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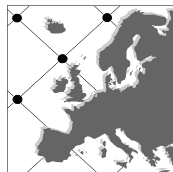

Working papers

Health Services for Children in Denmark, Germany, Austria and Great Britain

Claus Wendt

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Claus Wendt

Health Services for Children in Denmark, Germany, Austria and Great Britain

Working Papers from the *International Project on Family Change and Family Policies*, Research Department A, Mannheim Centre for European Social Research.

The International Project on Family Change and Family Policies, co-directed by Prof. Flora (University of Mannheim, Mannheim Centre for European Social Research) and Profs. Kamerman and Kahn (Columbia University School of Social Work, New York), analyses changes in family structures and family policies in long-term and comparative perspectives in 20 countries in Europe and overseas. Primary output will be publication of a 7-volume-series on family changes and family policies, including five volumes with country studies and two comparative volumes. Another major objective is building up a family policy database which will include regularly updated time series. The project is supported by the Deutsche Forschungsgemeinschaft (DFG). Related to this project, the European Commission finances a training and mobility programme for young researchers, which concentrates on recent developments of families in European welfare states in comparative perspective.

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Editorial Note:

Claus Wendt is a doctoral student at the Institute of Sociology, University of Heidelberg. He is writing a doctoral thesis on 'Health Care Systems of Denmark, Germany, Austria and Great Britain in Comparison'. His main research interest is comparison of welfare states (health policy, family policy, educational policy). From January 1997 to April 1998 he participated in the Training and Mobility Programme for Young Researchers (TMR) 'Family and Welfare State in Europe' with research stays in Roskilde, Denmark and Vienna, Austria.

Abstract

This paper compares health services for children in Denmark, Germany, Austria and Great Britain using the following dimensions: (1) coverage, where it is asked under which conditions children are covered by the health care system; (2) access, where the family doctor principle in Denmark and Great Britain is compared with the free choice of doctors in Germany and Austria; (3) organizational structure, which is important for co-ordination and co-operation of service providers and for the possibility of orientating oneself within the health care system; (4) comprehensiveness: level and extent of health services for children; and (5) financing, or how families with children are supported by different principles of financing.

The conclusion is that the health insurance systems of Austria and especially Germany take health needs of children into consideration to a lesser extent than the national health systems of Denmark and Great Britain. Due to the closer doctor–patient relationship, the family doctor principle of the national health systems gives children easier access to the health care system, and does a better job of ensuring that parents make use of preventive health measures for their children. On the other hand, the free choice of doctors in the health insurance systems is not considered helpful for building up a close and trusting doctor–patient relationship. Children are especially dependent on good co-operation between different service providers such as general practitioners, paediatricians, child health visitors and school nurses. Co-ordination and co-operation is easier and more targeted at the health of children when services are organized at the local level as in the Danish municipalities and the British districts, while the systems of Germany and Austria are characterized by a more fragmented organizational structure. But even when different health systems regard children differently, the financing principles in all four countries give a clear signal: families shall have no additional costs for securing health care for their children. There is a high financial redistribution from single households to family households in all four health care systems.

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1 Introduction

Health care systems are based on different ideas. The guiding idea of national health systems is the belief that the whole population has a right to health care in case of sickness. In countries where state insurance systems have been institutionalized, the dominant idea is that those who are included in the compulsory health insurance have a right to health care on the basis of contributions. Those who are not employed and do not pay own contributions only have derived rights in insurance systems.[1]

These considerations lead to the assumption that children (who do not pay own contributions in insurance systems) are treated differently in national health systems on the one hand and health insurance systems on the other. The guiding questions of this working paper are therefore the following: how are children seen in different health systems, how are they covered, which services are directly targeted at children, how are families with children financially assisted, and what impact do different health systems have on children?[2] Parsons (1991) defines health as a functional precondition for the existence of a society and therefore emphasizes the importance of health care systems. Another precondition for a society is the socialization of younger generations. Both preconditions are taken into account by asking how children—who as relatively weak members of the society need comprehensive protection—are treated in different health systems.

Health systems cannot be seen separately – they are integrated in the institutional framework of different welfare states. A characterization of the Danish, German, Austrian and British welfare states however would go beyond the scope of this working paper. When reading the text one should nevertheless keep in mind that a strong child-orientation is characteristic for the Danish welfare state in general, while in Germany and Austria the state insurance systems have a strong labour market link and are less focused on children. The British case is characterized by a strong child-orientation within the national health service while the support of children in general is seen as the duty of the family, and public child services are – compared to Denmark – less institutionalized.[3]

1.1 'Health services for children' in the context of family policy and health policy research

Health services for children have not been a major issue in recent comparative studies on family policy. Although definitions of family policy follow the wide-ranging definition proposed by Kamerman and Kahn (1978)—'family policy means everything that government does to and for the family'—health services are excluded. Health services are seen as implicit family

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1 Marshall 1992; Rieger 1992; Ham 1993; Klein 1992; Mommsen 1982; Ritter 1983; Ritter 1989; Rimlinger 1971.

2 These questions are based on a combination of an analysis of institutional regulations and an analysis of the effects of those regulations (Kohl 1999: 111).

3 Bahle 1995.

policy, but have not been systematically analysed in comparative studies.[4] Exceptions are examinations of maternity leave and maternity benefits and selected health services for mothers and children.[5]

Health policy studies, on the other hand, focus on the whole population, and, with a few exceptions, specific services for children are not sufficiently examined.[6] A preliminary information system for primary health care has been developed for the Nordic countries by the Nordic-Medico Statistical Committee (NOMESCO). NOMESCO provides comparative data and information on maternal and child health care.[7] The World Health Organization (WHO) emphasizes the importance of a developed primary health care system in several publications[8] indicating that special attention must be paid to the health risks of women and children. One of the main targets of the WHO program 'Health for all by the year 2000' is to support the health of children: 'It can be achieved by implementing strategies that ... organize disease prevention and health surveillance for all children, including good antenatal, postnatal, preschool and school health service' (WHO 1993: 37). Resolutions and special programmes have been provided to achieve these goals, but comparative analysis of the present situation of health care systems with a focus on children has not been carried out yet. Like the WHO, the Black Report (1980: 144) emphasizes the need for an effective primary health care system: 'Ease of access, good facilities, respect for the individual and availability of care and advice throughout infancy and childhood might be the watchwords of any planned development of services'. But this report also shows that 'lessons from abroad' are necessary for a better understanding of the home country.[9] The results of the Black Report lack verification from an international comparative perspective. The Organization of Economic Co-operation and Development (OECD) has also produced publications on this topic. Most of its work on health policy concentrates on providing comparable data on the OECD health care systems. Because of the huge number of included countries, OECD health care studies focus on selected areas of research, such as financing; health services for children are not included.

When analysts investigate 'health and family' they mainly focus on the family's impact on the health of family members[10] or on supporting the family's potential for health.[11] The everyday life of a family is seen as an important resource for supporting and maintaining family members' health. The connection between health and the family is taken for granted, although it has not been investigated systematically.[12] Researchers draw attention to the lack

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[4] Kamerman and Kahn 1978; Kamerman and Kahn 1991; Bradshaw et al. 1993; Neubauer 1993a; Neubauer 1993b; Bahle 1995; Hantrais 1995; Hantrais and Letablier 1996; Gauthier 1996; Millar and Warman 1996.

[5] Bradshaw et al. 1993: 256; Neubauer 1993b: 59–61; Hantrais 1995: 115f; Hantrais and Letablier 1996: 122–4, 163–5; Gauthier 1996: 172–80, Ringen 1997b: 79–83.

[6] Schneider et al. 1992, 1994, 1998; Alber and Bernardi-Schenkluhn 1992; OECD 1992; OECD 1994a; OECD 1994b; OECD 1995a; OECD 1995b; OECD 1996; World Bank 1995.

[7] NOMESCO 1993; NOMESCO 1994.

[8] WHO 1978; Whitehead 1991; WHO 1993; Dahlgren and Whitehead 1993; WHO 1994; Brandrup-Lukanow and Savas 1997.

[9] Jones 1985.

[10] Gerhardt 1989; Fünfter Familienbericht 1994; Kaiser 1996; Hurrelmann 1988; Hurrelmann 1994; Grunow 1994.

[11] Fünfter Familienbericht 1994.

[12] Grunow 1994.

of studies on family and health[13] and observe that research on public health care that takes the family into consideration is only in the early stages.[14]

1.2 Countries

This working paper compares health services for children in four countries. Germany and Austria have had compulsory health insurance systems since the end of the nineteenth century, whereas Great Britain and Denmark implemented national health systems after World War II. Apart from some system-dependent similarities, there are considerable differences within each type of health care system. For example, while the Austrian insurance system covers 99% of the population, Germany provides an exit option for higher-income groups, and compulsory health insurance coverage is lower. In Great Britain market principles have been implemented in the National Health Service (NHS) since the late 1980s,[15] which constitutes one of the differences between the British and the Danish systems. Health care is institutionalized differently in each of the four countries and therefore the various impacts different health care systems have on children can be analysed.

The Danish National Health Service was founded in 1972. Before that, Denmark had an insurance scheme with formally independent sickness funds. The proportion of GDP consumed by the health system was 6.4% in 1996; 80% of costs are funded by taxes, and the system covers the whole population. Its decentralized structure gives the Danish regions and municipalities major responsibility for organizing and running the health services. Regional authorities are responsible for hospitals, self-employed general practitioners (specialists have no right to set up their own practice), midwives, and some additional health services. Local authorities are responsible for the school health service, child dental care, and health visitors.

Great Britain replaced its health insurance system already in 1948 with the mainly tax-financed National Health Service. Since then, its basic principles have been coverage of the total population as well as free and equal access to health care for all citizens. In total, 6.9% of GDP is spent on health care. The NHS also has a decentralized structure, but unlike Denmark, in Great Britain the District Health Authorities (DHAs) are separate from local authorities. Since the late 1980s, market principles have been implemented in the NHS, making DHAs function as purchasers of health services for the population of their districts. Health services for children are mainly organized by Family Health Authorities (now connected with DHAs) and Community Health Councils.

Austria's health system has a tradition going back to 1888 when a compulsory health insurance system was introduced for selected groups of workers. Today it covers 99% of the population. The compulsory health insurance is financed mainly by contributions that employers and employees pay to the nine territorial insurance companies of the Austrian *Bundesländer*. In total, 7.9% of GDP goes to health services in Austria. Health services for

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13 v. Schweitzer 1995.
14 Fünfter Familienbericht 1994; Pfaff and Pfaff 1995.
15 Glennerster and LeGrand 1995a; Glennerster et al. 1994a.

children and juveniles are mainly provided by self-employed general practitioners and paediatricians.

The German health insurance system was implemented in 1883. Today, 88.5% of the population is covered by the compulsory health insurance. Other parts of the population are covered by private insurance; higher-income groups, for example, have the option to leave the otherwise compulsory health insurance. The German health system is characterized by a wide range of sickness insurance funds that finance health expenditures. In total, 10.5% of GDP is spent on health care. Health services for children and juveniles are mainly delivered by self-employed general practitioners and paediatricians; further preventive measures are organized by health centres (*Gesundheitsämter*) within the framework of the public health system.

The health care systems have been shaped by different basic ideas:[16] the right to health care for the working population on the basis of contributions to insurance systems *versus* health care as a social citizenship right in national health systems. The different forms of institutionalization result in different kinds of coverage, particularly for those who are not employed and do not pay own contributions. An important group within the category of 'coverage without own insurance contributions' is family members without compulsory insurance, that is, spouses and children not in employment. This leads to the assumption that health insurance systems show less awareness of children as a target group for health services than do national health systems. In Germany, for example, the coverage of children (who are particularly in need of protection) is the responsibility of the unified community (*Solidargemeinschaft*) that pays compulsory contributions to the statutory health insurance although—according to the Sachverständigenrat[17] (1997: 295)—it should be the responsibility of the whole society. The original idea of the insurance system—to guarantee (income) security for the employed population in case of sickness—should therefore be reformulated[18] in light of social and economic change in recent decades associated with marital instability, high unemployment, decreasing job stability, and worsening of the active/inactive ratio, among others.[19]

This comparative analysis is based mainly on quantitative data published by the OECD.[20] The Health For All Database of the World Health Organization, Regional Office for Europe, provides some further information, especially on health indicators.[21] The analysis of the institutional regulations is based on national data sources and publications. Since there are differences between international databases,[22] it is necessary to check those data using national data sets.[23]

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16 Here I follow the institutional approach of M. Rainer Lepsius (Lepsius 1990a; Lepsius 1995a; Lepsius 1997a; Wendt 1998).

17 Sachverständigenrat für die konzertierte Aktion im Gesundheitswesen: Board of experts for concerted action in the health care system.

18 Sachverständigenrat 1997: 260, 264.

19 Esping-Andersen 1996: 66–87.

20 OECD Health Policy Studies 1992–96; OECD Health Data 1998.

21 HFA Database 1996.

22 Schneider et al. 1998.

23 Sources for Denmark: Danmarks Statistik (Statistik Årbok, Social Sikring og Retsvæsen, Statistik tiårsoversigt); Ministry of Health (Kommunale Sundhedsordninger 1995: 7, 1996: 4); Nordic Medico Statistical

1.3 Method: Dimensions for comparing health systems

For international comparison it is essential to develop unambiguous and comparable dimensions to show differences as well as similarities in the four health care systems and to point at changes over time.[24] Impacts of health care systems shall thus be assigned to specific regulations to identify functional mechanisms of health care systems. Six dimensions are seen as important for the comparative analysis: coverage (2.1), access (2.2), organizational structure (2.3), comprehensiveness of health services (2.4), financing (2.5), and allocation of resources.[25]

Coverage refers to which part of the population is covered by the health care system. As Hsiao (1995: 23) points out, it is 'a primary goal of a developed nation's health care system ... to provide every citizen with coverage or to make basic health care universally available'. In the context of this working paper, important questions are therefore whether there is a legal claim to health services and whether citizens are allowed to opt out of the system by purchasing private insurance. For families it is especially interesting to know under what conditions family members are covered and whether they have to make some of their own provisions. My thesis is that coverage is guaranteed to a lower degree in health insurance systems than national health systems that have 100% coverage. When it is left the responsibility of the parents to purchase (private) health insurance or not, children are at the risk of not being covered in the case of sickness.

