HEALTH CARE REFORM IN THE NETHERLANDS, SWEDEN, AND THE UNITED KINGDOM

by Chris Ham and Mats Brommels

Prologue: *Many European countries are years, even decades, ahead of the United States in reforming their health care systems. At first glance, many of the nations appear to have followed similar paths. The three countries examined here all are considered leaders among their peer nations and have gone beyond initial reforms aimed at curbing spending growth to focus on responsiveness to patients and efficiency in use of resources, among other things. However, a closer examination illuminates some key differences, not the least of which is the pace of reform. Also, as the authors of this comparative essay note, "although the vocabulary of reform may be international, terms such as 'managed market,' 'budgetary incentives', 'purchasers,' and 'providers' are interpreted differently in the three countries." The experiences of the three countries offer lessons for U.S. policymakers, specifically on the role of government in health care, the importance of primary care, and the need to hold providers accountable to patients. These issues are central to the ongoing reform debate in the United States. Chris Hum is director and professor of health policy and management at the Health Services Management Centre, University of Birmingham, in England. He holds degrees from the University of Kent and the University of Bristol and has previously worked at the King's Fund College and the King's Fund Institute. He is the author of several key books on the British National Health Service and on comparative health systems. Mats Brommels is professor and director of the Programme in Health Services Management, University of Helsinki Medical School, in Finland. An internist, Brommels previously was a professor at the Nordic School of Public Health in Gothenburg, Sweden. He is an expert on health systems in the Nordic countries and has been involved in supervising the management training of physicians in Finland.*

Abstract: The experiences of three European countries that are actively engaged in reforming their health care systems–the Netherlands, Sweden, and the United Kingdom–point to a degree of convergence in the types of reforms being pursued. European experiences also offer a number of lessons for the United States. These include the importance of government intervention in the health care market to ensure universal coverage, the key role of primary care in ensuring access to basic health services and in containing costs, and the need to create a strong purchasing or insurance function to hold providers accountable on behalf of patients. The pace and scope of reform are affected significantly by the political process in each country.

During the 1980s many European nations put in place health system reforms aimed at curbing the rising rate of spending growth. These reforms have begun to show evidence of success, and European health policymakers have turned their attention to other objectives. These objectives include increasing the efficiency with which resources are used, extending patient choice and the system's responsiveness to users, and achieving a better balance among primary, secondary, and tertiary care.[1]

Three European countries-the Netherlands, Sweden, and the United Kingdom-have been at the forefront of reforms in Europe. The experiences of these countries are of interest both in their own right and in providing a context against which the health care reform debate in the United States can be considered. Recent developments indicate that there is a degree of convergence in these countries. This is most apparent in the emergence of managed markets in health care and in the debate about health care rationing and priority setting. Policymakers seeking to tackle weaknesses in the financing and delivery of health services are developing similar policy instruments in different countries and are using them to stimulate more efficiency in resource use and increased responsiveness to users. At the same time, they are reviewing the scope of coverage of health services, to reconcile growing demand with a finite supply of resources.

Notwithstanding the similarities, important and interesting differences of approach emerge on deeper analysis of the three countries. Insurers or purchasers can compete with each other in some countries but not in others. Other differences include the extent to which a managed market has developed among providers, the methods used to regulate provider competition and to deal with the consequences of market failure, and the interest shown in budgetary incentives to stimulate improved performance. The existence of these differences indicates that the degree of convergence in health care reform may not be as great as first appears. Put another way, although the vocabulary of reform may be international, terms such as "managed market," "budgetary incentives," "purchasers," and "providers" are interpreted differently in the three countries.

One of the most important differences is that the pace of change has varied among the three systems. In this respect, the Netherlands and the

United Kingdom represent polar extremes. Since Prime Minister Margaret Thatcher published her government's proposals for reforming the National Health Service (NHS) in 1989, the United Kingdom has witnessed a near-revolution in health services delivery. In the Netherlands the Dekker reforms of 1987 have been implemented cautiously, and there are continuing doubts as to whether policymakers will keep faith with the changes initiated by Dekker.[2] Sweden falls somewhere in between. The change of government in Sweden in the 1994 elections adds an element of uncertainty about not only the pace of reform but also its direction.

