



The aim of this chapter is to present a general comparison of the health systems of the countries included in the research project that has led to the present volume. It is introduced by a short discussion of the concepts of health care and health systems, and the methodology used, with particular emphasis on the question of constructing and using typologies (1). Then the historical background of the systems under analysis will be outlined, as well as the evolution of the European normative context (2). The following four main fields of comparison will be reviewed: personal scope (3), material scope (4), financing (5), and organisational structures (6).¹ Some shorter comments will be devoted to topics not covered by the four previous points (7). Finally, an assessment will be carried out to see if a separate comparison of the four main aspects leads to a consistent typology of the systems, and an interpretation of the differences between the types identified will be proposed (8).

It is important to note that this chapter only deals with health *care* policies, i.e. the delivery of benefits *in kind*. Cash benefits in case of sickness will not be analysed here.

I INTRODUCTION

1 *Short reflections on health care and health systems*

Human beings, like all living beings, can become ill or suffer injuries. Unlike most other living beings, however, they are able to react in a cooperative way toward such circumstances. People in better physical condition, and possibly with some previous experience of similar situations, provide care to those who need it. Such cooperation is necessarily asymmetrical and establishes a temporary or long lasting relationship of dependency. A characteristic feature of human groupings is that such dependency relationships are somehow structured, i.e. persons know who will probably will take care of them, or, conversely, who they will have to take care of.

For centuries, these caring structures existed on a small group scale, such as families and local communities. In the course of a complex process, treating the ill or injured became a state task. Let us briefly summarise the well known main stages of this process.

Initially, the state's role was intended to be marginal and its intervention triggered by severe public health problems. During the 19th century, industrialisation attracted a growing part of the population to the cities, making them leave traditional solidarity networks and exposing them to new health risks. Physical insecurity and feelings of injustice caused by these changes led to violent popular uprisings, an extreme case being the *Commune de Paris*. According to observers of the time, the bad health of the working class was identified as an important cause of such social conflicts, jeopardising governmental authority and the conditions required for developing industrial activities.

During the same period, general medical practice had expanded as a profession, becoming related to medical science and differentiated from other caring activities (for the case of France, see Guillaume, 1996). It offered health services of rapidly improving quality, but on a private basis, affordable only for people with comparatively high incomes.

This is the context in which Bismarck promoted social insurance funds (1883), designed to give poor workers and their families access to health services provided by independent practitioners, hitherto inaccessible owing to their cost. Later on, similar schemes were introduced in other European countries. During this first period, the state's role was marginal in the sense that it only supplied funding, and concerned only poor people (Köhler, Zacher, 1982).

A second period started after World War II. Health policies from that period differ to the previous period in two ways: they tended to address the whole population, and involved health providers operating under direct governmental supervision, mainly public hospitals. Factors favouring this policy turnaround were both political and technological. Politically, the aim was to offer 'social security' not only to poor workers but to the whole population, taking into account that the political evolution leading to World War II had been partly a result of the general economic insecurity prompted by the economic depression of the 30s. Technologically, the promising evolution of new diagnostic and therapy tools required important investments and organisational measures (notably improving the link between academic medical training and research, and inpatient health care provided by hospitals), which were taken by state governments. A relevant consideration underpinning these policies was that direct state involvement in health care provision would enhance the legitimacy of state power, or shape a new kind of state, more able to prevent war and totalitarianism. Thus, the state became, at least for some decades, a central entity directly involved in the structure of health care relationships.

One feature of the social policies of that period was a strong interrelationship, all being embraced in the single new concept of social security (see for instance 1952 ILO Convention 102, where health care is a branch of social security).

In recent years, many indicators suggest that the relationship between health policies and the state has entered a third period. The reform of health care systems has emerged as a specific topic within debate on the welfare state. If there is a 'system' to be analysed, in the sense of a strong relationship between a limited set of institutions, social groups and resources, it is no longer primarily at the level of 'social security' in the former broad sense of the phrase, but at the level of mechanisms providing health care. And the role of the state among the players in this 'system' has become a controversial issue. This is the period on which the present chapter will focus.

The issue, therefore, is understanding an evolution: how did 'health systems'² emerge as differentiated relevant unities; what transformations did they experience; what are the possible links between these transformations and internal and external factors?

When tackling these questions, normative statements have to be avoided. The aim is to give an account of what is going on, taking adequately into consideration the complexity of the current situation (Figueras et al., 2002). The discussion of political/ practical conclusions to be drawn from this analysis does not fall within our remit.

2 Methodology: why and how to use typologies in welfare studies

The reconstruction of the evolution referred to at the end of the previous section, consists mainly of constructing typologies. Typologies are quite a common instrument in the discussion of welfare policies. Nevertheless, it may be worth giving an explicit justification of their use.



A first justification is that typologies may help to provide a more precise and meaningful description of national institutions. Differences draw attention to what may be relevant and help formulate the characteristics of the systems under analysis. Specific features (e.g. insurance funds pay the cost of care directly to the general practitioners who provided it – German case) become significant when compared with different solutions adopted in other countries (patients have to pay, and are later reimbursed by their insurance – French case, among others : Döhler, Hassenteufel, 1996).

A more advanced justification is grounded on the assumption that the facts observed might be aspects of a transnational process. Similarities between national systems are then considered as revealing the impact of factors effective beyond national borders. If a group of states has institutional features in common, the question is whether they may be explained by sociological, political, or economical factors relevant in the whole region.

Taking as a starting point the short account of how the state's role evolved during the last century, there are several strong reasons for adopting the hypothesis of 'trans-national' factors effective in the field of health and health policies. The process of industrialisation concerned the whole western world; physicians as a professional category emerged around the same time in this area. Even the concept of the state, particularly important for understanding the evolution after World War II, developed partly in the context of international processes, such as the establishment of a new institutional and normative framework, through the creation of the United Nations and their specialised agencies. However, the EU-25 includes regions, notably in its Southern and Eastern periphery, which experienced later and weaker economic development. And the political regimes shaping the concrete structures of the actual Member States varied to a considerable extent: pluralist democracies in Western Europe, authoritarian regimes in Southern Europe and socialist regimes in Central and Eastern Europe until 1989.

The aim of the comparison is to examine whether these differences had an impact on the evolution of the health systems, and to identify possible other factors. A truly empirical procedure in this sense first has to attempt to identify 'types' of states on the basis of obvious institutional indicators (examining the common or different ways of defining who is eligible for a particular health care scheme, the benefits provided, and how it is financed and organised). Then these types will have to be confronted with less obvious independent variables such as recent political transformation, demographic trends, and so on, the question being to what extent the typology constructed helps to interpret the impact of these factors.

Within the framework of the research presented here, however, typologies may also have a more specific use. They can help us to formulate answers to the question whether there is any 'convergence' between the systems under analysis³.

If typologies are to be used in this way, they have to be constructed strictly on the basis of the concrete features of the systems under comparison, and without considering any broader information. All data not belonging directly to the health systems are considered as independent variables, which are confronted with the system types – as a complex dependent variable – only when the data is interpreted. The procedure is as follows: firstly, typologies will be constructed on the basis of the information discussed under the different headings of the chapter; secondly, it will be examined if the different typologies constructed are likely to be merged into one general typology; thirdly, the typology constructed on this empirical basis will be compared with other typologies that have emerged

in recent academic debate on the welfare state, and the possible interpretations will be discussed taking into consideration the context in which the systems under analysis is developed.

At this point, one distinction has to be emphasised. Our aim is to identify ‘types’ of health care systems. This is a matter of reducing the complexity of a universe of different and complex national systems, i.e. essentially a cognitive question. This cognitive question has to be clearly separated from the normative question implicitly raised by using the word ‘model’. Indeed, speaking about ‘models’, this suggests the notion of an institutional arrangement that could be a reference for defining political objectives. This is what is at stake in the discussion on the ‘European Social Model’ (among others, see Greber, 2001). The question whether comparison between ‘types’ may lead to normatively relevant statements will be addressed briefly in our concluding remarks.

3 Overall characterisation of the national reports on health

This chapter is based on national reports⁴ produced by members of the SPECIAL network. In all the countries analysed, intense debates are currently taking place on reforming the health system. These could not be ignored by the authors of the reports. The issues at stake at national level and the positions taken toward them inevitably shaped the national reports. General attitudes towards these debates vary significantly. Some explicitly endorsed one of the positions defended, either proposing a globally favourable assessment of the existing scheme, or arguing in favour of one of the reform projects.

Some topics of debate are almost constant throughout the countries under analysis. The main questions are how to reduce the cost of the systems’ operation, and, simultaneously, how to improve its responsiveness towards users’ needs, in particular by reducing waiting lists. Some topics typically are to be found in the reports concerning the Central and Eastern European Countries: the need to promote a more responsible attitude towards health matters among citizens, and the problems caused by the practice of ‘gratuities’. Some reports emphasise more specific issues such as: the quality of domestic debate on social protection issues (Estonia); the high level out-of-pocket health expenses (Finland); and social inequalities in terms of health care access (Great Britain).

II HISTORICAL BACKGROUND AND EUROPEAN CONTEXT

1 Central and Eastern Europe

During the last few years the majority of Central and Eastern European Countries underwent major political and social changes (Dixon et al., 2002; Figueras et al., 2002). For several decades some of these countries either belonged to the Soviet Union (Baltic countries), or were members of the Communist Block (Poland, Bulgaria, Hungary, Czech Republic, Slovenia, Slovakia, Romania). In many ways both structurally and functionally, the health care systems in these countries were very similar.