The second dimension is access to health care. While other studies focus especially on regional or social inequalities concerning access to health care, this working paper concentrates on the function of the general practitioner: is access to the health system regulated by a general practitioner who acts as a 'gatekeeper', or do patients have free access to different general practitioners and to self-employed specialists? For children it is important whether the whole family is in the care of one general practitioner (or family doctor), as in Denmark and Great Britain, or whether the family-doctor principle is undermined by free access to general practitioners, as in Germany and Austria. Since children only have access to the health system via their parents, an important question is whether their access to health care is improved by a close relationship with a family doctor or whether the right to choose one's own doctor and to have direct access to specialists improves the health care of children.

Committee (NOMESCO). Sources for Germany: Der Bundesminister für Gesundheit (Daten des Gesundheitswesens 1991–97); Der Bundesminister für Arbeit und Sozialordnung 1996; Sachverständigenrat für die Konzertierte Aktion im Gesundheitswesen (Sondergutachten 1987-1997). Sources for Austria: Österreichisches Statistisches Zentralamt/ÖSTAT (Gesundheitsstatistisches Jahrbuch 1970-1998); Bericht über das Gesundheitswesen 1970–92; Österreichisches Bundesinstitut für das Gesundheitswesen; Bundesministerium für Arbeit, Gesundheit und Soziales (Gesundheitsbericht 1995 und 1997); Hauptverband der österreichischen Sozialversicherung 1997b. Sources for Great Britain: Office of Population Censuses and Surveys (Health Survey for England 1991–95); Office for National Statistics, 1997 (Key Statistics for New Health Areas); Department of Health (Health and Personal Social Statistics for England 1991–98); Office of Health Economics 1997 (Compendium of Health Statistics); The NHS Confederation (1998/99 NHS Handbook).

[24] Kohl 1993: 80f.; Lepsius 1993: 142f.

[25] For the development of dimensions for the comparison of health care systems see: Black Report 1980; Whitehead 1991; WHO 1993; Dahlgren and Whitehead 1993; OECD 1994c; Hsiao 1995.

The third dimension is the organizational structure. Here it is of particular interest whether health services are organized and delivered on a national, regional, or local level and how different health services for children are co-ordinated. With their preference for organization and delivery of health services at the local level, national health systems can take the needs of children into account more readily than can the often fragmented insurance systems. The fragmented structure of insurance systems makes co-ordination and co-operation between different service providers more difficult.

A further dimension is comprehensiveness of health services. Here it is asked what kinds of services are provided for children. As already described, national health systems are intended to be more comprehensive and are targeted at the whole population. The assumption is that national health systems are also targeted on the needs of children more than are health insurance systems. This thesis will be proved by examining the following health services: preventive health care for children (2.4.1), health visiting schemes (2.4.2), school health services (2.4.3), and child dental health care (2.4.4).

Dimension number five is financing: how are families with children supported in different systems of financing? In statutory health insurance systems, families with children generally benefit financially from the fact that children are included without paying own insurance contributions. While national health systems achieve significant redistribution from higher- to lower-income groups via the progressivity of the tax system, insurance systems cause major redistribution from single households to family households (a redistribution that in tax-financed systems is undermined by direct taxes).

The last dimension is allocation of resources. How resources are spent on different services says much about the priorities of different health systems: prevention and primary care versus curative care. Data on the allocation of resources reflect the relative priority attached to different services and patients.[26] The problem is that most data on specific health services for children (school health services, child dental health care etc.) are not reliable and/or comparable.[27] The lack of data has led to different attempts to make health expenditure for specific services comparable. Bradshaw et al. (1993) for example identify five distinctive elements of a country's comprehensive child support package. One element is benefits and services that reduce the cost of health care for the family. The authors arrive at the unexpected result that health care costs are not an important issue for the family. The reason for this result might be the selected 'standard package of health care' with three prescriptions per person and year, three visits to a general practitioner, one visit to a dentist and one week in hospital per person. Because of these problems it has been decided not to include the dimension 'allocation of resources' in the comparative analysis.

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[26] Ham 1997: 49-50.

[27] OECD Health Data 1998; Daten des Gesundheitswesens 1997; Hauptverband 1997b; NOMESCO 1997; Compendium of Health Statistics 1997

2 Comparative analysis

2.1 Coverage

In Denmark and Great Britain health care is a social citizenship right. The national health systems guarantee 100% coverage of the population. Children and non-employed spouses are therefore covered in the same way as employed persons. This form of coverage means that there is no uncertainty about whether and how health care will be delivered in case of sickness or how it is financed. All people are included irrespective of the ability to pay for health services, level of income, change or loss of job, or—for example in case of divorce—marital status. Both countries provide the option of an additional private insurance. 'Patients thus have a wider choice of services, including services provided by private hospitals and private-practising physicians, and higher-grade service in public hospitals. Nevertheless, the people who opt out still have to pay taxes that fund the public insurance or facilities' (Hsiao 1995: 22). Having private insurance is therefore an indicator of how satisfied people are with the standard health system. The less satisfied patients are with services delivered by the national health system, the more people will purchase private insurance. If this assumption is correct, Danes value their health system more than the British do: only 1.9% of health services in Denmark are financed by private insurance, while in Great Britain 4.5% of total health expenditure is financed by private insurance.[28]

In insurance systems, the right to health care in case of sickness is based on contributions. This basic principle has been interpreted more leniently in Austria than in Germany; 99% of the Austrian population is covered by the statutory health insurance, and in general there is no possibility of opting out of the compulsory social insurance and having only private insurance. Children and non-employed spouses are included in the statutory health insurance without paying own contributions. It is therefore a family insurance. Of those covered by the Austrian statutory health insurance, 62.5% are liable to pay contributions, 34% are insured through a family member and do not have to pay contributions, and 2.5% are covered by welfare institutions of the health insurance funds (*Krankenfürsorgeanstalten*).[29] In Austria, as in national health systems, private insurance is therefore only a complementary insurance. In total, 13.7% of the population have additional private insurance that finance 7% of all health expenditures.

In contrast to the other three systems, German statutory health insurance does not cover the whole population. When the system was introduced, only selected groups of workers in legally defined enterprises were included. Today all workers and employees (up to a certain

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[28] The percentage of private health expenditure is a more reliable indicator for the importance of private health insurance than the percentage of the population that purchase private insurance. In Denmark, 27% of the population have additional private insurance, compared to 15% in Great Britain. Since contributions to and services from private health insurance can vary extremely, one has to be careful with an interpretation of these figures.

[29] Hauptverband 1997a: 14.

level of income) must be insured in the statutory health insurance. Non-employed spouses and children (up to a certain age) are included in family insurance without paying own contributions. Workers and employees with an income above a certain threshold (3,060 ECU per month in 1996) are allowed to opt out of the statutory health insurance and buy private insurance providing complete coverage. Self-employed persons and civil servants are not included in the statutory health insurance. Civil servants are 70% covered by public subsidy; for the other 30%, they must buy private insurance coverage. For self-employed persons the only possibility for security against the risk of sickness is private insurance. Private insurance finances 6.9% of total health expenditure; 9.1% of the population have only private insurance, 88.5% are covered by the statutory health insurance, and 2.3% are covered by additional public security measures.[30] In total, 99% of the German population are covered by these possibilities. In the statutory health insurance, 30.4% of those covered are family members who do not pay contributions,[31] while those with private insurance have to take out an insurance policy for their children and non-employed spouses.

The more persons are covered by private insurance, the less the situation of the family, the number of children or certain needs (for example during pregnancy) is taken into account. The share of those with private insurance therefore indicates how the principle of solidarity is embodied in the different systems. The share of private insurance is highest in Germany and Austria, with 7% of the total health expenditure, followed by Great Britain with 4.5% and Denmark with 1.9%. The choice of opting out of the German statutory health insurance is determined by individual cost/benefit decisions. Especially the German statutory health insurance therefore promotes market-orientated behaviour, and the principle of solidarity is decreasing.

In Germany there is greater insecurity concerning insurance coverage in different life or employment situations than in the other three countries. How are unemployed people or those on social assistance covered? How are young persons covered who have completed education or vocational training but do not yet have a job and therefore do not have compulsory insurance? How are non-employed spouses and their children covered after a divorce? What costs do self-employed persons have when they take up private insurance, and how can their children be insured? Are all self-employed persons able to finance the contributions to private insurance, especially when they or their family members belong to a high risk group such as diabetics? Should workers and employees opt out when they reach the income threshold or should they remain with the statutory health insurance since it covers children without paying additional contributions? Even if additional regulations to solve most of these problems have been implemented, people in Germany are confronted with such questions in certain situations, while they are of no importance in Denmark or Great Britain and little importance in Austria. The German system is more complicated and produces insecurity in specific situations. One reason for the higher insecurity is that the statutory health insurance is not targeted at the whole population and therefore additional security measures had to be implemented for those not covered by own insurance

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[30] Daten des Gesundheitswesens 1995.
[31] Daten des Gesundheitswesens 1995.

contributions, as the Sachverständigenrat (1997: 323f) emphasizes: 'Equalizing family burdens (*Familienlastenausgleich*) is not part of the insurance principle when seen in an actuarial light. In principle the redistribution within the health insurance should be reduced to a redistribution from healthy to sick people (*Schadensausgleich*). The equalization of family burdens – in which currently only members of the compulsory health insurance are included – should be mainly financed out of general taxation to cover the whole population'.

The financial redistribution towards families by the statutory health insurance shows that in Germany and Austria today the security of children in case of sickness is recognized as a responsibility of the whole society even if the basic principle of insurance systems is aimed only at the working population. In Austria this change in the basic principle has already led to all children being included in the statutory health insurance, and some health services for children are financed from general taxation through the family burdens equalization fund (see 2.5, 'Financing'). In Germany however children of self-employed persons and of those who opt out of the statutory health insurance are not covered by the statutory insurance. Since health services for children are not financed out of general taxation, they are not the responsibility of the whole society but only of those covered by statutory insurance.

National health systems not only reduce insecurity but also give children and non-employed spouses a direct right to health care, rather than an indirect right as family members of those with statutory insurance. While in Austria and Germany family members are therefore dependent on the person who is in employment and pays contributions, in Denmark and Great Britain they are not.

2.2 Access

When access to health care is examined it is generally asked whether the principle of equity is guaranteed and which groups of the population face particularly high barriers to entering the health care system.[32] Furthermore, access to the health care system can be regulated by a general practitioner, while in other countries there is free access to general practitioners and self-employed specialists. These two forms of access are typical for national health systems and insurance-based systems respectively, thus the effects of different principles of access can be analysed. Since children only have access to the health care system via their parents it can be assumed that barriers to entry have serious effects for children.

In general, access to health care is eased by a high staff–patient ratio in the health care system. According to this criterion, access to health care is easiest in Germany. In Germany the staff-patient ratio is, at 2,850 medical staff per 100,000 population, about one-third higher than in Denmark or Great Britain.[33] The ratio of general practitioners is also much higher in Germany (110 per 100,000 population) and Austria (120 per 100,000 population) than in

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[32] Daniels 1985; Mechanic and Aiken 1989; Whitehead 1991; Dahlgren and Whitehead 1993; OECD 1995a; Smaje and LeGrand 1997.

[33] There are no data on total health employment for Austria (Statistisches Jahrbuch m. J.; Handbuch der österreichischen Sozialversicherung 1997; Gesundheitsbericht an den Nationalrat 1997; OECD Health Data 1998).

Denmark (63 per 100,00 population) or Great Britain (58 per 100,000 population). The staff–patient ratio is analysed in more detail in Section 2.4, 'Comprehensiveness of health services'. In this section the difference in the number of general practitioners in Germany and Austria on the one hand and Denmark and Great Britain on the other is of interest, because in the national health systems access is controlled by the general practitioner. Furthermore, in these countries general practitioners provide services that in Austria and Germany are provided by specialists (for example paediatricians or gynaecologists).

This gives general practitioners in Denmark and Great Britain a completely different function from their colleagues in Germany and Austria. While Germany and Austria allow free access to general practitioners and specialists, in national health systems access is channelled by the general practitioner who thus has the function of a 'guide' and 'gatekeeper'. One effect of this function can be seen in the different numbers of doctor–patient contacts. The number of patient consultations is higher in Germany (6.4 consultations per capita) and Austria (6.3) than in Denmark (5.3) and Great Britain (5.9).[34] The higher number of consultations is an effect of free access to self-employed doctors as well as the effect of the specific form of reimbursement in Austria and Germany. The reimbursement per treatment in these two countries means that doctors can increase their individual income by increasing the number of patients they treat.

But what are the effects if a patient can change doctors easily or if change is more difficult? Hirschman (1974) has analysed some of the possible mechanisms through his concept of 'exit' and 'voice'. While the decision for 'exit' is connected to market principles, 'voice' is more a part of political mechanisms.[35] 'Exit' is the reaction to a worsening of services while 'voice' is the attempt to change unfavourable conditions instead of avoiding them.[36] 'Voice' is, according to Hirschman (1974: 28; 1992: 77), the only possible reaction for dissatisfied clients if 'exit' is unrealizable.

