

## *Chapter 8* **Health Care Policy**

**T**he most basic element of human welfare is good health. For centuries, governments were largely “off the hook” in this area because most people did not hold government directly responsible for individuals’ poor health. Governments tried to slow the spread of infectious diseases but did little else. Since the twentieth century, as preventive public health initiatives expanded, governments have also played a growing role in the curative care sector via regulation, funding, and, at times, the provision of care itself.

### **Common Policy Problems**

Health outcomes are the fundamental test of government success in the area of health policy. If many citizens are ill and dying, people will likely say that government efforts are insufficient to deal with the problem—even if government inaction is not the sole (or even principal) cause of these undesired outcomes. The complexity of health outcomes is what makes health policy such a difficult challenge for governments. Should policy focus largely on preventive measures such as vaccinations, clean air and water, and the like? Or is the problem the absence of medical intervention at the right time? Here, too, government can make a difference by sponsoring research to discover new treatments and by providing access to curative care.

Access to curative care is understandably important to most people. People want to protect their most important asset: their lives and those of their families and friends. Perhaps the most fundamental aspect of modern health care policy stems from the widespread belief in the possibility of curing any and all illnesses: citizens’ demands in the health sector are almost unlimited. Once people became confident that even devastating illnesses could be overcome, demands for curative care expanded and many of those demands involved the government as the provider of last resort. As a result, access to curative care is a major public policy issue.

Curative care is often expensive. Specialized health care professionals demand high wages, and new medical technologies and medicines fuel our hope that virtually any illness can be conquered. In many industrialized and late-industrializing countries, the cost of curative care has risen faster than the general rate of inflation. Whether most curative care is provided publicly or privately, governments frequently face pressure to control health care costs.

## Major Policy Options

In virtually every country the government manages and provides an array of public health projects, including health education through schools and the broadcast media, vaccination programs, sanitation projects, and the regulation of food and drug quality. In most industrialized countries these projects have covered such a high percentage of the population for so long that they tend to be taken for granted despite their crucial importance for health outcomes. In late-industrializing countries, public health programs vary more substantially from one country to the next in several key respects, including money spent per person; the organizational structure of public health; the number of public health professionals per person; and crucially, the percentage of the population reached by public health initiatives. Despite the undeniable importance of these differences in public health around the world, in this chapter we focus on the organization of curative care and cost-control issues because they represent more visible public policy issues in industrialized countries (and in many late-industrializing countries).

National policy models for curative care range from direct provision of care by the government to minimal government activity in providing care or even access to that care. The polar extremes here are not absolutes: private activity still occurs in government-run systems, and government has a considerable role in market-oriented systems. All countries are searching for what they believe is an optimal mix of public and private activity.

In the **national health service** model, citizens are guaranteed access to most curative care services through a system paid for and administered directly by the government. This approach has been prevalent in many communist economies, but it has also been used in some market economies, most notably the United Kingdom. In this model the government pays hospitals, physicians, and nurses directly to provide comprehensive care to all citizens. Access is guaranteed, but all or almost all costs are absorbed by the government, which has a direct interest in cost-control measures and the authority to carry them out. This can mean, however, that demand for certain services may exceed supply—sometimes significantly. For example, waiting lists for elective procedures can be lengthy. As a result, the national health service approach is sometimes called rationed care.

In many late-industrializing countries, a much more limited national health service is constructed via a system of government-run hospitals that frequently lack the resources needed to meet the demands on their services. Although citizens are legally guaranteed a right to care at these facilities, the quality and availability of care are more often insufficient. A much higher percentage of citizens in these countries seek out private care or forego care than has been the case in the United Kingdom, Italy, or most command economies.

The **single-payer** model guarantees all citizens access to health care via a single program in which almost all funds come from the government, but

care is provided privately. This approach tries to control costs and guarantee access by pooling all citizens into a single insurance program run directly by the government. The single insurer then negotiates the best rates from hospitals and physicians. Although conceivably all citizens could pay the government a premium earmarked for health insurance, in Canada the single-payer system is funded out of general government revenues. For further discussion of the development of the single-payer system in Canada, see Box 8-1.

Through **mandatory national health insurance**, government guarantees all citizens access to care but with multiple payers and multiple providers. Germany pioneered such efforts in the late nineteenth century, and many other countries followed this model during the twentieth century. In this approach, many citizens receive health coverage through private insurance (often tied into their jobs), but government regulations guarantee certain benefits or control costs and fees. The government provides health insurance to the unemployed, the self-employed, and retired citizens through various programs.

In the **market-maximized** model, the government provides no guarantee of access through either public hospitals or mandatory health insurance. In this approach the government might provide access for some categories of people but not all. This approach assumes that access to health care is not a right of citizens but rather a choice each citizen makes. Government regulation of private health insurers, while still significant, is not at the level found in the mandatory national health insurance model. The United States has been a proponent of the market-maximized model. Health care in the market-maximized model is also rationed—not by the availability of services relative to the urgency of their need but rather by one's ability to pay.

In addition to policy options dealing with access, policymakers have an array of alternatives for dealing with cost-control concerns. Some cost-control measures try to limit costs by altering the behavior of certain individuals in the health care system. For example, one way to reduce health care costs is to make patients pay at the time care is delivered. Even if private or public insurance will pay the lion's share of the bill, forcing patients to make a **copayment** may make them monitor their use of medical services more carefully. Conversely, if care is free at the point of service, patients may be more likely to pursue care even if, in the long run, it will result in higher health insurance costs for them. Critics of this cost-control approach argue that patients' decisions to pursue treatment should not be constrained by economic considerations.

Other cost-control measures try to influence the behavior of physicians. Many countries employ a **fee-for-service** system, in which doctors are paid a fee for each service performed. If the number of services that can be provided is not constrained, physicians can provide additional services to rule out certain diagnostic possibilities or to enhance their incomes. In contrast, doctors are sometimes paid on a **capitation** basis; they receive a fee based on how many patients they treat, not on how many services they provide. In the

### *Box 8-1*    **In Depth: Canada's Single-payer Model**

For the first half of the twentieth century, Canadian health policy generally resembled the situation in the United States. The desirability of publicly mandated or financed health insurance was debated several times, but no such policies were adopted. In the middle of the century, a series of five provincial governments created universal hospitalization programs—beginning with Saskatchewan in 1947. The popularity of these programs put national health insurance back on the institutional agenda, and in 1957 the government passed the Hospital Insurance and Diagnostic Services Act. The law required all provincial governments to provide hospitalization insurance for their residents under financing shared jointly by the federal and provincial governments.

As this policy was being implemented in the 1960s, its popularity raised the issue of providing a comprehensive insurance plan that would also cover outpatient services. Despite opposition from private insurers and the Canadian Medical Association, the 1968 Medical Care Act expanded the system to its present scope. The Canadian Medicare system—in which each provincial government serves as a single payer for covered services in its jurisdiction—was in place in all provinces by 1971.

Under this single-payer system, each provincial government provides universal health coverage to its residents. The federal legislation dictates the basic coverage of the Medicare system; provinces are allowed to provide additional coverage should they choose to do so. Coverage is portable from province to province, although citizens generally must reside three months in a new province prior to joining its plan. The Medicare system features fee-for-service billing in accordance with a fee schedule worked out between provincial governments and physicians' associations. Physicians who choose not to obey the fee schedule cannot provide treatment to Medicare patients; this aspect of the Canadian system expands greatly the number of physicians in the system. As a result, citizens are able to choose their physicians from virtually the entire medical community. Covered physician services include general medical and maternity care, surgical and laboratory services, and other specializations. Medicare covers all basic hospitalization services. Hospitals in Canada are nonprofit organizations, and most are privately run. However, the government controls the annual public budget associated with the Medicare program as well as the technology acquisition decisions made by hospitals.

Under the terms of the single-payer system, private insurance companies are not permitted to write policies for benefits provided under Medicare. However, private insurers are allowed to provide supplemental medical insurance to cover benefits not provided by the government. Over 65 percent of all Canadians have some form of private supplemental health insurance, often paid in whole or in part by employers. Since 1984, when the 1984 Canada Health Act virtually outlawed patient copayments, the system has been free to the user at the point of service. The vast majority of program funding comes from general government revenues at the federal and provincial levels (although nine provinces also levy earmarked taxes or patient premiums).

United States, **health maintenance organizations** (HMOs) provide most services based on capitation reimbursement. In the capitation system, physicians presumably will restrain themselves in providing services to strictly necessary care in order to remain within the bounds of their per-patient budget. Again, critics of this approach do not want economic considerations front and center when treatment options are being decided.

Another cost-control measure that focuses on the behavior of the medical community involves **limits on technology acquisition**. Studies have shown that making expensive technologies more available increases the likelihood that they will be used. Although this seems logical enough, cost-control advocates charge that much of this technology is overused—especially in countries that operate on a fee-for-service reimbursement system. They also argue that placing limits on the acquisition of medical technology by hospitals and private physicians can help keep costs under control. Limits on technology acquisition are associated with lower costs but also imply waiting lists to use certain technologies for which demand exceeds supply.

An organizational measure that tries to change cost dynamics in the health sector involves the use of a gatekeeper. Some health plans give patients the freedom to go to not just the general practitioner (GP) of their choice but to any physician of any specialty. In contrast, in a **gatekeeper system**, patients must see a GP and get a referral before going to see a specialist. In this way, the GP serves to control costs by trying to make the appropriate referral or no referral when the diagnosis or treatment does not require the participation of a specialist. This is the cost-control measure most widely used across countries—whether the health insurance plan is public or private. In the United States, **preferred provider organizations** (PPOs) use gatekeepers. PPOs also limit patients to the selection of doctors who agree to the insurer's fee schedule. The notion at work here is that the physician is a better judge of where the patient should go than is the patient. GPs are often preferred as gatekeepers because in most countries they make significantly less money than more specialized physicians. The gatekeeper approach is not without its controversies. In some countries, gatekeeper physicians at times complain that they are under pressure to keep costs low by keeping referrals under a certain budgetary limit.

The most frequent criticism of these cost-control alternatives stems from a desire to make health care decisions without reference to economic considerations. We cannot present ironclad evidence about the optimal amount that a country (or an individual) should spend on health care; it is a choice that must be made. Choices in health policy, as in other policy areas, are made by government officials who are responding to a variety of constituent groups. In turn, individual citizens also make choices with regard to their own health spending habits.

What is the average citizen concerned about in the health sector? Everyone needs medical attention from time to time, and people know that they could

incur serious medical problems (and expenses) due to illness or injury. That said, not everyone is equally risk-averse in his or her approach to health care. Some people want to spend as little as possible on health care, and others want complete coverage almost regardless of cost.

These different individual perspectives on health insurance are related to different approaches to medical insurance: the principle of **actuarial fairness** and the principle of **risk-pooling**. Actuarial fairness calls for people to be grouped by risk factors—enabling healthy individuals in low-risk occupations to join health insurance plans with other similar individuals. Thus high-risk patients (including those already diagnosed with chronic health problems) would be forced to pay higher health insurance premiums in recognition of the greater likelihood that they will require care. The principle of risk-pooling calls for solidarity of citizens based on a recognition that everyone is at risk of needing care because of chronic illness or accidents. That risk is then pooled across a large body of currently healthy and unhealthy individuals to provide maximal coverage at a lower cost. Advocates of actuarial fairness criticize risk-pooling because they claim that it asks the healthy to subsidize the unhealthy when they have no responsibility for the illnesses involved. Advocates of risk-pooling counter that even narrowly self-interested individuals should pool risks together to lower the costs of illness to the sick because today's healthy could become tomorrow's ill.

## Explaining Policy Dynamics

Health policy has become an increasingly visible issue on the systemic agenda during the late twentieth and early twenty-first centuries. That visibility has motivated a new wave of research on the dynamics of health policy making. Most research has consisted of national case studies, but several analysts have conducted cross-national comparisons. Although in past decades primary attention was paid to cultural, economic, and political factors, a series of studies at the turn of the century brought new attention to the role of institutions.

