Health Affairs

At the Intersection of Health, Health Care and Policy

Cite this article as:
R B Saltman and J Figueras
Analyzing the evidence on European health care reforms
Health Affairs, 17, no.2 (1998):85-108

doi: 10.1377/hlthaff.17.2.85

The online version of this article, along with updated information and services, is available at:
http://content.healthaffairs.org/content/17/2/85

For Reprints, Links & Permissions:
http://healthaffairs.org/1340_reprints.php

E-mail Alerts :
http://content.healthaffairs.org/subscriptions/etoc.dtl

To Subscribe:
http://content.healthaffairs.org/subscriptions/online.shtml

Health Affairs is published monthly by Project HOPE at 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133. Copyright © 1998 by Project HOPE - The People-to-People Health Foundation. As provided by United States copyright law (Title 17, U.S. Code), no part of *Health Affairs* may be reproduced, displayed, or transmitted in any form or by any means, electronic or mechanical, including photocopying or by information storage or retrieval systems, without prior written permission from the Publisher. All rights reserved.

Not for commercial use or unauthorized distribution

Downloaded from content.healthaffairs.org by *Health Affairs* on December 17, 2014
by guest

المنارة للاستشارات

www

Analyzing The Evidence On European Health Care Reforms

Experience in western European health care systems suggests lessons for reform in the United States, according to a major international comparison by the World Health Organization.

by Richard B. Saltman and Josep Figueras

PROLOGUE: What level of government regulation and/or intervention is optimal for a successful health care system? This paper sheds some light on the subject by reporting the results of a broad survey of health care systems in western Europe. The project drew together what the authors call the available "epidemiological, sociological, organizational behavior, and management evidence" as well as financial and economic information about these systems. Despite the diversity of the nations studied, some overarching themes emerge among nations that have had success reforming their health care systems. Of particular interest to U.S. policymakers, the authors discuss the relative success of supply-side reforms as opposed to cost sharing and other demand-side tactics.

Richard Saltman and Josep Figueras are affiliated with the Health Systems Analysis Unit of the World Health Organization (WHO)/Regional Office for Europe in Copenhagen, Denmark. They are co-project leaders of that office's ongoing study of health care reforms.

Saltman is also professor of health policy and management at the Rollins School of Public Health of Emory University in Atlanta and has been a consultant to health system reform projects for the Organization for Economic Cooperation and Development (OECD) and the World Bank. He holds a doctorate in political science from Stanford University.

In addition to his position as regional adviser for health systems analysis at WHO, Josep Figueras is a lecturer in health services management at the London School of Hygiene and Tropical Medicine. He received a doctorate in health planning and financing from London University.

© 1998 The People-to-People Health Foundation, Inc.

Downloaded from content.healthaffairs.org by Health Affairs on December 17, 2014 by guest
المنارة للاستشارات
www

ABSTRACT: Health system reform, in Europe as elsewhere, has often been influenced as much by theory and conjecture as by fact and experience. In a study published in September 1997, the Regional Office for Europe of the World Health Organization (WHO) drew together the available evidence about the health care systems in the fifty-one countries of the European region. This paper focuses on western European countries. It reviews a variety of policy strategies and then explores implications from this European experience for the formulation of U.S. health care policy.

HEALTH POLICY DEBATES around the world comprise a complicated cocktail of validated evidence intermixed with presumption and ideology. Although such debates appropriately reflect differing political, social, and clinical cultures, policy making based on sporadic access to and/or misinterpretation of available health systems research is more difficult to justify. This is not to argue in favor of a "cookbook" of standardized "recipes" for health system reform. Policymakers who have sought to balance the multiple demands involved in designing and implementing such reforms recognize that success requires as much art as science. At the same time, however, comparative experience gathered over the past ten years can, if properly assessed and digested, provide a sound evidence-based contribution to national health policy initiatives.

Since 1991 several international bodies, including the Organization for Economic Cooperation and Development (OECD), the European Union, and the World Bank, have published studies dealing with a number of aspects of health sector reform.[1] The World Health Organization's (WHO's) Regional Office for Europe recently completed a study of health system reform across the entire European region, to provide a broad conceptual base for comparative analysis.[2] It incorporated epidemiological, sociological, organizational behavior, and management evidence in addition to information regarding financial and cost containment efforts.

Comparing health care systems and reforms across different countries poses methodological challenges. The definition of the term *reform* lacks universal consensus regarding the degree of change that constitutes health sector reform. Analysts also sometimes seek to apply a monodisciplinary logic, such as that of neoclassical economics, in an effort to explain reform mechanisms and outcomes. However, the diversity across countries in social values, cultural patterns, and socioeconomic levels of development, as well as the inherent complexity in designing and implementing reforms, demands a broader approach. Consistent with these observations, the WHO study defined *reform* to mean an intentional, sustained, systematic process of structural change to one or more major health sector subsystems.

Downloaded from content.healthaffairs.org by *Health Affairs* on December 17, 2014
by guest
المنارة للاستشارات
www

The current period of health sector reform across Europe, broadly construed, began in the mid-1980s, prompted by a conjunction of demographic, technological, and financial pressures with a desire for greater efficiency, effectiveness, and patient choice and influence within existing service delivery systems. There also was rapidly expanding interest in quality of care. Many nations increased their public policy focus on the importance of administrative flexibility and entrepreneurism, as the Cold War ended in central Europe in 1989 and in the former Soviet republics in 1991. A health policy regime emerged across Europe that has sought to add institutional-level microefficiency to the existing achievement earlier in the 1980s of system-level macroefficiency.[3]

Health policymakers in western Europe have developed a range of strategies for policy intervention at various levels. For the WHO study's analysis, these policy responses were synthesized into two groupings. The first consisted of four themes that appear consistently—in a variety of guises—in many western European countries. The second looked at specific policy strategies that have been adopted, categorizing them within three main subsectors. Although the WHO study reviewed health policy development across the WHO European region's fifty-one member countries, this paper focuses primarily on recent experience in western Europe. The conclusions that emerge lead to several intriguing if controversial observations about the current U.S. health policy debate.

Four Reform Themes

Four broad themes influence organization and behavior within nearly all western European health care systems. Although these four themes do not reflect completed reforms in every country, they capture common challenges for health policymakers.

■ **Roles of state and market.** The first common theme is the changing role of state and market in health care.[4] Starting in the late 1980s many European governments began to reexamine the structure of governance within their health care systems. In many countries the presumption of public primacy is being reassessed.[5]

The greatest pressure for change has been in the relative role of the private sector in the operation and, in some countries, the funding of health care services. Although the debate on this issue sometimes has been simplified into "state versus market," in practice the issues are more complicated.[6] There is no single concept of a market that can be adopted for use within a health care system. Rather, market-style mechanisms include a number of different specific instruments such as consumer sovereignty (patient choice), negotiated contracts, and open bidding, which can be introduced on the funding, allocation, or

Downloaded from content.healthaffairs.org by Health Affairs on December 17, 2014
by guest
المنارة للاستشارات
www

production subsectors of the system. In practice, rather than a monolithic commitment to one of two abstractions—state or market—health care systems in both western and eastern Europe confront a range of smaller decisions on each of several mechanisms.

A number of countries use elements of both models—combining increased use of market-style incentives with continued public-sector ownership and operation of facilities. This hybrid approach has been given a number of different names: *internal market*, *public competition*, and *quasi-market*.[7] The design and implementation of this type of planned market has played an important role in health care reform in Sweden, the United Kingdom, Finland, Italy, and Spain, as well as in various central and eastern European (CEE) and Commonwealth of Independent States (CIS) countries.

■ **Decentralization.** The second broad theme in European health care reform is the decentralization of administrative and sometimes policy authority to lower levels in the public sector and to the private sector. In health sectors throughout Europe, a variety of state functions are decentralized within the public sector to regional and/or municipal authorities.[8] Decentralization is viewed as a response to the drawbacks of large, centralized public institutions, such as poor efficiency, slow innovation, and lack of responsiveness to patients' preferences.

