

Introduction

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This book presents a diagnosis of the health reform experiences of six small and midsize industrial democracies — Israel, The Netherlands, New Zealand, Singapore, Switzerland, and Taiwan — during the last two decades of the 20th century.¹ The countries span the globe, hailing from Asia, the Middle East, and Europe. The study seeks to contribute to cross-national policy learning by structured multicountry research. It looks at the health reform experiences of six quite different health care systems. In that sense, it represents a “most different system design” (Marmor, 1988), under a common analytical framework.

At first glance, the countries selected for this comparative study do not have much in common. They are located on different continents and vary greatly in size, population, ethnicity, and historical background (see the tables in the Appendix for statistical data on size, populations, income levels, economic growth, and health expenditure). The countries differ in dominant cultural orientations and economic circumstances, with very different traditions and styles of socioeconomic and fiscal policy-making.

¹ This study has its roots in an article for the *Journal of Comparative Policy Analysis* that the authors wrote in 2008. That contribution became the base for this more extended study. During the process of transforming an article into the book format, we added New Zealand as an interesting laboratory for change in health governance. Unfortunately, due to unforeseen events, we had to drop Chile as a full chapter in this volume. However, given the striking experiences in Chile — in particular, the sweeping policy shifts after the military takeover in 1973, and again after the return to democracy in 1990 — we refer to that country in referencing “exclusionary policy-making.” We would like to express our gratitude to Eliana Labra for her collaboration.

However, they also have some important features in common. They all are small-to-midsize industrialized democracies with open economies.² They share the general policy goal of providing universal access to good quality health care, and all six have sought to broaden insurance coverage while restraining public expenditure. Over time, they have faced similar fiscal strains (with the notable exception of Singapore), growing (and changing) demand for medical services, and shifting perceptions of the role of the state in society. Moreover, all have discussed a similar range of reform options, and all have enlarged access to health care services by expanding (public and private) health insurance.

Another common feature of the group is that — illustrating the need to make a careful distinction between policy as *intentions* or *plans* and policy as *implemented* change (Palmer and Short, 1989) — they actually undertook major reforms in the last two decades, rather than just discussing policy intentions. Public discontent with existing arrangements, combined with the availability of policy options and political willingness to act, created “windows of opportunity” (Kingdon, 1984) for such change. Finally, and perhaps most importantly, the cases selected fall somewhat “under the radar screen”: they are not usually included in international comparative studies

² One question we have not addressed extensively in this book is: What counts as a “small” or “medium”-size country? Most international comparative studies take one or more of the world’s largest industrialized countries as the main comparator: the United States, the United Kingdom, Canada, Germany, France, and sometimes other OECD member states. We use the term “small and medium-sized” to indicate countries that clearly do not belong to that group. In the introduction to his grand oeuvre, *Rich Democracies*, Harold Wilensky (2002) discusses the size issue. He argues that rather than the actual size in terms of the population or geographic area, it is the complexity of administration that matters. The countries studied in this book all have long traditions of public health care funding and contracting, under a variety of (complex) administrative arrangements. However, there is one other common feature of policy-making in small countries that is worth noting: the small size of the market and policy arena creates strong barriers to exit. First, there is much personal overlap in the health care field (such as board membership of hospitals or health insurance combined with political functions or expert advisorships); in the health policy arena, the major players know each other personally. Moreover, health care is mostly “local.” The findings of this study also confirm that most people do not want to travel long distances to obtain medical care, nor can they move to another town or region easily. This also limits the “consumer exit.”

(even while there has been a recent surge of interest in the experiences of Switzerland and Holland — see Naik, 2007; Harris, 2007; Herzlinger and Parsa-Parsi, 2004; Reinhardt 2004; Leu *et al.*, 2009).

This book addresses the following questions: Why have the six countries of this study, facing similar pressures to reform their health care systems and with similar options for government action, chosen very different pathways to restructure their health care? What caused a “window of opportunity” (Kingdon, 1984) for change in each case? What did they do? What was the position of the major stakeholders? And what happened after the implementation of those reforms? How did patients, health insurers, and health care providers choose and change their “voice” and “exit” strategies (Hirschman, 1970)?

This introductory chapter addresses some of the methodological issues of international comparison, especially the issue of categorizing countries, health systems, and health policies. It next summarizes the main findings of this study.