### Cultural Explanations

Cultural factors have been used most frequently in analyses of U.S. health policy making. A series of studies have emphasized the role of an individualistic and antigovernment culture in blocking the emergence of legislation that ensures universal access to medical care in the United States (Anderson 1972; Blank and Bureau 2004; Jacobs 1993; Patel and Rushefsky 1998; Starr 1982). As we noted in other chapters, cultural differences are frequently used to explain countries' use of government authority in responding to various policy challenges.

This approach, however, has proven more problematic in building an explanation of health policy making that holds up to cross-national examination.

When we look at the rest of the Anglo-American family of nations, we see a delay in the adoption of some form of universal access policy (especially in Australia and Canada). That said, we also see that two of those countries developed health policy models that are among the most government-intensive in some respects: the first national health service (in the United Kingdom) and the first single-payer system (in Canada). In fact, during the twentieth century, health care was one of the policy areas in which most countries actively debated fairly similar policy options (Immergut 1992: 11–12). Perhaps a more nuanced version of the cultural argument merits consideration. Citizens in the Anglo-American family of nations tend to prefer a limited government role and private responsibility. These attitudes can conceivably be exploited by organized groups and political parties seeking a smaller role for government (Morone 1995).

### Economic Explanations

The convergence thesis (Wilensky 1975) introduced in Chapter 2 has played a role in comparative studies of health politics. Recall that Wilensky argued that as countries become industrialized—usually measured by gross domestic product (GDP) per capita—they are likely to experience similar social and political pressures. These pressures culminate in the adoption of a wide range of similar welfare policies—in part because those greater economic resources provide more breathing room for the expansion of government spending and activity. Roemer (1977) applied this logic to explain the expansion of government activity and spending in health care across the industrialized world during the postwar era. In addition to Wilensky's emphasis on affluence, Roemer noted that advances in medical technology developed in industrialized countries provide an additional force driving toward convergence of spending levels. This logic has been less useful, however, for explaining differences among industrialized countries regarding the specific choice of policy models and the ongoing reform of those models since the 1980s.

A central feature of contemporary reform debates, as we noted at the beginning of this chapter, is a desire to control costs. These pressures continue to intensify as the populations of industrialized countries age, owing to the observed connection between age and demands for health care services (Abel-Smith 1994; Giaimo 2002). These demographic changes are particularly relevant in the area of health policy. Senior citizens are more likely than younger citizens to want and need medical attention. Accordingly, as the elderly constitute a rising percentage of the population, health care utilization tends to rise while the amount paid into the overall system tends to decrease (especially in countries with the **employer-mandate** model in which premiums are tied to wages). This graying factor, as we noted in Chapter 2, is projected to intensify further through the 2010s as the postwar baby-boom generation reaches retirement age (Raffel 1997).

## Political Explanations

Interest group politics approaches have also been used to explain health policy making. In fact, health care constitutes the one policy area discussed in this book in which a single interest group—the medical profession—has been argued to hold a defining role all by itself. As we note throughout this book, many interest groups work to influence policy making, and their effectiveness is tied to a variety of factors such as financial and organizational resources, personal connections to policymakers, and strategies for mobilizing public opinion in favor of their positions. Several analysts of health policy making have asserted that physicians' associations have a special form of political power not found in other spheres: they are the only group licensed to provide most forms of curative care (Anderson 1972; Quadagno 2004; Starr 1982). This power is deemed greatest when health policy concerns touch directly on physicians' professional domain, for example, regarding the form of payment: "As producers of a crucial service in industrial countries, and a service for which governments can seldom provide short-run substitutes, physicians have the overwhelming political resources to influence decisions regarding payment methods quite apart from the form of bargaining that their organizations employ" (Marmor and Thomas 1972: 436–437). Stated in its most extreme view, this assertion implies that physicians' associations hold a veto power over varied policy proposals not to their liking.

Over the years, however, a series of studies has demonstrated that doctors do not always have the ability to block reforms they oppose (Eckstein 1960; Glaser 1978; Immergut 1992; Klein 2006; Stone 1980). Instead, medical associations' policy-making influence varies in accordance with their own unity (Wilsford 1991) and with the constellation of other influences on policy making. For example, a study of health policy reform in ten industrialized countries concluded that a variety of factors—including internal divisions in the profession, the political cost of being labeled as obstructionist in prior reform debates, and the increasing importance of cost-control concerns—diminished medical associations' political influence during the 1990s (Raffel 1997). As more people perceive health care activities as affecting their own sectors of the government budget or the economy as a whole, other stakeholders (for example, government officials, business leaders, and diverse interest groups) become more reluctant to defer to physicians' associations in disagreements over health policy.

Other political explanations focus on the positions of the major political parties (Maioni 1997; Navarro 1995). When one steps back to consider the role played by political parties from a broader cross-national perspective in the welfare state literature, leftist political parties played an important role in stimulating the emergence and evolution of the welfare state in most industrialized countries, whereas rightist parties worked to slow its development (Castles 1982a; Esping-Andersen 1990). Health care proved no exception to this trend as the countries with the least important leftist parties—Canada



and the United States—were the slowest to devote active consideration to some form of national health insurance. In the contemporary period, center-right and rightist parties have played a visible role in promoting reforms deemed to reduce government's role in health policy by encouraging more discretionary behavior by health care providers and patients alike (Marmor 1997), whereas left-leaning parties have tended to be more critical of many of those measures. The ability of reform-minded political parties is contingent not only on the size and unity of its governing majority but also on a variety of factors beyond the parties' direct control (Tuohy 1999).

### **Institutional Explanations**

Cultural, economic, and political factors traditionally received the most attention in studies of health politics. Since the 1980s, however, scholars (Blake and Adolino 2001; Giaimo 2002; Hacker 2004; March and Olsen 1984; Morone 1995; Steinmo and Watts 1995) have attempted to highlight the role of institutional influences that past studies understated or, in some cases, ignored entirely. Perhaps the most widely read comparative institutionalist study is Immergut's (1992) analysis of the evolution of health policy in France, Sweden, and Switzerland. Immergut focused on how distinctions in government organization (federal versus unitary), the nature of executive-legislative relations (parliamentary versus presidential systems), and the ability to call a binding referendum shape health policy making by determining the number of veto points available across the policy-making process. In this analysis, the Swiss system characterized by federalism, a multimember chief executive, and frequent use of referenda in politics makes large reforms more difficult. Conversely, the unitary Swedish government, in which the prime minister frequently enjoyed a firm legislative majority with no threat of a referendum, provided a path toward party government. The number of veto points in France during the twentieth-century evolution of health policy lay between those two extremes. Although Immergut emphasized the role of institutional factors in preventing a straight line from groups' stated positions to policy making, she concluded her study with a call to remain open to a variety of influences (1992: 242–244).

### **International Policy Making**

No binding set of international agreements guides the curative care policies of the six countries examined in this book. All six countries are members of the World Health Organization (WHO) through their participation in the United Nations. The WHO serves as a clearinghouse for disseminating data on health outcomes, public health initiatives, and medical practices. It has reached consensus behind some binding commitments regarding the prevention of infectious diseases and, more recently in this century, regarding a set of public health initiatives related to tobacco use. However, the WHO does

not set firm parameters for the curative care measures at the center of contemporary health policy.

As discussed in Chapter 9, the Maastricht Treaty includes a series of social policy goals (the so-called social chapter). The language of the social chapter itself contains no specific references to curative care initiatives in the health sector. The language emphasizes public health policy instruments and outcomes—as was the case subsequently in the health component (Article 152) of the Treaty of Amsterdam that entered into effect in 1999. Despite the EU's focus on public health, one of the social chapter's major themes—a call for harmonized social policies among member states—coincides with the pressures associated with the single-market initiative in the EU. As we will see in our examination of EU health policy activity later in this chapter, the evolution of the single market has inserted EU governing bodies into some health policy questions despite the absence of any treaty-based agreement to have EU-wide standards for medical care. Beyond the activities of the EU authorities, the move toward more open competition among the member states also makes businesses more sensitive to varying costs associated with health care expenses. The cost pressure implied by economic globalization affects countries in and outside of the EU and its Social Community.<sup>1</sup>

## United States

### Background: Policy Process and Policy History

Throughout this book we turn repeatedly to different policy sectors to discover a shared truth: the policy process in the United States is usually the most decentralized among the six countries. With the possible exception of budgetary appropriations decisions, this is most true of contemporary health policy making. In part, the diffuse nature of health policy making stems from the absence of a unified national health policy. The United States has multiple segments to its health care policy:

- A government-mandated and -managed health insurance Medicare program for the elderly
- A Medicaid program for the poor with basic guidelines set by the federal government but with most specific standards and benefits determined by the state governments
- A majority of the population covered by private insurance providers regulated by both federal and state legislation

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<sup>1</sup>The statistics presented in the case studies on benefit levels and funding are taken from U.S. Social Security Administration (2009). Data for the United States are from July 2007, data for Japan are from July 2008, and data for the other four countries are from January 2008. The data on overall health care expenditures are from Organisation for Economic Co-operation and Development (2009b).

As a result, health care reform initiatives can emerge from a variety of public arenas. The decentralization of Medicaid and insurance regulation means that any of the state governments can make health policy. The field is even broader in terms of federal policy. A variety of executive agencies are engaged in health policy formulation, including the Centers for Medicare and Medicaid Services (in charge of Medicare implementation), the Department of Health and Human Services, and the Surgeon General's office. In addition, presidents can convene working groups to formulate policy recommendations. Many congressional committees hold hearings on one or more aspects of health policy; the percentage of congressional hearings held by the presumably dominant health committees in the House and the Senate comprises less than half of all hearings held on health care.

The United States is the only industrialized country that has no form of national health insurance. During the twentieth century, a series of (mainly Democratic) legislative efforts to generate some form of national health insurance failed as government focused instead on providing tax incentives for the provision of private insurance as a job benefit. This approach left many elderly and low-income citizens without health insurance. Criticism of this large block of uninsured people eventually resulted in the 1965 establishment of the Medicare and Medicaid programs as part of Lyndon Johnson's Great Society initiatives. Medicare is a federally managed insurance program that covers people aged sixty-five and over (later extended in 1972 to cover the disabled). About 14 percent of the population is served by the Medicare program. The Medicaid program provides care to different categories of low-income citizens, covering about 11 percent of the population.

The basic Medicare program (Part A) provides up to 90 days of hospitalization coverage (and up to 100 days of nursing home care) to pensioners over age sixty-four, to those who have been disabled for over two years, and to patients suffering from chronic kidney disease. A supplemental program (Part B) covers general and specialist physician services, laboratory services, and physical therapy. Medicaid covers many inpatient and outpatient services for uninsured pregnant women and children whose family incomes are below a specified minimum. In the early twenty-first century, roughly 15 percent of the U.S. population at any point in time had no health insurance and did not qualify for Medicaid coverage. Uninsured individuals who do not qualify for Medicaid benefits must either pay for services out of pocket or seek care from a limited number of nonprofit clinics.

Roughly 60 percent of U.S. residents have some form of private insurance (often, but not always, linked to employment). These plans had traditionally featured fee-for-service billing; however, from 1988 through 2005 the portion of the insured population covered by unmanaged fee-for-service billing fell from 73 percent to 3 percent. One-eighth of the population is covered by HMOs. These comprehensive health care providers try to limit the utilization incentives associated with fee-for-service billing by hiring an array of GPs and

specialists on a salary or capitation basis. Most private insurance is provided by managed fee-for-service plans. More than one-third of the population is enrolled in standard PPO networks, and another one-tenth in **point-of-service** (POS) plans that are a hybrid of managed care and unrestricted fee-for-service insurance. In POS health plans, patients can participate in a managed care system in an HMO or in a preferred provider network headed by a gatekeeper. However, they retain the option to see physicians outside of the network at a lower rate of reimbursement from the insurer.

Most hospitals are privately owned. Since the 1980s a noticeable shift has occurred from nonprofit to for-profit private hospitals. In recognition of the substantial number of uninsured citizens, the law requires all hospitals to provide emergency treatment to all citizens; in practice, violations of this principle occur. Under both Medicare and Medicaid, inpatient and outpatient services are paid for on a fee-for-service basis.