Successful decentralization, however, requires a supportive environment. This includes sufficient local administrative and managerial capacity, ideological certainty in the implementation of tasks, and readiness to accept several interpretations of one problem. Experience in a number of countries, particularly in postcommunist Europe, shows that when these preconditions are not met, decentralization has negative consequences such as service fragmentation, increased inequity, political manipulation by stronger interests, and a weakening of public-sector regulatory functions.[9] Experience in these countries also indicates that there are certain areas where decision-making power should not be decentralized. These include the basic framework for health policy; strategic decisions on the development of health resources; regulation concerning public safety; and monitoring, assessing, and analyzing both the health of the population and the quality of health services.

■ **Patients' rights.** A third theme of health system reform in Europe is citizen empowerment and patients' rights. There is a growing chorus from patients that they be allowed a greater say in logistical (selecting their physician and hospital) and clinical (participating in elective medical decision making) matters. They also are insisting on participation in local policy making.

In varying mixes, European nations allow patients to select their

Downloaded from content.healthaffairs.org by *Health Affairs* on December 17, 2014
by guest
المنارة للاستشارات
www

general practitioner, their specialist(s), their hospital, or their hospital physician. Choice of specialists and hospitals (for elective procedures) remains controversial. There is no clear consensus among countries as to whether patients should be allowed to refer themselves to specialist care or whether general practitioners should serve as gatekeepers to specialty care.

In several countries, including Germany and Israel, subscribers officially can choose their insurer.[10] In the Netherlands the attempt to introduce competition among insurers created a severe challenge to the maintenance of solidarity because of difficulties in developing a suitably sensitive risk adjustment formula for capitated payments.[11] In some CEE and CIS countries competitive insurance has proved to be expensive and to provide little additional service.[12]

A number of European countries, notably Finland and the Netherlands, have introduced mechanisms to protect patients' rights.[13] This does not necessarily involve public participation, but it is an attempt to make health service provision more sensitive to patients' concerns about the accountability of providers and the confidentiality of information. The Dutch Act on the Medical Contract treats the physician/patient relationship as a "special contract" in civil law. This gives the individual patient a direct claim on the doctor and the ability to enforce those rights through the courts, without any further action by government.

■ **Role of public health.** A fourth broad theme concerns efforts to increase the role of public health in health policy making. Current challenges to the health of the European population, such as the growing disparity in life expectancy and mortality between east and west, should certainly influence the reform approaches in CEE/CIS countries. In western Europe as well, strong public health concerns about issues of health promotion and disease prevention also exist.

In practice, health services have only a limited impact on the health status of a population. Key determinants of health lie outside the health sector; policies in areas such as education, housing, employment, and agriculture often have a greater impact on health. Recognizing this, public health advocates and organizations such as WHO have acted to increase the role of intersectoral initiatives in decisions about future health sector reforms.[14] Recent reforms leading to separation of purchaser from provider, decentralization, and a larger role for market mechanisms offer the opportunity for public health to take on new roles, including participating in purchasing health care and in implementing mechanisms to evaluate the effectiveness, efficiency, and quality of health services.

Downloaded from content.healthaffairs.org by Health Affairs on December 17, 2014
by guest

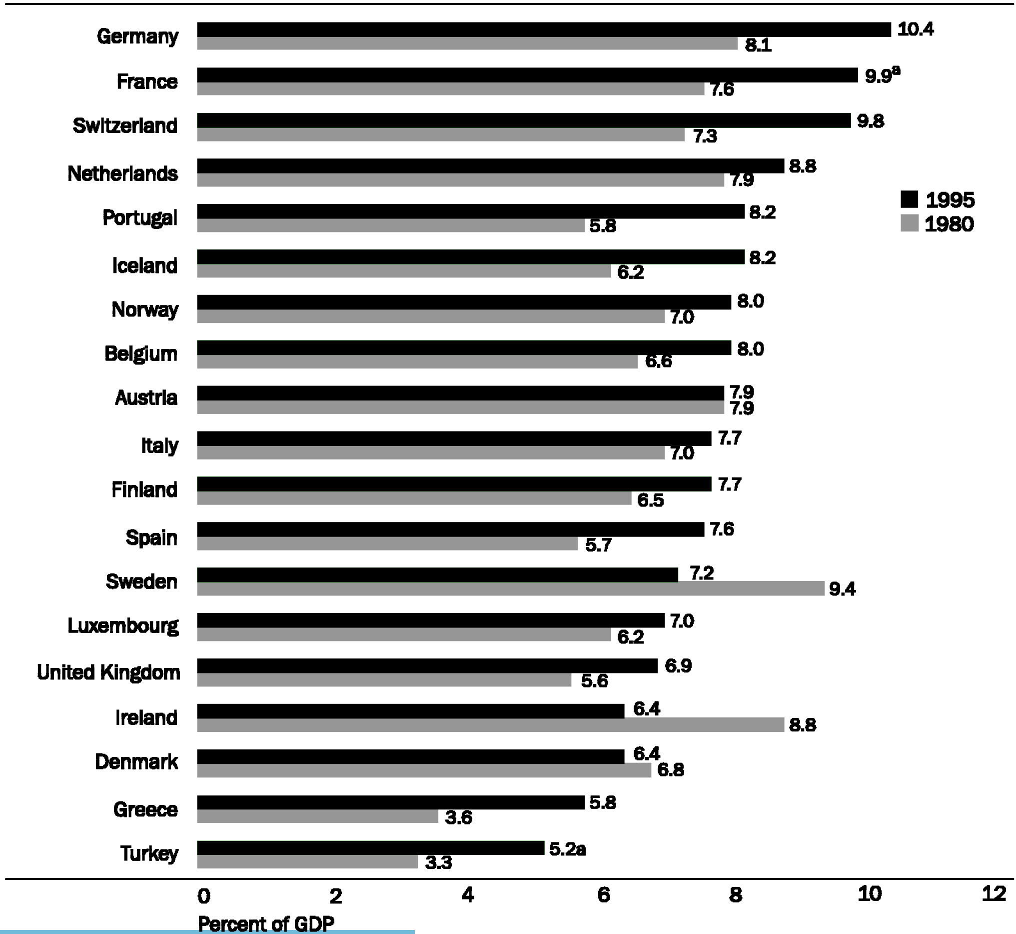
Strategies For Policy Intervention

In cataloguing reform strategies, the WHO study classified the evidence on the impact of different policy interventions according to four general categories: confronting resource scarcity, funding health care systems, allocating resources, and delivering services.

■ **Confronting resource scarcity.** Reform strategies address resource scarcity mainly by containing aggregate expenditures. Exhibit 1 presents a snapshot of the growth of health spending in western Europe. In response, countries have pursued or considered pursuing strategies that influence both the demand for and the supply of health care services. Cost control strategies on the demand side have focused on two controversial areas: cost-sharing arrange-

EXHIBIT 1

Total Expenditure On Health As A Percentage Of Gross Domestic Product (GDP), Western Europe, 1980 And 1995



SOURCE: Organization for Economic Cooperation and Development (OECD) Health Data, 1997.
[a] 1994.

Downloaded from content.healthaffairs.org by *Health Affairs* on December 17, 2014
by guest

المنارة للاستشارات

www

ments and priority setting for publicly funded services.

