Evolution of Health-Care Reforms

At the end of the 19th century, when organised health-care systems began to develop in many, mainly Continental European, countries, spending for health care was low due to the limited contribution the medical profession could make to healing the majority of sicknesses. The main task of health insurance, at that time, was to provide income replacement in case of sickness. It is only after the Second World War that treatment possibilities increased dramatically, e.g. by the discovery of penicillin and other antibiotics. This and the further scientific development caused people to change gradually their priorities with respect to health-care relative to other goods and services. But also most governments of the industrialised countries reacted and created or enlarged public health-care systems.

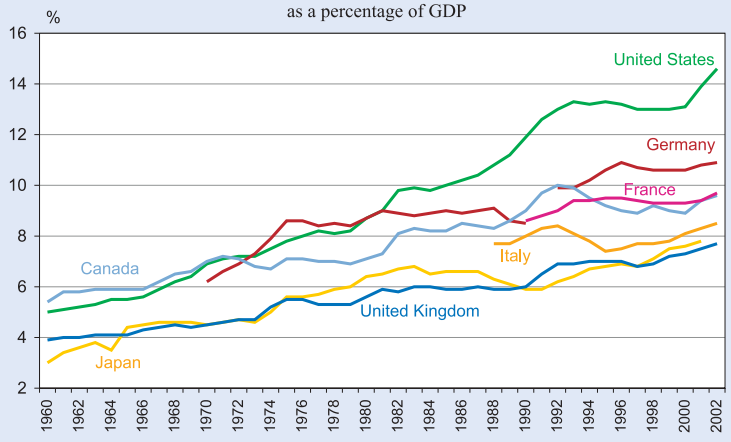
In 1960, the first year for which country-comparative data on total health-care costs are available, health-care costs as a percentage of GDP were still relatively low (see Figure). In the following years, however, health-care costs witnessed an unprecedented, nearly continuous rise. On average for some large industrial countries considered here ("G7")[1], the share of health-care costs in GDP has more than doubled in the last 40 years.

This development has mainly been driven by the continued advances of the medical profession, by increased coverage of the population enrolled in health-care insurance plans and by raising the (equality of) access to advanced levels of medical treatment for a widening range of sicknesses. During the last two decades, or so, a further cost-increasing factor grew in importance, the ageing of the populations.

The development of costs exerted two types of rising pressure. The first is the pressure on government finances, because in all countries the health-care systems are funded or at least supported by the government, albeit to differing degrees. The second pressure is on the labour market, at least in those countries where the contributions to health insurance are shared between employer and employee. This type of pressure, however, does not exist in countries with a totally tax-financed public health-care system, like that of the UK.

The necessary cost-containment could have been achieved by either administrative (regulatory) measures or by a more market-oriented solution. In a first attempt to control costs, it is the administrative method which has been used by practically all countries (Cutler 2002). Such methods (see Table) comprised, e.g., global budgets for hospitals and/or physicians (Canada, France, Germany, UK), prescription drug budgets for individual physicians (Germany) or for the whole country (France), tighter fee schedules for physicians (France, Japan, UK, US) and limited expansion plans for hospitals (Japan). The main reason for the dominating regulatory approach to health-care cost reductions can be seen in the – not unjustified – fear of governments and people that a market-oriented way of reform might harm the degree of equality in health-care burden sharing and health-care access reached over the course of time.

Health-care Costs, 1960 - 2002
as a percentage of GDP



Source: OECD Health Data (2004).

These regulatory measures, introduced mainly in the 1980s, were partly effective. They have helped reduce the growth path of costs, but have not been able to prevent costs from rising steadily, albeit at a different pace in the countries considered. Moreover, the administrative approach of non-market oriented rationing led to wait-

[1] For information on more countries (28) see the table "Evolution of Public Health-Care Systems" in DICE database (www.cesifo.de/DICE).

