# Health Care Briefing 2003

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## CNE Launches Health Care Site

CNE Health, the health care unit of the Centre for the New Europe, recently launched www.cnehealth.org, a website dedicated to current health care issues in Europe.

The site is not merely a repository of some of the best resources on health care reform in Europe; its 'The Pulse' column is updated at least once a day with articles, comments and links provided by some of Europe's leading healthcare specialists. Longer versions of some of the items in this briefing can also be found on the site.

## G10 White Paper Published in December

In December 2002 CNEHealth published a White Paper: 'Saving the European Pharmaceutical Industry: Price Regulation and "Recommendation VI"', in response to the 'G10' report on the provision of medicines within the EU.

The G10, (or, to give it its full name, the 'High Level Group on Innovation & Provision of Medicines') was set up by Commissioners Liikanen and Byrne in December 2000 to analyse the state of play within the EU in, as its name implies, innovation and the provision of medicines. Its report makes 14 recommendations. The White Paper deals with the most significant, Recommendation VI: That the Commission and Member States should secure the principle that a Member State's authority to regulate prices in the EU should extend only to those medicines purchased by, or reimbursed by, the State. Full competition should be allowed for medicines not reimbursed by State systems or medicines sold into private markets.

Recommendation VI constitutes a significant further step towards creating, particularly in the area of pricing, a more competition-based single market for medicines. It thereby provides precisely the opportunity sought by the Commission to improve the competitiveness of the pharmaceutical industry in Europe, and thus to help to improve public health and benefit consumers.

The White Paper discusses how, when and why Recommendation VI could be instituted. It can be viewed in full at http://www.cnehealth.org/pubs/12162002_G10_white_paper.pdf


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## First CNE Health Publication Makes Waves

CNEHealth's first publication, Economic Evaluation And The Funding Of Pharmaceutical Products, made waves across the EU. It was, for instance, used as evidence by the British House of Commons' Select Committee on Health Care's report into the National Institute for Clinical Evidence.

The report was prepared for CNEHealth by the pharmaceutical consultancy, Cambridge Pharma, and one of the report's authors, Dr Joseph Zammit-Lucia, spoke at a lunchtime seminar in January 2003.

The report argues that the rise of 'economic analysis' as the dominant tool in healthcare rationing decisions is deeply worrying and anti-democratic.

Economic analysis, which compares the costs and consequences of alternative treatments for a given condition, is promoted as a rational, scientific means of allocating resources and containing costs. But in reality it is little more than a spurious justification for rationing drugs that would have a significant impact on spending.

As the report's foreword puts it: "Quite apart from the technical problems – at the launch of any new medicine there is a shortage of information on its effectiveness in clinical practice, which makes informed decisions impossible – economic evaluation is not, as its advocates claim, value-free. Economic evaluation represents a set of value judgements which are hidden from view and may not reflect the values that the general public would like to use in the allocation of healthcare resources. Using economic evaluation obscures just how subjective rationing decisions remain and dresses them up in supposed objectivity."

The report continues: "Relying on economic evaluation to justify decisions to withhold drugs is deeply misleading, since it is politicians who set the rules by which economic evaluation operates. Indeed, the cynic's view of NICE is the only plausible view: the very purpose of basing rationing decisions on the outcomes of economic evaluation is to provide a supposedly objective alibi behind which intensely unpopular political decisions – what to ration – can be hidden. Subjective choices about which treatments to deny, and to which groups of patients, are thus disguised as objective decision-making, and given entirely spurious credibility, when in reality they are no more objective than any other political decision."

As well as being misleading, economic evaluation is also discriminatory and dangerous. The methodology used in economic evaluation has in-built discriminatory mechanisms against the elderly and the disabled. These groups, and others who could benefit, end up being denied treatment. There are also damaging long-term consequences. The more decisions that deny availability of treatments which might indeed be beneficial, the greater will be the stifling of medical progress and the prevention of long-term improvements in the development of high quality, cost-effective care.

Economic evaluation is a valuable tool if properly used and its benefits and limitations are recognised. However, as currently applied, it is effective neither as a cost-containment tool, nor as a means to a better allocation of available resources. It discriminates against whole groups of patients and is in danger of being hijacked to become no more than a cynical, spurious justification for rationing and the denial of healthcare.