Cost sharing. Most western European countries place little emphasis on cost sharing as a tool for either raising revenue or containing costs for physician and hospital services.[15] About half use some form of cost sharing for first-contact care, and about half apply cost sharing to inpatient and specialty outpatient care (Exhibit 2). However, patient copayments tend to be nominal and often are accompanied by a set of categorical exemptions. Only a few countries rely on cost sharing as a significant source of health sector revenue, and most patients in these countries typically purchase supplementary private insurance to defray out-of-pocket spending. In France, for example, 84 percent of the population carries private supplemental coverage that reimburses them for copayments.[16] The only exception to this general pattern is widespread cost sharing for pharmaceuticals, although here, too, cost sharing typically is buffered for pensioners, children, and the chronically ill. In CEE/CIS countries there is substantial real cost sharing, particularly in the inherited and as yet still unresolved problem of informal ("under-the-table") payments made directly to doctors or, in some countries, to hospitals.[17]

Priority setting. Making choices about the allocation of resources among competing demands has always existed in European health care systems. What is new is the pressure to move from implicit choices made by individual physicians to explicit choices made by a public political process. In recent years several countries including Finland, the Netherlands, Norway, Spain, and Sweden have established official inquiries to examine priority setting more systematically.[18] Some national reports have emphasized methods that measure the need for service as well as the cost and effectiveness of available procedures. There is, however, growing recognition that priority setting cannot be reduced to a technical exercise and that it should be combined with public debate. To date, western European governments have been willing to restrict payments for only a few marginal services.[19] Where policymakers have sought to adopt "basic packages" of services—for example, in Israel and the Netherlands—governments' unwillingness to restrict access to care has resulted in the labeling of 95–100 percent of all services as "basic."[20]

Supply-side strategies. A wide range of cost containment strategies have been pursued on the supply side. These include reducing the production of physicians and the number of hospital beds; controlling the price of the workforce or the supplies used to provide care; setting global expenditure ceilings or global budgets for providers; changing the methods of paying professionals; influencing the use of resources authorized by physicians; optimizing the use of technologies; and introducing more effective delivery patterns such as substi-

Downloaded from content.healthaffairs.org by Health Affairs on December 17, 2014
by guest

EXHIBIT 2
Patient Cost Sharing In Western European Health Care Systems

	Type of provider		
Country	**First contact**	**Referral**	**Pharmaceuticals**
Austria	80% of population has no cost sharing; the rest have coinsurance or are exempt due to low income	Mix of copayment and coinsurance (with exemptions); out-of-pocket liability limited to first 28 days in hospital	Copayment for prescribed drugs; nonprescription drugs are excluded
Belgium	Narrow range of copayments or coinsurance (less for low-income persons); extra-billing allowed	Variable copayments according to fee schedule; benefit reduced after 90 days (lower copayment for those with low income)	Copayment or coinsurance with rates ranging, by type of drug, from 0% to 85%; drugs not on positive list are excluded
Denmark	No cost sharing	No cost sharing	Variable coinsurance rate (0–50%) applied to reference price; drugs not on formulary are excluded
Finland	None; choice of annual prepayment or copayment, or copayment with out-of-pocket maximum; varies by municipality	Maximum payment levels per hospital day and per specialist visit	Coinsurance
France	Coinsurance; extra-billing allowed for defined categories of physician	Coinsurance for per diem rate plus copayment to cover meals; no out-of-pocket liability after 30 days	Most subject to coinsurance; no coverage for items not on national list of approved drugs
Germany	No cost sharing	Flat copayment for up to 14 days per year; thereafter, no out-of-pocket liability	Variable copayment; reference pricing; items on negative list are excluded
Greece	No cost sharing, although extra-billing is common among private physicians	No cost sharing for inpatient hospital care; some coinsurance for diagnostic services	Coinsurance
Iceland	Copayment, with higher rate for visits outside of normal working hours; higher copayment for home visits; out-of-pocket maximum	No cost sharing for inpatient hospital care; mix of copayment and coinsurance for specialist and hospital outpatient care; copayment for diagnostic services; out-of-pocket maximum	Mix of deductible per "day" of prescription, plus coinsurance, up to a defined out-of-pocket maximum; some items are entirely free and others are excluded
Ireland	No cost sharing for "Category I" population (34.5% in 1996); full charges for others, unless they buy insurance; insured persons face an annual deductible, which also serves as an out-of-pocket maximum	No cost sharing for "Category I" population in public hospitals; for the rest, copayment for first hospital outpatient visit per episode and copayment per diem for the first 10 days of public hospital care per year; insurance buys free care in public and private hospitals	No cost sharing for "Category I" population; others face a monthly deductible, which also serves as an out-of-pocket maximum for the month; items on the negative list of drugs are excluded
Italy	No cost sharing	No cost sharing for inpatient care; cost sharing introduced in 1990 in public hospitals for diagnostic procedures, specialist visits, and spa treatment	Deductible only for essential drugs; most other drugs have a deductible plus coinsurance; some drugs are excluded
Luxembourg	Coinsurance	Per diem copayment indexed to inflation	Coinsurance for outpatient drugs, except for "special diseases"; inpatient drugs are free
Netherlands	No cost sharing for publicly insured; varies for privately insured	No cost sharing for publicly insured; varies for privately insured	Reference price system; no coverage for excluded items

Downloaded from content.healthaffairs.org by *Health Affairs* on December 17, 2014
by guest

www
المنارة للاستشارات

EXHIBIT 2
Patient Cost Sharing In Western European Health Care Systems (cont.)

	Type of provider		
Country	**First contact**	**Referral**	**Pharmaceuticals**
Norway	Cost sharing, with annual out-of-pocket maximum for all services	No cost sharing for inpatient care; cost sharing for diagnostic services	Reference price system for essential drugs
Portugal	Cost sharing	Cost sharing	Two coinsurance rates according to type of drug; some items are free, but others are excluded
Spain	No cost sharing	No cost sharing	Coinsurance; items not on approved list are excluded
Sweden	Copayment, with annual out-of-pocket maximum for all services except inpatient care	Copayment per diem for inpatient care; copayments for therapeutic referrals	Copayment for first item prescribed; greatly reduced copayment for additional items; reference pricing for items with generic equivalents
Switzerland	Annual deductible plus coinsurance	Copayment per diem for hospital care	Cost sharing varies among insurers; items on negative list are excluded
Turkey	Mostly private providers who charge on a fee-for-service basis	Social insurance schemes cover all charges; uninsured face user fees	All social insurance schemes have coinsurance for outpatient drugs
United Kingdom	No cost sharing	No cost sharing, except for amenity hospital beds	Copayments, but 83% of prescriptions are exempt; items on negative list are excluded from National Health Service coverage

SOURCE: J. Kutzin, "Appropriate Role for Patient Cost Sharing in European Health Care Systems," in *Critical Challenges for Health Care Reform in Europe* (forthcoming).

tution of outpatient and primary care for more expensive inpatient care. These strategies have met with different degrees of success. Experience to date indicates that establishing budgets for the health care system or for each main subsector, based on targets and staffing limits, is among the more effective means of containing costs.[21]

■ **Funding systems equitably.** Countries with Beveridge-style funding systems—Nordic countries, Ireland, the United Kingdom, and southern countries (Greece, Italy, Portugal, and Spain)—have taken a variety of paths to a predominantly tax-funded health care system, but universal or near-universal access to care exists in all of these systems.[22] Their citizens remain committed to a public-sector role as the main provider of funds, ensuring universal access to care and equitable geographical distribution of resources.[23]

Countries with Bismarck-style funding systems (Austria, Belgium, France, Germany, Luxembourg, and Switzerland) typically have long-established, statutory insurance–based systems. Although inspired by similar principles, these individual social insurance systems differ significantly in their particular arrangements. Nearly all are subject to close regulation by government, which has been growing, on grounds either of cost containment (by, for in-

Downloaded from content.healthaffairs.org by Health Affairs on December 17, 2014
by guest

stance, putting a ceiling on premiums) or of equity and solidarity.[24] Most CEE/CIS countries are moving from state budgets toward health insurance funded largely through compulsory payroll contributions.[25]

In western Europe both tax-based and social insurance systems have been stable in the recent past, with major change confined to several Mediterranean countries that have moved from social insurance to tax-based arrangements.[26] No western European country has sought to renege on its commitment to ensure universal access to health services.[27] Opt-outs from the publicly accountable system are possible in only a few western European countries, Germany and the Netherlands being the two best-known examples; however, these are allowed in Germany (and required in the Netherlands) only for relatively wealthy persons, who purchase health insurance on their own.[28] Proposals in Italy and Portugal to establish opt-out arrangements had to be withdrawn after they encountered resistance. This pattern contrasts sharply with many CEE/CIS countries, where official policy statements maintaining universal access no longer reflect a reality in which patients need out-of-pocket payments or private insurance to receive adequate care.[29]

A few European countries are seeking to reform their funding systems through the use of competition among private insurers.[30] Germany, Israel, the Netherlands, and Switzerland have all considered, are attempting to introduce, or have introduced limited competition among not-for-profit and/or for-profit insurers.

