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Contents

Choices in health care: the European experience	1
Choice in the Danish health care system	5
Choice in the German health care system	6
Choice in the French health care system	9
Health care highlights	11
New Observatory studies published	12

Choices in health care: the European experience

Sarah Thomson and Anna Dixon

Choice and economic theory

Giving people the right to exercise a degree of choice when accessing health care is often assumed to be a desirable policy goal of intrinsic worth. It is also seen to play an instrumental role in meeting objectives such as responsiveness and efficiency in resource allocation. Whatever the objective, choices in health care are often complex and associated with costs and benefits.

Choice is a crucial element in the traditional economic model. The notion of consumer sovereignty rests on the assumption that the act of choosing between alternatives allows individuals' preferences to be revealed, resulting in an allocation of resources that is efficient because it reflects the sum of individual utilities. However, the limitations of the revealed preferences theory are particularly acute when applied to health, which is characterized by a degree of uncertainty, and health care, in which providers are likely to be much better informed than patients. Consequently, principal-agent relationships hold considerable importance in health systems, where individuals (principals) are often reluctant to make their own choices, preferring instead to delegate decisions to health care professionals or providers (agents).

If individuals are to exercise real choice, they must be well informed about the alternatives they face and have some awareness of the

consequences of their decisions. Some economists argue that choice may reduce individual welfare if:¹

- sufficient information is lacking;
- the costs of obtaining and processing information are high;
- making a 'bad' choice induces feelings of regret;
- allowing some people to exercise certain choices reduces the utility of those who are not allowed to exercise the same choices;
- the choices some people make negatively affect others; and
- the societal costs of providing choice outweigh the benefits.

Health system choices

Before evaluating the outcomes of choice-enhancing or choice-restricting policies it is necessary to understand the types of choices that are possible in theory, the factors that may constrain choice in practice and the possible motives and objectives of such policies.

Individuals can exercise choice at various decision points within a health system. Table 1 outlines three broad areas in which health system choices are likely to be available.

Where choice exists, it may be freely available to the whole population. In practice, however,

Table 1: Possible choices in health systems

Insurance – choice:	Provider – choice:	Treatment – choice:
<ul style="list-style-type: none"> • to have health insurance or be uninsured • between public or private health insurance • of basic benefits covered by health insurance • of public insurance fund • of contribution rate 	<ul style="list-style-type: none"> • of first contact provider • of general practitioner (GP) • of specialist • direct access to specialists • of hospital • of doctor in hospital 	<ul style="list-style-type: none"> • to refuse treatment • of treatment • of when to be treated • of setting, for example, level or location of care • of facilities or amenities • to participate in trials

Note: A detailed discussion of policies to increase choice of treatment is beyond the scope of this article, which focuses on policies to increase choices relating to insurance and providers.

it is rare for choices to be completely ‘free’.² Most choices are either explicitly or implicitly constrained. Examples of explicit constraints include restricting choice to:

- specific groups of people, such as those earning over a certain amount per year;
- a limited range of options, such as providers within a defined geographical area;
- a particular point in time or a one-off decision; and
- those who are willing to pay an additional fee.

Conversely, choice may be available in theory, but limited in practice, due to implicit constraints arising from the context in which it takes place.² Contextual factors include:

- individual capacity: knowledge and information;
- health system capacity: financial and technical resources;
- proximity to services;
- ability to pay: for access to private services or increased access within the public system;
- cultural or institutional norms; and
- institutional responses to particular

incentives, such as risk selection by competing insurers.

Making one type of choice can preclude other choices. For example, people in the United States who opt for insurers that are vertically integrated with providers or that operate on the basis of closed lists of preferred providers will have less choice of provider than people who opt for traditional indemnity insurers.

Policies that affect choice – either by increasing or restricting it – may have different motives and objectives. While these can vary between countries, it is possible to identify common trends. Some policies aim to increase equitable access to health care, for example by reducing variations in waiting times or contribution rates, or by extending choice to the whole population. Other policies aim to enhance health system efficiency, often by stimulating competition between providers or establishing contestability. A third policy goal is to encourage providers to be more responsive to consumers.

Why is choice on the health policy agenda?

In some western European countries choice has been a longstanding feature of the health system and is therefore not a current issue for policy debate, although the effects of these choices may be a

concern. In other countries governments have introduced policies deliberately intended to increase or reduce choice. These policies have been particularly prevalent since the early 1990s. There are a number of possible reasons why choice has emerged as a key item on the health policy agenda since that time.

During the 1980s, public integrated models of health care such as the National Health Service (NHS) in the United Kingdom and decentralized health systems in Scandinavia came under increasing criticism for their poor management, inefficiencies and lack of responsiveness to the needs and wants of users.³ This took place within the broader context of market reforms in other areas of public policy, which were fuelled by a new emphasis on the importance of economic perspectives in policy making, a growing interest in consumerism and rising concerns about the ability of public services to meet public expectations.⁴ Reforms in the health sector focused on the introduction of market mechanisms. Increasing patients’ choice of provider was seen as a means of stimulating competition between providers and giving providers incentives to adopt more patient-centred patterns of care.

In 2000, the World Health Organization’s report on the performance of health systems around the world included responsiveness as one of four key criteria used to measure health system performance.⁵ Health systems that offered patients a greater level of choice were deemed to be more responsive, although high scores for responsiveness might be accompanied by lower scores for other criteria – fairness in financing health care, for example.

Recent rulings from the European Court of Justice underline the fact that health systems within the European Union (EU) can no longer regard themselves as beyond the scope of EU competition law, prompting governments in some member states to extend patients’ access to providers abroad, particularly where waiting lists have become an increasing source of domestic political embarrassment.⁶

While contemporary reforms in different

countries are sometimes motivated by similar issues, it is worth noting that acceptable levels of choice vary between health systems and between different population groups. They also vary over time, so that what has been seen as 'normal' in one country or for one particular group of people may no longer be considered fair or appropriate.

