

Hungary 2007

Access to care and health status inequalities in a context of healthcare reform

Minutes



On behalf of
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DG Employment, Social Affairs and Equal Opportunities



Access to care and health status inequalities in a context of healthcare reform Budapest, 17-18 January 2007

The Peer Review was hosted by the Hungarian Ministry of Health. Austria, Bulgaria, Czech Republic, Estonia, Finland, France, Luxembourg, Portugal and Slovenia were the participating peer countries.

Day 1 (evening)

Welcome addresses

Welcoming the participants to Budapest, **Ágnes Horváth** (Senior Secretary of State, Ministry of Health, Hungary) emphasised that the conference would be focussing both on inequalities in health status and on access to healthcare. These are particularly important topics for Hungary at the present time, she pointed out, as it is currently in the middle of a health reform. Sixteen years ago, Hungary saw fundamental changes not only in its political regime, but also in the way of thinking of its population. In some sectors, however, the old system and the old ways of thinking survived. Hungary is very proud of its traditions and its achievements, such as those of Dr. Ignáz Semmelweis¹ and the high vaccination rate among Hungarian children. However, tradition also means gratuity payments, which are prevalent in the Hungarian healthcare system. And it means that evidence-based medicine is hardly used at all in Hungary. It also means that there are several different types of inequality, both in healthcare and in access to healthcare. So while Hungary is very proud of some of its traditions, there are also some that must be eliminated. The average Hungarian citizen's life expectancy is six years shorter than the European average. Not only do Hungarians live less long, they also live less healthily. It was these factors that prompted the Hungarian Ministry of Health to set about making reforms and transformations. In the second half of 2006, the Hungarian parliament adopted five Acts which changed the way in which Hungarian healthcare is regulated. The areas affected include pharmaceuticals, in-patient treatment, care packages and co-payment. A lot of changes have already occurred, and more are expected in the future. What is needed above all is a change in people's way of thinking. We have to learn whether and in what circumstances we are eligible for care. We have to learn that we are indeed responsible for ourselves and for our health. And we must learn that we are responsible for bearing costs. The State must not be made responsible for everything. One thing that must not be forgotten, either in Hungary or in Europe, is solidarity. Her colleague Zsombor Kovacsy would give a more detailed account of Hungarian policies during the next day's session. The Hungarians looked forward to hearing the views and experiences of other countries with reforming healthcare and improving equality of access to it.

Georg Fischer (European Commission, DG Employment, Social Affairs and Equal Opportunities) emphasised that the Budapest meeting was a first – the Commission had never before held a peer review of healthcare. So he was very grateful to the Hungarians for volunteering to be the first in this

¹ In the mid-nineteenth century, before the germ theory of disease was developed, Dr. Semmelweis drastically reduced the number of deaths from puerperal fever by insisting that medical staff wash their hands before treating pregnant women.

field, particularly as the future of healthcare is currently a prominent topic in Hungary and very serious issues are involved. Hungary is a country which is carrying out ambitious reforms, very much driven by the ideas of the open method of coordination. These involve looking at how to organise, for example, a healthcare or pension system in line with the basic social objectives of ensuring adequate universal access to high-quality service while maintaining the sustainability of the system. Where pensions are concerned, sustainability is usually a matter of financing the system in the long term. In the case of healthcare, it is not only about financing but also about the human resources available for the system. Through the open method of coordination, EU Member States have agreed to look together at the three objectives of universal access, high-quality service and sustainability. The reasons for this become clear if one looks at the issue of co-payment. Within the EU, one committee might say that having no co-payment is good, as it ensures universal access, whereas another committee might say that having co-payment is good, because it ensures sustainability. Through the open method of coordination, these two perspectives can be brought together, and a more complex picture of co-payment emerges. It can then be looked at as part of an overall strategy for a healthcare service which provides universal access in a sustainable way. This would be the aim of the following day's discussions. It is an extremely important topic. As an economist, he wanted to quote three numbers: 10-12, 4-6 and 30. 10-12 years is the difference in life expectancy between the Member States with the shortest-living and longest-living populations. 4-6 years is the difference in life expectancy between socio-economic groups within Member States. 30% is the difference in access to hospitals by high and low income groups. These figures set an interesting agenda for the discussions, partly in order to understand why these differences arise, but also to see how the Member States are tackling the issue and how social protection systems can contribute to meeting the challenges. He hoped that the review would produce three achievements:

- a little more knowledge about which policies work, and what we can learn from each other – with the participants from each country being able to take home at least one idea for implementation
- some interesting ideas for Hungary
- some common approaches which can then be reported back to the Social Protection Committee, so that it can move towards gaining a European perspective on access to healthcare and the reduction of health inequality.

Day 2

The meeting was chaired by **Judit Rézműves** (Ministry of Health, Hungary).

She introduced **Charles Price** (European Commission, DG Health and Consumer Protection), who would speak on social determinants in health inequalities and the Commission's work in that area. He noted a broad consensus within European countries on the need for fairness in health service provision. This distinguishes European countries from some other developed countries, where the issue is less prominent. The Charter of Fundamental Rights says that everyone has the right to access healthcare and to benefit from medical treatment under the conditions established by national laws and practice. In 2006, the Council of Ministers agreed a statement on common values and principles for health services, in which they stated that the overarching values are universality, access to good-quality care, equity and solidarity. Universality means that nobody is barred from

access to healthcare. Solidarity is about ensuring that nobody suffers undue financial hardship from sickness. Equity is related to access according to need, regardless of ethnicity, gender, age, social status or ability to pay. The common objectives of the Social Protection Committee are strongly in line with these principles. The objective agreed by Member States is to ensure access for all to adequate health and long-term care and to address inequities in health outcomes. The reasons for this concern with fairness and equity in health are, he thought, humanitarian values and concern for the welfare of fellow-citizens but also, increasingly, an understanding that there is an economic imperative. Falling birth rates and a rising average age mean that we cannot afford to waste any human capital. We cannot afford some sections of our population to be dropping out of the labour market in large numbers due to ill-health.

In some respects, the objectives are being achieved. All Member States provide systems which aim to give everyone access to healthcare, regardless of their social position. However, the discussion paper to be presented by the next speaker showed widespread inequalities across Europe both in access to healthcare and in health outcomes. These are socially patterned, with more ill-health being experienced by those who have lower levels of education and lower-paid jobs, who live in poorer parts of each country or who are disadvantaged by such factors as ethnicity or disability. For some crucial indicators such as infant mortality, the gap between rural and urban areas or between poor and rich areas implies that, in some countries, hundreds if not thousands of young lives are lost each year due to circumstances which are preventable and treatable. There are also examples of people not getting the care they need because of poor access or because they are not able to negotiate the system or pay for the system. We therefore face a situation in which we do not meet our high standards and values, and in some countries the situation appears to be getting worse.

So what can we do about it, and how can we support each other? There are three reasons for the inequalities in health outcome:

- Inequalities in wealth and education translate into inequalities of physical and social environment - differences in the supply of sanitation, water, food, warmth of housing and the support for families and communities.
- Differences in social background are very powerful forces which affect health behaviour – for example, smoking, alcohol consumption and drug-taking.
- Inequalities of social position affect both access to health services and the way that people benefit from them.

Effective policies to tackle this issue therefore require action on several levels:

- They must tackle poverty, disadvantage and social exclusion.
- They must tackle behaviour.
- They must tackle health services.

Examples of multi-sectoral policies which address health inequalities in all these areas are provided by a few countries such as Ireland, the UK, Sweden and possibly Finland. And in some countries, such as Spain, Slovenia and Italy, there are regions which have taken comprehensive action. Possibly the most cost-effective single action that a Member State could take to reduce inequalities in

outcome is vigorous policies against tobacco. All Member States are taking action against tobacco, but they are not all fully implementing measures such as taxation, smoke-free areas in public places, prohibition of advertising and the provision of smoking cessation. Other areas to be tackled by public policy are accidents, diet, physical activity, drugs and alcohol consumption.

Unless the points relating to poverty and behaviour are got right, the health services cannot redress the legacy of poor health. We have to be able to measure the use and the outcome of health services, by social group, if we are to be able to judge the performance of healthcare. Some countries have a long history of doing this, examples being Denmark and Sweden. Others are starting to do it with special surveys. Estonia, France and Lithuania have recently published surveys of this kind. Account also needs to be taken of the fact that the need for health services is unevenly distributed. Cardiovascular disease can be three times higher in some groups than in others. How does a health service manage that problem? Geographical distribution is another important issue. Left to themselves, health services aggregate in large urban areas where there is wealth but where the need for health services is actually lowest. This is known as the “inverse care law”. Hungary has recognised this problem, as have Latvia, France, Bulgaria and many other countries. Other barriers to health access include payments, language and cultural factors. Payments can reduce demand for healthcare, but often at the cost of discouraging the very people who should be using the health service more.

Last but not least is the issue of quality – getting the right kind of service to the right people at the right time. How can that quality be adjusted so that health services really address the needs of the different groups within society? All of the countries taking part in the peer review have some excellent initiatives in this field, particularly those targeted at specific groups, such as Roma, and outreach services. The EU recently did an evaluation of what is available, and it found that there is a real lack of properly evaluated interventions for tackling health inequalities. This is one reason why it is important that the different countries should collaborate. In addition to the work around the Social Protection Committee, the Commission has taken a number of other initiatives to assist that collaboration. DG Health and Consumer Protection supports an expert group on the social determinants of health inequalities, dealing with policy development and information exchange. It is also funding various projects which are developing good practice. One is the “Closing the Gap” project (www.health-inequalities.org). Another is Eurothine (<http://mqzlx4.erasmusmc.nl/eurothine/index.php?ind>). These will be reporting back later in 2007, and are likely to produce some very interesting output. It is also working with a high-level group on health services and medical care, linked to the High-level Committee on Public Health, and it has commissioned a review of the macroeconomic aspects, which Member States asked for because of their health ministries’ need to dialogue with ministries of finance on this issue. The Commission is proposing that health inequalities should be highlighted in the new Health Strategy, which was out for consultation until 7 February 2007. Research is another important area. The EU’s Equity project previously funded a number of activities in this area. The new Seventh Framework Programme also provides opportunities for funding research on health inequalities. The structural funds, for the first time, are making it easier for countries and regions to invest in health as part of their economic development package. Health equality is a very big challenge for health systems in the 21st century, and there is a long way to go. He looked forward to hearing the views and experience of the peer review participants and to informing them about the Commission’s plans for the coming years.