■ **Allocating resources effectively.** As pressures on health care systems to use available funds efficiently and more effectively have increased, a number of countries have sought to reconfigure the allocation mechanisms by which they distribute funds to service providers. Key reform strategies have addressed contracting, payment of professionals and institutions, purchasing of pharmaceuticals, and allocation of capital investments.

Contracting. A number of countries in Europe with tax-based funding have begun to move away from fully integrated models of provision to a separation of public or quasi-public third-party payers from providers. Contracting in these countries is increasingly viewed as an alternative to traditional command-and-control models of health care management in a publicly funded system.[31] This payer/provider split enables negotiations on price and quality and ensures provider compliance. In this model, public authorities at the district (United Kingdom), county (Sweden), or municipality (Finland) levels can act as purchasing agents on behalf of their citizens.[32] A further refinement is that part or all of hospital budgets are allocated to a primary health care agent (general practitioner, or GP,

Downloaded from content.healthaffairs.org by Health Affairs on December 17, 2014 by guest

المنارة للاستشارات

www

group in the United Kingdom; local subcounty political boards in Sweden; and municipal health and social affairs boards in Finland) to purchase specialty care for referred patients.

Contracting has been a part of Bismarck-style, social insurance–based systems since these systems' inception. However, these contracting arrangements existed primarily to guarantee a stable relationship between insurer and provider. Until recently such contracts did not focus on price or efficiency, nor were they understood to be contestable. Countries such as Germany and the Netherlands are now discussing the possibility of introducing more selective contracting of provider institutions based on price and quality.[33]

Payment shifts. A second strategy for reconfiguring allocation is to shift payment for professionals and institutions toward more performance-related approaches. The methods of paying for primary care practitioners, in particular, are undergoing substantial reform. As Exhibit 3 suggests, a wide range of approaches have been adopted in European countries. In insurance-based countries, primary care practitioners are usually independent contractors, mainly paid by fee-for-service tied to a negotiated schedule, often with some form of earnings ceiling.[34] Countries such as France and Germany have introduced a series of measures, including price regulation by adjusting fee-for-service scales; control of the quantity and mix of services through penalties for overuse; target expenditure levels; and capped overall spending. These mechanisms have been relatively effective in controlling costs at the macro level, but little is known about their impact in terms of equity and quality at the micro level.

By contrast, tax-funded health care systems tend to employ primary care practitioners directly and pay them a salary. However, primary care physicians in Denmark, Norway, Italy, and the United Kingdom are self-employed and paid by capitation or by a mix of salary, capitation, and fee-for-service. In general, cost containment problems in fee-for-service systems and low staff motivation in salary-based systems have stimulated a number of countries to adopt mixed payment systems. Such systems—with a substantial capitation-based component—appear to have been better able to achieve micro and macro efficiency objectives.

Similar trends can be observed in the reform of hospital payment systems, which fall into two broad categories: prospective budgeting and service-based payment. The most prevalent characteristic of prospective budgeting systems is that spending limits for a defined period are determined in advance (Exhibit 4). Prospective budgets based on historically incremental norms have been typical of tax-based systems. Several countries within this group are now moving

Downloaded from content.healthaffairs.org by Health Affairs on December 17, 2014 by guest

EXHIBIT 3
Primary Care Physician Payment In Selected European Countries

Country	Type of payment	Physician consultations per capita, 1993	Gatekeeping
Austria	Fee-for-service	6.1	No
Belgium	Fee-for-service	8.0	No
Denmark	28% capitation (flat fee); 63% fee-for-service; 9% allowances	4.8	Yes
Finland	Salary	3.9	Yes
France	Fee-for-service; salary in health centers	6.3	No
Germany	Fee-for-service	12.8[a]	No
Greece	Salary	–[b]	No
Ireland	Fee-for-service if higher income; capitation (age-differentiated fee) if lower income	6.6[c]	Yes
Italy	Capitation (age-differentiated fee)	11.0[c]	Yes
Luxembourg	Fee-for-service	–[b]	No
Netherlands	Fee-for-service if higher income; capitation (age-differentiated fee) if lower income	5.7	Yes
Portugal	Salary	3.1	Yes
Spain	Salary; capitation (age-differentiated fee)	6.2[d]	Yes
Sweden	Salary	2.9	No
Switzerland	Fee-for-service	11.0[a]	No
United Kingdom	Capitation (age-differentiated fee); fee-for-service; allowances and target payments	5.8	Yes

SOURCES: Organization for Economic Cooperation and Development (OECD) Health Data, 1997; and L. Rochaix, "Performance-Tied Payment Systems for Physicians," in *Critical Challenges for Health Care Reform in Europe* (forthcoming).
[a] 1992.
[b] Not available.
[c] 1988.
[d] 1989.

to activity-adjusted prospective budgeting to account for the level of services provided. Beginning from a different, retrospective-based system, several insurance-based health care systems in western Europe during the 1980s and 1990s (including Austria, Germany, and the Netherlands) also have adopted prospective global budget systems that incorporate some measures of hospital activity such as bed days or cases.[35] In these mixed payment systems, the prioritization of cost control is complemented by a concern for efficiency. A growing number of countries, including France and Ireland, are applying more sophisticated forms of adjustment for activity within a budget framework such as measures of case-mix and quality. Several European countries finance hospitals based on the volume of services provided. To avoid the problems generated by the open-ended nature of a volume-oriented approach, some countries have introduced prospective pricing combined with contracting. This allows payers to require hospitals to achieve specific objectives such as cost control and effective use of resources.

Downloaded from content.healthaffairs.org by *Health Affairs* on December 17, 2014
by guest
المنارة للاستشارات
www

EXHIBIT 4
Predominant Approaches To Funding And Financing Operating Costs For Acute Inpatient Hospital Services, Selected Countries In The European Region

Country	Predominant funding source	Predominant approach to financing operating costs: Prospective global budgeting	Predominant approach to financing operating costs: Service-based financing
Austria	Social insurance		Based on length-of-stay (Sickness Fund) and lump-sum subsidies (Ministry of Health)
Denmark	Decentralized, taxation	Based on historical expenditure	
England	Taxation		Based on activity determined by contracts
Finland	Decentralized, taxation		Based on bed days and services reimbursed by municipalities
France	Social insurance	Adjustment for activity/case-mix	
Germany	Social insurance	Planned replacement of fixed budgets by adjustment for activity	
Hungary	Social insurance		Performance-related financing system based on diagnosis-related groups
Ireland	Taxation	Adjustment for case-mix	
Italy	Taxation	Adjustment for case-mix	
Netherlands	Social insurance	Adjustment for activity	
Norway	Decentralized, taxation	Adjustment for case-mix	
Poland	Taxation	Based on historical expenditure	
Sweden	Decentralized, taxation	Prospective departmental budgets combined with activity-based financing	

SOURCE: M. Wiley, "Financing Operating Costs for Hospital Services," in *Critical Challenges for Health Care Reform in Europe* (forthcoming).