Examples of choice in western European health systems

Choice of public or private coverage

Arguments in favour of allowing people to choose between public and private health insurance tend to be based on the assumption that the threat of voluntary exit from the statutory health insurance scheme will stimulate competition between public and private insurers, leading to efficiency gains and greater responsiveness in the health system as a whole.

In practice, however, this type of choice is rare. Within western Europe it can only be found in Germany. Although governments in Austria (1999), Portugal (1993) and Spain (1975) have put in place arrangements that increase access to private health insurance for specific groups of employees, these arrangements are not contingent on individual choice, either because they are compulsory or because they involve collective decision-making.⁷ In Portugal and Spain they were introduced with the intention of clarifying boundaries between the public and private sectors.

Choice of public or private insurance in the German health system has created complexities and increasing controversy. Dissatisfaction with the current system and concerns about the future sustainability of the statutory health insurance scheme were key issues in the 2002 general elections, leading some to call for a radical overhaul of public and private health insurance.

Choice of public insurance fund

Choice of public insurance fund (sickness funds) has been a longstanding feature of social health insurance systems in some countries, for example, Belgium.

In others, it is a more recent phenomenon. Reforms that took effect in the Netherlands in 1993 and in Germany in 1996 made it possible for most people to choose between competing funds. However, the reforms were introduced for different reasons. Explicitly based on a model of regulated or managed competition, the Dutch reform of 1993 intended to dismantle the funds' (natural regional monopolies and create incentives for them to become more active and efficient purchasers of health care.⁸

In contrast, the German reform primarily used choice to encourage convergence in contribution rates – which varied significantly for people with similar incomes – although the reform was also politically motivated and it was expected that competition would increase incentives for funds to operate more efficiently.⁸

However, choice of fund is only likely to increase efficiency and equity if risk adjustment mechanisms sufficiently reduce incentives to select risks, if funds have access to tools that allow them to exert control over providers – such as selective contracting – and if people are able to change fund without incurring costs. The German and Dutch experience of choice between funds suggests that people are only willing to change fund where the benefits of changing significantly outweigh the costs involved. Giving people choice of fund carries additional transaction costs; and risk adjustment mechanisms are expensive to administer, even when carried out by a central authority.

Choice of first contact provider

Choice of GP already exists in most western European health systems, where it is seen as a fundamental right or norm. Some health systems, in which patients are required to register with a family doctor of their choice and do not have direct access to specialists, have experimented with alternative access routes to primary care services, such as walk-in centres in the United Kingdom.

In health systems where patients have significant choice of first contact provider and/or direct access to special-

ists, policies have tended to focus on restricting choice by requiring patients to visit a GP before accessing specialist care, as in France and Germany. Underlying these reforms are objectives to strengthen primary care, improve continuity, introduce capitation (with associated efficiency incentives for providers) and reduce expenditure (hospital outpatient care and specialist care are associated with higher intensity services). However, the reforms do not appear to be popular with patients who are used to high levels of choice and may affect the accessibility or quality of primary care services.

Choice of hospital

In contrast to ambulatory care, where patients may access services directly, inpatient care usually requires a referral unless patients are admitted through the accident and emergency department. This creates a greater role for professionals in determining the locus of treatment. For example, although patients in Germany have free choice of hospital, in practice the referring doctor has an important say in determining where a patient will be treated.

Where there is a diversity of providers, choice of provider may allow patients to choose between public and private providers. In Germany and France the mix of public, private non-profit and for-profit hospitals is such that patients may not even be aware of the status of the hospital; other factors are likely to have a greater influence on choice.

People living in border regions of Europe have often exercised the choice to access services in another country when bilateral agreements exist for the reimbursement of services provided to non-resident populations. More recently, some countries have set up systems to offer patient treatment abroad if they have been waiting a long time – for example in Belgium, Germany and the Netherlands.

Free choice of hospital within a country has also been introduced to lower waiting times by maximizing use of capacity – for example in England, Denmark (see the article on Denmark in this issue),

Sweden and the Netherlands, all countries in which patients have traditionally had little or no choice of hospital.

Initially introduced as part of waiting list initiatives, policies to increase choice of hospital are now becoming a permanent feature of these health systems. However, take-up has been surprisingly low. Patients tend to opt for conveniently-located facilities or ones with which they are familiar. These revealed preferences differ from the stated preferences of patients when asked about willingness to travel, which suggests that the information and other costs associated with a decision to be treated at an alternative provider currently may be too high.

Discussion

This brief article outlining trends in policies to increase or reduce choice in a number of western European health systems highlights a variety of policy objectives. Policies to increase choice do not appear to be primarily concerned with its intrinsic benefits. Instead they tend to use choice as a means of achieving other goals. Nor are these policies necessarily underpinned by the traditional economic model outlined above.

On the provider side, some policies focusing on first-contact provider have been motivated by a desire to increase access to primary care. Others have attempted to curb choice, particularly where it is seen to undermine continuity of care, result in duplication or threaten the quality of care. Strengthening the gatekeeper function, restricting access to specialist care and directing patients towards more cost-effective patterns of utilization all aim to improve expenditure control.

Policies to increase choice of hospital in countries such as Denmark, Sweden and the United Kingdom initially aimed to tackle the problem of waiting lists by maximizing use of existing capacity. In some cases, they have also become

concerned with putting competitive pressure on public providers to encourage them to operate more efficiently and to be more responsive to patients.

Emerging evidence of the impact of choice policies suggests that most patients are conservative, often preferring the existing level of choice available to them. Those that exercise choice are usually younger, healthier (or at least more mobile), more affluent and better educated. Factors that appear to be important in persuading people to exercise choice are price, convenience and prior experience. Factors shown to contribute to low take-up of choice policies include lack of adequate incentives for patients and/or providers, lack of sufficient information, the high costs of obtaining and processing information, institutional resistance and cultural norms.

