The preferences of healthcare customers in Europe

Zoetermeer, 2004

Index

Part 2 Comparison by socio-demographic group

Summary

The preferences of healthcare customers in Europe

The focus of this study is the customer

What does the European customer expect of healthcare services? This was the central question of the Fourth Clingendael European Health Forum. That we should enquire into the wishes and preferences of healthcare customers is not in itself particularly surprising. The days in which patients were expected to do what the word implies - be patient and suffer - are long gone. While the healthcare customer is not yet in the same position as someone buying a car, he has indeed been emancipated in terms of his relationship with other parties in the healthcare sector. 'Demand-driven services' is no longer an empty slogan. The government, the medical profession and health insurers now wish to know what the patient actually wants. It matters!

Does the 'European' healthcare customer really exist?

That we should enquire into the wishes of the *European* customer is perhaps a little more surprising. Does such a person exist? No - not yet. There are clear differences between Belgian, Dutch, French, British and German healthcare consumers. Nevertheless, it seems likely that there will be ongoing convergence in terms of their expectations, rights and obligations. After all, the European internal market, with its 'free movement of people, capital, goods and services', is becoming ever more important, not least in the healthcare sector. The influence of the EU on many aspects of daily life, including healthcare, continues to grow. The challenges facing the national healthcare systems of Europe are largely the same. In seeking solutions, the countries look to each other. There is clear evidence of convergence. The 'European healthcare customer' is, for the time being, a notional figure, but one whose significance must be acknowledged.

There are significant differences between the member states in terms of healthcare supply and demand

There is a close correlation between the structure of a healthcare system, the organisation of the services provided, and the manner in which the patient is able to approach healthcare providers. We now know much about the differences between individual countries in terms of the organisation of services and the insurance funding systems. NIVEL has examined, compared and described the insurance systems in Belgium,

Germany, France the Netherlands and the United Kingdom. However, relatively little research has been conducted into the differences between European customers in terms of their behaviour and viewpoints. In order to rectify this situation, at least in part, the Council for Public Health and Health Care (RVZ) commissioned TNS NIPO to conduct a study in the countries listed. This examined:

- the choices that customers wish to enjoy in the various phases of the healthcare process
- the wishes and preferences of customers with regard to innovation
- attitudes to undergoing healthcare treatment in another country.

Based on these differences, a number of interesting observations can be made

Based on the information gained in this study, the RVZ produced a profile for each country. These were then compared, one against the other. It is a perilous undertaking to attempt to draw any firm conclusions from such a comparison. Nevertheless, a number of interesting observations may be made:

- If customers are offered more options, they are likely to value options more highly.
- If customers are offered the choice between visiting their own general practitioner or a specialist, they will not necessarily opt to visit the specialist.
- Despite the existence of personal contributions (insurance excesses), customers are willing to pay more if they receive clear added value.
- Only the Dutch customer wants even more freedom of choice and a greater number of options than are already available. He is also willing to pay more to achieve this.
- The Dutch customer has a relatively positive attitude towards innovation in healthcare and towards healthcare services provided in another country.

Two distinct groups of customers will emerge, each with its own preferences

The European customer will be the result of the development that the various national healthcare systems undergo as part of the convergence process. However, there will be no single homogenous group: there are in fact two distinct groups. One is prepared to travel and is willing to pay for greater choice. The other wishes to enjoy healthcare services close to home and is less willing to pay more. Despite the obstacles to a pan-European healthcare system, certain factors can be identified which will accelerate its emergence. The RVZ has provided an impression of the European healthcare sector based on the preferences of these two groups.

One group will wish to receive treatment close to home

In part, the European healthcare system will retain a strong regional orientation. This is particularly the case in care for the elderly patients and those with chronic conditions. Low-complexity care services for other groups will also remain regional. The services for these groups of customers will be marked by their diversity, flexibility and efficiency.

The other will be willing to travel

Another segment, i.e. high-complexity services and care for patients whose conditions have limited treatment options (such as Alzheimer's and Parkinson's), may well be organised within Expertise Centres at European level.

With regard to the health insurance system, the RVZ sees advantages in a pan-European basic health policy. However, whether any such policy will ever be introduced remains to be seen. Similarly, the manner in which solidarity can be created, and the extent of that solidarity, are unclear.

1 Introduction

1.1 Reason for the study

The preferences of healthcare customers are politically relevant

This publication has been produced within the framework of the 4th European Health Forum. In this context, the Pharmaceutical Committee of the American Chamber of Commerce requested that the Council for Public Health and Health Care (RVZ) conduct a study on 'The preferences of healthcare customers in Europe'. Why this particular subject? From a political perspective demand-driven healthcare, the strengthening of the demand side, and innovation have become key topics. They are directly linked to issues of cost, cost control and increased efficiency. As healthcare makes up an increasingly large percentage of GDP (Gross Domestic Product), the need for accountability with respect to product delivery is also becoming greater. Customers are playing a leading role in all these developments. Satisfaction with the product or service delivered represents an important measure of 'the result'. In light of all this, the choice of topic becomes abundantly clear.

1.2 Why a European study?

Europe's sphere of influence will also include healthcare

The European factor is becoming steadily more important. Although developments in Europe are not expected to occur at a particularly fast pace, it is clear that a process of convergence has begun. This process was initiated at a financial and economic level, and it is expected to continue in the areas of legislation and insurance. In other words, it is quite probable that the four freedoms (i.e. freedom of movement of goods, services, capital and people) will also make themselves felt in the healthcare sector.

The differences between the various member states are still very significant

Yet little is known about the differences between the member states regarding customers' preferences

Healthcare is still primarily a national matter. Although countries try to keep healthcare outside the sphere of EU influence, the effects of measures taken by the EU in a variety of areas will inevitably impact on healthcare. Meanwhile, case law has already shown that these lines of national defence can be broken. Nonetheless, it cannot be denied that healthcare is a special sector. Healthcare, more than other sectors, is characterised by significant cultural differences between countries. Definitions of the concepts 'healthy' and 'ill' for example vary from country to country. Healthcare consumption is also very much determined by a country's culture. The organisation of

healthcare supply and the insurance system, too, exhibit their own specific national characters. These differences are all relevant to the convergence process. They act as the starting point, providing possible opportunities and raising definite obstacles. Member states look to each other for solutions to their own problems and for ideas on how to make improvements. Organisations such as the OECD and the WHO are working to compare national healthcare services or, more accurately, are working on ways of making them comparable. While some knowledge is available on the differences in consumption and organisation of healthcare supply, this does not apply to customer preferences. The first studies in this area recently rolled off the presses[1], but as yet information available on customer preferences in the different member states is still far from plentiful.

1.3 The questions raised

This study therefore maps out supply and demand in five member states

This is why the customer's perspective forms the basis for this study. The research was conducted in Belgium, Germany, France, the Netherlands and England: five member states with a comparable level of welfare, as well as comparable epidemiology and political issues. First, the differences between customer preferences in these five countries were mapped out. This was followed by an analysis of how healthcare supply and the healthcare system relate to customer preferences. This provides insight into the above-mentioned differences between the various countries regarding supply and demand in the healthcare sector.

And outlines the possibilities for convergence

As we have already observed, significant differences exist between countries and it seems unavoidable that the influence of Europe will also extend to include the healthcare sector. These observations invite us to ask what form Europe's influence will take and in which specific areas it will be felt. These questions, too, will be dealt with from the customer's perspective in the course of this study.

The present study represents *an initial inventory* and deals with the following questions: ·

- What are the most important differences between the five countries from the customer's perspective?
- What are the preferences of customers as regards options in the healthcare chain, innovation and healthcare provi-

sion abroad? What value do customers attach to these preferences in real financial terms?
- What measures have been taken by the authorities in each of the countries studied to meet the wishes of their citizens?
- In which areas and in what ways could convergence take shape? Customer preferences will also form the starting point in this section.

1.4 Research methods

General

In order to answer these questions, the Council for Public Health and Health Care (RVZ) commissioned two background studies. The first, a consumer survey in the five selected countries, was conducted by TNS NIPO, a leading Dutch organisation in market research, opinion polls and market analysis. The second study was carried out by NIVEL, the Netherlands Institute of Primary Health Care, specialising in health services research. NIVEL mapped out the healthcare supply and the healthcare system of the respective countries, by means of a literature survey and document analysis. The RVZ used the data obtained in these studies to outline the most significant differences between the countries in relation to supply and demand. It then proceeded to examine the possibilities for the convergence of healthcare in Europe.

Consumer survey conducted by TNS NIPO

TNS NIPO conducted a survey of customer preferences

TNS NIPO carried out a customer survey in each of the countries mentioned (see annex: Preferences of the European healthcare customer). In telephone interviews, customers (patients and non-patients) were asked about the importance they attached to healthcare options and their preferences when interpreting these options. This was done systematically for each phase of the healthcare process. The pre-diagnostic phase was examined first. In this phase the customers expressed a need for information above all else. They were asked how they looked for this information and who they consulted in order to obtain it. In relation to the diagnostic phase, customers were asked what aspects they regarded as generally important ("How important is it for you to be able to choose?") and what their preferences were in relation to the healthcare professional carrying out the diagnosis ("Which type of healthcare professional do you prefer?"). In relation to treatment, as well as answering questions about the healthcare professional, cus-

tomers were also asked about the treatment location. With regard to rehabilitation, customers were also asked about their preferences in relation to the professional providing treatment and the treatment location. The results of the survey were then checked against the financial value customers attached to healthcare options. This was done by asking customers how much extra premium they were willing to pay per month in order to gain access to a broader range of healthcare options. Lastly, the customers' interest in new developments, innovations and in treatment abroad were assessed. The information obtained from the survey was then analysed in two ways:

1. The countries were compared with each other (Part I of the TNS NIPO background study). This analysis illustrated the differences between the various countries.
2. The various categories of customers were subsequently compared at European level (age, income, educational level and previous healthcare experience).

The above analysis thus helped to clarify the differences between the various countries, as well as to outline the preferences of different customer groups across a section of Europe.

NIVEL study

NIVEL mapped out healthcare supply and insurance

The second background study was carried out by NIVEL (entitled 'Demand-driven healthcare from an international perspective'). It involved a literature survey and a document analysis. The chief purpose of this background study was to map out the opportunities for demand-driven healthcare in the different countries. Demand-driven care is made operational in terms of options and freedom to choose. NIVEL collected information on the healthcare organisation in the different countries and on the extent to which these healthcare systems offer scope for demand-driven care (organisation of healthcare by or according to the wishes and expectations of patients/consumers). Information was also collected on the actual consumption of healthcare in the different countries. This information was primarily intended to provide a better interpretation of the results of the TNS NIPO survey, since it is likely that the wishes and expectations expressed by customers are coloured by what they are accustomed to in their own healthcare system. The following questions were raised:

1. To what extent are options for choosing the individual treatment provider or treatment location anchored in the law, regulations or institutions?
    a. Are patients obliged to register with a specific general practitioner (meaning they are not free to select a doctor per complaint/condition)?

   b. Are specialists directly accessible?
2. To what extent is choice actually possible, in the sense that there is adequate healthcare provision?
   a. What is the number of doctors per head of population, broken down according to general practitioners and specialists if possible?
   b. What is the number of nurses and pharmacists per head of population (as possible 'alternatives' to doctors)?
   c. How many acute[2] hospital beds are available per 1000 inhabitants?
3. To what extent is choice actually possible in terms of financial access to alternative healthcare services? In other words, who is insured for what?
   a. What percentage of the population is covered by public health insurance or the national health service?
   b. What percentage of total healthcare costs is publicly funded?
   c. Which healthcare facilities require personal contributions?
   d. What percentage of total healthcare costs is financed by personal contributions?

In addition to the above, the study also looked at citizens' consumption patterns.

1.5 Bookmarks

Chapter 2 discusses the differences between the five countries. Chapter 3 looks to the future and outlines the points at which convergence seems most likely. Detailed information on the customer survey, on healthcare supply and on the various healthcare systems can be found in the background studies.

Comment 1

A consumer healthcare survey often leads to ambivalent reactions. It is doubtful whether customers' real-life behaviour would actually reflect the answers they give in the survey. It is not possible to establish this with certainty. Although customers rate healthcare options as important and are prepared to travel for treatment, it remains questionable whether their actual choices would reflect these preferences. In order to improve the reliability of results, current 'healthcare consumers' were surveyed in addition to healthy subjects. In addition, the content of the questions was made more true to life by linking realistic sums of money to customers' wishes. The reservations expressed above should

not be seen as reasons for abandoning the customer survey. Rather, they provide solid arguments for investigating current developments in customer behaviour as regards healthcare options and willingness to travel.

Comment 2

In its background study, NIVEL points out the complexity of comparing data on consumption and costs from the different countries. In order to make the data as comparable as possible, a limited number of sources were selected (OECD, WHO). This placed restrictions on the amount of data available in some cases. There are a number of other reservations which can be made regarding the results presented in this study. It is worth pointing out the study's limitations. Although NIVEL has a great deal of expertise in the field of 'health systems research', the present survey remains a literature survey carried out in the Netherlands by a Dutch national. Its status is therefore bound to differ from that of a comprehensive survey conducted by an expert from the country concerned. One last point that merits attention is the fact that the analytical units in this study are countries. Accordingly the figures presented do not give any insight into the differences that exist within a country, for example between rich and poor, between cities and rural areas, or in the case of Germany, between east and west.

2 Europe: national preferences

2.1 Introduction

"French doctors will diagnose vague symptoms as spasmophilia or something to do with the liver; German doctors will explain it due to the heart, low blood pressure or vasovegetative dystonia; The British will see it as a mood disorder such as depression; and Americans are likely to search for a viral or allergic cause."- Lynn Payer (1988)

In her book Medicine & Culture (1988), Lynn Payer made a number of bold statements on the differences between countries in the field of healthcare. Customers have different definitions when it comes to health and illness, and different preferences with regard to diagnosis and treatment. The manner in which healthcare providers offer medical care also differs, as do notions of solidarity and personal responsibility. All these factors collectively determine the consumption of healthcare and its organisation in a given country. Supply and demand form a single whole. The differences between countries represent the starting point for developing a European healthcare system, a starting point that is more complex than in many other sectors. This chapter sets out to make this underlying complexity explicit. First the differences between the countries will be explained, taking customer preference as the starting point. This will be followed by a number of pertinent observations based on the profiles of the various countries.

In order to clarify the differences between countries, the RVZ has drawn up a different profile for each country

2.2 National profiles

The annex to this study gives an elaborate description of the relationship and interactions between supply and demand in the countries examined. Here, the RVZ will limit itself to the most important findings for each country.

Belgium

"Affordable healthcare with options"

Belgians place a high value on healthcare options, their family doctor and treatment at home. Everything that makes treatment at home possible is welcome. Belgians therefore find telemetry an appealing innovation. However, there is little enthusiasm in Belgium for paying higher contributions for more healthcare options. This may mean that Belgian customers believe that they have sufficient healthcare options. How-

Belgian customers value options and healthcare at home

ever, it may also be that they think they pay more than enough for their medical care. Belgian customers are not prepared to travel far or to leave the country for qualitatively better treatment or greater expertise.

The healthcare supply in Belgium caters to these demands exceptionally well

Belgian consumers are waited on hand and foot. 'Freedom' is the key concept in Belgian healthcare. There is free choice as regards the family doctor and free access to specialists. The supply of doctors and facilities at both primary and secondary level could almost be characterised as overabundant and there is a great readiness among doctors to visit their patients at home. All of the above applies to primary and secondary care, i.e. to the treatment phase. As regards rehabilitation and long-term care, the match between supply and demand is less apparent. Despite generous healthcare provisions at both primary and secondary level, the cost of healthcare in Belgium is relatively low (8.7% of GDP). One notable feature is the high consumption of non-residential care. Of course, this reflects the customers' preference for treatment at home.

From a financial point of view, too, healthcare options and freedom of choice are well regulated

Financially, freedom of choice and accessibility are also taken care of. Ninety-nine per cent of the population is insured by means of mandatory health insurance, a branch of social security. However, the level of cover varies. Insurance for employees is broad but for the self-employed cover is limited to high risks. Approximately 70% of costs are publicly funded and although the non-refundable portion of medical expenses (personal contributions) is considerable, it can be reinsured. Solidarity is maintained by the fact that, in terms of taxation, there is an upper limit to these non-refundable medical expenses and by the fact that the socially disadvantaged are exempt from paying them.

There are indirect signs that Belgium does not have significant powers of innovation or high levels of transparency

No direct statement can be made on the power of innovation in Belgian healthcare. A few indirect conclusions may be drawn from the fact that Belgium has been slow to introduce outpatient treatment. Similarly, it takes a relatively long time for new drugs to reach the Belgian market. Belgium is also very tardy in delivering data to the OECD data set, which seems to say something about transparency. Unfortunately, it is not yet possible to answer the question of whether extensive healthcare provision and limited costs are matched by sufficient quality.

Germany

"Specialisation and luxury healthcare"

German customers make extensive use of specialised medical care and attach great importance to healthcare options

Germans are quick to consider themselves ill and tend not to be optimistic about their health. This general view may well play a part in the results of the present survey. Germans rate healthcare options more highly than people in other countries. They turn to specialists for information, diagnosis and treatment and prefer to be treated in a hospital or, even better, at a specialised clinic. This particularly high rating for healthcare options is also reflected with regard to rehabilitation. In this area the explicit preference for specialisation disappears and treatment at home is seen as an equivalent option. German consumers translate their appreciation for healthcare options into monetary terms and are prepared to pay additional sums, particularly for options in rehabilitation. German customers show average interest in innovation (including technical innovations). Their readiness to travel is also average. German customers do not show a particular interest in travelling abroad even if this gives them access to a specialised centre.

German healthcare is expensive and luxurious

German healthcare is expensive (10.6% of GDP). This is particularly true of inpatient medical care, which Germans make much use of. The number of admissions and prolonged stays in German hospitals is high. Although healthcare is expensive, customers receive a great deal in return. There is a generous supply of family doctors, specialists and facilities at both primary and secondary level. Germany is another country where facilities for rehabilitation are difficult to assess. It is well known that many of the elderly make use of informal care and that homes for the elderly have a bad reputation. Home care organisations have become an important institution.

Financially too, options are available but only at the cost of substantial personal contributions

Germans are free to change their family doctor every three months. Specialists are freely accessible and a chip card system ensures freedom of choice. Financial accessibility is thus reasonably well regulated. Ninety per cent of the population is insured by means of mandatory public health insurance (GKV) and there is *freie Kassenwahl* (free choice of health insurance fund). The package is broad and could even be said to be luxurious, with over 75% of medical costs being publicly funded. However, personal contributions are high and cannot be reinsured. They make up 10.6% of the total healthcare costs. By making use of contract doctors the insured can avoid paying a percentage of their personal contributions. The 10% of Germans who are not covered by mandatory health insurance can

turn to private insurance companies. These are nothing short of expensive. Separate insurance cover applies to healthcare for the elderly (*Pflegeversicherung* = private nursing insurance), with no personal contributions required.

The German system is rigid and inflexible

Germany's healthcare supply and its administrative structure do not facilitate innovation. Customers and healthcare supply appear to be matched in this regard. Powerful interest groups, the strict division between inpatient and outpatient facilities and the absence of genuine selective purchasing options for healthcare insurers are the main underlying reasons. The fact that the system is enshrined in law, in the *Sozialgesetzbuch V*, makes it difficult to implement change. This has been borne out in practice. For a long time, outpatient treatment was prohibited.

All in all, Germany has high-quality but expensive healthcare and, at first glance, its customers would appear to be satisfied. However, the sustainability of the German system, especially in financial terms, is a problem the country needs to address.

France

"Healthcare between the state and the market"

The French want choice and healthcare at home

France is a healthy country with a long life expectancy, a strong government and a strong market. This dualism is also reflected in its customers. They regard healthcare options as important, but not to the same extent as the Belgians or the Germans. French customers will choose to go to a specialist but not to a specialised clinic. They would rather stay at home even when convalescing. French customers value their pharmacists highly. Popular sources of information include the public media (TV, newspapers and magazines), the pharmacist and the authorities. Like the Belgians, the French are reluctant to pay more for their healthcare. One exception in this regard concerns options in relation to diagnosis. Interest in innovation is average. A surprisingly high percentage of the French expressed no opinion on the innovations presented to them.

French healthcare is also expensive. The market and the government both play a role

France is another country with a relatively expensive healthcare system (9.3% of GDP). It even has the highest costs per head of population for inpatient care. One explanation for this is the fact that the French healthcare system has been based on hospital care since its earliest days. Market forces primarily govern outpatient care. Doctors are free to set up practice and to determine their own fees. Customers enjoy freedom of

choice and options: free choice of doctor, direct access to specialists and a wide-ranging healthcare supply. As mentioned above, France has a long tradition of hospital-based care. The public sector operates alongside the market in secondary care. Sixty-five per cent of beds are in public hospitals, 35% in private for-profit institutions. Hospital care is wide-ranging. The same would appear to be true of rehabilitation and care for the elderly. French healthcare includes home care and social services.

Social insurance offers 100% cover and personal contributions are reinsured

The social insurance system is compulsory and offers good access to healthcare. It covers 100% of the population. Almost 76% of the costs are paid out of public funds. The system does not stand in the way of freedom of choice: payments are made according to a reimbursement system. Any restrictions raised by the high personal contributions (10.2%) are removed by the possibility of supplementary insurance cover. Eighty-seven per cent of the French are covered in this way. The French system has no separate insurance for long-term care. These costs are paid out of social insurance.

Although the state has its finger firmly in the pie, the social partners share the decision making

It is difficult to make a concrete statement about the speed of innovation in France. Implementing reforms in France does not appear to be as easy as in England. Although the French state has its finger firmly in the healthcare pie, in contrast to England, there are many other interested parties who participate in the decision-making on reforms. There is hardly any hard evidence from the field. Unfortunately, there are no data available on such issues as the speed with which outpatient treatment is being introduced. In terms of the time it takes drugs to reach the market following approval, France ranks in the middle bracket.