Cristina Masseria (thematic expert – LSE Health and Social Care, London School of Economics) presented the main discussion paper for the seminar. She would be concentrating chiefly on giving background on the literature available concerning health inequalities, as a basis for policy-oriented discussion. The data available are useful, but she warned that they should be treated with caution, as there are measurement issues associated with them. Nonetheless, the data warn of a problem, and they are an indication that more needs to be done about inequalities in healthcare. Everywhere, there have been huge improvements in health status, but at the same time, there are major differences. The big divergences in living conditions among the Member States are also causing differences in health status. Life expectancy varies greatly both between Member States and within each country. There is a pattern to these differences. They are due to variations in chronic conditions, communicable diseases and injuries in road accidents. Working on these three areas, it is possible to reduce the gaps between life expectancies in the various countries. Communicable diseases are the main cause of death in the majority of EU countries. There are big differences between countries in this respect. Hungary is not doing all that well, although the situation has improved considerably in recent years. In this respect, healthcare systems can do a lot to promote changes in diet, prevention, screening and new forms of treatment. These can be very effective in reducing the gap between countries. At the same time, there are big differences within countries.

There is a great deal of discussion about the contribution of the healthcare system to improving health. Often, it is said to be marginal. Certainly, education can do more. Nonetheless, the healthcare system does have a role. If we look at the difference between amenable and non-amenable mortality, it can be seen that the healthcare system does help to reduce amenable mortality. Where this is done effectively, it can reduce the gap in life expectancies. In general, treatable mortality is highest in the Central and Eastern European countries. There, rates were at their height both in 1991 and in 2001. In most countries, treatable mortality has fallen, suggesting an improvement in healthcare over the last ten years. However, the Baltic states, for example, have seen very little improvement. On average, in 1991, treatable mortality accounted for a proportion of deaths ranging from 13% in the Netherlands to 30% in Bulgaria for men, and from 26% in Sweden to 44% in Rumania for women. This proportion has not changed much. In the Netherlands, between 1875 and 1970, the medical contribution to a decline in mortality ranged between 4.7% and 18.5%. Between 1950 and 1984, without a reduction in amenable causes of mortality, male life expectancy at birth would have fallen by approximately one year. Treatable causes of mortality are mainly related to infant mortality, cardiovascular diseases and testicular cancer. This is where it is possible to have timely and effective care. But there are also preventable causes of mortality. These include lung cancer, cirrhosis of the liver and traffic injuries. Here too, the figures for Central and Eastern Europe are not encouraging. Hungary and Slovenia have the highest rates of preventable mortality. In Europe as a whole, preventable death rates among men are almost twice as high as for women. This is because men are more exposed to risks such as drinking and smoking. However, while preventable deaths among men declined markedly during the 1990s, there was no similar reduction for women. In some countries, such as Hungary, Rumania and the Czech Republic, preventable deaths among women have increased over the past ten years. The variations in preventable mortality across Europe are related to smoking, diet, levels of physical activity and alcohol consumption. These are areas in which the healthcare system can intervene to reduce the gap in life expectancy.

There are also differences between socio-economic groups inside each country. These differences are not randomly distributed. They are systematic. Genetic predisposition to illness certainly plays a role here. However, material circumstances, income, education and working conditions are just as important. A vicious circle sets in. Those who have better living conditions in early life tend to gain a better education and therefore have a higher probability of finding a good job and living in areas with good housing and a good social environment. This means that they have a lower probability of falling sick and, if they do become ill, they have a higher probability of recovery. Both absolute income and relative income are important here. While in Western European countries, there is no relationship between GDP per capita and life expectancy, such a correlation can clearly be seen in Central and Eastern Europe. But in both the West and the East, income inequality is associated with higher mortality. A study by Van Doorslaer, Masseria and Koolman shows that, in each country, those who have a higher income are also likely to have a better health status. There are differences in this between countries. Portugal and the UK are doing less well in this respect and the Netherlands and Sweden are doing better, according to the study. While cross-country comparisons should be treated with caution, it is clear that inequality exists both within and between countries. In the new Member States, both income and education have an important impact on health. In Estonia, for example, inequality of life expectancy at age 25 increased between 1989 and 2000. In 2000, the gap was approximately 20 years for men and 9 years for women. Education and income have an effect on all causes of mortality. Better-educated people have a lower probability of dying of lung cancer and respiratory diseases, as well as cardiovascular and cerebrovascular diseases. However, when looking at differences in life expectancy, it is always important to differentiate between men and women. As men are more exposed to preventable risks, there is greater scope for reducing their mortality rates. While health inequalities cannot be fully eliminated, countries that have implemented appropriate policies on tobacco, diet and alcohol consumption have seen inequalities decrease.

But there are also inequalities in access to healthcare. At first sight, this is a strange situation in Europe, where there is supposed to be universal coverage for a quite extensive package of healthcare. Although in theory everybody has access to healthcare in Europe, there are still a lot of barriers in practice. Within each country, different population groups have different needs and expectations. These have to be taken into account if we want to ensure equal access to healthcare. Equality of access is important, notably because it helps to reduce income-related or socio-economic inequalities in health. The normal rules for a market cannot be applied to the healthcare sector. It is not a real market and if it is not well-regulated, it may fail to achieve the optimal allocation of resources for delivery. Medical care is important because it can prolong survival, alleviate suffering and improve productivity. Health is a fundamental asset for society. Health services should therefore not be valued in terms of wealth, income or willingness to pay, but in terms of the needs of the population.

Healthcare services in Europe are mainly financed either through taxation, as in Spain, the UK, Denmark, Sweden and Portugal, or through social health insurance, as in Germany, the Netherlands and France. However, also in countries such as Spain, the UK, Denmark, Sweden and Portugal, we find private health insurance. This is mainly in the form of complementary health insurance for services that are only partially covered, such as dental care. International comparison shows that private health insurance is regressive, particularly where it plays a dominant or compulsory role, such as in the US and Switzerland. Complementary health insurance is also regressive, particularly when

it is purchased by middle income groups. But a study by A. Wagstaff et al. found that supplementary health insurance, when purchased by higher income groups, may be slightly progressive. However, this study looked at equity only in the payment of healthcare, and not in the distribution of healthcare. If higher income groups or young people are allowed to opt out of statutory health insurance, some problems of sustainability may be created, as the risk pooling within the statutory scheme will be reduced. This could mean that older people and poorer people end up paying even more.

In recent years, public health expenditure as a percentage of total public spending has increased in many countries. This is due to cost containment issues, which would be discussed in greater detail later in the session. Also, there are problems concerning informal payments, particularly in Hungary, Greece and Poland. Not only are there financial inequalities. Geography and socio-economic characteristics can also reduce access to healthcare. In about half of the countries, studies have shown that individuals with higher incomes are more likely to consult a physician. And in every country, people on higher incomes are more likely to visit a specialist. For inpatient care, the level of inequality is not really known, as longitudinal data are lacking.

To ensure equal access to healthcare in Europe, we have to examine people's needs in detail. If people in different socio-economic groups record the same use of healthcare, this does not necessarily demonstrate equality. In fact, it may represent a very inequitable situation. Poorer people are in greater need of healthcare. Therefore, they need to consume more of it than rich people, and older people need to consume more than young people. People with chronic conditions need to consume more than those who do not have chronic conditions. Thus, if needs are not taken into consideration, we can get a completely wrong picture of what is happening. What has to be guaranteed is equal access for equal needs, regardless of income, ability to pay or willingness to pay. We have to guarantee that at least a basic level of good-quality services is on offer for those who need them, and that they are able to access them when they need them.

Discussion

This opportunity to compare data on healthcare outcomes had been very interesting, said **Iva Holmerová** (Centre of Gerontology, Czech Republic). She asked if there are any data on how different segments of healthcare - drugs, inpatient care, outpatient care, GP² care - influence health status. **Juha Teperi** (National Research and Development Centre for Welfare and Health, Finland) shared the view expressed in the presentations that the actual use of healthcare must be examined, and not just the access measures. Finland had been really happy about the level of equity within its healthcare until the 1990s, because it had good legislation with strict provisions for equal access. During the 1970s and 1980s, a very dense network of basic healthcare services was built up even though Finland is a sparsely populated country. Financially, this was achieved through progressive taxation. However, since 1995, more and more data have been acquired on actual use across the income groups. The figures have surprised everyone – the politicians, the experts and now the general public. In both inpatient and outpatient care, and also in preventive medicine, more of the resources go to the better-off. So it is very important to examine the actual use of services. **Cristina Masseria** agreed that the available data often measure access rather than use. This is of concern to her as an economist, as it may well often give a false picture of what is happening. However, it is

² GP = General practitioner (local family doctor).

important to get an overall view, and there may still be some differences depending on the kind of health service required. Studies suggest, for example, that there is even more inequality in the use of care services than in acute care, but there are no real data on this. It is often impossible to differentiate between acute and non-acute care. It is not known what are the exact impacts on healthcare status of access to inpatient, outpatient and GP care. But a lot can be achieved through new treatments, screening and prevention. The mortality rates can be reduced, as can the health status gaps within each country. However, there is a general lack of reliable data, and this makes it difficult to evaluate the effectiveness of new policies. **Charles Price** added that it is crucial to measure health service use, but also health outcomes. Regarding the effectiveness of different types of treatment, he felt that a good deal of progress has been made over the past ten years in collecting evidence. We do now know what works and what does not work in a very wide range of treatments. The challenge now is one of health service management and organisation. How do you use that information to make sure that the service is delivering effective – and cost-effective – treatments to the maximum number of people, and that ineffective treatments are being reduced? For example, we know that, for people who have early chest pain, aspirin is incredibly cheap and incredibly effective. But how do you ensure that those people who need it are on it? Appropriateness is another challenge for healthcare. It is not always appropriate to manage a social problem by keeping somebody in hospital because they cannot take care of themselves at home. Providing care at home for that person may be what they prefer, as well as freeing up hospital space for other purposes.

The Hungarian National Health Strategy

Zsombor Kovacsy (Secretary of State, Ministry of Health, Hungary) gave an overview of the Hungarian government's current plans for healthcare reform. He noted that Hungary had been unfavourably ranked in several of the comparisons made by Cristina Masseria. Why has this situation occurred? Hungary does, after all, have practically universal access to healthcare. Expenditure on health has kept pace with the country's economic development, providing a comprehensive healthcare in-kind benefit package. But the results are extremely poor. For instance, there are big differences in life expectancy between Hungary's various regions (3-4 years). Life expectancy for males in Hungary is very low compared to other European countries. The distribution of the various levels of care differs greatly from one Hungarian region to another. Provision in the central region is much better than in some other parts of the country, and the level of spending also varies a lot. So there are a number of reasons why the Hungarian system has to change:

- The catastrophic morbidity and mortality rates make urgent action necessary.
- There are conflicts between the intentions of macro health policy and institutional interests. Within the Hungarian health system's sophisticated financing structures, there are several regulatory elements which are in absolute opposition to the most important health policy goals. These regulatory elements do not encourage the institutions to provide the kinds of service that would be beneficial for the health of the population. Rather, they support the abuse of healthcare resources.
- Financial and professional transparency is a general problem in the healthcare systems of previously State socialist countries. For example, the phenomenon of under-the-table

payments does not exist in Hungary alone, but it is a core element of the structure and functioning of Hungarian healthcare.