The following chapters analyze the health care reform experiences of Israel, The Netherlands, New Zealand, Singapore, Switzerland, and Taiwan during the last two decades of the 20th century and the beginning of the 21st century. Those chapters provide a brief overview of the historical developments of the health care systems, and the current arrangements for funding, contracting, payment, ownership, and administration (or “governance”) of health care. They address the origins of the health care reforms, the external and internal pressures for change, the discussion of policy options, the processes of implementation, and the often-neglected but almost universal “post-reform adjustments.”

The final chapter of the book discusses both the empirical findings and general conclusions about comparative methodology. The Appendix provides statistical data on each country’s size, population, economic growth, income levels, and health care spending. It also contains an overview of the dominant cultural orientations and modes of governance in health care.

The study is a truly international collaboration. The authors have all lived and worked in one or more of these countries, combining a variety of academic and administrative backgrounds with personal experiences.

They brought together a unique degree of in-depth knowledge that allowed for more detailed findings than studies solely based on the Organization for Economic Cooperation and Development's (OECD) aggregate data, or data from similar international sources. This has greatly improved our understanding of similarities and differences between the national experiences.

The conclusions of this book confirm the need to collaborate across countries and disciplines. No individual researcher can do a systematic study of change and nonchange in, say, more than three or four countries at this depth of understanding and detail. Second, the study confirms the need to pay more attention to small and medium-size countries. Most of the comparative research in the field focuses on big countries, with the United States, Canada, the United Kingdom, and sometimes France, Germany, Japan, and Australia among the usual suspects. There is far less research on the experiences of small and midsize countries, while, in fact, the vast majority of the world's nations fall into this category. To fill this gap, many more studies are needed. This research aims to take a step in that direction.

Analytical Frameworks

Harold Lasswell's famous book (1936), *Politics*, summarizes the essentials of public policy: Who gets what, when, how? In health politics, those essential questions translate into a wide range of public activities, including the direct provision of some public health services, research funding, medical education, regulating health professionals, protecting patients and the general public, and safeguarding access to health care services by spreading the costs of medical care across populations to protect family income against insurmountable costs of illness. The mechanisms for spreading the costs (or "pooling risks") of health care across large populations require public action to define the populations that have access to certain schemes, to define the entitlements under public coverage, to determine the level of contributions and other financial conditions, and to set rules for administration and monitoring the outcomes of the system. Private markets can pool risks, too,

but on a limited scale. In the private market, the insured face premiums that reflect their actuarial risk (expected future costs): the higher the risk, the higher the premium. Persons with certain medical conditions (such as a chronic illness or disability) may be denied coverage altogether. Community-rating in private insurance is based on segmentation of insured into more or less homogenous groups. In contrast, public health insurance offers coverage to populations regardless of their medical conditions, charges contributions based on their ability to pay, and aims to provide access to medical treatment without undue barriers to all who need care. Community-rating under social health insurance ignores the actuarial risk of the individual, but instead spreads payment across the wider populations via general taxation or income-related contributions for mandated social insurance.

Most industrialized countries share basic underlying principles and goals — sometimes solely rhetorical — in health policy: universal (or near-universal) access to health services and health insurance, solidarity (understood as fairness) in sharing the financial burden of medical treatment, and good quality of services (OECD, 1992).³

³ In the context of health insurance, the term “solidarity” — often taken as “equity” — translates into quite divergent arrangements. It generally refers to the sharing of the financial burden of health insurance. In a narrow (most-commonly-used and least-questioned) sense, “equity” means that everybody faces the same burden, and has access to medical services when he or she needs them. The measure for “the same burden” usually is taken as the same share of family income; thus, proportional tax is fully equal, while community-rated flat premiums are regressive, with higher income groups paying a lower share of their incomes than people with lower incomes. Another interpretation of “equity,” however, takes equity as a commonsense notion of fairness, namely the absence of insurmountable financial barriers to health care. For example, the early European sick funds charged the same contributions to all their members and offered equal medical services to all. Likewise, until recently, all members of a particular sick fund in Germany paid the same contribution rates (but the rates differed from fund to fund). The community-rating served as an equalization mechanism between the members, not between the funds. In contrast (until 2006), members of sick funds in The Netherlands all paid the same income-dependent contribution, plus a modest flat-rate premium per person. The British NHS gets most of its funding from general taxation; the degree of equity thus depends on the redistributive working of the tax system. These are three examples of funding mechanisms that general populations perceive as fair or equitable, even while the distributional effects are often not.