The report can be viewed in full at http://www.cnehealth.org/pubs/120001_Nice_treaty.pdf

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## Taylor on “Poor World Health, Rich World Wealth”

David Taylor, Professor of Pharmaceutical and Public Health Policy at the University of London, spoke at a CNEHealth lunchtime seminar on ‘Poor World Health, Rich World Wealth’. His thesis was that commercial companies alone cannot solve health problems of developing countries.

Responding to the arguments of Oxfam and other such aid organisations, which accuse the pharmaceutical industry of using its influence to maintain world wide system of intellectual property law and enforcement that is now denying the world’s poor access to essential medicines and blocking progress towards health for all, Professor Taylor suggested that whilst enabling all sections of the global population to gain the extended life expectancy enjoyed in developed countries is one of the world’s fundamental challenges, it is not clear that doing away with legitimate intellectual property rights will aid this process in the long term, or that individual companies can carry a responsibility that properly belongs to governments and peoples.

Intellectual property law exists to generate global public benefits. Legislation and the TRIPS agreement were created to defend the interests of the entire world community in continuing investment in research and innovation. Most economists accept that intellectual property needs protecting in market economies. Without patents, medicines such as today's AIDS treatments would not have been developed by privately financed organisations. However, it is also true that in the immediate future rich world citizens have more to gain from intellectual property protection than those of the poorest nations. The important issue is to find ways of providing very poor populations with cheap access to patented essential medicines in ways that do not permit "leak back" sales of such products to richer countries and so undermine research for the future.

Pharmaceutical companies are valuable national and international assets and have played a vital part in creating the medicines at the centre of the current debate. No commercial company can act as a charity without running the risk that it would soon have no more than good intentions to offer either its customers or its owners. But if policymakers can create purchasing funds, ensure that patented medicines supplied at low cost to poor populations do not "leak back" to rich world markets, and restrain medicine price negotiators in prosperous countries from demanding savings to match those offered to the poorest, progress could and should be made. Given appropriate incentives, the profit motivated pharmaceutical industry provides a powerful force for improving both public health and private wealth throughout the global community.

CNE Health has an ongoing programme of lunchtime seminars designed to explore what is right, and what is wrong, with the various healthcare systems in Europe. Recent seminars have looked at Sweden, Hungary, the Netherlands and Switzerland.

Peter Zweifel, one of the world's leading health economists, and a professor at the Socioeconomic Institute, University of Zurich, argued that the Swiss healthcare system is especially interesting for three key reasons. First, consumer preferences are respected to a degree found in few other countries. Second, Switzerland has a very decentralised political system, especially when it comes to health policy, where the 26 cantons have retained authority especially with regard to hospital regulation. Third, the Law on Health Insurance of 1994, which survived the test of a popular referendum in 1996, has introduced managed competition into the health care sector to an extent that seems to at least parallel the other two well-known examples, Belgium and the Netherlands.

The confederation is responsible for social health insurance, which became mandatory for the entire resident population under the new LHI. However, authority for health policy continues to be vested with the 26 cantons which mainly act as the financiers and regulators of public hospitals. The cantons also pay contributions toward operating costs and provide investment grants to private hospitals that admit patients with social health insurance. In return, cantonal parliaments decide about hospital fees, which precludes selective contracting between sick funds and individual hospitals. Finally, some public health services are financed (and, in part, provided - especially in the case of nursing homes for the aged) by more than 3,000 communes.

The Swiss system is far from perfect: given the high degree of retrospective subsidy provided by most cantons, the incentives for cost containment by hospitals are very weak. The incentives work indeed to the opposite effect: since cantons finance up to 80 percent of investments, communities may get 5 Swiss francs for each franc it spends itself on the modernization or extension of its hospital. And it has proved almost impossible for cantonal governments to close a hospital department, let alone an entire hospital. This keeps hospital density at a high 113 patients per 10,000 inhabitants, compared to 41 per 10,000 inhabitants in the United States (1995 figures).

But the strengths far outweigh the weaknesses. Health spending overwhelmingly reflects consumer preferences. The Swiss can express their preferences directly, because social health insurance is individually contracted.

