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Prologue: Most health care systems the industrialized world over share a number of common characteristics: they insure virtually all of their citizens, they allow patients to select their own physician, and they also constrain medical expenditures at some level that is deemed broadly acceptable to the polity. They also cope with a common reality: they operate in a state of continuous change, striving to adjust to the economic, political, and social demands of the moment. In this essay, Jeremy Hurst provides a glimpse of the nature of change in the 1980s in seven West European nations, all of which have pretty much stabilized the growth of their health care spending to a level that is commensurate with the growth of their national economies. Hurst is a senior economic adviser in the Department of Health, which oversees Britain’s National Health Service. He was one of the early pioneers among a small group of economists, health services researchers, and other analysts who have studied the health care systems of the industrialized world. In 1981, he spent a sabbatical year in the United States studying its health care system and that of Canada. In 1989 and 1990, he spent fifteen months at the Organization for Economic Cooperation and Development studying the reform of health care systems for its Working Party on Social Policy. Hurst, like most people who explore this ground, recognizes that the study of health care systems on a comparative basis is in its infancy. Nevertheless, Hurst and others have determined that many industrialized nations have found equitable ways of financing and delivering health care that achieve adequate outcomes (as far as they can be measured). The cost of most of this care is socialized throughout populations, with the rich supporting the poor, the healthy helping the sick, and the young subsidizing the old.
Lessons abound when countries reform their health care systems. During such a time, they think carefully about their health policy objectives, about their existing health care institutions, about the problems they face, and about the available solutions. This article is based on a study of recent reforms to the health care systems of seven Organization for Economic Cooperation and Development (OECD) countries, all of which happen to be in Western Europe: Belgium, France, Germany, Ireland, the Netherlands, Spain, and the United Kingdom.

International comparisons of health care reforms can offer an opportunity for countries to learn from each other’s experiences in managing health care systems, despite the well-documented differences between them in medical culture, in health care institutions, and in medical practices themselves. Most countries seem to share similar health policy objectives. Also, the apparent diversity in their health care financing and delivery systems disguises the fact that all are made up of different mixtures of some fairly common subsystems. I have written this overview with an eye to some recent European health care experiences that might be of interest to readers in the United States.

The Objectives Of Health Care Policy

Explicit and implicit statements of health care policy objectives among OECD countries suggest that all are pursuing fairly similar goals, although not all would attach the same importance to each goal. The following common objectives can be discerned. (1) Adequacy and equity in access: All citizens should have access to at least a basic minimum of health care, and there should be equal treatment for equal need where services are financed publicly. (2) Income protection: Patients should be protected from payments for health care that represent catastrophic threats to their income or wealth, and the payment for such protection should be related to individuals’ ability to pay. This will involve at least three types of transfer: insurance (the need for care is unpredictable); saving (the elderly use more services than the young); and income redistribution (the sick are often the poor). (3) Macroeconomic efficiency: Health expenditure should consume an appropriate fraction of gross domestic product (GDP); (4) Microeconomic efficiency: Health outcome and consumer satisfaction should be as high as possible for the available share of GDP spent on health services. This implies that costs should also be minimized for the appropriate mix of health care activities. (5) Freedom of choice for consumers: Consumers should be free to choose their doctors under both public and private insurance, and, with the advice of their doctors, they should be able to exercise some choice over subsequent treatments and
referrals to other providers. (6) Appropriate autonomy for providers: Doctors and other providers should be given the maximum freedom compatible with the attainment of the above objectives, especially in matters of medical and organizational innovation.

Needless to say, none of the countries in this study has succeeded in achieving all of these objectives, despite getting close to some of them. The fact that all have been involved in health system reforms over the past decade suggests that they are still moving toward reform.

