

# Briefing

## Health Services in Europe: 1988

### INTRODUCTION

The Office of Health Economics first drew attention to the fact that every country in Europe had some form of pre-paid national health care scheme in a publication in 1963. At that time it was commonly believed that Britain's National Health Service was unique in removing the burden of payment from the patient at the time of treatment. It came as news to many people in the early 1960s that the NHS was only one of many different ways of accepting both the cost of health care and its provision as a community responsibility. It became clear from the OHE booklet that health care could be provided as a collective responsibility in a very large number of different ways.

Later, during the 1970s, it became fashionable in Britain to examine more closely the various health schemes in Europe, in order to see whether Britain's Health Service could learn from experience abroad. This interest in European – and American – systems of providing health care has continued into the 1980's, and there is therefore a role for a short up-to-date review of the European scene. The present *OHE Briefing* aims to provide such a review. It makes no attempt to evaluate the success or failure of the very different national approaches: it only describes them in brief outline.

It deals with each of the major countries in turn, describing the extent of coverage, the methods of finance, the organisation of facilities, and the way in which payments are made to the providers. It also shows the percentage of GDP spent on health care in 1984, which is discussed in Box one. A copy of the list of questions which correspondents in each country were asked to answer is set out in Box two. Inevitably the answers came in a varied form, because the situation in different countries is often extremely complex, and cannot be explained within a few pages. However, the objective has been to give a brief overview of the principles which each country employs in providing medical care for its population. It is clear from these descriptions that there is very considerable variation in the methods of both finance and provision of care. The risks of sickness can be covered in a very large variety of ways. Some implications not only for Britain but for Europe as a whole are discussed in the final section of the *Briefing*. This emphasises the flexibility of some of the European schemes.

**Table 1** Public and Private Health Expenditure as a percentage of gross domestic product 1984

	Total	Private	Public
Sweden	9.4	0.8	8.6
France	9.1	2.6	6.5
Netherlands	8.6	1.8	6.8
West Germany	8.1	1.7	6.4
Ireland	8.0	1.1	6.9
Switzerland	7.8	—	—
Italy	7.2	1.1	6.1
Denmark	6.3	1.0	5.3
Belgium	6.2	0.5	5.7
Great Britain	5.9	0.6	5.3
Spain	5.8	1.5	4.3

Source: OECD (1987) Financing and Delivering Health Care; Paris

Inevitably, in a short publication such as this, no attempt has been made to relate the different European schemes to the patterns of morbidity or the demographic characteristics of each country. Although the national correspondents were each asked to mention their problems and the public attitudes to their health services, their answers give only a glimpse of the true position in each country. However, as is discussed more fully later, it seems to be clear that no country has perfectly solved the difficult problem of providing optimum medical services at an acceptable cost.

## BOX ONE

### HEALTH EXPENDITURE

Table One shows both the public expenditure on health and total expenditure on health as a percentage of each country's gross domestic product (GDP). The figures are largely what would be expected from the description of the various countries' health schemes. France, for example, shows the substantial margin between public finance and total expenditure which is largely covered by private 'top-up' insurance. Sweden, on the other hand, which is another high spender, covers almost all its costs from public funds. The amount covered by private expenditure in Sweden represents 0.8 per cent of GDP, as against 2.6 per cent in France. Britain, also, covers almost all of its health expenditures from public funds: private expenditure accounts for only 0.6 per cent of GDP. By contrast, again, the Netherlands leaves 1.8 per cent of GDP to be covered by private expenditure, reflecting the large proportion of the population covered by private insurance. In West Germany private expenditure amounts to 1.7 per cent, suggesting a relatively high expenditure for the 9 per cent of population privately insured. In general, the continental schemes allow greater freedom for the public to spend directly on health care in addition to public expenditure.

Overall, Spain and Great Britain are the lowest spenders, and France and Sweden the highest. As has often been pointed out in the past, there is a general tendency for richer nations to spend a higher proportion of GDP on health.