These considerations can be applied to the behaviour of patients. In Germany and Austria patients have free access and are therefore allowed to choose and change general practitioners and specialists. In Germany this has been made even easier with the introduction of an electronic card to replace the health insurance certificate, while in Austria changing doctors has been made more difficult by introducing a fee for the health insurance certificate. In both countries however patients have an exit option. Since the doctor—due to his/her professional competence—is superior to the patient,[37] the patient will choose 'exit' rather than 'voice' if dissatisfied with the medical treatment. The patient will choose another doctor rather than get involved in a discussion or even conflict with his/her doctor.

In Denmark and Great Britain, on the other hand, patients have a closer relationship to one general practitioner for a longer period of time. Patients register with one general practitioner who is paid according to the number of patients.[38] Since in general patients can only change family practitioners once a year, the exit option is restricted. If patients are dissatisfied with

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[34] OECD 1998, figures for 1995/96.
[35] Hirschman 1974: 16.
[36] Hirschman 1974: 25.
[37] Parsons 1991: 428ff.
[38] Since the introduction of the Fundholding principle this is only partly true for Great Britain (see below).

their medical treatment, they are forced ‘to raise their voice’. Patients in Denmark and Great Britain therefore have to co-operate with their family practitioner to a greater extent.

According to Hirschman (1974) clients have a greater influence on improving services through ‘voice’ than ‘exit’, after which any influence is lost. In a similar way one can argue with regard to the doctor–patient relationship that the patients having ‘to raise their voice’ results in greater influence on the medical treatment than does leaving one doctor and choosing another one. The more patients are actively involved, the louder their voices in the doctor–patient relationship.[39] When using Hirschman’s concept to analyse effects of health care systems, it is assumed that the experience of a successful use of ‘voice’ increases the probability of another successful use of ‘voice’,[40] and that the exit option loses its importance.

These assumptions explain why the restricted choice of doctors in Denmark is not seen as negative. Patients could choose another category by some co-payment arrangements that allow an unrestricted choice of doctors, but this option was used by only 2.6% of the population in 1994, an indicator that Danes are quite satisfied with their standard health system and a limited choice of doctors.

What does a close doctor–patient relationship mean for children? In Denmark and Great Britain, often the whole family is registered with one general practitioner for a longer period of time. This gives the doctor deeper insight into the medical and social situation of the family; he has the function of a family practitioner.[41] This function is recommended by the WHO (1993: 133): ‘It is particularly helpful if families can have a close, long-term relationship with their own family physician and family nurse. Family physicians and nurses require a broad health-for-all outlook and a commitment to improve the quality of life of the people they serve. General practice is progressing towards this ideal. The concept of the health-for-all nurse has started to take root since the European Conference on Nursing in 1988. These basic health care workers provide, for a number of families and households, continuous and integrated service and lifestyle counselling, home care and well-baby care’. This close bond of trust between doctors and patients is supported in Denmark and Great Britain, while patients in Germany and Austria can respond to disappointment by immediately changing doctors. The easy exit option encourages competition between doctors for patients and interferes with building up a bond of trust between doctor and patient. According to Morgan, a long-term and trusting doctor–patient relationship should be given priority. ‘In particular this has the benefit of preserving patients’ trust in doctors and their willingness to consult and discuss their problems freely in the future, for destroying this trust undermines the very foundation of the relationship between doctor and patient’ (Morgan 1997: 50).

The degree of specialization is lower in Denmark and Great Britain, when compared to services by gynaecologists and paediatricians in Germany. Direct access to specialists ensures a higher quality of care. But doctors in Denmark and Great Britain have greater knowledge of family burdens that can influence the health of their members. In combination with home visits by public health nurses, school health services and child dental health care,

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[39] Morgan 1997: 52.
[40] Hirschman 1974: 39f.
[41] Morgan 1997: 51ff.

the general practitioner helps to integrate and co-ordinate the overall health programme (see 2.4). This reduces potential barriers for children entering the health system. Since all health services for children are delivered on a local level (see 2.3), Lohkamp-Himmighofen (1993) calls the Danish system a 'one-shop system'. In Great Britain however reforms have been implemented since the late 1980s that are intended to strengthen the patient as client in the health care system and improve competition between service providers. These include improving patients' rights, for example the right to examine one's own medical record, and making it easier to change general practitioners.[42] In Germany and Austria, patients have a wider choice when selecting a doctor and direct access to health services provided by general practitioners, gynaecologists, and paediatricians. In comparison to Denmark and Great Britain, a higher degree of specialized care is ensured – an advantage that one should keep in mind when comparing the direct access to specialists with the family-doctor principle.

2.3 Organizational structure

The organizational structure has an important influence on how people can orientate themselves within a health care system, on the information they have on available services and therefore what health services they demand. Health care systems can have a strongly centralized structure or they can be organized at the regional or local level. These are in general the alternatives in national health care systems, while insurance-based systems are often fragmented, because the expenditures are mainly financed by a wide range of health insurance funds that cannot be assigned to the national, regional or local level. Since there is no homogeneous organizational structure, it is very difficult to ensure co-ordination between different health services and co-operation between different service providers.

Denmark

In Denmark the responsibility for health services is divided between the central government, counties, and municipalities. The central government defines the legislative framework of the health system. 'The most essential steering instrument in the Danish health care system is legislation passed by Parliament and government. This legislation defines the services that local authorities must provide. Usually, however, tasks are described in rather broad terms that leave counties and municipalities with a good deal of freedom to decide how to carry out the service' (OECD 1994: 126).

Until 1983 the health system was under the supervision and control of the Ministry of Social Services. These responsibilities were transferred to the Ministry of the Interior in 1983 and in 1987 to the Ministry of Health, where they remain. As a central agency of the government, the National Board of Health has (besides certain functions in the administration of the health services) an advisory and supervisory role with respect to various health functions of local authorities.

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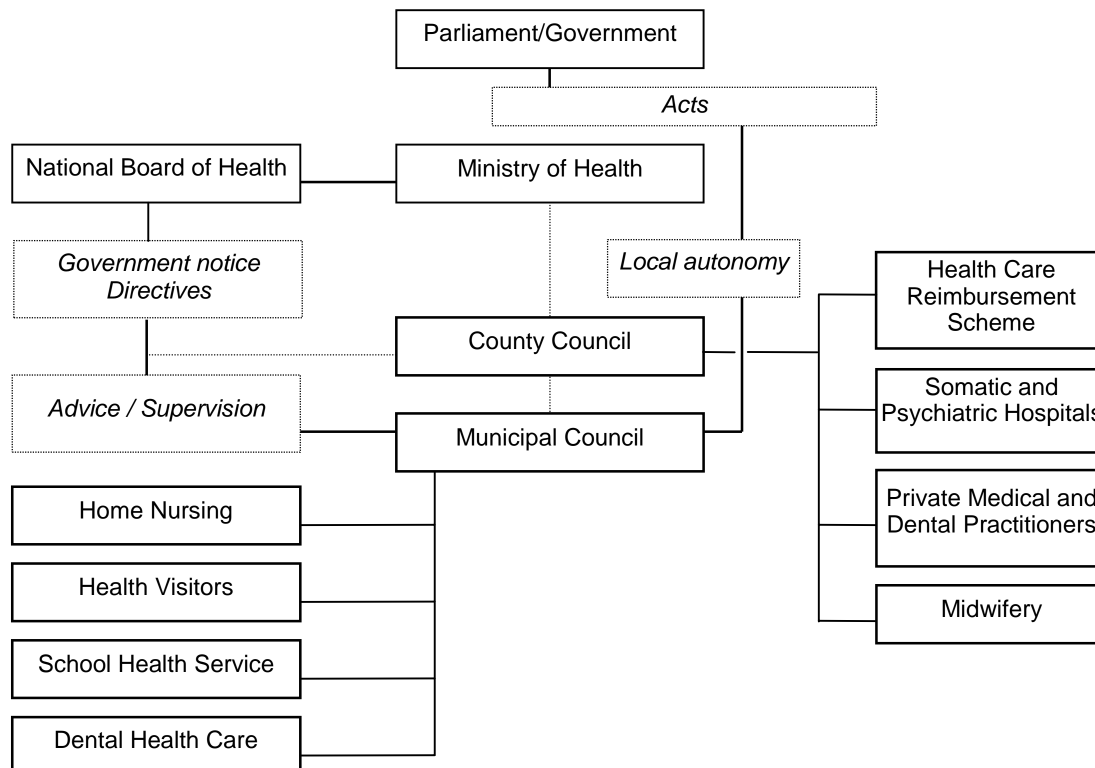
[42] Morgan 1997: 61.

Figure 1: Organizational structure of the Danish health care system



The entire responsibility for administering and running the institutions and programmes of the health system is assigned to the local authorities.

Denmark's 14 counties and the two municipalities of Copenhagen and Frederiksberg are responsible for running and planning most health care services, including psychiatric and somatic hospitals, psychiatric nursing homes, in-patient institutions for alcohol and drug addicts, midwifery, and institutions for the mentally handicapped. To some extent, the counties are also responsible for the health services offered by general practitioners, medical specialists, dentists, and physiotherapists. Since 1973, they also run the Health Care Reimbursement Scheme.

The 275 municipalities are the heart of the Danish health care system, especially concerning health services for families. The municipalities are responsible for planning and running such local and public health services as the child oral health care service, school health service, infant health visitors, and home nursing. 'In health care as in other areas, municipal and county councils are free to determine the quality and quantity of their services within limits and obligations set by legislation' (OECD 1994: 123).

Figure 1 shows that the organizational structure of the Danish health care system allows co-ordination of different health services at the local level with one authority being responsible for a wide range of services. The advantage of giving main responsibilities to local government is that the population has direct access to the authority in charge. The Danish organizational structure makes it easier for patients to gain information on available health services and to exercise their rights as patients. It has already been argued that the family-doctor principle supports communication between doctor and patient. The position of the

patient in the doctor–patient relationship can be strengthened by advice from the health authority.

Germany

In Germany, most services in the ambulant sector are delivered by self-employed doctors. Employed persons with income below a certain level must have compulsory insurance; they can choose the sickness fund they consider most cost-efficient. The global budget for these services is set by negotiations between the health insurance companies and the Medical Associations. 'An intrinsic feature of the German statutory health insurance system is the principle of administrative autonomy or self-government' (Kamke 1998: 173). The statutory health insurance is based on 960 sickness funds that are 'self-governing, self-sustaining and self-financing institutions' (Kamke 1998: 173). Three-quarters of all members are covered by two groups of sickness funds: *Allgemeine Ortskrankenkassen* and *Ersatzkassen für Angestellte*.[43]

The collective contracts between sickness funds and provider associations are generally negotiated at the national and regional levels. The Medical Associations receive a global budget from the sickness funds and have to ensure that the required health services are provided (*Sicherstellungsauftrag*). The self-employed doctors are reimbursed quarterly by the Medical Association for services delivered. The responsibility for the statutory health insurance is therefore left to non-governmental institutions, and the state is only responsible for enacting laws and fulfilling a supervisory function, carried out at the national level by the Ministry of Health and the Ministry of Labour and Social Affairs. The German *Bundesländer* contribute to the financing of the hospital sector. About 59% of all hospital beds are provided by the German *Bundesländer*.[44]

Since the state is – with some exceptions – not directly involved in financing and organizing the health care system, responsibilities for health services are not—as in Denmark—divided between the national, regional and local levels. The organizational structure of the German statutory health insurance therefore differs considerably from that of the Danish national health system (see figure 2).

In Germany, preventive measures are partly the responsibility of the public health authorities, which provide school health services and preventive dental care. But these measures are not connected to the services delivered by general practitioners, paediatricians, gynaecologists, or midwives. In general, there is no co-operation between the statutory health insurance and the public health authority. The German health system lacks an authority to co-ordinate the wide range of health services, as performed by Danish local authorities.

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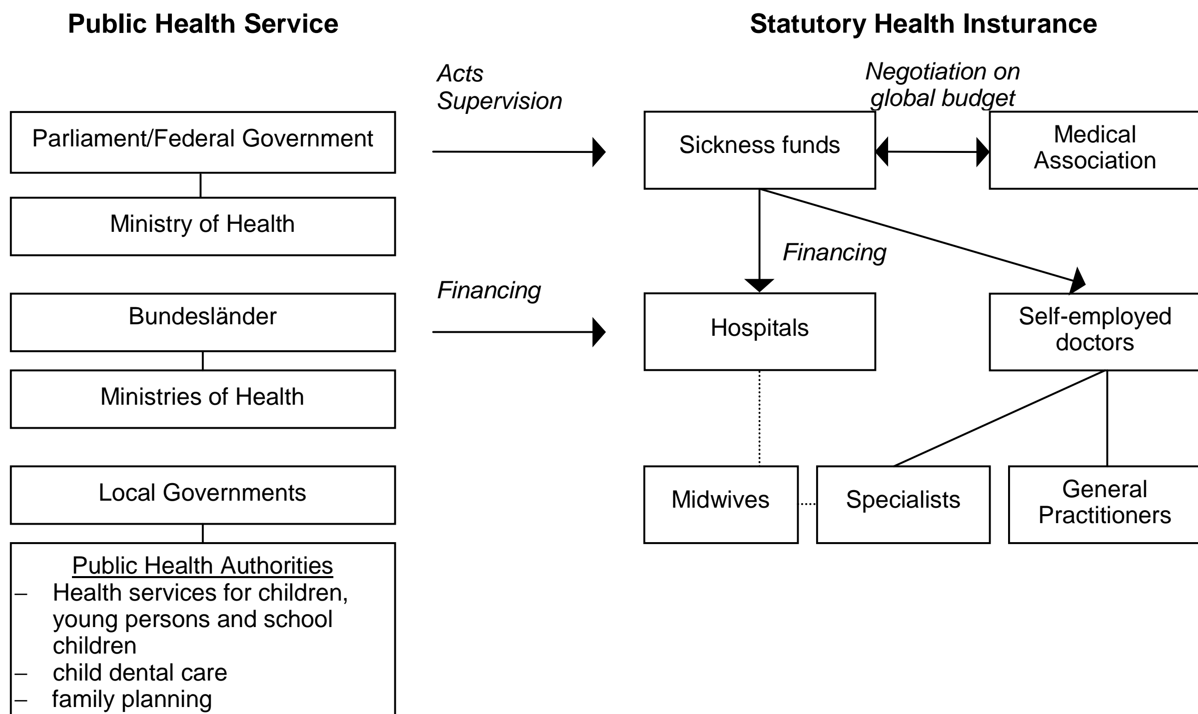
[43] Daten des Gesundheitswesens 1995.

