



Public Policy Institute for Wales
Sefydliad Polisi Cyhoeddus i Gymru

International Experience of Conditional Entitlement to Healthcare

August 2015

International Experience of Conditional Entitlement to Healthcare: A Rapid Evidence Review

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Contents

Summary	1
Introduction	2
Three Dimensions of Healthcare Entitlement	2
Healthcare Entitlement: The Impact of the Financial Crisis.....	4
The Breadth of Healthcare Provision.....	5
Range and Scope of Benefits.....	5
Share of Service and User Charges.....	6
Conclusions	14
Appendix.....	16
References	18



Summary

- The Welsh NHS is facing unprecedented financial pressures and difficult decisions have to be made about how to allocate and use healthcare resources. The aim of this evidence review was to explore whether there are lessons that might be learnt from other countries about how access to healthcare and entitlement can be made conditional in a way that reduces demand for services without having an undue impact on health outcomes.
- Drawing on a framework developed by the World Health Organisation (WHO), the available evidence is grouped according to three 'dimensions' of 'coverage' or entitlement to healthcare: population (who is covered); services (what range of services are covered); and costs (what proportion of the costs are covered).
- The financial crisis that struck Europe and the US in 2008 and its consequences has affected healthcare funding in many European countries as their governments have implemented austerity measures, restricting or changing entitlements to healthcare.
- Restrictions to entitlements before and after the austerity related changes are most often implemented in the WHO dimension of costs. User charges, particularly co-payments for pharmaceuticals, appears to be the most often used strategy.
- Reported experience suggests there are both intended and unintended consequences to cuts to healthcare entitlement and without pro-active safety nets or positive action the vulnerable may suffer financially and health wise.
- There is some limited evidence that relatively low co-payments 'work' in terms of modifying use/behaviour without disadvantaging certain populations or damaging health, whilst limiting costs.
- If changes are to be implemented in Wales it is likely that the drug budget may be more responsive to adjustments to entitlement and that small co-payments or deductibles may bring in revenue without affecting the vulnerable and encourage appropriate consultation and prescribing. Automatic Generic Substitution may be another worthwhile strategy to explore. More in-depth research on these recommendations would be appropriate to determine the best approaches.

Introduction

The Welsh National Health Service (NHS) is currently facing “twin challenges of rising costs and increasing demand, while continuing to improve the quality of care” (Alyward, 2014). The Minister for Health and Social Services has articulated a reform agenda for the Welsh NHS based on the principles of ‘prudent healthcare’; that is healthcare that responds to the needs of patients whilst actively avoiding wasteful care that cannot be clearly justified. The prudent healthcare agenda aims to address the problem of projected increases in demand for healthcare services in a time of limited (or declining) available resources.

In this context, the Public Policy Institute for Wales (PPIW) was asked to investigate whether other countries had succeeded in restricting entitlement to healthcare in a way that helped to manage the costs of a service without having an undue impact on health outcomes. Outside the UK, other countries have a long history of restricted entitlements to healthcare, with access being conditional on a range of criteria. This might include employing co-payments or restricting expensive interventions if the benefits are small or uncertain.