The Netherlands
"Option-based healthcare on the way"

The Dutch attach less importance to healthcare options than the Belgians, the French or the Germans

The Dutch attach less importance to healthcare options than the French, the Belgians or the Germans, but more than the English. The Dutch are not happy with the GP referral system and want direct access to specialists and hospitals. Healthcare options for rehabilitation are less important to the Dutch. However, if given a choice, their preferred form of treatment would be physiotherapy at home. Of all the nationalities interviewed, the Dutch are most willing to pay extra for added choice and improved access. Their interest in innovation is average. Improved access - in this case to new drugs - also

scores relatively high. Dutch customers are prepared to travel, not only for improved access but also for better quality.

There is not much freedom of choice in the Netherlands

The Dutch are not accustomed to healthcare options and access is a problem in the Netherlands. Healthcare supply at both primary and secondary level is tight, the exception being nurses, of which the Netherlands seems to have a generous supply. This disparity is unusual and cannot be readily explained. Freedom of choice is also limited. The GP referral system and named registration with a family doctor limit healthcare customers' options. In rehabilitation, healthcare supply appears to be more wide-ranging. It is striking that the Netherlands spends very little on outpatient care. This comparative study shows the problem of healthcare costs not to be any greater in the Netherlands than in other countries.

Financial accessibility is good, but freedom of choice is limited

Financial accessibility is well regulated in the Netherlands. The law governing mandatory health insurance (*Ziekenfondswet*, ZFW) covers 61% of those insured, but extensive private insurances also offer broad cover. The Netherlands does not have a personal contribution system. Financing from public funds is relatively limited at 63.4%. The way health insurance is organised does little to facilitate choice. Most of the costs, even for those privately insured, are paid indirectly though the insurance premium. Long-term care and home care are financed by a social insurance (AWBZ). In this sector, personal contributions do apply, as well as some options for purchasing healthcare directly.

The decision-making process in the Netherlands is complex

The decision-making process in the Netherlands is complex. It is difficult for healthcare insurers to insist on innovation due to contractual obligations and the shortage of supply. The former restriction is presently under discussion. The complexity of the situation in the Netherlands can be illustrated by the current discussion on diagnosis treatment combinations, where the development/research and decision-making process has taken 10 years. The Netherlands lies in the middle bracket as regards the introduction of outpatient treatment. Likewise, the time it takes for new drugs to become available to customers following registration is not particularly long.

The results of the survey reflect the problems in the Dutch healthcare system

The results of the survey clearly illustrate a number of problems in the Dutch healthcare system. The findings also show that the Dutch are prepared to pay more if the benefits they receive in return are made clear. In addition, it seems apparent

that the Dutch have yet to become accustomed to the notion of healthcare options.

United Kingdom

"State healthcare driven by demand"

Choice is least important for the English

Choice is clearly less important for the English[3] than for customers in the other countries. Trust in one's GP is high. A notable finding is the preference for treatment in hospital. With regard to rehabilitation, the English find choice to be the least important. They would rather be treated at home and by a physiotherapist. The English translate their limited appreciation of healthcare options in terms of a limited readiness to pay. They are only willing to pay more for faster access to treatment. The English attach particularly great importance to organisational innovations such as the healthcare consultant.

They are happy with their GP but not so satisfied with secondary care

England can be characterised by its GP referral system and emphasis on primary care. The high level of trust in GPs suggests that customers are satisfied with primary healthcare. Customers have some real healthcare options at primary care level. These choices do not extend to secondary care, which is limited and not directly accessible. Healthcare supply for rehabilitation is more wide-ranging, particularly in the home setting.

The NHS offers broad cover but no freedom of choice

The financial access offered by the NHS is good. One hundred per cent of the population is insured and 80.9% of the costs are financed by public funds. A drastic overhaul led to the separation of the payment system from healthcare provision itself. Healthcare purchasing was decentralised to the Primary Care Trusts (PCT) and there is now free choice of doctors at primary care level. The system therefore appears to offer freedom of choice and options. In practice, however, customers still have few options when it comes to voting with their feet. Personal contributions only apply to drugs. For long-term care only limited and means-tested access is guaranteed by the NHS. To cater to this need, private insurance schemes have appeared on the market. Only 10% of the English are covered by this type of insurance.

The NHS has formidable organisational powers

The NHS is characterised by an unprecedented rate of organisational reforms. Compared to the other four countries, there are few groups or organisations within the field that offer resistance. This is not always beneficial. Due to the relative ease with which it can implement changes in the supply of

healthcare, the NHS is in a state of permanent overhaul. However, this appears to fit in with the customers' affinity with new developments such as the healthcare consultant. England also has more data available on healthcare results than the other four countries and can therefore be said to lead the way in this regard as well. Waiting lists are a major problem in England. The NHS purchases medical care abroad. In recent years England purchased medical care in both Germany and France. Customers therefore have the possibility to travel abroad.

Conclusions of the national comparisons

The countries examined show marked differences not only in the organisation of healthcare supply and healthcare systems, but also in the preferences shown by their customers. In the introduction to its study, NIVEL outlines the differences between those countries with freedom of choice and healthcare options and those countries that tend to offer few healthcare options. It pointed out that many customers want what is available to them and what they are accustomed to. The Netherlands is an exception to this rule. Dutch people want more and are also prepared to pay more for it. This gives food for thought. A number of observations from this survey will be examined specifically from this Dutch perspective in Section 2.3.

2.3 Striking observations

Although there may be significant differences between countries, there are also significant similarities, particularly with regard to the political problems countries face and the solutions being considered by policy makers. Statements like "the Belgians do it better" or "people in France and Germany have to pay more out of their own pocket" can often be heard. In their search for solutions to major problems such as rising costs[4], shortcomings in quality, poor efficiency and slowness of reform, countries look to each other and draw conclusions on the possible effects of new policies. But is this realistic? We now know that it is a perilous undertaking to draw conclusions on the efficiency of policy measures from national comparisons. It is dangerous to pick out one particular element from a system. Figures are often not comparable and effects can seldom be attributed to a single component. This makes it difficult to draw conclusions other than that there are indeed differences between countries. However, a number of striking

observations can still be made from the data collected in the background studies to this research. These points are not so much based on *national comparisons*, but more on the *relationship between supply and demand* described for each country. These observations, discussed below, will be examined from the perspective of the problems affecting in the Dutch healthcare system.

A number of striking observations can be made based on national comparisons

1. The Dutch authorities have decided to introduce more demand-driven healthcare. Customers should be given a choice and be able to vote with their feet. The results of the survey indicate that customers would appreciate such reforms. It can be deduced from the survey that appreciation of healthcare options by customers is a learning process. However, it also appears that once customers are more familiar with options, they come to rate them highly. In Germany, Belgium and France, countries where healthcare options are plentiful, customers value this freedom of choice most highly.

Customers who are given options value them highly

2. The Dutch authorities are afraid that the introduction of more healthcare options will lead to a substantial increase in healthcare costs. It appears, from this survey at least, that greater freedom of choice and more options do not automatically encourage people to opt directly for (expensive) secondary care and specialists. In countries where specialists are directly accessible, customers still regard their GP as playing a distinct role. Nor do customers in these countries necessarily prefer treatment in a hospital. The results of the survey in Belgium and France and the data obtained for these countries in the NIVEL study cast at least some doubt on the authorities' fears in this respect.

The introduction of healthcare options does not automatically lead to a preference for secondary care

3. The Dutch authorities believe that the cost of healthcare is rising too quickly and are considering introducing personal contributions. In addition, the authorities are committed to greater transparency of the results achieved by public spending. It would seem that these factors are inextricably linked, for customers at least. The survey shows that customers are prepared to pay extra if the benefits they receive in return are clear. Fifty per cent of European customers are prepared to pay more than €2.50 extra premium per month and an average of €4.10 for increased options. In the Netherlands this figure is even higher, at €4.80. There is no direct correlation between

Personal contributions and transparency of healthcare delivery are inextricably linked

readiness to pay and an existing personal contribution system.

4. The Dutch authorities are of the opinion that healthcare in the Netherlands has little capacity for innovation. One idea in this regard is that strengthening the demand side compels innovation. Although far from comprehensive, this initial inventory provides no direct evidence that more freedom of choice or increased customer options accelerate innovation in the supply of healthcare.
   - The differing levels of interest in innovation shown by customers in the five countries are relatively small and are not related to the availability of healthcare options.
   - Although the national comparisons are far from exhaustive, this initial screening does not show that countries with more healthcare options demonstrate a higher capacity for innovation.

   Indeed this survey offers plenty of evidence to the contrary. Familiarity with changes in the organisation of healthcare supply, as demonstrated in England, leads to customers showing a greater interest in such developments (e.g. the healthcare consultant). From the customer's side, the pressure is not any greater in countries with more healthcare options and a stronger demand side. The authorities must therefore do more and will have to examine the impact of other factors, such as the presence of incentives for providers and the way in which the decision-making processes and administration are organised.

Strengthening the demand side alone is not sufficient to increase the healthcare system's capacity for innovation

5. Many parties in the Dutch healthcare sector still have a narrow view of Europe. Customers, too, have shown only a limited interest in healthcare abroad as a way of by-passing waiting lists. Just 1.5% of medical care is carried out abroad[5]. Although consumer survey results do not give any guarantees as to actual behaviour, customers do seem to show some readiness to travel. This is not only out of dissatisfaction with waiting lists but in particular to seek improved quality and expertise. At present, information regarding the quality of healthcare is not always available, far from it. If more were known on this subject, for example through benchmarking surveys, it is perfectly possible that a section of the population might show greater readiness to travel.

Customers want to travel if it is clear to them what the added value is

3 Possibilities for convergence

3.1 Introduction

In this chapter, the RVZ presents a vision of the development of European healthcare

Despite the significant differences between its various member states, it is likely that 'Europe' will exert an increasing influence on healthcare. This chapter outlines a number of possible developments that may contribute to the emergence of a European healthcare system. In no way is the RVZ professing to present a blueprint for these developments. The following description is intended to be read as an outline, a vision and a starting point for discussion.

Any discussion of this vision is bound to raise questions regarding the nature of possible changes in the way healthcare will be organised if a European healthcare system emerges.

1. Will the provision of services and healthcare improve and become more innovative for customers?
2. Will the changes reduce or increase costs?
3. Will risk solidarity be maintained and, if so, in what form?

The RVZ's outline of a European healthcare system given below is based partly on observations from the TNS NIPO and NIVEL background studies, and partly on the organisation's own knowledge and experience.

3.2 The players

First, the RVZ examines the motives of the different players

When it comes to healthcare, customers seek information and help in relation to a wide variety of questions. Doctors and other healthcare professionals respond by delivering the relevant healthcare. Hospitals, health centres and specialised clinics facilitate this process. Science and industry provide new diagnostic techniques and treatment methods. All of these parties can play a role in the convergence of healthcare in Europe. In order to be able to say something about the ways in which and the areas in which healthcare in Europe will develop, it is useful to start by looking at the different motives of these groups.

Customers

Customers want quality and accessibility

In most cases it is still the customer that takes the first step in the healthcare process. When a customer (or someone close to him) experiences a problem or is worried about his health, he

not only wants good quality, accessible medical care but is also ready to demand it to an increasingly extent[6]. The TNS NIPO survey shows that there are differences between the various groups of European customers[7]. The study basically identifies two distinct groups:

There are basically two distinct groups of customers

1. The first group consists of young people (18-34 years of age) and a considerable number of people between the ages of 35 and 54, relatively well-educated people, people with a higher income and people with an elective demand for assistance[8]. This group prefers to go to a specialist for treatment, shows a greater readiness to travel and has money to spare for increased healthcare options. The younger and better educated members of this group also have a preference for obtaining information via the Internet.
2. The second group consists of older people (55 and over), people who are less well-educated, people with a lower income and people who suffer from a chronic condition. This group often chooses to be treated by their GP and is less inclined to prefer treatment by a specialist. They are less willing (and less able) to travel and to pay more for extra options. They prefer to obtain information from the healthcare professional.

It is clear that an overlap between these two groups exists in some respects. This overlap was analysed by TNS NIPO. Their analysis showed hardly any correlation between education and disease profile, but did show a correlation between disease profile and income, and also age.

These two groups make their own demands on the supply of healthcare. The first group is looking for specialist care and is prepared to travel and pay extra to obtain it. The second group wants medical care close to home. How can healthcare providers respond to these demands?

Hospitals and other organisations

Providers can respond to the needs of these two groups

As the NIVEL study shows, there is evidence of an increasing number of private for-profit providers in Germany, France and England. Examples include the Röhn Klinikum in Germany, Capio in Sweden and Générale de Santé in France. When questioned, these providers say they see enough opportunities in the national market at present, although they are keeping an eye open for opportunities abroad[9]. The most important strategic advantage of these healthcare providers is the

fact that they are managed with great efficiency and are therefore in a position to deliver efficient healthcare.

and either concentrate on regional healthcare

It is quite possible that these providers will focus on the first target group. This group is interested in specialist treatment abroad. It might be appropriate to offer this group European centres specialised in specific forms of treatment. This could be an opportunity for the above providers. However, these providers could also choose to respond to the needs of the second group and offer low-tech medical care in a number of regions. By offering a tested management concept in a number of regions, these providers could realise benefits of scale (in costs and net results) and deliver highly efficient healthcare.

or set up European centres of expertise

Doctors and paramedics

This also applies to individual healthcare professionals

Doctors and paramedics have already shown an interest in foreign countries. More than 480 Dutch doctors are working in Germany at present[10]. This does not constitute a uniform group. Specialists have different ambitions to those of general practitioners. However, they all want to deliver the best possible care in their own field and familiarise themselves with new diagnostic and treatment methods. They are driven by quality and are looking for opportunities for further development or for better working conditions. A growing percentage of specialists in particular are also showing entrepreneurial initiative and are starting their own private clinics. Profit is an important motivating factor for this group and they will respond to market opportunities wherever they may lie. Employment opportunities form yet another motivating factor. These groups can also respond to both customer groups described above.

Health insurers

Europe also offers opportunities to health insurers

Health insurance funds providing mandatory health cover are in a different situation to that of private health insurers. Both aim to purchase good quality, accessible and affordable (efficient) healthcare. But for providers of private insurance there is a greater necessity to increase turnover and improve returns. This they can do by winning more customers, especially customers who are more attractive in terms of generating profits, or by delivering new services to the people they insure. Providers of mandatory health insurance mostly concentrate on a regional market and on increasing the number of people they insure. Their main concern is purchasing healthcare.

It is possible that insurers will look for new opportunities based on these objectives. Providers of mandatory health in-

surance are far more likely to focus on the second group. Demand for healthcare in this group is high and localised. Purchasing good and efficient healthcare is important in this respect. These health insurers could invite new providers in their region to improve the efficiency of healthcare services. For private insurers, it is the first group that holds more appeal. The development of new products for this group offers these insurers new opportunities.

For providers of mandatory health insurance, the second group is relevant

For private insurers, it is the first group

Until now insurers (both providers of mandatory health insurance and private insurers) have only provided healthcare abroad for reasons of accessibility (in order to by-pass waiting lists). The above shows that there are more opportunities open to insurers in this regard. Later in this chapter, the RVZ will examine the obstacles they may encounter in their cross-border dealings.

Other areas

Although they fall somewhat outside the immediate focus of this report, science and industry also have their reasons for crossing national borders. Science is by definition international in outlook, while industry continues to gear itself up for international operations. These two sectors therefore fit in well with the EU objective of creating an internal market. At present, they still encounter limitations in the area of reimbursement, particularly where the financial equilibrium of the national system might be put at serious risk by the consumption of cross-border healthcare. This is one of the problems which the European authorities might address. However, an in-depth discussion of such a wide-ranging issue goes far beyond the remit of the present document.

Industry and science are already focused on Europe to a large extent

Besides the economic considerations of healthcare providers and insurers outlined above, the field of public health gives its own specific impetus to European healthcare. An important factor for convergence is epidemiology. We are increasingly being confronted with infectious diseases. Large-scale epidemics such as SARS, TB and HIV/AIDS pose a major threat to public health. But other conditions such as obesity, diabetes, and alcohol and drug problems also require the attention of the authorities[11]. Some of these problems call for a localised approach. However, for infectious diseases and certainly for other large-scale epidemic diseases, a supranational approach is required.

This also applies to the field of public health

National governments quite often fail to act in the area of public health and prevention. The NIVEL report shows that the public health sector in France is snowed under due to the focus on curative care and the pressure of the market. In the Netherlands, too, only 2-3%[12] of the total budget has been earmarked for prevention. The European authorities have assumed wide-ranging responsibilities in the area of public health and the convergence process has seen substantial progress in this regard. Prevention programmes are being set up at European level and carried out locally. An increase in such developments is expected.

Europe has taken the lead in this regard

The government

The last but by no means the least important players in this process are the European and national governments. The motives of the European government are clear. Its principled objective of raising the standard of living of its citizens by promoting free movement between member states also applies to healthcare. This is something member states are required to actively promote. However, national governments are often on the defensive and the realisation that Europe is going to have a considerable impact is still limited. The reasons that national governments may already have for looking over the border are primarily to do with cooperation in such areas as food safety, combating infectious diseases and offering relief to disaster victims.

National governments are still on the defensive

3.3 Outlining the development of a playing field

What kind of dynamic could be established on the basis of the different motives outlined above? Before addressing this question, the RVZ has two considerations to add. The first concerns the relevance of the vision of the spread of healthcare which the RVZ described in its report 'Market Concentrations in Hospital Care' (RVZ, 2003). In this report, the RVZ states that the nature of the demand for healthcare (urgency, intensity in terms of capital and knowledge, and scope) determines the optimal degree of concentration or deconcentration. Secondly, the RVZ refers to the concept of 'the economy of flows' introduced by M. Castell. According to this theory, the knowledge economy and information technology lead to an international network economy. It is pre-eminently the task of regional governments to respond to this development by establishing suitable conditions for setting up business and by offering highly trained personnel ('revival' of the region). Cas-

In this section the RVZ analyses what kind of dynamic can be established

tell also predicts that the role of national governments will decrease. In light of the above, the following outline might emerge.

The regional playing field

A proportion of healthcare will remain regional

No one is prepared to travel to be treated for a sprained ankle or for routine diabetes check-ups. As the consumer survey showed, the second group is keen to obtain healthcare close to home. Even customers in the first group expressed a preference for their GP when it came to diagnosis. All of which suggests that a large proportion of healthcare will remain regional.

This kind of healthcare demands diversity, flexibility and efficiency

What does this kind of regional healthcare require from the providers? Customers demand diversity and flexibility. Another important aspect is efficiency. Why diversity? Besides the general practitioner and the specialist, customers also choose to obtain treatment from paramedics. Although customers feel it is important that the GP maintains his position in the healthcare process, they also want the freedom to consult a specialist or a physiotherapist. There is also a desire for new professions. Why flexibility? Customers want tailor-made services. Some want healthcare at home, perhaps even from a specialist. Others prefer the hospital. The demand for healthcare, like the target group, is diverse. Why efficiency? This is partly due to the scale of the customer groups. Efficient organisation of the healthcare process is important in the interest of affordability and to meet the customers' desire for low premiums.

Healthcare providers should be able to work both inside and outside the hospital

How should all this be organised? Firstly, removing the division between primary and secondary care is an important precondition for greater flexibility and diversity. In order to meet customers' wishes, it is desirable that general practitioners, specialists and paramedics can work at the customer's home and in district health centres, as well as in hospitals or clinics.

The delivery of efficient healthcare requires providers who excel in management

Secondly, there is the question of whether healthcare professionals are in a position to realise optimal management. On the evidence above, there are a number of providers in the market who could provide highly efficient healthcare and who would be interested in providing healthcare in a specific region. This means that these providers (or chains of providers) from different countries will seize on local opportunities in order to deliver better and more efficient healthcare and take on the management of healthcare professionals.

It seems inevitable that the tried and tested efficient organisation of healthcare, such as that offered by the Rhön Klinikum, will gain ground. As cost-related problems increase in the various countries, the local need for the expertise of these providers will also grow. It will be up to the regions to provide attractive conditions for setting up business, as well as highly trained personnel.

They could come from any country and step in to meet local needs

It may also be possible for proven concepts in elderly care and home care to be 'rolled out' internationally. The Netherlands has a number of 'best practices' which deploy ICT to meet the need of the elderly to continue to live at home.[13] There may also be a market for such concepts in other countries.

The rolling out of concepts can also take place in care for the elderly

On the one hand, ICT can be deployed to provide customers with information. This is an aspect that definitely appeals to younger people. On the other hand, ICT also provides the opportunity to tap into the international network economy. This largely involves access to knowledge, with specific expertise from all parts of the world being made available electronically. With the aid of video links, the opinions and even the skills of specialists can be made directly available.

ICT is a crucial factor in this process

The influence of Europe on this section of healthcare will therefore chiefly be felt in new forms of healthcare, new professions and new providers (facilitating organisations) who will also facilitate primary care thanks to their skills in the area of management and logistics. Besides their expertise in the area of management, these providers may also set requirements in relation to the quality of medical services and demand protocol-based and evidence-based ways of working. It is possible that doctors and paramedics will start practising in areas where there are relative shortages or where attractive employment conditions are offered by these facilitating organisations. A number of Dutch nurses are currently working in Sweden, having found work there through an employment agency. Such arrangements could also help 'best practice' to spread more rapidly.

Tried and tested management concepts will spread throughout Europe

The international playing field

The previous section clearly shows that an important percentage of the demand for healthcare will be met at regional level. By offering new healthcare providers attractive local conditions for setting up business, a region can create an attractive profile for itself and thus offer optimal healthcare to its citizens. However, there is yet another dimension to this process.

A part of the healthcare sector will concentrate on European centres

The survey shows that younger people with a demand for elective healthcare in particular are willing to travel. Customers want to travel for accessibility and quality. As the efficiency of healthcare services improves at local level, one would hope that travelling for access to care would no longer be relevant. Travelling for quality, on the other hand, is highly desirable and even necessary for some kinds of healthcare.

This process is already under way in the area of highly complex medical care

It is becoming increasingly evident that, as healthcare becomes more complex, the concentration of specific forms of healthcare is necessary in order to guarantee quality. For some sections of the healthcare services this will mean provision of care at European level. The first signs of this process are already visible. Academic centres are working to build a profile for themselves not only nationally but also internationally. This takes place primarily in the field of scientific development but also increasingly in the treatment of highly complex and/or rare conditions.