[44] Additional hospital beds are provided by charitable organizations (36%), and private hospitals (5%) (Daten des Gesundheitswesens 1995: 224).

Figure 2: Organizational structure of the German health system



Austria

In Austria an independent Ministry of Health was established in 1972 (today called the Ministry of Labour, Health and Social Affairs). The Ministry of Labour, Health and Social Affairs is responsible for preventive health care, for the mother and child health card (*Mutter-Kind-Paß*), and for overseeing the health insurance funds. 'The responsibility of central government is restricted to the education of health personnel, co-ordinating the financing of hospitals, legal regulations for the health insurance as well as preventive measures (for example industrial safety)' (Tálos and Wörister 1994: 76). The Austrian *Bundesländer* and local governments are responsible for the hospital sector. In 1992 the *Bundesländer* and local governments provided 70% of all hospital beds.[45]

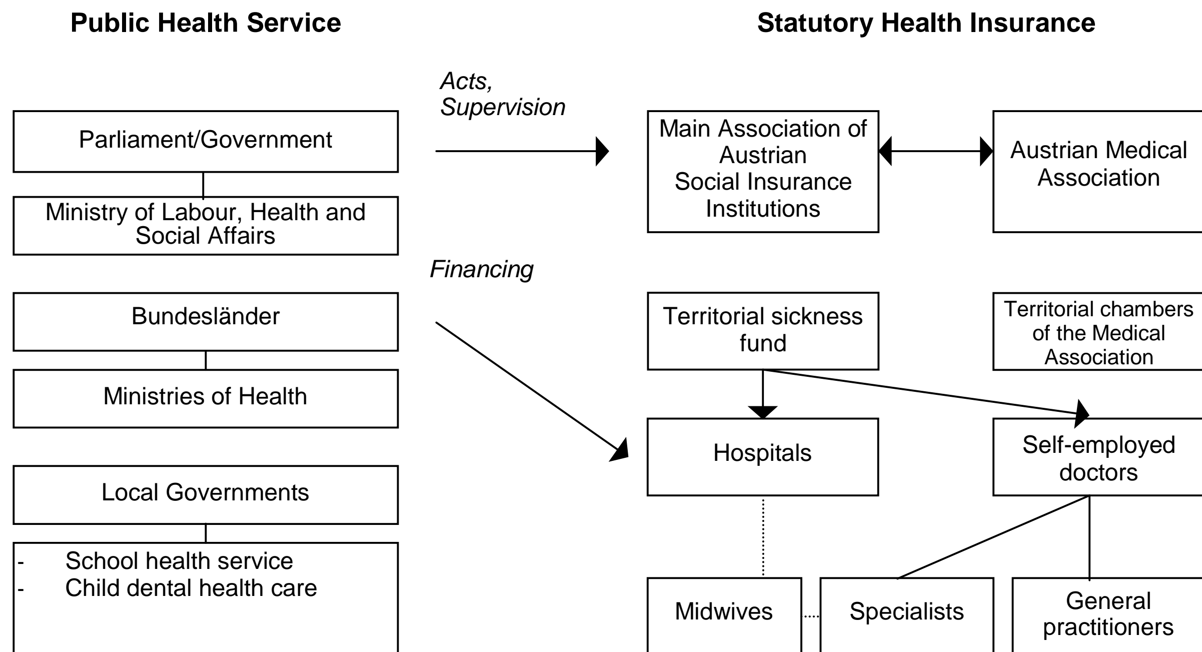
The main part of health services in Austria is financed by health insurance funds. Today 19 health insurance funds and 9 insurance companies belong to the 'Main Association of Austrian Social Insurance Institutions' (*Hauptverband der österreichischen Sozialversicherungsträger*). Each of the nine *Bundesländer* has a territorial health insurance fund (*Gebietskrankenkasse*) with which in general all workers and employees have compulsory insurance. In contrast to Germany, the Austrian health insurance funds provide some health services in own institutions, for example 134 outpatient clinics and 66 institutions for inpatient treatment (mainly special hospitals and sanatoriums).

Medical doctors are represented by the Austrian Medical Association, which is divided into nine territorial chambers. Membership is compulsory for medical doctors. 'The main responsibility of the Medical Association is to advise on bills concerning the medical

[45] Further hospital beds are provided by charitable organizations (16%), sickness funds (8%), and private hospitals (6%).

profession, and to represent medical doctors in negotiations – for example with the social insurance institutions' (Bundesminister für Gesundheit 1996: 64). Most of the self-employed doctors have a contract with one or more state insurance funds. These contracts are based on collective agreements on a regional level between the Austrian Medical Association and the Main Association of Austrian Social Insurance Institutions. Self-employed doctors can be paid (as a rule) on a fee-per-service or (as an exception) on a fee-per-case basis.

Figure 3: Organizational structure of the Austrian health system



Within the Austrian social insurance system, health care is the most fragmented institution.[46] To improve co-ordination of the various health and social services, some of the Austrian regions have implemented health and social units (*Gesundheits- und Sozialsprengel*).[47] Closer co-operation between different service providers is intended to ensure that patients receive the services they need; greater targeting of health services is therefore planned.

Great Britain

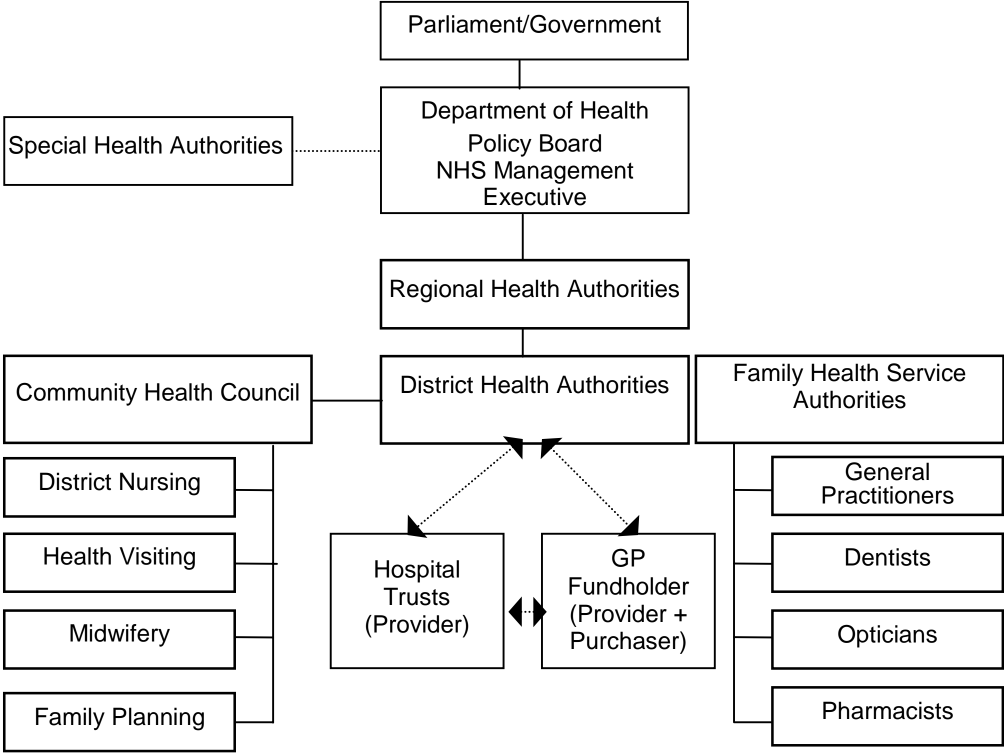
The British National Health Service (NHS) is financed mainly from taxes, and the budget is set by the central government. Since the NHS was founded, there have been a number of structural changes. The most recent reforms (starting in the late 1980s) have implemented market mechanisms in the field of health care.[48]

Since 1974 14 Regional Health Authorities (RHAs) have been the administrative bodies under the Department of Health. RHAs are responsible for planning and distributing resources within the NHS as well as supervising District Health Authorities (DHAs) and Family Health Service Authorities (FHSAs). The 190 DHAs are at the core of the British

46 Tálos and Wörister 1994: 76.
47 Bundesministerium für Gesundheit 1996: 55f.
48 Ham 1992; LeGrand and Vizard 1998.

health care system. They function as health service purchasers for the population of their district. To do so, they must collect data on health services covering the needs of their residents as well as information on which service providers deliver services at the lowest cost. On this basis DHAs make contracts with service providers, for example with hospital trusts (see below). In 1996 DHAs were joined with FHSAs to develop integrated health authorities. These authorities co-operate with general practitioners and local governments.

Figure 4: Organizational structure of the British National Health Service



The reforms since the late 1980s gave hospitals the chance to opt out of the NHS and gain an independent 'self-governing' status as Hospital Trusts. 'The reforms embodied in the 1990 NHS and Community Care Act and introduced on 1 April 1991 represented the greatest change in the organisation and management of the NHS since it was established. In essence, an internal market has been created within the NHS in which the responsibility for purchasing, or commissioning, services has been separated from the responsibility for providing them' (Robinson 1994: 2). The first National Health Service Trusts were implemented in April 1991. They are free to determine their own management structures, to employ their own staff, and set their own terms and conditions of service. In 1994, more than 90% of all hospitals had the status of independent Hospital Trusts, so that this market mechanism is now well established within the NHS. In April 1991, general practitioners also were given the option of independent status as General Practitioner Fundholders, under the condition that they have 11,000 (later 7,000) patients on their list.[49] In 1997 about 50% of the

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[49] Ham 1994: 19-20.

population were registered with a GP Fundholder. Practices with this status receive a budget calculated on the basis of the number of patients, their age, sex and further criteria; this budget has to cover the costs for some hospital services for their patients and for pharmaceuticals (less co-payments), the salary of the practice staff, and investment in the practice.[50]

Further, services of general practitioners are mainly organized by FHSAs. After the reforms of the 1980s and 1990s, general practitioners remain the 'gatekeepers' of the health care system. They are responsible for deciding whether patients should be admitted to hospital and therefore exercise major control over access to health services. Despite the introduction of budgets for GP Fundholders (who control about 10% of total health expenditure) most reimbursements of self-employed doctors are still on a fee-per-patient basis. FHSAs are responsible for co-ordinating services by general practitioners, dentists, opticians, and pharmacists; for negotiating contracts; and for paying out reimbursements. Since 1987, reforms (Promoting Better Health, 1987; Working for Patients, 1989; Caring for People, 1989) have given FHSAs and DHAs further responsibilities, such as providing the population with necessary information and dealing with complaints, supervising what medicines doctors prescribe, co-operating with RHAs on implementing the Fundholding principle, as well as writing reports for the Department of Health.[51] The reforms are targeted on improving primary health care, health promotion and preventive care by introducing a fee-per-patient reimbursement for dentists when treating children, along with regular check-ups and further preventive health measures.[52] Some health services for children are provided in their homes by health visitors who work in close co-operation with general practitioners.

The health care systems of Germany and Austria have been characterized as fragmented. As health insurance systems their organizational structure is based on the relation between health insurance funds that finance the health system, and the medical associations that represent the interests of medical service providers. Health services for children are only partly the responsibility of the statutory health insurance. Since they are not in line with the insurance principle, these services have been externalized and transferred to other institutions. Some responsibilities have been taken up by public health authorities, though without the co-operation of service providers of the statutory health insurance. In general the health insurance systems lack an institution to co-ordinate different health services at the local level and act as a contact for patients. This institutionalized fragmentation exists to a lesser degree in Austria than in Germany. The Austrian population is in general covered by nine territorial health insurance funds on a regional level and therefore the co-ordination of health services on the level of the Austrian *Bundesländer* is possible in principle. The introduction of local health and social units at the local level (*Gesundheits- und Sozialsprengel*) represents a step towards closer co-operation between local governments and territorial health insurance funds (*Gebietskrankenkassen*).[53] In Germany, co-operation at

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[50] Johnson 1990: 81.
[51] Ham 1993: 166-67.
[52] Ham 1991: 7-8.
[53] Bundesministerium für Gesundheit 1996: 55f.

the local level is more difficult because of the communication required between local governments, public health authorities, medical associations, and a wide range of (private and statutory) health insurance funds.

Denmark and Great Britain do not have these problems. The idea of health care as a social right implies that children are directly included in the health care system. Corresponding to this direct inclusion of children, structures have been developed to take their needs into account, co-ordinate health services for them and therefore support children's health. While in Denmark at the local level the political structure and the structure of the national health system overlap, thus integrating health and family policy within one administrative unit, in Great Britain the NHS (District Health Authorities) has been separated from the political structure (local governments). In Great Britain different child health services are mainly co-ordinated not by local governments, but by Family Health Authorities and Community Health Councils.

2.4 Comprehensiveness of health services

How comprehensive are health services for children in the four health care systems? A comparison of health employment provides an initial overview of the quantity of health services. In Germany, total health employment (2,850 per 100,000 inhabitants) is about one-third higher than in Denmark or Great Britain.

