Impatient for Change

European attitudes to healthcare reform

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European attitudes to healthcare reform

Helen Disney, Karen Horn, Pavel Hrobon, Johan Hjertqvist,
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part 1

Introduction

Introduction

Helen Disney

In early 2004, the Stockholm Network commissioned Populus to survey the views of 8,000 citizens across Britain, the Czech Republic, France, Germany, Italy, the Netherlands, Spain and Sweden. Our aim was to get a representative geographical sweep of opinion about the future of healthcare and what Europeans really understand by terms commonly used by politicians across Europe, such as 'patient choice'. Does Europe's political elite really understand what patients want from their health systems now and in the future and, if not, how large is the gap in expectations?

Healthcare experts from each country polled were commissioned to comment on the national findings and place them within the context of current and proposed healthcare reforms, as well as the broader political climate.

The following introduction provides an overview of European health systems and the political context within which they operate, before going on to analyse our pan-European poll findings and the conclusions for policy-makers. The results

should be of interest to anyone with a stake in the future of European healthcare.

Context

There is no such thing as a European health system. There are only national systems, embedded in their cultural and historical contexts. European governments are, however, struggling with many common problems in the arena of healthcare. Increasingly, they are looking to one another to learn from best practice as they grapple with some urgent policy dilemmas. The UK, for example, has already borrowed from Spain in devising the concept of foundation hospitals, not-for-profit entities that are decoupled from state control. Italy too has clearly borrowed from the Netherlands and Switzerland in recent reforms that aim to redistribute healthcare funds more fairly across the regions. Other examples abound.

As far as European patients are concerned, without doubt what unites them is an impatience for change and a fear that without reform their health services can only get worse over the next ten years. As many as 81% believe the quality of healthcare will stand still or decline in the next ten years without reform, and 84% now think that change is urgent or necessary. Yet, although they are aware of problems ahead, they also fear any departure from the status quo. The emotive nature of healthcare as a policy issue remains a strong barrier to change and one that politicians ignore at their peril.

Europe's traditional preference for a strong welfare state, providing healthcare and social care from cradle to grave, is central to its political identity. But it is now faced with a range

of pressures that seem to be threatening its existence – or at the very least the generosity of its entitlements.

This diverse collection of health systems has one key factor in common: a strong belief in the importance of providing a safety net for the poor. Any reform proposal must incorporate this belief in social solidarity – and the fear of losing it – if it is to have any chance of being taken seriously by voters.

Although each country's health system has its own peculiarities, European health systems can be broadly placed into two camps:

Tax-funded government monopolies/'Beveridgean' systems

Most healthcare is publicly funded and often publicly provided by government agencies or publicly funded employees, although in recent years most Beveridgean systems have begun a partial privatisation of the supply of healthcare. Sweden has devolved some responsibilities to its county councils; Spain has given new powers to regional governments and created a mix of public, private and part-public, part-private hospitals; while Britain is introducing a new form of not-for-profit trust, known as foundation hospitals, and new privately run but publicly funded diagnostic and treatment centres. The Beveridgean systems subdivide roughly into countries such as Ireland and the UK, where systems are mainly centralised, and the Scandinavian and southern European countries such as Sweden, Spain and Italy, where there is a greater regional focus and more devolved decision-making.

Social insurance or 'Bismarckian' systems

A combination of public and private funding and mixed

provision operates in countries such as Germany and the Netherlands. A compulsory level of basic insurance is topped up with a range of other insurance products. Employers and employees pay income-related premiums. The unemployed are covered by the state.

European healthcare reform therefore needs to be designed with country-specific considerations in mind. Certain proposals may have a Europe-wide appeal but they will each need to be adapted to suit the precise demands and specifications of individual nations.

Our survey of the attitudes of patients across eight European countries has been conducted at a critical stage in the development of European welfare systems. A rapid rise in patient expectations is putting national public health systems under pressure, with users questioning their lack of access, choice and quality. Medical science and technology are also advancing much more rapidly than the growth in tax funding and resources to fund them.

Just to aggravate the problem, Europe is sitting on a demographic time bomb. Europe's population is ageing, pushing up the likely demand for health services, since in the last few years of life healthcare costs tend to rise significantly. It is anticipated that the over-65 population will rise from 15.4% of the EU population in 1995 to 22.4% by 2025, with overall population growth hitting record lows in southern European countries.

Concurrently, Europe's working-age population is in decline and becoming more inclined to travel overseas for work, leading to a shrinking tax base at the very moment when additional funds for healthcare are required. The Swedish consultancy Mapsec estimates that losses to GDP from demographic change and a more mobile labour force could be as much as 6–10%.[1]

Fewer working-age people also means fewer available professionals to work in the health system. Shortages of nurses and doctors are already apparent in the UK and France and are likely to worsen over the coming decades. Taking all these overlapping factors into account, it is going to be very tough for governments to square the circle of effective, efficient, high-quality health provision.

Aggressive mass-media coverage is also common in every country surveyed. Stories about long waiting lists, patients left on trolleys or the deaths of elderly patients during the 2003 summer heatwave all add to the negative picture of European healthcare. This influence, however, should not be overstated, since in many countries – especially those with a strong tabloid culture such as the UK, Germany, Italy and Spain – our research shows that the media has a credibility gap, with more respondents than not finding it an unreliable source of information about healthcare.

Meanwhile, beyond the context of the nation-state, the gradual opening up of borders within the European Union promises to turn what were once stand-alone country systems into an integrated health service market. Such a development will reveal weaknesses among the national systems, as health consumers begin travelling abroad to get the treatment their home country denies them or can only offer them to an inferior standard.

This trend is already enshrined in law under the 1998 Kohll-Dekker ruling from the European Court of Justice. The verdict gave two European patients the right to claim reimbursement

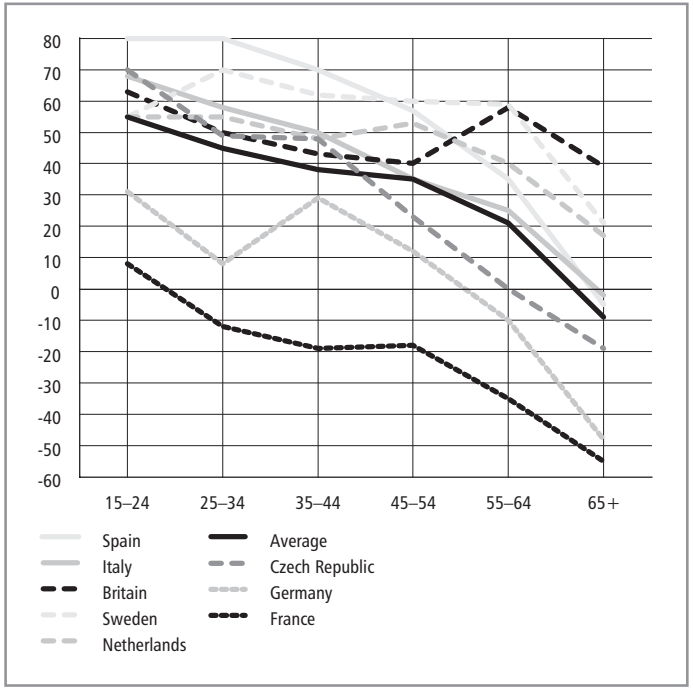

Figure 1 Travel for treatment

Net % of those willing to travel abroad for treatment if their healthcare system pays by age group

from their own national systems for treatment they had received in another EU member state. This is a highly significant ruling, since it effectively means that healthcare is now treated as a service under EU law. National health authorities can only refuse their citizens treatment elsewhere if they can prove that equal treatment is available at home within a reasonable timescale.

Just as consumers have embraced the 'no frills' revolution in the airline industry, which has allowed many to take very cheap flights around the globe for the first time and demystified foreign travel for those who could not previously afford it, so they are increasingly likely to come to see the benefits of travelling abroad for treatment when waiting lists at home prove too long.

Our research bears this out, with younger generations displaying a markedly higher willingness to travel abroad for treatment, as long as treatment is paid for by their health system. Some 64% of all those polled would travel to another country for treatment if their own health system paid, rising to as many as three-quarters among young people. Only older people and citizens in France and Germany are hesitant about the concept of going abroad for treatment, perhaps because their systems have previously not suffered the long waiting lists common to other countries such as the UK.

In general, waiting for treatment is now a key political concern in Europe with 83% of Europeans regarding waiting times as important to good-quality healthcare, but only 26% rating their respective health services as good in this regard.

Measuring expectations

Our survey defines patients' views using a variety of criteria, derived from cross-tabulation of the poll findings. The key terms used in this introduction and in the country reports that follow are defined as follows:

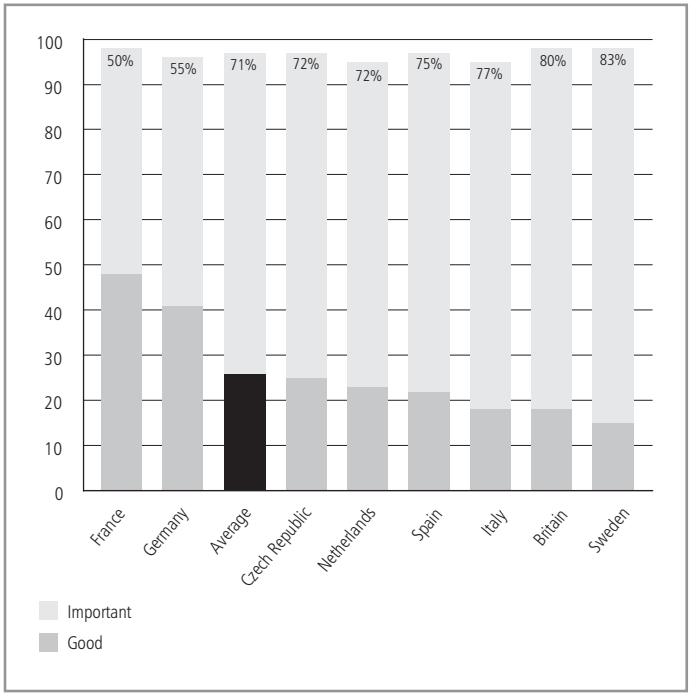

Figure 2 Delivery Deficit (waiting times)

Net % who think waiting times are an important feature of healthcare and that their health system is good in this regard

Delivery Deficit

Populus identified five key factors associated with good-quality health systems and asked respondents to rate whether these factors were important to them in their health system. They were then asked how well they felt their own system delivered them. The total number of responses indicating that a system was good at delivering a particular feature, such as access to new

medicines and technology, for example, was deducted from the proportions who felt that feature of healthcare to be important. An average Delivery Deficit for each country was derived from the mean score of each feature.

Solidarity Gap

This figure is the difference between those who believe equality of access to the same standards of healthcare is more important than the quality of individual care. On this

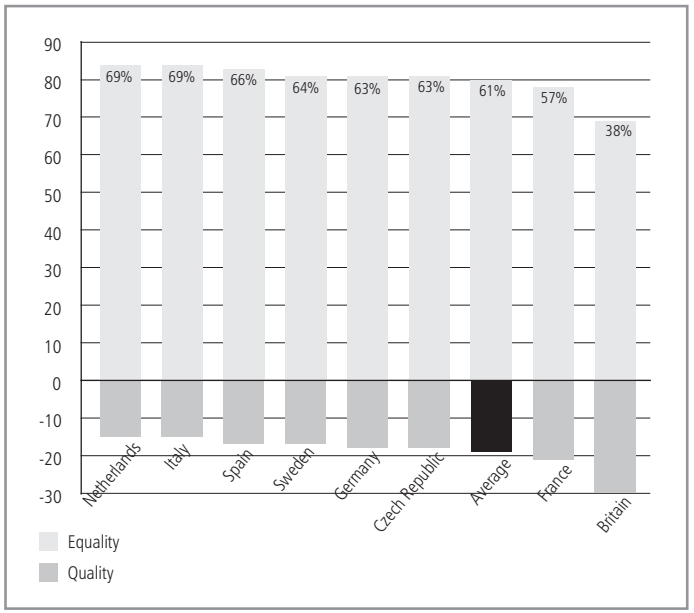

Figure 3 Solidarity Gap

Net % who think equality of access is a more important feature of their health system than the quality of personal care

measure, the Netherlands and Italy prize social solidarity most highly, while the UK, with one of the most socialised health systems in Europe, interestingly ranks at the bottom of the league.

Inferiority Complex

The Inferiority Complex is designed to measure how respondents view their system in comparison with those of other nations. People were asked for an opinion on whether their own health system performed better, worse or about the same as those of other European countries. For those who expressed a view, the scores for those responding 'the same' or 'worse'

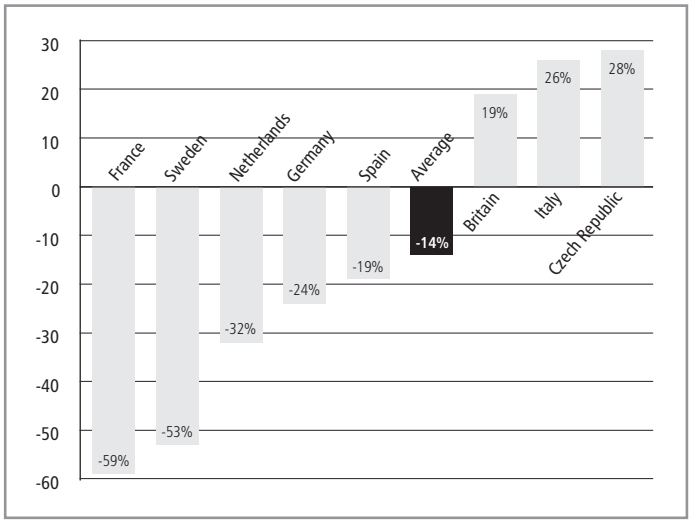

Figure 4 Inferiority Complex

Net % of those expressing an opinion who believe other European healthcare systems perform better than their own

were deducted from the score for 'better' to produce an overall Inferiority Complex rating for each country.

It is worth noting, however, that this set of questions, along with those asking about whether other systems are better or worse funded than the respondent's own, produced a large number of 'don't knows', suggesting that comparative information or experience about how other countries' health systems perform is still relatively scarce.

Britons and Swedes were significantly more willing to venture an opinion on foreign systems than other Europeans, although it is not clear whether this is because they are better informed after recent media coverage about what goes on in other European health systems or simply more opinionated than people elsewhere.

Czechs are the least confident about how their system performs compared with that of other nations, with a net inferiority complex of +28, against the relative superiority of the Swedes and the French, who score –53 and –59 respectively.

Pessimism Ranking

The Pessimism Ranking examines the prospects for health systems in the future if no reform takes place in the next decade. The total of those who believe things will improve is deducted from the total of those who think the situation will remain the same or worsen. On this measure, Germans are the most pessimistic nation, with a score of 88 against an EU pessimism average of 67. Even the least pessimistic country, Italy, scores 50, suggesting that politicians still have a long way to go if they want to keep voters happy when it comes to healthcare.

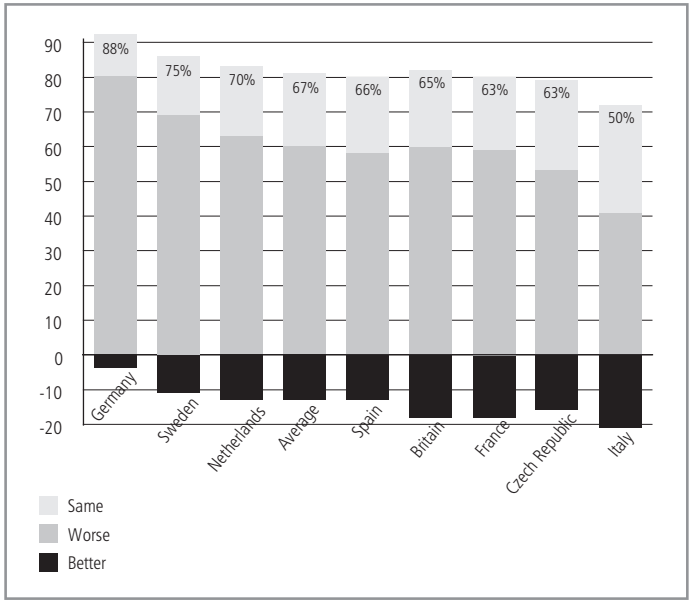

Figure 5 Pessimism Ranking

Net % who think healthcare standards will stay the same or get worse in their country over the next ten years

Reform Index

We asked respondents to assess whether their health systems needed reform and if so how urgently. We then ranked countries on a Reform Index by deducting the percentage who felt reform was unnecessary from those who felt reform was desirable or urgent. Again, Germans came out top of the Reform Index, perhaps in response to the intense public debate over Chancellor Schroeder's Agenda 2010 reforms of the German welfare system, which has highlighted the urgent need for change in the next few years. But the Germans are not alone. In all the

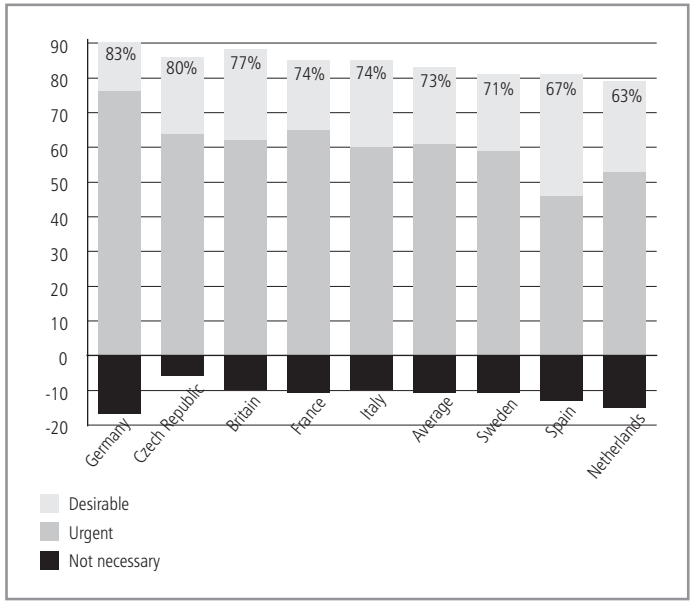

Figure 6 Reform Index

Net % who think healthcare reform is urgent or desirable in their country

countries polled, with the exception of Spain at 46%, well over half of respondents identified reform as an urgent priority.

We also asked respondents to rank their own country's health system with a simple mark out of ten. Across the countries surveyed, respondents gave their healthcare systems an average of 6 out of 10, ranging from 6.9 out of 10 in France down to 5.1 out of 10 in Germany. The message for politicians here seems to be: could try harder.

Options for reform

Consumers' hunger for improvement is already outstripping the fear of change generated by those with a vested interest in preserving the status quo. Reformers have an exciting opportunity, if they take the trouble to understand what the public wants and to show them that there is a way to effect change that is affordable, realistic and to everyone's benefit. But have politicians really understood what type of change the European public wants?

We asked respondents to rate a variety of options for change. The results may be surprising, especially for politicians who have placed a great deal of emphasis on patient choice.

The balance of Europeans who believe that choice, interpreted as increasing the range of doctors and hospitals, would increase the quality of care is just 25%, although the concept is much more popular in Spain (59%), France (42%) and Sweden (38%).

More innovation was also relatively popular, with a balance of 22% of Europeans thinking that increased access to medicines and treatments would improve the quality of care.

But contrast these low figures with the proportions who think waiting times are important (an average net percentage of 71) and the findings start to paint a different picture. Do patients really want a choice of doctor or hospital or are they more concerned about being diagnosed quickly and treated as soon as possible after diagnosis? Patient choice may be a useful mechanism for effecting system change but it is a means to an end, not an end in itself.

European patients are less clear when it comes to deciding

how improvements in healthcare will be paid for. A balance of 23% believe giving patients more control over how public money is spent would improve things. Britons, however, are more sceptical about this type of reform than the average – more people think ring-fencing is unlikely to improve the quality of care than believe it will lead to an improvement – making Britain the only European country polled that produces a negative rating on this measure.

An even smaller net percentage – an average of only 7% – think that making it easier to spend more of their own money on healthcare will improve standards. But here there is a clear split between Beveridgean and Bismarckian systems. In the Czech Republic, Britain, Sweden and Italy, with their predominantly state-controlled, publicly financed systems, more people believe greater personal health spending will improve things than do not. This suggests frustration with the amount of public money committed and/or the way it is spent. Meanwhile, in countries like Germany and France, which already have user charges or co-payments and a much more mixed economy in healthcare, the number who think more private spending on healthcare will improve things are outweighed by those who do not.

Conclusion

European healthcare systems are living on borrowed time. Population ageing, the rising costs of medical technology and more demanding customers have produced chronic underfunding, which will only worsen as time passes. Unless European health systems are reformed rapidly and decisively the consequences will be dire: longer waiting lists, much stricter rationing

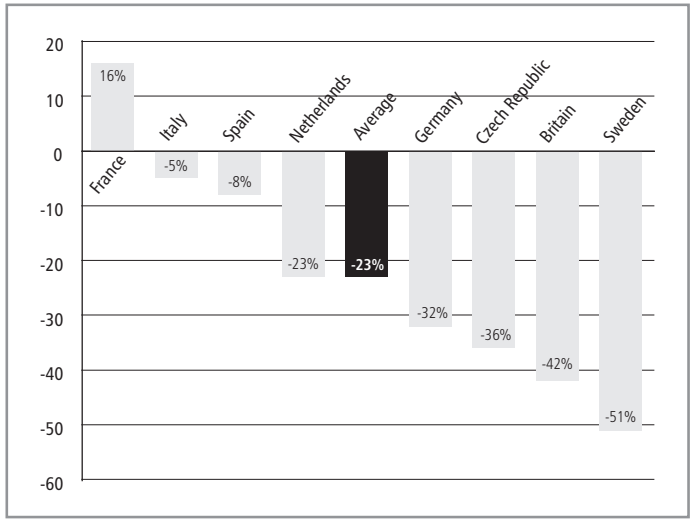

Figure 7 Underfunding at home

Net % who think their health system has too much or the right amount of funding at the moment

decisions, discontented medical staff fleeing the profession, a decline in pharmaceutical innovation and, worst of all, more ill health for Europe's patients.

The problem has become so bad that most Europeans are fully aware that it is time for a change. It is clear that they understand not just that Europe has a problem with funding healthcare but also that there is a need for reform. All those who expressed a view in the countries surveyed, except in France, think their system is underfunded, with the predominantly tax-funded systems of the UK, Sweden and the Czech Republic scoring highest on the scale. Again, though, there is a high degree of ignorance about how much funding other systems

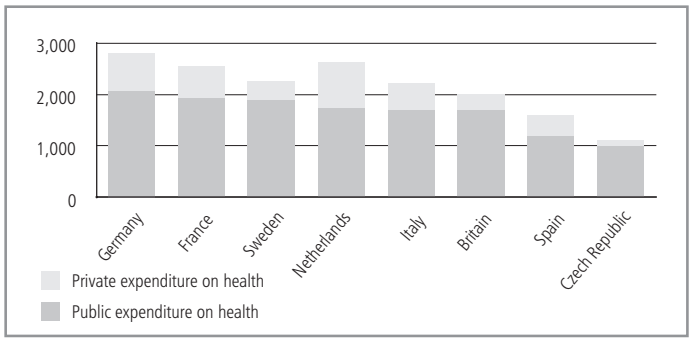

Figure 8 Actual health expenditure

Per capita, US$ PPP, 2001 (Source: OECD)

receive in practice. Actual health expenditure as a proportion of GDP is shown in Figure 8.

Meanwhile, the data on reform is especially stark when analysed by age group. Young people are so far unlikely to have had much need of the health service or to have thought much about whether they are getting value for money, as they may not yet be paying taxes. Older citizens no doubt feel that the system will not change significantly in their lifetime. In both these groups the desire for change still exists. However, the sense of urgency about reform is greatest among Europe's working-age, taxpaying population, who are anxious about their future and impatient for change. This wave of worriers should be of serious concern to policy-makers.