It is necessary for reasons of quality and affordability

This is a positive development in a number of ways. Firstly, for reasons of quality. As healthcare becomes more complex, a doctor or treatment team must see a greater number of patients in order to keep their skills up to standard. Because the number of patients suffering from rare and complex conditions tends to be relatively limited, concentration of treatment in specialised centres is essential. Secondly, concentration is desirable from a financial point of view. The facilities and equipment for treating the conditions outlined above are often expensive. It does not pay to make huge investments for a small number of patients. Concentration of healthcare and the transfer of patients to these centres is a far more efficient solution in such cases.

Concentration is also desirable for a number of chronic conditions that remain difficult to treat

There is another possible reason why European centres of expertise could develop. It is a fact that chronic conditions make up an ever increasing percentage of the demand for healthcare and entail considerable cumulative costs. To date, the medical world has only been able to come up with very limited answers to the demands of these patients. This opens a market for centres that focus on these problems and from which new treatment methods and approaches can develop and spread.

ICT is of great importance in this regard

Again, ICT is of great importance in this regard. The target group for these centres has an affinity with the Internet. But even people less familiar with this medium are often informed

of the availability of special treatments in centres of expertise by relatives or patients' associations.

Ultimately, regions have an important part to play in this development, too. Once again, they can raise their own profile by creating favourable conditions for setting up business and can become a centre of knowledge in the field of medical care.

Health insurance from a European perspective

Basic European insurance cover looks like an attractive proposition in the long term

Before discussing the possibilities for convergence in the area of health insurance, there are two points which the RVZ would first like to make:

1. Although it will undoubtedly take a long time before significant steps are taken in this area, there is much to be said for establishing a form of basic European insurance cover. Indeed, the larger and more diverse the group, the more the risks are spread and the greater the solidarity. Member states are fiercely opposed to such a move, however, and want to keep control of these considerable costs and limit solidarity to within their national borders.
2. The RVZ has observed another development in this regard. A striking conclusion of the TNS NIPO study is that young Europeans appear quite happy to look after themselves. There is a trend among the younger generation towards paying for what you need, a 'do it yourself' approach. The results of the survey therefore indicate possible reservations about the extent to which young people are prepared to invest in risk solidarity. New products such as personal savings plans for medical care (a medical savings account) would probably appeal to this group.

What form will risk solidarity take?

It is vital to consider how these two factors will interact in the future and whether they are compatible with each other This is a complex problem. The RVZ argues that a possible solution lies in establishing a basic European insurance cover with variable levels of risk solidarity and healthcare options per claim or group of claims. This would provide a finely tuned interpretation of the concept of solidarity and also offer freedom of choice to customers where possible.

Let us return to the possibilities for convergence in the short term. As is evident from the description of the different players, health insurers have their own reasons for transcending national borders. Initiatives in this area have so far been thin on the ground, except for the purchase of medical care to

avoid waiting lists and special arrangements in border regions. Far more frequent are the instances of insurance customers going to court to demand medical care abroad[14]. What can be done to rectify this situation in the short term?

In the short term, opportunities lie mostly

For private insurers, considerable opportunities lie with the first group of customers identified above (i.e. those who are willing to travel and pay). This group is interested in additional options and specialist care and in supplementary insurance cover. By identifying these options and offering them in the form of an insurance policy, private insurers can promote cross-border dealings. This group will also cast a wider net on the insurance market and look for the most attractive insurance policy.

in offering attractive complementary insurance

Most of the opportunities for providers of mandatory health insurance probably lie in the regional markets. These insurers could create a profile for themselves by offering attractive packages with preferred healthcare providers in the regional market. Identifying and inviting efficient innovative providers within the region will constitute an important task for these insurers. Above all, they must concentrate on purchasing medical care.

and improving the purchase of medical care

Preconditions

With reference to the above, a number of essential preconditions can be readily identified.

There are a number of important preconditions to be met before convergence can take place

1. *Transparency*
   Firstly, it is vital that information on the quality and cost of healthcare becomes available. Customers have indicated that they are prepared to pay more out of their own pocket if they know what they are getting in return. This survey shows beyond a shadow of a doubt that customers want to know what is on the market and above all, what they can expect for their money. Without information, customers will not seek out the best provider or look around for the availability of a centre of expertise. This applies to options in an insurance package as well. There are also others who require transparency. Providers are accountable to their financial backers and, as healthcare comes to account for an ever greater percentage of GDP, the pressure of public opinion will also lead to demands for accountability. Transparency is therefore an absolute precondition for initiating more transnational dealings.

   Transparency is crucial

2. *ICT*
   The importance of a sound information infrastructure

   as is ICT

hardly needs explanation. It is not only essential in keeping customers informed, but also in making information, expertise and skills locally available to both customers and healthcare professionals.

3. *Insurance*
   Many obstacles exist in the financing of healthcare and insurance. This is not the right place to embark upon a discussion of such issues. The question that must be asked, however, is whether the existing system of indirect payment via the insurance premium will continue to exist in its current form. It is more likely that a system of preferred healthcare providers will be set up than that the current system of contractual obligation will remain in place.

Obstacles in the area of insurance have to be removed

4. *Legal measures*
   Although this point no longer applies to all members states, for the Netherlands it is an absolute requirement that profit seeking be allowed. This is a major barrier to newcomers seeking to enter the Dutch market.

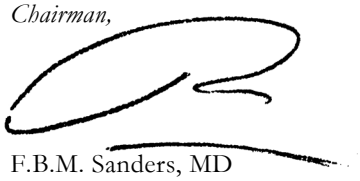
For the Netherlands, allowing profit seeking is particularly important

Conclusion

The path towards a European healthcare system is strewn with many obstacles. Nonetheless, there are reasons enough to assume that Europe will come to exert an ever greater influence on healthcare. There are advantages to be gained in the areas of quality and efficiency by accelerating the spread and widening the application of 'best practices', and by pooling knowledge and skills. There are a number of crucial and clearly identifiable preconditions that could have a powerful effect on the speed and success of these developments. Health insurers, too, could do their bit by identifying outstanding quality and concentrating on the purchasing of healthcare. The role of the customer in this process will continue to grow in importance.

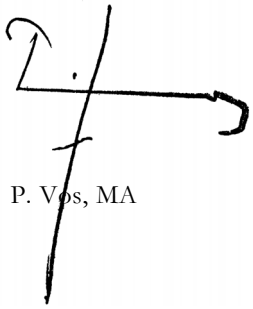
Council for Public Health & Health Care,

Chairman,



F.B.M. Sanders, MD

General Secretary,



P. Vos, MA

Notes

1 European patient of the future, Coulter, Magee, 2003.
2 The term acute beds is used by the OECD to refer to regular hospital beds.
3 See annex for comment on the use of the terms 'United Kingdom' and 'England'.
4 OECD newsletter 16-10-2003.
5 ZN, 2003. Excluding treatment for skiing accidents.
6 Council for Public Health and Health Care. Healthcare and Europe: a question of choice. Zoetermeer: RVZ, 2002.
7 Part II of the TNS NIPO report. For these socio-demographic analyses, national data have been weighted according to the size of the country.
8 People with an acute demand for assistance also expressed a preference for treatment by a specialist and also indicated their willingness to travel if this would improve the quality of care. In such cases, the nature of the complaint is an obvious determinant of whether travelling is possible and/or necessary (see also the report 'Market concentrations in hospital care', Zoetermeer: RVZ, 2003).
9 Statement by an employee of the Rhön Klinikum, 2003
10 Bundesarztekammer (Professional organisation of German doctors), 2003.
11 WHO report, 2002.
12 Obviously, the actual outlays for public health are greater, since a percentage of this care is provided by the curative sector.
13 Trynwalde, 2003.
14 Healthcare and Europe: a question of choice. Arrest Smits-Peerbooms.

Appendix

Supply and demand in the EU member states

Introduction

This appendix presents a profile of five European countries, based on the results of the TNS NIPO market survey and the NIVEL study. Each profile addresses four aspects:

1. The importance and form of greater choice, and the opportunities which healthcare supply and the insurance system can offer in this regard.
2. The (financial) value attached to greater choice, in the light of the existence of personal contributions.
3. Customer preferences with regard to innovation and the degree to which the supply side can support innovation[1].
4. Customer preferences with regard to provision of healthcare services in another country, and the degree to which the insurance system will support this.[2]

Belgium: customer preferences, healthcare supply and the system

Introduction

General

The Belgian consumer has much in common with his French and German counterparts, whose liberal views on healthcare he shares. The Belgian is used to choice and to bearing personal responsibility. Healthcare supply in Belgium shows great similarities to that in France and Germany, as does the system of funding. In all three countries, there is some degree of freedom of choice, while personal responsibility is established by payment of personal contributions.

Epidemiology and life expectancy

Like Germany, Belgium has a relatively old population, with 16.9% aged 65 or above. The most significant causes of death in Belgium are cardiovascular disease and cancer. Average life expectancy is 77.7 years (2002). In this respect, Belgium joins Germany at the bottom of the league table for the five countries studied.

Consumption

The Belgian patient makes greatest use of extramural and outpatient services. The average number of doctor consultations is high, at 7.9 per capita in 2000. Admissions to hospital number 170 per 1000 inhabitants, the average stay being 8.2 days. (2001). The consumption of clinical care services is therefore the lowest of the five countries studied.

Costs

Total expenditure on the Belgian healthcare system amounted to 8.7% of GDP[3] in 2002. This is the equivalent of USD 2293 (PPP[4]) per capita. Only England spends less. The emphasis on extramural care is reflected in the expenditure breakdown. Belgium devotes the highest percentage (34.3%) of total healthcare expenditure to extramural services, the equivalent of USD 691 (PPP). In this respect, it is at the top of the table.

The Belgian healthcare customer and his environment

What are the wishes and preferences of the Belgian customer? The market survey followed him through the healthcare process, from the moment he seeks information about health and

healthcare, through diagnosis and illness to rehabilitation (recovery and convalescence).

The importance and the nature of choice
When the Belgian customer seeks information, he prefers to consult a doctor. The pharmacist is his second choice. This is in line with the average behaviour of customers in all five countries studied. However, the Belgian deviates from the standard pattern in terms of his use of the Internet and of pharmaceutical manufacturers as sources of information, both of which score significantly lower than in the other four countries. Belgians seem to be less optimistic than others concerning the influence of better information on their healthcare consumption. Only 39% expect their consumption to fall, compared to the overall average of 49%.
Are the desired information sources readily available? Yes – the Belgian customer has access to many medical professionals who will answer his questions. There are 1.4 general practitioners and 1.7 specialists per 1000 inhabitants. With 11,191 pharmacists (1.1 per 1000 inhabitants), the preferred sources of information are in plentiful supply. The relative unpopularity of the Internet as a source of information reflects a general phenomenon in Belgium: Internet penetration is a mere 37%[5]. Only France scores lower.

Like his German counterpart, the Belgian customer attaches great importance to choice, with 88% finding this important. In almost all phases of the process, the Belgian finds choice significantly more important than customers in the other countries. The exception to this rule is the choice of treating physician. The Belgian is no more concerned about this than any other nationality.
For the Belgian customer, the general practitioner plays an important role in the diagnostic process. The choice of location for elective treatment is more important to the Belgian than to those in other countries. He prefers to remain in his own region. The general practitioner and the specialist are both options for the Belgian customer. If medication is required, the Belgian prefers to trust in the expertise of the medical professional. The pharmacist is seen more as a source of information than a prescriber of drugs and is therefore in third place. In addition to the treatment provided by a doctor, the Belgian also sees a role for the specialist nurse in dealing with such complaints as diabetes.
Choice of treatment location is considered extremely important by the Belgian who, far more than those in other coun-

tries, will opt to be treated at home where possible. He will also prefer to recover and convalesce at home, although there is a clear preference for a specialist doctor to be involved in the rehabilitation process where required.

The Belgian can indeed exercise considerable choice, particularly with regard to primary healthcare. The Belgian customer not only has free access to a large number of general practitioners (1.4 per 1000 inhabitants), most of whom work independently rather than in a group practice, but to the many specialists working in primary care. Some 34% of initial contacts with the specialist are in the form of a 'private consultation' within the primary healthcare sector.
General practitioners make a high number of house calls, with 34% of patient contacts involving a home visit. In the Netherlands, this figure is less than 5%. This would seem to be in line with the Belgian customer's preference for treatment at home. Although there is also a substantial degree of choice available in secondary healthcare, the Belgian tends to make less use of these options. Specialists in secondary healthcare are also freely accessible to the customer. Of all out-patient clinic consultations, 65% are at the initiative of the patient himself. The secondary care specialist is an independent professional and is paid per consultation or intervention. There is a large number of doctors and beds available: 1.7 specialists and 7.2 beds per 100 inhabitants, giving the Belgian customer the greatest choice in any of the five countries studied.
In Flanders, the preference for treatment at home is addressed by the *Wit Gele Kruis* (White Yellow Cross) organisation, which has 4515 peripatetic nurses able to offer professional nursing care. This figure is therefore not comparable with Dutch homecare services, which have few qualified nurses. No statistics are available for Wallonia.

The financial aspects of access to healthcare services are also well organised. Mandatory health insurance forms part of the general social security system, under the responsibility of the central government. The administration of the system falls to local health insurance agencies. Almost all Belgians (99%) are insured in this way. However, the entitlements vary somewhat. Those in full-time employment enjoy a broad package of services while the self-employed are covered only for the major risks requiring intramural care. Of all healthcare expenditure, 71.2% is public-funded. Only in the Netherlands is this figure lower. Supplementary insurance is available to cover the personal contribution requirement. Such insurance currently plays

only a marginal role but is growing in importance. Freedom of choice is guaranteed here, too. The reimbursement system offers considerable flexibility. It should be noted that Belgium does not have a separate regime for long-term care or home nursing, both of which fall under the same social health insurance.

The value attached to choice
The Belgian's preparedness to pay is average. The number of people who state they are *not* willing to pay more for more choice is 32%. However, when actual sums of money are mentioned, a slightly different picture emerges. Willingness to pay then falls, but remains around the average. The Belgian seems particularly unwilling to pay more for quicker treatment, or for greater choice in rehabilitation services. When presented with the bill for greater choice, the Belgian recants and falls back into last place, unwilling to pay more than € 3.70 additional premium per month.

This is not particularly surprising. Not only does the Belgian already enjoy considerable choice, he already pays a substantial price for his healthcare services. Most insurance claims are subject to an excess payment, particularly in the case of doctor consultations, prescription drugs and even hospital admissions. The patient is required to pay up to 25% of the costs of medical care out of his own pocket. In the case of prescription drugs, the payment may be as high as 80% of the price. However, tax relief applies above a certain threshold and there are exemptions for the lower income groups. It is worth asking whether the personal contribution system will continue to have the desired effect (of discouraging unnecessary demands upon medical services) given that supplementary insurance is growing in popularity. It seems likely that the reimbursement system has made Belgian healthcare customers aware of the cost and value of the services provided.

Preferences with regard to innovation
The Belgian customer is significantly more interested in the possibilities of telemetrics than customers in other countries. Some 56% consider this a positive development, as opposed to the average of 47% elsewhere. Again, this seems to be in line with the preference for treatment at home. The Belgian has somewhat less interest in the 'care consultant' concept, scoring around the average. However, there is slightly above average interest in new drugs which have fewer side-effects.

There is no simple answer to the question of how 'innovative' Belgian healthcare services may be said to be. Responsibilities are largely organised along territorial lines, with central government having entered into cooperative agreements with the local authorities. However, the management organisation seems less complex than that in, say, Germany. This may mean that changes of policy can be implemented more rapidly, but the lack of a direct financial relationship between healthcare insurer and healthcare provider could stand in the way of any directive role for the former. Moreover, change is not only dependent on the complexity of the management system, but also relies on the support which the relevant decisions will enjoy. Research indicates that the penetration of outpatient care is not as advanced as in England or the Netherlands. Notably, Belgium is slow in providing information for inclusion in the OECD database.
In Belgium, there is a considerable delay in bringing new prescription drugs onto the market after approval, averaging approximately 800 days.[6] In most cases, this delay is caused by the procedure for deciding whether the cost of the drug is to be covered by insurance. This requires additional authorisation by the Belgian Minister of Social Affairs.

Transnational movement
The Belgian is not particularly keen on travelling to another country to receive healthcare services. He is significantly less willing to do so than customers in other countries. Only 75% are prepared to make a journey of a few hours (as opposed to the average of 81%). The figure falls to 40% when the Belgian is asked to travel abroad merely because waiting lists there are shorter. Only the French are less willing to do so. This is hardly surprising, since Belgium has no waiting lists of note. Nevertheless, the interest in care services abroad is remarkably low. Even travelling to a European Expertise Centre is less appealing to the Belgian than to his counterparts in other countries. Unfortunately, little is known about the opportunities open to Belgians with regard to obtaining healthcare services across the border.

Conclusions
It is notable that Belgium does not seem to have a funding problem. Freedom of choice does not therefore automatically mean higher costs. Expenditure is at the same level as in the Netherlands. Nevertheless, Belgians generally get what they want and solidarity remains high. The only reservation is that many are required to pay substantial personal contributions.

Even so, the Belgian receives quite a bit in return. There is a very wide range of services and free access to specialists, even in primary healthcare. It is possible to receive care and treatment at home. The Belgian believes he already pays quite enough for healthcare. His interest in innovation is not remarkably high, and he is not particularly willing to travel abroad to receive healthcare services.

Germany: customer preferences, healthcare supply and the system

Introduction

General

German healthcare services may be described as being of very high quality. Chronic conditions are given considerable attention. There are, for example, many treatment programmes available for arthritis and circulatory problems. The German healthcare customer is used to being able to access a broad range of facilities. He also assumes personal responsibility for his health, and indeed is forced to do so in the financial sense, since he has to pay substantial personal contributions. The study did not examine the differences that exist within the individual countries. Although there may well still be differences between the former East Germany and West Germany, they have not been identified in this study.

Epidemiology and life expectancy

Germany is experiencing marked population ageing, with 16.9% of Germans now aged 65 or over. The main causes of death are cardiovascular disease and cancer. The standardised mortality from cancer is relatively low, while that from cardiovascular disease is relatively high.

There are marked differences in culture between the countries studied. This is reflected by the varying percentages of respondents who stated that they have suffered from a medical complaint for longer than three months. Indeed, the difference between the German interviewee and his counterparts elsewhere is particularly conspicuous. He is relatively quick to consider himself 'chronically ill', with 43% stating that they had suffered from a medical complaint for longer than three months (average: 34%). A similar picture emerges when asked about acute episodes and elective interventions. Statistics from other sources confirm this finding. OECD figures reveal that only 66.1% of Germans regard themselves as being in 'good health'. In all other countries, this figure is between 75% and 80%. Life expectancy in Germany is 77.7 years (2000), lower than in the Netherlands, France or England.

Healthcare consumption

Germany has a remarkably high consumption of healthcare services, particularly in the case of intramural curative care. The hospital admission rate is high, at 201 per 1000 inhabi-

tants, as is the average length of admission, 9.3 days (in 2001). Alongside France, Germany is responsible for the highest level of hospital bed occupancy. Compared with 0.8 in the Netherlands, France and Germany's figure of 1.9 days per capita may be seen as exceptionally high.

Costs
German healthcare is expensive, accounting for 10.6% of GDP in 2001. Germany has the highest expenditure on healthcare, at USD 2780 (PPP) per capita. The average German pays USD 542 each year for ambulatory health services. This is second only to Belgium. However, in percentage terms the picture is slightly different. Germany devotes only 22% of the total health budget to extramural care, compared to Belgium's 34.3%. Although the consumption rate for intramural care is high, the costs are lower than in France and only marginally higher than in the Netherlands.
For acute hospital care, the average German customer pays USD 841 per year. It is possible that indication plays a part here and that care is less intensive due to the length of the admissions.

The profile of the German healthcare customer and his environment

The importance and the nature of choice
The German healthcare customer displays a marked preference for the specialist. This is reflected in his choice of information sources, although it is interesting to note the parallel importance of medical reference works. These two sources are consulted significantly more often than in the other countries. At the same time, the German displays clear confidence in the information provided (by doctors) in magazines and newspapers and on television, all of which score higher than even the pharmacist. The German displays an average level of optimism concerning the effect of such information on his consumption of healthcare services: 47% believe that they will make less use of the services because they have better information (compared to the overall average of 46%).
The doctor is available to answer questions. The German customer has free access to general practitioners, of whom there are 1.1 per 1000 inhabitants. There are also specialists working in primary healthcare. With 0.6 pharmacists per 1000 inhabitants, this source of information is also readily accessible (in the Netherlands the ratio is only 0.2 per 1000 inhabitants). Relatively low penetration (39%) accounts for the fact that the Internet is not widely used as a source of information.

The German healthcare customer knows what he wants. He displays a requirement for choice, whether in the diagnostic phase, in the choice of a treating physician or in the rehabilitation phase, scoring higher in this regard than his counterparts in the other four countries studied. In exercising this choice, the German generally seeks out the specialist and the specialist clinic. Although 70% of Germans cite the general practitioner as the first point of contact in the diagnostic phase, the German specialist occupies this position more often than in any of the other countries. In the treatment phase, the popularity of the specialist rises to 61%. In this regard, the German customer is not so markedly different to his counterparts elsewhere. The German also prefers to obtain his prescriptions from the specialist, entrusting this responsibility to the treating physician significantly more often than customers in other countries: 78% as opposed to an average of 66%. The specialist nurse does not exist as such in Germany. In terms of rehabilitation, the German differs from the norm somewhat, in that all options available enjoy equal popularity: rehabilitation at home or at the clinic, overseen by a physiotherapist or a specialist rehabilitation doctor.