The density of general practitioners is nearly twice as high in Germany (110 per 100,000 inhabitants) and Austria (120) as in Denmark (63) and Great Britain (59). This difference is of interest because in Denmark and Great Britain access to health care is channelled by general practitioners, who also provide services (preventive health examinations, immunization, etc.) that in Germany and Austria are partly the responsibility of paediatricians and gynaecologists.

Table 1: Health employment per 100,000 inhabitants (1995)

	Denmark	Germany	Austria	Great Britain
Total health employment	2,108 (1993)	2,849	n.a.	2,035
Practising physicians	290 (1994)	336	266	156 (1994)
Practising specialists	n.a.	200	150	n.a.
General practitioners	63	112	124	59 (1994)
Practising dentists	52	74	46	38
Nurses	673	900	856	414 (1985)

OECD Health Data 1998

Table 2: Employment in family health services per 100,000 inhabitants (1994)

	Denmark	Germany	Austria	Great Britain
Gynaecologists	n.a.	16.1	10.9	6.6
Paediatricians	n.a.	12.8	8.7	6.2
Midwives, child health nurses, public health nurses, visiting nurses	69.8	60.6	57.2	150
Children's dentists	21.2	0	0	0
Health staff for babies and schoolchildren	27.5	n.a.	n.a.	5.2

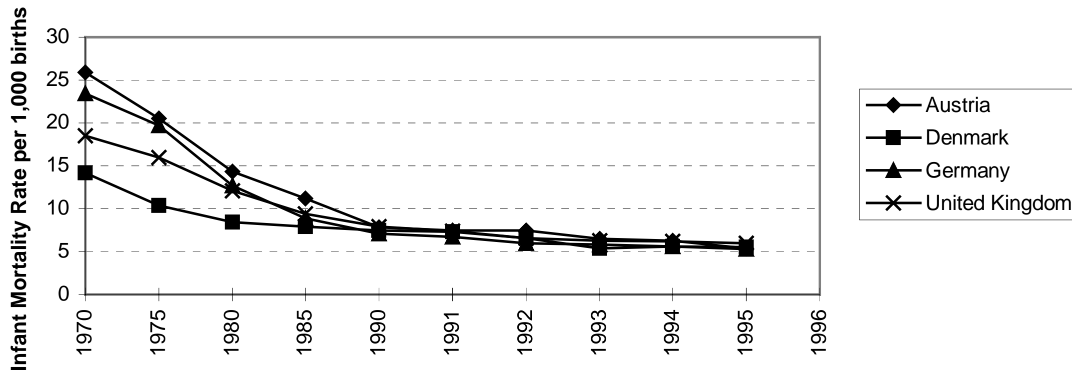
Sources: DK: Social sikring og retsvæsen, Statistisk Årbog; D: Daten des Gesundheitswesens 1997; A: ÖSTAT; Gesundheitsbericht 1997; UK: Regional Trends 33, 1998; Compendium of Health Statistics 1998

Germany has more than twice as many specialists (gynaecologists, paediatricians) working in the field of family health care as Great Britain (data for Denmark are not available). To compare health staff for children, midwives, child health nurses, public health nurses and health visitors have been added. While the number of specialists is higher in the two insurance systems, the number of non-medical staff is much higher in Great Britain and—when health staff for infants and schoolchildren is included—in Denmark, indicating that there is a stronger focus on high-quality care in Germany and Austria while Denmark and Great Britain give non-medical staff more priority in the field of child health care. In the following sections health services for children—medical examinations (2.4.1), home visits by public health nurses (2.4.2), school health services (2.4.3), and child dental care (2.4.4)—are analysed in more detail.

2.4.1 Health examinations for children

Pre- and antenatal preventive examinations have important effects for the health of children. Since health examinations for children were introduced in reaction to high infant mortality rates, this chapter starts with a comparison of mortality data before focusing on preventive care in the four countries. While a low stillbirth rate is an indicator of good antenatal care, a low death rate during the first week of life indicates effective obstetric and perinatal care. In general, the infant mortality rate is used as an indicator for the quality of antenatal and perinatal care (see Figure 5). In 1970 infant mortality in Austria (25.9 per 1,000 births) was nearly twice as high as in Denmark (14.2). Germany (23.6) and Great Britain (18.5) were between these extreme points. Up to now there has been a considerable decrease in infant mortality in all four countries: in 1996, the infant mortality rate was 5.2 in Denmark, 5.0 in Germany, 5.1 in Austria and 6.1 in Great Britain.

Figure 5: Infant Mortality Rate per 1,000 births



OECD Health Data 1998

These are very good results when compared with other OECD countries. Each country has achieved these results by different means. In Denmark, child health care is linked to the municipal health administration, while check-ups for children are the responsibility of the counties. Children visit general practitioners, and public health nurses make home visits, both according to standard schedules. Children are entitled to free medical examinations at the age of 5 weeks, and 5, 10, 15, and 24 months. In 1994, more than 97% of all children up to the age of two years received these medical examinations. Children over the age of 24 months have annual check-ups until they reach school age. More than 95% of all children under the age of one received immunizations from the family doctor against whooping cough, diphtheria, tetanus and polio.[54] In 1996 a new Act concerning preventive health measures for children and young people came into effect. It was intended to improve co-ordination of the various health measures to improve health and prevent disease of children.[55]

In Germany, curative health care measures have priority over preventive services. In 1971, when the 'early diagnosis program' (*Früherkennungsprogramm*) was introduced, Germany and Austria had the highest infant mortality rates of the four countries. 'Early assessment of disabilities and developmental risk is a necessary precondition for any intervention service' (Klein 1996: 58). This insight has only recently gained acceptance in Germany. The Health Structure Act (*Gesundheitsstrukturgesetz*) of 1993 introduced health promotion as an independent health policy task of the statutory health insurance. Child preventive health care as a legal responsibility of the statutory health insurance is laid down in §21, Fifth Book of the Social Security Code (*Sozialgesetzbuch V*); it is financed by the statutory health insurance. Today, nine preventive health care measures are provided by a paediatrician or general practitioner for children after birth, at the age of 10 days, 6 weeks, 4, 7, 12, 24, 48 and 64 months. Five immunizations are part of the nine preventive health examinations. The high

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[54] Sygesikringstatistik 1994; NOMESCO 1996; Ministry of Health 1997.
[55] NOMESCO 47: 1996.

participation rate of 90% indicates that the early diagnosis programme for babies and children is highly institutionalized.[56]

The success of the comprehensive measures is shown by the low infant mortality rate in the most recent years, similar to the rate in the other three countries. In contrast to Denmark, this result has mainly been achieved through increased treatment by specialists. The German system is demand-based,[57] and there is no way of checking whether those who are entitled to preventive health care actually use it. There is therefore the risk that especially children in low-income groups only have irregular health check-ups. Further, according to Meireis (1995: 66), there are only weak financial incentives for doctors to provide preventive health services.

In Austria, health examinations for babies and children have been the responsibility of the statutory health insurance since 1974. Until December 1996 there was a financial incentive (1,008 ECU in total) for regular participation in the preventive child health examinations. According to the mother-and-child health card, eight preventive health examinations have to be provided by a general practitioner or paediatrician. The examinations are supposed to be carried out in the first and fifth week after birth and at the age of 4, 8, 12, 24, 36, and 48 months. An orthopaedic health check is included in the third examination, the fourth examination includes a ear, nose and throat check, and the fifth an ophthalmic examination. In the first, 12th and 16th week of the child's life an ultrasound scan of the hip can be carried out. Participation in the Austrian immunization scheme is voluntary; immunizations are recommended and—if delivered—written down in the mother-and-child health card. The Ministry of Labour, Health and Social Affairs provides free immunization against tuberculosis, diphtheria, tetanus, measles, mumps, and German measles;[58] 90% of all children were immunized against polio, diphtheria, and tetanus, and 60% against mumps and German measles.

In Great Britain more than 90% of all births take place in hospital. The first health check is delivered before the mother and her newborn child leave hospital. If health problems are diagnosed, the general practitioner or health visitor must be informed. A further five health examinations are provided at the age of 6 weeks, 8, 21, and 39 months and when children start school at the age of five years.[59] All children have a right to these health checks: 'failure of a health professional to offer and carry out these tests, in the absence of special justifying circumstances, could lead to an action for compensation if it can be shown that had the defect been detected earlier, greater harm could have been prevented' (Dimond 1996: 221). From April 1990 on, general practitioners receive separate payment if they achieve immunization targets. By the end of 1990 70% of all general practitioners reached the upper target (90% of two-year-olds fully vaccinated with three doses against diphtheria, tetanus and polio, three doses against pertussis, and one dose against measles) and a further 17% reached the lower target (70% of the children on their list fully vaccinated). These

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[56] Daten des Gesundheitswesens 1997.
[57] Meireis 1995: 66.
[58] Gesundheitsbericht 1994.
[59] Davies and Davies 1993: 122f.

immunization target payments have turned out to be quite successful: in 1995/96 95% of all children received the recommended immunizations.[60]

The primary health care team has a central role in the delivery and co-ordination of child and family health services. 'The primary health care team concept has evolved since the start of the National Health Service (NHS). The attachment of community nurses, health visitors and midwives strengthened the view that delivery of good and efficient primary care depended on close co-operation between the various health professions and occupational groups' (Davies and Davies 1993: 189). General practitioners are supposed to carry out the health examinations for children in close co-operation with other health professions such as midwives and health visitors. DHAs are responsible for community child health services. 'In most districts these services are under the general supervision of a paediatrician with a special interest in community and child health. ... Immunisation is the responsibility of a designated doctor in each district' (Davies and Davies 1993: 114).

2.4.2 Home visits by public health nurses

In Denmark, the municipal health authorities are notified of all births and are responsible for the health care services offered to mothers and children by a visiting nurse. Every newborn is visited monthly by the health visitor for the first six months of its life. In special cases visits can continue until the child is two years old. In 1995, children under the age of one received 7.5 home visits on average.[61] 'Through the health visitors the local authorities, as part of their health care programme, are responsible for giving free advice, assistance and health examinations to check functional deficiencies of school children until the end of their compulsory education' (Ministry of Health 1997: 51). In 1994, 1,394 visiting nurses were employed by the municipalities. Group activities where parents with children meet at a room of the local authority and receive preventive health service, information, etc. for their children have become more important, and there were fewer home visits in recent years. Group activities increased more than 50% from 1989 to 1994, and in 1995 there were 11,061 groups with 38,468 meetings and 219,632 appearances.[62]

In Germany, health visits are the responsibility of neither the statutory health insurance nor the public health authority. But mothers have a right to visits by a midwife who checks on the health of the mother and child. Within 10 days after birth, up to 10 visits by a midwife can be reimbursed from the statutory health insurance. Until the eighth week after birth an additional eight visits can be provided. These home visits by a midwife are not regularly provided. But since up to 18 visits can be reimbursed by the statutory health insurance, it could be a basis for developing a health visiting system comparable to the Danish one.

In Austria as well, health examinations by general practitioners or paediatricians are not supported by home visits of public health nurses. The health report of 1997 (*Gesundheitsbericht 1997*) suggests that the mother-and-child health card should focus not

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[60] Social Trends 28, 1998: 134.
[61] Sundhedsstyrelsen 1996.
[62] Sundhedsstyrelsen 1996.

only on health promotion of mothers and children but include the social environment of the family,[63] as do the Danish and British health visiting schemes.

In Great Britain the midwife is responsible for health care of the newborn child for the first six or eight weeks after birth. After this period the health visitor advises the family concerning the health of the child regarding such matters as immunization, accident prevention, hygiene, and nutrition. The health visitor is generally employed at a health centre, and after about six weeks mothers are advised to bring their baby to be seen at the health centre or child health clinic. 'Most mothers attend regularly, especially during the first year of the baby's life. The fact that mothers come to a health centre or clinic does not mean that the health visitor ceases to visit the home, although the frequency of visiting is usually reduced' (Davies and Davies 1993: 126). If needed, the health visitor arranges for the general practitioner to examine the child. Immunization schedules are checked by the health visitor, who encourages parents to complete all immunizations. In 1995 midwives, public health nurses, and health visitors provided 5,633,000 preventive health treatments.[64] On average, all newborn children received 8.4 preventive health treatments.[65]

2.4.3 School health service

In Denmark, the municipalities are responsible for the medical examinations of all children by school and nursery school medical officers. In 1982, a new school health scheme was introduced. Compulsory examinations by a general practitioner were reduced to one, when children start school. Health nurses became the core of the school health scheme: they examine each schoolchild up to the ninth grade once each year,[66] checking (1) the physical, mental and psychosomatic condition of the children, (2) their linguistic and intellectual development, (3) behaviour disorders, (4) social burdens, and (5) chronic illness or handicap.[67] During preschool and the first school year, about 90% of all children in this group were examined. On average, more than three-quarters of all children up to the ninth grade were examined in 1993/94.[68]

In Germany, the responsibility for preventive measures for children and juveniles is transferred from the paediatrician or general practitioner to the 'youth health service' (*Jugendärztlicher Dienst*) when children start school. A paediatrician of the public 'youth health service' provides three regular preventive examinations. As part of these examinations, the immunization schedule is continued.[69] The focus is not on organic diseases but on psychosocial issues. The 'youth health service' is assigned to provide health education and preventive health care for schoolchildren.[70] These services are financed by the local government or the *Bundesland* responsible for the public health authority. In contrast to

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[63] Gesundheitsbericht 1997: 113f.
[64] Data for England and Scotland; Social Trends 28, 1998: 151.
[65] Data for England; Department of Health 1997: 24-32.
[66] Juul et al. 1989.
[67] Juul et al. 1989: 27.
[68] Sundhedsstyrelsen 1995.
[69] Meireis 1995.
[70] Meireis 1995: 66-77.

health examinations by self-employed paediatricians these services are provided in public institutions, thus ensuring greater supervision of children's health.[71]

Austria provides school health examinations for all children from their sixth to their 18th birthday. In general a standard annual health examination is provided for this age group. These examinations are regulated by the Ministry of Labour, Health and Social Affairs; they are not the responsibility of the statutory health insurance. The focus is on the examination of hearing, eyesight, and the children's physical condition. The General Social Insurance Law (§ 154 ASVG) provides for co-operation of school health staff with other preventive health institutions.

