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

Synthesis Report

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## Executive Summary

This was the first-ever Peer Review on healthcare issues held in Budapest (Hungary) in view of the Government plan to introduce new health care reforms that aim at reshaping the Hungarian health care system to enhance universal access, improve the access to high-quality services, and guarantee a long-run sustainability.

In addition to the host country, nine peer countries took part: Austria, Bulgaria, the Czech Republic, Estonia, Finland, France, Luxembourg, Portugal and Slovenia. Also participating were stakeholder representatives from the European Federation of National Organisations Working with the Homeless (FEANTSA) and the European Association of Paritarian Institutions of Social Protection (AEIP), together with representatives of the European Commission's DG Employment, Social Affairs and Equal Opportunity.

Therefore, the main objectives of the review were to achieve a better knowledge of health policies that can enhance both efficiency and equity; provide some useful feedbacks to the host country, Hungary; and identify 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.

Guaranteeing universal access to the population, reducing inequalities in health and access to health and maintaining sustainability are specific goals of public health or broader health policy in most EU countries. Health care systems are, in fact, a fundamental component of the social protection system, since without it the costs of care may be catastrophic for the majority of the population in particular for people with chronic and infectious diseases. Through the open method of coordination, the EU Member States have agreed to look together at three objectives: universal access, high-quality service, and sustainability through the work of the Social Protection Committee. The Commission is also proposing that health inequalities should be highlighted in the EU's new Health Strategy.

Europe has seen improvements in both health status, and living and working conditions over the past few decades. However, there is still large heterogeneity in living conditions that translate into diversity in patterns of health across the region. Good health can be considered one of the most fundamental resources for social and economic prosperity. Changes in socioeconomic conditions affect population health directly and through psychosocial factors. People at the lower end of the social ladder are more likely to report ill health than those near the top, both within and across countries.

The health care system also plays a role in explaining differences in health status both within and across countries as showed by the avoidable mortality studies. Therefore, it seems that much can be done to reduce overall mortality rates by targeting the health system, since even Sweden, which has one of the healthiest populations in Europe, could cut mortality by a quarter by better treating disease. Effective treatments and preventive care also played a major role in reducing mortality rates for cardiovascular diseases and various cancers in various European countries.

Most importantly, if access to health care is not equitable across social groups, it can exacerbate existing health inequalities. There is evidence that although people in more vulnerable categories have more need for health care they do not receive the care they need. Inequity is present almost

everywhere and this is due to geographical, financial, and/or socio-cultural barriers. The burden of payment for health care is a growing concern for people socially and economically vulnerable; and there is clear evidence that “the availability of good medical care tends to vary inversely with the need for it in the population served” (Hart, 1971). Offering universal access to health care services does not eliminate inequalities, as shown by most industrialized countries that have removed financial barriers to access. Different population groups such as the poor, the elderly, immigrant either legal or illegal, disabled, ethnic minorities may have different need for health care and different expectancies. A health system should be designed to address the needs of all the population in an equitable, efficient and responsive way.

The health status of Hungarians is poor when compared with the average of the European Union. Life expectancy and healthy life expectancy are far behind EU average. The composition of the causes of deaths is similar to other developed countries, but the rate of these diseases is higher and death occurs at an earlier age. In 2003, cardiovascular diseases accounted for 51% of mortality, malignant tumours for 25%, and illness of the digestive system, injuries, poisoning and other causes for 7% of the total mortality rate.

The basis of the current Hungarian Health System dates back to the 1980s although various reforms during the 1990s have tried to reshape the system. At the moment, the Hungarian health system is undertaking structural and significant reforms with the aim of, not only, efficiently responding to the new health challenges, but also of resolving old problems (differences in health status across regions and socio-economic groups, resource allocation within the country, wastes, under the table payments, etc). Short- and long-term measures have been implemented in areas such as emergency care, the national infant and child health programme, the national cancer control programme, family practitioner services and specialised outpatient care, inequalities in access to health care, providing the funding needed to finance healthcare, the insurance market, and pharmaceutical market.

The current system is indeed under unsustainable pressure, since there is both an excess of demand and a lack of resources (approximately 12% of eligible Hungarians do not pay their healthcare contributions). Adopting a system of “compulsory solidarity”, the health insurance administration should be in a position to monitor contributions and service provisions by April 2007, so that it will become possible to provide only basic care to those who refuse to pay their contributions although eligible. The main interventions are: need of a referral to access higher level of care, reduction of acute inpatient capacities that when reasonable will be transferred into chronic, outpatient, nursing, or rehabilitation capabilities, long-term care integration, introduction of service provider competition for social insurance funds, introduction of a co-payment for doctor visits and diagnostic tests, establishment of a legal and financing framework for providers, the coordination of primary health care at the sub-regional level, re-organization of the pharmaceutical sector, strengthening the monitor system and improving IT system, introduction of treatment of financing protocols, establishment of a health insurance supervisory body.

Although there is wide heterogeneity in health care systems in Europe (as showed by the presentations of Austria, Estonia and France), the challenges are similar. Each country is, in fact, faced with the problem of identifying policies that guarantee a sustainable access to equitable and efficient health care services to everyone, and improve the health status of the overall population. Recent challenges such as population aging and the role of new technologies, have posed an increasing burden of health care expenditure. Many countries have, therefore, decided to introduce or

increase co-payments, co-insurance with the aim of decreasing unnecessary health care demand and to raise more revenues. Although in all countries there are mechanisms in place to protect the more vulnerable categories, surely cost-sharing and out of pocket payments as well as informal payments are a financial barrier to access health care and a major burden for the elderly and the poor. In fact, a WHO Europe Report (2005) emphasised that financial barriers were the most limiting factors to accessing appropriate health care in the CCEE and CIS and the since the early 1990s the situation has deteriorated (Walters & Suhrcke, 2005).

Intermediate objectives in achieving this overall objective are therefore:

- Implementation of policies that increase coverage in particular for disadvantaged groups and ethnic minorities
- Identification of the needs of different groups (the elderly, the children, minority groups, foreigners, etc.)
- Reduce geographical disparities, whether between regions, between urban and rural areas or between richer and poorer areas
- Reorganisation of services to strengthen prevention
- Reduction of waiting times
- Enhance the role of information, not only for the effectiveness of the various health services, but also with regards to the real price of health care
- Improve efficiency and reduce waste
- Enhance the role of health-technology assessment
- Implementation of multi-sectorial policies
- Improve data collection and therefore the monitoring of the various policies

Further discussion at the European level is therefore essential to develop health care systems able to respond to the changing environment and expectations of the various population groups in each country that guarantees equity, efficiency and sustainability.

## 1. Thematic context: What is the role of the health care system in improving health and reducing socio-economic inequalities?

In May 2004 ten countries joined the EU, and another two in 2007, bringing the number of Member States to 27. Although mortality has declined and life expectancy has increased everywhere, there is still a wide level of heterogeneity that can be explained by different living conditions such as absolute and relative income, education, employment, housing, and transport. Health status appears not randomly distributed, and systematic differences in health pattern emerge across different socio-economic groups within and among countries. These differences seem determined not as much by genetic characteristics but by the social-economic environment. Health equity implies the “absence of unfair and avoidable or remediable differences in health among population or groups defined socially, economically, demographically or geographically” (Macinko and Starfield 2002). The WHO Constitution, already in 1946, assessed that “the highest standard of health should be within reach of all, without distinction of race, religion, political belief, and economic or social condition”.

