

Six countries, six health reform models? Health care reform in Chile, Israel, Singapore, Switzerland, Taiwan and The Netherlands¹

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Abstract

This research contribution presents a diagnosis of the health reform experience of six small and mid-sized industrial democracies: Chile, Israel, Singapore, Switzerland, Taiwan and The Netherlands during the last decades of the twentieth century. It addresses the following questions: Why have these six countries, facing similar pressures to reform their health care systems, with similar options for government action, chosen very different pathways to restructure their health care? What did they do? And what happened after the implementation of those reforms? The article describes the current arrangements for funding, contracting and payment, ownership and administration (or “governance”) of health care at the beginning of the 21st century, the origins of the health care reforms, the discussion and choice of policy options, processes of implementation and “after reform adjustments”. The article looks at factors that help explain the variety in reform paths, such as national politics, dominant cultural orientations and the positions of major stakeholders.

1. Introduction

This research contribution presents a diagnosis of the health reform experience of six small and mid-sized industrial democracies: Chile, Israel, Singapore, Switzerland, Taiwan and The Netherlands during the last decades of the twentieth century. The countries span the globe, hailing from Asia and the Middle East to Latin America and Europe. The study is a truly international collaborative undertaking. The authors have all lived and worked in one or more of those countries, combining varied academic and administrative backgrounds with personal experiences. They brought together a unique degree of in-depth knowledge of all six countries that allowed for more detailed findings than studies solely based on aggregate data of the OECD or similar international sources. This has greatly improved our understanding of similarities and differences between the national experiences.

Recent decades have seen a rapid proliferation of cross-national studies of social policy, in particular in the field of health care (Klein 1995). The majority of those studies, however, consist of collections of descriptive case studies. They often lack a common

¹ This study has its roots in a meeting of the German Bertelsmann Foundation in Helsinki in 2006, attended by four of the authors of this article. Over dinner, they agreed to join forces in an effort to describe and analyze the health reform experience of their countries in a separate publication. The authors are grateful to the Bertelsmann foundation for the opportunity to meet and discuss their project.

vocabulary and suffer from poorly defined terms (Marmor and Okma 2003). For example, the term “health reform” is regularly used but rarely defined in any operational way. Another common problem is the assumption that policy as formally stated in policy documents or law is the same as policy actually implemented (and adjusted later on). As we will show, for a variety of reasons, the ultimate outcome of reform often differs greatly from the original policy intentions. This study seeks to contribute to cross-national policy learning by structured multi-country research. It looks at the health reform experience of six quite different countries. In that sense, it represents a “most different system design” (Marmor 1988), under a common analytical framework.

In this contribution, we take “health reform” as major shifts in both decision-making power over the allocation of resources as well as financial risks in health care funding, contracting and ownership². Shifts in decision-making include, among others, the abolishment (or reinstatement) of selective contracting with providers, changes in the authority over capital investments, expansion or contraction of entitlements of public health insurance, or (new) restrictions on medical decisions imposed by practice guidelines and other rules. Further, decision-making and financial risk can shift from national to regional and local governments (or into the other direction), or from government control to individual insurers and individual patients and insured.

Changes in the distribution of the financial risk of medical treatment across the system also affect the organization of health care. As an example, the market-oriented change in The Netherlands in the early 1990s widened the power of health insurers to selectively contract health services. Anticipating this change, providers developed strategic alliances and sometimes, regional monopoly positions to safeguard their positions (Okma and De Roo, forthcoming). As another example, the Swiss health insurance of 1996 shifted decision-making power from the cantons to the federal level, but left financial risks for public health expenditure at the canton level. The individual mandate to take health insurance increased the role of private health insurers. As the insurers still have to contract all health providers, however, the latter did not face much financial risks and thus did not change their positions as much as their Dutch counterparts.

This contribution addresses the following questions: Why have these six countries, facing similar pressures to reform their health care systems, with similar options for government action, chosen very different pathways to restructure their health care? What did they do? And what happened after the implementation of those reforms?

The second section addresses the issues of categorizing countries, health systems and health policies. The study combines analytical categories from economic theory with concepts from political science in order to better understand the policy experience of the six countries of this study. The economic terms describe the basic constituent elements of health care: funding, contracting and provision of health services. The terms borrowed from political science to analyze the ‘working’ of the system refer to governance models, government regulation and underlying social values (or “*dominant cultural orientations*”).³

The next sections analyze the health reform experience care of Chile, Israel, Singapore, Switzerland, Taiwan and The Netherlands. Those sections describe the current arrangements for funding, contracting and payment, ownership and administration (or “governance”) of health care at the beginning of the 21st century. They also address the

origins of the health care reforms, the selection of policy options, processes of implementation and “after reform adjustments”. The sections look at factors that help explain the variety in reform paths, such as national politics and the positions of major stakeholders.

The final section contains general conclusions about comparative methodology and empirical findings. The main conclusion is that, indeed--and not surprising for scholars of public policy—national values (or dominant cultural orientations), institutions and politics all play an important role in the shaping and outcomes of health policy. The combination of fiscal and budgetary pressure and ideological change led to reassessments of existing arrangements everywhere. Only a few countries systematically studied experiences abroad in their search for new policy directions. The cases reveal a remarkable variety in reform activity, ranging from the implementation of a uniform nation-wide social health insurance (Taiwan) to quasi-privatized schemes in Singapore and The Netherlands, regulated private insurance within a regionally decentralized health system in Switzerland, to the continuation of the basic sick fund model in Israel with new procedures to establish uniform entitlements, and adjustments of the public-private mix of health insurance in Chile.

At first sight, the cases we have selected do not have much in common. The countries are located in different continents and show great variety in size, population numbers, ethnicity and historical backgrounds (the tables in the appendix present data on size, populations, income levels, economic growth and health care of the six countries). The countries also differ in “dominant cultural orientations” (see below) and economic circumstances, with very different traditions and styles of social policy-making.

However, they also have some common features. They all are small to mid-size industrialized democracies with open economies⁴. 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, growing (and changing) demand for medical services and health insurance and changing views of the role of the state in society. Moreover, all have discussed a similar range of reform options, and all have sought to enlarge access to health care services by expanding (public and private) health insurance and tax-based funding. Another common feature that sets the group apart is that –illustrating the need to make a careful distinction between policy as *intention* or plans and policy as *actually implemented* change-- all six countries actually undertook major reforms (as defined above) in the last two decades, rather than just discussing reform intentions. Public discontent, political willingness to act and the availability of policy options combined to create “windows of opportunity” (Kingdon 1984) for such change. Finally, and perhaps most importantly, the countries selected are “under the radar screen”: they are usually not included in international comparative studies.

The seemingly common experience in reform goals and means can easily lead to generalized conclusions of (global) convergence. However, the health politics of the six countries of this study have not converged into one common direction. Each country has implemented change within the restraints of existing national institutions and political boundaries. While the goals and range of options considered were strikingly similar, the six countries diverged widely in the actual reform models and process of implementation. Ideas, interests and political institutions played important roles. The differences reflect

country-specific cultural values (for example solidarity versus individual consumer choice), ideological views of the role of state and citizens, institutions (for example centralized versus decentralized political power) and interests (stakeholders that encourage, thwart or slow down reforms).

The timing and speed of change varied as well. In some countries, governments were able to rapidly implement major change. Others, facing strong opposition by organized stakeholders, had to adjust or even abandon their reform efforts. In several cases, the introduction of market competition went hand-in-hand with increased government control, leading to increased “hybridization” of health care systems. The current reality of growing diversity and hybridization (or perhaps, rather, “*complexification*”) of health care arrangements illustrate that systems do not fit easily within common categorizations.

At the level of specific programs and policies rather than at the national country level, however, we see more similarity in experience. For example, in several cases the efforts to change payment modes and methods for medical care took more time than originally envisioned. In most if not all countries, governments softened the effects of market competition by imposing restrictions on both health insurers and providers of care (for example, by mandating entitlements of private health insurance, forcing private insurance to accept everyone seeking insurance, imposing national fees and tariffs and quality norms for both publicly and privately funded health care and providing subsidy for low-income groups). In all cases, faced with popular opposition, governments moderated the effects of patient co-payments by exempting certain groups.

The conclusions confirm the need to collaborate across countries and disciplines. No individual researcher can do a systematic study of change and non-change 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 countries. The vast majority of comparative research in the field focuses on the big countries, with the US, Canada, the UK, and sometimes France, Germany and Australia as the usual suspects. There is little research focusing on the experience of smaller and mid-sized countries while, in fact, the vast majority of the world’s nations fall under those categories. To fill this gap, many more studies are needed. This research aims to take a step into that direction. Small nations, unite--in our comparative research!!

