投稿論文

# Implementing health care reforms in Europe: policies, actors and institutions

**Philippe Mossé**
**Economist,C.R.CNRS**
**Aix en Provence,France**

European health care systems have embarked programmes of radical reform intended both to contain costs, maintain quality and promote equity. In most countries, the instruments used and the declared objectives seem to be similar and derived from the American model. As a result, observers are tempted to infer that these health systems are converging towards a single liberal model.

In an attempt to qualify this view, the present article will seek to show that the reforms currently in progress must be evaluated not in terms of universal criteria but by reference to the historical contexts in which they are being implemented.

Thus, for example, the British and French reforms are running into difficulties that are often attributed to "resistance". It is shown here that these difficulties are due to the fact that the advocates of the reforms underestimated the influence of earlier dynamics and the importance of the implementation phases. To what extent lessons for Japan health care reform can be drawn from European experiences is an open issue.

**[Key words]**
Europe, Health Care Policy, Great Britain, France, Regulation, Welfare State.

---

An earlier version of this article was discussed in July 1997 during a Keio Economic Society Seminar while the author was a visiting professor at Keio University, Mita campus, Tokyo . The author wishes to thank Professors Naoki Ikegami, Haruo Shimada, Shigeru Tanaka and Kazuo Kikuno for their assistance, advice and warm welcome ; and for their keen comments, the two anonymous reviewers.

## Introduction

For the last decade, health care systems in the developed countries have been facing the same kind of challenges: how to reduce or contain health care costs while maintaining quality of care and equality of access. It is for this reason that, since the late 1980s, health care systems throughout the world have been the target of almost constant reform. Many comparative studies have been carried out in an attempt to describe what appears to be a universal trend.

Along with the extensive international diffusion of managed care techniques such as peer review, total quality management and DRG, this trend serves to strengthen the "convergence" model. Indeed in Europe, convergence has been a policy in itself since the 1992 Maastricht Treaty, which laid down certain economic and financial criteria to be fulfilled by 1 January 1999 by countries seeking to join the single currency EURO system.

International competition and global economic efficiency seem to be incompatible with high levels of public expenditure, given that levels of taxation and social security contributions are limited by high unemployment and slow economic growth.

This makes it difficult,if not impossible, to implement the Keynesian policies that were the panacea of the Fordist post-war period. Furthermore, advice from the OECD, as well as G7 / G8 recommendations, have pushed governments into introducing more competition and greater private-sector involvement.

Against this macro-economic and political background, most economists consider that European Monetary Union is not the cause of the tougher public economic policy but rather a mean of tackling a broader problem, namely the position of the European countries in the face of global economic competition. In a recent overview of current reforms, the WHO implicitly adopted the convergence model: "While the pressure for changes has been felt unevenly across different parts of Europe, there appears to be a set of parallel trends regarding governance" (WHO, 1996). Although this global interpretation is dominant, it will be demonstrated in this article that this convergence model has to be questioned.

The first point to be made here is that two types of convergence may exist. The first one is normative and centered on *a priori* quantitative objectives. The second, more pragmatic one, seeks to minimize the standard deviation of a given indicator among countries. Using

this second definition, it would have been possible to increase the public deficit, since the differences among European countries would have been relatively small. Following this rationale, some newly elected European governments are willing to relax the Maastricht criteria (e.g. the 3% public deficit relative to GNP and the tough relative price inflation threshold) [1].

Secondly, taking a broader perspective, convergence can be seen as an "artifact". Indeed, from a normative as well as from a "positive" point of view ,the convergence model is consistent only if no account is taken of the specific institutions and history in which any national health care system is rooted. Thus the convergence model has to be seen as the consequence of the domination of neo-classical ideology rather than as a theory in itself.

The process of European union (or, say, the collapse of the bubble economy and the aging population in Japan) can hardly be seen as the one and only explanation of the recent and future evolution of social welfare and policies. A more institutional perspective has to be taken in order to understand not only the aims of the reforms but also their contents, the difficulties they are currently encountering and the solutions that should be adopted in order to solve them.

Thus this article is an attempt to show that some differences among European countries not only exist but also have to be retained in order for the health care systems and reforms to be efficient.

The first part will begin with a brief survey of the main statistical data; this will be followed by a description of the two main models that can be used to explain the health care institutions, their functioning and the actors involved in most European countries.

The second part will focus on two countries, the United Kingdom and France, whose health care systems are rooted in very different historical models and have recently undergone structural reform. It will be demonstrated that the problems currently being encountered in both processes of reform are due to the discrepancy between, on one hand, the emphasis placed on theoretically defined micro-economic incentives, and, on the other hand, the lack of attention being paid to the actual implementation of the reforms.

## I/ Convergence: fact or fiction?

The convergence issue is one of the most important in the field of economic and social policy in Europe (M. Berthod-Wurmser, 1995). The success of the convergence policy is seen as the condition,

for a given European country to enter the Economic and Monetary Union (EMU), i.e. the Euro area, to be created in 1999. This policy is to be assessed through a set of five criteria: inflation rate, average long term interest, exchange rate, public debt and public deficit. From a welfare state point of view, the last criterion is not the least. As the E.C. Treaty stated in its number 104 article: "the budget deficit should be 3% of GDP or less, unless either the ratio has declined substantially and continuously and reached a level that comes close to 3%, or the excess over the reference value is only exceptional and temporary and remains close to 3%". As it could have been expected, the debate, focusing on nominal number, is about how and when member states will be able to fulfill the convergence criteria. Indeed, harmonization seems to be on its tracks, as, between 1993 and 1997, the average public deficit within the 15 European countries, felt from 6% to 3% of the GDP.

However, the impact of the deficit decrease is very different from one country to another, even in terms of size of the public sector itself. For instance, between 1992 and 1997, the share of public employee wages in the GDP went down from 12% to 8% in the U.K, while, in France, it went up from 13% to 14.5%. (E. Mermet and O. Jacobi, 1997). This example shows that, at least from a public policy point of view, assessing the convergence effectiveness only through the five criteria required for the EMU, can be misleading. Thus, economic analysis of the "convergence theory" has to confront broader quantitative and qualitative data.

