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Between 1977 and 1987, France, Japan, Australia, and Canada each averaged higher real annual growth in health expenditures than the United States.

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International Benefits: Part One—Health Care

- Voluntary employment-based private plans are the primary source of health insurance coverage for most of the U.S. population, while publicly financed compulsory schemes are primary in every other major industrialized nation.

- U.S. health care financing methods effect less income redistribution than those used in other countries.

- The provision of health care services in most industrialized countries is dominated by private physicians and hospitals.

- Perhaps the most significant difference between providers in foreign industrialized countries and those in the United States is the relative autonomy of U.S. providers in determining their payments.

- While foreign countries have relatively controlled procedures for determining provider fees, utilization control—particularly of outpatient care—is not universally practiced.

- In most countries, long-term care services that are medically intensive are covered under health insurance programs, while services that are primarily nonmedical tend to fall under the rubric of social welfare programs and are not covered by health insurance.

- Great Britain, the Netherlands, and the Federal Republic of Germany are in the process of considering major reforms in their health care systems in an effort to combat what they consider to be fundamental shortcomings.

◆ Introduction

In today's global economic environment, the labor practices and policies of other industrialized countries are of great interest to U.S. managers, academicians, and policymakers as business expands abroad and the United States strives to remain economically competitive.

In all industrialized countries, employees receive certain noncash benefits in addition to cash compensation for time worked. The level of total compensation varies considerably among countries, as does the proportion of total compensation that is devoted to benefits, which ranges from 22 percent in Canada to 47 percent in France (chart 1). In many industrialized countries, social security benefit programs are financed through payroll taxes, and these compulsory contributions may account for a significant portion of benefits labor costs. Social security programs provide a wide range of benefits, including health care services, minimum income guarantees for low-income elderly persons, unemployment insurance, and earnings-related pension benefits for retirees. In addition to legally required benefits, most employers also provide some additional voluntary benefits, including private health insurance, death and disability benefits, private pensions and other retirement income plans, and executive benefits.

The structure and level of benefits from social security programs and other private benefits vary considerably among countries. This *Issue Brief* is the first of two that discuss public and private benefits in eight foreign industrialized countries—Australia, Canada, France, the Federal Republic of Germany, Great Britain, Japan, the Netherlands, and Sweden—and in the United States. Part one is devoted to health care benefits, while part two will focus on cash benefits such as retirement programs, long-term disability, sickness and maternity, and unemployment.

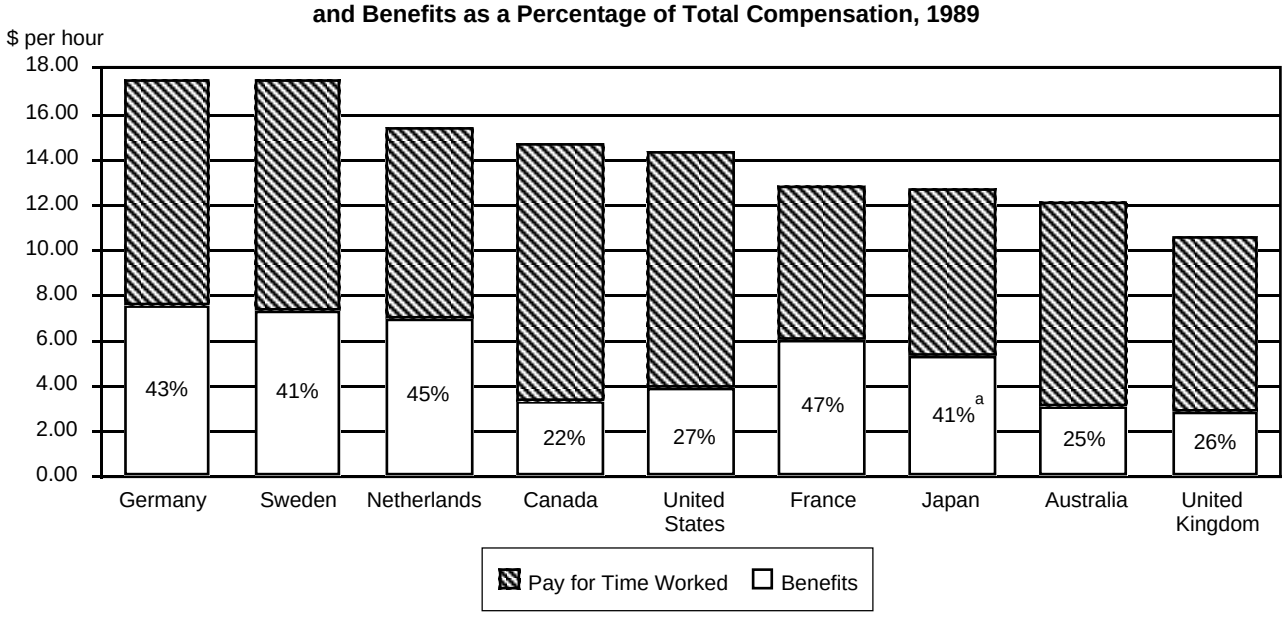
International health spending statistics indicate that the United States spends more than any other industrialized nation on health care, both as a percentage of Gross Domestic Product (GDP) and on a per capita basis. Yet, despite its large health care outlays, this country does not rank highly on gross health status indicators such as the infant mortality rate, which is higher in the United States than in most western countries, and life expectancy, which is about average. Furthermore, the United States is the only major industrialized nation without universal access to some basic level of health insurance; 33 million U.S. residents lacked health insurance from any source in 1988 (Chollet, 1990). These facts, well known among health professionals and policymakers, have generated a great deal of interest in foreign health care systems, which appear to have greater success on measures of national health expenditures, health status, and access to care.

This *Issue Brief* describes three dimensions of national health care systems: the role of public versus private insurance (in terms of prevalence, eligibility, and services covered); health care financing (public and private); and provider issues (composition, payment, utilization, and quality). It includes a discussion of international approaches to the financing and provision of long-term care and concludes with a comparison of the growth in health care spending across countries and an overview of recent and proposed reform efforts in the various countries.

◆ Public Versus Private Health Insurance

The United States is the only country considered in this discussion in which voluntary employment-based private health care plans are the primary source of health insurance coverage for most of the population; in every other country publicly financed compulsory schemes are the primary source of coverage for most residents. Private health insurance in other countries generally serves to supplement public insurance and/or provide primary coverage for relatively affluent indi-

Chart 1
Average Hourly Compensation Costs for Production Workers in Manufacturing and Benefits as a Percentage of Total Compensation, 1989



Source: Tabulations based on data from U.S. Department of Labor, Bureau of Labor Statistics, *International Comparisons of Hourly Labor Costs for Production Workers in Manufacturing, 1975, 1980, and 1982–89: Supplementary Tables for BLS Report 787* (Washington, DC: U.S. Government Printing Office, 1990).
[a]Includes semiannual bonuses, which may represent 20–30 percent of employees' annual compensation.

viduals. While publicly financed, compulsory health insurance constitutes the foundation of health care systems in foreign industrialized countries, there is considerable variation in the respective roles of compulsory and voluntary insurance. Health care systems can be categorized according to the roles and characteristics (individuals covered, services covered, and prevalence) of public and private insurance:

- voluntary private insurance dominant (United States);
- compulsory public insurance, with
  —limited supplementary private coverage (Japan, Sweden, Great Britain) or
  —widespread supplementary private coverage (Australia, Canada, France); and
- compulsory public insurance (income tested) or private insurance (Germany, the Netherlands).

Generally speaking, in countries other than the United States, private health insurance coverage tends to complement coverage under the public insurance schemes. Other factors, such as the tax treatment of private insurance premiums and government regulation of private insurance (discussed in a later section) may also affect the prevalence of private insurance coverage.

Voluntary Private Insurance Dominant (United States)

The primary source of insurance against health care expenses in the United States is employment-based group health insurance that is provided as an employee benefit (that is a noncash part of total compensation). In 1988, 66 percent of the nonelderly population received health care insurance through an employer, while only 10 percent had private health insurance

through another source, and 12 percent of the nonelderly were covered by public health insurance (Chollet, 1990). Employers in the United States are free to decide whether or not to provide health insurance as an employee benefit, but many find it favorable to do so.[1]

Employment-based health insurance plans usually provide comprehensive coverage for full-time salaried employees and their dependents (full-time wage earners may also be covered under such plans or they may be covered by a separate plan that is collectively negotiated through a union). Employers generally sponsor two types of health plans—a traditional fee-for-service plan and a prepaid group health plan such as a health maintance organization (HMO)—and allow employees to choose between the two.[2] Benefits generally include ambulatory and hospital care and limited coverage for mental health services, and they sometimes include dental, vision, and prescription drug coverage. HMO plans and an increasing number of traditional plans also provide coverage for primary and preventive care services. First dollar coverage is extremely rare in traditional fee-for-service health plans; health insurance usually requires a deductible (commonly, $150 per person per year). Coverage for physician services in indemnity plans is usually for 80 percent of usual and customary charges for a particular service (as calculated based on prevailing charges), up to a maximum out-of-pocket limit (commonly, $1,500 per year), after which insurance reverts to 100 percent. Patient cost sharing under HMO arrangements is usually limited to nominal copayments for particular services.

Public insurance plays a uniquely limited role in the U.S. health care system. Public insurance programs (Medicare, Medicaid, and CHAMPUS) jointly provide health insurance for only about 23 percent of the total population. Medicare coverage is somewhat similar to insurance provided by the public programs in other countries in that it provides a base level of coverage for the population it serves. However, Medicare benefits are considerably more limited than the social insurance schemes in other industrialized nations (table 1). The Medicare program provides coverage for virtually all elderly persons (aged 65 and over) and for the long-term disabled population. Medicare hospital insurance (HI, or Medicare Part A) is a mandatory entitlement program covering hospital care (with significant copayments and limits) and some home health care and skilled nursing facility services. Supplementary medical insurance (SMI, or Medicare Part B) is a voluntary insurance program, subject to a monthly premium, covering physician care, outpatient hospital services, and independent laboratory services. Most elderly persons opt to participate in Medicare SMI, which provides payment for 80 percent of covered expenses, subject to a $75 annual deductible (Piacentini and Cerino, 1990). Because Medicare leaves significant gaps in coverage, many elderly persons purchase supplemental private coverage (Medigap insurance) if they do not receive such benefits from their former employers.

Medicaid is a federal/state program intended to provide health care to medically indigent welfare recipients. Its provisions are complex and vary from state to state, but nationally the program covers approximately 40 percent of the population with incomes below the federal poverty level. Benefits vary by state to some extent but are generally comprehensive for the population they

[1]Employers (of all sizes) in Hawaii have been required by law since 1974 to provide health insurance coverage to employees. Hawaii is the only state with mandated employer coverage, but Massachusetts is currently phasing in such a law. Employers in other states may find health benefits useful for attracting and retaining employees, and, through risk pooling, can generally buy a dollar of health insurance at a significant discount from the amount employees would pay on an individual basis. Moreover, contributions to group health plans in the United States are not taxable as employee income and are deductible by employers as a business expense.

