation since the government's accounting for private payments only includes household co-payments for the utilization of health services covered by social or substitutive private health insurance. All other private payments are not taken into account. For instance, health care costs that are fully borne by patients are not considered. The political background for this accounting method is that the government does not assume political responsibility for the latter type of expenses. Its ironic effect is that any de-listing of services from the benefits catalogue of social health insurance, for instance most dental care for adults in 2004, does not result in a growth of private payments in the government statistics.[2]

The misleading nature of the government's estimation of the size of private payments is demonstrated by Statistics Netherlands (*Centraal Bureau voor de Statistiek, CBS*), a government agency producing all the national accounts. CBS estimates the proportion of private payments in health care funding for 2002 at 9.6% (a decrease from 10.3% in 2000). The explanation for the difference is that the CBS estimate includes a wider range of health services than the government's calculations. However, even when we accept the CBS figures as a better estimate, one cannot but conclude that the share of private payments in health care funding is still low compared to many other European countries.

In 2002, private payments, as a proportion of acute health care funding, were very modest: 2% for hospitals; 7.4% for general practitioners; 4.6% for medical specialists and 21% for dentists.[3] For long term care the level of private payments is higher. In 2000, patients paid privately for 11% of the costs of nursing homes and 26.4% of the costs for residential care. For home care private payments represented 5.7% of the bill.[4]

Since the early 1980s, the government has undertaken various attempts to introduce co-payments in acute health care. Most of these attempts proved unsuccessful and were aborted shortly after their introduction. Co-payments have only become customary for long term care. Cost sharing arrangements for this type of care are often related to individual earnings.[5] In 2004, the co-payment rate for home care was raised substantially. Recently, the Ministry of Health released a report which estimated its demand reducing effect at about 4%.[6]

The Dutch government not only chose the co-payment route, but also reduced the extent of health services covered by social health insurance (which can be understood as the introduction of a 100% co-payment rate). Some examples of health services no longer covered are: homeopathic drugs (1993); over-the-counter drugs (1994 and 1999); dental care for adults (2004); contraception pills for women 21 years and older (2004); first IVF treatment (2004); and some forms of patient transportation (2004). New de-listings for 2005 are: snoring treatments, flap-ear correction, upper eyelid correction, breast prostheses (unless after mastectomy), abdominal wall correction, and reconstruction surgery after sterilization (both men and women). All these treatments are considered unnecessary from a medical point of view or are seen to be a person's individual responsibility.

Another method to introduce private payments is to restrict the utilization of health services. For instance, social health insurance no longer pays for the first

nine sessions of physiotherapy. An exemption is made for patients with a chronic illness.

Last year the government proposed a mandatory deductible of €250 under social health insurance as an alternative to co-payments but the proposal was rejected by parliament. The most recent proposal is to introduce a 'bonus' arrangement for social health insurance. Patients who do not use medical care in a given year (or pay for it privately) will be rewarded with a bonus (reduction of their premium) that may amount to a maximum of €250 a year. To cover the costs of the bonus arrangement, the insured must pay a higher premium for health insurance. The government is presenting this bonus system as a key element of the health insurance reform slated for 2006.

Following its own accounting procedure, the government estimates that the fraction of private payments in health care funding will rise to 9% in 2005, mainly as a result of the bonus arrangement.[7]

A critical issue in the current political debate on private payments in health care concerns general practitioners (GPs). Should there be a co-payment for a visit to a GP, as is the case in some European countries? Most Dutch policy makers consider payments for GP visits to be undesirable on the grounds that co-payments would be unfair to poorer people and might have adverse effects on health status, ultimately leading to higher costs for the health care system. Such co-payments would also increase transaction costs; at present GPs are paid on a capitation basis so there is no billing of sickness funds, but the introduction of co-payments would generate additional administrative work. On the other hand, it could be argued that the absence of payments for GP visits lowers the overall effectiveness of co-payments as a tool for tackling the issue of moral hazard under health insurance.

