

## Chapter 3

### Healthcare Reform: Improving Efficiency and Quality of Care

*The Hungarian government has succeeded in creating a “momentum for change”, after a ten-year deadlock of reforms in the health system. The first section of this chapter describes the context of the reforms: relatively poor health status of the population and relatively low public spending on health in an international context; the underlying causes of the inadequate performance of the healthcare system; and narrow fiscal latitude for health reforms. The second part of the chapter discusses the measures taken in 2007, highlighting the important contribution of the health sector to fiscal consolidation, in particular the reform of the pharmaceutical market. The chapter also points out that cost-containment goals and regional political interests may at times have dominated efficiency and quality objectives, in particular in the reorganisation of the hospital network. In February 2008, the Hungarian Parliament passed an Act replacing the single-payer system by a decentralised system of compulsory health insurance funds with joint public-private ownership. The chapter highlights international experience suggesting that competition in health insurance markets does not automatically deliver intended improvements in cost-efficiency and quality. From this perspective, the chapter discusses the potential advantages and risks to the new health insurance system. The third part of the chapter discusses the scope for policy improvement, with some proposals for fine-tuning and extending the supply-side reforms and improving the quality and economic regulation. The need for the establishment of a long-term strategy to improve the population’s health status and to ensure sustainable financing and adequate human resources is also emphasised.*

## Background and key policy recommendations

The health status of the Hungarian population is one of the poorest among OECD countries, even when taking into account differences in per capita income levels, and the ratio of public expenditure on health care to gross domestic product (GDP) is modest compared to other OECD countries. Following fundamental changes to healthcare provision subsequent to the collapse of the communist regime, there was little reform action after the mid-1990s. Public dissatisfaction with the prevailing system and the need to control healthcare expenditure in light of a growing budget deficit has led to the revitalisation of healthcare reform since 2005. This chapter reviews the major changes that have been adopted and are currently implemented, and aim at increasing the quality and efficiency of the provision of health care.

The main policy recommendations emerging from the review and analysis of healthcare reform presented in this chapter propose the:

- **development of a coherent long-term strategy for improving the population’s health status**, ensuring sustainable financing and adequate human resources for high-quality health care;
- **elaboration of a need-based strategic plan for further restructuring of the hospital network**;
- **establishment of a robust regulatory framework improving economic and quality incentives for healthcare providers** and covering the multiple issues arising from the introduction of the new public/private insurance system;
- **implementation of a robust monitoring system to closely follow and assess the transition and the operation of the new insurance funds**;
- **creation of suitable economic, professional and organisational conditions for an enhanced role of general practitioners**.

This chapter also argues that the process of health reforms itself requires changes, including: the way in which reform concepts are prepared; the way that conflicts are settled between the government and key stakeholders in the healthcare system; and the monitoring and assessment of reforms. The detailed contents of – and motivations underlying – these recommendations are elaborated below.

Healthcare reform constitutes an important part of the government’s overall reform agenda, addressing several objectives: to make permanent savings in government spending, address structural deficiencies of the healthcare system, and raise client satisfaction by transforming the “provider-centred system” into a “consumer-centred” one.

The need for fiscal consolidation and for revitalising economic growth entails budgetary constraints for the reform, requiring containment of public spending on health. A key challenge is to meet these requirements in a way that does not jeopardise the continuing improvement in the population's health status by hindering longer-term modernisation of the healthcare system. Improving the health status of the Hungarian population is of vital importance for long-term economic growth (by raising productivity), as well as for narrowing the gap in well-being between Hungary and the more developed European Union (EU) countries. Sustainable financing of high-quality health care is a precondition for achieving the desired health outcome over the longer term.

## **Current situation**

### ***Health status***

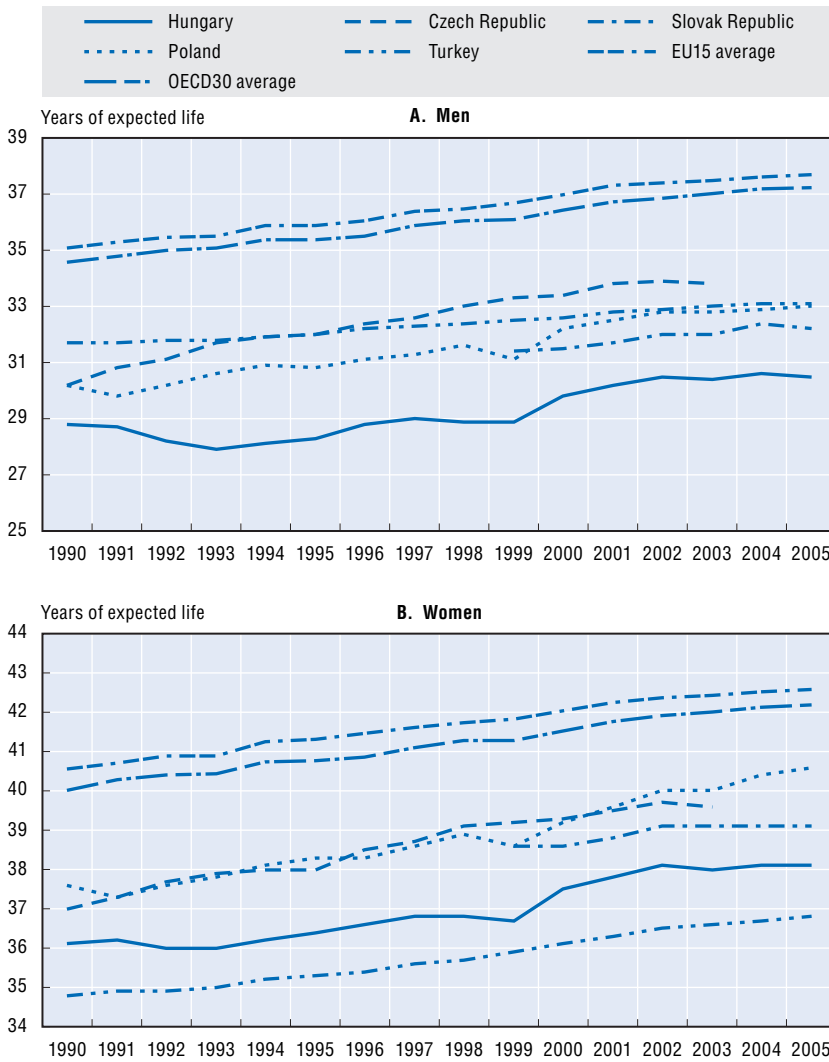
The health status of the Hungarian population is one of the worst in the OECD region: in 2005, life expectancy of males at birth was the lowest among OECD countries, and life expectancy of females was the second lowest, after Turkey. While the mortality structure is similar to the more developed countries, the level of mortality is far higher.<sup>1</sup> Although life expectancy has been improving in Hungary during the past decade, the gap between Hungary and the "old EU" has not narrowed since the early 1990s, in contrast to comparable trends in the Czech Republic and Poland. A crucial aspect of the problem is the high mortality rate of middle-age men: the life expectancy of males at the age of 40 was 30.5 years in 2005, 7.2 years less than the EU15 average, while the difference was only 6.3 years in 1990 (Figure 3.1).<sup>2</sup>

### ***"Fiscal space" of the healthcare system***

Hungary's public spending on health care, in percent of GDP, is below the OECD and the EU15 averages (Figure 3.2). In 2004, per capita public expenditure amounted to 42% of the EU15 average, reflecting an increasing gap compared to the early 1990s, when the ratio was 51%. The share of private expenditure (including under-the-table payment) in total health expenditure is estimated to be one of the highest in the EU. Private expenditure amounted to 29.5% of total health expenditure in 2004, when the corresponding EU15 average was 24.4%. Currently the share of private expenditure is likely to be above 30% in Hungary.