With a growing public share in health care funding, increasing efficiency and cost control has become one of the overriding concerns of governments. Most nations regard patient satisfaction, patient choice, and professional autonomy of physicians as important goals, too.⁴

Nonetheless, there is wide variety in the funding and contracting mechanisms of health care. For example, in Canada, Australia, Italy, New Zealand, the United Kingdom, Italy, Spain, and the Scandinavian countries, the major share of health care funding comes out of general taxation. In Austria, Belgium, Germany, France, Luxembourg, and The Netherlands, social (and, to a lesser degree, private) health insurance systems are the main source. In all countries, patients pay for some health care out of their own pockets or face copayments for other services. In most cases, however, governments have mitigated the effects of user fees by exempting certain groups or setting annual limits on the amount that families must pay (rather than, as is common in private health insurance, setting limits on how much reimbursement families can receive each year).

The variation in funding and contracting models in health care can be traced to country-specific historical developments. Two particular events in Europe played a crucial role. The first was the 1883 introduction of social health insurance for industrial workers and their dependents in Germany by Chancellor Bismarck; the legislation required that all industrial workers and their families become members of a sick

⁴ The notion of “consumer choice” in health care has taken on different meanings. For most patients and in most countries, “choice” refers to their ability to see a physician or other health care provider of their choice. In modern day health policy-making, the term commonly refers to the possibility of signing up with a health insurance or health plan of one’s choice. Paradoxically, the increased choice of plan sometimes reduces the choice of provider: when insurers can selectively contract, their insured may find that their particular plan has not contracted their regular or preferred provider — say, their long-standing family physician or dentist.

fund.⁵ The effect was that sick funds had more stable revenue streams and could create wider risk pools. In the 20th century, sick funds became core actors in the public policy arena, sharing the responsibility for social policy-making, but also facing more and more government regulation.

The second major innovation in the funding of health care in the 20th century was the establishment of Britain's National Health Service (NHS) in 1948 (Klein, 2005; Timmins, 1995).⁶ The NHS extended the German

⁵ That step raised great interest in many, if not all, industrialized countries across the globe. Several countries in Europe — and some in Latin America and Asia as well — followed the German example of state-sponsored (but not state-administered), mandatory social insurance to protect the families of industrial workers against the financial risks of illness, disability, unemployment, and old age. The unique feature of the Bismarckian scheme of 1883 was that it built on the existing institutions of the 19th century mutual societies, or sick funds, which, in turn, could already be traced back to the Middle Ages (De Swaan, 1988; Daschel, 2008). Bismarck did not replace those sick funds, but made membership mandatory for certain categories of workers. The sick funds (commonly but somewhat mistakenly labeled as “sickness funds”; the literal translation of the original, German term “*Krankenkassen*” means “fund of — and for — the sick”) remained legally independent, risk-bearing insurers for members and their families. Labor unions' representatives, workers, and employers all sat on the sick funds' boards. Each fund set its own premium (usually shared between worker and employer on a 50–50 basis). The funds offered modest amounts of income replacement in case of illness, disability, unemployment, or old age of the breadwinner. They also provided health services for their members, as they employed physicians and set up clinics.

⁶ In 1943, an expert committee headed by Beveridge presented a model for the entire system of social security after the war. It advocated a health system that would extend access to health care to the entire population by paying services out of general taxation and nationalizing health facilities. The war itself contributed to the creation of a “window of opportunity” (Kingdon, 1984): for the first time in history, members of different social classes met in times of duress; they had shared the underground shelters during air raids, for example, and were therefore ready to acknowledge that every person needed health care, regardless of income or background. The Beveridge report argued that the additional investments in hospitals and other services would only be temporary. The underlying assumption was that such investments would ultimately reduce public health expenditure, as it would help wounded war veterans and disabled workers return to the labor force as soon as possible. The nationalization of hospitals gave the government the say (and financial responsibility) on investing in expanding the capacity of hospital care. In the postwar decades, there was some concern about costs, but the NHS had become very popular. It did deliver on its promise of universal health care, albeit in a frugal way. And, once in place, it had created its own constituencies which helped to shape the almost “untouchable” position of the NHS for decades (Pierson, 1999).

insurance model by providing coverage to the entire population, paid out of general taxation. While nationalizing hospitals, the NHS retained the status of family physicians as independent practitioners.⁷

