

Gesundheit !*

The Stockholm Network's Newsletter on Health and Welfare
Volume I: Issue I. September 2007

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*Gesundheit [gə'zoont'hlt] 1: interjection, used to wish good health to someone; 2: (Ger) health; 3: (Ger) health care

Commentary

Why yet another newsletter on social policy issues? –Kristian Niemietz and David Torstensson¹

In the European debate, most people think liberal reform of social policy simply means cutting people's benefits. It is thus not surprising that liberalism has a bad name in large parts of Europe. Liberals often act accordingly by stating their case in an apologetic way, pointing solely to the constraints from tighter government budgets and sharper global competition. The most sympathetic response liberals can expect is that their reform proposals are labelled as "inevitable". But while ideas that are presented as a necessary evil might be grudgingly accepted, they clearly cannot fascinate, inspire or enthuse anyone.

This newsletter wants to make it clear that liberal social policies are not based on a defensive response to adverse necessities, but on a new vision. It is a vision of free, independent and self-determined individuals and voluntary communities who provide for themselves through long-term savings, property accumulation, insurance and voluntary solidarity. Instead of depending on welfare bureaucracies, inept at meeting diverse and changing demands, there would be a limited safety net but, beyond that, people could choose from a variety of long-term saving and insurance products from a competitive private sector. Such an alternative would also raise savings, investment, employment and productivity.

But the actual implications are more far-reaching than that. What is at the core of liberal

reforms is a shifting of power from state bureaucracies to civil society. If people were not forced to leave the bulk of their income to welfare monopolies but free to save for themselves, then over time, even low-income workers would accumulate large amounts of wealth. Directly or indirectly, most of this wealth would take the form of capital assets. In this way, workers become co-owners of a country's capital (of its machinery, estates, buildings...). Everybody would become a small-scale capitalist.

This newsletter will highlight developments in contemporary European health and welfare policy, and explain how they relate to this overall vision. Each issue will include a Commentary section, which will analyse a recent event or topic. The Topic of the Month will be a more in-depth study of a policy problem or idea. As we are also a think tank umbrella organisation, our Think Tanker's Corner gives a platform to our members, or anyone else who works in the field of ideas. When it comes to translating the broad brushes described above into detail, people who widely describe themselves as 'liberals' can legitimately disagree. The Head2Head section will make that clear.

While the idea of an ownership society may still sound to some like grey theory, we are now proud to give the stage to an author who has gone a long way to making it a reality – José Piñera, the father of the Chilean personal retirement account system.

¹ Kristian Niemietz is the Stockholm Network's Research Officer for Health and Welfare; David Torstensson is the Stockholm Network's Project Manager.

Topic of the Month

Towards a Europe of Worker-Capitalists - José Piñera²

It is a fact that the population in Europe is aging and declining. This has transformed the Bismarckian public pension system into the equivalent of a time bomb—an economic, social and political one. Since in 30 years one worker will support each retiree in Germany, imagine this nightmare: “In 2050, to save money and free precious workers, the Bundestag votes to abolish the pension bureaucracy. From now on, each retiree will be assigned his or her working-age slave, who will hand over half his salary” (S. Theil, “A Heavy Burden.”, *Newsweek International*, June 30, 2003).

Passengers in the Titanic

European workers in the pay-as-you-go (PAYGO) pension system are like passengers on the Titanic, heading toward the iceberg of an aging population. By destroying the essential link between effort and reward, between contributions and benefits, the Bismarckian system encourages what French 19th century economist Frederic Bastiat called “legal plunder.” And by making the finances of the system dependent on fertility rates and life expectancies, this unfunded, defined-benefit, PAYGO system has positioned itself on the

² Dr. José Piñera was the architect of Chile's private pension system when he was Minister of Labour and Social Security (1978-80). As founder and editor of the influential opinion journal *Economía y Sociedad*, which he founded in 1978, he advocated economic freedom, defended human rights, and promoted democracy. He is the author of eight books. Today, Piñera is the chairman of the International Center for Pension Reform, which he founded in 1994. For more articles and essays about Chile's reform and the resulting World Pension revolution visit: www.pensionreform.org. For questions, you can e-mail the author at: jose@chile.com.

wrong side of the European demographic megatrends of the 21st century.