## BELGIUM

**Public spend: 5.7%; private: 0.5%; total: 6.2% of GDP.**

The health insurance scheme in Belgium covers virtually the whole population. The finance is raised nationally by contributions levied on employers and employees, and then divided to about 1,745 separate 'sick funds'. These are organised into six major groupings.

The hospitals are owned by the local communes, by the state and universities, by the sick funds themselves, and by groups of doctors and others. Thus there is a huge multiplicity of providers of care.

All forms of sickness are covered by the health insurance schemes. Doctors in hospital are paid by who ever owns the hospital, but outside hospital doctors are private practitioners paid by the patients.

In hospital patients must contribute a fixed daily fee to cover nursing and 'hotel' costs. Patients also pay for their medical treatment and their medicines, but these costs are largely reimbursed by the sick funds.

Patients pay directly for medical treatment outside hospital, and are reimbursed at least 75 per cent of the cost from the sick fund. The poor, pensioners, widows and orphans receive about 80 per cent reimbursement.

Medicines are reimbursed at a variable rate according to their importance. Life saving medicines are paid for in full by the sick fund. For others, the patient must pay 25 per cent (up to a limit of 300 Belgian Francs), 50 per cent (up to a limit of 500 Belgian Francs) or 60 per cent, according to their therapeutic classification.

Again, pensioners and others pay a reduced proportion of the cost. Some 'social' medicines such as oral contraceptives are paid for in full by the patient. In each case, the balance of the price of the medicine is paid directly by the sick fund to the pharmacist.

Dental and ophthalmic treatments are covered in the same way as medical treatment.

The main problem with the Belgian scheme is its financial problems; however, it is very popular with the public. There is no tendency for private medicine to increase.

## DENMARK

**Public spend: 5.3%; private: 1.0%; total: 6.3% of GDP.**

National health insurance covers the whole population in Denmark. 95 per cent belong to a basic scheme, while the other 5 per cent belong to a more liberal scheme which allows greater choice of treatment. The basic scheme is almost completely funded out of general taxation, while the smaller scheme obtains a proportion of its costs from direct patient payments.

In practice, the Danish health scheme is the responsibility of the 14 counties, and the local government of Copenhagen. The hospitals are run by the counties. The scheme covers all forms of sickness.

Hospital doctors are employed by the counties, while general practitioners are private contractors controlled by the health scheme. Hospital and medical treatment is generally free, but patients pay directly to the pharmacy for their medicines. They are reimbursed for a proportion of the cost; 75 per cent, 50 per cent or nothing at all according to the type of medicine. In total, patients pay over 40 per cent of the cost of all prescribed medicines.

Dental and ophthalmic treatment is largely covered, although complicated formulae exist to define exactly which types of treatment are available and the circumstances of the patients to be covered.

The problems with the system are its rising cost, and the extent of interference with the doctors' freedom. A particular problem arises with the charges paid by the patient for prescriptions, because even if the patients are financially hard up they may be unable to get help from the social security system for the cost of their medicines.

Private health insurance has almost doubled its membership during the past ten years and new private hospitals are being built. This is because of delays in the availability of treatment under the state scheme.

## BOX TWO

### QUESTIONS PUT TO EACH COUNTRY

1. What percentage of the population is covered?
2. What method is used to raise the finance?
3. How is the health scheme organised?  
Who is responsible?
4. Who owns and runs the hospitals?  
What proportion of hospital beds in each part, if different?
5. Is chronic long-term sickness covered?
6. Who employs the doctors or are they private practitioners?
  - a) in hospital?
  - b) out-patient speciality?
  - c) family doctors/general practitioners?
7. Do patients initially pay the hospital/doctor/pharmacist or does the sick fund pay the supplier direct?
8. Do patients still have to pay some of the total cost with their own money?  
If so, how much for:
  - a) hospital?
  - b) doctor consultations?
  - c) medicines?
9. Is dental treatment covered?  
If so, how much?
10. Is ophthalmic treatment (spectacles) covered?  
If so, how much?
11. What problems are there with the total system?
12. Is it popular with the public?
13. Is private medicine (outside the state health scheme) increasing or decreasing?
14. What other comments have you?

