Twenty years trends in healthcare systems in 22 European countries.

Part 2: Trends healthcare reforms: from (macro) cost-control to market elements

In the past 20 years, healthcare reforms in various European countries seem to converge, however a single healthcare system in Europe is not realistic. Healthcare is a national matter, because a healthcare system is highly dependent and embedded in the history of a country, national culture, political circumstances, economic context, social insurance system and other circumstances. However, legislation and reforms are increasingly looking beyond their own national borders.

Four studies (1997, 2007, 2018 and 2019)[1] describe the healthcare system of 11 and 22 European countries. This series of articles will discuss trends over the past 20 years:

1. *Decrease in healthcare expenditure growth in the USA and Europe*
2. *Trends healthcare reforms: from (macro) cost-control to market elements*
3. *Towards a stronger primary care*
4. *From financing healthcare providers to clients*
5. *Trends in out-of-pocket payments European countries*
6. *Which European country has the best healthcare system?*

Absolute healthcare expenditure continues to grow, but in most of the European countries, healthcare expenditures-growth (% GDP) is stable or decreasing (see former article). Healthcare reform agendas in the different European countries seem to have paid off.
But what do these reforms entail and can you see trends over the years?

Healthcare systems are constantly changing. In addition to improving the accessibility of healthcare (most European countries studied have achieved universal access to basic healthcare) and income protection, reforms over the last 20 years have focused on cost-control, cost-shifting and improving efficiency (micro and/or macro level). The last 10 years there is a trend towards the introduction of more market-elements in healthcare.

Trends healthcare reforms:

- Cost-control
- Cost-shifting
- Quality and efficiency
- Introduction market-elements

Cost-control
Until about 10-15 years ago, healthcare reforms focused mainly on controlling macro-costs, in particular on the introduction of global budgets, budgets for providers and changes in the way healthcare providers were paid.

Cost-shifting
Over the years there has been a continuous cost-shift towards healthcare users to control (public) healthcare costs. There is an increase in out-of-pocket payments and discussion about the composition of the basic package, which often has been reduced. This mainly concerns physiotherapy, IVF, dental care and medicines.

Quality and efficiency
In the past 10-15 years, reform policy has been shifted to measures at micro and meso level, aimed to improve quality and efficiency. This may include strengthening primary care and integrating primary and hospital care.
In the European countries studied, attempts are being made to strengthen the role of general practitioners by introducing or expanding the gatekeeper function. In addition, efforts are being made to improve the integration of care in various ways.

[1] Healthcare in Europe 1997, 2007, 2018 en 2019. The finance and reimbursement systems of 11/22 European countries: Austria, Belgium, Czech Republic, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, the Netherlands, Norway, Poland, Portugal, Romania, Slovakia, Spain, Sweden, Switzerland ,Turkey, UK.

In most countries more attention is being devoted to developing quality standards, benchmarking performance, exchanging information and best practices (such as for exemple in Austria and France). The development and use of care indicators is still in full development. England and Sweden are leaders in this.

A number of European countries have a specific policy on waiting-lists. For example, waiting-list guarantees have been introduced in Finland and Sweden and additional funds have been allocated. Sanctions are: allowing patients to go to other districts or regions or to use private hospitals or private insurance.

Introduction market-elements
The past 10 years, in most European countries studied, there has been a trend of introducing healthcare market concepts:

- Decentralisation: countries with centralized healthcare management are shifting more responsibilities to local governments and (quasi) private institutions (providers, insurers). For example in Finland and Sweden, municipalities have been given more responsibility in organizing and offering care and determining their own contributions.

- Healthcare purchasing: in most countries attempts are being made to strengthen the (passive) role of healthcare purchasing of financiers. The financiers (public/private insurer, government) are increasingly responsible for cost-control, are increasingly receiving a budget target and are increasingly responsible for contracting care (including incentives for efficiency). More emphasis will be placed on negotiations between providers and financiers. For example in Belgium and the Netherlands, insurers have become more financially responsible and funds are distributed among insurers according to the risk-equalization system. Healthcare purchasing becomes interesting if there is actual competition between providers, such as in the UK, where financiers are no longer obliged to contract public hospitals and in Sweden where a free choice of hospitals has been introduced.

- Separation of healthcare purchasing - healthcare provision: when introducing market forces and thereby (regulated) competition, separation of healthcare procurement and healthcare provision is an important condition. In Sweden and the UK there has been a separation of duties and responsibilities from healthcare purchasing and healthcare provision. These roles have always been separate in the Netherlands.

- Pooling and healthcare purchasing: in order to achieve fair competition between healthcare providers in a system (without risk selection e.g. based on health, age, etc.), funds will have to be divided according to the predicted financial risk. Proper pooling of funds is an essential condition. The predictive value of the risk factors varies between countries: from less complex systems such as in Switzerland (age, gender) to the more complex, and better predictive risk factors, such as in the Netherlands (age, gender, region, (source of) income, health status).

Political will is one of the most important keys to success in reforms. Lack of political will is often an obstacle, but also changes from governments, ministers and senior officials.
On the other hand, proposals that are politically supported in a stable political field have a better chance of success. Most reforms are small changes in a healthcare system.

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