The centralist system of unified state health care was a major model in almost all former socialist countries (the so-called Soviet ‘Semashko’ health care model). After the Second World War, the development of a socialist political framework influenced the way the health care system was man-



aged. Private hospitals, pharmacies, and other private health enterprises were nationalised and brought under central state control. Private medical practice was allowed only in Hungary and Poland. However, full private employment or enterprise was not allowed either, or restricted to certain activities (private medical cooperatives, dental services).

Insurance companies and private general practices were dismantled and highly centralised state services were set up instead. In some countries existing health insurance systems were abolished. The state took over all health care coverage and financed it through taxes, i.e. central government became the sole funding entity and provider of health care services. Health-policy decisions under the socialist system were made centrally by political or governmental bodies.

Some of the countries even had a health insurance system during the Soviet era. For example, in the Czech Republic (former Czechoslovakia) the first model of health insurance was implemented in 1948, and health and social insurance were unified in a compulsory insurance system for all citizens. The Central National Insurance Fund was founded, which covered all health care and sickness benefits. In Slovenia, following reforms in 1954 and 1955, health insurance was separated from social security. Separate types of insurance were established for workers, public employees, craft workers, the self-employed, and later also for farmers, who acquired some minimal insurance coverage (such as coverage for emergency treatment in hospitals, treatment of infectious diseases and preventive health care). The providers of these health insurance policies were community health insurance institutes, administered by the representatives of employers and insured people.

Free health care provided to the population was one of the key issues of the socialist system. However, the scarce resources from the state budget allocated to the health sector were insufficient to cover all health care provider needs. In addition, lack of transparency in the allocation of resources resulted in an overall shortage of necessary capital investments in equipment and facilities, lack of some drugs, poorly paid health workers and an inequitable development of health services. Success indicators of the socialist health system were the number of graduated physicians and nurses as well as hospital beds, even if hospitals were under-equipped and outdated. People tended to be overhospitalised for routine conditions and became passive objects of the health care services. In contrast to the state's commitment to preventive care, primary health care providers suffered most. Although the system provided universal coverage and free comprehensive health services, this did not result in desirable health outcomes: the gap in life expectancy, infant mortality and other important indicators between the socialist countries and Western European countries increased continuously.

After the Soviet Union collapsed and the Communist Block crumbled, many Central and Eastern European Countries underwent major political and social changes. Almost all adopted a new Constitution defining the principles and basic democratic structure of the new Republics, including the right to private property and the establishment of a market economy with both public and private property. Against this backdrop, the health care systems were democratised and liberalised.

Legitimate acts and laws were passed to validate necessary and important changes in health care. From 1990-1991 until 1999, the legislative basis for the new health care systems was established in all transition countries. The most important ones covered new principles of financing and health insurance, reorganisation of health care infrastructure (mainly: decentralisation), privatisation of health care services and facilities, rules and regulations on public health, health protection, medi-

cal practice, drugs and medical devices, and so on. Long-term health care reform programmes were approved by the governments and (or) parliaments in some countries (Slovakia, Lithuania, Poland).

Changing a centralised and state-controlled health care delivery system into a decentralised one, promoting a private medical sector, and introducing health insurance (the new system clearly separating financing and provision) were common trends in all Central and Eastern European Countries. As a general rule, the Ministry of Health (Welfare) seems to be evolving from health care provider to policy-maker and regulator. However, **thoroughness and speed of change vary from country to country**. There is still an obvious political or bureaucratic resistance to change, economic difficulties, or both. The evolution has also been conditioned by frequent changes of government and amendments to the basic acts regulating health care provision, lack of managerial skills, monitoring, analysis and evaluation of the individual measures already taken or to be taken in the future. Frequently, decisions made were bureaucratic and centralised, not taking into consideration local needs and conditions (for example, reduction of the number of hospital beds in Slovakia). In some cases central governments justified their inactivity with a 'step by step reform philosophy' (Lithuania).

Although the transformation towards a market economy increased average living standards in Central and Eastern European Countries, it also considerably increased income differentiation and inequality in individual living standards. In the health protection system this trend resulted in a much improved supply of available medical services, medicines and so on for people with high incomes, but also increased the cost of medical protection for all the population, and created financial problems both for the national health system and people with average and low incomes. The last decade can be regarded as improving health protection in general, but on an unequal scale for people with high and low incomes.⁵

2 *Western Europe*

Considering the abundant literature on the history of Western welfare states (among many others, see Köhler, Zacher, 1982), a short note should suffice here. One first step is the development of independent general practitioners throughout the 19th century. These general practitioners were later involved in the implementation of schemes aiming at protecting poor workers. Given the increasing role of insurance funds and the expansion of their personal scope of activity, a clearer definition of the relationship between general practitioners and insurance funds had to be negotiated, a process which took place in several Western European countries in the first decades of the 20th century. In Germany, the result of these negotiations was the establishment of a system based mainly on agreements between funds and practitioners, where costs were paid directly by the funds to health service providers. In other countries such as France, governments became more directly involved and it was agreed that payments would have to be made by the patients themselves and later partially, or completely, reimbursed by the insurance funds (Letourmy, 1995; Döhler, Hassenteufel, 1996). This difference could be related to the fact that when the first negotiations were being held on this issue, Germany had stronger insurance fund networks than other countries.

in the late 1980s and early 1990s⁶, health appeared as a separate topic. Relevance was first given to the specific issue of health and safety at the workplace. This is the subject of Article 118-A of the 1986 Single European Act, of paragraph 19 of the 1989 Community Charter of Fundamental Social Rights of Workers (paragraph 19), as well as point 2 of the Protocol on Social Policy of the Maas-



tricht Treaty of 1991. This document also included a new article on public health, which gave rise in particular to a Community action programme in the field of public health 1997-2001, launched in 1997⁷. This programme, however, aims at evaluating the health status of the population, not the provision of health care. In broader terms, the 1992 Council Recommendation on the convergence of objectives and policies of social protection⁸, regards protection of health as one of the four missions of social protection, together with the guarantee of sufficient resources, social integration and labour market policies, and substitutive income through social security regimes. Over the following years, all the periodical reports of the Commission on Social Protection in Europe included a chapter on health care, making a global presentation of reforms in this field undertaken by the Member States (European Commission, 1994b, 1996, 1998, 2000, 2002). However, compared with other domains of social policy, in particular the promotion of employment (see further, chapter IV) and the combat against poverty, health policies were treated as a comparatively marginal issue at the European level. It was ignored, for example, in the 1993 Green Paper on Social Policy (European Commission, 1993), and the 1994 White Paper on Social Policy (European Commission, 1994a) only referred to health at the workplace and public health, not to health care. According to the principle of subsidiarity, it was still considered the exclusive domain of the Member States. In this The public hospital network was thoroughly reorganised after World War II. The most radical reform took place in the UK, with the creation of the NHS.

In recent years, health systems have become a public issue within the broader debate on the 'crisis of the welfare state'. Reforms were implemented in several countries, giving a more prominent role to private entities (Granalía, 1997) and markets (Glennerster, Le Grand, 1995). Compared with other branches of social protection systems, discussion of reform strategies in the domain of health involves specific actors, such as private insurance companies seeking to expand their scope of activities, and the pharmaceutical industry, concerned notably with policies aiming at favouring the use of generic medicines.

3 *The European Union as context*

The 1957 Treaty of Rome did not explicitly mention health policies. According to the terminology of that time, consistently adopted in international legislation, notably in 1952, in ILO Convention No 102, health care was a branch of social security. Social security, in turn, was mentioned in Article 51 on the protection of migrant workers, and Article 118 on the mission of the Commission in promoting collaboration between Member States in the field of social policy. Article 51 gave rise to the 1958 Regulations No 3 and No 4 – later replaced by Regulations No 1408/71 and No 574/72 – where detailed provisions were included on the access of migrant workers to health care in Member States other than the competent one. No measures in the field of health care were taken on the basis of Article 118.

Within the framework of the European Union's initiatives on matters of social policy sense, actually, the Maastricht Treaty excluded explicitly any measure of 'harmonisation' between the national provisions in this field.

In the late 1990s, social policy again became a priority for the European Union⁹, with the launching of the European Employment Strategy 1998 in Luxembourg (see the relevant chapter in this volume), and the adoption, by the European Council of 24 March 2000 in Lisbon, of the 'Open Method of Coordination' among its policy tools in the field of social policy. Even under these circumstances,

health was not the first priority. Procedures implementing the OMC were first started in the field of pensions and social inclusion (see the relevant chapters in this volume). Another event in that period relevant for the issue at stake here was the proclamation of the Charter of Fundamental Rights of the European Union in December, where ‘protection of health’ is mentioned (Article 35).

However, crucial development had taken place in the meanwhile contributing to speeding up the formulation of a specific European health policy. In the Kohll and Decker cases, the European Court of Justice stated the full relevance, in the field of health care, of the principles of free movement of goods and services.¹⁰ In accordance with these rulings, people can freely chose to seek medical treatment in a Member State other than the competent Member State. This will lead to more direct competition between health systems and, thereby, to a more urgent and concrete need for convergence. Over the last years, these cases were quoted as prominent justification for measures taken in this field by the European Commission and the European Council. As a preparatory document on the way to an ‘open method of coordination’ procedure, the Commission issued a Communication on “The future of health care and care for the elderly” in December 2001.¹¹ Let us remember some the most relevant steps taken since then. At the social summit of March 2002 in Barcelona, the Council recognised the three principles that should be taken into account in health care reform: accessibility of care, high-quality care and financial sustainability. A high level process of reflection on patient mobility and healthcare development in the European Union, gathering representatives of governments and different groups concerned (institutions, professionals, patients and so on) was carried out during 2003 (Commission, 2003). On the basis of its conclusions, the Commission proposed starting the work required by the ‘Open Method of Coordination’ in 2004. Preliminary national reports should be submitted in 2005. An assessment of the first phase of open coordination in the field of healthcare would be presented in the Joint report on social protection and social inclusion to be adopted in 2007.¹²

III PERSONAL SCOPE

1 General Remark

A preliminary and elementary remark has to be made on the notion of personal scope. As a matter of fact, it may have a broad and a narrow sense.