- Needs are changing, due amongst other things to the rapid ageing of the population.

Public healthcare should focus on the country's most important morbidity and mortality problems. Due to the lack of resources, health policy goals must be achieved in the most cost-efficient way. The only way of tackling the challenge of low health status is to pick out the most important three to five problems and to focus on them all the resources coming from EU and local funding, as well as the activities of the public healthcare system. One of the present government's most important aims is to create what is called a "new solidarity". This entails horizontal and vertical equity not only on the service provision side of healthcare, but also on the contribution side. It is estimated that about 12% of Hungarians do not pay the contributions that they should. This creates a big lack of financial resources. But by April 2007, the health insurance administration should be in a position to monitor contributions and service provisions, so that it will become possible to refuse service provision to those who do not pay their contributions even though they are able to do so. This does not mean that social protection will be reduced, but for those able but unwilling to contribute, this system will create what might be called "compulsory solidarity".

An important item on the Hungarian health policy agenda is to decide the future model for health insurance. One option is the multiple insurance system. This decision will be made during the spring of 2007. The structure and functioning of the healthcare system are in the process of being modernised. This process includes the principle of equal health for all. The structural imbalances in healthcare provision have to be eliminated. These imbalances exist both in geographical terms and in the ratio of acute to long-term care. By international standards, Hungary has overcapacity in acute beds. Enforcement of the cost-effectiveness principle is important in the pharmaceutical market and in the in-kind healthcare benefits package. The harmonisation of action is certainly reinforcing this cost-effectiveness principle. Unless the role of the individual is strengthened, it will not be possible to provide a sustainable healthcare package. The involvement of the private sector is another major item on the Hungarian government's agenda.

Major changes planned within the system are:

- Network restructuring, which is now under way.
- Public health focus, with priority going to areas such as oncology, cardiology, children's health and medical emergencies. All the public health activities will be organised around the most important causes of mortality and morbidity in Hungary.
- A Supervisory Authority, which will combine the functions of consumer protection, healthcare market surveillance and enhanced quality control of the Hungarian health insurance and service provision system.
- Long-term care integration. At present, long-term care provision is divided between the health and social departments. This means that some functions overlap, while others are not covered.
- Some new forms of co-payment. The main wave of these will be introduced on 15 February 2007 and this was, the Secretary of State said, a hot issue in the Hungarian media at the

time of the peer review seminar. As with all changes, only a small minority of the population is in favour of co-payment for visits to GPs and hospitals at the moment when the reform is being introduced, but the government believes that it will help to adjust care provision to the real needs of the population. There is a huge social protection regulatory system behind these co-payments, and this means that approximately four million Hungarians, out of a total population of ten million, will not have to pay the charges. In the government's view, this measure cannot possibly create more imbalances in care provision and access than already exist. It will concentrate the attention of the healthcare professionals on the real needs and problems of the population.

- Adjustments to hospital bed capacity. Hungary currently has 80,000 beds, of which 60,000 are for acute care. The intention is to have about 40,000 acute care beds, while the number of long-term care beds will have to increase, as much remains to be done in this area. The "permanent reforms" of the past 16 years did not support long-term nursing care, so it will need to receive increased attention, due to its growing importance.
- Improved geographical accessibility. The principle is that everybody will be within 50km of a hospital centre, 30km of a general hospital, 20km of an outpatient clinic and 15km of an ambulance. The big central hospitals are important, as it has been clearly shown that they produce better healthcare outcomes.

The aim is to achieve equal and sustainable care provision through a clear definition of healthcare packages, support for disadvantaged regions, the re-organisation of long-term care, integrated service centres and improvements in emergency care. The problem is how to meet the convergence criteria for the stability of the State budget while at the same time reducing the catastrophic morbidity and mortality rates. However, he believed that some aspects of the Hungarian healthcare reform can tackle both of these issues in parallel. These include the transformation of the oversized hospital network, greater cost-effectiveness in pharmaceuticals, strong monitoring of care provision, the centralisation of hi-tech facilities and fine-tuning of financing methods.

Commenting on the Hungarian health reform, **Péter Gaál** (Health Services Management Training Centre, Semmelweis University, Hungary) said it will reshape the whole foundations of the Hungarian healthcare system and will define its future. However, in some areas, there may be disagreement over the right tools to use in order to improve equity, quality and financial sustainability within the system. This is why he had chosen a topic – production efficiency - which might seem to deviate somewhat from the subject of the review. However, he hoped that it would become clear why he had chosen it, and that it would stimulate a useful debate. Production efficiency is an area in which there is not much disagreement about the problems facing the Hungarian healthcare system. Production efficiency requires that whatever we produce, we do so at the least cost. If the waste of resources can be eliminated, this can free up resources for other purposes, such as reducing regional inequalities in access to care. Proposals to increase production efficiency may also have direct consequences for the equity of the system. He would show that this is a significant problem in Hungary, but that it is also of relevance in other countries. Review participants might therefore be able to take home some of the ideas for further reflection.

While there is widespread agreement on the need for greater production efficiency in Hungarian healthcare, there may be different views on how to achieve it. The Ministry of Health's proposal in this area is the introduction of competing health insurance funds into the Hungarian healthcare system. He doubted that this is really a good way of eliminating production inefficiencies. To make the debate a constructive one, he would not just be criticising the government's proposals. He would suggest other options that have emerged in recent years as a really powerful alternative to competing health insurance funds.

Ineffective technologies, unnecessary services and service provision at unnecessarily high levels (for example, hospitalising patients who could be treated in an outpatient setting) all constitute pure waste. There is a great deal of evidence for such inefficiencies in Hungarian healthcare. At present, it is based on a social health insurance system which offers near-comprehensive and universal coverage. Service delivery is through facilities predominantly owned by local government. Although healthcare is still mainly publicly funded and provided, it has already deviated significantly from the integrated State socialist model, as financing and service provision have been separated. There is a purchaser-provider split. A single big purchaser, the National Health Insurance Fund Administration (NHIFA), contracts mainly with county government and municipalities for provision. Each citizen who is entitled to healthcare has a social insurance identification number. Specialist providers report to the NHIFA each month on the services provided to each patient, and are paid on that basis.

One proof of production inefficiencies is the huge variation between different regions of Hungary in the use of tonsillectomies, of prescription drugs for diabetes, and of antibiotics. And the statistics for some county hospitals show a 40% increase in Caesarean sections between 1999 and 2002.

Currently, Hungarian primary healthcare providers are capitated. This measure was introduced in 1992. Two other changes followed in 1993: outpatient specialist providers are paid on the basis of a fee for service and acute inpatient care is paid for on the basis of diagnosis-related groups (DRGs). The evidence on the impact of these new payment methods shows that capitation is an incentive to maintain a high rate of referral to specialists. Fees for service also stimulate greater activity, as do DRGs. Looking at the impact of DRGs on production efficiency in the hospital sector, it may be seen that, as might be expected, there was a strong increase in admissions between 1989 and 2000. At the same time, the NHIFA payment per DRG cost decreased greatly between 1994 and 2000. Although the DRG system really improved production efficiency in the acute inpatient care sector, it may be said to have done so at the cost of reducing the quality of care. However, there has been no dramatic deterioration in crude indicators of quality, such as the avoidable mortality rates.

It may be concluded that, in acute inpatient care, the DRG system has substantially improved production efficiency. But this does not mean that all the patients who have been hospitalised really needed to be treated in hospital. There is some evidence of unnecessary referrals to higher levels of care. Between 1990 and 2000, non-diagnostic referrals increased by more than 60% and hospital referrals per thousand patients attended increased by almost 30%. So the current payment system does not provide an incentive to treat the patient at the lowest possible level of care.

The original idea of the current round of reforms was that the purchasing function of the NHIFA should be strengthened. However, after the most recent elections, the government put forward the

idea of introducing competitive health insurance in order to tackle the production inefficiencies in the Hungarian healthcare system. This is a controversial proposal. A third possible option, which has tended to be forgotten but which in Péter Gaál's view ought to be debated, is known as the care coordination pilot, launched in 1999.³

He ended by outlining the international evidence on the effects of healthcare insurance competition. The assumption behind the model is that competition forces insurance companies to eliminate unnecessary services, so that the care coordination function is in the insurance companies' interests. In practice, however, companies can also compete successfully by concentrating on lower-risk patients. The model also implies a risk of undertreatment. Another concern is the administrative cost, to the healthcare system, of dealing with competing insurance funds. From the providers' perspective, if competition works well under this model, they will have to have multiple contracting. So a GP, for instance, would have to have a contract with each of the insurance companies that have clients in the GP's catchment area. This will certainly increase administrative costs, as will the multiple reporting requirements and multiple control systems introduced by the different insurers. The details of the Hungarian model are not yet known, but there might be a number of different payment methods. This would further increase the administrative burden on providers. And there might be multiple price negotiations, with each of the insurance companies. Prior approval of diagnostic and therapeutic interventions and of reimbursement might also be required. All of this would multiply the administrative costs. At the same time, the insurers' marketing costs and the profits required to ensure a return on their investment would have to be factored in. For example, under a similar scheme introduced in Chile, the administrative costs of the private insurance system are 10-20% of the total budget, as against 1.5% under Hungary's current NHIFA-administered system. So, if Hungary is really to gain anything from a competing health insurance model, the first 10-20% of any production efficiency increases would have to be set aside to compensate for increased administrative costs.