Medicare Part A is funded by payroll taxes. Employees pay 1.45 percent of earnings; employers pay an identical percentage of payroll. The self-employed pay the full 2.9 percent themselves; pensioners pay a flat-rate monthly premium (almost \$94). Medicare participants can pay a monthly premium to gain access to Part B, which covers outpatient care. The vast majority of participants choose to do so. The federal government covers the balance of expenses for the supplemental plan out of general revenues. Wealthy seniors can choose to replace these traditional Medicare programs with an optional Part C, through which they contract with a private insurer or invest in a health savings account. The 2003 Medicare Modernization Act created a new Part D, through which patients receive prescription drug benefits by paying an additional premium that is supplemented with government funds to cover catastrophic care; the average monthly premium is about \$30. About 90 percent of eligible seniors are enrolled in Medicare Part D. The Medicaid program is administered at the state level; funding is shared between the federal and state governments out of general revenues. Federal contributions now take the form of block grants, in which states have greater freedom to determine how to spend the federal funding.

Medicare rules include a variety of deductibles and copayments. Similarly, Medicaid patients can be held responsible for billing above the relevant Medicaid reimbursement schedule; however, they are not responsible for copayments. In the private sector, deductibles and copayments are also a substantial component of the system for most people. Out-of-pocket payments account for around one-eighth of the country's health expenses.

During 1980s and 1990s the U.S. health reform debate was dominated by two issues. The first, cost control, is quite familiar to other industrialized countries. The second issue is unique to the United States: the large number of uninsured residents. Some political forces approached coverage for the uninsured as a moral imperative. Others, especially many business groups, focused on how the cost of covering the uninsured is passed on to the

insured by overbilling by private providers to compensate for losses stemming from services for which uninsured patients failed to pay. Despite the notion that market competition among insurers and providers would lead to quality care at low cost, the United States was spending more money per capita and as a percentage of GDP than any other industrialized country. In addition to overbilling, predominant reliance on fee-for-service reimbursement, administrative costs associated with the multitude of payers and providers, and so-called defensive medicine (that is, tests conducted to rule out unlikely scenarios in an effort to avoid malpractice lawsuits) all increased U.S. health care spending. The willingness and ability of many providers to purchase the latest technology also led to greater utilization of expensive services.

In the 1980s the government attempted to control rising costs through fee schedules. A uniform fee schedule based on diagnosis-related groups (DRGs) was introduced unilaterally in 1983 to try to limit the government's rising obligations under the Medicare supplemental program. Over the rest of the decade, the government kept a keen eye on fee structures in the Medicare and Medicaid programs in an effort to cut costs. However, higher utilization rates per insured in Medicare and an extension of the covered population in Medicaid kept expenses on the rise. Beyond the halls of government itself, the implementation of cost-control efforts in the private sector placed new issues higher on the systemic and institutional agendas. The expansion of HMO activity and the extension of PPOs and other utilization-controlling efforts by traditional insurers generated debate over the pros and cons of managed care. In 1988 only 30 percent of the insured population was covered by some form of managed care plan; by 1998 that figure had risen to 86 percent. These cost-control measures drew complaints from both physicians and patients, who argued that necessary tests and treatments were sometimes not provided in the effort to control costs. These public discussions of perceived decreases in the quality and freedom of care, implied by curtailed utilization, placed insurer regulation on the agenda.

Against this agenda-setting backdrop, in 1993 the newly elected Clinton administration pledged to create a national health insurance system to deal with the twin problems of high costs and unequal access. Given the high-profile commitment of the president and the many business leaders who had spoken in favor of reform, many observers felt that some major reform would take place. However, once policy formulation began in earnest, the Democratic majority in Congress was divided on which model to adopt, and most Republican legislators bitterly opposed the managed competition plan favored by the president. In addition, the Health Insurance Association of America launched a biting media campaign aimed at reducing popular support for the president's plan by asserting that the proposal would reduce patients' choice, increase their costs, and decrease the quality of services provided. In the end, none of the handful of major health care bills proposed

during the 1993–1995 session received a floor vote. For the remainder of the decade, health reform efforts focused on incremental changes rather than on a government-led reform of the entire health care system.

### Contemporary Dynamics

The 2000 presidential campaign took place in a novel context of government budget surpluses obtained during the years 1998–2000. The Democratic Party candidate, Al Gore, pledged to use much of the surplus to shore up the finances of the Medicare program and of the Social Security retirement pension program. In addition, he proposed adding a prescription drug benefit to the Medicare program. The Clinton administration had pursued this idea during its second term, but it was blocked by Republican legislative opposition. On the campaign trail, Gore criticized Republicans in general (and presidential candidate George W. Bush in particular) for not protecting the elderly. The Bush campaign stressed a desire to eliminate most of the budget surplus via tax cuts. However, in a response to the Gore campaign, Bush also promised to generate a new prescription drug benefit for senior citizens. While interest group advocates of more sweeping health policy reform had pinned their hopes on a potential Gore-led presidency, the inauguration of George W. Bush in January 2001 turned most health reformers' attention squarely to the issue of prescription drug benefits for senior citizens.

Despite bipartisan support for some sort of Medicare prescription drug coverage, the policy formulation process revealed significant differences across and within party lines. President Bush and most Republicans in the House initially backed a proposal that would provide drug benefits only to seniors who opted to shift to the privatized Part C component of the Medicare program. In turn, moderate Republicans, especially in the Senate, preferred a bill that would provide some sort of benefit to all seniors but also wanted to increase private insurance providers' participation in Medicare. Democratic legislators sponsored alternative proposals that would provide the same drug benefits to all seniors from within the traditional, publicly managed Medicare program. Senior citizens' groups lobbied for benefits for all seniors, insurance companies pressured for a role in Medicare, and drug companies mobilized to head off any effort to control drug prices as a result of Medicare reform. The division of opinions fueled a series of nonevents during the 107th Congress (2001–2003). The Bush administration did not insist on a floor vote for its proposal because it believed (probably correctly) that it could not gain passage in the Senate. In turn, Democratic proposals for more sweeping reform failed to make it out of committee in the Republican-controlled House.

Once the Republican Party regained a small majority in the Senate via the November 2002 legislative elections, the Bush administration and the Republican congressional leadership agreed to make Medicare reform the major

domestic policy initiative for 2003. When this ran into opposition from moderates in both parties in the House and (especially) the Senate, the Republican bill was modified to grant drug benefits to all seniors but required that the drug insurance plans be offered by private insurance companies. Both the House and the Senate pursued a “donut-holed” drug benefit: in the final version of the legislation, seniors would receive coverage up to a \$2,400 spending threshold; then they would pay 100 percent of prescription costs until they reached a catastrophic threshold of \$3,850 in out-of-pocket spending—after which point the government would pay 90 percent of any additional prescription costs. The catastrophic component is an unfunded commitment to be paid from general government revenues. This particular program feature caused a rebellion on the House floor as several fiscally conservative Republicans initially voted against the bill. The House leadership took the unusual step of leaving the vote count open for several hours while furiously lobbying a handful of legislators to change their votes. The measure passed by a one-vote margin with a small number of Democratic votes.

The implementation of the 2003 Medicare Modernization Act did not proceed smoothly. Many senior citizens struggled to come to grips with a dizzying array of new prescription drug benefit plans. The law gave them only a few months to make a decision in order to access Part D without paying a penalty. In addition, the law and its implementing legislation permitted the private insurance companies participating in Part D to change their benefit packages and premiums frequently. Skeptics claimed that the Republican leadership had used the bill to bankrupt the Medicare system while filling the coffers of insurance companies and the pharmaceutical industry.

Complaints about the new system motivated the Democratic Party to make reform of Part D its first legislative initiative upon gaining a legislative majority in 2007. On a party-line basis, the Democratic bill to empower the Medicare program to negotiate drug prices (a power already enjoyed by the Veterans Health Administration, by Medicaid, and by large private insurers) passed the House. However, 41 Republicans in the Senate supported a filibuster that prevented consideration of the bill in the upper house during the 2007–2009 legislative session. Meanwhile, continuing concerns over both health costs and the plight of the uninsured reinserted those issues into the 2008 presidential campaign. The victory of Democratic candidate Barack Obama provided the potential to reinsert discussion of some form of universal health care proposal into the institutional agenda of the U.S. Congress during the 2009–2011 session.

The health care reform experience under the Clinton and George W. Bush administrations demonstrates a series of obstacles that make major expansion of government activity difficult in this sector. Many citizens are skeptical of government intervention. Interest groups are able to mount private and public lobbying campaigns on behalf of their preferred policy positions so that reformers find it difficult to see their vision rise to the top of the systemic

agenda unchallenged. The federal system dictates that policy can be made (and blocked) at multiple levels of government. The presidential system of executive-legislative relations permits not only the possibility of divided government but also the daily reality of a decentralized legislative process in which multiple poles of power exist in both houses of Congress. Remember, the Clinton health care proposal did not fail in a Republican-controlled legislature. It failed to get a floor vote in a session in which the Democratic Party held majorities in both houses. In a similar vein, the Bush Medicare reform initiative nearly failed because of opposition from Bush's own party in the Republican-controlled House of Representatives. This is a telling reminder about the limitations on the president's ability to generate major legislation in the U.S. political system. Advocates of sweeping health reform during the Obama presidency will need to devise strategies to mobilize public opinion and interest groups to pressure legislators to back an expansion of health insurance coverage in the United States.

## Japan

### Background: Policy Process and Policy History

National policy making in Japan has a corporatist element. The government interacts with sickness funds established by individual businesses and sectors of the economy. These sickness funds are in constant contact with the relevant health care provider organizations. The fee schedule is set in formal negotiations between the Central Social Insurance Medical Council and the Ministry of Health and Welfare. The central council represents various groups, including health care payers (sickness funds, management, and labor), the general public (represented by lawyers and economists), and health care providers (who have eight seats). Surprisingly, hospitals have historically been excluded from the council. It should not be surprising, then, that hospital physicians have tended not to fare as well as outpatient physicians and clinic heads in fee negotiations. Major reforms have been brokered historically not just in negotiations between the council and the Ministry of Health and Welfare but also in negotiations between various factions in the Liberal Democratic Party (LDP).

In contrast to the U.S. experience but in line with developments in Europe, Japanese health policy was built on a foundation of occupationally grounded government-mandated insurance plans, which began in the industrial sector in 1922 and expanded gradually to cover most employee groups. A separate, government-run National Health Insurance (NHI) program was established in 1958 by the LDP government to provide care for those not covered by employee health plans; every locality was required to have an insurance plan for such residents by 1961. Approximately two-fifths of the population is currently covered by the NHI program while 60 percent of Japanese residents have employment-based health insurance.



The sickness funds and the NHI program often have health care providers under contract. The system calls for outpatient physician services to be paid on a fee-for-service basis; fee schedules are negotiated by physicians and insurers. In many cases the NHI fees are lower than the employer-mandate fee schedules. Both the employee plans and the NHI program cover physician services, hospitalization, prescription drugs, and dental care. The employee plans often provide additional benefits or require smaller copayments.

Most hospitals are privately owned. Hospital physicians are salaried employees; however, reimbursements for hospital procedures are made on a fee-for-service basis. Many physicians own small clinics that provide inpatient treatment and, often, long-term care. Furthermore, many physicians are also pharmacists—enabling them to profit from the medicines they prescribe. Japan has tended to have the highest per-capita pharmaceutical consumption in the world.