The key question is, of course, how to move from one familiar system to another, probably more complex one in future. The UK and Scandinavian countries have no real tradition of individuals taking control of, and accepting responsibility for,

paying for healthcare. Britain is undergoing a limited experiment with 'patient choice' for specific treatments such as heart disease and cataract operations, but the population appears opposed to any scheme that could be perceived to undermine fair access to treatment. Regardless of the fact that the current systems are not actually fair and that access to medicines or good surgeons is something of a lottery, publicly funded health

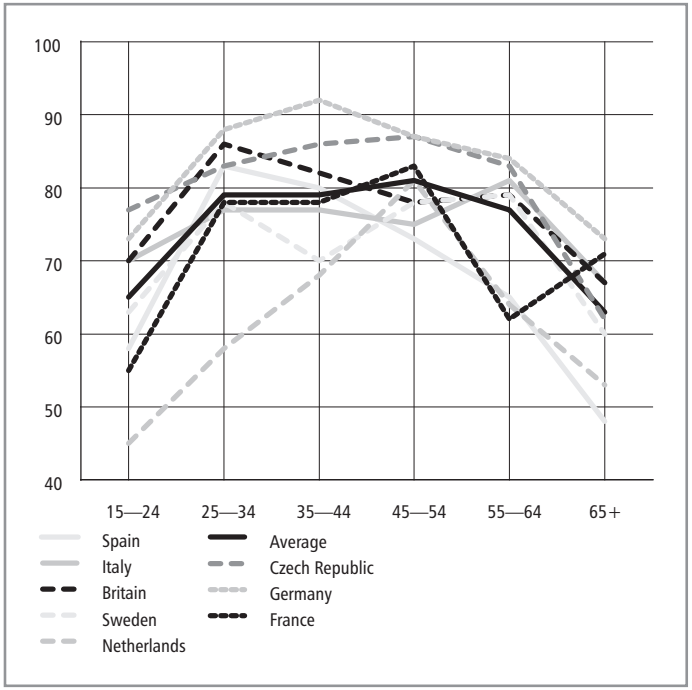

Figure 9 Age of anxiety

Net % of those believing healthcare reform to be urgent or necessary in their country by age groups

systems inspire a strong, if not religious loyalty. They are almost a part of the psyche of certain European countries.

Voters may know objectively that change is inevitable but they remain concerned that any reform will be costly and socially divisive – and are willing to punish politicians who do not address these concerns. Many Europeans are also unused to having to negotiate a complex market for health insurance products and have fears about how to go about it.

The Beveridgean systems are consequently experimenting mainly with reforming or part-privatising the supply of healthcare rather than trying to create a funding revolution.

Access to better health information, however, is one area that is ripe for what could be a relatively painless reform, right across Europe. Some 77% of those surveyed believe that giving patients more information about their illness would increase health standards. Better use could be made of the Internet and other forms of new media to give the public much wider access to health data, both about their illness and also about the quality of care provided by primary care doctors and hospitals. Beyond this, reformers need to leverage all the additional information now being accumulated and publicised to help stimulate demand for reform. As Europeans become more knowledgeable about the range of new treatments and medicines available elsewhere, and more aware of better standards and shorter waiting times in other countries, the desire for similar standards of treatment will become a political imperative.

It is also crucial for politicians to understand how reform ideas are perceived, to use the appropriate language and to employ the appropriate channels for delivering information. Voters are less interested in process than they are in results.

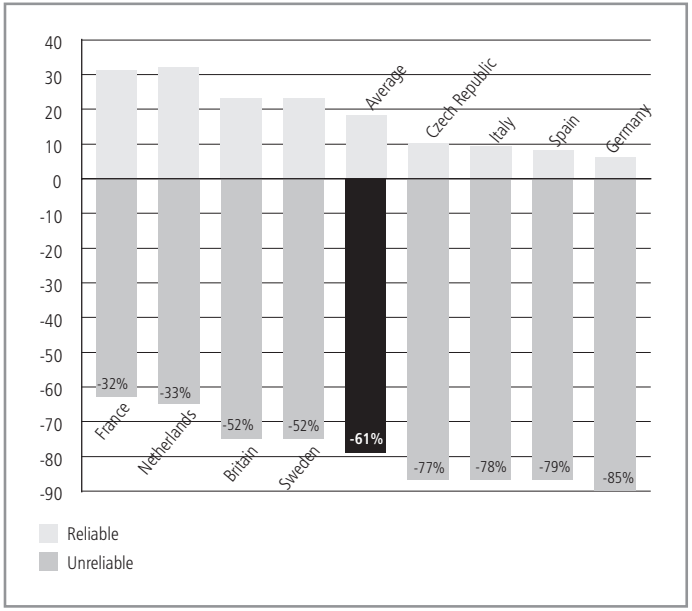

Figure 10 Credibility gap (politicians)

Net % who think politicians' statements are a reliable source of information about how well their healthcare system is performing

Few have the time or inclination to study in depth details of all the parties' health policy proposals, but they will plump for whichever party's ideas and values seem most likely to bring real benefits to them as patients. The European public is much more responsive to change when the debate is presented in human terms, when politicians focus on ends rather than means, when information comes from a trusted source, such as doctors and nurses, and when it is presented with the reality of coping with an ageing population.

More people (85%) would prefer to trust doctors' and nurses' opinions about how well their health service is performing than their own experience of it (78%), and certainly far more than they would trust the pronouncements of the media (43%) or politicians (18%).

Politicians are generally distrusted by citizens across the European countries surveyed, with most people far keener to rely on almost any other source, even the much-maligned healthcare industry or the media, than on the views of their elected officials. It is clear that politicians need to find some way to resolve the issue of trust and to win over the public if they wish to stay in power long enough to effect serious change.

Germany's Chancellor Gerhard Schroeder has suffered the consequences of pushing for reform under Agenda 2010 without taking voters along with him, and recently stepped down as leader of his party, signalling the depth of his current unpopularity among German voters.

In France, too, President Chirac and his premier, Jean-Pierre Raffarin, who have been pushing for economic reforms under Agenda 2006, have recently suffered a crushing defeat in regional elections.

Politicians in Spain, which was the first mainland European country to suffer a serious terrorist attack since 11 September 2001, are understandably more preoccupied with national security than with reforming their health system, which Spaniards in any case seem broadly satisfied with, at least for now.

In the UK, the push for reform is more urgent, with voters likely to judge Prime Minister Tony Blair's government at the next general election as much on its record in delivering on

public services as on its response to international affairs, such as the war in Iraq.

The Czech Republic's recent entry into the European Union will accelerate the drive for market-oriented reform, although patients used to the former communist-run health system may be less pushy and consumer-focused than those in the rest of Europe for a few years to come.

What is certain is that across the board Europe's politicians are struggling with a common set of problems. They have not yet found a convincing language or set of messages to win the public over when it comes to much-needed healthcare reforms. Policy ideas and studies on the relative merits of health systems are fairly plentiful, but we need a greater understanding of public opinion and the changing values and norms of European patients if policy-makers are going to devise new systems that truly meet their needs. The findings of this survey provide a preliminary key to begin understanding those values.

Whether we like it or not, Europe's health systems are no longer sustainable and will have to be overhauled. The question that remains unanswered is when European patients will begin to trust their politicians enough to let them confront that reality.

Notes

1 http://www.stockholm-network.org/confs.cfm/Molander.pdf.

part 2

Populus national polls and commentaries

Britain

Britain

Poll and analysis

Context

Most important features of healthcare and health system's ability to deliver them

	Important	*Good*	*Net*
The time between diagnosis and treatment	98	18	80
Being treated at a time and a place to suit you	91	25	66
Being treated using the latest medicines/technology	94	32	62
Having enough information to make an informed choice about your treatment	98	37	61
Being treated by a doctor of your choice	78	31	47
Average delivery deficit			**63**

Which is more important to you about your health system?
(Solidarity Gap)

	Equality of access	*Quality of personal care*	*Net*
Netherlands	84	15	69
Italy	84	15	69
Spain	83	17	66
Sweden	81	17	64
Germany	81	18	63
Czech Republic	81	18	63
Average	**80**	**19**	**61**
France	78	21	57
Britain	69	31	38

How do other European health systems perform compared with your own?
(Inferiority Complex)

	Better	*The same*	*Worse*	*Better minus the same/worse*
Czech Republic	65	26	10	28
Italy	63	26	11	26
Britain	60	29	12	19
Average	**43**	**32**	**25**	**-14**
Spain	42	35	26	-19
Germany	38	27	35	-24
Netherlands	34	41	25	-32
Sweden	24	43	34	-53
France	20	31	48	-59

Health System: marks out of 10

France	6.9
Netherlands	6.7
Spain	6.7
Average	**6.0**
Britain	5.9
Sweden	5.8
Italy	5.8
Czech Republic	5.3
Germany	5.1

Prospects for healthcare in 10 years' time if your system remains unreformed
(Pessimism Ranking)

	Improve	*Stay the same*	*Get worse*	*Stay the same/get worse minus improve*
Germany	4	12	80	88
Sweden	11	18	68	75
Netherlands	14	20	64	70
Average	**14**	**21**	**60**	**67**
Spain	14	22	58	66
Britain	17	22	60	65
France	17	21	59	63
Czech Republic	16	25	54	63
Italy	21	31	40	50

Does your health system need reforming? (Reform Index)

	Yes (urgently)	*Yes*	*No*	*Yes (urgently)/yes minus no*
Germany	76	14	7	83
Czech Republic	64	22	6	80
Britain	63	24	10	77
France	65	20	11	74
Italy	60	24	10	74
Average	**61**	**23**	**11**	**73**
Sweden	58	24	11	71
Spain	46	35	14	67
Netherlands	54	24	15	63

Analysis

Britons rank their health system bottom of those countries surveyed in terms of the gap between aspiration and delivery. They are also the least inclined to put equality of access ahead of quality of personal care of any country polled. Only in Sweden do a higher proportion of people think that their health system is underfunded in absolute terms, and only in the Czech Republic do more people think that their health service is underfunded relative to other European countries. A greater proportion of Britons believe that extra money for health should come from higher personal taxation than in other countries. Britain ranks third behind the Germans and the Czechs in terms of the need for reform. Its citizens give their health service 5.9 out of 10.

Three in five Britons (60%) say that healthcare will get worse

over the next decade in the absence of reform, ranging from 48% of 15–24-year-olds to 68% of those aged 35 to 64; 41% of those earning less than £5,000 a year believe this, rising to 68% of people earning over £30,000. Just over one in five Britons (22%) think standards will remain the same and a little over one in six (17%) believe standards will improve without reform. This gives Britain a 'Pessimism Ranking' of 65%, close to the survey average of 67% and fifth out of the eight countries polled.

When it comes to the need for reform, nearly two-thirds of British people (63%) say the task is urgent, including 70% of 45–64-year-olds but only 47% of 15–24-year-olds. A gender gap emerges here between the 58% of men who think reform is urgent and the 67% of women who believe this. An additional quarter of Britons (24%) believe reform is desirable and only one in ten (10%) think it unnecessary. Britain therefore has a 'Reform Index' score of 77%, slightly higher than the survey average of 73% and surpassed only by Germany and the Czech Republic.

More than two-thirds of British people (69%) feel their health system is underfunded in absolute terms, including three-quarters (75%) of women. This is a higher proportion than in any other country bar Sweden. One fifth (20%) say it is adequately funded and only 7% think it receives too much money. Relative to other countries, nearly two-thirds of Britons expressing an opinion (64%) – and more are willing to give a view than in any other country surveyed – think that their health system receives less money than its neighbours. Only in the Czech Republic do a higher proportion think this. A greater number of Britons (39%) think more money for healthcare

should be funded by higher taxation than in any other country surveyed. Only 12% think the money should come from higher personal spending, though 23% of those earning £40,000 a year or more think this. When asked where the extra money will actually end up coming from, two-thirds of Britons (67%) think it will come from higher personal taxation, including just over half (52%) of those earning less than £5,000 a year, and nearly three-quarters (73%) of those aged 15–24.

In terms of performance, only 12% of Britons prepared to express an opinion believe that other countries' healthcare systems perform worse than theirs does. This compares with three-fifths (60%) who believe other health services perform better; 69% of those earning £30,000 or more think this. With 29% thinking British standards are comparable with elsewhere, Britain has an 'Inferiority Complex' score of +19%, third in the study behind the Czech Republic and Italy. British people are more prepared to travel for treatment than people in the survey as a whole. Nearly three-quarters (73%) say they would go abroad against a quarter (25%) who say they would not; 15–24-year-olds are most in favour by 81% to 18%, but even among the over-65s an overwhelming majority of more than two to one would be willing to seek treatment overseas (by 68% to 30%).

While Britain performs close to the survey average in terms of the health service meeting individual needs (46% say it is good at this against 45% overall), it performs worst of all the countries surveyed in the specific measures used to calculate the 'Delivery Deficit'. It comes bottom in doctor choice and the use of the latest medicines/technology and next to bottom in waiting times and convenience. In terms of giving patients

Reforms most likely to increase the quality of care

	Likely	*Not likely*	*Net*
Giving patients more information about their illness	75	24	51
Increasing number of medicines and treatments	73	25	48
Increasing range of doctors and hospitals	61	37	24
Making it easier for patients to spend their own money on health	60	38	22
Giving patients more control over public spending on health	42	56	-14

sufficient information about their treatment it comes 6th out of 8. Waiting times are the most significant feature of healthcare for Britons out of the five offered, rated as important by 98% of them, while doctor choice is the least significant, offered up as important by only 78%. Fewer than one in five British people (18%) rate their health service as 'good' on waiting times, and only one in four (25%) rate it as 'good' on convenience – the lowest of any country surveyed. Similarly on access to the latest medicines/technology, no other country both rates it as highly as Britain, where 94% think it important, nor scores their health system so low at delivering it; fewer than a third (32%) say the NHS is good in this regard. Overall Britain's 'Delivery Deficit' is 63%, 12 points below the survey average and 6 points behind the next lowest ranked country, Italy.

In line with other countries, the single reform cited by Britons as the most likely to increase the quality of care is giving patients more information about their illness, though the balance between those who think it is likely to improve things and those who do not (75% against 24%) is lower than

in any country other than Germany. However, more people in Britain than in any other country (73%) think that increasing the number of available medicines and treatments will help. As many as 80% of 15–24-year-olds and of those earning less than £5,000 a year think this. Britain is also alone among the countries surveyed in more people thinking it unlikely that greater patient control over public spending on health will increase standards than think it likely, by 56% to 42%. Three in five Britons (60%) believe that making it easier for patients to spend their own money is likely to drive up quality against slightly less than two in five (38%) who do not; 15–34-year-olds, by a margin of 65% to 34%, and those earning more than £40,000 a year, by a margin of 70% to 30%, are the most keen in this regard.

Although Britain, in common with other countries, places a higher priority on equality of access than quality of personal care for its health service, it does so to a lesser extent than any other country surveyed. Just over two-thirds (69%) put equality first and just under one third (31%) quality first, the lowest and highest proportions respectively of any population in the study. Britain's 'Solidarity Gap' of 38% is 19% less than the next lowest ranked country, France, and 23% less than the survey average.

As with other countries, Britain trusts the opinions of doctors and nurses more than any other source of information (they have a Credibility Gap of +84% against a survey average of +74%). Personal experience and/or the experience of friends and family come next with a net score of +70% against an average of 61%. NGOs have a Credibility Gap of +44% against 41%. While Britons share a general scepticism about

Most reliable sources of health information (Credibility Gap)

	Reliable	*Unreliable*	*Net*
Doctors/Nurses	91	7	84
Experience	84	14	70
NGOs	69	25	44
Industry	68	29	39
Official stats	54	44	10
Media	36	62	-26
Politicians	23	75	-52

officialdom, nearly a quarter (23%) still regard politicians' statements as reliable compared to 18% of the poll overall and more than half (54%) think official statistics are reliable. The biggest differences with other countries surveyed lie first in media stories, whose Credibility Gap of –26% in Britain is beaten only by Italy. This is fuelled by a gender gap. While 41% of men believe media stories against 58% who don't, this figure falls to 32% against 66% among women. The second difference is that Britain is far more likely to take information from the health-care industry at face value. It has a Credibility Gap of +39%, higher than in any other country, with more than two-thirds of Britons (68%) regarding its information as reliable.

An overwhelming majority of Britons accept the idea that they should take more responsibility for keeping themselves healthy, by 96% to 4%. Just under one third (30%) think the government should play the main role in helping them, compared with just over one third (36%) who feel doctors should do this. However, 14% believe that other health professionals should take the lead, a figure second only to Sweden.

Summary

Britain

Delivery Deficit	63	Bottom
Solidarity Gap	38	Bottom
Inferiority Complex	19	3rd
Marks out of 10	5.9	4th
Pessimism Ranking	65	5th
Reform Index	77	3rd

Britain

Commentary

David Smith

Never have politicians in Britain been keener on taking the public temperature on the National Health Service (NHS). The Labour government, having injected huge sums of taxpayers' money into health, is relying on a shift in public attitudes towards the NHS. By the next election, ministers hope, the payback for that extra funding will be clear to all, bringing obvious benefits into the ballot box.

The Conservative Party, on the other hand, intends to push a very different argument. The tens of billions of extra funding has produced little in the way of improved services, or even higher levels of activity, it will argue. Better to hand over the stewardship of the NHS to somebody else.

Upon the outcome of that argument many votes will depend. It is, however, in many respects merely a rerun of a debate that has dogged the NHS for the best part of half a century.

Since the NHS came into being in 1948, as a self-declared 'beacon to the world', and an undoubted healthcare system pioneer, two things have been clear.

The first is that, in a service that is free at the point of delivery, demand will always tend to outstrip supply. Aneurin Bevan, the father of the NHS, was soon after its creation bemoaning 'the ceaseless cascade of medicine pouring down British throats' but nevertheless regarded it as a betrayal when, in 1950, his Labour government legislated for the introduction of charges for dental work and glasses.

The NHS's original universality ended after barely two years. Since then, health secretaries have struggled to make scarce resources stretch.

The second constant has been that, after the brief initial flush of enthusiasm about the new NHS, more than half a century ago, its customers and potential customers have often been dissatisfied. The NHS may be, as legend has it, a 'much-loved British institution', but behind that love lies a good deal of discontent. This has much to do with the fact that supply has been constrained by the availability of resources, so that rationing by waiting times or by the range of treatments on offer has been a regular feature of the NHS since its inception.

Dissatisfaction has also been due, however, to the supplier-driven nature of the NHS and its perceived lack of responsiveness to customer needs. The old dictum, that every time a bedpan is dropped on a ward a wail goes up in Whitehall, caricatures a centralised system, whose origins lie very much in late-1940s nationalisation. From both sides of the political divide, it has been commonplace in recent years to hear the old 'command and control' NHS condemned, in favour of a more localised and patient-responsive system. Where the debate does rage is over the best way of achieving that goal.

The UK's current Labour government is engaged in an experiment to try to respond to both of the long-standing, perceived shortcomings of the NHS. A massive injection of funds, promised by Tony Blair in a television interview in January 2000 when his government was under intense political pressure over the system's failings, has been enacted. This, the biggest sustained financial boost in the NHS's history, is designed to remove much of the resource constraint at a stroke.

The second aim, clearly related to this, is to re-establish the NHS's beacon-to-the-world status. Not only have ministers stressed that health funding will at least match the average elsewhere in the European Union, they have also stressed the superiority of the British system in relation to those in existence elsewhere in Europe and, of course, to that of America. Social insurance would produce a bigger funding burden, particularly for employers, than general taxation, they argue, whereas a system based on private insurance would make health inequalities far worse, not least by providing for incomplete coverage of the population. The Labour aim, of transforming the NHS's funding, reputation and delivery, is nothing if not ambitious.

Before coming on to that, it is worth briefly reviewing the recent history of NHS reform. By the 1980s, under the Thatcher government, it was clear that the system was not working. An administration committed to reducing the role of the state first targeted the management and organisation of the system. One tier of management, the 'area tier', was removed entirely. A report by Sir Roy Griffiths, a businessman, introduced the concept of 'general' management into the NHS. The system had been 'managed' by health professionals. The changes made clinical staff, although not consultants, answerable to managers.

These changes, along with a new emphasis on health promotion – championed by high-profile Conservative ministers such as Edwina Currie – were intended to produce a leaner, fitter NHS, which would be better focused and better managed. The public saw it differently, however. As Thatcher approached her tenth anniversary in government, the political atmosphere was one in which the closure of hospitals, or more usually hospital wards, dominated the headlines. Conservative 'cuts' (although real spending increased each year) were seen by many voters as fatally undermining the system.

It was in this environment that the Conservative government published its White Paper, *Working with Patients*, in 1989. The proposals, for introduction in April 1991, were far-reaching.

At their heart was the introduction of an internal market, a radical split between health purchasers and health providers (although all would continue to operate within the same publicly funded system). New, stand-alone NHS trusts, to manage hospital and community services, were answerable to central government – the Department of Health – but were intended to devolve responsibility to local levels. The intention was to bury the 1940s bedpan analogy once and for all. From now on, a dropped bedpan would reverberate only at local level. The centre would be occupied with the strategic direction of the system.

The purchasers in this new internal market were to be the general practitioners, the traditional gateway to the NHS. GPs were encouraged to become fund-holders, buying hospital services, including outpatient services, elective surgery and exploratory and diagnostic procedures, directly from the providers, the NHS trusts.

In the new system district health authorities, working with the GP fund-holders, assessed the health status of their resident population and their purchasing needs. The trusts, as providers, concentrated on providing services efficiently. The trusts were given the freedom to supplement funding by offering private beds or from commercial activities. Internal market charges were intended to be based on actual costs.

The aim was very ambitious – transforming a creaking and bureaucratic system into one that would be highly responsive to the health needs of the population. Improvements were sought in efficiency, quality of service, equity, choice and accountability. In practice, however, much bureaucracy remained. The line of responsibility on the purchaser side ran down from the Department of Health through eight regional offices, 100 health authorities, GP fund-holders and non-GP fund-holders.

Did the internal market work? Amid widespread public suspicion about the introduction of market principles into the NHS (the Conservative Party was assumed by many to have a secret privatisation agenda), the internal market was never properly given its head. Central control remained absolute. Failing providers, the trusts, were not allowed to fail. The underlying principle, increasing efficiency through competition, was smothered.

To the extent that there were effects, these were seen as increasing inequity within the system and adding, not reducing, bureaucracy. The recruitment of around 10,000 new managers in the early years of the internal market added to the impression that the effect of the reforms was to create a bureaucratic nightmare. That was unfair, but it meant the new system struggled for public acceptance. When the Labour government

was elected in 1997 on a platform of abolishing the internal market, few voters protested. As importantly, few tears were shed within the NHS itself.

Labour's plans were set out in a December 1997 White Paper, *The new NHS. Modern – Dependable*. It abolished GP fundholding, the most visible manifestation of the internal market, introducing new primary care groups (PCGs). The White Paper targeted £100 million of annual savings in management costs. Interestingly, however, the devolved responsibilities of NHS trusts were maintained, as was the purchaser–provider split, but with PCGs – each responsible for an average of 100,000 people – carrying out the purchaser role.

Under Labour's initial reforms health authorities were required to develop three-year health improvement programmes. Clinical governance, placing the responsibility for quality of care on trust chief executives, was established. Two new bodies, the National Institute for Clinical Excellence (NICE) and the Commission for Health Improvement (CHI), were introduced. The role of NICE was to ensure equal standards (a 'levelling up') and treatment availability across the country. CHI's job was to monitor service improvements.

Labour's 'big idea' for the NHS did not come, however, until it was three years into power. That big idea was simply stated. After keeping the health budget on a tight rein for its first two to three years, the government was to expand it hugely. The NHS plan of July 2000, 'a plan for investment, a plan for reform', announced 'an historic commitment to a sustained increase in NHS spending'. Too often, it said, patients had had to wait too long, while variations in standards across the country were unacceptable. 'Constraints on funding mean that staff often

work under great pressure and lack the time and resources they need to offer the best possible service,' the plan added.

The NHS plan was intended to tackle that. Following the 'historic commitment' to bring health spending in the UK up to the European Union average, Gordon Brown, Chancellor of the Exchequer, commissioned Derek Wanless to investigate the NHS's future funding needs. Wanless, former chief executive of the National Westminster Bank, was specifically asked to review public funding needs, and not advise on the split between public and private funding. NHS spending had, he said, grown by an average of 3.6% a year in real terms since the 1970s but had nevertheless fallen behind other EU countries. He recommended a faster rate of increase but warned that 7% a year real growth in spending (the figure subsequently adopted by the government) was at the upper end of what could be spent efficiently by the NHS.

NHS spending, £35 billion when Labour took office, is thus planned to increase to more than £90 billion by 2007/8, an increase of 44% in real terms from the point at which the big expansion started, in 2002.

The government insists that funding and reform go hand in hand. A parliamentary battle to win approval for foundation hospitals – top-rated NHS trusts which will be given greater autonomy – was seen by ministers as underlining the commitment to reform as well as cash.