## GREAT BRITAIN

**Public spend: 5.3%; private: 0.6%; total: 5.9% of GDP.**

The British National Health Service covers the entire population for all types of sickness. Eight-five per cent of its cost is funded out of general taxation, 12 per cent by social security contributions and 3 per cent from patient contributions.

The Health Service is controlled by central government through 14 Regional Health Authorities in England, and equivalent organisations in Scotland and Wales. All of its hospitals are owned by the state, and doctors working in them are directly employed by the Regions. Family doctors, pharmacists and dentists contract independently with the Health Service to provide their services.

The Health Service pays the hospitals and the independent contractors directly, although a proportion of prescriptions (about 20 per cent) are covered by a prescription charge of £2.60 per item, paid directly by the patient to the pharmacist. All other prescriptions are exempt, either because of the age of the patient, their 'poverty' or because of the type of disease from which they are suffering. Doctors are limited in the medicines which they can prescribe for certain ailments, and medicines advertised to the public cannot be prescribed under the NHS. There are no other charges to the patient for medical treatment.

Both dental and ophthalmic treatment are covered by the National Health Service, but charges are now imposed on all those who can afford to pay them.

The principal problems with the National Health Service appear to be its bureaucratic organisation and its centralised and relatively low funding compared to health expenditures in other European countries. It is still very popular with the public, especially amongst those who have benefitted from its care. This popularity has, however, declined slightly in recent years. Partly in consequence of this, private medical care has been expanding faster than the National Health Service, and now accounts, for

example, for about 15 per cent of all non-urgent surgery. Residential care of the elderly has also increasingly become the responsibility of the private sector, although much of it is still publicly financed through social security payments.

## FRANCE

**Public spend: 6.5%; private: 2.6%; total: 9.1% of GDP.**

In France, ninety five per cent of the population is covered by a national health insurance scheme. Those excluded consist mainly of those people whose official papers are out of order, or those who do not understand how to assert their rights.

The scheme is financed as part of national Social Security insurance, with contributions from employers and employees proportional to their earnings. The rates vary for different classes of employees and for the self employed.

The scheme is nationally organised, but some hospitals, for example, are owned by the state – about two thirds – and some privately. Public hospitals have an annual budget, whilst private hospitals are reimbursed for 'hotel costs' on a per-diem basis. In theory only thirty one long-term and costly diseases are fully covered by the insurance payments, but there is some flexibility in practice. Less serious complaints are only partly covered by state insurance.

Doctors are either paid by the state hospitals, or, more generally, receive a fee for item of service from the patient, which is partly reimbursed by the insurance fund.

Pharmaceuticals are reimbursed at different levels according to the severity of the condition which they are used to treat. A few 'essential' medicines are reimbursed 100 per cent, others at 70 per cent or 40 per cent, and 'trivial' remedies have to be paid for in full by the patient.

Many French people take out supplementary private insurance in order to cover the part of their costs not paid for by the Social Security scheme. For example, patients may have to pay 25 Francs per day in hospital for 'hotel charges', and 30 per cent of doctors fees for less serious illnesses. These charges are often covered by supplementary private insurance.

Dental and ophthalmic treatment is partially reimbursed in the same way as medical treatment.

As in all countries, the French Social Security scheme has continuing financial problems because the scope for medical treatment continues steadily to extend. The scheme is popular with the French public, but there are worries about its future, as costs continue to rise.

Private medical treatment, outside the Social Security system, has tended to decline over the years, but there is some indication that it is increasing again in the late 1980s.

## IRELAND

**Public spend: 6.9%; private: 1.1%; total: 8.0% of GDP.**

In Ireland there is a complex structure of health care. There are three categories of patients. 38 per cent of the population, who are unable to pay for their own care, receive a full range of health services without charge. 47 per cent, with an income below a certain level (£15,000 in 1987), receive private treatment in hospitals for a fixed charge, free medicines for certain illnesses and assistance in the payment of others, and general practitioner maternity and infant care services sometimes at fixed charge. The remaining 15 per cent, with a higher income, do not receive the general practice maternity and infant care services, but otherwise have similar benefits to those in category two.