Funding varies considerably across different employee plans. Most employees in such plans pay between 3.7 and 4.1 percent of their total income. Most employers also contribute at rates ranging from 3.7 to 4.1 percent. Government subsidies from general revenues cover 13 percent of most benefit costs and 16.4 percent of costs for elderly employees and covered retirees. In the main NHI system the insured pay a flat-fee premium that varies somewhat by locality; the average annual NHI premium was roughly \$750 in 2006. The government bears the brunt of the costs out of general revenues because it pays for half of all medical care provided and all administrative costs and provides additional subsidies to certain localities. In 1982 the government introduced a separate NHI program for the elderly that was intended to limit government obligations to less than half of total costs with the remainder paid by contributions from the sickness funds. In practice the system did not limit government obligations as much as anticipated. In 2008 the government created a new system for so-called old-old residents, aged seventy-five and older. In this system, older senior citizens will now pay a premium designed to cover 10 percent of costs (and the law mandates that this cost-sharing will increase as the aged's share of the population increases over time). In turn, the government and the sickness funds will share responsibility for the remaining costs.

Copayments are a major feature of the Japanese system. In the employee plans and in the NHI program, patients aged 3 to 69 pay a 30 percent copayment on all care up to a monthly out-of-pocket maximum, which varies by family income, up to a ceiling of about \$450. Patients aged seventy and over pay a 10 percent copayment unless they are classified as high-income, in which case they are billed the standard 30 percent. Hospitalized patients also pay a small per diem of roughly \$3, earmarked for food services, that is reduced for low-income patients.

The demographic transition has framed the evolution of the Japanese health care system. Japan had the oldest population in the world by the 1980s,

which helped to drive up health care spending. Copayment provisions were initially adopted in 1984. In 1994 a bipartisan consensus (shared by business leaders) led to a monthly copayment increase that was followed by another hike in 2002 up to the current 30 percent rate. Apart from that debate, in the late 1980s and 1990s reform discussions centered primarily on the elderly and, in particular, on the issue of long-term care. Historically, Japan has had high hospital occupancy rates (above 80 percent) and a long average length of stay (often over 50 days), largely because hospitalization has been used to provide long-term care.

These trends generated serious debate within and between the major factions of the LDP regarding how to address the need for long-term care. Rising costs in the 1980s were viewed as the first wave of a much larger problem, given the demographic trend toward an aging society. As was often the case during the LDP's heyday, policy formulation involved extensive consultation among party faction leaders, civil servants, business leaders, health professional associations, and (to a lesser extent) labor unions. Nearly a decade of debate culminated in the presentation of the LDP's Gold Plan for long-term care. A 1997 law created a new long-term care insurance system launched in 2000. The goal was to curtail costs by sharing financial burdens and by trying to stimulate the use of home care as an alternative to hospitalization.

### Contemporary Dynamics

The end to Japan's long period of sustained economic growth reshaped the health policy debate. In the 1970s and the 1980s, concerns for cost control were leavened by growing government revenues and by private sector commitments to employees. As the economic downturn of the 1990s extended into the new century, a broadening coalition of government officials began to look for ways to limit health spending. Despite the expansion of copayments discussed above, health spending as a share of GDP grew from 6 percent in 1990 to nearly 8 percent in 2002. When reform-minded Junichiro Koizumi became prime minister in 2001, his newly formed Council on Economic and Fiscal Policy took up the costs of caring for the elderly as a major arena for policy reform.

The most aggressive reformers in the Koizumi government wanted to combine new limits on health spending with decentralization and injection of new business activity via an expansion of competition in the hospital sector. Sickness funds vigorously backed the idea of changing the provision of insurance for the elderly because they viewed the existing NHI system for the elderly as an open-ended requirement in which they transferred money from their sickness funds to subsidize the NHI program. Many subnational governments also welcomed any reform that might reduce their financial obligations. In contrast, opposition political parties accused the LDP of abandoning its responsibilities and commitments to care for senior citizens; interest groups

for the elderly were similarly opposed. Japanese physicians' groups lobbied strenuously against proposed efforts to transform health care delivery. The diversity of opinions and the public visibility of the health system made the pursuit of reform difficult. Over time the Koizumi government abandoned some of its deregulation proposals in a successful effort to reduce physicians' opposition to the overall reform package.

Koizumi's electoral victory in 2005 broke the logjam regarding health reform. His successful effort to campaign against members of his own LDP party opposed to the privatization of the Japanese post financial network gave him a more disciplined legislative majority. The 2006 Health Reform Law focused on five areas. The major reform was the 2008 establishment of the old-old insurance system. This system placed explicit caps on the financial subsidies provided by the national government, subnational government, and private insurance companies while creating a system of patient premiums that would increase over time as the number of participants grew. This change is significant given that the share of the Japanese population aged seventy-five and older doubled from 5 to 10 percent during the years 1990–2007. The 2006 reform also decentralized oversight and management of the NHI system to forty-seven prefecture-level governments charged with determining financing schemes in accordance with local actuarial trends and tax bases. To reduce costs, the 2006 reform mandated efforts to promote healthy lifestyles via annual checkups and (like the previous Gold Plan) calls for reduced use of hospitalization for patients in long-term care situations. Finally, the law required a dramatic expansion of the use of electronic billing and electronic medical records. The heightened use of information technology aims at providing a more comprehensive database from which to review utilization patterns and to guide physicians in following evidence-based standards of care.

The implementation of the Koizumi-led health reform required a substantial shift in administrative staffing and practices. Prefectural agencies had to be established to manage the entire health insurance system. In addition, the lofty goals of instilling healthy lifestyles and promoting more cost-effective patterns of long-term care depend not just on administrative reforms but also on convincing patients to change their own behavior. The government's official cost-saving target in 2006 was an annual savings of \$20 billion nationwide by 2011. By 2008 the government had already reduced its forecast to a potential annual cost savings of perhaps as much as \$7 billion by 2011. As of this writing, it remains to be seen whether even this more modest goal will be attained.

The difficulties in shifting bed-usage rates faced by the Gold Plan and then by the subsequent 2006 Health Reform Law demonstrate another facet of the complexity of policy implementation. During the policy formulation and decision-making stages, the interaction of government officials and interest groups dominates our attention. In many policy areas, including health care, the activities of these players are crucial to effective policy implementation as

well. However, when the realization of policy goals also depends on the behavior of individual citizens, substantial cooperation between organized interests and government may not eliminate all implementation problems. In this case, generalized cultural norms form a barrier to full implementation. Culture—as discussed in Chapters 2 and 3—is a factor that can be slow to change.

## Germany

### Background: Policy Process and Policy History

In contrast to other countries, in Germany the health policy process has historically been more inclusive and more decentralized. An 1883 statute called for the establishment of labor-management boards to administer the sickness funds. Government played the role of the honest broker in disputes—but it was a broker with the power to alter the rules and provide subsidies. Over time, physicians began to form associations specific to each sickness fund through which to bargain over budgets and fees.

Since 1977 health policy making in Germany has been even more formally corporatist in its approach to interest group participation. Legislation established the federal Concerted Action process to oversee the government-mandated health insurance program. Twice a year representatives from over seventy groups meet to review the state of the health care system and to negotiate budgetary, fee, and utilization guidelines for the next six months in a variety of health subsectors including hospitals, outpatient services, pharmaceuticals, and dental care. These measures were taken to provide an inclusive setting from which to deal with the inflationary problems of the late 1970s. The Concerted Action group sets guidelines—often based on recommendations formed by its permanent professional staff—intended to shape subsequent formal negotiations between the regional sickness fund associations and the corresponding regional physicians' associations.

Germany adopted the first government-mandated health insurance program in 1883. A series of German governments gradually extended the mix of sickness funds tied to job categories until arriving at truly nationwide coverage during the postwar era. After reunification into a single Federal Republic of Germany, residents of the former German Democratic Republic (who retained their original pension and disability benefits in many instances) became participants in the German health insurance system.

As in Japan, Germany has a patchwork of government-mandated sickness funds with special systems existing for miners, seamen, public employees, and self-employed farmers. Almost all other employees, the unemployed, pensioners, and the self-employed are required to join the government sickness fund system if their annual income does not exceed a threshold determined by the government. In 2008 the threshold was over \$70,000; about one-quarter of the population has been above the threshold since reunification.

Those earning more than the threshold can choose to join the sickness fund system voluntarily; around two-thirds of such Germans do so. Most of the other third (less than 10 percent of the total population) have private insurance; however, citizens who choose private insurance cannot return to the sickness fund system. Through the year 2008, roughly 1 percent of the total population consisted of people above the income threshold who chose not to have health insurance. Beginning in 2009, however, all residents are now required to join the sickness fund system or to purchase private insurance. All sickness funds are required to cover physician services, maternity, hospitalization, and prescription drugs. A 1994 reform added a series of long-term care provisions (along with a boost in the payroll tax earmarked for that purpose). Semiprivate rooms and eyeglasses are not covered, but many Germans have supplemental private policies for these services.

Outpatient physician services are provided on a fee-for-service basis in accordance with fee schedules negotiated at the national and regional levels. Hospital physicians, however, work on salary. Hospitals are paid an all-inclusive per diem by the insured's sickness fund. The per diem varies by region and, since 1996, by illness. The government controls the acquisition of capital equipment by hospitals.

A majority of sickness fund revenues is generated by payroll taxes charged up to the annual income ceiling used to determine mandatory participation. Historically, as in Japan, funding varied across different sickness funds in Germany. A 2007 health finance reform, however, set a new uniform contribution rate effective in 2009. All employees now pay 8.2 percent of income on the first \$65,000 earned. Employers usually pay 7.3 percent up to the same income threshold. However, employers pay the full employee share for low-income workers (those earning less than \$600 monthly in 2008). The government contributes subsidies for maternity benefits, to pay for children's health care, and to help cover pensioners, the unemployed, students, and apprentices; these subsidies constitute around one-quarter of sickness fund revenues. Patients make 10 percent copayments for prescription medicines, and they must cover the difference in price between a brand-name drug and a generic. In addition, they pay a supplemental per diem for the first four weeks of hospitalization and roughly \$15 per outpatient visit.

Most contemporary health policy reform efforts in Germany have focused on cost control, beginning with the aptly named 1977 Health Care Cost Containment Act, which established annual spending targets for physician services and the current mechanism for fee negotiations. When the government squeezed the fee schedules, physicians often provided more services. In 1986 the government replaced the targets with annual caps; once the cap is breached in a region, the sickness fund pays out less than 100 percent of the normal fee. Because physicians submit fee vouchers to physicians' associations that are reimbursed by the sickness funds, the move to a cap gave physicians an incentive to police themselves. If a doctor bills for too many services, he or she is

eating into the fee schedule of all other physicians in the regional association. In 1988 the government responded to rising expenditures on prescription drugs by requiring the use of generic drugs. It also implemented several of the copayments applied in today's system. A 1993 reform introduced a host of new cost control measures: additional copayments, reference prices for prescription drugs, a cap on the supply of physicians, and a new formula to keep physicians' incomes in line with other workers' incomes. In 1997 most patients were given the ability to choose among all of the sickness fund options. In 2003 the Schröder government pursued a substantial increase in copayments and created a new "smart" identification card as a platform for holding prescription information and other forms of electronic medical records.

### Contemporary Dynamics

Reform measures were largely successful in controlling costs in the 1980s, during which time health spending stayed at just over 8 percent of the GDP. However, in the 1990s reunification placed additional fiscal pressure on the government (as described in Chapter 6). Health spending rose to over 9 percent upon reunification in 1991 and then reached 10 percent by 1995. Sickness fund managers complained of rising cost pressures, and patients disliked the increases in copayments. The network of mandatory sickness funds faced grim actuarial trends. Cost containment had gained a nearly permanent place on the systemic and institutional agendas.

A variety of possible solutions were brought forward from different elements of the policy network in the early twenty-first century. The two major political parties favored contrasting reforms in the 2005 election campaign. The Social Democratic Party backed a call for truly universal health care in which all citizens would be required to pay a uniform payroll tax in support of the health care system. The existing ability of affluent citizens to opt out of sickness fund system would be eliminated; private insurance plans could exist but only to provide supplemental benefits (similar to the system in place in Japan and in most of Europe). Labor unions backed this initiative and were particularly insistent on moving toward a universal system. The Christian Democrats countered with a call to transform the system into a flat-rate annual premium that would be identical for all residents regardless of income. The government would contribute subsidies to assist low-income residents, and all people would be encouraged to pay additional contributions to create a rainy-day fund. Major business confederations supported the Christian Democratic proposal along with some alternative ideas that would also place a firm cap on employer health insurance costs. Physicians' associations criticized the possibility that either reform might jeopardize the quality of care and leave some sickness funds unable to meet their obligations.

