THE REFORM OF HEALTH SCHEMES : a cliché or a reasoned choice ?

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SUMMARY

An analytic scheme is proposed for analyzing the major reforms which have been carried out recently in three European countries, France, Netherlands and United Kingdom. Such a scheme puts into perspective the relation between the insured, insurers and medical doctors. In each country studied, a pro-competitive approach has been tried, but its nature may be quite different according to the country. Three types of competition have to be distinguished : competition between suppliers vis-à-vis their own patients, through copayments, a road followed by France. Competition between suppliers of hospital care, vis-à-vis networks of budget holders, which is the British model. Competition between insurers themselves, with a dissociation between the income-related premium collected by the tax department and the fixed premium charged to the customer. The strength and weaknesses of the respective models are discussed.

Key words : Competition, Incentives, Weighted capitation, Dekker plan, British White Paper

1. THE CRISIS AFFECTING HEALTH SCHEMES IN EUROPE

Notwithstanding the great diversity of methods by which they are financed, health schemes in Europe are all in an identical state of crisis. The symptoms are :

- A rate of growth of health expenditure vastly in excess of the rate of growth of gross domestic product ;
- An increasingly heavy burden laid on the economy and on enterprises ;
- Growing deficits and a danger of bankruptcy in sickness insurance schemes ;
- And finally, for insured persons, a decline in the quality of the care provided.

All experts agree on the causes of the crisis – the fact that the absence of any margin for manoeuvre within general and compulsory protection schemes has destroyed, all the financial incentives which previously encouraged all concerned to seek greater efficiency. The development of private insurance on the periphery of the schemes has not been on a scale sufficient to have a significant influence on costs. There is clearly a need for reform. However, the principles and values on which that reform should be based must be defined before the technical details on the reform can be worked out.

1.1 The inherently inflationary nature of compulsory insurance schemes

Whichever country we look at, we find the same causes producing the same effects. In the United Kingdom, as in France and the Netherlands, we observe the same fragmentation of responsibilities, the same passivity in the financing machinery and an ever-increasing degree of state intervention.

The fragmentation of health schemes into separate areas jeopardises the continuity of care and encourages the passing-on of responsibilities. In France, according to J.C. Henrard, the receipts of the health service are five times those of the social services and expenditure on services provided in the home is only half that on placement. This dual imbalance in financial flows provides an incentive to look on the aging process as a condition requiring medical treatment and leading to hospitalization : 30 per cent of patients hospitalized for over 20 days in short-stay institutions have their periods of hospitalization extended with no medical justification ; 27 per cent of the persons hospitalized in establishments providing care and accomodation should not be there ; and 40 per cent of persons hospitalized in psychiatric establishments were not suffering from psychiatric conditions.

In the Netherlands the combination of different insurance schemes (AWBZ, public scheme, private scheme) gives rise to rigidities, as each category of risk is covered by different bodies. Frequently, a particular contingency is covered simultaneously by two institutions ; the competence of each is defined in an arbitrary fashion, often defying all economic logic : ambulatory and in-patient hospital care are covered both by regional and private funds ; care provided in the home is financed by the AWBZ ; and the State heavily subsidises the operating costs of retirement homes.

Everywhere the passivity of the financing machinery gives incentives to spend. In France, at no time since 1945 have medical fees been completely free of restriction ; they have been in cartel fashion by the parties to the national agreement or on an administrative basis by the state. In the Netherlands, general practitioners receive capitation fees, but specialist care given in hospitals is always paid for on a fee-for-service basis, notwithstanding the fact that each institution has its own over-all budget. Iin the United Kingdom the out-patient services are available practically to all comers as regards prescriptions, analyses and requests for hospitalization. Within hospital establishments themselves nothing has been done to encourage the medical staff to exercise economy in giving treatment, bearing in mind the constraint imposed on them by the amount of the over-all budget.

All these factors combine to produce “fixed-price” health schemes.

In a decentralized economic system, pricing plays a dual role. On the one hand, it serves as an instrument for the recovery of expenditure which should generate receipts and thus avoid deficits. On the other hand, it is a method of directing resource allocation which should ensure that resources are directed to high-productivity areas. However, in the field of social protection these two aspects have become dissociated ; the receipts of sickness insurance schemes (i.e., prices expressed in the form of contributions) no longer reflect the cost of the provision of care. The expenditure of sickness insurance schemes – that is to say, the incomes of the producers – have lost all connection with the value of the services provided.