Existing Health Care Financing And Delivery Systems

At first sight, the seven countries in this study exhibit a bewildering diversity of health care institutions. Yet, closer examination suggests that all are made up of different mixes of only about seven major subsystems of financing and delivery of health care, only one or two of which tend to dominate in any one country. The following classification draws on the work of Robert Evans, who describes several alternative sets of market and nonmarket relationships between four main sets of actors in health care systems: the population to be served; first- and second-level providers of health care; third-party payers; and the government as regulator.¹ One system found everywhere, at least in a supporting role, is direct, voluntary out-of-pocket payment for health care without any involvement of third parties. It is found everywhere for self-medication, for example. The other six systems are varieties of third-party payment. Three involve voluntary or private health insurance, usually with choice of insurer. Three involve compulsory or public health “insurance,” usually without effective choice of insurer. Quotation marks are used here because the public systems are often funded out of general taxation, as in Canada, and here the connection with the insurance principle is somewhat tenuous. Each type of insurance system, private or public, can be combined with each of three main methods of paying providers: indirect payment of providers by reimbursement of patients, often with cost sharing (there is no connection between the insurers and the providers); direct payment of providers (who are usually independent) by contracts usually involving fee for service or capitation; and direct payment of providers by global budgets and salaries in a vertically integrated system.⁴ The reimbursement and contract models generally have work-related payment systems and tend toward competition among providers. The integrated model usually lacks work-related payment, and the providers are usually under line management in the public sector, albeit with clinical autonomy in the case of physicians.

In sum, then, the three voluntary insurance systems are the private
reimbursement model (as in the U.S. Blue Cross); the private contract model (as in preferred provider organizations or prepaid group practice health maintenance organizations, HMOs, in the United States); and the private integrated model (as in the staff-model HMO). The three compulsory models that correspond to these are the public reimbursement model (as in Medicare payment of U.S. hospitals before 1983, when prospective payment by diagnosis-related groups was introduced); the public contract model (as in Medicare payment of HMOs); and the public integrated model (as in the U.S. Department of Veterans Affairs).

Apart from varying in their financing and delivery systems, countries vary in the way that their governments regulate their health care systems. A spectrum of regulation ranges from centralized command and control systems to decentralized arrangements with countervailing power between third parties and providers and a considerable measure of self-regulation. Armed with these distinctions, one can make a rough classification of the health care systems of the seven OECD countries.

**Belgium.** The Belgian health care system is dominated by a compulsory social health insurance system, which covers major risks for the whole population and minor risks for all but the self-employed. There is a mix of the public reimbursement model and the public contract model for ambulatory care; patients pay fees to doctors and are reimbursed for part of the cost. The fees, however, are set by contracts between insurers and providers. Public and private hospitals are paid directly by insurers, in the form of per diem payments under global budgets. The Belgian government is deeply involved in setting contributions, negotiating contracts with providers, and planning hospital investment.

**France.** The French health care system is arguably the most complicated of the systems in this study. Virtually the whole population is covered by a compulsory social health insurance system. As in Belgium, there is a mix of the public reimbursement and public contract models for ambulatory care. Patients’ fees are set by contracts between insurers and providers. About 25 percent of doctors, mostly specialists, extra-bill their patients. Private hospitals are paid per diem according to the contract model, but public hospitals are organized according to the integrated model, with salaried physicians and global budgets. The whole system is supplemented by voluntary insurance according to the reimbursement model. The French government is heavily involved in fee setting and in planning and budgeting for public hospitals.

**Germany.** The German system has a mix of compulsory social insurance for about 75 percent of the population and voluntary insurance for about 23 percent of the population. Slightly more than half of the voluntarily insured enroll with sickness funds; the rest insure privately.
The sickness funds pay doctors and public and private hospitals by fee for service under global budgets, according to the contract model. Private insurers reimburse patients. Although the federal government plays the leading role in regulating the system, it arranges for a balance of countervailing power between statutory insurers and providers, allowing considerable self-government. There is heavy regulation of private insurance.

**Ireland.** The Irish healthcare system has two eligibility categories, with about one-third of the population enjoying full eligibility for free health services funded out of general taxation and the remainder enjoying partial eligibility. General practitioners (GPs) are paid by capitation for fully eligible patients under the contract model and are paid fee for service, mainly out of pocket, by the partially eligible population. Hospital services are supplied mainly under the public integrated model, with some private beds in public hospitals. About 30 percent of the population has voluntary health insurance supplied by a single statutory insurer under a mix of the reimbursement and contract models. The Irish government is heavily involved in regulating public services and private insurance.

