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THE REFORM OF HEALTH CARE
A Comparative Analysis of Seven OECD Countries

Health Policy Studies No 2

OECD Member countries continue to face persistent difficulties with the financing, delivery and performance of their health care systems, despite the successful implementation of new policies since the mid-l970s. This report considers the ways in which these problems are being tackled in seven OECD countries (Belgium, France, Germany, Ireland, the Netherlands, Spain and the United Kingdom).

The report approaches these issues through a comparison of recent and prospective reforms to the health care systems in selected OECD countries. The countries selected, all in Western Europe, were chosen for a mixture of reasons including: the importance of the reforms they had made in the 1980s or were contemplating in the 1990s; the extent to which they represent the different types of health care system found among OECD countries; the willingness of their administrations to participate in the study; and the economy of conducting the investigation in one continent. In addition, the study draws on experience from North America (see Health Policy Studies No. 1: US Health Care at the Crossroads, issued in November 1992).

During the 1980s, the health care systems of all seven countries were dominated by one or more of the three sub-systems which involve compulsory finance.

Belgium relied on a blend of the public reimbursement (of patients) model and the public contract model. France relied on a blend of the public reimbursement, contract and integrated models. The Federal Republic of Germany and the Netherlands relied mainly on the public contract model. Ireland and the United Kingdom relied on a mixture of the public contract and integrated models. The Länder of the Eastern part of Germany and Spain relied mainly on the public integrated model.

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Voluntary health insurance accounted for no more than 15% of the health expenditure in any of the countries.

The difficulties experienced by each country tended to depend on which sub-systems of finance and delivery dominated:

-- Systems which still relied on vestiges of the public reimbursement model tended to have most difficulties with cost containment;

-- Countries which relied on the public contract model often suffered from lack of competition and excessive regulation;

-- Countries which relied on the public integrated model tended to suffer from managerial inadequacies and failures of responsiveness to consumers.

All seven countries initiated moderate or major reforms to their health care systems during the 1980s.

Several countries, particularly Spain, the Netherlands and Ireland, took further steps to extend eligibility for public medical care, bringing the last remaining groups of their populations into the public systems of coverage for basic medical care. Despite widespread calls for privatisation of finance, none of the other countries took significant steps to reduce their commitment to public coverage.

Several countries took important initiatives in the field of cost containment. In most cases, governments resorted to some extent to increased cost-sharing. However, most of the reforms aimed at containing costs were concentrated on the supply side. This involved the determined application of prospective, global budgets, especially for hospital expenditure in Belgium, France, Germany and the Netherlands. Compared with the 1970s, all seven countries greatly reduced the rate of growth of their health expenditures during the 1980s. Those countries which still relied, to some extent, on the public reimbursement model were rather less successful in this respect than those which relied on the public contract and integrated models.

Perhaps the most important reforms of the 1980s involved the introduction of improved incentives and regulations for providers and insurers, with the aim of raising the productivity of rationed resources. It is possible to distinguish three separate sets of developments.

-- There was some convergence on the public contract model. Belgium and France introduced tighter contracts into their reimbursement models, and the United Kingdom and the Länder of East Germany abandoned their integrated models in favour of contract models.

-- Some countries embarked on reforms to the contract model itself, by placing a fresh emphasis on: consumer choice; active, informed purchasing rather than passive funding by third parties; and on managed competition between providers. This was clearest in Germany, but

elements of such changes were also seen in Belgium and in the Netherlands. The new contracting models are characterised by mixed payment systems, which combine budgetary caps with work-related payment of providers. The expectation is that, by enabling governments to stand back somewhat, more self-regulation will be possible.

-- Finally, two countries -- the Netherlands and the United Kingdom -- embarked on experiments which involve the introduction of competition between third parties within their public systems. The two experiments are rather different. In the Netherlands it is envisaged that consumers will be able to choose between sickness funds and private insurers, with a central health care fund taking in income-related premiums and paying out risk-related premiums to the competing insurers. This amounts to a sophisticated health voucher scheme. The experiment in the United Kingdom involves giving part of the hospital budget to some, large (competing) general practices. This will enable general practitioners to purchase certain hospital services on behalf of their patients.

This last set of reforms is particularly controversial. The reforms are only gradually being introduced in the Netherlands and are recent in the United Kingdom. For this reason, it is not yet possible to gauge their full results. However, there are already signs that general practitioner "fundholders" in the United Kingdom are using their new purchasing power to negotiate a higher quality of hospital services for their patients.

Journalists may obtain a copy of the report from the OECD Press Division, 2 rue André Pascal, 75775 Paris cedex 16 (tel. 45 24 80 88 or 80 89).

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