In the first half of the 20th century, several countries in Western Europe followed the German example and implemented one or more income protection schemes for certain groups in society (for example, disability and unemployment benefits for industrial workers). It was only after World War II, however, that they developed a full range of modern welfare state arrangements, including old age pensions, disability and unemployment benefits, health insurance, sickness pay, and child support. In the first two decades after World War II, there was strong popular support for this expansion of state-sponsored schemes. Some countries followed the German example of employment-based schemes, while others preferred the population-wide NHS model. The spread of the two models was not restricted to Europe. Nations across the world sought to implement similar arrangements to protect the incomes of their populations (or population groups) against the financial risks of illness, disability, and old age. By the end of the 20th century, most, if not all, countries' health care funding had become hybridized, incorporating elements of both the German and the UK model by combining employment-based arrangements for certain categories of workers with population-wide and tax-based universal schemes. This hybridization has important consequences for efforts to place countries in categories (see below).

The 1970s saw a rather sudden turnabout from expansion and popular support for the welfare state arrangements to reassessment and retrenchment. A confluence of economic, demographic, and ideological factors contributed to reshaping the popular notion of the welfare state from a *solution* for social problems to a *cause* of economic stagnation and an economic burden (Wilensky, 2002; Marmor, Mashaw, and Harvey, 1990; Timmins, 1995). Economic stagnation in conjunction with persistent and

⁷ Almost ten years before the creation of the NHS in 1948, hospital care in New Zealand had already become a universal entitlement for the entire population, paid out of general taxation.

high levels of unemployment following the oil crises of the 1970s meant that state incomes stagnated or declined while public spending continued to grow. Moreover, as the end of the postwar baby boom became apparent, demographers realized that they had to revise their earlier demographic projections downward (and future pension outlays upward).

Adding to these economic and demographic pressures, there had been a marked ideological change regarding the role of the state. On both the left and the right of the political spectrum, critics agreed that state powers had become too wide, too dominant, and too intrusive in the lives of individuals. Existing welfare arrangements were challenged by growing discontent over fiscal burdens, disappointing results of public programs, rising consumerism, and patient advocacy groups claiming a stronger say in the allocation and organization of health care. These factors also fueled an extensive search by governments for alternative governance models that could reduce the dominant role of the state, decentralize decision-making, and provide more room for individual choice and entrepreneurial ideas (Ranade, 1998; Cutler, 2002). Some countries took hesitant steps to introduce market competition in health care, reducing state control over the funding and planning of health care services (such as determining hospital capacity, or the numbers of local general practitioners). They also sought to broaden the choice of provider and health plan for patients and the insured. Other countries turned to traditional tools for controlling public expenditure by setting strict budgets, reducing the scope of public insurance, and increasing direct patient payments.

The above internal and external pressures for change also encouraged national governments to look elsewhere for solutions and new ideas: “No one wants to be caught wearing yesterday’s ideas,” Rudolf Klein (1995) once observed. This search for new ideas fueled a rapid proliferation of cross-national studies in the field of health policy in the 1980s and 1990s. The majority of those comparative studies, however, consist of collections of *descriptive* case studies based on aggregate national statistics. They often lack a common vocabulary or focus, and suffer from poorly defined terms (Marmor and Okma, 2003). For example, terms like “health reform,” “managed competition” or “consumer-driven health care” are

regularly used, but rarely defined in any operational way. Many comparative studies aim to analyze processes of health reform across the globe, but few pay attention to what it is, conceptually, they seek to explain.⁸

Another common mistake is the assumption that policy as stated in formal government documents or law is the same as policy actually implemented. As we will demonstrate, for a variety of reasons the ultimate outcome of reform often differs greatly from original policy intentions and statements. Faced with public discontent over (intended or unintended) results, governments often feel pressured to adjust their policies.

In this contribution, we take “health reform” as major shifts in both decision-making powers over the allocation of resources, and financial risks in the funding, contracting, ownership, and administration (or governance) of health care. Such shifts include the abolition (or reinstatement) of selective contracting with providers, changes in the authority over capital investments, and expansion or contraction of public health insurance entitlements. They can also include (new) restrictions on medical decision-making imposed by practice guidelines and other rules. Further, decision-making power and financial risks can shift from the national level to regional and local governments (or in the other direction), or from government control to health insurers, individual patients, and the insured.