Reform includes a greater emphasis on prevention and public health. A subsequent Wanless report made recommendations for reducing obesity and preventable illnesses and diseases. Another new strand is 'personalisation', which includes NHS Direct, a 24-hour telephone and Internet information and advice

service, walk-in centres available for 365 days a year and other innovations. These include providing each patient with their own electronic 'healthspace', where they can record personal information about their health and lifestyle, and – from the end of 2004 – offering all patients who have waited more than six months for an operation a choice of an alternative hospital, including private sector alternatives. This 'Patient Choice' pilot has proved popular but the Populus 'Delivery Deficit' suggests this is not necessarily because patients are really interested in choosing a doctor per se. Only 78% rated this as being most important to them versus 98% who wanted a shorter time between diagnosis and treatment. So is talk of 'patient choice' just a convenient mechanism for getting waiting lists down?

In reality, the government is engaged in a large-scale financial experiment. The test is whether the NHS can respond to an enormous increase in funding.

Is it working? It is acknowledged across the political spectrum that waiting times for treatment have fallen. The government claims that compared with 1997/8 there are 450,000 more NHS operations, 860,000 more elective admissions and 187,000 fewer patients waiting for treatment.

Where the debate lies is over whether the money is spent effectively. Some improvement was inevitable. The problem for the government is that the improvement lags behind both the extra resources and public expectations.

Ministers argue that people's individual experiences of the NHS are good but that they get dragged down into general gloom about the service when they respond to surveys. The evidence in this report suggests that public scepticism goes considerably deeper than that. Britain scores highly on the Populus reform

index, just behind Germany and the Czech Republic, with 63% saying their health system needs urgent reform. Britons are also fairly pessimistic about the future prospects for healthcare if the system remains unreformed over the next decade, with 60% believing things will get worse. For a government whose election slogan was 'things can only get better', there is still a lot more work to do.

Czech Republic

Czech Republic

Poll and analysis

Context

Most important features of healthcare and health system's ability to deliver them

	Important	*Good*	*Net*
The time between diagnosis and treatment	97	25	72
Having enough information to make an informed choice about your treatment	94	28	66
Being treated using the latest medicines/technology	89	34	55
Being treated at a time and a place to suit you	89	40	49
Being treated by a doctor of your choice	92	66	26
Average delivery deficit			**54**

Which is more important to you about your health system?
(Solidarity Gap)

	Equality of access	*Quality of personal care*	*Net*
Netherlands	84	15	69
Italy	84	15	69
Spain	83	17	66
Sweden	81	17	64
Germany	81	18	63
Czech Republic	81	18	63
Average	**80**	**19**	**61**
France	78	21	57
Britain	69	31	38

How do other European health systems perform compared with your own?
(Inferiority Complex)

	Better	*The same*	*Worse*	*Better minus the same/worse*
Czech Republic	65	26	10	28
Italy	63	26	11	26
Britain	60	29	12	19
Average	**43**	**32**	**25**	**-14**
Spain	42	35	26	-19
Germany	38	27	35	-24
Netherlands	34	41	25	-32
Sweden	24	43	34	-53
France	20	31	48	-59

Health System: marks out of 10

France	6.9
Netherlands	6.7
Spain	6.7
Average	**6.0**
Britain	5.9
Sweden	5.8
Italy	5.8
Czech Republic	5.3
Germany	5.1

Prospects for healthcare in 10 years' time if your system remains unreformed
(Pessimism Ranking)

	Improve	*Stay the same*	*Get worse*	*Stay the same/get worse minus improve*
Germany	4	12	80	88
Sweden	11	18	68	75
Netherlands	14	20	64	70
Average	**14**	**21**	**60**	**67**
Spain	14	22	58	66
Britain	17	22	60	65
France	17	21	59	63
Czech Republic	16	25	54	63
Italy	21	31	40	50

Does your health system need reforming? (Reform Index)

	Yes (urgently)	*Yes*	*No*	*Yes (urgently)/yes minus no*
Germany	76	14	7	83
Czech Republic	64	22	6	80
Britain	63	24	10	77
France	65	20	11	74
Italy	60	24	10	74
Average	**61**	**23**	**11**	**73**
Sweden	58	24	11	71
Spain	46	35	14	67
Netherlands	54	24	15	63

Analysis

A higher proportion of Czechs believe their health system is underfunded relative to other countries than any other nation surveyed. The Czech Republic also has the greatest inferiority complex about the way its health system performs compared to those of its neighbours, and its anxiety for reform is exceeded only in Germany. Nevertheless, Czechs' assessment of the prospects for healthcare over the next ten years in the absence of reform is marginally less gloomy than the survey average, and on specific measures of performance against aspiration the Czech Republic's average score beats Sweden, Italy and Britain. Overall Czechs give their health system a score of 5.3 out of 10, below the average of 6 out of 10 and higher only than Germany in this survey.

Slightly over half of all Czechs (54%) say that healthcare will

get worse over the next decade in the absence of reform. This includes 60% of 35–64-year-olds, but only 38% of those aged 65 and over and 45% of 15–24-year-olds who think this. One quarter of Czechs (25%) think standards will remain the same, while one in six (16%) say standards will rise without reform. The Czech Republic therefore has a 'Pessimism Ranking' of 63%, compared to the survey average of 67%. This places it equal sixth out of the countries polled along with France, and with only Italy below it.

However, Czechs still perceive a need for reform. Nearly two-thirds (64%) describe reform as urgent, including 70% of 35–54-year-olds. A further fifth (22%) say that reform is desirable and only 6% think it is unnecessary, the lowest proportion in any country surveyed. This gives the Czech Republic a 'Reform Index' rating of 80%, second out of the eight nations in the poll, beaten only by Germany with 83%, and ahead of the survey average of 74%.

Two-thirds of Czechs (66%) think their health system has too little money, ranging from 81% of 15–24-year-olds to 54% of those aged 55 and over. Only Britain and Sweden have more people who believe their health systems have too little funding. More women think the Czech system is underfunded than men, by 71% to 61%. A mere 3% of Czechs think their health system has too much money. Nearly three-quarters (73%) of Czechs expressing an opinion think that other countries' health systems are better funded, the highest share of any country surveyed, including nearly four out of five (78%) of 15–24-year-olds who have a view. Only 11% think the Czech health system receives more money than its counterparts elsewhere, the lowest proportion in any country polled.

Despite this, fewer people in the Czech Republic (12%) than in any other country want to see more money for healthcare raised from higher personal taxation. As with the other nations surveyed, the favoured source of extra funding is higher costs on business; however, 19% of Czechs, including 28% of 25–34-year-olds, would prefer to see money come from higher personal spending. When asked where the money will in fact come from, however, one half (50%) say that higher personal taxation will be the source.

Concerns about relative underfunding are reflected in perceptions of relative performance. Only 10% of Czechs with an opinion believe that other countries' healthcare systems perform worse than theirs does. By contrast nearly two-thirds (65%) believe other health services perform better. Fully 72% of 15–24-year-olds with a view think this. With 26% thinking Czech standards are comparable to elsewhere, this gives the Czech Republic an 'Inferiority Complex' score of +28%, the highest of any country studied and comfortably above the survey average of –15%. However, Czechs are in line with the sample as a whole when it comes to their willingness to travel abroad for treatment. Nearly two-thirds (63%) would do so, while one third (33%) would not. As with other countries, younger Czechs aged 15–24 (by 83% against 13%) are more willing than older Czechs aged 65 and over (by 38% against 56%) to travel for treatment.

The Czech system performs poorly in terms of meeting individual needs. Fewer than two in five (37%) say it is good in this regard compared with three in five (60%) who say it is only fair or poor. However, on the individual measures of healthcare quality used to determine the 'Delivery Deficit', the Czech

Reforms most likely to increase the quality of care

	Likely	*Not likely*	*Net*
Giving patients more information about their illness	76	21	55
Increasing number of medicines and treatments	67	29	38
Giving patients more control over public spending on health	67	30	37
Making it easier for patients to spend their own money on health	66	30	36
Increasing range of doctors and hospitals	43	53	-10

Republic performs close to or above the average on three of them – waiting times, convenience and doctor choice – but it performs poorly on the use of latest medicines/technology (seventh) and offering patients enough information about their illnesses (last). In terms of priorities, waiting times are the most important healthcare feature of those offered to the sample; 97% think this is quite or very important. This is followed by the provision of information to patients, which 94% rate as important. Unfortunately only 28% of Czechs think their health system is good at providing this, the lowest rating for any country in the survey. On delivering the latest medicines/technology, important to 89% of Czechs, their health system is rated as good by barely one third (34%). Overall the Czech Republic's 'Delivery Deficit' is 54%, marginally worse than the survey average of 51% and fifth out of the eight countries surveyed.

Czechs choose greater patient information as the single reform most likely to increase the quality of healthcare. Three-quarters (76%) believe this will improve things against one fifth (21%) who do not, though people over 65 are more sceptical

Most reliable sources of health information (Credibility Gap)

	Reliable	*Unreliable*	*Net*
Doctors/Nurses	81	14	67
Experience	75	20	55
Industry	55	39	16
Official stats	56	40	16
NGOs	48	37	11
Media	38	58	-20
Politicians	10	87	-77

(63% against 29%). When it comes to increasing the range of doctors and hospitals, the Czech Republic is one of only two countries surveyed (the other being Germany) where those thinking that this is unlikely to improve healthcare outnumber those who believe that it will. Czechs believe to a greater extent than any other nation studied that making it easier for patients to spend their own money will increase standards. Two-thirds believe this (66%) against a third (30%) who don't. Support is particularly pronounced among 25–44-year-olds, three-quarters of whom (75%) think the idea would be likely to lead to better-quality care. There is also stronger support for giving patients more control over public spending on health than in any country surveyed except Italy. Two-thirds again (67%) think this is likely to raise standards against a third (30%) who do not.

Czechs follow the consensus in putting equality of access ahead of quality of personal care as a priority for its health service. Four-fifths (81%) do so against one fifth (18%) who do not. This figure drops slightly to 74% against 23% among

25–44-year-olds. The Czech Republic's 'Solidarity Gap' is 63%, very near to the survey average of 61% and equal sixth with Germany out of the eight countries studied.

Across the countries surveyed, people trust the opinions of doctors and nurses more than any other source of information, and the Czech Republic is no different. It gives health professionals a Credibility Gap of +67%, slightly lower than the survey average of +74%. Czechs give personal experience/the experience of friends and family a credibility rating of +55% (against an average of +61%) and make it their next most trustworthy source. The country is marginally more sceptical about politicians than its neighbours (–77% against an average of –61%) and about the media (–20% against an average of –10%). However, the Czechs regard information from non-government organisations (NGOs) with more suspicion than any other country. Less than half (48%) rate them as a reliable source while nearly two-fifths (37%) say they are unreliable. This is partly fuelled by older Czechs. Nearly a third (31%) of over-65s do not know whether they are reliable or not.

When it comes to taking greater personal responsibility for keeping healthy, 98% of Czechs think they should do this against 2% who don't. Some two-thirds of Czechs (65%) believe that doctors should play the main role in helping them, the highest proportion of any country surveyed, while just 12% think the government should play the predominant role, the lowest number outside Germany.

Summary

Czech Republic

Delivery Deficit	54	5th
Solidarity Gap	63	=5th
Inferiority Complex	28	Top
Marks out of 10	5.3	7th
Pessimism Ranking	63	=6th
Reform Index	80	2nd

Czech Republic

Commentary

Dr Pavel Hrobon

The Czech Republic is the only country of all those surveyed which has historic experience of a communist-type national health service. Perhaps surprisingly, the results of the poll, which was conducted a few months before the country's official entry into the EU, do not show substantial differences on most topics from the average of surveyed countries. There are, however, several exceptions.

Czechs value their system highly on several performance criteria, namely waiting times, convenience and choice. Overall, the Czech system scores just slightly below average on the 'Delivery Gap' (performance against aspiration). Czechs are also the second-most optimistic nation regarding their system's sustainability. Despite this, they are clearly persuaded that the situation in other European countries must be better. They believe that their system is underfunded and does not provide enough access to modern technology. These beliefs do not fully correspond with reality and may be attributed to two underlying factors.

The first factor is a slowly eroding but still lasting admiration of the EU countries. In other words, an 'Inferiority Complex', the name given by Populus to the comparison of a national health system with other European countries, is to be taken literally in the Czech case.

The second factor worth closer examination is the relationship Czechs enjoy with their doctors. Any observer of the Czech health system would soon discover a close correlation between public perception of the state of the health service and physician satisfaction. Frequent provider complaints about insufficient funding and the widely discussed (albeit not especially threatening) financial situation of some hospitals and health insurers are the likely drivers behind the public belief in the lack of funding and the need for reform.

Another important issue is the level of trust citizens have in physicians and in their own abilities to take care of their health. The Czechs lead the poll in believing that physicians have the greatest role in helping people to keep themselves healthy. On the other hand, they are very critical of the amount of information they receive from their physicians – Czech doctors score last of all countries surveyed – and trust this information less than citizens in most other surveyed countries. Developments in the physician–patient relationship are therefore likely to remain one of the key drivers of further changes in people's perception of health system performance.

To put these findings into context it is worth considering recent developments in the Czech healthcare system. The Czech Republic decided to reinstall a system of statutory health insurance after the fall of communism in 1989. This choice was influenced by its historical experience before 1948 and by

the example of neighbouring German-speaking countries. It also represented an understandable reaction to the rationing and shortages of the previous, communist-run national health system. However, design of the new system has been burdened by contradictions. The system allowed for the existence of competing not-for-profit health insurers but did not create a sufficient legal and regulatory environment for beneficial payer competition.

The aims of the new system included continued guaranteed access to a broad range of health services for the whole population, financing independent from the state budget, choice for both citizens and providers and improved access to modern technology. Most of the stated goals have been achieved thanks to a substantial increase in funds dedicated to healthcare in the first half of the 1990s. However, effectiveness in the spending of these funds was in many cases questionable. The extensive growth of the early 1990s has been curtailed by financial problems, which appeared a few years after the introduction of the new system.

The situation has been solved through administrative regulation of costs. The next logical step should have been the improvement of system efficiency. Such an effort, however, never really took off. Since 1998 the system has been kept in a status quo characterised by periodic shortages of funds, repeatedly resolved through one-off subsidies. Answers to key issues such as selective contracting of providers by payers, systematic evaluation of quality and patient engagement in decision-making have been put on hold.

The system still provides many short-term advantages to patients. Co-payments are the lowest among OECD countries,

patients have free choice of provider and many Czech hospitals are, despite regional differences, well equipped with modern technology (for example, infant mortality and rates of coronary artery surgery are more than comparable with the European average).

On the other hand, there is a growing disquiet concerning waiting lists and the sub-optimal quality of some providers, and, moreover, severe discontent with the traditional paternalistic approach to patient needs which is ubiquitous among most providers as well as characteristic of the state as a whole.

Many no longer view healthcare as an entitlement but as a service that should be provided according to individual patient needs and preferences. A significant gap is emerging between the standards required by different generations. While the system performs well under the 'old' standards, some of its characteristics are becoming increasingly incompatible with the expectations of the middle and younger age groups.

This process is well reflected in the poll results. The Czech system scores poorly on meeting individual patient needs. Some 66% of Czechs, more than any other surveyed nation, are persuaded that making it easier for patients to spend their own money on health will improve quality of services. They are also strong believers in the beneficial effects of giving patients more control over public spending on health, providing them with more information about their illnesses and increasing the number of medicines and treatments available. On the other hand, they are (with the exception of Germany) the only surveyed nation sceptical about increasing the range of doctors and hospitals.

These facts represent good news for would-be reformers of

the Czech health system. They can also take heart from the high 'Reform Index' score of the poll – the Czechs are second only to Germany in perceiving a need for health reform. They will, however, have to take care to explain to their voters how they will increase the efficiency of the system without curbing the social solidarity that is valued by the Czechs no less than in any other surveyed nation. And they will certainly need to win at least partial 'approval' of health professionals, as well as to deliver some pretty tangible results of the reform efforts early on. Otherwise it will be very hard to overcome the suspicion the Czechs have of media and politicians. Their relative distrust of non-governmental organisations (NGOs) is easily explained by the current, relatively limited presence of NGOs in the Czech health system.

Despite numerous opportunities for efficiency increases, any health reform will have to target the growing disparity between demand for health services and available public finances. The Czechs seem to be more ready than most other nations (albeit not happy about it) to cover more costs from their own income. According to the poll results, most of them would actually prefer businesses to cover more healthcare costs, but they do not regard this as a realistic approach. In any case, they oppose higher taxes but are afraid of being forced to pay them.

What is the actual situation with regard to proposals for change in a nation seemingly so ready for a healthcare system reform? While the governmental recipe concentrates on short-term fixes and is still being debated within the ruling coalition, the opposition recently came out with a bold proposal for substantial changes in the current healthcare system. They suggest an institutional reform based on cost competition

between payers, who will purchase care from providers based on its quality and cost.

Such pressure will lead to the restructuring of provider services, enable the growth of effective providers and force the ineffective and inflexible ones out of the market. This proposed institutional reform would be accompanied by a reform of financing, which would motivate patients to engage in sensible consumption of care and enable them to choose health services that suit their individual needs. The current massive transfer of funds in favour of the social groups in need would be preserved. The government would collect contributions in the form of a health tax (based on percentage of income) and redistribute it to personal health accounts administered by health insurers. Citizens would have to spend part of the contributions on obligatory insurance to cover 'catastrophic' illnesses. The rest would serve, according to people's choices, to cover direct payments to providers or the purchase of supplementary insurance. Such an arrangement would also open the door to a gradual shift from pay-as-you-go financing to government-assisted personal savings.

Should these plans be implemented, some of the current EU candidate countries might even become front runners in needed health reforms. This idea may sound strange, but a bold healthcare reform is already being implemented in Slovakia, and others may follow. Few experts doubt the need for substantial change in current European healthcare systems. Most candidate countries have implemented similar systems in the last decade. The simple fact of funding shortages is likely to make reform inevitable in candidate countries much earlier than in the current EU member states, which have much deeper pockets to subsidise their current systems.

France

France

Poll and analysis

Context

Most important features of healthcare and health system's ability to deliver them

	Important	*Good*	*Net*
The time between diagnosis and treatment	97	47	50
Having enough information to make an informed choice about your treatment	93	44	49
Being treated using the latest medicines/technology	91	52	39
Being treated at a time and a place to suit you	86	48	38
Being treated by a doctor of your choice	91	74	17
Average delivery deficit			**39**

Which is more important to you about your health system?
(Solidarity Gap)

	Equality of access	*Quality of personal care*	*Net*
Netherlands	84	15	69
Italy	84	15	69
Spain	83	17	66
Sweden	81	17	64
Germany	81	18	63
Czech Republic	81	18	63
Average	**80**	**19**	**61**
France	78	21	57
Britain	69	31	38

How do other European health systems perform compared with your own?
(Inferiority Complex)

	Better	*The same*	*Worse*	*Better minus the same/worse*
Czech Republic	65	26	10	28
Italy	63	26	11	26
Britain	60	29	12	19
Average	**43**	**32**	**25**	**-14**
Spain	42	35	26	-19
Germany	38	27	35	-24
Netherlands	34	41	25	-32
Sweden	24	43	34	-53
France	20	31	48	-59

Health System: marks out of 10

France	6.9
Netherlands	6.7
Spain	6.7
Average	**6.0**
Britain	5.9
Sweden	5.8
Italy	5.8
Czech Republic	5.3
Germany	5.1

Prospects for healthcare in 10 years' time if your system remains unreformed
(Pessimism Ranking)

	Improve	*Stay the same*	*Get worse*	*Stay the same/get worse minus improve*
Germany	4	12	80	88
Sweden	11	18	68	75
Netherlands	14	20	64	70
Average	**14**	**21**	**60**	**67**
Spain	14	22	58	66
Britain	17	22	60	65
France	17	21	59	63
Czech Republic	16	25	54	63
Italy	21	31	40	50

Does your health system need reforming? (Reform Index)

	Yes (urgently)	*Yes*	*No*	*Yes (urgently)/yes minus no*
Germany	76	14	7	83
Czech Republic	64	22	6	80
Britain	63	24	10	77
France	65	20	11	74
Italy	60	24	10	74
Average	**61**	**23**	**11**	**73**
Sweden	58	24	11	71
Spain	46	35	14	67
Netherlands	54	24	15	63

Analysis

The French give their system 6.9 out of 10, the highest mark in the poll. In terms of the general score for delivery against aspiration, France ranks second only to Germany. More people in France believe their system is good at meeting individual needs than in any other country; more think that their system has enough or too much money and fewer feel that other healthcare systems are better funded. The French have an unsurpassed confidence in the performance of their healthcare system relative to other countries and, alone in the survey, only a minority would travel abroad for treatment. However, France's appetite for reform is in line with the survey average and a clear majority believe that French healthcare will deteriorate over the next ten years in the absence of reform.

Nearly three in five French (59%) believe their healthcare

will get worse over the next decade without reform. Nearly three-quarters (71%) of those aged 45–64 believe this, but only 50% of over-65s and just 43% of 15–24-year-olds do so. Around one in five French people (21%) think standards will remain the same and just over one in six (17%) believe things will improve in the absence of reform. France's 'Pessimism Ranking' is therefore 63%, above only Italy's 50% and below the survey average of 67%.

Just under two-thirds of French people (65%) believe reform is urgent, including 69% of those aged over 45. A further fifth (20%) think reform is desirable; 27% of 15–24-year-olds and 26% of those earning over €60,000 believe this. Only one in ten French people (11%) regard reform as unnecessary. This gives France a 'Reform Index' score of 74%, in line with the survey average of 73% and behind Germany, the Czech Republic and Britain in the survey.

Fewer than two in five French people (37%) feel that their health system is underfunded, the lowest of any country surveyed. A similar proportion (37%) think it is adequately funded and one in six (16%) believe it is over-funded. This makes France the only country in the survey where the numbers who think their healthcare is adequately or overly funded outnumber those who think it is underfunded in absolute terms. Relative to other countries, nearly half the French (48%) who expressed a view think their country spends more money on health, though only just over a quarter (26%) of 15–24-year-olds believe this. Overall, just one in five (19%) expressing an opinion believe other European countries spend more on healthcare – again the lowest figure in the survey.

In common with other countries, France would like to see

extra money for health coming from higher costs on business. Two-fifths (40%) say this, ranging from more than half (52%) of 25–34-year-olds to just one third (33%) of those earning more than €60,000 a year. When asked where extra money will end up coming from, only a third of French people (32%) believe it will come from higher personal taxation, the lowest proportion in any country, while a quarter believe it will come from higher personal spending (25%) and a quarter from higher costs on business (24%).

When it comes to performance, only one fifth (20%) of French people with an opinion believe other European health systems are better compared with a third (31%) who think they are of a similar standard and nearly half (48%) who think they are worse. This includes nearly three-quarters (73%) of people earning €60,000 or more who think they are worse. This gives France an 'Inferiority Complex' of –59%, the lowest of any country. Perhaps because of this France is the only country where fewer people would be prepared to travel abroad than to stay at home for treatment, by 61% to 37%. Only among 15–24-year-olds does a narrow majority favour foreign treatment (by 53% to 46%). Among the over-65s the majority against travelling rises to 76% against 20%.

France comes in the top three of every measure used to calculate the 'Delivery Deficit'. It is best on waiting times, equal best on the use of the latest technology/medicines and second to Germany on convenience and choice. Waiting times rank as the most important feature of healthcare to French people, higher than giving patients information about their treatment. Nearly one half (47%) rate the French system as 'good' on waiting times – the highest of all the countries surveyed – including 59% of

Reforms most likely to increase the quality of care

	Likely	*Not likely*	*Net*
Giving patients more information about their illness	80	17	63
Increasing range of doctors and hospitals	70	28	42
Giving patients more control over public spending on health	65	32	33
Making it easier for patients to spend their own money on health	40	56	-16
Increasing number of medicines and treatments	45	52	-7

those earning more than €60,000. Over half (52%) also say the French system is good at offering access to the latest medicines/technology, again the highest of any country surveyed. Three-quarters (74%) believe the French system is good at delivering doctor choice; 81% of 55–64-year-olds and 86% of over-65-year-olds say this. As a result, the overall 'Delivery Deficit' for France is 39%, second only to Germany and comfortably better than the survey average of 51%.

