

# Values, Institutions and Shifting Policy Paradigms: Expansion of the Israeli National Health Insurance Basket of Services



David Chinitz

Hebrew University–Hadassah School of Public Health

## INTRODUCTION

### Values and Institutions: Paradigmatic Considerations

The past decades of health reform have evolved a number of strands of decision - making orientations. These orientations have developed with varying degrees of self -consciousness on the part of decision makers and analysts. They have come in and out of policy making sometimes simultaneously, sometimes sequentially. In some cases decision-making approaches are introduced step-wise, with one perspective or philosophy, such as economics, dominating the thrust of discussion while other areas, such as social justice theory and ethics appear to take up the residual issues spawned by the economists.

Indeed, it seems fair to say that, analogous to linear programming, the economists have appeared to be maximizing their own impact, bowing, if necessary, only when finished their work to the set of constraints posed by other disciplines. The members of other disciplines can be only so indignant about this. The consensus that the root of the health care policy problem has been the need to attend to cost containment has put the economists in the driver's seat. So much so, that even the economists have sometimes forgotten that the economic calculus involves utility as much as costs. Of course, economists have developed measures of utility that purport to capture non-monetary benefits of health services and reflect the values of society, but here they have been very much in need of the "constraint" disciplines: political science, ethics (if this is a discipline), sociology, psychology, etc.

The subordinate role filled by the "residual" orientations has run its course. Indeed, the "economics first" approach to health policy has only served to clarify that we need to go back to the drawing board. Health care reform, economist style, has led health policy quite forthrightly into areas where economics falters. Somatic health care services, with all their nasty measurement problems, especially regarding health outcomes, stretch the economic calculus to the limit. Once into areas of mental health, long term care, preventive care, and health promotion, economics cannot go it alone, not even in the first instance. A cost benefit approach reliant on measurable outcomes is standing with the water up to its neck when it comes to acute care. One more step into the boundary areas mentioned above and economics drown.

Fortunately, economics itself has produced the remedy to this predicament, although by no means one well integrated into mainstream, neo-classical economics. Led by Nobel laureates Herbert Simon and Douglass North, together with the father of transaction cost economics, Oliver Williamson, institutional economics opens the way to cope on the boundaries. While neo-classical economics has achieved the status of mathematical elegance, institutional economics is still very much a verbally articulated realm of discourse. It is, as von Bertalanffy might put it, not yet unambiguous, based on strict deduction, and verifiable, based on observed data. However, institutional economics provides a new way of looking at complex policy problems. Its perspective is, as of now, more lateral than linear. Neo-classical economics has given us cost-utility analysis and outcomes research as tools for handling the difficult problems of the health care system. However, when it comes to handling the boundary areas, going boldly, as it were, into inter-disciplinary, multi-sectoral realms such as mental health and disease prevention, intuition speaks for an institutional approach.

Institutional economics provides us with at least three constructs, perhaps paradigms that appear up to handling these challenges. From Herbert Simon comes the notion of comparative institutional analysis (Simon, 1978). Simon's point was that social policy issues rarely begin with clear objective functions that can be maximized. Simon suggested that the appropriate way to solve such problems was to compare institutional alternatives. Wildavsky later amplified this with his dictum that policy analysis is always the choice among bundles of alternatives that combine ends and means,

never just one or the other (Wildavsky, 1979). The simultaneous consideration of several ends/means combinations tends to elucidate the values held by those supporting different policy options. Eugene Bardach (2004) crystallizes this approach in the form of the policy tradeoff matrix, which simultaneously considers ends and means. An example is provided later in this paper.

The second major input coming from institutional economics is Douglass North's emphasis on the public understanding and support of the major policy institutions in society. Some of North's key points relevant to this discussion are:

- ◆ Political institutions will be stable only if under-girded by organizations with a stake in their perpetuation.
- ◆ Both institutions and belief systems must change for successful reform since it is the mental models of the actors that will shape choices.
- ◆ Developing norms of behavior that will support and legitimize new rules is a lengthy process and in the absence of such reinforcing mechanisms, polities will tend to be unstable.

Finally, Oliver Williamson (1975, 1996) has given us one key dimension, in some ways more mathematical, for carrying out Simon's notion of comparative institutional analysis, namely, transaction cost analysis. Williamson's insight was that institutions are the mechanism by which transactions are arranged. For any given interchange, different institutional arrangements will produce varying levels of cooperation, cheating, opportunism, etc. Williamson also noted that different styles of organizing transactions appeal to different "atmospheric" characteristics of society, such as social tension, trust and culture. More about the special role of considerations of atmosphere, especially social values, below. Much of the literature concerning implementation of policy, especially that of Bardach (1979), echoes Williamson's focus on the way in which institutions shape the behavior of stakeholders in policy environments.

This paper applies this perspective on paradigms of policy analysis to questions regarding values and institutions in health policy. I argue that derivatives of neo-classical economics, such as the "new public management," have exhausted themselves on the altar of health care reform, though not without significant contribution to policy solutions. However, this process

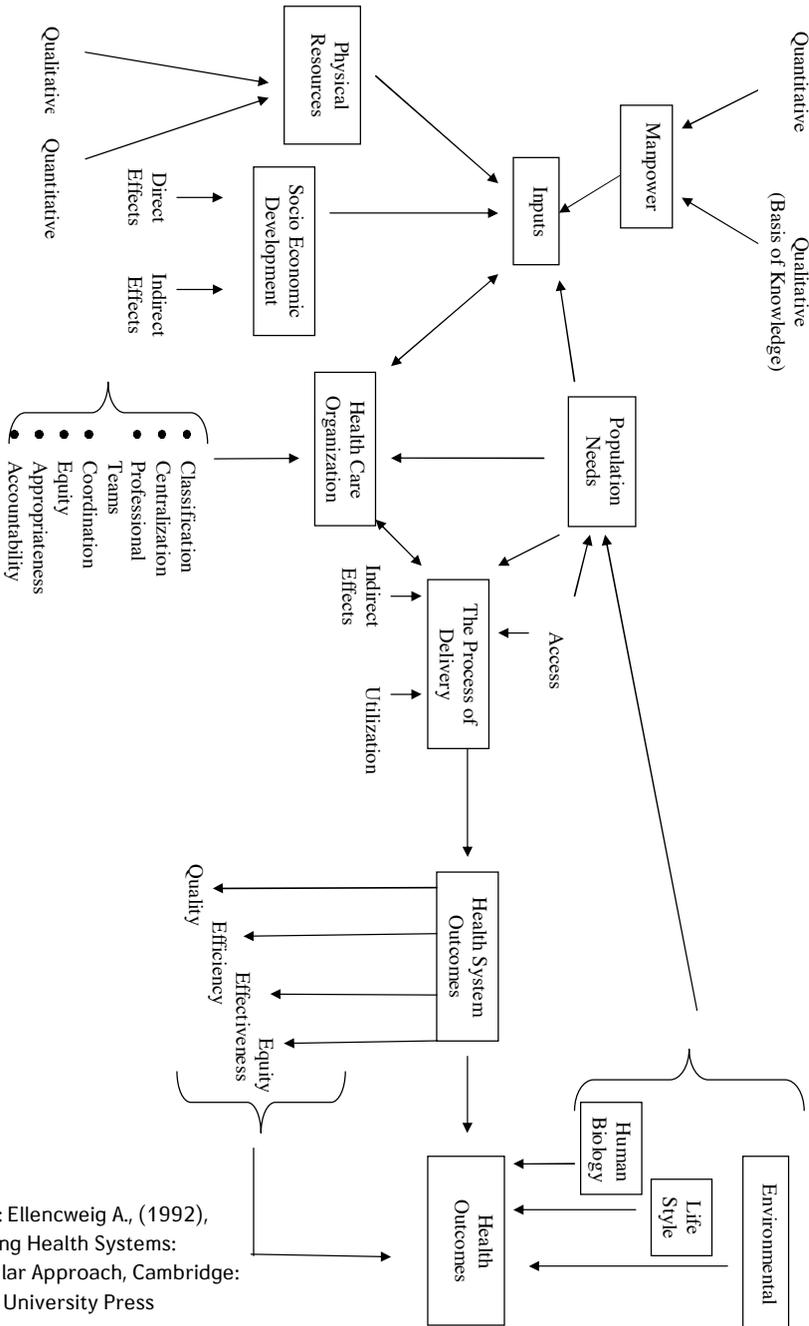
has called forth the need for a more institutional approach, not least because, at one and the same time, values are so forthrightly implicated in health policy, but are also difficult to articulate and handle through economic modeling of tradeoffs. A key argument of the paper is that it is the very success of a policy paradigm that sows the seeds of policy failure when the model is assumed appropriate for an expanded menu of missions.

Section 1 expands more specifically on the themes raised in the introduction and presents necessary background on the two case studies to be presented in the context of the Israeli health system reform. Section 2 deals with the first of these, highlighting the question of public understanding as alluded to above in connection with defining and updating a standard basket of health services mandated by law. Section 3 takes up the recent developments in Israeli mental health policy as an example of the conceptual policy analytic issues raised as health reform moves beyond somatic care, again focusing primarily on the attempt to define the mental health services basket. The conclusion draws lessons regarding policy paradigms from the two cases for Israeli and international health system policy.

## **I. Sideways: Lateral Thinking in Health Reform**

I have already introduced the argument that the orientation of health system reform is shifting from the paradigm of economics to a pre-paradigmatic general systems approach. This perspective derives from a volume produced in 1992 by Avi Ellencweig, *Analyzing Health Systems: a Modular Approach*. Ellencweig took Donabedian's rather rudimentary application of systems theory to health and fleshed it out by delineating a macro model of a health system. This is seen in Figure 1.

**Figure 1: A Macro Model of Health System**



Source: Ellencweig A., (1992), Analyzing Health Systems: A Modular Approach, Cambridge: Oxford University Press

One of the virtues of this model is that if one is studying one module, or a relatively limited number of modules, it is likely that existing paradigms will be able to handle the complexity. For example, health care reform has been predominantly occupied with the two process modules, health care organization and the process of delivery. Hence, economics was well equipped to play a key, leading role in the discussion. Even when the analysis broadened out to issues of outcomes, the existing disciplines, led by economics and epidemiology, were able to progress by developing a new field: evidence based medicine. Health technology assessment, increasing refinement of reimbursement methods such as risk adjusted capitation and risk adjusted outcomes measurement are examples of developments that, while they have their limitations, will no doubt remain robust features of health policy making for the foreseeable future.

On the other hand, these spearheads of health reform seem to have faltered when dealing with issues of inputs, such as the health work force. Relatively little policy analytic attention has been given to this issue. A tenable hypothesis to explain this is that the challenges of changing the medical profession, re-tailoring medical school curricula, controlling the stock and flow of physicians (especially in an era of professional mobility) have been, at least until now, too big for well-defined disciplines to handle. While there are some outstanding examples of physician leaders who have plunged head first into the realm of policy and management, it seems that the vast majority of physicians in Western countries remain at odds with the central thrusts of health policy based on models such as new public management.

As the preoccupation with the middle, process models, exhausts itself and reaches its limits, the need to expand health reform into the further reaches of Ellencweig's model becomes clear. The disciplines needed for this expansion are those that can provide models for managing policy on the boundaries, for example between health and social services. Sociology, psychology, social work, marketing, education and others come to mind. In particular, a focus on institutional arrangements seems relevant as the need to manage complex interactions among actors from different sectors seems salient.

In the following sections we look at these developments in the context of two examples from Israel. The first is the implementation of the 1995 National Health Insurance Law (NHI) the implementation of which was

based on a fairly well defined version of regulated competition. The second is the failed implementation of the transfer of mental health services from government to the country's health funds. This last change has always been perceived by reformers and opponents alike as a continuation of the implementation of the National Health Insurance Law, which provides for the transfer of mental health services to the health funds.

Arguably, the greatest policy learning coming out of NHI has come in the area of defining and especially updating the standard basket of services. Therefore, this dimension will feature in the presentation of the two cases. It will be argued that the two cases support the conceptual analysis presented above. In particular, it will be argued that empirical evidence suggests that the decision making processes related to defining the basket of physical/somatic services in the context of regulated competition among sick funds have increased public understanding and merit public trust, markers of a relatively successful paradigm. Regarding mental health services, however, it will be argued that the very success of the regulated competition paradigm for physical health blocks development of an alternative paradigm based on improvement of existing public services.