One question is knowing who is entitled to health care in a given country (personal scope in the broad sense). According to the information contained in most of the national reports, the answer to this question is: everybody. Two different mechanisms may lead to this answer. One concerns the case of emergency. In several countries, care has to be provided in all emergency cases (Sakslin, *Nat. rep. Finland*: 4, 14; Sanchez-Rodas, *Nat. rep. Spain*: 12; Männik, Einasto, *Nat. rep. Estonia*: 12; Czucz, Hajdu, *Nat. rep. Hungary*: 5; Clark, Murphy, *Nat. rep. Ireland*: 20; Bubnov-Škoberne, *Nat. rep. Slovenia*: 17). The other mechanism is the possibility, which exists in all the countries compared, of finding a private practitioner or hospital where the treatment is provided on a paid basis. Obviously, access to such private health care depends on actual prices and the patients’ financial resources.

The narrow sense of the expression ‘personal scope’ derives from the existence of public schemes



providing medical treatment, urgent or not, without requiring the payment of the full price of the treatment at delivery. Access to such public schemes is usually restricted to specifically defined categories of people. Such schemes exist in all the countries compared here.

2 Outline of a typology

As far as the definition of personal scope in this narrow sense is concerned, three main types of schemes are to be found. Entitlement to medical care may derive from:

- (a) residence
- (b) contribution to health insurance
- (c) inclusion in a particular social security scheme.

Conditions (b) and (c) are similar in some aspects. In both cases, inclusion in the scheme's personal scope requires the payment of contributions. However, significant differences pertaining mainly to organisational differences, make it advisable to distinguish between the two categories. Condition (c) is to be found within the framework of health systems closely connected to the social security administration; condition (b) where the health system was set up clearly separate from the social security administration.

2.1 Residence-based systems

Residence is the only condition defining the personal scope of the health systems of the following countries: Denmark (Abrahamson et al., *Nat. rep. Denmark*: 10), Finland (Sakslin, *Nat. rep. Finland*: 13), Portugal (Guibentif, Soares, *Nat. rep. Portugal*: 12) and Great Britain.

In Greece, a residence-based system has co-existed with a contribution-based system since the creation of the National Health System in 1983 (Kremalis, *Nat. rep. Greece*: 11, 29).

Questions deserving more detailed analysis are: what is the precise definition of 'residence', and what are the administrative procedures for recognising residence in concrete cases? In Greece, temporary residence seems to be sufficient (Kremalis, *Nat. rep. Greece*: 11). Permanent residence is explicitly required by Finnish legislation, interruptions of up to one year being admitted (Sakslin, *Nat. rep. Finland*: 14).

Danish legislation stipulates a waiting period of six weeks (Abrahamson et al., *Nat. rep. Denmark*: 10). This waiting period, however, does not apply to people moving from EU countries. Exceptions also exist under certain conditions for people moving from some other countries in application of bilateral agreements, as well as to people who have studied or worked abroad for Danish interests.

2.2 Personal scope defined by the contribution to a compulsory health care insurance system

Access to health care can also be conditioned by contribution to health insurance operating within

the framework of a compulsory health insurance system that is not part of the social security system. This is the case in many Central and Eastern European Countries (Sredkova, *Nat. rep. Bulgaria*: 16; Medaiskis et al., *Nat. rep. Lithuania*: 31; Czepulis-Rutkowska et al., *Nat. rep. Poland*: 5; Radicova, *Nat. rep. Slovakia*: 11; Bubnov-Škoberne, *Nat. rep. Slovenia*: 1).

A common feature of these schemes is a provision concerning people with no income, or insufficient income to pay insurance contributions. According to this provision, the contributions of these people have to be paid by the State (Papes et al., *Nat. rep. Czech Republic*: 3; Czepulis-Rutkowska et al., *Nat. rep. Poland*: 5; Radicova, *Nat. rep. Slovakia*: 13; Bubnov-Škoberne, *Nat. rep. Slovenia*: 17).

Among systems of this type the status of dependent family member varies. In Poland, their coverage is included in the insurance of the person responsible for them (Czepulis-Rutkowska et al., *Nat. rep. Poland*: 5). In the Czech Republic, dependent family members have their own insurance, their contributions being paid by the State (Papes et al., *Nat. rep. Czech Republic*: 3).

2.3 Personal scope defined by the inclusion in a social security scheme

In several countries, personal scope is defined by a list of professional categories corresponding to different social security schemes (Pfeil, *Nat. rep. Austria*: 13; Sanchez-Rodas, *Nat. rep. Spain*: 12; Kessler, *Nat. rep. France*: 3; Kerschen, *Nat. rep. Luxembourg*: 8; Centel, *Nat. rep. Turkey*: 2). In these cases, the right to health care is part of a broader right to social security granted on a professional basis (Bismarckian systems). It covers not only the worker, but also the members of his/her family.

Such systems may not cover the whole resident population, since they exclude people who do not belong to any social security scheme. In response to such situations, special mechanisms of health care access were created in some countries, such as the *couverture maladie universelle* in France (Kessler, *Nat. rep. France*: 3), or access to medical care for people under 18 and pregnant women illegally residing in Spain (Sanchez-Rodas, *Nat. rep. Spain*: 12).

2.4 Other cases

In Germany, the health insurance system is somehow comparable to the systems listed under (c) (Schulte, *Nat. rep. Germany*: 13). But there are some significant differences (some categories of people are not subject to the public insurance scheme; the role of enterprises and the social partners). And its structure is, globally speaking, more complex, as a result of longer historical development.

In Hungary, the role played by the Health Insurance Fund also makes the system comparable to those listed under (c) (Czucz, Hajdu, *Nat. rep. Hungary*: 3, 7). However, the very nature of the system – insurance-based or based on civic rights – is said to be still under discussion (Czucz, Hajdu, *Nat. rep. Hungary*: 4). Moreover, the system also includes a special scheme for non-citizens ('TAJ card'), based on special health insurance contracts (Czucz, Hajdu, *Nat. rep. Hungary*: 5).

Ireland has a health system comparable to those listed under (a). However, beneficiaries have to be covered in principle by paid health insurance within the Pay Related Social Insurance scheme

(PRSI; Clark, Murphy, *Nat. rep. Ireland: 2*, 15). Alternatively, access is provided through the Medical Card scheme, which is available for some categories of disadvantaged people (Clark, Murphy, *Nat. rep. Ireland: 3*, 28).

IV MATERIAL SCOPE

1 Short description of the benefits provided

1.1 Central and Eastern Europe

Compulsory plans cover a certain range of basic benefits either with or without co-payment. The extent of health insurance coverage depends on benefits included in the basic health care package. The better the social and economic situation in the country, the more health care services covered by compulsory schemes. On the other hand, problems caused by the state's financial deficit leads to limitations in terms of health care coverage and, at the same time, increases private co-payments. The structure of health care coverage therefore varies.

Some of the Central and Eastern European Countries (Slovenia, Bulgaria, Latvia) have basic health care packages, fully covered by the compulsory health scheme. However, Slovenia's and Latvia's health care package is quite different: in Latvia only emergency, maternity care and treatment for those aged under 18 years is entirely free, while in Slovenia treatment for infectious diseases, all preventive dental programmes, care of children and students, reproductive health services for women, treatment and rehabilitation of occupational diseases, as well as a number of specified diseases and conditions (such as mental diseases, epilepsy, cerebral palsy, diabetes and psoriasis) are fully covered. In addition, in Slovenia at least 50%, and possibly as much as 95% of the cost of services such as surgery, intensive care, treatment of oral and dental conditions, medication on the positive list, and spectacles and hearing aids are covered by compulsory insurance.

In other countries (Czech Republic, Hungary, Slovakia, Estonia, Lithuania) health insurance covers all or part of the costs relating to health check-ups, primary, secondary and tertiary care, deliveries, emergency medicine and blood transfusions, rehabilitation and so on. Sickness benefits are part of the health insurance system in one of the countries, but separately covered by other social insurance schemes in the others (Czech Republic, Lithuania, Poland).

1.2 Western Europe

People who fulfil the personal conditions previously discussed in section 3 have access to medical treatment and hospitalisation if necessary. Pharmaceuticals are refunded according to rates which may vary according to category of beneficiary (notably pensioners) and product (Kessler, *Nat. rep. France*, 14; Kremalis, *Nat. rep. Greece*, 13). In some countries, dental care and prostheses are reimbursed only for specific categories of beneficiaries (children), or up to a certain limit. Differences concern not the services or goods materially provided, but the administrative conditions for accessing them (authorisation of the sickness fund or of the general practitioner) or the conditions for reimbursement (see section 5 on financial issues). Among the treatments not included, dentistry and physiotherapy are mentioned (Abrahamson et al., *Nat. rep. Denmark: 9,11*). Conversely, dentistry

is included in the system in Great Britain (Tahiraj, *Nat. rep. Great Britain* 42).

2 *Typology ?*

On this point, there are many differences between the national systems, making it difficult to draw lines between different and clearly identifiable types.

V FINANCING

1 *General data on health expenditures*

In this preliminary section we shall only consider the general issue of health expenditure. Specific topics will be discussed in the course of the presentation of the typology.