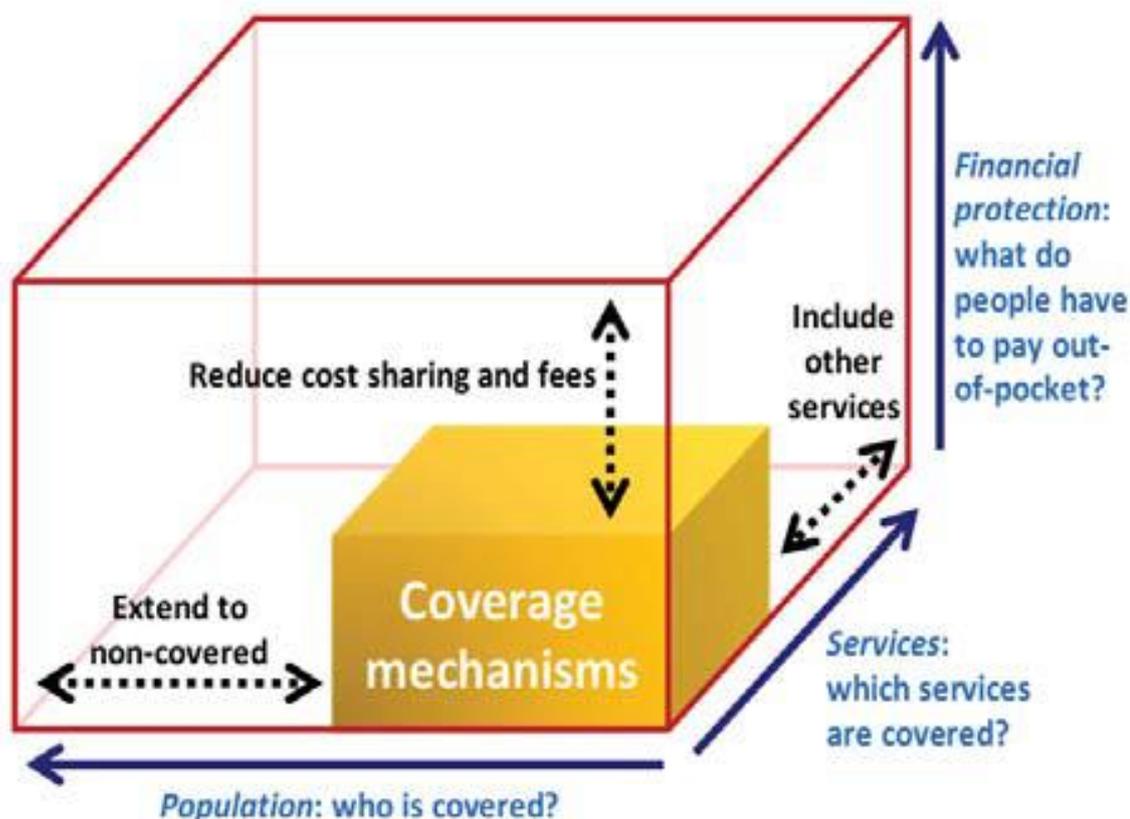
This report is based on a rapid review of the literature (peer review published journals and grey literature) and aims to summarise international experience of conditional entitlement to healthcare (and its implementation), focusing on those approaches and measures that are relevant and applicable to the Welsh NHS. We have largely kept the scope of the research to Europe with the Bismark/Beveridge National Health Service models in mind (see Appendix for a summary of different healthcare financing models).

Three Dimensions of Healthcare Entitlement

The structure of this report is based on the theoretical framework of the dimensions of entitlement defined by the World Health Organisation (WHO). In a 2010 report on health systems financing (Etienne, 2010), the WHO suggest that “levels of health coverage determine the extent to which people are protected from the financial consequences of ill health (financial protection) and have access to need healthcare services. When public resources for health care are limited”, the report authors suggest that “policy makers may try to relieve financial pressure by reducing coverage” (<http://www.hfcm.eu/web/introduction/health-coverage>) (Figure 1). As this latter point fits well with the scope of this research we use the WHO domains described in the report to guide our review and reporting.



Figure 1: Dimensions of healthcare entitlement



Source: WHO (Etienne, 2010)

The dimensions of coverage and entitlement, WHO suggest, are:

- “the population covered ‘breadth’ or universality,
- the range of services covered: the ‘scope’ of the benefits package,
- the share of service cost covered: ‘depth’ and whether or not people have to pay user charges for covered services.

By reducing any aspect of publicly financed coverage, policy makers are effectively shifting costs to individuals. This creates opportunities for private finance in the form of out-of-pocket payments (including user charges) and voluntary (private) health insurance” of the necessary coverage for healthcare (<http://www.hfcm.eu/web/introduction/health-coverage>).

With a clear theoretical framework of the dimensions of entitlement laid out by WHO, the next part of this report considers how these dimensions of entitlement were explicitly or implicitly implemented by European countries. The financial crisis that began in 2008 has accelerated or driven changes in entitlements and has enabled researchers and commentators to gain some understanding of the impact of these changes on health.

Healthcare Entitlement: The Impact of the Financial Crisis

The financial crisis that struck Europe and the US in 2008 and its consequences affected healthcare funding in many European countries as governments have implemented 'austerity' measures. An overview paper from the European Observatory on Health Systems and Policies reviews the consequences of the crisis upon health policy and public health (as far as they could ascertain) (Karanikolos et al., 2013). They draw interesting comparisons between Iceland - where the financial crisis hit hard but no healthcare reforms or reduction in spending on healthcare were undertaken - and other countries which implemented a variety of cuts and restrictions on access to healthcare. In Iceland there has been no perceptible impact of the crisis on health since 2008 but in other European countries an increase in mental health problems and infectious diseases can, the authors suggest, potentially be attributed to governments' responses to the financial crisis.