Looking at the social gradient in health, income, education and occupational status affect health, life expectancy, and mortality risk both directly, and indirectly, through psychosocial factors. People at the lower end of the social ladder are more likely to report ill health than those near the top, both at the individual and population level. A health gradient is present all along the social spectrum. Lifestyle choices such as diet, housing, job control, physical exercise, smoking, and alcohol consumption clearly have an effect on health that are also influenced by social factors (Mackenbach 2002).

### 1.1 Contribution of the health care system to health inequalities

The health care system also plays a role in explaining health inequalities. The contribution of health care to the population health has long been controversial. Several approaches have been developed in attempts to quantify the contribution of the health system to health improvement. The most widely used to date uses of readily available mortality data and makes assumptions about certain causes of death that should not occur in the presence of timely and effective medical intervention. This method has given rise to the development of numerous terms including “avoidable mortality” and “mortality amenable to health care” (Rutstein, Berenberg et al. 1976; Charlton, Hartley et al. 1983; Holland and Breeze 1985; Holland 1988; Mackenbach, Bouvier-Colle et al. 1990; Holland 1991; Westerling 1992; Holland 1993; Holland, Fitzgerald et al. 1994; Holland 1997; Nolte and McKee 2004).

By differentiating causes of death into conditions amenable or not to medical care, various researches (Carr-Hill 1987, Mackenbach 1988, 1996; McKee ) have shown that since the mid 1950s there has been a more rapid decline in amenable causes than in non-amenable causes. Mackenbach (1988) found that in the Netherlands between 1875 and 1970 the medical contribution to the decline in mortality ranged between 4.7% and 18.5%; and between 1950 and 1984 without the significant reduction in amenable causes of mortality, male life expectancy at birth would have actually fallen by almost a year due to increases in other causes of death (Mackenbach, 1996). There is also evidence that in Europe barriers to access adequate health care may contribute to the east-west gap in mortality and to social inequalities in mortality. Bojan et al. (1991) and Boys et al. (1991) show that

death rates from amenable causes were higher in the east than in the west; and Velkova et al (1997) estimated that amenable causes account for 24% of the east-west gap in male life expectancy and 39% of the gap in female life expectancy between birth and age 75. Improved access to timely and effective health care has a significant impact on health, in particular through reductions in infant mortality and in deaths among the middle aged and older people. Studies indicate that improvements in life expectancy can be attributed largely to improvements in mortality from amenable conditions, particularly during the 1980s (Nolte and McKee 2004). These improvements in most countries resulted from falling in both infant and the middle-aged mortality.

Avoidable mortality can be defined in various ways. A recent comprehensive study of in Europe used data extracted from the WHO mortality files for the period 1990-2002 (Newey, Nolte et al. 2003), to identify levels and trends in 'treatable' and 'preventable' mortality. Treatable mortality was highest in central and eastern European countries (particularly Romania, Bulgaria and Hungary) in both 1990/91 and 2000/02. Portugal is the only EU 15 country to display similarly high levels. Levels were lowest in France (women) and Sweden (men). For preventable mortality, death rates among men at least twice those of women there in all countries, with (Newey, Nolte et al. 2003). This gender gap in preventable mortality is most pronounced in the new Member States of central and Eastern Europe, which also show the highest absolute values, especially for Hungarian men. This gap reflects the much greater exposure to risks such as drinking and smoking among men.

## 1.2 Inequality in access to health care services

In light of increasing social inequalities in health in many European countries, there is growing interest in assessing the inequity in access to health care, since differences in access to health services across socioeconomic groups may exacerbate already wide health inequalities. As emphasized by the Open Method of Coordination, universal coverage of the population for a fairly comprehensive package of medical services is a fundamental policy goal within the EU. Governments are not only committed to pursuing the efficient delivery of high quality medical care, but also to ensuring equitable access to these services. This goal can be achieved only if access depends on population need and not on the ability to pay as expressed in many European policy documents and easily identifiable in the recent joint declaration of Belgium, Germany, Portugal, Spain, Sweden, and the United Kingdom; "*The fundamental values of equity, universality and solidarity underpin health systems throughout Europe. All our systems, although they vary greatly in how they are organised, managed, and financed, seek to provide equity of access to high quality, efficient and financially sustainable health care services to the entire population, based on need rather than ability to pay. All systems are based on solidarity – between ill and health, between poor and rich, between young and old and between who live in urban and rural areas*" (Judge et al. 2005).

### 1.2.1 Health care financing and delivery across Europe

In European countries the health care system is financed either through taxation or social health insurance and it covers the all population although there are some exceptions such as in Austria, Estonia, Germany, Greece, the Netherlands, Slovenia, and the Slovak Republic. This is due to either the organization of the provision of a universal system (e.g. Germany, the Netherlands, and Ireland where a large proportion of the population needs to purchase substitute VHI) or for the entitlement

criteria (residency or citizenship) or a failure to register with the relevant authority (e.g in Austria coverage for unemployed people is related with appearance to a job centre).

The amount of public health expenditure as percentage of total health expenditure varies from 36.6% in Cyprus and around 50% in Greece to 100% in Romania and Bulgaria (the role of informal payments is not taken into account) and no systematic differences across Europe were identified. In recent years due to an increasing burden of health care expenditure many countries have introduced or increased co-payments, co-insurance with the aim of decreasing unnecessary health care demand (Thomson and Mossialos, 2004). User-charges are particularly common for pharmaceuticals but also for secondary and sometimes primary care. The rationale for introducing user-charges is two-fold:

- Reduce excessive use of health care services and therefore increase efficiency and contain the increase in health care expenditure
- Raise revenues

According to the neoclassical economics theory, the demand of health care services exceeds its Pareto efficient level whenever the costs are fully covered by the insurance (moral hazard concept). This happens because patients are unaware of the real costs of the health care services they consume and therefore they demand more than needed. With the introduction of a price signal (user-charges) the consumers will reduce the demand of unnecessary services which provide little benefits to the patients or may even be harmful enhancing micro (more effective care) and macro (cost-containment) efficiency.

However, the health care market violates almost all the principle of a perfect market (perfect information; large number of small producers and consumers so that the formers are price taker; goods and services are perfect substitutes; any firm may enter or exit the market as it wishes; and consumers aim at maximizing utility; while producer aim at maximizing profits). Therefore, it is possible that micro and macro efficiency cannot be achieved with the introduction of cost-sharing in the health care market. The majority of the evidence of cost-sharing is coming from the USA, where a large randomized controlled study has been run (RAND experiment), while few studies have been done in Europe and are mainly observational.

In Belgium households spend on average 8% of their budget on health care, but the oldest and the poorest spends approximately 15% against a 4% for the richest households. Moreover the same survey showed that while on average 29% of interviewers reported difficulties in bearing the financial burden of out-of pocket payments for health care; this percentage increased to 68% among households in the lowest income group compared to 7% in the highest income group (Loucky et al. 2001). The burden of payment for health care is a growing concern for people socially and economic vulnerable; and there is clear evidence that “the availability of good medical care tends to vary inversely with the need for it in the population served” (Hart, 1971).