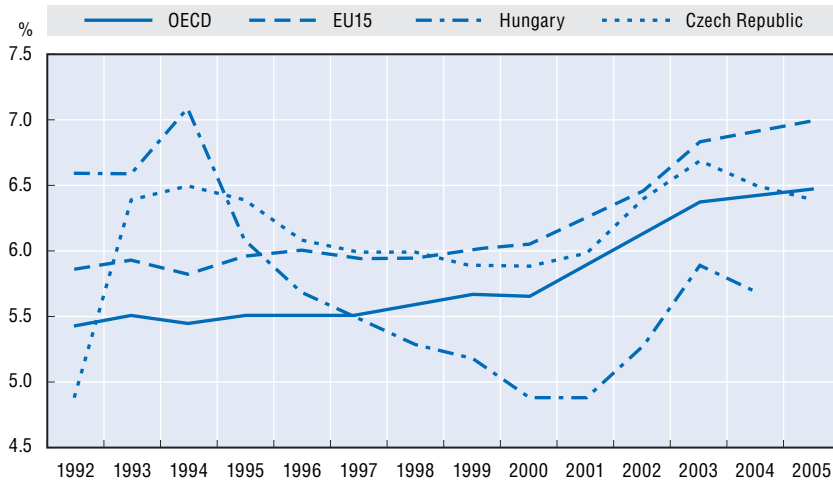
The character of private health care expenditure is different from that in the high-income EU countries: the share of out-of-pocket payments is higher than the OECD average, while voluntary health insurance is insignificant.<sup>3</sup> The incentives created by the widespread practice of informal ("under-the-table") payments have been a major obstacle to structural reforms, including the development of voluntary health insurance.

Figure 3.1. Trends in life expectancy at age 40: Hungary and selected countries, 1990-2005



Source: OECD (2007a), "OECD Health Data 2007: Statistics and Indicators for 30 Countries", electronic database available on line at [www.ecosante.org/oecd.htm](http://www.ecosante.org/oecd.htm) and on CD-ROM, data downloaded in October 2007.

Figure 3.2. Public expenditure on health as a share of GDP, 1992-2005

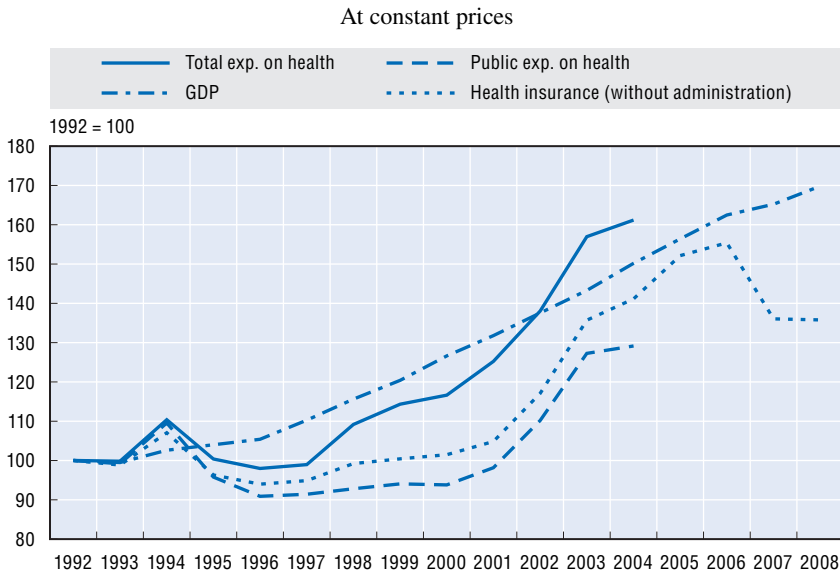


Source: OECD (2007a), “OECD Health Data 2007: Statistics and Indicators for 30 Countries”, electronic database available on line at [www.ecosante.org/oeed.htm](http://www.ecosante.org/oeed.htm) and on CD-ROM, data downloaded in October 2007.

Policy makers thus face a difficult situation: fiscal conditions require a reduction in public spending.<sup>4</sup> At the same time, the relatively poor overall health status, the relatively low current level of public spending on health, and the need for improving the overall performance of the healthcare system probably justify more resources. This conjuncture exerts pressure on the government (and other actors in the healthcare system) to improve efficiency. However, decreasing public expenditure is a constraint for addressing several key obstacles to efficiency and quality of care.

Public spending on health grew by only 29%, while GDP increased by over 50% between 1992 and 2004 (Figure 3.3).<sup>5</sup> However, within the decade, growth rates were very volatile (Figure 3.4). Health expenditure, measured as share of GDP reflects this (Figure 3.2). Between 1992 and 2000, public expenditure on health, as a share of GDP, decreased from 6.6% to 4.9%, reflecting an atypical trend, compared with other OECD countries where public spending on health as a percentage of GDP remained stable or increased. As a result of a 50% increase in public salaries in 2002, the share of public spending on health increased again to 5.7% by 2004. Then, due to the fiscal consolidation, public health expenditure is estimated by the OECD to have decreased to around 5.1% GDP in 2007.<sup>6</sup>

Figure 3.3. **Trend of GDP, social health insurance, public and total health expenditure, 1992-2008<sup>1</sup>**

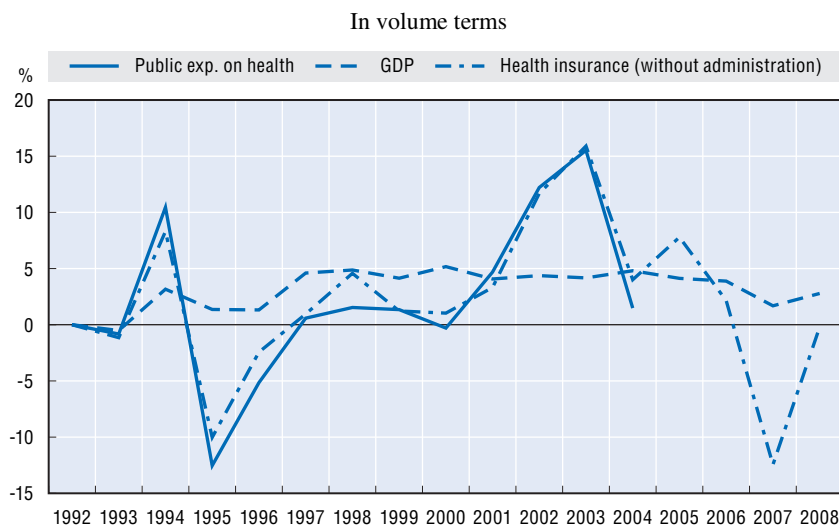


1. 2007 data are preliminary and 2008 data is the budget target.