On reforms most likely to increase the quality of patient care, France, in line with other countries, believes that giving patients more information about their illnesses would lead to better standards by a margin of 80% to 17%, though those on higher incomes are more sceptical (only 67% earning €60,000 or more think more information will lead to more quality against 33% who don't). Large majorities also think standards will improve by increasing the range of doctors and hospitals (70% against 28%) and giving patients more control over public spending on health (65% against 32%). However, no country thinks that making it easier for patients to spend their own

Most reliable sources of health information (Credibility Gap)

	Reliable	*Unreliable*	*Net*
Doctors/Nurses	92	5	87
Experience	82	14	68
NGOs	79	14	65
Official stats	65	30	35
Industry	63	32	31
Media	59	37	22
Politicians	31	63	-32

money is less likely to improve healthcare than France – 56% think it is unlikely and only 40% think it likely; 25–44-year-olds are the most sceptical in this regard by 38% to 60%, while those earning €30,000 to €60,000 are evenly divided (49% who say it would improve things against 48% who say it would not). The French also tend not to believe that increasing the number of medicines and treatments will drive up standards. Over half (52%) think it unlikely, the highest proportion of any country surveyed.

As with all the other countries surveyed, France places a higher priority on offering equal access to the same standards of healthcare for everyone than on offering individuals access to the best possible care for themselves and their family. Nearly four in five (78%) say equality comes first against 21% who stress quality of personal care. There is, however, a noticeable gender gap, with 73% of males stressing equality versus 81% of females. The overall 'Solidarity Gap' rating for France is 57%, lower than the survey average of 61% and ahead only of Britain.

France is one of the most trusting nations surveyed when it comes to sources of health information. Relatively speaking, it is the most trusting of politicians' statements, of media stories and of doctors' and nurses' opinions. It is also the second-most trusting of information from NGOs and of official health statistics.

In common with every other nation surveyed, the French trust doctors and nurses more than anyone else; they have a Credibility Gap of +87%, the highest score for any data category in any country surveyed. Even politicians do relatively well in France with a Credibility Gap of –32% compared with a survey average of –61%, the best of any country. Official statistics are considered reliable by a margin of 65% to 30% (giving a Credibility Gap of +35%), second only to the Netherlands.

France is unique in this survey for the fact that more people find media stories about health reliable than unreliable, by a margin of 59% to 37% (Credibility Gap +22%). The media enjoy this positive rating across all age groups and income levels. Non-governmental organisations also enjoy broad support in France with a Credibility Gap of +65%, second only to their score in the Netherlands, while the French give the healthcare industry a mark of +31% compared with a survey average of +16%.

More than nine out of ten French people (93%) agree with the proposition that they should take more responsibility for keeping themselves healthy, compared with only 6% who disagree. The margin of 87% is almost identical to the survey average of 89%. However, France is towards the bottom of the survey in believing that the government has a primary role in helping its citizens stay fit. Only 18% believe this while three in five (60%) think that doctors have the greatest role to play.

Summary

France

Delivery Deficit	39	2nd
Solidarity Gap	57	7th
Inferiority Complex	-59	Bottom
Marks out of 10	6.9	Top
Pessimism Ranking	63	=6th
Reform Index	74	=4th

France

Commentary

Cécile Philippe

Major protests during the spring of 2003 prompted the French government to delay its proposals for healthcare reform. Reforms are now expected to take place in the autumn of 2004. In the meantime, the government has set up the Haut Conseil (High Council) for the future of social insurance. Headed by Bernard Fragonard (president of the Cour des Comptes, the French state auditors), the council, colloquially known as the Fragonard Commission, has gathered 57 stakeholders in 17 categories, making a total, along with 23 politicians, of 80 attendees. It published its initial findings on 23 January 2004. Noting the financial disaster affecting social security, the commission concluded that the system requires urgent reform through the improvement of the healthcare system, modification of the conditions for reimbursement of the cost of drugs and treatments, and action in terms of state revenue.

So how do the French Populus poll findings square with the proposals for reform, and what messages resonate most strongly for politicians?

The French social security system has been in financial crisis for a long time: the new plan for reform is the seventeenth created since 1977 in order to save the system. Expenditure on healthcare has increased enormously from 3.5% of GDP in 1960 to 8.9% in 2002. Today, the social security debt is equivalent to one month of the French economy's consumption, namely €11 billion, and this is expected to continue to grow rapidly.

Some thirty years after the system was set up in 1945, the 1976 Barre Reform was instigated to stop reimbursement of the cost of what came to be called 'comfort' medicines. Two years later, the Veil reform increased taxes. In the last few decades the same two tactics have been used by politicians to limit the explosion in costs: by increasing either personal or business contributions and/or limitation of reimbursement.

At the same time, the French healthcare system is described by the official report of the High Council as being one of France's biggest collective successes. In supplying people with equal access to healthcare, it has increased social cohesion. The French share this opinion. They give their system the highest mark (6.9) in the poll when asked to rate their health system out of 10. More people in France believe their system is good at meeting individuals' needs than in any other country bar Germany. They have 'an unsurpassed confidence in the performance of their healthcare system relative to other countries'. This is certainly the reason why France gets the lowest score for 'Inferiority Complex' of any country at –59%.

French people seem to be quite happy with a system that is believed to be really good on waiting times, on the use of the latest technology and medicines, on convenience and choice. As a result, the overall 'Delivery Deficit' for France is only 39%

as against a survey average of 51%. Nearly one half (47%) rate the French system as 'good' on waiting times – the highest of all the countries surveyed. Over half (52%) also say the French system is good at offering access to the latest medicines and technologies, again the highest of any country surveyed. Some 74% believe the French system is good at delivering doctor choice. To some extent this contradicts the official report of the Fragonard Commission. Indeed, in order to emphasise the need for reform the report describes patients' complaints about the system, which do not seem to reflect public opinion. It states that 'public opinion will not accept new financial efforts if, at the same time, it remains convinced that the healthcare system, which it criticises for abuses and waste, is not re-examined in depth' (p.11).

The problem with the French social security system seems to be not that it does not provide a good service but rather that it is too expensive and that the state is outpaced by consumer expectations. French people are very attached to their system of 'solidarity', as revealed in the poll findings. As in all the other countries surveyed, French public opinion places a higher priority on offering equal access to the same standards of healthcare for everyone than on offering access to the best possible care for individuals and their families. Some 78% say equality comes first against 21% who stress quality of personal care. This fact was patently absorbed by the Fragonard Commission, even though every year the evidence points to the fact that 5% of the people insured take up 60% of the reimbursements. For an average reimbursement in 2000 of €20,000 per person, this minority costs 30 times more to support than the rest of the population.

France's social security deficit increases at €20,000 every minute. At the same time, French people do not think that their system is inadequately funded. France is the only country in the survey where the numbers who think their healthcare is adequately or over-funded outnumber those who think it is underfunded in absolute terms. Relative to other countries, nearly half of the French people surveyed who expressed a view (48%) thought that their country spent more money on health than other European countries. This may be why the High Council feels that it would be impossible to continue to finance the system simply by increasing personal taxation and taxes on business.

It is difficult to perpetuate a system that reimburses patient care costs completely (or almost completely), especially because the need for care has increased and continues to increase rapidly. People want more but at the same time they do not want to pay more through the state, which they actually do not believe to be in charge of their health. France comes towards the bottom of the survey in believing the government has a primary role in helping its citizens stay fit. Only 18% believe this, while 60% believe that doctors have the greatest role to play. This is confirmed by the fact that – in common with all the other nations – the French trust doctors and nurses most when it comes to health decisions. Relatively speaking, it is the most trusting of doctors' and nurses' opinions among the surveyed nations.

French lack of willingness to pay more through the state is made evident in the poll. When asked where extra money will end up coming from, only 32% of French people believe it will come from higher personal taxation – the lowest proportion of

any country surveyed. Others believe that it will come either from higher personal spending (25%) or from higher costs on business (24%). This fits with the far from clear-cut reform proposed by the High Council.

France's appetite for reform as revealed in the poll is in line with the survey average. A clear majority believe that French healthcare will deteriorate over the next ten years in the absence of reform. Yet France's 'Pessimism Ranking' is below the survey average: 63% as against 67%. Just 65% of French people believe reform is urgent and a further fifth think reform is desirable. Despite this, they do not seem to know what the reform should consist of and they do not want to give up any aspect of the current system – suggesting that they are not quite ready for major reform. They are left with only one solution, namely decreasing the rate of reimbursement of personal care (debt is not an option any more). This method can only be instituted gradually because, as mentioned above, people are keen on the principle of free access to healthcare, and no country thinks that making it easier for patients to spend their own money is less likely to improve healthcare than France.

The French healthcare system is more efficient than one might think at first glance. Doctors and nurses provide good service and access to hospitals and to new technology is high. The main reason is that even though the system is highly regulated it has never been nationalised. The state is considered an intermediary for the purposes of payment, but in no case should it take over the role of doctors and nurses. Since current state revenues and people's healthcare consumption no longer coincide, and since the state must avoid getting into more debt, it has no choice other than to disengage itself from

its role in the reimbursement of personal care. Such disengagement, according to the poll, can only be progressive, as people have a long way to go in understanding that state intervention does not necessarily make the system more just or efficient. It is happening, however, because at the same time people do not want to cut their personal healthcare consumption and because the French are the most trusting of politicians' statements (among them the need for reform). Politicians do relatively well with a credibility gap of –32% compared with a survey average of –61%, emerging as the best of any country in the poll.

To conclude, we should consider one area of reform that ought to develop extremely well because it fits perfectly with people's expectations. It concerns the information given to the consumer.

The High Council argues that it is perfectly reasonable for people to want clear and detailed information. It notes that it is legitimate to prohibit commercial competition between general practitioners. It is also true that it is difficult to translate into indicators the complexity of the 'art of curing'. But as the Fragonard report argues, the consequence is that in France, unlike in other countries, figures concerning both healthcare performance and healthcare quality remain very hard to come by.

Change is necessary because avoiding competition does not justify not transmitting clear and detailed information to the insured patient. The report recognises that this is a fundamental aspiration for people who want to make a free and informed choice, and it calls for reform. Until now information has been transmitted by imperfect means and has been shared unequally.

This tallies with the information revealed in the poll. Even though those on higher incomes are more sceptical, as far as the reform most likely to increase the quality of patient care is concerned, France, in line with other countries, believes that giving patients more information about their illnesses would lead to better standards (80% as against 17% who do not believe so). This message should certainly resonate strongly with politicians. Indeed, the Fragonard Commission came to the conclusion that it is of great importance to find ways of allowing better information to reach patients.

At the time of writing, however, the French government has just suffered a serious political setback in the country's regional elections, in which the mainstream right-wing parties (UMP/UDF) lost control of all but one (Alsace) of the mainland districts. The results were widely interpreted as showing a loss of confidence in President Chirac and his premier, Jean-Pierre Raffarin, who have been promoting a degree of market-oriented economic reform under the so-called Agenda 2006. A troublesome European election in June is likely only to make matters worse for the centre-right. Either way, after the public's rejection of Agenda 2006, parties across the political spectrum are likely to run scared from tackling healthcare, suggesting that radical reform of the French health system is improbable over the next few years, whatever the views of French patients.

Germany

Germany

Poll and analysis

Context

Most important features of healthcare and health system's ability to deliver them

	Important	*Good*	*Net*
The time between diagnosis and treatment	97	42	55
Having enough information to make an informed choice about your treatment	98	57	41
Being treated using the latest medicines/technology	86	47	39
Being treated at a time and a place to suit you	92	58	34
Being treated by a doctor of your choice	90	74	16
Average delivery deficit			**37**

Which is more important to you about your health system?
(Solidarity Gap)

	Equality of access	*Quality of personal care*	*Net*
Netherlands	84	15	69
Italy	84	15	69
Spain	83	17	66
Sweden	81	17	64
Germany	81	18	63
Czech Republic	81	18	63
Average	**80**	**19**	**61**
France	78	21	57
Britain	69	31	38

How do other European health systems perform compared with your own?
(Inferiority Complex)

	Better	*The same*	*Worse*	*Better minus the same/worse*
Czech Republic	65	26	10	28
Italy	63	26	11	26
Britain	60	29	12	19
Average	**43**	**32**	**25**	**-14**
Spain	42	35	26	-19
Germany	38	27	35	-24
Netherlands	34	41	25	-32
Sweden	24	43	34	-53
France	20	31	48	-59

Health System: marks out of 10

France	6.9
Netherlands	6.7
Spain	6.7
Average	**6.0**
Britain	5.9
Sweden	5.8
Italy	5.8
Czech Republic	5.3
Germany	5.1

Prospects for healthcare in 10 years' time if your system remains unreformed
(Pessimism Ranking)

	Improve	*Stay the same*	*Get worse*	*Stay the same/get worse minus improve*
Germany	4	12	80	88
Sweden	11	18	68	75
Netherlands	14	20	64	70
Average	**14**	**21**	**60**	**67**
Spain	14	22	58	66
Britain	17	22	60	65
France	17	21	59	63
Czech Republic	16	25	54	63
Italy	21	31	40	50

Does your health system need reforming? (Reform Index)

	Yes (urgently)	*Yes*	*No*	*Yes (urgently)/yes minus no*
Germany	76	14	7	83
Czech Republic	64	22	6	80
Britain	63	24	10	77
France	65	20	11	74
Italy	60	24	10	74
Average	**61**	**23**	**11**	**73**
Sweden	58	24	11	71
Spain	46	35	14	67
Netherlands	54	24	15	63

Analysis

The German health system scores more highly in terms of delivering what people say is important to them than any other system covered by this study. However, there is a clear consensus among Germans that the system they have is unsustainable in the long term. No other country is more pessimistic about the prospects for healthcare standards in the absence of reform, and nowhere else is reform seen to be as urgent as it is in Germany. This is reflected in the fact that Germans give their health system only 5.1 out of 10, the lowest mark for performance in any country surveyed.

Fully 92% of Germans think that healthcare standards will stand still or get worse over the next ten years without reform, with only 4% saying they will improve. This gives Germany a 'Pessimism Ranking' of 88%, comfortably at the top of that

particular league table.

Three-quarters of Germans (76%) now regard healthcare reform as urgent, and a further 14% think it is desirable. Only 7% believe the status quo is an option, giving Germany a 'Reform Index' score of 83%, again top among the countries surveyed. The sense of urgency surrounding change is greatest among those generations – 35–44-year-olds (88%) and 45–54-year-olds (83%) – that are likely to become the most intensive and extensive consumers of healthcare in the next decades. The old (67% of 65s and over) and the very young (57% of 15–24-year-olds) have the least sense of urgency.

When asked what direction these reforms should take Germans are evenly split (47% to 49%) on whether an increase in private spending on healthcare is likely or unlikely to increase the quality of care. This makes them mildly more sceptical about personalising consumption than all countries put together.

More than three in five Germans (62%) think their health system is underfunded even though one half of those expressing a view (51%) believe it to be funded as generously as or more generously than other countries' health systems. Slightly fewer than two Germans in five with an opinion (38%) believe healthcare is better in other European countries while 72% think it is of the same standard or worse. This gives Germany a negative 'Inferiority Complex' rating of –24%, below the sample average of –14%.

Perhaps as a result of this, almost as many Germans (48%) would refuse to go abroad for treatment if their health system paid for it as would be prepared to travel (50%). German women predominantly dislike the idea by 55% to 43%, whereas German

men support it by 57% to 40%. Among the over-65s, only 25% would go abroad versus 72% who would stay at home; 15–24-year-olds are, though, more intrepid and 65% would seek treatment abroad as against 34% who would not.

A clear plurality (46%) would like to see more health spending funded by higher costs on business; the young (60% of 15–24-year-olds) and the low-paid (58% of those earning €7,500–15,000 a year) are the most keen. However, 46% of Germans also expect any spending increases to come from higher personal taxation.

Providing everyone with equal access to the same standards of care is a greater priority in their healthcare system for 81% of Germans compared with 18% who say that ensuring that they and their family have access to the best possible care is more important. This 'Solidarity Gap' of 63% is in line with the average (61%) of the sample as a whole. Equality is marginally more important to German women (84%) than to German men (77%).

While the survey as a whole believes quality of care would increase with a wider range of available doctors and hospitals (by 61% to 36%) and with more medicines and treatments (by 59% to 37%), Germans do not. Some 50% think a greater choice of treatments is unlikely to raise standards as against 45% who think that it would, and 54% believe more doctors and hospitals would make no difference versus 42% who do. Germany is also marginally less enthusiastic about the beneficial effects of giving patients more information about their illnesses: 70% see it as leading to an improvement in healthcare versus 77% among their European counterparts.

All the countries surveyed have 'Delivery Deficits', defined

Reforms most likely to increase the quality of care

	Likely	*Not likely*	*Net*
Giving patients more information about their illness	70	26	44
Giving patients more control over public spending on health	58	37	21
Making it easier for patients to spend their own money on health	47	49	-2
Increasing number of medicines and treatments	45	50	-5
Increasing range of doctors and hospitals	42	54	-12

as the difference between those features of healthcare that are important to the public and the ability of health systems to deliver these same features to a good standard. On four of the five measures chosen, Germany's Delivery Deficit is the least of all the countries surveyed. On the fifth, waiting times, it is second – narrowly behind France. With an average Delivery Deficit of 37%, Germany heads the overall rankings.

When it comes to individual measures of healthcare quality, Germans place a slightly higher importance than respondents from across Europe on the ability to see a doctor of their choice (90% against 84%). Nearly half as many again believe the German system does a good job of delivering a choice of doctor as the survey average (74% versus 53%) and more than half as many again (42% compared with 26%) believe it performs well in terms of the time taken between diagnosis and treatment. This is particularly true of older Germans (52% of 55s and over) and those who have used the German health system recently.

Overall the gap between aspirations and reality on waiting times remains large in absolute terms (55% in Germany versus

Most reliable sources of health information (Credibility Gap)

	Reliable	*Unreliable*	*Net*
Doctors/Nurses	81	14	67
Experience	70	23	47
NGOs	58	17	41
Industry	47	48	-1
Media	45	52	-7
Official stats	41	52	-11
Politicians	6	91	-85

a European average of 71%).

As with every other country, Germany values the opinions of doctors and nurses above all other sources of health information. It is, though, in relative terms more sceptical than average about the reliability of personal experience in judging the quality of healthcare. Some 70% of Germans say that personal experience or the experience of friends and family is a reliable guide to performance against 23% who say it is unreliable. This 'Credibility Gap' of 47% is exceeded only by Italy and is most marked among older Germans and those with an annual income in excess of €60,000.

In a world that is profoundly suspicious of politicians' statements – which have a Credibility Gap of –61% across all surveyed countries – Germans lead the way in their cynicism. Just 6% think politicians' statements about health are reliable, while 91% believe them to be unreliable. The resulting Credibility Gap figure of –85% is the lowest rating for any data category in any country in the survey.

This sentiment is carried over into the German public's view

of official health statistics: 41% think them reliable while 52% see them as unreliable, a Credibility Gap of –11% compared with the survey average of +15%.

Finally, in common with every other country polled, an overwhelming majority of Germans (98% to 1%) believe people should take more responsibility for keeping themselves healthy. However, when asked who has the greatest role in helping them, only 11% say the government compared to an average of 27%. More of the German population (14%) are looking to non-governmental groups such as patients' advocates for assistance, the highest ranking for NGOs in the survey. But 58% still think that doctors should play the primary role.

Summary

Germany

Delivery Deficit	37	Top
Solidarity Gap	63	=5th
Inferiority Complex	-24	5th
Marks out of 10	5.1	Bottom
Pessimism Ranking	88	Top
Reform Index	83	Top

Germany

Commentary

Karen Horn and Andreas Mihm

At first sight, the results of the Stockholm Network/Populus poll on the way people view changes in the German health system may seem surprising. In particular, the strong agreement on the alleged need for reform (82%) and the extremely low trust in what politicians say (91%) require some explanation. After all, who is supposed to carry out the required reforms, if not the very politicians being characterised as untrustworthy?

In general, the poll supports the data from earlier opinion polls conducted in Germany.[1] A perception of the need for reform, high confidence in the medical profession and a lack of trust in politicians are ever-present right across Germany, from Bavaria to the Danish border. However, the negative scores have never previously been as pronounced as in the Stockholm Network/Populus poll.[2] The reason can be found in the way things have evolved politically in Germany over the past year.

Early in 2004, Germany underwent another round of health reforms. Chancellor Gerhard Schroeder has placed an especially high value on this: 'the reform of public health insurance is the most important and most urgent part of political renewal within the country. For it is only through reform that we can ensure the high level of medical care that we have now and into the future.'[3]

This reform is different from those carried out since the 1970s in so far as the financial scope is much wider and the commitment required from all political agents is also much higher. The reform was decided upon by the government together with Germany's main opposition party, the Christian Democrats (CDU). Its goal is to stabilise the financial basis of public health insurance in the short run and to lower the contributions paid by employers and employees (50% each).[4] Overall, the goal is to reduce the amount spent by the public health insurance system to around €135 billion (which means reducing it by €10 billion). Other spending cuts are planned to follow.

How is this going to be done? Primarily, it will be achieved by shifting costs to patients. Since the beginning of the year, patients have been required to pay an admission fee of €10 every three months to see a doctor or to go to hospital. They also have to pay a franchise contribution for medication on prescription and for other medical services (such as hospital care or physiotherapy). Entire groups of services that were previously covered by public insurance have now been cancelled entirely. For example, public insurance no longer covers part of the cost of a funeral, and the costs of *in vitro* insemination or taking a taxi to the doctor's surgery (for example, to undergo dialysis) are covered only in special circumstances.

This has led to an important public debate. For Germany has also seen other cutbacks in the social network lately. This may explain why public opinion is as negative as the Stockholm Network/Populus poll suggests. Its results may therefore exaggerate the degree of anger, dissatisfaction and mistrust within the German population as far as the health system alone is concerned. What is clear is that there is a great deal of overall pessimism about public services.

In order to evaluate the healthcare reform that has taken place in Germany, as well as the further need for reforms, it is necessary to take a closer look at the structure of the German healthcare system and its sources of finance.

The system is organised as follows. Employees earning up to €3862.5 per month have to seek mandatory insurance with one of the existing 300 health insurance companies. Unemployed spouses and children are covered at no additional cost. An employee whose salary rises above the ceiling may become a voluntary member of the public insurance system or contract with one of the 50 existing private insurance companies. It is important to note, however, that it is currently impossible to change tack: once you are covered by a private company, you will no longer have access to the public system.

Self-employed people and civil servants may seek private insurance. While contributions in the public system are calculated on a pay-as-you-go basis, premiums in the private insurance system reflect the statistical risk accorded to a given age group and take into account existing (and known) illnesses. Children and spouses have to pay individual premiums. Around 8 million people in Germany have opted for entirely private health risk cover. The remaining 72 million Germans (90%) are

insured through the public system. Only the public part of the system is affected by the recent reforms.

Compared to this 'market share', the amounts spent by the public insurance companies are relatively modest, at €145 billion out of €230 billion in total. The difference shows that people with private insurance tend to contribute more to the system – because physicians and hospitals may charge higher amounts. On the other hand, it also reflects the fact that people with public insurance need to contribute through additional channels, such as through franchise payments or additional insurance contracts. Beyond these facts, it would be wrong to focus on sheer cost-cutting strategies: the system gives jobs to some 4.1 million people, accounts for one tenth of GDP and represents a growing part of the economy. Sheer cost cutting would not only damage medical care as such, but also limit economic growth.

The need for profound reform of German healthcare is expressly accepted not only by the elites but also by a majority of the population. The reason for this is partly historical. The system forms part of Germany's cultural heritage, dating back to proposals made by Chancellor Bismarck at the end of the nineteenth century, as well as to decrees made by Chancellor Brüning in 1932. Brüning decided that fees payable to practitioners had to be negotiated globally between insurance companies and the medical profession. Thereby, he created a stable cartel between the suppliers and the clients of health services that is still in place. Today, insurance companies continue to pay a global honorarium to the doctors' associations, calculated according to the number of patients insured rather than the health status of the latter. If the number of

visits to the doctor increases, or if morbidity rises within the population, the price for the services provided by the medical profession will drop. And since employers deduct employees' contribution to public insurance from their gross salary and transfer it to the insurance companies' accounts before it shows up on their pay cheque, the patient frequently has the illusion that medical treatment comes free of charge.