■ **Delivering services efficiently.** Policymakers have sought to identify measures that act directly on the performance of health care institutions and providers. Measures adopted variously in a number of countries have included developing quality-of-care programs, restructuring the internal and external organization of hospitals, enhancing the capacities of primary care, and using less intensive forms of care.

European countries are recognizing that well-formulated health care reform should include efforts to improve both the processes and the outcomes of the care provided. A wide range of related strategies have emerged under this "outcomes movement," among them quality assurance, health technology assessment, continuous quality improvement, systematic reviews, and clinical guidelines. A number of European countries participate in the Cochrane Collaboration, based in the United Kingdom, which seeks to prepare and maintain systematic reviews of available medical evidence.[36]

Downloaded from content.healthaffairs.org by Health Affairs on December 17, 2014
by guest
المنارة للاستشارات
www

Recent reform of service delivery has also involved the decentralization of management functions to provider institutions, coupled with the development of more effective management within institutions. In several countries, including Finland, Sweden, and the United Kingdom, the traditional hierarchy between health authorities—at the regional, area, or local level—and hospital providers is being replaced by more decentralized management arrangements.[37] A growing number of countries are introducing some form of independently managed hospitals, variously known as self-governing trusts, public firms, or independent public hospitals.[38]

A particularly important group of delivery-reform strategies concerns the restructuring of primary and hospital care via substitution among several service levels.[39] Patterns of health care organization and delivery across care settings have been changing because of growing pressures to contain costs, epidemiological changes related to demographics, increased expectations of patients, and the development of new technologies.

This process has raised the profile of primary and community health care in many countries. There is growing recognition that more cost-effective alternatives to inpatient hospital care exist and that hospital facilities can be further reduced. In almost all western European countries, the total number of hospital beds fell significantly between 1980 and 1995 (Exhibit 5), probably as a result of cost containment policies, changes in technologies, and increased reliance on primary and social care. Policymakers in several countries believe that hospital restructuring requires a combination of market and planning mechanisms. For instance, efforts to close hospital beds in the United Kingdom have shown that this process cannot be left to market devices but requires a planned approach that can achieve savings while maintaining access.[40]

Assessing The Evidence

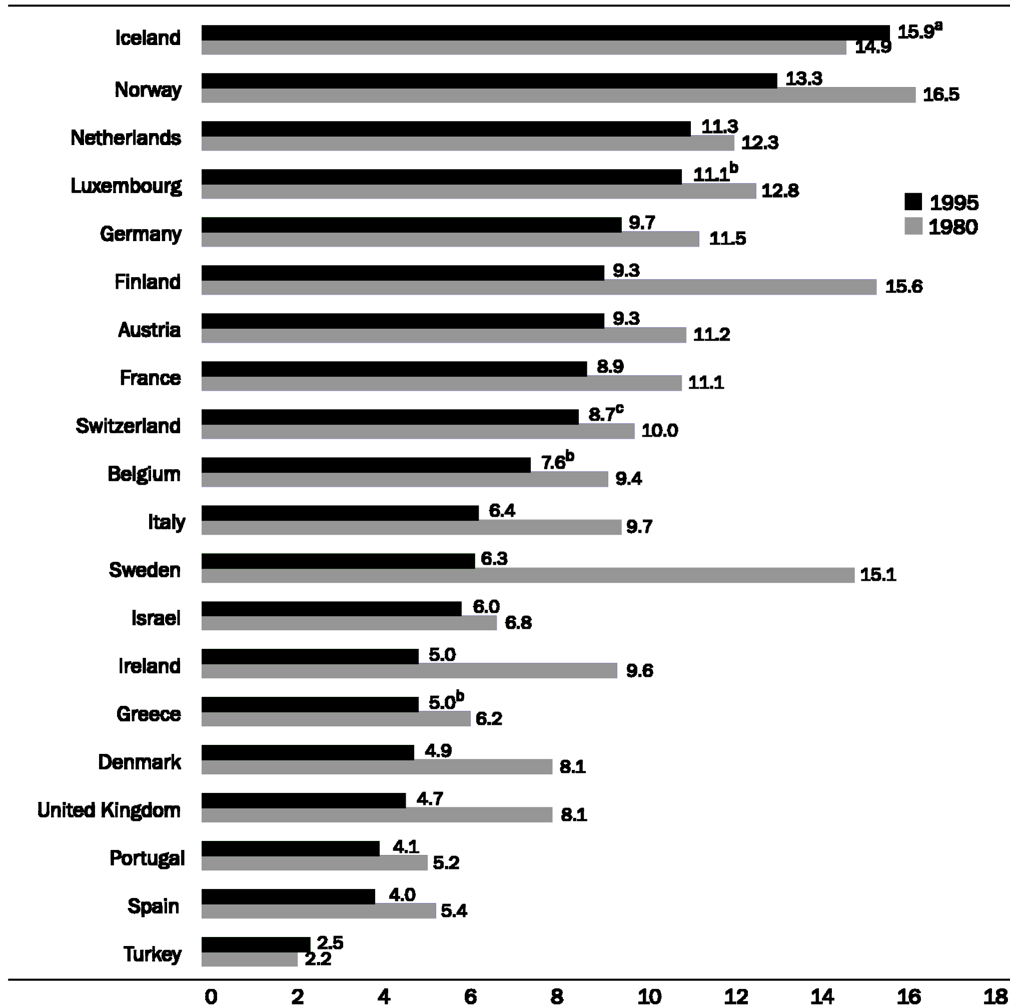
Although reform approaches, and their outcomes, vary across countries, several common conclusions can be useful to policymakers in most developed countries. The broad character of these conclusions, however, makes them more indicative than prescriptive, intended to inform domestic policy debates rather than to foreclose them.

■ **Determining success.** The concept of success in health care reforms tends to be both relative and temporal. Nonetheless, the evidence to date from across Europe clearly suggests that some strategic directions are more likely to achieve their intended objectives than others are. *Success* can be defined in two ways. Normatively, it should reflect the ability of the proposed reform to create health gain for a population and to maintain or improve the overall equity and

Downloaded from content.healthaffairs.org by *Health Affairs* on December 17, 2014
by guest

المنارة للاستشارات
www

EXHIBIT 5
Number Of Hospital Beds Per 1,000 Population, Western Europe, 1980 And 1995



SOURCES: Organization for Economic Cooperation and Development (OECD) Health Data, 1997; and World Health Organization (WHO) Health for All database for Israel and Switzerland.
[a] 1992.
[b] 1994.
[c] 1991.

solidarity of the health care system. Operationally, success should reflect a reform's ability to achieve the technical objectives intended by its designers. These typically involve a mix of fiscal, social, political, and organizational goals.

Reforms pursued on the supply side (for example, allocation and production components) have fared relatively well.[41] In the area of allocation, efforts to change provider behavior include public contracting for hospitals, along with capitated or mixed models of payment for GPs. In the area of production, relatively successful meas-

Downloaded from content.healthaffairs.org by Health Affairs on December 17, 2014
by guest

ures include provider-oriented initiatives such as continuous quality improvement, technology assessment, practice guidelines, and the substitution of less intensive for more intensive services. Also deserving mention is the reorganization of budget-driven public hospitals into various types of public firms; that is, managerially independent institutions whose payment is tied to production.

The supply-side reforms being undertaken in European countries are overwhelmingly being designed and introduced by public-sector officials. Despite substantial interest in the use of competitive mechanisms among various public providers, these public officials have not pursued privatization of core health functions or public institutions. This reflects a growing recognition by many national policymakers that the issue of provider competition is conceptually distinct from the issue of private ownership.[42] In terms of the results achieved, it appears to be less important whether the reforms pursued are regulatory or competitive in nature. Rather, the sentinel factor for operational as well as normative success has been that the reform focuses directly on the provider side.