1.1 Central and Eastern Europe

International comparisons of health care expenditure are extremely difficult because of the definitions underlying health statistics as well as varying accounting practices. Data on health care expenditure should therefore be used with caution, as the boundaries of what constitutes health care can vary significantly between countries.

Data from 1998 (see Statistical Appendix) show that Slovenia and the Czech Republic have the highest proportion of health expenditure of total GDP (7,7% and 7,6% respectively). These figures are higher than the average of Central and Eastern European Countries, but lower than the EU average of 8.6%. In Romania, Latvia, Bulgaria, Turkey and Lithuania, the proportion of health expenditure of total GDP is lower than the average of Central and Eastern European Countries. When comparing these figures with those of table 1 (next page), it is evident that the proportion of out-of-pocket spending on health care is much higher in countries with a lower proportion of health expenditure of total GDP.

1.2 Western Europe

Three categories can be distinguished here (see Statistical Appendix). Two countries are clearly below the average: Luxembourg (5,9%) and Ireland (6,1%), and two are above the average: France (9,6%) and Germany (10,5%). Coincidentally, the issue of health funding has led to fierce public debate in both France and Germany in the last few years. Between these two categories, we found rather different figures, from Finland (6,9%) and Spain (7,1%) to Netherlands (8,6%) and Belgium (8,8%). It is not easy, however, to divide this third category into sub-groups.

Country	Source of finance				
	Public		Private		Other
	CHI	Taxes	OOP	P(VI)	
Bulgaria	-	80	20	-	-
Czech Republic	80	10	8	-	2
Estonia	68	12	15	-	3
Hungary	71	12	17	-	-
Latvia	-	79	21	-	-
Lithuania	66	8	23	-	3
Poland	-	73	27	-	-
Romania	56	15	29	-	-
Slovakia	67	24	8	1	-
Slovenia	85	3	-	12	-
Turkey	22	43	35	-	-
Malta	-	60	40		-
Cyprus	-	-	-	-	-

Table 1. Percentage of main sources of health care finance in EU candidate countries

CHI – Compulsory Health Insurance;

OOP – Out-of-pocket payment;

P(VI) – Private (Voluntary) Insurance;

Sources: Health Care Systems in Transition. The European Observatory on Health Care Systems. Reports: Bulgaria, 1999, Czech Republic, 2000, Estonia, 2000, Hungary, 1999, Latvia, 2001, Lithuania, 2000, Poland, 1999, Romania, 2000, Slovakia, 2000, Slovenia, 2002, Malta, 1999, Turkey, 1996.

2 Typology

Here again, we find three groups, roughly corresponding to those identified in the section on personal scope: mainly tax-financed systems (a), systems financed by a national health insurance system (b), systems financed as part of the social security system (c). Under these three headings, it will be worth describing in particular, general aspects of the funding system (i); and the expenses to be made by the people concerned (ii).

2.1 Tax-financed systems

2.1.1 General aspects

The health system is financed mainly by taxes in Denmark (Abrahamson et al., *Nat. rep. Denmark*: 11), Finland (Sakslin, *Nat. rep. Finland*: 19), Great Britain (GB: 42), and Ireland (Clark, Murphy, *Nat. rep. Ireland*: 1, 15).

The State Budget is also central to the financing of the Portuguese National Health Service, even if care provided to people affiliated to social security schemes is reimbursed to the system by these schemes.

In all these countries, the beneficiaries have to make a significant direct contribution, a point which the Finnish report emphasises in particular (Sakslin, *Nat. rep. Finland*: 19). The aim of this direct contribution is to ease the financial burden borne by the tax-payer.

An additional general measure has been implemented in Finland and Ireland, where the system, in addition to the State's contribution, is partly financed by a specific insurance scheme, statutory sickness insurance (Sakslin, *Nat. rep. Finland*: 20) and the Pay Related Social Insurance scheme (PRSI; Clark, Murphy, *Nat. rep. Ireland*: 2, 15). In Ireland, there is also public Voluntary Health Insurance (Clark, Murphy, *Nat. rep. Ireland*: 3).

Tax-based national health services co-exist with private health insurance companies, which contribute significantly to financing. We shall come back to the functions of private health insurances later under section 5.

2.1.2 Direct charges for users

Taxes (on income and VAT) to be paid in the country under comparison are not considered here. The part going to the health budget should be added, strictly speaking, to what people have to pay for their health system. However, the exact proportion is quite difficult to calculate and remains unknown to the people concerned.

Two main items referred to in the systems under discussion here were co-payments – partial payments for care provided by the system and payment of pharmaceuticals and treatments not provided by the system.

Co-payments (fees) for treatment provided by the system are required in Finland (Sakslin, *Nat. rep. Finland*: 19) and Portugal (Guibentif, Soares, *Nat. rep. Portugal*: 6). In Denmark, users may opt between two schemes, one (Group 1) without co-payment but the ability to choose the general practitioner limited to those registered with the health administration of their county; the other (Group 2) with free choice of general practitioner, but partial payment of the treatment (Abrahamson et al., *Nat. rep. Denmark*: 8). Co-payments are not required either in Great Britain (Tahiraj, *Nat. rep. Great Britain* 42, 43), or Ireland.

In Ireland, however, users – as well as their employers, if it is the case – have, with some exceptions, to pay contributions to the Pay Related Social Insurance scheme (PRSI; Clark, Murphy, *Nat. rep. Ireland*: 2, 5, 15). A similar scheme exists in Finland, as already mentioned, where beneficiaries



have to contribute to statutory sickness insurance (Sakslin, *Nat. rep. Finland: 20*). In some respects these two schemes are comparable. Their individual function, however, is different. In Ireland, the payment opens in general terms a right to access the system. In Finland, insurance reimburses partially or entirely concrete expenses, i.e. practitioners' and hospital fees as well as pharmaceuticals (Sakslin, *Nat. rep. Finland: 19*).

As a mechanism which should limit the costs to be borne directly by patients, Finland has a yearly ceiling on fees for health care service (Sakslin, *Nat. rep. Finland: 20*).

Available information on treatment not offered by the national health services, and therefore paid directly by users or a voluntary additional private insurance scheme, did not allow us to reconstruct a precise and systematic picture.

2.2 Systems based on a national health insurance scheme

Here we meet the group of Central and Eastern European Countries, a category we shall find again in the next section, precisely because its main organisational feature concerns the institution in charge of financing.

2.2.1 General aspects

The main funding source in these countries are contributions to the national health insurance funds. However, several reports also mention direct state contributions, as regards investments or special state supported health protection programmes (Sredkova, *Nat. rep. Bulgaria: 22,30*; Papes et al., *Nat. rep. Czech Republic: 4*; Czepulis-Rutkowska et al., *Nat. rep. Poland: 8*). A typical state method for contributing to the health system is paying the contributions of several categories of people (earlier discussed under point 3.B.b). The contributions are calculated in a way similar to what we can find among countries discussed under (c).

The social insurance schemes are financed by employer and employee contributions. In Slovakia, the Czech Republic, Estonia, Slovenia, Romania, Hungary and Lithuania health care insurance contributions come to 12-14% of gross employee income, while in Poland and Bulgaria they are considerably lower (7,5% and 6 % respectively). The proportion of employer and employee contributions differs from country to country: in the Czech Republic, Estonia, Hungary and Slovakia the employer is the main contributor; in Slovenia, Bulgaria, Romania contributions are divided equally, while in Poland, employees pay a larger share of contributions. In Lithuania, insurance contributions (3% of payroll) are paid by employers, but 30% of personal employee income tax is paid into a Health Insurance Fund, which means employees contribute more.

The self-employed pay a similar overall proportion of their total income, and the public sector covers payments for unemployed people. The law usually defines the contribution rate. In the majority of residence countries, population coverage is based on permanent residence and (or) employment by a state-based organisation.

Regarding contributions payable by employers, there are problems of compliance which have a significant financial impact (Sredkova, *Nat. rep. Bulgaria: 27*).

In these countries, private insurance plays a limited financial role for the time being.

2.2.2 Direct charges for users

The first item to be mentioned here are contributions to the national insurance fund. It should be noted that in some of the countries concerned, these contributions are paid to the tax office (see for instance Männik, Einasto, *Nat. rep. Estonia*: 13). It would be interesting to analyse the impact of this procedure on the public image of these contributions, compared to the case of type (c) analysed in the next point of this section, where contributions visibly enter into a social security system separate from the State budget.

Fees or co-payments due for treatment received are mentioned in several of these countries, in some cases explicitly related to governmental efforts to promote a sense of responsibility amongst its citizens (Czucz, Hajdu, *Nat. rep. Hungary*: 5,6; Czepulis-Rutkowska et al., *Nat. rep. Poland*: 3,9; Radicova, *Nat. rep. Slovakia*: 2,6; Bubnov-Škoberne, *Nat. rep. Slovenia*: 2). Conversely, such payments do not exist in the Czech Republic (Papes et al., *Nat. rep. Czech Republic*: 3).

Out-of-pocket costs consist of full or partial payments for pharmaceuticals (major part), dental care, visits to private primary care physicians, cosmetic surgery, abortions, infertility treatment, eyeglasses, chronic care and treatment in a sanatorium, medical devices such as wheelchairs, incontinence pads, and so on. In some countries (Poland, Bulgaria, Lithuania, Latvia and Romania) 'envelope payments' to hospital staff for better access to elective surgery, other treatment or medicines at the hospital is still very common.

There are no precise statistics on funding, and wide disparities among different sources of information. However, in almost all Central and Eastern European Countries private payments were increasing. Unfortunately, voluntary health insurance does not play an important role in the health care coverage system (except Slovenia, where 98% of the population is covered by voluntary insurance), People therefore have to pay directly out of their own pockets. Some out-of-pocket costs are official, some – unofficial (see also Table 1).