This cartel functioned perfectly for as long as the booming economy in post-war Germany made it possible to pour more and more money into healthcare. The rising incomes of most employees allowed contributions to grow, even though percentage rates remained stable. The insurance companies' incomes grew, and so did scope for redistribution in favour of the medical profession. The economy slowed down considerably in the 1990s, however, and unemployment grew. This, together with stagnating incomes from existing jobs, had a seriously adverse effect on the insurance companies' revenues. The scope of healthcare services, however, was not reduced, but rather was extended. Inexorably, higher contributions were the consequence. Contributions reached their peak at the end of 2003, with an average rate of 14.4% of gross income. In spite of these relatively high contributions, the public insurance system finished 2003 with a deficit of approximately €3 billion, for the second year in succession.

Contributions are formally split equally between employer and employee. A strong faction of German Social Democrats, as well as the trade unions, ensure that this policy doesn't change. As a matter of fact, however, these contributions to health insurance are, of course, part and parcel of labour costs (as are contributions to pensions and the long-term care insurance

system). And higher labour costs result in additional lay-offs instead of the job creation that the government is hoping for. For this reason, the current government is essentially aiming to reduce contributions. Its absolute priority is not to add any more jobless people to the 4.6 million already registered.

As well as cost cutting, the government is also attempting to reform the fundamental structures of German healthcare. The relationships between the different agents (patients, insurance companies, doctors, hospitals) are supposed to become more transparent, thanks to more competition. The ultimate goal is higher efficiency and better-quality health services. This is absolutely necessary since, according to the OECD as well as to the Scientific Council of the German government,[5] the quality of healthcare is not all that good in Germany. Even though Germans spend only a little less money on healthcare than the Americans and the Swiss, who lead the rankings, the results produced by this spending seem to correspond at best to the European average. As our poll findings show, the German population shares this feeling. For this reason, most political parties claim that, for the major problem within the system to be solved, the strong cartels that exist between doctors, hospitals and insurance companies need to be broken up. These groups, however, defend themselves as best they can, trying to protect their spheres of power and influence. Nevertheless, almost everybody is aware that further reforms of the system are necessary.

As we can see, the short- and medium-term repercussions on growth and employment are not especially significant. Indeed, they are small compared to the challenges that the German social security system will be confronted with in the long run.

From 2010 onward, the gap between expenses and revenues will grow faster, owing to the higher costs of healthcare stimulated mainly by an ageing population.

We are fortunate in one sense that people are living longer, but this increased lifespan also means that old people suffer from more and more diseases. To make matters worse, while there are more and more retirees, the number of actively employed people is also decreasing. The proportion of 65-year-olds in Germany will rise from 17.5% (2004) to 23% over the next 20 years.

By the year 2050, one German in three will be older than 65.[6] The famous phrase coined in the 1950s by Chancellor Konrad Adenauer, in which he said that 'people will always have children', has proved to be fatally flawed. Meanwhile, Germans have opted out of what has been called the 'contract between generations'. They have fewer children than needed to maintain the population. And since the financial underpinning of social security depends on the number of active people, the entire system as it is constituted at present – whereby the younger generation's taxes are used to take care of the older generation – is being called into question.

The challenge for the political and social elites is to prepare the system for future changes and to transform it in such a way as to make it sustainable. The first step is public debate. Fortunately, general awareness of the problem has increased over the past few years, as the poll shows. Some 80% of the population believe that the system will become worse if nothing happens during the next ten years. Revealingly, people between the ages of 33 and 54 are the most concerned: nowadays they have to pay for themselves *and* for the retirees. And they already know

that once they retire themselves they will receive substantially less support, meaning that they have to put more money aside today.

Germany's recent reforms enforce this trend. People are adapting to the fact that they will have to spend more on healthcare themselves.[7] From next year, public insurance will no longer cover certain kinds of dental care (*Zahnersatz*). Instead, patients will have to pay individual franchises. They will be free to choose between public and private insurance in terms of covering these new financial risks, but they will not be free to decide that they want to carry the (limited) risk themselves. Insurance will be mandatory. This again shows how tremendously scared German politicians are of allowing their electorate to decide what is good for them in terms of providing for the risk of illness. Accordingly, they are extremely sceptical of reform models that emphasise a higher degree of individual responsibility for the patient and as much competition as possible within the system – even if a general minimum of health services is guaranteed by law.

The economics profession, along with insurance companies and the pharmaceuticals industry, has provided many such models over the past few years. These do not seem to have the slightest chance of becoming reality, however – and our poll shows why. Four out of five people still believe that 'equal access' to healthcare is more important than the 'quality of personal care'. This is the mentality underlying the strong social and redistributional features of the German health system – features that it it is expected to retain.

It is also entirely unclear whether the tide of opinion in favour of reform will continue or ebb away. With some help

from the economics profession, the major political blocs have as yet only designed outlines for possible reform. They agree that the relationships between insurance companies, hospitals and doctors need a new basis. More competition is needed between public and private insurance companies. Doctors must be required to update their qualifications. There need to be quality comparisons between doctors and hospitals. Patients should have more rights. There needs to be more transparency in the system, so that quality can improve and prices can become more realistic.

If there is agreement on these fundamental goals, however, there is complete disagreement on the funding of the insurance system.[8] The dispute centres on two models,[9] both of which are far from a model of pure competition – which may, in turn, increase their political chances. But they rely on fundamentally different philosophies.

On the left, the Social Democrats argue in favour of extending the scope of mandatory insurance. Higher incomes are supposed to generate higher contributions to the system. Private insurance is to be limited exclusively to the business of providing additional insurance for health services that are not covered by public insurance. This idea of 'citizens' insurance' appears to be highly popular. Its proponents argue that the system generates some social redistribution within itself, as people with higher incomes would have to pay higher contributions.

On the right of the political spectrum, the Christian Democrats – whose election chances are considered to be very high at the time of writing – suggest a different approach. Their proposal for a 'flat health premium' of about €200 accords with

the economic facts. Children would be covered at no additional cost, as in the existing system. The state would step in for citizens unable to pay the premium. These subsidies would be paid out of general tax revenues, which would therefore ensure a 'social component'. Possibly, it might then be necessary to raise the rate of VAT. At any rate, this solution would have the advantage that employers would no longer carry the entire burden of rising contributions.

Both concepts are controversial within each of the parties – there are many economic and legal questions that have not yet been answered. It is clear, however, that these questions need to be answered by 2006. The new Bundestag (German parliament) which will be elected in 2006, will no longer be able to avoid the question of a fundamental, structural reform of the German healthcare system.

Notes

1 *Branchenbarometer Krankenversicherung, Aktuelle Entscheider – und Bürgerbefragung: Herausforderungen und Reformen*, Allianz Private Krankenversicherung, FAZ Institut für Management, Markt- und Medieninformationen, Frankfurt, 2004.

2 Opinion poll carried out by Emnid for the Verband Forschender Arzneimittelhersteller, presented on 13 March 2003, Berlin.

3 www.bundesregierung.de.

4 *Gesetz zur Modernisierung der gesetzlichen Krankenversicherung (GMG), Bundesgesetzblatt 2003*, no. 55, 19 November 2003.

5 *Finanzierung, Nutzerorientierung und Qualität, Gutachten*

2003, Sachverständigenrat für die Konzertierte Aktion im Gesundheitswesen, Berlin, 2003; *Bedarfsgerechtigkeit und Wirtschaftlichkeit, Über-, Unter- und Fehlversorgung, Gutachten 2000/2001 des Sachverständigenrates für die Konzertierte Aktion im Gesundheitswesen*, Berlin, 2003.

6 *Informationdienst des Instituts der deutschen Wirtschaft Köln* (*iwd*), no. 10, Cologne, 2004.

7 Opinion poll carried out by Emnid on behalf of Ratiopharm, presented on 19 February 2004.

8 *Nachhaltigkeit in der Finanzierung der Sozialen Sicherungssysteme, Bericht der Kommission Rürup-Kommission, Bundesministerium für Gesundheit und Soziale Sicherung*, Berlin, 2003; *Bericht der Kommission Soziale Sicherheit zur Reform der sozialen Sicherungssysteme* [Herzog-Kommission], Berlin, 2003.

9 *Bürgerversicherung und Kopfpauschale, Im Dickicht der Gesundheitsreform, Stiftung Marktwirtschaft, Argumente zu Marktwirtschaft und Politik*, no. 79, November 2003; see note 1.

Italy

Italy

Poll and analysis

Context

Most important features of healthcare and health system's ability to deliver them

	Important	*Good*	*Net*
The time between diagnosis and treatment	95	18	77
Being treated at a time and a place to suit you	92	26	66
Having enough information to make an informed choice about your treatment	94	30	64
Being treated using the latest medicines/technology	91	44	47
Being treated by a doctor of your choice	92	61	31
Average delivery deficit			**57**

Which is more important to you about your health system?
(Solidarity Gap)

	Equality of access	*Quality of personal care*	*Net*
Netherlands	84	15	69
Italy	84	15	69
Spain	83	17	66
Sweden	81	17	64
Germany	81	18	63
Czech Republic	81	18	63
Average	**80**	**19**	**61**
France	78	21	57
Britain	69	31	38

How do other European health systems perform compared with your own?
(Inferiority Complex)

	Better	*The same*	*Worse*	*Better minus the same/worse*
Czech Republic	65	26	10	28
Italy	63	26	11	26
Britain	60	29	12	19
Average	**43**	**32**	**25**	**-14**
Spain	42	35	26	-19
Germany	38	27	35	-24
Netherlands	34	41	25	-32
Sweden	24	43	34	-53
France	20	31	48	-59

Health System: marks out of 10

France	6.9
Netherlands	6.7
Spain	6.7
Average	**6.0**
Britain	5.9
Sweden	5.8
Italy	5.8
Czech Republic	5.3
Germany	5.1

Prospects for healthcare in 10 years' time if your system remains unreformed
(Pessimism Ranking)

	Improve	*Stay the same*	*Get worse*	*Stay the same/get worse minus improve*
Germany	4	12	80	88
Sweden	11	18	68	75
Netherlands	14	20	64	70
Average	**14**	**21**	**60**	**67**
Spain	14	22	58	66
Britain	17	22	60	65
France	17	21	59	63
Czech Republic	16	25	54	63
Italy	21	31	40	50

Does your health system need reforming? (Reform Index)

	Yes (urgently)	*Yes*	*No*	*Yes (urgently)/yes minus no*
Germany	76	14	7	83
Czech Republic	64	22	6	80
Britain	63	24	10	77
France	65	20	11	74
Italy	60	24	10	74
Average	**61**	**23**	**11**	**73**
Sweden	58	24	11	71
Spain	46	35	14	67
Netherlands	54	24	15	63

Analysis

Italy is the least pessimistic country of those surveyed about the prospects for the quality of its healthcare in the absence of reform over the next decade. However, only Britain ranks lower in the overall measure of the difference between what people want from their healthcare system and what they actually get, and Italians give their system the worst ranking in the survey for meeting individual needs. A large majority feel that other countries' health services are better than their own. Italy – along with the Netherlands – places the greatest emphasis on offering everyone equal access to the same standards of healthcare. Italians award their health system 5.8 out of 10.

Two out of five Italians (40%), including more than a half (54%) of those earning more than €60,000 a year, think that

Italian healthcare will deteriorate over the next decade without reform, nearly a third (31%) believe standards will remain the same and one in five (21%) think they will actually improve. Over a quarter (26%) of 15–24-year-olds think this. With a 'Pessimism Ranking' of only 50%, Italy comes bottom of this league table by some distance compared with an average ranking across the countries surveyed of 61%.

Despite this, three-fifths of Italians (60%) say reform is needed urgently, with those nearing retirement (67% of 55–64-year-olds) the most keen. A further quarter (24%) believe reform is desirable and only 10% think it unnecessary. This gives Italy a 'Reform Index' score of 74%, in the middle of this particular ranking, close to the average for those countries surveyed of 73%.

Italians place themselves at or near the bottom in four out of the five measures chosen to define the 'Delivery Deficit'. In terms of the measures themselves, Italy is slightly keener on doctor choice than the average (92% against 85%) but otherwise shares the priorities of other countries with little variation. In terms of performance, however, Italy ranks sixth in waiting times and the use of latest medicines/technology, seventh in allowing patients to make an informed choice and joint last in convenience. Only in choosing a doctor does Italy score better than the survey average, with more than three in five people (61%) saying the Italian health system does a good job. As a result Italy has an overall Delivery Deficit of 57%, better only than Britain among the countries surveyed.

And it comes bottom when people are asked how good their countries' health systems are at meeting individual needs. Barely a quarter (27%) give the Italian health system a

Reforms most likely to increase the quality of care

	Likely	*Not likely*	*Net*
Giving patients more information about their illness	84	14	70
Giving patients more control over public spending on health	69	26	43
Increasing range of doctors and hospitals	64	34	30
Making it easier for patients to spend their own money on health	55	39	16
Increasing number of medicines and treatments	56	40	16

rating of 'good', ranging from nearly two-fifths (39%) of over-65s to less than one fifth (19%) of 35–44-year-olds.

Italy is the keenest of any country in the study to give patients more information about their illnesses – 84% say this would be likely to increase the quality of healthcare, including 91% of poorer Italians earning less than €7,500. Italy also embraces more enthusiastically than any other country the idea of improving healthcare by giving patients more control over public health spending. More than two-thirds (69%) believe this will raise standards; poorer and younger Italians are the most eager while richer Italians are the least keen.

Italians are also more open than many of their European counterparts to the idea of making it easier for patients to spend more of their own money on healthcare. A majority (55%) think this would make a positive difference to quality of care, though here those approaching retirement are markedly less enthusiastic than the generations below them. Two-fifths (40%) would like to see extra money for health come from higher costs on business. This includes nearly two-thirds (64%)

of 15–24-year-olds, but less than a third (30%) of those earning €45,000 or more and only a quarter (25%) of those aged over 65. Asked where the extra money will actually come from, a half of all Italians (49%) believe the answer to be higher personal taxation, in line with the average of the rest of the countries surveyed.

Though nearly one half (48%) believe the Italian health system is underfunded, more than a third (36%) think its funding is adequate, the highest proportion of any country polled outside France. Nonetheless, of those with an opinion, three-fifths (60%) of Italians think that other European countries spend more on their health services and more than this (63%) believe that these nations perform better than Italy. Only one in ten (11%) imagine that healthcare elsewhere is worse. Italy's 'Inferiority Complex' rating is +26%, second only to the Czech Republic among the countries surveyed.

It is unsurprising, then, that two-thirds of Italians (67%) would be prepared to seek treatment abroad if their health system paid for it against just over a quarter (28%) who would not. The willingness to travel for treatment declines steadily with age, from more than four in five (82%) of 15–24-year-olds to less than half (46%) of those over 65.

Equality of access to the same standards of healthcare is a higher priority for more than four in five (84%) of Italians, compared with fewer than one in six (15%) who put securing access to the best possible care for themselves and their family first. This sentiment is shared across generations and income groups in Italy, with very little variation. It gives the country a 'Solidarity Gap' of 69%, joint top with the Netherlands.

Most reliable sources of health information (Credibility Gap)

	Reliable	*Unreliable*	*Net*
Doctors/Nurses	75	21	54
NGOs	68	21	47
Experience	69	28	41
Official stats	43	52	-9
Industry	36	57	-21
Media	32	63	-31
Politicians	9	87	-78

Overall, Italians are among the most sceptical of any country surveyed when it comes to assessing the reliability of sources for health information. They have less regard for the media than any other nation in the poll, with one third (32%) saying they can be relied on against nearly two-thirds (63%) who say they can't – a 'Credibility Gap' rating of –31%. Suspicion is particularly pronounced among Italians earning over €45,000 a year, nearly three-quarters of whom (74%) think the media unreliable.

In common with everywhere else, politicians are distrusted as an information source in Italy (by 87% to 9%), but it is one of only three countries – the others are Germany and Spain – where fewer people believe official statistics to be reliable than not (by 43% to 52%). And that reliability figure is boosted by the fact that 61% of 15–24-year-olds are willing to believe in them.

Even the opinions of doctors and nurses count for less in Italy than elsewhere. While three-quarters (75%) of Italians believe them to be reliable, one in five (21%) do not. The Credibility Gap for doctors and nurses is therefore +54% compared with +74% for the sample as a whole.

Italy is also the only country where people trust information from non-governmental organisations (Credibility Gap +47%) more than they trust their own or their family's personal experience of healthcare (Credibility Gap +41%). As for the healthcare industry, it also suffers at the hands of the Italians. Its average Credibility Gap is +16%, and in no other country is it lower than –2%, but in Italy it is –21%.

As with the rest of the sample, Italians agree that they should take more responsibility for keeping themselves healthy (94% against 4%) and just over a third (36%) believe that government has the greatest role in helping them. However, nearly half (48%) believe doctors should perform this function first and foremost, while only 4% envisage a primary role for other health professionals.

Summary

Italy

Delivery Deficit	57	7th
Solidarity Gap	69	=Top
Inferiority Complex	26	2nd
Marks out of 10	5.8	=5th
Pessimism Ranking	50	Bottom
Reform Index	74	=4th

Italy

Commentary

Alberto Mingardi

Italians are relatively optimistic about the prospects for the quality of healthcare over the next decade compared with the other nations surveyed, even if no reform takes place. But it is also clear from the Stockholm Network/Populus poll that there is an important gap between what Italians want from their healthcare system and what they actually get. Italians feel that their system is profoundly inadequate in terms of meeting individual needs, and they instinctively believe that other countries are in a better situation than they are.

These data seem to be contradictory, but Italians' relative optimism may be explained by our country's proverbial political inactivity. Giuseppe Tomasi di Lampedusa summed it up perfectly in his book *The Leopard*: 'If we want everything to remain as it is, it will be necessary for everything to change.'

These words depict the mind of the Italian politician better than a whole political treatise. They also explain the general attitude of the Italian people. The business of Italy's political class is essentially to remain afloat. This does not mean they are going to accomplish any of the necessary reforms (and, quite rightly, the citizens of the *Belpaese* do not expect them to), just that they are going to keep us as far from sinking as is necessary for them to continue dancing on the ship's bridge.

Italy's health system has undergone some relative changes in the last 20 years. Four reforms have been enacted since 1978, although they have not succeeded substantially in achieving the goal of shifting the system from an integrated, centralised one based on social insurance contributions to a decentralised model. Healthcare services remain largely publicly financed, with some competition being allowed between public and private accredited producers.

Federalism, largely due to the political efforts of the Lega Nord, has been widely debated in Italian politics: but talk is cheap, and the political discussion has not generated any fruitful political reform. Regional autonomy widened a little but the Legge Bassanini of 1997[1] fell very far short of its alleged *raison d'être*: lip-service was paid to the principle of subsidiarity (a cornerstone of Catholic social doctrine), but lower grades of government are not in reality inheriting powers and responsibilities from the central state. Even so, the 20 regional governments are required to guarantee a benefit package to be delivered to the population via locally based health providers, including local health units, public hospital trusts and privately accredited providers.

Today there are 1,874 hospitals in Italy, of which 1,075 are public and 799 private, including those owned by religious orders. There are 373,408 beds available – 278,886 in public hospitals and 94,522 in private ones. This means an average of

259.4 beds per public hospital and 118.3 for a private one. Some 65% of public and private hospitals are situated in the northern and central regions of Italy. Politically, this is a sensitive issue, since consumer satisfaction tends to be lower in the south of Italy and because the 1997 reforms introduced regional taxes on companies and public sector employees. In 2000, a further fiscal reform created an equalisation mechanism in an attempt to level out the extreme differences in regional tax income and geographical differences in per capita spending. Since 200l, a fixed proportion of VAT revenue has been ring-fenced to create a National Solidarity Fund (*Fondo Perequativo Nazionale*) to redistribute funds across the regions. Regional redistribution (north to south) is a standard feature of Italian *politique politicienne*.

Regional disparities are due not just to funding or a difference in demographic density between north and south but also to the fact that many of those hospitals now owned and managed by the state were established by private charitable institutions. For a long time, Italy has been a mosaic of voluntary, private facilities taking care of the sick and those in need. Long before the welfare state, private voluntary organisations took the lead in providing income and welfare support for the poor.

If you travel in the Lombardy region, you will find that some hospitals still bear the name of the noble family that first established them. Before legislators started to believe that implementing solidarity was one of their missions, rich families believed it their duty to give something back to the community. It was the expression of a profoundly felt urge to take care of fellow human beings less fortunate than oneself.

Religion also played a big role in Italian notions of charity

or welfare. But an even bigger role was played by the interaction of these two factors: social pressure was put on the rich to donate part of their money to the poor. Whether by virtue of the pressure of religious authority, the need to be approved by their peers or even authentic altruism, the rich were historically the big players in providing free or cheap healthcare to the poor.

Until unification, Italy was a land of institutional pluralism with a great tradition of spontaneous charities and of religious and secular institutions providing essential services to the poor. Unification, however, started a process of centralisation and harmonisation that reached its climax in the republican constitution signed in 1948.

The constitution, which resulted from a political bargain, clearly set the framework for a mixed economy where private property is protected in so far as it maintains 'a social function' and the 'right to strike' is constitutionally guaranteed.

It is perhaps no surprise that in such a document health is defined as a 'fundamental right' (Article 32): this basic misconception is at the very roots of most of Italy's and Europe's current healthcare troubles.

Indeed, the 'right to health' can be better understood as an entitlement. It means that some citizens will receive treatment at someone else's expense. This does not apply merely to the poor: having health as a fundamental right entitles anyone to 'free' care. Yet there is no such thing as a free lunch. Free care is simply care paid for by taxpayers.

Most of Italy's healthcare budget is still derived from public sources. In 2000, private spending made up 26.3% of the total budget, according to the World Health Organization. Most of

this comes from out-of-pocket expenditure (91%), with only 9% spent on private health insurance.

The welfare state – as Anthony de Jasay defined it – determines a 'churning society'. One of the problems is that no one knows who is paying for what. Taxpayers' money goes into a melting pot, from which some is taken to pay for someone's children's education, and some for someone's mother's medical treatment. Under this system, price consciousness is rarely a factor, leading to ever-growing demands for more services.

Still, equality of access to the same standards of healthcare is a higher priority for more than four in five (84%) Italians. This contrasts with the fact that 94% of them think they should take more responsibility for keeping themselves healthy.

Italians' concern about equality of access may be understood as proof of the fact that the welfare state does not keep its promises. Italy's best hospitals – with few exceptions – are private. When their own health is at stake, those people who are well insured or wealthy enough to afford it choose to buy a service, rather than having the state guarantee their right to health in a public hospital.

Health should really be considered a good or a service, to be bought privately by different individuals. This is what it is: not a 'right' bestowed upon us but a 'good', something we can buy from the market. Indeed, it is a very material good: the work of a dentist, dietitian or cardiologist; the pills we take to feel better; the time, work and loving patience of nurses.

This philosophical shift is the a priori of any *serious* reform. At the moment, Italy has problems funding hospitals at the regional level. In the past few years, some efforts have been made to partially deregulate the country's public health services

(which currently still depend on the Ministry of Healthcare) and place them under regional governmental control. Yet the amount of money allocated for health has skyrocketed in recent years (in 2000, Italy's National Health Service posted a €3.68 billion deficit), suggesting that regionalisation is no guarantee of a better and more market-oriented service.

Under the proposed federalist reform, the individual regions are supposed to be able to provide their citizens with healthcare services, but they are not equipped with the necessary power to collect taxes. The situation is changing, but unless the regions are given the power to collect taxes directly, instead of begging money from central government, the most probable outcome is ever-growing regional deficits.

This is all complicated by the fact that, owing to its ageing population, Italy's health expenditure is projected to grow considerably in the future. The country has one of the lowest total fertility rates in the world and life expectancy at birth is above the EU average.[2]

So if a true federalist reform is not undertaken by the Italian legislature the regionalisation of healthcare risks becoming not a tool for greater flexibility in providing service but rather a device for geographical redistribution – with regions seeking more and more funds from central government.

Italy has other problems too. One of the most notable is the distribution of medicines: Italian pharmacies are highly regulated and licensed, and yet it is impossible to purchase pills in any other outlet. This has obvious repercussions on prices and on the quality of the health service. Allowing competition in selling medicines is an essential step towards a better situation for the patient.

Although Italy used to be a strong producer in a handful of sectors, notably radiology, cardiology and ultrasound equipment, high taxes and bureaucratic constraints have discouraged growth. Multinationals are increasingly entering the market through the acquisition of small and medium-sized Italian manufacturers. Consequently, over fifty local biomedical companies have disappeared in the last six years. Now only 25% of diagnostic and biomedical products sold in Italy are manufactured locally.