2. Categorizing countries and health care systems

According to reports of Organization for Economic Co-Operation and Development (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, OECD 1994). There are five main sources of funding and three dominant contracting models. In industrial countries, the major funding sources are general taxation (general revenue, earmarked taxes and tax expenditure), public and private insurance, direct patient payments (co-payments, coinsurance, deductibles and uninsured services) and voluntary contributions. There are three basic contracting models. 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). Examples of integrated private model are some of the “Health Maintenance Organizations” (HMOs) in the US—that, in fact, closely resemble the 19th century German sickness funds that owned clinics and employed physicians. The second model is the “contracting model”, where governments or other third payers negotiate long-term contracts with health care providers. The third model, common in private insurance, is that of reimbursement where the patient first pays his provider and then seeks reimbursement from his insurance agency.

At the provision side, the ownership and management of health services can be public, private (both for profit and not for profit), or—common in most countries—a mix of those. 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 borderlines with other services are not always clear, and national health policies express 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, tax funding and government ownership make for strong government influence whereas private funding (insurance and direct patient payments) combined with legally independent providers restricts the role of the state (as in Switzerland or The Netherlands), even while governments often can—and do—impose rules to protect patients or safeguard the quality of health care.

OECD countries have developed a variety of health governance models (Okma, 2002). Douglas and Wildavsky (1982) identify three “dominant cultural orientations” in welfare states: “competitive individualism”, “hierarchical collectivism” and “sectarianism”. The majority of the social democratic states of North Western Europe base their fiscal and social policy on principles of solidarity and equality. They have strong collectivist traditions, with modest individualism and weak sectarianism. They also have strong bureaucratic traditions. In some countries, in particular Germany and The Netherlands, those bureaucracies engage in semi-permanent consultation with the organized stakeholders in the “neocorporatist” style of governance (even while in The Netherlands that practice has declined in the last two decades). The United States, in contrast, is a more liberal welfare state, with weak collectivism and an outspoken streak of sectarianism. Market competition and individual liberty are guiding principles in much of its social policy. Another categorization of social policy takes the underlying welfare principles as starting point, distinguishing *income protection*, *behaviorist*, *residualist* and *populist redistributive* principles to characterize social policy (Marmor, Mashaw and Harvey 1990). Those general orientations and principles translate in certain styles of policy-making in health care (Okma 2002).

It would be an error, however, to take such general orientations as representations of particular countries. Models do not cover countries on a one-to-one basis. Different styles of governance can exist side by side, and over time, there may be shifts from one style to another. For example, Dutch health policies shifted from a solidarity-based model towards elements of market competition, with a rise of behaviorist principles and a more residualist role of the state in unemployment and disability policies. Taiwan, as we will show, went into opposite direction by transforming its existing health insurance schemes

into a population-wide national insurance. The Swiss, Israel and Dutch health policy arenas all reveal features of neocorporatist policy-making where governments share the responsibility over social policy with organized interests. Of the six countries of this study, Singapore appears least bounded by ideology or labels, preferring a pragmatic approach. In fact, as we will see, the above typologies of welfare state arrangements serve more to characterize certain categories of policies than entire countries or health care systems.

3. Health care reform in Chile

Chile is a mid sized industrial country in southeastern Latin America located between Argentina and the Pacific Ocean, with a population of about sixteen million in 2004. Over ninety percent live in urban areas. Chile has long been one of the leaders in social policy change in Latin America, sometimes called the “regional benchmark for structural reforms” (OECD 2003). In 1924, Chile was one of the first countries in Latin America with public pensions and health insurance (De Viado and Flores 1944). Three factors combined to open a “window of opportunity” (Kingdon 1984) for introducing social insurance at that time, not only in Chile, but also in other countries in Latin America. First, European countries, in particular Germany, provided the model of employment-based social insurance to protect family incomes of industrial workers in case of disability, illness and old age. Second, there was growing awareness of the need for government actions to address the poor health of the working population, poverty and labor unrest after the Second World War. Third, there was political willingness to act.

The social health insurance of 1924 only covered urban manual workers. It explicitly excluded rural and domestic workers and self-employed. There were separate schemes for employees and civil servants. The entitlements included sickness and medical benefits, maternity benefits, health services for infants up to two years old, and benefits in case of invalidity, old age and death. In 1942, the above schemes for white-collar workers merged into the Servicio Médico Nacional de Empleados (SERMENA). SERMENA was based on individual capitalization funds and preferred provider arrangements with independent providers (Labra, 1995). In 1952 Chile began to implement the Sistema Nacional de Salud (SNS), resembling the British National Health Service. Public health was seen as a universal citizen’s right. Both membership and range of entitlements of the social health insurance gradually expanded. “Indigents” who could not prove their income received a “certificate of poverty” that provided access to the SNS.

In September 1973, the Pinochet military regime overthrew socialist president Allende who had been elected three years before. Heavily influenced by the neoliberal ideology of the University of Chicago School of Economics, the regime favored a reduced role of the state and a shift towards privatization and consumer choice as driving forces in healthcare (Jost 1999). It drastically reduced social spending and public health services.

Since the early 1980s, insured under the public scheme FONASA can opt out and seek coverage from the private insurance Institución de Salud Previsional (ISAPRE). The expectation was that the exodus from the social insurance would strengthen the private

insurance and reduce the public sector to a minimum. In fact, predictably--and similar to the experience of other countries--, the “opting out option” led to a spiraling process of risk selection as the young and healthy went private, but the sick and elderly had to remain in (or return to) the public scheme as they faced serious access barriers in the private market.

The return to democracy in March 1990 brought social policy based on a mix of market orientation, social solidarity and strong public responsibility. The new government announced massive additional investment to improve the quality of public services and reduce waiting times. It did not do away with the dual health insurance system, however, but imposed extensive regulation on health providers and insurers. The share of private insured has since dropped from twenty-five percent in 1996 (Jost 1999) to twenty-three percent in 1999 (Sapelli 2004) and 16.3 percent of the population in 2006 (FONASA 2007). In 2006, almost 60 per cent of the population had coverage under the public scheme (FONASA 2007). General taxation provided 49.9 per cent of health funding, public health insurance 42 per cent, patient co-payments 6.6 per cent and other sources 2.5 per cent (FONASA, 2007). Patients under the public scheme face modest amounts of co-payments, but over 60 per cent of the population is exempt from paying those fees.

The private ISAPRE schemes mostly function as traditional for profit insurers. They offer coverage for health care and pay for sick leave. Since 2005, they face extensive government regulation: a certain minimum coverage, uniform premium structure, and community-rated premiums. ISAPREs do not have to accept all applicants, but they must cover both insured and dependents. Families cannot split their coverage between the public and private insurance –if one spouse is in, the whole family must be under the same scheme. Most ISAPREs charge user fees, with co-payments between 30 and 50 per cent, subject to caps to mitigate the financial burden for lower income families. Some of the private insurers own health facilities, or have preferred provider arrangements with health care providers (Jost, 1999). The largest one, CONSALUD, owns clinics and hospitals and is able to steer its insured towards those facilities. Another large one, Banmedica, has formed an integrated financing and delivery model with a large hospital in Santiago. It requires its members to choose a gatekeeper primary care physician (an internist or pediatrician) from a closed panel list.

Chile has a long tradition with free choice of provider (the SNS introduced free choice to its white collar workers in 1968), and insurers are hesitant to impose too many restrictions on their insured (or face the wrath of the medical association). The introduction of “integrated forms of managed care” has been a slow process (Jost 1999). In total, the system offers fairly broad access to public health services (including primary care, immunization and other preventive services, elderly care and mother and child care). For other health care services, however, there are two separate systems: the public one (for the FONASA insured) and the private one (for the ISAPRE insured). The latter tend to be concentrated in wealthy urban areas, especially in Santiago (FONASA 2007). There are separate services for the police and armed forces. The variety of public and private schemes has led to fragmentation. As in other countries, the dual insurance system with voluntary enlisting faces rising problems of risk selection and moral hazard (Sapelli 2006; Höfter 2006). The public system is plagued by a lack of funding and

shortages of qualified personnel. There are frequent strikes by health professionals dissatisfied with low pay and poor working conditions.