The stalemate in the 2005 legislative elections framed the decision-making phase. The two major parties in the subsequent "grand coalition"

government led by Angela Merkel had both committed to major health reform, but they disagreed on specifics. In the end the Merkel government negotiated a brokered set of reforms over two years that embraced elements of both major proposals while leaving open to future governments some key decisions. The 2007 Act to Strengthen Competition in Statutory Health Insurance introduced several changes that entered into effect on January 1, 2009. In line with the prior Social Democratic proposal, the reform set a uniform, total percentage contribution rate of 15.5 percent of income; there was no shift to a flat-fee payment system. However, all contributors into this unified national health fund can select the sickness fund of their choice—a market-oriented component favored by Christian Democrats. Sickness funds can determine if they want to offer additional benefits and can also provide refunds if they run a profit; this is intended to inspire greater cost-effectiveness in the sickness funds. To avoid having some sickness funds harmed by adverse selection (that is, by having too many sick insurees), a third major element of the reform created a morbidity-based adjustment system in which sickness funds would receive funds in accordance with the risk factors associated with their members. A fourth component of the law provided an additional safeguard for sickness funds by permitting them to levy a surcharge contribution of up to 1 percent of their total revenues if they are running a deficit; however, use of the surcharge clause permits all insured contributors to change sickness funds should they choose to do so. A fifth feature of the reform, favored especially by Social Democrats, increased government subsidies into the new health fund. Finally, the Christian Democrats were most insistent on the new cap on employer contributions. While the contribution rate for most employees increased, the contribution rate for most employers declined in the new system.

As of this writing, only very preliminary information is available regarding implementation of the reform measures that began in January 2009. Many analysts criticized the decision to permit sickness funds to continue to collect contributions during 2009 (as they had done in the prior system); the sickness funds then distribute funds to the government, which redistributes them to the sickness funds based on patient enrollment and morbidity trends. The principal criticism is that this incremental change in how payments are collected is needlessly inefficient. Critics are mobilizing for the creation of a single government agency into which health fund contributions will be paid because that will stop employers from having to earmark payments toward a variety of sickness funds. However, with the September 2009 elections on the horizon, few people expect any tinkering with this or other aspects of the new health care system until a new government is in place.

The intentionally mixed nature of the 2007 reform law leaves the future of the system tied to the results of the next elections. Business groups tend to place their hopes on the notion that a Christian Democratic victory will provide the best chance of retaining the cap on employer contributions obtained in the last

reform. Conversely, labor unions and center-left political parties assert that the recent reforms placed the costs of adjustment on working families.

The response to cost pressures in contemporary health policy demonstrates the consensus-seeking nature of German political dynamics. The pursuit of consensus was amplified by the emergence of Merkel's "grand coalition" following the 2005 elections. Neither of the two major political parties wanted to abandon its respective commitments to health reform, but they now each lacked the legislative might needed to ensure that their vision would take clear precedence. Seeking consensus by producing a multifaceted compromise avoids more vibrant conflict, but it does not ensure that all (or even most) major constituencies are fully satisfied. In this situation, most participants consoled themselves (and their constituents) with the knowledge that the 2009 elections might provide a new constellation of forces more in line with their preferred policy options.

## France

### Background: Policy Process and Policy History

Health policy making in France takes place largely at the national level. The action centers around two agencies—social security and finance. Historically, major proposals for reform have emerged out of the social security agency and are then reviewed by the Finance Ministry staff. At times, however, the initiative for reform has stemmed from the Finance Ministry in response to pressure to cut costs.

The ongoing debate over budgets and fee schedules also takes place at the national level. The association of sickness funds negotiates with the three major physicians' associations over fee schedules. These agreements must then be approved by both the finance minister and the social security minister. The sickness funds can use the central government's veto power in disagreements over fee schedules in two ways. First, the funds can try to reduce demands from physicians by claiming that the government will simply reject them later. Second, if the funds want to appear conciliatory, they can go along with physicians' demands when they are confident the government will reject that portion of the agreement. In both cases the strength of the sickness funds' negotiating position is determined in part by having open communication with the relevant ministries. The funds' position is enhanced further because they need consent from only one of the three physicians' associations in order to form an agreement. The physicians' bargaining strength lies in their predominant role in establishing the relative values among different service groups such as the ratio of the cost of open heart surgery to the cost of a heart stress test.

Government intervention in the curative care sector in France began in earnest with the 1930 Social Insurance Act, which provided health insurance to low-income workers. After World War II, a series of laws expanded the



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system until it covered virtually all citizens by 1978. The resulting patchwork of programs, comprising a variety of plans directed toward different occupational groups, is a government-mandated insurance system. The system is dominated by the general health insurance plan, which covers over 84 percent of the population. Special systems exist for occupations including the agricultural and mining sectors, public employees, and the self-employed. Because the majority of French citizens are covered in the general system, our discussion focuses on that plan.

The general system covers all eligible employees with 60 hours of paid employment in the previous 30 days (or 120 hours in the previous 90 days) with contributions duly paid into the system. Because it is a national health insurance system, coverage is portable across the country. Physician services are provided on a fee-for-service basis. The insured usually pays for services first and is then reimbursed by the local sickness fund for a percentage of the cost (usually around 70 percent, but reimbursements vary from 30 to 100 percent). Reimbursements are calculated in accordance with negotiated fee schedules for the fund; the patient is responsible for excess fees. Covered services include general medical and maternity care, surgical and laboratory services, other specializations, dental care, and medicines.

Hospitals are a mix of public and private institutions. Although fewer than one-third of all hospitals are public, they account for over two-thirds of the available beds in the system. In response to cost-control concerns, in the mid-1980s French public hospitals were placed on fixed global budgets while private hospital care was financed by reimbursements via the sickness fund system. A 2003 reform under the center-right Raffarin government will merge financing for both public and private hospitals into a unified system by 2012. Rather than global budgeting or fee-for-service, all hospitals will be financed primarily on a per-patient basis via the use of DRGs—supplemented by a fixed yearly grant to cover emergency room expenses and by additional, optional grants to fund research initiatives and other special projects. The insured pays a flat per diem (almost \$24 in 2008) for hospital room and board. Disabled children, soldiers injured in war, and employees injured in job-related accidents are exempt from the per diem. All inpatient medical services are handled as part of the insurance program and reimbursed as described earlier. The system as a whole provides comprehensive coverage for everything but semiprivate rooms and, in some instances, eye care and chiropractors. Patients enjoy unrestricted access to specialists; the system has no gatekeeper provisions. Approximately 85 percent of the population has supplemental private insurance to cover copayments and additional services not covered in the general plan.

The bulk of sickness fund revenues comes from payroll taxes. Employers pay 12.8 percent of total payroll into the general system. Employees pay just 0.75 percent of total earnings; however, most of the funds collected by the 7.5 percent income tax surcharge (the general social contribution) go toward

the sickness fund system. The government contributes subsidies into the system taken from a 12 percent surtax on automobile premiums and from excise taxes on pharmaceutical advertising, tobacco, and alcohol. The government also provides funds for hospital construction.

The French system is not free to the user at the point of service. As we noted earlier, patients generally pay for services and are then reimbursed by the insurance program. In addition, most services call for a 30 percent copayment on the part of the patient. In fact, copayments for many users tend to exceed 30 percent annually because more services are reimbursed at less than 70 percent (either by regulation or in practice because of fee differences) than the few reimbursed at over 70 percent. Treatment for serious prolonged illnesses (including cancer and diabetes) is exempt from copayments. These twin funding measures—initial payment in full by the patient and a substantial copayment—are cost-control aspects of the system that try to limit utilization by influencing patient behavior. The effectiveness of copayments as utilization control is limited because over 85 percent of the population has supplemental insurance to cover the copayments.

Health reform efforts in the 1980s and early 1990s tried to control costs by focusing on providers. In 1983 public hospitals were placed on fixed annual budgets to control average lengths of stay. In subsequent years the government took a stronger stance in negotiations with physicians over the national fee schedule. As in Germany, many physicians responded by billing for additional services. An increasing percentage of physicians were permitted to bill for certain services in excess of the established fee schedule; by the late 1980s nearly 30 percent of all physicians could do so. That extra billing had to be paid out of pocket by the patient (or, in turn, by private supplemental insurance). The center-right Juppe government proposed a firm cap on physician services only to see the proposal fail amid fierce opposition from physicians' associations.

Upon taking office in 1997, the center-left Jospin government shifted the reform debate to persistent inequalities faced by users. In 1998 all insured adults received an electronic card to maximize the portability of their insurance information for billing purposes. The government then turned toward the unequal availability of supplemental insurance, which historically represented a stark division in coverage and utilization between low-income citizens and the rest of the population. The 1999 Universal Health Coverage Act created a truly universal health care system by creating government funding for the small minority of poor citizens (less than 1 percent of the population) who did not qualify for coverage under the previous rules. More important, the law created a subsidy by which French residents under the poverty line could qualify for government financing of a supplemental insurance policy to cover the large copayments in the French system—thereby leveling the playing field for utilization decisions made by low-income citizens.

### Contemporary Dynamics

The 2002 elections provoked a sea-change in the balance of forces in French politics. Jospin's defeat in the first-round presidential elections in April was followed by a massive victory by Jacques Chirac in the May presidential run-off and then by a major victory by his center-right bloc in the June legislative elections. The Raffarin government was formed with a large parliamentary majority that it took as a mandate for reform in several policy areas.

The Raffarin government, emboldened by its large electoral victory, took up the banner of sweeping health reform that had been one of the downfalls of the previous center-right governments led by Alain Juppe and Dominique de Villepin in the mid-1990s. The government proposed a "Hospital 2007" reform package to modernize French hospital care via a shift to DRG-based billing—which would move public hospitals away from global budgets while moving private hospitals away from fee-for-service billing. In addition, public hospitals and their medical staff would receive new operating autonomy. The Raffarin government also proposed to reopen the controversial issue of physician reimbursement for outpatient care. The Juppe reforms of the mid-1990s had created a legal mechanism for reaching formal contracts with physicians' associations, but in the ensuing years only the general practitioners had ever reached an agreement with the government. Medical specialists welcomed the end of a Jospin government that they felt had suppressed official fees, but they also viewed these new negotiations in an atmosphere of conflict and mistrust dating back to the strikes against the Juppe government. Labor unions and center-left political parties opposed many elements of the Raffarin package as focusing more on the use of market mechanisms and less on the issues of access and quality of care. The Raffarin government, in response, labeled its hospital proposals a pursuit of equality for public and private hospitals (rather than as an attempt to inject competition into the hospital sector).

At the decision-making stage, the government moved most quickly in the areas where public opinion most sided with its reform ideas: controlling drug costs and hospital reform. A reform of the social security law authorized the pilot creation of a series of reference prices and the shift toward generic drugs for a small minority of pharmaceuticals. The 2003 hospital reform law will merge financing for both public and private hospitals into a unified system by 2012. Private hospitals moved immediately in 2003 to billing on a per-patient basis via the use of DRGs, whereas public hospitals will gradually increase the use of that financing mechanism over a ten-year period culminating in 2012. For both public and private hospitals, these funds can be supplemented by a fixed yearly grant to cover emergency room expenses and by optional grants to fund research initiatives and other special projects. Regional health authorities also received new funds to renovate several aging hospital facilities. In 2005 a second reform law gave hospital boards and clinical staffs more managerial autonomy in terms of how facilities would be used and in how to subcontract services from other providers. The goal of the overall reform is to

encourage hospitals to work efficiently within each DRG to provide care as needed. The 2004 Health Insurance Reform Law focused on the dynamics of outpatient care. All insured adults would receive an enhanced electronic identification card suitable for containing their medical records; they also gained legal control over those records. The 2004 law also introduced a gatekeeper mechanism into the French system of outpatient care. Patients could refuse to contract a primary gatekeeper physician; however, if they did not use the gatekeeper system, all reimbursements would decrease by 10 percentage points.