In France, towards the end of 1990s 15% of the population faced substantial financial barriers to accessing health care (Couffinhal and Paris, 2003). With the introduction of compulsory health insurance for those on low income (CMU) in 2000 the situation has improved, although in 2003 still 11% of the population reported to have forgone health care because of the costs (Auvray, Doussin and Le Fur, 2003).

In Poland, various surveys showed that 40% of the population had to pay out-of-pockets for health

care in 2003 (Czapinski and Panek, 2004) and that the amount of out-of-pocket payments rose to 0.9% for inpatient care and 70% for pharmaceuticals, but fell for dental care. And although there were fluctuations between 2000 and 2003 out-of-pocket payments were perceived as a barrier to access health care for more than a quarter of the population and approximately 60% of households not having enough money to pay for the prescribed drugs decided not to buy them.

A quarter of a million Swedish faced difficulties in purchasing drugs (Whitehead & Dahigren, 2006) and indeed 60% of people with economic problems did not buy the prescribed medicines. Moreover, approximately 28% of individuals in poor socioeconomic circumstances did not seek medical care although they need to in comparison with 10% of those with a stable economic situation.

Germany in 2004 has introduced a 10 euros fee for the first contact with an ambulatory doctor or with a dentist. Recent results show that this has led to a reduction in the number of doctor visits, but there is still no evidence regarding the proportion of unnecessary to necessary visits reduction and the effect on people with lower socioeconomic circumstances (Grabka, Schreyogg, and Busse, 2005; Zok, 2005). However, FEANTSA (2006) has reviewed the effect of this reform on the homeless (who since 2004 have to pay the medical consultation fee of 10.00 euros per quarter, and a co-payment to medicaments, remedies and therapeutic appliances), showing that more than half Wohnungslosenhilfe facilities state that the health status of homeless people has deteriorated since the introduction of the reform. Moreover, 82% of the facilities reported an increased need for consulting and support activities, and 62% of them had supported their clients financially (through donations) to allow them to get necessary medical treatments although this may not be sustainable in the long-term.

Moreover, evidence in the Netherlands showed that revenue raises due to the introduction of user-charges was not enough to compensate the increase in administrative costs, and the policy was abandoned (Kasje et al. 2002). In Finland although there are co-payments for public healthcare (€11 for a GP visit), some big cities decided not to make the charge because the administrative costs would have been too high<sup>1</sup>.

A Report from WHO Europe in 2005 emphasised that financial barriers were the most limiting factors to accessing appropriate health care in the CCEE and CIS and that since the early 1990s the situation has deteriorated (Walters & Suhrcke, 2005).

Although in all countries there are mechanisms in place to protect the more vulnerable categories, surely cost-sharing and out-of-pocket payments as well as informal payments are a financial barrier to access health care and a major burden for the elderly and the poor. *"If the assessment shows that out-of-pocket payments to be low, it does not necessarily indicate that all is well. The low burden could be because poorer groups cannot use the service at all, because of the cost."* (Whitehead & Dahigren, 2006: 68) Moreover, although they reduce the demand of health care it is less clear if they are efficient and equitable. The RAND Health Insurance experiment showed not only that the introduction of cost-sharing reduced inappropriate services but also appropriate service; but they also increased the demand of emergency services for people in lower socioeconomic groups. Moreover, as shown by a Dutch experiment cost-sharing is not effective if applied to secondary care under a gatekeeper regime, since patients often do not have control over follow-up treatments and they may cost more than they generate (Louckx, 2002).

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<sup>1</sup> Mervi Kattelus, Ministry of Social Affairs and Health, Finland.

### 1.2.2. Geographical barriers

Availability of health care resources is a prerequisite for achieving equal access across the population. There is no clear pattern between western and CEE countries in the number of hospitals and hospital beds per 100,000 inhabitants. The number of hospitals per 100,000 ranges from 0.9 in Sweden to 16.7 in Cyprus, and the number of beds from 255 in Turkey to 892 in Germany (Eurostat data, 2006). The number of hospitals and hospital beds are larger among the new Member States than in the EU-15, consistent with the literature indicating an oversupply of health care resources in this region.

The probability of being admitted to hospital varies across OECD countries and for the European ones it ranges from 5% in Greece to 14% in Austria (Van Doorslaer et al. 2004). Distributional patterns are different for the number of nights spent in hospitals; among the European countries those with the lowest average numbers of nights spent in hospitals are Portugal (0.63) and Greece (0.66), while those with the largest are Hungary (2.5) and Austria (2.01).

There are important differences between countries in rates of doctor visits (Van Doorslaer et al. 2004). On average, more than 70% of the adult population visited a doctor in the last year; this proportion is lower in Greece (63%) among the EU countries. Much larger variation is found for the percentage of people visiting a specialist. This ranges from 20% in Ireland or 30% in Denmark and Norway, to 60% in Austria and France. In high-use countries like Germany, Hungary, France, Belgium and Austria the frequency of visits is around 7-8 doctors' visits per year, which is twice the rate in low-use countries like Finland, Switzerland, or Denmark. These cross-country differences in utilisation rates are not correlated with doctor/population ratios. However, differences in remuneration types and cultural differences in seeking medical advice might partly contribute to these differences.

In addition to limited supply of health care resources, geographical distance to hospital might be a barrier in fulfilling the goal of universal access to health care. In the EU-15 more than 50% of citizens live close to hospitals (the distance can be covered in less than 20 minutes either by car, public transport or foot). The proportion lowers somewhat for the new Member States, where 38% of citizens have easy access to hospitals (Alber and Kohler 2004). Citizens of the EU-15 are more likely to reach hospitals by using either their cars or public transport, whereas in the new Member States and three candidate countries it is more common to bridge distances by foot.

Easy access to primary care is secured for 85% of the EU-15 citizens but only for 62% of the citizens in new Member States and Candidate Countries. In the EU-15 only in Portugal and Spain more than 30% of the respondents reported to travel more than 20 minutes to reach a primary care facility. In the new Member States and three Candidate Countries the countries with a smaller percentage of citizens that report easy access (< 40%) are Estonia, Turkey, Lithuania and Latvia (Alber and Kohler 2004).

To achieve equal access to health care, proximity to hospital or primary care should not depend on individual socioeconomic characteristics such as income and economic activity. However, in some EU-15 and almost all new Member States and three Candidate Countries people with higher income report easier access to hospitals (Alber and Kohler 2004). The accessibility gap in the EU-15 between the highest and lowest income quartile is higher than 20% in Belgium, France, Italy, Portugal and the UK; in the new Member States only Czech Republic, Slovenia, Estonia, Lithuania,

and Latvia the difference is less than 20%, but in Hungary and Slovakia is even larger than 30%. Unemployed and retired people have on average greater difficulty in reaching hospitals than the employed in all European countries, but the difference is more marked in the new Member States and the three candidate countries (Alber and Kohler 2004).