The European Observatory on Health Systems and Policies review (Karanikolos et al., 2013) cited above was based on a survey of European Union (EU) country based health policy experts, undertaken by researchers in April 2011. The survey was subsequently reported more fully in 2013 by Mladovsky and Thomson (Mladovsky and Thomson, 2013). The findings confirmed that almost every health system in EU was:

“affected by fiscal constraints associated with the economic crisis.... A third of EU countries made explicit cuts to the health budget, mainly those countries hit hardest by the crisis; Hungary and England froze health budgets, representing a cut in real terms.... Many countries tried to lower public spending on health by shifting costs to individuals. Around half of all EU countries increased user charges for essential services, particularly outpatient prescription drugs. Over a third reduced entitlement to specific services” (for example, the Netherlands) (Mladovsky & Thomson, 2013).

These publications suggest a:

“trend toward cuts in coverage, although some countries also reduced or removed charges to protect low-income groups. Policies that remove entitlement to health benefits for specific groups of people give” the public considerable “cause for concern, but only Ireland and the Czech Republic went down this route” (Mladovsky & Thomson, 2013).

Using the theoretical framework laid out in the introduction, the next part of this report structures the findings around the three dimensions of entitlement described by WHO: population covered, range of scope and benefits and share of service and user charges.

The Breadth of Healthcare Provision

In response to the 2008 financial crisis, some EU countries took steps to limit health coverage through reductions in population coverage. When the crisis struck, there was little variation across European countries in the share of the population covered. Crisis-driven increases in unemployment and policy changes highlighted the role of healthcare ‘insurance’ status in creating inequalities in access to healthcare across EU countries, with potentially serious implications for inequalities in health status.

For EU citizens reciprocal agreements are in place to enable healthcare services to be accessed when outside of the home country. In the UK “entitlement to free NHS hospital treatment is based on 'ordinary residence' in the UK (not nationality), being registered with or referred by a GP, or payment of UK taxes or national insurance. Ordinary residence means, broadly, living in the UK on a lawful and properly settled basis” (Public Health England, 2015). By contrast, in Spain a Royal Decree implemented in 2012 meant that about 873,000 non-residents lost entitlement to comprehensive care. Research by Legido-Quigley and colleagues in 2013, reports that there were over 1000 identified Spanish resident individual’s eligible for healthcare but without appropriate documentation to enable access to healthcare. The unintended consequence of this austerity measure meant that healthcare for vulnerable populations such as the homeless who may not have their proof of residency easily available, could be under threat, and population health problems due to untreated HIV and tuberculosis could ensue (Legido-Quigley et al., 2013).

In the Czech Republic, the “population coverage saw a rise in the minimum level of health coverage for high risk conditions for foreign citizens residing in the country and responsibility for coverage was transferred to private insurance (resulting in higher premiums for foreigners) “ (Roubal, 2012a, p.15).

Policies that remove entitlement to health benefits for specific groups of people may give the public considerable cause for concern, if these are extended beyond non-residents. However our review found no examples of concerns being reported.

Range and Scope of Benefits

Countries have tried to save money by limiting the scope of publicly financed benefits package. For example, in the Netherlands, in- vitro fertilisation (IVF) and physiotherapy services were removed from the benefits package. While some countries had or have set up safety net mechanisms such as means-tested entitlement to publicly financed coverage, these have not

always been effective in protecting people after the financial crisis and have actually added to financial pressures for the health services (Karanikolos et al., 2013).

Roubal reports on changes in the Czech Republic where longer term strategies were instated from 2011, aimed at restricting the scope of the benefits package. “Previously, many procedures were reimbursed at the physician’s discretion” (Roubal, 2012a, p.16). Generally, the healthcare providers were “reluctant to introduce formal price lists as” they are “closely observed by the media and negatively judged by the general public” (Roubal, 2012b). Therefore, the potential impact of such measures might be controversial (Roubal, 2012). From 2012, reimbursed services were evaluated through a programme of Health Technology Assessment (also incorporating evidence from abroad), intended to lead to a better definition and selection of the basic benefit package. In parallel, plans were put in place in 2012, to improve the dissemination of information to patients on reimbursable services (Roubal, 2012a).

Share of Service and User Charges

Austerity measures resulted in “many countries” trying “to lower public spending on health by shifting costs to individuals”. Following the financial crisis, “around half of all EU countries increased user charges for essential services, particularly outpatient prescription drugs. As mentioned before, over a third reduced entitlement to specific services” as occurred in the Netherlands. “This suggests a trend toward cuts in coverage, although some countries also reduced or removed charges to protect low-income groups” (Mladovsky & Thomson, 2013).