To explore these issues in more detail, we describe the basic features of the health care systems in these three countries and then review the main reform themes that have emerged so far. In our conclusion, we seek to identify the relevance of European experience for the United States.

System Overviews

The Netherlands. The changes taking place in the Netherlands build on the Dutch system of social insurance. This system insures the entire population for serious and prolonged disability and sickness. Other health care risks are covered by compulsory social insurance for those below a certain income level and by voluntary private insurance for those above that level. The costs of social insurance are met mainly by a payroll tax involving contributions from both employees and employers. Hospitals are run on a not-for-profit basis, and doctors are mainly private practitioners. Government regulates the system through controls over doctors' fees, hospital budgets, and the use of health care technology.

Following the Dekker Report of 1987, a strategy of reforms has been pursued that involves the introduction of a universal insurance arrangement covering virtually all health services and administered by competing insurance organizations. The latter include private, nonprofit companies and public-sector sickness funds responsible for administering social insurance. The distinction between private companies and sickness funds eventually will disappear. The cost of the basic benefit package will be met by payroll contributions from employees and employers and will not be adjusted for risk. In addition, insurers will charge a nominal premium to cover part of the cost of the benefit package. It is anticipated that in time the amount of the nominal premium will vary among insurers, thereby stimulating competition on the demand side.[3]

The other key element of the Dekker proposals was that insurers should contract selectively with health care providers, which in the Netherlands are largely private. Dekker argued that selective contracting by insurers with providers would create a market on the supply side, which would

increase efficiency and raise standards of care.

Sweden. Sweden attaches high priority to the provision of health services to the entire population paid for through national and regional taxes. Nearly all hospitals and health care facilities are owned and run by elected county councils, and most doctors are salaried employees. These arrangements have enabled the Swedes to provide a standard of health care long admired by international observers.[4] Despite this, pressures have begun to build, and a series of national and local reforms have been initiated.

At the national level, the government has acted to reduce waiting times for hospital admission, reform primary care services, and further integrate medical and social services for the elderly. In addition, two committees have been set up to examine the financing and organization of health services on the one hand and priority setting on the other. At the local level, a number of county councils have taken the initiative to experiment with different approaches to reform. There are several common themes among these approaches. One of the most significant is the attempt to strengthen primary care by employing more general practitioners (GPs). Another is the separation of purchaser and provider roles within the county councils and the introduction of performance-related reimbursement for hospitals. Yet another important aim is to increase patient choice; in the past Swedish patients were expected to use the primary health care center or hospital nearest to where they lived, which limited their choice of providers. None of these changes has yet entailed moving away from a health system funded through taxation and committed to universal access and equity in service provision. These remain important values in Sweden.

The United Kingdom. The British NHS has been transformed by the proposals published in 1989 in *Working for Patients,* a white paper that was the outcome of a review initiated by Margaret Thatcher.[5] In essence, the document proposed to keep a national health service funded out of general taxation and available largely free at the point of use. The main changes it contained concerned the delivery of health care, including the development of a so-called internal market. In practice, this has meant that district health authorities–the bodies appointed by the government to run local health services–have become purchasers of services for their communities. Most hospital and community health services are no longer managed directly by district health authorities but are run by self-governing NHS trusts. In addition, groups of GPs serving 7,000 or more patients may choose to hold a budget with which to buy some services for their patients as GP fundholders. NHS trusts thus are in the position of competing for contracts and resources from district health authorities and GP fundholders.

These changes, initiated in 1991, have been implemented progressively since then. By 1995 it is anticipated that all NHS services will be run as

trusts, thereby enabling district health authorities to concentrate entirely on their purchasing role. At that point, there are likely to be approximately 3,000 GP practices involved in fund holding that cover approximately half of the population. The increasing separation of purchaser and provider roles and the greater freedom given to purchasers to move contracts have resulted in competition among providers in London and the major urban areas. This is producing significant changes in the provision of hospital services, as NHS trusts that compete unsuccessfully are forced to reduce their capacity and in a number of cases merge with neighboring providers.

Against this background, we now review the main reform themes in these three countries.