At the same time, with a new system of patents (‘*brevetto dell’inventore*’) that protects the individual researcher at the expense of the research institution within which he works, the government is damaging the pharmaceutical industry, which may find it easier to form partnerships with universities rather than with the single ‘inventor’ of a particular component or solution. This new discipline constitutes a serious disincentive for companies to invest in research partnerships with academia.

On the social level Italy is experiencing two problems. There is a lack of awareness on the part of civil society, which closes its eyes to poverty because people tend to think: ‘Isn’t this the sort of the thing we pay taxes for?’ On the other hand, we also get poor-quality services from the government.

The poll findings, which place Italy second behind only the Czech Republic in terms of its ‘Inferiority Rating’, bear out the evidence of other surveys suggesting low levels of patient satisfaction with the Italian health system. In a European survey conducted in 1992, Italy came second (after Greece) out of the twelve EU member states, with particular dissatisfaction in the southern regions.[3]

More responsibility and better service are what we should be looking for, but this implies seriously reforming the Italian constitution, as well as dismantling people’s prejudices.

Notes

1 Bassanini’s Law, intended to transfer greater powers to the regional health authorities and extend subsidiarity.

2 European Commission, *The health status of the European Union – narrowing the health gap*, 2003.

3 *Health Care Systems in Transition – Italy*, ed. Ana Rico and Teresa Cetani, European Observatory on Health Care Systems, 2001, p. 113.

Netherlands

Netherlands

Poll and analysis

Context

Most important features of healthcare and health system's ability to deliver them

	Important	*Good*	*Net*
The time between diagnosis and treatment	96	24	72
Having enough information to make an informed choice about your treatment	98	48	50
Being treated using the latest medicines/technology	85	39	46
Being treated at a time and a place to suit you	81	36	45
Being treated by a doctor of your choice	81	44	37
Average delivery deficit			**50**

Which is more important to you about your health system?
(Solidarity Gap)

	Equality of access	*Quality of personal care*	*Net*
Netherlands	84	15	69
Italy	84	15	69
Spain	83	17	66
Sweden	81	17	64
Germany	81	18	63
Czech Republic	81	18	63
Average	**80**	**19**	**61**
France	78	21	57
Britain	69	31	38

How do other European health systems perform compared with your own?
(Inferiority Complex)

	Better	*The same*	*Worse*	*Better minus the same/worse*
Czech Republic	65	26	10	28
Italy	63	26	11	26
Britain	60	29	12	19
Average	**43**	**32**	**25**	**-14**
Spain	42	35	26	-19
Germany	38	27	35	-24
Netherlands	34	41	25	-32
Sweden	24	43	34	-53
France	20	31	48	-59

Health System: marks out of 10

France	6.9
Netherlands	6.7
Spain	6.7
Average	**6.0**
Britain	5.9
Sweden	5.8
Italy	5.8
Czech Republic	5.3
Germany	5.1

Prospects for healthcare in 10 years' time if your system remains unreformed
(Pessimism Ranking)

	Improve	*Stay the same*	*Get worse*	*Stay the same/get worse minus improve*
Germany	4	12	80	88
Sweden	11	18	68	75
Netherlands	14	20	64	70
Average	**14**	**21**	**60**	**67**
Spain	14	22	58	66
Britain	17	22	60	65
France	17	21	59	63
Czech Republic	16	25	54	63
Italy	21	31	40	50

Does your health system need reforming? (Reform Index)

	Yes (urgently)	*Yes*	*No*	*Yes (urgently)/yes minus no*
Germany	76	14	7	83
Czech Republic	64	22	6	80
Britain	63	24	10	77
France	65	20	11	74
Italy	60	24	10	74
Average	**61**	**23**	**11**	**73**
Sweden	58	24	11	71
Spain	46	35	14	67
Netherlands	54	24	15	63

Analysis

Relatively speaking, Dutch people think that their health system performs well. They give it 6.7 marks out of 10, the second-highest ranking among the countries surveyed. They also think it performs well compared with the health systems of other countries; only Sweden and France are more confident about their own systems relative to their neighbours'. More people place equality of access ahead of quality of personal care in the Netherlands than in any other country except Italy, and no other country has a greater proportion of people who feel that healthcare reform is unnecessary. However, only Sweden and Germany have more people who think that healthcare will get worse over the next ten years in the absence of reform.

Nearly two-thirds of Dutch people (64%) say that healthcare will get worse over the next decade in the absence of reform.

Some 71% of those aged 35–64 think this, as do 75% of those earning more than €45,000 a year, but only 44% of 15–24-year-olds and 56% of the over-65s believe the same. One fifth of the Dutch (20%) think standards will remain unchanged, while one in seven (14%) say standards will actually rise without reform. This gives the Netherlands a 'Pessimism Ranking' of 70%, compared to the survey average of 67%, and places it third out of the eight countries surveyed, behind Germany and Sweden.

Despite this, only a little over half (54%) of people in the Netherlands believe that healthcare reform is urgent, including 62% of 35–64-year-olds and 65% of those earning €45,000 and above, but only 35% of 15–24-year-olds and 44% of the over-65s. A further quarter (24%) say that reform is desirable and 15% think it is unnecessary, the highest proportion in any country surveyed. The Netherlands therefore has a 'Reform Index' rating of 63%, bottom of the countries surveyed and 10% below the survey average of 73%.

Slightly fewer than three in five Dutch people (57%) think their health system is underfunded in absolute terms. Women (60%) are more likely to think this than men (54%). However, nearly one fifth (19%) say it receives too much money, the highest proportion for any country, including one quarter (25%) of those earning less than €15,000. Less than a third of those Dutch expressing an opinion (31%) believe that other countries' health systems have more money spent on them, and less than a quarter (24%) of over-65s think this. A third (33%) think other countries devote less money to health and slightly more than a third (37%) think they devote the same.

Only in Britain do a higher proportion of people think

that extra money for healthcare should come from increased personal taxation; 30% of Dutch people believe this, including 43% of those earning more than €45,000 a year. However, as with every other country surveyed except Britain, higher costs on businesses is the favoured option for raising extra money. Just over two-fifths (42%) would prefer this means, including 57% of 15–24-year-olds. When asked where the money will ultimately come from, nearly three-fifths (57%) say the source will be higher personal taxation – just above the survey average – including 72% of those earning €30,000 to €60,000, but only 49% of the over-65s. However, 20% believe that businesses will bear the burden, the largest proportion to choose such an option outside of France.

When it comes to the performance of the Dutch health system relative to other countries, a third of those expressing an opinion (34%) think their neighbours perform better. Two in five Dutch people (41%) think they perform the same and one quarter (25%) think other health systems perform worse than their own. This gives the Netherlands an 'Inferiority Complex' score of –32%, higher only than Sweden and France and comfortably below the survey average of –14%. The Dutch are more willing to travel abroad for treatment than any others in the survey: 70% would do so compared with a quarter (26%) who would not, including 75% of 15–34-year-olds (against 20% who wouldn't), but only 56% of over-65s (against 40%).

Nearly one half of Dutch people (48%) say that their health system is good at meeting individual needs. This is marginally exceeded by the 50% who rate it only 'fair' or 'poor'. On the individual measures of healthcare quality used to determine the 'Delivery Deficit', the Netherlands performs near the

Reforms most likely to increase the quality of care

	Likely	*Not likely*	*Net*
Giving patients more information about their illness	79	18	61
Giving patients more control over public spending on health	57	36	21
Increasing number of medicines and treatments	66	29	37
Increasing range of doctors and hospitals	63	32	31
Making it easier for patients to spend their own money on health	49	44	5

average on all of them, exceeding it for convenience, use of latest medicines/technology and offering patients enough information about their illnesses. It falls just short of the average on waiting times and doctor choice. In terms of priorities, 98% of the Dutch rate patient information as quite or very important. This is closely followed by waiting times, rated as important by 96%, and the latest medicines/technology, cited as important by 85%. Doctor choice and convenience are each rated as important by 81% of the Dutch. Nearly one half of Dutch people (48%) consider their system 'good' with regard to patient information, and a quarter (24%) assess it as 'good' on waiting times, again in line with the survey average. Only on doctor choice does the Dutch system significantly under-perform, ranked good by 44% of people compared to a survey average of 53%. Overall this gives the Netherlands a Delivery Deficit rating of 50%, fractionally better than the average of 51% and behind only Germany and France among the countries surveyed.

In common with other countries, the Dutch think more

Most reliable sources of health information (Credibility Gap)

	Reliable	*Unreliable*	*Net*
Doctors/Nurses	90	6	84
Experience	82	13	69
NGOs	81	12	69
Official stats	80	13	67
Industry	66	29	37
Media	45	51	-6
Politicians	32	65	-33

patient information would be the single most effective healthcare reform of those offered to them. Nearly four out of five (79%) believe this would increase standards against fewer than a fifth (18%) who do not; 87% of 15–24-year-olds believe this as against 13% who do not. Dutch people are also keener than the survey average to increase the numbers of medicines and treatments available to patients. Two-thirds (66%) believe this will increase quality of care – including nearly three-quarters (74%) of 15–24-year-olds, as against 25% who do not. More Dutch people also believe that increasing the range of doctors and hospitals available will improve healthcare than the survey average. Some 63% think this as against 32% who think it is unlikely to do so. Again it is the youngest who are the keenest, with 71% of 15–24-year-olds in favour.

More people in the Netherlands put equality of access ahead of quality of personal care as a priority for their health service than in any other country surveyed except Italy. Over four-fifths (84%) do so as against fewer than one in six (15%) who do not. This figure drops slightly to 76% against 24% among those

earning over €60,000. So the Netherlands has a 'Solidarity Gap' of 69%, above the survey average of 61% and equal top with Italy of all the countries surveyed.

No country trusts official statistics more than the Dutch. They give them a 'Credibility Gap' rating of +67%, nearly twice the score of the nearest country (France with +35%) and more than four times the survey average (+15%). Nevertheless, the opinions of doctors and nurses remain the most respected source of health information, trusted by 90% of Dutch people. Personal experience/the experience of friends and family has a Credibility Gap of +69%, level with non-governmental organisations, which receive a higher credibility rating in the Netherlands than in any other country surveyed. Relatively speaking, the healthcare industry also scores highly: 66% of Dutch people find it a reliable source, giving it a Credibility Gap of +37%, surpassed only in Britain. Politicians and the media also fare slightly better in the Netherlands than elsewhere. They have Credibility Ratings of –33% and –6% respectively compared with the survey average of –61% and –10%.

When it comes to taking greater personal responsibility for keeping healthy, 89% of the Dutch think they should do this against 10% who do not, the highest proportion in the survey. More people in Netherlands think the government should play the main role in helping them (42%) than in any other country studied.

Summary

Netherlands

Delivery Deficit	50	3rd
Solidarity Gap	69	=Top
Inferiority Complex	-32	6th
Marks out of 10	6.7	=2nd
Pessimism Ranking	70	3rd
Reform Index	63	Bottom

Netherlands

Commentary

Eline van den Broek and Gerrold Verhoeks

The Dutch healthcare system is made up of a web of laws and regulations relating to the provision of healthcare, funded by a corresponding insurance system. The system is remarkably complex, and we will not attempt to provide a complete synopsis here. Yet there are some basic features of the system that need to be taken into account when analysing the attitudes of Dutch patients. The crucial element of the system is strong government regulation of the provision of healthcare, which has led to several problems over the past few years. At the same time, patients cope with limited choice and an inequitable division of charges, as a result of an outdated dual insurance system consisting of sickness funds and private insurers.

During a period of rising unemployment and limited economic growth in the Netherlands, there was a strong need for cost control. Over the preceding decades, strong regulation gradually thwarted the relationship between care providers, insurers and patients. Care providers have been forced to

implement strict budgetary controls, while at the same time cost control limits insurers' and care providers' room to negotiate.

The provision and funding of long-term care and so-called uninsurable risks, such as care for the elderly or people with chronic physical or mental disabilities, is largely regulated by the AWBZ, a compulsory national insurance applicable to all Dutch citizens. Additional treatments are provided by health insurance funds and private insurers. The way in which funding is dispersed depends on the size of a person's gross income per annum. In 2004, the wage ceiling is set at a gross income of €32,600 for employees and €20,800 for the self-employed.[1] All citizens earning below this amount pay partly income-dependent contributions towards a sickness fund, which is obligatory. Insurers have to make contractual agreements with care providers in order to satisfy their duty to provide care. There is no selection on the basis of health, because there is a general duty of acceptance. This differs from the optional private insurance that people earning above the wage ceiling can employ. Private insurance premiums are nominal and dependent on risk profile. Therefore, premiums vary considerably; the elderly and those suffering from chronic diseases especially have little or no freedom of choice. People make only a few personal payments and as a result they are currently not being stimulated to take any responsibility for cost control.

Healthcare providers are forced to implement strict budget control and therefore have only limited means by which to provide care. In the past, this resulted in large waiting lists. To illustrate: hospital X receives €10,000 for knee operations per year. Assuming that a knee operation costs €1,000 and the hospital performs one operation per month, the last two months

leave the hospital with no budget and with patients having to be put on a waiting list. The following year the hospital experiences the same problem and the size of the waiting list increases. This problem was solved by so-called 'compensation after production': hospitals receive extra money later when they deal with more cases than their budget allows.

Although the new measure broadly solved the waiting-list problem, it still serves as a good example of the main problems inherent in the current system. First of all, government budget and price control causes inefficiency in the provision of healthcare. Care providers simply fulfil their budgets; they are not stimulated to develop flexibility, innovation and entrepreneurship. Receiving additional compensation later increases production, but at the same time sends a signal that strict budget control should be abolished in general. The current system does not adequately respond to patients' needs because it does not focus on demand. The Stockholm Network/Populus poll, which establishes Dutch citizens' attitudes towards the current healthcare system, reports that there is a critical difference between what people identify to be the most important features of healthcare and the system's ability to deliver them.

The second problem with the current health system is that patients have limited or no freedom of choice. Privately insured patients encounter the problem of risk selection, which limits accessibility for the elderly and chronically ill people. Sickness funds do offer the possibility of switching to another insurer annually, but the possibilities are limited to taking greater personal risks by paying voluntary personal payments. It might be interesting, for example, for young and healthy people to pay a reduced premium by bearing the greater personal risks of

personal payments. In addition to limited freedom of choice, there is little or no information available on the provision of healthcare. As a consequence, the insured cannot easily choose between hospitals because they simply do not know which hospital is better for their particular problem.

Government steering of healthcare supply should make room for a competitive market, which is transparent to everyone. In the current system, people are not aware of the costs of healthcare because compulsory personal payments play only a minor role.

Apart from these problems, certain trends have been observed which accentuate the flaws of the current system. There is an enormous increase in the ageing of the population, which will continue over the next few decades. The future healthcare user will be much more demanding, will be able to afford to spend more and will no longer be satisfied with standard care. Moreover, the organisation of healthcare will change as a result of technological innovation. Meanwhile, risk pooling and social solidarity are being put under pressure by predictive medicine, relying as it does on genetics.

It might seem obvious from the above that reform is essential. The poll reports that most Dutch people believe that the quality of healthcare will decline over the next ten years in the absence of reform. Under the current system the government safeguards the public interest by regulating healthcare supply, but now supply steering must also make room for competition. Accordingly, there are two main proposals for reform: reorganisation of healthcare provision and adjustment of the outdated insurance system.

Reorganisation of care supply means that the government

will effect a shift from regulating the supply of healthcare to stimulating competition. Relaxing the rules with regard to budget and price controls will make it crucial for care providers and insurers to negotiate. Care providers will compete with one another to attract as many patients (in other words as much income) as possible. The government will lay down requirements for the minimum quality of healthcare provision but there will be freedom of movement, which will stimulate care providers to innovate and to provide a better quality of care than their competitors. Insurers will compete with one another on premiums to attract as many clients as possible. Those who offer the most advantageous alternative premiums will appeal to the most clients. A competitive market is preferable to the current system because it is likely to bring about greater efficiency in the allocation of resources. Moreover, competition will stimulate entrepreneurship, flexibility and innovation, and the providers of healthcare will be stimulated to correspond better to patients' needs.

Besides the transformation towards a self-regulating market, the insurance system will be reformed. A general insurance provision has been proposed by the government, which will generate more freedom of choice for patients and greater efficiency within the insurance system. Through the adoption of a statutory general insurance provision, all Dutch residents will be obliged to have insurance, and accordingly there will no longer be a wage ceiling. The statutory insurance will also establish that insurers have a duty of acceptance. People will have to pay a nominal premium to their insurers, which will serve as an incentive for competition between insurance providers. To ensure risk solidarity, there will be a stable system of risk

equalisation. In this way, all citizens will have equal access to the insurance system, including the elderly and chronically ill people. By means of the general insurance provision the government will be able to ensure that all citizens receive the same minimum standard of care. The reformed insurance system incorporates the increased solidarity that the Dutch demand in the poll: 84% find it more important to give everyone equal access to the same standards of care than to ensure that they themselves and their families have access to the best possible care.

The suggested reforms seem to be adequate solutions to the problems mentioned above. A self-regulating market in the provision of healthcare will bring about greater efficiency and increased focus on demand, and should stimulate entrepreneurship, flexibility and innovation. Moreover, the reformed insurance system will assure freedom of choice for all patients and equal access to a minimum quality of healthcare.

The poll emphasises, however, that the Dutch are still quite attached to their current social model and welfare state. When asked whether healthcare reform is urgent, only 54% of people state that it is. In fact, 15% find reform altogether unnecessary, and another 24% say it is desirable but not urgently needed. Many Dutch people are thus content with the current system, even though they are aware that it will not produce improved standards over the next ten years. What does this tell us? That the Dutch are really satisfied with the current system? Not exactly: the Dutch think that the system is not sufficiently able to deliver the most important features of healthcare. In view of the fact that they give the health system a rating of 6.7 out of 10, however, second highest among the countries surveyed,

they seem not to understand the urgency of reform. What we can conclude is that there are two basic conditions that have to be met in order to facilitate the desired objectives of reform.

First of all, patients have to be able to choose in the sense that they have to know what it is that they are choosing. There must be sufficient transparency about the provision of healthcare. Insurers need to know about the quality and availability of care because they act as agents, buying healthcare for the people they insure. Patients obviously need optimal data on the variety of care provision, its quality, the reliability of care providers, and the differences in premiums among insurers, so that they have enough information to make a considered choice. To achieve this, the government has to make sure that there will be adequate benchmarking, quality scores and other related information. They could broadcast this kind of information via websites and independent healthcare organisations, for example. Besides the provision of information, the government should remove potential barriers to switching insurer. If there are many obstacles to such switching, a market-based competitive system will not work.

In addition to having the ability to choose, patients must actually be willing to exercise a choice between different options. The government has to make sure that patients will respond to a self-regulating market of care provision in a way that ensures that the market runs smoothly. In this respect, the (financial) benefit for patients should be considerable, so that they actually put effort into finding out which type of insurance is beneficial and which hospital offers better quality. The government could facilitate financial regulations that act as a catalyst to stimulate personal responsibility and encourage

patients to choose between different options. Personal payments, for example, are crucial. Through the facilitation of compulsory personal payments, patients will be motivated to inform themselves of all the options available and to choose the most advantageous. Aside from personal payments, the difference in nominal premiums of the general insurance provision has to be high enough to persuade people to switch insurers.

Although most of the features relating to modifications of the current healthcare system have already been worked out in great detail, it seems that the government is not fully aware of the last two arguments. If healthcare users will not respond to competition in the provision of healthcare, and if they are not likely to feel that it is to their own advantage to do so, there will still be inefficiency in the allocation of resources, limited scope for entrepreneurship and innovation, and the provision of healthcare will still not respond adequately to patients' needs.

Notes

1 Proposed reforms to the Dutch health system are outlined in full in *A Question of Demand, Outlines of the Reform of the Health Care System in the Netherlands*, International Publication Series Health, Welfare, and Sport no. 14E, The Hague, March 2002, available at http://www/minvws.nl/en/folders/meva/question_of_demand.asp.

Spain

Spain

Poll and analysis

Context

Most important features of healthcare and health system's ability to deliver them

	Important	*Good*	*Net*
The time between diagnosis and treatment	97	22	75
Being treated at a time and a place to suit you	94	37	57
Having enough information to make an informed choice about your treatment	96	51	45
Being treated using the latest medicines/technology	86	46	40
Being treated by a doctor of your choice	87	49	38
Average delivery deficit			**51**

Which is more important to you about your health system?
(Solidarity Gap)

	Equality of access	*Quality of personal care*	*Net*
Netherlands	84	15	69
Italy	84	15	69
Spain	83	17	66
Sweden	81	17	64
Germany	81	18	63
Czech Republic	81	18	63
Average	**80**	**19**	**61**
France	78	21	57
Britain	69	31	38

How do other European health systems perform compared with your own?
(Inferiority Complex)

	Better	*The same*	*Worse*	*Better minus the same/worse*
Czech Republic	65	26	10	28
Italy	63	26	11	26
Britain	60	29	12	19
Average	**43**	**32**	**25**	**-14**
Spain	42	35	26	-19
Germany	38	27	35	-24
Netherlands	34	41	25	-32
Sweden	24	43	34	-53
France	20	31	48	-59

Health System: marks out of 10

France	6.9
Netherlands	6.7
Spain	6.7
Average	**6.0**
Britain	5.9
Sweden	5.8
Italy	5.8
Czech Republic	5.3
Germany	5.1

Prospects for healthcare in 10 years' time if your system remains unreformed
(Pessimism Ranking)

	Improve	*Stay the same*	*Get worse*	*Stay the same/get worse minus improve*
Germany	4	12	80	88
Sweden	11	18	68	75
Netherlands	14	20	64	70
Average	**14**	**21**	**60**	**67**
Spain	14	22	58	66
Britain	17	22	60	65
France	17	21	59	63
Czech Republic	16	25	54	63
Italy	21	31	40	50

Does your health system need reforming? (Reform Index)

	Yes (urgently)	*Yes*	*No*	*Yes (urgently)/yes minus no*
Germany	76	14	7	83
Czech Republic	64	22	6	80
Britain	63	24	10	77
France	65	20	11	74
Italy	60	24	10	74
Average	**61**	**23**	**11**	**73**
Sweden	58	24	11	71
Spain	46	35	14	67
Netherlands	54	24	15	63

Analysis

Spaniards rank their health system as one of the best among the countries surveyed. They give it 6.7 out of 10, equal second with the Netherlands, and behind only France among the nations studied. Consequently, fewer people in Spain than in any other country regard the task of reforming healthcare as urgent, and only France has a smaller proportion of people who regard their health system as underfunded. Even so, Spain mirrors the survey average in terms of its pessimism over the prospects for healthcare in the absence of reform, and also on the specific measures of performance against aspiration. More Spaniards are prepared to travel abroad for treatment than in any other country apart from Sweden.

Nearly three in five Spaniards (58%) say that healthcare will deteriorate over the next ten years without reform. Close to

two-thirds (64%) of 25–54-year-olds believe this, but only two-fifths (40%) of those aged over 65 do so. Three-quarters (75%) of those earning over €45,000 believe this to be true. One fifth of Spaniards (22%) think standards will remain the same, while one in seven (14%), including a quarter (26%) of over-65s, say standards will actually rise in the absence of reform. This gives Spain a 'Pessimism Ranking' of 66%, compared to the survey average of 67%, and places it fourth out of the countries polled.

Spain perceives a need for reform but it is viewed as less urgent than it is in other countries. Less than half (46%) describe reform as urgent, the lowest proportion of any nation surveyed. This includes 52% of women but only 40% of men and less than a third (31%) of the over-65s. Nevertheless, more than one third of Spaniards (35%) regard reform as desirable – the highest number of any country in the study – and only one in seven (14%) see reform as unnecessary. Spain therefore has a 'Reform Index' rating of 67%, below the survey average of 73% and seventh out of the eight nations in the poll, beating only the Netherlands.

Less than a half of Spaniards (44%) view their health system as underfunded, the lowest proportion of the nations surveyed bar France. In generational terms the proportion ranges from less than a third of over-65s (32%) to more than half of 35–44-year-olds (52%). More than a quarter (28%) think the Spanish health system is adequately funded and only 8% think that it receives too much money. Compared with other countries, more than half of Spaniards (55%) prepared to express a view think that their own health system receives less money, including 70% of 35–44-year-olds. Only one in six (17%) believe it receives better

funding than the systems of other countries, while just over one quarter (28%) think it receives about the same.