Prior to the 1994 reforms, a per-enrollee subsidy was paid to the sick funds in return for their serving as regulated carriers of social health insurance. Today, cantons are mandated to fix a benchmark ratio of premiums to taxable household income (typically between 8 percent and 10 percent), beyond which households receive a premium subsidy. The 1994 law also eliminated the "any willing provider" clause. This opened the way to the creation of HMOs and PPOs, ending an era of uniform contracts that had lasted 80 years. Now, competition forces providers to come up with products with a favorable benefit-cost ratio - although not necessarily at minimum cost (in combination with possibly lower quality).

There are two main inhibitors of competition: first, cantons must withdraw from hospital financing; second, there must be no uniform nationwide fee schedules.

Removing the role of the catons in hospital finance will permit hospital managements to conclude preferential contracts with health insurers, which would provide hospitals with market signals, encouraging specialization in areas of comparative advantage. And a hospital unable to contract with any competitive insurer would have to close down. HMO and PPO patients would profit from lower rates, and quite likely improved quality, due to increased volumes of procedures of a given type.

There are ongoing attempts on the part of both sick funds and cantonal medical associations to create a uniform fee schedule. Such a schedule would eliminate price competition in spite of the abolition of the "any willing provider" clause. More importantly still, health insurers are prevented from negotiating fees with particular physician groups in an attempt at creating optimal financial incentives for quality treatment tailored to both patient and provider types. Individual schedules for each contract between a single insurer and a group of health services

providers may cause excessive administrative costs. But the sensible alternative is not the creation of a single uniform fee schedule, but a choice among several standardized schedules.
The idea of choice is now firmly rooted in the thinking of all parties concerned. Consumers are increasingly learning to compare different health insurance plans; social health insurers compete much more intensely for enrollees; physicians are getting slowly accustomed to the concepts of evaluation and quality assurance; and hospitals are becoming interested in treatment alternatives that are less costly in order to meet insurers' demands.

Dr Peter Gaal, director of the M.Sc. programme at the Health Services Managment Training Centre (HSMTC), Semmelweis University, Budapest, led a seminar on health care reform in Hungary, which has transformed its healthcare system from centralised Semashko state control to a more pluralistic, decentralised
model, with contracts between local government and providers replacing direct ownership. Funding is now predominantly through social insurance via the Health Insurance Fund. The HIF collects premiums and allocates funds to 20 county branches, which in turn enter into contracts with health care providers. The HIF is under-financed, and the state government is obliged to cover its deficit. The result is a mix of tax and social insurance-based funds. Coverage is universal and provides access to all ambulatory and secondary hospital health care. Health insurance contributions are collected from employees, who pay 3% of their total income, and employers, who pay 15% of the employee's gross salary
plus a lump sum tax or 'healthcare contribution'.
Patients make co-payments on certain services, including pharmaceuticals, dental care and rehabilitation. These out-of-pocket payments have increased substantially since 1990, and currently contribute 18% to health care financing.
Municipalities own primary care and outpatient clinics, and municipal
hospitals provide secondary care. County governments run county hospitals that provide secondary and tertiary care. Some private, church owned hospitals still exist, but most still operate under HIF financing. Most pharmacies are privatised, but the overall role of the private sector continues to be minimal. The national government owns university and specialist hospitals, but most health care provision comes from
local governments.
'Gratitude' payments by patients, a Communist legacy, continue to play an important role in Hungary. Lower then average salaries in the healthcare sector encourage these 'gratitude payments' to guarantee quality or more speedy access to care. They substantially supplement most physicians' salaries, but their existence clearly puts poorer patients at a disadvantage. These under-the-counter payments contribute substantially to financing health care, creating perverse incentives and hindering the reform process. But they also show that many Hungarians regard their healthcare as part public good and part consumer good, and are willing to pay more for their healthcare to guarantee good service.

Machel Nuyten, senior healthcare adviser at the VNO-NCW, the Dutch employers' organisation, spoke about the Netherlands' healthcare system, focusing on the relaxation of supply side restrictions and the greater role of market forces.
Dutch health care is an unusual mix of public and private. According to the Ministry of Public Health, Welfare and Sport, the Dutch healthcare system has three important characteristics: public and private financing; the predominantly private character of supply; and a typically Dutch consultative approach to policy-making (known as the 'Poldermodel', and based on negotiation, consensus building and compromise between various interest groups, often via special advisory councils such as the Social and Economic Committee). There is also a key fourth: strong supply-side controls, which result in so-called 'soft-rationing' in the form of long waiting lists.
Dutch healthcare expenditure per capita is above the EU average, but well below expenditure in France and Germany. In 2001, 8.7% of GNP was spent on health care. That figure has remained fairly constant since
1980 (7.5% in 1980 to 8.1% in 2000. Among OECD countries, only the United States has a greater share of private health insurance.
Dutch health care is a hybrid of the German social insurance model and the American private insurance model. One guiding principle is that if people are able to pay for themselves they

should – and so, unlike their German neighbours who may, having reached an annually determined income threshold, choose whether or not to leave the statutory scheme, the Dutch must leave.