Conversely, the available evidence indicates that reforms have been less successful when they have focused on the demand side, specifically, on the application of market-style incentives to individual patient–based demand. To assess the impact of recent reforms, it is necessary to split the concept of demand along two separate dimensions. The first dimension distinguishes between aggregate population–based demand at the macroeconomic level and individual patient–based demand for services at the microeconomic level. Organized efforts to reduce the former typically have focused on public health measures and have been ongoing since the advent of improved sanitation and immunization. Since the 1970s policymakers have added smoking reduction, reduced consumption of fat, increased exercise, and environmental cleanups to their reform strategies. These various population-based interventions contrast sharply with more recent strategies that focus directly on demand at the individual patient level, which some contend has led to aggregate population–based demand's being all but ignored in the 1990s.

The second dimension along which demand needs to be split concerns the institutional framework through which individual patient–based demand is expressed. Despite complicated funding arrangements, it is nonetheless possible to classify the predominant source of revenue in terms of a system's broad financial and social structure: funding systems based predominantly on publicly accountable payers (whether constructed on taxation or statutory social insurance), characterized by the bedrock principles of universal access and sustainable systemwide financing, versus funding

Downloaded from content.healthaffairs.org by Health Affairs on December 17, 2014
by guest

المنارة للاستشارات
www

systems based predominantly on privately accountable payers that are responsible for ensuring neither universal access nor sustainable financing. Nearly all western European countries had put in place some form of publicly accountable payers for all or nearly all of their citizens prior to the current reform period, and all remain committed to universal access and sustainable financing. Despite occasionally heated debates, none has shifted from publicly to privately accountable funding.

The few countries that have attempted to incorporate privately accountable payers within what was to remain a publicly accountable funding structure have encountered serious difficulties. Successive Dutch governments have struggled for ten years to devise a scenario that could introduce competitive funding while still maintaining a high level of solidarity.[43] In Israel the effort to consolidate an existing structure of privately accountable payers into a new statutory system of universal national health insurance has generated deficits and growing political controversy.[44]

To the extent that financing-side reforms seek to introduce incentives for cost-reducing behavior by shifting provider-generated costs directly onto the patient, these proposed reforms (as noted above) either have not been introduced or have been sufficiently buffered that their demand-reducing impact has been largely neutralized. As Exhibit 2 shows, many European countries reject cost sharing because of problems related to supply-induced demand and equity concerns. Compensating administrative procedures such as exemptions for low-income or chronically ill citizens can partly address resulting inequities but greatly reduce the impact of cost sharing. Few explicit rationing measures have actually been adopted. As with cost sharing, policymakers instinctively recognize the consequences of delisting a service from the publicly reimbursed package and are unwilling to accept such a breach of solidarity.

Overall, the first conclusion from the European health care reform experience indicates that attempts to indirectly affect providers' behavior by generating financial pressure through individual patient–based demand or competing privately accountable payers does not work well, either financially or socially.

■ **Balancing state and market.** The issue of "state or market" is in many respects a 1990s reprise of the intense debate in Europe about public versus private during the 1980s.[45] Policy attention, however, has now shifted to the degree of reciprocity in this relationship. Contrary to the writings of neoclassical economists (much like those of Marxist theorists before them), the advent of the market no more leads to the withering away of the state than did Soviet communism. Reform experience in Europe has shown that the

Downloaded from content.healthaffairs.org by Health Affairs on December 17, 2014
by guest

greater the reliance on market mechanisms, the greater the need for a reinvigorated state role. Countries such as Sweden have found that the lower down in the public sector they decentralize power over the health system, the more important it becomes to have a central structure to set standards, monitor and evaluate performance, and prevent opportunistic behavior.[46] Several CEE/CIS countries have belatedly sought to develop a state regulatory apparatus to reduce the negative consequences of giving market forces free rein.

This renewed role for the state, however, requires a fundamental shift in emphasis. Instead of controlling inputs, the state needs to monitor outputs and, in the health sector, outcomes. Instead of directly managing providers, governments need to focus on setting broad strategic objectives for the entire health care system and regulating public and private providers to ensure that objectives are achieved. To do this, the state not only must continue to function, but it must work more effectively. As David Osborne and Ted Gaebler are fond of saying about public policy generally, the state needs to "row less and steer more."[47]

Reflections On The United States

Applying conclusions drawn from health system reforms in one group of countries to the formulation of policy in another country that is socially, politically, and culturally different is far from a straightforward task. Therefore, it is not surprising that policy learning may not be directly transferable from European evidence and experience to the U.S. health care system. Also, U.S. policymakers may be reluctant to take on broad conclusions about health care reform experiences elsewhere. In addition, U.S. policymakers typically bring what has been termed a possessive individualist belief system to the evaluation of policy-related evidence generally.[48] Thus, the conclusions from this European study are most likely to be useful in the United States at a conceptual rather than a practical policy level.

■ **Managed care vs. managed competition.** Starting from this perspective, the first general conclusion—that reforms have been relatively more successful when they have been focused on allocation and provision—suggests intriguing and rather controversial items for the U.S. health policy agenda. The observation that supply-oriented reforms work better casts a spotlight on the differences between the concept of managed care and the various models of managed competition. *Managed care* has been defined as applying one or more of seven specific elements: limited choice of providers, selective contracting, financial incentives for providers, gatekeeping, physician profiling, utilization review, and organizational culture.[49]

Downloaded from content.healthaffairs.org by Health Affairs on December 17, 2014
by guest

المنارة للاستشارات
www

Several of these elements resemble existing mechanisms used on the supply side by publicly accountable European payers, typically with some degree of both normative and operational success. As a systematic effort to alter the incentives of providers, managed care can be considered a supply-side approach within the definition used in the WHO study. As currently practiced in the United States, however, managed care among privately accountable payers has led to a number of perverse consequences including undertreatment of patients, gag rules on providers, restrictions on patients' choice of providers, as well as continued high spending.

The conclusions of the WHO study with regard to reforms that focus on the demand side (aggregate population–based demand, individual patient–based demand mediated by publicly accountable payers, and individual patient–based demand mediated by privately accountable payers) can serve to further reinforce the essential distinction between managed care and managed competition. With regard to aggregate population–based demand, the United States has a relatively respectable if uneven record. Efforts to reduce cardiovascular disease by changes in smoking, dietary, and exercise habits have been quite effective for some middle-class segments of the U.S. population. The United States has been particularly active in developing measures to attack tobacco use, from prohibiting smoking in public buildings to recent legal decisions that hold tobacco companies liable for the medical consequences of using their products. Conversely, the U.S. record on such measures as immunization and obesity is poor, which reflects in part the uneven social class and racial distribution of many public health measures.

With regard to individual patient–based demand, the picture in the United States is decidedly more complicated. Publicly accountable funding arrangements for the elderly (Medicare) and a portion of the poor (Medicaid) coexist alongside a funding system of competing privately accountable payers for the middle class and the employed. One consequence is that a growing percentage of the population has fallen into the gap between these two funding arrangements and does not have any health care coverage at all. In this regard, the United States lags behind not just western European countries but even most CEE/CIS countries, which have retained universal coverage at least in principle.

A related issue concerns current U.S. efforts to shift publicly funded patients into privately accountable managed care. Some argue that the increased flow of public funds to competing private plans will pave the way for future federal regulatory measures seeking to make these plans more publicly accountable. As suggested below, however, such an expansion of public accountability may be

Downloaded from content.healthaffairs.org by Health Affairs on December 17, 2014
by guest

www

المنارة للاستشارات

difficult to achieve.