For proximity to general practitioners the level of income-related inequalities is lower in all countries. The average difference between the lowest and highest income quartile is 2.7% in the EU-15, and 11.9% in the new Member States; but large heterogeneity is observed across the EU-15 countries (Mossialos et al, 2005). Individuals with lower income have significantly easier access in Austria (17.9% difference favouring lower income groups), but the reverse is true in Greece (14.9), Finland (14.4), Belgium (13.4%), and the UK (12.3). In the new Member States and the three Candidate Countries, people with higher income live closer to a doctor, in particular in Cyprus (21.2%), Hungary (15.5%), Slovakia (14.6%), and Poland (12.9%). Unemployment does not seem to be related to greater difficulties in reaching a general practitioner (GP), but working people have on average easier access to a doctor than the retired in almost all European countries. The gap tends to be larger among the new Member States but differences are significant almost everywhere (Alber and Kohler 2004).

### *1.2.3. Inequity in access to health care –results from the OECD study*

European countries finance the majority of their health services from public sources and embrace the equity principle that health care should be allocated according to need, and not on the basis of willingness or ability to pay for the services. Yet, notable differences in the characteristics of each health care system are observed. The increasing tension between affordability and equity has encouraged many countries to re-examine their public-private mix and implement reforms that aim at improving efficiency while maintaining equity.

Socioeconomic inequalities in health care use have been detected in Estonia in 1999 (Habicht and Kunst 2005). Individuals living in rural areas were more likely to visit a GP or to use telephone consultations but less likely to seek specialist care. Women used all health services, except hospital care, more intensively than men. Education, income and economic activity were important determinants of health use even after controlling for health needs. People with a more favourable socioeconomic status were more likely to use all services but hospitals.

The OECD Health Equity study (Van Doorslaer et al. 2004) shows that without standardising for needs, in virtually every OECD country<sup>2</sup>, low-income groups are more intensive users of doctor services than higher income groups. However, by disentangling the doctor visits in GP and specialist care, it emerges that the probability of contacting a GP is, on the whole, fairly equitably distributed by income, with a few pro-rich (Finland, and Portugal) and pro-poor exceptions (i.e. Greece, Spain and Germany where there is no gate-keeping systems). The pattern is very different for specialist visits. In

<sup>2</sup> The study presents estimates of inequality and inequity distributions for total doctor visits and separately for general practitioner and medical specialist visits, inpatient care and dentist visits in 21 OECD countries: Australia, Austria, Belgium, Canada, Denmark, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Mexico, the Netherlands, Norway, Portugal, Sweden, Spain, Switzerland, the UK and the USA.

all countries, the better-off have a significant higher probability of visiting a specialist, although with important differences between countries in the degree to which this occurs. On the contrary, people at the bottom end of the income distribution are more likely to be admitted to hospitals in almost all OECD countries and to spend more nights in hospitals, but the picture is more heterogeneous after standardizing for population's needs.

However, after standardizing for population's needs the probability of doctor visits is higher among richer groups for half of the countries with the exceptions of Austria, Belgium, Denmark, France, Germany, Greece, Hungary, Ireland, Spain, and the UK (Van Doorslaer et al, 2004). The level of income-related inequity in total number of doctor visits seems to be less pro-rich than when the probability of a doctor visit is measured.

Regarding GP care, the need-standardized distributions are significantly pro-poor in ten countries, and pro-rich in Finland. Therefore, in almost every OECD country, the probability of seeing a GP is fairly equally distributed across income, but once people go, the poor are more likely to consult more often.

On the contrary, in all countries, after controlling for need, the rich are more likely to seek specialist care than the poor, and especially so, in countries that offer options to seek private care like Finland, Portugal, Ireland, Italy and Spain. However, pro-rich inequity in specialist visits was observed also in countries without such private options, and with GP gatekeepers, like Denmark, Norway, Sweden, and to much less extent also in the Netherlands and the UK. The level of pro-rich inequity is even higher when the total number of specialist visits is measured, since the conditional use reinforces the pro-rich patterns induced by the inequitable probability distribution. In virtually all countries, distributions are significantly in favour of the higher income groups, with the only exceptions of Norway, the Netherlands and the UK.

For the majority of countries it was not detected any inequity both in the probability and the total number of nights spent in hospitals. Significant inequality was found only for the countries with large sample sizes. Individuals with higher income were more likely to be admitted to hospitals in Mexico and Portugal. On the contrary, pro-poor inequity was found in Australia, Canada, Switzerland and the USA (Van Doorslaer et al. 2004). The difficulty in measuring inequity in hospital care may be due to the skewed distributions of hospitals care (i.e. many people did not go to hospitals) and the difficulty of explaining length of stay with the information available in these surveys.

### 1.3 The setting

Health care systems are a fundamental part of the social protection system, since without it the costs of care may be catastrophic for the majority of the population in particular for people with chronic and infectious diseases. Preventive and medical care are vital to guarantee that individuals can flourish as a human being. Through the open method of coordination, the EU Member States have agreed to look together at three objectives:

- universal access,
- high-quality service ,
- sustainability ,

through the work of the Social Protection Committee. The Commission is also proposing that health inequalities should be highlighted in the EU's new Health Strategy.

In some respects, these objectives are being achieved. All Member States provide systems which aim to give everyone access to healthcare, regardless of their social position. However, widespread inequalities across Europe both in access to healthcare and in health outcomes are evident almost everywhere. Ill-health is concentrated among 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. 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.

Moreover, all countries are faced with sustainability issues. The introduction of always new technologies and the population aging are posing increasing pressures on health care budget. User-charges and private insurance are often seen as the way forward to enhance cost-containment and reduce demand of unnecessary health care services. However, there is evidence that these instruments do not reach the targeted audience and affect more the poor than the rich.

The Hungarian Government is on the process of introducing new and ambitious reforms in the health care sector that may reshape the all health care system to enhance universal access, improve the access to high-quality services, and guarantee a long-run sustainability. This first Peer Review on health care hosted by Hungary had therefore three main objectives:

- Achieving a better knowledge about policies that can enhance both efficiency and equity
- Provide some useful feedbacks to the host country, Hungary
- Identify 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.

## 2. The Hungarian National Health Strategy

The health status of Hungarians is poor when compared with the average of the European Union. Life expectancy and healthy life expectancy are far behind EU average. In 2004, the gap in life expectancy at birth was 7 years for men and 5 years for women; and for the healthy life expectancy the gap was even larger. The composition of the causes of deaths is similar to other developed countries, but the rate of these diseases is higher and death occurs at an earlier age. In 2003, cardiovascular diseases accounted for 51% of mortality, malignant tumours for 25%, and illness of the digestive system, injuries, poisoning and other causes for 7% of the total mortality rate.

Cardiovascular disease (CVD) has been frequently highlighted as playing an important role in the rise and subsequent decline of adult mortality in new member states (Mesle' 2002; McKee & Shkolnikov 2001; Zatonski & Boye 1996), and the main contributor to differences in health indicators between east and west Europe (Powles et al. 2005). Lung cancer was the commonest cause of death after CVD in more than half the EU in 2002, making it an important public health challenge for Europe. Hungary has one of highest rates of cardiovascular diseases, cancers (especially lung cancer with a twice as high rate than the EU average), and disease of the digestive system in Europe. The leading

contributors of lung cancer are the number of cigarettes smoked per day, the degree of inhalation and the initial age of smoking (Tyczynski et al. 2002; Didkowska et al. 2005). The relative risk of developing lung cancer is 20-30 times higher for smokers than for non-smokers. Approximately 28,000 people die of smoking-related diseases every year (Hungarian report). The rate of alcohol consumption and obesity/overweight are also very high, and drug addiction in the adolescent is becoming a new challenge, together with the aging of the population. Moreover, large heterogeneity in both morbidity and mortality indicators are present also inside the country with significant differences across regions and between rural and urban areas.