Schemes of this kind encourage users to indulge their appetites and put blinkers on decision-makers. The social contributions levied on the beneficiaries no longer constitute “bills” addressed to insured persons and reflecting what their health care providers actually cost them. An insured person who uses his freedom of choice to turn to less extravagant producers will not receive any financial reward for doing so. The machinery of equalization will ensure that any cost reduction will benefit others equally with himself. The remuneration of the producers has been dissociated from the quality of the care they provide, since any medical act, whether justified or not, creates an entitlement to a fee. In the absence of any link between the amount of the remuneration and the value of the service rendered, providers of services can act inefficiently without being sanctioned for their poor management by loss of income.

None of the measures proposed to rectify the imbalances in the accounts of social protection programmes approach the problem in these terms ; they consist exclusively of financial measures – where economic incentives are needed. The state, itself unable to exercise over-all control over the system, with its multiplicity of decision-making centres, has intervened at the level of the detailed functioning of the scheme and gradually whittled away the freedom of action of each individual. It is forced to react to check the excessive expenditure of the social security scheme in the same way as, say, the Bank of France tries to neutralize the effects to spendthrift budgetary policies by stringent monetary controls. The State believes that a price freeze and the rationing of demand for short-term services will suffice to check the trend in health expenditure. However, present policies have no chance of success, since they run counter to the motivations of the actors within the scheme.

1.2 Private insurance does not ensure control of costs

Insurers have no means of controlling health care expenditure – and even if they had, there is no evidence to suggest that they would really have the will to use them. The scope of intervention by them is in fact extremely limited and confined to minor risks – but it is the major risks which cost most. Even supposing that they could restrain costs, one may express some scepticism concerning the scale of the benefits they could obtain thereby. An insurance company may be able to reduce expenditure on certain types of therapeutic treatment ; but it will never be able to induce a doctor to treat its patients differently according to the institution they are insured with. Any savings it will be able to achieve will benefit its competitors as much as itself. This situation will lead to the paradoxical result that the promoter of a sensible treatment policy will be the one whose competitive position will suffer most as a result, since he will be bearing the entire cost of establishing the monitoring machinery but will not receive the whole of the ensuing benefit.

The insurer will seek to maximize his profit not so much by productivity gains – which are costly and difficult to achieve – as by seeking as far as possible to avoid becoming the victim of anti-selection measures. When an insurer offers uniform rates, making no distinction based on age or sex, he may be tempted to eliminate items which cost him more than they bring in. This practice is known as the selection of risks. However, if there are no restrictions regulating the setting of premium levels, rates will show a natural tendency to vary under the pressures of competition, and selection of tisks will become unnecessary, since the levels of premiums will vary according to the degree of risk. In practice the levels of premiums constitute a half-way house between those applicable under a system of uniform contributions irrespective of age and those obtained on the basis of purely technical considerations and reflecting the actual cost of the risk. Thus the contribution paid by an insured person may be unrelated to the risk he constitutes. Anti-selective elements may then develop, with insured persons who are good risks paying more than they should and poor risks less than the potential charge they represent. The former will consider themselves penalized and will transfer to another insurer. To cover the needs of those remaining, the insurer will have to raise his premiums ; this will have an even more dissuasive effect on his goods risks and depress his profits still further. To break out of this vicious spiral, insurance companies have hade to resort to personalize contracts in order to balance the composition of their portfolios of insured persons. Their strategy in doing so is to vary the range of guarantees offered in order to induce each individual to disclose the degree of risk it presents. Obviously, high risk individuals will choose policies offering maximum guarantees, even if they are expensive, while low risk individuals will settle for more restricted – but cheaper – guarantees. This choice safeguards profits ; but is also divides markets up into segments and prevents transfers between the sick and the healthy.

1.3 The need for reform

Current health policies, however legitimate their objectives, are policies of despair. Barriers and prohibitions abound on all sides. The entire system needs redesigning from scratch. However, before the redesigning process can begin, the principles on which the system must be based have to be spelt out.

The first principle is that of solidarity. Sickness insurance is not like fire insurance. Its objective is not only to protect individuals against adversity but also to safeguard them against the financial consequences of contingencies which have traditionally been deemed to be uninsurable. Consequently it requires a pooling of risks at the most comprehensive level imaginable – that of the community as a whole.