Many jurisdictions operated a range of approaches to user charges – coverage of pharmaceuticals or co-payments for access to primary or secondary care services, dentistry or diagnostics tests – either prior to or during the economic crisis. Unlike the UK, however there is a longstanding history of some type of co-payment and or co-insurance, to enable complete coverage of healthcare in the rest of Europe, unlike in Wales. These were defined by Gemmill and colleagues as follows;

- “Co-payment: the user pays and fixed fee (flat rate) per item or service”;
- “Co-insurance: the user pays a fixed proportion of the total cost, with the insurer paying the remaining proportion”;
- “Deductible: the user bears a fixed quantity of the costs with any excess” (Jemiai, Thomson & Mossialos, 2004, p.1) born by the health service and/or insurer paying the remaining proportion. This can apply to specific cases or to a period of time. (Gemmill et al., 2008)

User charges: prescriptions

Pharmaceutical expenditure in the EU at the time of the financial crisis exceeded €180 billion in 2008 and accounted, on average, for around 17% of EU countries' total expenditure on health (OECD 2011). The scale and growth of these costs challenged the ongoing sustainability of some national health systems; universal coverage, solidarity in financing, equity of access, and the provision of high-quality healthcare (Kenneally and Walshe, 2012). This situation resulted in increasing international reliance on specific pharmaceutical cost-containment policies.

Among the cost-containment policy measures implemented in Europe were initiatives introducing positive lists for reimbursement of pharmaceuticals, promotion and consumption of generic drugs rather than branded drugs. This included, in some cases, automatic substitution of branded drugs with the (cheaper) generic drug by pharmacists of branded (more expensive) drugs prescribed by physicians (Automatic Generic Substitution), and tiered reimbursement of drugs, frequently deployed as a cost (and benefit) control mechanism.

France has operated a tiered reimbursement system for pharmaceuticals (i.e. differing levels of patient co-payment for differing drugs) for many years. For certain drugs (those of considerable 'medical benefit' and drugs provided to patients in hospital) the government reimburses 65% of the cost. Drugs of moderate benefit are reimbursed at 35% and low benefit at 10-20%. If there is no recognised medical benefit then there is no reimbursement and the drug is excluded from the positive reimbursement list. If a patient wants this drug then they are liable for the full cost.

In 2008, pre-crisis, Gemmill and colleagues undertook a comprehensive review of the impact of prescription drug charges in high income countries (Gemmill et al., 2008). Based on this review they concluded that enabling patients to opt for cheaper alternatives such as generic substitutes for brand name drugs has the advantage of enabling cost savings and increased efficiency. Whilst they emphasised the importance of protecting the poorer and older groups of (higher) prescription drug users, relatively small co-payments/deductibles are tolerable and raise income.

In 2007, the prescription charge (a co-payment) for drugs was abolished in Wales with the goal of improving access to healthcare for the disadvantaged. Two studies published in 2010 present an assessment of the impact of this policy. Groves and colleagues looked at prescribing for those previously eligible for the prescription charge. Prescriptions rose for older people (45-59 years) and over the counter purchase of medications decreased. Prescribing for those on modest incomes also rose. Whilst the rise in number of items

prescribed was anticipated there appeared to be little or no effect on prescribing for people with the lowest incomes suggesting that those at whom the abolition was aimed may not have been the ones who exploited that change in policy (Groves et al., 2010). Another study by Cohen and colleagues examining the rate of prescribing after abolition in Wales with a comparable area in England suggests the relatively small observed increase in prescribing rates in Wales has a minimal impact on rates of prescribing overall, as the majority of people who were exempt from charges would not be affected by this legislation. (Cohen et al., 2010).

The impact of the financial crisis on healthcare in Ireland, as changes were implemented, has been (and continues to be) studied in a range of research projects. Approximately 85% of total expenditure on pharmaceuticals supported by government funding “in Ireland relates to state expenditure on pharmaceuticals and payments to pharmacists under the ‘General Medical Service (GMS)’” (Brick et al., 2010) for drugs covered via the Community Drugs Schemes (CDS), reimbursing the exemptions for Medical Card holders,¹ the Drug Payment Scheme (DPS)² or the Long Term Illness (LTI) scheme.³ Pharmaceutical expenditure under the GMS schemes “has increased from €831m in 2005 to €1.3bn in 2009 (195% in real terms). The growth can be explained by a combination of increases in the price (e.g. newer, more expensive drugs) and volume (e.g. increase in eligibility) of drugs prescribed... Recent attempts to control this expenditure in Ireland have focused largely on two particular measures, namely, attempting to secure better value for money via amendments to the pricing and reimbursement mechanisms” for drugs provided and increasing the degree of co-payment/deductibles on the part of patients (Brick et al., 2012). The former strategy resulted in the prices of off-patent medicines that had a generic equivalent, being reduced by 20% in 2007, 15% in 2009 and a further 40% in 2010. Some of these measures also effectively reduced expenditure for on-patent and generic pharmaceuticals (Carone , 2012).