## **II. Institutions, Values and Public Understanding: the NHI Standard Basket**

In 1995 Israel enacted a National Health Insurance Law (NHI) to replace a situation in which the vast majority (96%) of Israelis were insured voluntarily in four sick funds. Despite this virtue of nearly universal coverage the system was plagued by a number of problems:

- Financial instability
- Public dissatisfaction
- Provider dissatisfaction
- Underutilization of hospital infrastructure
- Fragmentation of services
- An uninsured population large in absolute terms

The National Health Insurance Law was part of a three pronged effort at reform enunciated by the Netanyahu Commission, a state commission of inquiry that reported its findings in 1990. The other two planks of the intended reform, changing government hospitals to public trusts and

reorganizing the Ministry of Health, were never officially implemented by the government, due mainly to the resistance of hospital labor unions. From a rational planning point of view, the partiality of the reform is a recipe for policy implementation frustration. Nonetheless, from a policy learning point of view (Helderman, Schut, van der Grinten, & Van de Ven, 2005), the chain of events set in motion by the enactment of National Health Insurance is too important to be seen only through the lens of a comparison to what a "perfect" policy would have led to.

In particular, the Israeli National Health Insurance Law created one radical change the effect of which is not dependent on the implementation of the entire envisioned reform: mandate of a standard basket of services that the four sickness funds are required to provide to their members if prescribed by a physician. The emphasis on this provision was a reaction to the prior situation in which each sick fund could determine its own basket of services, and was not legally required to provide any particular service. While other countries, such as the Netherlands (Berg & Van der Grinten, 2004) and New Zealand (Chinitz, 1999) abandoned the idea of a core basket of health services, Israel went quite clearly, if not resolutely, down this road.

The Israeli basket of services is listed as an appendix to NHI. It includes not only the names of specific procedures and pharmaceuticals, but also detailed guidelines as to the indications for use of these services. Thus, if a physician prescribes an "off indication" or "outside of the guideline" use of a particular drug, the sick fund is within its legal rights to refuse to comply. Qualitative research by this author indicates that physicians spend up to 10% of their time engaged in quarrels with sick fund managers over these points. The physicians often win these arguments, but the sentinel effect is bound to be large, and the organizational implications in terms of both efficiency and morale, significant.

NHI gives parliament the right to remove items from the basket, and to add items on condition that budgets are made available by the government (implying agreement between the Ministers of Health and Finance) to cover the anticipated costs. As a result of political processes described elsewhere (Chinitz, Shalev, Galai, & Israeli, 1998), it was decided in 1998 to create a public committee to consider the addition of new services to the basket, with the Ministry of Finance agreeing to provide an annual increment of about 1% to the known cost of the basket for this purpose.

The professional committee meets several times a year and its activities

are often covered in the media. The process begins with a ranking of potential new services, based on health technology assessment performed in the Ministry of Health (MOH), presented to the committee. The twenty-four man committee, made up of physicians, MOH representatives, sick fund representatives and public representatives, then deliberates based on various ethical, economic and social criteria in order to arrive at a ranking and a decision as to which services will be included within the available budget.

Not surprisingly, the list of services, mainly pharmaceuticals, seeking entrance into the basket, far exceeds the available funding. In notable cases, such as the decision to add herceptin for treatment of breast cancer to the basket, pressure exerted by lobby groups and parliamentarians overcame, apparently, the inclination of the professional committee based on health technology assessment. Moreover, the level of funding varies substantially from year to year, and the decisions of the committee are subject to Cabinet approval, such that the process remains a mix, sometimes unstable but still impressive, of science and politics.

### **Public Attitudes and Understanding Regarding the Standard Basket: Methods, Findings and Policy Implications**

Beginning in 1995, a group of researchers at the Hebrew University created a framework for monitoring public attitudes towards the determination of the standard basket of services. Fortunately, funding was available from the Israel National Institute for Health Policy Research, to carry out a series of surveys and focus groups on this subject from 1997 till the present. From 1999, the project included surveys of physicians as well as of the general public. The methodology is described in a final technical report to the Institute (Chinitz, Alster Grau, & Israeli, 2004); here we focus on the major results.

The main advantage of this research project is its longitudinal aspect. Whatever the methodological problems involved in measuring public priorities at any one point in time, repeated surveys provide an indication of whether public priorities are shifting. This would be expected as public consciousness of the issue, for example due to media coverage of the policy processes surrounding the standard basket of services, becomes more acute.

## Public and Physician Priorities for Coverage under NHI

A major finding of the project, pertinent to the discussion here, was that the Israeli public, while giving most vignettes higher rankings than produced by a similar US study (Fowler, 1994), did differentiate among different services areas. In addition, over time we found two striking findings: first, the scores, in general went down. This might indicate that the Israeli public was becoming sensitized to the need to prioritize services, thus lowering the rankings given in general<sup>1</sup>. Second, as indicated by the highlighted row in Table 1, there appeared to be a shift from prioritization of life extending treatments in the case of terminal illnesses and, to an extent, even in the case of life extending treatments in non-terminal conditions (transplants, expensive to treat diseases, interventions for premature infants), towards increased preference for treatments adding quality to life.<sup>2</sup>

**Table 1:** Public rankings of health services over time  
(1 = low priority, 10 = high priority, average scores and relative rank)

	1997	2001
Transplants	8.8 (1)	7.87 (1)
Expensive treatments	8.23 (2)	7.62 (3)
Nursing care	8.1 (3)	7.39 (6)
Minor problems	8.0 (4)	7.23 (7)
<b>Terminal conditions</b>	<b>7.88 (5)</b>	<b>6.77 (12)</b>
<b>Quality of life</b>	<b>7.82 (6)</b>	<b>7.69 (2)</b>
Mental health	7.75 (7)	7.61 (4)
Fertility treatments	7.69 (8)	7.5 (5)
Second opinion	7.64 (9)	7.06 (8)
Anxiety relief screening	7.6 (10)	6.83 (9)
Addictions	7.3 (11)	6.82 (10)
Cosmetic treatments	7.29 (12)	6.78 (11)
Alternative medicine	7.07 (13)	6.09 (14)
Dental care	6.64 (14)	6.12 (13)

1. As discussed in the technical report *sic*. These lowered scores were maintained over time.

2. Between 1997 and 2001 cost and effectiveness information was increased in some of the vignettes, such that this may explain some of the shift in rankings.

In order to strengthen the validity of the results, we posed budget pie questions to the respondents asking them to indicate to which of several competing services they would allocate a budgetary increment. As reported elsewhere (Chinitz et al., 2004), we found considerable similarity in the results produced by the two methods. In the first two surveys, and according to both methodologies, we found that public health interventions such as preventive dental care and smoking cessation receive relatively low scores. However, in the 2003 survey, both the public and physicians gave high scores, at least according to the budget pie method, to screening for diabetes and breast cancer, and the physicians also ranked preventive dental care and smoking cessation relatively highly.

An interesting question concerns the degree to which the indicated preferences of the public and physicians correspond with the decisions of the Committee to Update the Standard Basket. Comparison of physician priorities, for example, regarding services decided upon by the committee reveals disagreement between physicians and the committee. As indicated, for many health services, physician and public preferences are comparable. Moreover, other findings from the surveys indicate that the public places high levels of trust in physicians' views on health care resource allocation decisions. Thus, the possibility is raised that if the committee were aware of these physician and public preferences, the ultimate allocation decisions might shift, in particular away from dramatic life saving interventions or treatment of highly expensive rare conditions, to an emphasis on prevention and quality of life.

These findings were supported not only by data from the discussions in focus groups held with physicians, but even in a small number of questionnaires filled out by members of the public committee. In a number of cases, members of the committee gave higher rankings to services that had not been approved by the committee, than to services that were approved. Given that, informally, the committee indicates that decisions are made "unanimously," a picture emerges that some form of political or social pressure may be at work leading to approval of dramatic life saving services. Alternatively, what might be reflected by these results is the internal make-up of the committee with relatively influential members favoring expensive cures over preventive interventions. One wonders how the committee would decide if aware that, when compared to prevention of pneumonia, all services receive lower priority for both the public and the physicians.

These findings raise the possibility, discussed below, that such surveys could be used by, say, the public committee to "adjust" the pressure felt to fund dramatic life saving interventions and give higher priority to prevention and screening.

### **Public and Physician Attitudes towards Health Policy and Priority Setting Processes**

The robustness of the priority setting process is likely to be influenced by the level of trust in institutions in general, awareness of the process, trust in the decision making process itself and attitudes towards the proper locus of medical decision making.

On the first point, the investigators broke new ground by asking respondents specifically about trust in the health system and various bodies that might be involved in making health policy decisions. It is well known from other studies that levels of trust in government institutions have been on the decline and have reached new lows. Thus, it may be somewhat surprising to note that Table 2 indicates higher than perhaps expected levels of trust in institutions dealing specifically with health, such as the Ministry of Health and the sick funds.

**Table 2:** Trust in Institutions Dealing with Health Policy

TRUST	Public 2001		Public 2003		Public 2004		Doctors 2003	
	Full/high	some	Full/high	some	Full/high	some	Full/high	some
MOH	34	34.5	41	35	35	32.5	41	42
Sick Funds	45	34.5	49	35	43	33	38.5	43
MOF	15.5	22	16	19	17	20	10	24
HARI	36	21	38	23	22	19.5	54	25.5
Knesset	13	18	15	22	13.5	21.5	13	32.5
Media	24	26	28	32	30.5	26.5	23	34
Consumers	18	15	19	14	15	11	18.5	24
Court	42	21	48	25	35	23.5	44	28.5

Abbreviations in table: MOH=Ministry of Health; MOF=Ministry of Finance; HARI=Israel Medical Association.

Regarding awareness of the decision making process regarding the basket of services, Table 3 indicates that between 1998 and 2001 levels of awareness rose and then seemed to retreat after that. The interpretation of these findings is below in the discussion section.

**Table 3:** Percentages of the Public and Physicians Thinking that Different Bodies Decide on the Basket (by year).

	Public 2001	Public 2003	Public 2004	Physicians 2003
Ministry of Finance	32	37	30	27
Ministry of Health	31	19	29	20
Health Funds	8	8	8	10
Committee to Update the Basket	3	18	7	31
Other, don't know or no answer	26	18	26	12

The study also examined the degree of trust the respondents have in the system of updating the basic basket. Table 4 presents the results:

**Table 4:** Trust levels of the Public and Physicians in the Basket Updating System (percents by year).

	Public 2001	Public 2003	Public 2004	Physicians 2003	Physician Focus Groups
Full trust or high trust	24	24	16	17	35
Some trust	36	36	34	47	58
Low trust or no trust	35	33	35	33	7
No answer	5	7	15	3	

The results indicate that when the process of updating the basket was initiated, over two thirds of the general public indicated trust or some trust in the system. This percentage declined in 2004. Physicians exhibit higher levels of trust in the system in 2003 and physicians responding in focus groups have the highest level of trust in the system.

Finally, we asked respondents a question about the locus of medical decision making in specific cases. Our results show that while about one third of the public would prefer the patient's physician to make decisions, there is similar support for a committee of experts.

### **SUMMARY: Priority Setting, Public Understanding, Policy Paradigms**

The study produced findings in two major areas relevant to the theme of this paper. The first major area concerns the priorities of the public and physicians regarding inclusion of different services in the basket. The second has to do with knowledge about and attitudes, in particular trust, regarding the process of updating the basket of services. The two areas are related, as the process can be influenced, enhanced, or made more difficult in view of changing public priorities. At the same time, citizens' priorities may be influenced by their awareness of substance and process of decision making regarding the basket.

This last point relates to the rising and ebbing levels of trust in decision making processes regarding the basket of services. When the process is explained to both the public and physicians, and when it was relatively prominent in public discussions (as was the case between 1999 and 2003) levels of awareness and support for it appear relatively high. However, during periods when the process was stalled, as for example during 2003-2004, the public appears to feel that decisions about the basket are being made more by the Ministry of Finance than by a professional committee, and trust in the system wanes as well. This indicates that public attitudes and trust in the health policy system are affected by the degree to which the process is visible. Politicians and decision makers have preferred to limit the visibility of health priority setting processes. This research suggests that a public well informed about the activities of a professional committee charged with updating the basket of services may relieve some of the perceived pressure for decision makers.

The research demonstrates that the public is able to cope with the difficult issues raised in the survey instrument. It also indicates that public responses are influenced by developments in the health system, such as the "freezing" of the budget for additions to the basic basket during 2003-2004. This has a negative effect on levels of trust in the policy - making

machinery, though levels of trust in health policy-making institutions such as the Ministry of Health and the sick funds remain high, certainly relative to levels of trust in government institutions in general. It would appear desirable to nurture such trust.