About 64% of the population have compulsory health insurance, and 31% take out private insurance voluntarily. The remainder, consisting of provincial and municipal civil servants, have insurance under a public law scheme.

The result of strong supply-side controls by the Ministry is rationing through waiting lists, which separate Dutch healthcare from that in France and Germany and are a source of great frustration to patients.

Government involvement in Dutch health care began in 1941 when German occupying forces introduced Bismarkian compulsory social insurance for the poor with the Health Insurance Act. After more than 50 years of reforms, the 1998 coalition government agreement identified three 'compartments' in Dutch health care:

1) Expensive, uninsurable and long-term health care paid for under the Exceptional Medical Expenses Act (AWBZ)
2) Acute medical care paid for under the compulsory Health Insurance Act (Zfw)
3. Other health care, not in the first two compartments.

The Ministry has overall responsibility for healthcare, each year, publishing a spending ceiling known as the 'macro healthcare budget'. The Health Care Insurance Board (CVZ), oversees the implementation of the AWBZ and the Zfw at a national level. It gives permission, subject to regional capacity, to organisations wishing to provide health care. It also accredits statutory and private healthcare insurers.

The Dutch have choice of ambulatory physician, but unlike, their French and German neighbours who may visit specialists without referral, GP gate-keeping plays an important role in access to specialist medical services. In 2000, there were 7,704 GPs, or one GP for every 2,059 inhabitants, a fall from 2,190 GPs per inhabitant in 1990.32 On average each GP has 2,300 people on his or her personal list. GPs are mainly independent contractors working in private practice. GPs receive an annual capitation fee for Zfw patients. Private patients may choose any doctor, but like Zfw patients, must register with a GP. Services to private patients are provided on a fee-for-service basis, after which reimbursement is claimed.

More than 90% of Dutch hospitals are owned and managed on a private not-for-profit basis. The remainder are public university hospitals. During the 1990s, the government actively sought to reduce the number of hospitals and limit the number of available beds as well as overall technology investment.

Although most specialists are self-employed, specialist care is almost exclusively organised by hospitals. Specialists are paid by a combination of capitation and fixed fee-for-service for certain technical interventions and diagnostics.

Since 1983, hospitals have been financed by a global budget. A draft budget is calculated for each of 136 hospitals, based on anticipated activities and expected expenses for capital investments and personnel. The National Health Tariffs Authority (CTG) oversees the setting of the annual global budget for hospitals. Budgets are drafted according to anticipated need and expected costs, but are kept as low as possible to encourage efficiency. They are calculated on fixed rates for the number of people within the service area, the number of licensed hospital beds, the number of licensed specialist units and the volume of production units (i.e. hospital admissions, inpatient days, day surgery etc.). Once annual departmental budget limits are reached, a hospital specialist cannot continue to treat, thus waiting lists grow longer.

In an effort to reduce waiting lists, payments to hospitals have been performance related. Those hospitals that produce fewer in patient days than agreed with insurers are ultimately paid less. However, there is little evidence to suggest that these initiatives have had the desired effect upon waiting lists.

Since the Dekker Plan of 1986, health care has also been the subject of much reform. Although the Dekker Plan was not fully implemented, important changes have taken place. Mandatory contracting of services by sickness funds was abolished, and decision-making power over planning and contracting was shifted from the government to the health insurance agencies. Although the reforms were full of market orientated rhetoric, proposals have not been implemented and many were reversed by subsequent coalition governments. There has been a policy trend in favour of markets and competition, but this has not been constant.