The second principle is that of the legitimacy of diversity of aspirations among individuals. Solidarity does not mean egalitarianism. To attemps to achieve absolute equality with regard to

recourse to care is to refuse to recognise the wide range of individual preferences and all alternative forms of recourse. Equality means uniformity, and uniformity breeds immobility. One day a decision will have to be taken concerning what inequalities are acceptable.

The third principle is that of the elimination of omnipresent state control. The time when the fundamental role of the state was continually to "do more things and to do them better" is past. The fundamental task of the state today is to improve efficiency. The professionals of the health sector are the only persons with sufficient knowledge of the needs of the population and the technically usable resources to be able to give effect to a policy of productivity and competitiveness. Consequently there is no alternative to increasing their autonomy and thus to develop their role into that of heads of efficient and competing enterprises.

The fourth principle relates to the need to discipline markets. The market cannot be left to its own devices, as it might be destroyed under the pressure of dominant enterprises almost as soon as it was created. Whenever such a situation appears to be developing, the public authorities have a duty to impose rules of conduct which will ensure that markets remain neutral. This field – the organization of the market and the balancing of the forces within it – seems to be the only one in which the state can act.

2. HOW TO PROMOTE A COMPETITIVE APPROACH

The introduction of a greater element of competitiveness into the system seems inevitable. The main problem is that of determining at what level it should apply. There are three possible forms of competition :

- Competition among providers of services vis-à-vis their clientele – in other words, the dissociation of fees and reimbursement scales and a return to the direct negociation of fees between the parties. This is the approach which has been adopted in France ;

- Competition among providers of services vis-à-vis groupings of numerous and differentiated purchasers. This is the approach currently being pursued by the British government ;

- Thirdly, the setting of insurance institutions themselves in competition with one another by dissociating the amounts of the premiums charged from the proportion of fees to be borne by policyholders themselves. This is the basic principle underlying the Dekker project.

2.1 The French example : competition among providers of services vis-à-vis their clientele

This approach requires the patient, on a statutory or de facto basis, to pay a share of the cost. The logic underlying this approach is that, to curb the wasteful provision of services, it will suffice to develop a sense of responsibility among the citizens by increasing the cost of care to insured persons. However, it is unrealistic to expect that price can be established as a regulator of demand simply by increasing the share of the cost borne by the patient and for three reasons :

- Insured persons can in practice maintain benefits at their previous levels by recourse to private complementary insurance to cover minor risks. They are unlikely to show any inclination to reduce their expenditure, since they are sure of obtaining reimbursement in full.

- If no shift towards private insurance takes place, the user may be expected to react to the increase in his financial contribution. However, it has often been observed that the elasticity of consumption of medical services in relation to an increase in the share of the cost borne by the patient is low. In 1959, the government reduced the rate of payment for radiological

interventions from 2.30 to 1.60 francs. The radiologists did not reduce their fees ; thus the share of the cost borne by users was in fact increased by 300 per cent. These figures imply a demand elasticity of only 0.02.

- Finally, when the consumer's share of the cost increases, it is necessary to ensure that the effect of that increase is not offset by any compensatory machinery. However, physicians cannot remain passive in the face of a decline in their levels of activity. There is every likelihood that they will tend to see their patients more frequently. Moreover, where there is no uniform rate of coverage for all types of care, one type may be substituted for another. For instance, if cost-sharing is confined to minor risks while hospitalization costs are covered in full, the number of admissions into hospitals will increase, since an insured person will naturally choose the forms of care which offer him the most favourable rates of coverage, and the physician will have no incentive to resist that tendency.

If all these three drawbacks can be neutralized, an increase in the share of the cost borne by the patient will lead to a fall in user demand. But there is no guarantee that such reductions of expenditure, resulting as they do solely from the choice of the insured person, will be effected wisely. Moreover, such a decrease in medical consumption may have unacceptable effects from the standpoint of national solidarity. In all cases it will be politically dangerous. As William Galser said recently, "Politicians who propose the introduction of cost-sharing lose votes ; governments whiwh introduce it lose the next elections".