The initial implementation of these reforms went more smoothly than many analysts had predicted. Firm consensus on the need for modernization galvanized support from the hospital community. In turn, patients opted for the gatekeeper system option in larger numbers than had been anticipated; by 2008 roughly three-fourths of insured residents had contracted a gatekeeper physician. Some analysts argued that the reimbursement penalty was driving patient behavior, whereas others claimed that a considerable number of citizens mistakenly thought that the gatekeeper system was mandatory rather than optional. To reduce the ongoing conflict with the major physicians' associations, the Raffarin government reached collective contracts in 2005 with several major associations for the first time this decade. To get specialists to agree to the new gatekeeper system, the new contracts authorized a wider variety of specialists to engage in extra-billing in any situation in which patients are consulting specialists outside of the gatekeeper system.

The reelection of the center-right bloc in the 2007 presidential and legislative elections produced an extension of the call for decentralization that began in earnest under the Raffarin government. In 2008 the Fillon government was preparing a series of proposals to create a network of regional health authorities to govern the hospital system. Some observers called this a first step toward decentralizing all medical care. As of this writing, it is premature to predict the outcome of this particular reform effort.

The ability of physicians to block the Juppe reform proposals demonstrates a situation in which the policy network privileged the physicians' position. The formal inclusion of physicians' unions in bargaining over fee schedules enabled physicians to play the labor card despite their historical emphasis on free-market principles in the health sector. The physicians' associations depicted themselves as unionized workers attempting to protect the other unionized workers jeopardized by the threat of inferior care that doctors claimed would result from the cap. Divisions among doctors had weakened their bargaining position in fee negotiations in the past, but the threat of a firm cap enabled the three major physicians' groups to speak with one voice on this particular issue, further enhancing the doctors' ability to mobilize opposition to the cap from elements of organized labor and from the public at large. Conversely, the emergence of a large center-right majority in 2002 showed that the relative power of physicians' groups is contingent not just on its unity but also on that of the government. The Raffarin government's

legislative power and internal discipline enabled it to pursue successfully several of the reforms that the Juppe government felt forced to abandon.

## **United Kingdom**

### Background: Policy Process and Policy History

The National Health Service (NHS) plays a major role in policy formulation in the health care sector in the United Kingdom. The senior administrators are charged with setting fee schedules and global budgets in consultation with the health minister, the Treasury, and relevant health providers' associations. Because services are provided directly under NHS supervision, the agency also provides the vast majority of data suitable for program evaluation. For three decades after its inception in 1948 the NHS was largely autonomous—at least once it demonstrated an ability to meet most of its core functions with limited annual funding increases from the national government. Prime ministers and their health ministers tended to view the NHS as a popular government program that had proven itself relatively free of the cost pressures evident in other countries in the 1970s. This set of assumptions gave the NHS more freedom to determine how to allocate limited resources, but it also made it difficult for the NHS to generate political support for increasing its funding. Nevertheless, this historical autonomy was neither unlimited nor formally guaranteed. The executive always retained the capacity to consider reshaping not just the flow of NHS funding but also its basic mode of operation. The potentially activist role for the prime minister in health care policy was realized by the Thatcher government in the 1980s, and subsequent governments retained an activist stance in the 1990s and the early twenty-first century.

The United Kingdom's first national health insurance legislation in 1911 provided incomplete care to a limited number of low-income citizens. During the next three decades, dissatisfaction with the system increased despite efforts to expand the percentage of citizens covered and the range of services provided. The Beveridge Report in 1942 recommended sweeping reforms. Shortly after the end of World War II, legislation led to the creation of the NHS—which mirrored many of the Beveridge recommendations. Three decades later the Thatcher government began a series of attempts to inject competitive dynamics and financial incentives into the NHS system, culminating in the 1990 National Health Service and Community Care Act, which created the beginnings of the NHS system as we know it today. As we see in this section, the Blair government continued along the path of inserting market dynamics and patient choice into the NHS. In addition, health care was one of the public services devolved to local authorities in the late 1990s by the Blair government. Accordingly, the funding, precise organization, and nature of medical services vary somewhat among England, Northern Ireland, Scotland, and Wales.

The NHS provides a comprehensive range of services to all citizens. All patients must enroll with a GP who serves as a gatekeeper for referrals to

specialists. Capitation reimbursement is the key aspect of GP compensation: it constitutes half of their income. A base salary (40 percent) and, since 2004, a quality points system for merit-based pay provide the rest. The NHS covers all physician services, hospitalization, dental and eye care, long-term care, and prescription drugs. Since 1999 a clinical committee of physicians determines each year the precise mix of services available in each service area.

Most hospitals are publicly owned and managed by one of twelve district health authorities in the NHS system. Public hospitals receive fixed global budgets from the NHS based on actuarial trends in their area. Since the 1990 reform, large hospitals with over 250 beds are able to become self-governing trusts with the freedom to raise their own capital and to set staff pay levels. Such trusts (now constituting 95 percent of all hospitals) can also keep any surplus for capital improvements. Long-term care is provided by the Community Care Sector of the NHS, which also administers public health initiatives.

Over 90 percent of the system is paid for out of general government revenues. In each of the four devolved regions, the NHS has a network of local trusts that provide primary care and purchase specialist services in their respective local districts. Although the Beveridge Report called for services to be free at the point of service, copayments have been introduced over the years that support roughly 10 percent of NHS services. Patients pay a maximum copayment of roughly \$400 for dental care and are charged a \$13 flat-fee copayment for prescription drugs. Low-income citizens, children, and pregnant women are exempt from dental and pharmaceutical copayments. The elderly are exempt from prescription drug copayments. Around 11 percent of British citizens have some form of private health insurance. Most have supplemental coverage for nonemergency care to avoid waiting lists in the NHS for such services.

Eliminating waiting lists was a watchword for the proposed Thatcher reforms in the 1980s and early 1990s. In contrast to most other industrialized countries, the major British health reform issue had not been cost control. Of the six countries examined in this book, the United Kingdom spent the smallest percentage of its GDP on health care—then and now. With its fixed global budgets, minimal fee-for-service reimbursement, salaried physicians, and limits on technology acquisition, the NHS has possessed from the outset many of the cost-control measures discussed in other countries. Instead, the market-oriented Thatcher government used formal program evaluations and anecdotal patient complaints to try to build support for reforms focused on improving the quality of services and the speed with which they were provided.

In passing a comprehensive reform in June 1990, the Thatcher government highlighted guaranteed maximum waiting periods for different procedures. This guarantee dovetailed with the Tories' prior strategy of building public support for change by focusing on patient-level outcomes. Guarantees aside, the principal thrust of the reform adopted was the introduction of competition for resources inside the NHS system. In addition to granting autonomy to large primary practices and hospitals, the 1990 reform enabled district health

authorities (the basic administrative unit of the NHS) to purchase necessary care from an array of public and private care providers. In theory, this is the most profound aspect of the reform because the district health authorities can punish inefficient public providers by replacing them with public or private competitors. When Thatcher resigned and was replaced as prime minister by John Major in 1991, the Major government decided to increase NHS funding as an additional path toward greater responsiveness.

### Contemporary Dynamics

In the 1997 election campaign, Tony Blair's Labour Party candidacy emphasized the arrival of a "third way" in health care and other policy areas that would be neither largely statist nor largely market-driven. His Conservative opponent, incumbent prime minister John Major, charged that the Labour Party would likely raise tax rates in an effort to meet its promises to reduce waiting times and improve NHS performance. Major claimed that the landmark 1990 NHS reform would continue to bear fruit if given a chance to flourish. The large Labour parliamentary majority that emerged from the 1997 elections ultimately gave the Blair government considerable leeway with which to define its vision for NHS reform.

The policy formulation stage was dominated by competing intraparty and interparty differences. Most Labour Party members argued that an injection of additional funding formed a critical element of modernizing the NHS and improving patient care. Intraparty divisions widened, however, on the role of decentralization and competition within the system. Tony Blair, a native of Scotland, was firmly committed to devolving health care administration to the four constituent nations of the United Kingdom. In addition, he supported an agenda of enhanced patient choice and a continuation of some of the competitive dynamics associated with the Conservative reform agenda. More progressive backbenchers opposed the market-oriented reforms and, in particular, argued forcefully that Thatcher's creation of independent GP clinics would lead to doctors who placed profits over the interest of their patients. Conservatives, on the other hand, wanted to see the 1990 reforms maintained. Indeed, some Tories sided with voices in the insurance industry who favored a shift toward a system of competing private insurers in a government-mandated national health insurance program more similar to the French and German models.

The initial steps of the Blair government in 1997 and 1998 pleased the more progressive elements of the Labour Party. The government reversed the Thatcher reform that gave GP clinics potential autonomy and focused on increasing funding levels for the NHS. Given the diversity of internal perspectives and the complexity of the issues, the government opted to spend three years developing a specific vision for sweeping reform. The 2000 NHS Plan outlined the path the Blair government would take in health reform. To the dismay of progressive Labour backbenchers and to the surprise of many



Conservatives, the Blair government invigorated the system of hospital trusts established under Thatcher; insisted that the primary care trusts offer a menu of provider and treatment options to every patient; continued the pursuit of shortened waiting times and the provision of more services per expenditures; and reformed the remuneration of GP clinics. Rather than the fund-holding model of autonomous GP clinics, beginning in 2004 all GP salaries would include a merit-based component based on evaluations of the quality of care provided and the efficiency of their practices. In turn, the continuation of the hospital trust system granted greater funding and operating autonomy to high-performing hospitals. In 2004 the government replaced a firm reliance on fixed, global hospital budgets with a new system in which a base budget would be supplemented with a patient-based supplement calculated on a DRG-basis (termed a “healthcare resource group” [HRG] in British jargon). Also in 2004, the NHS bureaucracy was decentralized into a network of twenty-eight Strategic Health Authorities that set performance targets, monitor performance, and reward hospitals and GP clinics that meet the stated goals.

The implementation of the sweeping reforms initiated by the Blair government in the four years preceding his 2007 resignation proved to be a complex affair, given the many dimensions of change. Administrative, clinical, financial, geographic, and managerial reforms were superimposed over a brief period. To try to ensure improved services amid the many structural changes, the Blair government increased health spending from 6.8 percent of GDP in 1997 to 8.6 percent by 2007.

In initial assessments, governmental and nongovernmental studies have demonstrated a decline in waiting times for nonemergency services as well as an increase in the treatment and health care provider options presented to patients. The Blair government trumpeted these studies as evidence of policy success, and Gordon Brown’s government has thus far continued along the lines established by the NHS ten-year plan presented in 2000. The debate over policy evaluation in the broader policy network centers on a different question: were these successes generated by the changes in administrative and incentive structures, or were they driven primarily by the Blair government’s considerable injection of new financial resources in the health sector? The answers that emerge from this debate will help to frame the policy debate for the next electoral cycle.

Health reform during the Blair government demonstrates the role that personal popularity and a large parliamentary majority can play in deepening party discipline. Blair’s commitment to enhanced use of financial incentives in the NHS proved unpopular with many rank-and-file legislators in private conversations. However, Blair’s centrality to the emergence of the large “New Labour” majority gave him considerable latitude in guiding the direction of policy reform. Now that the Labour parliamentary majority has shrunk and Blair has retired from electoral politics, the legacy of the Blair reforms to the NHS will be determined by future British voters and politicians.

## Italy

### Background: Policy Process and Policy History

In Italy the process for health policy making differs from the process for other policy areas. In other areas the lead role is played by the central government within a unitary state. Since passage of the 1979 National Health Service Law, however, the locus of health policy making shifted to the twenty regional governments. Those governments set global budgets and arbitrate fee schedules and other matters for the local health units (USLs) in their respective territories. The USLs administer services via contracts for a combination of public ambulatory clinics, public hospitals, and private providers. At their creation in 1979, the USLs became public enterprises governed by boards appointed to represent the partisan balance of forces in the regional government. The central government sets the basic parameters for services that must be provided, but the regions can determine whether to provide additional services. Policies are largely implemented (and reforms discussed) between the regional governments and the boards of their respective USLs.