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User charges in Sweden

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Since 1980, private expenditure on health in Sweden has increased considerably more than the average consumer price index – about 30% from 1993 to 1998.[1] Patient fees increased from 13% of health expenditure in 1993 to 16% in 1998 primarily due to rising patient fees for dental care and pharmaceuticals.[2] The current proportion paid by patient fees in Sweden is among the highest in Europe.[3]

Preventive primary care for maternal and child health, and visits to 'youth clinics' – usually for contraceptive advice – are free of charge. Since the early 1970s, patients have been charged a set fee per doctor visit that has subsequently increased. Patient fees for any visit to a doctor were uniform and fixed at the national level until 1991. Since then, each county council determines the local patient fees below a maximum limit set at the national level. This practice has resulted in increased and differentiated patient fees.The current median patient fee for a primary care visit is about SEK100 (€11) and about SEK200 (€22) for a visit to a specialist. A visit to a gynaecologist and to a specialist in geriatric care is charged the same as for primary care.[2] In Stockholm County the fee for a primary care visit was recently raised to SEK140 (€16).

In certain counties, children and teenagers are exempt from outpatient fees. However, in other counties children bare the same or slightly lower costs as adults.[2] The charge for emergency visits to hospitals is approximately SEK250 (€28). Currently, the maximum fee for inpatient care is SEK80 (€9) per night – children and youths below 20 years are exempt. The annual maximum out-of-pocket payments per person for ambulatory and inpatient care is SEK900 (€100).

Since 1997, a new system was instituted for patient charges for pharmaceuticals. Over a twelve-month period the patient pays the full cost of drugs up to SEK900 (€100), with a subsequent increasing marginal subsidy up to SEK1,800 (€200) above which the patient pays nothing.[4]

Dental care is free for all children and teenagers 19 years and under. New dental insurance was introduced in 1999 to improve the subsidy given to individuals with special dental care needs due to a disease or other functional impairment. Such persons now only pay for the ordinary fees applicable in outpatient care. Others pay the whole amount up to

SEK3,500 (€387), above which they are also entitled to a subsidy. However, patient charges are still high.[4]

No major proposals have been presented to reform the current user charges system. In the debate over this issue, there is concern that higher patient fees may increase inequities in both access to health care and utilization of health services as lower income groups tend to abstain much more from seeking care, particularly for dental care, and from purchasing prescribed drugs. However, since many county councils face great financial problems they may still consider increasing patient charges. A recent decision by the Stockholm county council to raise patient fees for doctor visits by 20% and to introduce fees for Pap smear screening resulted in protests among doctors. The Swedish Medical Association has proposed that responsibility for health care should move from county councils to the state.

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User charges in Ireland

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The Irish health care system combines a public health system with universal entitlement for those on low incomes with a fee-based private system. Entitlement to the Irish health care system depends on eligibility, which is determined on the grounds of personal income as follows:

Category I: because of their low income, these individuals (also known as medical card holders) and their dependents are deemed eligible to receive all health services, including General Practitioner (GP) care, consultant services, dental, ophthalmic and aural service, and prescription medicines, free of charge at the point of use. Irrespective of income, all persons over 70 years old are also considered to have Category I entitlement. At the end of 2003, there were 1,158,143 eligible persons under the General Medical Scheme which covers the above groups, constituting 29% of the population.

Category II: people who fall under this category have to pay the full cost of GP care and prescription medicines up to a pre-defined limit. They are also entitled to specialist outpatient services at public clinics, and maintenance and treatment in public wards of public hospitals subject to a per diem charge. Medical expenditure is eligible for tax relief.