A practice which seems to have a serious financial impact on users concerns 'informal payments' required in addition to legally established co-payments (Czucz, Hajdu, *Nat. rep. Hungary*: 4; Dózsa, 2002; Czepulis-Rutkowska et al., *Nat. rep. Poland*: 10). A similar problem is the fact that certain pharmaceuticals which should be provided free of charge in hospitals have to be paid out-of-pocket by patients (Czepulis-Rutkowska et al., *Nat. rep. Poland*: 9).

2.3 Systems financed within the framework of a national social security system

To be included in this group are the systems of Austria, France, Germany, Greece (as far as one of its two schemes is concerned), Luxembourg, Portugal (where the National Health Service is primarily financed by taxes, but co-exists with a Bismarck-style social security system that contributes to its funding) and Turkey. Spain seems to be a borderline case between types (a) and (c), since there is a link between the Health System and a Bismarckian social security system, within the framework of which social security contributions have to be paid. However, health care benefits can be qualified as non-contributory (Sanchez-Rodas, *Nat. rep. Spain*: 15), since the financing of the health system



is nowadays mainly tax-based.

2.3.1 General aspects

In these systems, the main financial source are contributions paid by employees, employers and the self-employed, to the social security system in general (Pfeil, *Nat. rep. Austria*: 15; Kessler, *Nat. rep. France*: 22; Kerschen, *Nat. rep. Luxembourg*: 9; Guibentif, Soares, *Nat. rep. Portugal*: 14).

In the face of growing funding problems encountered by all the systems compared, there is a trend toward more direct payments required from patients, and the creation of alternative general financial sources. The latter applies particularly in France, with taxes on certain health-damaging goods (alcoholics and tobacco), and the introduction of the *contribution sociale généralisée* (CSG; Kessler, *Nat. rep. France*: 22). In Luxembourg, state subsidy is important. It also has a special tax on electricity related to the long-term health care scheme, and an 'additional social contribution' was recently introduced, similar to the French CSG (Kerschen, *Nat. rep. Luxembourg*: 10). Turkey also insists on the role of the state (19).

Since there are aspects of common management of the different branches of social security, financial problems, which may vary from branch to branch, may also lead to questioning the distribution of financial resources between the different branches (Kessler, *Nat. rep. France*: 23, Guibentif, Soares, *Nat. rep. Portugal*: 14).

A specificity of the German system is the possibility, above a given monthly salary level, to opt out of the statutory insurance system (Schulte, *Nat. rep. Germany*: 12).

In the countries analysed here, just as in all other countries, private insurance companies play a role. This topic will be discussed later under section 6.

2.3.2 Direct charges for users

In the first place we have to mention social security contributions (figures: Pfeil, *Nat. rep. Austria*: 15; Kremalis, *Nat. rep. Greece*: 28). There are ceilings on the income to be taken into account (Pfeil, *Nat. rep. Austria*: 15).

Recent measures have increased these contributions. In Austria, workers have to pay an additional amount to cover their spouse (Pfeil, *Nat. rep. Austria*: 16). In France and Luxembourg, recently introduced 'social taxes' also have to be taken into account (increase of periodic individual payments to be made to the state, related to the global cost of the social system).

Co-payments or partial payments to be made directly by users exist in Austria (Pfeil, *Nat. rep. Austria*: 16) and France (Kessler, *Nat. rep. France*: 14). In Austria there is a clear trend to increase these co-payments, but people with low revenues may be entitled to pay lower amounts or exempted (see for instance Portugal).¹³

Here again, related to the increasing role of private insurance companies, contributions for complementary private insurance schemes are increasing.

VI ORGANISATIONAL STRUCTURES

1 Territorial organisation

1.1 Central and Eastern Europe

In the majority of Central and Eastern European Countries the Ministry of Health is the governmental body responsible for health care (Slovenia, Czech Republic, Hungary, Lithuania, Bulgaria, Romania, Slovakia, Malta, Turkey), while in others it is the Ministry of Social Affairs (Estonia), the Ministry of Health and Welfare (Poland), or the Ministry of Welfare (Latvia). Whilst the role of central government differs from country to country, certain tasks and responsibilities are common or very similar, such as planning and development of national health policy, coordination and supervision of health care at the national level, involvement in drafting legal acts and issuing the relevant regulations for the sector, developing and implementing national programmes on disease prevention and health promotion, setting and supervising quality of health care as well as medical technology standards. It is also responsible for major capital investments.

During the process of decentralisation local governments at regional or (and) municipal level were given more autonomy in planning, regulating and managing health services in their areas. The majority of countries has transferred partial or full responsibility for financing health and health care to the municipalities or regions. Consequently, the role of local governments in both the financing and provision of health care services has expanded significantly. More than that, ownership of many health care facilities has been devolved to municipalities: small and medium-size hospitals, primary and outpatient health care facilities, public health institutions, shelters for the homeless, homes for orphaned children and so on.

Although decentralisation might be considered a significant step towards democratisation and pluralism, a number of shortcomings were revealed. One major obstacle was avoiding central dominance in health care administration and financing. In Slovakia, the Ministry of Health still controls health insurance companies, for example by issuing or withdrawing permits for operating health insurance companies. It owns, runs and controls almost all inpatient health care facilities with the authority to appoint and dismiss their directors, is responsible for postgraduate and continuous education of health workers, still owns, runs and controls secondary nursing schools, the Slovak Postgraduate Academy of Medicine, and so on. The Ministry of Health in Lithuania is strongly involved in drafting legal acts and issuing regulations for the sector, and also runs a few (13) health care facilities, shares responsibility for running two major Lithuanian teaching (university) hospitals, and supervises and controls the activities of the Patient Sickness Fund. In some of the countries, a reluctance to delegate tasks and responsibilities to local governments was an obstacle to health reforms.

In contrast, other countries have been 'forcing' the process of decentralisation, which has resulted in over-decentralisation. The decision to decentralise was implemented without adequate preparation, in terms of staff training, accountability procedures and guidelines for policy sustainability.

The process of devolution has also had a number of negative effects in Latvia. As payment for services was on the principle that 'money follows the patient' when patients were referred to a facility outside the district, the facility had to invoice the district of residence through an 'inter-territorial



invoice'. However, as money for health care formed about 85% of the local budget, both the local government council and the local health manager preferred to retain as much spending as possible within their own district and strengthen their own institutions. This meant that there was a reluctance to refer patients to other institutions even if they required more specialised treatment, while individual districts tried to develop their own facilities. Meanwhile, access to diagnostic and medical equipment varied throughout the country. In 1997 health care financing was re-centralised. The districts stopped receiving funds for the provision of health care services. Since then, funding for health care is no longer allocated to local governments, but is now distributed to regional sickness funds through the State Compulsory Health Insurance Agency, on the principle of equal financing per capita.

1.2 Western Europe

Regional structures play a significant role in many Western European countries. However, these structures have a very different legal and organisational nature: local or regional governmental structures (Tahiraj, *Nat. rep. Great Britain*, 19; Sanchez-Rodas, *Nat. rep. Spain*, 21; Rico, 1997) or locally operating funds (Schulte, *Nat. rep. Germany*, 13: *Allgemeine Ortskrankenkassen*). Differences between regions or municipalities may have consequences in terms of access to the health service (Sakslin, *Nat. rep. Finland*, 12, 30) or give rise to different administrative practices (Clark, Murphy, *Nat. rep. Ireland*, 16). They may also lead to coordination problems (Pfeil, *Nat. rep. Austria*, 21; Kessler, *Nat. rep. France*, 21).

2 Health service institutions.

2.1 Central and Eastern Europe

The law defines the health care delivery system and institutions in the majority of Central and Eastern European Countries. There are two categories of health care facilities in all of these countries: state-owned or public (run by the Central Government and district / municipality authorities) and non-governmental (private) belonging to private enterprises and churches, communities, or non-governmental organisations. The vast majority of health care facilities are still owned by the state, but the non-governmental part is gradually increasing. The number of privatised health care institutions and facilities, their size and their ownership vary from country to country

2.1.1 Primary health care

Developing the primary health care sector with the key player - family physician (general practitioner) - is becoming the most important part of health care reforms in all of these countries. Unfortunately, the majority are taking just the first steps in strengthening and developing the institution of primary health care and still lag far behind as far as EU countries are concerned.

Primary care is mostly provided in various publicly-owned outpatient facilities: (ambulatory) health care centres, polyclinics, dispensaries and so on. Usually, these facilities are to be found in local communities near the places where people live, work or study and owned by municipalities.

As the institution of general practitioner is still underdeveloped in the majority of reference countries,

the first “contact doctor” is usually an internist, paediatrician, gynaecologist or dentist. Midwives and nursing staff can be a part of a primary care team. In some countries (Latvia, Lithuania), where an old ambulatory care system still exists, primary care in rural areas could be provided in medical posts or paramedical stations by nurses or midwives.

Primary health care services include general medical care, maternal and child health, gynaecology, dentistry, home care by nurses and basic emergency medical care as well as some preventive services such as immunisation and screening. Depending on the location and equipment available at the primary health centre some diagnostic or curative procedures (x-ray, ultrasound examination, physiotherapy) can be performed. In some countries (Poland, Hungary, Lithuania) emergency care is provided separately by emergency ambulance services. The package of primary care services varies from place to place (for example, urban and rural areas) and from country to country.

A primary health physician plays the role of gatekeeper to specialised care. If secondary or tertiary care is needed, the patient can be referred to a particular specialist or hospital for consultation or treatment. People can choose a primary health care physician, and are free to change within a certain time frame (it differs from country to country).