The German enjoys considerable freedom of choice. He may change his general practitioner every three months, has free access to the specialist and is able to choose between a large number of doctors. The broad range of options in primary healthcare may explain the absence to date of the specialist nurse: there are, after all, plenty of doctors available. Free access to such a broad range of services can also be seen in secondary care. Germany does not have a 'gatekeeper' referral system and there are no waiting lists of any note. The focal point of healthcare services is specialist care, reflecting the preferences of the customer. Germany has an ample supply of specialist care, with no fewer than 2.1 specialists per 1000 inhabitants, 9.7 nursing staff and a large number of acute beds: 6.7 per 1000 inhabitants. Most of the country's 2240 hospitals are relatively small, with an average of 245 beds. Of these, 21% are private, profit-making institutions. The remaining hospitals are either public (37%) or private 'not-for-profit' institutions (41%). The supply of secondary healthcare services therefore matches demand for specialist care.

As noted above, the German customer sets great store by choice in rehabilitation services. But what is the actual status of such services? In 2001, there were 1388 *Vorsorge- und Rehabilitationseinrichtungen* with over 189,000 beds. It is difficult to

present any firm statement regarding the quality of these institutions, since only a small proportion of the beds are available for rehabilitation and convalescence. Some 1.2 million elderly people are cared for informally, by family or friends.

Freedom of choice and ready accessibility are also to be seen in health insurance. Germany has a social security insurance system, the *Gesetzliche Kranken Versicherung (GKV)* which provides cover for 90% of the total population. Seventy-five per cent of expenditure is public-funded. There is a *freie Kassenwahl*, used by 3-5% of policy-holders each year. The overall package is broad and some provisions can even be described as 'luxurious'.

Alongside the GKV, there are two types of private insurance, offering a full package of services and a supplementary 'top-up' package respectively. Both are nothing short of expensive. Although German healthcare services are provided without direct payment (i.e. no invoices are issued and no money changes hands), this does not limit freedom of choice. The customer has an electronic smartcard to prove his entitlement, and this allows him free access to general practitioners and specialists in the primary healthcare sector.
The introduction of the *Pflegeversicherung* in 1994 has served to improve access to healthcare for the elderly and infirm. The German *Kranken Kassen* also provide employment and income insurance.

The value attached to choice
As implied above, there is a price to be paid for such high-quality healthcare services. Nevertheless, the German customer remains prepared to pay for choice. Even when a firm figure is stated, the number of interviewees who state they would not be prepared to pay that extra amount is significantly below average. Willingness to pay more for rehabilitation services is markedly higher than average, while that for diagnostics is significantly below average. It is interesting to note that the German's willingness to pay is affected less by the presentation of a firm figure than that of respondents in other countries. Consumers were not daunted by the figures stated, whereupon the Germans finished in second place in terms of willingness to pay more, with € 4.20 per month being the average acceptable additional premium.

Nevertheless, the Germany system is already notable for its high insurance excesses. The German pays a personal contri-

bution of 10.2%, very nearly on the same high level as the French (10.6%). This, together with budgeting, has been applied as a cost management instrument, but with limited success. The German customer pays a prescription charge of € 4 to € 5 per prescription. He also pays an additional charge for hospital care, medical devices and rehabilitation services. The *Pflegeversicherung* itself does not require a personal contribution, but cover is limited to certain maximum amounts.

Preferences with regard to innovation
The German healthcare customer is indeed interested in new techniques and technologies, new services and new drugs, but does not score markedly higher in this regard than those in other countries. Approximately 50% of respondents stated an interest in telemedicine (average 47%), while interest in new forms of healthcare service (65%) and new drugs (61%) are also at the average level.

German healthcare services are not marked by a particular drive towards innovation. There is still no place for the specialist nurse in the German system and the concept of outpatient treatment for conditions previously requiring hospital admission was only recognised in 1993. Germany therefore lags behind in many ways. The strict division between clinical and ambulatory services stands in the way of substitution and chain care. Oddly, this has not raised customer interest in the 'care consultant' concept. This may be due to the strong emphasis on intramural care, whereby the problems of coordination and transfer may not be so acute. After all, anyone leaving hospital or a rehabilitation centre fully cured is unlikely to require aftercare in the primary sector.

The marketing authorisation of new drugs is subject to extreme caution. The system is highly regulated and slow. However, once a drug has been approved, it is available immediately.
The high level of professional interest in technical innovation is interesting, although the customer only shares this interest to a limited degree. Perhaps this is more a question of the doctors' ambitions rather than patient demand.

The system and management structure do not facilitate innovation in the services offered. There are strong interest groups and a strict division between clinical and ambulatory care. In the primary healthcare sector, the federations representing the ambulatory doctors (*Kassenärztliche Vereinigungen*) have made

agreements with the health insurance providers, resulting in arrangements of a strong corporate nature and considerable influence. Although this is currently the subject of political debate, the insurance funds are not yet able to enter into individual contracts with providers. Insurers do not therefore enjoy full selective purchasing opportunities The overall effect is that the healthcare insurers' opportunities to promote any revision of the system are limited. Similarly, the manner in which healthcare services are defined by law (the *Socialgesetzbuch V)* renders change difficult. Any change of direction usually requires a revision of the relevant Act, which in a parliamentary democracy is a drastic and somewhat inflexible instrument.

Transnational movement
The German is attached to his own healthcare system. Although somewhat less so than the French or Belgian consumer, the German patient wishes to receive treatment in his own country. Even if travel to another country will result in quicker treatment, German interest remains average. In the first part of this survey, it became clear that the German healthcare customer attaches particular value to specialist care. It is therefore somewhat surprising to note that willingness to travel remains average even if travelling would result in treatment by a highly qualified specialist or at a European Expertise Centre.

Conclusions
The German healthcare customer wishes to receive specialist treatment and generally gets what he wants; there is considerable choice, freedom of choice and a broad range of services. It is possible that even more facilities in rehabilitative care are required, given the higher willingness to pay noted in this segment.

The German customer is prepared to pay for choice. However, healthcare services are already expensive. To an even greater degree than in its neighbours, Germany is facing the problem of an unaffordable system. Budgeting and personal contributions have done little to help. Discussions about restricting the package are now ongoing but are being complicated by intransigence within the insurance system and the relationships between the insurers and the healthcare providers. Opportunities to change this situation are limited. It must therefore be asked whether the system will remain viable for much longer. Restrictions to the insured package are currently the favoured

solution. The survey does not suggest that the German healthcare customer shares the government's concerns about the sustainability of healthcare services.

France: customer preferences, healthcare supply and the system

Introduction

General

The duality between *liberté* on the one hand and *egalité et fraternité* on the other can also be observed in the French healthcare system. A strong government and an equally strong market, freedom of choice and personal responsibility determine not only customer preferences, but also the range of services available, the structure of the system and its funding.

Epidemiology

France's population includes 16.2% aged 65 and above. The main causes of death are cardiovascular disease and cancer. However, it is interesting to note that the standardised mortality from these conditions is relatively low compared to that in the other countries studied. The Frenchman is not readily inclined to consider himself sick: only 27% of interviewees in the NIPO survey stated that they had suffered from a medical condition for more than three months. This is significantly lower than in the other countries studied. Life expectancy is higher than elsewhere, at 79 years (2000).

Consumption of healthcare services

Like the Belgian, the Frenchman consults the doctor frequently. His average of 6.9 visits per person per year puts him in second place. The number of hospital admissions is unknown, as is the average length of stay in acute beds, for which the OECD has no statistics. Nevertheless, it may be stated that the per capita production figure for French hospitals is 1.9 days per annum. France, like Germany, therefore has a high score in this regard.

Costs

France devotes 9.3 % of GDP to healthcare. Although the Frenchman spends somewhat less on healthcare than his German counterpart, this is nevertheless a high overall score in the international comparison. Primary healthcare accounts for 23% of total expenditure and costs USD 496 per capita. Even more is spent on French hospital care services than in Germany: USD 931 per capita (i.e. 39% of total expenditure).

The profile of the French healthcare customer and his environment

The importance and the nature of choice

To whom does the Frenchman turn with his questions on health and illness? The first notable finding is that French doctors represent a significantly less popular source of information than those in other countries. It would seem that their task in this regard has been usurped by the pharmacist, the television, newspapers and magazines. Patient associations are also a more popular source of information than in other countries. In addition to such 'market sources', the government itself appears to be a significant source of information, more so than in Germany, the Netherlands or Belgium. In this sense, the Frenchman has something in common with his English counterpart. It is not difficult for the French customer to access his preferred sources of information, as there is certainly no shortage of pharmacists, with 1 per every 1000 inhabitants. Moreover, over 3.3 doctors (1.6 general practitioners and 1.7 specialists) per 1000 inhabitants are freely accessible for questions.

In terms of preferences for choice, the French clearly demonstrate the duality referred to above. They consider choice to be important, but less so than the Belgians or Germans. Accordingly they occupy third place in the comparative rankings. The French patient sees a clear role for the general practitioner in diagnosis. In the treatment phase, he attaches relatively high value to a choice of treating physician (first place in the comparison) and prefers to consult a specialist, in line with the average result. The Frenchman attaches considerably more importance to the treatment location for chronic conditions than his counterparts elsewhere, not sharing the German preference for the specialist clinic. He would rather remain at home. To the French patient, the specialist doctor is more important than the specialist clinic.

When it comes to prescription drugs, the care provider is the overriding authority: the patient will accede to his advice and does not wish to have any say in the choice of medication. But although the doctor is in first place in this respect, the French pharmacist scores higher than his colleagues elsewhere.

For rehabilitation services, the Frenchman remains consistent in his preference for the specialist doctor rather than the physiotherapist. His preference for treatment at home is somewhat less marked in this phase.

In considering France, the word 'centralism' soon comes to the fore. The public sector plays a very important part in many aspects of French life and healthcare is no exception. The influence of the public sector is clearly visible. However, on the other side of the equation there is a strong market: sometimes too strong, as illustrated below.

The supply of services available to the customer is extensive and offers considerable choice. With 3.3 doctors per 1000 inhabitants, (of whom 1.6 are general practitioners) the French are well served. Unfortunately, the OECD statistics do not indicate primary healthcare consumption separately. The ambulatory private practice is popular among doctors, 56% of whom work in such a setting in addition to their position on the payroll of a hospital. The large number of freely accessible specialists in the primary care sector is in keeping with the Frenchman's preference for treatment close to home and his preference for treatment by the specialist.

French healthcare services are marked by a considerable degree of freedom, with scope for the market and market forces on both the supply and demand side. This can be seen in several areas. There are both general practitioners and specialists working in primary healthcare. Doctors are permitted to set up a practice wherever they choose. Although fees are established centrally, they are not binding for all doctors. Those working in the free private sector and those with particular skills and qualifications are permitted to charge higher fees. France operates an insurance reimbursement system, whereby the patient knows exactly how much he is paying for his care. The French doctor sells himself well and knows the power of marketing. He will display his diplomas conspicuously. However, little is known about performance measurement.

French healthcare services centre around the hospital. Secondary healthcare also offers an extensive supply, with good accessibility and free choice. With 6.7 acute beds, 1.7 specialists and seven nursing staff per 1000 head of population, the French are well provided for. The influence of the private sector is obvious here, too. Some 35% of hospital beds are in private 'for profit' clinics and hospitals, which account for 22.8 % of hospital expenditure. Such clinics are mostly concerned with surgical interventions. The downside to the focus on specialist, technical and curative care is that public health issues and services of societal importance are pushed into the background.

France has 10,400 institutions offering care for the elderly or long-term care. However, French hospitals also provide much accommodation for those requiring long-term care. It is therefore difficult to quantify the exact supply in this sector, and similarly difficult to draw any conclusion with regard to the extent to which supply meets demand in terms of customer preferences. The NIVEL report states that 1.4 million French people make use of homecare and related social services. This is in keeping with the preference for treatment at home. In percentage terms, it means that 1.7% of the population receive care at home, a higher figure than in the Netherlands.[7]

France has a mandatory social insurance system which offers good access to care services. France and England are the only countries which have insurance systems covering 100% of the population. Of all healthcare expenditure in France, 75% is public-funded. The government determines the content of the package of services insured. Everyone, with the exception of undocumented aliens, is covered. The system does not impair freedom of choice. Payment relies on the reimbursement system. Any problems caused by the high personal contribution (insurance excess) are resolved by means of supplementary insurance, which is held by 87% of French people. It has been shown that they opt for treatment by a specialist more often. The French system does not have any separate insurance to cover long-term care, which is funded from the social insurance revenue.

Value attached to choice

The French believe that they already pay enough for healthcare. The level of willingness to pay more for more choice is among the lowest in the five countries studied, on a par with Belgium. Compared to respondents elsewhere, a significantly greater number of French said 'no' to almost all the options presented in the survey. The number of interviewees who wished to see absolutely no expansion of the current choice was also higher than in other countries. However, one notable exception is that the Frenchman displays a higher willingness to pay more for greater choice in diagnostics. This serves to confirm that he considers choice in this area important, as previously noted. Given that the pattern of willingness to pay more closely follows that of the perceived importance of choice, we may conclude that the French healthcare consumer has a good sense of value for money.

The direct payment relationship (reimbursement system) between the healthcare provider and the patient, together with the high personal contribution, averaging 10.2%, may explain why the French customer is not prepared to pay more. He sees the bill for services rendered, and has developed a keen sense of cost awareness. The insurance excess for a hospital consultation is 25%, and up to 65% for prescription drugs. However, the costs of medication for chronic conditions can be reimbursed in full. People on invalidity pension or incapacity benefit do not have to pay the personal contribution.

Preferences with regard to innovation
The French show average interest in innovation within the care services themselves. A relatively large number of respondents have no option regarding the innovations described. They tend to trust in the doctor rather than in technology: remote blood pressure measurement is not seen as an exciting development. Neither is there much interest in new drugs or the services of the 'care consultant'.

Although France has a social insurance system rather than a National Health Service along British lines, the state does play a major role in the healthcare sector. However, the French government does not have the far-reaching opportunities to bring about change that exist in the United Kingdom. The social insurance system is administered by health insurance agencies under the direction of employer and employee federations. The social partners therefore also have some influence. No information is available concerning the speed at which outpatient treatment for conditions traditionally requiring hospital admission is being introduced. The 'time to market' of prescription drugs is average.

Transnational movement
The French are willing to travel for treatment, but that willingness extends only as far as the national border. Treatment in another country is not considered to be an attractive option, whether to obtain treatment more quickly or to enjoy the attentions of a European Expertise Centre. Indeed, the French are the least willing to travel of all the nationalities studied.

Conclusions
The great freedom in the relationship between customer and provider is clearly a normative characteristic of the French healthcare system, as evinced by the high personal contributions, the reimbursement system and a large number of 'for

profit' hospitals and clinics. Nevertheless the French are not dissatisfied and feel less need for greater choice than either the Belgians or the Germans. Like the Germans, the French consider curative care and technology to be leading factors, but have a stronger preference for treatment at home. This preliminary investigation found no major discrepancies between the existing supply of services and customer preferences.

The Netherlands: customer preferences, healthcare supply and the system

Introduction

General

The Netherlands is currently in a transitional process. Healthcare customers, providers and insurers must contend with the shift from a supply-driven system to one which focuses on results and self-regulating markets. The role of the government is also changing, from prescriptive decision-maker to supervisory regulator.

Epidemiology and life expectancy

The average age of the Dutch population is relatively low, with only 13.6% aged 65 or above. The main causes of death are ischemic coronary disease, cerebrovascular conditions and cancer. The average life expectancy is 78 years (2000). The OECD statistics reveal that 78.5% of the Dutch consider themselves to be healthy, which makes them more positive about their health than respondents in any of the other countries studied.

Healthcare consumption

Healthcare consumption is not particularly high in the Netherlands. The average number of doctor consultations is 5.9 per person per year, the second lowest figure (next to the United Kingdom's 4.9). The average length of a hospital admission is 8.6 days. The OECD database does not state the number of admissions. However, with 0.8 nursing days per capita and an average hospital stay of 8.6 days, the consumption of intramural care appears to be relatively low.

Costs

According to the OECD figures, the Netherlands' expenditure on healthcare in 2000 was 8.6% of GDP. This is the equivalent of USD 2348 (PPP) per capita, placing the Netherlands in the middle bracket. The Netherlands has the lowest per captia expenditure on extramural care, at only USD 293. This is 15% of the overall budget and contrast sharply with Belgium's 34.3%. Dutch per capita expenditure on acute intramural care is USD 829 (PPP), 35.3% of overall spending.

The profile of the Dutch healthcare customer and his environment

The importance and the nature of choice

Where does the Dutchman go to obtain information about health, healthcare and illness? It would seem that the Dutch doctor enjoys only moderate patient confidence. Just 57% of respondents cited the medical practitioner as the most important source of information (average: 65%). Both the Internet and patient associations are relatively popular. This is not surprising: the Netherlands has a high Internet penetration (61%) while very few doctors are directly accessible. With 0.5 general practitioners per 1000 inhabitants, the Dutch consumer only has restricted opportunities to obtain information directly from the medical profession. The Dutch are not particularly optimistic about the effect of good information on their healthcare consumption: only 43% expect any effect, compared to the average of 46%.

The Dutch customer has yet to become accustomed to choice. His aspirations in this regard are higher than those of the English, but have not yet reached the level of the Germans, French or Belgians. The Dutch are not happy with the 'gatekeeper' referral system. In the diagnostic phase, the Dutchman attaches less value to the general practitioner than any of the other nationalities studied, while the specialist is far more in demand to treat chronic illnesses such as diabetes than is the primary care doctor (63% versus 25%). Specialist nursing care is also seen as valuable. The Dutch customer's relatively low confidence in the healthcare provider is also reflected in his choice of drug prescriber. He tends to investigate and consider all available options. The pharmacist, the health insurer and his own opinions weigh heavily in the process. Particularly notable is the low value attached to the treatment location for a chronic condition and for rehabilitation. As far as treatment is concerned, the hospital is the most attractive option. In the case of elective treatment, the choice of location is far more important to the Dutch (84%) and there are few objections to this being provided in a neighbouring country. With regard to rehabilitation, the Dutch patient shows a slight preference for treatment at home. The physiotherapist is more popular than the specialist rehabilitation doctor.

Much as they would like it, the Dutch do not at present have direct access to the specialist. It falls to the general practitioner to refer patients to the appropriate specialist. Without a referral the costs of specialist care will not be reimbursed. The

customer is clearly not happy with this situation. He would prefer direct access to the specialist, not only for treatment but for diagnosis too. It is impossible to state with any certainty whether this is a problem of quality, quantity or both, although it is clear that the Netherlands does not have an overabundance of general practitioners.
Secondary healthcare is also subject to some constraints: there are 3.5 acute beds and 0.9 specialists per 1000 inhabitants, and a very restricted supply of services available to the customer. The waiting lists for treatment for chronic conditions illustrate this, often exceeding 15 weeks. However, there is a remarkably high number of qualified nursing personnel. With 12.8 nurses per 1000 inhabitants, the Netherlands actually leads the field in this regard.

There are over 100 hospitals in the Netherlands (2001), of which 35 have a rehabilitation ward. Rehabilitation may also take place in one of 331 nursing or convalescent homes. However, most Dutch customers would prefer to undertake the recovery process at home. The Netherlands has 104 regular and 217 commercial homecare organisations which, while primarily offering home help, may also provide nursing services.
The survey revealed that the physiotherapist is popular in the Netherlands. Indeed, the Dutch client can choose from over 12,000 qualified physiotherapists.[8]

Financial accessibility is well organised. The *Ziekenfondswet* (Mandatory Health Insurance Act, ZFW) covers 61% of the population, but comprehensive private insurance also provides broad coverage. Only 63.4% of healthcare expenditure is public-funded. Supplementary insurance coverage is available to all, including those with compulsory insurance. Long-term care and homecare are financed under another social insurance scheme, the *Algemene Wet Bijzondere Ziektekosten* (Exceptional Medical Expenses Act, AWBZ). Customers may change health insurer once a year. The insurance system does not promote freedom of choice to any great degree, most payments being made directly to the designated healthcare provider. However, under the AWBZ, customers may purchase their own care services by opting for an individual budget rather than the standard arrangement. In short, the insurance system offers wide access, but little real purchasing choice and little customer influence.

Value attached to choice
The Dutch are very willing to pay extra for greater choice, occupying first place in the league table of countries studied on this point. Only 24% of respondents rejected all additional options offered (average: 33%). Even when presented with firm figures, there was a continued willingness to pay, especially for greater choice in diagnostics, type of treatment and for more rapid access to treatment. Compared to other nationalities, the Dutch do not wish to pay very much more (the median of respondents in the Netherlands is € 5.00 compared to an average of € 4.80), but the *number* of Dutch respondents willing to do so is the highest of all five countries studied.

What conclusion may be drawn from this? Is this result to be interpreted as an expression of dissatisfaction? Do the Dutch wish to be able to 'buy' influence and control? This certainly cannot be discounted. However, a reservation must be noted: unlike his counterparts in France, Belgium and Germany, the Dutch customer rarely sees the price tag attached to the care he receives. For those with mandatory insurance, the premiums are paid automatically through their employers. The direct payment system is dominant in the Netherlands. Only those with private insurance pay first and are reimbursed later, but even they often only see the bill for smaller amounts. Larger amounts are subject to agreements between the health insurers and the healthcare providers. This is particularly true of expensive intramural (clinical) care. The ZFW system does not generally require any personal contribution to be paid (while the private policies do indeed carry an excess). The lack of a personal contribution under the ZFW may account for the differences between the Dutch customer and those elsewhere in terms of willingness to pay extra.

It should also be noted that the OECD statistics indicate that the Netherlands does have quite substantial personal contributions (8.6%). These mainly apply to care services financed under the AWBZ scheme. Here, the consumer does indeed see the direct costs. However, the willingness to pay extra for rehabilitation services is not noticeably lower than for other healthcare segments.

Preferences with regard to innovation
The Dutch show average interest in new forms of healthcare service provision. In the case of telemedicine, 47% would opt for such treatment, this being the exact average of the five countries studied. There is also some support for the 'care

consultant' concept (71% compared to an average of 69%). A factor here may be that the Dutch consumer is already reasonably familiar with the care consultant. The marked hierarchy of Dutch professionals results in a strict division between primary and secondary healthcare, and coordination between the two is often less than perfect. It is therefore hardly surprising that the Dutch customer displays a slightly higher than average interest in the care consultant.
Interest in drugs with fewer side-effects is considerable, with 72% citing a preference in this regard (compared to the average of 63%). New prescription drugs reach the market relatively quickly in the Netherlands, the average period between marketing authorisation and availability being approximately 160 days[9].