[2]Although the HMO Act of 1973 required all employers to offer a federally qualified plan if approached by the plan, HMO enrollment only became widespread during the 1980s as employers began to search for a solution to increasing health care costs. Other health plan schemes, such as preferred provider organizations (PPOs), are also gaining in popularity. For a more extensive discussion of employer health plans in the United States, see Barber and Horkitz, 1990.

Table 1
The Role of Public Health Insurance Programs, by Country

Country	Coverage		Services Covered and Proportion of Charges Paid by Plan		
	Prevalence	Eligibility	Hospital care	Ambulatory care	Outpatient prescription drugs
Australia	100%	Residents	100% in public hospital with hospital physician	85%; out-of-pocket max: $16/service and $119/year	100% subject to $9 beneficiary copayment per prescription
Canada	100%	Residents	100% ward-level accomodations	100%	Varies by province: in all provinces, 100% for elderly; in three provinces, 80% for nonelderly
France	100%	Residents	80%–100%; $6 daily deductible	75% scheduled fee	40–100%, depending on necessity
Germany	90%	Residents (compulsory for hourly employees and salaried employees earning <$33,353/yr)	100%; Small daily copayment for first 2 weeks	100%	100% subject to $2 beneficiary copayment per prescription
Great Britain	100%	Residents	100%	100%	100% subject to nominal beneficiary copayment per prescription
Japan HIE	52%	Employees	90% for employees; 80% for dependents; out-of-pocket max: $392/month[a]	90% for employees; 70% for dependents; included in maximum[a]	90% for employees; 70% for dependents
Japan NHI	48%	Those covered by HIE	70%; 100% for elderly, with $3 per day copayment out-of-pocket max: $392/month[a]	70%; 100% for elderly, with $6 per month deductible included in maximum[a]	70%; 100% for elderly
Netherlands ZFW	62%	Employees earning less than $26,649/year	100% up to 365 days	100%	100%
Netherlands AWBZ	100%	Residents	Nursing home and institutional coverage subject to income-based cost sharing up to a maximum of $707 per month	n.a.	n.a.
Sweden	100%	Residents	100%; $10 daily user fee[b]	100%; $10 user fee/visit[b]	100% essential drugs
United States Medicare	13%	Elderly (aged 65 and over)	100% first 60 days with $592 deductible; days 61–90 with $148/day user fee; days 61–150 with $296/day user fee[c]	80%; $75 annual deductible	not covered
United States Medicaid	9%	d	100%	100%	100%

Source: Selected documents (see bibliography).
Note: All figures are expressed in U.S. dollars, converted using January 1990 exchange rates.
[a]All copayments count toward $392 monthly out-of-pocket maximum for a single illness.
[b]Maximum of 15 user fees in a one-year period.
[c]Each Medicare recipient is entitled to coverage for one hospital stay in excess of 90 days.
[d]Medicaid eligibility varies by state. In general, recipients of Aid to Families with Dependent Children (AFDC) and pregnant women and children under age 6 in families with incomes under 133 percent of the poverty level are eligible for coverage.

cover. Reimbursement rates are low in some states, however, limiting the number of providers willing to treat Medicaid patients.

CHAMPUS, the Civilian Health and Medical Program of the Uniformed Services, provides comprehensive health insurance coverage for active-duty and retired members and their dependents (who are not eligible for Medicare) of all branches of the military.

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Japanese employers are required to contribute to a government health insurance plan for their employees, pursuant to the Health Insurance law.

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Compulsory Public Insurance /Limited Supplementary Private Coverage (Great Britain, Sweden, and Japan)

Public health insurance in Great Britain, Sweden, and Japan is compulsory for all residents, and private supplementary health insurance plays a limited role.

Great Britain and Sweden—Public programs in these countries provide comprehensive coverage for virtually all medical care, with nominal charges for most services in Sweden and for auxiliary services in Great Britain (table 1). Both systems include comprehensive coverage for primary care and preventive services. Private health insurance is generally reserved for business executives and their families, although recent studies suggest that its prevalence has been increasing rapidly (Joseph, 1990; Rosenthal, 1986). Private health insurance is most commonly used to pay for private hospital accommodations and for privately provided nonemergency surgery for which there would otherwise be potentially long waiting periods. To some extent, the limited function of private health insurance in these countries may be related to the public programs' comprehensiveness and satisfactory performance.

Japan—Public health insurance in Japan is an amalgamation of several different programs, as opposed to the single programs of Great Britain and Sweden. Japanese employers are required to contribute to a government health insurance plan for their employees, pursuant to the Health Insurance Law. Firms that employ more than 700 employees may choose to "contract out" of the government plan by establishing an independent health insurance society through which they provide employee health benefits.[3] Japanese residents not covered under the Health Insurance Law (hereafter referred to as HIE—Health Insurance for Employees) or one of a number of special programs (for example, for seamen, school teachers, public service employees, and utility workers) must be covered under National Health Insurance (NHI). Public health insurance, under both HIE and NHI, compulsorily covers virtually all medical goods and services, with the exception of routine physical examinations and the normal delivery of a baby (table 1).

Cost sharing under Japan's public insurance schemes can be significant; copayments range from 10 percent to 30 percent of a uniform fee schedule for most services and are subject to a relatively high out-of-pocket limit of approximately $390[4] per month for a single illness. Under HIE (for both contracted-out plans and the government plan), ward-level hospital care is covered at 90 percent for employees and 80 percent for dependents. Ambulatory care is covered at 90 percent for employees and 70 percent for dependents. Coverage is usually 70 percent (but can be lower, depending on economic circumstances) under NHI for all insured individuals, with the exception of the elderly (aged 70

[3]Health insurance societies could be considered as private plans because they are individually financed by the private firms that establish them. For purposes of this discussion, however, they are considered public, because they can only exist as an alternative to coverage under the government plan for employees.

[4]All figures are expressed in terms of U.S. dollars based on January 1990 exchange rates except as noted.

and over) and the disabled (aged 65 and over), who pay only nominal user fees—$3 per day in the hospital and $6 per month for outpatient care (Iglehart, 1988). Although Japan has no private insurance per se, HIE plans frequently provide additional benefits, including cash benefits to cover the normal delivery of babies and partial coverage of patient cost-sharing requirements, with the level of supplementary medical benefits varying by fund.

Compulsory Public Insurance/Widespread Supplementary Private Coverage (Canada, Australia, France)

As in Great Britain, Sweden, and Japan, public health insurance in Canada, Australia, and France[5] is compulsory for all residents, but supplementary private insurance is common in these countries. Compulsory coverage typically consists of comprehensive ambulatory and hospital care (ward-level accommodations) and certain additional coverages (for example, dental care, vision care, prescription drugs, and other medical goods). Cost-sharing provisions vary significantly by country. Private health insurance generally provides coverage for various services not covered by compulsory insurance and may include coverage for upgraded hospital accommodations, a portion of patient copayments, dental services, prescription drugs, prosthetic devices, and other items, depending on the country.

Canada—Each of Canada's 10 provincial public plans provides 100 percent coverage for comprehensive ward-level hospital and medical care (table 1). Certain provinces provide coverage for other services such as chiropractic, podiatry, osteopathy, and naturopathy. Optometry, excluding the cost of eyeglasses, is covered by most provincial plans. Dental care for children and prescription drugs for senior citizens are also covered in many provinces. Cost sharing is limited to auxiliary health services such as dental care, prescription drugs, and other medical goods. Coverage for these items varies by province. Although compulsory coverage is comprehensive, most Canadian employers provide employees with a supplementary health care plan. Most provincial governments prohibit private insurance from covering any services covered by the provincial medical plan, so private insurance is generally designed to cover other items. It typically includes private or semiprivate hospital accommodations, prescription drugs, ambulance services, private home nursing care, out-of-country expenditures, limited convalescent home care, care from auxiliary medical practitioners (for example, chiropractors, osteopaths, podiatrists, and naturopaths), and medical equipment and prosthetic devices. Some private plans may be subject to modest deductibles ($20 per year) and/or copayments (10 percent to 20 percent), (Charles D. Spencer & Associates, 1990).

Australia—Australia's Medicare program reimburses 100 percent of hospital expenses (accommodations and medical care), so long as care is provided in a public hospital by a hospital-appointed doctor (table 1). Medicare also covers 85 percent of scheduled fees for ambulatory care, subject to relatively low out-of-pocket maximums (Charles D. Spencer & Associates, 1989). But the Australian scheme requires significant user fees for hospital accommodations when care is provided by patient-selected physicians and does not provide coverage for accommodations in private hospitals (Charles D. Spencer & Associates, 1989). Inpatient care by a patient-selected physician is covered for care in both public and private hospitals at 75 percent of the scheduled fee, but cost sharing is not subject to out-of-pocket maximums. Medicare also covers part of the cost of most prescribed medicines. Optometrist services are covered but not the cost of eyeglasses. Australian Medicare does not cover dental, chiropractic, physiotherapy, or home nursing services (Charles D. Spencer & Associates, 1989).

[5]Coverage for medical services under the French Social Security system is not technically compulsory for all residents, but an estimated 99 percent of the population is covered. Compulsory coverage extends to all employed persons, pensioners, some nonearners, and dependents of the compulsorily insured. Residents not included in compulsory coverage are generally eligible for voluntary affiliation.

Supplementary private health insurance is common in Australia, but because of commercial insurance regulations introduced in 1985 (discussed in a later section), it is frequently obtained on an individual basis through Registered Health Funds (RHFs) rather than through employer-sponsored plans. RHF coverage must include at least the standard daily charge for shared accommodations not covered by the public plan (accommodations in a public hospital when the patient chooses the doctor and accommodations in a private hospital), the 25 percent of the Medicare scheduled fee for inpatient medical services not reimbursed in those settings, and the cost of surgically implanted prostheses (Charles D. Spencer & Associates, 1986). In addition to these minimum requirements, RHF plans may include coverage for additional services but may not provide reimbursement for the cost of in-hosptial medical or surgical care in excess of the Medicare scheduled fee. Enrollment is open to anyone paying the standard premium (double for families). RHF plans may be offered at lower than the standard rate, with a deductible.

France—The public program in France calls for relatively significant cost sharing. Eighty percent of hospital costs are reimbursed (100 percent for serious illnesses), subject to a $6 daily user fee (table 1). Ambulatory care is reimbursed at 75 percent of scheduled fees for care from physicians who agree to charge according to a standard fee schedule. Dental care, including preventive care, is also reimbursed at 75 percent of a set fee schedule. Prescription drug coverage ranges from 40 percent to 100 percent, according to the necessity of the medication.

Cost sharing under the French scheme is not limited by an out-of-pocket maximum but is generally covered by private employer-sponsored health plans. Because of the burdensome cost-sharing requirements of the French social security medical benefits, French companies consider voluntary supplemental schemes as a necessary extension of the social security system (Carbonel, 1990). Employer-provided supplementary insurance covers employees as well as their spouses and dependents. Supplemental health insurance can be provided through *mutuelles*, nonprofit organizations managed by their members (usually contracted for wage earners), or through insured plans (primarily for white collar employees). Supplementary benefits under insured plans generally include 100 percent coverage for the difference between scheduled fees and social security reimbursement, plus 90 percent of charges above the scheduled fee for most medical services. Benefits provided under *mutuelles* are usually limited to the difference between scheduled fees and social security reimbursement. However, private insurance may not reimburse the patient for the daily hospital fee.