The majority of hospitals as well as local clinics and municipal primary care centers are public. A small number of private for profit clinics mainly serves the urban elite. Long-term contracts between FONASA and hospitals provide the base for paying inpatient care. Hospitals receive prospective budgets (over sixty percent is historically based) plus additional payments for specific activities. Private insurers provide about fifteen percent of the hospital income; they negotiate contracts and fees with (preferred) providers.

In the late 1990s, the government announced a shift towards capitation payment of primary care and case-based payments (or DRG-based payments) for hospital care (Jost, 1999). But this turned out a complex process. In the mid-2000s, case-based payment contributed only about ten percent of hospital budgets. Facing much opposition to market-oriented change, the government reaffirmed its strong commitment to maintaining a public health system as a viable alternative to the private sector.

The Chilean experience illustrates that a change in political regime can create a “window of opportunity” for change. But dominant values as well as long-standing institutions restrain what government can in fact implement. Even while the military regime shifted towards private health insurance, it did not do away with all public health services. Likewise, the restoration of democracy in 1991 did not do away with private health insurance. There have been efforts to regulate the private insurance, but private insured still face problems of risk selection and exclusion of pre-existing conditions from coverage.

4. Health care reform in Israel

Israel, a small country at the Eastern shore of the Mediterranean bordered by Lebanon, Jordan and Egypt with about six million habitants, is another country with a long tradition of public health insurance. In 1911, labor unions established the first mutual sick fund, followed by three other funds in the 1920s and 1930s (Rosen 2003). The health insurance started as an employment-based scheme modeled after the employment-based (Bismarckian) social health insurance of Germany, but gradually expanded to cover all but the entire population. In the late 1980s, 95% of the population had voluntarily enrolled with one of the four (not for profit) funds. Despite this nearly universal coverage, the system was plagued by financial instability, public and provider dissatisfaction, hospital overcapacity and fragmentation of services. Finally--at least in the eyes of Israeli public and politicians--there were too many uninsured (as in The Netherlands, even a small share of uninsured can cause political pressure on government to take action, see below).

In 1995 Israel enacted the National Health Insurance Law (NHI) that mandates all residents to register with a sick fund. By extending the social insurance from employed persons to the entire population, it created a hybrids between the Bismarckian model and the National Health Insurance. The NHI is a population-wide social health insurance, administered by four major (competing) sick funds. The NHI was part of a three pronged reform proposed by the 1990 Netanyahu Commission, a state commission of inquiry.

Two other planks of the reform --changing government hospitals to public trusts and the reorganization of the Ministry of Health --never materialized because of too much resistance of hospital labor unions. From a rational planning point of view, the partiality of the reform is a recipe for frustration. Nonetheless, from a policy-learning point of view (Helderman et al 2005), NHI's enactment set in motion a chain of events worth looking at. The NHI led to one radical change that in itself did not depend on the full implementation of the envisioned reform: a legally defined universal standard basket of services. Previously, each fund could determine its own entitlements, and was not required to provide any particular service. While other countries like the Netherlands (Berg and Van der Grinten 2004) and New Zealand (Chinitz 1999) abandoned the idea of (explicitly) defining a core basket of health services, Israel went quite clearly, if not always resolutely, down this road.

The major funding sources for health care in Israel are social insurance contributions, tax subsidy and modest amounts of patient co-payments. In recent years, co-payments for hospital stay and prescription drugs have gone up, but there are many exemptions and caps on the total amount that families pay each year, with lower caps for elderly. As the mandatory social health insurance offers a wide range of entitlements, supplemental health insurance plays an insignificant (but growing) role. This covers the costs of private physicians, treatment in private clinics and complementary medicine.

Israelis can choose the fund they want to register with, and can change two times per year. In 1995, the first year they had this option, about 4 per cent of the population actually switched, but after that, the rate of change went down to about one per cent. The largest fund, Chalit, covers 60 per cent of the population, the other three about 36 per cent. The NHI explicitly lists its entitlements in an appendix. It not only specifies procedures and pharmaceuticals, but also provides guidelines for applications. If a physician prescribes an "off indication" or "outside of the guideline" use of a particular drug, the sick fund is within its legal rights to refuse to reimburse⁵. Parliament can add (or de-list) entitlements within the available public budget to cover the anticipated costs (the Ministry of Finance agreed to expand the annual budget by about 1% for this expansion). In 1998 the government set up a Public Committee to assess the addition of new services (Chinitz et al 1998). The Committee meets several times a year and media regularly cover its activities. It ranks potential new services, based on health technology assessment by the Ministry of Health (MoH). In a typical neo-corporatist mode, the Committee is made up of twenty-four physicians, experts of the MoH and sick funds, and public representatives. It bases its deliberation on ethical, economic and social criteria in order to decide which services will be included. Not surprisingly, the list of services seeking entrance into the basket, mainly pharmaceuticals, usually exceeds the available funding, and there is much pressure from patients and lobby groups.

Insured can seek supplementary insurance offered both by sick funds and private health insurance (one quarter of the population chose the latter). In the early 2000s, some funds expanded their supplemental coverage with drugs and some other services not covered under the basic insurance. Ironically, the Ministry of Finance opposed this move, as it would increase national health expenditure and create a two-tiered system.

Health care providers include hospitals owned by government and sick funds, clinics owned by sick funds, self-employed physicians who have contracts with funds, and private for profit hospitals, laboratories and institutes. Mother-and-child care, mental

health care and nursing care are not included in the NHI and are subject to different arrangements. All insured can select a primary care physician who works in a nearby clinic of their health fund, or a self-employed physician with a contract with their fund. Access to non-emergency care generally requires a referral from the health fund physician or pre-approved from the fund. While Israelis can, and do, exercise choice of hospital, referrals generally include direction to a specific provider. Hospitals receive capped budgets, though the funds typically reimburse 50 per cent of budget overruns. Emergency care and outpatient clinics are paid on a fee for service base. Physicians in hospitals usually receive salaries, while independent general practitioners receive capitation payment for each individual on their patient list. Independent physicians receive a capitation payment for those patients making a visit. The capitation payments are generally a form of capped fee for service, and do not involve risk bearing on the part of the physician. The MoH sets the per diem rates and fee schedules for the entire country.

National professional associations of hospital physicians, nurses and other providers negotiate salaries on behalf of their members. In Jerusalem, physicians are permitted private work in hospital under strict regulation. Elsewhere, ad hoc arrangements allowed physicians to do private work in hospital, but these were halted by order of the State Attorney General and the issue has not been resolved. Many physicians based in public hospitals have after-hours private practices and perform procedures at private hospitals.

The sick funds are legally independent entities, but the MoH has overall responsibilities. It sets the rules, defines benefits, is involved in planning and allocation of budgets, sets hospital budgets and imposes limits on public spending as well as numbers of physicians. The National Health Insurance Institute administers the funding of the NHI. It collects contributions via the tax system and allocates those over the funds. The collective bargaining and active participation of the main organized stakeholders resembles the neocorporatist style of social policy-making of Western Europe. In general, this gives providers of care a strong veto position.

Private insurers can set their own premiums, and membership is subject to underwriting. The National Health Insurance Regulator, a branch of the Ministry of Finance, regulates private health insurance. Recently, the Insurance Regulator intervened and overturned the refusal of private insurers to pay for pharmaceuticals for which a substitute existed in the national standard basket of services. Traditionally the MoH has monitored both the basic insurance and supplemental coverage. The ministry has the reputation of an ineffective regulator. It owns two thirds of general hospital beds. This has created a conflict of interest and sometimes inability to turn its attention from the day-to-day management of hospitals towards planning and regulation. In recent years, the MoH has turned out to be a better at financial regulation than at quality assurance. Through control over hospital reimbursement rates, it has been able to stabilize hospital expenditure. As of 2006, the health funds were, by and large, working within balanced budgets for the standard basket of services. The Ministry has been less adept at regulating quality of care. Lacking resources, and confronting less than complete cooperation from physicians' associations, it has not been able to create a framework for ongoing quality assurance in provision and insurance. Physicians' associations and health funds participate in benchmarking and other quality assurance efforts, but they do not agree on

public disclosure of measured results. The MoH is a frequent target of critical media coverage of medical error and malfeasance, and has set up investigative and disciplinary committees to deal with these concerns.

Israeli health policy-making thus provides an interesting example of a combination of strong government involvement on one hand and political timidity to enact radical change. The strong veto position of organized interests evidently contributes to the government's incapacity to implement change rapidly. The Israeli experience illustrates as well another possible interpretation: namely, that partially implemented reforms may offer a more realistic and interesting comparative experience than "perfect" policy reform that is not implemented.