¹ People who hold a Medical Card are entitled to a range of Health Services free of charge. These include “the supply of prescribed approved medicines, aids and appliances like wheelchairs, crutches etc. In some circumstances a deposit may be required for aids and appliances which will be refunded on return of the aid or appliance. In 2014 a €2.50 charge applies to all prescription medicines dispensed to medical card patients” (LYIT, 2015, p.23)

² This scheme is aimed at those who don't have a Medical Card and normally have to pay the full cost of their medication. Participants pay no more than €144 for all prescribed approved medication each calendar month. This maximum amount is subject to review by the Irish Government.

³ People suffering from certain conditions can get free drugs, medicines and medical and surgical appliances for the treatment of that condition.

The Irish Health Minister also restricted the entitlement to GMS coverage for high-income persons older than 70 years in January 2009 and increased the DPS patient co-payments from €100 to €120 a month in the 2010 budget (subsequently rising to € 144). This policy measure resulted in reduction in public spending on community drugs by an estimated €380m in 2011. The policy restricting free prescription drugs for persons older than 70 years, though effective in reducing public cost, increased the total cost of the drugs supplied. The policy-induced cost increase stems from a fees anomaly between the two main community drugs schemes (Kenneally & Walshe, 2012).

In 2010, the Irish government also introduced a (small) co-payment charge for people on the GMS drug scheme which was anticipated to bring about cost savings through reductions in moral hazard⁴, reduced (unnecessary) prescribing and additional revenue. An ideal co-payment level would reduce use of unnecessary prescriptions but not impact issue and payment for essential medicines. Research was undertaken by Sinnott and colleagues in order to understand whether moral hazard played a part in prescribed medicine utilisation when implementing the introduction of co-payment (and subsequently increasing co-payments) for government funded medical schemes in Ireland (Sinnott et al., 2013). The researchers initially undertook a qualitative research project to explore patient attitudes and opinions surrounding the introduction of a 50 € cent per prescription co-payment, in October 2010, for people on the GMS medical card scheme. Overall, the subjects interviewed for the study (n=32) felt that the co-payment principle appropriate, but questioned whether the amount was high enough to avert moral hazard. In 2013, two further rises were imposed in Ireland (the final co-payment now being 2.50 € per item) and the impact has been evaluated in a second piece of research by Sinnott. Initial findings on the impact of these increases (the jump from 50 € cents to 1.50 €) suggest that the increase has no significant impact on the use of drugs defined as 'essential medications' (for this study defined as anti-hypertensives, statins, oral antidiabetics, thyroid hormones and anti-depressants) with the exception of anti-depressants, where use did reduce (Sinnott et al., 2014). There was however a significant reduction in 'less essential medications' (defined in this study as proton pump inhibitors, H2 receptor antagonists, Non-steroidal anti-inflammatory drugs (NSAIDs), anxiolytics/hypnotics). Further research is ongoing and awaits publication, but the initial conclusions from these findings suggest that small charges and small increases in charges do not have impact on

⁴ A situation where a party is more likely to take a risk if they are protected against the consequences – i.e. not having to pay for the prescription would mean that there may be no incentive to take the medication.

adherence to essential medications, though the impact on anti-depressants needs further research.

In Australia, co-payments for prescription medicines are means tested. Kemp and colleagues modelled the relationship between discretionary income available to households, with differing incomes, entitlements to prescription medicines and also calculated the medicine cost as a proportion of discretionary income to determine the relative burden of these costs for different household income levels (Kemp et al., 2013).

The researchers determined “the amount of discretionary income available to households after basic living and healthcare” expenditure and modelled impact “for households with high pharmaceutical subsidies (pensioner and non-pensioners with social security entitlements) and households with general subsidies” to help with prescription drug charges and with low, middle or high incomes. The researchers then “calculated the proportion of discretionary income that would be needed for medicines if one household member had diabetes or acute coronary syndrome, or if one member also had two co-existing illnesses (gastro-oesophageal reflux disease and depression, or asthma and osteoarthritis)” (Kemp et al., abstract).