The basis of the current Hungarian Health System dates back to the 1980s although various reforms during the 1990s have tried to reshape the system. Nowadays, purchasers and providers are separated and the system is mainly a social health insurance scheme funded from employer and employee, although a two-component hypothecated health care tax coexists. The National Health Insurance Fund Administration (NHIFA) is the only purchaser and it contracts with health care providers and reimburses them according to various payment methods (capitation for family doctors services, fee-for-service points for outpatient specialist care services, DRGs for acute and patient days for chronic inpatient care). Most medical doctors and other health workers are salaried public employees, among the lowest paid professionals in the Hungarian economy. The system is highly decentralized, local governments are responsible for the provision of health care for the local population, and they can contract out the service delivery to private providers.

Hungarian health system is at this moment undertaking important, structural, and significant reforms. The aim of these reforms is not only to efficiently respond to the new health challenges (e.g. aging population) and to keep up with new medical technology, but also to resolve old problems such as differences in health status and resource allocation within the country, wastes, under the table payments, etc. The first reforms started in August 2005, under the previous government, and the first "21 steps" were implemented later that year aiming at introducing short- and long-term measures in the following areas:

- Emergency care
- The national infant and child health programme
- The national cancer control programme
- Family practitioner services and specialised outpatient care
- Inequalities in access to health care
- Providing the funding needed to finance healthcare
- Strengthening the principle of insurance
- Pharmaceutical market.

The new administration (June 2006) is continuing on these lines and even moving forward, with the aim of creating a much more efficient and equitable system that guarantees high quality and cost-effective preventive and curative care to all without unofficial payments. More emphasis will be on the principle of insurance and on the role of individuals.

The current system is indeed under unsustainable pressure, since there is an excess of demand on one side and a lack of resources on the other (the employment rate is low when compared to other

countries, and many people are entitled to disability benefits because of their serious health problems). It is estimated that about 12% of eligible Hungarians do not pay their healthcare contributions. Adopting a system of “compulsory solidarity”, the health insurance administration should be in a position to monitor contributions and service provisions by April 2007, so that it will become possible to provide only basic care to those who refuse to pay their contributions although eligible. Moreover, with the aim of reducing unnecessary demand for health care a small co-payment was introduced in February 2007. The main interventions are:

- Need of a referral to access higher level of care
- Reduction of acute inpatient capacities that when reasonable will be transferred into chronic, outpatient, nursing, or rehabilitation capabilities.
- Long-term care integration. At present, long-term care provision is divided between the health and social departments. This means that while some functions overlap, others are not covered.
- Introduction of service provider competition for social insurance funds. Under the new system the National Health Insurance Fund Administration will not buy unnecessary services.
- Introduction of a co-payment for doctor visits and diagnostic tests
- Establishment of a legal and financing framework for providers (e.g. hospitals) to allow transparent accounting (profit or loss statements). The providers may be profit-oriented and new employment schemes will be introduced to allow more flexible wages.
- The coordination of primary health care can be done at the sub-regional level
- Re-organization of the pharmaceutical sector (drug reimbursing scheme, prescription habit, pricing reimbursement, and co-payment)
- Strengthening the monitor system, expanding invoicing and improving IT system.
- Introduction of treatment of financing protocols (technology assessment) with the aim of rationalise the provision and the use of services
- Establishment of a health insurance supervisory body

Geographical differences are enormous not only in health status but also in service provision. To reduce such inequalities the new reforms will guarantee 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.

Adjustments to hospital bed capacity are necessary. Hungary currently has the longest length of stay of hospital in Europe and has a capacity of 80,000 beds, of which 60,000 are for acute care. The aim of the intervention is to reduce the number of acute beds to 40,000, but to increase the number of long-term care beds. At present the responsibility of care and organization of long term care is delegated to local governments with clear differences across regions and no consideration of population needs. The new reform aims at reducing geographical inequalities in access, guaranteeing a standard basic quality of care, and ensuring financial sustainability.

An important item on the Hungarian health policy agenda is to decide the future model for health insurance. This decision will be made during the spring of 2007. One option is the multiple insurance system. Currently, the social insurance system is based on a uniform national risk pool and health care is mainly financed by employees' and employers' contributions. However, because of the aging of the population and the high rate of invalidity and unemployment, only one third of the population is eligible for paying the contribution (and approximately 12% of these are not paying as mentioned previously). This clearly creates enormous pressures of the health care budget. To overcome such burden, the new administration will introduce co-payments to disincentive the demand of unnecessary services (40% of the population will be excluded by the payment of co-payments, and there will be a ceiling of 20 visits. When 20 visits are reached a reimbursement system will come into play), but is also thinking of changing the health insurance model. The National Health Insurance Fund Administration will not be forced to buy unnecessary and inefficient services and in particular can choose among the various providers based on quality. Other health insurance schemes will be allowed to enter the market and to compete among themselves. Competition among providers already exists, although limited. Indeed, local government has a mandate to provide care and to buy services from the local providers.

## 2.1 Production efficiency: health insurance competition versus care coordination program

The Health Care System aims at achieving both equity and efficiency although a conflict between efficiency and equity criteria is plausible. An efficient distribution may not be equitable and vice versa. Differences between libertarian and egalitarian viewpoints on equity are direct consequences of the equity-efficiency trade-off. The libertarian viewpoint is oriented to a "private" system, and the level of access depends on one's willingness and ability to pay. On the contrary, according to the egalitarian view a publicly financed system should offer equal opportunity of access for those in equal need, independent of ability to pay (Williams 1993). In European countries a mixture of systems provides health care, but the egalitarian viewpoint seems to predominate. Equity is an important policy objective in the policy agenda of European countries. Indeed, both the access and the receipt of health care depend on needs and not on the ability to pay almost everywhere. However in recent years, governments have introduced various cost-containment policies that enhance efficiency more than equity due to the increasing pressures on health care budgets. As far as production efficiency is obtained without damaging the health of the worst-off and reducing their capacity to pay, and as far as free up resources are used for reducing inequalities in access to care, no trade off exist between equity and efficiency criteria.

Production efficiency requires that the production of one good is achieved at the lowest cost possible, given the production of the other goods (economy works on its production possibility frontier). Therefore, to achieve production efficiency waste of resources should be eliminated, and unnecessary resources should not be used in the long-run. Indeed, in the short-run a suboptimal use of resources may be needed to enable the organization to promptly cope with internal operational problems, external changes such as variations in demand, and capital investments. To avoid discussing these issues, in the following part of the analysis we will focus only on "pure waste": the use of ineffective or dominated technologies, the provision of unnecessary services, and the provision of the same service at higher cost. 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. For example evidence on the new payment methods, introduced in the 1990s, shows that the capitation system for primary care creates incentive to maintain a high rate of referral to specialists. Looking at the impact of DRGs on production efficiency in the hospital sector, it may be seen that admissions' rate increased between 1989 and 2000, but NHIFA payment per DRG cost decreased greatly between 1994 and 2000. Moreover, there is also 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.