4. Health care reform in Singapore

Singapore is a tiny island city-state with a population of 4.5 million, one of the densest populated countries in the world. It is a parliamentary democracy that gained self-rule from the British in 1959, and independence from Malaysia in 1965. The ruling People's Action Party has been in power since 1959 – hence, it has the rare advantage of being able to pursue its reform agenda without much opposition or undue interruption. In 2005, Singapore spent about S\$7.6 billion or 3.8 per cent of its gross domestic product (GDP) on health care. Of this, government expended only about S\$1.8 billion or 0.9 per cent of GDP. The main funding sources for health care are employer benefits (35%), government subsidies (25%) and out-of-pocket payment (25%). In addition, there are three schemes to help families pay their medical bills: Medisave, Medishield, Medifund. Medisave accounts for 8 per cent of total health care expenditure, while Medishield and Medifund together account for about 2 per cent. Private insurance covers about 5 per cent of all costs.

The Singaporean health care reforms trace back to 1960. Barely six months into office, the newly elected government introduced for the first time user fees. It charged 50 cents (1 US dollar = 1.48 Singapore dollars in 2007) per visit to a government outpatient clinic. Further, it decentralized primary care from the overcrowded General Hospital (which registered 2400 out-patients a day) to a network of 26 satellite outpatient dispensaries and 46 maternal and child health clinics - a process that would take four years to complete. These steps were, in hindsight, a harbinger of things to come.

Before 1960, health care was mainly funded from government revenues, but standards in the decrepit and poorly equipped hospitals were not high. Less than 50 doctors were in possession of higher qualifications. The Minister of Health declared in 1967 that “health would rank, at most, fifth in order of priority” for funds—after national security, job creation, housing and education, in that order (Yong, 1967). It was not until the 1970s that medical specialization began in earnest, and not until the 1980s that the government responded to the rising aspirations that accompanied growing affluence. In 1983, it unveiled a National Health Plan that included an ambitious hospital construction and expansion program to replace the old buildings inherited from the British colonial times, and an innovative health funding model to propel Singapore medicine into the modern, high-tech era. The philosophy behind the reform—that nothing comes free--was

very unorthodox for a government elected on a democratic socialism platform. The emphasis was on individual responsibility, with the state as payer of last resort.

In the early 1960s, the political leadership had taken an abrupt right turn ideologically (leading to its eventual withdrawal or perhaps expulsion from the Socialist International in 1976). It trumped the political left (from which it had openly split) in the battle for the hearts and minds of the hard-working Singaporeans. Since then Singapore has eschewed, at least rhetorically, egalitarian welfarism in favor of market mechanisms to allocate finite resources. In practice, this meant using pricing to curb demand but at the same time, softening the consequences to protect lower income groups. Pragmatism, not ideology, would guide social policies in the decades that followed. Government and people focused single-mindedly on expanding the size of the economic pie. The government encouraged citizens to assume personal responsibility for their own welfare, while it pledged to continue subsidizing vital areas like housing, health and education to make them affordable for all.

Singapore introduced Medisave in 1984 as an extension of the existing national superannuation scheme, the Central Provident Fund (CPF). The CPF is a compulsory, tax-exempt, interest-yielding pension savings scheme. It started in 1995 (it was already implemented elsewhere in Britain's colonies including British Malaysia and some African countries to ensure that the social security needs of would not drain the British public funds). Medisave represents 6-8 per cent of wages (depending on age) sequestered from the individual's CPF account. The account holders can use Medisave to pay for hospitalization and acute medical care (including hospice care, certain expensive outpatient treatments like day-surgery, radiotherapy, chemotherapy, renal dialysis, in vitro fertilization and hepatitis B vaccination). Account holders can also use the fund to pay for hospitalization of their spouses, children, siblings or parents and any unspent balance passes on to their beneficiaries after their death (Lim 2004a).

Medishield, the voluntary, low cost catastrophic illness insurance scheme complements Medisave. Medisave funds can be used to pay for the Medishield premiums. The third "M"—Medifund—is the state-funded safety net that takes care of those without the means to pay, including people not covered by Medisave or Medishield, or those who have run out of their quota in these schemes. Medifund was set up as an endowment fund. Its interest is distributed to the public hospitals to cover costs of patients genuinely unable to pay their hospital bills. The government periodically tops up (from budget surpluses) the various schemes in such way as to preferentially benefit low-income families and the elderly. In addition, in 2000, it set up an "Eldercare Fund" to provide subsidies to voluntary welfare organizations that offer care to the elderly. This fund is expected to reach 2.5 billion Singapore dollars by 2010. Eldercare was followed in 2002 by Eldersshield, an insurance scheme for severely disabled elderly Singaporeans, with premiums payable out of their Medisave accounts. The combined Medisave accounts of all Singaporeans now amount to S\$36 billion (or 24.3 billion US dollars). That is a not insignificant sum considering that the annual total healthcare expenditure in Singapore is almost seven billion Singapore dollars. A further redistributive element is embedded in the graded hospital wards, ranging from single rooms to open dormitories with eight or more beds. Patients in class A beds pay full costs, while those in Class C enjoy 80 per cent subsidy. The MoH estimates that more than 96 per cent of B and almost 98 per cent of C patients should be able to fully pay for their bills from their Medisave

account. Access to necessary medical care for the poor is guaranteed by a government promise that “no Singaporean will ever be denied needed health care because of inability to pay” (Lim 1998).

Singapore’s hospital restructuring process started in 1985 and took 20 years to roll out. The backdrop of this was the economic recession of the mid-1980s when the government sought to transfer the engine of economic growth from the public to the private sector. A 1986 Report of the Economic Committee mentioned healthcare as a prime candidate for deregulation and privatization. The government considered various models to reduce or eliminate control by the Ministry of Health (MoH) and to grant hospitals autonomy, ranging from a statutory board to manage public hospitals to wholesale privatization to increase efficiency. At first, the government chose the latter. Widespread public unhappiness over the planned privatization, however, led to months of intense debate in public forums, media, and parliament. In a rare instance of retreat in the face of negative public opinion, government modified its original privatization plan. It opted instead for “corporatization” of the public hospitals and specialty centers (Phua 1991, Preker and Harding 2003). Thus, one by one, these institutions gained autonomy in fiduciary and operational matters as independent entities within the meaning of Singapore’s Companies Act. The government created a monolithic government company, the Health Corporation of Singapore (HCS) Private Limited in 1987 to own and manage all corporatized hospitals and specialty centers. The independent hospitals, although “private” in name, each under its own board of directors, were actually public since they were owned 100 per cent by the HCS, which in turn was 100 per cent government-owned. By the year 2000, every public hospital and specialist medical center had become corporatized. Hospitals were free to set their own directions and to compete with each other. As market mechanisms and structures replaced old bureaucratic ones, efficiency and service levels indeed improved. As each hospital increasingly focused on its own survival and bottom line, however, competition became counter-productive. Dysfunctional aspects surfaced such as the poaching of staff from other hospitals by offering higher salaries. Non-cooperation between institutions resulted in missed opportunities for exploiting economies of scale such as central drug purchasing or developing a common information technology (IT) platform for electronic medical records. Each hospital CEO vied to increase its market share through high-tech acquisitions and other means, confident that HCS or the MOH would eventually bail them out if they ran deficits. Hospital expenditures rose sharply, contributing to health care cost inflation.

The government intervened in 2000. Believing the competition would work better with a smaller number of competitors, it arbitrarily regrouped the corporatized institutions into two competing “clusters” - the National Healthcare Group and the Singapore Health Services. These quasi-independent clusters would still report to the MOH as the Ministry appointed its boards. Simultaneously, the two clusters took control over all the government polyclinics for primary care. Thus in one fell swoop, government achieved horizontal and vertical integration of all public sector health care providers at the primary, secondary and tertiary levels. Shortly after, it introduced DRG-based payments, followed by global budgeting, both aimed at curbing supply-side moral hazard.

The reforms resulted in raised standards of care and levels of service that are a far cry from the overcrowded wards and unresponsive outpatient clinics of yesteryear.