I envision in the future intense, exacerbated, maybe even violent, age wars. The young resenting the confiscation of a substantial part of their hard-earned salaries; the old living in permanent fear of the growing budget deficits and the possibility of substantial benefits cuts, either directly or through inflation.

Some European leaders are beginning to recognise the fiscal consequences of these demographic imbalances. But regrettably most of them seem to believe that changing some parameters of the public pension system will solve the crisis. Those measures are necessary and may partially correct the abuses of the system, but not its flawed roots.

Funded versus Unfunded Europe

A division is emerging between what I would term ‘Funded Europe’ versus ‘Unfunded Europe’. The first group comprises countries with large private pension systems (Britain and The Netherlands), those that have recently introduced personal retirement accounts, both funded and notional, and could go even further (Sweden and Poland), and those with such sound public finances that they are able to “fund” the PAYGO system with general tax revenues (Ireland and Luxembourg). The second group comprises the four big countries that make up the bulk of the EMU population and GDP— France, Germany, Italy, and Spain—and all the rest with unfunded PAYGO systems. Some studies estimate that the unfunded liabilities arising from PAYGO public pension programs are now more than 200 percent of GDP in France and Italy, and more than 150 percent of GDP in Germany.

The first skirmishes have already begun around the compliance with the Maastricht rules. While a Belgian prime minister said that the rules on deficits are “our bible”, a French prime minister

retorted, “My duty is not to solve mathematical problems to please a particular office or country”.

“Unfunded Europe” leaders may want in the future to follow the old Latin American recipe—namely, huge devaluations, so that the ensuing inflation reduces the purchasing power of benefits. But “Funded Europe” will probably oppose such a course. A clash may ensue amidst the centres of decision making in Europe, especially within the board of the European Central Bank. Of course, this perspective may be behind the reluctance of increasingly “funded” countries like Britain, Denmark, and Sweden to join the eurozone.

A new social paradigm in Chile

In 1980, we created in Chile a system of personal retirement accounts that has transformed every worker into an owner of financial capital. After 26 years of operation, the results are impressive:

- given a choice between staying in the public PAYGO system or switching to the funded system of personal accounts, 95% of Chilean workers are now in the funded system;
- they have never lost one peso to fraud or mismanagement, since we did what I then called “*a radical reform with a conservative execution*”;
- the average rate of return obtained by the workers funds, for 26 years, has been 10.1 % a year, above inflation;
- this has led to an enormous wealth accumulation by workers, surely one of the foundation stones of the current political stability of Chile;
- the system has created 120 billion dollars (equivalent to 80% of Chilean GNP) of “pension capital”, dynamising the economy and its now highly developed capital markets;

- macroeconomic studies show that, through the increase in the productivity of capital and labour, this system has contributed a full extra point of yearly economic growth to the economy;
- and this reform has created a nation of workers-capitalists, ultimately a nation of free men.

The end result of this reform, and those others that were consistent with this vision of a free market economy and an open society, is that Chile has abandoned the Third World and is well on its way to the First World.

The way out for Europe

If Europeans want to avoid the explosion of the pension time bomb, and even keep their common currency, they will have to abandon the Bismarckian pension paradigm, and, while keeping a government-financed safety net, begin moving toward a comprehensive retirement system based on ownership, individual freedom, and self-reliance. Ultimately, if Europeans, Americans, or the Japanese do not want to have enough babies, they will have to accumulate enough euros, dollars, or yen in personal retirement accounts.

Introducing a defined contribution pension system based on personal retirement accounts will re-establish the essential link between effort and reward, and contribute toward a culture of responsibility, savings and work.