The main focus of this study is on changes in health insurance, medical care provided in hospitals, and individual medical practices, including prescription drugs and medical aids. However, the borderline between medical care and related social services (such as long-term care for the elderly or disabled) is not always clear, and countries have different views on what constitutes “health care.” Another limitation of

⁸ “Governance,” another example of a conceptually fuzzy term, is a rising star in today’s terminology. Basically, it refers to the administration of health insurance and health care. Interestingly, it has traveled from the government to the corporate sector and back to the public sector (Okma, 2002: footnotes 14 and 18). During this migration, it also shed its neutral meaning and took on a normative connotation under the label “good governance” and, more recently, “stewardship.” In this contribution, we take “governance” in a neutral sense: administration (both public and private) of health services and health insurance.

this study is its main focuses: health policies aimed at protecting family incomes against financial risks of illness, and policies to improve the organization of health care services. Because of these focuses, it pays less attention to policies that predominantly or exclusively aim to improve the health of the population (such as by improving road safety, food quality, consumer protection, or changes in lifestyle).

The study combines analytical categories from economic theory with concepts from political science. The economic terms describe the basic constituent elements of health care systems: the funding, contracting, and provision of health services. The terms borrowed from political science serve to analyze the “workings” of the health care system and the behavior of the main actors: governments, patients, the insured, health insurers, and providers of health care services. Klein and Marmor (2006) argue that the major models of political science fall under three broad headings: ideas, interests, and institutions. Those terms refer to underlying social values (or “dominant cultural orientations”), organized stakeholders in society, and political institutions that shape social policy in all countries.

The selection and combination of the aforementioned analytical frameworks is, by its very nature, somewhat eclectic. There is no common vocabulary across the different disciplines, and there is no generally accepted hierarchy of public policy theories (Okma, 1997a). Nonetheless, the wider selection of theoretical frameworks for this study (discussed below) has proven useful for examining the six countries’ health reform experiences because it has allowed a systematic comparison of some of the core features of their health care systems as well as the causes and consequences of varied policy change.

According to reports of the OECD, it is possible to describe any given health care system in terms of a country-specific mix of public and private funding, contracting, and modes of providing medical services (OECD, 1992, 1994). In general, there are five main sources of funding and three dominant contracting models. The major funding sources are general taxation (general revenues, earmarked taxes, and tax expenditure), public and private insurance, direct patient payments (copayments, coinsurance,

deductibles, and uninsured services), and voluntary contributions. For some developing countries, external aid can be a major source as well.

There are three basic contracting models in health care. The first is the “integrated model,” with funding and ownership of services under the same (public or private) responsibility. The best-known example of this model is the original British National Health Service (NHS) of 1948. The NHS provided tax-funded health care for all, largely paid out of general taxation. A modern-day example of an integrated private model is the health maintenance organization (HMO) in the United States (at least, the original form of the Kaiser Permanente HMO).⁹ In fact, that model closely resembles the 19th century German sick funds that owned clinics and employed physicians to provide health services to their members. The second model is the “contracting model,” where governments or other third party payers (mostly the administrative agencies of social health insurance and, in some cases, private health insurers) negotiate long-term contracts with health care providers. The third funding model (or, rather, payment model), common in private insurance, is that of reimbursement, where the patient first pays his provider and then seeks reimbursement from his insurance agency.

On the provision side, the ownership and management of health services can be public, private (both for-profit and not-for-profit), or — in most countries — a mix of the two. Moreover, there are country-specific mixes of formal and informal care, traditional and modern medicine, and medical and related social services. In this contribution, the emphasis is on medical care but, as we stated earlier, borderlines with other services are

⁹ It is important to note that the term “health maintenance organization,” or HMO, includes a variety of organizational models (Hacker and Marmor, 2007). In the 1970s, HMOs were heralded as organizations that would help contain health expenditure in the US by selectively and critically contracting health services on behalf of their insured. Over time, HMOs faced increased dissatisfaction of insured and physicians over such restrictions (e.g. the gag rules that prohibited physicians from discussing the terms of their contracts with others, or the limited lengths of stays allowed for women after childbirth). More and more states passed law to restrain the restrainers, and many HMOs changed strategy by shifting risks to groups of providers based on capitated payments for a certain group of patients.

not always clear, and national health policies reflect divergent cultural views about such borderlines.