Reform-Related Themes

Separation of purchaser and provider roles. Both Sweden and the United Kingdom are moving away from integration of responsibility for financing and delivering services in county councils and district health authorities, respectively, to separation of purchaser and provider roles. In Sweden this involves a separation of responsibilities within the county councils. As an example, political boards in the Stockholm County Council have been given responsibility for purchasing services at the district level. These boards contract with county council hospitals, over which they do not have direct management control. In the United Kingdom district health authorities have in most cases ceased being integrated organizations. Responsibility for providing hospital and community health services rests instead with NHS trusts, enabling district health authorities to take on the role of purchasers for their communities. On average, each authority serves around 500,000 persons. District health authorities work alongside GP fundholders, who provide primary care services to the patients they serve and purchase a limited range of secondary care services for these patients. This is intended to create an incentive for fundholders to deliver care directly to patients whenever possible, although it also creates a risk that patients may not be referred for specialist services when they should be.

The Dutch social insurance system has not had to separate purchaser and provider roles, because these functions have always been distinct. What has changed is the requirement that insurers, whether sickness funds or private companies, take on a more active role in their negotiations with providers. Put another way, the intention is that Dutch insurers should shift from being relatively passive payers to become more discriminating and prudent purchasers.

Competition among purchasers. In Sweden each political board has responsibility for purchasing services for the population in its area. This

means that there is no competition among purchasers. Partly because of this, Sweden places great emphasis on patients' choice of doctor and hospital. The use of services therefore reflects multiple decisions made by patients as well as the priorities established by political boards. A different situation exists in the Netherlands, where the Dekker reforms have been designed to stimulate competition among purchasers or insurers. To avoid the dangers of risk selection, all insurers will offer the same benefit package and will be required to accept all subscribers. Furthermore, the capitation payments received by insurers will be determined nationally, and the aim is that these will be adjusted for the risks represented by different patients[6]

The British system combines features of the Swedish and Dutch systems. As in Sweden, the major purchasers (district health authorities) do not compete with each other. Each district health authority buys services for the residents who live in its area, and citizens can only change their health authority by changing residence. Alongside health authorities, GP fundholders are responsible for purchasing certain services for their patients, and the resources they control are deducted from the allocation of the relevant health authority. This means that to some degree there is competition between health authorities and fundholders. There also is competition among GP practices, as fundholders seek to demonstrate that they can provide and purchase services more effectively than can GPs who are not fundholders. As the NHS reforms are implemented, patients may decide to move to fund-holding practices. Also, more practices are choosing to become fundholders, to share in the perceived benefits of the scheme.

An important difference between the United Kingdom and Sweden is that in Sweden purchasers are made legitimate by virtue of election. In the United Kingdom health authorities are appointed by the government, and they are not directly accountable to their communities. To earn credibility as "champions of the people," a phrase used by health ministers to describe purchasers' role, health authorities have used a wide range of methods to involve local people in their work, including adoption of locality purchasing arrangements.[7] In this respect there are similarities to Sweden, where county councils also have organized the purchasing function on a locality basis. In Stockholm nine political boards serve a population of 1.7 million, and in Bohus fourteen political boards serve a population of 300,000.

Competition among providers. In all three countries one of the main purposes of health care reform is to promote competition among providers. This is in part a response to the perceived shortcomings of planning and management, and in part a reflection of changing political values. Not least, the election of conservative governments and interest in drawing on ideas from business management have been important factors in the introduction of markets into health care. A key figure in this process has been

American economist Alain Enthoven, whose ideas on managed competition have been studied in all three countries.[8]

In the United Kingdom competition has developed most rapidly in London, where the combination of a large number of hospitals in close proximity to each other and reductions in the purchasing power of health authorities has produced major changes since 1991. The difficulties encountered by a number of famous teaching hospitals in competing for resources led the British government to establish an independent inquiry into the future of London's health services. The resulting report recommended the closure or merger of ten inner-city London hospitals and the concentration of medical education and research in fewer sites.[9] Proposals also were put forward for strengthening primary care services. These recommendations provoked a storm of criticism, but many of the recommendations were implemented nonetheless, albeit in a modified form.

Stockholm also offers a fertile environment for competition. As a result of the creation of a health care market in Stockholm, productivity rose sharply, leading some to believe that there was overcapacity in hospital provision. It is anticipated that there will be a reduction in the number of hospitals and beds and that acute hospital services will be concentrated in four sites instead of ten, with the remaining hospitals taking on a supporting role as community or convalescent facilities. These changes have been brought about by a combination of competition and planning.