In Great Britain a medical doctor appointed by the DHA is responsible for organizing the school health scheme together with a senior nurse officer. They have to ensure regular contact and exchange between the members of the primary health care team. All children receive regular examinations by a school medical doctor at preschool, when they start school, and at the age of 14 years. If health problems are observed by school health nurses, teachers or parents must make sure that further health examinations are carried out. School doctors and school health nurses are responsible in particular for investigating communicable diseases in the school, and for continuing the immunization programme, as well as health education and hygiene.[72]

2.4.4 Child dental health care

In Denmark, systematic preventive oral health care was instituted by the Child Oral Health Care Act, 1972, requiring municipalities to establish children's oral health care clinics for the treatment of all children under the age of 16 (since 1986 under 18). The 16- and 17-year-olds can choose between municipal clinics and private practitioners. Oral health care must include general as well as individual preventive measures, regular examination of the dental development and oral health of each child, and treatment of oral disease and malocclusions to the extent necessary for maintaining the oral system in a healthy and functional condition. In 1972, children were examined every six months. Now that caries have substantially been brought under control, examination intervals are typically 10–12 months.[73] In general, municipalities staff their own clinics. Children's dentists are paid by agreement, but have standard working hours and a standard salary. The child oral health care program is decentralized, i.e. clinics are located throughout the municipalities. Most are in schools.[74]

In Germany, systematic preventive dental health care for children is not part of the statutory health insurance with the exception that insured persons from age of six up to age 20 have the right to one preventive dental health care treatment per year.[75] Some examinations are provided at schools by the public 'youth health service'.

In Austria there is no regular preventive dental health care programme for children providing standardized services. Some examinations supposed by the dentists' reimbursement

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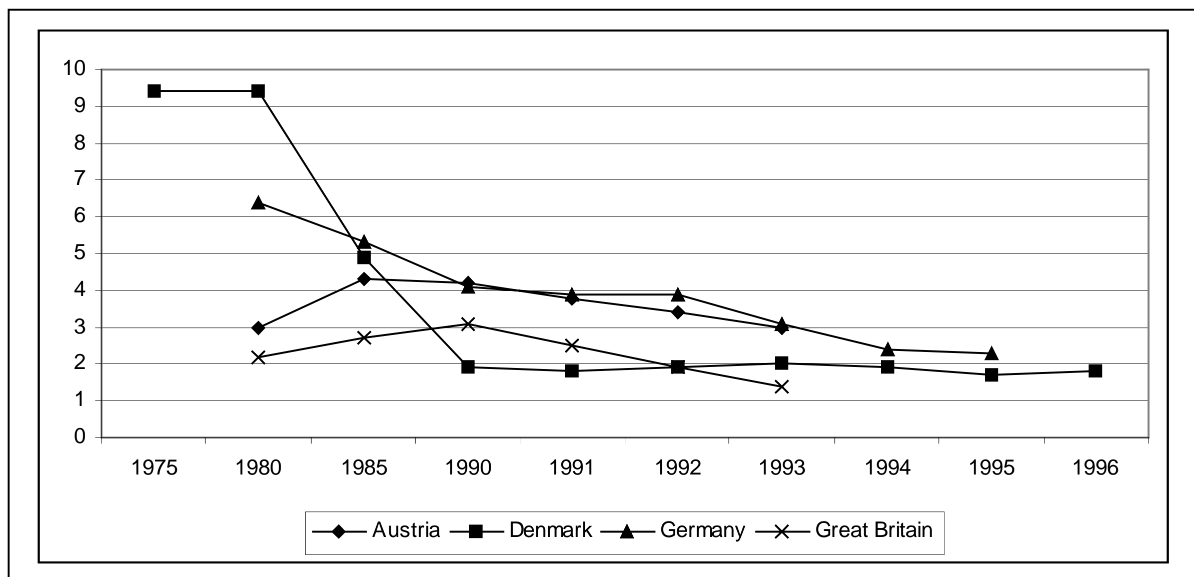
71 Meireis 1995: 67.
72 Davies and Davies 1993: 131f.
73 Friis Hasché 1994.
74 Friis Hasché 1994.
75 Sozialgesetzbuch V (SGB V), § 21.

scheme are free of charge and are therefore of preventive character,[76] and within the framework of the youth health scheme (*Jugendlichenuntersuchungen*) dental health is checked as part of the basic health examinations (*Basisuntersuchungen*). In § 156 ASVG a voluntary preventive dental health care programme is proposed for schools and kindergartens. In some regions dental health checks have been implemented,[77] but the programme is not legally binding and there are considerable differences between the *Bundesländer*. In 1989 a survey on the dental development of children at age 6 indicated a caries rate of 60 to 80% in the *Bundesländer*. In reaction, some *Bundesländer* introduced comprehensive caries prophylaxis programmes. In Styria for example child dental health nurses visit kindergartens four times a year and primary schools three times a year. The participation rate increased to 83.6% in kindergartens and to 89.1% in primary schools in 1993.[78]

In Great Britain new dentist's contracts were introduced in October 1990. Now children can be registered with a dentist who is paid on a per-patient basis instead of a fee-for-service basis as before. Children up to age 16 (or, if in vocational training, up to age 19) receive dental treatment free of charge. In 1996/97 7,270,000 children were registered with dentists in England.

Figure 6: Decayed, missing or filled teeth at age 12



OECD Health Data 1998

The Danish child dental health scheme introduced in 1972 has turned out to be quite successful. The rate of decayed, missing or filled teeth (DMF) of children at age 12 was reduced from 9.4 in 1980 to 1.8 in 1996. In both Germany (2.3 DMF in 1995) and Austria (3.0 DMF in 1993) children's dental health improved considerably. With 1.4 DMF teeth of children

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[76] Hauptverband 1998.
[77] Mayrhuber, Pink, Müller-Bruckschweiger 1996.
[78] Soziale Sicherheit 6/1994.

at age 12 (1993), Great Britain shows the best results. The data indicate that national health systems with their strong focus on prevention and health promotion result in good health for children. Child dental care is a field of health care where effects of targeted preventive measures can clearly be shown, while in other parts of the health care system it is often uncertain whether good health status is the effect of good quality of service.

2.4.5 Child health services in comparison

As the Black Report (1980) and the WHO publications indicate, good co-ordination of the various health measures is essential for good results in health care, as are services targeted on the specific needs of certain risk groups. The health services compared in this chapter indicate that this is especially the case in national health care systems. In Denmark babies and children up to the age of six are entitled to eight examinations by a general practitioner; these health checks are supplemented by home visits from public health nurses who check children's health once a month during the first six months of life and, if necessary, continue home visits until the child is two years old. When children start school they are examined by a school medical doctor, and later the responsibility for checking the health of schoolchildren is taken over by school health nurses who examine children once a year. The child dental health programme is also directly targeted at the needs of children who are examined every 10 or 12 months by a children's dentist. With the exception of the general practitioner, who is reimbursed by the regional health authority, all services are financed and co-ordinated by local authorities and co-operation between general practitioners, health visitors and school health nurses is promoted.

In Great Britain, the primary health care team is mainly responsible for health services and health prevention for children. General practitioners, community nurses, health visitors and school health nurses are, among other health professions, part of the primary health care team, ensuring good co-operation between the different service providers. With only three health examinations by general practitioners, the British NHS provides the fewest health examinations during the first year after birth, thus additional health checks by health visitors are especially necessary during this period of the child's life. To promote preventive dental health care, the fee-per-service payment for dentists has been replaced by a per-patient scheme. Data provided in figure 6 indicate the good quality of the British child dental health programme.

In Germany there is a strong focus on specialist health care during the first year of the child's life, when six of the nine preventive health care examinations are provided. Visits from a midwife can also be reimbursed by the statutory health insurance, but only within the first eight weeks after birth. In contrast to Great Britain, children receive the most attention from the health care system when they are very young, and for children older than one year few services are provided. When children start school, the public health authority, rather than the general practitioner or paediatrician, becomes responsible for their check-ups, including dental examinations. In general there is no systematic prevention and health promotion for children in Germany, services of the different health professions are not co-ordinated (see Figure 2), and there is no service provider with a supervisory function in the health care

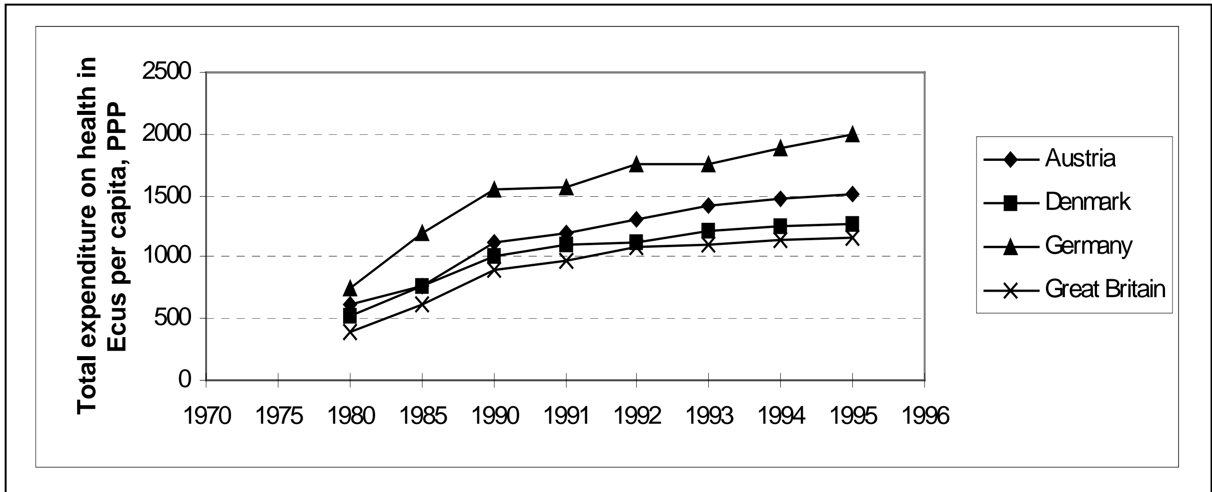
system like the health visitors and general practitioners in Denmark and Great Britain. Since the close relation of a child to a family practitioner is not institutionalized, no regular examination of children's health is guaranteed.

Austria is planning to strengthen the family doctor principle. The introduction of fees for health insurance certificates is intended to promote a closer doctor–patient relationship. In comparison to Germany, the Austrian statutory health insurance is less fragmented, and it is therefore easier to co-ordinate child health services as in pilot schemes such as health and social units (*Gesundheits- und Sozialsprengel*). In order to promote child dental health, some *Bundesländer* have introduced child dental health nurses, a first indication that specialist health care will be supplemented by other health professions.

2.5 Financing

In all four countries a considerable part of GDP is spent on health care: in Denmark health expenditure is 6.4% and in Great Britain 6.9% of GDP, in Austria and Germany it is significantly higher, at 7.9% and 10.5% respectively. Calculated in ECU per capita, health expenditure in Germany is about 31% higher than in Austria, 56% higher than in Denmark, and 72% higher than in Great Britain (see Figure 7). In comparison to the other countries, Germany has not been able to implement effective cost control mechanisms.

Figure 7: Health expenditure in ECU per capita



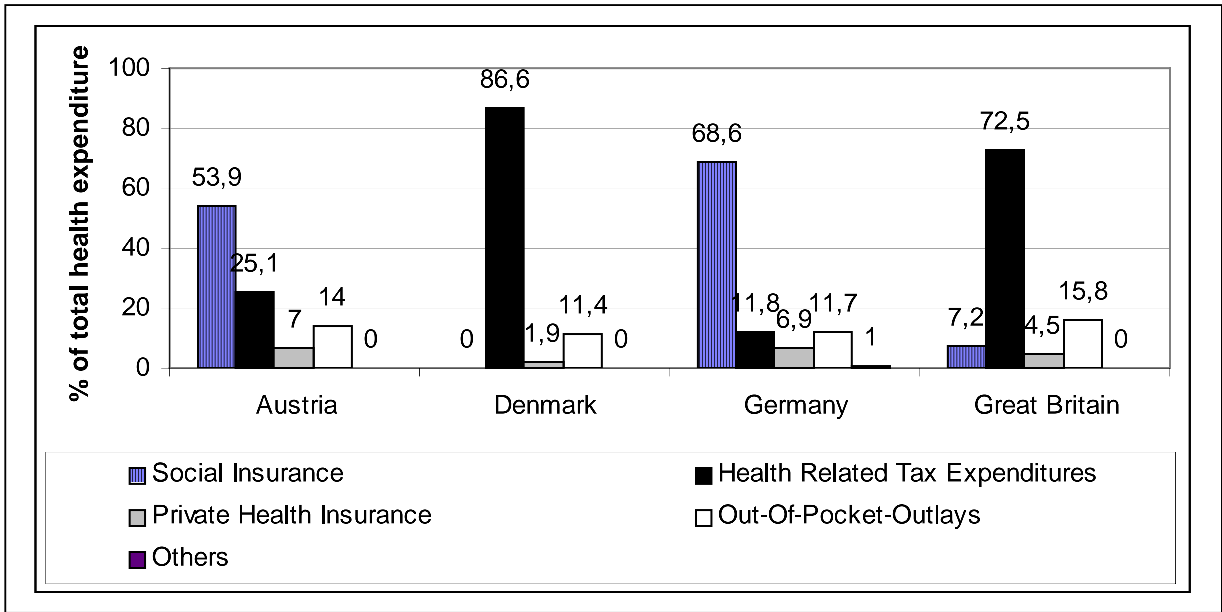
OECD Health Data 1998

The health budgets are financed from taxes, social insurance contributions, private health insurance or direct payments from private households. With the principle of financing, some preliminary decisions have been made about the health systems: financing from taxes or from insurance contributions effects a considerable redistribution from higher- to lower-income groups, from single-person households to family households, and from healthy to sick persons. When most of the population is covered by private health insurance, hardly any

redistribution takes place. If costs are transferred to private households, a similar effect takes place. The argument in favour of co-payments is that they increase self-reliance and thus reduce demand for health care to the amount that is medically necessary. High co-payments mean however that the costs are increased for those in poor health.