Average waiting time for elective surgery nowadays is a mere two weeks while a recent survey showed overall patient satisfaction at 80 per cent (Lim 2004b). Mandatory hospital quality committees and voluntary Joint Commission International (JCI) accreditation ensure clinical quality and patient safety. In fact, one-third of Asia's accredited health care facilities are now found in Singapore (Newsweek 2007). The city-state's vibrant biosciences research and development environment also enhances its reputation as a center of medical excellence. In 2005, more than 374,000 foreign patients sought treatment in Singapore, four out of five in private clinics and hospitals. Growth in the number of foreign patients has been averaging 20 per cent in the last few years, thanks to the stepped-up efforts by Singapore Medicine, a government-industry partnership established in 2003 to turn Singapore into a leading medical hub.

Patients have complete freedom of choice of providers, which include 29 well-equipped hospitals and specialty centers with 12,000 beds (or 3.7 beds per 1,000 population). A thriving private sector accounts for about 21 per cent of inpatient beds and 80% of outpatient attendance (Ministry of health 2007). The government has signaled it would like to see the private share of hospital beds increase to 30 per cent. Four of the for-profit chains are currently listed on the Singapore Stock Exchange. The government actively encourages competition and publishes hospital bill sizes and selected quality indicators on its website to encourage consumer choice.

The health care system of Singapore thus reflects a mix of strong market orientation and individualism, with a high acceptance of government intervention. The absence of a tradition of well-organized stakeholders and opposition groups has contributed to the rapid adoption of top-down policies. The combination of individual savings accounts with employer subsidies and public (means-tested) subsidy targeted at low-income families make for a quasi-private system under tight government control. Another unique feature of Singapore is its extraordinary high savings rate that combined with high economic growth rates (averaging eight percent per annum over the last twenty years) makes for a comfortable starting point of public policy. Patients are accustomed to cost sharing rather than depend on state largesse. The cost-sharing formula has to some extent countered the "moral hazard" generally associated with fee-for-service, third party reimbursement. Singapore has deliberately avoided the more costly "leveling down" option of universal access regardless of ability to pay, in which the "undeserving rich" enjoy the same benefits as the poor. Compared to OECD countries, Singapore has been very successful in containing the level of health care spending to below 5 per cent of GDP (see table 2). It remains to be seen, however, whether it will be able to maintain that low spending level. As Singapore's economy matures, economic growth will inevitably slow down, lessening the masking effect of the expanding GDP denominator. Moreover, Singapore has a very young population. The elderly now constitute only 8 per cent of the population, but are projected to increase to twenty-five percent in 2030. Hence, rising healthcare expenditure is likely to create sharper trade-offs between efficiency, quality and equity and may also accentuate disparities between the different socioeconomic classes (Lim 2005).

Paradoxically, just when governments elsewhere are mulling over cutbacks in health spending, Singapore's health care planners are busy laying out the groundwork for the *expansion* and upgrading of its health facilities over the next 10 years, costing billions of dollars. There are two reasons for this. First, in order to safeguard generate human

capital needed to sustain Singapore's dynamic economy, the population needs to grow by another two million (largely through immigration), stabilizing at 6.5 million persons. Second, Singapore Medicine is targeting 1 million foreign patients by 2012 and it reckons this will generate three billion Singapore dollars in revenues and create 13,000 new jobs (Choo 2002). Hence demand for quality health care services, on both domestic and foreign fronts, cannot but rise. For the pragmatic government with a knack for turning necessity into virtue, that is not necessarily a bad thing.

5. Health care reform in Switzerland: from social insurance to federalist arrangements

Switzerland is a small landlocked country in Central Europe between Germany, Austria, Italy and France (it shares three of its four formal languages with its neighboring countries). It is a federal state composed of twenty-six smaller states (cantons), with a population of 7.2 million. Three particular characteristics of the political and institutional context provide a high degree of voice, choice and exit opportunities (Hirschman 1970) to Swiss citizens: a decentralized political system with institutions of direct democracy, a long tradition of social security and a liberal economic culture. Swiss health care has its historical base on the two institutional pillars of direct democracy and federalism.⁶ Swiss citizens can intervene directly in the political decisional process by referendum to approve or reject reform proposals. Historically, this has slowed down major change. Federalism, expressed in the autonomy of the cantons, allows for distinct regional models. Combined, those two factors have resulted in large regional variations and seemingly insurmountable barriers to nation-wide (and pro-poor) reform (Crivelli et al. 2007).

Health Insurance

Having been given the mandate to legislate on sickness and accident insurance in 1890, the federal government passed the first Swiss health insurance law in 1911 (Civitas2002). This law established a statutory package of benefits. In contrast to the social insurance in France and Germany, it stated that individuals, not employers are to contract insurance. By 1990, nearly 98% of the population had purchased (voluntary) insurance.⁷ The sick funds faced financial difficulties throughout the middle of the 20th century. Moreover, the left-wing parties made several attempts to improve the equity of health insurance by making the premiums dependent on income. However, only three of the ten reforms proposed by Parliament or civil society between 1974 and 2003 passed via popular vote, two of those based on federal decrees and focusing on minor aspects.

The third proposal accepted via popular vote, however, was a major reform--the Revised Health Insurance Law of 1994. It came into effect in January 1996. The three main objectives of the reform were to strengthen solidarity, to improve cost control and to promote fair competition between health insurers. The law strengthened the role of the federal state, and ushered in the ability for sick funds to offer innovative insurance plans

organized along “managed care” lines. It mandated all citizens to take health insurance and safeguards access to standard benefits that include inpatient and outpatient treatment and care for the elderly and handicapped, with unlimited stays in nursing homes and hospitals. In 1999, alternative and complementary medicine benefits became part of the basic coverage, but they were dropped again in 2005. Within the framework of federal and cantonal regulation, about ninety insurers (that have to be not for profit for the mandatory basic coverage, but can be both for profit or not for profit when offering supplemental coverage) offer today a wide array of plans with varying conditions and costs.

The insurance companies were originally federal, regional, religious, or occupationally based (Civitas 2002). Due to frequent mergers, their number has dropped since the mid-20th century from 1100 local insurers to about ninety in the early 2000s. Most are operating on a national scale. Membership varies greatly, ranging from 102 to 1.3 million insured in 2006. They have lost their original identity as social insurer and now act as regular commercial insurers. Insurers group together in the national association, Santesuisse, to negotiate fees with providers.

The Swiss Constitution confers full sovereignty upon the cantons for administering health insurance (as it does for all other matters not specifically in the domain of the federal government, the Confederation). For health insurance programs, the Constitution sets three basic requirements: universal access to a benefit basket defined by the Confederation, the right of insured to change health insurer yearly and uniform insurance contracts. Within those legal limits, independent and competing health insurers negotiate contracts with providers, and offer the basic insurance coverage under a wide array of insurance plans. Insurers must register with the Federal Office of Public Health. This agency also monitors the insurance market. The cantons administer and regulate any insurance programs that meet the standards.

Swiss consumers (and not employers or government) select health insurance plans, the size of deductibles and other conditions according to their own needs and preferences. They can change insurer every year (and insurers have to accept them). The 1994 law made insurance compulsory for all, expanded the guaranteed benefit package and reduced inequities by an extended (and complicated) system of cross-subsidization. It also allowed citizens to switch between insurers more easily than in the past. Each adult citizen signs an individual insurance contract.

Government regulation plays a significant role, for example in mandating that all citizens take insurance, defining the basic coverage and minimum deductible, co-payments, open enrollment and mandated contracting of all providers by all health plans. It is interesting to note that with the exception of the mandatory contracting, quite a few of those rules are similar to the current Dutch laws (see below). Health insurers have to offer community-rated premiums for all who live within a given area, independent of income, wealth or individual health risk of the insured person. Insurers receive extra funds to compensate for over-representation high-risk groups like elderly or chronic ill in their portfolio (Beck et al. 2003). Community-rating was seen as one of the core elements of the reform to safeguard coverage for the high-risk poor. Insurers can offer discounts to young adults (age 19-25) and have to offer lower premiums for children (up to age 18). To alleviate the impact of this regressive financing, the state gives subsidies to low-income households. In 2004 the subsidies amounted to twenty percent of total premium

revenues. It is worth noting, however, that subsidies have failed to grow apace with premiums, and low and middle-income families now pay a higher share of their means than better off.

Managed care and consumer choice

There is no limit in choice of provider, unless insured opt for an alternative plan that restricts choice in exchange for lower premiums. The current health insurance is based on a notion of “managed competition” that shifts competition mechanisms from the patient-physician relation to both the health insurer-insured and health insurer-provider relationships (Bolgani et al. 2006). Those are similar to the family of US health maintenance organizations (HMO), “preferred provider organizations” (PPO), or “independent practice associations” (IPA) that include networks of family doctors. Those plans entail practices of selective contracting, gatekeeping, and financial bonus-malus incentives for providers to adhere to guidelines (Lehman and Zweifel, 2004). Insured can switch insurer or opt for another plan each year. “Managed care” plans offer premium discounts in exchange for a restricted freedom of choosing the doctor. A second set of discounted plans offers lower premiums but higher deductibles. As in other countries, such plans tend to attract younger, healthier, better-informed and more mobile people.