Compulsory Public Insurance (Income-Tested) or Private Insurance (Germany, the Netherlands)

The public health insurance schemes in Germany and the Netherlands are also quite comprehensive, but neither are compulsory for the entire population.[6] Private health insurance in Germany and the Netherlands provides comprehensive coverage for persons who are not members of statutory health insurance and provides supplementary coverage for some who are covered under the statutory scheme (more so in the Netherlands than in Germany).

Germany and the Netherlands—In Germany, membership in the statutory system is mandatory for all wage earners, apprentices, unemployment beneficiaries, and disabled individuals and for pensioners, salaried employees, and some self-employed persons earning up to $33,353—approximately 75 percent of the population (table 1) (Charles D. Spencer & Associates, 1990). German employees at all income levels are eligible to participate in the statutory health system but can never rejoin it if they choose to opt out (relatively few do so).

[6]The Dutch health care system has two parts. Basic comprehensive health insurance is provided under the Compulsory Health Insurance Act and is compulsory only for employees below a certain income level. Insurance for exceptional medical expenses, however, is a national insurance scheme and is compulsory for all residents.

Similarly, in the Netherlands, coverage under the Compulsory Health Insurance Act (ZFW) is required only for wage earners and salaried employees (and their dependents) earning less than $26,649 annually—approximately 62 percent of the population (William M. Mercer, 1990). Unlike the German system, however, voluntary membership under ZFW is not permitted. Coverage is available for low-income persons and pensioners (subsidized by the government), and the government pays the entire cost of coverage for persons disabled from birth, but individuals with incomes above the threshold must buy private insurance (U.S. Department of Health and Human Services, 1990). However, coverage under the Exceptional Medical Expenses Act (AWBZ), which provides coverage for catastrophic medical expenses, is compulsory for all residents.

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The public schemes in both the Netherlands and Germany provide 100 percent payment for virtually all medical goods and services, with an emphasis on primary care and preventive care.

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The public schemes in both the Netherlands and Germany provide 100 percent payment for virtually all medical goods and services, with an emphasis on primary care and preventive care (table 1). Germany recently began requiring a nominal daily fee for the first two weeks of hospital care and modest copayments for prescription drugs, dentures, and eyeglasses in an effort to cope with ever-increasing health care costs.

Private health insurance in the Netherlands and Germany provides comprehensive coverage for those who are not members of the statutory scheme and provides supplementary coverage for some who are members. More than one-third of Dutch residents are ineligible for coverage under ZFW and rely on private health insurance for comprehensive coverage. Typical private plans provide comprehensive hospital coverage (with a choice of hospital accommodations that affects the premium), full specialist coverage for medical and surgical procedures, optional primary care coverage with limited copayments, and other sundry optional coverages. Supplemental coverage can be purchased through private health insurers or nonprofit service plans. In addition to sponsoring private health insurance for high-income employees and their families, some employers provide ZFW participants with coverage for semi-private hospital accommodations and treatment (Charles D. Spencer & Associates, 1990).

Approximately 9 percent of the German population has opted out of the statutory scheme and is dependent on private insurance for comprehensive coverage (Reinhardt, 1989). Coverage provided by private insurers for those who are not covered by statutory insurance is quite similar to that provided by public insurance. Private insurance coverage to supplement coverage from statutory sickness funds is rare and is reserved for employees whose earning exceed the social security ceiling ($33,353) (Charles D. Spencer & Associates, 1990). These benefits generally provide for private hospital accommodations (the statutory system usually provides for three- or four-bed wards) and occasionally provide indemnity coverage for hospital confinement.

◆ Health Care Financing

This section reviews four characteristics of health care financing for each country's public and private health insurance programs: fiscal administrative structure, financing sources, the tax treatment of contributions, and government regulation (of private insurance).

Fiscal Administrative Structure

Public health care systems can generally be characterized by one of two administrative structures: those based on a single national plan, which are administered by regional or local entities, and those based on multiple independent plans, which are funded and

administered individually (in accordance with national standards). In either case, there is a considerable degree of variation in the roles played by the applicable administrative entities. In some cases, regional organizations serve only to administer claims, while other entities are responsible for contracting with providers. In Great Britain and Sweden, regional entities are themselves responsible for providing health care services. In some countries, individual financing is also determined on a decentralized basis.

The United States (Medicare), Japan (HIE), France, Holland, Sweden, and Great Britain all have national public health plans that are regionally administered. The U.S. Medicare program is administered by the Health Care Financing Administration (HCFA). HCFA contracts with private carriers and public agencies (nonprofit Blue Cross and Blue Shield plans, commercial insurance companies, and group practice prepayment plans (that is, HMOs)) to serve as intermediary administrative agents that determine and make payments to providers of services or to patients. In Japan, the Social Insurance Agency (a national organization) serves as the HIE plan's financial intermediary. Insurance divisions of prefectural departments and social insurance offices provide local administration of benefits. In France, the National Sickness Insurance Fund receives payroll tax contributions, and Primary (local) Sickness Insurance Funds handle insurance registration and reimburse beneficiaries for expenses.

The Dutch health care system is similar to those above, but regional health funds play a greater administrative role. Payroll taxes go to a single national fund and then flow to approximately 35 government-approved sickness funds (Kirkman-Liff, 1989). Sickness funds handle claims administration, but they also contract with providers to administer medical benefits (similar to a U.S. HMO).

In Great Britain and Sweden, the regional administrative role is even greater than that of the Dutch sickness funds. In Great Britain, the National Health Service (NHS) operates through approximately 190 District Health Authorities (DHAs), which are responsible for both administration and provision of health care benefits. The NHS allocates to each DHA a budget weighted to reflect the characteristics of the population it serves. The Swedish health care system operates through 26 county councils. Like the DHAs in Britain, county councils are responsible for both their population's health and the provision of health care services (Lindgren, 1989). But unlike DHAs, Swedish county councils are empowered by the national government to finance health care services through a proportional income tax on their residents.

Public health programs in Canada, Germany, Japan (NHI and contracted-out plans), and the United States (Medicaid) are based on multiple plans that are individually funded and administered. Each of these programs is free to establish contributions and benefits within certain guidelines, although in most cases, plans within a single national system offer similar benefits. In Canada, the 10 provinces and the two territories each administer a provincial health plan, subject to certain federal requirements. Similarly, the U.S. Medicaid program consists of 50 individual state plans (plus plans for the U.S. territories), administered by each state government.

In Japan, health insurance established under NHI is administered through municipal health funds established by each town. Health insurance under HIE for employers who choose to establish their own health insurance societies (large employers) is also based on multiple independent entities that have the power to tax participants for contributions and are subject to government supervision.

The German health care system consists of approximately 1,200 sickness funds, including local funds, industrial funds, crafts funds, rural funds, blue collar workers' funds, white collar workers' funds, and special funds for sailors and miners (Henke, 1989). Sickness funds are managed within the private sector under the

stewardship of a board of trustees representing unions and employers but are subject to tight federal statutes governing benefits and financing (Reinhardt, 1989). Each sickness fund sets contribution rates to cover expenses. Sickness funds negotiate payments with physician associations and hospitals.

The administrative structure of private health insurance plans is rather consistent across foreign industrialized countries. **Most private plans are administered through private health insurance companies, although some are managed by independent nonprofit organizations (for example, French *mutuelles*, Australian Registered Health Funds, and Dutch service plans) and some are managed by employers (for example, Japanese insurance societies and U.S. self-insured plans).**

Financing Sources

Health care financing has significant implications for income redistribution. **In most foreign industrialized countries, health care systems are financed in a way that involves a larger transfer of income for health care services than does the U.S. health care system.** This may be a result of culturally different priorities: the United States places considerable value on a pluralistic system that allows freedom of choice, while many foreign countries place relatively greater value on equal health care as a fundamental right of citizenship (even at the expense of greater government control).

Public health plans are funded through some combination of general revenues (national and regional) and/or payroll taxes (employer and employee) and sometimes require small beneficiary premiums (table 2). Health plans that are financed by proportional payroll taxes redistribute income from relatively high-income individuals to lower-income individuals (since everyone receives the same benefits regardless of the amount they contribute).[7] Health insurance schemes financed by general revenues have a similar income redistributive effect. Financing through payroll taxes or general revenues also transfers income from single taxpayers without dependents to those who support a spouse and/or children (since most public health schemes cover dependents). The vast majority of individuals in foreign industrialized countries are covered under plans that are financed predominantly through proportional taxes and general revenues (that is, public schemes), while 73 percent of insured Americans are in private health plans financed through group premiums.

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Health plans that are financed by proportional payroll taxes redistribute income from relatively high-income individuals to lower-income individuals.

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Generally speaking, health plans based on group premiums serve mostly to transfer income from healthy individuals within the group to sick ones (since everyone pays the same amount regardless of income). Some may subsidize employees with families as well (in cases where employees are not required to contribute the full marginal cost of insuring their dependents). Primary private plans are generally funded jointly through employer and/or beneficiary premium contributions. Private plans that supplement the public scheme range from fully employer-financed coverage to coverage that includes no employer contribution (table 3).

In most countries (except France and the United States) employee contributions to voluntary schemes are not tax-deductible (although they may generally be deducted from payroll for convenience). And in most countries (except Canada, France, and the United States) employer contributions to voluntary schemes are either non-tax-deductible to the employer or

[7] A cap on the level of earnings subject to taxation (as for Medicare in the United States and in the Netherlands) limits the extent of income redistribution.

Table 2
Financing Sources for Public Plans, by Country

Country	Percentage of Population with Coverage	Payroll Taxes: Percentage of Payroll			Proportion of Health Expenses Financed by General Revenues		Beneficiary Premium	Other
		Employer	Employee	Ceiling	National	Regional		
Canada	100%	a	n.a.	n.a.	38%	62%	b	n.a.
France	99%	12.6%[c]	5.9%[c]	none	d	n.a.	n.a.	1.4% of old age security pension + 2.4% of private pension for retirees
Germany	90%	4%–8%[c]	4%–8%[c] (same as employer)	none	n.a.	n.a.	n.a.	6.5% of social security pension + income-based percentage of private pension for retirees
Great Britain	100%	e	e	n.a.	85%	n.a.	n.a.	n.a.
Japan HIE	52%	4.15% + 0.5%[c] on bonuses	4.15% + 0.3%[c] on bonuses	none	n.a.	n.a.	n.a.	n.a.
Japan NHI	48%	n.a.	n.a.	n.a.	50%	f	Income-adjusted up to $2,543 per year	70% of health expenses for retirees are financed through transfers from HIE funds
Netherlands ZFW	62%	4.95%	3.15%	$26,649	n.a.	n.a.	$8/adult $4/child per month	n.a.
Netherlands AWBZ	100%	n.a.	5.4%	n.a.	n.a.	n.a.	Income-based up to $707 per month	n.a.
Sweden	100%	10.1%[c,g]	n.a.	n.a.	6.5%	65%[h]	n.a.	n.a.
United States Medicare Part A	13%	1.45%	1.45%	$51,300	n.a.	n.a.	$29/month	n.a.
Medicare Part B	13%	n.a.	n.a.	n.a.	75%	n.a.	n.a.	n.a.
United States Medicaid	9%	n.a.	n.a.	n.a.	50%	50%	n.a.	n.a.