General Practitioner care

The General Practitioner service is a mixture of public and private provision, the same GPs treat medical card holders as well as private patients. According to the 1999–2000 Household Budget Survey, the average Irish household spent over €120 per annum on doctor's fees.[1]

Hospital services

All public hospital services are provided free of charge to medical card holders. Those with Category II entitlement are required to pay a co-payment when using inpatient and outpatient services in public hospitals. In 2004, these charges were €45 for an out-patient visit and €45 per night in a public ward, subject to a €450 maximum payment per annum. The per diem payment for a stay in a semi-private or private bed in a public hospital ranged from €133 to €401.[2] Patients with private health insurance do not face cost-sharing for inpatient treatment; for outpatient expenditure, such as GP visits, they are obliged to pay a substantial deductible before the health insurance company will reimburse them. Patients provide the hospital with their health insurance details and the hospital sends the bill directly to the insurer for payment. A set fee for GP, consultant services and outpatient charges may be reimbursed by the insurers when total expenditure in the year exceeds an annual ceiling, approximately €500 for a family, and €220 for an individual.

The National Household Survey, 2001[3] reported that 46% of the adult population choose to buy private health insurance even though they are entitled to inpatient public hospital services at nominal charges.

Most general hospitals and some specialist hospitals have accident and emergency or casualty departments which patients may attend without being referred by a GP. For attendances without a GP referral letter, there is a charge in the form of a €45 co-payment.

Pharmaceuticals

The Drugs Payments Scheme (DPS) applies to persons who do not have a medical card. Under the DPS individuals and families pay a deductible of €78 per calendar month for approved prescribed medicines in that month. Expenditure above that limit is funded directly by the State.

User charges

Prior to 1987, outpatient services and inpatient care in (public wards of) public hospitals were provided free of charge to the majority of the population. Along

with budgetary cutbacks, user charges were introduced to provide patients with an incentive to reduce their attendance at Accident and Emergency departments for unnecessary free treatment that could be treated just as well and at a lower cost by a GP. In the period that user charges have been in operation in Ireland's health care sector very limited work has been done to analyse their impact. There are no immediate plans to introduce any changes or reform to the current system of charges. The Drugs Payment Scheme that was introduced in 1999 has undergone a few price increases; initially it was €54 per month, whereas since January 2004 the deductible is €78. Regarding the public hospital inpatient charge, the charges currently in operation are unlikely to have a major impact on making patients cost conscious. Given that medical charges do not apply to one third of the population and that non-medical card holders are covered by health insurance for stays in hospital, only a small amount of the population (approximately 25%) are directly affected by them.

According to Nolan[4] the charges for public services in Ireland, as they are today, are regressive. They are flat-rate rather than income-related and apply to two thirds of the population. It is argued that while insurance may be considered as progressive, expanding its role to cover these charges is not a solution to their regressivity.

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Major reforms in Slovakia

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The Slovak health care system has undergone substantial and gradual change from an integrated health care model with socialist central planning to a pluralistic and decentralized social health insurance system. All permanent residents and economically active immigrants are eligible to in-kind benefits from mandatory social health insurance. They have free choice among five not-for-profit health insurance companies, which act as collectors, purchasers and third-party payers. The operations of the two largest funds, together covering 78% of the population, are underwritten by the government with the government guaranteeing the payment of any debts. In turn, these insurance funds must submit their annual budgets to parliament for approval. Contribution rates are uniform and are defined by law. Employees pay 4% and their employers 10% of salaries or wages while self-employed individuals pay 14% of their assessed income.

The government pays contributions on behalf of family dependants, pensioners, and the majority of other economically inactive residents, which represent less than 14% of the minimum wage. In 2002, social health insurance accounted for 86% of total health care expenditures, while 3% were financed by government and 11% by out-of-pocket payments; voluntary health insurance is negligible. Informal out-of-pocket payments for health services are deemed to be substantial, but accurate data are not available and this money is not accounted for in the national financial statistics.

Since 1999, total and public health expenditures have remained relatively stable, amounting to 5.8% of GDP in 2002, which is close to the average of central and south-eastern European countries but below the expenditure levels of neighbouring countries and the EU15 average (8.9%).