Evolution of health-care systems in selected large industrial countries

	Introduction of public health-care system	Important reforms from 1945 – 1980	Important reforms from 1981 - today
Canada		1947: First provincial health insurance program; 1966: Establishment of Medicare; 1971: Last province enacts Medicare.	1984: Canada Health Act; physicians must accept government payment as payment in full; Hospitals: global budgets established with universal coverage; Certification of Need required for expansion of a hospital; 1991: Federal payments to provinces cut; tighter supply-side limits by provinces; merging of hospitals; cutback in public coverage (dental care, visions exams).
France	Late 19th century: Local sickness funds for certain workers; 1928: Compulsory health insurance for low-wage workers in certain industries.	1967: National insurance fund for salaried workers; agricultural and self-employed covered by other funds; 1978: National coverage achieved; 1979: Fee schedules tightened.	1984/85: Global budgets introduced for public hospitals to tighten expenditures; 1993: Global budgets introduced for private hospitals; 1994: National targets for pharmaceutical expenditures; 1996: Global budget for the health system as a whole; review of physicians responsible for overspending; regional hospital agencies to manage funding; increase of patient co-payments.
Germany	1883: Introduction of mandatory health insurance; 1884: Extension to work related accidents; 1889: Old age and disability; services included: sick pay, maternity pay and death compensation.	1949: Reestablishment of the health care system which was in power at the end of the Weimar period; 1977: Health Insurance Cost-Containment Act: Requirement to pursue a goal of stability in contributions for the sickness funds and the provider of health care; expenditure cap on ambulatory care; global budgets for physician associations.	1981: 90% coverage achieved; 1982: Out-of-pocket payments for drugs increased; 1984-86: Global budgets introduced for hospitals; 1989: Health Reform Act: Reference pricing system for drugs, increased patient co-payments, modest reduction of covered services; 1993: Health Care Structure Reform Act: links growth of health-care spending to growth of wages; more bundling of hospital payments; increase of patient co-payment; risk adjustment for sickness funds; prescription drug budgets for physicians; 1996: Health Insurance Contribution Rate Exoneration Act; 1997: First and Second Statutory Health Insurance Restructuring Acts, with choice of public sickness fund for the insured and increase of co-payments; 1998: Act to Strengthen Solidarity in Statutory Health Insurance; 2004: Reform Act of Statutory Health Insurance: higher co-payments; possibility for public health insurers to give rebates to low-cost insured; ordering of pharmaceuticals by e-mail permitted; reform of pharmacists' mark-up.
Italy	1861-1920: Autonomous mutual aid associations for artisans and workers; the Catholic Church and charitable institutions established several health care providers; moreover, provincial and municipal networks provided social assistance to disabled and needy people; 1898: First insurance for occupational accidents; 1923: Right for hospital care for the needy.	Mutual aid societies converted to local branches of national insurance program; 1958: Creation of an independent Ministry of Health; 1978: Creation of the National Health Service.	1990: Move from per-diem to DRG payments for hospitals; 1992: Creation of regional enterprises to limit spending; regional enterprises can contract out services, hospitals can become independent; 1994: First National Health Plan: definition of national health targets and establishment of uniform levels of assistance should be guaranteed to all citizens; 1995: Patients can opt out of SSN; 1998: Second National Health Plan.

(Table continued)

	Introduction of public health-care system	Important reforms from 1945 – 1980	Important reforms from 1981 - today
Japan	1922: Health Insurance Law covered some workers (extended in 1938)	1958: National Health Insurance mandated; 1961: In all local governments implemented.	Early 1980s: tighter fee schedules for hospitals and physicians; 1985 - 87: Hospital beds and expansion capped; 1997: Substantial increase in patient co-insurance, mandated prices for pharmaceuticals eliminated.
United Kingdom	1911: Manual workers and low wage workers covered.	1946: National health insurance. 1948: Introduction of the National Health Service: Collective responsibility by the state for a comprehensive health service which was to be available to the entire population free at the point of use.	1990: National Health Service and Community Care Act: GPs become "fundholders", they receive capitates payment per patient and must pay for services (drugs, inpatient care, emergency care), hospitals become "trusts" (similar to not-for-profit business); Global budgets established with NHS; salaries of physicians established with NHS; 1998 reform: Local Health Action Zones to set health goals and coordinate goals; Primary Care Groups made up of all physicians in an area will replace fundholders.
United States	In general: No universal public health insurance.	1965: Creation of Medicaid (support for the poor) and Medicare (support for the elderly).	1983: Prospective payment for hospital admission; 1992: Fee schedule for physicians; 1993 proposal (failed): universal insurance coverage; 1996: Health Insurance Portability and Accountability Act: guarantees portability of insurance for job to job transitions; 1997: Balanced Budget Act: choices in Medicare are expanded; 2003: Medicare and Medicaid reimbursement of drug costs expanded.