Source: Selected documents (see bibliography).
[a]Three provinces charge employer payroll taxes: Ontario, 0.98–1.95 percent of payroll, depending on size of payroll; Manitoba, 2.25 percent of payroll; and Quebec, 3.36 percent of payroll.
[b]Two provinces (Alberta and British Columbia) require beneficiaries to pay a premium, but health care cannot be withheld in cases of nonpayment.
[c]Finances cash sickness and maternity benefits (to be discussed in part two of this series) as well as medical care benefits.
[d]In addition to payroll and pension contributions, the government subsidizes health benefits through a special 12 percent tax on automobile insurance permiums plus the proceeds of taxes on pharmaceutical advertising costs, alcohol, and tobacco.
[e]Employer and employee contributions to National Insurance Fund account for approximately 15 percent of total NHS costs.
[f]Local governments subsidize NHI benefits costs.
[g]This proportional payroll tax, plus some transfer payments from the government, is paid into a Social Health Insurance Fund. The majority of this fund (65 percent) finances sickness cash benefits (to be discussed in part two of this series), but social insurance contributions represent 19 percent of the total medical care bill.
[h]County council income taxes finance 65 percent of the total health care bill. These taxes averaged 13.5 percent in 1985 (Lindgren, 1989).

counted in the employee's taxable income. Tax treatment may influence the prevalence and extent of private insurance. This may be one of the reasons, for example, that employer-sponsored private health insurance is not a common benefit in Sweden or Great Britain.

Regulation of Private Insurance

As in the United States, private health insurance in foreign countries is subject to government regulation. Some regulations relate to services that may or may not be reimbursed by private health insurance, while other regulations specifically address health care financing. Private insurers in Australia and Germany are subject to stringent financing regulations that are designed to maintain universal access to health care.

In Australia, private insurance can be purchased on an individual basis from Registered Health Funds (RHFs) or provided through an employer-sponsored group plan. In addition to providing specific coverages, RHFs must provide community-rated coverage to any individual who enrolls and pays the standard premium. RHFs were recently denied the ability to impose a waiting period for preexisting conditions (Charles D. Spencer & Associates, 1990). Family coverage is available for two times the standard premium, and plans may be offered at lower community rates with a deductible. RHFs must also satisfy specific reporting requirements, maintain minimum reserves, and contribute to a reinsurance fund (Charles D. Spencer & Associates, 1986). In 1985, the Australian government passed a law requiring all private commercial insurers to register under the National Health Act and thereby to operate in a manner similar to RHFs. This has curtailed the growth of new employer-sponsored health plans (preexisting plans were not subject to the new regulations) except in cases where the plan is large enough to be 100

Table 3
Health Insurance Financing of Private Plans, by Country

	Private Plan Is Primary Source of Coverage			Private Plan Is Supplementary Source of Coverage		
Country	Percentage with coverage	Employer	Employee	Percentage with coverage	Employer	Employee
Australia	0%	—	—	70%	0–100[a]	10–100[a]
Canada	0	—	—	90	50–100	0–50
France	0	—	—	90	50	50
Germany	8	50%	50%	7	100	0
Japan	0	—	—	0	—	—
Netherlands	32	50	50	70	50	50
Sweden	0	—	—	7	100	0
Great Britain	0	—	—	10	0–100[a]	0–100[a]
United States	63[c]	0–100[d]	0–100[d]	4[b,c]	0–100	0–100

Source: Selected documents (see bibliography).
[a]Employers may pay the full cost of private health benefits (usually for executives) or they may offer employees the option to buy into a private plan. In Australia, employees frequently buy into an RHF plan, independent of their employer.
[b]Approximately 32 percent of Medicare recipients persons have some type of private supplementary coverage, usually through their former employer or through individual Medigap plans.
[c]Percentages are estimated based on U.S. Department of Commerce, Bureau of the Census, "Receipt of Noncash Benefits, 1987" (unpublished) and Deborah J. Chollet, "Update: Americans without Health Insurance," *EBRI Issue Brief* no. 104 (Employee Benefit Research Institute, July 1990).
[d]According to the U.S. Department of Labor, in 1989 48 percent of workers received wholly employer-financed individual health coverage and 31 percent received wholly employer-financed family coverage (U.S. Department of Labor, Bureau of Labor Statistics, *Employee Benefits in Medium and Large Firms, 1989* [Washington, DC: U.S. Government Printing Office, 1990]). In cases where employee contributions were reported, they averaged approximately 30 percent of total premium costs. Approximately 13 percent (8 percent of total) of Americans with private coverage purchased that coverage independent of any employer in 1989.

percent self-insured (Charles D. Spencer & Associates, 1986).

Commercial insurers in Germany are also subject to stringent financial regulations. Private insurance premiums must be based on the average actuarial risk of five-year age cohorts (Reinhardt, 1989). Carriers may require applicants to undergo a health examination, and are permitted to reject high-risk individuals at that time or to charge a risk premium. Once a private carrier provides coverage, however, it may raise the premium only to reflect changes in overall health care costs, not in response to changes in the insured's age or health status. Under such a flat-rated system, beneficiaries effectively build a reserve for old age. Under German law, an individual who moves from one private plan to another would be rerated based on the average actuarial risk of his current five-year cohort, thereby losing that reserve. These regulations are designed to lock individuals into health plans for life, thereby avoiding adverse risk selection and uninsured individuals.

◆ Provider Issues

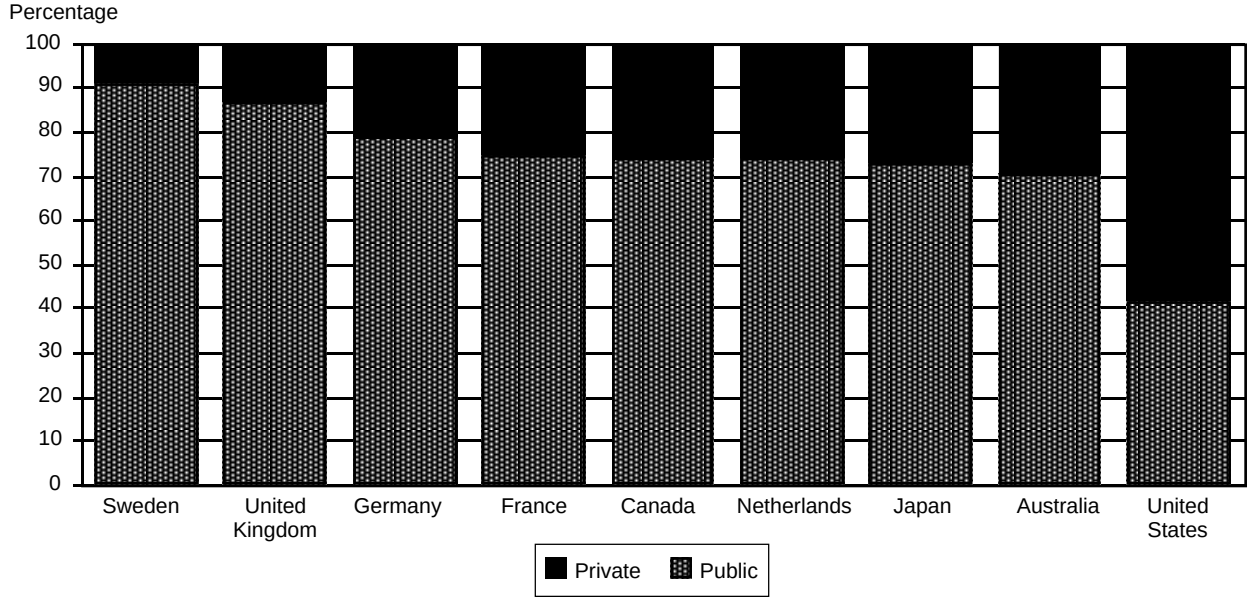
While health care providers and facilities in foreign industrialized countries are not radically different from those in the United States, there are considerable differences in the amount of control providers exert over the price and quantity of health care services. **Generally speaking, central government control and planning are characteristic of the supply side of health care systems that are based on public programs.** Centralized control is not as large a factor in the

[8]When characterizing providers, it is important to distinguish between financing and ownership. For example, "public" is frequently used to describe a private provider that receives funding from public sources (for example, the majority of Canadian hospitals). In fact, the majority of Canadian hospitals are privately owned.

[9]The majority of French acute care hospitals are private, but public hospitals are larger and accounted for approximately 70 percent of beds in 1980 (Lacronique, 1984).

Chart 2

Public and Private Health Care Expenditures as a Percentage of Total National Health Care Expenditures, 1987



Source: U.S. Department of Health and Human Services, Health Care Financing Administration, *Health Care Financing Review*, 1989 annual supplement (December 1989).

U.S. system, where public health care programs account for only 41 percent of national health expenditures (chart 2). This section discusses provider composition (government versus private), the determination of provider payments, utilization control, and the quality of care in foreign health care systems.

Provider Composition

The provision of health care services in most industrialized countries is dominated by private physicians and hospitals.[8] Sweden and Great Britain, where the majority of hospitals are government owned, are the most notable exceptions.[9] In the other countries under consideration, there is a mix of government and private hospitals, but physicians are generally private practitioners (Canada, France, Germany, Japan, the Netherlands, and the United States). However, physicians may be under contract with the public health plan. In some countries (Germany, Japan, Sweden, and Great Britain and, in France, in government hospitals), hospital-based physicians are salaried hospital employees (government employees in cases where the hospital is government-owned). Outpatient care is generally given in private physicians' offices, with a few exceptions. In Sweden and Japan, outpatient services are delivered in local outpatient clinics. In Sweden, a patient who requires hospital care, is referred to a hospital by his or her assigned clinic.