In order to demonstrate that this perspective can also be fruitful from an health economics perspective, it is necessary to go through three steps.

First, actual data and figures have to be looked at (I.1). This study has to be done having in mind that any attempt at comparison is necessarily open to criticism, since national statistical definitions are very heterogeneous and have to be over-simplified before they can be compared. In the second step, qualitative analysis is needed in order to test the convergence hypothesis further, taking into account the historically defined and settled relationships between the actors (I.2) as well as the set of tools being developed in most countries by the reforms (I.3).

### I.1/ The key figures: a brief survey

In so far as quantitative data can help in describing national situations, the recent evolution of welfare and social protection statistics shows little unequivocal evidence of convergence between European countries.

For instance, in 1980 the total amount of

welfare expenditure as a percentage of GDP, ranged from 10% in Greece to 30% in the Netherlands. The range was almost identical fifteen years later, with a minimum of 16 % in Greece and a maximum of 33% in Denmark. Indeed the relative and absolute growth of welfare expenditure has not been accompanied by a trend toward equality. In most cases, those countries that already had a high level of welfare spending in 1980 recorded an increase almost as great as that of countries at the other end of the expenditure range (between 2 and 6 percentage points). It may be that the main variable determining the increase in welfare spending is not the initial level of welfare expenditure but GDP.

If we now turn to the evolution of total redistributive expenditure (i.e. total taxes and mandatory social security contributions) as a percentage of GDP in the main European countries since the 1980s, the trend towards convergence appears even weaker. Table 1 shows that, according to OECD sources, this indicator decreased in Great Britain from 37 % to 34 %, while it rose in both Germany and France, albeit by different amounts - from about 35 % to 40 % in Germany and 43 % in France. Over the same period, the USA figure remained virtually unchanged (29.2 % to 29.8 %) but the figure for Japan jumped from 19.7 % in 1980 to 31 % in 1994 (Koseisho, 1996).

Strangely enough, the convergence trend, at least as reflected in this rather rough data, appears to be stronger between Great Britain and Japan than between France and Great Britain !
The same phenomenon can be observed in the health care sector. It is well known that the share of health care expenditure in total welfare expenditure and GDP

Table 1

Texes and social security contributions as a% of GDP (OECD)

| | 1970 | 1980 | 1993 |
|---|---|---|---|
| **Germany** | 35.7 | 40.7 | 40.5 |
| **France** | 35.1 | 41.4 | 42.8 |
| **United Kingdom** | 37.2 | 34.8 | 34.4 |
| **Europe** | 34.4 | 38.0 | 40.0 |
| **Japan** | 19.7 | 25.4 | 31.0 |
| **USA** | 29.2 | 29.3 | 29.8 |

*Sources:Eurostat and OCED,1996.*

increased throughout the world. But this universal trend did not lead to equality. Expressed as a percentage of GDP, there is still a considerable degree of variation in OECD countries, with the range extending from 6% in Great Britain and Japan up to 14% in the USA Furthermore, when calculated in terms of purchasing power parity, the range is even wider (from 500 in Greece to 3300 in USA) [2].

From a broader point of view, however, the use of share of GDP as a key indicator might be questioned. Firstly, it says nothing about efficiency. Secondly, it may reflect the willingness to pay of a whole nation. Thus, whatever the level, it cannot in itself be considered "good", "bad" or "appropriate". It would be much more constructive, therefore, to look at the difference between the actual amount of money spent in a given national health care delivery system, and the amount of money the people it serves "want" to spend. At first sight, an exercise of this kind would appear to be unnecessary in democracies, where such decisions are, in theory at least, under the voters' control. It might be thought that the level of health care expenditure reflects a nation's choice, whether mediated through Parliament, the election process or the "fourth estate", i.e. the press and broadcast media. Unfortunately, this is not the case. For instance, it cannot be claimed that US citizens want to spend such a large amount of money on health (R. Evans, 1997). President Clinton's proposals for health care reform were one of the reasons for his election, but they could not be realized because of strong lobbying from private insurance companies [3]. In France, the maximum increase in health expenditure is determined annually by the government, and in theory is not to be exceeded. To date, however, the figure laid down has always been surpassed because of a lack of control over decisions taken by the main providers.

A good guess would be that Japanese people would, on the contrary, be willing to spend more on health, firstly to improve the working conditions of health workers and secondly to meet new medical needs. And indeed, for the last decade, the annual rate of increase in health expenditure in Japan has been 8%, one of the highest rates among OECD countries.

### I.2/ The Beveridge and Bismarckian models: the persistence of old archetypes

Over and above this quantitative evolution, the two models of the welfare state that have developed in European countries remain in place. The Bismarckian and Beveridge models are named after the individuals who introduced them, the former in Germany at the end of the 19th century, the latter

in Great Britain during the Second World War[4]. Based on two different concepts of society and of the welfare state, the two models are each characterized by a distinctive set of features relating to funding, mode of operation, principal actors, etc.

Table 2 shows the main features of the two models. Of course this kind of typology makes sense from an analytical point of view, but many economists consider it no longer relevant.

From an historical perspective, radical economists would argue that institutions such as trade unions, the State and welfare administration are linked together in a much more sophisticated way than fifty years ago. In consequence, new typologies and classification criteria have to be developed in order to understand and improve current national social welfare systems (B.Theret, 1996). For conventional economists, the tendency to explain current changes by focusing on market evolution and monetary policies does not allow much room for institutions and historical analysis. In normative neo-classical theory, the market must remain the major coordinating and regulating mechanism. Analysis of institutions may cause this fundamental fact to be overlooked.

However, if the two welfare models are regarded as "paradigms", it becomes clear that the principles and ideologies on which they were based are still capable of explaining most of the on-going changes in Europe and elsewhere.