Unfortunately, recent developments in policies regarding the basic basket of services appear to do the opposite. Failure to fund updating of the basket has led to controversial expansion of health fund supplemental insurance and vociferous debates about the very future of National Health Insurance. These developments threaten support for the institutional paradigm upon which NHI is based. Ironically, at the same time, the paradigm is being stretched, perhaps inappropriately, to cope with the interdisciplinary and multi-sector realm of mental health. This paradigm stretch is discussed in the next section.

### **III. Values and Institutions in Mental Health Reform<sup>3</sup>**

As mentioned above, mental health services were supposed to have been dealt with similarly to what has been described for somatic health services. The fact remains that despite the announcement by various Ministry of Health (MOH) officials of target dates for doing so over the last twelve years, the policy was never implemented. The recurring outcome has been perceived by many as an unacceptable implementation failure. Alternatively, it could be taken as a hint that the policy is not worthwhile. From a policy learning point of view, it could be the case that the perceived success of NHI after repeated attempts at adoption has "addicted" reformers to radical change. Moreover, the fact that in recent years the health funds have become financially balanced while providing service generally considered satisfactory by the public, strengthens the impression that the health funds should be the auspices for anything related to health services.

---

3. This section is based on intensive participant observation of the author as a consultant to the Association of Public Psychologists and Social Workers opposed to the transfer of mental health services to the health funds, and is based on position papers written in that context. While clearly not an objective perspective, it should be pointed out that the author's position on the reform was already laid out in a 1998 paper on the subject (Chinitz 1998a).

Indeed, the mental health reform, while covering ambulatory as well as inpatient care, is labeled by many, including the Minister of Health, as the "psychiatric" reform, indicating the dominance of the bio-medical model in policy making. Placing mental health squarely in the medical realm encourages the perception that the health funds are the proper locus for this activity. Finally, the success of the process for updating the standard basket of services makes it attractive to seek to define mental health entitlements in a similar manner.

Perhaps one of the key stakeholder groups, Ministry of Finance (MOF) officials, in previous years seen as major budgetary opponents of the mental reform, came around to support it because of the successful financial management of the health fund system. During the years of failed implementation, the MOF has succeeded in reducing the government work force, especially in ambulatory mental health clinics, contributing to long queues for outpatient mental health care. Pressure to implement the reform is quite strong from various stakeholders, including MOH management and patient groups. MOH is keen to add to the health system any resources MOF will make available. Patient groups want to see mental health given the same legal status as somatic health. The MOF, for its part, also views the transfer of mental health to the health funds as part of an overall ideological position seeking to reduce direct government operation of services. The debate over the mental health reform now focuses primarily on the size of the budget to be given to the health funds in order for them to agree to add mental health services to their standard basket. The MOH and MOF agreed on amount of about 160 million NIS; even if this is ultimately doubled, one could envision the MOF agreeing, in part in order to achieve a reduction of the public workforce, based on the perception that government worker salaries and benefits are more expensive than health fund workers.

In order to close the deal, however, MOH and MOF had to agree on a list of entitlements for mental health structured similarly to the existing health fund basket. Hence the basket envisioned for mental health services is defined in terms of maximum numbers of sessions for ambulatory care. The staff of the mental health clinics argues that the definition of the basket in such terms, based on diagnoses of mental illness, will eliminate preventive care for citizens in psychological crisis situations that do not necessarily qualify as diagnosed illness. As the debate

has evolved, MOH officials have promised that initial assessments will be available to all individuals seeking mental health intervention. Be that as it may, it is still not obvious that mental health benefits should be defined in the same way as somatic health benefits. For example, and somewhat ironically, in the context of managed behavioral health care in the US, mental health benefits have been increasingly mandated based on the notion of "parity," namely, not limiting numbers of treatment sessions in the same way that numbers of somatic treatments or doctors visits are not limited.

The paradigm of a standard basket, then, a subject of significant policy learning regarding physical health services, is arguably problematic for mental health services. The latter may require a more flexible articulation of entitlements, leaving care providers with latitude to design care protocols tailored to individual cases. The problem is, however, that stakeholders supporting the proposed reform argue that a flexible definition of entitlements will lead to overuse of services, especially talk therapy, for too wide a section of the population. As one MOF official put it, "not every hi-tech employee who loses his position should be entitled to talk to a psychologist at public expense."

Public psychologists respond that failure to take up such cases, based on professional assessment, could lead to deteriorating mental health in the future. They argue that they are able to determine what basket of care is best suited to each person in their care. Suggestions have even been made that public mental health workers are able to sort out patients based on socio-economic level, politely suggesting to better-off patients that they seek care in the private sector. This raises a kind of reverse equity dilemma; namely, can a universal public entitlement to mental health services be rationed according to ability to pay in order to stretch the public budget further? Public understanding and trust, to the extent they have become more robust since the enactment of NHI, might be strained by this type of arrangement.

One diagnosis of this situation is that the paradigm of regulated competition, while relatively successful for physical health, is not appropriate for mental health. We are moving out from the inner modules of the health system to modules having to do with social care. What is the best way to institutionalize care of needs that fall on the boundaries between modules?

Following the guidance provided by Simon, Wildavsky, Williamson and Bardach as discussed above, one can fill the policy vacuum by enumerating alternative institutional arrangements and comparing them in terms of criteria important to major stakeholders. The payoff matrix presented in Figure 2 constitutes a framework for this analysis.

**Figure2:** Payoff Matrix for Israeli Mental Health Reform Alternatives:

	Continuity	Coordination	Training	Medical Records	Prevention	Community Orientation	Cost	Cost Effectiveness	Cost Benefit
Status quo	+	+	+	+	+	+	+	-	+/-
Expand existing Services	+	+	+	+	+	+	+/-	+/-	+/-
Flexible basket of services provided by existing system	+	+	+	+	+	+	-	+/-	+/-
Detailed basket of services with sick fund public clinic contracting	+/-	+/-	+/-	+/-	+/-	-	+/-	+/-	+/-
Transfer of mental health to sick fund basket	-	-	-	-	-	-	+	+/-	+/-

The rating proposed in the cells are, to say the least, arguable (although the author subscribes to them!). For the purposes of this paper let us assume that the alternative appearing in the third row, a flexible basket of mental health services to be provided by the existing public system, is indeed the preferred option. What is meant by this is a form of flexible planning

(Saltman & Von Otter, 1992) in which agencies, such as community mental health clinics, are expected to provide appropriate care to their populations, measured according to parameters such as case management, waiting times, and client satisfaction. If this is the case, we are talking not about new public management, quasi markets, the third way, or regulated competition. We are suggesting a different paradigm in which transactions between purchaser, provider and client are more formalized and explicit than under the current system, but not based, necessarily, on contracts and competition. We are in the realm of better public management, a better combination of what Bardach calls purposefulness on the part of public servants, public understanding and trust. At first glance, the proposition to base mental health services on such grounds seems naïve, especially after two or more decades of new public management and ostensibly enforceable contracts dominating health reform. Yet, there would appear to be persuasive arguments for revisiting public management and investigating ways of motivating better performance, especially when the deficiencies of applying regulated competition (the model in the last row) to mental health services are taken into account. While this would appear to be reversion to an old paradigm (nanny state?), after the ensconcing of health policy in the framework of regulated competition it is arguably development of a new paradigm.

#### **IV. CONCLUSION**

The Israeli case presents perhaps the most comprehensive and successful attempts to implement a program of universal health care coverage through a system of regulated competition. In the area of physical health services, the system appears to have coped adequately with one of the most daunting challenges facing regulated competition: the definition and update of a standard basket of health services to be provided within a pre-determined national budget. While the process of updating the standard basket mandated by NHI is not without its problems, it appears to constitute a reasonable melding of science and politics that merits public trust, or at least has withstood the barbs of public scrutiny.

The success of NHI implementation has lifted it to paradigmatic status in Israeli health policy circles. Disregarding the contingency approach, most major stakeholders appear to assume that what is good for physical health

is good for mental health. Thus, ironically, successful policy implementation in a complex, value laden realm may turn into bad policy in another similarly value laden realm.

The question is how to reconfigure the disciplinary pecking order that provides the conceptual framework used in one stage of health system reform in order to address the needs of future stages. It would appear that many health systems have reached this policy crossroads. While past reforms have emphasized the contracting, pricing, outcome measures, and regulatory practices appropriate to economic, market driven models, future reforms would seem to call for more inter-sectoral coordination, and better public management based on purposefulness and trust. These characteristics are typically assumed to be in short supply. However, the response to this predicament should not be a knee jerk reliance on markets, but rather, a spreading out of available institutional alternatives and their comparison according to criteria that reflect the values of major stakeholders.

The one dimension that both approaches require is, following North, an adequate level of public understanding and trust in the institutions that evolve in order to tackle complex, value laden public policy decisions. Health policy makers should seek to identify what has worked, institutionally, in terms of nurturing public understanding in bio-medical health policy, and apply these institutional lessons in other areas, such as social health policy.

## REFERENCES

---

- Bardach, E. (1979). *The implementation game*. Cambridge, MA: MIT Press.
- Bardach, E. (2004). *A practical guide for policy analysis: The eightfold path to more effective problem solving*. Washington, D. C.: CQ Press.
- Berg, M, van der Grinte, T, & Klazinga, N (2004). Technology assessment, priority setting, and appropriate care in Dutch health care. *International Journal of Technology Assessment in Health Care*, 20(1), 35-43.
- Chinitz, D. (1995). Israel's health policy breakthrough: The politics of reform and the reform of politics. *Journal of Health Politics, Policy and Law* 20: 909-932.
- Chinitz, D. & Israeli, A. (1997). Health reform and rationing in Israel. *Health Affairs* 16:4 206-211.
- Chinitz, D. (1998a). Managed care of lessons from abroad: A comment on early lessons from the rise of managed behavioral health care by John Showalter. *Israel Journal of Psychiatry*, 135,(3), 178-183.
- Chinitz, D., Shalev, C., Galai, N. & Israeli, A. (1998b). Israel's basic basket of services: The importance of being explicitly implicit. *British Medical Journal*, 317, 1000-1007.
- Chinitz, D. (1999). Health policy in Israel: Technocracy vs politics revisited. *Social Security*, 54: 53-68 (Hebrew).
- Chinitz, D., & Israeli, A. (1999). Rationing-How and who? *Israel Medical Association Journal*, 1(3), 210-213.
- Chinitz, D. & Israeli, A. (2001). *Health care rationing and the uninsured: Diagnosis and care in international perspective*. Davis, CA: Springer-Kluwer.
- Chinitz, D., Alster Grau, I, & Israeli, A. (2004). *Public attitudes towards inclusion of services in the standard basket under national health insurance: Final technical report to the Israel National Institute for Health Policy Research*.
- Chinitz, D. (2007). Review essay: Coping accountably in a dangerous world. *Health Economics, Policy and Law*, Vol. 3 forthcoming.
- Coulter, A., & Ham, C. (2001). *The global challenge of health care rationing*. Buckingham: Open University Press.
- Ellencweig, A. (1992). *Analyzing health systems: A modular approach*. Oxford: Oxford University Press.
- Evans, R. G. (2005). Fellow travelers on a contested path: Power, purpose, and the evolution of European health care systems. *Journal of Health, Politics, Policy and Law*, 30, 277 - 294.
- Fowler, F., Berwick, D., Roman, A., & Massagali, M. (1994). Measuring public preferences for health insurance coverage. *Medical Care*, 32, 625-639.
- Helderman, J.-K., Schut, F. T., van der Grinten, T. E. D., & van de Ven, W. P. M. M. (2005). Market-oriented health care reforms and policy learning in the Netherlands. *Journal of Health Politics, Policy and Law*, 30: 189 - 210.