A number of aspects of the Dutch healthcare system serve to slow innovation. The (political) decision-making process, for example, is complex. Special interest groups are allowed considerable input. The fact that public tasks are carried out by private providers and insurers is a further complicating factor. The Dutch government therefore has far fewer opportunities to insist on innovation and modernisation that that of, say, the United Kingdom. The supply shortage in primary healthcare and the contracting obligations of health insurers in secondary healthcare mean that insurers also enjoy few opportunities for innovation in the form and structure of healthcare services. A good example of the complexity of the processes in the Netherlands is the introduction of diagnosis treatment combinations, where the research, development and decision-making process took a full ten years. With regard to the rapidity at which wider outpatient services have been introduced, the Netherlands is in the mid range.

Transnational movement
Although not particularly willing to travel, the Dutch healthcare customer is willing to go to another country if treatment will be available sooner (67% compared to the average of 47%). He is also willing to travel for better quality. The European Expertise Centre concept would encourage 77% to travel abroad (average 69%). Dutch healthcare insurers can already purchase some services in neighbouring countries, primarily with a view to avoiding the waiting lists. However, little use is made of this opportunity in practice[10]. Only 1.5% of care services are purchased outside the Netherlands. This is in line with patient demand, but interest in this aspect is considerably

greater than current uptake would suggest.

Conclusions

The Dutch healthcare customer seems to be somewhat dissatisfied. In particular, he wants greater choice in the form of free access. He is prepared to pay for choice and for better access to healthcare services. In terms of quantity, supply appears to fall short of demand. The need expressed for more choice in the diagnostic and treatment phases is food for thought. Notably, despite the 'gatekeeper' referral system, the Netherlands spends relatively little on extramural care. To the Dutch customer, the prime motives for travelling to another country for treatment are to avoid waiting lists and to enjoy a high quality of care.

The United Kingdom: customer preferences, healthcare supply and the system

Introduction

General

The various regions of the United Kingdom each have their own healthcare organisation and management system. However, England and Wales combined form the most significant region in demographic and economic terms, representing 88.6% of the total population. The study of healthcare supply and organisation structure therefore focused on the situation in England and Wales, which for the sake of convenience is referred to simply as 'England'. However, the market survey and the OECD statistics relate to the entire United Kingdom.

England has a National Health Service. Over the past 15 years, this system has moved towards greater decentralisation and a results-oriented, customer-oriented model. However, this shift in culture is far from complete. It would appear to involve a major transition, both for healthcare providers and consumers. In the case of healthcare customers, the importance of choice is not yet fully clear. One very positive result of the history of state influence is the well-equipped public health system.

Epidemiology and life expectancy

England is now experiencing the effects of population ageing, with 15.9% aged 65 or above. Life expectancy at birth is 77.8 years (2000). Main causes of death are cancer and cardiovascular disease.

Healthcare consumption

England has the lowest number of doctor consultations of all the five countries studied. The English patient visits the doctor 4.9 times a year on average. Annual hospital production is 1.1 nursing days per capita. The average length of admission is remarkably low at 7.0 days. Overall, the consumption of intramural hospital care may therefore be said to be low.

Costs

Healthcare expenditure in England is low, at 7.3% of GDP. Unfortunately, figures relating to the per capita costs of extramural versus intramural care are not available. However, the total of USD 1992 reinforces the foregoing conclusion.

The profile of the English healthcare customer and his environment

The importance and the nature of choice

The English healthcare customer goes in active search of information about health and illness. In doing so, he prefers to consult the medical practitioner. With 72% taking this route, there appears to be significantly more confidence in doctors than displayed by patients in the other four countries. The Internet, reference books and the government are also more popular choices than elsewhere. Although the absolute percentage is low, English consumers have greater faith in information provided by pharmaceutical manufacturers than those in other countries. The English set great store by good information, with 60% believing that it will reduce their consumption of healthcare services (average 46%).

The English customer clearly finds choice less important than customers in other countries. This is apparent in both the diagnostic phase and the rehabilitation phase. For diagnosis, the Englishman will generally consult the general practitioner, who enjoys considerable confidence. The specialist nurse also seems to be gaining in importance. A similar picture can be seen in the choice of treating physician. Here too, the general practitioner is a trusted figure. Strangely, this confidence is not reflected in the choice of prescriber. Prescription drugs are the only healthcare product for which customers are required to pay a personal contribution.

Customers in England are used to primary healthcare serving an important function. Indeed, England is the prime example of the 'gatekeeper' referral system at work. Patients are free to select their own general practitioner. With only 0.6 general practitioners per 1000 inhabitants, there is not an overwhelmingly large supply, but these doctors enjoy extensive support from practice nurses (0.2 FTE/1000), a telephone advice service (NHS Direct) and various walk-in medical centres. Customers do therefore have some degree of real choice.

There is no direct access to the specialist, but customers do not seem to express a particular desire for such access. In both diagnosis and treatment, they place their confidence in the primary healthcare providers and show little interest in being able to approach the specialist directly.

The questions relating to the choice of treatment location prompt an interesting response. The English customer prefers to undergo treatment for a chronic condition in the hospital.

This is surprising, given the healthcare system's focus on primary and home care.

Two aspects may be at work here:

- First, a general observation. Healthcare customers in England have extremely limited options and lack freedom of choice. Although the NHS has in the last 15 years made a transition from a fully supply-driven system to a self-regulatory system (with output financing, strict supervision of quality and performance, and greater freedom of choice for patients), 'patient focus' is still somewhat paternalistic in nature. In other words, the concept is attractive in theory, but not widely applied in practice. Freedom of choice remains restricted: patients fall within the area covered by a Primary Care Trust (PCT) according to their place of residence. While there is customer representation within the PCT, it is the healthcare providers who determine the form of the primary healthcare services and who decide where secondary healthcare services are to be purchased.
- Secondly, secondary healthcare services suffer severe shortages. With 3.9 acute beds per 1000 inhabitants, customers in England have markedly fewer facilities than those in France, Belgium or Germany. The figure of 1.4 hospital doctors per 1000 inhabitants is also on the low side. However, there are 9.0 qualified nurses per 1000 inhabitants, which may be seen as a generous figure. The reasonably well-developed private sector is also noteworthy. The NHS is able to contract capacity and services from private hospitals. Unfortunately, production figures for these institutes are unavailable.

In short, the supply of services does not seem to match customer preferences, either in terms of quality or quantity. It may be that the English express their dissatisfaction by placing the emphasis on treatment in the hospital setting.

In rehabilitation services, little importance is attached to choice. The preference is for treatment by a physiotherapist rather than in a clinic. Care for the elderly and long-term care services are geared towards enabling people to remain in their own environment for as long as possible. The district nurse plays an important part in this respect.
In the case of long-term intramural care, private providers have a major role, supplying 85% of this type of care. Supply

amounts to over 8.9 beds per 1000 inhabitants. There is a large number of providers and the facilities are mostly small scale.

The financial accessibility of the NHS is good. All services are available to everyone, and offer access to acute and curative care. Following major reorganisations, the payment and supply functions are now separate. Procurement responsibility has now been decentralised to the Primary Care Trusts, with free choice of doctor in primary healthcare. The system does therefore *appear* to offer options and freedom of choice. However, as previously noted, the customer has few real opportunities to exercise this choice in practice.

In long-term care, the NHS provides only restricted and income-dependent access. Residential care is financed in part by local authorities and in part by central government. It is means-tested: customers must first call upon their own financial reserves before becoming entitled to public assistance. Partly due to this arrangement, a number of private insurance policies have come onto the market but these have yet to become popular. Given the effects of population ageing, this may well cause problems in the future, since only 10 % of the English hold private insurance. In most cases, these policies cover such aspects as residential care and alternative medicine. Access to such care is therefore not well established.

Value attached to choice

The limited value attached to choice is reflected by the English customer's willingness to pay, which is around the average of the five countries studied. There are, however, two significant exceptions: faster treatment and greater choice in the rehabilitation phase. When told the actual increase in premiums required to offer more choice in rehabilitation services, the willingness to pay dwindled to nothing, although respondents were still willing to pay more for quicker treatment. This is hardly surprising given the capacity shortage in the secondary healthcare sector.

Customers in England are not used to paying directly for their care. The only exception is prescription drugs, for which the patient must pay a prescription charge of € 9.74 per item, or a fixed charge of € 104 per year regardless of the number of items. This serves to explain the limited willingness to pay more for prescription medication.

Preferences with regard to innovation
The English are willing to embrace innovation in healthcare. The 'care consultant' is seen as an attractive concept. Technology and new drugs attract less interest. It must be asked whether innovation supply matches demand. In terms of organisational development, this is surely the case. The NHS is notable for the unrivalled pace at which it implements innovation. Compared to the situation in the other four countries, there are few organisations that stand in the way of innovation. This is not always an advantage. Given the relative ease with which the NHS can change the form and supply of healthcare services, it is in a permanent state of reorganisation, although this is in keeping with the customer's affinity for new developments.
England has a greater quantity of information concerning the results of healthcare than any of the other four countries. In this respect, too, it leads the way.

Transnational movement
The English customer's general willingness to travel is the highest among the countries studied. This is probably due to the shortage of secondary healthcare services, whereupon it is hardly surprising that the English should be willing to travel elsewhere to be treated more quickly. Around 51% are even prepared to cross the English Channel (average: 30%). Quality is also an important motive: 83% would be willing to visit a European Expertise Centre (average: 69%). The NHS already purchases healthcare services in other countries, having done so in Germany and France in recent years. The opportunities certainly exist, and all treatment is free to the patient However, it is not clear how many customers have made use, or will make use, of these opportunities.

Conclusions
In England, the customer, the system and the providers all seem to be following the same path towards a more demand-driven regime, although the focus is more on meeting existing demand than on allowing demand to prevail. The customer has yet to become accustomed to greater choice. His preferences are less explicit than those of other nationalities. The waiting lists may play a role here, with customers believing that they preclude greater choice. However, this hypothesis is contradicted by the results from the Netherlands, where customers face the same waiting lists but nevertheless attach greater importance to choice. It therefore seems more probable that there are simply too few real options open to English custom-

ers for them to fully appreciate the importance of choice. As the Dutch saying goes, "unknown is unloved".

Notes to Appendix

1 Insofar as it is possible to make any statement in this regard.
2 Ditto.
3 Gross Domestic Product.
4 Purchasing Power Parity.
5 Nielsen, Net Ratings, 2003.
6 EFPIA, 2002.
7 The LVT treats 150,000 patients a year, i.e. 1% of all those receiving home care. This is lower than in France, where the percentage is 1.7.
8 NIVEL, 2000.
9 EFPIA, 2002.
10 ZN, 2003.

Consumer empowerment

Carolien Hendrix

Index

Summary

Consumer empowerment

The healthcare services market may be said to be 'imperfect', in that the end user does not have unrestricted freedom of choice. There are countless intermediaries, not to mention a regulatory government, between the supply side and the consumer. The supply side therefore has access to some information which does not derive directly from the consumer. Often, the consumer's voice is not adequately heard.

In late 2003, the Council for Public Health and Healthcare (RVZ) commissioned TNS NIPO to conduct a study into the preferences and attitudes of healthcare consumers, both in the Netherlands and in four other European countries: Belgium, France, Germany and the United Kingdom.

It was decided to base the study on the 'care chain', with attention devoted to each of the successive phases that the patient goes through when receiving major medical treatment. The key question was defined as follows: In what phase (pre-diagnosis, diagnosis, treatment, rehabilitation) is the demand for greater choice most apparent, and what are the consumer's preferences with regard to realising this choice? The study also sought to gauge interest in medical innovation and the consumer's willingness to travel to another country in order to receive medical treatment. It further sought to establish the (monetary) value which consumers attach to greater choice. Alongside a comparison of the countries investigated, indicating the degree to which results are influenced by nationality, the results have also been analysed with regard to other demographic factors, and according to prior experience of the healthcare system (i.e. whether the respondent is a 'patient', or merely a 'potential patient').

In each country, a representative sample of five hundred respondents (N = 500) were interviewed. The initial fieldwork was conducted by telephone between 26 May and 3 July 2003. The calls were made from the Netherlands and Luxembourg, and all interviews were conducted in the same, uniform manner.

Main findings

The European healthcare consumer attaches great importance to personal choice. Within the 'care chain' (the progressive process that the patient will undertake when receiving medical attention), the demand for choice is greatest at the beginning, i.e. in the information, diagnosis and treatment phases. Nevertheless, the demand for greater choice remains high in the later phases of the chain. In general, it may be stated that countries in which healthcare supply is demand-driven (France, Germany and Belgium), the demand for choice is greater than in the other countries studied (the Netherlands and the United Kingdom). Supply would seem to determine demand, at least in part.

Demand for choice

The information phase

The European healthcare consumer is able to obtain information from a variety of sources. Information provided by the medical practitioner is the most favoured in each of the countries studied. There are significant differences with regard to the use of the Internet. In the Netherlands, some 50% of respondents regard the Internet as a primary source of information. In France and Belgium, the figure is far lower.

The diagnosis phase

An overwhelming majority of Europeans (approximately 75%) prefer a diagnosis to be made by the general practitioner. A minority prefer a diagnosis by the specialist, with the figures in the Netherlands and the United Kingdom being somewhat above average in this respect.

The treatment phase

In the treatment phase, the preference for the general practitioner is less evident. The majority of people prefer to see the specialist. Once again, the Dutch healthcare consumer stands out as attaching greatest value to specialist care.

In many countries, specialist care is associated with hospital (inpatient) treatment. Nevertheless, despite the observed preference for treatment by the specialist, approximately 50% of respondents would prefer to receive treatment at home (the remainder preferring treatment in the hospital).

The rehabilitation phase

There are significant differences in preference with regard to rehabilitation, particularly in the choice between a specialist

rehabilitation doctor and a physiotherapist. In the United Kingdom, over 80% of respondents favour the physiotherapist, while in France the situation is exactly the reverse. The differences are less marked in the Netherlands, Germany and Belgium.

The financial consequences of greater choice

It can be seen as stating the obvious to say that consumers desire more choice than is currently available. The study therefore examined whether they are actually prepared to pay the price associated with such choice.

Greatest willingness to pay more for more choice is to be seen among the Dutch, three quarters of whom would be prepared to pay a higher monthly premium (the average acceptable increase being in the order of € 4.80). Notably, the Dutch consider it most important that consumers should be able to exert some influence over the availability of the latest prescription drugs with fewest side-effects.

The French are the least inclined to pay extra for more choice. Almost half decline to do so.

Innovation

European healthcare consumers are broadly comparable in their attitudes to new developments. In order to render the responses as reliable as possible - after all, people like to be seen as modern and innovative - respondents were presented with a number of hypothetical situations. Consumers are extremely positive with regard to the latest prescription drugs (and are willing to pay more for them, if necessary) and are equally willing to embrace the concept of the 'care consultant'. Approximately 50% of respondents recognise the benefits of remote blood pressure monitoring ('telemetrics'), rather than having to attend the surgery to have blood pressure tested by a doctor or nurse. In contrast to many other healthcare-related topics, it is notable that Europeans have reasonably similar attitudes to innovation.

Transnational movement

The consensus noted above certainly does not apply to treatment in other countries. The Dutch and British are far more willing to travel abroad for treatment if this will serve to circumvent the waiting lists. (In the other three countries, waiting lists are much less of a problem.)

However, waiting lists are not the only consideration. The Dutch and British are the most positive with regard to treatment at a 'European Expertise Centre'. Again, it is the French who expect relatively little of the concept, although the differences with the Germans and Belgians are not marked.

Part 1

Comparison by country

1 Preferences with regard to choice

The study carried out an in-depth examination of choice in the various phases - information, diagnosis, treatment and rehabilitation. Do consumers really wish to be able to exercise choice? If so, where is demand for choice greatest? Consumers were asked about their preferred source of medical information, the influence of readily understandable medication information, and their preferences with regard to prescribing practices. A number of hypothetical situations from each phase of the healthcare chain were presented. Respondents were asked:

- *Paragraph 1.1 Pre-diagnosis phase (which information source?)*
  Who or what is your preferred source of information?

- *Paragraph 1.2 Diagnosis phase (by whom?)*
  Suppose that you have been feeling unwell for some time. You suspect that you may be suffering from some chronic condition. Who would you prefer to examine you for the purposes of diagnosis?

- *Paragraph 1.3 Treatment phase (by whom?)*
  Your suspicions prove founded. You are diagnosed as having diabetes. Do you have any preference with regard to who is to treat you?

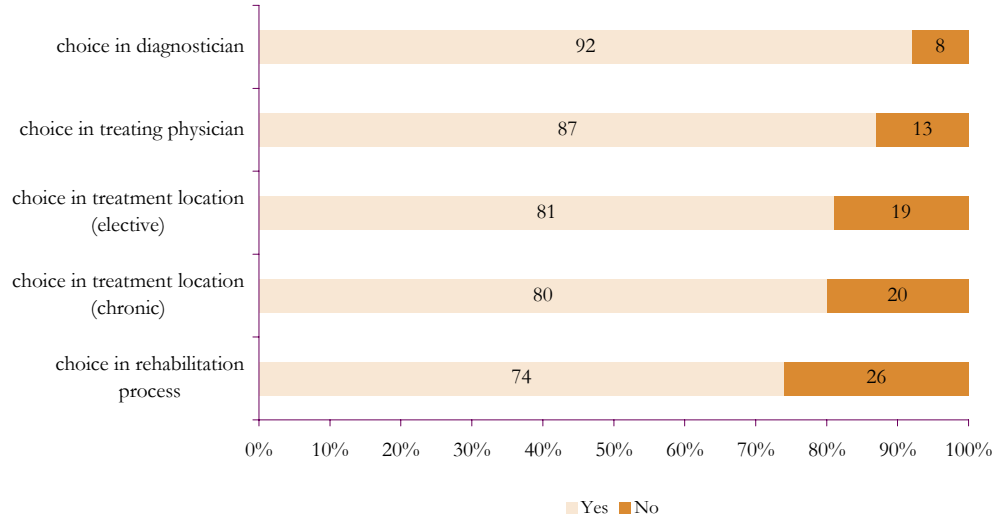
- *Paragraph 1.4 Treatment phase (where?)*
  Do you have a preference in terms of the treatment location? Consider both a chronic and an elective situation.

- *Paragraph 1.5 Rehabilitation phase (where and by whom?)*
  You have to recover following an operation on your back. This requires a rehabilitation process which may be assisted in various manners. Do you have any preference in terms of where, and under whose supervision, the process will take place?

For each situation, respondents were asked to indicate whether they wished to have a choice and, if so, what their preference would be. The graph below presents an overview of the healthcare chain phases in which European consumers would appreciate greater choice.

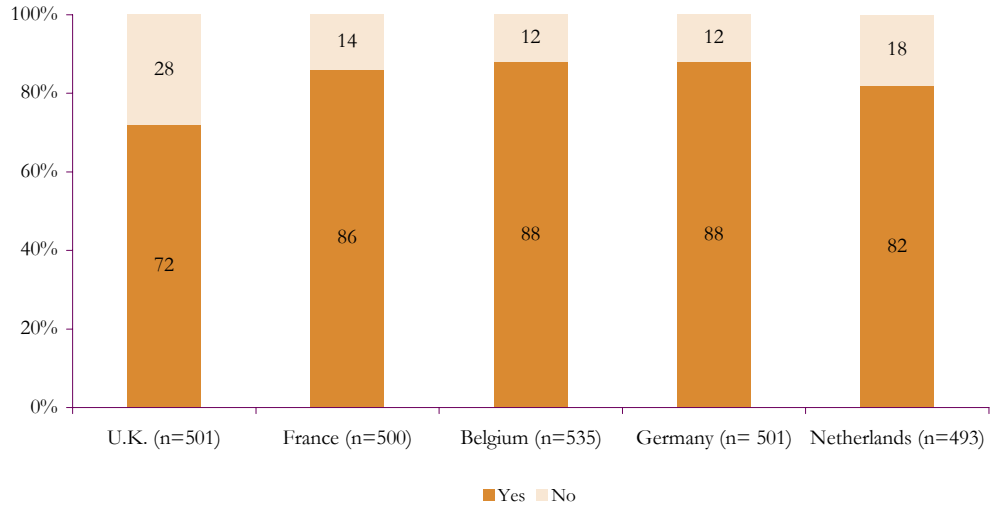
The overall attitude of the notional 'European healthcare consumer' has been calculated by weighting the total score of the study by a factor derived from the relative population of each country studied (since there are significant differences in this respect). The graph therefore presents a summary of the research results, weighted to form the opinions of the 'European' consumer:

1 Do you wish to be able to choose...? (n=2530)
(Figures weighted according to European population distribution)



Graph 2 presents the average requirement for choice in each of the countries studied. The results for all five hypothetical situations have been averaged per country. As can be seen from the chart, the British attach least importance to choice.

2 Average requirement for choice within the healthcare chain, by country



In this section, we examine the differences between the countries in terms of choice and preferences. Greatest importance seems to be attached to freedom of choice in the diagnosis phase. Overall, an average of 92% state that they do indeed have a preference for a particular diagnostician. Is this also the case in each individual country? The following table presents an overview of the requirement for freedom of choice in each country.

3 Do you wish to have greater choice in....?

U.K.		**France**	
Diagnosis	79%*	Diagnosis	96%*
Treating physician	76%*	Treating physician	92%*
Treatment location (elective)	75%*	Treatment location (chronic)	88%*
Treatment location (chronic)	67%*	Treatment location (elective)	80%
Rehabilitation	62%*	Rehabilitation	72%
Average	72%	Average	86%

Belgium		**Germany**	
Diagnosis	96%*	Diagnosis	98%*
Treating physician	90%	Treating physician	92%*
Treatment location (elective)	87%*	Treatment location (elective)	84%*
Treatment location (chronic)	86%*	Treatment location (chronic)	83%*
Rehabilitation	80%*	Rehabilitation	83%*
Average	88%	Average	88%
Netherlands		**Highest choice requirement per healthcare chain phase**	
Diagnosis	90%	Diagnosis	Germany (98%*)
Treatment location (elective)	84%	Treating physician	Germany and France (92%*)
Treating physician	83%	Treatment location (elective)	Belgium (87%*)
Treatment location (chronic)	78%	Treatment location (chronic)	France (88%*)
Rehabilitation	73%	Rehabilitation	Germany (83%*)
Average	82%		

(*): significant difference compared to other countries, assuming 95% reliability.