Sections 2.5.1 'Taxes and insurance contributions', 2.5.2 'Private insurance', and 2.5.3 'Co-payments' investigate what effects different principles of financing have and whether families with children are financially supported or whether they experience additional financial burdens. When comparing health financing one has to take into account that not all data are of good quality and in comparable form. Schneider et al. (1998: 37) describe this problem as follows: 'Until now the Federal Statistical Office has presented no detailed budget showing revenues and expenditures for the German health care system. Most other countries as well lack such a budget. In its health expenditure calculation the OECD just differ between public and private expenditure'.

Figure 8: Sources of financing in % of total health expenditure



OECD Health Data1998

2.5.1 Taxes and insurance contributions

The national health services are mainly financed through taxation: 72.5% in Great Britain and 86.6% in Denmark. These data show that other sources of financing are of minor importance in the two countries. Since 7.2% of the British NHS is financed out of insurance contributions and private insurance also contributes to health financing to a larger extent, tax financing is lower in Great Britain than in Denmark. In spite of the growth of private health insurance, the basic principles of the British NHS have been maintained since 1948. These principles—tax financing, free and equal access, and comprehensive health care for all citizens—survived

even the years when the Thatcher government started to implement market principles in the NHS.[79] In Denmark the share of tax financing is even higher than in Great Britain. With 1.9%, private insurance is only of marginal importance. The Danish population does not consider health services beyond the basic health care provided by the national health system to be necessary. This assumption is supported by the fact that for some co-payment arrangements only 2.6% of the Danish population choose another category that allows patients unrestricted access to general practitioners and specialists (data for 1994).

Tax financing is of lesser importance in the two health insurance systems. While in Austria 25.1% of total health expenditure is financed out of taxes, the share is only 11.8% in Germany. Health insurance contributions cover 68.6% of total health expenditure in Germany and 53.9% in Austria. These data published by Schneider et al. (1998) are in contrast to what had been expected when considering the higher coverage of the Austrian statutory health insurance. Although in Germany higher-income groups, self-employed persons and civil servants are not included in the compulsory insurance scheme, this scheme makes up a greater proportion of total health expenditure.

The Austrian statutory health insurance spends 7.5 billion ECU on health services.[80] It is mainly financed out of insurance contributions of employers and employees. Workers and their employers pay 3.7% each, and employees and their employers contribute 3.15% of gross income (data for 1997). The income threshold is 2,697 ECU per month.[81] Above this level no further contributions have to be paid. Eight million Austrians are covered by the statutory health insurance; 40% of them are workers and employees in the compulsory insurance scheme, along with voluntarily-insured persons, 34% are family members who do not pay own contributions, 23% are pensioners, and 3% are unemployed persons.

The German statutory health insurance spent 106.5 billion ECU on health services in 1994.[82] Eighty-three billion ECU of the total budget comes from insurance contributions from employers and employees, 18.2 billion ECU from contributions of pensioners, and 5.3 billion from other sources. The average contribution was 6.625% of gross income for employers and employees in 1994 up to an income threshold of 2,568 ECU per month. Workers and employees with a higher income are allowed to opt out of the statutory health insurance and purchase private insurance. In the statutory health insurance 30.4% are covered by a family insurance without paying own contributions.

In Austria a higher percentage of total health expenditure is financed from taxes. Some health services, for example mother-and-child health care examinations or maternity benefit, are reimbursed by the family burdens equalization fund that is partly financed from taxes. Fifty per cent of youth health examinations and the total costs of preventive health care for uninsured persons are financed out of general taxation as well.[83] The higher share of tax financing in Austria and the regulation that higher-income groups are not allowed to opt out of the statutory health insurance means that the contribution level is much lower than in

[79] Ham 1993; Ham 1994; Klein 1995.
[80] Hauptverband 1997a: 14.
[81] Hauptverband 1997a: 151f.
[82] Daten des Gesundheitswesens 1995.
[83] Tálos and Wörister 1994: 121.

Germany (in Austria employers and employees together pay 7.4%; in Germany the rate is 12.5%). Another effect of the exit-option of higher-income groups is that the coverage of children and other persons in need of care is the responsibility of the community of those covered by compulsory insurance rather than the whole society. But even for the German statutory health insurance with its strong connection to the labour market, it is increasingly proposed that the protection of weak parts of the population should be the responsibility of the whole society.[84]

What are the effects of these different principles of financing? Since national health systems are mainly financed by (progressive) taxes, there is a high redistribution effect from higher- to lower-income groups. The principle of solidarity is therefore very strong in both national health systems. Since tax progression is higher in Denmark than in Great Britain and a higher proportion of health expenditure is financed out of taxation the redistribution effect is also greater in Denmark. When health systems are mainly financed from insurance contributions (with a fixed proportion of the gross income) the redistribution is weaker. Because of the income threshold for higher-income groups, there is even a regressive development of insurance contributions: above a certain level, contributions remain constant and decrease as a proportion of gross income.

While national health systems lead to greater redistribution from higher- to lower-income groups, health insurance systems cause greater redistribution from single-person households to family households. Since non-employed family members are in general insured by the statutory health insurance without paying own contributions, single-person households finance a considerable part of the costs for health care of family households when only one family member has compulsory insurance.[85] For Germany, Pfaff and Pfaff (1995) come to the conclusion that families have a considerable financial advantage when at least two family members are insured without paying own contributions. Since this advantage is greater when a spouse and one child are covered by the free family insurance than when two children are covered, in Germany marriage with one non-employed spouse receives more support than children.[86] In Germany redistribution takes place only within the statutory health insurance; privately-insured persons do not participate in the financial support of the family.

2.5.2 Private insurance

Private insurance calculates contributions according to the health status of the insured person. 'Private insurance systems cover individuals or groups, setting premiums on the basis of their risk characteristics. They are flexible, providing a range of insurance packages with different degrees of risk. High-risk individuals may find it difficult to obtain coverage' (OECD 1995a: 22). Reliance on private insurance distributes the burden according to ex ante expectation of illness. The higher the share of private insurance, the more health costs are left to high-risk groups. For example, women—partly because of the costs of delivery—are

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[84] Sachverständigenrat 1997: 295

[85] Sachverständigenrat 1997: 272.

[86] Pfaff and Pfaff 1995; Daten des Gesundheitswesens 1997.

considered a high-risk group and have to pay higher insurance premiums than men. Parents have to purchase separate insurance policies for their children. The principle of solidarity is not relevant and there is no special focus on those population groups that are most in need. In Germany private insurance pays 6.9% of total health expenditure, in Austria 7.0%, in Great Britain 4.5%, and in Denmark only 1.9%.

Since in Denmark and Great Britain private insurance premiums are in addition to the tax-financed national health systems, there is still a redistribution from higher-income groups to those who are only covered by the national health systems. In Denmark 27% of the population have some kind of private insurance. Members are reimbursed for co-payments for pharmaceuticals or dental care by their private insurance.[87] In Great Britain the Thatcher government tried to strengthen private insurance starting in 1979.[88] It was suggested that private health insurance should partly replace the NHS, but this idea did not gain acceptance.[89] The share of the population however that purchases private insurance increased from 5% in 1979 to 15% in 1997, although the only new measure to promote private insurance was the introduction of tax incentives for people aged 60 and over.[90] In national health systems private insurance is only a complementary insurance, and people cannot opt out of the system. The share of private insurance in financing health care is still very low in both countries.

In Austria as well private insurance is only possible as complementary insurance. According to the Ministry of Labour, Health and Social Affairs, 1.1 million Austrians purchased private insurance in 1996, or 13.7% of the population. The complementary private insurance provides higher-quality hospital care and reimbursement for the cost of choosing a doctor without a contract with the statutory health insurance (*Wahlarzt*) to reduce waiting times. Further, co-payments for pharmaceuticals or stays at health resorts are reimbursed by private insurance.[91] Germany is the only one of the four countries where private insurance can be purchased not only as complementary insurance. Self-employed persons are not included in the statutory health insurance, and workers and employees with a salary above the income threshold (2,635 ECU) can opt out of the statutory health insurance. Civil servants are partly covered by the state: 70% of the costs for health services are covered by the state and 30% has to be covered by private insurance. For children the state contributes 80% of the health costs. In total 6.9 million people had only private insurance in 1993. An additional 5.3 million persons had complementary insurance, so that 15.1% of the population was fully or partly covered by private insurance.[92] The number of people covered by private insurance is no more than in the other three countries—the main difference is that in Germany about 8.5% of the population is covered by private insurance only and is not part of the unified community (*Solidargemeinschaft*).

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87 Ministry of health 1997: 16.
88 Mays 1997: 199f.
89 Hill 1994: 429.
90 Klein 1992: 215; Social Trends 1998: 146.
91 Gesundheitsministerium 1996: 77; Volkswirtschaftliche Vertragsgesellschaft 1996: 174ff.
92 Daten des Gesundheitswesens 1995: 292; Bundeministerium für Gesundheit 1993: 32f.

In contrast to the statutory health insurance, in private insurance the principle of equivalence (*Äquivalenzprinzip*) dominates. Each family member has to purchase a separate insurance policy, and the premium depends on age, sex and health status of the insured person.[93] This basic principle in combination with the exit option of higher-income groups in Germany means that high-risk groups and workers and employees with children are covered by the statutory health insurance while single persons with a high income and a good health status choose private insurance. Because this group opts out, the statutory health insurance takes in less in contributions than it must spend to provide health services for this group.[94] The exit option therefore has a direct impact on increasing the contribution level in the German statutory health insurance. Solidarity with high-risk groups and families with children however is left to lower- and middle-income groups.

2.5.3 Co-payments

Co-payments have often been justified as a cost control measure. The argument is that they reduce the 'moral hazard'—the demand for health services that are not medically necessary in return for contributions or taxes.[95] The higher the co-payments, the lower the demand for health services. This would mean however that patients question the treatment of medical doctors and for example do not take the prescription drugs prescribed by the doctor or that people don't seek treatment in the first place unless really necessary—a reaction that in general cannot be expected.[96] Reduced drug consumption can be achieved by controlling the prescribing behaviour of medical doctors. Co-payments do not effectively reduce the demand for health services and therefore do not result in a reduction of total health expenditure. The effect is however that costs for health services are transferred from the state or health insurance funds to private households. Co-payments are a burden for those who regularly use health services due to their bad health, and for lower-income groups. The greater the reliance on direct charges for use, the greater the burden carried by those who are ill. When 'out-of-pocket outlays' are determined, the situation of the family is often not taken into consideration. Low-income families are especially vulnerable to a high proportion of direct charges.[97] For these groups access to health care is made more difficult.[98] The share of co-payments in total health expenditure is 11.4% in Denmark, 11.7% in Germany, 14% in Austria, and 15.8% in Great Britain.

Pharmaceuticals and dental care in particular are partly or completely financed by patients. In Denmark, the health care reimbursement scheme subsidizes certain prescription drugs according to a list published by the Ministry of Health. The drugs are divided into three groups and the subsidy represents 50%, 75% or 100% of their price.[99] In 1991, 45% of the cost for prescriptions was covered by the health care reimbursement scheme.[100]

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[93] Arman and Arnold 1991: 43ff.
[94] Sachverständigenrat 1997: 289.
[95] OECD 1995: 54.
[96] Parsons 1991: 428-479.
[97] See the overview on cost-sharing for health care services in OECD countries in: OECD 1995a.
[98] OECD 1995: 50-55
[99] NOMESCO 1997: 54f.
[100] OECD 1994a.