Because of an historical "coincidence", the first six nations to enter the Common Market in the 1960s had all adopted the Bismarckian model (Germany, France, Belgium, the Netherlands, Luxembourg and, to some extent, Italy). Since 1995, the EU has had fifteen member states and as a result the two models are more evenly distributed.

Table2

The main features of the Beveridge and Bismarckian models

| Feature | Beveridge model | Bismarckian model |
|---|---|---|
| Principle: | Solidarity | Insurance |
| Coverage: | Universal | Workers |
| Funding: | Taxation | Wages |
| Benefit: | Flat-rate | Proportional |
| Leading Actor: | Government / State | Employees / Employers |
| Means: | Legislation | Collective agreements |

For good historical reasons, Britain has traditionally been presented as having a purely Beveridge model, while Germany has been regarded as a pure Bismarckian country (D. Lambert, 1997). However, according to the features listed in table 2 and to OECD data, it would seem that Denmark adheres more closely to the Beveridge model than Beveridge's native country. For their part, France and Japan, at least up until the 1980s were more Bismarckian than Germany itself. For instance the percentage of welfare directly funded by mean of taxes (instead of contributions from wages), which is the main feature of the Beveridge model, is higher in Denmark than in Great Britain (81% compared 45%), while in France it is only 19% and in Germany 25%.

If we turn more specifically to health care systems, they can be described briefly on the basis of the four main economic characteristics: financing, the mode of payment for doctors, the patients' contribution and freedom of choice.

### i/ Financing:

As in Japan, but unlike the USA, most health-care systems in Europe are financed by a mix of public and social insurance, and being insured is mandatory.

In Germany however, high-earners have to purchase their own insurance, and insurance companies and mutual providers compete to attract clients. In most European countries, as in Japan, social insurance is organized on a corporate or occupational basis. In Bismarckian systems, being in employment (or a member of an employee's family) is the condition for being insured. However, the actual rate of cover is close to 100 %, since government programs replace social insurance for low-earners, the unemployed and pensioners.

In many cases, however, the financial burden on the State is much heavier than this complementary role would suggest, although it remains almost hidden. Given the chronic deficit that afflicts many social insurance systems financed out of employers' and employees' contribution, governments are often forced, directly or indirectly, to top up the insurance funds. Nor should it be forgotten that the State also pays contributions as an employer. In Southern European countries, where most of the new jobs create are in the public service, the contributions paid by the State as employer are quite high.

### ii/ Paying the doctor:

The two major types of payment usually quoted are "fee for service" and "capitation".

Fee payment is often seen as inflationary, giving more power and autonomy to doctors, while capitation is seen as an efficient way of controlling costs as well as opportunistic behavior on the part of doctors. In fact, over and above the basic principles on which the systems are based, the key points are the actual regulatory instruments used. In some cases, capitation may allow a certain degree of autonomy and competition, as doctors' incomes depend on the number of registered patients. On the other hand, fee systems can be sophisticated enough to exert real control over clinicians' decisions and even contain outpatient and inpatient costs (R. Niki, 1996).

Comparison of the relative efficiency of the two systems is even more difficult, since, in many countries, there is actually a mix of fee, salary and capitation (as in Finland, Greece, Spain and Great Britain ). Fees might be paid for specific services provided by otherwise salaried doctors. A given doctor may be paid by either system, but two kinds of payment system may also coexist in the same country for two separate types of doctor ; this is true in most cases, including Japan. In this latter case, a typical medical career path, consisting of salaried employment in the early phase and a subsequent move into private practice, is based on economic rationality. As a result, in Japan many hospital doctors join or establish a private clinic or practice as they turn forty [5)]

### iii/ Patient fees:

In every country, patient fees or contributions vary according to the type of care. Hospital and inpatient care is always virtually free. However, in France a lump sum of about 2,000 yen a day has been paid by hospital inpatients since 1983. On the other hand, patients' contributions to the cost of drugs, spectacles and dental care can be high (as much as 80 % in some cases). The economic rationale for this virtually universal and widely accepted policy is that these types of care can be postponed until the patients save enough money to be able to pay out of their own pockets (B. Abel-Smith, 1992).

In no European country are patient fees systematically lower for the insured person than his/her dependents, as they are in Japan. In many countries, on the contrary, some care (such as dental treatment) is cheaper for children than for adults.

### iv/ Freedom of choice:

The question of whether total freedom of choice is more likely in Bismarckian or

Beveridge-type models is a controversial issue that will not be addressed here. However, clinicians are likely to have greater autonomy in Bismarckian countries than in Beveridge-type ones, where the State is both their employer and the leading actor in the health care system.

Freedom of choice for patients does not mean pure competition. Given the informational asymmetry that exists, referral processes are driven largely by practitioner networks, which can in turn give rise to supplier-induced demand. "Gatekeeper" procedures [6] are often seen as a good way of avoiding unnecessary consultations with specialists.

***

This general background being given, European health care systems were gradually built up after the Second World War, with relatively little change taking place until the 1970s as full advantage was taken of the thirty or so years of sustained economic growth that followed the war.
From a health care management point of view, no quantitative regulation was needed, mainly because national wealth was rising year on year. The increased supply of health care was also consistent with human capital theory, since it was seen as a precondition for improving individual and collective labor productivity. From a humanitarian point of view, it was also logical that a significant part of economic growth be used for redistributive purposes. Last but not least, the actors involved in health technology, innovation and employment were also pushing for more health facilities and provision.

Nevertheless, the situation has changed radically since the end of the 1970s. There has been a real reversal: public health-care systems may flourish during periods of economic growth, but are one of the first casualties when economic and social crisis rears its head and then becomes a more or less permanent feature on the landscape. The main reasons for this change are summarized briefly below.