1.1 Pre-diagnosis

Respondents were asked to name their preferred source of medical information. The results indicate that the European healthcare consumer prefers to obtain information from medical practitioners (doctors and specialists) and pharmacists. Respondents were asked to cite only three information sources, whereupon the following results were obtained:

4 From which source would you prefer to obtain medical information? (in %)

	European consumer n=2530	U.K. n=501	France n=500	Belgium n =535	Germany n=501	Netherlands n=493
Medical practitioner	65	72*	55*	66	69*	57*
Pharmacist	44	39	49*	39	45	39
TV/newspaper/ magazine	35	19*	41*	28	46*	22*
Internet	30	36*	17*	21*	33	47*
Medical reference book	24	27*	19	19	26*	19
Government	6	10*	9*	6	1*	6
Patient association	5	5	9*	5	2*	10*
Pharmaceutical manufacturer	5	8*	4	2*	3	4
None of the above	4	2*	8*	4	3	5

(*): significant difference compared to other countries, assuming 95% reliability.

The popularity of the medical practitioner as a source of information is highest in Germany (69%*) and the United Kingdom (72%*). The pharmacist enjoys greatest popularity in France (49%*), while the Internet may be seen to be a popular source of medical information in the Netherlands (47%*). In France (41%*) and Germany (46%*) media such as television, newspapers and magazines are consulted for medical information more frequently than elsewhere.

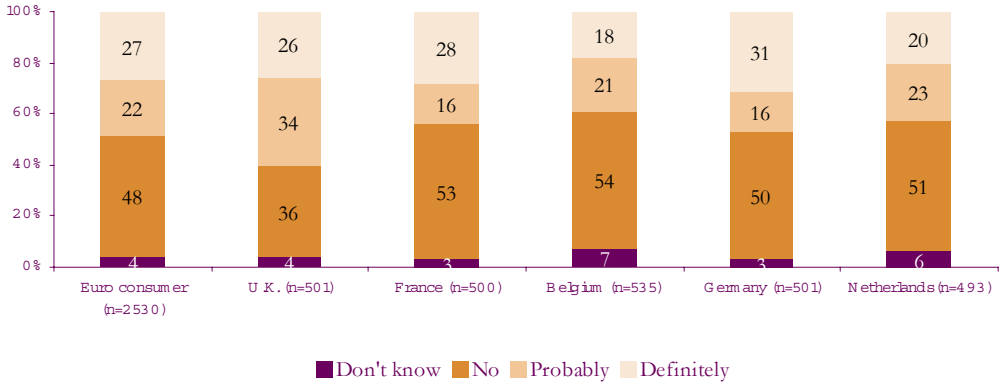
The United Kingdom is the only country in which a significantly larger proportion of respondents prefer to receive medical information from pharmaceutical manufacturers (8%*).

The influence of readily understandable information

Overall, almost half of the European consumers (49%) believe that they would visit their general practitioner less often, whether with an actual complaint or for advice, if they had access to readily understandable medical information. The remainder believe that such information will not affect the frequency of their visits to the doctor. It is interesting to note that there are differences between the countries in practically every category. The highest number of respondents stating

that good information would decrease the frequency of doctor consultations is to be found in the United Kingdom (60%*).

5 Would you visit your doctor less often if you had access to readily understandable medical information?



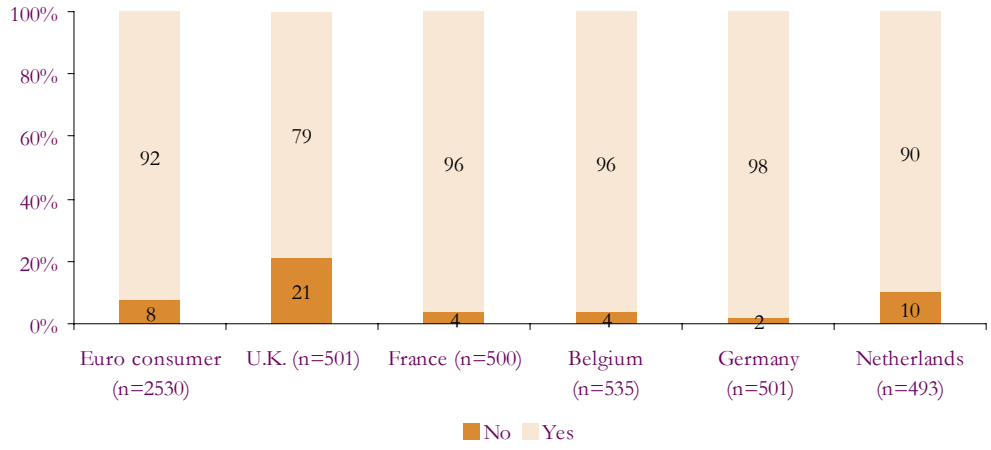
The Belgians and the Dutch are relatively undecided, with only 39%* and 43%* respectively believing that they would 'definitely' or 'probably' visit the doctor less often if able to access readily understandable medical information.

1.2 Diagnosis

When asked to consider a hypothetical diagnosis situation for a suspected chronic condition, the symptoms being consistent with those of diabetes, an overall average of 92% of respondents state a preference for the type of medical practitioner by whom they wish to be examined.

The British form an exception here, with as many as 21%* having no preference. Conversely, practically all German respondents (98%*) do indeed have a preference.

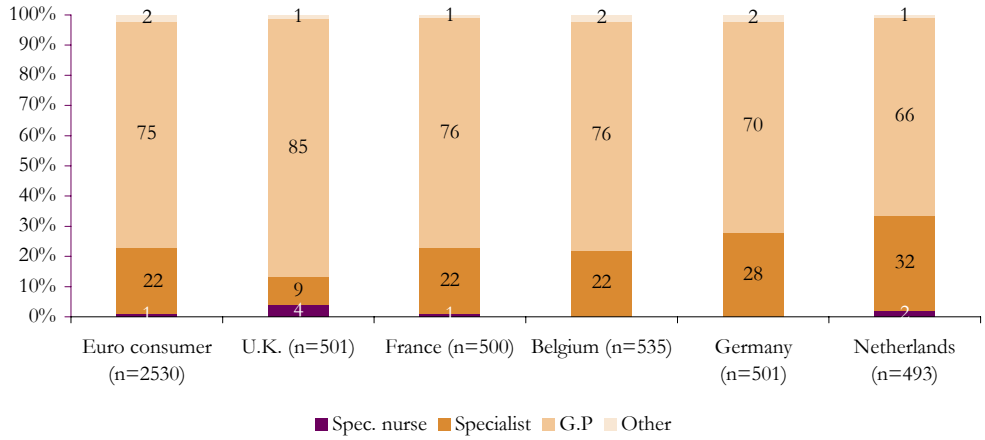
6 Do you have a preference in terms of the person carrying out a diagnostic examination?



In the Netherlands, 90% of respondents state a preference for the type of medical practitioner conducting the diagnostic examination.

But who is the preferred diagnostician? In the situation presented, in which the symptoms suggest diabetes, the percentages differ from country to country, but in all cases the general practitioner leads the field.

7 By whom would you prefer the diagnostic examination to be carried out? (Respondents stating a preference, by country)



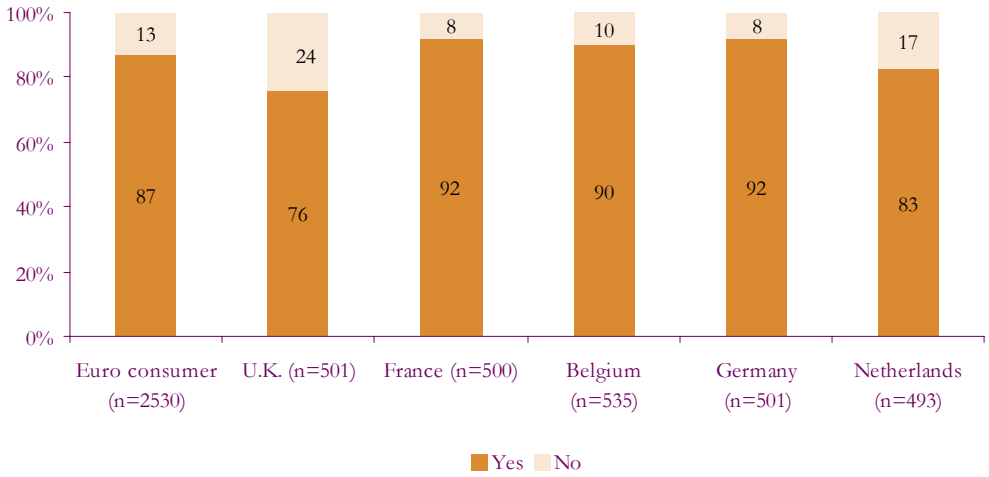
In the Netherlands, a relatively strong preference for the specialist may be observed (32%*), while the comparable figure for the United Kingdom is only 9%*. Here, there is an above-average preference to be seen for the general practitioner (85%*). Diagnostic examination by a specialist nurse enjoys little favour any country (average: 1%). Only in the United Kingdom is there mild interest in this approach (4%*). In Germany, the specialist scores particularly high (28%*).

1.3 Treating physician

When respondents are asked to consider a hypothetical treatment situation (once again, chronic diabetes is indicated), an average of 87% have some preference for the type of medical practitioner who will provide treatment. (In the diagnosis phase, 92% had a preference.)

Here again, the U.K. forms an exception to the general trend, with 24%* having absolutely no preference. In Germany and France, almost everyone (92%*) has a preference for the type of medical practitioner by whom treatment is to be provided.

8 Do you have a preference in terms of the treating physician?

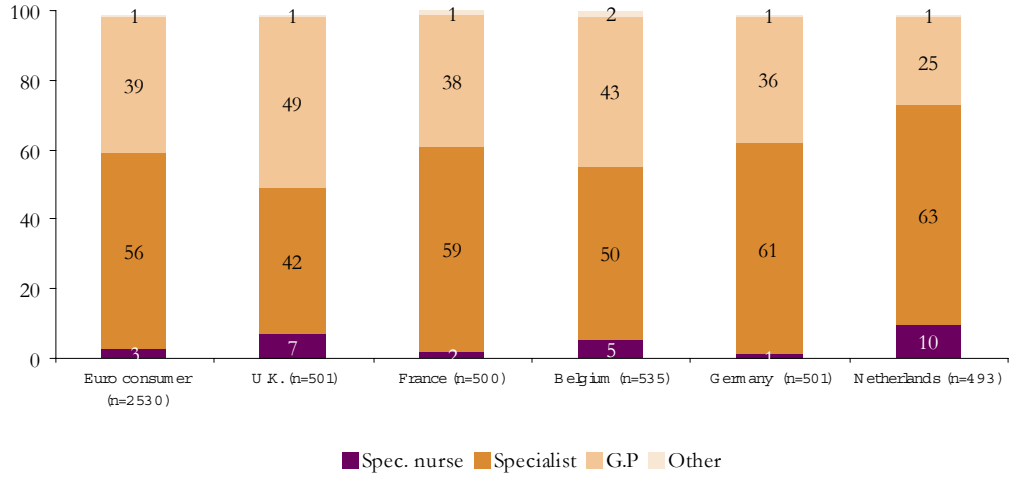


In the Netherlands, 83% have a preference for the type of medical practitioner providing treatment for a chronic condition.

But who is the preferred treating physician? In most cases (56%), it is the specialist. The Dutch in particular would prefer to receive treatment for a chronic condition from the specialist (63%*).

The situation is very different in the United Kingdom, where the general practitioner is the favoured treating physician (49%*).

9 By whom would you prefer treatment to be provided? (Respondents stating a preference, by country)



Once again, the specialist nurse is not the first choice. However, treatment by nursing personnel is more popular in the Netherlands than elsewhere (10%*). Preference for the specialist is significantly lower in the U.K. than elsewhere, scoring only 42%*.

Preference for prescriber

It is often the case that several prescription drugs are available, all having the same therapeutic effect but differing in their price, side-effects, efficacy, method of administration, etc.

Who should decide which of these broadly equivalent drugs is to be prescribed? Should this be the sole responsibility of the treating physician (general practitioner or specialist) or should the patient also have a say in the matter? Or perhaps the pharmacist or the health insurer should have the last word?

According to the European healthcare consumer, it should fall to the treating physician (68%) to determine exactly which drug is to be prescribed. The Germans hold this view significantly more often than their counterparts elsewhere (78%*). The British frequently believe that the patient himself should be able to choose (26%*), while a significant proportion of French respondents would like the decision to be made by the pharmacist (19%*).

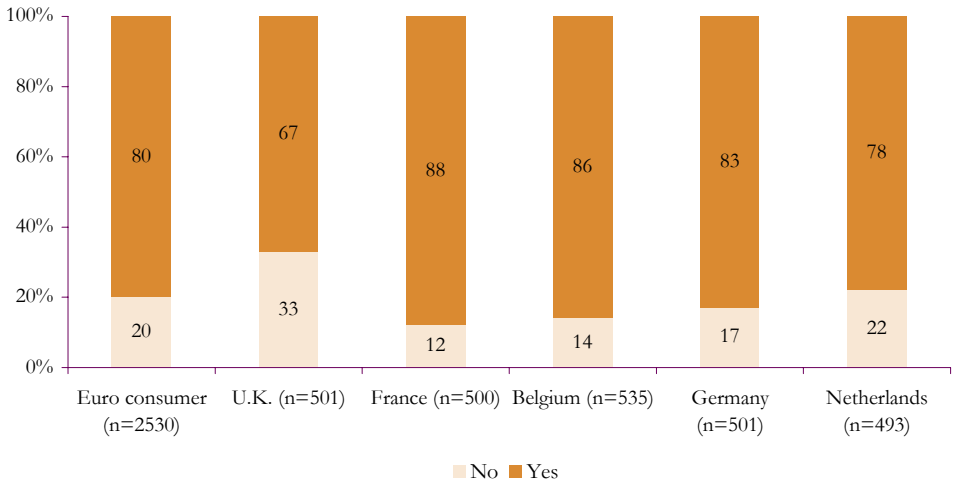
10 Who should determine which drug is to be prescribed, assuming the existence of several options?

U.K.		**France**	
Treating physician	59%*	Treating physician	66%
Patient	26%*	Pharmacist	19%*
Pharmacist	7%	Patient	7%
Health insurer	2%	Health insurer	3%
Treating physician and patient jointly	1%	Treating physician and patient jointly	0%
Belgium		**Germany**	
Treating physician	62%	Treating physician	78%*
Patient	17%	Patient	14%
Pharmacist	11%	Pharmacist	4%*
Health insurer	4%*	Health insurer	1%*
Treating physician and patient jointly	1%	Treating physician and patient jointly	1%
Netherlands		**European consumer**	
Treating physician	62%	Treating physician	68%
Patient	13%	Patient	15%
Pharmacist	9%	Pharmacist	9%
Health insurer	6%*	Health insurer	2%
Treating physician and patient jointly	4%	Treating physician and patient jointly	1%

1.4 Treatment

Overall, 80% of European healthcare consumers state some preference for the treatment location, given the hypothetical diabetes diagnosis. This is significantly lower than the number stating a preference for diagnostician (92%) or treating physician (87%).
Here too, the British have least preference, with no fewer than 33%* stating no preference whatsoever.
In France, the majority of respondents (88%*) do have a preference for the treatment location, should diabetes be diagnosed.

11 Do you have any preference in terms of treatment location?

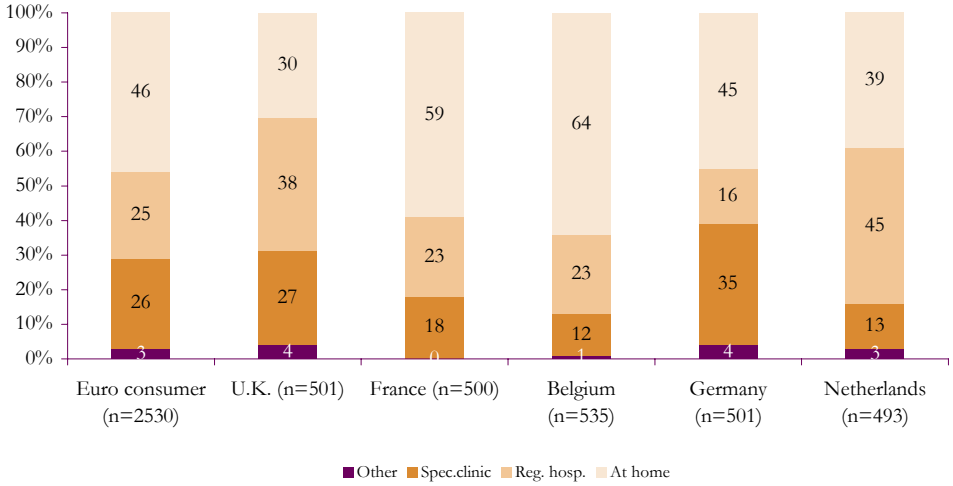


In the Netherlands, 78% express a preference for treatment location in the case of diabetes.

Exactly what location would consumers prefer? Most respondents (46%) would prefer to receive treatment at home. This is particularly true of the Belgians (64%*) and the French (59%*).

Once again, the U.K. shows a different picture. Here, the preference is for the regional hospital (38%*). In the Netherlands, the regional hospital is also the preferred location (45%*). The specialist clinic finds greatest favour in Germany (35%*), where the regional hospital is the least popular treatment location. Only 16%* of German respondents cite the hospital as the preferred treatment location for diabetes.

12 Where would you prefer to receive treatment for a chronic condition? (Respondents stating a preference, by country)

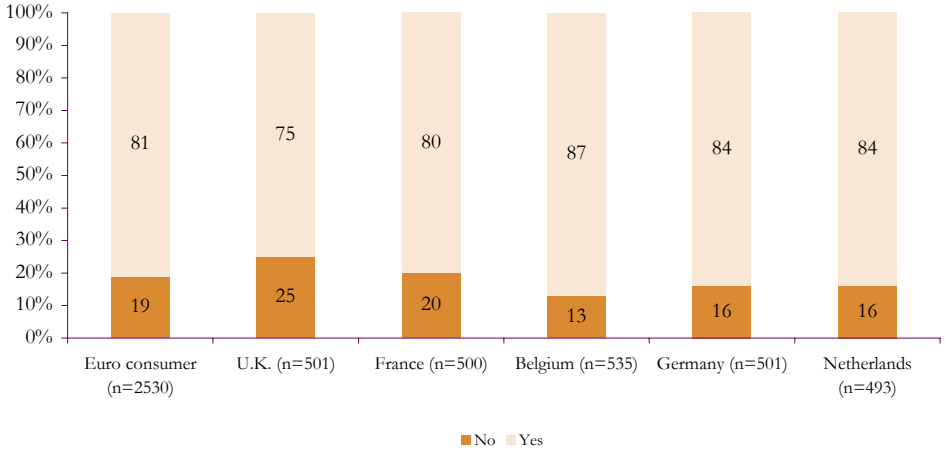


Respondents were also asked to consider a hypothetical elective surgery situation, in which a knee operation is required. While there is no urgency, this operation will eventually be unavoidable. Unlike the former hypothetical situation involving diabetes, this example involves a non-acute, non-chronic condition. Two possible treatment locations were presented.

The study revealed that an average of 81% of European consumers have a preference for one or other of the options.

Here too, the U.K. is slightly out of step with the other countries, with no fewer than 25% of respondents stating that they have absolutely no preference. In Belgium, a smaller group (13%) have no preference.

13 Do you have any preference for treatment location in the case of an elective intervention?

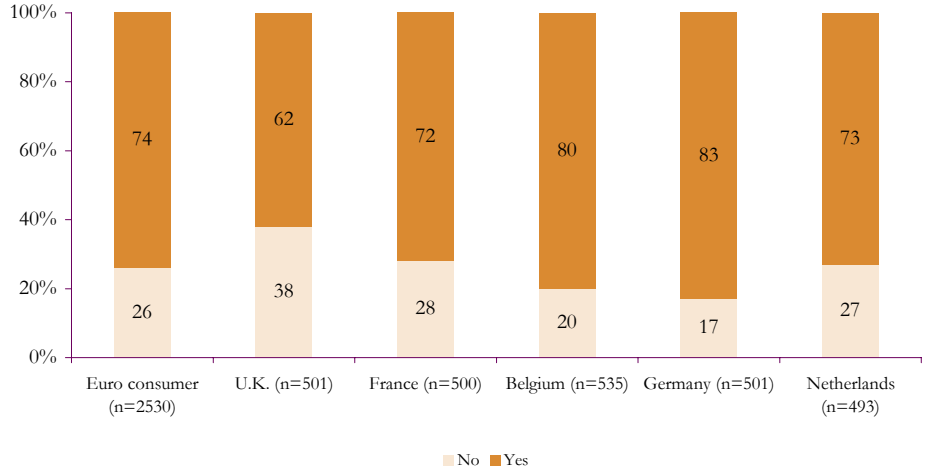


1.5 Rehabilitation

Respondents were asked to consider a hypothetical situation in which rehabilitation is required following a back operation. Four options were presented. An average of 74% expressed a preference for one of the four options.

Once again, the British prove relatively easy to please: 38%* have no preference at all.

14 Do you have any preference in terms of the location and supervision of a rehabilitation process?



The four rehabilitation options presented were: in a clinic, at home, by a physiotherapist or by a specialist rehabilitation doctor.

Overall, all four options enjoy a similar degree of preference, although the rehabilitation process at home, assisted by the physiotherapist, is slightly more popular than the other choices (28%).