During the last decade, all of the Central and Eastern European Countries have shifted their primary health care to the family practice model where the key role falls on the general practitioner. University and postgraduate training in the specialty of general practitioner has been introduced and the number of trained (or re-specialised) family physicians is growing rapidly. For example in Latvia, the number of family physicians increased from 27 in 1991, to 801 in 1999, and almost 2000 general practitioners were registered in Lithuania by the end of 2001.

Private practice is occupying an increasingly important position in primary health care in all Central and Eastern European Countries. Most private practitioners are located in health centres, rent office space, or work at publicly owned facilities on a contractual basis with the local authorities. The weight of private practice is still very different in different countries and mostly depends on financing. In countries where primary care physicians work on a contractual basis with health insurance companies, private practice is most common. In the Czech Republic already in 1995, about 91% of general practitioners, 87% of paediatricians and more than 90% of dentists were in private practice. After financing arrangements were introduced in Hungary, private practice increased from 10% to about four fifths of all practitioners between 1992 and 1997. Private practice is an important part of primary care in Slovenia and Slovakia. In the Baltic countries, Bulgaria and Romania, private care is still very low.

2.1.2 Secondary and tertiary health care

Specialised ambulatory medical services are provided in various forms, mostly in polyclinics or hospital outpatient departments (or polyclinics affiliated to hospitals). In Slovenia, the Czech Republic, Estonia, Malta and Lithuania, secondary outpatient care can be provided by private specialists. Their services are usually covered on a contractual basis by the patient’s insurance fund (patient sickness fund), or paid directly by the patient (Lithuania).

There are different levels of hospitals for specialised inpatient care in each of the reference countries. Although the process of privatisation has already started, the vast majority of hospitals are still



state-owned.

Local (municipal) hospitals usually have 40-100 beds and provide care in internal medicine, surgery, paediatrics and obstetrics/ gynaecology. Some of these hospitals have been transformed into long-term care and nursing facilities (Lithuania). These hospitals are usually owned and financed by local authorities, or provide care on a contractual basis with insurance funds.

In county or district hospitals the number of beds usually does not exceed 200. These hospitals can provide more specialised care (ophthalmology, neurology, emergency medicine and so on) to the population.

Regional or central hospitals are located in the big cities; the number of beds can vary from 300-400 to 1000 or even more. These hospitals are highly specialised. National health institutes and university hospitals can be simultaneously funded either directly by the government or through national programmes.

The private hospital sector is still very small in all of the reference countries. In 1998, there were 40 private hospitals in Poland and only two have between 200–400 beds. There are 64 private hospitals in the Czech Republic, but they make up only 9% of all hospital beds. An almost similar situation is observed in Hungary, where privately owned hospitals make up 6% of all hospital beds. Some countries have very few private hospitals: in Bulgaria – 16, Latvia – 9, Estonia – 5.

2.1.3 Human resources

Despite the fact that some of the Central and Eastern European Countries (Hungary, Lithuania, Bulgaria) have more physicians per 1000 population than the EU average, the average of all reference countries (2,8/1000) is lower (see Statistical Appendix). The difference between reference countries and the EU is even bigger, when it comes to the number of pharmacists and dentists per 1000 population. Some of the countries have very low numbers of pharmacists and (or) dentists (Romania, Bulgaria, Turkey).

Malta and the Czech Republic have the highest number of nurses per 1000 population (11/1000 and 8,9/1000 respectively), which is even higher than the EU average (8,0/1000). But most of other reference countries have considerably lower numbers than the average 6.2 per 1000 population (see Statistical Appendix).

In most Central and Eastern European Countries (with the exception of Slovenia and the Czech Republic) salaries of health workers are still very low, and even lower than the national average.

2.2 Western Europe

Primary health care in Western Europe is delivered mainly by private independent practitioners. However, public arrangements, under the initiative of municipalities (Sakslin, *Nat. rep. Finland*, 25) or the National Health Service (Kremalis, *Nat. rep. Greece*, 13; Guibentif, Soares, *Nat. rep. Portugal*), exist in some countries. As a rule, these countries have set up a network of public hospitals, but private hospitals are also allowed to operate (Pfeil, *Nat. rep. Austria*, 16; Abrahamson et al., *Nat.*

rep. Denmark, 12; Sakslin, *Nat. rep. Finland*: 26; Kessler, *Nat. rep. France*, 33; Kremalis, *Nat. rep. Greece*, 13; Tahiraj, *Nat. rep. Great Britain*, 43). There are arrangements allowing departments of public hospitals to be run on a private basis (Clark, Murphy, *Nat. rep. Ireland*, 17).

3 Typology

Given the complexity of all the systems under analysis, it is far from easy to identify features offering an obvious criterion for a typology. Two institutions, however, are worth being considered as characterising, for descriptive purposes, two quite different types of system: firstly, systems that include a strong structure of public care providers, which may be called national health service (a), secondly, systems characterised mainly by the existence of public national health insurance funds (b). National systems where there is no equivalent to any of these two institutions also have some common traits (c).

A problem with this typology is that it is based on logically non-exclusive categories. It is established on the assumption that some of the systems' elements are likely to be more 'characterising' than others; firstly, because of the centrality of their role within the national context; secondly, because a comparably central role is played by a similar institution in different countries. The identification of such elements may help to organise our data with due consideration to their diversity.

3.1 Systems including a strong structure of public care providers

The most convincing distinction that can be made between all the systems compared separates those that include a strong structure of public entities providing health at three levels: primary, secondary and tertiary level, from those where a significant part of providers, in particular at primary level, operate as private entities. We shall consider here the first of these two categories, which includes Finland, Great Britain, Greece (where the National Health System co-exists, however, with a system linked to the social security system), Ireland, Lithuania (Medaiskis et al., *Nat. rep. Lithuania*: 22), Poland (Czepulis-Rutkowska et al., *Nat. rep. Poland*: 9), Portugal and Spain.

Within the framework of these systems, care-providing entities are public bodies working under the direct supervision of the governmental department responsible for health matters. Professionals generally work under the status of public service providers. The state plays an important role in the financing of such systems, even if other sources are relevant as well (see the previous section 5 on financing). Concerning these other sources, the case of Portugal and Spain deserves special mention. In these two countries, the social security systems contribute to a considerable extent to the funding of the health system (see also point (c) of this section).

Despite the public nature of the system, the health institutions and professionals of all the countries considered here seem to have a significant level of administrative, professional and financial autonomy and liability. In Portugal, recent reform has strongly emphasised the autonomy of several hospitals by changing their legal status, from public bodies to private corporations (*sociedades anónimas*).

In countries where such public systems are established, private entities can also be found – individual practitioners, hospitals (Sakslin, *Nat. rep. Finland*: 26; Kremalis, *Nat. rep. Greece*: 13; Clark, Murphy, *Nat. rep. Ireland*: 3; Guibentif, Soares, *Nat. rep. Portugal*: 18) – and play a significant role.

Even within public hospitals, mixed public-private schemes are reported (Clark, Murphy, *Nat. rep. Ireland: 17*; Guibentif, Soares, *Nat. rep. Portugal: 18*)¹⁴. The private sector may work in many different ways with the public sector within such frameworks. It may offer special treatment to categories of people who can afford to pay for them. It may also offer a *de facto* necessary complement, filling coverage gaps in the public system, or offering an alternative in case of long waiting periods (Sanchez-Rodas, *Nat. rep. Spain: 7*). In Portugal a new regulatory health agency was established in 2004, with the aim of improving cooperation between public and private entities.

Within this category, there are considerable differences in terms of the level of decentralisation (i) and funding schemes (ii). It also has to be noted that systems in this category have evolved differently from country to country.

3.1.1 Level of decentralisation

The more centralised systems are to be found in Great Britain, Greece and Portugal. Regional health systems exist in Ireland, where they are run by Regional Health Boards (Clark, Murphy, *Nat. rep. Ireland: 16*) and in Spain, where most autonomous communities have set up their own health system (Sanchez-Rodas, *Nat. rep. Spain: 21*). In Finland, health services are run by the municipalities (Sakslin, *Nat. rep. Finland: 23,25*), while hospitals providing specialised health care are organised at the district level (Sakslin, *Nat. rep. Finland: 17,21,25*). In Poland, health care centres depend on the local government (Czepulis-Rutkowska et al., *Nat. rep. Poland: 8*).

In practice, the difference between the three sub-types mentioned – public health services organised on a national, regional or local basis – is not always as clear cut as it first appears. Some local autonomy may be recognised within nationally organised systems, and some national coordination exists even where local authorities bear the main responsibility.

3.1.2 Funding schemes

There is a significant difference between the Portuguese and Spanish systems and the other public health systems considered here. Indeed, in both countries, the health systems are strongly linked to the national social security system. This is clearly the case in Spain, where access is subject to affiliation to the social security system (Sanchez-Rodas, *Nat. rep. Spain: 21*). It is also the case in Portugal, albeit in a less visible way, where access is guaranteed to all residents. Nevertheless, users of the health system have to record the national or foreign social security scheme to which they are affiliated, for the costs of their treatment to be charged to that scheme (Guibentif, Soares, *Nat. rep. Portugal: 7*).

Among the remaining countries included under this heading, one can distinguish between systems financed mainly by the state (Sakslin, *Nat. rep. Finland*,; GB; Kremalis, *Nat. rep. Greece*), and those where the financing mechanism includes a health insurance system (Medaiskis et al., *Nat. rep. Lithuania*; Czepulis-Rutkowska et al., *Nat. rep. Poland*).