The combination of those three core elements — funding, contracting (including the payment modes), and ownership — largely determines the allocation of financial risks and decision-making power over the main players in health care. For example, the risk-rated premiums of private insurance expose low-income families to higher costs than social insurance (particularly because level of income often correlates with health status: the lower the income, the poorer the health of population groups). Moreover, private insurance may require families to pay more out of pocket by restricting reimbursement, or excluding coverage of some conditions altogether. Social insurance, with income-related premiums and without exclusions, reduces such financial risks for families. As another example, tax funding and government ownership make for strong government influence, whereas private funding (insurance and direct patient payments) combined with legally independent providers shifts the decision-making power to insurers and providers of health care (as in Switzerland or The Netherlands). This is so even while governments can — and often do — impose rules to protect patients or safeguard the quality of and access to health care (for example, by deciding whether to include dental care for adults, contraceptive care, mental health care, or home care in the entitlements of social health insurance).

The above economic terms help to characterize certain features of health care systems and policy-making. They do not explain the *causes* or *effects* of policy change (but can point to the fact that certain features will allow for change more rapidly and more easily than others). In trying to understand why countries have embarked on particular reform paths, we have to look not only at the external and internal pressures for change, but also at the structural features of social policy-making and particular events in time that enable politicians and other policy entrepreneurs to change the system.

OECD countries have developed a variety of administrative or governance models in health care and health insurance. Douglas and Wildavsky (1982) have identified three dominant cultural orientations in welfare

states: hierarchical collectivism, competitive individualism, and sectarianism.¹⁰ The first refers to the social-democratic states of northwestern Europe that have based their fiscal and social policy on principles of solidarity and equality. They have collectivist traditions, with strong bureaucratic traditions to implement policy. In some countries, particularly Germany and The Netherlands, those bureaucracies engage in semipermanent “neocorporatist” consultations with organized stakeholders (though this practice has declined in the last two decades in The Netherlands; see the chapter in this volume). The United States, in contrast, is generally seen as being more of a liberal welfare state, with a strong emphasis on competition, individual rights and responsibilities, weak collectivism, and an outspoken streak of sectarianism. Market competition and individual liberty are guiding principles in much of its social policy. In The Netherlands, the neocorporatist tradition was also influenced by religious sectarianism, as many of the associations that played a major role in Dutch politics had religious backgrounds (Lijphart, 1968).

Corresponding with — and adding to — the above three models, which refer to the way government and interest groups in society interact, are the labels (semi-) “pluralist,” (semi-) “corporatist,” and “exclusionary,” which refer to modes of policy-making (Labra, 2007). Douglas and Wildavsky’s individualistic orientation corresponds with notions of pluralism, and their hierarchical collectivist orientation with corporatist

¹⁰ Another categorization of social policy takes the underlying welfare principles as starting points: income protection, behaviorist, residualist, and populist redistributive (Marmor, Mashaw, and Harvey, 1990). Income protection is the basic principle of social insurance: it mandates certain groups (or the entire population) to contribute according to their ability to pay, and provides all participants with entitlements according to their needs. Behaviorist policies seek to change the behavior of recipients. For example, it encourages welfare recipients to actively seek employment. The basic idea behind residualist principles is that individuals and families are responsible for their own economic support and the state will step in only as a last resort; for example, low levels (or short duration) of unemployment or disability benefits as a condition for receiving income support. The redistributive policies aim to spread resources amongst populations; for example, education policies may aim to raise the general level of education so that everybody can benefit. These underlying principles (similar to the “dominant cultural orientations”) translate into certain styles of policy-making and governance in health care.

styles. The exclusionary mode, however, indicates the power of a strong central government (in the extreme form, a military dictatorship like that of Pinochet in Chile from 1973 to 1990) to exclude certain groups from decision-making over social policy. We will come across examples of all of these policy styles in this book.

It would be an error, however, to assume that such orientations provide an entirely accurate representation of a particular country. Models do not cover countries on a one-to-one basis. Different styles of governance can exist simultaneously, and over time there may be shifts from one style to another (see also the Appendix of this volume). For example, in the 1980s and 1990s, Dutch health policies shifted from a solidarity-based model toward a hybridized model with elements of market competition, stronger behaviorist principles, and a more residualist role of the state in unemployment and disability policies (see footnote 9 for an explanation of those terms). Still, strong popular support for universal access to health care (and for solidarity in the distribution of the financial burdens) has restrained the efforts of governments to shift to privatized health care. Taiwan, as we will demonstrate, went in the opposite direction by transforming its existing public health insurance schemes into a population-wide national insurance. The Swiss, Israeli, and Dutch health policy arenas all reflect, in different degrees, features of “neocorporatist” policy-making, where governments share the responsibility for social policy with organized interest groups (Lijphart, 1968). New Zealand has a legacy of “Westminster” politics, where traditionally one party had the majority and could play “winner takes all” politics. But, in recent years, the country has experimented with new, regional models of administration. Of the six cases in this study, Singapore appears least bounded by ideology or labels, preferring a pragmatic approach.