Spain is keener than any other country except Germany to see extra funds for health coming from higher costs on business: 44% want to see this, including 55% of 15–24-year-olds. Only 5% want to see extra money coming from higher personal spending – the lowest proportion of any country surveyed – and even among those earning in excess of €60,000 a year this proportion rises only to 20%. However, when asked where additional funds are likely to end up coming from, nearly three-quarters of Spaniards (73%) believe they will pay in the form of higher personal taxation – the highest proportion among all the countries in the study. Fully 90% of those earning between €45,000 and €60,000 think this. By contrast, only 6% believe businesses will be asked to meet the extra cost – the lowest number in our study.

When it comes to relative performance, two in five Spaniards expressing a view (42%) believe that other countries' healthcare systems outperform their own. Closer to one half (47%) of 15–44-year-olds believe this. However, one quarter of Spaniards (26%) believe that other countries' healthcare systems perform worse than theirs does and just over one third (35%) think they perform the same. This gives Spain an 'Inferiority Complex' score of –19%, slightly below the survey average of –14%, placing it fourth among the countries studied. Spaniards nevertheless exceed the average in terms of their willingness to travel abroad for treatment. Nearly three-quarters (73%) say they would be willing to do this compared with one fifth (22%) who would not. In generational terms the proportion ranges from 88% of 15–24-year-olds who would be willing to travel (as

Reforms most likely to increase the quality of care

	Likely	*Not likely*	*Net*
Increasing range of doctors and hospitals	78	19	59
Giving patients more information about their illness	77	19	58
Increasing number of medicines and treatments	59	33	26
Giving patients more control over public spending on health	58	34	24
Making it easier for patients to spend their own money on health	42	49	-7

against 8% who would not) to 50% of over-65s who are against travelling (as against 44% who are not).

In general, the Spanish population regards its health system as good at meeting individual needs. Spain and France are the only two countries surveyed where those rating their health system as 'good' outnumber those who rate it as 'fair' or 'poor'. Three in five Spaniards (60%) give it a 'good' rating, compared with one in three (32%) who rate it as 'fair' and just 6% who say it is poor. When it comes to the individual measures of healthcare quality used to determine the 'Delivery Deficit', Spain performs above average on the use of latest medicines/technology (third) and on patient information (second). It performs below average on waiting times (fifth), doctor choice (seventh) and convenience (sixth). In terms of priorities, waiting times is the most important healthcare feature among those offered to the sample; 97% think they are quite or very important, though only 22% think the Spanish system is good at dealing with them. This is followed by the provision of information to patients, which 96% rate as important and 51% say is well

provided. Convenience is regarded as important by 94% (with 37% saying it is delivered well), followed by doctor choice, regarded as important by 87% (49% say it is well delivered), and the use of the latest medicines/technology, which 94% regard as important (and 46% consider well delivered). Overall, Spain's Delivery Deficit is 51%, the same as the survey average and fourth out of the eight countries surveyed.

By a very narrow margin, Spaniards think that increasing choice in doctors and hospitals is the single reform most likely to increase the quality of healthcare. More people in Spain believe this (78%) than in any other country surveyed. Only one fifth (19%) do not. Most enthusiastic about more choice are 55–64-year-olds (85% think this will increase standards as against 10% who do not); 15–24-year-olds are more sceptical – 75% think it will improve things as against 25% who do not. More patient information is seen as likely to increase standards by 77% (against 19%). Again, 55–64-year-olds are the most keen (82% against 15%). However, when it comes to making it easier for patients to spend more of their own money on healthcare, only two-fifths of Spaniards (42%) believe this is likely to improve standards, while nearly one half (49%) do not. This puts Spain in the company of Germany and France as the countries in the survey where sceptics outnumber believers in this regard.

This is reflected in the higher priority that Spain gives to equality of access over the quality of personal care in its health service. More than four-fifths (83%) place equality first as against one in six (17%) who do not. Solidarity matters less to 25–34-year-olds – who still back it by 75% against 24% – than to the over-65s, who do so by 87% against 12%. Spain's

Most reliable sources of health information (Credibility Gap)

	Reliable	*Unreliable*	*Net*
Doctors/Nurses	80	15	65
Experience	77	17	60
NGOs	60	25	35
Industry	44	46	-2
Media	39	54	-15
Official stats	36	58	-22
Politicians	8	87	-79

'Solidarity Gap' is 66%, ahead of the survey average of 61% and behind only the Netherlands and Italy of the eight countries studied.

Spain is one of the most sceptical countries surveyed when it comes to evaluating sources of health information. Though it trusts doctors and nurses first ('Credibility Gap' +65% against an average of +74%) it does so in less overwhelming numbers than any country except Italy. Spaniards give personal experience/the experience of friends and family a Credibility Rating of +60% (against an average of +61%) and make it their next most trustworthy source. However, when it comes to official statistics the Spanish are the most sceptical nation in our survey. They give health statistics a Credibility Gap of –22% compared with an average rating of +15%. Politicians also perform poorly, with a Credibility Gap of –79% against a survey average of –61%.

On taking greater personal responsibility for keeping healthy, 95% of Spaniards agree they should do this compared with only 3% who don't. Two in five (41%) believe that government should play the main role in helping them, the second-highest

proportion of any country surveyed, while one third (32%) think that doctors should take the lead.

Summary

Spain

Delivery Deficit	51	4th
Solidarity Gap	66	3rd
Inferiority Complex	-19	4th
Marks out of 10	6.7	=2nd
Pessimism Ranking	66	4th
Reform Index	67	7th

Spain

Commentary

Alastair Kilmarnock

In the run-up to the recent Spanish general election health was conspicuous by its absence as a major issue. The Spanish parties, and public, were much more concerned with the constitution, the claims of the Basque and Catalan separatists, the threat and actuality of terrorism, and the unity or fragmentation of Spain. The centre-right Partido Popular (PP) – the party generally expected to win and unexpectedly beaten by the socialists – made most play with its management of the economy and its employment, retirement and state pension policies. Neither party gave any prominence to health. This was true even before the horrendous bomb attacks in Madrid on 11 March, after which all official campaigning was suspended. The reasons for this low health profile are not far to seek. Health service delivery is no longer within the competence of central government, but belongs to the regions. And, despite substantial areas of dissatisfaction (as demonstrated by the Stockholm Network/Populus poll), the basic healthcare 'settlement' is broadly accepted by both major parties and the public at large.

What are the main features of the Spanish healthcare 'settlement'? The new constitution of 1978 recognised all citizens' rights to healthcare. The underlying principle is that of a tax-funded universalist service, free at the point of use, as in the UK. But from there on the Spanish system diverges sharply from its British counterpart. The General Health Care Act of 1986 devolved virtually all management and delivery functions to the seventeen *comunidades autónomas*, the autonomous regional governments (communities) created by the constitution. These are not just regions devised for administrative convenience but basic building blocks of the Spanish state. As far as healthcare was concerned, a sort of 'variable geometry' operated. The more economically advanced or ambitious regions (Catalonia, Andalusia, the Basque country, Valencia, followed by Galicia, Navarre and the Canaries) fully assumed their health powers well before the poorer or less self-confident regions, whose healthcare was run for them by a central government agency called Insalud, but by 2002 all the remaining regions had assumed full health powers and Insalud was abolished.

So how is healthcare power now distributed between the central and regional governments? There is little fiscal autonomy (except in the Basque country and Navarre, which have special tax status). But the transfer of powers on the expenditure side is very great. An annual block grant from general taxation is made to each community. None of this is earmarked. There is no specific ring-fenced allocation for health. It is the community, not central government, which decides its health needs on the basis of population, demographic profile and so forth. Furthermore, a community can, if it wishes, boost health expenditure from its own (limited) resources. Not surprisingly, this degree of

devolution leads to a wide discrepancy in (public) health expenditure between different regions. According to Dr Marciano Sanchez Bayle (spokesman for the Federation of Associations for the Defence of Public Health) in *El Mundo* on 8 March, the budgeted expenditure for 2004 ranges from €735 per inhabitant to €1,218, with a median of €976. Similarly, hospital beds per 1,000 range from 6.1 in Navarre to 3.2 in Castilla–La Mancha; and the median is below the EU average. Within this overall pattern, communities controlled by socialists tend to spend more than those controlled by the centre-right.

So a question of equity arises? Certainly. That question is bound to be associated with radical devolution. Are there any measures to redress imbalances? Well, the government recently passed a law of Quality and Cohesion, more of symbolic than of practical value. The fact is that the central state has surrendered a huge measure of power, which it cannot reclaim except by reversing the whole process, which would be politically unacceptable. Virtually the only functions left to the Ministry of Health are *sanidad exterior*, that is to say quarantine, vaccination programmes and the licensing of medicines. As to the overall public expenditure on health in Spain, the latest available OECD figure is 5.4% against an EU average of 5.7% (2001). This is generally thought to have remained steady. Private health spending is agreed to have gone up slightly from 2.2% to 2.3% of GDP.

Turning now to the poll, we find Spain drawing for second place in consumer satisfaction, behind only France in first place. Also, fewer people in Spain than in any other country (46% against the average of 73%) regard the task of reforming healthcare as urgent. And despite the general situation of a

lower and more varied regional spending pattern than in other comparable countries, Spaniards again come second only to France in the relatively low proportion who think their system is underfunded. On the face of it these results are surprising. What can explain them?

It is tempting to conclude that the key to Spanish attitudes lies in the fact of devolution itself. All Spaniards are local patriots, and if there is anything beyond dispute it is that the devolution debate is closed and there is no question of unscrambling it in order to return to a more centralised system. No body or professional or political party I have spoken to wants that. There is a tension in Spanish socialism between national solidarity and the tug of regionalism, with which the socialist party (PSOE) is also closely identified. In the case of health, regionalism has won. In fact it was during the long spell of socialist power that the core devolution act was passed in 1986. Of course, one of the advantages of such a diverse system is that it gives the ruling party in each community full licence to design a health service in accordance with its own ideology and the majority preference of the regional electorate. *El Mundo*, which supported the PP's economic and social (but not foreign) policies, drew up a wish list before the recent elections which included the suggestion that all public hospitals (69% of the total in Spain) should be governed by the *Ley de Fondaciones*, giving them complete control of their own resources. There is absolutely no likelihood of this coming about in Andalusia, where 95% of hospitals are public bodies owned by the Junta de Andalucía; only one, the Hospital Costa del Sol, is an *empresa pública*, whose management has a performance contract with the Junta, which owns it. None of this will change. Indeed, the recovery by the PSOE of

an absolute majority in the regional elections (which fell on the same day as the national elections) confirms majority support for the Andalusian model. By the same token, PP-controlled regions will be able to continue their switch to 'foundation' hospitals if they can carry their electorates with them.

Let us take a closer look at how this diversity works in practice, and especially at labour relations, which are crucial, as the wage bill constitutes 55% of health service expenditure. I will take Andalusia first. In the province of Málaga, where I live, there are two massive hospitals (the Universitario and the Carlos Haya) in the capital, with over 1,000 beds and 5,000 employees each. Then there are smaller district hospitals (mine, serving a mountain population of 55,000, has only 200 beds); other hospitals serve larger populations, up to 550,000 in Málaga itself. Each hospital is a planet around which revolve a number of satellite primary care districts, each with a *centro de salud*, where all GP consultations take place. (GPs are not independent contractors as in the UK but employees of the service.) All the medical, nursing and ancillary professionals, both in hospitals and in the primary care system, are employees of the regional government; this means they are part of a 'statutory' labour regime, which is in effect the same as that which applies to the civil service. Remuneration is governed by collective agreements between the regional governments and the unions; doctors and nurses are paid on the same scale in Málaga, Seville or a mountain *pueblo*. But even in socialist regions, virtually all hospitals now contract out their support services (ambulances, cleaning, laundry, kitchen, cafeterias, etc.) to the private sector, which is governed by normal private labour law, with easier provisions for termination or dismissal. The picture will not

differ widely across the communities controlled by the PSOE, which means over half of the Spanish landmass; but the PP still controls important strongholds, including Galicia, Madrid, Valencia and Murcia, where different models of delivery will prevail.

In Valencia, for example, which has run its health service since 1987, a new model of private investment in hospitals and franchising of services has been set up. Under the administrative franchise model, the licensee contracts physicians in accordance with private labour law instead of the tenured statutory regime. Under such contracts, payment is directly linked to results, and to fulfilment of the objectives of the hospital. Galicia has developed non-profit 'public foundations' under whose statutes all staff are contracted under the private labour regime. Catalonia, with a long history of private and mutual medicine, has pioneered 'consortia' integrating primary and hospital care and mental health, delivered through the collaboration of private and public bodies. The political climate under the 23-year rule (just ended) of the centre-right CiU[1] was favourable to these developments. A left-wing coalition has now come to power, but it seems unlikely that this elaborate, eclectic edifice of healthcare will all be torn down.

What, then, are the perspectives for the future development of healthcare in Spain after the unexpected win of the PSOE on 14 March 2004? In the first place, radical change is not likely. The devolved 'settlement' is here to stay. There is not a lot the government could claw back even if it wanted to without very contentious legislation in a Chamber of Deputies in which they do not have an overall majority; besides, most regional socialist 'barons' will want to preserve the health powers they have got.

But some changes there will have to be, if Spain is not to slip in the next Populus poll. I spoke to the (medical) director of an Andalusian *centro de salud*, who passionately wants to reduce waiting lists. He was quite scornful of the PSOE's published pledge of a maximum seven days for the first diagnostic tests, ten days for the first specialist consultation, and 45 days for an operation. He believes no one should have to wait more than fifteen to twenty days after tests and diagnosis for a standard elective operation. The only way to achieve this is to 'open hospitals in the afternoon' (this does not mean they are actually 'closed' in the afternoons but that only the duty physicians and surgeons are available in those post-prandial hours); this would mean higher staff costs. The Andalusian plan is to cover these by reducing pharmaceutical costs, which have risen relentlessly over the past few years to constitute some 30% of health budgets across Spain. The incoming party has undertaken to break the current pact with the industry, and to make more use of generics, limited lists, etc. (a not unfamiliar story). They will try to avoid a reversion to unpopular co-payments. Centre-right communities will continue to seek savings through improved management, more use of the private sector, performance contracts, and so forth. But on one thing there does seem to be a consensus – namely, Spanish (public) health spending must rise to the EU average if it is to continue to earn the approval of the Spanish people.

Can any lessons be learnt from the Spanish model by other countries? What suits a semi-federal state may well be less acceptable to a unitary state. The 'equity gap' will undoubtedly worry some health planners. (I think it is half offset by the Spanish perception of equity *within* the region, if not *across* the

region.) Politically controlled local health services also attract the charge of corruption and nepotism. You can't get a job as a hospital porter unless you carry the ruling party's card, etc. There is something in that too. But on the plus side there are boosts to morale, pride, performance and innovation which cannot be ignored. One of the greatest virtues of devolution is that it releases energies and provides them with channels not found in a monolithic, centralised system with a million-strong workforce. If the Spanish system demonstrates anything beyond its suitability to Spain, it is that it's no good chucking money at the eternal problems posed by the almost insatiable demand for tax-funded health services; you have to find a structure that commands the respect and loyalty of both those who deliver and those who use the service. With the reservations revealed in the poll, Spain seems on the whole to have achieved just that.

Notes

1 Convergence and Union, a coalition of the Democratic Convergence of Catalonia (CDC) and the Democratic Union of Catalonia (UDC).

Sweden

Sweden

Poll and analysis

Context

Most important features of healthcare and health system's ability to deliver them

	Important	*Good*	*Net*
The time between diagnosis and treatment	98	15	83
Having enough information to make an informed choice about your treatment	98	39	59
Being treated at a time and a place to suit you	85	29	56
Being treated using the latest medicines/technology	78	34	44
Being treated by a doctor of your choice	66	29	37
Average delivery deficit			**56**

Which is more important to you about your health system?
(Solidarity Gap)

	Equality of access	*Quality of personal care*	*Net*
Netherlands	84	15	69
Italy	84	15	69
Spain	83	17	66
Sweden	81	17	64
Germany	81	18	63
Czech Republic	81	18	63
Average	**80**	**19**	**61**
France	78	21	57
Britain	69	31	38

How do other European health systems perform compared with your own?
(Inferiority Complex)

	Better	*The same*	*Worse*	*Better minus the same/worse*
Czech Republic	65	26	10	28
Italy	63	26	11	26
Britain	60	29	12	19
Average	**43**	**32**	**25**	**-14**
Spain	42	35	26	-19
Germany	38	27	35	-24
Netherlands	34	41	25	-32
Sweden	24	43	34	-53
France	20	31	48	-59

Health System: marks out of 10

France	6.9
Netherlands	6.7
Spain	6.7
Average	**6.0**
Britain	5.9
Sweden	5.8
Italy	5.8
Czech Republic	5.3
Germany	5.1

Prospects for healthcare in 10 years' time if your system remains unreformed
(Pessimism Ranking)

	Improve	*Stay the same*	*Get worse*	*Stay the same/get worse minus improve*
Germany	4	12	80	88
Sweden	11	18	68	75
Netherlands	14	20	64	70
Average	**14**	**21**	**60**	**67**
Spain	14	22	58	66
Britain	17	22	60	65
France	17	21	59	63
Czech Republic	16	25	54	63
Italy	21	31	40	50

Does your health system need reforming? (Reform Index)

	Yes (urgently)	*Yes*	*No*	*Yes (urgently)/yes minus no*
Germany	76	14	7	83
Czech Republic	64	22	6	80
Britain	63	24	10	77
France	65	20	11	74
Italy	60	24	10	74
Average	**61**	**23**	**11**	**73**
Sweden	58	24	11	71
Spain	46	35	14	67
Netherlands	54	24	15	63

Analysis

Sweden's pessimism about its healthcare prospects over the next ten years in the absence of reform is exceeded only by Germany's. More people in Sweden think that their health system is underfunded than in any other country surveyed. Despite this, Sweden's confidence in the performance of its health system relative to those of other European nations is second only to France's, even though, on the overall gap between delivery and aspiration, the country lies towards the bottom of the league table, performing worse than the European average. This is reflected in the fact that more Swedes are willing to travel abroad for health treatment than in any other country. Swedish people give their health system a rating of 5.8 out of 10.

More than two-thirds of Swedes (68%) believe Swedish healthcare will get worse over the next decade without reform.

Three-quarters (75%) of those aged 35–64 believe this, compared with just over half (52%) of over-65s. Around one in five Swedes (18%) believe standards will remain the same and only one in ten (11%) think things will improve in the absence of reform. This gives Sweden a 'Pessimism Ranking' of 75%, above the survey average of 67% and second only to Germany's 88%.

When it comes to the need for reform, nearly three in five Swedes (58%), including two-thirds (66%) of 45–64-year-olds, think this is urgent. A further quarter (24%) think it is desirable. Only one in ten (11%) believe reform is unnecessary, including 15% of those aged over 65 and 19% of those earning less than €7,500. The 'Reform Index' score for Sweden is therefore 71%, marginally below the survey average of 73% and above only Spain and the Netherlands in the survey.

Only a quarter of Swedes (24%) who have a view believe other European healthcare systems perform better than theirs, ranging from over a third (35%) of 45–54-year-olds to just one in ten (10%) of those earning €7,500 or less. A third of Swedes (34%) expressing an opinion believe other health systems perform worse, including 44% of 15–24-year-olds and nearly one half (47%) of those earning €7,500 or less a year. Just over two in five Swedes (43%) say Swedish standards are the same as elsewhere. This gives Sweden an 'Inferiority Complex' of –53%, the lowest score in the survey apart from that of France.

Swedes feel both that their health system is generously funded by European standards and that it is underfunded in absolute terms. Nearly half of those with an opinion (48%) think their European neighbours have less to spend. Even so, nearly three-quarters (73%) of Swedes, including 84% of 15–24-year-olds, say their system has too little money, the highest

proportion of any country surveyed. Only one in five (22%) say it receives enough or too much money, the lowest proportion among the countries surveyed.

Given the choice, a third of Swedes (35%) would like to see extra money for health raised from higher costs on business; however, nearly two in five (37%), including 43% of 25–34-year-olds and 45% of those earning over €45,000, believe the money will have to be found through higher personal spending, the highest proportion among any country in the survey.

Sweden broadly shares the priorities of other countries when it comes to the measures used to calculate the 'Delivery Deficit'. The two exceptions are choice of doctor, which is important to only two-thirds (66%) of Swedes compared with an average of 85%, and being treated with the latest technology/medicines, rated as important by 78% of Swedes against a survey average of 88%. In terms of delivery, Sweden performs near the average on every measure but one, the time taken between diagnosis and treatment. Fewer than one in six (15%) give the Swedish system a rating of 'good' for this, ranging from 27% of the over-65s to 6% of 25–34-year-olds. This drags Sweden's overall Delivery Deficit down to 56%, third from bottom, ahead of Italy and Britain.

Perhaps because of this, Swedes are the most intrepid population in the survey in terms of their willingness to go abroad for treatment. Three-quarters (75%) say they are willing to travel. Even three out of five (60%) Swedes over the age of 65 are prepared to do this, along with 84% of 25–34-year-olds.

In common with people in other countries, Swedes believe giving patients more information about their illnesses is more likely to increase standards of care than any other reform they were asked to comment on. More than three-quarters (77%)

Reforms most likely to increase the quality of care

	Likely	*Not likely*	*Net*
Giving patients more information about their illness	77	20	57
Increasing range of doctors and hospitals	68	30	38
Increasing number of medicines and treatments	58	37	21
Giving patients more control over public spending on health	54	39	15
Making it easier for patients to spend their own money on health	52	43	9

believe this, and the elderly (82% of over-65s) and poorer Swedes (91% of those earning less than €7,500) are particularly keen. More than two-thirds (68%) also believe that extending the range of doctors and hospitals is likely to lead to greater quality. Three-quarters of 15–24-year-olds believe this, as do a similar number (74%) of 25–34-year-olds.

By a wide margin, Swedes think offering everyone equal access to the same standards of healthcare is more important to their health system than offering access to the best possible care for themselves and their family. More than four in five (81%) say equality comes first compared with 17% who stress quality of personal care, but there is a difference between men, 77% of whom think equality is more important, and women, 85% of whom place equality first. The difference is more stark in terms of income: 88% of those earning less than €15,000 think equality is the priority, while only 74% of those earning more than €45,000 think the same. Sweden's overall 'Solidarity Gap' rating is 64%, higher than the survey average of 61% but behind the Netherlands, Italy and Spain.

Most reliable sources of health information (Credibility Gap)

	Reliable	*Unreliable*	*Net*
Doctors/Nurses	92	6	86
Experience	86	11	75
Official stats	63	29	34
Industry	62	31	31
NGOs	49	31	18
Media	47	51	-4
Politicians	23	75	-52

Overall Sweden is one of the least sceptical nations surveyed when it comes to trusting sources of information about healthcare. While every country believes the opinions of doctors and nurses to be overwhelmingly reliable, more than nine out of ten Swedes (92%) say this as against 6% who do not. This 'Credibility Gap' of +86% is exceeded only by that of France (+87%)

Swedes rate personal experience and the experience of friends and family higher than any other country surveyed: 86% find them reliable as against 11% who find them unreliable (Credibility Gap +75%). Swedes share a general scepticism about politicians' statements, 23% trusting them as against 75% who do not, though among 15–24-year-olds this diminishes to 37% against 60%. Nevertheless, nearly two-thirds of people in Sweden (63%) believe official health statistics as against 29% who do not, again fuelled by 15–24-year-olds, 70% of whom believe them as against 20% who do not.

While a slim majority of Swedes (51% to 47%) find media stories about health unreliable, only the French, among the nations surveyed, are inclined to believe the media more.

Where Sweden stands out is in its relative distrust of non-governmental organisations. Though a half (49%) regard them as a reliable source of health information, nearly a third (31%) do not. That Credibility Gap of +18% is higher only than the Czech Republic's, and these two countries are the only ones surveyed where information from the healthcare industry is considered more trustworthy than data from NGOs. This is partly a function of age: 70% of 15–44-year-olds regard industry-supplied information as reliable compared with only 54% of those aged 45 and over.

Swedes agree that they should take more responsibility for keeping themselves healthy. Although the margin is a wide one, 88% to 9%, it is joint lowest with the Netherlands of the countries polled. A quarter of Swedes believe that the government has the greatest role in helping them stay healthy, and only 23% – the lowest proportion polled – believe doctors have. However, 21% – the highest in any country polled – think that other health professionals should take the lead.