Competition has developed much more slowly in the Netherlands. This reflects the more cautious Dutch approach to health care reform, the limited scope of competition in many parts of the country, and prevailing cultural characteristics. Insurers and providers thus far have shown no great interest in disrupting long-established relationships and are unlikely to do so unless the financial constraints under which they operate become tighter. On the other hand, the emergence of private, for-profit hospital chains in some areas may provide the stimulus that is now lacking.[10]

Emergence of regulated or managed markets. In none of these countries have policymakers sought to abandon planning and regulation. Rather, the aim has been to combine some market incentives with a framework of rules to guide competition and the capacity to intervene to tackle market failure. The reforms that are taking place are in this way leading to the development of regulated or managed markets.

As we have noted, the British government responded to the financial difficulties encountered by London hospitals by establishing an independent inquiry to review the situation and make recommendations. In addition, funds were allocated temporarily to enable hospitals to balance their budgets, and the London Implementation Group was set up to oversee the process of change. London's experience illustrates that policymakers

were not prepared to allow the market to operate without hindrance. In practice, the signals thrown up by the market were joined with a strategic overview and transitional funding to ease the rationalization of services.[11]

Experience in Sweden in many ways parallels that in the United Kingdom. The operation of the market in Stockholm identified the existence of significant acute hospital overcapacity and the need to reduce the number of hospitals and beds. This was handled by politicians and managers within the county council. The management of one inner-city hospital was awarded to a private health care contractor, and an attempt was made to transfer management of a second hospital to the ownership of a multinational hospital corporation. The latter, however, withdrew because of concerns about political instability. Despite this, services at both hospitals were reviewed, resulting in the closure of their accident and emergency departments and a concentration on day surgery and nonacute cases.

Market management has yet to arise as a significant issue in the Netherlands because, as our earlier analysis has shown, there has been very little competition to date. Insofar as the issue has been discussed, it has been mainly in the context of the rules needed to prevent anticompetitive behavior. This applies both to insurers, among which mergers already have resulted in a significant reduction in the number of purchasers, and to providers. Early indications are that the risks of connivance between purchasers and providers to prevent the development of a market may be greater in the Netherlands than in the United Kingdom and Sweden, and this will require the implementation of a strong regulatory framework.

Use of budgetary incentives. An important factor underlying health care reform has been the use of budgetary incentives to stimulate improved performance. This applies to hospital care, primary care, and community-based care. Incentives also have been employed to influence the demand for care, most notably by way of copayments or user charges.

In relation to hospital care, policymakers have sought to find a way of ensuring that the money follows the patient. In Sweden the most advanced example of this is in Stockholm, where hospitals have been funded per case since 1992. In anticipation that this would cause providers to increase productivity, prices paid by purchasers were set at a level 10 percent lower than prevailing prices in 1991. This was designed to keep overall spending within the budgets agreed to by the county council. In the first year of the Stockholm model, productivity increased faster than anticipated. This resulted in a significant reduction in waiting times for hospital treatment. To this extent, budgetary incentives had the desired effect, although an unintended and unwanted consequence was that spending exceeded the allocated purchasing budget. Prices then had to be reduced, and the system of paying hospitals per case came under review.

Experience in the United Kingdom offers a mirror image to that of Sweden. The NHS reforms include three main mechanisms for funding hospitals: block contracts, cost and volume contracts, and cost per case contracts. In practice, most contracts initially were block contracts; in many respects, these were similar to the prospective global budgets through which providers were funded before the introduction of the reforms. Instead of having the money follow patients, patients were required to follow the money by using those hospitals under contract to the health authorities where they lived. GP fundholders were an exception to this; they relied much more on cost and volume and cost per case contracts and had the flexibility that health authorities often lacked to make their purchasing decisions sensitive to the needs and demands of patients.[12]

A different example of the use of budgetary incentives was the introduction of "fines" in Sweden when patients who were ready to be discharged were required to remain in the hospital because of the absence of alternative facilities. This situation often arose because municipal councils, the bodies responsible for community care in Sweden, were unable to provide the care needed upon discharge. To tackle this problem, municipal councils had to pay the cost of keeping patients in the hospital when this form of care was deemed to be no longer necessary. The effect was to eliminate almost entirely the number of beds occupied inappropriately and to free up facilities for patients needing treatment in an acute hospital.