Source: For 1992-2004 data: OECD (2007a), "OECD Health Data 2007: Statistics and Indicators for 30 Countries", electronic database available on line at [www.ecosante.org/oecd.htm](http://www.ecosante.org/oecd.htm) and on CD-ROM, data downloaded in October 2007; for 2005-2006 GDP data: Central Statistical Office; for 2007 and 2008 GDP data (estimates): Updated Convergence Programme; for 2005-2008 health insurance data: Ministry of Finance.

The Health Insurance Fund<sup>7</sup> has been in deficit almost since its inception in 1992 until 2007. Several factors help to explain this: a low employment ratio; widespread evasion of paying contributions; and a discretionary reduction of the rate of employer contributions curtailed revenues. The rate of employers' contributions decreased from 19.5% of wages in the early 1990s to 11% in 2006, and then to 5% in 2008 (if adjustments for the lump-sum health tax<sup>8</sup> are taken into account, the aggregate employers' contribution rate fell to around 12.6% in 2006 and 6.5% in 2008); the employees' contribution rate increased, however, and on balance the total contribution rate decreased from 23.5% in the early 1990s to 15% in 2006 and 11% in 2008 (12.5% if adjustments for the lump-sum health tax are included). This latest decrease was due to the transfer of tasks to the Pension Fund (disability pension for recipients below pension eligibility age). The deficit of the Health Insurance Fund was considerably reduced with the introduction of a mandatory transfer from the state budget on behalf of the pensioners and persons receiving social allowances as well as certain other categories, such as children, students, beneficiaries of maternity leave, prisoners, etc. in 2006.

Figure 3.4. Annual growth rate of GDP, social health insurance, public health expenditure, 1992-2008<sup>1</sup>



1. 2007 data are preliminary and 2008 data is the budget target.

Source: For 1992-2004 data: OECD (2007a), “OECD Health Data 2007: Statistics and Indicators for 30 Countries”, electronic database available on line at [www.ecosante.org/oeed.htm](http://www.ecosante.org/oeed.htm) and on CD-ROM, data downloaded in October 2007; for 2005-2006 GDP data: Central Statistical Office; for 2007 and 2008 GDP data (estimates): Updated Convergence Programme; for 2005-2008 health insurance data: Ministry of Finance.

On the spending side, the Health Insurance Fund Administration has successfully contained spending on healthcare services since the early 1990s. However, it failed to harness the growth of spending on pharmaceuticals over this period.

### *Financing and delivery of health services*

Sweeping reforms were introduced in the Hungarian healthcare system in the first half of the 1990s (*e.g.* the possibility of private provision of health care, private practice of general practitioners [GPs], the social insurance scheme, voluntary non-profit insurance funds, diagnosis related group [DRG]-type<sup>9</sup> payment for inpatient care, etc.). The reform process, however, halted in the mid-1990s<sup>10</sup> and resumed only in 2005.

Unsatisfactory performance of the Hungarian healthcare system is manifest in significant differences in quality of – and access to – care, and low responsiveness to consumers’/patients’ demands. Furthermore, supply-side constraints (including low income in the public sector and outdated healthcare facilities) due to relatively low public spending are exacerbated by serious inefficiencies in the utilisation of available resources (Goglio, 2005).

The underlying causes – often interdependent – of inadequate performance are manifold: an outdated and **unbalanced structure of healthcare delivery** (e.g. a dominant role of inpatient care, little use of day-surgery, a limited role for group-practice in primary care, etc.); **perverse efficiency incentives** for providers (e.g. provider payment methods and the system of under-the-table payment work against the replacement of inpatient care by other forms of health care); acute **shortage of nurses and** increasing shortage of **doctors** (related to low remuneration in the formal system); **uncoordinated service delivery** (e.g. weak gatekeeping role of GPs; lack of co-ordination in the treatment of chronic diseases, etc.); **lack of incentives and tools** for the Health Insurance Fund Administration to act as an effective **purchasing agent**; lack of incentives and autonomy for **hospital managers** to improve efficiency (across the vertical spectrum of care); and overall, deficiencies in the **governance** of the healthcare system throughout the whole transition period.

### Assessment of the reforms

The revitalisation of healthcare reform started with the so-called “programme of 21 steps” in 2005, which proposed the strengthening of the existing insurance framework<sup>11</sup> and a supply-side, disease-based approach to structural changes in healthcare delivery<sup>12</sup> in order to improve access, quality and efficiency, as well as measures to contain the rise in expenditure on pharmaceuticals. The successor programme of the new coalition government, inaugurated in June 2006, included and extended many elements of the original programme (Ministry of Health, 2006).

Three major factors have shaped the government’s reform measures introduced in the healthcare sector:

1. the pressure to reduce public spending on health care to meet the requirements of the Convergence Programme (through measures with an immediate impact on both the supply and demand for care);
2. the commitment of the government to structural reforms in order to improve the performance of the healthcare system; and
3. the (political) objective of changing the role of – and relationship between – the state, private business actors, and individuals (patients) in the healthcare system.

### *Contribution to fiscal consolidation and greater efficiency*

In general, reduction in public spending on health care may entail measures to reduce the supply and the demand, an increasing rationing of the access to care and/or increasing efficiency. The Hungarian government attempted all these through:

- reform of the pharmaceutical market (changes in the reimbursement scheme and regulation of pharmaceutical prescription, transparent price competition among

both generic and patented drugs, and introduction of a new rebate system, involving risk sharing between all actors of the market);

- a restructuring of hospital care, in particular a reduction of inpatient capacity, which allowed setting a reduced target for the overall expenditures by the Health Insurance Fund;
- a strengthening of the referral system, and the introduction of a formal, transparent system of waiting lists in hospitals;
- a considerable increase in co-payments for pharmaceuticals and the introduction of co-payments for primary care, outpatient care, and inpatient care.

In addition, the revenue of the Health Insurance Fund increased in response to two measures: a more effective enforcement of the payment of contributions achieved through a change in regulation<sup>13</sup> and an overall review procedure conducted by the National Health Insurance Fund. This has resulted in the clarification of the insurance status and registration of more than 650 000 persons, of which about 162 000 are new contribution-payers.<sup>14</sup> The main increase, however, came from the introduction of a regulation on contribution payment by the central government on behalf of around 5.9 million persons (the pensioners, persons receiving different social allowances and the homeless) in 2006.<sup>15</sup>

The measures taken in 2007 made an important contribution to fiscal consolidation: The Health Insurance Fund closed with a surplus, the first ever since its establishment in 1992. In 2007, the spending by the National Health Insurance Fund Administration (NHIFA) on health services and medical goods was 7% (HUF 80 billion) lower in nominal terms and around 13% in real terms than in the previous year, including a decline in nominal terms by 16% for expenditures on pharmaceuticals.<sup>16</sup> The HIFA has thus succeeded in reigning in the perennial over-spending on pharmaceuticals by the public health system.