- Hunter, D. (2003). *Public Health Policy*. Cambridge: Polity.
- Israeli, A. & Chinitz, D. (2003). Updating the basket of health services. *Harefuah*, March, 2003. (Hebrew).
- Klein, R. (2001). Accountability, society and health care. In D. Chinitz (Ed.), *The changing face of health systems*. Jerusalem: Gefen Publishing.
- Light, D. (2003). Universal health care: Lessons from the British experience. *American Journal of Public Health*, 93: 25-30.
- Martin, D. K., Pater, J. L., Singer, P. A. (2001). Priority-setting decisions for new cancer drugs: A qualitative case study. *Lancet* 358: 1676-82.
- Morone, J (1990). *The democratic wish*. New York: Basic Books.
- Mullen, P. (2001). Public involvement in health care priority setting: Are the methods appropriate and valid? In A. Coulter & C. Ham (Eds.), *The global challenge of health care rationing*. Buckingham, UK: Open University Press.
- National Academy of Sciences (1998). Panel on cost effectiveness analysis. Washington: NAS.
- North, D. (1993). The Sveriges Riksbank Prize in Economic Sciences in Memory of Alfred Nobel 1993 Prize Lecture, Lecture to the memory of Alfred Nobel, December 9, 1993. Nobel Prize Organization.
- Ryan, M. (2001). Eliciting public preferences for healthcare: A systematic review of techniques. *Health Technology Assessment*, 5:(5).
- Saltman, R, & Von Otter, C. (1992). *Planned competition and public markets*. Buckingham, UK: Open University Press.
- Von Bertalanffy, L. (1969). *General system theory*. New York: George Braziller.
- Wildavsky, A. (1979). *Speaking truth to power*. New Brunswick, NJ: Transaction Books.
- Williamson, O. (1975). *Markets and hierarchies*. New York: Free Press.
- Williamson, O. (1996). *The mechanisms of governance*. New York: Oxford

# Health Status and Health Care Reform in Hungary



**Peter Mihályi**

Department of Finance, University of Veszprem and  
Department of Economics, Central European  
University

## **INTRODUCTION**

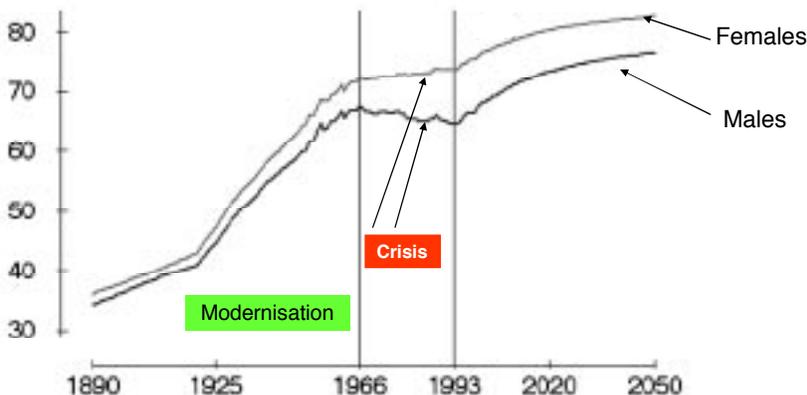
The Hungarian health care system is in crisis. This is a sweeping generalization, but the feeling behind it is shared and voiced without reservation by patients, health care workers and government officials alike. But this allegation is a misleading and paralyzing exaggeration. First, the health care systems of virtually all OECD countries are subject to similar criticism. Second, the reality is that both exemplary and disastrous building blocks can be found in the Hungarian system. It would be a mistake to throw out the baby with the bathwater.

Let us start with the most important facts. Hungary is often referred to in the EU-25, as a country where people have the worst life expectancy. Indeed, according to the 2004 figures, the data for both sexes were the lowest (77.2 and 68.7), except for the three Baltic countries. However, from the context of the reform objectives, the important thing is to see the change. As **Graph 1** illustrates, Hungary was hit by an epidemiological crisis between 1966 and 1993. But it is over. Since 1994, overall life expectancy rose by 4.0 years (from which 1.64 is attributed to the drop in cardio-vascular mortality). In 2005, 45% of female deaths occurred among those beyond 80 years of age (for males 23%). **The improvement in average life expectancy is one of the most significant positive outcomes of the regime change.**

Hence, in this regard Hungary is already on track; further improvements are to be expected without any reform.

In the first half of the 1990s, important and progressive measures were introduced in health care financing. Since then, GPs have been financed on a per capita basis, with the help of a risk-equalizing redistribution scheme across the age and gender profile of the registered patients. In ambulatory and acute hospital care the German point system and an adapted version of the American DRG-system were introduced. Many useful elements of the formerly centralized resource planning system have also been retained (100 per cent patient coverage, nationwide disease management, centralized collection of morbidity and drug consumption data, etc.). There is no reason to make changes here, either. Since 1999, much experience has been gained from the so-called HMO-experiment through which patient management and financing of 2 million people was outsourced to 15 geographically defined clinical networks (Milhalyi, 2003).

**Graph 1:** Life expectancy at birth (years)



Today, for the Hungarian health care system as a whole, there are three outstanding issues awaiting urgent solutions. First – and in our view foremost – the insurance system needs to be reformed. This paper is entirely devoted to this subject matter. The other two issues, namely the regulation of the pharmaceutical markets and the restructuring of hospital care, will not be touched upon at all in order to remain within space limitations.

## THE BISMARCK- BEVERIDGE MIX

With respect to health care financing, the extent of the continuity of the system that existed in the communist past is still striking. Like in all other Soviet-type economies, until 1989 the provider side was financed out of general revenues of the central budget. Technically speaking the entire population was covered (universal insurance), although there were no health plans, nor any earmarked contribution payment for health purposes. Under the direct influence of the German *Soziale Marktwirtschaft* model, the first democratically elected government opted for the reinstatement of the Bismarckian social insurance model. This was thought to be a logical continuation of the path that was followed in pre-1945 Hungary, when 52 sickness funds provided coverage for 22% of the working population. There was not much public debate on this decision, because other matters – such as multi-party democracy and privatization – occupied the mindset of most intellectuals.

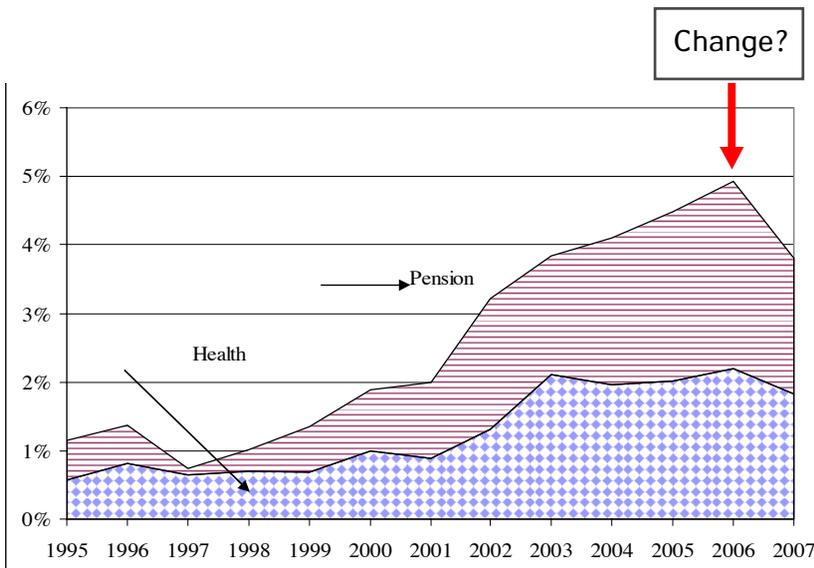
By 1994, the new social insurance model was in place. Two extra-budgetary funds were created for health and pensions, respectively. At the time of their creation, both funds were close to equilibrium. The mandatory payroll contributions were sufficient to finance existent expenditures. At the time of its inception, law makers tried to make the shift from the old system to the new as painless as possible.

1. The health care benefit package remained vaguely defined, as under communism.
2. Virtually no punishment was built into the system against free-riders – i.e., people with reasonable, but unreported income.
3. Health contributions were channeled to a single authority (The National Health Insurance Fund – OEP in Hungarian) in order to minimize the costs of administering the disbursements to the provision side.

As became clear only much later, the result of these compromises was that the system greatly resembled the Beveridge model, where entitlements are not linked to contribution payments and virtually the entire decision-making power rests with the Ministry of Health. As years have passed, the small initial deficits of the health fund have started to grow. In percentage terms, health fund expenditures in 2006 surpassed current

revenues by more than 30%. Compared to GDP, this shortfall is more than 2%. As **Graph 2** illustrates below, the trends are exactly the same with respect to the pension fund. The two problems are juxtaposed; therefore the reform of the entire social security system cannot wait any longer!

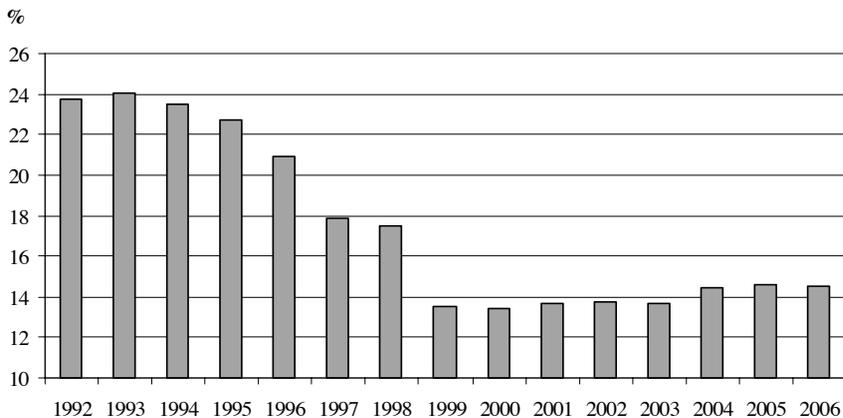
**Graph 2:** The deficit of the two social security funds  
(as a % of GDP)



With hindsight, three main origins of these deficits can be cited, stemming from two roots in a certain kind of **post-communist populism**. Firstly, the reduction of contribution rates (**Graph 3**) was a celebrated fiscal objective of four successive governments. It was argued that high contribution rates constrain entrepreneurial activity, hence curbing GDP growth. With a vague reference to the Laffer-curve effect, this policy was hailed as a sophisticated supply-side policy measure. The rates were reduced—both for employers and employees—without even considering proportional cuts on the expenditure side. It was hoped—naively of course—that lower contribution rates would lead to higher employment levels. Secondly, expenditures from the health fund were allowed to grow year by year in order to accommodate the pressure for wage hikes and the rise of pharmaceutical prices. These

developments were even hailed as evidence of progress, social justice and technological advancements. A third problem was the tolerance of tax evasion. The Bismarck-Beveridge mix has created a triple incentive for employers and employees to hide wage-type payments. In this way not only personal income taxes, but social security health and pension contributions can be spared as well. Initially, such opportunistic behaviour was characteristic to the small- and medium-sized firms in the private sector, but later, large state-owned enterprises and other state run entities (including the health care sector itself) have started to introduce camouflaged employment schemes. It is no exaggeration to say that the **social security system as such has become the strongest incentive of the black and grey economy.**

**Graph 3:** Payroll contributions compared to gross wages  
(employers + employees)



Finally, it is worth challenging the frequently underscored advantage of the present financing mechanism, namely its cost-effectiveness. In the official documents of OEP, administrative costs are reported as 1.5% of outlays. This is a misleading figure in many ways. Out of HUF 1500bn annual outlays, about HUF 500bn is merely a technical item (financial support to families), for which there are virtually no costs whatsoever. Another problem is that OEP does not collect the payroll contributions – the associated expenditures are financed from the operating budget of the tax authority.

And finally, it is important to underscore that certain important activities (e.g., conscientious purchasing, ranking and rating of providers, morbidity and mortality analysis) are simply not performed by OEP, although they all belong to the routine tasks of an insurance company. In sum, we assume that the true costs of operation are likely to be in the 3–5 percentage range, similar to the operation costs of many for-profit companies.

## THE INTERNATIONAL CONTEXT

*Three waves of reforms.* During the last three or four decades, there were three successive reform waves in the developed market economies. Hungary, as a latecomer to this group, has had to handle all three issues at the same time.

- ◆ The access to healthcare was put into the limelight of policy makers in the OECD countries. Except for the US, in most countries **universal coverage** was achieved by the late 1980s. Hungary, however, achieved this goal as early as 1972. Hence, there is no more work to be done in this direction.

- ◆ **Cost containment** was the popular policy issue of the 1980s and the 1990s. In this regard, Hungary belongs to the group of moderately successful countries. Between 1990 and 2004, the share of total health expenditures rose by 1.2 percentage points<sup>1</sup>, mainly because non-wage costs were kept under strict state control.