One proof of production inefficiencies is the huge variation between different regions of Hungary in the use of tonsillectomies (the standardised procedure ratio varies between 41% and 130%), 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.

As mentioned previously the Ministry of Health's aims at enhancing production efficiency by introducing competing health insurance funds into the Hungarian healthcare system. In a free competition insurance funds will have an incentive at enhancing the level of efficiency of the contracted providers and reducing pure waste. However, the success of insurance companies will also depend on whether the insurance premium covers all costs inclusive of administration costs. In a system which is based on solidarity and universal coverage of the all population, risk selection is not acceptable and regulation is necessary to guarantee citizens. Moreover, incentives and regulations need to put in place to guarantee that the implementation of a competitive insurance funds scheme does not conflict with the objective of delivering high quality and cost-effective preventive and curative care. Hungarian health policy in the future years will concentrate more on oncological diseases, heart and vascular diseases and the nursing and long-term care needs of a rapidly ageing population. Prevention and the management of chronic diseases are indeed two key areas of for improving the health of the population and reducing the gap with other European countries. However, chronic diseases are not insurable, therefore can not be managed on a pure health insurance basis, while prevention in a competitive environment is not in the interest of the insurers, since it requires upfront investment, which pays off in the distant future, and these investments are wasted should the insured decide to switch insurer. A basic healthcare insurance package should be provided for all citizens, together with supplementary packages.

An effective tool to prevent risk selection is risk adjustment. However, the more sophisticated the risk adjustment formula, the more expensive it is to administer. Not just the administrative systems are multiplied, but the more intensive the competition is, the more expensive its administrative costs are. When insurers operate in the whole territory, they have to contract with several providers scattered around the country. Furthermore, providers may have separate contracts with each insurer, since patients may enrol in different companies in each geographical region. According to the Chilean experience administrative costs may be as high as 10-20% of the budget (currently they are 1.5% of the NHIFA). Therefore, 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.

Although the details of the health insurance competition model that the Government plan to implement are still unclear, there is a wide debate in the country regarding its feasibility. Peter Gaal proposes a different scheme to reduce production inefficiency: the Hungarian care coordination pilot initiated in 1998. This resembles the managed care in the US and the fundholding experiment in the UK; but with significant differences. Indeed, the care coordination organization (CCO) assumes responsibility only for the care coordination function and leaves revenue collection, pooling, budget setting, financial resource allocation, contracting and purchasing with the NHIFA, where the administrative costs of these activities are the lowest.

The main elements of the Hungarian care coordination pilot are:

- The CCO can only be a health service provider (group of primary care doctors or polyclinic or hospital).
- For an adjusted capitation payment it assumes responsibility for virtually the whole spectrum of services (from primary to tertiary care) of a population signed up for primary care in a geographic area of concern.
- The budget calculated on the basis of the capitation payment is not transferred to the bank account of the CCO. The CCO is only a “virtual fundholder”.
- The CCO provides care and can collaborate with other providers to optimize the treatment of their patients.
- All health care providers are paid for on a monthly basis for the services they provide according to nationally uniform payment techniques (capitation in primary care, fee-for service in outpatient specialist care and DRGs in acute inpatient care). Payments are made by the NHIFA to all providers, who provided services for the CCOs’ population.
- Payment data are available for each individual patient, because health care providers are obliged to report their activities to the NHIFA using a social insurance identification number unique to each patient.
- The balance is calculated at the end of each year; savings are transferred to the CCO and can be used for remuneration and investment purposes.

For example, if the CCO is a group of primary care doctors, patients on their practice lists become their CCO population. Polyclinics and hospitals are obliged to contract with local GPs to have people to care for, but GPs can refuse to take part in the experiment.

The success of the care coordination activity depends on the involvement of and cooperation with other health care providers. CCO can coordinate care and influence other providers through financial incentives: savings can be shared with cooperating providers. Moreover, the CCO can analyze utilization data, which are provided by the NHIFA on the basis of the social insurance identification number of patients.

So, the Hungarian pilot does not change the ownership structure of the system, it does not reduce patient choice, and it does not change the payment systems for providers, but it manages the patient pathways in the delivery system, and focuses on gate keeping.

### 3. Other countries' experience: Austria, Estonia and France

#### 3.1 National Health Strategy in Austria

The Austrian health care system has a federalist structure that follows the structure of the country. In Austria the healthcare is 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 governments and states (*Länder*). The outpatient, rehabilitation sectors, and the field of medicines, are organized by negotiations between the 21 health insurance funds and the Federation of Austrian Social Insurance Institutions and also between the chambers of physicians and pharmacists and the statutory professional associations of midwives or other health professions. Although various health care sectors have traditionally been regulated and financed differently, in recent years there have been increased efforts to introduce decision-making and financing flows which are effective across all sectors. The main principles of the Austrian healthcare system are:

- Equal access for all.
- Solidarity through compulsory health insurance.
- Public provision of healthcare.

In 2004, Austria spent around €25 billion on health care, 10.2% of its gross domestic product. Since Austria has adopted the health accounting system developed by the OECD, the published health expenditure figures increased, placing Austria in the upper middle range of EU Member States, alongside Germany, France and the Netherlands. The Austrian system is very hospital-centred, with approximately 50% of all the funds allocated to the hospital sector, while outpatient care represents 21% of total public expenditure, medical advices 17% and long-term care 11%.

The financing of the health care system is pluralistic in accordance with the constitution and social insurance laws. The social health insurance system is the most important source of financing, providing approximately 50% of total health care expenditure. The insurance is mandatory and based on membership of an occupational group or place of residence; thus there is no competition between health insurance funds. Moreover, it covers all services linked to the treatment of an illness, therefore benefit claims are independent of the contribution paid. During the last reform, in 2005, health insurance contributions were increased. Although the present government programme foresees a further rise of 1.5%, the financial situation of the social health insurance will remain tight.

The remaining 50% of health expenditure is equally split between on one side the federal government, the *Länder* and local authorities through taxation and long-term care cash benefits, and the other privately expenditure. In 2004 indirect cost-sharing (services whose costs were fully borne

by the insured) covered 13.5% of total health care expenditure, direct cost sharing (co-payments) covered 7.6%, and private insurance premiums approximately 2.4%. More than half of indirect cost sharing was bore for acceding to hospital care, followed by dental care. Direct cost sharing affects almost all services provided by social health insurance and has increased in recent years. However, people in need of social protection and the chronically ill are exempted from the prescription fee, and guidelines are issued for exemptions in other service areas (approximately 12% of the Austrian population is exempted from direct cost-sharing).

The public health service is the responsibility of the *Länder*, which delegate most of the relevant tasks to district administrative or local authorities. In 2003, the ratio of beds to inhabitants of 6.0 beds per 1000 persons was clearly above the EU average of 4.2 per 1000 inhabitants. In addition, Austria had by far the highest admission rate: 28.4 per 100 inhabitants. The average length of stay in 2003 was shorter than that of the EU average (6.4 days compared to 6.9 days); the utilization of bed capacity at 76.2% was marginally below (77.5%). However, there are inequalities among the country's 32 health regions as regards coverage by GPs and specialists and the distance to hospitals.