Firstly, general economic growth slowed down ; as a result, given the elasticity of health care, the growth in health expenditure began to decline in some countries. Secondly, government and social security budget deficits became a real concern because of economic globalization and monetary orthodoxy. Thirdly, the positive impact of investment in health declined dramatically: on one hand, the marginal outcome of health expenditure was decreasing as the total amount spent was rocketing ,on the other hand, more and more care was being provided for individuals who were no longer productive (e.g. the elderly).

As a result, by the beginning of the 1980s, tough health care policies were being launched.

**I.3/ Context dependency of the new model:**

In an attempt to deal with the economic and financial crisis while at the same time maintaining a high level of social protection, the reforms being put in place in most European countries are based on a three-pronged strategy. Each element in this strategy is assumed to be effective because it can be justified theoretically.

i/ In countries where it used to be high relative to others, such as France or Germany, the share of wage-earners' contributions relative to taxation is being reduced. Because of rising unemployment, it is increasingly difficult to finance welfare expenditure out of wage-earners' contributions. However, thanks to the growth of national wealth (GDP), it is still possible to fund a rising level of welfare provision out of taxes on consumption, income or business profits.

This is the case also in Japan, where the consumption tax rose from 3% to 5% in April 1997, in order to finance the growing social insurance needs.

The theoretical justification for these reforms has its origins in an assessment of the link between employment and growth. This link is seen as likely to grow weaker for structural reasons, despite economic policies intended to stimulate growth as well as employment.

ii/ A minimum level of coverage and provision is being (more or less explicitly) defined. Above that level, the private sector (for-profit insurance companies and/or private providers) may intervene.

Up to now, Japan seems not to be involved in this privatization process, at least as far as health insurance is concerned: "the extent of supplemental private health insurance policies in Japan is very limited covering only peripheral services of limited scope" (A. Yoshikawa, 1996, p.4). In many countries, however, the premiums paid for private insurance policies have risen at a rate in excess of 5% per annum.

The effectiveness of this measure is based on the notion that patterns of behavior giving rise to "moral hazard" can be reversed. The hypothesis, implicit or otherwise, is that if the insurance principle replaces the solidarity principle, agents will have an incentive, ceteris paribus, to make less use of the health care services.

iii/ Attempts are being made to improve health providers' awareness of their economic and financial responsibility either by means of incentives, constraints or training. In many European countries, contracting is seen as a good means of achieving this objective (WHO, 1996).

Incentive and contract theory come together here to suggest that, in view of the asymmetry of information between physicians and patients, the signing of a formal contract is the best way of seeking to reach the optimum economic outcome. Moreover, encouraging physicians to conform to scientifically legitimated standards is not incompatible with the current evolution of medicine, which is becoming increasingly technological.

***

Viewed from this broad perspective, it would seem that the same tools are being used everywhere, each one fitting more or less within a theoretical framework.
Using the two historical welfare models as referents, and adopting a dynamic perspective, there does seem to be some degree of convergence in health policy.
At first sight, for the last decade or so, the prevailing trend everywhere in Europe has been towards the development of a new model that is not a mix of the two pre-existing ones but rather looks like a post-Beveridge model.

This model has three main features. First, the public part of the health insurance is still dominant but there is a strong tendency to shift the burden from wages contribution to taxes. Second, according to the traditional Beveridge model, there is a policy will to maintain or to reach the universal coverage goal. The importance of the third feature is rather new, as it concerns the constant rise of private markets mechanisms either on the supply or on the demand side (Johnson, 1995).

However, despite the fact that those features are seen almost everywhere in Europe, no one policy tool has the same effect in different countries. That is the reason why the current paradigm of the health care systems might better be called; nationally defined post-Beveridge model.

The implementation of two "Managed Care" items, gives good examples of this societal contextualization:

The gatekeeper mechanism is often describe as one of the best ways to reduce the number of inappropriate visits. However, it would not be as efficient in France (where many so-called general practitioners in fact behave like specialists, selecting patients, using a

single technique etc.) as in Japan (where most doctors are general physicians).

Like many instruments of health policy, restrictions on patient choice are, paradoxically, less efficient in professional contexts where they are needed and less necessary in professional contexts where they would be efficient.

It is also clear that the efficiency of the fee schedule mechanism depends on the way it is used. OECD experts point out that, because of a discrepancy between price and cost "doctors may promote procedures where price offered relative to costs is the highest, leading to misallocation of resources" (OECD, 1996). While agreeing with the first part of the sentence, it is quite possible to disagree with the second. Firstly, costs are often the results of previous resource misallocation. Secondly, to shift physician behavior from one practice to another might improve efficiency in terms of public health as well as from an economic point of view. Ultimately, the most important question is not how strong the link is between cost and prices. The strategic issue, which is both an economic and a sociological one, is to decide which of the leading actors and institutions are to be involved in the up-dating and fine-tuning of the fee schedule. Largely because there is no consensus on the question, the French fee schedule has remained more or less unchanged for years !

In Japan, on the other hand, the fee schedule is considered as a powerful tool for regulating the price and quality of physician outpatient and inpatient practices (N. Ikegami and J. Campbell, 1995). It is so because the management of the fees is included in a large institutional game.

Those examples show that focusing on context and on the interactions between actors, as well as on the overall coherence of any given policy in theoretical terms, is a precondition not only of academic research but also of effective reform. "Propositions in political economy find empirical support or refutation in the observable behavior of individuals in their capacities as collective decision-makers" (Buchanan, 1987, quoted in A.Culyer and R. Evans, 1996). As shown in Part II below, the difficulties being encountered in the implementation of health care reform in the UK and France confirm the relevance of such an approach.

## II/ British and French health care reforms: the will and the way.

It may well be argue that health care reforms cannot be analyzed without taking into account at least the

regulation of the entire welfare system, if not the organization of society as a whole.

However, it seems relevant for comparative purposes to isolate health care. Tackling the whole welfare system would have led to a superficial analysis. Since one of the aims of this article is to demonstrate that economic theory and analysis must be grounded on actual and precise facts rather than on a broad perspective, this limitation of scope is also a methodological choice.