In 1996 and 1997, the first years after the introduction of the new insurance, membership in managed care plans quadrupled. In the early 2000s, after a period of stagnation, policyholders seem to be migrating again to managed care contracts to escape rising premium levels. Still, in 2005, only about ten percent of insured had chosen one of those models. Limited financial benefits (there are legal restrictions to the maximum deductible insurers can offer) as well as cultural factors (in the French and Italian speaking cantons, only a small minority of the population has chosen for those plans) explain the limited growth in managed care. Some insurers offer supplementary coverage in addition to the obligatory basic federal plan.⁸ Insurers have latitude insurers in all matters beyond the coverage of the federal benefit basket, combined with the effects of federalism that leaves much regulation to the canton level. This has resulted in a wide variation of plans. As cantons also differ significantly in their public spending strategy, per capita health spending, supply of hospital and ambulatory care and consumption levels greatly vary across cantons. This has resulted in large differences of financial burdens to the insured between and within cantons, perpetuated by a lack of consumer mobility across plans. For example, in 2004, a family of two parents and two small children with an income of US\$ 42,000 paid 4.7% of their disposable income in the canton Obwalden but sixteen percent in Neuchatel (Baltasar et al. 2005).

Despite those differences, citizens did not exit from either their canton or health insurance on a large scale (Colombo 2000; Frank and Lamiraud 2007). Obviously, most Swiss do not want to switch and remain faithful to their fund even if premiums are (much) higher than elsewhere. Less than three percent of the policyholders switched insurer in 2006. Empirical evidence shows –similar to the experience of other countries where insured can choose their plan-- that people who do change mostly represent “good risks”: the young, healthy and higher educated (Beck et al. 2003; Strombom et al. 2002). The alternative is “partial exit”, a change to another policy with the same insurer. Here, the evidence shows that most change occurs in the high band of deductibles (more than

1200 francs per year). The death rate of those who had selected the minimum deductible is twice as high as that of the insured who had selected the average amount (Geoffard et al. 2006). Without doubt, a process of self-selection lies behind this pattern of preferences in deductible.

The mandatory nature of the statutory package means that insurers cannot compete on the basis of the benefits or quality of care. They must contract with all hospitals and self-employed practitioners in the canton of the insured person's residence. In case of an emergency, they also have to reimburse treatment in other cantons. They can only differentiate with the level of the basic premium and the quality of administrative services, or with alternative plans that restrict choice of provider in exchange for lower premiums. Self-employed health professionals receive fee for service payments, while hospital budgets are based on a mix of direct government subsidy, DRG-based payment and other fees.

Health care provision in Switzerland

Swiss citizens receive their medical treatment in a wide range of settings in hospitals, clinics and ambulatory care facilities. Switzerland has over 400 hospitals, around 270 of which are public or publicly subsidized. There are 5.6 beds per 1000 people, and hospital stays are relatively long. Perhaps due to these factors, hospital expenditure is the highest in Europe. Medical specialists practice privately and in hospitals, though most patients are referred to hospitals for specialized procedures.

The basic insurance covers one third of prescription drugs, subject to a ten percent co-payment. Patients pay for all other drugs directly, or seek supplementary coverage. This means that the Swiss pay heavily for pharmaceuticals and there is generally a desire to increase the use of generic drugs.

The Swiss health care system is based on a liberal conception of health and medicine. The patient-consumer plays a central role, with freedom to choose health plan as well as provider. Proponents of "consumer-driven" health care (Herzlinger and Parsi 2004) argue that this model of competing health plans promises to combine universal coverage with effective cost control. However, critics point to the fact that extensive government regulation, not competition or high out-of-pocket payments has been the driving force to keep costs down (Reinhardt 2004). The underlying regressivity in the design of premiums and the failing of fiscal subsidies to match the rates of increase in insurance cost (and premiums) has become a source of discontent for much of the lower and middle classes (Bolgiani et al. 2006). The federal government has repeatedly tried to reduce the inequity of premium levels across the cantons, but made little progress so far.

Decentralized decision-making and cost control

Empirical evidence shows that the Swiss model has not been very successful in controlling health spending. The decentralized decision-making has led to wide regional variety in regulatory settings, roles of public and private actors, capacity, use and spending levels (Crivelli et al. 2006). In fact, there is not one system but twenty-six cantonal subsystems, connected by the Federal health Insurance Law since 1996. This

decentralized system offers little room for regional cross-subsidization. In spite of the decentralized nature of the Swiss health insurance, the system has kept some of the neocorporatist elements in the bargaining over fees and tariffs. The associations of provider represent their members in collective bargaining at the federal and canton level, and insurers still have to contract with all providers.

One of the problems in assessing the working of the Swiss system is that most experts limit their comparison to Switzerland and the US, often ignoring the particular political and social context of both countries. It is not possible to understand the Swiss health system without paying attention to the crucial role of direct democracy and federalism on the one hand, and the economic and social traditions on the other. The Swiss can exercise their “sovereignty” as citizen-voter, insured and patient. The system provides radical forms of vote in the institutions of federalism and direct democracy that effectively provide veto points to any system change. Insured can switch health insurer each year. In principle, they could also move from one canton to another, but in general the mobility of Swiss citizens is very low; linguistic barriers explain part of that low mobility. Rather than “voting by feet” (Tiebout 1956), citizens can induce change by the instruments of direct democracy: the referendum and popular initiative. The referendum is similar to a veto and has the effect of delaying or freezing the political process; the popular initiative can lead to constitutional amendment. Both mechanisms reduce the power of federal and cantonal government, and make decision-making complex and often slow.

The fact that Swiss citizens can chose between exit, choice and voice has caused strong tensions, and resulted in weak governance of the health care system. The competitive model assumes that consumers are willing and able to use their options based on full information about price and quality. That assumption is particularly questionable in a system characterized by a chronic lack of information and transparency. There is no systematic information available about performance indicators like clinical quality, efficacy and effectiveness of individual providers, prerequisites for consumer choice and exit. Another problem is that the proliferation of plans does not combine well with cantonal responsibility for the availability of health care. By law, cantons have to safeguard sufficient health care capacity and this has led to the creation of regional monopolies and fragmentation of the hospital system (Crivelli 2007).

6. Health care reform in Taiwan

Taiwan consists of one major and several smaller islands, with a total land size of 36,000 square kilometers. It has one of the highest population densities in the world. Of the population of 22.8 million, the majority lives in urban areas and less than two percent live in the mountainous areas and offshore islands.

Taiwan’s total national health spending was 6.2 per cent of GDP in 2005. The National Health Insurance (NHI) accounted for 57 per cent, out-of-pocket spending 34 per cent, tax subsidies almost 6 per cent and other (private) sources about 4 per cent (DOH data). The NHI is financed on a pay-as-you-go basis with the income-based contributions typical of social insurance. Insured, employers, and government all pay a share of premiums (Cheng, 2003). In 2005, 35 per cent of the NHI revenue came from

employers, 38 per cent from insured, and 27 per cent from government (BNHI). The contributions are levied on a per capita basis up to a maximum of three dependents per insured. Any additional dependents enjoy the NHI coverage for free. The government subsidizes 100% of the contributions for the poor and unemployed veterans.

For over 50 years (1949-2000), Taiwan was under the one-party rule of the Nationalist government (Kuomintang, or KMT) that retreated to the island after defeat by the Chinese communists in 1949. From the 1960s to the 1990s, Taiwan's economy enjoyed high growth rates, propelling Taiwan into the ranks of the "Asian Tigers", the groups of four Asian economies--Taiwan, South Korea, Singapore and Hong Kong--that impressed the world by their robust and sustained economic growth and development.

Health Insurance

As Taiwan's economy prospered, the government turned its attention to social policy. By the late 1980s, there were 10 different health insurance schemes, each covering a particular subset of the population, for example the Labor Insurance (1950), Government Employees Insurance (1958), Farmers Insurance (1985) and Low Income Household Insurance (1990). Altogether, the schemes only covered about 59 per cent of the population, leaving 41 per cent or 8.6 million of the then population of 21.4 million people uninsured. The uninsured were mostly children under 14 and adults over 65--vulnerable populations with the greatest health care needs. Private health insurance as that in the U.S. did not exist (Cheng 2003).