As an alternative, the idea behind the care coordination pilot in Hungary is that the care coordination organisation (CCO) can only be a care provider. For an adjusted capitation payment, this CCO assumes responsibility for virtually the whole spectrum of services to the population signed up for primary care via GPs in a given geographical area. The budget, calculated on the basis of the capitation payment, is not actually transferred to the account of the CCO, which is only a virtual fund-holder. The CCO provides care and can collaborate with other providers to optimise the treatment of patients. All other healthcare providers, and the CCOs, are "paid for" as under the currently existing rules. If, at the end of the year, a CCO is in surplus on its virtual budget, the sum concerned is actually transferred to its bank account, and can be used for remuneration and investment. The CCO could be a group of GPs, polyclinics or hospitals. If it is a group of GPs, the CCO covers the patients on the GPs' lists. If it is a group of polyclinics or hospitals, it is obliged to contract with local GPs in order to obtain a panel of patients to care for. A CCO structure would motivate providers to generate savings, in which they would share. However, there are also professional and legal motivations, because CCOs will receive the actual utilisation data, for their patients, from the NHIFA. By analysing such data, they can develop strategies to optimise treatment. The main conceptual difference

³ He circulated details of this pilot to peer review participants – see p.10 ff. of his draft paper *Equity and health care reforms in Hungary: comments on the government's reform proposal* (Budapest, Peer Review Seminar, 17-18 January 2007).

between this CCO model and those in the US (managed care) and the UK (fund-holding) is that only the care coordination function is assigned to the CCO. Everything else, from revenue collection to budget-setting to the payment of providers, remains centralised at the level of the NHIFA. One advantage of the CCO model is that there is no incentive to undertreat patients. All providers, including the CCOs themselves, have to generate enough income to survive until the end of the year, when the actual savings are transferred to the CCO's bank account. The CCO has no incentive to deny treatment, as patients are free to turn to other providers. Also, the CCOs will be aware that undertreatment at one stage is likely to increase the cost of treating a patient at a later stage. The CCO model assigns the various healthcare system functions to the level at which they can be provided at the least administrative cost.

Discussion

Raymond Wagener (General Inspectorate of Social Security, Luxembourg) asked if one intention of the Hungarian reforms was to introduce a risk equalisation mechanism. He also wondered if there were many studies that came out in favour of introducing health insurance competition. Such systems do exist in Germany and the Netherlands, but he had read studies that were not very convinced about their advantages. Historically, the starting point for Luxembourg's system had been very similar to that in Germany and the Netherlands, but Luxembourg has a healthcare financing monopoly, i.e. a healthcare insurance monopoly. The competition is among the providers, and there is integration between public and private service providers. How does Hungary envisage the provider side of its future system? Will there be only public providers? Or will there be both public and private providers, and to what extent will they integrate? **Herta Rack** (Federal Ministry of Health and Women, Austria) noted that one of the slides for Péter Gaál's presentation stated that "the effectiveness of the 'gate-keeping' function of family doctors is dubious." She asked him to amplify on this, as Austria is planning to strengthen the role of family doctors. **Georg Fischer** reminded participants of the purpose of the seminar, which was to look at health inequalities and access. He felt that, while the two Hungarian speakers had set out various financing options, they could have explained more clearly the implications for access to healthcare. From earlier speakers, he had received the message that the objective of "access for all" should perhaps be complemented with "access to the services that patients need". Perhaps the policy aim should be that each group within society should receive access to the healthcare that it needs, regardless of income or wealth. The needs would then be analysed differently, taking account of such factors as age and gender. So he asked the speakers to explain how they viewed the various options in the light of these objectives. He also recalled that healthcare policies must take account of the resources available in each country. On co-payment, he noted that Hungary is aware that this can impact differently on different social groups and that, consequently, some 40% of the Hungarian population will not be required to make co-payments under the current reforms. But if such a high percentage is exempted, can co-payment really play the positive roles that are expected of it, such as reducing unnecessary treatments? **Üllar Kaljumäe** (Health Care Board, Estonia) asked if, under the proposed competitive system in Hungary, all insurers would be obliged to offer a basic healthcare package covering a prescribed range of services. **Juha Teperi** wanted to know if there are any elements in the Hungarian reforms that would promote prevention, both outside and within the healthcare system. **Cristina Masseria** asked if the Hungarian health insurance companies would be obliged to accept all applicants. Otherwise, there might be discrimination against people at higher risk of needing healthcare, and perhaps also against

people in certain geographical areas. Currently, a small proportion of the Hungarian population is becoming wealthier, while the majority is very poor. This situation has an impact on health. Will the reforms diminish or increase that impact? She also wondered if Hungary's shortage of healthcare supply, and the related problem of "under the table" payments, might not reflect the fact that Hungarian doctors legitimately earn about €400 per month. Would the reforms change that situation? **Miklós Szócska** (Acting Director, Health Services Management Training Centre, Semmelweis University, Hungary) asked for pointers to publications on healthcare capacity planning methodology - or to experts in this field, as he would like to invite them to make presentations. **Péter Bakos** (ReFoMix, Hungary, and the European Federation of National Organisations working with people who are homeless) asked if homeless people will be exempted from co-payments, and whether the reforms will ensure that they are not denied access to healthcare.

Replying, **Zsombor Kovacsy** emphasised that no decision had yet been taken on the introduction of a multiple insurance system. If it is introduced, an equalisation system will of course be put in place. Competition among providers already exists, but the Hungarian system is based on local government's having a duty to provide care. That is why such competition is limited. The government would like to introduce more competition among providers, but the present financing system does not really support this. Regarding the impact of the reforms on equality of access, he sees the definition of healthcare packages as a primary step which will clarify the population's entitlements to healthcare. Currently, this entitlement is unclear, due to the practice of illegal payments. The restructuring will aim to promote greater real equality of access, across social groups and regions. He confirmed that 40% of the population will be exempted from co-payments. It would have been politically and socially impossible to do otherwise, given the strong feelings of solidarity within Hungary. He was absolutely sure that homeless people would be included in the 40%. On prevention, he agreed that, since 1999, Hungarian healthcare policy has had a short-term outlook. Coverage now has to be focussed on the most important public health challenges. The first wave of reform is mostly about the restructuring of the healthcare provision system itself. This does not mean that prevention and health improvement were not on the policy-makers' agenda. He predicted that Hungarian health policy will concentrate on oncological diseases, heart and vascular diseases and the nursing and long-term care needs of a rapidly ageing population. The reforms do provide for a basic healthcare insurance package, together with supplementary packages. The definitions of these packages are more or less ready. If the multiple insurance system is adopted, the companies will be obliged to offer the packages as defined. The basic amount of the co-payment is a little more than one euro per visit, or per day in hospital. Taken together with the 40% exclusion, he was sure that the level of these payments will not create more inequity within Hungarian society. Above a ceiling of 20 visits, a reimbursement system will come into play. To Miklós Szócska, he replied that he would be happy to facilitate access to the experts who helped to plan the restructuring programme.

As regards the gate-keeping function, **Péter Gaál** felt that financial considerations really do have an impact. The family doctor has to manage the practice on the basis of the capitation payment, so there is an incentive to refer patients on to specialist care and possibly to inpatient facilities. He was pleased to hear from Zsombor Kovacsy that no decision had yet been taken on the introduction of health insurance competition. It was sometimes argued that, by passing the responsibility for the management of healthcare on to the insurance companies, government would be freed up for other tasks, but in fact a multiple insurance model requires greater regulatory capacity, as all aspects of

healthcare then have to be regulated in order to avoid adverse outcomes. Competition works well if it is in the interests of providers to accept everybody, but to achieve that in a multiple insurance market requires heavy regulation. He argued that this would be an impossible task.

Zsombor Kovacsy replied that, if a competitive model is introduced, it will be compulsory for the competing insurers to accept all applicants.

Peer country presentations

Austria

Introducing the Austrian system, **Herta Rack** emphasised that healthcare is the constitutional responsibility of the federal government – with the important exception of the hospital sector. For the hospitals, only the general policy legislation is adopted at the federal level. The running of the hospitals is governed by agreements between the federal government and states (*Länder*). The principles of the Austrian healthcare system, which have remained untouched by every reform so far, are:

- Equal access for all.
- Solidarity through compulsory health insurance. This insurance covers all services linked to the treatment of an illness. Benefit claims and their scope are, basically, independent of the contribution paid.
- The provision of healthcare is a public task.
- The financing of healthcare is mixed (public/private). There are more than 4,000 different flows of finance within the system.

Like other countries, Austria has adopted the health accounting system developed by the OECD. This has resulted in an increase in the published health expenditure figures, placing Austria in the upper middle range of EU Member States in this regard, alongside Germany, France and the Netherlands. Austrian healthcare expenditure is around €25 billion, or about 10.2% of GDP. Social health insurance is the most important source of financing. It provides about half of the total healthcare expenditure. The financial situation of this social health insurance is the biggest challenge facing the Austrian system. During the last reform, in 2005, health insurance contributions were increased, and the present government programme foresees a further rise of 0.15 %. But the financial situation of the social health insurance will remain tight. A quarter of healthcare expenditure is financed by taxes, and the remaining quarter is covered by private spending, including supplementary private health insurance. Around 50% of all the funds go to the hospital sector. The Austrian system is very hospital-centred, with high admission rates for acute care.

Turning to the question of access, she pointed out that, in international comparison, Austria has a well-developed healthcare system in terms both of quality and of quantity. In outpatient care, the number of physicians is above the EU average, as are the number of hospital beds in inpatient care (although the number of beds is currently being reduced) and the provision of major medical

equipment. However, there are inequalities among the country's 32 health regions as regards coverage by GPs and specialists and the reachability of hospitals.

A guiding principle of the Austrian system is that access may not be rationed on grounds of age, gender etc. Indicators for access include statutory health insurance, which covers 98% of the population. For the remaining 2%, some improvements have been achieved. The most recent measure has been to introduce an e-card for welfare recipients. It remains to be seen what the new government will do to plug the remaining gaps in statutory insurance cover. Another indicator is that there are no significant waiting lists for medical services, thanks to high staffing and equipment levels. Only a few non-urgent operations entail longer waiting times. However, she added that Austria currently has no nationwide data about waiting lists. Life expectancy in Austria is above the EU average, and the indicators for morbidity and mortality are generally good. However, there is a need for further policy measures to gradually reduce the existing disparities in health status within the Austrian population – among age groups, between men and women and among the regions, notably between Eastern and Western Austria. Less favourable socio-economic structures in some parts of the country's East have produced an East-West divide. There are higher levels of obesity in certain parts of the East and a higher incidence of diabetes in lower-income areas, particularly among rural women. It is hoped that the promotion of performance quantity standards will facilitate a more uniform regional distribution of service delivery. The intention is to implement standards for efficient interface management and to upgrade the delivery of such services as palliative and hospice care, neurorehabilitation and psychotherapy.