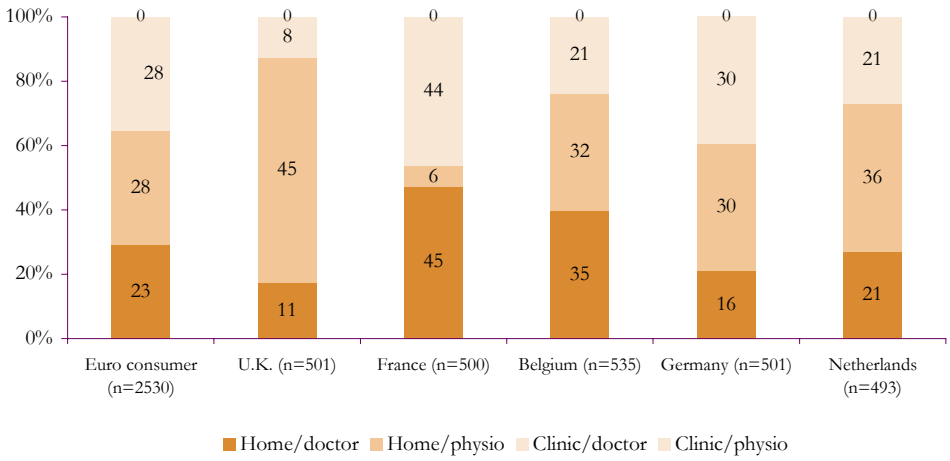
However, when the various countries are considered individually, significant variations emerge. The British clearly prefer a rehabilitation process supervised by the physiotherapist although it is seen as less important whether the process is conducted at home (45%*) or in a clinic (36%*).

Exactly the opposite situation may be observed in France, where the specialist rehabilitation doctor enjoys a clear preference. However, once again it makes little difference whether the services are provided at home (45%*) or in a clinic (44%*).

Belgians prefer to undergo the rehabilitation process at home, but there is no clear preference for the physiotherapist (32%) or the specialist doctor (35%*).

In Germany and the Netherlands, each of the four options enjoys some support, although in the Netherlands, treatment at home by the physiotherapist is the most popular (36%*).

15 Where, and by whom, would you prefer your rehabilitation process to be conducted? (Respondents stating a preference, by country)



These preferences can also be represented as a table:

16 Where, and by whom, would you prefer your rehabilitation process to be conducted? (Respondents stating a preference, by country)

U.K.	%	France	%
At home by physiotherapist	45%*	At home by specialist rehab. doctor	45%*
In a clinic by physiotherapist	36%*	In a clinic by specialist rehab. doctor	44%*
At home by specialist rehab. doctor	11%*	In a clinic by physiotherapist	6%*
In a clinic by specialist rehab. doctor	8%*	At home by physiotherapist	6%*

Belgium	**%**	**Germany**	**%**
At home by specialist rehab. doctor	35%*	At home by physiotherapist	30%
At home by physiotherapist	32%	In a clinic by specialist rehab. doctor	30%
In a clinic by specialist rehab. doctor	21%*	In a clinic by physiotherapist	24%
In a clinic by physiotherapist	12%*	At home by specialist rehab. doctor	16%*

Netherlands	**%**
At home by physiotherapist	36%*
In a clinic by physiotherapist	22%
In a clinic by specialist rehab. doctor	21%*
At home by specialist rehab. doctor	21%

(*): significant difference compared to other countries, assuming 95% reliability

2 Perceived value

It is, of course, possible to improve and modernise healthcare services in Europe. Quality and accessibility are two aspects in which room for improvement exists. But are consumers prepared to pay more for improved healthcare? Or are they content with a system which does not function as well as it could, and in which the choices are restricted? In other words, what is the perceived value of extra choice and freedom of choice in the healthcare sector?

The study presented respondents with five hypothetical situations relating to the diagnosis, treatment and rehabilitation phases. In each case, respondents were asked whether they would be prepared to pay more for greater choice.

The five situations were worded as follows:

- Diagnosis: Are you willing to pay higher insurance premiums if this enables you to choose *who* you will be examined by?
- Treatment: Are you willing to pay higher insurance premiums if this enables you to choose *who* you will be treated by and *where* treatment takes place?
- Medication: Are you prepared to pay higher insurance premiums if this enables you to choose *what* you are treated with?
- Waiting lists: Are you prepared to pay higher insurance premiums if this enables you to choose *how soon* you will be treated?
- Rehabilitation: Are you prepared to pay higher insurance premiums in return for greater choice in *rehabilitation services*?

This section examines the differences between the countries studied in terms of the perceived value of greater freedom of choice in healthcare services. The total result for each aspect is also shown, this being the overall European response (n=2530), weighted according to population distribution (there being significant differences between the countries in this regard).

Consumers in the various European countries demonstrate greatest willingness to pay higher premiums in return for ac-

cess to the latest generation of prescription drugs (46%). The Dutch are the most inclined to pay more (52%*).

17 Respondents willing to pay higher insurance premiums in return for extra choice (amount of increase not yet known; in %).

	Euro consumer n=2530	U.K. n=501(%)	France n=500	Belgium n=535	Germany n=501	Netherlands n=493(%)
Choice in diagnostician	31	32	35*	34	27*	36
Choice in treating physician and treatment location	39	38	39	40	39	40
Choice in type of treatment	44	45	41*	47	45	52*
Choice in speed of treatment	39	51*	33*	34	34*	46*
Choice in rehabilitation	38	44*	30*	36	40	40
No additional choices sought	35	36	40*	32	35	24*

(*): significant difference with other countries, assuming 95% reliability

It is interesting to note that the Germans are relatively reticent to pay an increased premium in return for greater choice in the diagnostic phase (27%*). The British are more willing to pay increased premiums if this will result in quicker treatment (51%*), while this aspect does not appeal quite so much to the French (33%*).

The French are the least inclined to pay more and therefore seek no additional choices (40%*). A relatively high percentage of British (51%*) and Dutch (46%*) respondents are willing to pay an increased premium if this results in prompt treatment. British consumers also attach above average value to more freedom of choice in the rehabilitation phase (44%*).

In order to quantify the additional premium in real terms, the study then proposed an actual monthly increase. With four of the five countries studied being in the 'euro zone', it was decided to set this amount at € 2.50. Only the United Kingdom uses another currency: pounds sterling.

An exception was made for the United Kingdom to correct for the difference in purchasing power, whereby the suggested additional premium became £ 2.50.

When consumers who state a willingness to pay more are told the actual financial consequences, the price tag serves to dissuade many (18%).
The table below shows the percentage of respondents who are willing to pay an additional € 2.50 per month for each option. The figures in brackets show the percentage of willingness when the actual amount of the additional premium is not yet known. The effects of citing a firm price can therefore be seen at a glance.

18 Respondents willing to pay higher insurance premiums in return for extra choice (amount of increase known; in %).

	Euro consumer =2530	U.K. n=501	France n=500	Belgium n=535	Germany n=501	Netherlands n=493
Choice in diagnostician	26 (31)	22* (32)	30* (35*)	23 (34)	26 (27*)	31* (36)
Choice in treating physician and treatment location	33 (39)	28* (38)	34 (39)	31 (40)	36 (39)	37 (40)
Choice in type of treatment	39 (44)	36 (45)	35* (41*)	37 (47)	42 (45)	47* (52*)
Choice in speed of treatment	33 (39)	39* (51*)	29* (33*)	28* (34*)	31 (34*)	42* (46*)
Choice in rehabilitation	32 (38)	32 (44*)	26* (30*)	27* (36)	36* (40)	35 (40)
	42 (35)	46 (36)	47* (40*)	39 (32)	38* (35)	28* (24*)

(*): significant difference with other countries, assuming 95% reliability

The Dutch emerge as most willing to pay an additional premium in return for quicker treatment (42%*) and for access to the latest generation of prescription drugs (47%*). Greater choice in the rehabilitation phase is the most appealing aspect to the Germans (36%*). The British are least willing to pay extra for more choice in the treatment phase (28%*). The percentage of respondents who are *not* willing to pay any additional premium whatsoever is highest in France (47%*) and lowest in the Netherlands (28%*).

The average European consumer seems willing to pay an additional € 4.10 per month in health insurance premiums. This average includes those (42%) who are unwilling to pay any additional premium whatsoever.

There are significant differences between the countries in this respect. The Dutch are willing to pay the highest increase (€ 4.80) in return for greater choice. Similarly, the number of additional options in which individual respondents express an interest also varies from country to country.

19 Willingness to pay increased premiums (% of respondents per suggested increase)

	Euro consumer n=2530	U.K. ** n= 500	France n=500	Belgium n=535	Germany n=501	Netherlands n=493
€ 0	42	46	47*	39	38*	28*
€ 2.50	17	17	14*	23*	17	20
€ 5	11	8*	10	13	12	17*
€ 7.50	10	8	7*	10	13*	12
€ 10	10	9	9	6*	10	12
€ 12.50	11	13	13	9	10	11
Average	€ 4.10	£ 3.90	€ 3.80	€ 3.70	€ 4.20	€ 4.80
Median	€ 2.50	£ 2.50	€ 2.50	€ 2.50	€ 2.50	€ 5

(*): significant difference with other countries, assuming 95% reliability
(**): suggested premium stated in pounds sterling

If the results are then cumulated, assuming that a respondent willing to pay an additional € 12.50 will also be willing to pay € 10, etc., the following picture emerges:

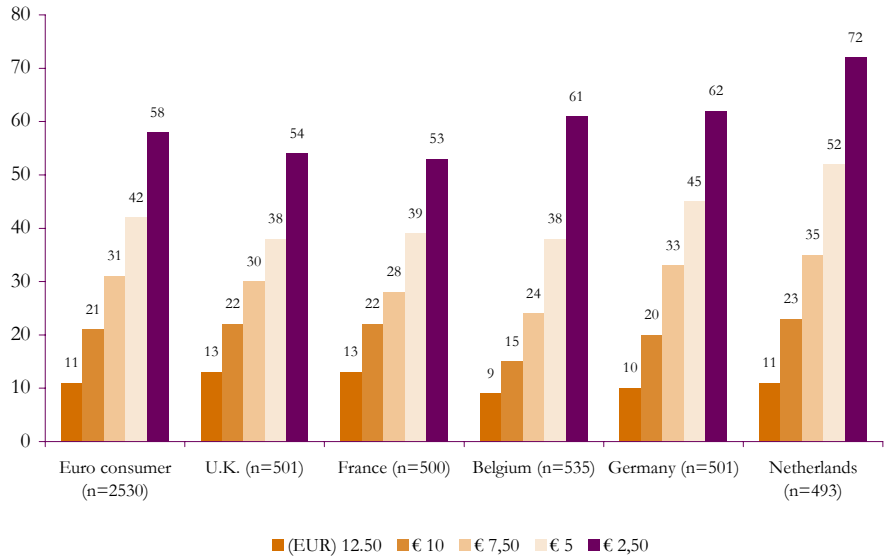
20 Cumulated willingness to pay increased premiums (in %)

	Euro consumer n=2530	U.K. * n= 500	France n=500	Belgium n=535	Germany n=501	Netherlands n=493
€ 12.50	11	13	13	9	10	11
€ 10	21	22	22	15	20	23
€ 7.50	31	30	29	25	33	35
€ 5.00	42	38	39	38	45	52
€ 2.50	58	54	53	61	62	72

(*): suggested premium stated in pounds sterling.

These findings may also be presented in the form of a bar graph:

21 Cumulated willingness to pay increased premiums



Dutch consumers emerge as the most willing to pay an increased premium in return for greater freedom of choice in healthcare services. Almost three quarters of Dutch respondents (72%) are prepared to pay an extra € 2.50 or more. Only 53% of French respondents are willing to do so. In the Netherlands, over half the respondents (52%) are willing to pay € 5 or more, compared to just 38% in Belgium and the United Kingdom.

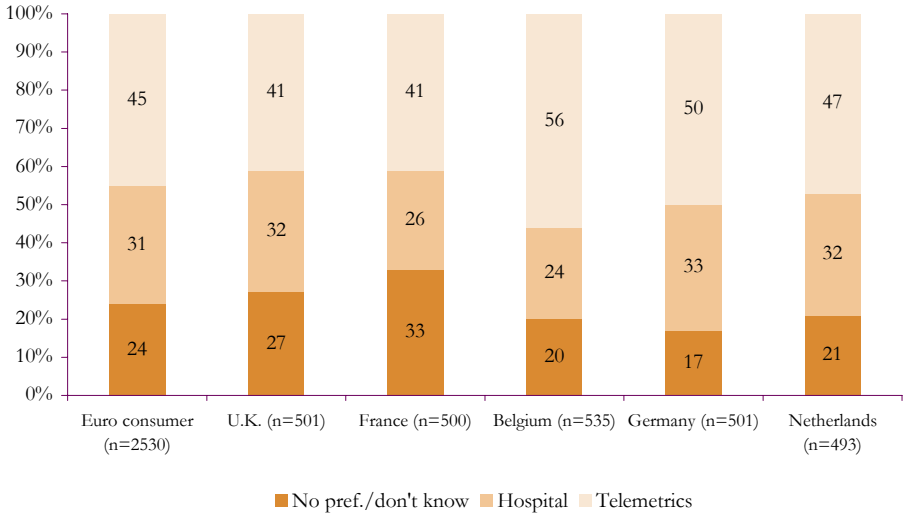
3 Innovation in treatment approaches

Science does not stand still. Progress is being made in all sectors, and medicine is no exception. New drugs, new methods of administration and improved forms of care are being developed all the time. But are consumers interested in innovative forms of care or new pharmaceuticals?

To answer this question, or at least to gain an initial impression, the study once again asked respondents to consider a number of hypothetical healthcare situations. This section describes the differences observed between the countries studied.

Attitude to innovative blood pressure monitoring
The prospect of an innovative method of measuring blood pressure, involving a radio transmitter worn on the person, appeals to almost half (45%) of European consumers. The Belgians are most open to this 'telemetrics' approach (56%*). A significant proportion of French respondents have no opinion (33%*).

22 What is your preferred method of blood pressure monitoring?

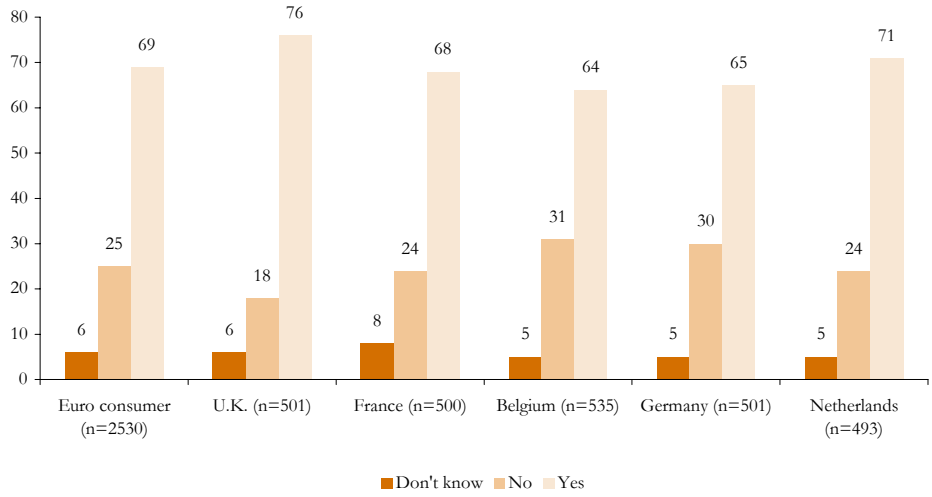


Attitude to innovative care methods
Respondents were asked to consider another (semi-)hypothetical situation in order to gauge attitudes to innovation in an-

other sphere. This situation involves the patient being assisted throughout the entire healthcare chain by a 'care consultant'. The care consultant assumes many of the tasks which would otherwise fall to the patient, such as making appointments and obtaining information. This form of patient assistance already exists in the United Kingdom but has yet to be put into practice in the other countries studied.

The survey reveals a clear interest in this form of patient assistance. Almost seven out of every ten European respondents (69%) stated that they would like to have the support of a care consultant during the treatment and rehabilitation phases. That the figure is particularly high in the United Kingdom (76%*) is of course due to the fact that this form of care has already been implemented there.

23 Would you like the support and assistance of a 'care consultant' during the treatment process?

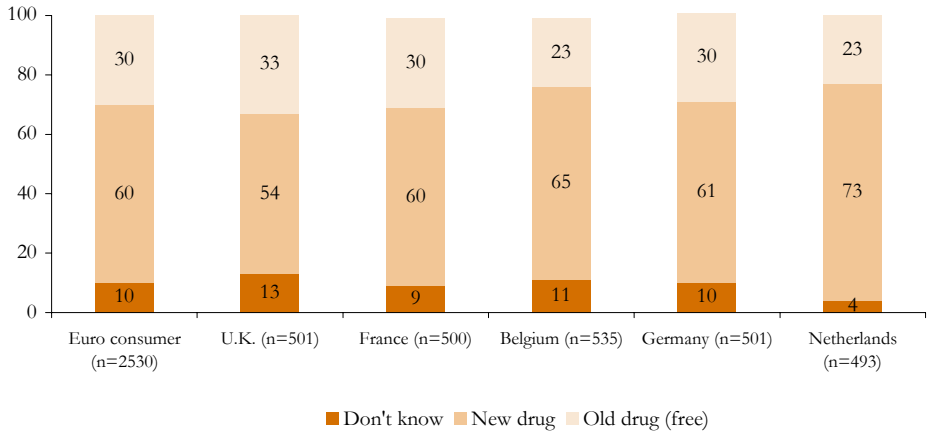


Attitude to innovative medication

Respondents' attitudes towards innovation in prescription drugs were gauged by means of another hypothetical situation. They were asked to choose between treatment using a drug which is provided free of charge, and treatment with a new drug which has fewer side-effects, but for which a surcharge (personal contribution) must be paid.

Six out of ten European consumers (60%) would opt for the new drug with fewer side-effects, the surcharge notwithstanding. The Dutch are the most willing to do so (73%*) while the British are the least willing (54%*).

24 Would you opt for treatment using a drug which is provided free of charge, or would you prefer a new drug which has fewer side-effects, but for which you are required to pay a personal contribution?



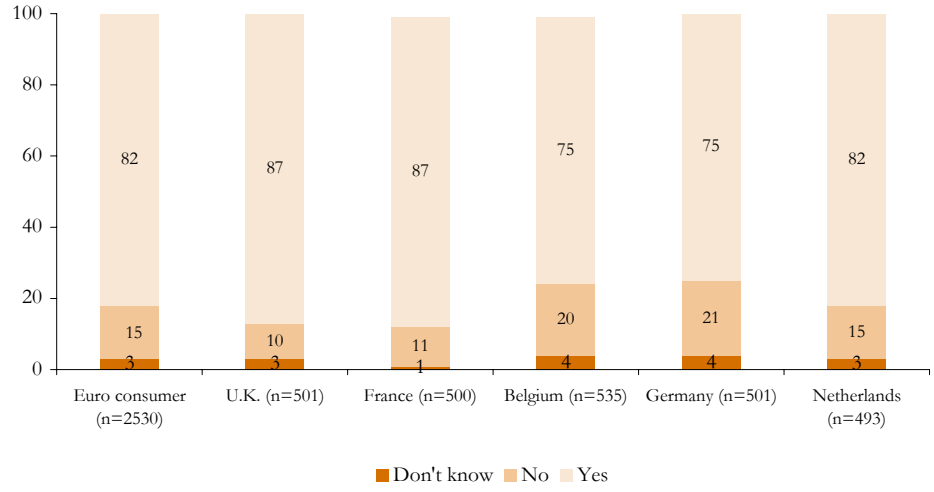
4 Transnational movement

Europe is becoming a united whole in many respects. It seems likely that there will be closer cooperation in healthcare services in the future. It will then be possible to alleviate the waiting list problem in one country by providing treatment in another, involving the transnational movement of patients. The question is whether consumers will be willing to travel abroad for, say, prompter treatment or more innovative forms of healthcare service. Are consumers prepared to undertake a journey of several hours in order to receive medical attention?

Better treatment

There is a high degree of willingness to travel for several hours in order to consult a specialist with a particularly good professional reputation (82%).

25 Are you prepared to travel for several hours in order to be treated by a specialist with a particularly good professional reputation?



The French and the British are the most willing to travel (87%*), while Belgians and Germans are the least willing to do so (both 75%*).

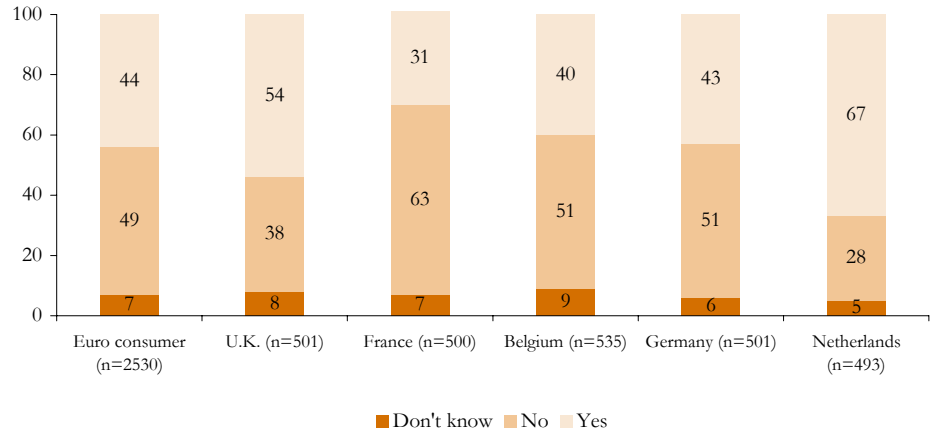
Avoiding waiting lists

The study reveals that slightly less than half (44%) of all European respondents would be willing to travel to another country

for a form of treatment which is subject to a waiting list in their own country.