2.2 The British approach : competition among providers of services vis-à-vis groupings of purchasers

In 1974, all the functions of the National Health Service (NHS) were integrated within a single administrative structure. The government had an overall responsibility for the proper functioning of the scheme, but the management of the latter was in the main delegated to the Regional Health Authorities (RHAs). The reforms introduced in 1990[1-2-3] have followed and strengthened that tendency in some respects, since they increase the powers of the basic health units. In other respects, however, they constitute a complete break with the past ; specifically, they put an end to the integration of the care and financing functions, which has been one of the basic principles of the British system since 1945.

On the demand side, the new legislation substantially increases the number of areas for negotiations between the administrative and the health care machinery. Credits are still allocated at the regional level ; but the operational management of the services has been finally taken out of the hands of the RHAs and transferred either to long-standing structures – district health authorities (DHAs) or local family practitioners'committees – or to bodies of a completely new type – pre-financed medical groups.

Each region has a budget from which it has to meet the health care needs of the population for which it is responsible – including the provision of ambulatory care, which is no longer financed directly and almost indiscriminately by the central government, as was previously the case. The rules governing the allocation of credits have also been changed. In addition, a new method of calculation has been introduced in which regional mortality rates have been replaced by data concerning the structure of the population of the region by age and sex as indicators of health care needs. The amount of finance provided will henceforth be based on individuals ; each region will receive a flat-rate payment for the health care of each individual, the amount varying according to the degree of risk he or she represents.

The regional authorities reallocate the funds they receive to the direct providers of care on the basis of similar principles, with one difference, namely that the amounts payable vary according ro the

nature of the health care responsibilities each institution bears. The resources allocated to the districts are calculated to enable them to finance hospital care and community health services (prevention, assistance and care provided in the home). The credits allocated to the groups are designed to cover both the cost of ambulatory treatment and part of that of hospital treatment. The doctors in charge of the groups have responsibilities going beyond their usual remits. They negotiate, on behalf of their patients, for the provision of certain specific hospital services and pay for them. This is the case for diagnostic examinations (not a surprising feature, since there are no private laboratories in the United Kingdom and consequantly all analyzes are effected in hospitals) and also for a certain number of non-emergency surgical acts and specialist consultations. These groupings of purchasers with responsibility for their spending budgets force producers to compete fiercely with one another.

On the supply side there has also been a return to pluralism. Public hospitals may choose to remain under the control of the district authorities ; but they may equally opt out of that control and assume the status of public industrial and commercial establishments – which the law allows them to do. In the former case, they continue to be financed by the supervisory authority ; in the latter case, charges for services rendered constitute their sole source of income. The management and financing of private establishments are not affected ; however, they may offer their services to the public sector. The regional authorities themselves may attemps to ease their budget constraints by charging an adjacent region for services provided to the latter's residents.

The final outcome is that all users and suppliers are able to negotiate their supply and demand on a decentralized basis. In concrete terms, a quasi market has been established within a system of social protection financed entirely on a socialized basis. If the provision of hospital services on a contractual basis becomes general practice, the outcome will be a diversion of resources towards the most efficient establishments, whatever their legal status – public or private.

The contracts between the parties concerned are selective and relate to prices, activities and quality. Provision exists for three types of contracts – capacity reservation contracts ; group treatment purchase contracts ; and individual billings. Contracts of the first type enable district health authorities and managing physicians to secure a certain diagnosis and treatment capacity for essential services against payment of a lump-sum contribution. Group treatment purchases relate primarily to technical activities which can be programmed or to specialized services which are not available in every district. By definition, such services are non-emergency in character and offer the possibility of choice to those responsible for ensuring their availability. Such contracts are negotiated on a basis of objectives by activity ; they are charged on the basis of full cost where is no surplus capacity and on the basis of marginal cost where there is. Thus the GHM system on which they are based is only used for purposes of billing. Finally, payment on a case-by-case basis is used for exceptional situations not falling within the scope of contracts of the first two types.

The objective of the reform is clear – to improve efficiency, without compromising the principle of solidarity, by laying emphasis on competition, the differentiation of negotiating structures and a plurality of sources of supply. It introduces into the framework of a closed budget conditions for negotiation which are equitable because they are evenly balanced, eliminating the process of financing of production structures by a single buyer. Price modulation on the basis of performance becomes possible without opening the door to complaints of subjection to any form of "capricious sovereignty".