At the request of the Hungarian hosts, **Ursula Fronaschütz** (Federal Ministry of Health and Women, Austria) presented Austria's current healthcare reforms. Implementation of reforms requires the use of the correct instruments, she emphasised. In Austria, legislation on this issue can be introduced either at the federal level or in the country's different states (*Länder*). There may also be common routines or projects agreed jointly between the federal level and the *Länder*. She focussed on one particular instrument – the National State Treaties, which are regular agreements between these two levels. They usually run for four years. The current one is for 2005-2008. They have proved very valuable in getting all the stakeholders to agree on priorities for a four-year period. Many of the issues cited in the presentations on the Hungarian healthcare reform are, she said, very similar to those in Austria. Major long-term topics in the current Austrian healthcare reform are healthcare structural planning; quality and interface management; eHealth and health telematics; and DRG systems and documentation. More horizontal topics are integrated care and long-term sustainability. A new organisational structure has been introduced. There is now a federal-level Health Agency, which is the central institution for planning, management and financing and includes representatives of all major stakeholders in the Austrian healthcare system. This is important, as such a forum is needed in order to reach agreement on reforms. There are also health agencies, known as "platforms", at the level of the *Länder*. They implement the guidelines and planning principles outlined by the Federal Health Agency, while taking account of economic conditions and specific regional needs. Traditionally, planning was directed towards acute hospital care. A compulsory hospital plan has been in place since 1997. But since 2005, there has been a major change. A new concept, called "service provision planning", has been introduced. Instead of quantitative regulation of beds and service locations, the idea is to calculate the required minimum amount of medical services per region. Provision of services should take place irrespective of location or organisational form. There is also a new

emphasis on integrated planning, across all healthcare sectors. This is difficult to achieve in Austria, as the various sectors have traditionally developed in different directions.

Ten years ago, major efforts were made to improve quality through non-binding projects. However, this proved to be insufficient. So in recent years, a more binding legal framework has been developed. The National State Treaty includes quality tests, but even more importantly, there is now a Federal Act on the Quality of Health Services. This sets out a horizontal strategy for the development of quality work. The Act covers standards, structure, process, outcome and quality reports, and it establishes a Federal Institute for Quality in the Healthcare System.

There was also a need to support integrated healthcare management through the supra-institutional exchange of information. Hence the emphasis on health telematics (eHealth). The goal is to expand the legal, technical and organisational framework and promote cooperation among stakeholders, in line with eGovernment and EU activities. A Federal Healthcare Telematics Act was brought in, not without difficulties. Current priority projects are electronic health records and ePrescriptions, as well as the eCard introduced in 2006.

DRG and documentation systems have to be developed further. A DRG-based hospital financing system was introduced ten years ago. The major challenge now is to implement documentation and classification systems for diagnoses and procedures in the outpatient sector. This is not an easy undertaking. A “reform pool” has also been introduced. This is designed to intensify the desired financial shifting of patients and services between the outpatient and inpatient sectors.

Her conclusions on the Austrian reforms:

- Healthcare reforms are considered to be an ongoing process, the basic idea being evolution rather than revolution. The treaties, too, are a continuing process.
- Different topics are intertwined and have to be dealt with at the same time. Trade-offs have to be made.
- Systematic involvement of all partners is needed to ensure results. Just writing papers is not enough. The important thing is to convince the partners.
- A balance has to be found between federal, provincial and community interests. This is particularly important in a country with a federal background.
- Reforms have to be tailored to each nation’s needs, but international comparisons such as the present peer review are helpful.

Estonia

Dr. **Heli Paluste** (Ministry of Social Affairs, Estonia) explained that a number of factors had to be taken into account when planning the reform of Estonian healthcare. One is the gradual decrease in the country’s population since the early 1990s. Another is the low population density in the rural areas. The population has been concentrating in a few urban areas, where the municipalities have correspondingly higher administrative and financial capabilities. About one-third of the country’s population now live in the capital, Tallinn. This concentration is continuing. The population is ageing, which is a problem that Estonia has in common with many European countries. The reforms that took

place in the early 1990s established a significant degree of decentralisation in the healthcare system. The planning of primary care and some specialist care was devolved to the municipalities and several sickness funds were established. However, some problems arose, due to the fact that certain functions were devolved to levels that proved unable to perform them efficiently. So towards the end of the 1990s and at the turn of the century, a certain amount of recentralisation took place. Healthcare planning was firmly established at the national level and the sickness funds were reorganised into one central health insurance fund. Increased rights and obligations have been delegated to the health insurance fund and the providers. Healthcare providers have the legal status of private entities, but most of them are owned or funded by the State or the municipalities. Direct responsibility for provider performance has been delegated to the hospital supervisory boards. The privatisation of primary care began in 1998 and was completed in 2001. Regulation is ensured by the Healthcare Services Organisation Act of 2001. Before the reforms, the hospital network was a rambling system, characterised by an inefficient use of resources. This resulted in specific but not clearly acknowledged problems of accessibility. Hospitals and outpatient clinics were frequently overcrowded, but officially there were no waiting lists. Accessibility and quality were affected by the behaviour of doctors and patients, by a lack of motivation among medical personnel, and also by the deepening stratification of society due to rapid economic change.

The main principles for the restructuring of the hospital network were the “golden hour” principle (everybody to be within 70km or one hour’s journey of an acute care hospital); hospital catchment areas of a size sufficient to ensure better quality of specialised care and efficient use of resources; and the development of nursing care services, so as to enable more efficient use of active care. In comparison with both old and new EU Member States, the reduction in the number of hospital beds in Estonia has been very steep, as has the reduction in the average length of stay in acute care hospitals. Remarkable improvements have been achieved, but there is still overcapacity in the hospital network, so the reforms must continue. Major problems in long-term and nursing care include the insufficient availability of home nursing services, a shortage of long-term and nursing care beds and inadequate care access for elderly people. The problem most often cited at present is the “grey area” between healthcare and social welfare services. This is a serious obstacle to the continuity of care. The main challenges are therefore to integrate nursing and social care services, increase the availability and quality of both home care and institutional care and ensure that services are provided on the basis of thoroughly evaluated needs.

Primary care is now organised around GPs at the county level. Citizens are free to choose their GP, and the GPs function as gatekeepers for the system. GPs now also receive specialist training. Legally, GPs are either sole proprietors or companies contracting to the Health Insurance Fund.

According to the latest official data, health insurance covers 94% of Estonian residents. For about half of these, contributions are paid by employers, the State or themselves. The other half is insured without contributing. This does not favour the sustainability of the system, but it would be difficult to change this situation. Co-payments are low (up to €3 for a GP or specialist visit and up to €1.50 per day for the first 10 days of hospitalisation) and are applied to reduce the use of services. On the other hand, out-of-pocket payments considerably reduce access to dental care, especially for low-income groups. Surveys show that, while most of the health spending in low-income households is on pharmaceuticals, richer households spend more on dental care. While appointments with GPs can

generally be made within three days, there are long waiting lists for specialist care both in outpatient services (up to 90 days) and inpatient services (up to 3.5 years).

Current priorities for health policy-makers in Estonia include:

- reducing the number of uninsured persons, as those without insurance have access to emergency services only
- reducing waiting lists
- continuing the reforms, by ensuring better access to primary care and continuing the improvements in the hospitals.

The bad health status of the Estonian population, and inequality of health outcomes between different socio-economic groups as a result of patterns of health-related behaviour and healthcare utilisation, are not yet acknowledged by Estonian society or by the country's politicians. However, during the elaboration of the national health policy document in 2006, these issues were emphasised. Some of the measures needed to overcome these inequalities are not directly connected with healthcare, such as the reduction of unemployment and poverty. However, this in no way detracts from the need for health promotion and disease prevention, especially the implementation of relevant strategies to control the spread of HIV and tuberculosis and the promotion of healthy choices and lifestyles through the National Heart Strategy and the National Cancer Strategy.

The sustainability of the healthcare system is a major current topic in Estonia. At the time of the seminar, negotiations were continuing on the minimum salary for Estonian health professionals, and strike notices had been given. The sustainability of the system's finances and human resources are serious challenges for Estonia, in the context of growing health expenditure and the free movement of health professionals within the EU – despite the rapid growth of the Estonian economy. Important choices will have to be made in the coming years if the expectations of the population are to be met and equality of access to healthcare is to be achieved.

France

Catherine Dumont-Fourchard (Ministry of Health and Solidarity, France) described her country's Universal Healthcare Cover scheme (CMU: *couverture maladie universelle*). The basic social security regulations in France cover only part of healthcare costs. In 2005, 77.5% of the medical care costs and medical goods were covered by social security and 12.9% by additional insurance, while 8.7% had to be paid directly by the persons themselves. Different medical care situations are covered:

- 92.5% of hospital care
- 65.7% for the providers of ambulant care (general practitioner etc.)
- 61.9% for medical goods (drugs, prosthesis...)

This shows that additional insurance coverage is insignificant in the case of hospitals but determinant for other types of care, particularly in areas such as dental and optical care and more generally in first aid. It is indispensable that the authorities intervene in order to avoid leaving an important part of the

population without additional coverage. This especially concerns those who do not have the means to acquire additional coverage, and who suffer the social and health consequences of that lack.

Ensuring medical follow-up for the most vulnerable has long been an important concern in France. Before the CMU was set up, the most vulnerable used to benefit from the state medical assistance programme. In 1999, 3.3 million people were insured in this way. However, the intervention of many different actors (local communities, sickness insurance, the State etc.) caused difficulties.

The law which gave birth to the CMU:

- Enables people who live in France to take advantage of health insurance if they are not otherwise insured. Today, this mechanism concerns around 1.5 million people.
- Enables people whose incomes are below a certain ceiling (around €600 per person per month), to have a complementary insurance to take care of 100% of the whole health expenses if they are refundable by the French social security. Today, this CMU programme covers around 4.8 million people.
- Ensures State assistance for the health expenses of foreigners in illegal situations.

Another law supplements this scheme by providing assistance for the acquisition of complementary health insurance by people whose resources are equal to the CMU ceiling + 20%.

Today, around 4.8 million people benefit from the CMU system. These figures have remained constant ever since the scheme was launched. The CMU recipients are younger than other social insurees. 44% of CMU recipients are under 20 years old, as against 25% of the population as a whole. Women are also more present among CMU recipients.

There are geographical inequalities in the numbers of CMU recipients, with a major concentration in the most disadvantaged areas of France: Seine Saint Denis, Provence, Alpes, the Côte d'Azur and the overseas *départements*.

The percentage of people covered 100% for long-term care is higher for the recipients of CMU than for those of other insurance schemes. People benefiting from CMU are in worse health than others, but expenditure on their ambulatory care is lower than for other insured people. Nevertheless, hospital expenditures are higher. In 2002, a recipient of CMU spent €2,133 EUR on care while an average insured person spent €1,700 EUR. But this difference concerns hospital expenditure only.