The researchers concluded that “prescription medicines for chronic conditions pose a substantial financial burden to many working households, particularly those with low incomes” (Kemp et al., abstract) who are not eligible for reduced or zero pharmaceutical subsidies. Whilst the researchers could not provide evidence that prescriptions for medicines were not being filled, collected or taken because of limited disposable income, the possibility that this may be happening is plausible. Further research on this topic is ongoing.

In Spain, Legido-Quigley and colleagues (Legido-Quigley, 2013) studied the impact of the introduction of co-payments for drugs. From October 2013, pensioners had to pay an increasing share of the cost of a prescribed medicine and people with some cancers, rheumatoid arthritis, HIV and hepatitis C had to pay 10% of their medication costs in hospital pharmacies up to a limit of EUR4.20 per prescription. The researchers found that 17% of pensioners could not complete their course of treatment because of the relatively high and increasing prescription costs.

There is mixed evidence on the success of the introduction of prescription co-payments. On the basis of the research reported here it is clear that introducing or increasing these charges can have negative consequences for certain sectors of communities or people with specific costly conditions but it would also seem that careful selection of the absolute charge and relative proportion of charges can reduce healthcare costs (although modestly) while having virtually no impact on health outcomes.

User charges: Medical services

User charges for medical services as well as pharmaceuticals are also prevalent throughout Europe and elsewhere. Ireland has been unusual for a high-income country in having the majority of the population make full market payments for using general practitioner services and in promoting a two-tier system of access to hospital care in which those with voluntary (private) health insurance are able to jump the queue. The changes in Ireland since 2008 encompassed further user charges for medical services as well as prescriptions.

The Irish 'Programme for Government of March 2011' (Irish Government, 2011) committed to "*developing a universal, single-tier health service, which guarantees access to medical care based on need, not income*" – the first commitment in the history of the Irish Republic to introduce universal access to healthcare. The 2011 commitment was particularly significant coming in the midst of Ireland's worst economic crisis in living history. However user charges for medical services and private insurance prevail in Ireland. Progress toward reform has been reported as difficult. Despite lowering unit costs and generating efficiencies to cope with reduced budget funding, the coverage of current services is becoming more limited. Some care is being restricted (e.g. social care and dentistry). Some population groups formerly eligible are now excluded from free access to medical cards – the means of accessing health services free of charge - in particular wealthier people aged over 70 years and user charges for medicines and inpatient and outpatient care have increased (Thomas S et al., 2012; Thomas et al.; 2013; Thomas and Burke, 2012). It remains to be seen if or how these charges will impact the health of the Irish population but the research programmes described here are continuing.

Another country with a history of user charges is Sweden, which has a highly decentralised healthcare system based on the Beveridge system. Provision of health services is not free at the point of delivery and minimum charges for medical services apply, however the Swedish system is thought to be good value for money, compared to the UK NHS (Bidgood, 2013). Privately-run primary care, acute hospitals, dentistry, psychiatric care and social care clinics and deregulated pharmacies were introduced into the system, with the goal of increased productivity and efficiency, enlarged range of service, reduction of costs, better access and access to the same staff as in private clinics and were able to eliminate some of the bureaucratic "*obstacles of public organisation*" (Bidgood, 2013).

A study reported by Svensson and Jakobsson at the International Health Economics Association congress in July 2014 (Svensson & Jakobsson, 2014) evaluated how patient co-payment for medical services can be used as a tool to help reduce the financial pressure on

public healthcare budgets or if co-payments may, in fact, increase future long term costs, by causing preventive care to be de-prioritised. The research also explored whether co-payments increase income-related health inequalities because low-income populations are more price sensitive.

Patient co-payment in most Swedish regions increased by 33% from approximately €17 to €23. The price change was not implemented in one region for administrative reasons. This enabled the researchers to investigate whether differing prices for accessing primary care general physician healthcare led to differences in utilisation; and particularly how it impacted different socio-economic/demographic sectors of the population. Using routine data comparing the region with another which had a price increase, the results indicated no effect on healthcare utilisation due to the price change. This result held “across different socio-economic subregions in the treatment region... The price reform” did “not seem to influence the utilisation patterns in the population and there” was “no evidence of moral hazard in the demand for GP visits”. The researchers propose that a “potential reason for the absence of any price effect may be, in absolute terms, the relatively low price (and price change) as a share of the Swedish citizen’s typical budget” (Svensson & Jakobsson, 2014).