A guiding principle of the Austrian system is that access to health care should depend on population needs and should not be influenced by factors such as age, gender, and socioeconomic conditions. Statutory health insurance covers 98% of the population, and some improvements have been achieved to reach the 2% still uncovered due to a failure to register with the relevant authority (coverage for unemployed people is related with appearance to a job centre). 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. Moreover, 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.

Life expectancy in Austria is above the EU average, and the picture presented also by other indicators for morbidity and mortality is generally favourable. However, inequalities exist within the Austrian population among age groups, between men and women and among regions, especially between Eastern and Western Austria. There is therefore a need for further policy measures to gradually reduce these disparities in health status. Less favourable socio-economic conditions in some parts of the East have produced an East-West divide in health status. Differences in obesity and incidence of diabetes are also identified across regions; in lower-income areas of the East, particularly among rural women, there is a higher incidence of diabetes. Promotion of performance quantity standards is in place to 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 services such as palliative and hospice care, neurorehabilitation and psychotherapy.

Health reforms have primarily dealt with cost containment and with structural reforms to improve the planning of capacities, the cooperation of stakeholders and the coordination of financing flows. They 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*. A further particular instrument is the National State Treaties, which are regular agreements between the federal and the regional levels, and have proved very valuable in getting all the stakeholders to agree on specific priorities. They usually run for four years, the current one is for 2005-2008.

Major long-term priorities in the current Austrian healthcare reform are

- healthcare structural planning;
- quality and interface management;
- eHealth and health telematics;
- DRG systems and documentation.

More horizontal topics are integrated care and long-term sustainability.

In 2005 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. Other health agencies, known as “platforms”, are also present at the level of the Länder. Their role is to 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 mainly directed towards acute hospital care, with a compulsory hospital plan in place since 1997. But in 2005, 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.

In Austria, healthcare reforms are an ongoing process, the basic idea being evolution rather than revolution. 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. A balance has to be found between federal, provincial and community interests. This is particularly important in a country with a federal background. Moreover, reforms

have to be tailored to each nation's needs, but international comparisons such as the present Peer Review are helpful.

### 3.2 National Health Strategy in Estonia

Estonia is the smallest of the Baltic states, with a population that since the early 1990s is gradually declining. 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 urbanization process is still under-way. Moreover, as in all other European countries, the population is ageing.

Since independence, the Estonian health system has undergone two major changes:

- from a centralized, state-controlled system has moved to a decentralized one;
- from a system funded by the state budget to one funded through social health insurance contributions.

The social health insurance system operated through the Central Sickness Fund and 22 regional sickness funds was introduced at the beginning of the 1990s. In 1994, responsibility for planning health services was partially decentralized to the county level through the 15 county governors and the county doctors. However, in recent years, The Government's reforms have aimed at re-centralizing some health system functions since certain functions were devolved to levels that proved unable to perform them efficiently. 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. 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.

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.

In 2001, the Estonia Health Insurance Found (EHIF) obtained its present status as a public independent legal body, replacing the Central Sickness Fund and 17 regional sickness funds. Its main role is as an active purchasing agency, and its responsibilities include:

- contracting health care providers
- paying for health services
- reimbursing pharmaceutical expenditure
- paying for some sick leave and maternity benefits.

At the end of 2003, the EHIF covered 94% of the population. Entitlement to EHIF coverage is based on residence in Estonia and membership in specific groups defined by law. For about half of these, contributions are paid by employers, the State or themselves. The other half are insured without contributing creating clear sustainability issues for the system.

Health care in Estonia is largely financed publicly. Public resources cover approximately 76% of total health expenditure in Estonia, with earmarked payroll taxes as the main source of health care finance. Out-of-pocket payments (not including private health insurance) account for 83.9% of private spending of health care. Co-payments are applied to reduce the use of services, and amount to €3 for a GP or specialist visit and €1.50 per day for the first 10 days of hospitalisation. There is evidence that 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.

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. 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);
- continuing the reforms, by ensuring better access to primary care and continuing the improvements in the hospitals;

Trends in health status have not been positive in Estonia. At the end of the 1930s, life expectancy in Estonia matched that of the Scandinavian countries, but the Second World War and the Soviet occupation led to a decrease and then stagnation in life expectancy. Although in recent years life expectancy has started rising again, it still lags behind the EU-15 average, particularly for men. Cardiovascular diseases are the main cause of death in Estonia, accounting for 45.6% of all causes

of death among men and 62.2% among women (2000). The next most important causes of death are cancer (10.5% for men and 17.1% for women) and death due to external causes (17.4% for men).

Infant mortality has fallen steadily in recent years. World Bank figures show a decline from 18.0 in 1990 to 10.0 in 2002. However, as in other transition countries, the birth rate has fallen dramatically, to 8.8 per 1000 population in 1998. Since 1998 it has again increased, but demographers do not expect it to reach population replacement levels. Dealing with the consequences of the outbreak of HIV/AIDS in 2001 has been a major public health and health system challenge in Estonia. The HIV/AIDS epidemic began among injecting drug users in the north-eastern part of the country, and by 2003 the total number of people diagnosed as HIV-positive was 3600, equal to 0.26% of the population.

The first comprehensive study of inequalities in health in Estonia was initiated by the World Bank in 2002. The Estonian Health Insurance Fund (EHIF) has also assessed regional differences in health service utilization. Both studies show large and increasing disparities in health behaviour and status among population groups (distinguished on the basis of income, education level, place of residence and ethnicity/language group). In line with findings from studies published in other countries, higher health status and health-enhancing behaviour were more common in groups with university-level education and greater income. During the 1990s, inequalities in mortality and health behaviour among socioeconomic groups and ethnic/language groups increased. For example, Russian speakers had higher rates of mortality from nearly all causes of death, particularly alcohol poisoning and homicide. The main exception was traffic accidents, which as a cause of death was higher among ethnic Estonians.

In many areas, the behaviour of the Estonian population has become more health-enhancing. The biggest changes in dietary habits include the replacement of vegetable fats for animal fats in food preparation and a general decrease in the consumption of fats. Whereas at the beginning of the 1990s only 28% of people used vegetable oil as the main fatty substance in food preparation, by

2000 this proportion had increased to 86%. The frequency of daily consumption of fresh fruit and vegetables has also increased since the beginning of the 1990s.

The prevalence of daily smoking among the population older than 15 increased from 28.2% in 1990 to 35.8% in 1994, but it has decreased steadily since, reaching 28.9% in 2002. This is similar to the EU-15 average but higher than the Scandinavian average (22.23%).

During the elaboration of the national health policy document in 2006, issues such as 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 were emphasised.

The sustainability of the healthcare system is a major current topic in Estonia. Negotiations are under way for 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.

### 3.3 National Health Strategy in France

The French health care system is characterized by health insurance funds under the supervision of the state, and a combination of public and private supply. Patients benefit from freedom of choice in access to health care, and direct access to the specialists and an abundant supply, particularly of self-employed doctors.