**The Netherlands.** The Dutch system has compulsory social health insurance for the whole population for chronic care and for about 70 percent of the population for acute care. The remainder of the population relies on voluntary insurance for acute care. The sickness funds pay GPs by capitation, specialists by fee for service, and hospitals (which are mainly private) by per diem patients under global budgets according to the contract model. Private insurers reimburse patients. Throughout the system, the price, volume, and capacity of both publicly and privately financed services are closely regulated by the Dutch government.

**Spain.** The Spanish health care system is dominated by a compulsory national health system funded by a mix of general taxation and social insurance contributions. Both ambulatory medical care and hospital care are funded mainly according to the integrated model, with salaried doctors and global budgets for most public hospitals. However, some public and private hospitals are funded according to the contract model. There are significant supplementary voluntary payments, both direct and through private insurance. Most private insurance follows the contract principle. The system is closely planned and regulated by the Spanish government.

**The United Kingdom.** The British National Health Service (NHS) offers comprehensive services to the entire population funded mainly out of general taxation. Independent. GPs are paid by a mix of capitation payments, fee for service, and allowances under the contract model. Until 1991, public hospitals were organized under the integrated model, with global budgets and salaried doctors. A small, supplementary voluntary
insurance sector operates mainly under the reimbursement principle. The public system is under the direct management of central government, albeit with delegation.

**Common elements and differences.** The health care systems of these seven countries have some major features in common as well as some important differences. All have universal, or virtually universal, third-party coverage. Also, all rely mainly on compulsory insurance. There is a secondary distinction between those public systems in which the source of funds is mainly social insurance and the insurance carriers are sickness funds, and those systems in which the source of funds is mainly general taxation and the “insurance” carrier is the government. However, whether there is a single government funding body, as in the United Kingdom, or over 1,000 sickness funds, as in Germany, what is important is that good and bad risks are compulsorily pooled together, and risk selection is eliminated either at a national level or within local communities or other population groupings. Only in Germany do significant numbers of people in higher-income groups rely on voluntary insurance for all risks. In Ireland and the Netherlands, many citizens rely on voluntary insurance for noncatastrophic risks. All of the countries have supplementary voluntary insurance.

Focusing on the dominant compulsory systems, all but one of the countries rely on just one or two of the three public models of financing and delivery of health care outlined above. Belgium relies on a mix of the public reimbursement and public contract models. Germany and the Netherlands rely only on the public contract model. Ireland and the United Kingdom rely on a mix of the contract and integrated models. Spain relies almost wholly on the integrated model. Only France relies on all three models. The pure public reimbursement model has been abandoned everywhere because of its vulnerability to moral hazard.

Belgium, France, and Germany have mainly work-related payment systems for providers within the public system, with fee for service for ambulatory care doctors and elements of fee for service in their hospital payment systems. Spain relies least heavily on work-related payment systems, with salaried physicians and global budgets throughout. Ireland, the Netherlands, and the United Kingdom occupied an intermediate position at the end of the 1980s) with different mixes of capitation payments and fee-for-service payment for general practitioners but rather inflexible global budgets for hospital services.

Finally, all have a mix of central regulation with some reliance on local self-regulation of their health care systems. Germany stands out in that its central regulation is deliberately designed to foster local self-government of health care. Private insurance tends to be heavily regulated where
it provides the main source of coverage for significant groups of the population, as in Germany, Ireland, and the Netherlands. It tends to be lightly regulated where its role is merely supplementary.

Performance And Problems Of The Seven Systems

Adequacy, equity, and income protection. Although by the late 1970s there was considerable satisfaction with the level of health insurance coverage in all seven countries, there was still concern in some about remaining inequities in access for certain groups and about geographical variations in services. In Spain and the Netherlands, critics charged that the social insurance systems were not universal. The problem here was not so much that the excluded groups lacked coverage—all or most could buy private insurance—but that such groups were not contributing to the compulsory insurance pool for the rest of the population.