There are two difficulties with the CMU system:

- The population targeted by CMU is around 6 million, but only 4.8 million are recipients. Analyses were conducted to find out why. There are 3 reasons:
 - A lack of information. The person concerned has never heard of this scheme.
 - The fear of stigmatisation.
 - Apathy and desocialisation among some of the most vulnerable people, especially those on welfare benefits.
- Some practitioners refuse to treat CMU recipients. The extent of this problem is not known. Some inquiries have been conducted, but the samples were too limited to permit conclusions

to be drawn at the national level. However, refusal of treatment is a reality. It mainly concerns dentists and specialists who practise free pricing, which they cannot do in the case of CMU recipients. An inquiry made in Val de Marne region showed that the rate of refusals by specialists and dentists could reach 41%.

Faced with that situation, the Ministry of Health decided on a number of measures:

- A reminder of practitioners' obligations and the statistical follow-up of care refusal.
- Distribution of information to CMU recipients concerning their rights.
- Encouraging CMU recipients to choose a principal general practitioner.
- Easy access to rights (social insurance card to be issued at short notice).
- Systematic complaints if it is observed that treatment is being refused.

The CMU has now been running for seven years. It has made it possible for everybody to benefit from health coverage. In a context where CMU recipients, particularly due to their financial situation, are more prone to illness than the population as a whole, research has shown that the CMU has helped to reduce financial barriers to healthcare access. The system still needs to be improved, so that everybody who needs it can have real access to care and doctors are no longer able to refuse care for financial or organisational reasons.

Stakeholders' presentations

Sibylle Reichert (AEIP: European Association of Paritarian Institutions) explained that the AEIP represents first- and second-pillar social security institutions active in the field of coordinated retirement schemes, pension funds, health and provident benefits and paid holiday schemes. The term "paritarian" means that the social protection institutions are jointly managed by representatives of the employees and employers. The AEIP's values are solidarity and transparency. She felt that, to tackle inequalities in health access, the most important thing is to place the individual at the centre of the reflections. It is also important to have qualitative, comparable data at the European level, as a prerequisite for reducing inequalities. The most difficult aspect is to change people's behaviour. It is important to make people aware at a very early age of what it means to be in poor health and to teach them how they can avoid illness. At the level of companies and sectors, there are possibilities for prevention through health and safety at the workplace. Another possibility is to give people more choice, but then accurate information has to be provided and individual preferences have to be taken into account, so that people are able to choose different treatments or indeed to care for themselves. Provision must also be made for complaints management. As the AEIP represents institutions that are managed by the social partners, it has to take account of the employees' need for social justice and welfare but also the employers' concern for economic issues and higher profits. In 2006, the AEIP presented a reflection document on solidarity and its applicability to modern social protection schemes. AEIP thinks that through solidarity inequalities can be out balanced. Solidarity means treating unequal situations equally through the transfer of means. Solidarity is a European value which lies at the core of social Europe. But solidarity is also a changing concept. It has to adapt to modern social protection and health reforms. In healthcare, solidarity means risk-sharing through collective agreements and/or compulsory membership. It is a matter for the individual but also for the collective, because if individuals are not responsible for themselves, how can they be responsible for

the collective? However, personal responsibility within the health sector is difficult, due to asymmetric information. Concerning the socio-economic factors, it has to be kept in mind that health is one of the fastest-growing markets. Does that mean that everybody can have access to this market? At the same time, healthcare is considered to be an economic activity. Does that mean that everything can be privatised, and we can forget about solidarity? Inequalities also have a huge economic impact, because people who are in poor health are not able to be productive and to add to economic growth. There is a need for rehabilitation measures, so that people are quickly inserted back into employment and thus avoid poverty. We should ask ourselves whether investment in access to healthcare will solve all the problems. The AEIP places great importance on cooperation between economic and social actors.

As the Finnish EU presidency emphasised, health should be considered in all policies. She asked whether geographical problems in access to health care might be overcome by providing cross-border care, as some projects in the Euroregions show. In order to overcome organisational barriers to access to healthcare, market instruments could be used. For example, a hospital in southern Germany brought in a consultancy to look at its procedures, and they found that if it hired a hospital organisation manager, it could save a lot of money but also give the staff more time with the patients and reduce the waiting lists. So there are sometimes simple solutions to complicated issues. The role that could be played by the EU is rather limited, as healthcare falls under the subsidiarity principle. Nonetheless, through the open method of coordination, the EU could provide benchmarks for quality standards, equivalence of medical practice, licensing and accreditation, and patient rights. As 2007 is the European Year of Equal Opportunities for All, this can help to raise awareness about inequalities in the health sector. It is also important for all the Commission's DGs to cooperate on healthcare issues. The paritarian institutions practise the open method of coordination on a smaller scale. They do benchmarking and look at how the reforms in different countries work and how inequalities are tackled within these reforms. They promote solidarity, cross-border projects and cooperation. The territorial approach to social protection is important, and the AEIP has set up a task force on this. In future, the regions will play an increasingly important role in healthcare, because they are the closest to the citizens. Finally, to fight inequalities, cross-sectoral cooperation is essential, as many synergies can be achieved between the different sectors of social protection.

Dearbhal Murphy (FEANTSA: European Federation of National Organisations Working with the Homeless) said FEANTSA has member organisations in 30 European countries. Most of those members are umbrella organisations of service providers. FEANTSA is co-funded by the European Commission and has existed since 1989, when it was launched by a national organisation which felt that there was plenty of scope for learning and sharing at the European level on the issue of homelessness. FEANTSA's contribution to the present peer review is drawn from recent work that it has done on the issue of health and homelessness. This was FEANTSA's priority theme in 2006. Member organisations in each country cooperated to produce a report looking at the health aspects of homelessness. FEANTSA has spent a lot of time developing a definition of "homelessness" that can usefully be shared across the EU. This is called the ETHOS typology of homelessness. It takes account of the legal, physical and social domains of homelessness. It breaks homelessness down into four conceptual categories: being roofless; being houseless; being insecurely housed; or being inadequately housed. These four situations relate to health in different ways. Most of FEANTSA's work on health and homelessness concerns people who are roofless or houseless – i.e. rough

sleepers and people who are living in low-threshold homeless services. However, it has also looked more superficially at the relationship between health and insecure or inadequate housing. Health issues there include damp and cold, overcrowding, fire risks, bad indoor air quality, and hazardous substances in dilapidated housing. Living in bad housing can also lead to mental health problems. Meanwhile, the lack of amenities and public transport hampers access to healthcare.

The relationship between bad health and homelessness is a complex one of both cause and effect. Bad health can lead to homelessness. Mental health problems, substance abuse, or the loss of employment after an accident can set off a spiral down into homelessness. And once somebody is homeless, that will have a very negative impact on their health. Homeless people are more exposed to infectious disease. They are likely to be living in unsanitary conditions. Substance abuse can be aggravated or triggered by homelessness. FEANTSA's work on this showed that a homeless person will generally have a whole range of health problems at the same time, leading to a high aggregate vulnerability. This is a challenge for the healthcare system, because the holistic joining up of different care areas is not something that is very well done in European healthcare.

Some of the main barriers which emerged from FEANTSA's report, and which are common right across the EU, include not having an address; the complexity of the procedures for gaining access to entitlements; and any requirements for out-of-pocket payments, however small. She referred participants to her written report for an example of the disastrous impact in Germany of the recent introduction of a quarterly consultation fee of €10.

Improving homeless people's access to healthcare involves taking advantage of the expertise and willingness to cooperate that exist within civil society and in the homeless services. Homeless people have to be helped to overcome the requirement for an address and to overcome financial barriers, by tailoring public health insurance packages.

FEANTSA sees major potential for the open method of coordination in this area of access to healthcare, in terms of mutual learning. Equally, the work of DG Health and Consumer Protection around health inequalities can help galvanise the political will to use resources to tackle the problem. The work to improve healthcare quality and financial sustainability – work which is to some extent being driven by Europe – should not lose sight of the issue of health inequalities. It is vital that the specific and general aims of healthcare should not be jeopardised by the opening of the internal market in services. Europe is a forum where civil society gets a chance to be involved in policy processes. It is a place for them to bring their expertise to the table. She hoped that this will also be the case in relation to health inequalities.

Discussion

Introducing the general discussion, **Cristina Masseria** said the seminar had shown that there are both efficiency issues and inequality issues in European healthcare. Poor people have worse living conditions, higher mortality rates and lower life expectancy. They have higher smoking rates, a higher probability of being alcoholics, higher suicide rates, and a higher probability of being obese. And of course, not all poor people are the same. Some are children, some are older people, some are

immigrants, some are unemployed, some are homeless, some are minorities. So the same policies cannot be adopted for all of them. Policies have to be targeted towards the different groups concerned. There is growing evidence that some policies do work – for example, the taxing of tobacco and the ban on smoking in public places. Health policy must make use of such evidence. Obesity is becoming a serious problem. Many children in Europe are now obese, and in future this may reach epidemic proportions. Many countries are beginning to do something about it. These are new policies, so there is not yet any clear evidence, but that evidence must be collected, in order to see what really is effective. Mental health problems are being tackled in some countries, but many others are not doing much about this issue. Indeed, studies show that only five countries spend at least 10% of their health budgets on mental health. The majority of countries spend less than 2.5%. Prevention is another important area. For instance, there are studies showing that screening for breast cancer is effective. However, only a few countries have national policies on breast cancer. That is also the case for other screening programmes. Evidence should be used. The same applies when discussing the cost-effectiveness of new treatments or drugs. If we want to reduce the costs, we need agencies that can determine which treatments and drugs are effective and how they can be reimbursed.

What is missing in many countries is a multi-sectoral policy. The healthcare system is important in improving the health status of the population, but education, information, social care, employment policies and many other aspects also play a vital role. They need to be coordinated in order to reduce health inequalities and raise life expectancy. Children and young people are another important aspect of the healthcare access discussion. The French contribution had shown that 44% of those in the CMU are aged under 20. Young people often do not have a voice, and therefore tend to be forgotten, but they are the future. It is really important that there should be policies specially oriented towards young people and children – for example, on tobacco and obesity. There is diversity among national policies, and that it is a good thing. Each country and each region is different, so it is important to have policies that are based on that diversity. But it is also important to share information and to learn from each other. That is why meetings such as this seminar are so useful.