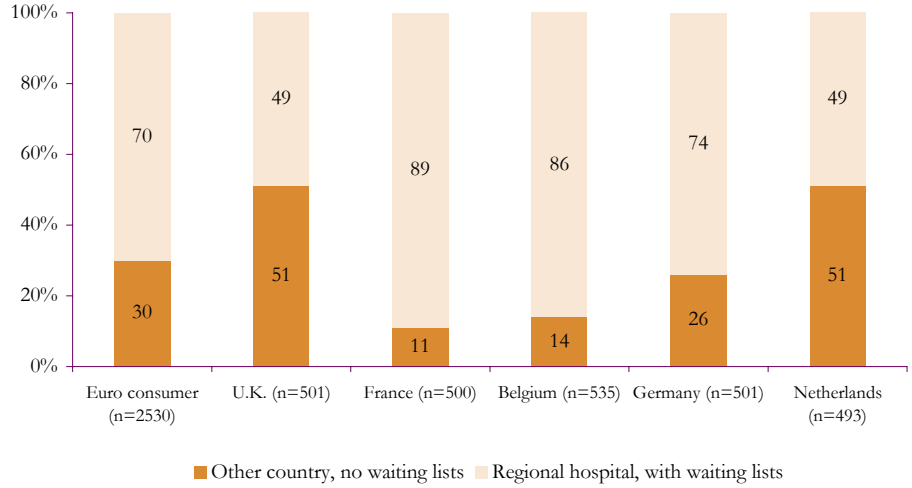
The willingness to travel for this purpose is greatest by far in the Netherlands (67%*). The majority of French respondents (63%*) would prefer to receive treatment in France.

26 Are you willing to travel to another country to receive treatment for which there is a waiting list in your own country?



As noted in Section 1.5 above, preferences differ enormously where the respondent is required to choose between an elective intervention in a regional (local) hospital with a waiting list or the same procedure in a neighbouring country with no waiting list. The graph included in Section 1.5 shows only the respondents who stated that they did have a preference. The following graph (27) is based on the entire respondent sample.

27 Where would you prefer to undergo an elective medical or surgical procedure?

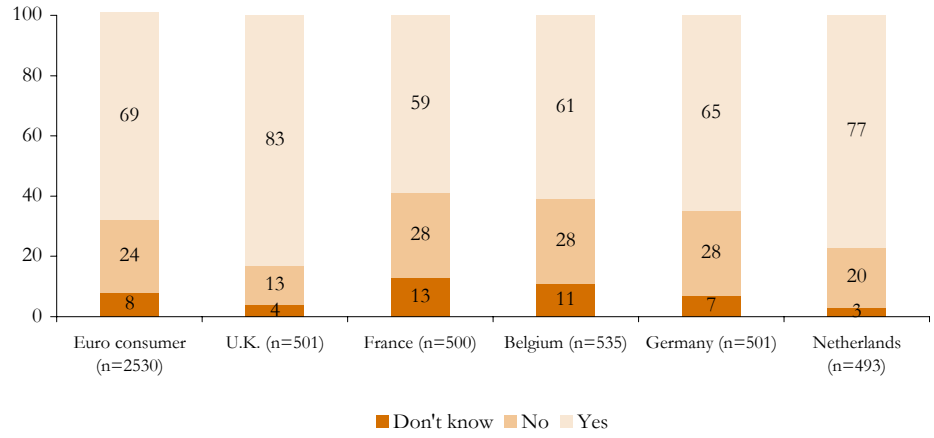


Attitude to the 'European Expertise Centre' concept

The study further reveals that the majority of respondents have a positive attitude towards the concept of European Expertise Centres (69%). Slightly less than a quarter (24%) state that they would not wish to be treated in such a centre, were this ever to become necessary.

The British (83%) and the Dutch (77%) are the most willing to embrace the concept of the European Expertise Centre (83%*), while the French (59%*) and Belgians (61%*) show least enthusiasm.

28 If necessary, would you be willing to be treated at a European Expertise Centre?



Part 2
Comparison by socio-demographic group

5 Gender

5.1 Information seeking

Although the medical professional (general practitioner or specialist) is the most popular source of information for both men and women, a distinct difference between the sexes emerges in terms of their likelihood to consult Internet sources. Men cite the Internet as their preferred source of information significantly more frequently than women: 34*% against 27%*. Women cite the pharmacist as a preferred source more often than men: 48%* against 40%*.

29 What is your preferred source of medical information (%)?

	men n=1221	women n=1306
Medical practitioner	63	67
Pharmacist	40*	48*
Internet	34*	27*
TV/ newspapers/magazines	33	37
Medical reference book	20*	27*
Patient association	5	5
Government	7	5
Pharmaceutical manufacturer	5	4
None of the above	5*	3*

5.2 Preferences in diagnosis and treatment

The general practitioner is the person most likely to be consulted when a problem first emerges, but is a somewhat less important figure in the treatment phase.

Men state a preference for the specialist more often than women. The difference is relatively small in the diagnosis phase (24% men, 20% women) but more marked in the treatment phase (61%* against 52%*). There is no significant difference between men and women with regard to the preferred treatment location (at home or in the hospital). However, men are far more willing to undergo an elective procedure at a

hospital in another country if this will serve to circumvent the waiting list (34%* men, 26%* women).

In the rehabilitation phase, men state a preference for the clinic/physiotherapist option significantly more often than women (24%* against 19%*), while women are more inclined to select the at-home/physiotherapist option (32%* against 23%*).

Men are prepared to pay more for greater choice than women (€ 4.20 against € 3.90). Access to the latest generation of prescription drugs is particularly important to men in this context (41% men against 37% women).

30 Respondents prepared to pay additional premiums in return for greater choice (amount of premium known; by gender in %)

	men n=1221	women n=1306
Choice in diagnostician	27 *(31)*	26 (32)
Choice in treating physician and treatment location	33 *(38)*	33 (39)
Choice in type of treatment	41 *(45)*	37 (44)
Choice in speed of treatment	34 *(38)*	32 (40)
Choice in rehabilitation	33 *(38)*	31 (38)
No additional choices sought	41 *(37)*	42 (34)

5.3 Transnational movement

In both the elective intervention and in general, men are more willing to travel than women if this will serve to avoid the waiting lists (50%* against 40%*). Men take a slightly more positive view of the European Expertise Centre concept (70% against 68% of women).

5.4 Innovation

No clear picture emerges in terms of innovation preferences. As stated above, the study gauged attitudes to innovation by means of three hypothetical cases: remote blood pressure measurement, the services of the 'care consultant' and payment of a surcharge for the latest prescription drugs. Women seem to be rather more positive towards the idea of remote blood pressure monitoring (48% against 43% of men) and towards the idea of the care consultant (72%* against 66%*), but are rather less enthusiastic concerning access to the latest prescription drugs (56%* against 63%*).

6 Age

6.1 Information seeking

Young people state a preference for the Internet more often than their seniors (45%* against 36%* and 12%*). All age groups show a preference for information to be provided by the medical professional.

31 What is your preferred source of medical information? (by age in %)

	18-34 n=734	35-54 n=941	55+ n=851
Medical practitioner	62	65	69*
Pharmacist	45	44	43
Internet	45*	36*	12*
TV/ newspapers/magazines	36	36	34
Medical reference book	26	25	20*
Patient association	5	6	5
Government	7	8	4*
Pharmaceutical manufacturer	4	4	5
None of the above	2*	3	7*

6.2 Preferences in diagnosis and treatment

When European consumers are asked to consider a hypothetical diagnosis situation, an average of 92% do have a preference in terms of the person by whom they wish to be examined.

Young people between 18-34 (86%*) are significantly less likely to have a preference (86%) than the over-55 age group (96%*).

The majority (75%) of those stating a preference indicate a desire to be examined by the general practitioner. Among young people, the figure is slightly lower than the average, at 72%.

Young people are significantly more likely than their seniors to state a preference for a specialist in the treatment phase (in the study's hypothetical diabetes case): 68%* of the 18-34 age group wish to see a specialist, compared to 46%* of the over-55 group. Confidence in the general practitioner's ability to treat diabetes is particularly low among the 18-34 group: only 27%* state a preference for treatment by the general practitioner.

32 Preference for treating physician, assuming a diagnosis of diabetes, in %

	18-34	35-54	55+	total
General practitioner	27*	39	50*	39
Specialist	68*	56	46*	56

The young people's marked preference for treatment by a specialist is not accompanied by a preference for treatment in a hospital setting. The 18-34 age group are less likely to state any preference for treatment location (28%* 'no preference', against 16%* in the 35-54 age group).

Young people show a relatively high degree of willingness to make sacrifices in order to avoid waiting lists. Willingness to travel to another country is high among the 18-34 group, as is the willingness to pay a higher personal contribution or higher insurance premiums.

33 Efforts expended to avoid being placed on a lengthy waiting list (in %).

	18-34	35-54	55+	total
Prepared to travel to another country for elective surgery	36*	30	23*	30
Prepared to pay higher premiums to ensure prompt treatment	49*	37	33*	39

In the rehabilitation phase, young people are less likely to express a preference for a certain treatment option than their older counterparts (69%* of the 18-34 group have a preference, as opposed to 77%* of the over-55s). Where a preference does exist, the younger age groups are more likely to cite the

clinic/physiotherapist option (27%* against 18%* of the over-55 group), while the over-55s are more inclined to opt for the clinic and specialist rehabilitation doctor (31%*).

To summarise: young people are, in general, less likely to have a preference for a certain treating physician than their seniors, but where there is a preference, it is for a specialist. On the other hand, they dislike waiting lists and are more prepared than those in other age categories to take action whereby waiting can be avoided.

It is interesting to note that, in general, young people have fewer preferences, but are nevertheless keen to acquire more explicit options. They are also prepared to pay the price of greater choice: the average respondent in the 18-34 age group is willing to pay an additional € 4.80 per month in insurance premiums, compared to the € 3.50 offered by those over 55. With regard to waiting lists in particular, young people are extremely willing to reach deeper into their pockets.

6.3 Transnational movement

If the prevailing views of young people come to fruition, national boundaries will become far less distinct in the healthcare sector. Those in the 18-34 age group are far more willing to seek healthcare services in another country than those in the other age groups. As demonstrated above, young people have little objection to receiving treatment in another country if this will serve to circumvent waiting lists. It is also apparent that the young have a much more positive view of the European Expertise Centre than that held by their seniors. These findings are illustrated by the table below.

34 Attitude towards healthcare services provided in another country (in %)

	18-34	35-54	55+	Total
Preference for treatment elsewhere, having no waiting lists	36*	30	23*	30
Willing to travel abroad to avoid waiting lists	53*	49*	32*	44
Willing to be treated at European Expertise Centre	77	71	59	69

6.4 Innovation

Young people are generally expected to have a more positive attitude to new developments. Does this hold true in terms of health and healthcare? Once again, attitudes to innovation were gauged by means of three examples: remote blood pressure monitoring, the 'care consultant' concept, and access to the latest prescription drugs, subject to payment of a surcharge.

In fact, the findings are not as predictable as one might imagine. With regard to access to modern drugs and attitudes to the care consultant concept, young people may be seen to be very much more enthusiastic about such developments than the over-55s. The findings for the 35-54 age group show little marked deviation from the youngest age group. However, it is this middle group which is by far the most positive about remote blood pressure monitoring. In short, young people are not automatically the most positive with regard to innovation.

35 Attitude to new developments (% in favour)

	18-34	35-54	55+	total
Remote blood pressure monitoring	42	52*	42	45
Care consultant concept	78*	71	59*	69
Access to latest drugs on payment of a surcharge	64	64*	52*	60

7 Education

Social studies invariably reveal significant differentiation by age. This is also the case when considering educational level. The reason is obvious: young people are, on average, better educated than their seniors. Cross-sectional analysis by educational level will therefore tend to reveal certain parallels between those with higher educational qualifications on the one hand, and the younger age groups on the other. It is useful to ask whether this type of parallel can also be seen in terms of the healthcare preferences expressed.

7.1 Information seeking

When respondents are classified according to educational background, all groups show a clear preference for the medical professional (general practitioner or specialist) as the main source of information. The study shows that 65% of European consumers prefer to obtain their medical information from this source.

Those with a basic standard of education like to consult the media (television/radio/newspapers and magazines), while those who have completed further vocational education or university studies show a clear preference for the Internet. The latter group is also more likely to consult a medical reference book.

36 What is your preferred source of medical information (in %)?

	Basic n=476	Secondary n=1042	Higher n=633	University n=359
Internet	18*	28	36*	41*
Medical reference book	17*	21	25	34*

7.2 Preferences in diagnosis and treatment

Those with a basic level of education are more likely to have no preference in terms of the diagnostician than those who

have completed further education (4%* against 14%*).

As previously noted, the majority of respondents prefer to be examined by the general practitioner in the first instance. However, it is interesting to note that it is the respondents with a lower educational level who display a relatively strong preference for the specialist at this stage of the healthcare chain (29%* compared to the average of 22%).

In the treatment phase, however, the specialist and the general practitioner enjoy equal preference regardless of the respondents' educational level (49%* for both groups). The relative preference for general practitioner and specialist, in both the diagnosis and treatment phases, is shown in Table 37 below.

37 Preference for general practitioner or specialist in the diagnosis and treatment phases (in %)

	Basic n=476	Secondary n=1042	Higher* n=633	University n=359	Total n=2530
Diagnosis phase					
G.P.	68*	76	79	76	75
Specialist	29*	21	19	22	22
Treatment phase					
G.P.	49*	40	36	30*	39
Specialist	49*	55	58	64*	56

The higher educated groups are more likely to have no preference for treatment location (at home or in the hospital) than those with a more basic education (23% against 17%).

Of the respondents expressing a preference, those with a basic standard of education are slightly more likely to prefer treatment at home (47%, against 40% of the higher/university groups).

In the rehabilitation process, the former group is more likely to express a preference for one of the four treatment options than those with further education (80%* against 69%*).

University graduates are more inclined to select the clinic/physiotherapist option than any of the other groups (30%*).

Interestingly, it is not the university group that expresses the greatest requirement for more choice, but those with another form of further education (higher: 68%*; basic: 52%; graduates: 60%). Moreover, this group is more willing to accept the financial consequences of having greater choice, the acceptable premium increase being € 4.70, compared to the € 3.80 offered by the average member of the basic education group.

7.3 Transnational movement

The two higher education groups (there being little difference between university graduates and graduates of higher vocational education) are far more willing to travel abroad for treatment than the lower education groups, where this will avoid being placed on a waiting list. The European Expertise Centre concept enjoys strong support among those with higher education, but not among university graduates.

38 Attitude to care in another country (in %).

	Lower n=476	Secondary n=1042	Higher n=633	University n=359	Total n=2530
Preference for another country with no waiting lists	20*	28	36*	37*	30
Willing to travel to another country to avoid waiting lists	34*	42	52*	50*	44
Treatment at European Expertise Centre	62	71	73	67	69

7.4 Innovation

Those with higher educational qualifications seem relatively open to modern developments. In some cases (and particularly in terms of 'care consultant' concept), it is those with higher educational qualifications who are most likely to recognise the benefits, while in other cases (e.g. remote blood pressure monitoring) it is the university graduates who do so. Notably, the university graduates do not show overwhelming enthusiasm for the care consultant concept.

39 Attitude to new developments (% in favour)

	Lower n=476	Secondary n=1042	Higher n=633	University n=359	Total n=2530
Remote blood pressure monitoring	42	46	46	49	45
Care consultant	65	69	76*	66	69
Care consultant concept	52*	59	65*	66*	60
Access to latest drugs on payment of a surcharge	33*	36	47*	39	39

8 Patient or non-patient

8.1 Profile of 'patients'

In the preceding sections, we have examined the influence of certain socio-demographic variables on healthcare preferences. It is also possible that respondents' past experience of healthcare services will influence their desire for greater choice, whereby we may identify a 'patient' group and a 'non-patient' group. Prior to any consideration of this aspect, it is useful to present a profile of the patients, who are 'experts by virtue of experience', in order to gain greater insight into the degree to which the variables are likely to correlate with past contact with the healthcare profession. In this respect, a distinction is made between three types of medical condition: chronic, acute and elective[1]. Those who had not suffered from any medical condition in the previous year were included in the analysis as 'non-patients.'

([1] Elective conditions may be defined as those which are not acute and which do not therefore require immediate treatment, but which will inevitably require medical attention at some time in the future.)

Gender
Gender appears to have little influence on respondents' experience of illness. Although the chronic group does include a greater proportion of women, the difference is not significant.

Age
Advancing age can bring infirmity: those with some past medical condition (chronic, acute or elective) are, on average, older.

40 Medical profile by age (in %).

	Chronic	Acute	Elective	Total patients	Non-patients	Total
18-34	26	32	33	28	33	29
35-54	32	39	38	35	44	37
55+	42	29	29	37	23	34
Total	100	100	100	100	100	100
Average age	49.0	45.1	44.6	47.7	43.5	47

There is no marked link between educational level and past medical history. However, there is a clear link between past medical history and income. The chronically ill often earn (considerably) less than average; respondents reporting no medical condition in their recent past are more likely to have an average income.

41 Medical profile by income (in %).

	Chronic	Acute	Elective	Total patients	Non-patients	Total
Below average	26	19	22	25	17	23
Average	48	48	49	47	55	48
Above average	17	25	20	19	18	19
Not stated	9	8	9	9	10	8
Total	100	100	100	100	100	100

The conclusion is that health correlates most closely with age, and to a lesser extent with income.

8.2 Information seeking

It is notable that respondents with no experience of healthcare services are significantly less likely to cite the medical professional as preferred information source than those with a (prior) chronic, acute or elective condition (49%* against 68%*, 70%* and 68%).

8.3 Preferences in diagnosis and treatment

Respondents with experience of elective care are less likely to state a preference for a particular diagnostician (88%* have no preference).

The stated preferences do not vary greatly between the different socio-demographic groups. An overall average of 75% of Europeans would prefer to consult their general practitioner, while 22% prefer to see a specialist. The consumer's medical history has little influence on the preference for one or other type of diagnostician.

Respondents with no (prior) medical condition show a slightly greater preference for the general practitioner (79% against 74%), while existing/past patients opt slightly more often for the specialist (23% compared to 18%).

Not only are the differences at the beginning of the healthcare chain relatively small, they remain so in the subsequent treatment phase. However, Europeans with experience of acute or elective care are more likely to prefer treatment to be provided by the specialist (60%* of acute patients and 61%* of elective patients).

Table 42 shows the preference for general practitioner or specialist in the diagnosis and treatment stages.

42 Preference for general practitioner or specialist (in %).

	Chronic	Acute	Elective	Total patients	Non-patients	Total
Diagnosis						
G.P.	74	74	72	74	74	75
Specialist	22	22	25	23	18	22
Treatment						
G.P.	40	35*	34*	42	39	42
Specialist	55	60*	61*	54	56	54

Only minor differences are to be noted with regard to preferred treatment location. The number of Europeans with no recent experience of healthcare who are likely to prefer treatment at home is higher than the average, at 51%. Europeans with recent experience of services for an acute condition are significantly less likely to state a preference for home treatment than the other interviewees (42%*).

In the rehabilitation phase, the differences remain relatively small, as illustrated by the following table.

43 Where would you prefer the rehabilitation process to take place and by whom should it be supervised? (Respondents stating a preference; classified according to experience of healthcare serves, in %)

	Chronic n=1012	Acute n=683	Elective n=628	None n=326
Clinic/physiotherapist	21	24	23	18
Clinic/specialist doctor	27	22*	25	32
Home/physiotherapist	28	32*	31	23
Home/specialist doctor	23	22	20	27

Interestingly, there is very little difference between the groups in terms of the extra choices for which they would be prepared to pay extra. Past experience does not affect preference, except in the case of 'elective' patients, whose willingness to pay extra for the latest generation of prescription drugs is slightly higher than average (43%* compared to the average of 36%).

44 Respondents willing to pay additional premium in return for greater choice (amount of additional premium known), by experience with healthcare\ services, in %

	Chronic n=1012	Acute n=683	Elective n=628	None n=326
Choice in diagnostician	26 *(31)*	25 *(29)*	27 *(33)*	27 *(33)*
Choice in treating physician and treatment location	33 *(39)*	31 *(36)*	34 *(39)*	34 *(41)*
Choice in type of treatment	39 *(44)*	37 *(42)*	43* *(46)*	34 *(43)*
Choice in speed of treatment	32 *(38)*	34 *(39)*	33 *(38)*	34 *(43)*
Choice in rehabilitation	32 *(38)*	32 *(38)*	35 *(42)*	30 *(38)*
No further choice sought	43 *(37)*	42 *(37)*	40 *(35)*	42 *(34)*

Respondents with experience of elective care are prepared to pay the highest premium increase (€ 4.30) in return for greater choice.

8.4 Transnational movement

Patients with an existing or recent medical condition are more willing to travel to another country for treatment, thus avoiding waiting lists, than those in the 'non-patient' group (46%* against 36%*). The greatest degree of willingness to do so is seen among the elective patients (51%*).

The European Expertise Centre may also count on greater support among patients than among the non-patients (70% against 65%), although the difference is less marked than that prompted by the opportunity to avoid waiting lists. Elective patients are the most positive with regard to the European Expertise Centre concept (73%*).

45 Attitude to care in another country (in %)

	Chronic	Acute	Elective	Total patients	Non-patients	Total
Preference for treatment in another country with no waiting lists	30	33*	31	31	25	30
Willing to travel to another country to avoid waiting lists	46	49*	51*	46*	36*	44
Treatment at a European Expertise Centre	70	70	73*	70	65	69

8.5 Innovation

People with previous experience of healthcare services are more open to modern developments than those with no recent experience. Those with prior acute and elective conditions show a markedly higher willingness to pay a surcharge for prescription drugs if this will ensure that they receive the very latest pharmaceuticals. A similar situation is to be seen with regard to remote blood pressure monitoring: the elective and acute patients show the most positive attitude, while those without recent experience of healthcare services show relatively little interest.
Enthusiasm for the care consultant concept follows a broadly similar pattern, although the differences between patients and

non-patients are relatively small (i.e. not significant). The findings are illustrated in Table 46.

46 Attitude to new development s (% in favour)

	Chronic	Acute	Elective	Total patients	Non-patients	Total
Remote blood pressure monitoring	47	52*	46	46	42	45
Care consultant	71	69	70	70	66	69
Access to latest drugs (on payment of surcharge)	60	64*	65*	60	57	60

Council for Public Health & Health Care
P.O. Box 7100
2701 AC Zoetermeer
The Netherlands
Tel +31 (0)79 368 73 11
Fax +31 (0)79 362 14 87
E-mail mail@rvz.net
URL www.rvz.net