The surprising wholesale move to universal coverage in 1995 built on these schemes, and was made possible by a window of opportunity created by the confluence of several factors: the abolition of the martial law in 1987 that had ruled Taiwan since 1949 in favor of a democratic government, rising popular demand for universal coverage, a political challenge of Taiwan's Nationalist government from the opposition party, the Democratic Progressive Party (DPP), and last but not least, the strong, personal leadership on the issue by Taiwan's then President Lee Teng-Hui (Cheng 2003). That leadership played a critically important role in establishing Taiwan's National Health Insurance in 1995.

To prepare for the introduction of the NHI, government bureaucrats and scholars conducted extensive studies of health systems abroad in the 1980s. The planning took seven years, from 1986 to 1993. The planners drew heavily on foreign experience. The end product of this planning process--the NHI--was described as "a car that has been domestically designed and produced, but with many component parts imported from over ten countries" (Cheng 2003). Next, Taiwan's Parliament deliberated over the NHI bill for over eighteen months and passed the bill in July 1994. On March 1, 1995 the NHI was implemented by presidential decree, an amazing five years ahead of schedule (Cheng, 2003). Virtually overnight the hitherto uninsured (41% of Taiwan's population) gained equal access to health care. Within a year, their health care utilization approached the same level as those who had health insurance prior to 1995 (Cheng 2003).

The action of an impatient President to push the implementation of the NHI so far ahead of schedule led to a period of confusion and chaos not unlike that which accompanied the introduction of the Medicare program for America's elderly in 1965 (Cheng 2003). Critics and skeptics alike expected that the NHI would fail before it could

take off because of the inadequate preparation. In retrospect, however, the hasty implementation of the NHI may have been a blessing in disguise. In 1997, a financial crisis struck Asia. Even though it affected Taiwan less than Thailand, Malaysia, Indonesia and South Korea, Taiwan's economic growth nevertheless slowed after 1998. Growth rates dropped to just over four percent in 2000 and to minus 1.7 per cent in 2001 (compared to the high average growth rate of 10.7 per cent from 1992 to 1995, the period before the NHI). In such economic climate, the government might have raised more concerns about the affordability and sustainability of the ambitious NHI (Cheng 2003; DOH 2006).

The public warmed to the program quickly. In nationwide surveys of satisfaction, for most of the time after its inception, over seventy percent of the respondents declared themselves satisfied with the NHI, a ratio much higher than in many other countries (Cheng 2003). Only in 2006, after budgetary strains caused increases in out-of-pocket spending, public satisfaction fell to 64 per cent (BNHI satisfaction survey 2006). Significantly, the satisfaction rate of the residents in remote mountainous areas and offshore islands reached 89 per cent in 2005. Those populations were particularly happy with their improved access to health care through the government program of Integrated Delivery Service (IDS) designed specifically for those groups to improve access.

In brief, the NHI is a mandatory single payer health insurance. The Bureau of National Health Insurance (BNHI) administers the NHI under the Department of Health. The administrative costs of the BNHI were a mere of 1.5 per cent of NHI's total budget in 2007 (Cheng 2007). This low administrative cost is largely due to the efficiency of the nation-wide modern and uniform administration supported by a powerful information system, absence of legal costs of litigation, absence of marketing and advertising expenses and price controls by government.⁹ In 2002, Taiwan's Supreme Court ruled that no one in Taiwan may be denied care because of lack of ability to pay (Cheng 2003). Clearly, Taiwan's society considers access to health care as a fundamental right for all.

The NHI benefits are comprehensive. They include inpatient care, ambulatory care, laboratory tests, diagnostic imaging, prescription drugs and dental care (except orthodontics and prosthodontics), traditional Chinese medicine, day care for the mentally ill, limited home care, and certain preventive services (pediatric immunizations, well-child check-ups, adult health checks including prenatal care and pap smears). Moreover, the NHI covers vision care, kidney dialysis, and DOH-approved orphan drugs to treat rare disorders (Cheng 2003).

Health care services in Taiwan are delivered through a predominantly private delivery system. Patients enjoy free choice of provider and of therapy. Providers receive their revenues from three sources: predominantly fee-for-service payments by the BNHI, direct payments by patients (user fees and co-payments), and sales of goods and services not covered by the NHI (Cheng 2003).

Like most if not all health systems around the globe, Taiwan's NHI has been plagued by financial woes since 1998, three years after the NHI was implemented. On the one hand, the public enjoys free choice of providers and there is relatively high utilization of health services. On the other hand, policy pundits and the media have convinced the public that there is "waste, fraud and abuse" in the system, which government should eliminate before raising charges on households and employers (Cheng 2003; Cheng 2005).

It has become fashionable in the debate on health policy –not only in the US but also in many other countries-- to equate the word “choice” with “choice among private health insurers and health insurance products”. It is doubtful, however, that this is the choice ordinary people have in mind when they speak of “choices in health care.” More likely, they have in mind unrestrained choice of provider and therapy. The most important lesson to be drawn from Taiwan’s experience is that a single payer system-- without choice among private insurers or wide variety in insurance products—can easily and relatively cheaply provide consumer choice of health care providers and therapies. Taiwan’s experience also illustrates the need for policy adjustments after reform. In fact, it confirms the general finding that health reform does not mean the once and for all fixing of problems. The “after reform maintenance” requires permanent monitoring and adjustment.

7. Health care reform in The Netherlands

The Netherlands is a small, densely populated country (population of sixteen million in 2006) located between Germany in the east, Belgium in the south, and the North Sea in the north and west. The country is a mid-size open European economy with a strong international trade position. It has a stable democracy, and a long tradition of consensual, “neo-corporatist” policy-making, where governments share the responsibility for social policy making with organized groups in society (De Swaan 1988; Lijphart 1968).

In 2007, total health spending exceeded 50 billion euros (US\$70 billion), or about 3,100 euros (US\$ 4,340; in 2006 One euro equaled about 1.4 US dollar) per person per year. Of this total, about 47 per cent came out of the new basic health insurance (introduced in 2006, see below), 42 per cent from the contributions for the long-term care insurance AWBZ, about 7 per cent from patient co-payments and about 5 per cent from tax subsidies (MoH 2006). All legal residents have to sign up with one of the forty or so health insurers to obtain coverage for the basic insurance, and most Dutch citizens have done so. They pay, on average, about 1,200 euros (US\$ 1,440) per person per year as flat rate premiums directly to their insurer (they also pay about 1,000 euros for the AWBZ scheme). The government pays for the premiums of children up to 18 years old. The insurers receive the other half of their incomes from earmarked taxes that employers pay into a central fund administered by the Tax Department.

The Netherlands health reform debate started in the early 1970s with efforts to centralize funding and administration, and regionalized health care planning (Okma 1997a). In the early 1980s, the combination of the economic shock of the oil crises (with economic stagnation and high unemployment), the fear of aging population and the erosion of faith in government planning led to a change in direction of Dutch welfare policies. Successive governments implemented cuts in levels and duration of welfare support, unemployment and disability benefits and (only partly successfully) tried to reduce unemployment rolls and numbers of disability beneficiaries (Visser and Hemereijk 1997). Next, the attention shifted to health care (Okma 1997). In 1987, an expert committee proposed to reduce the role in government and strengthen competition and consumer choice (Commissie Dekker 1987). At first, the proposals met with strong resistance from health providers and many other stakeholders. Parliament only hesitantly

supported the bill (all major parties were internally divided). Government decided to gradually implement the plans and the first “health reform bill” passed in 1989 (MoH 1988). After a few years, however, opposition resurfaced, political support eroded and the reform process effectively came to a halt (Okma 1997). The 1994 “Purple Coalition” of Labor, Liberal Conservatives and Liberal Democrat parties shelved the reforms, and announced piecemeal improvement of the current system instead (Okma and De Roo, forthcoming). Interestingly, it did not reverse the reform steps of its predecessors. In the early 2000s, health reform made its comeback on the political agenda (De Roo 2002, Strategisch Akkoord 2002). The 2003 governing coalition of Liberal Conservatives and Christian Democrats decided to take up the basic ingredients of the earlier Dekker proposals, with an even stronger orientation on market competition (Hoofdlijnenakkoord 2003). As the coalition had a comfortable majority, the reform bill passed Parliament in a surprisingly short and uncontested way in 2005. The return of the Labor Party PvdA in 2007 to the coalition government did not affect the introduction of the insurance (Regeerakkoord 2007). The main players in the field, in particular health insurers and some large providers, had already anticipated on the introduction of the new scheme, and expressed far less opposition than during earlier reform debates.