Challenges

National accounts do not adequately reflect either the annual deficits of health insurance companies (about 10% of revenues since 1995) nor their cumulative debts. Total health care debt reached SKK32.6 billion (€815 million) by the end of 2003. The reforms before 2002 are widely perceived as having failed to reduce the discrepancy between the generous scope of services covered by health insurance and the lack of financial resources available. Indeed, the increasing debts of health insurance companies and providers have created a sense of financial crisis and urgency to increase and clarify the accountability of actors and the amount of funds available.

The perception of crisis also relates to good governance, accountability, and an insufficiently prudent use of resources. For example, although acute bed capacities were decreased in recent years they are still the highest among western and eastern European countries whilst at the same time, the occupancy rate of acute hospitals (66%) is found to be very low by international comparison.[1] In addition, the staffing levels of existing wards, irrespective of the actual occupancy rate, is mainly due to local lobbying against staff reductions, creating a heavy financial burden for the whole health care system.

Previous reforms

Outpatient care has seen substantial privatization since 1996. By 2002, virtually all pharmacies, 93% of primary care providers and 49% of specialized outpatient care facilities were operated by private providers on the basis of a contract with a health insurance company. Yet, until January 2002, the Ministry of Health owned and operated almost all inpatient facilities. Since then, most secondary care hospitals and adjacent

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polyclinics have been transformed into non-profit public benefit entities or devolved to self-governing municipalities or regions; and some outpatient clinics have been sold to private providers.

From October 2002, the re-elected coalition government introduced stabilization measures (pending longer-term health system reforms), including age and sex adjusted prescription limits for drugs and medical devices at individual provider level. All health insurance companies are obliged to negotiate the limits with individual providers, monitor and enforce these limits according to the negotiated contract. The stabilization measures also include the introduction of – hitherto limited – co-payments, which now relate to the service aspects of basically all health care services and products. Persons in material need, children under six years of age, blood donors, psychiatric patients and chronically ill patients are exempted from co-payments. Following protests by members of parliament, the Constitutional Court ruled in May 2004 that the co-payments introduced in 2003 did not restrict peoples' constitutional right to health care, due to the extent of fees introduced and appropriate exemptions provided for vulnerable groups. It is too early to evaluate the impact of these measures on patient utilization and access but the introduction of prescription limitations, patient co-payments, and the new system of drug categorization and drug price negotiations have led to a reduction in drug prescriptions and medical devices.[2]

Latest reforms passed

Following several amendments during the summer, on 21 October 2004 parliament passed a package of six health reform bills. Despite considerable controversy, including the overturning of a presidential veto, the core elements of the reforms were retained with support from the governing minority coalition and some members of independent and opposition groups. The reforms are wide-ranging and redefine virtually all the competencies and relations between health care actors to clarify responsibilities.

Some of the major measures include: independent financial audits will be required for all institutions above a certain annual turnover; nurses and midwives will be permitted to work as independent providers, prevention programmes will be enhanced, including expanded screening programmes to match existing major national programmes for cardiovascular and oncological diseases. Moreover, the range of services reimbursed fully by mandatory health insurance will be restricted to priority diseases, defined by a ministry of health task force. Several other conditions may also be fully reimbursed on the basis of a decision of the Ministry of Health Categorization Committee, which will categorize 'non-priority conditions' and specify the level of co-payments. The introduction of voluntary complementary health insurance (VHI) for individuals aims to help cover co-payments for excluded benefits. VHI will be offered by established health insurance companies as well as new, for-profit health insurance houses. Finally, health insurance companies, currently operating on a not-for profit basis, and the state-owned health facilities, will be transformed gradually into for-profit joint stock companies.

Whilst some reform measures – such as state insurance contributions based on average salaries, the establishment of voluntary, complementary, 'individual' health insurance, clear priority setting, and greater involvement by the private sector in health care delivery – received broad consensus, the redefinition of the basic benefits package and the transformation of health insurance companies to for-profit joint stock companies raised substantial disagreement amongst MPs, the health care arena, and the public. The six health reform acts will take effect in January 2005, with implementation over several stages. However, press reports indicate that some opposition parties may yet launch a challenge to the reforms in the Constitutional Court.

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