On the financing of health policies, she recognised that costs are rising everywhere and that something has to be done about it. The three main models are out-of-pocket payments, the expansion of health insurance, and cost-sharing. All these models raise policy questions. Who should bear the healthcare costs? What are the implications for equity and for efficiency? There is some evidence about the effect of user charges – although unfortunately not enough evidence, and the majority of it is from the US, where randomised control studies have been carried out. In Europe, unfortunately, studies have tended to be observational. And it is not easy to extrapolate from US findings results that are applicable to Europe, which is a completely different setting. There are good reasons for wanting to introduce user charges, the main one being to reduce excess demand. The second reason is to raise revenue, while directing users to more cost-effective treatments and appropriate patterns of care. But do user charges work? They can enhance efficiency, but only if supply and demand are independent. The introduction of user charges may have completely different effects on demand than on supply. Also, do people have sufficient information to make the right choice? If user charges do reduce utilisation, which groups begin to use the services less? And what is the impact of user charges on healthcare costs? Do they really decrease? What is the impact on the health status of the population? Can a system of user charges be designed which enhances

efficiency without lowering equity? The evidence is that user charges shift costs to individuals, and that they do indeed lead to a significant reduction in the use of healthcare. However, they reduce the use both of appropriate and of inappropriate healthcare. Often, user charges are not really effective as a means of achieving cost containment. In the US, however, where differential charges have been introduced, they do seem to be quite effective. The main problem is that user charges create barriers to healthcare access by people on low incomes. So an exemption system needs to be put in place, as in Hungary. However, an exemption system is likely to require significant administrative capacity. This will generate higher transaction costs which may limit revenue collection. A few years ago, the Netherlands studied the introduction of user charges but decided against it, as the transaction costs would have been too high. User charges also reduce the use of preventive services, and this is where we really need to be careful. To diminish the gap in health status between high-income and low-income groups, preventive services are essential. If user charges are introduced for primary care, patients go to emergency services instead, and they tend to go when their health is already rather bad. So in the long term, user charges may be ineffective and may create more costs than they save. On the other hand, if user charges are introduced for secondary care, they are unlikely to have much impact on use, as admission to secondary care is generally decided not by the patient but by the patient's doctor. In terms of cost containment, incentives on the supply side may possibly be more effective than those on the demand side. She hoped that the discussion would produce good suggestions for designing a system that is sustainable but also efficient and equitable, and which is not based on a short-term view.

Moderating the discussion, **Ana Xavier** (European Commission, DG Employment, Social Affairs and Equal Opportunities) said the aim should be to provide some constructive feedback to the Hungarian hosts and at the same time to produce some advice for the EU Social Protection Committee, which would be looking at this issue. The core topic for discussion was unequal access by different groups within society. The meeting had also heard that healthcare can make an important contribution to the improvement of health, and particularly to the reduction of preventable and treatable mortality. So the question now was what can health services do to improve health status and reduce inequalities, and how can policy help the health services to do so. Discussion points arising from the previous contributions included the priority given to increasing coverage for certain groups within the population. How can this be achieved? Also, how can services be made to reach certain people? How can the needs of different groups be met? How can geographical disparities be reduced, whether between regions, between urban and rural areas or between richer and poorer areas? More ideas and experiences on payment for care would also be useful. And how can services be reorganised to strengthen prevention? How can waiting times be reduced – is this just a question of management? How can education, awareness and information be improved? How can efficiency be improved and waste reduced, thus freeing resources for the promotion of equity? How can data collection and monitoring be improved on health status, access and use by population groups? What should be the links to policies in other sectors – for example, on reducing unemployment and social exclusion? How can structural funds be used for health promotion and for filling infrastructure gaps in cohesion regions?

Mervi Kattelus (Ministry of Social Affairs and Health, Finland) reported that, although Finland does have co-payments for public healthcare (e.g. €11 for a GP visit), some big cities have decided not to charge them because the administrative costs would have been too high. She asked if the

Hungarians had made any calculations or estimations of the administrative costs. **Juha Teperi** agreed with Cristina Masseria that there is not much empirical research on the effects of various payment policies. In Finland, a modelling exercise was conducted which asked if it was possible to generate substantial revenues that would help to finance the services and if it was possible to control demand for the services. In the Finnish context, the modelling clearly showed that neither of these aims could be achieved. This is because more than 80% of Finnish healthcare expenditure is generated by about 15% of the population, who are generally poorer than average. So co-payment is no longer much of an issue in Finland, as no further progress could be made towards the goals. He also argued that, even if all the structural barriers to access could be overcome, there will always be groups of people who are not really able to understand and articulate their own needs within the system. Thus structural change on its own is not enough. There has to be an active policy of going out and finding such people.

Georgi Uzunov (Ministry of Health, Bulgaria) said that his country has made big changes in healthcare over the past ten years. This was also a big experiment, so he had been interested to hear of other countries' recent experiences. He would concentrate mainly on negative aspects of the Bulgarian reforms, in the hope that the Hungarians and others might be able to avoid making the same mistakes. The Bulgarian reform began in primary care. The changes caused damage to prophylactic medicine, previously a strong point of the Bulgarian system. Primary healthcare worsened, leading to many problems including an increase in mortality rates. He felt that it might have been better to start by reforming the hospitals, rather than the GPs. As more than a million people in Bulgaria are members of vulnerable minorities, an outreach programme has recently been launched in order to improve their access to healthcare. The programme has started in five regions of Bulgaria. Mobile units go round checking on the real health situation of these minorities, as different reports have been received from various sources. Up to now, data collection has been very poor, so the first step is to clarify what healthcare problems actually exist in these areas. A year ago, a special fund for hospital care was created. Indicators have been drawn up, so that people who for one reason or another do not pay contributions to the insurance system can be treated free of charge. He was very interested in the Hungarians' future plans, but he was rather worried about the question of co-payments. In Bulgaria, where most of the population is not rich, most people are exempt from charges when they visit the doctor or go to hospital. At present, the standard payment is 1% of the minimum wage, which works out at about one euro. But most people do not pay. He felt that, if Bulgaria tried to use co-payment as a source of healthcare finance, this would simply produce a large budget deficit. The income that had been planned for would not materialise.

Replying to the Finnish question about administrative costs, **Zsombor Kovacsy** said that an important precondition for considering what can be done to ensure equal care is legality. He stated that Hungary, like other Central and Eastern European countries, is not very strong in the transparency and legality of healthcare professional and financial procedures. So the government and the health insurance administration are constantly looking for ways to ensure legality within the system. As international examples had shown, legally required payments can serve that aim. Also, as he had already pointed out, Hungarian attitudes to solidarity do not really permit either the introduction of co-payments of more than a few Euro nor the extension of co-payments to more than 60% of the population. The administrative burden is certainly of concern. It is likely to be heavier in

primary care, but the estimate is that it will not consume more than half of the sums raised by co-payments.

Iva Holmerová, looking at the issues from her point of view as a geriatrician, recalled that the theme of the meeting was access to care, not access to cure. In the Czech Republic – and in a number of other countries, judging by what had been said – long-term care is a particular problem. Long-term care is a vast field of inequity, unfairness and poor practice, at least in her country. Geriatricians are convinced that the reform of long-term care is, to a certain extent, the key to healthcare reform. It would, for example, reduce the problem of “bed-blockers” in hospitals. She noted that Hungary planned to reduce the number of acute care beds and to increase the number of “other” beds. Would these “other” beds be for post-acute care or for long-term care? **Üllar Kaljumäe** said that, in view of the percentage of Hungarians who would be exempt from co-payments, he was pessimistic about their effectiveness as a means of reducing the unnecessary use of services. **Zsombor Kovacsy** said that, over the past sixteen years of reforms in Hungary, there had been a feeling that long-term care is somehow not really part of healthcare. Thus long-term care was the loser during one and a half decades of transition. However, the most recent reform initiative makes more of an attempt to favour long-term care, which in Hungary includes post-acute care, rehabilitation and the healthcare side of institutional nursing care. In total, the government would like there to be less beds than now, but the reduction has to be on the acute side, while the number of long-term beds should be increased by several thousand. Portugal is also in the process of introducing a new long-term care model, reported **Anabela Candeias** (General Directorate of Health, Portugal). This integrative model is attempting to merge the social and healthcare sectors. Most long-term care is to be provided through five service lines – convalescence units, medium-term and rehabilitation units, long-term and maintenance units, palliative care units and day centres or units for the promotion of functional independence. The new model allows for the development of new services and is aimed at offering responses adjusted to the needs of groups with different levels of dependency. This approach to elderly persons and others in a situation of dependency is from a global, integrated, multidisciplinary, equitable and community-based perspective.

Raymond Wagener wondered why nobody was talking about the definition of healthcare. This is a very broad term, and it is obvious that some parts of healthcare will not be financed through solidarity. Somebody has to decide which aspects should be left to private financing. Cosmetic surgery, for example, will no doubt be left mainly to private financing. Some aspects of healthcare have been traditionally financed by solidarity and it is very difficult to change that. The discussions about health spa cures in Germany and Luxembourg are a case in point. The issue of co-payments comes up in Luxembourg every two or three years. But it is not a good policy instrument, because it is difficult to isolate a single policy objective which could be achieved through co-payments. One of the arguments advanced in favour of co-payments in Luxembourg is that patients should be made aware of the cost of their treatment. However, for reasons of equity, co-payments have to be kept small. So the objective of signalling the real cost of healthcare is not achieved in this way. It would be achieved by giving information about the complete costs, but not through co-payments. As the co-payment charge has to be kept low, the objective of reducing use is not achieved either. In the case of hospitals, the argument that co-payment in some way pays for the meals that patients would otherwise have taken at home is also not valid. Farmers, for example, would suffer financially from having to make co-payments for a stay in an urban hospital. So would people who have to remain in hospital after an

operation. In Luxembourg, therefore, co-payment may be used as a means of raising some money, but not as an instrument of policy. One point that crops up regularly in Luxembourg's ongoing debate about healthcare is transparency and information. Not enough is known about what is happening on the provider side. Although the World Health Organisation has been promising procedure classifications for years now, these have never materialised, so international comparisons are difficult. Neither is there any European classification of procedures. As for competition, it is bad for the efficiency of healthcare systems. Healthcare is the only activity which does not fulfil a single one of the conditions for a perfect market. In Luxembourg's case, the problem is not how to foster competition but how to persuade hospitals to collaborate more closely, so as to avoid duplication and waste. He also felt that healthcare services should be more dispersed, rather than concentrating them in expensive hospitals. Another positive move, already discussed in Germany, might be to develop health insurance that promotes preventive care, rather than just curative care.