- ◆ Since the outset of the new millennium, **consumer choice** and **competition** appear to be the main driving forces of health policy in Anglo-Saxon countries. On the provider side, Hungarians have no reasons to complain at all. Except for the populace living in small, far away villages, most Hungarians have many options when choosing between a GP or a specialist, or going to the ambulatory unit of a hospital without co-payment or any other costs. Although there are *de jure* built-in constraints in the rules of utilization, up until now, these rules were totally disregarded *de facto* by the vast majority of people seeking care. Moreover, the extensive development of parallel providing structures during the past 40 years

---

1. As a percentage of GDP, the figures were 7.1 and 8.3 per cent, respectively.

allows for a comfortable choice. Waiting times and queues are virtually unknown in Hungary for almost all types of care.<sup>2</sup> With or without gratuity payments informed patients can freely shop around in the system. On the other hand, Hungarians do not have any possibility of choice on the financing side. Seemingly all Hungarians are "insured" with the only existing sickness fund, OEP. There is no opting-out possibility, there are no private health insurance policies to buy. There is no territorial devolution either. The nationwide risk pool of 10 million citizens is kept together by the force of the law. From the perspective of the individual, this was never a matter of choice, there was no contract signed by both sides. When OEP was created in 1992 by administrative *fiat*, employees, pensioners and other family members were simply given a health card to document their eligibility for OEP financed services. Neither contributions nor expenditures are recorded on an individual basis. Out of the 10.3 million health card holders<sup>3</sup> only 4.2 million are insured; 5.2 million pensioners, under-aged children and other family members are eligible to health care services only because the law says so. Hence, from the perspective of an individual, this is a truly Beveridge-type system, in which every citizen has the right to free health care at the point of delivery, irrespective to any past or current payment.

According to both the Beveridge and Bismarckian standards, there is **too much choice on the provision side**. The rules of referral exist mostly on paper. Patients can go to whatever hospital they like, they can "order" expensive laboratory examinations almost without any control. Working couples can send grandma to hospital for the summer holiday, if there is nobody at home to look after her. Since there is vast excess capacity in the system, the state owned health care institutions are happy to receive and service them. Judged by the logic of the Bismarckian system, however, there is **too little choice on the financing side**. Those who contribute cannot choose among health plans, their contribution is automatically

---

2. Except for transplantation, where the physical shortage of donors represent the effective constraint.

3. There are 10.0 mn Hungarians living inside the country. An additional 300 thousand health cards are hold by Hungarians living abroad.

deducted from the salary and transferred to the account of OEP. But now, let us put aside the confusions arising from this strange, Hungarian mix of the Bismarckian and the Beveridge systems, and concentrate at the widely discussed shortcomings of both systems in the context of the globalized 21<sup>st</sup> century. In this regard, post-communist Hungary faces the same issues as all the other OECD or EU countries. Since the possibility to reform such a vast social system like health care exists only in a rare historic moment, it is of utmost importance to use the present window of opportunity and shape the system according to the requirements of the new era.

*The limits of collectivist schemes.* In the 20<sup>th</sup> century, sickness funds and other state sponsored, collective health care financing schemes were designed to protect male industrial workers against the financial consequences of injuries at work and ill health after retirement. These male workers were organized according to the logic of unionization: similar working conditions, similar health problems, similar family structures. Thanks to the unions, collecting payroll taxes was easy. Any attempt to avoid contribution payment would have been considered as a crude breach of workers' solidarity. When these workers' schemes were gradually expanded to cover family members, then later to office workers and finally to farmers, the cohesive force of solidarity weakened due to the increased diversity of membership. Until the mid-20<sup>th</sup> century, the sickness funds, as well as the Beveridge-type NHS models, were more or less in actuarial balance. Birth rates were high, life expectancy was low. But this has all changed with the gradual advancement of modern medicine. First of all, the increased length of life brought about fundamental changes in family structures:

- ◆ most working age families have more than one breadwinner;
- ◆ divorce and remarriage are frequent;
- ◆ more and more people live in family without wedlock;
- ◆ fertility rate among women varies greatly;

as well as many other changes.

In addition to these demographic changes, the consequences of prolonged life and the growing importance of services are to be noted:

- ◆ the beginning of working life shifted from 15 years of age to 25 or even 30;
- ◆ short-term, temporary working arrangements, free-lancing, and various other forms of self-employment are more frequent (particularly among the schooled young cohorts and the already

- retired seniors);
- ◆ borders disappear within Europe, workers move at short notice, their presence in another country is not even recorded.

Using the terminology of labor economics, these are all **atypical work forms**, which are intrinsically resistant to comprehensive, all inclusive tax and insurance regulations. As a result, there is a growing need for insurance portability from country to country. This is doable, of course, as long as the insurance policy is firmly tied to the individual wherever he/she is, rather than to him/her as a member of national risk pool with a presumed permanent residence in a given country.

Modern medicine has produced tons of evidence to underscore the importance of self-inflicted health problems. Life style factors, such as smoking, drinking, obesity which are – to a great extent – matters of individual choice, have demonstrated direct effects on ill health. As a result, people who are paying lot of attention to their own lifestyles are tempted to question the moral righteousness of collectivist health financing schemes. "Why should I pay for the medical treatment of my fellow countrymen, if his or her health problem is largely due to his or her irresponsible lifestyle?" As empirical surveys show, after 50 years of communism, Hungarians do not feel much solidarity to their countrymen in any sense.

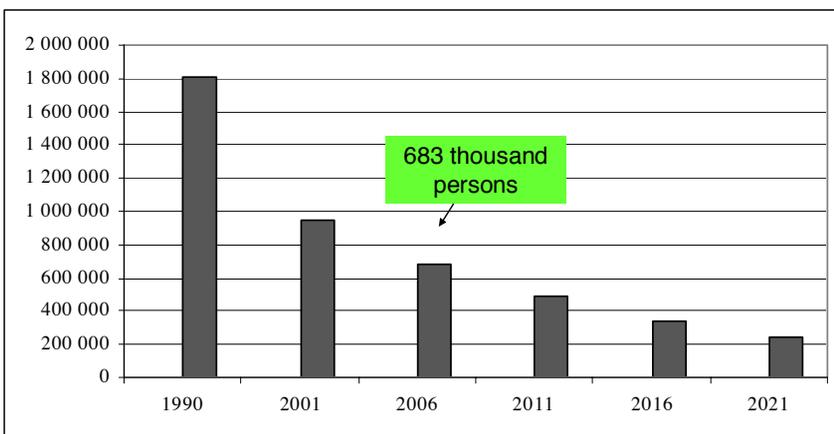
Finally, the new understanding of health problems needs to be mentioned. In the 19<sup>th</sup> century, ill health was a more or less a well-defined, objective state of affairs. Infection, injury, pregnancy are all straightforward issues, therefore the costs of treatment are also easily calculable. Once this is not the case, the maintenance of solidarity within collectivist forms of health insurance becomes less and less tenable. In our times, doctor-patient encounters are often aimed at various forms of pain reduction, the compensation of age-related discomfort. Very often people seek help from doctors in order to improve their nature-given, genetically determined characteristics. This applies not only to the often cited example of cosmetic surgery (e.g., breast enlargement), but in a broader context. People with under-average characteristics do not merely aspire to be at par with the average person; they want to be as strong, as pretty as the celebrities they know from the glossy magazines and the internet. In the language of descriptive statistics, for many, not the average, but the extreme outliers have become the norm to be emulated. But this new development also has

a certain amount of social content, too. With the advancement of the idea of prevention, health care has partly become a fashion of the educated classes.

## THE POST-COMMUNIST LEGACY

As it happens in most countries, path dependency limits the reform options. Forty years of collectivist planning and communist ideology have greatly discredited all forms of solidarity. In health care financing, the strongest evidence is the relentlessly increasing contribution avoidance, the so-called free rider problem. On the utilization side, there is a strong **pro-rich bias** in the system. The working-age cohorts of the middle-class and the norm-creating upper class are accustomed to unlimited, free choice. For them, the basis of comparison is medical care in Austria, Germany or in the United States, whatever they know about it from personal experience, friendly anecdotes and popular TV-series. This legacy in itself begs for strong, simple and merciless disciplinary type of reforms: flat insurance fees to neutralize the incentive to hide earned personal incomes, high co-payments and/or deductibles to reduce frivolous utilization.

**Graph 4:** Under socialism – nominally a classless society – a larg *underclass* came into being. Adults (15+) without completed elementary studies (8 years)

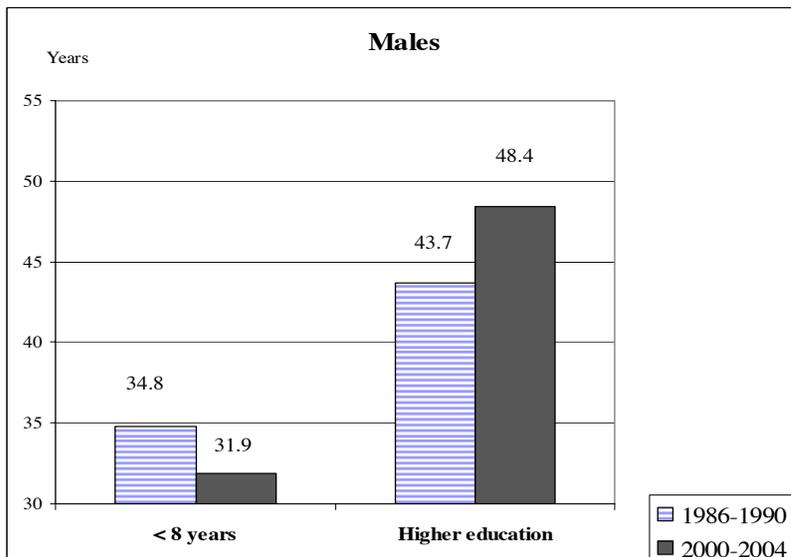


of uneducated, unemployed, poor people most of which are trapped in small villages, or village-type small towns (**Graph 4**).

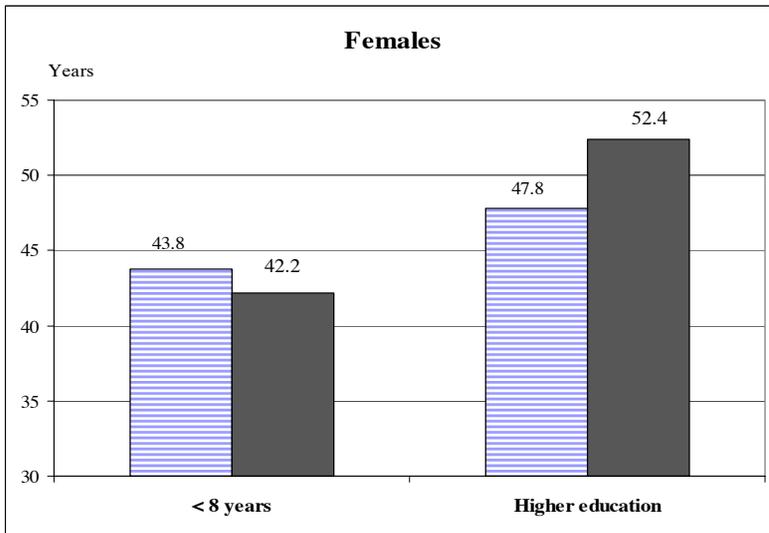
At the time of the regime change, this segment of the population represented 18% of the population; their share has since dropped to below 7% due to a natural attrition process, and further decline is to be expected. The demographic characteristics of this underclass are horrifying in every respect. These people are destined to die young, their life expectancy is actually shortening (**Graph 5a,b**) and their subjective well-being is much worse than that of their more educated fellow citizens (**Graph 6**). Since about 1990, the life expectancy gap at age 30 rose from 8.9 years to 16.5 years when males without 8 years of schooling are compared with males with a higher education degree. The same gap among women is smaller, but shows an even larger increase (4.0 years to 10.2 years). When the two extremes are compared (uneducated males vs. educated women), the gap is currently more than 20 years. The existence of such a gap is known in other European countries as well. What is unique in Hungary is the width of the gap.