In many cases the low proportion of people exercising choice means that the expected system responses have not materialized due to marginal impact on providers' total activity and budget constraints. As a result, policy objectives rarely have been fully met. At the same time, several of these policies have had unintended or unforeseen consequences, such as risk segmentation. The fact that choice is more likely to be exercised by certain groups of people suggests that policies to extend choice of provider could lead to polarization in other ways, for example between affluent and poor areas, where providers in the former are able to attract better quality personnel. Other unanticipated consequences include high transaction costs and political risks for government.

Some governments have commissioned independent evaluations of the implementation of choice policies, but on the whole it seems that initial enthusiasm for these policies has been based more on theoretical assumptions about the potential benefits of choice in promoting managed competition within public

sector markets than on empirical evaluations of choice in action in other health systems. Furthermore, culture and embedded norms may be significant in determining the extent to which patients exercise choice. These should not be ignored. Further work on cross-national differences would provide useful insights into the likely impact of similar reforms.

REFERENCES

1. Rice T. Should consumer choice be encouraged in health care? In: JB Davis (ed.) *The Social Economics of Health Care*. London, Routledge, 2001.
2. Levett R, Christie I, Jacobs M, Therivel R. *A Better Choice of Choice: Quality of Life, Consumption and Economic Growth*. London, Fabian Society, 2003.
3. Enthoven AC. What can Europeans learn from Americans? *Health Care Finance Review*, December (49–63), 1989.
4. Freeman R. Competition in context: the politics of health care reform in Europe. *International Journal of Quality in Health Care*, 10(5), 1998.
5. World Health Organization. *The World Health Report 2000: Health Systems — Improving Performance*. Geneva, World Health Organization, 2000.
6. Brouwer W, van Exel J, Hermans B, Stoop A. Should I stay or should I go? Waiting lists and cross-border care in the Netherlands. *Health Policy*, 63(3), 2003.
7. Mossialos E, Thomson S. *Voluntary Health Insurance in the European Union*. Copenhagen, World Health Organization Regional Office for Europe, 2004.
8. Schut F, Gresz S, Wasem J. Consumer price sensitivity and social health insurer choice in Germany and the Netherlands. *International Journal of Health Care Finance and Economics*, 3, 2003.

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Choice in the Danish health care system

Mickael Bech

The Danish health care system is currently a decentralized public integrated system in which 14 counties and 2 municipalities levy income and property taxes to finance the majority of their activities, including health. Hospitals are owned, managed and financed by the counties. General practitioners (GPs) are privately self-employed but must be licensed by the county. GPs play a key role as gatekeepers.

In the past, the various parties in parliament have generally supported increasing patient choice. However, the current conservative government's decision to include private providers as part of the policy to increase choice was controversial. Increasing choice has gradually undermined the sustainability of the radically decentralized public system in Denmark and has been one of the driving forces behind the present policy debate focusing on structural reform.

Choice in ambulatory care

Residents in Denmark over 16 can choose between two groups to receive GP care. Individuals enrolled in Group 1 are registered with a GP within 15 km of their home – 5 km in the Copenhagen area – and have free access to GPs and specialists. They need a referral from their GP to see a specialist – except for ear, nose and throat specialists or an ophthalmologist. If they consult a specialist without a referral they are liable to pay the full fee. Every six months, they are entitled to switch to a new GP but a small fee is applied in some counties. No official figures exist on how often this right is used but switching is considered

to be somewhat infrequent.

Individuals in Group 2 are free to visit any GP and specialist but there is a co-payment for all services except for hospital treatment. However, only 1.7% of the population has opted to be in Group 2.

Choice in hospital care

While free choice of GP may have little impact on the health care system, free choice of hospital has evolved to have a large impact on the system. The option for patients to choose to be treated in a hospital outside their county was introduced in 1993. Alongside this policy, a general goal was set to reduce waiting times to a maximum of three months. Information on waiting times was also made available, with waiting times for common elective treatments being posted on official websites. The aim of free choice was to allow patients at a basic (non-specialized) treatment level to benefit from unused capacity and to even out differences in waiting times between hospitals. The years following 1993 showed limited use of the free choice option across counties. In 2000, 7.9% of non-acute inpatient treatments and 6.7% of non-acute outpatient treatments, were performed in a county other than the patient's county of residence.¹ Patients must pay for their own travel expenses which may represent a barrier to the use of free hospital choice.

The impact of choice

The limited use of free hospital choice led to renewed discussions surrounding the legislative framework.² One of the result-

ing decisions was to strengthen the competitive element of free choice. In 2000, diagnosis-related group (DRG) rates – reflecting the average treatment cost for a patient within a DRG – were introduced as the payment method between counties for patients choosing to cross county borders for basic-level treatment.

Prior to January 2000, the home county – where the patient resides – paid per diem charges to the county receiving the patient. These charges were set at a low level (the marginal cost of treating an additional patient). Therefore, counties had no incentive to build up higher capacity on the basis of out-of-county patients. In many cases, it was considered that the per diem rate did not actually cover the marginal cost. The implementation of (generally higher) DRG rates gave counties a stronger incentive to attract out-of-county patients. Hospitals also tried to keep their own patients by offering them the appropriate hospital treatment. Because DRG charges are generally higher than the original per diem charges, the obvious winners of this policy change were the counties with a positive net inflow of patients.

The introduction of the new type of inter-county payment method, together with other policy changes led to a rearrangement of the counties' hospital remuneration schemes. Traditionally, hospitals were remunerated with global budgets but now they are increasingly partly remunerated according to their activity in order to motivate them to increase their activity levels and productivity. Since 2000, counties have partly remunerated hospitals through case-based payments. In 2000, this form of payment of hospitals represented 3% of overall remuneration, a percentage that has continued to increase.