When launched, the UK and French reforms had the same goal: to contain costs while maintaining quality. However, the two countries took very different routes.

Because the British NHS was firmly rooted in a Beveridge model and because of an assumed historical tendency towards individualism (B. Abel-Smith, 1992), the key notion in the U K reform was to increase overall efficiency by introducing greater competition among providers.

Because the French system is based on the Bismarckian model, it was dominated by health professionals. This characteristic, which is common throughout Europe, is combined in France with an historical tendency towards the centralization of decision-making generally described as "Jacobinism". This combination explains why the key notion in the French reform was to strengthen the power of the State while increasing economic awareness among physicians.

The means used to achieve these objectives is the subject of the next two sections. A third section will attempt to assess the effectiveness of the current reforms.

**II.1/ UK : competition as panacea.**

Before the end of the 1980s, the British NHS was highly centralized and cost levels were rather low compared to other developed countries. At the same time, however, the quality of care was fairly poor and waiting lists were of major concern to patients and doctors. To avoid this, a black market amounting to privatization by stealth had slowly established itself and was forcing the whole NHS away from its founding principles.

In 1989, the Conservative government put forward proposals for the introduction of an "internal market" into the NHS. The one hundred or so District Health Authorities (DHAs) would be responsible for running this new market on a bid and contract basis. The Conservative government sought to attain its entrepreneurial objective by mean of three major changes [7] :

i/ DHAs were no longer to be the sole providers of service on a geographical and community basis. Rather, they were to be transformed into "purchasing agents". As described in the 1989 white paper "Working for Patients": "each DHA's duty will be to buy the best services it can from its own hospitals, from other authorities' hospital, from self-governing hospitals and from the private sector". To achieve this objective, a fixed amount of money was to be given annually to each DHA, according to the age and mortality structure of the population for which it was responsible.

ii/ Hospitals were to become independent Trusts. Each independent acute institution was expected to obtain patients by selling its services to various DHAs. They would be entitled to contract with their staff and have complete decision-making autonomy in respect of capital expenditure. They were also to be allowed to seek private funding in order to build new units or to extend their activities. However, a minimum level of regulation was to be maintained (such as the provision of accident and emergency units and services) as the conditions under which a hospital was allowed to enter the now otherwise deregulated market.

iii/ Relationships between general practitioners (GPs), hospital and other second-line services were to change dramatically. Group GP practices with more than 9000 registered patients were to be allowed to act as agents for their patients (other patients remained the responsibility of the relevant DHA). When the reform was introduced, about 9 % of GP practices, covering about 25% of the British population, were eligible to be fund-holders. The government's intention was to encourage GPs to negotiate fixed-price contracts for each specialty and diagnosis, referring patients to whichever publicly operated, not-for-profit or for-profit hospital offered the "best deal" in each case.

Clearly, these three major changes were intended to "transform the centrally planned health system into the most thoroughly mixed market in Northern Europe. General managers in the public sector at hospital, DHA and GP level are encouraged to adopt managerial techniques associated with private business. As patients would have greater opportunities to change their general practitioner, they would find themselves obliged to obtain ambulatory and inpatient care in accordance with contracts negotiated by the DHA or the GP fund-holders .. from the perspective of the White Paper proponents, the reform would enable the public system to adopt the flexibility and the efficiency of the private sector" (R. Saltman and C. Von Otter, 1992).

Despite the growing opposition of labor unions (fearing for privatization) and the medical associations (afraid of the new power given to managers), the reform was scheduled to be implemented by April 1991.

From a theoretical point of view, it has often been noted that the whole reform is grounded on Adam Smith's liberal, neo-classical notion of the "invisible hand". Indeed, the whole reform is inspired by the classic definition of the market as being atomistic and fragmented. Furthermore, it is assumed that competition is the best way to achieve efficient resource allocation.

However, the British reform does not endorse the main assumptions of customer sovereignty and rational choice. The economic theory best suited to describing the British NHS revolution is agency theory. In effect, the patient's / principal's only choice is between a GP fund-holder or a DHA. He/she "delegates" his/her decision-making power to his/her physician/agent. After that, the choice is either to comply with a bid he/she did not have to sign (and which is free of charge to the patient) or to pay for private care.
Far from being a market in which the "money follows the patient", as is often noted (H. Oxley and M. Mc Farlan, 1995, p. 35), the competition introduced into the British system forced the patient to follow the money.

It has to be noted here that this theoretical issue is also a political, social and ethical one. Since agency theory rather than neo-classical theory provides the intellectual foundation for the reform, it is less necessary to increase either patient autonomy or his/her information level. As a result, financial incentives have to be designed in such a way as to influence physician (and other provider) behavior rather than that of patients.

**II.2/ France: normalizing practices.**

The French health care system is one of the most costly in the world and its performance not as good as it used to be relative to other OECD countries. Even with the reform of the hospital financing system in 1983, which involved a shift (in public hospitals only) from a per perdiem to a global budgeting system, the cost of hospital treatment continued regularly to exceed the maximum amount decided at national level. The main reason is not so much increasing needs for medical treatment but rather the fact that local hospital doctors, managers and even city mayors (who head their local hospital board) have all tended to encourage greater expenditure. When the first phase of structural reform was decided on, the number of hospital beds to be eliminated

was put at 15%.

The whole system of ambulatory care also seemed to be out of control. Clinicians had virtually unrestricted decision-making powers and the regulatory instruments that existed were unable to control either the level of supply or its hugely unequal geographical distribution. Provision in areas such as south-eastern France and Paris was excessive and growing, while medical facilities in some rural areas were inadequate.

Reform of ambulatory care began in 1991; in that year, the medical unions and associations signed an agreement with the government and the health insurance administration that aimed to control costs while maintaining quality of care. It consists of a list of several practices ("Références Médicales Opposables") to be avoided in outpatient and inpatient care. The rationale for avoidance might be either a rough cost/benefit assessment or the danger of the practice. A rigorous monitoring system was put in place by the medical profession itself at regional and national level in order to ensure control physician compliance with these guidelines. Physicians prescribing or performing these "forbidden practices" would be liable to pay a fine calculated in accordance with the frequency, extent and cost of the practices.