**Graph 5a, 5b:** Life expectancy of people with different schooling levels at age 30

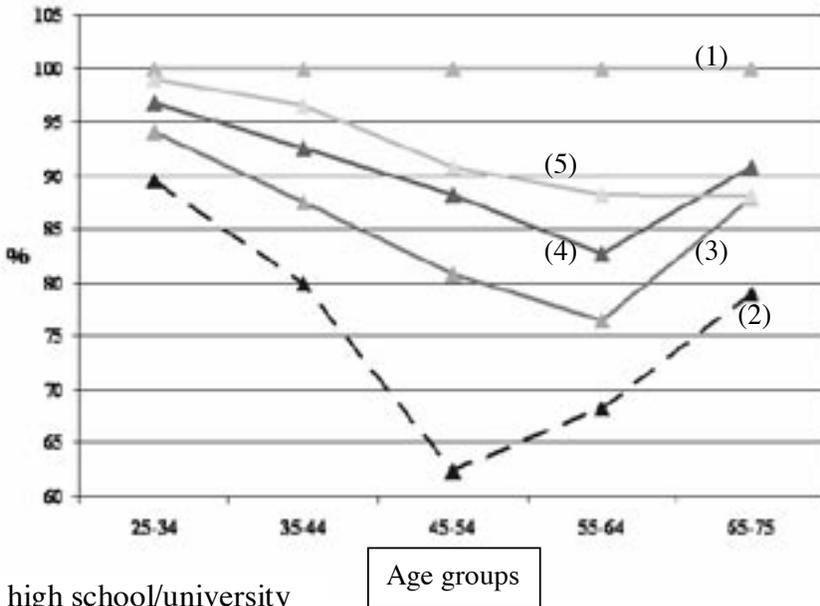
**5a:**



5b:



Graph 6: Self-assessment of health status in 2001



- (1) high school/university
- (2) less than 8 years
- (3) 8 years
- (4) apprenticeship
- (5) baccalaureate (12 years)

In view of the overall development level of Hungary ( $\approx$  \$ 10 000 GDP/head), the proportion of uneducated people is not extreme; similar data are registered in Greece, Portugal, Spain and many Latin American countries. The crux of the problem is two-fold. Firstly, the absence of family-based, rural employment opportunities both in agriculture and the service sectors, where these people could find work locally without travel costs and wasted travel time. Hungary, as it is well-known, privatized and restructured its economy in a historically very short period. Today, the service sector, industry and agriculture are dominated by brand new and large entities (many of them foreign owned), and they all prefer the young, upward-mobile generations vis-à-vis the older laborers with traditional skills. Secondly, the relative generosity of all kinds of social assistance means (including the still existing forms of **pro-poor** institutions within the health care sector itself), actually reinforces the rationality of many poor people in choosing welfare, rather than work.

The problem, illustrated by Graphs 4-6, is actually much bigger than it seems at first glance, because many children live in households, headed by undereducated parents. First, in such families nuptiality is higher than average, hence the underclass is reproducing itself. Children growing up in such families will drop out from school, and will "naturally" grow in into an unhealthy lifestyle (smoking, drinking, obesity, etc.) – as it happens elsewhere, too.<sup>4</sup> Second, the problem has a racial aspect, too. Most people living in extreme poverty are gypsies. Hence, it goes without saying that the vision and the implementation of the health insurance reform should take into serious consideration what will happen to the underclass. A strong safety net is required to **prevent the further deterioration** of this already alarming situation. At the same time, this would also help to avoid more racial division.

At a final, positive note on the post-communist legacy, the relative plasticity of the existing institutions need to be mentioned. Since the 1989 regime change, the new structures of the Hungarian health care system didn't have too much time to ossify. Therefore, a Hungarian government

---

4. People often ascribe this problem to the Roma community. This is partly correct. But not all poor and undereducated Hungarians are ethnic Romas. About 1/3 of them are ethnic Hungarians.

with a comfortable majority in Parliament has much more room for maneuverability than its counterparts in Western Europe or America. Existing institutions and the medical professionals working in them don't like reforms. They are inherently conservative, like everywhere else. But they are willing to go along and make the necessary adjustments, if the rules of the game are changed in a constitutional manner.

## **INTRODUCING A REAL INSURANCE MODEL**

The Hungarian government is committed to introduce a new model constructed from the elements of the recently installed Dutch and Slovak insurance models<sup>5</sup>, as well as the plans elaborated in the Czech Republic (Hroboň, Macháček, & Julínek, 2005). At the same time, however, certain values and features of the existing system need to be preserved; otherwise the changes would be so dramatic that the society would simply not tolerate them. In view of the election cycles, a critical mass of changes needs to be instituted in 2008, at the latest.

---

5. For the description and analysis of current health affairs in Slovakia, the best source of information is *Into Balance*, the quarterly review of the Health Policy Institute ([www.hpi.sk](http://www.hpi.sk))

**Table 1:** Changing and remaining elements of the present health financing system

Main issues	Change now?
1. Significant redistribution among social groups (male – female; young – old; poor – rich; urban – rural). → Solidarity will be maintained.	NO
2. The rules of participation and contribution payment are anchored in law. → Virtually 100% coverage will be guaranteed.	NO
3. Soft budgetary constraint. Revenues do not cover outlays. → The insurance system should be self-financing, capable to operate without subsidy or indebtedness.	YES
4. Medical care is financed from payroll contributions, taxation, and illegal payments. → Clear rules for insurance fees.	YES

Further characteristics are:

- ◆ Managed competition among for-profit sickness insurance companies operating within the mandatory range of 0,1 – 2 million members;
- ◆ Rigorous regulatory oversight<sup>6</sup>;
- ◆ Strengthened connections between contribution payments and eligibility, but special protection to promote public health objectives and to guarantee equal access to medical care in case of catastrophic illnesses;
- ◆ Rapid depolitization of the health care system; the government, the Ministry of Health will not be always in the first line of fire in case of local conflicts;
- ◆ The insurance companies will have to operate with hard budget

---

6. The act on the functions and the prerogatives of the Health Insurance Supervision was passed by Parliament in December 2005. The new body started operations in the first half of 2007.

- constraints. There will be no state guarantee for the companies;
- ◆ There will be no risk rating; insurance firms cannot reject applicants; contributions will be redistributed through a risk-equalization fund;
  - ◆ Once a year, clients may change their affiliations;
  - ◆ After a 3–5 year transition period, clients of the insurance companies can choose among different policies

The new model is planned to be introduced from 1 January 2008, once the detailed legislative base is approved in Parliament during the second half of 2007. Hungarian citizens will – individually – join the newly established sickness insurance companies via a simple, signed unilateral declaration. It remains to be decided what will happen to OEP. Basically, there are two possibilities. The gradualist option is that OEP will continue to operate in the old form, as long as anyone wishes to remain there. The radical solution is that after a pre-determined deadline – say 12 or 18 months –, the remaining OEP-members will be transferred to the new insurance companies according to some kind of random algorithm. The advantage of this solution lies not only in its radicalism, but more importantly in the elimination of the suspicion that OEP is the poor people's insurance company. Indeed, there is a wide-spread agreement across the entire Hungarian political spectrum that **the biggest challenge of the reform is to prevent the emanation of a two-tier system.**

An important, and more or less original feature of the model will be the separation of the "medical package" into three tiers (or financing pillars).<sup>7</sup> This will be similar to the approach applied in the World Bank designed Hungarian pension reform of 1998, where three financing pillars were also created. Table 2 provides an overview of this novel approach. Clearly, a lot of border case decisions will be required in the process of law making. The important thing is to ensure that the inevitable conflict between the for-profit insurance companies and the financially vulnerable households (i.e., the poor families) will be moderated in two important areas. Through the tax financing of Pillar I., the funding of public health, blood collection, etc.,

---

7. This was proposed first in Ministry of Finance (1998) and Mihályi (1999). The Czech reformers also suggest a 3-pillar division. See Hrobon *et al.* (2005)

will be assured independent of business considerations. As far as the most expensive, individual treatments are concerned, the nationwide risk-pool will be maintained.

**Table 2 :** The three pillars of the health care package

Level (pillar)	Shares in costs	Content	Insurance fee	Responsible institution
III.	15-20 %	Catastrophic illnesses involving very high costs (e.g., transplantations, absolutely new innovative drugs). Long-term care (e.g., mental illness, alcoholism therapy).	Proportional payroll taxes	Mandatory privately-run, for-profit health insurance companies (initially 6-8 only will be allowed..)
II.	60-65 %	Basic or routine care. Everything which is not covered by Pillar I and III	For a long transition period proportional payroll tax, flat fee after that.	
I.	20 %	Definitely: Preventive care, public health measures, blood collection, school health, emergency ambulance, etc. Perhaps: Sickness payments, financial support in cases of pregnancy and child birth, etc. .	None	Central budget and its institutions

Hence, no single individual – whether rich or poor – will face the danger of a tug-of-war vis-à-vis his or her insurance company, when life is at stake. The approval of the decision and of financing the burden of such interventions will remain in the hands of the health administration. As is clear from Table 2, OEP will be closed down once the privately-managed insurance companies start operation. It is noteworthy, however, that initially, the state will have a guaranteed 51% ownership right in each of the companies, even if management rights are going to be delegated to the private investors.

Another important element of the model is the risk-equalizing capitation scheme suggested for Pillar II. As a matter of fact, this scheme is not a novelty in Hungary. The so-called HMO Experiment which now covers more than 2.3 mn citizens, has been utilizing this scheme since 1999. There are now 12 managed care centers (clinical networks), each of them with more than 100 thousand persons. Their experience shows that out of the 18 currently used separate budget line items, the first 5 or 10 lines represent 90 or 99% of Pillar II expenditures, respectively.

At the time of writing, the insurance reform appears to be on track, although with a major time delay: Parliament will vote on the necessary legislative changes only in the second half of 2007. Thus, the establishment of privately-managed health insurance funds (German-type *Krankenkassen*) cannot take place before mid-2008, at the earliest. This will leave only few months before the 2009 European election, and the political risk will therefore be quite high from the perspective of the incumbent Government. On the other hand, if the reform is successfully implemented, the positive results could be evident before the 2010 nationwide parliamentary elections, and could make a positive contribution there.

## REFERENCES AND FURTHER READING MATERIAL IN ENGLISH

- American Chamber of Commerce in Hungary (2006). *Health as a Pillar of Hungarian National Competitiveness*, Position Brief. Budapest: AmCham
- Bokros, L. (2004). Competition and solidarity - An essay on economic policy turnaround and structural reforms indispensable for the convergence of Hungary with Europe: The 130 points [Electronic Version]. *Comparative Economic Studies*, 46: 2, 193-220.
- Csaba, I., & Semjén, A. (1998). Welfare institutions and the transition: In search of efficiency and equity. In L. Halpern & C. Wyplosz (Eds.), *Hungary: Towards a market economy* (pp. 294 – 350). Cambridge, UK: Cambridge University Press.
- Csillag, I., & Mihályi, P. (2006). *Tsihe Last Chance – An 18-month program for stabilization and reforms in Hungary*. Budapest: Globális Tudás Alapítvány, new edition by Eastern European Economics
- Dorotinsky, B. (1998). *Transplanting managed care to Hungary*. U.S. Treasury mimeo.
- Fehér, F., Heller, Á., & Márkus, G. (1983). *Dictatorship over needs*. Oxford, UK: Basil Blackwell.
- Figueras, J., McKee, M. & Lessof, S. (2002). Ten years of health sector reform in CEE and NIS: An overview. Paper prepared for USAID Conference, *Ten Years of Health Systems Transition in Central and Eastern Europe and Eurasia*, Washington, D.C.
- Fuenzalida-Puelma, H. L. (2002). *Health care reform in Central and Eastern Europe and the former Soviet Union (a literature review)*. Local Government and Public Service Reform Initiative. Budapest: Open Society Institute.
- Gottret, P., & Schieber, G. (2006). *Health financing revisited (a practitioner's guide)*, Washington, D. C.: The World Bank.
- Hroboň, P., Macháček, T., & Jullnek, T. (2005). *Healthcare reform for the Czech Republic in the 21<sup>st</sup> century Europe*. Prague: HealthReform.CZ
- Jakab, M., & Fidler, A. (1998). *Health reform options in Hungary*. Background paper for World Bank conference held in Visegrád, Hungary.
- Kaser, M. (1976). *Health care in the Soviet Union and Central Europe*. London: Croom Helm.
- Kornai, J. (1998). *Az egészségügy reformjáról*, [Reforming the Hungarian Health System]. Budapest: Közgazdasági és Jogi Könyvkiadó. (English translation available)
- Kornai, J., & Eggleston, K. (2001). *Welfare, choice and solidarity in transition (Reforming the health sector in Eastern Europe)*. Federico Caffè Lectures, Cambridge, UK: Cambridge University Press.
- Lewis, M., (2000). *Who is paying for health care in Eastern Europe and Central Asia?* Washington, D. C.: The World Bank.