There are two opposite concepts of competition. Under the first, competition is visualized as an instrument for the promotion of efficiency. Under the second, it is an and in itself which enables consumers to express their preferences, with regard not only to the choice of producers but also to the level of protection desired. The British approach is based on the first concept ; it places responsibility for the budget in the hands of administrators and physicians, rejecting all medical

"consumerism". It also rejects privatisation of the financing of social protection in that associations of managing physicians are prohibited from supplementing the finance provided by the authorities with complementary resources obtained from mutualist of private sources. The Thatcher machinery was designed to cater as well as possible for the interests of the greatest possible number within a limited amount of collective resources ; it makes no special provision for a favoured minority. This conception of a closed budget implies choices, and the logic of the scheme implies that private insurance can play only a marginal role, since if the latter were to develop significantly the hierarchy of emergencies as laid down within the collective framework might be challenged by the most favoured minority.

This position, overtly based on the principle of solidarity, is faithful to the ideals of the founding fathers of the system ; but as European unity comes closer it will soon become untenable. From 1993 onwards a Frenchman will be able to take out a policy with an British company for the reimbursement of the cost of treatment given in Germany – or in some other country. Instead of evoking the threat of the privatisation of social protection without being able to stave it off, it would be better to recognize its inevitability the better to define an appropirate place for it. Consequently, to improve the quality of the service provided within the framework of a unified system of risk management, exploration of means of associating public and private financing is necessary. In this field the example of the Netherlands has many and useful lessons to offer.

2.3 Setting insurance institutions in competition with one another : the experience of the Netherlands

In 1986, the Netherlands government set up a group of eight experts, under the chairmanship of Mr Dekker, a former managing director of Philips, to carry out a study on the reform of the system of social protection and the distribution of care. In March 1987, the group submitted its report, entitled "The will to change"[4-5]. A year later, the government publisdhed a memorandum entitled "change ensured" which clearly showed that the public authorities had accepted responsibility for effecting reform. Owing to a change in the composition of the majority in the legislature, the introduction of the reform was delayed, but its principle was not challenged ; it is currently being introduced. The principal subjects it covers are the scope of sickness insurance, its financial organization, and the methods of regulating it.

The first change introduced by the reform relates to the definition of insured persons and the scope of the protection provided. Previously all Netherlands citizens were covered in respect of their "exceptional" expenditure – for example, stays in hospital lasting more than 365 days, residence in retirement homes. This "dependency" branch of insurance (the AWBZ) accounted for more than half of all the expenditure of the public insurance scheme. It was compulsory and was financed by contributions from employers and self-employed persons fixed as percentages of income. In contrast, in the sickness insurance sector there were three schemes existing side by side – a public insurance scheme, financed by contributions based on earnings, membership of which was compulsory for persons whose annual incomes did not exceed 51,000 guilders (about US dollars 30,000). In 1987, 64 per cent of the population were members of this scheme. There was also a special scheme providing automatic coverage for all employees of the state and local authorities ; it covered 6 per cent of the population. Finally, in addition to the public insurance schemes, there was a voluntary private scheme for members of the high income groups, members of the liberal professions and heads of enterprises, which provided cover for 32 per cent of the population.

The proposals of the Dekker committee, which were substancially accepted in 1988 by the government, constituted a complete break with this dual system of protection. The separation between the health and the medico-social sectors and between the high income and low income groups were abolished. A single insurance scheme, covering the whole of the resident population, was established. Coverage is not subject to any conditions relating to past occupational activity or

other contributions to society – in other words, the scope of social protection has been made universal[6]. It covers all contingencies, even those which have traditionally been excluded even in the countries with the most advanced social legislation ; dependency is covered as well as sickness. It is clear that the Netherlands authorities realized the urgent need to treat the two problems as one so as to be able to deal with them in a co-ordinated fashion. In all, the compulsory scheme now covers 85 per cent of all medical and medico-social expenditure. Insured persons may – but are not obliged to – take out complementary insurance to cover the remainder. The administration of the scheme is handleded partly by commercial insurance companies and partly by semi-public funds of the conventionnal type ; every insured person is free to choose the institution to which he will affiliate. These bodies are also required to ensure the procision of both statutory and non-statutory benefits and are thus in direct and exclusive contact with their members. Risk management is completely unified. To gain official approval institutions must comply with two rules – they must not refuse cover to anyone ; and they must refrain from adjusting premium levels in line with the personal situations of individual insured persons.