Cost containment. In all seven countries, costs grew rapidly in the 1970s) judging by their health expenditure shares of GDP (Exhibit 1). To some extent, this resulted from planned extensions to the breadth and depth of public insurance coverage, But to some extent, it was the unwelcome consequence of generous insurance coverage and relatively open-ended payment systems. For example, at the beginning of the 1980s) Belgium, France, Germany, and the Netherlands all had per diem payments for hospital care without global budgets. The oil shocks in the 1970s followed by the recession of the early 1980s meant that repetition of such growth rates was unacceptable to governments. All adopted policies of cost containment, and growth in health expenditures decelerated sharply in these countries in the 1980s) judging by their health

<table>
<thead>
<tr>
<th>Health Expenditure As Percentage Of Gross Domestic Product (GDP), Seven OECD Nations, 1970-1989</th>
</tr>
</thead>
<tbody>
<tr>
<td>Belgium</td>
</tr>
<tr>
<td>France</td>
</tr>
<tr>
<td>Germany</td>
</tr>
<tr>
<td>Netherlands</td>
</tr>
<tr>
<td>Ireland</td>
</tr>
<tr>
<td>Spain</td>
</tr>
<tr>
<td>United Kingdom</td>
</tr>
</tbody>
</table>


* The 1970 estimate may be underestimated.
expenditure shares of GDP (Exhibit 1). The slowdown in growth was least pronounced in Belgium, France, and Spain. The reforms that led to this slowdown, or relative lack of it, are discussed below.

In some of the countries in this study, stability in the health expenditure share of GDP was discussed openly as a suitable target for cost containment. In others, stability in the health expenditure share can be adopted only as a rough benchmark for judging the success of cost containment policies. We would expect the desired health expenditure share to be constant if, say, the income elasticity of demand for health care were one; the rising costs of labor inputs and of cost-increasing technology were offset by rising productivity in health services; and demographic and morbidity changes were neutral. However, such circumstances might not apply. A much more stringent benchmark would be stability in real health expenditure itself, using a specific health service deflator. On this test, most of the countries in the study would have failed. Overall volume growth during 1980-1989 ranged from 2 percent in Ireland to 46 percent in France, according to figures reported to the OECD. The latter figure raises doubts about the deflator. However, the rank order of growth rates of real expenditure among the seven countries during this period was exactly the same as the rank order of growth rates of health expenditure shares of GDP. Consequently, my conclusions below about countries’ relative success with cost containment would be more or less the same, whichever of these benchmarks were used.

**Efficiency.** With the achievement of high levels of insurance coverage and success with cost containment, efficiency emerged as the main concern in most of the countries. The concerns took a rather different form between the systems or parts of systems that relied on relatively open-ended reimbursement or contract arrangements and fee-for-service payments to providers; and the systems or parts of systems that relied on capitation or the integrated model.

In systems that relied on the reimbursement or contract models with fee for service, there were fewer complaints about poor outcomes or poor service. A recent survey of satisfaction with healthcare systems by Robert Blendon and colleagues suggests that in the Netherlands, Germany, and France, between 41 and 47 percent of the population was satisfied with their health care system. This was below Canada (56 percent satisfied) but well ahead of the United States (10 percent satisfied). There was, however, concern in Germany and France about excessive growth in the volume of services. Belgium, France, Germany, and Ireland (which paid GPs by fee for service until 1989) had higher rates of consultations, prescribing, and acute hospital admissions than the Netherlands, Spain, and the United Kingdom (Exhibit 2). There was particular concern in
Exhibit 2
Rates Of Medical Care Activity In Seven OECD Nations, Various Years

<table>
<thead>
<tr>
<th>Country</th>
<th>Consultations with GPs and specialists per person, various years</th>
<th>Medicines prescribed outside of hospitals per person, 1982</th>
<th>Acute admissions per 100 persons, 1986</th>
</tr>
</thead>
<tbody>
<tr>
<td>Belgium</td>
<td>7.4</td>
<td>9.9</td>
<td>16.0</td>
</tr>
<tr>
<td>France</td>
<td>7.8⁹</td>
<td>10.0⁹</td>
<td>19.4</td>
</tr>
<tr>
<td>Germany</td>
<td>10.8⁶</td>
<td>11.2⁶</td>
<td>18.0</td>
</tr>
<tr>
<td>Netherlands</td>
<td>5.4⁴</td>
<td>3.7⁴</td>
<td>10.7</td>
</tr>
<tr>
<td>Ireland</td>
<td>6.5⁵</td>
<td>9.5</td>
<td>16.0</td>
</tr>
<tr>
<td>Spain</td>
<td>4.2</td>
<td>9.6⁵</td>
<td>9.0</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>5.2¹</td>
<td>6.5⁵</td>
<td>12.9</td>
</tr>
</tbody>
</table>

³ Public patients of general practitioners (GPs) only, 1987. Ireland paid GPs by fee for service up to March 1989.
⁴ B. O’Brien, Patterns of European Diagnosis and Prescribing (Office of Health Economics, 1984).
⁵ IMS Nederland B.V., Farmaceutische Almanak (1989).

some of these countries about excessive diagnostic tests and overemphasis on high-technology medicine at the expense of prevention and long-term care. Finally, several countries that relied on the reimbursement and contract models had been obliged to introduce heavy-handed and detailed regulations in an attempt to contain costs. These arrangements were increasingly seen as harmful to efficiency.