The health care benefits for those entitled to them are financed largely out of public funds. The schemes are administered by the government, mainly through eight health boards.

The hospitals are owned partly by the Health Boards (financed through State funds), partly on a voluntary basis, (still largely financed by the state) and partly private. These private hospitals are funded from patient's fees. In 1985 there were 91 Health Board hospitals, 40 voluntary hospitals, and 18 private hospitals.

**Table 2** Direct payments by 'sickfund' patients

	Medicines	Doctors' fees	Hospitals
Belgium	some	approx 25%	Yes, but fully reimbursed
Denmark	25%; 50% or full cost	none	none
Great Britain	£2.60, but 80% exempt	none	none
France	some 30%; 60% or full cost	approx 30%	approx 25%
Ireland	for some patients, costs up to £28 per month	sometimes	sometimes, at fixed prices in private wards
Italy	most, £1 or more	none	none
Netherlands	£1	fixed charge	only for chronic sick
Spain	usually 40% with exemptions for pensioners	none	none
Sweden	approx £6, with exemptions	approx £5 the first 15 visits	approx £5 per day
Switzerland	10% of cost or 50% if medicine is not on recommended list	£20 in hospital and 10% of ambulatory care	Yes, in private hospitals
West Germany	approx 60p per prescription	none	approx £2 per day

Certain long-term illnesses, such as mental handicap, diabetes, haemophilia and multiple sclerosis are fully covered regardless of the patient's income.

The general practitioners are independent professionals, who claim reimbursement of fees for the services they provide. Some hospital doctors, and especially junior hospital doctors, receive a salary.

Category One patients receive all their treatment free without payment, and the professionals are reimbursed by the Health Boards directly for all their care. Category Two and Three patients pay the agreed set charges for most services themselves although they are entitled to free treatment in public wards, and free medicines above a limit of £28 per month. Only Category One patients receive free dental and ophthalmic care.

As in other countries, the main problem is the lack of resources for the health schemes.

## ITALY

**Public spend: 6.1%; private: 1.1%; total: 7.2% of GDP.**

The health insurance scheme covers the entire population. It is funded through social security contributions, at a level determined by State law each year. Currently this totals 9 per cent of salary, but is supplemented out of general taxation. The control of the scheme is in the hands of central government, with the participation of the Regions.

Local health units own and control the hospitals, and provide all preventative and curative services in their area. They also supervise reimbursement of pharmaceutical expenditures by patients. Doctors are employed by the local health units.

Hospital and medical expenses are completely free, but patients have to pay a 'ticket' for prescribed medicines. Life saving medicines, such as anticancer preparations and heart medicines are free. For 'generic' medicines there is a fixed charge of 2,000 lire, and for branded medicines there is in addition a sliding scale depending on the cost of the pack. For the most expensive packs of medicine the additional 'ticket' costs 3,000 lire.

Most dental treatment is covered by the scheme, but not the cost of spectacles.

There are continued criticisms of the scheme, which is regarded as excessively complex.

With greater affluence in Italy, there has been an expansion of private health care, even though this is not generally regarded as superior to care under the State scheme.

## NETHERLANDS

**Public spend: 6.8%; private: 1.8%; total: 8.6% of GDP.**

The Netherlands is the exception in Europe, in that only about 60 per cent of the population is covered by the official health insurance scheme. All those who earn more than 49,150 Guilders a year are free to subscribe instead to private health insurance schemes.

Nevertheless, the whole population is compulsorily covered by a separate insurance scheme to cover chronic disability and similar disastrous health problems. The ordinary sick fund is financed by the employees and self employed whom it covers. There are payments of 5 per cent of salary from the employees and an equivalent contribution from their employers. The special cover for chronic sickness is financed by employers only with contributions of 4.54 per cent of annual salaries.

The health insurers (sick funds) are organised on a regional basis, and originate from private organisations such as religious or charitable bodies. There is a central Sickfund Council controlling their finances, under the guidance of the central government.

About 85 per cent of the hospitals are owned and run by the government through a local Board. The majority of hospital specialists are self employed. The family doctors are generally in private practice, with a small number organised into groups or at health centres.