Some months after this agreement, the health insurance administration issued a "health record booklet" ("carnet de santé") to be filled in by patients and physicians at the end of each contact ; the aim was to avoid duplicating laboratory analyses or X-ray examinations as well as discrepancies in prescriptions over time.

The reform of hospital care started in the 1980s with the introduction of a new information and financial system. The new information system, named PMSI and very similar to the American DGR system, is intended to make hospital budgets and resource allocation dependent in part at least on case mix rather than on a fixed global budget.

In 1991, the internal management of hospitals was also reformed. Firstly, each hospital was required to draw up a five-year action program that took account of the wishes of medical and other staff and of likely budgetary restrictions. Secondly, not the least of the new measures introduced in the wake of the nurses' strikes and general social unrest of 1988 and 1989 was the recognition of nurses' decision-making power within hospital departments.

The structural reform was actually implemented in April 1996. It relies on powerful national and regional institutions.

Of these, the most important are the Regional Hospitalization Agencies. Directors of these agencies are appointed by central government but their sphere of responsibility is limited to one of the 24 geographical and administrative regions (each of which has an average of 2.3 million inhabitants). Their function is to coordinate the development of public and private health care.

The main instrument at their disposal is a contractual arrangement between the agencies and each individual hospital, concluded in each instance for a five-year period. The contract covers operating expenses as well as medical projects (including the conversion of wards from one specialty to another, the introduction of new services, mergers, etc.). However, if the bargaining procedure fails, the agencies may reject individual projects. They may also refuse to deliver the total budget they are entitled to distribute to hospitals in the region in accordance with nationally defined capping limits. They may also force hospitals to merge or to cooperate in order to reduce costs through economies of scale and the sharing of resources. A government decree promulgated in April 1997 gives the agencies the right to close beds if their occupancy rate falls below 60% for three consecutive years (Ph. Mossé , 1997).

The establishment of the regional agencies was accompanied by the creation of two national ones.

The first of these is responsible for defining the public health objectives to be achieved by the health system as a whole. These priorities may vary from one region to another in accordance with the judgments of national and regional experts.

The second, even more important agency, named ANAES, brings together medical experts and representatives of the Ministry of Health. One of its functions is to establish quality criteria and to manage the accreditation process (a sort of quality assurance certification scheme for French hospitals).

Contracting, standardization and cost reduction are the key points of the French reform. Contrary to the British experiment, however, the main actors are central or regional government agencies. Instead of decentralized competition, greater powers have been given to the Ministry of Health and to specialist agencies.

It is now some time since both countries embarked on reform of their health care systems, and it is possible to assess not only the gap between the stated goals and the actual results but also the implementation process itself.

## II.3/ The revenge of actors and institutions

In both countries, the reforms seem, if not at a standstill, then at least in need of a new lease of life. In both cases, these difficulties can be interpreted as the revenge exacted by actors and institutions for policies that focused on economic agents and the incentives to which they might respond [8].

In Britain, despite the "strong political will" once cited as a fundamental condition of a successful health policy (WHO, 1996), many examples can be given of the failure of the reform.

In brief, those elements that have worked are not competition-oriented, while those elements that are competition-oriented have not worked.

i/ The private funding of hospitals under the Private Finance Initiative, which was seen as a good way of improving competition, is stuck at the planning stage. About 25 schemes have been approved by the Treasury, but because of so-called "bureaucratic delays" construction has yet to begin. Hospital trusts are cutting back on beds in order to attract private finance, and there is a fear that waiting lists will grow longer. In the spring of 1997, "1.1 million people were waiting for surgery .. an all-time record" (The Economist, May 5 1997).

ii/ At the beginning of the reform, DHAs and hospital trusts were allowed to sign either "block contracts" (BCs: purchasers pay a lump sum for a wide range of services) or "cost per case contracts" (CCCs: hospital agrees to provide a range of specified treatments with set prices per case or service). Given the aim of introducing competition into the system, the expectation was that the number of cost per case contracts would rapidly exceed the number of block contract. However, a study conducted in 1994 / 1995, showed that, on the contrary, 70% of contracts are block contracts or similar and that only 1% are pure CCCs (J. Raftery et al., 1996).

This failure was, in a way, predictable. Firstly, the British Medical Association was opposed to the reform. Since collection of the data required to assess cost and quality relies on doctors' willingness to cooperate, it was difficult for hospitals and DHA managers to make a rational and informed choice. Secondly, transaction costs are even higher in the health care industry than in other sectors (O. Williamson, 1979). As a result, a sort of hybrid arrangement, somewhere between market and hierarchy, is more likely to be effective than a pure or a quasi-market economy. Furthermore, the patient/doctor relationship (whether or not it involves principal/agent incentives)

needs to be rooted in time, trust, confidence and mutual learning. All of these characteristics are almost the polar opposites of the flexibility and self-interest required in the competitive market.

In France, the main problems stem from the lack of consideration given to the implementation of reform and to the dynamic on which the whole health care system had previously been based (Ph. Mossé, 1998).

A massive wave of strikes and demonstrations against the reforms, involving most trade unions as well as medical associations and ordinary citizens, took place in December 1995. Even if most French people were in favor of structural change, the institutional actors wanted to play a decisive role in its implementation. Their involvement was particularly intensive during the "preparatory" phases, when the reform plan was being decided. However, the implementation phase was seen as a largely technical matter. As a result, the changes, which were regarded as "minor", were decided by the French government alone. The unions, however, saw them as important, not because the changes were of such great significance in themselves but because they were not involved in the decision-making process.