In countries that relied wholly or in part on the integrated model, with salaries and global budgets, there was reason for some satisfaction with the level of health outcomes achieved. For example, improvement in perinatal mortality in the United Kingdom was second only to that in Germany over the period 1980-1987 (Exhibit 3). There was, however, dissatisfaction with delays to treatment and what was seen as a paternal-

Exhibit 3
Perinatal Mortality In Seven OECD Nations, 1980-1987

<table>
<thead>
<tr>
<th>Country</th>
<th>Perinatal mortality (percentage of live and still births)</th>
<th>Percent change in perinatal mortality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Belgium</td>
<td>1.41%</td>
<td>1.04%⁶</td>
</tr>
<tr>
<td>France</td>
<td>1.29%</td>
<td>0.99%</td>
</tr>
<tr>
<td>Germany</td>
<td>1.16%</td>
<td>0.73%</td>
</tr>
<tr>
<td>Netherlands</td>
<td>1.11%</td>
<td>0.94%</td>
</tr>
<tr>
<td>Ireland</td>
<td>1.48%</td>
<td>1.04%</td>
</tr>
<tr>
<td>Spain</td>
<td>1.44%</td>
<td>1.06%³</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>1.34%</td>
<td>0.90%</td>
</tr>
</tbody>
</table>

⁶1986.
³1980-1986.
istic style of service, unresponsive to consumers’ wishes. The integrated model seemed to encourage waiting lists and, on some occasions, a take-it-or-leave-it attitude by providers toward minor or intractable illness. A plausible reason for this was that global budgets and salaries gave perverse incentives to providers. Blendon and colleagues’ survey suggested that only 27 percent of Britons were satisfied with their health care system. This could have been due to lower health expenditure per capita in the United Kingdom than in the Netherlands, Germany, or France. However, Sweden, with higher expenditure per capita than any of these countries but, like the United Kingdom, relying on the integrated model, achieved a satisfaction rating of only 32 percent.

Some of the contrasting problems of different arrangements are brought out by an Anglo-French comparison of medical care. French GPs (paid by fee for service) gave longer consultations, arranged more return visits, ordered more tests, prescribed more drugs, and worked longer hours (mainly waiting for patients) than their British counterparts (paid mainly by capitation and salary). On the other hand, they seldom worked in group practices, kept poorer records, and seldom delegated work. The picture for specialists was somewhat similar. French patients seldom waited for appointments with GPs or specialists or for admission to hospital. British patients were more often kept waiting on all counts. The (British) authors concluded, “The British patient under the NHS receives skilled, delayed and often impersonal treatment. The French patient receives skilled, prompt and personal treatment.” It should be pointed out, however, that France has about 80 percent more doctors per capita than the United Kingdom has.

Recent Reforms

The seven OECD countries have enacted recent reforms, which I classify here according to the main health policy objectives set out at the beginning of this article.

Adequacy, equity, and income protection. Despite calls for more voluntary financing of health care in several of the countries in this study, none of them made significant reductions in their compulsory schemes during the 1980s. Rather, in the middle of the decade, Spain extended its compulsory scheme from about 85 percent of the population to nearly 100 percent, by bringing in the self-employed. At the end of the decade, the Netherlands announced its intention to extend compulsory coverage for acute care to the 30 percent of the population that hitherto had been excluded. Also, the United Kingdom retained universal access to the tax-funded NHS, following a major review of the system by the Conser-
ervative government in 1988 (see the related article by Patricia Day and Rudolf Klein in this issue of *Health Affairs*).

True, there was a significant growth of voluntary health insurance in several of the countries during the 1980s, but this was usually growth in supplementary insurance, stimulated by the results of cost containment and some modest increases in cost sharing within compulsory schemes.