For those covered by the State sick funds, the insurers usually pay all costs directly to the hospitals, doctors and pharmacists. Privately insured individuals pay their own costs and then claim reimbursement. Patients covered by the chronic sick insurance scheme must make a contribution to hospital costs, and sick fund patients pay a flat rate consultation fee for specialist treatment and for prescribed medicines (2.50 Guilders per item). There is an annual maximum payment of 125 Guilders per family.

The cost of dental and ophthalmic treatment is partially covered for sickfund patients. These treatments are not usually covered for privately insured patients.

The present system of health care in the Netherlands is not considered satisfactory, because it is too expensive, too bureaucratic and with insufficient co-ordination between the public and private sectors.

There are plans to introduce more comprehensive state health insurance in the early 1990s.

## SPAIN

**Public spend: 4.3%; private: 1.5%; total: 5.8% of GDP.**

In Spain 95 per cent of the population is covered by the national health insurance scheme.

Twenty two per cent of the cost comes from general taxation, and the remainder from Social Security contributions. These in total represent 31 per cent of earnings, with the employer paying 26 per cent and the employee 5 per cent.

The health scheme is run by a central administrative body, decentralised into 17 regions. The overall control lies with the Ministry of Health and Consumption.

About 70 per cent of hospital beds are publicly owned, divided equally between the central governments, the central health authority and local government. The 30 per cent of beds owned privately are divided between 'for profit' organisations (18.5 per cent) and 'not for profit' organisations (13.3 per cent). All sickness, including long-term chronic illness, is covered by the scheme. Doctors are generally employed by the Health Authority.

All health care costs are paid directly by the Health Authority, except that patients generally pay 40 per cent of the cost of prescribed medicines. Old age pensioners are exempt from this payment, and it is reduced to 10 per cent for certain chronic illnesses such as diabetes.

Dental, ophthalmic and psychiatric treatments are generally not covered by the scheme.

The problems with the health scheme are seen as an unequal distribution of hospital beds and too little time for domiciliary consultations. Hospital treatment is generally satisfactory, but ambulatory care is considered inadequate.

Private health care is at a steady level of about 25 per cent of total health care expenditure.

## SWEDEN

**Public spend: 8.6%; private: 0.8%; total: 9.4% of GDP.**

The entire Swedish population is covered by the national health insurance scheme. Ninety per cent of the cost is covered out of various forms of taxation, and 10 per cent represents patients' out of pocket payments.

The scheme is run by the 26 County Councils, which have the right to raise local taxes to help fund their schemes. The majority of hospitals are owned by the councils. There is a very small proportion of private hospitals (about 1 per cent of bed-days). Chronic long-term sickness is covered by the scheme.

All doctors are directly employed by the County Councils, except for a very small proportion (5 per cent) of private practitioners.

Costs are paid directly by the County Councils, with the exception of the following direct payments by patients. Hospital patients pay 55 Swedish Crowns per day, which is deducted from their cash sickness benefit. For their first 15 visits to the doctor each year patients pay 50 Swedish

**Table 3** *Payment for pharmaceuticals by insurance and State funding*

	percent
United Kingdom	76
Spain	67
France	65
Netherlands	64
Italy	64
Sweden	62
West Germany	56
Denmark	53
Belgium	52
Switzerland	52
Ireland	48

Source: EFPIA in Figures: Brussels: 1988

Crowns to the County Council. For prescribed medicines, patients pay 60 Swedish Crowns per prescription. The chronic sick are exempt from this payment, there is also a maximum payment per year, beyond which medicines become free.

Dental treatment is covered, although again there are substantial charges to the patient, varying from 40 per cent for cheaper treatments to 25 per cent for more expensive procedures. Spectacles are only provided for children up to the age of 18.

As in all other countries 'there are indications that the system is inefficient; how inefficient, nobody knows'. The public are, however, generally satisfied with the system.

Private medicine is provided by about 5 per cent of doctors, and some private nursing homes exist. There is a gradual increase in private medical care.