These differences are worth emphasising because they lead to a categorisation which fits quite well into the main types of social protection system duly identified by relevant comparative studies: we have the Beveridge systems, financed by the state budget (Ireland, United Kingdom, Northern

Countries) and the ‘Southern European Model’ (Ferrera, 1996, MIRE, 1997) – even if less consensually recognised than the Beveridge and Bismarck types – (Portugal, Spain). The Greek system could actually be said to belong to this second type because the national health system co-exists with a health system based on the social security system.

Lithuania and Poland could be considered as belonging to an intermediary category between type (a) – defined by the existence of a National Health Service – and type (b) – defined by the existence of a National Health Insurance Fund. We shall therefore have to come back to these two cases in the next section. A similar analysis could possibly apply to other Central and Eastern European Countries. However, the analysis of the available reports suggests in these other cases a less central place for the public sector in the field of health care, given the current growth of the private sector.

3.2 Systems where a public national health insurance fund plays a key role

Apart from the existence of a public network of health care providers, discussed in the point before as characterising one group of countries under comparison, the other institutional feature shared by several countries is the existence of a public National Health Insurance Fund¹⁵. This institution is typically to be found in Central and Eastern European Countries. The case of Denmark seems to be comparable in many aspects. Taking the significant differences into account, we shall successively present a comparative analysis of the Central and Eastern European Countries (i), and a separate comment on the Danish case (ii).

3.2.1 Central and Eastern European Countries

In the early 90s, Slovenia, the Czech Republic, Hungary, Slovakia and Estonia already introduced new health insurance schemes based on contributions to health insurance funds. The health insurance funds have some features of a state agency and public independent legal person.

Another group of countries (Poland, Lithuania, Latvia, Bulgaria and Romania) took decisions in favour of gradual changes, financing health system through general taxation. A few years later these countries (except Latvia) also moved to the compulsory health insurance systems: Lithuania – in 1997, Poland and Romania – in 1998, Bulgaria – in 2000. At the moment all countries previously mentioned have a mixed financing system based predominantly on social insurance contributions and taxation (public revenues) simultaneously with private co-payments (mostly, out-of-pocket payments). The public financing system represents a compromise between the proponents of tax-based and insurance-based systems. With the introduction of new social insurance systems, all employed and self-employed individuals are obliged to be insured.

Let us now list the national insurance funds existing in these countries:

- Bulgaria (Sredkova, *Nat. rep. Bulgaria*: 10, 30): National Health Insurance Fund;
- Czech Republic (Papes et al., *Nat. rep. Czech Republic*: 5, 13): General Health Insurance



Company of the Czech Republic;

- Estonia (Männik, Einasto, *Nat. rep. Estonia*: 10): Sick Fund;
- Hungary (Czucz, Hajdu, *Nat. rep. Hungary*: 8): National Health Insurance Fund;
- Lithuania (Medaiskis et al., *Nat. rep. Lithuania*: 32, 35, 38): National Patients' Fund;
- Slovakia (Radicova, *Nat. rep. Slovakia*: 5): General Health Insurance Company;
- Slovenia (Bubnov-Škoberne, *Nat. rep. Slovenia*: 1, 19): Institute of Health Insurance of Slovenia.

Apart from these national health funds, public regional funds are to be found in Bulgaria (Sredkova, *Nat. rep. Bulgaria*: 30) and Lithuania, where the Territorial Patients' Fund co-exists with the National Patients' Fund (Medaiskis et al., *Nat. rep. Lithuania*: 32, 35). In Poland, regional sickness funds form the 'key elements' of the national system (Czepulis-Rutkowska et al., *Nat. rep. Poland*: 10). In Slovakia (Radicova, *Nat. rep. Slovakia*: 5), there are Departmental health insurance companies, with activities in specific areas.

In all these countries, public health funds play a central role in managing the health system. On the one hand, they receive – in some cases via tax offices – contributions paid by beneficiaries, in certain cases also by their employers or the state (access to the system is subject to the payment of these contributions as previously discussed under point 1.B.c); see also point 5.B.b). On the other hand, they finance the activity of health care providers, on the basis of agreements periodically renegotiated (Sredkova, *Nat. rep. Bulgaria*: 30; Papes et al., *Nat. rep. Czech Republic*: 13; Männik, Einasto, *Nat. rep. Estonia*: 15; Czepulis-Rutkowska et al., *Nat. rep. Poland*: 8; Bubnov-Škoberne, *Nat. rep. Slovenia*: 19).

Given the relevance of their activity, their management and supervision is a sensitive issue. Some reports point out the representation of different sectors of the country in the bodies involved. In Bulgaria, the government, trade unions, employers' organisations and municipalities are represented in the Assembly and Managing Council (Sredkova, *Nat. rep. Bulgaria*: 30). In Estonia, the Sick Fund Council groups representatives of the ministers of social affairs and of finance, as well as the chairman of the Parliamentary social committee (Männik, Einasto, *Nat. rep. Estonia*: 10). In Lithuania, there is tripartite representation as well, but a strong position for the representatives of the state, and representatives of the medical professions as well. In some countries, difficulties are reported with regard to competent coordination (Czepulis-Rutkowska et al., *Nat. rep. Poland*: 11) or an appropriate interest representation (Czucz, Hajdu, *Nat. rep. Hungary*: 13).

In some of the countries considered here, private insurance companies are admitted as well. For the time being, however, this private insurance sector plays a marginal or at least limited role (Sredkova, *Nat. rep. Bulgaria*: 20,31; Männik, Einasto, *Nat. rep. Estonia*: 13; Czucz, Hajdu, *Nat. rep. Hungary*: 8; Radicova, *Nat. rep. Slovakia*: 5). The private sector has a specific function in Slovenia, where it covers co-payments due by patients (Bubnov-Škoberne, *Nat. rep. Slovenia*: 3).

As far as care providing entities are concerned, a significant part belongs to the public sector. This

is the case particularly in Lithuania and Poland, already analysed in section (a), where we noted similarities between their network of care-providing institutions and the national health systems of some Western EU countries. In other countries, a private sector – private surgeries and hospitals – is mentioned as well (Papes et al., *Nat. rep. Czech Republic*: 10; Czepulis-Rutkowska et al., *Nat. rep. Poland*: 9; Radicova, *Nat. rep. Slovakia*: 2,3; Bubnov-Škoberne, *Nat. rep. Slovenia*: 2). In Hungary, payments made by the National Health Insurance Fund to private entrepreneurs operating in the field of health amount to 14.22% of the treatment / prevention budget (year 2000; 1995: 7.44%; Czucz, Hajdu, *Nat. rep. Hungary*: 9). In Estonia, the whole sector will soon be privatised (Männik, Einasto, *Nat. rep. Estonia*: 15). The relationship between the private and public sector seems to range from a regular integration, which means that care provided by the private sector is at least partly funded by the national health insurance fund (for example Czucz, Hajdu, *Nat. rep. Hungary*; Bubnov-Škoberne, *Nat. rep. Slovenia*), to less formalised forms of competition (for example Czepulis-Rutkowska et al., *Nat. rep. Poland*).

3.2.2 The case of Denmark

In Denmark, a public national health also fund plays a fundamental role: the Health Care Reimbursement Scheme (Abrahamson et al., *Nat. rep. Denmark*: 7). However – and there lies the crucial difference with the countries discussed in the point before – this fund is financed from the state budget, not by the beneficiaries' contributions. Access to health care, therefore, is not subject to the payment of contributions, but to residence in Denmark (see section 2.B.a) before).

As far as other aspects are concerned, the Danish case can be considered comparable to those discussed before. The fund finances a mix of public and private institutions (private hospitals: Abrahamson et al., *Nat. rep. Denmark*: 12), partly on the basis of collective agreements (Abrahamson et al., *Nat. rep. Denmark*: 8). There is private health insurance as well, notably covering co-payments due by patients (Abrahamson et al., *Nat. rep. Denmark*: 11).

3.3 Health systems which are part of a national social security system

Here we meet the Welfare States commonly qualified as Bismarckian. Within these countries, health insurance is a branch of the social security system. Their contemporary structure is the result of the long-term development of self-governed funds created on a regional – in some case national – or occupational basis and financed basically by part of the social security contributions paid by the people affiliated to the social security system (Pfeil, *Nat. rep. Austria*: 19; Schulte, *Nat. rep. Germany*: 6; Kessler, *Nat. rep. France*: 3; Kremalis, *Nat. rep. Greece*: 11 – where there is also another scheme organised around the National Health System; see section (a) before – Kerschen, *Nat. rep. Luxembourg*: 5, 8; Centel, *Nat. rep. Turkey*: 10).

Apart from regular social security health funds, all these countries have private health insurances as well (see for example Kessler, *Nat. rep. France*: 12).

As a rule, these systems seem to have developed in parallel with a strong private medical profession. Related to this fact, beneficiaries can freely choose their general practitioner, who runs his/her



surgery on a private basis (Kessler, *Nat. rep. France*: 34; Pfeil, *Nat. rep. Austria*: 6). Within this kind of framework, health-cost matters are negotiated between the social security system and the medical profession as a whole (Schulte, *Nat. rep. Germany*: 5; Kessler, *Nat. rep. France*: 34). Secondary and tertiary health care, on the other hand, is provided by both public and private hospitals (Pfeil, *Nat. rep. Austria*: 16; Kessler, *Nat. rep. France*: 33). The financing of these institutions is also governed by periodical agreements.

As mentioned before (point a of this section), Portugal and Spain have social security systems comparable to those analysed here, and the contributions paid by the people affiliated are used for financing the health system, or at least for defining eligibility. However, the existence of a state (region)-run health system, which constitutes the core element of the health organisation as a whole, has led us to include these two countries in the category of 'national health service' countries.