As of 1st July 2002, the maximum waiting time guarantee has changed from three months to two months*. If the home county of a patient is not able to provide treatment within this time period, the patient has an extended right to seek treatment in another hospital, including a private hospital in Denmark or in another country – with which the home county has an agreement. This

*Exceptions to the maximum waiting time guarantee exist for specific treatments such as organ transplantation, sterilization, fertility treatment, hearing aid treatment, cosmetic surgery, psychiatric treatment, sex-change operations and convalescent treatment.

policy is expected to increase the number of patients going to private hospitals; currently, less than 1% of hospital beds are in the private sector.

The present government's main policy objective is to decrease waiting times but patients' rights to free choice are also promoted. The number of patients who opted to use their extended choice of receiving treatment in a private hospital increased from 2,044 in the 3rd quarter of 2002 to 5,135 patients in the 2nd quarter of 2003 and finally to 5,481 in the 2nd quarter of 2004. Most of these patients received orthopaedic surgery, eye surgery, and ear and nose treatments. The number of patients going for treatment abroad was 131 in the last two quarters of 2002; 96 in the first half of 2003; and 89 in the first half of 2004.

Counties are responsible for paying the bill for resident citizens using the free choice of hospital option. As a result of this policy, the counties' total expenditure rose from around Dkr 30 million (€4 million) in the 3rd quarter of 2002 to Dkr 80 million (€11 million) in the 2nd quarter of 2003. The counties argue that the national government should compensate them for this increase in expenditure since it is due to the extended free choice policy that counties have no ability to control their expenditure.

With free choice of provider, it is not possible for counties to directly control patient choice and they can only exert indirect influence through contingent factors such as waiting times, i.e. a county can keep its patients or attract patients from other counties by reducing waiting times. Waiting times are a function of demand and hospital production. Counties can encourage hospitals to increase their production by implementing stronger financial incentives, for example, by implementing case-based reimbursement. However, counties are constrained by their health care budgets. If they exceed their budgets taxes have to increase and/or lower budgets have to be allocated to other county activities. The counties face a dilemma: if they provide financial incentives to hospitals to increase production this may lead to budget deficits; but if they do not

promote higher hospital production patients may choose to be treated in other counties, ultimately also leading to higher costs for the home county.

Concluding remarks

The Danish example illustrates a common problem faced when patients have free choice while the regional level (counties, districts, cantons, regional NHS authorities) remains accountable for the cost of patient treatment both within and outside regional borders. The region may have a financial interest in keeping patients within its own borders since the marginal cost of hospital treatment for an additional patient within the region does not exceed the potential costs for treating a patient across borders. However, the region has no direct control over a patient's choice. The region's only alternative is to control hospitals' financial incentives by setting the mix of reimbursement mechanisms. This involves a trade-off between

increasing hospitals' incentives to increase activity and the region's ability to stay within its budget. The policy of free hospital choice and the resulting economic uncertainty for the counties may have been one of the 'raisons d'être' behind the recent Danish reform which aims to restructure the decentralized county health care system into a system with five national regions in 2007.

REFERENCES

1. Sundhedsstyrelsen. *Afregning af Fritvalgspatienter* [Remuneration of free choice patients]. København, Sundhedsstyrelsen, 2002.
2. Vrangbæk K, Bech M. County level responses to the introduction of DRG rates for 'extended choice' hospital patients in Denmark. *Health Policy*, 67(1), 2004.

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Choice in the German health care system

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Germany's plural health care system places a high emphasis on free choice of providers and insurers, coupled with a comparably high density of capacities and health care personnel that allow for ready access to ambulatory as well as inpatient care. In 2003, statutory health insurance (SHI) covered the majority (88%) of the 82.3 million inhabitants, private health insurance (PHI) approximately 10%, specific free governmental care schemes another 2% and 0.2% were not covered by any third-party payer scheme.¹

Choice of providers

SHI-insurees basically have (SHI-reimbursed) access to 99% of all beds in public or private hospitals which are

contracted by sickness funds. SHI-insurees also have access to 95% of all ambulatory physicians who are accredited as SHI-affiliated physicians (competing with each other for patients while being a mandatory members of strictly regulated but self-governed regional physicians' associations). The remaining 1% of hospital beds and 5% of office-based physicians are only accessible to private patients who have either PHI coverage or pay out-of-pocket.¹

SHI-insured patients have free choice of, and direct access to, SHI-reimbursed care from most providers in ambulatory care, including SHI-affiliated family physicians, specialist physicians, psychological psychotherapists (since 1999), and

dentists, as well as to pharmacists and long-term nursing care providers. They may also freely choose amongst other health professionals for ambulatory care, outpatient clinics at hospitals, and elective inpatient care but access to SHI-reimbursed care is available only upon referral by an SHI-affiliated physician. Patients are not charged if they fail to attend an appointment.

Family physicians (about half of all ambulatory physicians) are not gate-keepers in Germany, although their coordinating competencies have been strengthened in recent years. Until 2003, there was no binding regulatory mechanism or financial incentive to reinforce the legal requirement to choose and keep a family physician for at least three months. While about 90% of the population report that they have a family physician, patients frequently choose office-based specialists directly. In representative surveys performed between 2001 and 2003 as part of the survey-programme *Healthmonitor*,² the share of direct specialist consultations at the last reported contact was around 60%. In practice, access (and choice) of ambulatory specialist physicians is restricted in cases of immobility since few specialist physicians offer home visits.