## SWITZERLAND

**Total spend: 7.8% of GDP (approximately 2.5% private).**

Ninety eight per cent of the population is covered by one of some 450 'sick funds'. Funding of health expenditure is in equal parts by general taxation (paid as subsidies to the hospitals) by individual insurance premiums, and by direct payments, including supplementary private insurance.

The insurance schemes are run by the federally regulated 'sick funds', and the supply side (hospitals) is in theory organised privately. However, many hospitals are publicly owned: others are owned by charities and private organisations. As indicated above, even private hospitals receive a state subsidy, and are therefore partly controlled by government.

Long-term sickness is not covered by the 'sick funds' but by another mandatory social insurance scheme only in case of disability. Remaining patients must therefore pay privately or depend on public financial support for chronic care.

Hospital doctors are generally directly employed by public hospitals, and may also be employees in the private sector. Others are private practitioners, with GPs having no access to a hospital, as a rule.

Most patients pay their doctors, and claim a refund. However, the 'sick funds' pay hospitals and pharmacists directly.

Treatment in public wards is entirely free, but in private hospitals costs are covered only to the extent of the patient's insurance. There is a payment by the patient of 50 Swiss Francs per quarter or illness episode and of 10 per cent of the cost for all ambulatory consultations and for prescribed medicines.

There is an upper limit to these payments of 500 Swiss Francs per year, unless the insured has opted for a higher annual deductible.

Dental treatment is not normally covered, and although ophthalmic treatment comes under the insurance scheme patients receive only a fixed sum for their spectacles.

The principal problem with the current scheme is a lack of incentive to provide the most cost-effective treatments. More intensive treatment results in higher incomes for the providers. The public are, however, generally satisfied with the scheme.

As the private/public mix already exists fully within the existing scheme there is no tendency for private medicine to expand.

## WEST GERMANY

**Public spend: 6.4%; private: 1.7%; total: 8.1% of GDP.**

In West Germany 88 per cent of the population is covered by about 1,200 public insurance schemes, and about 9 per cent have private health insurance from about 40 companies. About 2 per cent have cover under various welfare schemes, and less than one per cent of the population has no health insurance cover at all.

The public insurance schemes are funded by insurance contributions, which vary from over 15 per cent of income for local sickness funds to about 11 per cent for funds organised through employing firms. The private insurance funds charge fees according to the risk group (ie normally by age) of the insured person.

There is a complex mix of public and private organisation in the funding of health insurance, which goes back in Germany to the days of Bismarck in 1883. Membership of the public insurance funds is compulsory for lower paid workers, and continues to cover them in retirement.

The hospitals are owned partly by the government (about 51 per cent of beds), partly by non-profit private organisations (35 per cent) and partly by for-profit private companies (14 per cent).

Doctors in the community including specialists, are private practitioners. The hospital doctors, who do not generally provide outpatient services, are employed by the hospitals. The outpatient doctors are either paid directly by privately insured patients (who claim reimbursement) or else are paid fees for items of service directly by the public insurance organisations. Doctors bargain directly with the insurance funds over their total remuneration.

A similar arrangement exists in hospital, where the hospital is paid directly by the public insurance funds, on a daily rate basis, whereas privately insured patients pay the hospital agreed fees and claim reimbursement. Patients covered by the public insurance schemes pay a fixed prescription charge of 2 DM for each item, regardless of its cost. Medicines for minor ailments are paid in full by the patient. Privately insured patients pay in full for all their medicines, but may be able to claim reimbursement. Patients in hospital pay 5 DM per day.

Dental and ophthalmic treatment is covered by the public insurance schemes, although they pay only 60 per cent of the cost of dentures, and will pay for their spectacles only once in three years, unless the patient's eyesight has deteriorated meantime.

The problems of the schemes can be summarised as their inefficiency and the threat of continually rising costs. In particular, the payment of fees for item of service encourages excessive supply of treatment. Also, the strict separation between ambulatory and hospital treatment presents problems. As in every country, the high cost of care for the elderly is a particular problem, as its cost has to be subsidised by the working population.

There are currently drastic proposals to reduce health care costs, but these are supported by only 30 per cent of the population.