The system in Japan is rather uncoordinated. Care can either be delivered in a clinic (a facility with fewer than 20 beds) or in a hospital (a facility with 20 or more beds) (Iglehart, 1988). Unlike most health care systems, however, the Japanese system does not clearly distinguish between clinic-based services and those performed in a hospital, leading to redundancy in equipment and services provided.[10] Clinic-based physicians are not permitted to follow patients into the hospital, where care is provided by salaried physicians. The lack of cooperation between clinical physicians and hospital-based physicians in Japan is based on a traditional and continuing political rivalry between the two groups.[11]

Provider Payment

Perhaps the most significant difference between providers in foreign industrialized countries and those in the United States is the relative autonomy of U.S. providers in determining their payments. The setting of fee schedules, capitation fees (for general practitioners (GPs) in the Netherlands and Great Britain), and global hospital budgets (Canada, the Netherlands, Sweden, and Great Britain) can best be characterized as a process of collective bargaining between providers and public health plan representatives, with strong central government influence in most cases. In five Canadian provinces, Germany, and the Netherlands government control includes the setting of expenditure caps or targets. In the Canadian provinces governed by expenditure targets or caps and in Germany, physician fees are adjusted downward to compensate for higher-than-planned utilization in order to prevent total expenditures from exceeding defined targets. This fee-setting practice contrasts with that of the United States, where provider fee schedules (public and private) derive from what is normally charged in the market for medical services and are not currently governed by expenditure caps or targets. Moreover, in most countries (Canada, Germany, Japan, the Netherlands, Sweden, and Great Britain), negotiated fee schedules are binding (that is, physicians cannot charge the patient in excess of the scheduled fee). In the United States, only the Medicare program limits the amount physicians can charge.[12]

[10]By law, a patient can occupy a clinic bed for only 48 hours, but this mandate is not enforced (Iglehart, 1988).

[11]For a complete discussion, see Iglehart, 1988.

[12]Medicare physician payment reform (under the Omnibus Budget Reconciliation Act of 1989) limits the percentage of the Medicare-allowable rate that physicians can bill. The new law, set to start in 1991, blocks physicians from charging more than 125 percent of the prevailing Medicare fee in 1991, 120 percent in 1992, and 115 percent in 1993. Various states have recently passed their own laws limiting physician balance billing.

In Canada, for example, the provincial governments and medical associations periodically negotiate binding physician fee schedules. For the most part, these negotiations focus on the overall increase to be applied to existing fee schedules, while medical associations themselves are free to reallocate spending among the various groups of general practitioners and specialists (Health Insurance Association of America, 1990a). In British Columbia, Saskatchewan, Manitoba, Ontario, and Quebec, which jointly include more than 80 percent of the Canadian population, governments explicitly account for unplanned increases in the prior period's utilization when determining the overall increase to be applied to fee schedules (Lomas et al., 1989).[13] In Quebec, Manitoba, and Ontario, if physician expenditures have exceeded a predetermined target, fee increases in subsequent years are adjusted downward until payments are recouped. In British Columbia, physicians temporarily work at reduced fees to offset payments in excess of the target, and in Saskatchewan, current fees are paid at a discounted rate to counteract anticipated utilization increases for the year (Lomas et al., 1989). Canadian hospitals are funded through global budgets, which are determined in annual negotiations with the provincial health ministry.

In Germany, sickness fund associations negotiate a relative value fee schedule[14] with ambulatory physicians and per diems with individual hospitals. The government is able to influence the outcome of the negotiations through Concerted Action, a quasi-governmental body composed of representatives from all parts of the health care system: government, payers (public and private), providers (hospitals and physicians), employers, and labor unions (Kirkman-Liff, 1990). A separate fee schedule and a separate hospital per diem governs physicians treating privately insured patients. Although the sickness funds' fee schedule is binding for patients who are part of the statutory scheme, doctors can (and generally do) charge privately insured patients up to 2.3 times the private fee schedule. Hospital per diems for privately insured patients are lower than those for sickness fund patients because, unlike the statutory system per diems, they do not include the services of hospital physicians. Like the fee arrangements used by the Canadian provinces discussed above, German fees reflect unanticipated increases in utilization. In 1985, the German government negotiated overall physician expenditure caps with the physician association. If utilization threatens to put total expenditures over the cap, the monetary value per relative value point is automatically reduced.

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The Japanese health care system does not include explicit expenditure targets, but government influence in fee negotiations is apparent nonetheless.

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The negotiation process in the Netherlands is similar to that in Germany. Binding physician fee schedules are determined through complex negotiations between the government and national physician associations (general practitioners and specialists), with the Central Office on Health Care Tariffs, a quasi-governmental body, guiding the process (Kirkman-Liff, 1989). Sickness funds and private insurers both negotiate under this structure, in which a "norm income" and a "norm

[13] Although expenditure caps and targets that incorporate utilization increases may contain costs, they do not necessarily control utilization on an individual physician level. Quebec is the only Canadian province that employs mechanisms for controlling the quantity of individual physician services provided as well as overall expenditures. Individual physician expenditure caps or targets also exist in Germany and the Netherlands and are discussed in the next section along with other utilization control mechanisms.

[14] A relative value fee schedule values each procedure in terms of its value relative to other procedures. Generally, this is done by assigning point values for each possible medical service. Fees are then determined by multiplying the number of points by a fixed dollar value per point. Relative value fee schedules are currently employed in Germany and Japan and were recently adopted by Medicare for Part B payments.

patient size" are agreed upon. The Dutch system does not incorporate an explicit mechanism for adjusting fees downward to reflect increases in utilization, but income adjustments are made at the individual physician level (as described in the next section). Once those guidelines are determined, however, provider associations negotiate separate schedules with the sickness funds and the private insurers. Sickness funds also negotiate fixed prospective budgets with the individual hospitals (Jonsson, 1990).

The Japanese health care system does not include explicit expenditure targets, but government influence in fee negotiations is apparent nonetheless. The Ministry of Health and Welfare sets binding service fees in consultation with the Central Social Insurance Medical Council, an advisory body representing the public, payers, and providers. Inpatient fees are always paid to the hospital, where staff physicians are full-time salaried practitioners. Like Germany, Japan sets fees according to a relative value scale similar to that recently adopted for Medicare Part B payments.

In Great Britain and Sweden, where most hospitals are government-owned and physicians are salaried government employees (except for GPs in Great Britain), governments (through DHAs and county councils, respectively) have explicit control over provider payments. British GP compensation is based on a government-determined capitation payment and additional fees according to services rendered.

In France, the government and providers negotiate a schedule of conventional physician charges (*tarifs conventiones*) and hospital per diems (Lacronique, 1984). Physicians are not required to participate in the *conventiones*, but if they do not, their patients are reimbursed according to a much lower fee schedule. Consequently, most physicians do participate. Originally, participating physicians could not charge in excess of the *tarifs conventiones*, but since 1985 they have been permitted to charge whatever they like ("free fees"), while their patients are still reimbursed according to the schedule. Moreover, private insurers (but not *mutuelles*) generally cover 90 percent of charges in excess of the *tarifs conventiones*, up to a maximum of 300 percent of the scheduled tariff, resulting in a reduced incentive for patients to identify less expensive physicians and for doctors to moderate charges (Carbonel, 1990).

U.S. private insurers conventionally reimburse providers at a certain percentile (commonly 85 percent or 90 percent) of a schedule of usual, customary, and reasonable (UCR) charges. UCR charges, however, are a function of what other local providers are charging for services rather than being set or negotiated. The process for determining provider fees in the Netherlands provides an interesting contrast to the system of UCR charges. In Holland, one of the first steps in payment negotiations is the determination of a "norm income" for physicians. The norm income is later divided by a negotiated "norm patient list size" to determine capitation payments and fees. Kirkman-Liff (1989) has described the process of determining the norm income.

> The tasks, responsibilities, and duties of physicians are compared with those of government officials, to determine a salary scale for the calculation of physician income. The fringe benefits (especially pensions) of the equivalent government position are calculated as a lump sum, which is added to the income figure. These calculations do not consider the actual average or median physician income; it is a negotiated, desired standard for practicing physicians.

U.S. government payers reimburse providers according to more restrictive fee schedules than private insurers. The Medicare prospective payment system (PPS) for Part A reimbursement, adopted in 1982, reimburses hospitals prospectively according to the diagnosis

[15]The DRG system is a patient classification scheme that catagorizes patients who are medically related with respect to diagnoses and treatment and are statistically similiar in their lengths of hospital stay.

related group (DRG)[15] for which a patient is admitted to the hospital. The hospital is paid the same amount for a particular admission regardless of services rendered, and payment is binding. (PPS has reduced inpatient utilization, which is discussed in the following section.) Part B fee schedules (physician fees) are arrived at in a manner similar to those for private payers. Medicare Part B reimburses physicians at the 75th percentile of customary, prevailing, and reasonable (CPR) charges (a measure similiar to UCR). Physicians may be permitted to bill patients for part of the difference between charges and actual Medicare reimbursement, depending on state law. In 1989, Congress approved a new resource-based relative value scale (RBRVS) for Medicare physician payments that values physician services relative to one another. RBRVS will effectively increase the value of primary care services to reflect the costs of high-technology procedures. Medicaid provider payment schemes, while they vary by state, are generally lower than Medicare payments.

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Germany and Quebec have explicit physician expenditure caps that are enforced through adjustments to physician fee schedules.

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Utilization Control

While foreign countries have relatively controlled procedures for determining provider fees, utilization control—particularly of outpatient care—is not universally practiced. **Utilization control measures include macroeconomic approaches such as prospective hospital operating budgets and microeconomic controls such as prospective payments for inpatient services, utilization review of providers (physicians and/or hospitals) by payers and/or peers, the use of general practitioners as gatekeepers to secondary and tertiary care, and physician income caps.**

Among the countries discussed in this paper, Canada, France, the Netherlands, Sweden, and Great Britain finance hospitals through prospective global operating budgets. Hospitals operating on prospective budgets may effectively control the quantity of services provided, because additional services do not generate any additional income, and administrators want to stay within their budgets in order to be considered successful. By the same token, however, hospitals may keep patients longer than necessary, because care for days at the margin (when the patient is relatively healthy) cost less than that for a new (relatively sick) patient.

The United States has attempted hospital utilization control at the microeconomic level. Mechanisms for controlling utilization include the PPS for Medicare Part A payments, utilization review by payers (public and private), and peer review organizations. Under PPS for Medicare Part A claims, Medicare reimburses the hospital a fixed amount for a given admission according to a designated DRG, regardless of actual services rendered. A hospital operating under PPS, similiar to the one governed by a global budget, does not have any financial incentive to provide excess care. Under PPS, however, each marginal day spent in the hospital reduces the hospital's average net income per admission, and hospitals may face a financial incentive to discharge patients too early.

Utilization review (UR) programs for inpatient care are widespread among U.S. public and private payers and include such measures as preadmission review and case management. The review is often conducted by a third party UR firm hired by the actual payer to prevent unnecessary hospital admissions. Retrospective utilization review for Medicare Part A payments is conducted by peer review organizations (PROs) under contract to Medicare. PROs review hospital treatment and deny payment in cases where they deem utilization to have been inappropriate.

In countries or systems in which GPs serve as gatekeepers to secondary and tertiary care, they may represent another system of hospital utilization control. Dutch

sickness fund GPs and GPs working for HMOs in the United States, for example, are monitored not only on their own utilization but on the frequency with which they make referrals for specialist care. In terms of outpatient utilization control, Dutch sickness fund GPs and GPs working for certain U.S. HMOs are paid a fixed amount (capitation) for each patient they see regardless of services provided, and face no incentive to provide excess care. In countries such as Great Britain, however, where GPs are paid partially on a fee-for-service basis and referral behavior is not strictly monitored, there is no reason to believe that gatekeepers effectively control utilization.