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 Universal coverage of the population (CMU) was set up in 2000, 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 specified 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.
- 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 population is younger than the overall population, the percentage of individuals under 20 years old is indeed 44% in the former against the

25% of the population as a whole. Women are also more present among CMU recipients than in the overall population. Geographical inequalities are also evident in the numbers of CMU recipients, being more concentrated in the most disadvantaged areas of France: Seine Saint Denis, Provence, Alpes, the Côte d'Azur and Antilles.

People benefiting from CMU are in worse health than others. Expenditure on ambulatory care is lower than for other insured people, but hospital expenditure is significantly higher. In 2002, a recipient of CMU spent on average € 2,133 EUR on health 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 de-socialisation 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.

The overall picture of the state of health in France is positive, as showed by indicators such as life expectancy and life expectancy without disability. In international comparisons, France performs well also with regard to cardiovascular diseases, and its relative position with respect to mortality due to

alcoholism, cirrhosis and cancer of the cervix is improving. However, France suffers from a high rate of premature male mortality due to smoking and accidents, and social and geographical inequalities in health are substantial. Mortality rates are higher in the northern part of France (from Brittany in the west to Alsace in the east), and in regions located between the north east to Auvergne and the centre of the country. Alcohol and tobacco use are related with socioeconomic status and are often higher in poorer regions affected by high rates of unemployment.

## 4. Conclusion and discussion

Guaranteeing universal access to the population, reducing inequalities in health and access to health and maintaining sustainability are specific goals of public health or broader health policy in most EU countries.

Europe has seen improvements in both health status, and living and working conditions over the past few decades. However, there is still large heterogeneity in living conditions that translate into diversity in patterns of health across the region. Good health can be considered one of the most fundamental resources for social and economic prosperity. Changes in socioeconomic conditions affect population health directly and through psychosocial factors. People at the lower end of the social ladder are more likely to report ill health than those near the top, both within and across countries.

The health care system also plays a role in explaining differences in health status both within and across countries as showed by the avoidable mortality studies. Therefore, it seems that much can be done to reduce overall mortality rates by targeting the health system, since even Sweden, which has one of the healthiest populations in Europe, could cut mortality by a quarter by better treating disease. Effective treatments and preventive care also played a major role in reducing mortality rates for cardiovascular diseases and various cancers in various European countries.

Most importantly, if access to health care is not equitable across social groups, it can exacerbate existing health inequalities. There is evidence that although people in more vulnerable categories have more need for health care they do not receive the care they need. Inequity is present almost everywhere and this is due to geographical, financial, and/or socio-cultural barriers. The burden of payment for health care is a growing concern for people socially and economic vulnerable; and there is clear evidence that “the availability of good medical care tends to vary inversely with the need for it in the population served” (Hart, 1971). Offering universal access to health care services does not eliminate inequalities, as shown by most industrialized countries that have removed financial barriers to access. Different population groups such as the poor, the elderly, immigrant either legal or illegal, disabled, ethnic minorities may have different need for health care and different expectancies. A health system should be designed to address the needs of all the population in an equitable, efficient and responsive way.

Although significant policy developments aimed at reducing health inequalities have been seen in some countries (e.g. England, Sweden and at local level in the Netherlands), to date there has been little evidence that they have been successful. This relative lack of evidence is due on the one hand to the long time lags from policy implementation and changes in population health, and on the other hand limited capacity for research and evaluation. Furthermore, in many countries, data collection and accuracy on health and health inequalities is limited, making developing policies difficult. In new

Members States and ACC, policies to tackle health inequalities are more limited than in the west, although actions to address poverty and social exclusion have been or are in the process of being developed and implemented. It is vital that countries move towards formal coordination across sectors if improvements in health inequalities are to be realized. A common limitation is the lack of evidence to support policy decisions and to evaluate effectiveness of programmes. Finally, it is important to note that there are several limitations with the surveys available for comparing data between European countries. Improvements are needed in: (1) scope; (2) comparability; (3) motivations of behaviours; and (4) accessibility.

Various policies and initiatives have been implemented across Europe to reduce the prevalence of tobacco use. Policies in Ireland, the UK, Norway, and Iceland appear to have been the most effective in reducing national smoking rates between 1985-2005, where prevalence declined by 20% to 25%; the least successful were Luxemburg, Romania, and Latvia. Ireland was in the forefront regarding the prohibition of smoking in public areas, followed by Norway, Malta, and Italy. While more research is needed to evaluate the effectiveness and cost-effectiveness of national tobacco strategies, evidence suggests that increases in cigarette prices and taxes and the implementation of comprehensive clean air laws have been successful in reducing smoking rates. In light of the increasing rates among young people in many countries, further policy action is needed targeting youth; evaluations of the impact of recent tobacco control measures aimed at children and adolescents are needed. Also, numerous studies point to the link between socioeconomic status and smoking habits, such that individuals in lower socioeconomic groups have higher rates of smoking in all countries. Therefore, policies need to take this into account and to target the more disadvantaged groups. Encouragingly, initial evidence suggests that recent tobacco control measures have reduced health inequalities.

At the national level, there has been renewed attention to obesity with many countries in all parts of the EU recently introducing public health programmes. These largely focus on improving nutrition and levels of physical activity in the population. Recognising that childhood obesity requires urgent attention, many countries have also introduced policies focusing on schoolchildren to reduce obesity. Some countries, including Sweden, Belgium, the Netherlands and Ireland, have taken action to restrict advertising of low-nutritional value products to children. However, difficulty in assessing the effectiveness of individual policy interventions to combat obesity has hindered EU-wide strategy development. EU-wide policy holds a particularly important place because of the transnational nature of some aspects of factors influencing obesity rates, such as food manufacturing and agricultural policies. The results of the 2005 European Commission green paper for consultation on fighting obesity are eagerly awaited.

The WHO Venice Office after analyzing the various health care systems concluded that the health care system can help reducing poverty and inequity in health by (Ziglio et al. 2003):

1. Confronting the inverse care law by improving coverage, eligibility, geographical and cultural access, and equitable resource allocation
2. Prevent that use of health care causes poverty by addressing the burden of payments
3. Help counteract the effect of socioeconomic inequalities in health for examples by proving outreach services to homeless, people belonging to ethnic minorities, and other people living in poverty

4. Tackle the wider determinants of health inequalities by promoting multi-sectorial perspectives.

#### 4.1 Lessons learned

Three main lessons have been learned during this Peer Review:

1. The importance of prevention
2. The presence of an “inverse care law”.
3. The sustainability issues and the role of co-payments

Each country is, in fact, faced with the problem of identifying policies that guarantee a sustainable access to equitable and efficient health care services to everyone, and to improve the health status of the overall population. Intermediate objectives in achieving this overall objective are:

- Implementation of policies that increase coverage in particular for disadvantaged groups and ethnic minorities
- Identification of the needs of different groups (the elderly, the children, minority groups, foreigners, etc.)
- Reduce geographical disparities, whether between regions, between urban and rural areas or between richer and poorer areas
- Reorganisation of services to strengthen prevention
- Reduction of waiting times
- Enhance the role of information, not only for the effectiveness of the various health services, but also with regards to the real price of health care
- Improve efficiency and reduce waste
- Enhance the role of health-technology assessment
- Implementation of multi-sectorial policies
- Improve data collection and therefore the monitoring of the various policies

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