From 2004, sickness funds are legally obliged to offer SHI-insurees the choice to subscribe to a gate-keeping system or to keep to the traditional system. In exchange for the reduction in choice and direct access to specialists, subscribers may be offered a bonus. Up to now, the gate-keeping option has only been offered by a few sickness funds but is supported by 80% of the population, particularly the elderly and lower social classes (most of whom, however, already utilise their family physician as their first contact physician).²

The user charges that were introduced for physician and dentist visits in 2004 should increase private funding but at the same time will also encourage unnecessary physician and dentist visits. A co-payment of €10 applies on the first visit to a SHI-affiliated doctor or dentist and for any further visit without a referral within a period of three months. This

measure allows the coordinating role to be performed either by a family physician or any first-contact specialist physician. The number of physician visits (especially of specialists) decreased by 10% in the first quarter (January–March, 2004) compared to the same period in the previous year and by 8% in the third quarter (July–September). According to *Healthmonitor* 2004, the rate of direct consultations at the last reported specialist physician visit decreased from 60% in previous years to 53% and the rate of referred consultations increased from 40% to 47%.²

Since 2004, the user charge for physician visits, introduced jointly with an increase of co-payments for all other types of care and stricter exemption mechanisms, received substantial criticism from patients and the media for placing an unfair burden on the sick and the poor; and restricting and reducing access to care and choice. Low-income groups (19%) reported more often than higher income groups (8–13%) that they avoided a physician visit due to cost. Compared to 23% of those in good health, only 8% of chronically ill patients avoided a physician visit and 39% of the latter reported having made additional visits to their first-contact physician to request a referral to avoid additional user charges.² In practice, the new physician co-payments only represent a small share of all co-payments, particularly when compared with drugs (€5 to €10 per package).

Second opinions initiated by patients or physicians are reimbursed by sickness funds and are not regulated by specific rules or sanctions other than the new co-payment rules. The user charges are expected to reduce this kind of voluntary second opinion to a certain degree which, however, is still often sought within ambulatory care and across sectors but less so among different hospitals.

Obligatory second opinions are required to control an SHI-insuree's eligibility for major dental work, larger medical aids or medical rehabilitation. They are fully reimbursed by the sickness funds and performed by physicians working for the regional SHI medical review boards,

which is financed jointly by sickness funds active in the particular region. In addition, sickness funds may require second opinions to review the necessity of hospital admissions, sick pay or fund-specific benefits like exercise programmes for insurees with ischaemic heart disease. SHI-insurees are obliged to comply with these second opinion reviews or examinations, but they may also lodge complaints against any decisions with their sickness funds branches and with the social courts.

Choice of health insurers

Choice between the comprehensive SHI scheme, comprehensive substitutive private health insurance (PHI) and no health insurance at all is another long-standing characteristic of the German health system.³

The population with SHI coverage (88%) was composed of:

- c. 78% mandatory members and their non-earning family members;
- c. 10% voluntary insurees and their non-earning family members who have not opted-out of SHI even though their gross wage/salary exceeds the income threshold for mandatory SHI membership (€3,862 per month in 2004).¹

The population with PHI coverage (10%) was composed of:

- c. 2% self-employed, mostly with voluntary comprehensive (substitutive) PHI coverage, many being ineligible for SHI-coverage;
- c. 4% other voluntary insurees, especially employees and their family members who have opted-out of SHI, mostly with voluntary substitutive PHI coverage;
- c. 4% civil servants, retired civil servants and their family members with voluntary complementary PHI coverage to compensate for expenditures not paid by their major scheme of coverage, provided freely by the government.

Uninsured residents (0.2%) included:

- mainly self-employed persons, retired self-employed persons and their

family members, who do not want or cannot afford PHI coverage,

- and, for example, former voluntarily SHI-insurees who failed to pay their contributions.

Altogether, c. 14% of the population had free choice between SHI and PHI (and no free government care) in 2003. The majority of these (c. 10% of the population) chose to be covered by comprehensive SHI, while c. 4% chose comprehensive (substitutive) PHI.

Free co-insurance for non-earning family members and sharing contributions with employers makes voluntary SHI particularly attractive to employees with (large) families and for those with worse health risk profiles who would have to pay higher PHI premiums. In contrast, substitutive PHI typically is attractive to young healthy single employees earning above the threshold for mandatory SHI-membership and to the self-employed. The self-employed, whether rich or poor, are not eligible to choose SHI coverage unless they have been SHI-members previously as employees. A decision to leave the SHI system in favour of PHI can only be revoked under a restricted number of circumstances. Changing from one private health insurer to another is possible but is usually accompanied by financial disadvantages.²

In the early 1990s choice among sickness funds was available to about half of SHI members, and this choice was extended to almost every SHI-member in 1996. Since then, SHI-members and their co-insured family members have access to all regional and substitute funds (formerly open to white-collar membership). Company-based funds and guild funds may decide whether they allow access to subscribers beyond their traditional membership (company employees and craftpersons), but once they do offer open access they cannot reverse this decision (since 2004). Sickness funds taking part in the competitive SHI market are obliged to contract with all applicants for membership and co-insured status. Only the farmers' and sailors' funds, as well as the miners' fund, retain the system of profession-based membership. Initially, SHI-members were given the opportuni-

ty to change funds once a year but it was felt that this encouraged too many insured people to switch funds. Since 2002, the right to change fund is possible at any time but there is an obligation to remain with a particular fund for at least 18 months. However, voluntary members of SHI – those earning above the income threshold – and their co-insured family dependants can still move from one fund to another at any time with two months' notice.

The individual's choice of sickness fund was an important, but not the only aspect, of the policy to introduce competition among sickness funds. Even before choice and competition of sickness funds was introduced in 1996, a risk structure compensation (RSC) scheme had been introduced in 1994 to give funds a more level playing field in the new competitive SHI market. The RSC mechanism was to redistribute revenues among sickness funds by:

- (1) compensating for different expenditures due to differences in risk structures via the categories of age, gender and any incapacity to work, and
- (2) adjusting for different revenues resulting from income differences among members of various funds.