Think Tanker's Corner

Slovakia: A free market health care revolution and its rollback – Peter Tatar³

It is easy to describe the Slovak health reform of 2002-2006 and the recent steps taken towards its destruction. More difficult is to answer the question of why the well functioning health care system is being destroyed.

A major reform of health care in Slovakia took place in 2002 – 2006. Its aim was not a pure free market system but a regulated system utilising market principles. Price and quality competition incentives were introduced.

In the early stages of the reform, the debt incurred by the old health system and excessive health services consumption were stopped by low user fees and rational drug policies.

All citizens were entitled to equal treatment in case of an equal need and covered by health insurance. Health insurance was compulsory for all individuals. Health funds were private companies competing in the purchase of health care services according to quality, health outcomes and cost benefit. The profits of health funds were to be used primarily for treatment of citizens on waiting lists. Citizens had free choice of health fund and, in addition, independent commercial health insurance allowed the reimbursement of treatments that were not covered by compulsory universal insurance.

³ Dr. Peter Tatár was an adviser to the Slovak Health Minister 2003-2006 and a member of the Slovak parliament 1998-2002 and 1990-92. As a member of various NGOs and foundations, he has been active in the fields of promoting liberty, human rights, and supporting disadvantaged minority groups.

Providers of health care were obliged to operate according to commercial codes. State hospitals were obliged to become joint-stock companies within a defined period. Accessibility of care was guaranteed by the “minimal public network of providers”, i.e. minimal number of providers for a given area and population. Health funds were obliged to sign contracts with providers to provide for this minimal public network set by regulation. The market choice of these providers was the role of health funds. Contract-based providers were reimbursed directly by the health funds. Other providers charged costs directly to patients, health funds might reimburse that up to the amount of usual reimbursement of the contracted provider.

Scope of care fully covered by the compulsory health insurance was defined in terms of a priority list. Other treatments could be co-paid by the patient. Standard diagnostic and therapeutic procedures were also under preparation. The categorization of pharmaceuticals intended to provide the maximum effect under the most efficient conditions. The reform remained unfinished due to premature parliamentary elections in early summer 2006. The aim of the reform was to create a system that would be fair and financially sustainable.

Rollback of the reformed system started after the change of the government in 2006 and goes on progressively. Privatisation of health funds and hospitals was stopped. User fees were cancelled. Two state health funds covering about 70% of the market remained dependent on the ministry of health. Independence of the Healthcare surveillance authority has been changed back into dependency on the government. All state hospitals remain the property of and under the management of the ministry.

Government intends to replace the market based “minimal public network of providers”

with the political and bureaucratic decisions of the Ministry of Health, according to which health funds automatically have to reimburse all health care providers irrespective of their quality and effectiveness. The drive towards quality and effectiveness will obviously stop. The debt of the state system has begun to rise considerably again.

Profits made by health funds were declared as adverse and unacceptable by the prime minister. His Minister of Health has no vision.

Government forces health funds to use all their profit explicitly on health care. This would end any motivation for health funds to manage their resources effectively. The Minister of Health wants to abolish the free choice of health fund by citizens receiving social benefits. These people will now be clients of state health funds only. The free choice of provider will be replaced by the bureaucratic decisions of local doctors and local hospitals.

Government protects hospitals from bankruptcy. This will profoundly deepen the debt of the system which the former government had eliminated. Government wants to recreate the monopolised state health care system. The state will be an insurer, provider, regulator and controller again. The quality of healthcare and health outcomes stagnates, debt rises, informal payments continue.

What took place between 2002 and 2006 was a courageous reform project that had the potential of replacing a burdensome poor-service monopoly with a competitive high-quality system responsive to consumers' needs. Unfortunately, the project has been ended before it really yielded fruit

Head2Head

Should government have a role to play in in-patient care?

Recent British government proposals that routine clinical services should be transferred from hospitals to polyclinics have been criticised as leading to a massive closing down of emergency units. Should government really decide on questions of this nature at all?