According to the State Audit Office Methodological Institute (2007), the total net budgetary savings of the reforms in the health sector amounted to 0.4% of GDP in 2007. Of this total 72% was accounted for by savings on pharmaceutical expenditures, 14% by the introduction of co-payments for health services, and 14% by the increase of revenues from insurance contributions.<sup>17</sup>

The government has succeeded in creating a “momentum for change”, with a widespread consensus that the health system is in need of serious reform. The measures were also aimed at introducing structural changes in order to improve the performance of the health system, in particular in terms of allocative efficiency and transparency. The induced price competition among generic pharmaceuticals resulted in the reduction of drug prices and changes in the structure of consumption. This, together with other measures has not only resulted in a radical reduction of public pharmaceutical spending, but can serve as a starting point to develop a sound system of pharmaceutical financing.

On the other hand, some aspects of the reform measures suggest that cost-containment goals and local political interests may at times have dominated cost-effectiveness and quality objectives. The reformed regulations provide strong incentives for doctors to control the amount of the pharmaceutical reimbursement they induce. In the case of those medicinal products where the patent of the active ingredient is expired, generic products are available, and the fix reimbursement system is applied, the physicians have to recommend the prescription of the lowest priced product or the reference product, as well as inform the patients about the price/patient co-payment of the different bioequivalent products of that group of medicines. (The patient can choose to have higher cost medicines in the given group of medicines.). The fix reimbursement system has been extended to patented products and pharmaceuticals with different active ingredients within several therapeutic categories. However, the therapeutic equivalence of these products is often not justified (Kerpel-Fronius, 2007). As the regulation and the related financial incentive system<sup>18</sup> does not take into account the heterogeneity of patients (*e.g.* co-morbidity, differences in susceptibility, etc.) and the differential health benefit of products in each therapeutic reference categories, disincentives in choosing the optimal dose of the most cost-effective therapy may arise (Kaló, 2008).

It is widely agreed that improving quality and efficiency in the Hungarian hospital network requires reduced and more regionally as well as functionally concentrated capacity. However, the actual implementation has been influenced by regional political lobbying, focusing on closing hospital beds<sup>19</sup> instead of entire hospitals. So far, 6 out of 173 hospitals were closed and acute care activity was terminated in 12 hospitals.<sup>20</sup> Time pressure – partly due to the need of achieving budgetary savings quickly – did not allow sufficient time for an optimal planning and harmonisation between the changes in bed capacities, tasks and financing<sup>21</sup> (Dózsa, forthcoming).

As a result of a combination of different measures, such as a reduction in the “performance-volume limit” of providers,<sup>22</sup> the introduction of co-payments, and a stricter referral system, the number of outpatient cases decreased by 13% and the acute inpatient cases by 12% in the period of January-November 2007 compared to the same period in 2006. Despite the considerable increase (35%) in the number of beds for rehabilitative and long-term care, the number of hospital days provided in these areas of care decreased by 5%.

Following this first round of reforms the government now faces a different type of challenge: to invest efficiently. Hungary plans to spend EUR 1.2 billion from the EU Structural Funds for the modernisation of the healthcare infrastructure over the period 2007-13.<sup>23</sup> Allocation of these investments will influence the quality and efficiency of health care in the coming decades. International experience shows that countries increasingly have found it is necessary to implement national or regional hospital (or healthcare) plans for optimising major investments. In Hungary, the strategy for using the EU investment resources was considerably changed in 2007. In early 2006, the then Healthy Society Complex Programme proposed to devote part of the investment resources to a few high-priority programmes such as the National Emergency Care Programme, the National Anti-Cancer Programme, and a few other hospital investments of key importance to be

implemented based on a co-ordinated national plan. These high-priority programmes, however, have been abandoned and the majority of the EU investment resources will be distributed through several projects of grant applications by service providers. This carries the risk of uncoordinated developments and suboptimal utilisation of resources (Dózsa, 2008).

### *Introduction of co-payment in primary, outpatient and inpatient care*

The introduction of co-payments – “visit fee” in primary and outpatient care and “hospital daily fee” inpatient care – was intended as a symbolic change: the end to free-of-charge health care. It can also be considered a first step towards tackling the problem of under-the-table payments. The system was introduced relatively smoothly. While the demand for care has fallen in response, it is not known to what extent this decline includes services with potential health gain. A wide-ranging system of exemptions and compensation (covering around 40% of the population) is to protect against undesirable effects on access to care. As the main opposition party has initiated a referendum to repeal co-payments, future developments are unclear.

The revenue from visit fees and hospital daily fees however proved considerably less than expected: HUF 13.9 billion (instead of the estimated HUF 23.3 billion), which amounts to around 2% of public spending on healthcare services (excluding pharmaceuticals).

Co-payments are a common feature of the healthcare systems in OECD countries. Patients paid some co-payment<sup>24</sup> for primary care in 19, for outpatient specialist care in 21, and for inpatient care in 16 OECD countries, and for pharmaceuticals in all OECD countries according to most recent data available. The OECD study, *Towards High-Performing Health Systems* (OECD, 2004), concluded that establishing modest cost-sharing requirements may be appropriate when policy makers wish to reduce the burden on the public budget. However, it warned that the induced reduction in the demand for health services may not necessarily enhance efficiency, given that consumers may skimp on preventive care and other appropriate treatments, entailing higher expenditure in the future.

### *Reform of health insurance*

Act No. 115/2006 reinforced the insurance character of the financing system, tightening the link between service entitlements and contribution obligations. The amended regulation distinguishes a basic service package (available independently of insurance status for all free of charge, comprising *e.g.* emergency service, maternal care, etc.) and the social insurance package,<sup>25</sup> which is available only if the insurance contribution is paid by or on behalf of the person. Healthcare providers are obliged to check the insurance status of the patient through an online monitoring system.

In order to improve the transparency and oversight of the insurance system and protect insureds’ rights, the Health Insurance Supervisory Authority has been established, with the role of supervising the operation of healthcare providers (the quality of health services,

investigating patients' complaints, etc.) and the health insurance market, once created (see below).

### *Reform of the institutional system of compulsory health insurance*

In 2007, fundamental changes in the public health insurance were introduced. According to a summary by the Ministry of Health, "The second phase of the reform ... aims at constructing a new financing framework, one which can truly be called an insurance system, resting on the combined foundation of solidarity and competition." The key idea of the reform is to involve private insurance companies in investing and administering the health insurance system.<sup>26</sup> The underlying expectation is that competition among insurance funds will lead to competition among service providers and hence improvements in quality and efficiency. According to the Ministry of Health, only the involvement of private insurance companies can ensure the efficient operation of, and effective cost control in, the social insurance system (Ministry of Health, 2007).