Prescriptions are free of charge for pregnant women, but not for children. This subsidy provides only limited financial relief for the family. Danes do not have to pay a hospital daily fee so that there are no direct expenses for a hospital stay. For dental care, between 40% and 65% of the cost is reimbursed by the national health service but there is no reimbursement for gold fillings, crowns or prostheses. In Denmark, dental health care for children up to age 18 is free. These services are provided by children's dentists employed by local governments. For families, this results in a financial relief of about 100 ECU per child and year (1987).[101]

In Germany there are co-payments for pharmaceuticals of 4, 5 or 6 ECU according to package size. In 1991 50% of all prescriptions were financed by the statutory health insurance.[102] For therapy (physiotherapy, massage) patients have to contribute 15% of the respective price, and for aids such as bandages or insoles 20%. Unemployed persons, low-income groups (income below 732 ECU per month),[103] children under 18 years, and pregnant women receive these free of charge. For hospital stays, patients have to pay 7.7 ECU per day (up to 14 days per year); again, these user charges do not apply to children. For dentures patients have to pay 55% (45% if they have regular preventive examinations). Orthodontic treatment is reimbursed by the statutory health insurance only for children and young persons up to 18 years. Further dental treatment and preventive measures are completely covered by the statutory health insurance.[104]

In Austria a fee of 3.3 ECU that must be paid up to four times a year for the social insurance certificate was introduced in 1997. The aim of this fee was to give patients an incentive to stay with one doctor for a longer period and therefore to strengthen the family doctor principle. In addition, patients have to pay a prescription charge of 2.78 ECU.[105] For therapy and aids such as bandages patients have to pay 20% of the price. Children up to age 15 (or children entitled to extra family benefit irrespective of age), persons with an income below 496 ECU per month (1994), and patients with certifiable infectious diseases do not have to pay these contributions. During a hospital stay patients have to pay a catering fee of between 4.2 and 4.5 ECU per day in 1997.[106] If the stay exceeds four weeks, family members do not have to pay the fee for the rest of the hospital stay. During pregnancy women do not have to pay user charges. Dental care is free, with the exception of the fee for the health insurance certificate. For dentures and for orthodontic treatment the statutory health insurance reimburses between 50% and 80% of the costs. For repairs the level of reimbursement is 80%.[107]

In Great Britain co-payments contribute 15% to total health expenditure. Patients have to pay either 7.8 ECU per prescription or 111.8 ECU for the whole year and are free of any further co-payments. At 16% of total health expenditure, Great Britain spends the highest proportion on prescription medicine of the four countries. But patients do not have to make any co-

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[101] Friis Hasché 1994.
[102] OECD 1994b.
[103] Daten des Gesundheitswesens 1995: 313.
[104] Bundesministerium für Gesundheit 1994: 115; Kamke 1998: 188.
[105] Hauptverband 1997: 6f.
[106] Braunder 1997: 79.
[107] Arman and Arnold 1991: 40.

payments for 86% of all pharmaceuticals (data for England, 1996). For dental care as well part of the treatment is free or at reduced fees. In total 29% of all dental care was financed by patients in 1996/97.[108] For children dental treatment is free. In general the following groups are free of co-payments: children up to age 16 (18 if in education), women during pregnancy and up to 12 months after delivery, men over 65, women over 60, and persons receiving social assistance.

Table 3: Co-payments (1994, 1995)

	Denmark	Germany	Austria	Great Britain
Co-payments in % of total health expenditure	12%	12%	14%	15%
Fee for social insurance certificate	0	0	3.3 ECU[109]	0
Co-payments for medicine	25%–50%	4, 5 or 6 ECU	2.78 ECU	7.8 ECU 111.8 ECU per year
Co-payments for remedies or aids	n.a.	15%–20%	10% or 20%	n.a.
Co-payments for dentures	35%–60%	45%–55%	20%–50%	30%
Daily fee for hospital stay	0	7.7 ECU[110]	4.2–4.6 ECU	0

The comparison of co-payments indicates that direct charges are not used as an instrument to control costs but to finance the health care system and transfer costs to the patient without reducing health services. Using co-payments to reduce health services has been described as the wrong way because the patients must trust their doctor to prescribe the right medicine. Trust is a necessary condition for a functioning doctor–patient relationship. Therefore in all four countries there are exceptions for those groups of the population for whom co-payments would be a high barrier to necessary health services. Children, chronically sick persons, and low-income groups are in general exempt from user charges.

3 Conclusion

What general conclusions can be drawn from the comparison of the four health care systems? The financing principles of all four health systems give a clear signal: families shall have no additional costs for securing health care for their children. Children are covered in national health services as well as in statutory health insurance systems without paying additional contributions. This is not the case when children are covered by private insurance where they must be covered under a separate insurance policy. In general children are

[108] Department of Health 1997: 27.
[109] Up to four times a year.
[110] Up to 14 days a year.

exempted from co-payments so that direct health costs for private households do not increase the expenditures for children.

Figure 9: Redistribution effects of different principles of financing

principle of financing	redistribution		
	from healthy to sick persons	**from higher- to lower-income groups**	**from single persons to family households**
Taxes	high	high (tax progression)	high (but: indirect taxes counteract redistribution)
Statutory health insurance	high	middle to high (contributions are proportional to income)	high (family members are covered without paying own contributions)
Private insurance	middle	no redistribution	no redistribution
Co-payments	selective (when high-risk groups are exempted)	selective (when low-income groups are exempted)	middle to high (when children are exempted)

The German statutory health insurance is the only one of the four countries with an exit option for higher-income groups, thus for part of the population private insurance is an alternative to the standard health care system. The greater the share of private insurance, the weaker the redistribution effect. Another effect is that the coverage of children is mainly the responsibility of the unified community (*Solidargemeinschaft*) of persons with compulsory insurance and not—as in the other countries—of the whole society. Because the exit option is reserved for higher-income groups and because family members are covered by the statutory health insurance without paying own contributions, people with higher incomes and no children tend to leave the statutory health insurance, while families with children have a high incentive to stay in the statutory health insurance where children are covered without paying additional contributions.

If all parts of the society are included as in Denmark, Great Britain or Austria the only problem is the level of redistribution; there is consensus within the society regarding the direction of redistribution: from high- to low-income groups, from healthy to sick persons, and from single households to families with children. But if parts of the population—as in Germany—are allowed to opt out of the system of redistribution, the question is whether this regulation is just or whether services that have positive effects for the whole society should be financed by the whole society and therefore out of general taxation. If health services for children are seen as the responsibility of the whole society because—as Beske, Thiede and Hallauer (1996: 81) emphasize—they are family policy or social policy, then opting out can be seen as a weakness of health insurance systems. To solve this legitimacy problem, the board of experts (*Sachverständigenrat*) recommends externalizing those services that are not in line with the insurance principle.[111] In particular, allowing people to opt out of the redistribution from single households to family households causes a legitimacy problem for the German health system, a problem that has already been solved by the Austrian statutory

[111] Sachverständigenrat 1997: 323f.

health insurance which covers the whole population and does not allow opting out of the system.

Further, it is necessary—and part of the legitimacy problem—that health care systems produce positive results. Positive results means that health care systems have to work efficiently. An efficient provision of health services is possible if patients can find their way around the health care system as easily as possible. In this respect, the form of access to the health care system and its organizational structure are important. It has been argued that a close relationship to a family doctor is necessary, so that doctors can build up a detailed knowledge of their patients' health status and health risks. Limiting the choice of doctors supports the 'voice option' and therefore closer co-operation between doctor and patient. If this co-operation continues for a longer period of time, the patient can build up trust, which is a necessary precondition for successful medical treatment.

One can argue however that the principles of self-reliance and patients' rights are better respected if patients have a free choice of doctors. This argument can be qualified by the fact that patients in Denmark and Great Britain can choose a different doctor at least once a year. Further it has to be taken into account that a family doctor not only functions as a 'gatekeeper' to the health care system; he or she is also a 'guide' with the authority to transfer patients to specialists providing the necessary treatment. This authority is an argument for the 'guiding function' (*Lotsenfunktion*) of a general practitioner and against a free choice of doctors.

Figure 10: Effects of the family doctor principle and of free choice of doctors

	Doctor		**Patient**	
	Guiding function	Control function	Exit	Voice
Free choice of doctors	—	—	+	—
Family doctor principle	+	+	—	+

A free choice of doctors has a negative effect on the guiding and control functions of the general practitioner, and, for patients, a positive effect on the exit option and a negative effect on the voice option. The family doctor principle on the other hand has a positive effect on the guiding and control functions of the general practitioner; for the patient, it has a positive effect on the voice option and a negative effect on the exit option.

The control function is of great importance when focusing on the health of children and is therefore a strong argument for the family doctor principle. Again, self-reliance is reduced and one must decide between the principle of patients' self-reliance and the state's responsibility for its citizens. If it is the aim to guarantee comprehensive health care for all citizens, the control function of the general practitioner has to be strengthened. This is especially important when focusing on health services for children. In Germany and Austria a high proportion of the population takes part in the early diagnosis programmes for children (about 90%). But low-income groups in particular do not participate regularly in preventive

health care measures. In Denmark and Great Britain, the family doctor and the health visitor can make sure that all children take part in the preventive programmes. In Germany and Austria, strengthening the family doctor principle is currently under discussion. Up to now, both countries have supported the free choice of doctors and therefore the exit option, at the cost of the general practitioner's guiding and control function. Particularly the 'guiding function' of the general practitioner helps patients find their way around the health care system. Health systems are too complex for patients to be able to demand the best possible treatment without any guiding.

Orientation can also be improved by the organizational structure of the health care system. The Danish national health system is organized on a local level and the British NHS on a district level. In Denmark local authorities are responsible for providing information for their population, and in Great Britain district health authorities purchase health services for their population and are also responsible for providing information. In both countries the organization on the local level encourages the population to identify with their health care system. Since one authority is responsible for co-ordinating the various health services, co-operation between the different service providers is improved as well. In Denmark, co-operation takes place between general practitioners, health visitors and school health nurses, and in Great Britain co-operation is institutionalized within the framework of the primary health care team.

The organizational structure of the German and Austrian health insurance systems cannot be classified as national, regional or local. In both countries health insurance funds and medical associations negotiate in general on a regional level in collective contracts. But there are no institutions that co-ordinate the various health services on a regional or local level. In Germany some health insurance funds are not even represented on a local level. The fragmented organizational structure makes it quite difficult for patients to get information on health care services. This is less the case in Austria than in Germany. In Austria in general one territorial health insurance fund in a *Bundesland* is responsible for financing health services. Therefore the political level corresponds to the organizational structure of the health care system, which makes it easier to develop integrated health care institutions, as currently being tested in Austria in the form of integrated health units (*Gesundheitssprengel*).

Only when responsibilities are clearly defined is it possible to define standardized health targets for the population of a municipality (Denmark) or district (Great Britain). The health targets of the WHO programme 'Health for All to the Year 2000' for example have been taken up and developed further in Denmark and Great Britain, but there was no authority in Germany or Austria responsible for implementing health targets.

In national health systems children are not only directly covered; they are also defined as an independent target group. This is indicated by the comprehensive provision of health services for children that include not only immunization and an early diagnosis programme provided by general practitioners or paediatricians, but also home visits by public health nurses, treatment by children's dentists (in Denmark) and school health services. These are co-ordinated in Denmark by local health authorities and in Great Britain by the primary health care team (see Figure 11).

Figure 11: Responsibility and provision of health services for children

		Denmark	Germany	Austria	Great Britain
Early diagnosis programme	responsibility	Local authority	SHI[a]	SHI	DHA[c], PHCT[d]
	provision	Family doctor	Paediatrician	Paediatrician	Family doctor
Immunization	responsibility	Local authority	SHI	SHI	DHA, PHCT
	provision	Family doctor	Paediatrician	Paediatrician	family doctor
Health Visitor Scheme	responsibility	Local authority			DHA, PHCT
	provision	Health Visitor			Health Visitor
School health services	responsibility	Local authority	PHA[b]	Local authority	DHA, PHCT
	provision	School nurse	School doctor	School doctor	School doctor, School nurse
Child dental health care	responsibility	Local authority	SHI	SHI	DHA, PHCT
	provision	Children's dentist	Dentist	Dentist	Dentist

a SHI: Statutory Health Insurance; b PHA: Public Health Authority (*Öffentlicher Gesundheitsdienst*); c DHA: district health authority; d PHCT: primary health care team

The following examples indicate that children in Denmark and Great Britain are treated as an independent target group. In Denmark a comprehensive child dental health care scheme has been implemented and the number of examinations was only reduced when caries were under control. In Great Britain general practitioners have a financial incentive to give all children on their list complete immunization. They receive additional payment if certain immunization targets are reached. To give British dentists a higher incentive to emphasize preventive treatment, the former fee-for-service payment for British dentists has been replaced by payment per child.

Figure 12: Effects of payment of first-contact doctors[112]

	Prevention	Quantity	Quality
Salary	+	—	—
Fee-for-service	—	+	+
Fee per patient	+	—	+/—
Cost-per-case	—	+	+/—
Contingent fee	+	+	+

In the health care systems of Denmark, Germany, Austria and Great Britain fee-for-service payments or payments on a per-patient basis predominate. In Germany and Austria self-employed general practitioners and specialists are mainly reimbursed on a fee-for-service basis, thus the incentive for preventive treatment is very low. Since in both countries resistance against salaries and payments on a per-patient basis is very high, preventive

112 OECD 1994: 13.

treatment could be improved by contingent fees, as Great Britain has demonstrated with the introduction of financial incentives for reaching immunization targets. If self-employed doctors are mainly financed on a per-patient basis, the incentive for preventive treatment is higher, but since doctors are paid whether the patient comes to their practices or not, the incentive to see the patient as often as possible is very low. Since patients can switch their general practitioner at least once a year, the doctor has to guarantee that patients are satisfied with the treatment and therefore must emphasize the quality of treatment.

In sum, the needs of children can be taken best into consideration in a health system that is organized on a local level where health targets are defined for the population of the district or municipality, where children have a long-term and close relationship to a family practitioner who co-operates with further (non-medical) health service providers, such as health visitors. The Danish National Health System fits best in this category; it seems to be most targeted at the children's health needs. It could be argued that Denmark could improve the quality of health services and the responsiveness of service providers by introducing market mechanisms as in the British NHS. We find Germany at the other end of the scale. In Germany there is no incentive to build a close and long-term relationship to a family practitioner and no incentive for co-operation between different service providers. The German statutory health insurance is characterized by a fragmented organizational structure that makes it very difficult to implement standardized targets to improve the health of children. On the other hand most child health services in Germany are provided by specialists – an indicator for the choice of high quality care. Austria demonstrates that insurance systems are also able to cover the whole population, thus defining health as a social citizenship right and reducing the risk for certain groups such as children of being excluded from the health care system. The Austrian attempts to develop integrated health units indicate that the currently fragmented health insurance system can produce a more homogeneous organizational structure allowing better co-ordination and co-operation.

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