As far as primary care is concerned, Sweden has sought to move away from a salaried GP service to one based on independent contractor status. In the new system, GPs are paid on the basis of capitation payments. This is intended to overcome the lack of incentives in a salaried system to undertake an increased workload. Under the rules established by the Swedish government, only GPs who attract a thousand or more patients will be eligible for payment. These proposals provoked strong opposition and resulted in a strike by doctors in 1994.

Recent changes to the GPs' contract in the United Kingdom have moved in a similar direction. These changes, introduced in 1990, increased the proportion of income received by GPs through capitation payments from 46 percent to 60 percent. The contract also included extra payments to GPs for undertaking health promotion work. This was so successful that on average each GP earned 56,000 (U.S. $9,500) more than the government had planned in the first year of the new contract. In response, the health promotion elements of the contract were renegotiated to reduce the level of additional spending incurred.

A different example concerns the use of incentives to influence the demand for care. This is illustrated by various attempts to reduce demand by imposing copayments for treatment. These charges are being used most

extensively (and perhaps surprisingly) in Sweden, where patients have for some time contributed to the cost of consulting a GP or specialist and staying in a hospital, subject to an annual ceiling. To encourage patients to use a GP instead of visiting a specialist directly, a number of county councils have imposed lower charges for GP than for specialist services. It is too early to evaluate the effectiveness of this arrangement.

Role of public health. The traditional orientation of health systems has been to treat illness with high-quality services. The "rediscovery" of public health has caused a rethinking of this model, evident at an international level in the World Health Organization's (WHO's) strategy, Health for All by the Year 2000.[13] The WHO's strategy has influenced the development of health policy in the Netherlands, Sweden, and the United Kingdom, with national governments in all three countries undertaking analyses of the major causes of mortality and morbidity in their populations and publishing reports setting out policies for improving health.

In the United Kingdom public health occupies a central place in the work of district health authorities. Each authority appoints a director of public health, who assesses health needs and evaluates the cost-effectiveness of different services. There is therefore close integration of public health in the work of health authority purchasers and an increasing emphasis on purchasing for health improvement as well as for health services.

In Sweden public health is centered mainly in independent institutions and academic centers. The tradition of doctors trained in public health medicine is weaker in Sweden than in the other two countries. In the 1980s, with the growing interest in an intersectoral approach to health policy, county councils established community medicine units at the county level. This means that public health is not as fully integrated into the work of purchasers in Sweden as it is in the United Kingdom.

Public health in the Netherlands plays no part in the work of insurers. This is because sickness funds and private insurance companies have been solely concerned with health services in the past and have concentrated on ensuring that patients have access to these services and that providers are paid for delivering them. Elected local authorities in the Netherlands have been responsible for public health matters, including communicable disease control, environmental health, and preventive programs such as vaccination and immunization. There has been little contact between insurers and elected local authorities in the past, although this may change as sickness funds move from being payers to becoming purchasers and seek to transform themselves into health funds.

Patient choice. The desire to increase the choices available to patients and make services more responsive to users is common to all three countries. In the Netherlands, where patients have always had extensive choice

of both doctors and hospitals, the importance of this issue is taken for granted. It therefore figures less prominently in the health policy debate in the Netherlands than in Sweden or the United Kingdom.

Sweden has put the greatest emphasis on patient choice, largely because choice has been tightly constrained in the past. This reflects a wider set of developments in Swedish society following the election of a conservative coalition government. As a consequence, patients in Sweden now have almost total freedom to choose doctors and hospitals. At this stage it is unclear whether this can be combined with effective spending control.

The position in the United Kingdom is quite different. Patients' choice of GPs has been built into the NHS since its establishment in 1948. In turn, GPs have been able to choose the hospital specialist to whom patients should be referred. The NHS reforms have not altered the ability of patients to choose their GPs, but they have led to some restrictions on referrals to hospitals. GP fundholders are free to use the hospitals of their choice for the services they purchase, but nonfundholders are required to use hospitals under contract to the health authority within which they practice. This is supplemented by the availability of resources to fund extra-contractual referrals, when a GP wishes to refer a patient outside the terms of contracts.