The impact of insurer choice

The impact of choice of sickness funds, competition and risk structure compensation among sickness funds can be summarised as follows:¹

Choice and actual change of sickness funds have become more popular. The percentage of SHI-insurees reporting that they are ready to switch funds has increased steadily from 9.3% in 1998 to 23.4% in 2003. While no data on actual moves are available, net gains and losses in membership may be taken as an indicator. Since the introduction of free choice of funds in January 1996 until January 2004, the general regional funds have lost 16% of their membership (now 18.6 million). The substitute funds (formerly with white collar membership) have lost 11% of their insurees and currently have 15.8 million members, although in the first few years they

gained members. The most substantial gain in terms of members was achieved by the company-based funds which doubled their membership to 10.4 million. Further gains were made by the substitute funds which formerly covered blue-collar workers (5% increase, now 1.0 million members), and guild funds (3%, now 3.1 million).¹

Contribution rates were the prime motive for changing sickness funds, while the SHI-benefit catalogue is largely uniform and prices are fixed or negotiated on a collective basis. Indeed the net gains and losses in fund membership were correlated with the contribution rates of the funds. Sickness funds with higher than average contribution rates lost members while those with lower than average rates gained members.¹

The choice and movement of members between funds has not equalized the different risk structures among funds. In contrast, the opportunity to change funds has segregated membership further; i.e. those who are healthier, younger and higher-earners moved more often and towards cheaper funds. This, in turn, led to an increase of the transfer-sums to be redistributed among funds via the RSC scheme from 7.9% of RSC-relevant expenditures (c. 90% of total SHI expenditure) in 1995 to 10.3% in 2001, 10.4% in 2002 and to 10.9% in 2003 when disease management programmes were taken into consideration (see below).¹

To counteract the adverse effects of choice and competition among funds (for example, risk selection) and to give sickness funds a financial incentive to organize better quality care for their chronically ill insurees, a further category was added to the existing RSC scheme in 2003. It relates only to those chronically ill SHI-insurees who agreed to take part in specifically regulated disease management programmes (for example, diabetes, breast cancer).⁴ By November 2004, one million SHI-insurees had subscribed to a disease management programme for diabetes, breast cancer or ischaemic heart disease. In 2007, a risk structure compensation scheme that is more morbidity-orientated is planned.

Concluding remarks

Free choice of health care providers has remained an important value among German citizens and policy-making throughout the cost-containment period since it is perceived as an easy and appropriate way to meet citizens' preferences and encourage providers' responsiveness, quality and accountability. The actual realization of choice has, on the one hand, been eased by increases in information services and virtually all ambulatory providers of health and long-term care. On the other hand, unfettered free choice of health care providers for SHI-insurees is being tempered somewhat by prospective provider reimbursement and (regressive) co-payments, which particularly affect the poor and sick, whom, however, may apply for exemptions. Preliminary evidence suggests that the increased restriction of access and choice via co-payments since 2004 has been associated with an increase of coordinated care and a decrease of physician visits. Its impact on appropriateness and sickness fund expenditure cannot be evaluated until final SHI accounts are published or claims data at regional physicians' associations are evaluated in more depth.

Overall, there is a high level of choice between health insurers in the German health care system. However, the wealthy mainly have a legal choice between PHI and SHI. While opportunities to choose among sickness funds were extended to most SHI-members by law, in practice, choice was exercised mainly by the richer and healthier SHI-members, as encouraged by positive member/risk selection strategies ('cream skimming') of competing sickness funds. Competition and choice also exerted pressure on individual sickness funds to become more productive, and encouraged mergers as well as managerial and informational innovations. With regard to the entire SHI system, greater choice increased rather than equalized differences in risk structures among funds. The RSC scheme – rather than choice and competition – buffered the effects of this trend on fund expenditures, although insufficiently, and was instrumental in decreasing variations of contribution rates among sickness funds.

These developments have led policy-makers to intensify reallocation and to plan for a permanent but regularly reviewed RSC scheme that will take actual morbidity and related spending requirements more into account.

REFERENCES

1. Busse R and Riesberg A. *Health Care Systems in Transition – Germany*. Copenhagen, World Health Organization on behalf of the European Observatory on Health Systems and Policies, 2004.
2. Böcken J, Braun B, Schnee M (eds). *Die ambulante Versorgung aus Sicht von Bevölkerung und Ärzteschaft*. In: *Gesundheitsmonitor* 2004. Gütersloh, Bertelsmann, 2004.

3. Mossialos E and Thomson S. *Voluntary Health Insurance in the European Union*. Copenhagen, World Health Organization on behalf of the European Observatory on Health Systems and Policies, 2004.

4. Busse R. Disease management programs in Germany's statutory health insurance system. A Gordian solution to the adverse selection of chronically ill people in competitive markets? *Health Affairs* 2004, 23(3): 56–67.

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Choice in the French health care system

Paul Dourgnon

Choice of health insurers

There are two kinds of health insurance nets in France: (i) compulsory public health insurance which covers part of ambulatory care and most of inpatient care and; (ii) private (mainly non-profit) complementary health insurance which covers costs that are not reimbursed in full to patients by public health insurance – for example, user charges for ambulatory care, inpatient care and prescription drugs. Public health insurance is provided to employees and their dependants by three main occupation-based sickness funds which together cover 95% of the population.* Individuals do not have choice of sickness fund and contribution rates and the level of benefits covered are

set centrally. However, insurees are entitled to move from one fund to another if they change professions.

Complementary voluntary health insurance (VHI) covers 86% of the population through individual contracts (45%) or through collective (group) contracts (55%); of the latter 52% are compulsory and 48% are optional. Studies have shown that many of those who benefit from collective optional complementary VHI believe it is obligatory. Furthermore, an additional 7% of the rest of the population benefit from universal complementary health insurance coverage through the Universal Medical Coverage Act (CMU, introduced in 2000) which is publicly funded and provided either by

* The National Health Insurance Fund for Salaried Workers (CNAMTS), the Sickness Fund Administration for Self-employed Workers (CANAM) and the National Farmers' Health Insurance Fund (MSA).

sickness funds (88%) or private insurers (12%). Complementary VHI plans usually include benefits for dependants.¹

In 2002, 12% of those insured chose to change insurer for their complementary VHI; this figure does not include those who took up or ended an insurance plan.² This rate mostly reflects changes in professional status, including retirement, as more than half of all complementary VHI plans are contracted through employment. However, it also reflects individual choices. In France, ageing is correlated with a lower tendency to change insurer for complementary VHI while a higher income or worsening health status are factors linked to a higher probability of changing insurer. However, not renewing complementary cover altogether is linked to worsening socioeconomic status but not to age, retirement or health status.