The aim of the reforms was to control costs administratively while maintaining quality, but few incentives were put in place, and the negotiating process is a weak one. As a result, most recent decisions are perceived as constraints and "punishments" instead of incentives to contain costs. This applies to the 1.5% upper limit for the increase in health care expenditures for 1997 decided on by the French government. In a rather self-contradictory statement, this threshold was seen, at the same time and by the same persons, as "unrealistic" and "an unacceptable move towards health care rationing".

For the same reasons, some element of the reform have now either been abandoned or have proved ineffectual. For instance, the health record booklet was posted to several million French households, but it is used neither by patients nor by doctors. Another example is the prescription of medicines. The Ministry of Health requests physicians to prescribe generic drugs rather than
branded medicines wherever possible, but has introduced few (if any) financial incentives to encourage them to do so. As a result, this "measure" has had virtually no effect on the very high level of consumption of prescribed medicines in France[9].

More generally, little attention has been

paid to the main underlying dynamic in the French health care system, which is a mix of specialization and monopolistic competition.

In hospitals, for instance, the new and very much needed information system is now operated mainly by a new category of medical staff in specialist medical information departments. As a result, economic awareness and cost efficiency concerns are being monopolized by a minority of actors instead of being spread among all categories of medical and paramedical staff.

In ambulatory services, the dynamic of specialization runs even more strongly counter to the reform. At the moment, and for some months to come at least, GP associations are involved in setting up the new French managed care system; organizations representing specialists, on the other hand, have withdrawn from all involvement in shaping the reforms, complaining that they were not regarded as key actors during the implementation process.

In hospitals, the gap between the rhetoric (greater autonomy for individual hospitals) and the new organizational structures (which give more power to regional and governmental agencies) has led to opportunistic behavior, local alliances and a search for extra resources. Today, it is those hospitals able to attract private money from the pharmaceutical industry, donations, real estate, etc. that are in a strong position. Since the ability to attract such funds is unevenly distributed, the reform has led to greater inequalities than before, not in terms of number of beds, which is no longer a significant indicator, but in terms of flexible resources.

## Conclusion

As health care reform is now a politically sensitive issue in Japan, it should not be forgotten that the British and French governments of John Major and Alain Juppé were both defeated during the spring of 1997 in part, at least, because of their welfare policies. One the face of it, a willingness to implement structural reforms in the health care system seems to be the best way, for a government to lose an election !

However, the issues involved also have theoretical implications from an economic and social policy perspective.
If one looks at the French and British experiences from a Japanese point of view, two main features appear. The first one refers to the egalitarian philosophy and deals with what can be seen as an ethical or a societal issue. The second one refers to the type of the involved rationality, as such it is related to political economy as applied to Health

Economics.

## - Reforming health care as an ethical dilemma:

Some of the changes the Japanese health care faces today seem to be close to the ones European countries are implemented. But in Europe those changes are included in the larger move towards the post-Beveridge model that, among other consequences, widens inequalities among citizens. In such a move, egalitarianism, the explicit philosophy on which the Japanese health care is grounded, would be in jeopardy.

Therefore, and despite the fact that the Japanese system is"rather egalitarian"(R. Niki, 1996), the first step of a structural reform would be to identify existing inequalities. The second step would be to decide to what extent some inequalities are affordable from a social as well as from a financial point of view. The difficult part of such a strategy is not only to point out, ex ante, the"losers"and the"winners", but also to continuously assess the policy outcome in term of Public Health. In France, as low-medium class households are not always able to buy a private complementary insurance, they can be seen, roughly speaking, as the actual losers. In other countries the choice has been made not to perform less efficient therapies (using, for instance QALY's) ; in this strategy, oldest patients are less likely to be the winner group.

Indeed, this kind of choices are tough, especially in societal context where denying the existence of social differences is, in itself, a part of the social cohesion. However they have to be explicit, at least to some extent ; otherwise invisible actors (e.g. lobbies) might actually decide.

## - Reforming health care as a policy issue:

From an Health Economics perspective, the key point seems to be the very definition of rationality and efficiency. According to textbooks of political economy, being efficient and acting rationally involves reducing the gap between a desired economic objective and the actual situation. In consequence, the policy to be implemented has to be based either on financial incentives or on State regulation. Since a goal can be clearly identified (cost containment, reduction of public budget deficit, cost-effectiveness, etc.), an exercise in modeling using the single dependent variable methodology can be carried out, with the final assessment being based on ex post and ex ante measurement.

In fact, this somewhat mechanistic approach cannot be applied effectively to health care policy. The definition of a

policy target is, simultaneously, a major policy issue, the outcome of social and economic conflicts and the product of an often concealed struggle. It has been demonstrated that, even in private firms, interest and efficiency goals differ from one agent to another (M. Aoki, 1990). This applies *a fortiori* to health care (K. Arrow, 1963). Rather than selecting an *a priori* target and then deciding on a time schedule for achieving it, it is the task of public policy to create and manage the socio-economic conditions for the successful implementation of a continuous and collective process. While the first approach relies on the substantive rationality hypothesis, the second takes account of the fact that individual and collective rationality are more likely to be procedural (H. Simon, 1976).

One may say that "bargaining" is one pillar of the Japanese society. Indeed, many institutions are performing and actually rule the Japanese health care system for decades. However, the financial and economic crisis changes the context within which the"search for consensus"takes place. This context being given, the French and the British experiments strongly suggest that implementation is the major dimension of a reform process. It is a strategic field in which the interaction among actors and the ways in which they anticipate change may have a decisive effect on the failure or success of the reform project.