Sources: Publications of the European Observatory on Health Care Systems: Health Care Systems in Transition, on individual countries, different years; Cutler (2002), see references.

ing lists for hospital admissions and ambulatory physician services in many countries (Osterkamp 2002) and to other forms of restricted access to medical services as well as to inefficiencies in the provision of health care at the micro (hospital and physician) level. The ultimately insufficient cost-containment as well as the negative effects of rationing on the widely pursued aim of equal access to health care and of equal health-care burden sharing induced a second wave of reforms in the 1990s, which pursued a stronger market-based approach of health-care reform and cost-containment (Cutler 2002).

The main building blocks of that reform wave were competition and incentives. Competition can prevail between insurers as well as between providers. Incentives can be designed to induce the insured to reduce the use of those health services that are not urgent or of little individual benefit, while incentives for providers should lead them to more cost-efficient ways of healing sicknesses.

Due to the concern for equality of access and burden sharing, governments were reluctant to use market-oriented methods for reforming health-care systems. But rationing, as it has developed, was likewise not without unwanted repercussions on equality. Thus, what the 1990s saw as health-care reforms were mainly mixtures of both approaches. Administrative regulations have often been tightened, but elements of competition and incentives have also been increasingly introduced. Competition between providers has been intensified in nearly all countries and competition between insurers has been made possible or intensified (Germany, US). However, it is mainly in the US where health

insurers have developed from a passive "payer" to an active "player" in the health-care market. They became managed-care insurers of one form or the other and organise and closely supervise the behaviour of patients and providers. The period of stable health-care costs in the US during the 1990s is generally seen to be the result of more active health insurers.

Incentives for patients to behave cost-consciously have been intensified by higher co-payments. This instrument has been used in practically all countries, but the levels of co-payment still differ substantially. Payments to providers have changed from a fee-for-service to a fee-per-patient, per-day or per-admission basis. Specifically, the UK went far in allowing the primary care physicians to act self-responsibly and competitively by making them "fundholders" on behalf of the patients.

After 2000 health-care costs started to increase again in nearly all countries considered here. Thus, reform pressure continues – all the more as populations are progressively ageing. What will be the nature of the next wave of reforms to come?

Outside the large industrialised countries, in Singapore, an innovative model of a health-care system has been created (Schreyögg and Kin 2004). It is a (partly) funded system with obligatory private medical savings accounts to which regular contributions of an equal percentage of income must be made. The accumulated funds can be used for health treatments of higher costs than occur with everyday sicknesses. Such everyday sicknesses must be paid for by the patient out-of-pocket. For the special case of "catastrophic" costs and in case the accounts are not yet filled or recently used for another treatment, the government steps in. Equality of access to high-level medicine is guaranteed. Equality of burden-sharing is achieved by differentiated government subsidies for hospital treatment. The differentiated subsidies are linked to the hospital bed class. A low-income patient who accumulates funds in his accounts only slowly, usually chooses a low hospital bed class in which accommodation and treatment is heavily subsidised, whereas a high-income patient who accumulates funds quickly chooses a higher bed class for which there are lower or no government subsidies. Thus, tendentially, the personal medical savings accounts are more slowly filled and more slowly emptied in the case of low income earners and more quickly filled and more quickly emptied for high income earners. A specifically intelligent – namely, resource saving – feature of the Singapore health system is the possibility to use accumulated funds, above a minimum ceiling, for certain other private purposes, bequests included.

In a small health-care sub-market in the US there is some experimentation with private medical savings accounts, which is also the main content of the recent and ongoing debate about "privatisation of health care" in the US. But also in China (PR) and South Africa, elements of a private funded system have been introduced. Medical savings accounts are likely to have an increasing reform appeal also in other countries when cost pressure continues to mount.

R. O.

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