Although some economists have argued that a pure form of managed competition has yet to be achieved, its impact on the U.S. health care system is clearly visible when considered in international comparison.[50] As already mentioned, experience in Europe indicates that attempting to influence providers' behavior indirectly, by altering individual patients' demand for care as expressed through competing private insurers, could lead to a variety of perverse outcomes, including adverse selection, selective disenrollment, and high transaction costs. These negative outcomes have been well documented in the United States.[51] This suggests that managed competition is a problematic model for organizing even part of U.S. health care funding. Seeking to implant at least some elements of managed care in the U.S. health care system may be a worthwhile effort if the services are funded by some form of publicly accountable payer. However, attempting to do so through reliance upon managed competition among privately accountable payers is unlikely to provide a financially or socially satisfactory outcome.

■ **Degree of regulation.** The second conclusion—that a strong role for the state is necessary to set standards as well as to monitor and evaluate performance—relates directly to the ongoing U.S. debate about the need for increased regulation of managed care. Unlike most European countries, the United States does not have a national framework law that stipulates the duties and responsibilities of each major health-sector actor; nor does the U.S. government have effective instruments of control over total health spending.

In response to a growing chorus of patients' concerns, however, both state and federal governments have introduced a variety of narrowly drawn regulations, such as those establishing by law a series of minimum length-of-stay protocols for hospitals for a few highly visible clinical services such as labor and delivery. In 1996 the U.S. Congress also passed the Kassebaum-Kennedy bill, which encouraged the portability of insurance. Recent state-level and federal proposals suggesting a series of changes to current regulatory arrangements highlight the possibility that government's relatively weak role in the health sector may be coming under more systematic scrutiny.[52]

In the present deregulatory political climate in the United States, however, the likelihood of having Congress greatly increase federal controls over private insurers and providers appears to be rather small. The proposed establishment of a national health care budget and of a national health council to define federal quality standards were among the most controversial elements of the 1994 Clinton health plan, and the resurrection of these or similar measures would undoubtedly draw the concerted opposition of the for-profit health

Downloaded from content.healthaffairs.org by Health Affairs on December 17, 2014
by guest

insurance industry. It thus seems unlikely that current U.S. reform efforts will parallel the decisions of countries such as the Czech Republic or Sweden, where increased decentralization was deemed to require much strengthened public-sector governance and supervision. Such a shift in U.S. policy would likely require Congress to repeal the 1974 Employee Retirement Income Security Act (ERISA) restriction on state governments' ability to regulate the health-related decisions of self-insured companies—an action that most large employers would likely oppose. Continued fiscal pressure on the federally funded Medicare program, or a major scandal in the managed care industry that compromised care for the middle class, could lead Congress to dramatically reverse its current course. It seems fair to conclude, however, that without an unanticipated external impetus, the U.S. health sector most likely will not be held politically accountable for its actions to anywhere near the extent that currently exists in most European countries.

The conclusions from the WHO study of European reforms, when contrasted with health sector decision making in the United States, suggest that a central distinction is the importance of collective responsibility and political accountability in western European health care systems, as compared with the emphasis upon individual responsibility and financial accountability in U.S. health policy. This distinction can be attributed to a variety of factors: history, geography, political culture, the role of immigration, and the recentness of war on national soil.[53] It also appears to reflect the reliance in the United States since the early 1980s on neoclassical economics and its fascination with individual preference. However one assesses the cause, the WHO study points up the degree of fundamental divergence in the organizational principles and objectives of most western European countries and the United States. Given these seemingly unbridgeable conceptual differences, suggestions of convergence among the health care systems of developed countries—beyond the transference of narrowly technical mechanisms—appear to be misplaced.

Both the WHO Regional Office for Europe's study of European health system reform and this paper rely heavily on more than thirty commissioned papers, written by academics and policymakers from across Europe. Seventeen of these papers will be published in their original form by Open University Press in June 1998. The authors also thank three anonymous reviewers for their helpful comments on this paper. The WHO study focused on the member states of the European region and did not discuss the United States. The section of this paper dealing with U.S. health policy reflects the opinion of its authors and not those of WHO or its member states.

Downloaded from content.healthaffairs.org by Health Affairs on December 17, 2014
by guest
المنارة للاستشارات
www

NOTES

1. Organization for Economic Cooperation and Development, *The Reform of Health Care: A Comparative Analysis of Seven OECD Countries* (Paris: OECD, 1992); OECD, *The Reform of Health Care Systems: A Review of Seventeen OECD Countries* (Paris: OECD, 1994); B. Abel-Smith et al., *Choices in Health Policy: An Agenda for the European Union* (Dartmouth, Aldershot, England: Office for Official Publications of the European Communities and Dartmouth Publishing Company, 1995); and World Bank, *World Development Report: Investing in Health* (New York: Oxford University Press, 1993).
2. World Health Organization, *European Health Care Reform: Analysis of Current Strategies*, ed. R.B. Saltman and J. Figueras (Copenhagen: WHO Regional Office for Europe, 1997); and R.B. Saltman, J. Figueras, and C. Sakellarides, eds., *Critical Challenges for Health Care Reform in Europe* (Buckingham, U.K., and Philadelphia: Open University Press, forthcoming).
3. B. Abel-Smith, "Who Is the Odd Man Out? The Experience of Western Europe in Containing the Costs of Health Care," *Milbank Quarterly* (Winter 1985): 1–17; and B. Abel-Smith and E. Mossialos, "Cost Containment and Health Care Reform: A Study of the European Union," *Health Policy* 28, no. 2 (1994): 89–132.
4. *State* is used in the European sense of nation-state, except in discussion of U.S. health reforms, where it refers to that country's fifty constituent states.
5. R.B. Saltman and C. von Otter, *Planned Markets and Public Competition: Strategic Reform in Northern European Health Systems* (Buckingham and Philadelphia: Open University Press, 1992); M. Brommels, "Contracting and Political Boards in Planned Markets," in *Implementing Planned Markets in Health Care: Balancing Social and Economic Responsibility*, ed. R.B. Saltman and C. von Otter (Buckingham and Philadelphia: Open University Press, 1995), 86–109; A. Anell, "Implementing Planned Markets in Health Services: The Swedish Case," in *Implementing Planned Markets in Health Care*, 209–226; R. Klein, "Big Bang Health Care Reform—Does It Work?: The Case of Britain's 1991 National Health Service Reforms" *Milbank Quarterly* (Fall 1995): 299–337; and E. Goldstein et al., *Trends in Health Status, Services, and Finance: The Transition in Central and Eastern Europe*, Social Challenges of Transition Series, Technical Paper no. 341 (Washington: World Bank, 1996).
6. R. Evans, "Going for the Gold: The Redistributive Agenda behind Market-Based Health Care Reform," *Journal of Health Politics, Policy and Law* (April 1997): 427–465; and W.C. Hsiao, "Abnormal Economics in the Health Sector," *Health Policy* 32, no. 1–3 (1995): 125–140.
7. A. Enthoven, *Reflections on the Management of the NHS*, Occasional Papers 5 (London: Nuffield Provincial Hospital Trust, 1985); R.B. Saltman and C. von Otter, "Revitalizing Public Health Care Systems: A Proposal for Public Competition in Sweden," *Health Policy* 7, no. 1 (1987): 21–40; and J. Le Grand and W. Bartlett, eds., *Quasi-Markets and Social Policy* (London: MacMillan, 1993).
8. Saltman and von Otter, *Planned Markets and Public Competition;* M. McKee and J. Figueras, "Comparing Health Care Systems: How Do We Know If We Can Learn from Others?" *Journal of Health Services Research and Policy* 2, no. 2 (1997): 122–125; and Goldstein et al., *Trends in Health Status, Services, and Finance.*
9. D. Hunter et al., "Optimal Balance of Centralized and Decentralized Management," in *Critical Challenges for Health Care Reform in Europe.*
10. D. Chinitz, A. Preker, and J. Wasem, "Balancing Competition and Solidarity in Health Care Financing," in *Critical Challenges for Health Care Reform in Europe*; and F.W. Schwartz and R. Busse, "Fixed Budgets in the Ambulatory Care Sector: The German Experience," in *Fixing Health Budgets: Experience from Europe and North America*, ed. F.W. Schwartz, H. Glennerster, and R.B. Saltman (New York:

Downloaded from content.healthaffairs.org by *Health Affairs* on December 17, 2014
by guest

www

المنارة للاستشارات

Wiley and Sons, 1996).
11. W.P.M.M. van de Ven and F.T. Schut, "The Dutch Experience with Internal Markets," in *Health Care Reform through Internal Markets: Experience and Proposals*, ed. M. Jérôme-Forget, J. White, and J.M. Weiner (Washington: Brookings Institution, 1995), 95–118.
12. Goldstein et al., *Trends in Health Status, Services, and Finance.*
13. M. Vienonen, ed., *Citizens' Choice and Patients' Rights* (Copenhagen: WHO, 1996).
14. WHO, *Health for All Targets: The Health Policy for Europe* (Copenhagen: WHO Regional Office for Europe, 1991).
15. J. Kutzin, "The Appropriate Role for Patient Cost-Sharing," in *Critical Challenges for Health Care Reform in Europe.*
16. V. Rodwin and S. Sandier, "Health Care under French National Health Insurance," *Health Affairs* (Fall 1993): 111–131.
17. See, for example, E. Delcheva, D. Balabanova, and M. McKee, "Under-the-Counter Payments for Health Care: Evidence from Bulgaria," *Health Policy* 42, no. 2 (1997): 89–100.
18. National Research and Development Center for Welfare and Health, *From Values to Choices: The Report of the Working Group on Prioritization in Health Care* (Saarijärvi, Finland: Grummerus Kirjapaino Oy, 1995); Ministry of Welfare, Health, and Culture, *Choice in Health Care* (Rijswijk: Ministry of Welfare, Health, and Culture, 1992); Royal Ministry of Health and Social Welfare, *Retningslinjer for Prioritering innen Norsk Helsetjeneste* (Oslo: Norges Offentlige Utredninger, 1987); Abel-Smith et al., *Choices in Health Policy* (Stockholm: Ministry of Health and Social Affairs, 1995); and F. Honingsbaum et al., *Priority Setting Processes for Healthcare* (Oxford: Radcliffe Medical Press, 1995).
19. C. Ham, "Priority Setting in Health Care: Learning from International Experience," *Health Policy* 42, no. 1 (1997): 49–66.
20. A. de Roo, "Contracting and Solidarity: Market-Oriented Changes in Dutch Health Insurance Schemes," in *Implementing Planned Markets in Health Care*, 45–64; and D. Chinitz and A. Israeli, "Health Reform and Rationing in Israel," *Health Affairs* (September/October 1997): 205–210.
21. Abel-Smith et al., *Choices in Health Policy.*
22. A. Wagstaff et al., "Equity in the Finance of Health Care: Some International Comparisons," *Journal of Health Economics* 11, no. 3 (1992): 361–387.
23. E. Mossialos, "Citizens' Views on Health Care Systems in the 15 Member States of the European Union," *Health Economics* 6, no. 2 (1997): 109–116.
24. Chinitz et al., "Balancing Competition and Solidarity."
25. J. Marrée and P.P. Groenewegen, *Back to Bismarck: Health Insurance in Eastern Europe* (Aldershot: Avebury, 1997).
26. J. Figueras et al., "Health Care Systems in Southern Europe: Is There a Mediterranean Paradigm?" *International Journal of Health Sciences* 5, no. 4 (1994): 135–146.
27. Chinitz et al., "Balancing Competition and Solidarity."
28. Many of those forced out of the Dutch compulsory system elect to insure with not-for-profit subsidiary companies tied to their former Sickness Funds, choosing in effect to continue similar financial arrangements to those made by their compulsory fund.
29. Goldstein et al., *Trends in Health Status, Services, and Finance.*
30. Chinitz et al., "Balancing Competition and Solidarity."
31. S. Savas et al., "Contracting Models and Provider Competition," in *Critical Challenges for Health Care Reform in Europe.*
32. Saltman and von Otter, *Planned Markets and Public Competition.*
33. N. Edwards, M. Henscher, and U. Werneke, "Changing Hospital Systems," in *Critical Challenges for Health Care Reform in Europe.*

Downloaded from content.healthaffairs.org by Health Affairs on December 17, 2014 by guest

34. L. Rochaix, "Performance-Tied Payment Systems for Physicians," in *Critical Challenges for Health Care Reform in Europe*.
35. K.P. Pfeiffer, "The Possible Effects of a New Hospital Financing System in Austria;" S. Richard and K.H. Schönback, "German Sickness Funds under Fixed Budgets;" and H. Maarse, "Fixed Budgets in the Inpatient Sector: The Care of the Netherlands," all in *Fixing Health Budgets*.
36. Cochrane Library, Oxford, *Cochrane Collaboration* (London: BMJ Publishing Group, 1996) (database).
37. C. Ham, ed., *Health Care Reform* (Buckingham and Philadelphia: Open University Press, 1997).
38. Hunter et al., "Optimal Management."
39. M. Warner, *Implementing Health Care Reforms through Substitution* (Cardiff: Welsh Institute for Health and Social Care, 1996).
40. Ham, ed., *Health Care Reform*.
41. In the WHO study, allocation is combined with production, forming the supply side of the system; this leaves funding as the source of demand. This placement of allocation reflects the reality that in most European health care systems, in practice, allocation and production are administered jointly or closely regulated in a coordinated manner by a public-sector agency.
42. Saltman and von Otter, *Planned Markets and Public Competition*.
43. A. de Roo, "Contracting and Solidarity in Health Care: The Dutch Experience," in *Implementing Planned Markets in Health Care*, 45–64; and van de Ven and Schut, "The Dutch Experience with Internal Markets."
44. D. Chinitz, "Israel's Health Policy Breakthrough: The Politics of Reform and the Reform of Politics," *Journal of Health Politics, Policy and Law* (Winter 1995): 909–932.

45. G. McLachlan and A. Maynard, eds., *The Public-Private Mix in Health* (London: Nuffield Provincial Hospital Trust, 1982).
46. P. Orn, "Flera hundra förfalskade provsar lämnade laboratorie företaget," *Läkaretidningen* 93, no. 7 (1996): 532.
47. D. Osborne and T. Gaebler, *Reinventing Government* (Reading, Mass.: Addison-Wesley, 1992).
48. C.B. MacPherson, *The Theory of Possessive Individualism* (Cambridge, England: Cambridge University Press, 1964); and J. Morone, "American Political Culture and the Search for Lessons from Abroad," *Journal of Health Politics, Policy and Law* (Spring 1991): 129–143.
49. N. Kane, "Costs, Productivity, and Financial Outcomes of Managed Care," in *Implementing Planned Markets in Health Care*, 113–133.
50. A.C. Enthoven and S.J. Singer, "Market-Based Reform: What to Regulate and by Whom," *Health Affairs* (Spring 1995): 105–119.
51. H.S. Luft, "Modifying Managed Competition to Address Cost and Quality," *Health Affairs* (Spring 1996): 23–38.
52. R. Pear, "Congress Weighs More Regulation on Managed Care," *New York Times*, 10 March 1997, 1; and T.S. Purdum, "Panel Seeks HMO Overseer for the Bellwether California," *New York Times*, 6 January 1998, 1.
53. D.J. Rothman, "A Century of Failure: Health Care Reform in America," *Journal of Health Politics, Policy and Law* (Summer 1993): 271–286; and T. Skocpol, "Is the Time Finally Ripe? Health Insurance Reforms in the 1990s," *Journal of Health Politics, Policy and Law* (Fall 1993): 531–550.

Downloaded from content.healthaffairs.org by *Health Affairs* on December 17, 2014
by guest

المنارة للاستشارات

www