In the Czech Republic, the reforms in 2012 drove “cost shifting to households... through increases in user charges. From 2012, user charges for hospital inpatient stays ...increased (from €2.40 to €4.00 per day)” and “new legislation enabled providers to charge fees for services that have the same medical outcome but are economically more costly than other comparable treatments”. These are, ‘nicer to have’ “such as lightweight plasters, laser treatment to remove varicose veins, better quality lenses, and joint replacements (with the standard of clinical care remaining the same as that provided under the social health insurance system)” (Roubal, 2012, p.13). As yet, the impact of these measures is not known.

The relatively low changes in charges for medical care in Sweden suggest that modest changes may have no impact if implemented. However this needs to be seen in context, as the Swedish population is relatively affluent compared with some European countries. Introducing a small increase where charges exist is potentially less challenging than introducing charges where there are none. The impact of charges and changes in charges in the Czech Republic and Ireland may be pertinent for Wales.

Medical services covered and co-insurance

Some healthcare systems provide ‘core’ services to all or some of the population and the people without (full) coverage take out supplementary private insurance. This can drive

conflicting incentives within the healthcare services. Examples of this are provided by Israel and Ireland.

Traditionally, the healthcare system in Israel “has been considered a high-performance system, providing universal, affordable, high-quality care to all residents.... Universal coverage in Israel is funded through taxes, including an income based health tax that replaced mandated employer contributions in 1998. However, this tax funds only the universally entitled general care that was granted in 1995 and it does not pay for entitlements to maternal and child health, obstetric, mental health, or long-term care”. To supplement the state sponsored coverage, many people in Israel purchase private insurance but, according to Chernichovsky, commenting on the changes, people “end up spending more out of pocket even for services covered by the entitlement. Additionally, many publicly paid physicians also moonlight at private facilities to earn more money” (Chernichovsky, 2013). The decrease in public funding and decrease in the number of physicians working in the public system lead to inequities and inefficiencies in access and provision of the healthcare and also the private use of public medical infrastructure (Chernichovsky, 2013).

The Irish healthcare financing system has an unusually complex mix of public and private financing. Approximately half the population purchase supplementary private health insurance resulting in a similar situation as reported in Israel. There are “negative implications of allowing incentives related to privately insured care to interfere with delivery of public hospital treatment where there is interaction between public and private provision of care” (Smith & Normand, 2009).

The Netherlands is now characterised by a multitude of health insurance providers acting in competition, and being separate from caregivers/hospitals. According to Daley and Gubb, these changes can be viewed as positive, as the Dutch healthcare system now has a high level of accessibility to patients. Healthcare intervention “decisions are taken, to an unusually high degree, by medical professionals with patient co-participation. Through paying nominal premiums patients” they “are becoming increasingly cost conscious and willing to ‘vote with their feet’ to drive up standards” (Daley & Gubb, 2013).

The latter example perhaps suggests that nominal co-insurance payments may drive positive changes, but the situation described for Israel and Ireland, where the public services suffer as private services paid by private insurance develop and a two tier service emerges is not desirable.

Conclusions

Kaufman, in the context of US healthcare, suggests that:

“in a culture of entitlement is the belief that one deserves certain rewards, rights and privileges based on tradition or past achievements. In a culture of accountability rewards rights and privileges are only earned on the merits of one’s current behaviours and actions and the measurable results they produce” (Kaufman, 2011).

Kaufman suggests that the transition between the cultures is perilous and the “*entitled party*” usually feels disappointed, angry or mistreated. Per capita spending in healthcare in the US is the highest in the world, for health outcomes that are not proportionate. Kaufman also suggests that the US “culture of entitlement, deeply embedded in the US healthcare system”, has driven up the per capita healthcare spending. “Patients believe they are entitled to state-of-the-art care, physicians believe they are entitled to a high degree of clinical autonomy and historical levels of compensation, hospitals believe they are entitled to be reimbursed at the highest rates in the world and suppliers (e.g. insurance and pharmaceutical companies) believe they are entitled to high margins” (Kaufman, 2011). For Wales, not taking a grip on redefining a ‘culture of entitlement’ albeit in the context of a healthcare system founded on the principle of solidarity, potentially results in a high degree of resistance to change and political challenges.

The entitlement changes driven by the recent financial crisis are, in effect, a natural experiment. Learning from the experiences of countries and jurisdictions outside of Wales that were affected (and unaffected) by the crisis, we see that there are some implementation challenges and (unintended) consequences of restricting entitlement to healthcare. In Sweden and Ireland particularly, there are indications that some changes can be made without undue impact on healthcare uptake and on the vulnerable.

User charges and prescription co-payments are regressive taxes and potentially increase financial burden on low income households and older people. Such policies can potentially reduce healthcare uptake and health outcomes for these vulnerable populations if they are excluded from policies and have no protection.