## DISCUSSION

It is clear from these brief descriptions of the national health schemes in different European countries that there is a considerable variation in their approaches to the problem. Methods of funding vary; the ownership and organisation of the facilities varies; the way doctors and others are employed and paid differs; and the extent to which individuals must pay part of the costs themselves also varies, as shown in Table Two. There is, however, one common similarity. No country believes that it has an entirely satisfactory solution to the question of how best to cover the health needs of its population at an acceptable price. A look at Continental Europe provides no ready made answer to the present uncertainty about how Britain's Health Service might be modified, for example.

More fundamentally, in 1992 the European market is intended to be unified, and it might be expected that some degree of uniformity in the provision of health care should follow. From the descriptions in this *Briefing* it is clear that it will be extremely difficult to introduce any integrated system of health insurance or European health service for the European Community as a whole. Even within individual countries there are variations, without any clear indication of which variant is superior. The priority must be for cautious experiment, and rigorous evaluation, rather than radical change.

Above all, what is lacking in such an evaluation is any measure of the outcomes of different systems of health care. The unique contribution of the European Commission after 1992 could be to organise and sponsor the evaluative studies which have so far largely been absent. Any more drastic form of European Community interference, in the present state of ignorance, would be unwise. Health economists have in recent years been developing the tools with which to make the necessary evaluations. So far they have been used only on a limited scale. However, there is no reason why, with appropriate resources, larger international studies should not now be undertaken.

One concept under discussion at present is to limit the free provision of health care to the relatively less affluent and to those suffering from some form of medical catastrophe – whether it is a costly acute medical crisis or a long term chronic disease. The nearest approach to this policy in Europe so far appears to be the Dutch model. A study some years ago suggested that the health status of the Netherlands was comparable to that in Britain and France.<sup>(1)</sup> These latter countries had widely differing types of cover, but both provided comprehensive health care for the whole population through their national schemes. But

according to the information received from the Netherlands during the preparation of this *Briefing*, the Dutch do not consider their present position satisfactory. They are considering more extensive cover. Clearly, therefore, other countries – and Europe as a whole – need to be cautious in pursuing the concept of limited cover only for the less affluent and for the catastrophically sick.

On the other hand, there is almost universal concern at the rising cost of comprehensive free health care. Perhaps some balance needs to be struck. But once again the keynote must be evaluation. The brief reports from the various countries collected for this study still suggest general public satisfaction with their health care, even though the providers and the organisers realise its shortcomings.

One particular aspect of the variations between European schemes seems to demand special attention. This is the variation in the amount and methods of calculation of the 'co-payments' by patients, shown in Table Two, not only for prescriptions but also for medical consultations and hospital care. Table Three shows specifically the variation in the proportion of the cost of medicine paid for by third parties (insurance or the state). It varies from 76 per cent in the UK to 48 per cent in Ireland. In countries apart from Britain private payments for a part of health care costs do not seem to have attracted the attention which they have received from British politicians and they do not seem to have detracted from the general popularity of the national health schemes. There is economic logic in expecting a modest contribution to costs at the time of treatment. This is perhaps an aspect of the European experience which Britain might consider. However, much more study of the exact European experience is needed, which is beyond the scope of the concise overview in this *Briefing*.

If changes are to be made, and in particular if a greater degree of uniformity across Europe is to be achieved, the changes must *increase* an already relatively high level of public satisfaction rather than reducing it. This, above all, must be the message for the Eurocrats as 1992 approaches, and for Britain as it continues to review its own National Health Service in 1988.

## REFERENCE

- (1) Maynard A and Ludbrook A (1981) Thirty years of Fruitless Endeavour? In: Van der Gaag J and Perlman M (Editors) Proceedings of the World Congress of Health Economics. North Holland

### Office of Health Economics

The Office of Health Economics was founded in 1962 by the Association of the British Pharmaceutical Industry. Its terms of reference are:

To undertake research on the economic aspects of medical care.

To investigate other health and social problems.

To collect data from other countries.

To publish results, data and conclusions relevant to the above.

The Office of Health Economics welcomes financial support and discussions on research problems with any persons or bodies interested in its work.

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