- Marrée, J., & Groenewegen, P. P. (1996). *Back to Bismarck: Eastern European health care systems in transition*. Aldershot, UK: Avebury Ashgate.
- Mihályi, P. (1998). Reforming the Hungarian health care system. *The Vienna Institute Monthly Report*, 12, 21-25.
- Mihályi, P. (2000). *Magyar egészségügy: diagnózis és terápia* [Hungarian health care: diagnosis and therapy]. Budapest: Springer Orvosi Kiadó.
- Mihályi, P. (2000b). Post-socialist health systems in transition: Czech Republic, Hungary, and Poland. *CEU Department of Economics Working Paper, WP4/2000*.
- Mihályi, P. (2003). HMO experiment in Hungary: A unique road to health care reform. *CEU Department of Economics Working Paper, 9/2003*.
- Mihályi, P., & Petru, R. (1999).: Health care in the Czech Republic, Hungary and Poland – the medium-term fiscal aspects. *CASE – CEU Working Papers Series*, No. 28.
- Ministry of Finance (1998). *Recommendation to the Ministry of Welfare – Ministry of Finance's proposal on health care reform*. Budapest. (Translation from Hungarian).
- Orosz, É. (2001). *Félúton vagy tévúton? Egészségpolitikánt félmúltja és az egészségpolitika alternatívái*, (Half way or wrong way? [The recent past of our health policy and its alternatives]). Budapest: Egészséges Magyarország Egyesület.
- Orosz, É., Ellena, G., & Jakab, M. (1998). Reforming the health care system: The unfinished agenda. In L. Bokros, & J. J. Dethier (Eds.), *Public finance reform during the transition: The experience of Hungary*. Washington, D. C.: The World Bank.
- Orosz, É., & Burns, A. (2000). The healthcare system in Hungary. *OECD Economics Department Working Papers*, No. 241.
- Saltman, R. B., & Figueras, J. (Eds.). (1997). *European health care reform (Analysis of current strategies)*. Copenhagen: WHO Regional Office for Europe.
- Saltman, R. B., Bankauskaite, V., & Vrangbaek, K. (Eds.). (2007). *Decentralization in health care*. McGraw-Hill.
- Shakarishvili, G. (Ed.). (2005). *Decentralization in healthcare (Analyses and experiences in Central and Eastern Europe in the 1990s)*. Budapest: Open Society Institute.
- WHO (1999), (2004). *Health care systems in transition: Hungary*. European Observatory on Health Care Systems.

# Problems and Questions Regarding the Treatment of Political Leaders\*

> Shlomo Mor-Yosef, Yuval Weiss and  
Yair C. Birnbaum  
Hadassah Medical Organization,  
Hadassah Medical Center

Throughout the course of history, the medical problems of political leaders have been the subject of closed-door discussions. Since the public generally did not have any solid data as to the medical condition of their political leaders, discussions were relegated to the world of gossip. In recent years, heads of state and leaders of the Western world, including Israel, have kept their medical conditions secret, including hospitalizations, and have not shared many details with the public.

With the hospitalization this year (2006) of Prime Minister Ariel Sharon, the Hadassah Medical Center was compelled to deal with many issues related to the hospitalization of a political leader in a climate demanding public transparency and in the midst of a national election campaign. With no similar precedent to guide us, we did so under stressful conditions and with great uncertainty. There are no straight forward answers to the issues and dilemmas raised in this paper; issues with which we were compelled to grapple and, in similar situations in the future, issues with which other hospital management's will need to contend. In many respects we have now set a standard in Israel for dealing with these complex matters.

---

\* This article has been reprinted with the permission of The Israel Medical Association Journal, in which it was originally entitled, "Issues in hospitalizing political leaders." IMAJ, 2006, 8:754-756.

## The Medical Team

When a political leader, arrives at the hospital for the first time as a patient, hospital management must decide who is going to be part of the medical team that will treat the patient. Should the physician, or physicians, who are familiar with his or her medical history be responsible for his/her care, or should specialists in the particular field be responsible? A political leader is treated by an interdisciplinary team of senior physicians, whose opinions may or may not be in agreement with one another. Therefore, first and foremost, a coordinating physician, preferably a department head, must be appointed to oversee the case.

Following the initial assessment, certain immediate decisions should be made, such as whether experts from other hospitals should be included in the medical team or whether, at an early stage, the political leader should be transferred to another hospital. The decision must be based on the political leader's specific medical needs – such as special equipment or a subspecialty that does not exist in the admitting hospital – or on the fact that another hospital is familiar with the political leader's medical history. Additionally, logistical and security considerations need to be taken into account.

## Physical Location

In Israel, unlike some other countries, we do not have a medical institute designated for the treatment of political leaders. A dilemma may arise as to whether to hospitalize such a patient in the department relevant to his disease or in an area of the hospital that will allow for greater logistical convenience such as security considerations and "hotel level" accommodations.

While the first priority must be the medical needs of the patient and the need for minimal interference with the daily activities of the hospital, security considerations cannot be ignored. The need to provide the political leader with suitable hospitalization conditions has to be dealt with within the framework of a public healthcare system that operates with an average occupancy rate of around 100% and a chronic shortage of intensive care beds. Hospital management must ensure that the special services provided to the political leader will not be at the expense of other patients. Treatments and surgical procedures in other patients should not be cancelled due to

the extra attention the political leader may receive, and the need for maximum security should not interfere with the routine activities of the hospital.

Medical monitoring should be balanced between the need to provide the leader with appropriate observation and care, such as private nurses and a private room, and what is acceptable within the system.

The free movement of patients and their family members within the hospital cannot be restrained and the hospital staff must be allowed to move freely in most areas of the hospital. One has to remember that in a medical center such as Hadassah there are not only Israeli and Jewish patients and staff members. Every person entering the medical center should be allowed the same freedom of movement to which he or she is entitled under ordinary circumstances.

### **Treatment Protocols**

When treating public figures (and incidentally, medical personnel as well) there is a tendency to deviate from the routine and from established protocols and guidelines and grant them "special" treatment. It is our opinion that in treating dignitaries we need to adhere, as much as possible, to conventional and acceptable medical treatment while being careful not to overtreat "just to be on the safe side". There is no doubt that the political leader will be treated by the best physicians in the hospital, among other reasons due to their ability to resist pressure from various parties and interest groups that request and sometimes even insist that the political leader receive a particular treatment which may not be necessary and in some cases may be detrimental or not evidence-based.

The high professional level of the medical treatment team may result in setting a standard of care that will then have to be met when dealing with "ordinary" patients. Medical management has a role to play in keeping the discussions and decisions within the boundaries of evidence-based medicine.

## **INFORMATION AND THE MEDIA**

### **Communication of Information**

There is no law or regulation in Israel addressing the type and amount of information that a hospital is required to share with the public. Tension is created between the media and the public's desire to receive detailed information and the medical team's desire to protect their patient's privacy. Therefore, the decision as to what information should be released is at the discretion of the political leader himself. We need to know what he has consented to: Into how much detail should we go regarding the current illness? Are we releasing information with regard to his entire medical history or are we only releasing information related to the current hospitalization? The political leader's decision can of course change due to public demand, pressure from the media, or at the advice of his staff. It is critical to receive the political leader's personal consent unless of course he is unable to express his wishes. The decision then generally rests with his family.

Another dilemma which must be faced is whether to provide information together with an analysis or only release the facts. Each approach has its pros and cons. If only factual information is released then interpretation is left to outsiders who obviously do not have all the information that the hospital medical team has. The analysis produced under such circumstances may be problematic, once again creating tension and a lack of trust between the medical team and the public, and between the medical team and the media.

Information released to the public, which includes the medical team's analysis may be exposed to criticism, for example, that the analysis is tendentious and reflects too much optimism or pessimism.

One of the medical team's most difficult challenges is to adhere to the medical facts while at the same time presenting the information to the public in a manner that is clear to all, using language that is neither too simple nor too heavy with complex medical terms.

## **The Frequency and Manner in Which Information is Released**

This question must also be addressed. The determining factors are the political leader's medical condition and its dynamics. In our opinion, medical bulletins should be issued once a day, at the same hour, to all media personnel, by a single spokesperson from the hospital, and preferably by a physician who can also answer medical questions. The more dynamic and more critical the situation, the more important it is for the spokesperson to be a key medical figure in the hospital and preferably the same person for the entire dynamic period of the hospitalization.

In very dynamic situations there may be a need to update the public more frequently, e.g. when there is a change in the political leader's condition, be it an improvement or deterioration; or when there is a need to perform unplanned surgical procedures, special treatments or examinations. Under chronic conditions information can be released on a less frequent basis.

This protocol can only be successful when there is full cooperation and total involvement of the medical team. During the chronic stage of hospitalization, information can be provided in writing or electronically via the professionals who routinely deal with public relations and the media.

## **Modus Operandi vis-à-vis the Media**

The hospitalization of a political leader causes great media interest, especially when the hospitalization is unexpected and dramatic. In such situations there is a need to establish a policy on how to deal with the press. Is the press allowed to enter the hospital? What areas, if any, is the press allowed to photograph? Who is the press allowed to interview? To which subjects and issues raised by the press will we respond? Who provides the press with background information, on what subjects, and at what point during the hospitalization? Is information released to the press individually or collectively at one time? The answers to these questions as well as the entire issue of public relations and press-hospital relations, including policies regarding the release of information, must be managed by the individual whose responsibility it is during normal times of calm. As such, he/she recognizes and understands the needs of the press while personally knowing the hospital's staff, and the routines of both.

## **Medical Information and Privacy**

The members of the press corps are known for their aggressiveness in searching for additional information over and above what has been provided; they attempt to find new facts or even gossip related to the political leader's medical treatment. Therefore, there is a need for special precautions to prevent information from being leaked from the hospital's written and computerized medical records. The staff should be instructed regarding the importance of medical privacy and the need to stand firm in the face of outside pressures or temptations.

## **Medicine and Politics**

The hospitalization of a political figure is not only a medical event but a political one as well. It is the task of the medical staff treating the patient, to keep its comments exclusively within a medical framework, since there are various individuals from across the political spectrum who may attempt to exploit the medical event and the medical team's words for political purposes. One should also consider the risk that in some circumstances an attempt may be made to influence the medical team's reports.

## **Coping with Medical Criticism**

As a result of the exposure to a political leader's hospitalization, there is a tendency by some in the press corps and in the medical community to evaluate the content and quality of the medical treatment, finding fault, and suggesting alternative treatments. This is particularly true when the treatment results do not meet expectations. The first decision to be made in such circumstances is to decide to what extent the hospital and the medical team are interested in taking part in this dialogue during the time that the political leader is hospitalized. The second decision to be made is to what extent are we free to divulge relevant medical information to this public medical dialogue. There is no doubt that this dialogue should take place, but timing and venue are crucial.

In our opinion, the proper venue for this medical dialogue is within appropriate medical frameworks such as medical meetings or relevant professional journals. This public discussion should take place following

the culmination of the political leader's treatment and not during the acute phase of his illness when therapeutic decisions are continuously being made on a round-the-clock basis.

## **CONCLUSIONS**

The emergency hospitalization of a senior political leader such as a prime minister raises many medical and non-medical dilemmas. In our case, unexpected circumstances put us in uncharted territory. Our approach to the issues and dilemmas raised in this paper evolved during the first hours and days of the hospitalization of Prime Minister Sharon.

We strongly felt that only one spokesperson should appear before the public, but the content and tone of the medical statements were discussed in advance in a larger forum, thus allowing for input from all key medical personnel involved in the treatment of Mr. Sharon.

It is imperative that one senior physician be designated to coordinate and oversee the medical issues of the case. A member of the hospital's management, preferably the Hospital Director, should be charged with the responsibility of coordinating the non-medical administrative issues that arise and a senior staff person should be appointed to determine policy with regard to dealing with the media.

The issues and dilemmas we have raised should form the basis of a checklist that every hospital should prepare, so that if and when the need arises the issues can be properly dealt with during the course of a political leader's hospitalization.

# Global Health Problems Need International Solidarity and Global Responses

 Hans Stein  
European Public Health Centre (EPHC)

The challenges that must be faced in the future by health systems throughout the world, especially in developed societies, are well known. They are similar to those of the past, and even the details are predictable. The challenges consist of:

- ◆ demographic changes with declining birth rates, a higher life expectancy and ageing populations leading to a graying society
- ◆ changes in disease pattern, new health threats and epidemics, as well as increasing life-style-related diseases
- ◆ enormous scientific progress, new health technologies and pharmaceuticals, an explosion of e-health, all contributing to an expansion, as well as growing costs of the health and medical care systems
- ◆ growing economic constraints and limited resources increasing the need for more efficiency and effectiveness
- ◆ a rapidly growing private health market increasing inequalities
- ◆ at the same time, growing expectations by better informed citizens and patients for whom good health is a major personal goal in life

Changing needs, growing expectations and limited resources continually put health systems everywhere under permanent and growing pressure. Health is steadily becoming a dominant topic in the social and political discussion.