Indeed, the Dutch have experienced the 'two steps forward, one step back' model of incremental change.
The system has too many incompatible aims: health care, income redistribution, welfare policy, housing, long term care.There is a complicated and inefficient bureaucracy (with little opportunity for innovation – a vital element of any healthcare system). The focus is on the system rather than the patient. Real freedom of choice is limited (uniform supply means there is no effective choice for patients, and it chokes innovation by providers). Quality of care has deteriorated because there is no choice. The system is divisive. Health inequalities are serious in the Netherlands. There is no exit strategy for the less-well-off. Increasing costs are exacerbated by greater inefficiency. There is a shortage of labour (because annual limits are set, and because qualified personnel leave health care). The system cannot cope with existing, let alone likely future demand.
If consumer and patient demand are to be met, each of three healthcare markets must be enabled: the healthcare insurance market, the care provision market, and the care procurement market. Thus, there must a sufficient number of insurers and those insurers must be able to
choose from a good range of providers. In the resulting demand-driven model, the insured and their insurers [will be] given more freedom of choice and have much more say in how care is provided. The health sector should be opened up to providers in order to stimulate competition and the operation of the free market. Price deregulation should be introduced, so that efficient production is made financially attractive to
those involved in health care – thereby eliminating some of the perverse incentives that exist currently.
A system of compulsory national health insurance should be introduced, resting on financial solidarity between high- and low-income groups, and between high- and low-risk groups. Everyone will have private law agreement with a risk-bearing health insurer of choice. These insurers (formerly health insurance funds, agencies, civil service plans and private insurers) whether they are for- or non-profit organisations, will negotiate with providers and compete on the basis of price, volume, and quality and effectiveness.
This move to a demand-driven model must be done in stages – the aim being to prevent monopolies and oligopolies in the provision of care and to reach a position of oversupply and healthy competition. This will require major government level changes in relation to supply controls and pricing, while maintaining existing quality control legislation and avoiding geographical shortages in supply and the oversupply of very expensive technologies.
Monopolies in provision of any good or service generate inefficiency and stifle innovation. Competition can lead to greater efficiency and ultimately to better standards of healthcare for all. Governments should regulate health care. They need not both pay for and provide it. The further adoption of market forces in health care is not synonymous with a USA style healthcare system. It is disingenuous, and usually suggestive of a political bias, to suggest so.

Johan Hjerqvist, the Director of the Timbro Health Unit in Stockholm, and one of the brains behind the Stockhom health reforms which have been influential across the globe, analysed their impact at a lunchtime seminar.
Stockholm County Council is attempting to transform public health care from an old-style, politically administered monopoly to the consumer-related, incentive-driven network of the future. Despite Sweden's deeply-rooted belief in the welfare state, Stockholm has been in the forefront of reform.
Thanks to the new mix of public funding, public-private co-operation, and freedom of choice, consumers are now gaining access to a healthcare market which allows individuals to use public funding for treatment throughout Sweden. The number of contracted private healthcare providers has risen, reflecting consumer choice and the apparent preference of many young doctors and nurses to work for private contractors.
A guaranteed maximum waiting period; the Diagnosis Related Group (DRG) system, which allocates a price to every diagnosis or treatment and only compensates hospitals once the service has been delivered; requiring healthcare authorities to inform people of the options available to them; publicly-funded private care provision; these elements of the Stockholm reforms combine decentralisation, consumer influence, and productivity incentives.


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Liz Kendall of the Institute for Public Policy Research in London, and a former adviser to the Blair government, introduced her research into the 'Twentyfirst Century Patient' at a CNE Health seminar.
Across Europe, the idea of focussing on the patient has been a slogan often more honoured in the breach than in reality.
Profound challenges to the ways in which health services are organised, delivered and experienced are on the horizon. The human genome project is increasing our understanding of the role genetics plays in disease, creating new opportunities for diagnosis and treatment. Developments in information technology are opening up new ways of delivering and accessing health services. These and other technological advances are influencing, and influenced by, wider socio-cultural changes in society, where patients are increasingly informed and less deferential and where knowledge is no longer the sole preserve of health professionals.

In recent years, a number of analyses of likely future trends in health and health care have been produced. Most assessments of future developments, whether these focus on policy issues such as evolving professional boundaries or the onset of new technologies like telemedicine, tend to focus on the attitudes of and implications for professionals and policy makers, not on what current or future patients' views or reactions might be. Yet developing an understanding of patients' attitudes towards likely future trends is crucial, not only because they could affect if and how future developments are implemented but also because of broader democratic and accountability issues.