**Cost containment.** All seven countries in this study experienced considerable success with cost containment during the 1980s, compared with the 1970s, as Exhibit 1 suggests. In Ireland, the health expenditure share of GDP actually fell sharply. Extra cost sharing imposed on patients within public schemes, especially for nonessential pharmaceuticals and for the hotel element in inpatient hospital care, played a minor role in containing costs. Two factors contributed more substantively: partial or complete capping of direct third-party payments to providers, and determined government policies to use such mechanisms to contain costs. Mechanisms for capping total expenditure on hospitals were already in place in Ireland, Spain, and the United Kingdom. Germany introduced prospective global budgets for physicians’ associations in 1977. The Netherlands, Belgium, France, and Germany all introduced prospective global budgets for hospitals during the 1980s. Single-source funding was not a necessary condition for cost containment; the Netherlands and Germany succeeded with cost containment despite having multiple public and private insurers.

Three countries—Belgium, France, and Spain—had less success with cost containment than the others, judging by the rise in their health expenditure shares of GDP. In the case of Belgium and France, this was not for lack of policies favoring cost containment. Rather, it was likely to have been the unwanted result of their residual attachment to the reimbursement model and, more specifically, of fee-for-service payments for ambulatory care with fee controls but without global budgets, and, in the case of France, of the absence of global budgets for private hospitals. In the case of Spain, the economy grew rapidly in the 1980s, and the Spanish government chose to continue to build up health services from a relatively low base. Nevertheless, services were not allowed to grow as rapidly as they had done in the 1970s.

The suggestion that global budgets are effective in containing costs is borne out by a recent econometric study of OECD data, which found that global budgets for hospitals were associated with a 13 percent reduction in national health expenditure, other things being equal.\(^9\)

**Efficiency.** Three of the countries in the project carried out reforms that might be described as introducing or strengthening managed competition in provider markets. In two of the countries, the United Kingdom
and the Netherlands, a direct link can be traced with the ideas of Alain Enthoven, although there were also home-grown influences. Germany introduced a form of managed competition for ambulatory medical care at the time of the 1977 reform, which introduced global budgets for physicians’ associations. The global budgets were managed by the physicians’ associations, but they allowed for consumer-led competition between individual doctors because physicians were paid by fee for service and patients had free choice of doctors. In 1989, Germany moved toward competition between hospitals by allowing sickness funds, for the first time, to refuse to renew contracts with “surplus” hospitals. The United Kingdom announced arrangements to strengthen competition between general practitioners in 1987. Moreover, the major reforms announced in 1989 introduced separation between the purchase of hospital services by District Health Authorities, advised by GPs, and the provision of hospital services by competing public and private hospitals. Well-managed public hospitals were encouraged to become self-governing “trusts.” A key aim of the hospital reforms was to introduce work-related payment systems within global budgets, with a view to encouraging hospitals to become more effective. The Netherlands announced major reforms to its health care system in 1987, which proposed, among other things, the removal of any provider’s right to contract with any sickness fund. This opened the way to competition among providers.

There were also some important moves toward competition between insurers or “insurers” in two of the countries. As part of the major reforms announced in 1989, the United Kingdom introduced “fund holding” among GPs. This allowed for large, well-managed group practices to volunteer to hold part of the hospital budget, allowing their GPs to buy certain hospital services on behalf of their patients. This gave such GPs a role as active purchasers of health care and, taken together with the enhanced competition between GPs, gave British consumers some opportunity to choose their third-party payer. As part of the structural reforms announced in 1987, the Netherlands proposed to introduce a fully competitive market for basic health insurance within an extended social insurance system. This would provide insurance against more than 90 percent of health expenditure at risk. The key innovation was to be a central health insurance fund, which would receive income-related contributions from the population and would pay out risk-related premiums to competing sickness funds and private insurers, following consumers’ choice of insurer. This amounted to a sophisticated health insurance voucher scheme. There would be sharing in the cost of the premiums, no more than 15 percent of the cost, to encourage cost-conscious choice of insurers by consumers. The consumer’s share of
the premium would be specific to each insurer, a flat rate, and subject to competition between the insurers. There are some parallels here with the choice that U.S. Medicare offers of indemnity insurance or an HMO.