However, there is one difference to the past that is not yet sufficiently recognized: the processes of globalization leading to the internationalization of health risks and greater interdependence, possibly even convergence, of

different health systems.

Is the growing impact of globalization merely a threat, or can it provide heretofore unknown opportunities to solve existing and future problems?

The decisive and as yet unanswered question is, if and how far will health systems be able to cope with these challenges. Will they do better than they did in the past? Will they be better able to combat the spread of communicable diseases, promote positive health determinants, create health-enabling conditions and provide good health care that is both accessible and affordable to everyone everywhere? I have my doubts.

My main concern for the future is not that we might be facing a scarcity of innovative ideas for reforms. For many years now there has been an abundance of new ideas. No doubt experts all over the world will continue to produce new ideas incorporating the new dimension of globalization. There will always be a wealth of publications, reports, green and white papers. They will contain ideas as to how health systems should be reformed and how their efficiency and effectiveness might be improved. They will present ideas about different funding options leading to permanent financial sustainability, about decentralization, privatization, about introducing more and better market mechanisms, improving quality, maintaining equity and access, and about how the participation and rights of the patients could be improved. This is just a random and in no way complete list of the topics studied in the past.

There never was a scarcity of ideas and there will be none in the future. The real question is, will they remain merely ideas on paper or will they actually be implemented.

In order to improve the performance of health systems there is a need for innovative ideas. But most of all there is a need for political will and commitment. Have we had this commitment in the past? How successfully have health systems coped with the challenges they have had to face? Will they be able to cope in the future?

Governments as a whole tend to be rather conservative. They fear innovations and experiments. Nevertheless, for many years health systems everywhere seem to be in a permanent state of transition.

In the last three decades there have been a large number of reforms in many countries. In the 18 years since 1988, we have had seven major health reforms in Germany. However if one looks at the results of past reforms in a multitude of countries, many have not achieved their self-set objectives:

they have not led sufficiently to equity, or to an improvement of the quality and performance of the health system. One might say that they failed in transforming innovative ideas into reality.

Most reforms had less to do with health and more to do with economics. They were mainly aimed at cost containment, very often to be achieved by rationing services and limiting the individual's legal rights and entitlements. They explored new financial sources for the health systems, very often by increasing insurance contributions, increasing taxes or – the easiest way – by increasing "co payments," calling it greater individual responsibility.

But the equation that more money automatically leads to better health or even better health systems simply doesn't work. The fact that "health equals wealth," that it is a productive economic factor in terms of employment, innovation and economic growth, is often neglected.

The reforms claimed to serve the needs and preferences of the patient as the key person in health and healthcare. But in reality they were quite often not patient-centred, a term that today is commonly used but rarely defined. Often they were chiefly technology-, doctor-, hospital- or sometimes even disease-centred.

Most of all, the reforms were system-centred. Their aim was not to fundamentally change, but rather to uphold and stabilize the existing national systems the way they had developed historically with their different approaches for organizing and financing health systems. The system as such, be it the Beveridge system or the Bismarck system, is often considered itself to be a national value, a part of the national heritage to be defended against external threats.

The present situation in most health systems can best be summarised by gaps:

- ◆ gaps between the expectations of citizens and patients and that which the existing national health system can provide
- ◆ gaps between the "evidence-based" innovative ideas developed by experts and their implementation in national health reforms
- ◆ gaps between health care – a major national health policy priority – and prevention of disease – a minor one

I fear that purely national health systems will not be able to bridge these gaps in the near future.

Instead of concentrating on developing innovative ideas for repairing existing health systems, it might be more worthwhile to examine why health reforms in the past have not performed better than they have. This might even show that the existing national context, as well as the differing interests of the stakeholders, could often lead to only partial reforms and short-term solutions. The necessary sustainable improvements in health—in public health as well as in health-care systems—need continuous long term, integrated efforts.

We must ask ourselves if national health systems, as they have developed in the world of the 19<sup>th</sup> and 20<sup>th</sup> centuries, are able to provide this. Will they be able to cope with the challenges of the future, in a world that is fast turning into a global one? In other words: how long and how successfully can today's health systems survive as isolated national islands in the tidal wave of globalization?

I fear policy makers as well as experts still underestimate the consequences of globalization, which already has a profound and increasing impact upon health, and which makes purely national solutions more difficult, if not impossible, to effect.

The number of publications on globalization and health is still limited, but such publications do exist. I would like to mention a recent one that summarized many of the published innovative ideas: "European Perspectives on Global Health," edited by Ilona Kickbusch and Graham Lister published by the European Foundation Centre (EFC). It cites a definition D. Held has given for globalization: "Globalisation can be defined as the widening, deepening and speeding up of worldwide interconnectedness in all aspects of contemporary social life."

Health undoubtedly is quite an important aspect. It therefore follows, as stated by Dean Jamison, Jules Frenk and Felicia Knaul in *The Lancet* (1998) that, "although responsibilities for health remain primarily national, the determinants of health and the means to fulfil that responsibility are increasingly global."

What political consequences must be learned? Global health refers to those health issues which go beyond national boundaries and governments. They require new types of actions and new kinds of instruments, as well as new forms of governance at both the national and the international level. This addresses not only governments, but a wide range of players.

Globalization influences health both positively and negatively, in direct and indirect ways:

Globalization leads to more rapid spread of health problems.

- ◆ Both the range and incidence of infectious diseases spread as a consequence of increasing worldwide travel.
- ◆ Global marketing contributes to the proliferation of non-communicable, lifestyle related diseases by promoting smoking, alcohol abuse, and changing patterns of food consumption leading to obesity.

Globalization has already helped to increase scientific and technological knowledge and will continue to do so.

- ◆ The development of medicines, vaccines and medical appliances allows new forms of treatment and prevention.
- ◆ Communication and transport possibilities have significantly improved by removing technical barriers and overcoming national borders to access cross-border medical information as well as treatment.

E-health, a term including health informatics, health telematics, and telemedicine or telehealth (a process presently still driven by technology rather than policy) will enable a whole range of new responses improving and transforming health-care services quite independently of the health system.

At the same time, globalization has increased inequalities between as well as within countries. As the health sector has continued to grow in developed countries, where the "health industry" has become a major economic growth factor, it has increased the economic restrictions in many poorer countries. Even within the EU, rising professional mobility is creating problems, as some countries find it increasingly difficult to retain medical staff who are attracted by higher salaries in richer countries.

Globalization is changing the face and content of international politics.

Industries including foods, pharmaceuticals and insurance companies, have become global players in a global market made possible by liberalized global trade systems.

Health itself has become a major global market, whether we like it or not. Health cannot remain a sole national responsibility in an increasingly

interdependent world. The global character of health policy requires global responses, not just national ones.

We have to ask and answer a number of questions:

- ◆ Are national health systems prepared to participate in giving that global response? Or will existing national interests prevail in the future?
- ◆ Can the existing independent national health systems really survive as they are today?  
Or are they doomed for failure unless fundamental rethink takes place?

We have to consider the views of national health systems. As different and differing as they may be, they agree that health is and has to remain first and foremost a national responsibility, which must be protected at all cost against outside domination or even influence. In a paper published in 2003 on "European Integration and Health Policy," the German social scientist Wolfram Lamping described the situation in which, "the welfare state, and especially health policy, actually appear to be an enclave within the integration process and consequently one of the last realms - and one of the last retreats - of national policy competence."

He concluded that "national governments have jealously and successfully tried to prevent any transfer of substantial health policy competence to the supra-national level and they still have great difficulty in accepting healthy policy as a matter of the [European] Union's concern."

The draft of the EU Treaty establishing a "Constitution for Europe," whose fate is still very doubtful, is in many ways an impressive example of the prevalence of this kind of thinking:

- ◆ Health is not one of the EU objectives.
- ◆ Health is not an area of exclusive or even shared competence as are "economic and monetary policy, employment, social policy, agriculture, environment, consumer protection research, energy."
- ◆ Health is an area where the Union may take coordinating complementary or supporting action, a position shared with other areas such as culture, tourism or education.

This describes the envisaged future legal position, hardly any change from the present situation. What is the political reality in Europe?

The EU member states are rediscovering "values and principles" as an important element of health policy. In a recent Council meeting, the health ministers of the EU named "universality, access to good quality care, equity and solidarity" as overarching values being shared across Europe.

So far so good. But the main thrust of the ministerial statement was not to establish these principles as European values, asking for European action to implement them on a European level. On the contrary, they were considered as values of the national health systems which should be protected from undue European interference.

It is obvious that a lot of rethinking is required.

National health policy decision makers will have to be aware and to accept the following:

- ◆ In a globalized world there is no such place as abroad.
- ◆ Problems as well as solutions reach across national borders.
- ◆ There is no distinction between internal national and external international solutions.
- ◆ Good health for all requires responsibility be shared among many partners.

The steadily increasing interdependence of global health requires:

- ◆ common global values such as universality, equity and solidarity
- ◆ innovative ideas to define these values
- ◆ political will and commitment to transform these ideas into reality

This can only be achieved by a new kind of international collaboration, cooperation and coordination going far beyond the present day exchange of ideas and the sharing of experiences. These will continue to be important, but they are not enough.

There is a need for joint global health strategies and joint actions involving not just governments and international organizations but also new partners such as industry, non-governmental organizations and researchers. Civil society as a whole, including patient groups, will have to play a role, because it is only with their participation that the essential public support can be achieved.

Global health action therefore needs new kinds of instruments and resources including:

- ◆ legislation in the form of international laws for health

- ◆ the establishment of special agencies
- ◆ funding and supporting programs

The following are recently established positive examples:

- ◆ the new International Health Regulations (IHR 2005) designed to strengthen global health security against health threats and emergencies
- ◆ the Framework Convention on Tobacco Control (FCTC) aiming successfully to counter this biggest avoidable threat to health.
- ◆ the development of the European Centre for Disease Prevention and Control (ECDC) designed to coordinate surveillance activities and to ensure early identification of potential threats to public health
- ◆ the creation of "Health-Technology Assessment Networks" intended to establish border crossing quality standards for new health care interventions

These are just first steps. Some further developments currently being debated are:

- ◆ the establishment of a European Institute or Observatory for Health as a shared evidence-base for policy-making in order to improve healthcare, first throughout Europe, later globally
- ◆ the creation of networks of centres of reference intended to provide high quality and cost-effective care open to patients from many countries whose home countries cannot provide the care needed
- ◆ the coordination and support of programs for providing cross-border services such as telemedicine

All these examples not only show the wide potential for global health, but they demonstrate that global health strategies and actions cannot be sufficiently achieved by individual health systems and states. They need the power, the potential, the resources and the legal competences of international institutions. The European Union no doubt is predestined to be one of the key actors for global health in future.

Of course there are others: WHO, OECD, World Bank, WTO to name just a few, who already are partners in global health.

It is encouraging that global health is named as a priority in the ongoing

debate about a new EU health strategy.

I hope that Europe:

- ◆ will make global health a top priority
- ◆ will establish strategic priorities for global health
- ◆ will include global health in all its fields of policy including foreign, security, agricultural, trade and environmental
- ◆ will establish new institutions and programs for global health

My main concern for the future is that the prioritization of global health will not be easy to achieve. The restrictive position of the EU member states is one of the main hurdles to overcome. But I am optimistic. EU global health activities are fully in line with the principle of subsidiarity, stating that the "Community shall take action only and insofar as the objectives of the proposed action cannot be sufficiently achieved by the Member States and can therefore, by reason of scale or effects be better achieved by the Community" (EU Treaty of Nice, Article 5).

To sum up, I cite the former EU Commissioner for Health, David Byrne, who did much to establish health as a European issue. He concludes an article titled "The future of health *sans cordon sanitaire*":

The future of global public health is a future not characterised by isolation, but by global cooperation, global governance and global partnership. The benefits if this cooperation in the future will lead to an overall more healthy society, characterised by enhanced economic output and reduced strain on public healthcare systems. The perception of society will develop into a more cooperative, integrative, prioritised and proactive view of public health.

These are the words of David Byrne. I have nothing to add.