Various physician utilization control measures have been implemented in Canada, Germany, and the Netherlands, and experiments to control physician prescribing practices have been undertaken in France and Great Britain. In Quebec, Germany, and the Netherlands, UR by peers (Germany) and by payers (Quebec and the Netherlands) is employed to control physician over-utilization in the face of expenditure caps and targets.

As mentioned earlier, Germany and Quebec have explicit physician expenditure caps that are enforced through adjustments to physician fee schedules. But macro-expenditure caps, while they limit health care expenditures, do not necessarily limit utilization. In a system in which total physician expenditures are limited, each physician may face an economic incentive to increase the quantity of services (the number of patients and/or the number of procedures per patient) in order to preserve his or her own income. Moreover, a physician who abuses the system through unnecessary services reduces the income of his or her peers. To prevent this from occurring, Quebec and Germany have implemented utilization monitoring and feedback mechanisms for individual physicians. In Quebec, the government sets a quarterly maximum payable to each GP. After an individual physician reaches that limit, services are reimbursed at only 25 percent of the scheduled fee. In Germany, sickness fund physician associations conduct economic monitoring based on physician cost profiles calculated from extensive data collected by the sickness funds. Physicians receive cost analyses of their practices from the physician association and are notified of an automatic reduction in reimbursement if they are more than 40 percent over the average on various cost measures (Kirkman-Liff, 1990).

Dutch physicians, while not subject to expenditure caps, are monitored with respect to the targeted "norm income." GP income is fairly predictable because it is based on capitation fees. However, specialists, who are paid on a fee-for-service basis, might face an incentive to provide excess services in order to boost their incomes absent any control on utilization. For this reason, Dutch sickness funds pay specialists according to the fee schedule, but at year end total individual income is compared with the norm income, and adjustments are made for those in excess of the norm. Specifically, physicians must pay back one-third of the first $15,000 above the norm and two-thirds of any income beyond that.

In addition to controlling utilization by paying specialists regressively above a targeted income, the Dutch health care system includes utilization review and feedback programs. Dutch providers are required to collect and provide to the sickness funds extensive data on all services provided and fees paid for sickness fund patients in order to receive payment for their services. The sickness funds then compile doctor-specific profiles from which they compute local and national averages. Detailed profiles are reviewed with doctors in one-on-one and/or group discussions to encourage appropriate utilization. In addition to formal review, sharing practice data in peer groups has led to the spontaneous formation of voluntary peer review programs (Kirkman-Liff, 1989).

In response to rapid health expenditure growth, other countries are also experimenting with supply side cost containment programs aimed at controlling utilization.

For example, France and Great Britain have experimented with mechanisms for controlling physician prescribing patterns. The Thatcher government has also included extensive utilization monitoring systems as a major element in the proposed reforms to the National Health Service (NHS). **Utilization control programs reflect a general acknowledgement that the growth in utilization, as well as the growth in prices, must be decreased in order to contain health care expenditures.**

Quality

The quality of health care provided in foreign countries is an issue of great concern to those who study international health care systems. Economists frequently ask whether or not Americans are receiving better care for their higher health care expenditures. Gross indicators such as infant mortality and life expectancy would suggest that this is not the case. In 1987 (the latest year for which data are available), the U.S. infant mortality rate was higher than those of all other major industrialized countries, and U.S. life expectancy at age 60 was among the shortest (table 4). However, gross indicators such as these may reflect environmental and lifestyle factors as well as the quality of health care.

Table 4
Infant Mortality and Male and Female Life Expectancy at Age 60, by Country, 1987

Country	Infant Mortality[a]	Male Life Expectancy at Age 60	Female Life Expectancy at Age 60
		years	
Japan	0.5 %	19.9	24.0
Sweden	0.6	18.7	23.1
Netherlands	0.6[b]	18.3	23.6
France	0.8	18.4	23.7
Canada	0.8[b]	18.4[c]	23.3
Germany	0.8	17.3[b]	21.7[b]
Australia	0.9	18.3	22.8
United Kingdom	0.9	16.8	21.2
United States	1.0	18.2	22.5

Source: Organization for Economic Cooperation and Development (OECD). *OECD in Figures*, supplement to the *OECD Observer* (June/July 1990).
[a]Deaths in the first year of life as a percentage of live births.
[b]Figure for 1986.
[c]Figure for 1984.

There is general disagreement over the nature of medical quality and how to measure it. One common measure against which some evaluate quality is access to health care. But even the question of access is multifaceted and can be considered from several points of view, including waiting time for access, equity in access, and/or availability of certain technologies. In the United States, for example, a health care program that requires two-year waiting periods for nonemergency surgery might be considered to be of poor quality. In Great Britain and Sweden, however, where such waiting exists, a health care system that rations care based on the ability to pay and leaves 33 million people without health insurance (that is, the U.S. health care system) would probably be considered unacceptable. Other characteristics of a high-quality health care system may include formalized quality assurance mechanisms, such as licensing and accreditation, and a legal system that allows recovery of damages resulting from medical malpractice. Given that these items are highly subjective as measures of quality, the following discussion briefly addresses their presence in foreign industrialized countries.

Waiting time for medical care, mentioned in the example above, is frequently cited as a consideration when evaluating the quality of care in foreign health care systems. Queuing for nonemergency surgery and certain high-technology procedures has been documented in Canada, Sweden, and Great Britain (Iglehart, 1990; Potter and Porter, 1989; Rosenthal, 1986). In these countries, regional entities determine the available supply of hospital services, and to the extent that demand for these services is greater than the supply, queuing results. While some foreign industrialized countries ration care implicitly by making decisions that limit the supply of care available to everyone, the United States generally does not set limits on supply, at the expense of higher overall health expenditures. Care can also be rationed explicitly according to expected outcome and/or quality of life. In

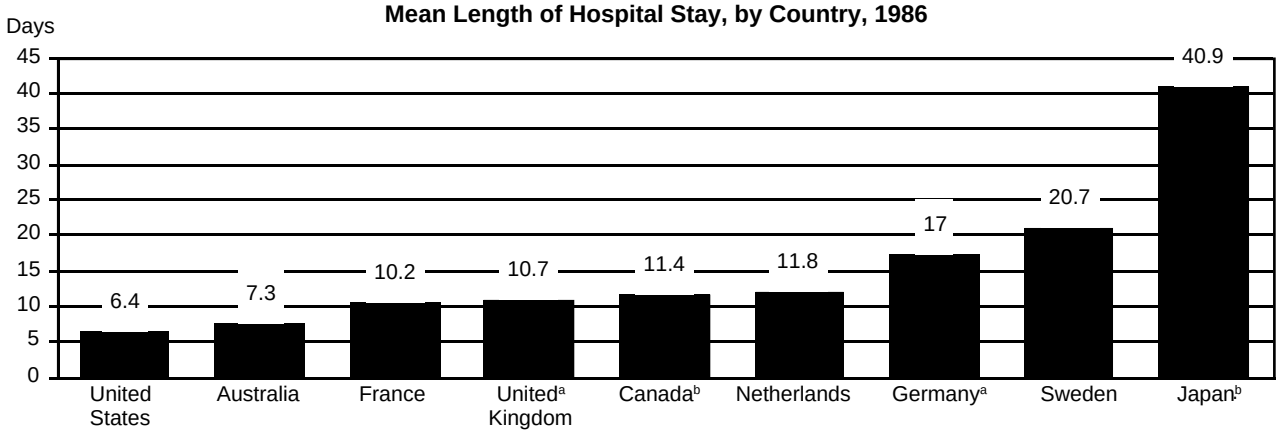
Great Britain, the NHS rations hemodialysis treatment to patients with end-stage renal disease according to age, based on considerations of potential for health improvement and quality of life. A system such as this, which explicitly rations care, may be considered poor in quality by some but viewed by others as the only solution in a system with limited resources. In the United States, health care is rationed according to the ability to pay. Americans without health insurance are denied access to care that others receive routinely (for example, vaccinations, prenatal care, and other preventive care), based on their inability to pay for it.

Generally speaking, hospitals that operate according to regionally planned budgets may make different decisions with respect to capital investment in new technology than hospitals that operate in the market-like environment that characterizes the United States. Regional planning agencies may be more likely to consider the benefits relative to the incremental cost of a new technology, and this may slow the rate of technology diffusion, adding to the queuing discussed above. In contrast, hospital administrators in a fee-for-service setting may be more likely to consider the demand for a certain technology and whether its services will be reimbursed by a third-party payer.

Formalized quality assurance programs are widespread in the United States, where the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), a private organization funded by various provider associations, establishes quality standards that must be maintained for hospital accreditation. Health care facilities are judged on various items, including the age and modernity of their equipment, cleanliness, and staffing ratios. Likewise, states require physicians to pass an examination for licensure. In other countries, governments are more involved with setting quality standards, such as hospital staffing ratios, but in general, quality standards are less formal. It is not at all clear, however, that foreign countries' lack of organizations such as JCAHO and the National Committee for Quality Assurance (another accreditation agency) implies that providers are of lower quality.

The use of litigation to control medical malpractice is considerably more common in the United States than in other countries. This may be a result of a tort system that encourages litigation by the way it assesses liability and damages. In Great Britain, legal counsel must be paid a retainer (as opposed to most U.S. malpractice attorneys, who are paid on a contingency basis), and plaintiffs are held responsible for the defendant's court

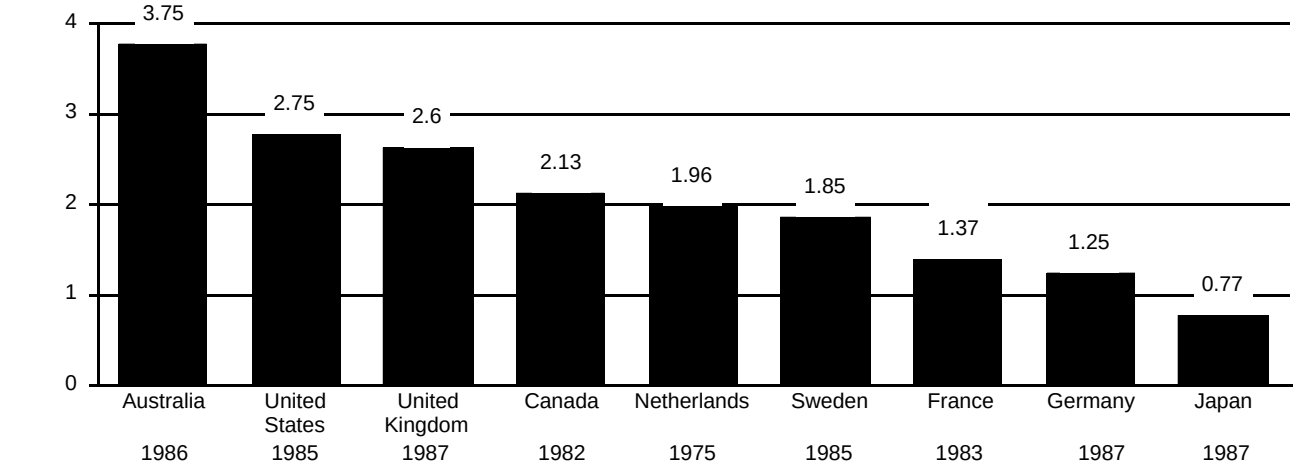
Chart 3
Mean Length of Hospital Stay, by Country, 1986



Source: U.S. Department of Health and Human Services, Health Care Financing Administration, *Health Care Financing Review*, 1989 annual supplement (December 1989).
[a]Figure for 1985.
[b]Figure for 1984.