The issue of patient choice raises the question of whose wishes should shape health service priorities. In the United Kingdom the existence of GPs as gatekeepers and health authorities as purchasers means that there is implicit acceptance that the demands and preferences of patients should not have overriding priority, although this view is coming under increasing challenge. In contrast, in the Netherlands and Sweden there is mistrust of professional or bureaucratic controls and greater faith in the ability of individuals to determine what is in their own best interest.

Rationing. An issue closely related to patient choice is rationing or priority setting. This issue is being addressed in all three countries. Committees have been appointed by governments in both Sweden and the Netherlands to advise on how priorities should be set. The first report of the Swedish committee was published in 1993.[14] The committee formulated a number of ethical principles as a starting point for setting priorities and rejected discrimination based on age, social characteristics, and economic status. It identified several levels of priority, attaching greatest importance to treatment of life-threatening acute diseases and severe chronic diseases, palliative terminal care, and treatment of diseases that reduce autonomy.

In the Netherlands the Dunning Committee outlined an approach to determining which services should be included in the basic benefit package to be purchased in the reformed insurance system.[15] The committee argued that the inclusion of services in the benefit package should be based on a number of tests. More specifically, it suggested that only those services that

are necessary, effective, and efficient and that cannot be left to individual responsibility should be in the package.

In the United Kingdom there has been no national initiative along the lines of those found in Sweden and the Netherlands. Instead, the government has asked health authorities to determine priorities for service development in the context of guidance issued by the Department of Health. At the time of writing, this guidance has identified priorities for health improvement in five areas, it has set standards for the delivery of health services in the Patient's Charter, and it has required health authorities to improve efficiency.[16] In the absence of an agreed national list of what the NHS is expected to provide, health authorities are responsible for determining the limits of service provision.[17]

Concluding Comments

The evidence summarized in this paper presents a number of lessons for the United States. Although the Clinton plan failed to gain legislative approval in 1994, a number of principles it contained are still a central part of the debate. To begin with, the evidence suggests that in pursuing the path of managed competition the Clinton plan was in tune with European developments. Countries that have relied on planning as an instrument of control are introducing competition into their health care systems just as market-oriented systems seek to impose a greater degree of regulation. To this extent, there is convergence in health care reform among the three nations we examine here, although there are important differences in the meaning attached to terms such as "managed competition."

As our analysis has shown, the closest parallels exist between the Dutch reforms and the U.S. reform proposals. This applies particularly to both countries' commitment to introduce managed competition among both insurers and providers and to achieve universal coverage. There are fewer similarities with the United Kingdom and Sweden, in which a single-payer approach has been maintained and in which competition has occurred mainly among providers. Nevertheless, the interest in these two countries in combining planning and markets is indicative of policymakers' desire to find new ways of increasing efficiency and enhancing service responsiveness. This includes the use of competitive incentives of the kind often associated with the United States.

In promoting universal coverage, the Clinton plan was consonant with European developments. Universal coverage has always existed in the publicly funded systems of the United Kingdom and Sweden, and it is being introduced progressively in the Netherlands. As research carried out by the Organization for Economic Cooperation and Development (OECD) has

shown, other European countries also have moved toward universal coverage, reflecting recognition that government intervention in health care markets is required if equity and access are to be guaranteed.[18] This has been achieved through a variety of insurance mechanisms and is not dependent on the introduction of national tax-financed systems.

European experience highlights the need to make trade-offs in health system design. Countries such as the United Kingdom and Sweden, which have long placed a high value on universality, equity, and access, have to some degree sacrificed patients' freedom of choice in the process. As we have noted, Sweden is seeking to rectify this. The measures taken to increase patient choice have put pressure on budgets, and it remains to be seen whether costs can be contained at a level of 8.6 percent of gross domestic product (GDP). Against this, it is worth noting the experience of the Netherlands, where patient choice is a well-established feature of a system that allocates only 8.3 percent of GDP to health services.

Why has the Dutch system apparently been so successful? The reasons are complex, but a contributory factor is the priority attached to primary care there. The existence of a system of family physicians in which GPs act as gatekeepers also explains the ability of the British NHS to deliver comprehensive services to the entire population while spending 6.6 percent of GDP. International evidence thus suggests that comprehensive primary care is important both in ensuring access to basic health services for all and in containing costs. This has important implications for the United States.