Discussion

All seven of the OECD countries in this study have shown a persistent or growing preference for universal, or neat universal, public health insurance arrangements. All have, in the past decade or earlier, more or less mastered the art of cost containment. This has been achieved mainly because their governments have adopted global budgets for public expenditure on health care and firm policies for making such budgets stick. There is a noticeable contrast here with Medicare’s experience with prospective payments for hospitals using diagnosis-related groups without global budgets. These developments mean that in these seven countries, central governments now take on the awesome responsibility of setting policy on the level of the bulk of health expenditure. It seems that central governments feel that only they can balance the marginal benefits with the marginal costs of extra public spending on health care.

Despite continuing variation in methods of paying providers and in methods of regulation between the seven countries, there are some signs of convergence on the public contract model and increased reliance on market or quasi-market relationships that permit governments to regulate at arms length. There are good reasons for convergence on the public contract model. The public reimbursement model is vulnerable to failures of cost containment. The public integrated model is vulnerable to failures of microeconomic efficiency. The contract model seems to have the potential for combining macroeconomic efficiency with microeconomic efficiency. It is also the most suitable of these three models for promoting appropriate autonomy among providers and a measure of self-regulation.

Some new varieties of the contract model are emerging from the reforms. In the case of first-level providers, it is normal for third parties to play a relatively passive and enabling role; allowing competition to be led by consumers. The question remains whether it is better to pay primary care doctors by capitation, by fee for service, or by some mix of the two, as in the United Kingdom. In the case of hospital care, there are more choices. The third-party payer can be a public or quasi-public monopoly insurer, such as a sickness fund, or it can be the primary care gatekeeper, as with the GP “fundholders” in the United Kingdom. In the former case, there are choices as to whether the third-party payer is a relatively passive fundholder-following, rather than leading, the referral patterns of primary care doctors—r is a relatively active purchaser. The
second role seems particularly appropriate where there are questions about the distribution of public expenditure among major patient groups, such as those in need of acute care and those in need of long-term care. There are choices as to how global budgets are combined with work-related payment systems for hospitals. There are also choices as to whether public third parties confine their contracts to public hospitals, creating an “internal” market; whether hospitals become or remain independent; or whether a mixture of hospitals is envisaged, as in the emerging system in the United Kingdom. It remains to be seen how competition will work out in practice in those systems where the public sector has an interest in both sides of the market.

The new arrangements that are proposed in the Netherlands, to be introduced in the early 1990s are arguably a new variant of the financing and delivery of health care in Europe, not represented among the seven models described above. They are, however, familiar in the United States in the form of the HMO option under Medicare. They promise to offer choice of insurer under a universal, and capped, social health insurance scheme. As such, they offer a fresh potential for improving efficiency while preserving the desired level of equity. The main question that arises, as with the HMO option under Medicare, is whether risk selection can be controlled by some combination of incentives (risk-related premiums), regulations (such as open enrollment), and an ethical code (spelling out the social responsibilities of the participating parties).

Finally, it is interesting to see that three researchers who have explored the theoretical characteristics of optimal payment systems for U.S. health services have drawn the following conclusion: “Payment systems that achieve the desired balance between protecting consumers from financial risk and controlling costs are characterized by generous insurance coverage and financial incentives on providers to control costs.” The best financial incentives for providers appear to be “mixed reimbursement system[s] . . . with some part of payment prospective and some part of payment cost based.” Alternatively, the payment system may be a mixture of capitation and partial reimbursement of provider costs. Also, “supply based policies are the preferred instruments for cost control. . . . Cost based reimbursement is never part of an optimal health care payment system.” For examples of such “optimal” payment systems, health policymakers need look no further than the reformed health care systems of the seven OECD countries I have outlined above.

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NOTES

4. In this article, the term reimbursement is normally used only to describe compensating patients wholly or in part for medical care outlays. This corresponds to British and French usage (remboursement). The direct payment of providers by third parties is referred to as “payment of providers.”
6. Ibid.
8. Ibid.
15. Enthoven, Reflections on the Management of the NHS.
19. Ellis and McGuire, “Optimal Payment Systems for Health Services.” This is the only time in this article that the term reimbursement is used in the sense of payments to providers.