VII SELECTION OF OTHER ISSUES

Here we shall only consider some topics concerning Central and Eastern European Countries.

There are still a number of shortcomings in terms of primary health care. The work of primary health care doctors is still geared towards curative rather than preventive services. Restricted scope of provided services leads to high rates of specialist referrals. Poor equipment of primary care facilities (especially in rural areas and small cities), low effectiveness and quality of care, popular distrust toward newly established primary health care institutions encourages people to bypass primary care and go directly to specialists, even if they have to pay out of their pocket. In many countries the geographical distribution of outpatient health care facilities is still unequal: there are more primary care centres (polyclinics) and possibilities for choosing primary care physicians in large cities than small towns or rural areas.

Inpatient care faces numerous problems in the reference countries. Over-supply of hospital beds compared to the Western European average is characteristic for all Central and Eastern European Countries. It is a legacy of the past, when the number of hospital beds was an indicator of quality of medical care. Over-supply is one of the major constraints of inefficient hospital usage, long length of patient stays and low bed occupancy rates. On the other hand, as there is a shortage of beds for long-term care and rehabilitation, numerous people requiring social rather than medical care (especially the elderly) stay in hospitals. This increases considerably the average length of hospital stays and health care expenses. Health insurance is therefore paying for social care provided in hospitals.

The level of reimbursement in many of the Central and Eastern European Countries seems to be insufficient to meet treatment costs, so hospitals constantly face severe financial deficits. On the other hand, financial difficulties do not allow central governments to find money for capital investments (for renovating hospitals and purchasing new medical equipment). The financial deficit experienced by hospitals causes a shortage of essential supplies and medication so that patients are forced to pay out of their own pockets (Bulgaria, Poland, Baltic countries). The survey of Lithuanian hospitals conducted in 1995 indicated that about 30% of pharmaceuticals used in hospitals are in fact paid for by patients, though officially they should be provided free of charge. Under-the-table

payments inherited from the Soviet era are still quite common in some hospitals.

Inpatient care is still utilised where it could be replaced by outpatient care. The Czech Republic, Hungary, Romania, Slovakia and the Baltic countries have very high hospital admission rates. Hospitals have better diagnostic and treatment facilities compared to outpatient clinics. This favours a tendency for interventions to be carried out in hospitals instead of primary health care or ambulatory care. High rates of hospitalisation are also supported by limitations in the referral system and the absence of financial incentives for avoiding hospitalisation.

The imbalance between primary care, hospital care and community care results in high health care costs and makes the planning of hospital care delivery systems difficult.

An important issue for the new Member States is coordination of health protection required by EU Regulation No 1408/71. Intensified migration of their nationals (including job-seeking workers) towards old Member States will increase the expenditure of health insurance funds due to essential differences between the cost of medical treatment in East and West. Additional workers and administrative skills are also required to run coordination procedures.

According to coordination principles, the main medical treatment costs of retired persons who change their country of residence and posted workers are covered by the insurance institutions of the country of origin (where insurance rights are acquired). Besides direct payment for medical treatment to the competent institutions of the country of origin, some other approaches in this case are applied. For example, the Lithuanian Patients' Fund pays health insurance contributions on behalf of all posted workers and retired people residing in EU countries to the relevant insurer in each country.

In the case of other persons travelling abroad, only the cost of urgent medical treatment is covered by the insurance institutions of the country of origin. Nevertheless, the responsible administrations are concerned about the real costs of international payments. In Lithuania it was estimated that expenditure for medical treatment of nationals abroad would not increase expenditure of the Health Insurance Fund by more than one percent.

One more aspect connected with the free movement of workers should also be mentioned. In most new Member States (with the exception of Slovenia and the Czech Republic) the salaries of health workers are still very low, and in some even less than the national average. On the other hand, these people are sufficiently educated to provide good quality medical services. Many doctors, nurses and other medical workers therefore intend to leave their country of origin and seek much better paid work in the old Member States. For the new Member States it means the quality of their health protection may decline.

VIII TENTATIVE GENERAL TYPOLOGY AND CONCLUDING REFLECTIONS

The foregoing discussion allows us to draw a rather clear distinction between four main types of health systems.

Two of them correspond to the well-known Beveridgian and Bismarckian types (Lambert, 2000). It

is more difficult to link these two types to the three 'regimes' identified by Esping-Andersen (1993, p. 26 ff). Types characterised by a strong institutional link between health care and social security correspond to the 'corporatist regime'. On the other hand, types characterised by a strong structure of health providers depending on the state are to be found in countries associated by Esping-Andersen both to the 'social democratic' and the 'liberal' regime. This is probably due to the fact that Esping-Anderson constructs his typology giving central relevance to the employment system, while the present analysis had to focus on the health system. The distinction between these two models has actually been recognised on several occasions by the European Commission, referring to the difference between 'tax-financed health care systems' and 'health insurance systems' (Commission, 1994, p. 99) or between systems 'based on insurance' and based on 'direct provision of services'.¹⁶

Beyond these two 'canonically' recognised types, there are two more. The 'Southern European Model' (Ferrera, 1996) appears as well, here in the field of health characterised as a mix of National Health Service and Bismarckian social security system. A fourth type corresponds to the Central and Eastern European Countries, characterised by the central position of a National Health Insurance Fund.

Let us remember that this typology is not to be used for an individual discussion of national systems. This would result in erroneous simplifications. On the one hand, and the foregoing analysis is detailed enough to show it clearly, the cases of many countries would oblige us to admit borderline cases. This certainly applies to Denmark, but also to Poland and Lithuania. It is also the case for Germany, which, in this field, would possibly deserve to be considered as a type of its own. On the other hand – and the national reports are rich enough to make it apparent – the relatively simple distinctions we can derive from the institutional analysis lose part of their relevance when we start to take sociological and political data into account. Portugal and Turkey are, among other countries, examples of this problem.

This typology is intended to help in the interpretation of the development observed. The present discussion will be restricted to the two more recent types, considering the rich literature available on the two others. Can the characteristics of the Southern and the Central and Eastern types be related to aspects of the political and economic changes which took place in these countries? A relation between these types and the political transitions in these countries indeed seems plausible.

In Greece, Portugal and Spain, authoritarian regimes were replaced in the 1970s by pluralistic democracies. The newly established regimes had to show a clear political change in comparison with the former regimes. These were characterised in particular by severe restrictions to political liberties, but also by huge social inequalities, which were overtly tolerated and, in Portugal and Spain, to some extent justified by the regime's corporatist ideology. The establishment of national health services, accessible to the whole population, were strong symbols of the state's transformation into a caring entity and based on the principle of equality (for the case of Portugal, see Guibentif, 1997). Two other factors may have favoured this change. One is that at that moment, the development of welfare policy was already an almost unquestioned international trend (debate on the 'crisis of the welfare state' started in the late 70s). The other concerns the relationship between the government and the medical profession. The medical profession probably did not take, in the domestic arena, such a strong stand as in more developed European countries. On the other hand, it was not in a condition to oppose successfully the political initiative of a national health service. Informal adjustments took place later, enabling private medical practice to maintain itself and even develop without

effective coordination with the national health service.

In Central and Eastern Europe, the political regimes to be replaced were based on restrictions to individual initiative, and on an authoritarian notion of equality, reducing all signs of diversity. Under these conditions, the main topics in the debates on social protection after transition were, logically, the re-establishment of free choice for patients, and free practice for service providers. Systems set up around a national health insurance fund are indeed likely to evolve in this direction. Financial factors cannot be neglected. The issue in recent years is how to get the cost of health systems under control. Again, the type of health system we encounter in Central and Eastern Europe fits this objective.

One other output of defining types of health systems is to identify the main problems which have to be solved by any system, but which were given, for historical reasons, more visibility in some countries than others. Having identified these problems, we are able to examine under better conditions national and regional evolutions. These problems are: – organising social solidarity; – coordinating the concrete work of providing health care at the scale of large societies; – rationalising the financial structure of the system.

One question to be tackled at the end of this chapter was: do the processes under observation deserve to be qualified as processes of ‘convergence’? The answer, based on the typology, would have to be rather cautious. On the one hand, there are significant differences between the health systems of the Western EU Countries (three different types). If there is convergence as far as the effort of cost containment is concerned (see also Cornelisse, Groudswaard, 2002), other aspects remain clearly different. On the other hand, the Central and Eastern European Countries are bringing into the enlarged European Union one more type, significantly different from those in Western Europe.

In order to better appreciate the impact of this fourth type within the European context, its dynamic should be analysed in more detail. This is the aspect which is most difficult to grasp on the basis of the available data. Two points in particular should be clarified: (1) More details on recent evolutions, before and after the transition to democracy (remember that the knowledge we were able to systematise about the Western Welfare States takes into account, one could say almost canonically, more than a complete century); (2) More data on the players in this evolution, notably ‘global players’ (insurance, the pharmaceutical industry, inter-governmental organisations, NGOs) whose role could explain partly the similarities between the systems of the Central and Eastern European Countries (on this point, see also, in this volume, the chapter on social actors).

In any event, the existence, within the new EU-25, of one more type of health system confirms the plurality of institutional arrangements in this field. A plurality which is not only a fact observed by researchers, but which is recognised and accepted by the actors involved, as part of the institutional pluralism that characterises the EU, and as a source of organisational creativity in the search of best practices. In this sense, coming back to the issue of ‘models’ shortly mentioned in the introduction to this chapter, it could be said that the model, in this field, is the typology itself, as a whole. And evolutions of the typology, logically, might be considered as evolutions of the model.



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