Ana Xavier suggested that the view emerging from the seminar was that, if we want to introduce co-payments, we have to be aware of their limitations in terms of achieving certain objectives and we have to design them in an appropriate manner, both in order to maintain equity and to raise revenue. A very interesting point had also been raised about the connection between long-term care and healthcare, and an approach to their integration had been suggested in the Portuguese contribution. As the point had been raised by the Czech Republic, she wondered if there were any Czech ideas as to how sorting out long-term care could help to solve some of the healthcare problems raised during the seminar. This is a burning issue in the Czech Republic, **Iva Holmerová** replied, but she was afraid that the Czechs do not have any very clear ideas about it. Czech politicians do not like to talk about it, so it has not been raised as a political problem, even though it is a problem in practice for many families. However, there is now a new law on social care, which establishes a duty to provide healthcare in social institutions as well. This is a first step towards combining healthcare with social care. The Czech society of gerontologists and geriatricians has strongly requested the Ministry of Health to help resolve this problem.

Ana Xavier asked **Raymond Wagener** for more details on his suggestion that hospitals should collaborate in order to avoid duplication. He replied that there is a need for more exchange of information between hospitals and between doctors. For example, Luxembourg is going to make laboratory analyses directly available to doctors. The doctors have asked for this, and it entails cooperation between the Ministry of Social Security, the health insurance and the doctors. Collaboration between hospitals could involve exchanging laboratory results or making infrastructure available for use by other hospitals. But this does entail striking the right balance between competition and the need to work together, and that is not easy. **Péter Gaál** agreed that there is a lot of room for cooperation and the potential for the elimination of unnecessary or parallel services should be used.

Health reform is continually under way in every country, said **Damijan Jagodic** (Ministry of Health, Slovenia). But in Slovenia, it has not produced big changes. People are basically satisfied with the healthcare system. His section in the health ministry has as its first goal to find health solutions for vulnerable groups, including refugees, homeless people, disabled people and drug users. The first step taken to promote healthcare access for vulnerable groups was to send a questionnaire to all the non-governmental organisations involved with them, asking for their suggestions. These were

compiled into a 200-page book. A second publication, in 2006, was a translation of European recommendations for healthcare employees on working with vulnerable groups. A third book, which will be published in English during 2007, will reproduce the views and recommendations of doctors, at all levels of healthcare in Slovenia, who work with vulnerable groups. This book will be sent to all the peer review participants. He added that many of the points made by Dearbhal Murphy had sounded familiar. **Dearbhal Murphy** agreed with Juha Teperi that it is not enough simply to improve the system. Specific, targeted outreach is needed in order to reach the most vulnerable. The Slovenian experience showed that the NGO sector, which works with these vulnerable groups, has the expertise and contacts to be a partner in that process. Regarding competition in healthcare, while this can be positive, vulnerable consumers such as the homeless are at risk from a market logic, so any competition has to be introduced very carefully. Another point which she saw emerging from the seminar was the need for a multidisciplinary approach and closer cooperation across the sectors. She had attended the previous peer review in this series, held in Sweden in December 2006. It had looked at Swedish pilot projects in which social services and health services are located in the same premises and work together to improve health outcomes, but also employment and social outcomes, for the people they come into contact with. Tackling health inequalities involves looking at the larger picture, so she felt that the Swedish approach to joining up services was a useful one. Health has to be a focus right across social inclusion policies and structural policies in general.

Péter Gaál wondered what the seminar participants, on the basis of their own experiences, would tell the Prime Minister of Hungary if he asked them whether he should proceed with the plan to introduce competing health insurance funds. The Czech Republic has some experience of competing health insurance companies, **Iva Holmerová** replied. In the early 1990s, a number of market-based companies were allowed into the general health insurance system. There was one non-profit insurance fund, and all the others were private. Nine of those companies are still operating, but the Czech government soon decided that it had to regulate the companies' behaviour by introducing a law which defines very strictly the insurance package which has to be offered. So, in her view, the result has been 10-20% administration costs and 1-2% competition. **Zsombor Kovacsy** felt that a distinction should be made between the consequences of the multiple insurance system itself and the functioning of the market in several countries. He thought that the Czechs had, perhaps, managed to combine the disadvantages of a state system with the disadvantages of the multiple insurance model. **Iva Holmerová** wished him greater success in his attempt to introduce competition into the health insurance market. **Sibylle Reichert** said the introduction of a competitive system is a very difficult question because it entails deciding what the companies should compete on. Should they compete on benefits, or on the contributions that people have to pay? It is also possible, as in Germany, to have insurance funds which compete but which are non-profit. Another important issue is how to maintain the principle of solidarity, so that there is no risk selection by the companies. **Cristina Masseria** asked about the risk of creating a cartel. This had happened in the Italian complementary health insurance sector, where there was no real competition. **Zsombor Kovacsy** replied that, if a multiple system is introduced in Hungary, a sectoral competition authority will be put in place which will have the responsibility of preventing such situations. **Ana Xavier** asked if the competition would be on the basic insurance package, or only on complementary insurance as in Italy. **Zsombor Kovacsy** replied that the Hungarian plan envisages a uniform basic benefit package, which would not be subject to competition on price, whereas additional services might be. There would also be strong regulation against risk selection by the insurers. **Ana Xavier** suggested that the Hungarians

might wish to examine the Dutch experience, and **Raymond Wagener** added that the Belgian case would also be worth looking at. Belgium does not have competition on the basic package, but the health insurers there do compete on the supplementary packages. **Iva Holmerová** said that the starting point for the new Hungarian system is much better than that facing the Czechs many years ago, as the Czechs went through a complete change of systems. The Hungarians already have experience of capitation and DRGs, so they are better equipped to decide. **Zsombor Kovacsy** said the Hungarians are not necessarily wiser, but they do have more information.

Heli Paluste said that Estonia has been working on a number of specific strategies in recent years – for example, the strategies on HIV, heart disease and tuberculosis. Central government cooperates with local authorities on these strategies, in order to reach the groups concerned. This approach has produced some successes. **Charles Price** asked about Estonian research published in 2002 which looked at changes in health status and mortality by education group, both men and women. This showed quite marked improvements for those educated at university, but a significant widening of the gap between the university-educated and the lowest-educated. This is perhaps the most startling research to have been published concerning the influence of education on health status, and he wondered what influence it has had on health policy in Estonia. **Heli Paluste** replied that there are indeed big differences in health between different education groups in Estonia, but beyond that she did not feel qualified to comment.

Conclusions and closing remarks

Georg Fischer began by listing three points that he had learned from the day's discussions, in terms of the analysis of the issue.

The first is the importance of prevention. However, a somewhat contradictory message had then seemed to emerge that healthcare policy cannot actually do much about prevention, which is more a matter for other policy areas. While certainly not denying that other policies – on education, occupational health and safety, social issues and employment – should all act on prevention, he felt that everybody should think a bit more about how the 20% of GDP that EU countries spend on social protection could be used more efficiently to promote prevention.

The second is the “inverse care law”, which in essence says that the care is where it is needed less and the care capacities are not where they are needed mostly. This applies geographically, but also in terms of social groups and age groups. In particular, there needs to be more thought about how to ensure that children have access to healthcare, including prevention. Similarly, the needs of older people and long-term care had been emphasised. The needs of the disadvantaged had been well illustrated by the account of the health problems faced by homeless people. Some of the points made there could certainly also be applied to other disadvantaged groups. Geographical inequalities had been cited in several contributions. However, he wondered how much of this was due to geography as such, and how much was really a matter of social disadvantage. If there are few rich people in a region, it will probably do less well in terms of access to healthcare. Some the regions which seem to have less capacity happen to be border regions, and it may be that just across the border there are very good care capacities. Perhaps cross-border cooperation between neighbouring European

countries might be a solution. Is it really necessary to have two central hospitals, one on each side of a river, just because the river happens to be the border between two countries?

The third point to come out of the discussions is the resource issue. This leads into a multitude of discussions. Can the market help? What role might be played by co-payments and financial incentives? What could be the role of care coordination? Various other structural issues also emerged. Part of the resource story is the risk that powerful lobbies might impose their interests on the sector, but he felt that no very clear view had yet emerged on that. His impression was that it is very easy to find good arguments against co-payments and against making more use of the market, but he was not sure that this is as helpful as it sounds, because the resource issues are still there. Resources are not unlimited, whereas demand for healthcare probably is. And rightly so, because people want to live better and more healthily and to have the best possible care. One of the solutions to this is transparency. Everybody seemed to be in agreement on that. We need to have transparency about the impact that solutions have on problems, benefits and costs.

Regarding the extension of coverage, he had very much liked the concept of outreach programmes, to get to the people who do not use healthcare.

The package, and who decides the content of the package, is another important issue. The crucial importance of primary healthcare also emerged clearly from the debate. Have we really thought through the potential of technology? Have we really thought through the potential of cross-border provision? Where should the fine line be drawn between stakeholders and lobbies?

His overall conclusion was that it will always be the job of policy-makers to look at the three broad objectives, put them together, look at them in a comprehensive way and find a solution. Governments, notably national governments in the case of healthcare, will have to make the decisions on how they organise and finance services, and what kind of balance they are looking for. Dialogue is useful, and he would like to push the peer review work a bit more in the direction of the last discussion, where participants had got a bit closer to each other. Let us be a bit more "review". Let us try to get closer to the very complex issues on which decisions have to be made.

Zsombor Kovacsy did not think that there is a division in Europe between countries choosing one or other of the health insurance models – the national system or the multiple-insurer competitive system. With the strong involvement of equal access issues, where there is a multiple insurance system present, a strong will for cooperation and balancing the risk selection problems and other challenges presented by the nature of the system is feasible. On the other hand, where a national system exists, there is a need for some competition on the provider side and, on the purchaser side, opportunities have to exist to meet the different needs of the population for a healthcare package. In his view, therefore, the two systems will be getting closer to each other. As regards tackling the access issues efficiently, what he had learned is that the level of data collection is a big challenge in several countries. He agreed that geography is not the only criterion for structuring the system, and that other factors must be taken into account. Prevention and long-term care had been mentioned. These are both important parts of healthcare. Policies in all fields must take their health impact into account. One of the advantages of seminars of this kind is the ability to compare the results of different measures taken in several countries. But as he had mentioned in the discussion of the Czech

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example, it is important to distinguish the results that spring from the nature of a measure or system and those that derive from the methods by which it is applied in a given country. Only so can the real value of the various options be judged. On the future planning of such reviews, he agreed with Georg Fischer that the final debate was most valuable, while most of the presentations in the morning, including his own, had been more introductory in nature. His suggestion would be to hold a two-day seminar and devote a whole day to intensive debate. He thanked all the participants and hoped that they would all meet again.