Health status does not seem to play a major role in the choice of whether or not to take out complementary VHI.² To date, there has been no evidence indicating that self-selection (the idea that people with poor health would choose more generous insurance plans) applies to the French complementary VHI market.³ Upon retirement, ex-salaried workers with complementary VHI coverage through a group contract can keep benefiting from their plan for up to six months. After this period they can choose to buy an individual plan. Their former insurer has a legal duty to provide them with a new individual plan, but not necessarily with the same level of coverage, and this new plan is subject to a maximum premium increase of 50%. The same rule applies to dependants if the main holder of the complementary VHI plan should die.

Choice in ambulatory care

Patients are free to choose any physician or specialist for an initial consultation and then to seek additional expertise from another professional, incurring no extra cost sharing.

Despite the entrenched principle of free choice of physician, to improve coordination and continuity of patient care

France introduced a voluntary form of gatekeeping called the 'referring physician' (*médecin référent*) scheme in 1998. Both GPs and patients were given financial incentives to join the gatekeeping system – namely, physicians would receive an annual payment for each registered patient (doubled in 2001 to €46) in addition to the fee charged for each consultation, while patients benefited from a third-party payment scheme which sheltered them from direct fee payments whenever they visited their doctor. In return, certain conditions would need to be met by both parties. For doctors these included charging set fees, maintaining individual medical records, ensuring that a proportion of prescribed drugs are cheaper brands or generics and providing continuity of care. Patients would be required to consult their GP in the first instance (except in emergencies) and to bring their medical record to each consultation. However, as of 2004 this scheme seems to have been a failure with only 1.8% of CNAMTS insurees having a 'referring physician' and only 10% of GPs signing up to the scheme.⁴ This 'gatekeeping experiment' can be seen as an attempt to restrict choice that has been rejected by both patients and doctors.

Nevertheless, as part of the most recent French health care reforms, the gatekeeping system will be supplemented by a 'regular physician' (*médecin traitant*) scheme, the idea being that patients will designate a 'regular physician', a GP or a specialist, who will act as a primary care professional, coordinate treatments and make referrals for specialist or inpatient care. Still, this system will not be compulsory, but will be backed by stronger financial incentives than the initial 'referring physician' scheme. Additional charges will be introduced to patients who do not designate a 'regular physician' or have direct consultations with other professionals.

Choice in hospital care

With the exception of psychiatric inpatient care, patients enjoy complete free choice of hospital. The user charge for inpatient care – 20% of the per diem rate – should theoretically be calculated on

the basis of hospital proximity to the patient's residence, subject to various factors such as the type of hospital and the region. However, this cost-sharing policy is difficult to administrate and therefore is not usually applied. Transport costs are covered for the distance to the closest hospital while additional transportation costs are charged to the patient. This rule does not apply to emergency cases.

Psychiatric inpatient care is geographically organized into zones providing for a particular population. This does not imply a strict reduction in the freedom of hospital choice – except for enforced hospitalizations – but patients are medically oriented by health-care professionals to their geographic sector.

Besides proximity, determinants of hospital choice for patients include:

- (i) the practitioner (GP) or the specialist who prescribes hospital care by suggesting a hospital or a particular surgeon;
- (ii) waiting lists; and
- (iii) a hospital's reputation as assessed by opinion pieces in newspapers. Studies have shown that patients with a higher socioeconomic status have a lower tendency to choose the hospital closest to them.⁵

Concluding remarks

It is argued that patient freedom of choice combined with wide access to care offered by a combination of public and private health insurance create incentives for medically unjustified visits. In France, shopping around for ambulatory care has never been scientifically assessed, but nevertheless, this issue stands at the top of the reform agenda. Assessments of the level of 'unjustified' visits to a physician suffer from a lack of adequate data, with estimates indicating the tendency to 'shop around' by users of ambulatory care varying from 1 to 10% depending on how 'shopping around' is defined.⁶ These studies tend to point out that shopping around is linked with poor health status.

In the quest to reduce medical costs and raise the quality of care, the current health insurance reforms in France almost solely focus on patient behaviour. In this respect, it is noteworthy that the

introduction of the 'regular physician' scheme will restrict patient choice. This emphasis does not echo the conclusions of the recent report by the 'high council for the future of health insurance' (*haut conseil pour l'avenir de l'assurance maladie*). The independent council seemed to have reached a consensus among health-care professionals and policy-makers that rather than focusing on patient behaviour, future reforms should insist on improving the quality and organization of health care for patients.⁷

REFERENCES

1. Le Fur P et al. *Santé, soins et protection sociale en 2002. Enquête sur la santé et la protection sociale (ESPS) France 2002*. (Rapport No. 1509). IRDES, série résultats, December 2003.
2. Grignon M, Sitta R. Qui change de couverture complémentaire maladie et pourquoi? Une étude longitudinale réalisée à partir de l'enquête ESPS 1988–1998. *Questions d'économie de la santé*, 64, February 2003.
3. Buchmueller TC, et al. Access to physician services: does supplemental insurance matter? Evidence from France. NBER Working Paper Series (No. 9238, 2002/09), NBER 2002.
4. Sandier S, Paris V, Polton P. *Health Care Systems in Transition: France*. Copenhagen, World Health Organization Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, 2004.
5. Lucas V, Tonnelier F. Distances réelles d'accès et attraction hospitalière. *Solidarité santé*, 4, 1996.
6. Assurance Maladie des Professions Indépendantes. *Etude de la justification médicale*. CANAM, régime d'assurance maladie des professions indépendantes (Novembre 2001).
7. Ministry of Health, the Family and Disability Services. *Rapport du haut conseil pour l'avenir de L'assurance maladie*. Ministère de la santé, de la famille et des personnes handicapées, Paris, 2004.