Targeted user charges selectively applied to the ‘nice to haves’, caps in financial contribution or exemptions for poorer households or regular users of care may mitigate loss of health outcomes but a careful eye on policy implementation would be necessary to ensure increased transaction costs in implementing these policies do not offset any efficiency savings. Applying user charges in primary care, in ambulatory care or in secondary care may control demand,

but can lead to greater spending in other areas – emergency care for example. Restricting entitlement to statutory coverage for wealthier households may leave the pool of those covered by statutory healthcare with a concentration of older poorer and sicker people.

The findings of Gemmill and others (Gemmill et al., 2008; Sinnott, 2014; Groves et al., 2010; Cohen et al., 2010) who looked at the impact of co-payments for medicines on prescribing and uptake indicates this is an area for investigation. There are indications that there may be a balance between a modest co-payment for prescriptions and minimising harm related to uptake in 'essential medications'. Further research can perhaps identify this.

Policies incentivising health professionals to deliver rational prescribing and dispensing, coupled with Automatic Generic Substitution of branded medicines, where possible, could be promoted, together with information on benefits/minimal harms of switching.

However, lowering coverage thresholds and encouraging a corresponding increase in private, voluntary co-insurance has a role in controlling demand but research suggests there are some risks leading to adverse selection and risk premiums. This might result in the most vulnerable or those in poorest health being at higher risk and publicly funded health services picking up the health and financial impact of management of the high risk cases.

Empirical evidence of the impact of attempts to restrict entitlement to healthcare is limited and what evidence there is provides an inconsistent picture.

Based on this review, co-payments for prescriptions could be an effective way of introducing conditionality without adversely affecting health outcomes.

Appendix

Healthcare financing systems

“Each country devises its own set of arrangements for meeting the basic goals of a healthcare system: keeping people healthy, treating the sick, and protecting families against financial ruin from medical bills” (WHO, 2014). Despite each healthcare system being unique, healthcare systems tend to follow general patterns. There are four basic healthcare funding models, plus the United States of America which includes all models within the healthcare system.

The Beveridge Model (also known as ‘Tax-funded’)

Named after William Beveridge whose 1942 report *Social Insurance and Allied Services* formed the basis of Britain's National Health Service. In this type of system, healthcare is provided and financed by the government through tax payments. Many, but not all, hospitals and clinics are owned by the government; some doctors are government employees, but there are also doctors who collect their fees directly from the government. In the UK this is the general practitioner who runs a practice as a ‘small business’. Countries using the Beveridge model or variations on it include the UK, Spain, most of Scandinavia and New Zealand.

The Bismarck Model (also known as ‘Social Insurance’)

Named after the Prussian Chancellor, Otto von Bismarck, who invented the welfare state as part of the unification of Germany in the 19th century, the model is based on an insurance system - the insurers are called "sickness funds" - usually financed jointly by employers and employees through payroll deduction. Bismarck-type social health insurance plans have to cover everybody, and are ‘non-profit’ organisations. The Bismarck model is found in Germany, France, Belgium, the Netherlands, Japan, Switzerland, and, to a degree, in Latin America. Although this is a multi-payer model -- tight regulation enables the cost-control that the single-payer Beveridge Model provides.

The National Health Insurance Model

This system has elements of both Beveridge and Bismarck. Payment comes from a government-run insurance program that every citizen pays into. Since there's no need for marketing, no financial motive to deny claims and no profit, these universal insurance programs tend to be cheaper and much simpler administratively than for-profit insurance. The single payer tends to have considerable market power to negotiate for lower prices; National Health Insurance (NHI) plans also control costs by limiting the medical services they will pay for, or by making patients wait to be treated. The classic NHI system is found in Canada, but

some newly industrialized countries, Taiwan and South Korea, for example have also adopted the NHI model.

The Out-of-Pocket Model

Only the developed, industrialised countries - perhaps 40 of the world's 200 countries -- have established healthcare systems. Most of the nations on the planet are too poor and infrastructure is too disorganised to provide any kind of mass medical care. In this case if the less affluent patients cannot find enough money to pay a doctor's bill, they do not get medical care.

The United States of America Model

The US healthcare system has elements of all of the financing approaches described above in a fragmented national healthcare system. For certain communities (e.g. military veterans) the funding for healthcare is from the government and essentially tax funded). Americans over the age of 65 receive Medicare which is more like the NHI model, as is Medicaid which is for persons of all ages whose income and resources are insufficient to pay for healthcare. Working Americans tend to get health insurance from private providers paid for by their employers.

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