The compulsory protection scheme is financed by contributions of two types. First, there is a general social contribution, the level of which is set by the government on the basis of the real contributing capacity of each individual up to a specified ceiling. This change puts an end to the earlier system of earnings-based contributions paid by employers and workers. The receipts of the sickness insurance scheme are collected entirely within the taxation system. A national risk equalization on fund has been established to receive all the contributions collected and to allocated funds to approved insurance institutions (taking into account the structure of the membership of each institution, by age and sex) in the form of a flat-rate health allowance, which is the same for every insurance institution. The interest of this form of financing is obvious : the value of health allowances moves in parallel with the level of the needs of the entire insured population. Thus the receipts of insurance companies remain proportionate to the costs they incur, and there is no inducement for them to select good risks.

The general contribution is supplemented by a compulsory individual contribution, which each insured person pays directly to the institution of his choice. The amount is the same for all members of a particular institution, regardless of age, sex or previous medical history and is equivalent to that part of the real cost of basic services which is not covered by the payments received from the equalization fund. The less effectively an insurance company controls its own management costs and those of the health system, the higher the amount will be. The introduction of a system in which the premiums are the same for all members of a particular institution but vary from one institution to another introduces an economic incentive into consumer choice. Thus, assuming equal levels for coverage, insurers have a direct incentive to control their costs so as to keep the amount of the contributions levied from the persons insured with them down to levels acceptable to the latter.

This basic compulsory set of services which all insured persons enjoy may be supplemented by additional benefits, which are provided against payment of an optional contribution to cover their cost. Thus each individual can choose, over and above the basic level of protection, the level of coverage most closely in line with his aspirations and his ability to pay. Once the principle of solidarity has been supplanted by that of security, at least as far as “de luxe” benefits are concerned, the tutelary value which the state attaches to medical care becomes compatible with freedom of expression of individual preferences.

The spirit of the reform is one of resolute promotion of competition. The reform itself will, it is hoped, bring expenditure under control and improve efficiency by introducing competition in two areas – that of freedom of choice of insuring institution and that of control of producers by institutions.

The automatic inclusion of all practitioners in the national agreement on application ceases, and the value of individual acts or of capitation fees is no longer fixed at the national level.

The insurers are in competition with one another and will thus have to offer policies providing statutory coverage at the best rates in order to attract customers. They will conclude selective agreements with practitioners seeking to practice medicine economically. The latter, since they will no longer enjoy an absolute guarantee of employment, will have an incentive to incorporate the economic dimension into their thinking and to look closely at the effectiveness of their prescriptions. Insured persons, too, will have to adopt new attitudes, since they will have to choose the institution which will cover them ; they will be able, if they so wish, to continue to choose their doctor freely within a conventional insurance scheme, or they may choose a contract binding them to specific approved practitioners, with or without freedom of access to specialists. All things are possible ; nothing is imposed ; and there is ample scope for the expression of individual preferences.

3. CONCLUSION

The proposed reforms in the United Kingdom and the Netherlands are based on systems of financing care related to the individual ; a national equalization fund pays out uniform annual health alloxances the amount of which varies according to the age and sex of the persons covered. They differ as regards the choice of the institutions responsible for administering those funds : in the British system the allowances are paid to regional authorities or to pre-financed medical groups, while in the Netherlands system the insurance institutions themselves have that responsibility. The French proposal[7-8] to establish “co-ordinated care networks” predates both these plans ; it was similar in structure but placed the administrative responsibility in different hands – those of the general practitioners. It also differed from the other two as regards the scope of the responsibilities accepted. Under the French plan, the administration of all care – including hospital care – was placed in the hands of the general practitioners. Under the British plan, their responsibility is confined to non-emergency surgical acts and examinations carried out in hospitals ; major surgery and care are outside their field of competence. Finally, the scope for the operation of voluntary complementary insurance differs in the three schemes : the Netherlands proposal admits it for “de luxe” care only ; the French proposal included a priori under the heading of cost-sharing both the compulsory individual contributions and the voluntary contributions provided for in the Dekker plan. In addition to these differences of detail, it has to be pointed out that in France’s two neighbours something has actually been done, whereas France is still at the proposals stage.

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