The health sector was the first major function transferred from the central government to the regions. Health expenditures, funded by transfers from the central government and by revenues raised at the regional level, constituted a majority of regional government budgets throughout the 1980s. Some proponents of decentralization at the national level trumpeted the passage of the 1979 law as the first step toward the creation of meaningful regional governments. In contrast, as time passed, critics grumbled that regional administration of the health sector was more politicized and less professionalized than it had been at the national level. In particular, some observers questioned the professional credentials of not just the boards governing the USLs but also of the general managers charged with directing the USLs' activities. Others pointed out that the central government's pledge to cover revenue shortfalls at the regional level gave little incentive to both the regional governments and the USLs to administer their services efficiently.

Italy had developed a government-mandated system earlier on in the twentieth century. If anything, the Italian system of numerous sickness funds organized by occupational groups was more complex than its French and German counterparts. By the 1970s over 90 percent of the Italian population was covered. As the system expanded, many observers came to criticize the disparities in care across occupations, the duplication of effort and services across public and private care providers, and the continuing exclusion of the unemployed and several other categories of citizens.

In 1978 the so-called national solidarity government—a heterogeneous coalition that included the support of the traditionally excluded Communists—tackled these criticisms by adopting the national health service model. The reform, passed in January 1979, promised to provide universal coverage free to the user at the point of service. In 1992 a major organizational and financial reform created a more decentralized system.

Italians are currently guaranteed access to the National Health Service (SSN). Similar to the British NHS after the Thatcher and Blair reforms, the Italian system is a patchwork of public ambulatory clinics, public hospitals, and private providers contracted by the USLs responsible for providing care mandated by the national and regional governments. Coverage is portable across localities and regions. Some regions cover items not included in the national mandate. The system covers general and specialist physician services, hospitalization, prescription drugs, maternity, and dental care.

Most of the hospital sector is public. Since the 1992 reform, large public hospitals can separate administratively from the USL. Such hospitals must run balanced budgets and can spend surpluses on additional capital acquisitions or staff compensation incentives. About 30 percent of the population has some form of private insurance—to cover copayments, to extend coverage to additional services, and in many cases to provide comprehensive insurance as an alternative to the SSN.

Traditionally, a slim majority of funding came from payroll taxes (of which employers paid a larger share than employees). Government subsidies from general revenues filled in gaps in revenues and provided coverage for the unemployed. In 1998 the D'Alema government moved to fund the entire system out of general government revenues at the national and regional levels—thus eliminating the use of payroll taxes in health financing. In particular, a new value-added tax (VAT) collected by regional governments will bear primary responsibility for funding the health service. The reform also created a National Solidarity Fund by which the central government tries to adjust for the uneven tax bases across the regional governments. These financing changes toward the use of general revenues in pursuit of more evenly distributed funding mirrors the system already employed in the United Kingdom.

Patients pay a copayment of up to \$54 for each outpatient service. They pay a copayment of up to 50 percent for most prescriptions. Several categories of persons are exempt from the copayment and deductible requirements: children (six years and under), disabled persons, and low-income patients who already qualify for welfare assistance. Out-of-pocket payments are twice as important in Italian health finance as they are in the United Kingdom: in 2008 they comprised over one-fifth of total health spending.

The Italian SSN has been the subject of reform efforts almost annually since its inception in 1979. As we noted earlier, copayments have been introduced on an increasing number of services. In some cases, governments revoked major copayment hikes, only to reinstate them (often at higher levels) later. Copayment increases and a reduction in the number and nature of exempt pharmaceuticals have reduced prescription drug use per capita. These decisions helped to control costs by controlling utilization, but they also helped to place the efficiency of the SSN on the institutional agenda. Critics of copayments did not always succeed in defeating the introduction of (or increase in) copayments on certain services, but they did force the major parties to consider reform measures.

In the early 1990s the Northern League became a strident advocate for market-oriented reform in the health care sector. Beset by the political stalemate and serious budgetary woes, elements of the Christian Democratic and Socialist parties began to consider serious reform of the SSN's internal dynamics and funding mechanisms. Advocates of limited use of market mechanisms were strengthened further at the policy formulation stage by events in the United Kingdom and the Netherlands, where governments were introducing similar reforms. This policy debate culminated in comprehensive reform legislation in 1992. In addition to further adjustments in copayments, a decision was made to adopt major changes in the administrative structure of the SSN. This "reform of the reform" empowered the national government to set more specific nationwide coverage and planning guidelines and to apportion funding to regional governments based on population and additional criteria. The regional governments now found themselves obligated to generate revenues to cover any expenses in excess of the national government contribution. Before the reform, the national government had pledged to cover all unforeseen health expenses. This reform made SSN funding similar to the Canadian health care system in that regional governments have an incentive to control costs to avoid raising taxes and imposing fees on their constituents. Furthermore, the 1992 reform made the USLs autonomous public enterprises no longer controlled by boards appointed to represent the partisan balance of forces in elected government. The USL general managers are chosen based on professional qualifications and receive five-year contracts with a possibility of renewal. Hospitals gained operating autonomy and would now be reimbursed on the basis of DRGs rather than on a uniform per diem basis.

### Contemporary Dynamics

The 1992 reform reshaped the debate over the future of the SSN. It helped to reduce perceived and real problems associated with the politicized boards of the past. The move toward a more professionalized management made it easier to implement other elements of the 1992 reform. Fiscal reforms were designed to ensure that—at the implementation stage—managers and regional politicians would have an incentive to comply with the cost-control goals that helped to motivate the legislation. Not all implementation problems were overcome, however. One of the most controversial aspects of the 1992 legislation was not implemented in the years that followed. The reform called for citizens (and occupational groups) to be allowed to opt out of the SSN—thereby reducing much of their SSN payroll tax—beginning in 1995. In 1993 the Democratic Party of the Left (the PDS), lobbied hard for the abolition of this clause. With the 1996 election of the center-left Olive Tree coalition led by Romano Prodi, the possibility of opt-out provisions became remote. However, the major center-right parties campaigned on platforms calling for the ability to withdraw from the system or, in the case of the Northern League, for the abolition of the entire system.

The Prodi government began working on building a consensus to deepen the financial reforms begun in 1992. When the Prodi government narrowly lost a vote of confidence in 1998, the reform effort continued under the new center-left government led by D'Alema. Both governments pushed a hybrid agenda—analogue to the Blair government's aims in the United Kingdom. On the one hand, they wanted to reform health care financing to reduce the role that regional socioeconomic inequalities played in limiting the number and quality of medical services available in the poorer regions. On the other hand, they also sought to increase further the role of market incentives and government monitoring in ensuring greater effectiveness and efficiency in the health sector. The mixed agenda made it more difficult for center-right parties and interest groups to criticize the reform package. In turn, opposition to the increased use of market incentives from progressive groups was mitigated by the promise to reduce inequality.

The 1999 Health Reform Law markedly modified health finance in Italy. Regional governments were now guaranteed the vast majority of regional corporate taxation. In addition, the law launched a National Solidarity Fund in 2001; the fund is guaranteed one-fourth of VAT revenues, and those finances are supplemented with additional money from the national government. The goal of the fund is to distribute additional revenues to the poorer regional governments in pursuit of reduced disparity in the quality and availability of health care. The reform also called for a review of the list of comprehensive services that would be provided and the establishment of clinical standards for each service. In an effort to cultivate greater complementarity between the public and private sector health systems, the 1999 reform permitted private-sector providers more access to practice within the SSN and also encouraged private insurance companies to offer more supplemental insurance policies (as opposed to the frequent sale of duplicative, substitute private insurance).

The immediate implementation of the 1999 reform law took place largely under the center-right government led by Silvio Berlusconi from 2001 through 2006. The lower profile of the Northern League in this second Berlusconi-led government reduced the visibility of previous demands to permit Italian taxpayers to opt out of funding and participating in the SSN. Furthermore, the efforts of the 1999 reform to extend the use of market mechanisms and private-sector activity was largely congruent with major themes of the Berlusconi electoral campaign. As a result of these factors, the Berlusconi government implemented the core aspects of the 1999 reform law without proposing major changes. Indeed, perhaps the most noticeable health reform of the second Berlusconi government was the enactment of a ban on smoking in public areas.

In the 2006 and 2008 election campaigns, critics on the center-left argued that the Berlusconi government was not sufficiently committed to the creation of a robust National Solidarity Fund that could achieve the goal of reducing health care inequality. However, neither election campaign saw

health reform rise to a prominent level on the systemic agenda. With the reelection of a third Berlusconi-led government in 2008, the immediate future seemed unlikely to generate major health policy reforms.

The reform of the SSN over time in Italy illustrates the impact of a changed vision for health policy among many European progressives. At the launching of the SSN in the late 1970s, most analysts predicted that—if and when leftist parties displaced the Christian Democrats—Italy would witness the creation of a much more centralized SSN. In stark contrast to those predictions, the Italian experience with center-left governments in the 1990s and in the early twenty-first century saw a shift toward a more decentralized health system in which market dynamics played a greater role.

## **European Union**

### **Background: Policy Process and Policy History**

Formally speaking, there is no health policy making process in the EU. The Maastricht Treaty mentions public health initiatives but also expressly prohibits any EU effort to harmonize “the laws and regulations of the member states” in health policy. Article 152 of the 1997 Amsterdam Treaty represents the boldest formal assertion of EU authority in health policy to date in that it calls for public health concerns to inform EU activities. However, the strongest formal power available to the EU in public health is the creation of recommendations to the member states. Article III-178 of the 2003 draft text of the (as yet unratified) European Constitution would have clarified further than any previous accord the role of the EU in public health. Nonetheless, the closing, seventh paragraph of the draft article makes it clear: “Union action in the field of public health shall fully respect the responsibilities of the Member States for the organisation and delivery of health services and medical care.”

Because the shared belief of the member state governments holds that curative care policy is the exclusive competency of national governments, only informal health policy mechanisms are in place in the EU, and they focus on public health concerns. The member states’ health ministers meet periodically to share information and to develop, as needed, coordinated approaches to meet public health challenges. This episodic form of public health coordination expanded in response to the outbreaks of mad cow disease and hoof-and-mouth disease in the early twenty-first century. The European Commission formed a set of recommendations in 2003 that culminated in the creation of the European Centre for Disease Prevention and Control.

Amid the absence of a health policy mandate in the curative care realm, the locus of EU intervention in this sector stems not from health-centric organizations, but rather from the ongoing regulatory activities of the EU and from the judicial decisions handed down by the Court of Justice of the European Communities. The diffuse call for EU activity to be informed by

public health concerns has motivated a majority of the Commission's twenty-four directorates-general to invoke public health rationales for some of its directives. Thus the Directorate-General for Health and Consumers is not the only arm of the Commission potentially engaged in health policy. The Commission has no express authority in health policy, but it does have authority to influence the regulation of working conditions, purchasing arrangements, and equality of treatment of consumers—all in the pursuit and defense of a European single market. In turn, the EU judicial system arbitrates disputes regarding whether EU community-wide standards can be imposed over national practices and standards in a variety of activities.

### Contemporary Dynamics

During the 1990s and the 2000s, the EU's Council of Ministers and the Court of Justice made several binding decisions that have affected the course of health policy and of medical services more broadly. During the 1990s, many of these policy decisions took place in a policy network in which health policy and medical professionals were largely absent. The health community had (wrongly) assumed that the formal recognition of member state competence in health policy would keep their sector free of EU decisions. The events of the ensuing years would eventually change that perception of so-called benign neglect. As a result, in the early twenty-first century, health policy interest groups have shown more interest in lobbying EU officials.