A clear lesson emerging from Europe is that insurers or purchasers have a significant role to play in managed markets, because of the power traditionally exercised by health care professionals and providers and the need to create a capacity to hold providers accountable on behalf of patients. As Dutch experience illustrates, the development of regulated competition among providers in a pluralistic system depends on insurers' becoming purchasers and not simply payers. The importance of intermediate bodies of this kind was acknowledged in the Clinton plan in proposals to set up regional health alliances. Despite this similarity, an important difference from European experience is that alliances would exist alongside insurers, instead of replacing them. This creates a risk that the purchaser function will be duplicated unless the two roles are intended eventually to merge.

Finally, the pace and scope of reform are greatly affected by each country's political process. The United Kingdom has moved very quickly because of the existence of a unitary political system coupled with governments that have enjoyed legislative majorities and were committed to promote change. In contrast, the Netherlands has reformed its health services much more slowly as a succession of coalition governments have revised the original Dekker proposals, not always in a consistent direction,

and as the interest groups affected by the proposals have lobbied for their own preferences. In turn, the pattern of Swedish reform reflects the decentralized nature of that country's health system and the ability of county councils to initiate change within the context of national legislation. The political process is clearly a potent factor in the United States as health system reform is debated and legislated. It now appears certain that reforms will constitute only an incremental response to the problems facing the U.S. system throughout the rest of the decade.

NOTES

1. Organization for Economic Cooperation and Development, *The Reform of Health care: A Comparative Analysis of Seven OECD Counties* (Paris: OECD, 1992); and C. Ham, R. Robinson, and M. Benzeval, *Health Check: Health Policy in an International Perspective* (London: King's Fund Institute, 1990).
2. Advies van de Commissie Structuur en Financiering Gezondheidszorg: *Bereidheid tot verandering* ('s Gravenhage: Distributiecentrum Overheidspublikaties, 1987).
3. W. van de Ven, "From Regulated Cartel to Regulated Competition in the Dutch Health Care System," *European Economic Review* 34 (1990): 632-645.
4. O.W. Anderson, *Health Care: Can There Be Equity?* (New York and London: Wiley, 1972).
5. Secretary of State for Health and Others, *Working for Patients* (London: Her Majesty's Stationery Office, 1989).
6. For more on the risk adjustment process, see W. van de Ven et al., "Risk-Adjusted Capitation: Recent Experiences in the Netherlands," *Health Affairs* (Winter 1994): 120-136.
7. B. Mawhinney, *Purchasing for Health* (London: NHS Executive, 1993); and C. Ham, *Locality Purchasing* (Birmingham: Health Services Management Centre, 1992).
8. A.C. Enthoven, *Reflections on the Management of the NHS* (London: Nuffield Provincial Hospitals Trust, 1985); A.C. Enthoven, *Theory and Practice of Managed Competition in Health care Finance* (Amsterdam: Elsevier, 1988); and A.C. Enthoven, *Management Information and Analysis of the Swedish Health care System* (Lund: IHE, 1989).
9. B. Tomlinson, *Report of the Inquiry into London's Health Service, Medical Education, and Research* (London: HMSO, 1992).
10. F. Schut, "Workable Competition in Health Care: Prospects for the Dutch Design," *Social Science and Medicine* 35, no. 12 (1992): 1445-1455.
11. C. Ham, *Management and Competition in the New NHS* (Oxford: Radcliffe Medical Press, 1994).
12. H. Glennersteret al., *A Foothold for Fundholding* (London: King's Fund Institute, 1992).
13. World Health Organization, *Targets for Health for All* (Copenhagen: WHO, 1985).
14. Health Care and Medical Priorities Commission, *No Easy Choices-The Difficult Priorities of Health Care* (Stockholm: Ministry of Health and Social Affairs, 1993).
15. Government Committee on Choices in Health Care, *Choices in Health Care* (Rijswijk: Ministry of Welfare, Health, and Cultural Affairs, 1992).
16. Department of Health, *The Health of the Nation* (London: HMSO, 1992); and Department of Health, *The Patient's Charter* (London: HMSO, 1991).
17. C. Ham, F. Honigsbaum, and D. Thompson, *Priority Setting for Health Gain* (London: Department of Health, 1994).
18. OECD, *The Reform of Health Care.*