In conclusion, it can be said that the current difficulties besetting the reform of European health care systems should be considered as an opportunity to improve matters elsewhere or in the future. From this optimistic perspective, three main lessons might be drawn:

## Appendix 1

### British and French reforms:the will and the way.

| | **U. K.** | **France** |
|---|---|---|
| Historical model: | Beveridge | Bismarckian |
| Former leadership: | Central Administration | Physicians |
| Diagnosis: | Insufficient supply | Excessive supply |
| Target 1: | Waiting lists | Cost |
| Target 2: | Quality | Equality |
| Target 3: | Efficiency | Quality |
| Theory: | Agency | Integration |
| Means: | Competition | Certification |
| Main Lack: | Information | Actors' involvement |
| Main Failure: | Transaction Cost | Implementation |

i/ Reforms should not be regarded either as "top-down" or "bottom-up" but rather as an opportunity for an iterative decision-making process involving all the relevant actors .

ii/ negotiation and economic incentives should be seen as complementary ways of creating the conditions for such an iterative process actually to occur.

iii/ implementation and assessment techniques have to take into account not only the extent to which a pre-determined goal has been achieved but also the extent to which the actors are involved in a continuous process of change.

As N. Brunsson (quoted by D. Hughes, L. Griffiths and J. Mc Hale, 1997) argued, "organizational reform is usually portrayed as radical, once and for all change, it can be better seen as a repetitive activity that is easy to start but difficult to finish".

## REFERENCES

B. Abel - Smith. Cost containment and new priorities in health care, Avicbury press, 1992: 134.

Masahiko Aoki. Toward an economic model of the Japanese firm. Journal of Economic Literature 1990; 28, 1: 1-27.

Kenneth Arrow. Uncertainty and the welfare economics of medical care. American Economic Review 1963; 53 ,5: 941 - 973.

Marianne Berthod - Wurmser. Régulation et réformes de la protection maladie en Europe. 1995. Paris; MIRE: 30.

Antony Culyer and Robert Evans. M. Pauly on Welfare economics, normative rabbits outs of positive hats. Journal of Health Economics 1996; 15: 247.

Robert Evans. Going for the gold, the redistributive agenda behind the market-based health care reform. Journal of Health Policy and Law 1997; 20, 2: 427 - 465.

L. Hill and R. Mc Comb. A post mortem on the Clinton health care proposal. International Journal of Social Economics 1996; 23, 8: 21 - 28.

David Hughes, Lesley Griffiths and John Mc Hale. Do quasi-market evolve ? Institutional analysis and the NHS. Cambridge Journal of Economics 1997 ; 21, 2: 259 - 270.

Naoki Ikegami and John Campbell. Medical care in Japan. New England Journal of Medicine 1995; 1295 - 1299.

Norman Johnson, ed.. Private markets in

Health and Welfare. Berg Pub. Providence, USA; 1995; 247.

Denis-Clerc Lambert. La diversification du financement des dépenses de santé en Europe. Lyon 1997: 30.

Emanuel Mermet and Otto Jacobi. The economic and monetary union, consequences for public services. European Federation of Public Service Unions, July 1997: 53.

Ministry of Health and Welfare. Health and Welfare statistics in Japan, Tokyo, Kosheisho 1996: 206.

Philippe Mossé. Le lit de Procuste, hôpital impératifs économiques et missions sociales. Toulouse: Ed. Eres, 1997: 162.

Philippe Mossé. La rationalisation des pratiques médicales, entre efficacité et effectivité. Sciences Sociales et Santé 1998 ; 2.

Ryu Niki. Recent medical care financing reform for Japan's aging society. Journal of Public Policy 1996 ; 2: 69-81.

Hiroatsu Nohara. Le modéle japonais de gestion des ressources humaines. Aix en Provence, 1997:25.

OECD Economic outlook 1996; 59: 20 - 27.

H. Oxley and M. Mc Farlan. Health care reform: controlling expenditures and increasing efficiency. OECD Economic studies 1995, 24, 1: 7 - 55.

John Raftery et alii. Contracting in the NHS quasi-market. Journal of Health Economics 1996, 5: 353 - 362.

Richard Saltman and C. Von Otter. Planned markets and public competition. Open University Press 1992: 178.

Herbert Simon. From substantive to procedural rationality in Methods and appraisal in Economics. Cambridge University. press 1976: 129 - 148.

Bruno Theret. National system of social welfare in international perspective: the Japanese exception?. Tokyo, September 1995.

WHO. European Health Care Reform, Analysis of current strategies. 1996 ; 41.

Oliver Williamson. Transaction cost economics, the governance relation. Journal of Law and Economics 1979; 22: 233 - 261.

Aki Yoshikawa, Jayanta Bhattacharya and William Vogt. Health Economics in Japan. Tokyo University press, 1996: 331.

## FOOT NOTES

1) A European Commission proposal, published in 1992,explicitly initiated a trend towards convergence within welfare systems. It was presented not so much as a condition of progress towards monetary union but as a way of improving living standards in European countries (specially the southern ones).

2) It has to be noticed that the first indicator (% of GDP) places Japan in around 20th position among the OECD countries, while the second (absolute expenditure) puts Japan in about 8th place.

3) Some authors argue that President Clinton's own mistakes allowed "private interests" to obstruct an excessively bureaucratic and sophisticated reform (L. Hill and R. Mc Comb, 1996).

4) W. Beveridge (1879 - 1963) was a British economist willing to add new roles to the traditional ones the State used to play (defence, justice, etc.) according to conventional economic theory. The Beveridge report that laid the basis for the British NHS was published in 1942. O. Bismarck (1815 - 1898) was a German statesman, prime minister of Prussia, who implemented the first social insurance system in Europe. Both were guided in their choices and ideologies by historical events: industrial revolution in 19th century Prussia and the disasters of World War Two, respectively.

5) This mobility can be compared with the construction of wages and of status differentiation within Japanese manufacturing firms (H. Nohara, 1997).

6) The term "gatekeeper" is used to denote a tool for managing the referral process. It prevents patients from consulting a specialist before having seen a general practitioner. This is one of the key tools for managing care in the competition-oriented American HMOs, and also one of the major regulatory instruments in the planned British NHS.

7) This paragraph is mainly based on R. Saltman and C.Von Otter, 1992 chapter 5.

8) A table in the appendix summarises the situation in Great Britain and France in respect of health care reform.

9) It is estimated that generics represent 11% of pharmaceutical sales in Japan, 5% in France and 30% in the USA.