As discussed in Chapter 10, the EU has taken a growing interest in higher education policy since the 1970s. Part of that activity focused on creating common standards for various degree paths. In 1993 an EU directive created common standards for recognizing medical and nursing degrees issued within the community. Although historically each country (and its respective professional associations) retained sovereignty over when and how to recognize degrees earned in other countries, the EU's pursuit of common professional standards and equal national treatment created an end-run around the long-standing autonomy of national medical and nursing professions. Although this directive was challenged in the courts, the Court of Justice upheld the principle that nondiscrimination among member states requires that medical and nursing degrees earned in one member state be recognized by all other member states—provided that they meet the minimum standards established by the EU directive. This decision was opposed by many professional associations. However, despite this innovative ruling, the mobility of doctors and nurses has remained relatively limited.

The evolution of a different 1993 EU action, Directive 93/104/EEC, came to have a more profound impact on curative care in the early twenty-first century. This 1993 labor policy, often referred to as the Working Time Directive, established a series of common, EU-wide labor standards in pursuit of harmonized work conditions across the single market. Among the standards involved are a maximum weekly total of 48 hours and a minimum daily

rest period of 11 hours. A 2000 amendment to this directive expressly included physicians as being subject to this labor policy. Medical interns and residents traditionally are on call for very long hours in the United States and elsewhere around the world. Advocates of this form of extended medical training argue that it exposes young doctors to the widest possible array of diagnostic and treatment scenarios. Critics, including advocates of extending this particular EU labor standard to include physicians, argue that it constitutes an unfair and potentially dangerous labor practice.

The implementation of this extension of the Working Time Directive into the medical community quickly brought about a legal challenge. In the 2000 *SiMAP* case (Case C-303/98, ECR I-7963), the Court of Justice rejected the argument that physicians were resting when they were sleeping in the clinic or hospital during their on-call hours. The Court ruled that all on-call hours constituted hours worked and, thus, must be counted toward the legal weekly maximum of 48 hours. In the 2003 *Jaeger* case (C-151/02, ECR 2003 I-08389), the Court ruled that physicians, upon waking up from an on-call nap that took them past their daily work limit, were entitled immediately to the legally prescribed compensatory rest. Many national health ministries fought these decisions because the full implementation of these uniform labor standards has forced a sea-change both in physician training and in how emergency clinics are staffed. Rather than serving on-call for extended hours, interns and residents must now be scheduled for shorter periods of time to ensure compliance with EU law. This requires more staffing. In addition, some initial studies have sided with the traditional pedagogical defense of lengthy on-call training: they argue that physicians are now exposed to fewer “teaching moments” over the course of their clinical training.

The two preceding examples of EU activity in health policy illustrate a role via the regulation of professional credentials and labor practices. Perhaps the next frontier of EU activity in health policy may stem from a desire to have EU consumers treated equally when they cross national borders between member states. A host of EU laws attempt to prevent citizens from being discriminated against when they travel within the EU. When patients find themselves living in a different member state from their country of citizenship, two Court of Justice decisions require national health insurance systems to fund insurees’ medical treatments even when the provider is in another member state. Some observers have asked whether the evolution of policy and case law will lead to an expansion of “medical tourism” in which affluent citizens try to identify the best country in which to receive various medical treatments.

The dynamics of EU activity in health policy illustrate the logic of “spill-over” in the expansion of EU competencies. To date, the EU still has no formal role in curative care policy. Instead, competency over health services is reserved for member state governments. Nonetheless, the actions of EU



institutions in pursuit of their identified competencies in labor practices, professional credentialing, and nondiscrimination of EU citizens have led to laws, regulations, and court cases that shape the contours of health policy.

## Cross-national Trends

In the 1990s and the early twenty-first century we can observe considerable convergence in the content of health policies. All six countries have enacted reforms designed to control costs. Most countries have pursued the creation of electronic medical record-keeping systems. In addition, there has been some convergence toward a mixed approach to health policy as a whole. The most market-oriented country, the United States, has increased government involvement, whereas the two countries employing the national health service model (the United Kingdom and Italy) pursued reforms designed to inject some market mechanisms into their health care systems. In terms of health policy outcomes, the United States is exceptional in that it has the worst outcomes on several major indicators, despite spending more money than any other industrialized country. Consideration of the contemporary dynamics of reform on this policy issue highlights cultural and economic factors as central to agenda setting, whereas political and institutional influences are important in the decision-making process.

### Policy Outputs

Most industrialized countries pursue one of two options: a national health service or mandated national health insurance via a mix of public and private providers. The latter option is by far the most common. Among the six countries examined in this book (and compared to other countries as well), the United States has opted for minimal government activity in the health sector. Italy and the United Kingdom have adopted the national health service model, and France, Germany, and Japan have adopted the prevailing model in the industrialized world: mandatory national health insurance.

During the 1990s and the early twenty-first century, these countries instituted reforms aimed at curtailing costs in one or more sectors of their respective health care systems. Copayments have been adopted in new areas and increased in existing areas in all six countries. Copayments represent an attempt to reduce costs in two senses. First, they transfer a portion of the cost from the government-funded or government-mandated plan to the patient. Second, they can influence patients' choices about utilization—provided that patients do not have a supplemental insurance policy to cover the copayments.

These countries' governments have taken a harder stance, to varying degrees, in negotiating fee schedules for physician services. This is particularly true in France and Germany, where the climate for negotiations has been more publicly bitter than in years past. This same dynamic of increased

tension has occurred in the predominantly private U.S. system as physicians complain about tighter fee schedules and utilization reviews conducted by private insurers.

### Policy Outcomes

Although the reform concerns are fairly similar in some senses, significant differences remain in the health policy models and in the levels of health care expenditures in the six countries. Are these policy differences associated with any differences in policy outcomes? Here we examine briefly outcomes in the three main policy problems discussed at the beginning of this chapter: health outcomes, access to curative care, and cost control.

It is difficult to assess the role of government policy in promoting good health outcomes across individuals or across countries. One might think that average life expectancy is a good health indicator because it measures the basic threshold of health: continued life. However, life expectancy is problematic as a measure of how well the health care system is performing because life span is affected by a variety of factors including diet, exercise, surroundings, genetics, stress, and health care. For this reason, studies of comparative health policy often rely on infant mortality statistics (the number of infants who die prior to age one) as an indicator of health system performance. Although factors other than access to care and its quality influence infant mortality rates, this measure has fewer additional intervening factors than does life expectancy. Table 8-1 provides infant mortality and life expectancy statistics for the six countries examined here.

In 2006 the United States had the highest infant mortality rate and the lowest life expectancy at birth among the six countries. The United States also experienced the least improvement in its infant mortality rate from 1996 to 2006. These outcomes have often been used in the policy debate to criticize the effectiveness of the market-maximized model. The lowest infant mortality rates (albeit by a small margin in some cases) are found in the countries with mandatory health insurance (France, Germany, and Japan) and in Italy. The United Kingdom is in the middle of the pack.

On the access issue, the United States also does not compare favorably to the other six countries. In the United States, 45 to 50 million people lack health insurance at any given time. A few other countries allow citizens above a high income threshold to opt out of health insurance, but most choose not to do so. Thus about 15 percent of the U.S. population has no health insurance, whereas in the other five (and most other) industrialized countries less than 1 percent of citizens lack access to a comprehensive health care program, and those who do tend to be wealthy.

One might assume, then, that the United States' relatively poor performance in health indicators and in access to health care is simply the result of a societal choice to spend fewer resources on health care. Such a scenario

**Table 8-1** Infant Mortality and Life Expectancy in Six Countries, 1996 and 2006

Country	Infant Mortality in 1996 (% of live births)	Infant Mortality in 2006 (% of live births)	% Change in Infant Mortality (1996–2006)	Life Expectancy at Birth in 1996 (years)	Life Expectancy at Birth in 2006 (years)	% Change in Life Expectancy (1996–2006)
France	0.49%	0.38%	–22%	78.1	80.7	3.3%
Germany	0.50	0.38	–24	76.9	79.8	3.8
Italy	0.62	0.37	–40	78.7	81.2	3.2
Japan	0.38	0.26	–32	80.3	82.4	2.6
United Kingdom <sup>a</sup>	0.61	0.50	–18	76.9	79.1	2.9
United States	0.73	0.67	–8	76.1	78.1	2.6
Average	0.56	0.43	–24	77.8	80.2	3.1

SOURCE: Organisation for Economic Co-operation and Development (2009b).

<sup>a</sup>The life expectancy data are for 1996 and 2005.

**Table 8-2** Health Care Spending in Six Countries, 1996 and 2006

Country	Total Health Spending in 1996 (% of GDP)	Total Health Spending in 2006 (% of GDP)	Change in Spending (1996–2006)	Government Health Spending in 1996 (% of GDP)	Government Health Spending in 2006 (% of GDP)	Change in Spending (1996–2006)
France	10.4%	11.0%	6%	8.3%	8.7%	7%
Germany	10.4	10.5	1	8.5	8.1	–5
Italy	7.4	9.0	22	5.2	6.9	33
Japan	7.0	8.1	16	5.8	6.6	14
United Kingdom	6.8	8.5	25	5.6	7.0	25
United States	13.5	15.8	17	6.1	7.1	16
Average	9.3%	10.5%	14%	6.6%	7.4%	15%

SOURCE: Organisation for Economic Co-operation and Development (2009b)

would certainly be congruent with the view that a private sector approach (1) enables people to choose precisely how much health care they want and (2) provides for greater efficiency via the operation of the free market. Nevertheless, precisely the opposite pattern of events has occurred. The United States spends significantly more than these other countries on health care (as a look at Table 8-2 indicates), yet it performs poorly relative to those thrifter countries.

In 2006 the United States spent nearly 16 percent of its GDP on health care. In the other five countries healthcare spending averaged 9.4 percent. Despite the largely market-oriented nature of the U.S. system, government health expenditures as a percentage of GDP remain very close to the average for all six countries. Another way to look at these trends is in terms of spending per person. In 2006 the United States spent \$6,933 per person on health care. Norway (\$4,507), Switzerland (\$4,165), and Luxembourg (\$4,162) were the only other industrialized countries in the world spending over

\$4,000 per person. Among the other five countries examined in this book, average annual spending per person was \$3,005—less than half what the United States spends. The average across all industrialized economies was just over \$2,900 per person. Furthermore, among the six countries examined in this book, the United States spent a higher percentage of GDP on government-funded health care programs than all but France and Germany, despite covering a smaller percentage of the population in public programs. Efforts to explain higher health care spending in the United States point to several factors including:

- Higher administrative costs due to the variety of insurance plans (estimated by some analysts to constitute as much as 20 percent of costs)
- Fee-for-service reimbursement of both outpatient and hospital physicians
- The absence of firm global budgets for hospitals
- Defensive medicine (that is, multiple and expensive tests to protect against potential malpractice lawsuits)
- Cost-shifting from the uninsured and underinsured to the insured

### Understanding Policy Reform

Thinking back to the case studies, you can see how popular discontent (or its absence) has shaped the reform agenda. In France and Germany, reform proposals have focused on maintaining the current system while restraining costs in various ways. In the other four countries, major reform proposals have been debated.

However, discontent with the system alone does not imply that sweeping reform is on the way. As we have seen in other policy areas, decision making and implementation are subject to a variety of influences beyond general public opinion and political trends. For example, with its solid, one-party legislative majority, the Thatcher government was able to pass reforms similar to proposals that failed in Sweden, where they were advocated by many leaders of a shakier, four-party coalition government. The structural decentralization of decision making in the United States made it easier for opponents of reform to block new proposals that had considerable public support in some sectors. In the realm of implementation, professional patterns and loyalties limited the adoption of some market-oriented behaviors in the British reform, whereas cultural obstacles slowed the Japanese provision and utilization of long-term care called for in 1992 legislation and, later, in the 2000 Gold Plan and the 2006 Health Reform Law.

Although widespread concern over health care as a priority does not guarantee that government action will be taken (much less predetermine its nature), it does guarantee that health care will remain on the agenda. This is especially true given that the percentage of elderly citizens is on the rise in all six countries. Senior citizens incur the largest health care expenditures per

capita of any age group. They also are the one category of citizens that receives government health care in some fashion in all six countries. Health policy will continue to find a place on systemic and institutional agendas in the 2010s as the baby-boom generation reaches retirement age.

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