Summary

Sweden

Delivery Deficit	56	6th
Solidarity Gap	64	4th
Inferiority Complex	-53	7th
Marks out of 10	5.8	=5th
Pessimism Ranking	75	2nd
Reform Index	71	6th

Sweden

Commentary

Johan Hjertqvist

Are the findings of the Stockholm Network/Populus poll for Sweden surprising – or do they simply confirm what we would expect from what is still Europe's most streamlined welfare state?

Before answering this question we should bear in mind a few things about the modern history of Sweden – fundamental factors of great importance in any comparison of European nations.

Outranking every other country, Sweden still believes strongly in the concept of the welfare state. All EU members exhibit welfare values, as illustrated by the outcomes of this poll. But nowhere do you find the unique Swedish combination of trust in public policies, public funding and public provision of health services. The impact of the Social Democrat hegemony can best be measured by the way in which most Swedes accept the collusion of 'state' and 'society'. Such a fusion would be unthinkable in large parts of the present EU and, judging by historical precedent, even less acceptable among the new member states.

The continuing, strong standing of the public Swedish welfare systems leads to not only strong figures for reliability but – correlated to this – very weak support for 'private' solutions in healthcare. In the Swedish context 'private healthcare' means 'privately owned but operated within the publicly funded system'. True private alternatives are very limited.

Entrepreneurs within the public system are appreciated and generally given a far better ranking by the public in polls and by patients in customer surveys than their public competitors. Since the upsurge of neo-liberal political power in the early 1990s, which attacked the monopoly in the public provision of healthcare by the 21 elected county councils (regional governments for healthcare), an increasing number of private for-profit entrepreneurs has emerged. Today, they deliver roughly 10% of all services, less in more remote parts of the country and more in the big cities; in the metropolitan area of Stockholm almost 50% of primary care services and 20–25% of all services are provided by contracted entrepreneurs.

Although the electorate appears to have returned to traditional Social Democrat values as far as elections are concerned, this share of the market looks rather stable. But there is nothing like a popular uproar calling for a stronger private influence. A number of polls show that most Swedes think such a development would improve the conditions for patients as well as healthcare staff, but when elections come around they nevertheless vote for the status quo. Encouraging entrepreneurs has become primarily a means for the administration to tackle recruitment problems and poor access to services.

Another important Swedish characteristic is the sense of being an outsider when it comes to European integration.

For a long time, the Swedish government declared that EU membership would undermine the classic Swedish tradition of neutrality, and that it was thus an unappealing idea. Sweden joined the European Union only when the economic advantages suddenly looked irresistible. In the 2003 referendum on joining the euro, a large majority turned down the proposal to join a common currency union. Today, European integration is looked upon with great suspicion. This explains the confusion in the Swedish political establishment when the European Court or other EU institutions rule against Swedish principles and practice. The ruling on the mobility of the European patient is a striking example.

Recently the Supreme Administrative Court of Sweden interpreted European case law in such a way that a Swedish county council was obliged to pay for the treatment in Germany of a severely ill Swedish patient. What the patient and her relatives judged to be the relevant treatment was not available in Sweden.

There have been similar cases before, and each time national and regional governments have claimed that accepting EU case law would undermine the Swedish health system. Between the lines an attitude emerges which is hostile to strange ideas from continental Europe about safeguarding the individual, in case they infiltrate our superior Swedish values whereby the interests of the system come before those of the patient.

This decision sent shock waves through the Establishment, provoking at first denial and nostalgia, then the painful insight that being a part of the EU might call for respect for the common law. When the new situation was finally accepted as a fact, the minister of health quickly declared that mobility and

portable funding were here to stay, leaving economic responsibility in the hands of the county councils.

A third value of great importance in interpreting Swedish patients' attitudes is the Swedish notion of self-esteem. The feeling that Sweden can do perfectly well without any closer cooperation other than being in the United Nations is another way of saying that we still believe that conditions in Sweden are superior to those in almost any other nation. In the 1970s such a belief had firm backing in statistics and reality. Today, the truth is a little bit different.

Instead of fighting for a top position in the league of the wealthiest nations, we muddle through in the middle (if I recall the figures correctly, Sweden is now number fifteen among the OECD economies). We are below rather than above the EU average. Typical Swedes makes less money than Norwegians and Danes, not to mention the British, the Swiss or workers in the Netherlands (only our taxes are still at the top of the rankings).

Such realities ought to affect Swedish confidence, but apparently this is not the case in healthcare policy. As we see from the results of this survey, the Swedish population still seems to believe in the superior standard of its national health service. Such an attitude explains some of the results, and at the same time provokes new reflections. Behind what looks like confidence in the system are an increasing number of alarm signals and signs of common mistrust.

From this introduction to Swedish values (of importance when one wants to understand this formally rational but, in reality, deeply emotional and nostalgic nation), let us now move on to discuss the specific poll results.

The most important quality criteria are rapid access to care and adequate information, according to the Swedish audience. These priorities are very logical and correspond well with my own observations. You might ask why.

Well, the flip side of the shiny equality-of-care medal reveals long waiting times for appointments and even worse queues for treatment. Sweden's strong emphasis on equality leads to rationing of services. When the strong, articulate consumer is absent, it is easier to leave people waiting in line. As borne out by the Swedish Health Consumer Index (Timbro Health, 2004), not one of the 21 Swedish county councils succeeds in treating more than 80% of patients waiting for a selected number of representative diagnoses within three months. This is the limit defined in what will probably become the national access guarantee from the beginning of 2005. Indeed, people often have to wait a year or more for elective surgery on knees or hips or to have a hearing aid installed.

Swedes are becoming less and less patient about long waiting lists. Using the public Internet service that provides waiting-time updates, you can benchmark all the hospitals and improve your access if you are ready to travel to an efficient unit. If it will reduce your waiting time, most county councils are willing to pay for your visit to a hospital in another district. A similar scheme is also being piloted in the UK under the title 'Patient Choice'.

Most politicians today accept that access is the top priority. For a number of years to come, the Swedish government wants to put another billion kronor a year into public healthcare to make its national treatment guarantee (maximum 90 days' waiting time) a reality. The Social Democrats are finding that

today healthcare is a more critical issue than unemployment.

So how come no more than 66% say their top priority would be seeing a doctor of their own choice? Is choice an overrated luxury? On the contrary, when two out of three Swedes rate choice in healthcare as very important, something radical has happened.

It is important to remember that in Sweden there is no tradition of the permanent, long-standing relationship with a GP or family doctor. A Dane, a Belgian or a British person would find such a relationship essential, but in Sweden people are disillusioned by constantly meeting new faces in the primary care unit. The blessing of a stable doctor–patient relationship is unknown to most Swedes. Taken in this context, 66% in favour of choice is astonishingly high.

Like other Europeans, Swedes prefer equality of access to having access to the best care for themselves. What does such a statement really mean? It is probably worth looking deeper into this question. Is it a way of alienating oneself from the popular image of US healthcare? Or is it paying lip-service to European values that patients are happy to ignore as soon as a crisis occurs in their own family? The answer is probably a bit of both.

Now we move into the most interesting area: the Swedish self-image.

As explained above, the lack of a Swedish inferiority complex is not very surprising. Here we are second only to France. In international terms, we have very low infant mortality and a long lifespan as indicators supporting such an attitude. Swedish studies show that many patients believe that their contemporaries in, for example, the UK have to pay much

more for prescribed pharmaceuticals than in Sweden. They seem totally unaware that in the UK 80% of patients receive all their medication free of charge while in Sweden 60% have to bear the whole cost. In the same way perceptions concerning having to wait to see a doctor or to receive treatment are deeply rooted; when Swedes who move to Brussels to work for the EU institutions notice that in Belgium there are no waiting lists they become very confused.

Compare the high ranking accorded to the Swedish system with the equally striking pessimism about the sustainability of publicly funded healthcare. Second only to Germans, Swedes reveal a deep anxiety about the future. Some 68% believe that, without reform, in ten years' time there will be a breakdown in the system.

Reform can be perceived in many ways, and to some respondents 'more money' is a likely interpretation. But regardless of this there is a remarkable gap between confidence in the competitiveness of Swedish healthcare and the deep pessimism relating to how this superior system will survive. There seems to be a profound feeling of disorientation among the population, resulting in a strong vote for systemic reform. But reform to what end?

According to other polls there is growing scepticism about the future of the county councils and the capacity of the tax system to fund tomorrow's healthcare. Four out of ten Swedes say they are prepared to spend more of their own money on healthcare, no doubt influenced by a lively debate about tough priorities within public healthcare, the likely result of which is that a number of minor diseases will no longer be treated by the public health system.

Three out of four are willing to travel abroad to get treatment. Although this figure may again be affected by the current lively debate on the subject in the media, it is nonetheless remarkable. It adds to the fascinating complexity of the Swedish attitude: we tend to publicly defend our healthcare system and its basic values, but when it comes to individual decisions we are ready to act in our own best interests. Every second respondent finds additional private funding the key to a better quality of care – again contradicting how patients behave in the political arena.

To close, let us have a look at opinions about health consumer information. Improving such consumer knowledge is the key to improving healthcare, according to the survey. Again this is a striking result in a population apt to rely on official authorities and public statistics. My conclusion is that Sweden is opening the door to a consumer breakthrough in healthcare, still placing confidence in official statistics but demanding the freedom of the individual to select and assess such information and turning it into a platform for individual action in the arena of health policy and services.

The Swedish welfare state is shaking. Though the fortress still flies the flag of equality, the health consumers are at the gate. If and when they understand that the traditional system can no longer deliver they will show no mercy.

Appendix

Poll structure and statistics

- The eight countries surveyed were Britain, the Czech Republic, France, Germany, Italy, the Netherlands, Spain and Sweden.
- 8,000 interviews were conducted over the phone between 26 January and 22 February 2004.
- For each country, 1,000 interviews were conducted among a sample aged 15+ representative of the age, gender and regional composition of the country.
- Data from each 1,000-person sample is accurate to within ± 3%.
- Each survey has a confidence level of 95%, i.e. if the same poll were repeated among other random samples it would yield the same results within the margin of error described above on 19 out of 20 occasions.

Tot/Ans = Total number of answers received
%/Ans = Percentage of those answering
%/Resp = Percentage of respondents (i.e. those completing the survey)

Final top-line findings

Q1a. When was the last time you personally used one of the following healthcare services?

A family doctor or GP service?

	Tot/Ans	*%/Ans*	*%/Resp*
1. In the last week	1,788	22.3	22.3
2. In the last month	1,920	24.0	24.0
3. In the last 3 months	1,369	17.1	17.1
4. In the last year	1,518	19.0	19.0
5. More than a year ago	1,264	15.8	15.8
6. Never	142	1.8	1.8

Q1b. When was the last time you personally used one of the following healthcare services?

A hospital doctor?

	Tot/Ans	*%/Ans*	*%/Resp*
1. In the last week	506	6.3	6.3
2. In the last month	638	8.0	8.0
3. In the last 3 months	659	8.2	8.2
4. In the last year	1,313	16.4	16.4
5. More than a year ago	4,218	52.7	52.7
6. Never	667	8.3	8.3

Q2. Thinking about the general state of [country X's] healthcare system today, how would you rate its performance between 0 and 10, where 0 means it is performing extremely badly and 10 means its performance is outstanding?

0 min, 10 max, 6.02 mean

	Tot/Ans	*%/Ans*	*%/Resp*
Don't know	226	2.8	2.8

Q3. How good would you say [country X's] healthcare system is at meeting the individual needs of the patients it treats?

	Tot/Ans	*%/Ans*	*%/Resp*
1. Very good	569	7.1	7.1
2. Good	3,035	37.9	37.9
3. Fair	3,075	38.4	38.4
4. Poor	901	11.3	11.3
5. Very poor	228	2.8	2.8
6. Don't know	193	2.4	2.4

Q4. Now thinking about other healthcare systems in Europe, how well do you think they perform on average compared to [country X's]?

	Tot/Ans	*%/Ans*	*%/Resp*
1. Much better	680	8.5	8.5
2. Slightly better	1,408	17.6	17.6
3. About the same	1,584	19.8	19.8
4. Slightly worse	980	12.2	12.2
5. Much worse	240	3.0	3.0
6. Don't know	3,109	38.9	38.9

Q5. Thinking about the level of funding of [country X's] healthcare system/health service today, would you say it has:

	Tot/Ans	*%/Ans*	*%/Resp*
1. Significantly too little money	1,909	23.9	23.9
2. Slightly too little money	2,641	33.0	33.0
3. About the right amount of money	2,020	25.2	25.2
4. Slightly too much money	479	6.0	6.0
5. Significantly too much money	245	3.1	3.1
6. Don't know	707	8.8	8.8

Q6. Now thinking about other healthcare systems in Europe, how much money would you say they have spent on them compared to [country X's]?

	Tot/Ans	*%/Ans*	*%/Resp*
1. A lot more money	710	8.9	8.9
2. Slightly more money	1,289	16.1	16.1
3. About the same amount of money	1,184	14.8	14.8
4. Slightly less money	960	12.0	12.0
5. A lot less money	294	3.7	3.7
6. Don't know	3,564	44.5	44.5

Q7. Would you personally be prepared to travel to another European country for an operation if your own healthcare system paid for it?

	Tot/Ans	*%/Ans*	*%/Resp*
1. Yes	5,085	63.6	63.6
2. No	2,648	33.1	33.1
3. Don't know	268	3.3	3.3

Q8. Which of these statements comes closest to your view of how [country X's] healthcare system works today?

	Tot/Ans	*%/Ans*	*%/Resp*
1. It does not offer access to care for everyone	1,299	16.2	16.2
2. It offers access to care for everyone, but individual patients do not always receive the best treatment available when they need it	4,807	60.1	60.1
3. It offers the best treatment available to every patient when they need it	1,639	20.5	20.5
4. Don't know	256	3.2	3.2

Q9. Which of these is more important to you personally when it comes to [country X's] healthcare system?

	Tot/Ans	*%/Ans*	*%/Resp*
1. Giving everyone equal access to the same standards of care	6,396	79.9	79.9
2. Ensuring that you and your family have access to the best possible care	1,501	18.8	18.8
Don't know	104	1.3	1.3

Q10. If the way [country X's] current healthcare system is run remains unchanged for the next ten years, what will happen to the quality of care in [country X]?

	Tot/Ans	*%/Ans*	*%/Resp*
1. It will improve a lot	279	3.5	3.5
2. It will improve a little	845	10.6	10.6
3. It will stay about the same	1,713	21.4	21.4
4. It will worsen a little	2,432	30.4	30.4
5. It will worsen a lot	2,401	30.0	30.0
6. Don't know	331	4.1	4.1

Q11. Does the way healthcare is organised in [country X] need reform?

	Tot/Ans	*%/Ans*	*%/Resp*
1. Yes – urgently	4,852	60.6	60.6
2. Yes – but not really urgent	1,876	23.4	23.4
3. No	826	10.3	10.3
4. Don't know	447	5.6	5.6

Q12. I am going to read out a list of sources for information about how well [country X's] healthcare system is performing. In each case can you tell me how reliable you think they are?

Official statistics?

	Tot/Ans	*%/Ans*	*%/Resp*
1. Very reliable	991	12.4	12.4
2. Somewhat reliable	3,378	42.2	42.2
3. Not very reliable	2,531	31.6	31.6
4. Not at all reliable	649	8.1	8.1
5. Don't know	452	5.6	5.6

Politicians' statements?

	Tot/Ans	*%/Ans*	*%/Resp*
1. Very reliable	192	2.4	2.4
2. Somewhat reliable	1,224	15.3	15.3
3. Not very reliable	3,192	39.9	39.9
4. Not at all reliable	3,110	38.9	38.9
5. Don't know	283	3.5	3.5

Stories in the media?

	Tot/Ans	*%/Ans*	*%/Resp*
1. Very reliable	480	6.0	6.0
2. Somewhat reliable	2,937	36.7	36.7
3. Not very reliable	3,153	39.4	39.4
4. Not at all reliable	1,126	14.1	14.1
5. Don't know	305	3.8	3.8

Opinions of doctors and nurses?

	Tot/Ans	*%/Ans*	*%/Resp*
1. Very reliable	3,190	39.9	39.9
2. Somewhat reliable	3,627	45.3	45.3
3. Not very reliable	761	9.5	9.5
4. Not at all reliable	137	1.7	1.7
5. Don't know	286	3.6	3.6

Information from the healthcare industry (e.g. insurers or pharmaceutical companies)?

	Tot/Ans	*%/Ans*	*%/Resp*
1. Very reliable	1,072	13.4	13.4
2. Somewhat reliable	3,327	41.6	41.6
3. Not very reliable	2,368	29.6	29.6
4. Not at all reliable	734	9.2	9.2
5. Don't know	500	6.2	6.2

Information from NGOs (e.g. patients' advocates and pressure groups)?

	Tot/Ans	*%/Ans*	*%/Resp*
1. Very reliable	1,751	21.9	21.9
2. Somewhat reliable	3,357	42.0	42.0
3. Not very reliable	1,487	18.6	18.6
4. Not at all reliable	333	4.2	4.2
5. Don't know	1,073	13.4	13.4

Personal experience/experience of friends and relatives?

	Tot/Ans	*%/Ans*	*%/Resp*
1. Very reliable	2,962	37.0	37.0
2. Somewhat reliable	3,286	41.1	41.1
3. Not very reliable	1,176	14.7	14.7
4. Not at all reliable	216	2.7	2.7
5. Don't know	361	4.5	4.5

Q13a. I am going to read a list of factors associated with good-quality healthcare. For each one, can you tell me how important they are to you personally?

The time between diagnosis and treatment?

	Tot/Ans	*%/Ans*	*%/Resp*
1. Very important	6,656	83.2	83.2
2. Somewhat important	1,090	13.6	13.6
3. Not very important	128	1.6	1.6
4. Not at all important	32	0.4	0.4
5. Don't know	95	1.2	1.2

Being treated at a time and a place to suit you?

	Tot/Ans	*%/Ans*	*%/Resp*
1. Very important	4,959	62.0	62.0
2. Somewhat important	2,139	26.7	26.7
3. Not very important	701	8.8	8.8
4. Not at all important	132	1.6	1.6
5. Don't know	70	0.9	0.9

Being treated by the doctor of your choice?

	Tot/Ans	*%/Ans*	*%/Resp*
1. Very important	4,907	61.3	61.3
2. Somewhat important	1,866	23.3	23.3
3. Not very important	989	12.4	12.4
4. Not at all important	178	2.2	2.2
5. Don't know	61	0.8	0.8

Being treated using the latest medicines or technology?

	Tot/Ans	*%/Ans*	*%/Resp*
1. Very important	4,815	60.2	60.2
2. Somewhat important	2,187	27.3	27.3
3. Not very important	721	9.0	9.0
4. Not at all important	82	1.0	1.0
5. Don't know	196	2.4	2.4

Having enough information to make an informed choice about your treatment?

	Tot/Ans	*%/Ans*	*%/Resp*
1. Very important	6,558	82.0	82.0
2. Somewhat important	1,122	14.0	14.0
3. Not very important	214	2.7	2.7
4. Not at all important	46	0.6	0.6
5. Don't know	61	0.8	0.8

Q13b. I am going to read a list of factors associated with good-quality healthcare. For each one, can you tell me how well do you think [country X's] health system is currently performing in …?

The time between diagnosis and treatment?

	Tot/Ans	*%/Ans*	*%/Resp*
1. Good	2,091	26.1	26.1
2. Fair	3,670	45.9	45.9
3. Poor	1,895	23.7	23.7
4. Don't know	345	4.3	4.3

Being treated at a time and a place to suit you?

	Tot/Ans	*%/Ans*	*%/Resp*
1. Good	2,982	37.3	37.3
2. Fair	3,381	42.3	42.3
3. Poor	1,268	15.8	15.8
4. Don't know	370	4.6	4.6

Being treated by the doctor of your choice?

	Tot/Ans	*%/Ans*	*%/Resp*
1. Good	4,277	53.5	53.5
2. Fair	2,378	29.7	29.7
3. Poor	882	11.0	11.0
4. Don't know	464	5.8	5.8

Being treated using the latest medicines or technology?

	Tot/Ans	*%/Ans*	*%/Resp*
1. Good	3,274	40.9	40.9
2. Fair	3,028	37.8	37.8
3. Poor	768	9.6	9.6
4. Don't know	931	11.6	11.6

Having enough information to make an informed choice about your treatment?

	Tot/Ans	*%/Ans*	*%/Resp*
1. Good	3,341	41.8	41.8
2. Fair	3,020	37.7	37.7
3. Poor	1,280	16.0	16.0
4. Don't know	360	4.5	4.5

Q14. I am going to read out a list of possible reforms to healthcare in [country X]. For each one, can you tell me how likely they are to increase the quality of care in your country?

Increasing the range of doctors and hospitals where you can choose to be treated?

	Tot/Ans	*%/Ans*	*%/Resp*
1. Very likely	2,303	28.8	28.8
2. Quite likely	2,588	32.3	32.3
3. Not very likely	2,169	27.1	27.1
4. Not at all likely	700	8.7	8.7
5. Don't know	241	3.0	3.0

Increasing the number of medicines or treatments that you or your doctor can choose from?

	Tot/Ans	*%/Ans*	*%/Resp*
1. Very likely	1,741	21.8	21.8
2. Quite likely	2,953	36.9	36.9
3. Not very likely	2,286	28.6	28.6
4. Not at all likely	644	8.0	8.0
5. Don't know	377	4.7	4.7

Giving patients more control over the way public funds on health are spent?

	Tot/Ans	*%/Ans*	*%/Resp*
1. Very likely	2,270	28.4	28.4
2. Quite likely	2,435	30.4	30.4
3. Not very likely	2,105	26.3	26.3
4. Not at all likely	796	9.9	9.9
5. Don't know	395	4.9	4.9

Making it easier for patients to supplement current spending on health with their own money?

	Tot/Ans	*%/Ans*	*%/Resp*
1. Very likely	1,692	21.1	21.1
2. Quite likely	2,416	30.2	30.2
3. Not very likely	2,270	28.4	28.4
4. Not at all likely	1,215	15.2	15.2
5. Don't know	408	5.1	5.1

Giving patients more information about their illness so they can exercise more choice in how they are treated?

	Tot/Ans	*%/Ans*	*%/Resp*
1. Very likely	3,446	43.1	43.1
2. Quite likely	2,725	34.1	34.1
3. Not very likely	1,259	15.7	15.7
4. Not at all likely	327	4.1	4.1
5. Don't know	244	3.0	3.0

Q15. Given the pressures of an ageing population, advances in medical science and competing priorities for social spending, do you think that people should take greater responsibility for keeping themselves healthy?

	Tot/Ans	*%/Ans*	*%/Resp*
1. Yes	7,511	93.9	93.9
2. No	384	4.8	4.8
3. Don't know	106	1.3	1.3

Q16a. And who do you think has the greatest role to play in helping people keep themselves healthy?

	Tot/Ans	*%/Ans*	*%/Resp*
1. Governments	2,145	26.8	26.8
2. Doctors	3,523	44.0	44.0
3. Pharmaceutical companies	133	1.7	1.7
4. Other health professionals (e.g. pharmacists, public health workers, nurses)	679	8.5	8.5
5. Non-profit groups	730	9.1	9.1
6. Don't know	791	9.9	9.9

Q16b. Could you please name two others who have a role to play (in helping people keep themselves healthy)?

	Tot/Ans	*%/Ans*	*%/Resp*
1. Governments	1,547	21.5	19.3
2. Doctors	2,298	31.9	28.7
3. Pharmaceutical companies	1,622	22.5	20.3
4. Other health professionals (e.g. pharmacists, public health workers, nurses)	2,945	40.8	36.8
5. Non-profit groups	1,901	26.4	23.8
6. Don't know	523	7.3	6.5
7. No answer	531	7.4	6.6

Q17a. Given the pressures I just mentioned on healthcare provision in the future, more spending is likely to be needed on health. Where do you think most of this extra money should come from?

	Tot/Ans	*%/Ans*	*%/Resp*
1. Higher taxes on individuals	1,817	22.7	22.7
2. More personal spending by individuals	1,144	14.3	14.3
3. Higher taxes or employment costs paid by businesses	3,249	40.6	40.6
4. Don't know	1,791	22.4	22.4

Q17b. And where do you think most of this money will end up coming from?

	Tot/Ans	*%/Ans*	*%/Resp*
1. Higher taxes on individuals	4,139	51.7	51.7
2. More personal spending by individuals	1,781	22.3	22.3
3. Higher taxes or employment costs paid by businesses	1,178	14.7	14.7
4. Don't know	903	11.3	11.3