Another important point to note is that “styles of governance” are not identical to policy outcomes, though underlying values and dominant orientations make certain policy outcomes more likely than others. Thus values affect policy; conversely, policies may help to reshape and strengthen values (Hirschman, 1970; Marmor, Latham, and Okma, 2006). For example, the British NHS and Canada’s Medicare have become

important symbols of solidarity in the UK and Canada, and in both countries politicians do not want to be seen undermining the universal coverage.

Theories of historical institutionalism and path dependency (Immergut, 1992; Pierson, 1999; Baumgardner and Jones, 1993) emphasize that major change in social policy is rare; it occurs only in specific circumstances. Institutional legacies and popular support for existing policy arrangements create powerful barriers to change. In this regard, the countries studied in this volume are somewhat atypical: all of them did actually implement major adjustments in the funding, contracting, provision and administration (or governance) of health care. All faced unique “windows of opportunity” for change (Kingdon, 1984). Such opportunities occur, Kingdon argues, at the confluence of three more or less independent streams: the *problem stream* (a general sense of urgency or feeling that a major problem requires action), the *policies stream* (the availability of acceptable and feasible policy solutions based on the gradual accumulation of knowledge and perspectives among specialists), and the *politics stream* (fueled by certain political events, such as a change of administration). Policy entrepreneurs, Kingdon adds, are like surfers waiting for the next big wave (Kingdon, 1984) and the policy window is the opportunity to push their pet solutions. Like a wave, the policy window may disappear again, and thus timing is crucial for presenting and implementing major policy change.

With a similar but somewhat more elaborate approach, Tuohy (1999) has distinguished between a “structural dimension” and an “institutional dimension” of health care systems. The structural dimension reflects the “balance of power” between the three main groups of actors in health care: the state, medical professionals, and private finance. The institutional dimension refers to mechanisms of hierarchy, collegiality, and markets. A major change in the balance of power between the three main groups of actors in health care requires an “extraordinary mobilization of political authority and will” (Tuohy, 1999). Both Taiwan and Singapore provide examples of determined political leaders rapidly implementing reforms by playing crucial roles as policy entrepreneurs.

One theoretical approach used in this volume analyzes the changing behavior of the actors in the health policy arena, including governments, patients, providers, and insurers. Hirschman's notions of "voice" and "exit" are useful tools for analyzing the consequences of health care reform (Hirschman, 1970, 1980, 1993). He sees two classic mechanisms for consumers and citizens to express dissatisfaction with given arrangements: exit or voice. Exit is the base for consumer sovereignty and plays a crucial role in economic traffic. If consumers do not like the price-quality ratio of a given product (and if there is sufficient competition on the market and, therefore, choice), they may simply exit and look elsewhere, thus forcing companies (or governments) to adjust and improve the quality of their goods and services. However, the signal of exit is somewhat poor in information, since it does not provide management with much information on what is wrong. Moreover, exit is an indirect instrument for expressing dissatisfaction, and customers usually do not have interest in improving the products by their withdrawal, but just in finding a better consumption solution (Hirschman, 2008). The second mechanism, voice, usually plays a larger role in the political arena than in the market because, for many consumers or citizens, the exit option (from a region or community) is costly or difficult to put into practice. Citizens thus use their voice in exercising their citizenship, and different political regimes allow for different degrees of voice for their citizens (in the extreme form, i.e. the military dictatorship, opposing voice is eliminated altogether). Voice is costly, can even be dangerous (such in a repressive political system), and usually requires a number of members to start collective action in order to be efficient. On the one hand, voice is a public good since the cost of it to an individual member exceeds any conceivable individual benefit. On the other hand, voice is more frequently performed by loyal members of an organization who are strongly motivated to step in once quality deterioration has passed a certain threshold (Hirschman, 2008). Hirschman (1970) assumed that there was a tradeoff between the two mechanisms of voice and exit: if the two mechanisms are jointly available, the recourse to exit might diminish the volume and power of voice. However, Hirschman (1993) argued that

the two could complement each other. He presented situations where exit mechanisms worked better when consumers could also express their voice, and vice versa.