Mid-December 2007, the Parliament passed the Act on Compulsory Health Insurance Funds (CHIFs), reflecting a compromise between the governing coalition parties.<sup>27</sup> According to the Act, the compulsory health insurance will be managed by (initially) 22 health insurance funds, with joint public-private ownership (51% public, 49% private). The Ministry of Health expects that these will be merged into seven to ten CHIFs. CHIFs will be established on a territorial basis: an insurance fund in each of the counties and four insurance funds in Budapest and Pest county. However, subscribers can choose any of the CHIFs, irrespective of their territorial base, and CHIFs are expected to compete for potential clients also outside their territories. CHIFs will receive a fixed per capita payment for their members from the Health Insurance Fund. The mandatory service package will be standardised for all CHIFs. They can offer, however, some extra services (*e.g.* cover the co-payments for inpatient and outpatient care, etc.).

The National Health Insurance Centre (successor of the National Health Insurance Administration), will manage the Health Insurance Fund,<sup>28</sup> the National Risk-pooling Fund (financing certain high-cost services), provide social insurance identification numbers, manage per capita payments, decide about the inclusion/exclusion of pharmaceuticals in the benefit package and contract the pharmacies.

The Act introduces three major changes simultaneously: regional decentralisation of the purchasing function, competition between insurance funds, and partial privatisation. This new health insurance system has two special features, which do not exist in other social insurance systems in Europe: the joint public-private ownership of the health insurance funds and the combination of regional decentralisation and competition. The new insurance system will bring both opportunities and risks for improving the performance of the healthcare system (Fidler and Gottret, 2007; Kutzin, 2007; Sinko and Gal, 2007). Whether and to what extent the expectations will materialise and at what prices depends on many factors, including the appropriateness of the new regulatory framework.

Main potential advantages of the new insurance system compared to the current one are:

- The possibility to choose one's insurance fund may increase satisfaction of some consumer groups.
- Insurance funds may put greater emphasis on consumer preferences, in particular those elements that are easy to judge for the patients (waiting time, amenities, etc.).
- The new system may provide incentives for insurance companies to also offer voluntary health insurance policies,<sup>29</sup> which can contribute to the elimination of the under-the-table payments.
- The decentralisation may increase innovation in the way service delivery is organised.

Countries have chosen different reform approaches during the past decades: for example, whereas Germany and the Netherlands chose competition among sickness funds, Austria decided against introducing competition and committed itself to increasing cross-sickness fund planning and co-ordination. International experience (Mossialos *et al.*, 2004; Saltman *et al.*, 2004; WHO, 2006) seems to suggest that competition between insurers does not necessarily result in superior performance compared with national or local single-payer systems. The OECD's *Toward High Performing Health System* states:

*“Competition in health insurance markets, where it occurs, does not automatically deliver intended improvements in cost-efficiency. Much depends on the grounds on which insurers compete. Insurers ... face incentives to compete not only on the basis of real efficiency gains, but also through risk selection and other practices that shift costs to other payers. ... From a technical and policy standpoint, it is very difficult to counter these incentives, which can be strong, given that a small share of insured population accounts for a large share of health costs.”* (OECD, 2004, p. 113.)

The main potential risks to the new system are:

- In the absence of a perfect capitation formula, insurance funds may have incentives for competing for favourable risks (“cherry picking”), instead of competing on the ground of quality (Van de Ven *et al.*, 2003).

- A key interest of the insurance funds (shaped by the minority owner commercial insurance companies supplying the CEO) will be to reduce the costs of services. Obvious ways to achieve this would be to require pre-authorisation for certain services, managed care programmes, or selectively contracting with chosen suppliers. If these tools are chosen solely on the grounds of cost, quality of care and even technical efficiency could be threatened.
- Even if quality of care is included in the contracts, choice may be restricted for patients enrolled in particular insurance funds.

Under the specific Hungarian circumstances further potential problems and risks may arise, in particular:

- Administrative costs of the insurance system will increase<sup>30</sup> due to both decentralisation and competition (*e.g.* advertising, sales personal, etc.). The National Audit Authority pointed out in its report: “It is highly uncertain that the restructuring and reduction of the delivery capacity will bring about savings that can compensate for the increase in administrative costs and the profit of the invertors, and it is probable that access to, and quality of, care may decline” (State Audit Office Methodological Institute, 2007).
- It is unclear what kind of cost-containment methods the new insurance funds will be able to apply. The current key method for cost-containment is a volume-limit on services set by National Health Insurance Agency for each hospital and outpatient multi-specialty centre.<sup>31</sup> If the government wants to encourage competition among providers, this mechanism cannot be sustained.
- A highly complex system will be introduced in an environment with lack of adequate information on quality of services, serious shortcomings in economic and quality regulation, and a weak capacity of law-enforcement. Most of the details of the regulation of the new system are still under preparation.

### Scope for policy improvement

The need for reform of healthcare system is apparent. As indicated in the previous sections, there remain a large number of distortions and inefficiencies that need to be addressed. However, inadequate co-ordination may weaken and distort the potential benefits of individual reform components. Perhaps the most critical issue is to **improve the governance** of the healthcare system. This would include the **development of a coherent long-term strategy for improving health and sustainable financing, and improving pertinent regulation**. To maximise long run benefits from reforms introduced in the past two or three years requires the **extension and fine-tuning of the supply-side reforms and the establishment of a robust regulatory framework and monitoring system to underpin the new insurance system**. The process of health reforms in itself requires changes:

including the way in which reform concepts are prepared; the way that conflicts are settled between the government and key stakeholders in the healthcare system; and the monitoring and assessment of reforms.

### *Fine-tuning and extension of the supply-side reforms*

Generally speaking, structural reforms should change relevant conditions facing the stakeholders in the healthcare system (institutional framework, incentives, information), to enable them to adapt better to changing economic and social circumstances. In pursuing the reorganisation of the Hungarian healthcare delivery, the following measures seem to be particularly important:

- To develop a need-based strategic plan for further restructuring of the hospital network. There are plenty of international examples to learn from, and the existing national programmes (National Emergency Programme, National Cardiovascular Programme and National Anti-Cancer Programme) could serve as valuable input (Health Policy Monitor, 2004).
- Improve accountability and transparency in the operation of hospitals by making changes in the governance structure, *e.g.* encouraging the transformation of hospitals currently operated as budgetary organisations into public companies.
- To create suitable economic, professional and organisational conditions for an enhanced role of GPs.

### *Strengthening the role of the general practitioners*

Since the creation of the Family Physician Service in 1992, a major health policy goal has been to strengthen the GPs' gatekeeper role, to ensure that patients receive quality care when and where it is needed.<sup>32</sup> Reform measures in 2007 focused on making the rules governing the referral system<sup>33</sup> and the prescription of pharmaceuticals by GPs stricter.

Presently there exist economic, organisational and human resource obstacles to strengthening the role of GPs; the remunerative system<sup>34</sup> provides no incentives to strengthen their role as gatekeepers. Most GPs work in solo practice and a proper system of supervision and quality assurance is lacking. The age-composition of GPs is alarming: 67% of GPs<sup>35</sup> are older than 50 (of which 28% are older than 60). The geographical mobility of GPs is low due to the system of "practice-rights", introduced in 2000.<sup>36</sup> There are large regional and social (class) differences in patients' compliance with the requirement to first see a GP.