YES! -David Furness⁴

A feature of the recent NHS reforms has been the creation of a market in which private providers play a much greater role in inpatient care. This raises important questions about the relative roles of the state, the private and the third sector in providing healthcare. Private companies can bring fresh ideas and innovation from which the whole system can benefit. They also provide a greater range of choice for patients. Done right, this can both empower the patient and push up standards. These arguments also apply to third-sector providers of health care. Existing state providers and new providers all improve their performance as a result of increased competition. We have already seen this happening in the NHS. There should be no artificial limits on private care but it is important that there is a level playing field where competition between state and private providers is fair. The state must play a major role in any health system to guarantee equity, but this is not the same as being the major provider of care. The best providers should be successful in any given medical specialty, whether they are operated by the state or the private sector. Outcomes for patients should be more important than ideologically driven arguments about the intrinsic qualities of public or private providers.

⁴ David Furness is the Health Project Leader of the Social Market Foundation

NO! -Helen Evans⁵

Today, all healthcare systems have been nationalised. Even so-called private health care is forced by government to rely on doctors, nurses and other health professionals who are regulated by central dictat. The uniformity of rules that such interventionism lays over health systems means that not only do health professionals suffer from the dead hand of government but customers find themselves faced with more expensive, less responsive and less innovative services than they would otherwise have access to. In 1948 the British government foolishly nationalised 3,118 independent hospitals, homes and clinics to create the National Health Service. Following decades of under-funding this estate has only recently been improved as the result of a reintroduction of private capital and know how through private sector partnerships. Where there has been any slight reduction in NHS waiting lists one finds that the figures directly correlate to the additional capacity now offered by Britain's 200 independent hospitals as well as a new generation of Independent Sector Treatment Centers. I believe that it is only with more private sector involvement and the adoption of a genuine market that everyone in society, including the poor, will be able to access high quality treatment and care. It is with the disadvantaged in mind that the state must give way and have no role to play in in-patient care services.

⁵ Dr. Helen Evans is the Director of Nurses for Reform

Book Review

“Wachstumsmarkt Gesundheit”⁶ by Peter Oberender, Ansgar Hebborn & Juergen Zerth - Kristian Niemi

Since the mid-1970s, a recurring ritual has been established in German health politics: Expenditures jump to unrecorded levels, talk of a “cost-explosion” makes it to the headlines, government enacts a cost-containment-bill under heavy protests, and spending growth is more or less dampened. This lasts until the next febrile convulsion breaks out.

Oberender et al reveal the root of this repetitious boom-and-bust cycle: the health care system has been thoroughly and deliberately “de-economised”. But forbidding market prices to guide the use of scarce resources does not make scarcity itself disappear. Instead, the steering wheel is taken over by political bodies and quasi-public monopoly chambers. Patients’ freedom of choice and doctors’ therapeutical autonomy are continually eroded.

The authors briefly propose two solutions, a “pragmatic” and an “idealistic” one: First, the boundaries of the existing bureaucratic top-down system could be drastically rolled back; the problems associated with this type of economic organisation would keep on intensifying, but only in its confined sphere. Secondly, and better still, the government’s role in health care could be reduced to providing those people who lack it with sufficient medical purchasing power. Monopolisation, subsidisation and bureaucratic stifling of the supply side would become unnecessary. Health care would become a consumer-responsive boom market.

After three decades of contradictory reforms health care policy in Germany has become overly complex and to many observers beyond comprehension. Due to this fact, the public still falls for politicians who disguise their short-sighted measures as the next grand panacea. But those who have read this book will no longer fall for that. The strength of this book is that it familiarises the reader both with basic theories of health economics and the actual history of German health care policy in a scholarly yet accessible manner. However, the authors’ case for market-based reforms would have been stronger if they had backed them up with data from the experiences of other countries. There may presently be no overall best-practice health care system, but there are certainly countries which are successful in some areas. Yet, both within the evaluating as well as comparative sections, international examples are rare.

Notwithstanding these minor points, Oberender et al provide an excellent analysis of the futile struggle of a system against the false premises on which it is based.