Chart 4

Hospital Staffing Ratio per Occupied Bed, Latest Years Available



Source: U.S. Department of Health and Human Services, Health Care Financing Administration, *Health Care Financing Review*, 1989 annual supplement (December 1989).

fees if the judgment is in favor of the defendant. In Sweden, there is a no-fault liability system for government providers. Although state medical malpractice laws in the United States may protect individuals from negligent care, they may also have adverse effects on care by altering physician behavior. Specifically, physicians are encouraged to provide a greater quantity of tests and other services to avoid charges in court that they did not exercise all options (a practice known as defensive medicine). In addition, the U.S. malpractice system increases the cost of medical care because physicians must purchase costly malpractice insurance.

While there is no clear answer concerning what constitutes quality, there are significant variations in the way in which care is delivered across countries. In the United States, for example, the mean length of hospital stay (6.4 days) in 1987 was shorter than that of any other major industrialized country and more than three times as short as that of Sweden (chart 3).[16]

Hospital care also differs across countries with respect to the number of hospital staff per occupied bed. Australia, the United States, and the United Kingdom have significantly higher hospital staffing ratios than European countries or Japan (chart 4). Until more research is conducted that relates variations in these and other practice patterns to actual outcomes, it will be difficult to evaluate the relative quality of various health care systems.

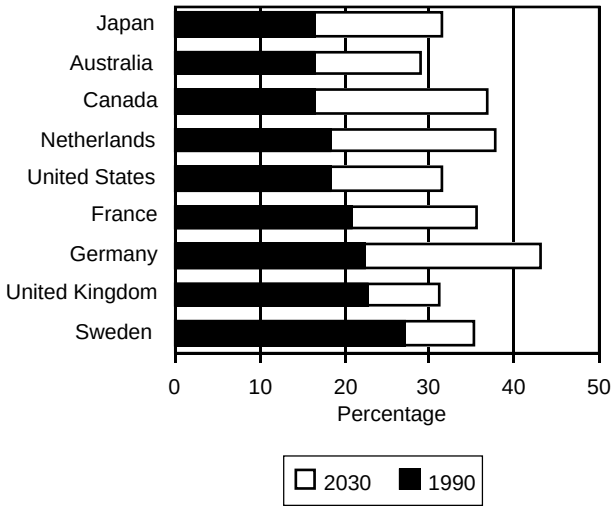
◆ Coverage for Long-Term Care

This section reviews international programs for the financing and provision of long-term care services. Long-term care services include services provided in institutional settings such as long-term care or chronic disease hospitals, geriatric wings of acute care hospitals, nursing homes, and old age or personal care homes as well as alternatives to institutional long-term care such as home health care, homemaker care, adult day care, and respite care. People live longer today than ever before, and as the proportion of the population aged 65

[16]Japan's mean length of stay was more than six times that of the United States, but may be skewed by the large number of elderly who occupy hospital beds on a long-term basis (as opposed to going to nursing homes or other long-term care institutions).

[17]The following discussion draws heavily from Doty, 1990.

Chart 5
Old Age Dependency Ratios: Population Aged 65 and over as a Percentage of Population Aged 15–64, 1990 and 2030



Source: Winfried Schmahl, "On the Future of Retirement in Europe Especially of Supplementary Pension Schemes." Prepared for the International Seminar: The Future of Basic and Supplementary Pension Schemes in the European Community—1992 and Beyond, Bremen, Germany, January 1990.

and over continues to rise in the next 20 to 30 years (chart 5), the demand for long-term care services will continue to increase. Moreover, greater activity in the formal economy by those who were traditionally providers of nonmedical long-term care services (that is, women) means that there has been and will likely continue to be a greater need for the provision of these services outside the family setting.

In most countries, coverage for long-term care services that are medically intensive (acute hospital care, convalescent care, and home health care) is included under the health care plans described in this report, while services that are primarily nonmedical (nursing home care and home help services) tend to fall under the rubric of social welfare programs and are not covered by health insurance.[17] In the United States, for example, private Medigap policies generally cover long-term services provided in acute care hospitals, while Medicare provides coverage for convalescent care in skilled nursing facilities and for limited home health care services. These categories of care are primarily medical in nature and are covered in a manner similar to other medical services, with limited deductibles and copayments. Nursing home care, home help care, adult day care, and other services that are geared more toward providing assistance with activities of daily living (for example, dressing, bathing, and eating), however, are currently provided on a means-tested basis by Medicaid (for institutionally based care) or by community-based programs (for long-term care in alternative settings). Although data on the prevalence of long-term care services funded by non-Medicaid sources are not readily available, recent state surveys have found that Medicaid figures represent only one-half of total public spending on home- and community-based care in the United States (Doty, 1990).

There is, however, a great deal of variation among countries with regard to the kind of institutional care that is covered by public health insurance. In Canada, for example, provincial health plans cover all care provided in nursing homes or hospital-based "extended care facilities," which represent the majority of the institutional population receiving long-term care services.[18] Less than one-quarter of institutionalized elderly Canadians live in welfare-financed personal care homes. In England and the Netherlands, however, admission to long-term care facilities providing services covered under NHS and the AWBZ, respectively, is strictly limited to those requiring relatively medically intensive care. In England, only one in five institutionalized elderly persons receives care in geriatric wards of NHS hospitals (the only form of inpatient long-term care covered under NHS), while the majority of institutionalized elders reside in local authority homes supported by local welfare funds or in private nursing and residential care homes supported in part by means-

[18]Hospitals operating on tight operating budgets, such as those negotiated between Canadian provincial health plans and hospitals, may not have a great incentive to move nonacute long-term care patients to alternative settings, because the cost of caring for them is significantly lower.

[19]For a more complete description of the range of alternative care

tested supplemental social security payments. Likewise, fewer than one-third of Dutch elders residing in long-term care institutions qualify for support under AWBZ. The remaining institutionalized elderly population reside in "old people's homes" (similar to U.S. nursing homes) and receive means-tested subsidies from the government. In Germany, homes for the aged and nursing homes are considered to be social care facilities and as such are ineligible for sickness fund coverage.

The French approach the medical/social service dichotomy differently. National health insurance provides coverage for the medical component of long-term care in any setting (14 percent of expenses, on average), while the residential component of long-term care expenses may be subsidized through need-based public assistance (Doty, 1990).

The portion of institutional long-term care costs that is not covered by public or private health plans is generally financed through private payments or welfare programs on a means-tested basis. The rationale behind requiring private financing of long-term care services for those who are able to pay is that individuals should be responsible for basic living expenses, which represent the bulk of expenses in long-term care facilities (as opposed to acute care facilities, where medical expenses are greatest). In the United States, the financing of long-term care has received a great deal of attention because of the impoverishment, or "spend-down," that is required before elders can receive coverage for nursing home care under Medicaid. While some countries (for example, Sweden) may not require elders to expend capital resources before becoming eligible for public assistance, the United States is not alone in providing long-term care assistance on a means-tested basis; England, France, the Netherlands, and Germany provide long-term care subsidies according to ability to pay. In Germany, welfare authorities carry means testing even further in assessing the resources of adult children to determine whether they should be required to contribute to the costs of their parents' care (Doty, 1990).

In Australia, Canada, and Sweden, residents of long-term care facilities are charged fees in relation to social security benefits. In Australia and Canada, fees are set at a percentage of the social security pension. In Sweden, nursing home residents contribute their full social security pension, plus between 60 percent and 80 percent of other private income to the cost of care.

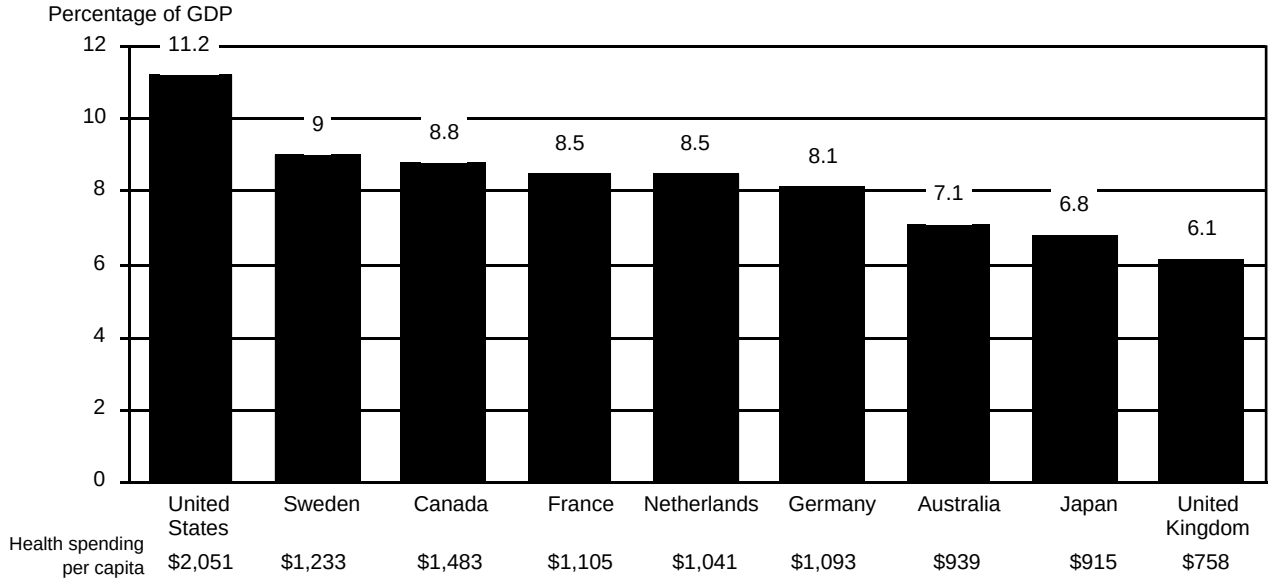
Noninstitutional long-term care alternatives (home help, day care, etc.) are available through local government programs in many countries (for example, Great Britain, Canada, France, the Netherlands, and Sweden), with payment on a sliding scale according to income. In the United States, state and county-funded programs, as well as programs funded by Social Service Block Grants and the Older Americans Act, provide community-based long-term care services, many of which are means-tested. In response to the growing need for elderly care services, local governments in various countries have developed innovative programs to encourage community care alternatives. In Taito, Japan, the local government has established a program whereby volunteers who help the elderly in their homes earn coupons that can be redeemed for similar aid in the future for themselves or their relatives (Martin, 1989). Similarly, local governments in Germany, Sweden, and Great Britain have caregiver assistance programs that allow relatives to be paid to provide home care.[19]

In the United States, the issue of long-term care insurance coverage has received a great deal of public policy attention in the past year and was the focus (along with access to basic health care) of the U.S. Bipartisan Commission on Comprehensive Health Care (the Pepper Commission). The commission's report recommended a universal national financing scheme for basic long-term care coverage (U.S. Bipartisan Commission on Comprehensive Health Care, 1990). Meanwhile, private insurers have begun to respond to

programs, see U.S. Congress, 1984.