Despite the emphasis on the enhancement of role of GPs, several recent regulations have further narrowed their scope of decision making. For example, the range of medication that a GP is allowed to prescribe has been considerably narrowed, as one of the measures to contain pharmaceutical expenditure. Focusing on changes in the referral system, and in

particular trying to induce patients through financial incentives to first see their GP does not seem to work in isolation. More comprehensive and co-ordinated changes are needed in the economic, professional and organisational conditions of the primary care system.

In 2004, a committee led by the National Institute of Primary Care proposed to transform the system of practice rights into a system of concession contracts. This proposal merits further consideration.<sup>37</sup>

Adjustments in the payment system, in conjunction with the introduction of quality assurance tools,<sup>38</sup> are required to provide adequate professional guidance and financial incentives for treatment of patients with chronic conditions, such as hypertension, diabetes and asthma. This would strengthen the role of GPs in the co-ordination of care. A performance-related component could be added to the current capitation-based remuneration. The key issue is to define, measure and reward performance in a way conducive to meeting public health objectives. A feasibility study on the adaptation of the “Quality and Outcomes Framework” system developed in the United Kingdom for this purpose may be helpful.<sup>39</sup>

The international experience<sup>40</sup> with multi-doctor practices may also merit studying. These enable medical practitioners – doctors, nurses, medical assistants, administrative personnel, etc. – to work as teams with strong links to local social services. They permit more flexible work arrangements: for example, nurses may take over more tasks in advising and monitoring patients with chronic diseases.

### ***Improving the regulation of the healthcare system***

A consistent regulatory framework<sup>41</sup> is a precondition for the adequate operation of the new insurance system. The Hungarian government faces demanding tasks: the current rules and practice of economic and quality regulation are in serious need of improvement. Most of the details of the new regulations concerning the operation of the new health insurance system have to be prepared and introduced in the coming months. Some of the crucial issues are discussed below.

#### ***Service coverage and access to care***

The service package will be divided into two parts. High-cost services will be financed by the National Health Insurance Centre from the National Risk-pooling Fund. This is thought to be a guarantee for equal access to high-cost services for serious diseases. The other services will be financed by CHIFs. There is a potential risk of continuous debates between the government and (the minority owners of) the CHIFs over the content and the budget of the two packages (such as the inclusion/exclusion of new technologies). Clear principles for drawing the borderline between the two packages (and related budgets) may be difficult to agree on.

The Prices and Fees Committee, to be set up as an advisory body to the ministers of health and of finance will have the task to propose the inclusion/exclusion of

technologies/services in the compulsory health insurance (except pharmaceuticals and other medical goods), and to develop specific rules and procedures of financing. Clear principles and transparent mechanisms are needed concerning the decision-making by the Fee-schedule Committee, including the resolution of disagreement between patients and providers over the decisions of the committee.

The allocation of resources to CHIFs will be carried out by use of a capitation payment mechanism, which entails two broad challenges: (i) to correct the large inequities in the access to health care; and (ii) eliminate the incentives for risk selection (Nagy *et al.*, 2007). The Capitation Committee, an advisory body to the Minister of Health, will be responsible for the improvement of the pertinent formula defined by the Act. It will be of vital importance to monitor and regularly assess the formula, as well as to inform the general public about the extent to which the formula meets specified requirements.

### *Quality assurance and control*

Deficiencies in quality regulation contribute to the differences in quality of healthcare services across regions.<sup>42</sup> They also will seriously hinder the possibility of the new insurance funds to get reliable and comparable information about the quality of care. In particular the following problems require attention, regardless of the institutional form of the insurance system:<sup>43</sup>

- **The definition of tasks and competences of the health care providers requires amendment.** The National Emergency Care Programme defined two levels of emergency care facilities (with pertinent requirements in technology and staff) in 2006, then the Act on the restructuring of the hospital network defined the categories of centre and local hospitals – without adequate harmonisation between the two approaches.<sup>44</sup>
- **The decision range of general practitioners and paramedical personnel should be considerably widened.**
- **Conditions for licensing and accreditation should be made more stringent.** During the reorganisation of hospital capacity, several hospitals have retained their license, despite deficiencies in meeting the minimum requirements in several speciality areas.
- **A more consistent development and application of medical guidelines would be desirable.** There is no adequate system of enforcing and monitoring the compliance of providers with the medical guidelines.
- **A robust and widely accepted and accessible indicator system is needed** to provide comparable information on the quality of care across providers for facilitating better decision-making and patient-enabling choice.<sup>45</sup>

- **The provider payment systems should encourage the existence (or sanction the lack) of a quality assurance system of providers.** Although the Act on Health Care of 1997 requires providers to have an accredited quality assurance system, the regulation has not been fully implemented so far.

### *Economic regulation*

A precondition for effective competition between providers is that quoted prices (tariffs of provider payment systems) are accurate and transparent. Deficiencies in the current Hungarian provider payment systems, impeding effective competition between providers, will also seriously hinder effective competition among the new health insurance funds.

An improvement in regulation is needed to ensure that the DRG (diagnosis-related group; HBCS – *homogen betegség csoportok* [homogenous disease groups]) tariffs are continuously adapted to changes in the costs of treatments. As the last cost-review in the Hungarian DRG system was conducted in 1999, the relationship between the actual costs of treatments and the tariffs (DRG points) has become seriously outdated. A new cost-review is planned in 2008.

Under the tight budget constraint of health insurance, it is necessary to apply some sort of cap on the volume of services. However, the current system tends to distort the relationship between the need for, and supply of, different components of health care and may harmfully affect the quality of care.<sup>46</sup>

The Fee-schedule Committee will also be responsible for making proposals to change tariffs and other elements of provider payment methods. The proposed system seems unbalanced: besides the government only one side of the market – the insurers – are represented in the committee, while providers are not. Under such a system the information the body receives may be distorted. There are different possibilities for a more balanced composition for such a body: members of the committee could be recruited from both sides, or could be independent experts, so that providers and insurers can only comment.

### ***Transition to the new health insurance system***

The implementation of the new insurance system will be a complex task: it involves the establishment of new insurance funds, reorganisation of the current National Health Insurance Administration into a new agency, changes in the way patients can access care, changes in the relationship between insurers and providers, in the administration of the payment processes, development of day-to-day relationship between insurers and clients, and development of new control mechanisms by government agencies (*e.g.* Health Insurance Supervisory Authority, Competition Agency, etc.). As mentioned, most of the pertinent details are not yet known.

The Hungarian government faces two risks:

- The risk of diversion of human resources and administrative effort of the Ministry of Health from important measures needed to improve healthcare delivery to the problems of implementing the complex new insurance arrangements;
- The risk that the regulations and guaranties supporting the Act will not be sufficiently effective to prevent problems that may occur due to some structural elements of the new system, as discussed above.