The authors of this volume have all applied combinations of the above economic and public policy models to describe and analyze the health reform experiences of their country of study.

Main Findings

The main findings of this study confirm that, indeed — and not surprising for scholars of public policy — national *values* (or dominant cultural orientations), *institutions*, and *interests* play an important role in the shaping and outcomes of health policy (see also Klein and Marmor, 2006). The combination of fiscal pressures, demographic shifts, and ideological change led to reassessment of existing arrangements everywhere.

The seemingly common experience in external and internal pressure and the similarity in reform goals and means can easily lead to generalized conclusions of (global) convergence. However, the health politics and health policies of the six countries of this study have not converged in one common direction. While the policy problems, policy goals, and range of policy options considered were strikingly similar, the six countries diverged widely in reform directions and processes of implementation. Each country implemented change within the restraints of existing national institutions and political boundaries. Only a few countries systematically studied experiences abroad in their search for new policy directions but in most cases countries “borrowed” reform notions from others without much reflection.

The cases reveal a remarkable variety in reform activity, ranging from the expansion of the basic sick fund model in Israel, changes in central control and regional governance models in New Zealand, to quasi-privatized schemes in Singapore and The Netherlands, the implementation of a uniform nationwide social health insurance in Taiwan, and universal

coverage administered by regulated private insurers within the regionally decentralized health system in Switzerland.

The *timing* and *speed of change* of the health reform processes varied as well. In some countries, notably Taiwan and Singapore, the government was able to implement major change rapidly. Others, facing strong opposition from organized stakeholders, had to adjust, delay, or even abandon part or all of their reform efforts. In several cases, the introduction of market competition went hand in hand with increased government control. The current reality of growing diversity and hybridization (or perhaps, “complexification”) of health care arrangements also illustrates that countries or health care systems do not fit easily within common categorizations.

One important finding concerns the level of analysis. The last two decades have seen a proliferation of studies that focus on countries as a whole, and seek to place countries in certain categories. For example, the widely quoted work of Esping-Anderson (1990) uses the term “three worlds of welfare” to distinguish three categories of welfare states: the “liberal welfare state,” with frugal levels of income protection and means-tested targeted services; the “social-democratic state,” with high levels of income protection and tight central control; and the “functionally decentralized consensual, corporatist state.” The last refers to countries where the governments share the responsibility for social policy with organized interests.

Such categorization is based on the assumption that countries share certain features that serve as a base for framing certain patterns of inference, and that can help explain developments and outcomes of their social policy. However, over time, systems have changed shape. In fact, most if not all countries’ health care systems have become hybridized by combining elements borrowed from the Bismarckian employment-based income protection schemes with the population-wide model of the British NHS. In some areas (most notably, old age pensions and health care), states have assumed more responsibility for income protection than in other areas (such as housing or education). Countries also combine elements of the “liberal welfare state” with arrangements that are more

“social-democratic” in nature. With such hybridization, any effort to place countries in preset categories has become problematic (Goodin *et al.*, 1999). Nevertheless, as we will see, certain styles of policy-making are still visible in certain policy areas, for example in the way governments interact with certain organized interest groups in discussing and implementing change in health care.

However, at the level of specific programs and policies, rather than at the national level, we see more similarity in experiences. Most if not all countries are changing the payment mode for hospital care from general budgets based on historical costs to per diem payment, and next, to case-based payment. Almost all countries are moving toward mixed payment models for independent practitioners that combine fees for service with some forms of capitation and specific payment for certain services. Countries with public funding are experimenting with different forms of “purchaser–provider splits” that separate the responsibility for funding health care from the actual provision of services. And almost everywhere, in spite of market rhetoric and stated policy to reduce the role of the state in health care, governments are using their budget control powers to restrain health care expenditure. As another example of a common policy experience, most governments softened the effects of market competition by imposing restrictions on both health insurers and providers of care. This is an example of “bounded privatization”: while aiming to shift risks and decision-making power to nonstate actors, governments preserved their regulatory role by mandating certain entitlements in the coverage of private health insurance, forcing private insurance to accept everyone seeking insurance, or imposing national fee schedules for health services or quality norms for both publicly and privately funded health care. Faced with popular opposition, governments often moderated the effects of patient copayments by exempting certain groups.

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