⁶ Lucius & Lucius Verlag, Stuttgart 2002
Title translates as “Boom Market Health Care”

News Flashes

Please find below a selection of some of the recent developments in health and welfare public policy from across the continent. As part of the Health and Welfare newsletter's re-launch these newsflashes will aim to put a focus on areas and regions that are usually not in the policy spotlight.

Hungary 3/9/07

The Hungarian opposition Fidesz party spelled out its support for full state ownership of the health service except for where employees are offered shares and collective wage bargaining. Hungarian Socialists compared this top down approach to the Soviet era communist party. <http://hatc.hu/index.php>

Bulgaria 31/8/07

The Bulgarian government is to publish a new strategy for healthcare in September. There is speculation that policy may take a neo-liberal turn. Up for consideration will be the rate of health insurance, a current moratorium on the sale of state and municipal health-care facilities, the closure and replacement of ineffective units, and the possibility of bringing new stakeholders into the National Health Insurance Fund, which is currently a monopoly. Watch this space. <http://thebulgarianpost.com/>

Romania 31/7/07

The Economist has recently written of the dangers of Romanian Prime Minister Tariceanu's headlong dash for an infrastructure and welfare system of European standard. His government has already decided to double state pensions, which is likely to cost E2bn next year, along with a massive infrastructure programme. Such policies are likely to bring the Romanian budget deficit close to the 3% ceiling, and since the economy, driven by consumer spending, is already growing healthily, this may be the wrong time to indulge in populism. <http://economist.com/index.html>

Slovakia 3/9/07

Transforming a public hospital in Slovakia into a joint stock company might soon be at odds with the country's laws. The Slovak Health Ministry is proposing a law that would completely halt the transformation of Slovakia's hospitals into joint stock companies, a move started by the previous government to cut Slovak health institutions' debt. The Health Ministry is concerned that the state would lose its influence over hospitals that become joint stock companies.

An ongoing argument about the level of social security that employers should pay on behalf of their workers is a contributory factor to the opposition's staging of a no-confidence vote in the Slovakian minister of Labour, Social Affairs and Family, Viera Tomanova. Incompetence and bribery are also alleged. Whether she survives will presumably be known soon. <http://slovakspectator.sk/>

Russia 6/9/07

In its desire to stimulate the growth of private pensions, the Duma has been discussing the notion of a co-financing mechanism, which would see the state matching private contribution up to the amount of 10,000 roubles (£200) per annum via the state pension fund (PFR). The idea has been fully endorsed by President Putin and relevant ministries, although some concerns have been voiced regarding the PFR's capacity to administer these extra responsibilities. <http://www.kommersant.ru/>

Stockholm Network Publications

“Health Technology Assessment in Context”
– Meir P. Pugatch and Helen Davison
(launched July 2007)

This paper considers the development of Health Technology Assessment (HTA) within its broader economic, political and historical context.

http://www.stockholm-network.org/downloads/publications/Health_Technology_Assessment_in_Context.pdf

“What an Ageing Europe Can Learn from a Latin Tiger” – Kristian Niemietz **(launched September 2007)**

This paper describes Chile’s privatised, funded system of old-age provision with the purpose of illustrating why personal retirement savings accounts are preferable to European pay-as-you-go systems.

http://www.stockholm-network.org/downloads/publications/Chile24Sep_3.pdf

“Can Free Market Solutions Salvage the Collapsing Welfare State?” – David Torstensson **(forthcoming)**

This paper has two main lines of enquiry: Firstly, to provide a broad historical and conceptual overview of what we mean by the welfare state and a free market solution; and secondly, to determine what part free market solutions can play.

“Health Technology Assessment in the UK and Germany” – Kristian Niemietz and Meir P. Pugatch **(forthcoming)**

This paper examines the role and functioning of Health Technology Assessment in the UK and in Germany. The UK set up the National Institute for Clinical Excellence (NICE) in 1999; Germany followed in 2004 with the Institute for Quality and Efficiency in Health Care (IQWiG).