It takes time to improve the regulatory framework. Lack of adequate information about the quality of providers and lack of adequate experience in supervision of the insurance market underlines the importance of closely monitoring the transition and the operation of the health insurance funds.

An adequate system of monitoring, from a technical point of view, requires capacity building within the healthcare administration and involvement of research institutions. Transparency and accountability of the monitoring would require the involvement of the key stakeholders in the healthcare system.<sup>47</sup> A good monitoring system could help in benchmarking, identifying best practices, facilitate their diffusion, and also improve public support for the reform process.

Based on international experience, such monitoring should pay special attention to the following issues: changes in the benefit package, detecting incentives and methods to practise risk-selection; the conflicts between the incentives for decreasing the costs of services that the system generates and the goals of improving quality and allocative efficiency; effects on the ability of patients to choose providers; and the trends in administrative costs of insurers.

### ***Widening the reform agenda***

Establishing a long-term strategy to improve the population's health status is an important input to a sustainable economic growth strategy. The latter also requires a sustainable financing mode for the resulting healthcare system. In the future, cost increases resulting from development of medical technology and the needs of an ageing population will exert constant pressure on the funding of the healthcare system. An additional factor likely to contribute to the upward pressure for health spending is the current low income of physicians and nurses employed in the public sector.<sup>48</sup>

Developing a strategy for sustainable financing<sup>49</sup> entails a thorough examination of the potential technological, demographic, social and economic trends that may affect the healthcare system over the next one or two decades. In this context the desirable role (and share) of the main sources of financing – the state budget, social insurance, voluntary insurance, and out-of-pocket payment – should be defined. One possibility would be to increase the share of revenues not related to labour income in financing compulsory health

insurance. Another issue of key importance is ensuring adequate human resources in the healthcare sector, which is a precondition for high-quality health care. This necessarily would entail a strategy to address the interrelated problem of the system of under-the-table payment and low wages in the public sector.

As health status and inequalities in health are influenced by socio-economic factors, individual behaviour and health care, an effective strategy should address these determinants as well. In this context, the strengthening of the co-ordination between health policy and other government activities (*e.g.* tax reform, agricultural policy, etc.)<sup>50</sup> is pertinent. In fact, such an approach is needed to implement Article 152 of the Maastricht Treaty, to ensure the “health in all policies” requirement.<sup>51</sup> Recent analysis of pertinent international experience could help the Hungarian government to develop such a strategy (Stahl *et al.*, 2006).

## Notes

1. Mortality from cancer and stroke was the highest, and mortality from ischemic heart disease the second highest among OECD countries.
2. Other countries performed better: the life expectancy of Czech males at the age of 40 was 4.9 years lower than the EU-15 average in 1990, but only 3.3 years lower in 2002.
3. In 2004, average EU-15 out-of-pocket payments amounted to 18% and private insurance to 5.6% of total health expenditure (and other private sources amounted to around 0.8%). In Hungary out-of-pocket payments and “under-the-table” payments amounted to 24% of total health expenditure, voluntary insurance to around 1%, and other private payments (companies and charities) to around 4.4%.
4. According to the government’s Convergence Programme, the share of public spending on health care in GDP is to be reduced by 0.6 percentage point between 2007 and 2009 (State Audit Office Methodological Institute, 2007).
5. The yearly average growth rate was 2.1% for public expenditure on health and 3.4% for GDP.
6. OECD, 2007a for the 2004 data, and OECD estimates for 2007 data.
7. The current (pre-reform) single-payer social health insurance system is operated by the National Health Insurance Fund Administration (NHIFA). The term Health Insurance Fund is used for the centralised fund, which is a separate part of the state budget.

8. Besides the 8% health insurance contribution, employers pay a HUF 1 950 flat rate monthly health insurance tax per employee.
9. Acute hospital care is reimbursed according to Homogeneous Diseases Groups (HDGs), a concept inspired by the American Diagnosis Related Groups (DRGs).
10. Except a pilot project of Care Coordination, which however failed to bring the expected changes in the delivery of care.
11. In particular, via the tightening of the connection between contribution payments and access to services and a more transparent regulation of what services are available to the insured, and under what circumstances.
12. Including the National Emergency Care Programme, National Anti-Cancer Program, and National Cardiovascular Programme.
13. According to Act No. 115/2006 healthcare providers are obliged to check the insurance status of patients through an online control system before providing services.
14. Information provided by the Ministry of Finance.
15. In 2007 around 34% of healthcare spending by the NHIFA (excluding cash benefits) was covered by the contribution paid by the central government on behalf of 59% of the entitled persons.
16. It was HUF 326.6 billion in 2007, compared to HUF 388.7 billion in 2006. Consumption of pharmaceuticals has also fallen due to the price sensitivity of patients' demand. The annual growth rate of overall private pharmaceutical expenditure was only 10% in 2007, implying that the decrease in real consumption and some price erosion have partially compensated for the 50% increase in statutory co-payments.
17. As in the second half of the year HUF 28 billion were spent on easing tensions in the hospital sector, the restructuring of the hospital sector did not result in net savings in 2007.
18. If the GP's one-month prescription data in the selected therapeutic categories exceeds the national average by more than 15%, from July 2008, the GP concerned will/can be penalised by the withdrawal of 1%-5% of his/her capitation fee received from the Health Insurance Fund. There is a period of four months when GPs can modify their prescription practice before the penalty is applied. .
19. Altogether 9 000 hospital beds were closed: the number of acute care hospital beds decreased by 26%, while beds available for rehabilitation and long-term care increased by 35%.
20. Many experts believe that the closure or transformation into nursing homes of around one-third of the hospitals would have been desirable. See, for example, Nepszabadsag (2007).

21. The bed structure of each hospital has been determined by Ministerial decree, rarely based on comprehensive cost-benefit analysis, and thus often resulting in sub-optimal changes in many hospitals.
22. The “performance-volume limit” was added to the provider payment systems in 2004. Each year, the NHIFA sets for each provider a monthly limit of the maximum number of DRG points and outpatient points (under a relative fee-for-services system), for which the given provider can receive payment.
23. Including EUR 119 million from domestic revenues. Data provided by the Ministry of Finance.
24. Here the term “co-payment” is used for all forms of cost-sharing.
25. Services not included in either of the two packages are available mainly for out-of-pocket payments, or through voluntary insurance.
26. The original concept of the Free Democrats (the party to which the Minister of Health belongs), namely the exclusive role of commercial insurance companies in providing compulsory health insurance was not agreed by the Socialist party, the majority party in the government coalition.
27. The President, however, sent the Act back to the Parliament, calling for reconsideration of several issues related to the content and process of the reform. A major argument of the President was the lack of adequate support by society and the professional staff for key elements of the Act. He also stated that the act left too many important details unresolved and lacked assessment of possible impacts. On 11 February 2008, the Parliament passed the Act with some additional amendments.
28. The National Health Insurance Fund will have the following responsibilities: the National Risk-pooling Fund to finance certain high-cost services, administrative expenses of the National Health Insurance Centre, the allocation of funds among the CHIFs on an adjusted per capita basis (of which 3.5% can be used for administration).
29. Compulsory health insurance funds are not allowed to offer voluntary health insurance, but a commercial insurance company holding shares in a CHIF can do so.
30. Administrative costs in decentralised insurance systems are obviously higher than in single-payer systems. When competition is introduced in an already decentralised social insurance system, it may lead to a decrease in administrative costs at a system level, due to a concentration (merger) of insurance funds, but even after such mergers, such costs are almost certain to be higher than in a single-payer system.
31. Each provider is given a monthly limit of the maximum number of DRG points and outpatient points (under a relative fee-for service system), for which it can receive payment from the NHIA.