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Health care highlights

European Union

A draft Regulation has been published recently by the European Commission ((EC) No 726/2004). The Draft sets out the procedure for companies to apply for a conditional marketing authorization. This type of authorization allows certain medicinal products for particular conditions to be marketed before all the relevant clinical trial data is made available. The specified categories of medicines pertain to the severity of the disease, urgent public health threats recognised by the World Health Organization or European Union Institutions and orphan medicines. The authorization is valid for a year with renewal options available.

Belgium

A draft bill aimed at combating the excessive advertisement of medicinal products was passed in the House of Representatives on November 18, 2004. It focuses mainly on modifying article 10 of the Act on Medicinal Products of March 25, 1964. Rather than prohibiting all promotion of medicines, the draft bill ensures a tighter regulation of advertising so as to limit any influence on physicians' prescription patterns.

The draft bill includes: (i) a broader scope of prohibition to wholesalers; persons entitled to prescribe, deliver or administer medicinal products and; institutions where the prescription, delivery and administration of medicinal products take place; (ii) exceptions to the prohibition apply to gifts and benefits of 'insignificant value' – to be defined by Royal Decree – and specifications are set on the nature of the hospitality given to health-care professionals at scientific events and; (iii) a 'visa' procedure for manufacturers, importers and wholesalers attending scientific meetings involving at least one night's residence. These new provisions are to come into force upon their publication in the Belgian Official Gazette. The date is to be determined by a Royal Decree: December 31, 2006 at the latest.

Germany

In a recent case, the German Federal Social Court (*Bundessozialgericht*) upheld a lower court's judgement denying reimbursement claims by a patient for a drug legally imported from another EU country where it is licensed but with no market authorization in Germany. Since the drug had not been tested in Germany, the court based its decision on safety and the protection of health. However, this ruling applies for this individual case only; cases with special circumstances are to be further examined.

France

From 1 January 2005, patients will be reimbursed €1 less per consultation (www.ameli.fr). Exemptions apply to those benefiting from Universal Medical Coverage or state-provided medical aid, persons under 18 and pregnant women from their sixth month on to 12 days after their delivery date. Complementary voluntary insurance funds choosing to reimburse patients at the old rate lose certain fiscal advantages and benefits.

Netherlands

In 2005, the Dutch Ministry of Health, Welfare and Sport (www.minvws.nl) will replace the Law on Medicine Provision with the new Law on Medicines. The government will continue to pursue its objective of limiting pharmaceutical costs through price controls. However, the law will take a simpler and more deregulated approach and will focus solely on the provision of medicinal products. Directives will no longer be issued to pharmacists. Access to over-the-counter drugs will be extended to supermarkets, petrol stations and other specific retailers. If the new Law is not adhered to, the Dutch Health Care Inspectorate will be entitled to impose financial penalties.

Norway

In January 2005, the Norwegian Ministry of Health and Care Services will publish a document outlining the main mental health service and policy reforms



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Belgium



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of Greece



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implemented since the introduction of a national mental health programme (<http://odin.dep.no/hod/engelsk>). In 1998, faced with an inadequate level of specialized mental health services, the Norwegian Parliament recommended a reorganization of services in this sector and a major increase in funding to take place between 1999 and 2008. A strong emphasis also has been placed on the participation of the patient (the users' perspective), preventive measures, integration of services, a move towards community based services and wider dissemination of information on mental health issues.

United Kingdom

Based on a review of the safety of Selective Serotonin Reuptake Inhibitors (SSRIs) carried out by an independent group of medical experts, the United Kingdom's Medicines and Healthcare products Regulatory Agency (www.mhra.gov.uk) has issued new safety advice for this group of antidepressants. The reviews suggests that there should be a stronger warning indicating the possible withdrawal reactions experienced at the end of a course of treatment with SSRI and that in most cases, the lowest recommended dose of SSRI should be prescribed.

New Observatory studies published

Social Health Insurance in Western Europe

Richard B. Saltman, Reinhard Busse and Josep Figueras (eds)

A further study in the European Observatory on Health Systems and Policies Series with Open University Press, *Social Health Insurance in Western Europe* uses the seven Social Health Insurance (SHI) countries in western Europe – Austria, Belgium, France, Germany, Luxembourg, the Netherlands and Switzerland, as well as Israel, to review the core structural and organizational dimensions, as well as recent or current reforms and innovations, of these health care systems. The book uses a framework based on typical SHI characteristics and explores the nature of the pressures that these health systems confront to be more efficient, more effective, and more responsive; and reviews their success in addressing these pressures to date. It also examines the implications of these responses on the defining characteristics of SHI. Finally, the book draws out a set of policy lessons about past experience and likely future developments in SHI systems in a manner that is useful to policy makers in Europe and elsewhere.

The book is available from Open University Press, www.openup.co.uk

ISBN 0-335-21363-4 Paperback: £24.99 ISBN 0-335-21364-2 Hardback: £70.00

Health Systems in Transition: learning from experience

Josep Figueras, Martin McKee, Jennifer Cain and Suszy Lessof (eds)

The period following the break-up of the Soviet Union has brought enormous political and socioeconomic change to the European Region. The health sector has not been spared the effects of transition, and the countries emerging from the process have each engaged to varying degrees in health system reform. It is at last possible to reach some judgement about how this process has unfolded, to identify successes and failures, and to understand better the scale and nature of the remaining challenges. This book draws on the experience and lessons learned in the region over the past ten years of transition in key health system areas, such as health care financing, the restructuring of hospitals, public health and gains in health system quality.

The book is available in full text from the Observatory's website, www.observatory.dk

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