[20]See Chollet, 1990, for a thorough discussion of the uninsured and

Chart 6
Total Spending on Health as a Percentage of Gross Domestic Product (GDP) and Total Health Spending per Capita, 1987



Source: Organization for Economic Cooperation and Development (OECD), *OECD Figures*, supplement to *OECD Observer* (June/July 1990).
Note: Per capita health spending figures represent currencies converted to U.S. dollars using OECD purchasing power parities what control for price level differences among countries.

the demand for protection against potential impoverishment from long-term care expenses, and some have begun to market long-term care insurance to employment-based groups. According to a recent survey of insurers, 118 U.S. employers offered their employees the option to purchase long-term care insurance for themselves and/or their parents in 1989 as opposed to 7 in 1988 (Health Insurance Association of America, 1990b). Americans are apparently not the only ones who value such protection; in May 1990, BASF became the first German employer to offer long-term care insurance to its employees (Charles D. Spencer & Associates, 1990).

◆ Trends

National Health Expenditure Growth

It is a well-known fact that the United States spends more on health care than any other nation (chart 6).

The United States is not alone, however, in experiencing rapidly growing health care expenditures. A comparison of the growth in health expenditures among the countries under consideration in this discussion reveals that between 1977 and 1987, France, the United Kingdom, Australia, and Canada each averaged higher annual nominal growth in health expenditures than the United States (table 5). Increases in nominal growth measures can be attributed to several factors: price inflation (general and health specific), population growth, and growth in the utilization or intensity of health care services provided. The United States experienced the highest growth due to health care-specific inflation (2.3 percent) during this period, with Canada close behind (2.0 percent).

A comparison of real growth in health care expenditures (that is, growth exclusive of inflation) reveals that France, Japan, Australia, and Canada outgrew the United States from 1977 to 1987. The United King-

Table 5
Decomposition of Growth in National Health Care Expenditures, by Country: 1977–1987

	10 Year Compound Annual Growth Rate								
	France	United Kingdom	Australia	Canada	United States	Sweden	Japan	Germany	Netherlands
Nominal Growth	12.8%	12.3%	12.3%	11.9%	11.4%	10.5%	8.3%	5.9%	5.5%
Inflation	7.1	10.1	8.7	8.5	8.0	9.0	3.5	3.8	3.7
GNP price index	8.5	8.7	8.5	6.4	5.6	8.4	2.2	3.4	3.2
excess health care inflation	–1.3	1.3	0.2	2.0	2.3	0.5	1.3	0.4	0.5
Real growth	5.4	2.0	3.3	3.2	3.1	1.4	4.6	2.0	1.8
population growth	0.5	0.1	1.4	1.0	1.0	0.2	0.7	–0.1	0.6
utilization/intensity	4.9	1.9	1.9	2.2	2.1	1.2	3.9	2.0	1.2

Source: Employee Benefit Research Institute tabulations of data from U.S. Department of Health and Human Services, Health Care Financing Administration, *Health Care Financing Review*, 1989 annual supplement (December 1989).

dom, whose growth is mainly attributable to general inflation, experienced relatively slow real growth (2.0 percent average annual growth) in national health care expenditures during this period. Controlling for population growth, **France and Japan experienced the highest average annual growth in health care expenditures attributable to increases in utilization and intensity during this period (4.9 percent and 3.9 percent, respectively).**

Factors Affecting Health Care Expenditures

Certain factors external to the financing and organization of individual health care systems may affect the growth in health care spending. Notable among these are rising per capita income, the aging of the population, and the rapid development of new medical technology.

The percentage of national income devoted to medical care has been found to rise more than proportionately with per capita income (Schieber and Poullier, 1989). This finding suggests that as individual incomes rise, the individual consumption of health care services increases. Continuing increases in per capita income (and the resultant increase in the demand for health services) may be one factor in the continuing growth of health expenditures as a percentage of national income.

The increasing number of elderly persons (chart 5) directly affects overall health spending. An aging population causes an increase in the intensity of health care services provided, because older people generally require more health care services than younger individuals. Moreover, as the ratio of elderly to working age persons increases, the health care burden on the economy as a whole increases.

The rapid development of advanced health care technologies also has the potential for making health care more expensive. To the extent that relative cost-benefit analyses are considered when making decisions to invest in new technology, such developments (for example, extracorporeal shock wave lithotropsy for kidney stones and gallstones) could replace less efficient technologies and have potential for reducing health care expenditures. But in many cases new technologies (for example, coronary bypass surgery) do not replace old ones but rather present opportunities to treat illnesses that have been untreatable (this also contributes to keeping more people alive longer). These developments, while they are generally considered socially desirable, contribute to growing health care expenditures.

proposals relating to reform of the U.S. health care system.

◆ Foreign Systems Considering Major Health Care Reform

Aside from incremental measures to stem the growth in health care expenditures (for example, beneficiary copayments, physician expenditure caps, and emphasis on preventive care), some countries are considering major reforms in an effort to combat what they consider to be fundamental shortcomings in their systems. The United States is one such country, where the existence of 33 million uninsured individuals has become unacceptable to many public policymakers.[20] Great Britain and the Netherlands are in the process of reforming their systems to improve inherent inefficiencies, and policymakers in Germany are discussing a solution to the inequity created by its pluralistic health care system. The proposed reforms to each system will be addressed in turn.

The proposed reform of Great Britain's NHS has captured a great deal of attention since the British government released a policy paper in early 1989. In short, the government's proposal seeks to improve the NHS' efficiency through a number of structural reforms that encourage the development of an internal market for health care services. DHAs, now monopolistic suppliers of health care services to their respective populations, would become purchasers of health care services on behalf of their districts (Enthoven, 1989). The NHS would continue to allocate budgets to DHAs based on the same criteria as the current system, but DHAs would be free use the funds to purchase health care services from other authorities and/or the private sector. Competition among individual providers would be encouraged by allowing hospitals to apply for status as self-governing trusts that would independently determine staff salaries and working conditions and be free to borrow in the capital market (Day and Klein, 1989). The government's plan also includes experimentation with the idea of GP budget-holders—large GP practices that would be allocated budgets for a broad range of services beyond primary care (diagnostic tests and treatment for elective surgery but not treatment for chronic conditions) now provided free by NHS hospitals. An important element of the proposal includes strengthening managerial audit of utilization and quality. Financing and administration of benefits would remain unchanged.

Driven by increasing costs and inefficiency in the Dutch health care system, the Dutch government introduced in March 1988 a proposal (the Dekker plan) to gradually restructure the health care system (Charles D. Spencer & Associates, 1988). Like the British government's proposal, the Dekker plan was aimed at improving efficiency by creating internal competition for the provision of medical services. The proposal calls for replacing the two-part ZFW/AWBZ system with a single state scheme (BV), under which all residents (regardless of income) would be compulsorily covered. Individuals would have the option of purchasing private

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The German statutory health insurance system is currently suffering from stresses resulting from the very quality that Americans admire—its pluralistic nature.

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supplementary insurance for services not insured by BV. The BV plan would be insured and administered by sickness funds, private insurers and nonprofit service plans. Individuals would be free to choose among carriers (although premiums would not vary by carrier), who would therefore have to compete for subscribers. Like the current scheme, BV insurers would contract with providers for medical services but, unlike the current scheme, they would not be obliged to contract with all providers. Financing under the Dekker plan would continue on an income-related basis, with a small flat-rate premium. A central fund would collect the income-based contributions and pay each insurer a risk-related premium based on the characteristics of its subscribers. Better coordination of health services, including the substitution of more cost-effective

treatments, is also a major focus of the new plan. Implementation began in January 1989 but has been delayed because the new Dutch government wanted time to revise the plan. Implementation is expected to be complete by 1996 (Charles D. Spencer & Associates, 1990a).

The German statutory health insurance system, although frequently cited as a model that the United States would do well to emulate because it successfully provides universal access in a pluralistic environment, is currently suffering from stresses resulting from the very quality that Americans admire—its pluralistic nature. Presently, the contributions to various sickness funds vary more than twofold, ranging from approximately 7.5 percent to 16 percent payroll taxes (Reinhardt, 1989). This inequity, partly the result of an aging population that is unequally distributed among the funds, has led some firms to establish independent sickness funds for their employees in an effort to keep them from the more costly older funds. Taken to the theoretical extreme, this trend would drive relatively healthy populations into separate risk pools, leaving unhealthy individuals to bear their own burdens (similar to the pluralistic health insurance situation in the United States today). Local sickness funds, whose average contribution is highest (13.5 percent in 1988, versus 11.5 percent for company-based funds) are calling for legislation that would mandate interfund financial transfers to compensate for the difference in risk borne by individual funds. While transfers have occurred among a single type of sickness fund (for example, company-based funds), none have yet occurred across fund type. Moreover, other funds oppose this approach which, taken to *its* extreme, would result in a nationally financed plan (Reinhardt, 1989). The German government plans to make an explicit policy decision in 1992 on the future direction of health care financing (Reinhardt, 1989).

◆ Conclusion

In most industrialized countries, basic health benefits

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The supply side of foreign health care systems is characterized by greater government control than exists in the U.S. system.

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are provided to the majority of the population through one or more publicly financed compulsory plans. This contrasts greatly with the U.S. health care system, in which the majority of insured persons receive basic health insurance benefits through privately financed employment-based plans. Public financing through payroll taxes and/or general revenues redistributes relatively more income than private financing based on individual or group premiums. Consequently, the U.S. health care system effects less income transfer for health care from high-income to low-income persons. Moreover, eligibility for public health insurance is universal in most foreign industrialized countries, while in the United States, 33 million residents have no health insurance coverage.

Generally speaking, public health insurance programs include coverage for the medical component of long-term care, while long-term care services that are primarily nonmedical tend to be covered by means-tested welfare programs and/or community-based services. Private insurers in Germany and the United States have begun to offer insurance to protect against potential impoverishment from long-term care needs.

The supply side of foreign health care systems is characterized by greater government control than exists in the U.S. system. Provider payment levels are generally determined by government-influenced bargaining between payers and providers, as opposed to being set by providers themselves (as they are to a great extent in the United States). The United States and many other industrialized countries have begun to take steps toward controlling both the fees paid for health services and the quantity of services delivered in

an effort to slow the rapid growth in health care expenditures that all industrialized countries are facing.

Health insurance represents but one component of employer spending on benefits compensation. Part two of this series will focus on pensions and other cash benefits.

This *Issue Brief* was written by Karen Horkitz of EBRI with assistance from the Institute's research and education staffs.

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