32. Besides making GPs the first contact for patients, the initial reform in the early 1990s envisaged expanding preventive medicine, care-management for patients with chronic disease, and developing a system of quality assurance. General medicine as a specialisation was introduced. However, as a whole, the hoped-for changes in the role of GPs and patients' attitudes have not been achieved so far.
33. For example, consulting a specialist without GP referral not only involves more than three-times higher co-payment, but also precludes further referral to another specialist (unless the patient pays the full price). As mentioned, GPs are required to prescribe the cheapest suitable medicine.
34. The revenue of a GP practice does not depend on the services provided. The main element of the payment system is an age-adjusted per capita payment after each person registered with a GP.
35. Excluding GPs who concentrate on paediatric care for children.
36. The right to operate a practice became a transferable asset, which not only could be sold, but even deeded to one's spouse or descendants. It may not only be expensive, but also risky to buy a "practice license", for if the owner wants to change location, s/he cannot be sure that the "practice right" can be sold at a favourable price.
37. Small areas with a certain number of GP practices would be defined by a national body as concession areas. The national body managing the concession areas would contract with GPs, regulate the concession prices, and would have to buy back the concession right when the GP retires or leaves the area.
38. Planned by the Ministry of Health in 2008.
39. Introduction and proper operation of such a payment arrangement would require a well-designed programme. The ideal arrangement may be to start with a pilot; introducing a "learning by doing" process with proper monitoring; and co-operation between professional organisations of GPs, patients' organisations, and the new insurance funds.
40. International experience with the gatekeeping role of GPs is summarised in Annex 3.A1.
41. Two major components are: quality regulation (including, in a wider sense, the regulation of service coverage, protection against risk selection, quality assurance and control, and enabling patient choice) and economic regulation. The Netherlands, which introduced a system of competition between private insurers for provision of compulsory health insurance in 2006, has also instituted a new Healthcare Authority which proactively sets conditions for market forces with a view to achieving efficiency, choice, quality and accessibility of healthcare markets. The Authority supervises both healthcare providers and insurers. It supplements the work of the Health Care Insurance Board, which makes risk adjustment payments.

42. Although many elements of quality assurance and control exist (e.g. legal requirements for licensing, providers are obliged to operate a quality assurance system, etc.), they do not add up to a coherent system.
43. International experience shows that effective tools for quality assurance are important independently of the financing system.
44. Several centre hospitals do not have the technology and staff required for the highest level of emergency care; on the other hand, more hospitals have the status of centre hospital than would be reasonable on technical grounds.
45. The Health Insurance Supervisory Agency – among others – started to develop a quality indicator system in 2007.
46. As mentioned, in 2004 a system of hospital-specific, monthly volume (performance) limits was added to the provider payment systems, both for inpatient and outpatient care. Until 2006, providers received a reduced payment for the above-limit performance, according to a regressive scale. Since July 2006, NHIFA does not pay for the above-limit cases at all. As the volume limits were set (and remain) based on the 2003 basis of the providers' performance, the distortions then prevalent became built into the system. Empirical research suggests that this may adversely affect the quality of care: the greatest losses (compared to the pre-2004 financing) occurred in hospitals providing more specialised care and treating more serious diseases (Boncz, 2007).
47. For example, monitoring results could be reported to the National Health Council.
48. OECD data shows the remuneration of Hungarian physicians and nurses, as a ratio of GDP per capita, is lower than almost all other OECD countries (OECD, 2007b, p. 62).
49. An example to learn from is the Wanless (2002) report, commissioned by the UK Government.
50. Recent changes have actually tended to go in the opposite direction: the supervisory role of the National Public Health Authority has been reduced by taking away the tasks of food health and occupational health. Furthermore, a cross-department institution, the Office of Government Officer for Prevention was eliminated in 2006.
51. This requires that “a high level of human health protection shall be ensured in the definition and implementation of all Community policies and activities.”

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## *Annex 3.A1*

### ***International Experience regarding the Function of Gatekeeping***

Gatekeepers are, most generally, primary care physicians who oversee/control access to the healthcare system. These systems are widespread in northern Europe and in most countries with integrated models of financing. They play a growing role within the context of managed care insurance arrangements, in the United States and elsewhere.

Two key reasons for putting in place a gatekeeping system are:

- Rationing of healthcare resources by limiting access to specialist care. The expectation is that the primary care physician will provide appropriate/quality care but limit the use of healthcare system at a higher level (specialists or hospital) to where it is medically warranted.
- Improve co-ordination of care: by channelling information and choice of medical options through the gatekeeper, the GP may be able to ensure that the patient is receiving quality care when and where it is needed. This is particularly important for patients with chronic conditions.

There is some tension between the two dimensions: there may be a temptation to place more emphasis on cost control in the first case, with the risk that patients receive too little care.

There are a number of conditions likely to make gatekeeper arrangements work better.

- First, there must be patient confidence that the gatekeeper provides appropriate care. The less confidence that patients have in the quality of the care provided, the greater the value of the provider choice to the patient. These problems appear less in countries where concerns over quality issues have been largely dealt with through a combination of treating general medicine as a specialisation in its own right; periodic re-certification of medical practitioners; and adequate oversight of practice patterns either by independent public bodies or by professional associations to ensure that “best practice” medicine is being provided.

- Second, payment arrangements must provide the appropriate incentives. Many countries have now moved to mixed payment systems that combine elements of capitation, fee-for-service and lump sum or salary. Finding the right balance between the components remains difficult and will depend on the context in each country. If care co-ordination is an important goal then payment arrangements will need to be adjusted to ensure that doctors are reimbursed for co-ordination activities, particularly for the chronically ill.
- Third, information flows need to improve: co-ordination of care requires that the medical practitioner has the necessary information to make appropriate clinical decisions. For example, specialists or hospitals may fail to send discharge information back to the GP and – as pointed out in a recent survey of care co-ordination policies (Hofmarcher *et al.*, [2007], “Improved Health System Performance through Better Care Coordination”, *OECD Health Working Papers*, No. 30, OECD, Paris) there are particular co-ordination difficulties at the transition into long-term care.
- Finally, new models for providing and paying for primary care need to be explored. “Budget holding” in the United Kingdom provides an example of how these arrangements can potentially provide incentives to control costs. Where the primary practice has an indicative budget to provide services for its registered patients, it may be more judicious in providing services, but at the risk of preventing access to medically beneficial treatment for individual patients.