In January 2006, a new “basic health insurance” (or rather, mandate to take out private insurance, somewhat similar to the Swiss health insurance mandate) replaced the former mix of public and private health insurance (Bartolomee and Maarse 2007)¹⁰. The funding of the new scheme consists of a mix of direct contributions, earmarked taxes and government subsidy. The scheme combines elements of both the former private and former social insurance¹¹. All residents can choose their insurance for the basic coverage and can take out supplemental coverage. The term “basic” is actually somewhat misleading as the entitlements include a wide range of preventive services, inpatient and ambulatory medical care, prescription drugs and medical aids. That coverage more or less equals that of the former sick fund scheme. Efforts in the last ten years to scale down this range of entitlements by de-listing items from the social health insurance in the past have not been very successful; in fact, they read as a “catalogue of failure” (Maarse and Okma 2005).

Health insurers receive about fifty percent of their revenue from flat rate premiums directly from their insured, and about fifty percent from a central fund that channels the earmarked contributions withheld by employers via the tax system. Low-income families can apply for fiscal subsidy.¹² Patients face modest amounts of co-payment for inpatient and outpatient care. By law, premiums for the basic coverage are community-based, but insurers set their own premiums. Insurers cannot turn down applicants. They attract new customers (or try to retain their clients) by offering low flat-rate premiums and good services; providers are competing for contracts with the insurers by offering low rates and good services. In that way, at least on paper, all Dutch citizens will get good quality and not too expensive health care.

In 2006, about one fifth of the population changed their insurer and coverage at the introduction of the new scheme, mostly via collective contracts. That number was higher than expected, and prompted some to declare victory of the competition model (Laske-Aldershof et al 2004). In the second year of the new insurance, however, less than five percent of Dutch insured changed fund, over eighty percent of those as part of a collective employment-based contract (Smit and Mookveld 2007). Thus in fact, only

about one percent of the change of health plan was “consumer-driven”. In a way, the new scheme has strengthened the employment-base of the health insurance even while its basic underlying notion is that of individual choice. A new phenomenon in the Dutch insurance market is the rise of collective contracting by certain groups of patients (at least for groups that insurers are willing to accept).

In 2007, the number of uninsured was rising as families had difficulty in paying the monthly flat rate premiums (that before were withheld by employers as part of earmarked taxation or by welfare offices). Even while compared to the US, the number of uninsured is still very low, less than 3 per cent of the population, it poses a political problem for the government. First, government proposed that if uninsured would end up in hospital, they would face the costs of hospitalization themselves and would not only have to take insurance at the spot but pay a fine as well. Then, as a study showed that that (young) immigrants, single parents and welfare recipients were over-represented in the delinquent population, it realized that model would be hard to enforce (CBS 2007). The government next proposed to abolish the direct payment of flat rate premiums for welfare recipients altogether and have the local welfare offices administer those charges (a solution already proposed by the welfare offices of Amsterdam and Rotterdam in 2005). The MoH also took over the costs of debt collection from the insurers as long as they would keep the delinquents on their roll (MoH 2007).

Thus far, the new competition has not been successful in driving down premiums or health expenditure (Kreis 2005). In 2007, average premiums went up by about ten per cent and most experts expect a further hike as several health insurers has spend excessive amounts on marketing and advertising to keep or extend their market share (Smit and Mookveld 2007). As the new competitive model went into effect in January 2006, it is too early to assess to what extent that competition has improved the quality and efficiency or patient-friendliness of the system.

Dutch hospitals and other health facilities have a centuries-long tradition of private, not for profit ownership and governance by self-appointed boards (De Swaan 1988; Okma 1997a). The last two decades have seen the rise of new specialty, investor-owned for profit clinics (mostly for elective surgery on an outpatient base). Still, that has hardly affected the dominant not for profit pattern. And many hospital managers do not feel at ease with the new demands of market competition (Rosenberg 2006; Rosenberg 2007). There has been a rapid process of mergers and takeovers that led to smaller numbers of bigger hospitals as well as vertical and horizontal integration of health services (Boot 1998; RVZ 2003). This market concentration has raised concerns of the national competition authority (NMa). In some cases, NMa denied approval of mergers when those might lead to regional monopolies or exclude competition altogether.

One of the side effects of the increased emphasis on competition has been the erosion of the traditional corporatist bargaining model in The Netherlands (Okma 2002). For many decades, associations of hospitals, medical professionals and other providers met with representatives of the public and private health insurers to negotiate contracts and discuss policy developments. As the NMa has ruled that such collective bargaining, in fact, implied undue market protection and exclusion of newcomers, they had to abandon this practice. Hospitals, general practitioners, dentists and others have now to seek contracts with the health insurers on an individual basis. This has greatly added to the administrative complexity (and costs) of the system.

The majority of general practitioners and dentists work in solo or small group practices. Other health professionals, for example physical therapists, dieticians or speech therapists, work in hospitals or nursing homes, and a minority as self-employed practitioners. Within the overall framework of government regulation, insurers negotiate with hospitals, self-employed health practitioners and other health care providers.¹³ The incomes of family physicians consist of a mix of payments. They receive a fixed amount ("capitated payment") for each patient, fees for certain activities and special subsidies (e.g. for buying computers). The largest share of hospital budgets is (still) based on historical costs, but the system is slowly shifting to case-based payments. At first, government encouraged medical specialists and hospitals to develop case-based tariffs themselves, but this decentralized process led to over 40,000 tariffs (only covering about ten percent of all hospital activity) and turned out too complicated to administer. The implementation of the "home-grown" and very complicated DRG-based hospital payment model has slowed down, and in 2007, government announced a drastic simplification.

While the policy rhetoric in The Netherlands emphasizes market efficiency, less government and more consumer choice¹⁴, the state has not reduced its presence. In fact, it has extended its role in different ways. Under responsibility of the Ministry of Health (MoH) and the Ministry of Finance, a new health competition authority *Zorgautoriteit*, monitors the functioning of insurance and health care markets. The MoH itself has become active in sponsoring the development of new payment models and other cost control mechanisms.

In 2002, it announced that the responsibility for long-term care AWBZ would shift to local authorities (and not, as in former reform plans that failed, to the health insurers). That would also have meant the imposition of stricter means testing to restrain access to those services. However, in 2007, government announced a moratorium on changes in the long-term care insurance AWBZ. Thus far, there has been not much debate on the question whether the area of long-term care should be open to more competition and consumer choice (Okma 1997b). In the past, certain patient groups in this field (in particular groups of psychiatric patients and relatives of mentally retarded persons) have been effective in pushing for improvement. Also, the AWBZ scheme offers vouchers or cash benefits to chronic ill patients who then can contract services of their own choice. Within a few years, this cash benefit scheme became very popular and in 2005, over 50,000 patients received on average over 20,000 euros per year. The total budget for those vouchers now exceeds 1 billion euro, while the total budget for home care serving over 600,000 patients per year, is about 2 billion euro. Clearly, those developments in long term care are examples of direct consumer voice and consumer exit (Hirschman 1970). It is less clear whether patients are keen to develop such role in the area of acute medical care (Okma and oijens 2005).

Is important to note that the 2006 health insurance reforms have not (fully) replaced earlier models of government planning and control. Reflecting strong support for solidarity in social policy, Dutch governments have regularly taken steps to mitigate the financial effects of privatization, for example by exempting certain services or population groups from user fees. Some experts argue that the different modes of governance complement each other (Helderman 2007). In fact, the current Dutch health care system shows an intricate layering and overlap of competing and sometimes

conflicting governance models. Traditional models of social insurance, notions of regionalized governance, and new elements of market competition combine with increased central government control. The current health governance in The Netherlands reflects efforts to decentralize into a territorial direction (from central government to regional and local authorities) and to decentralize in a 'functional' sense (from state to markets and individuals). At the same time, faced with budget pressures (or perceived budget pressures, or perceived potential future budget pressures), central government has not given up its role (Scheerder 2005, MoH 2004), nor has it reduced the size of central administration. It has actually expanded its role in monitoring and supervision of health care and health insurance. The system is less market-oriented than some experts claim (Schut and Van de Ven 2005; Enthoven and Van de Ven 2007), or some foreign observers who see the Dutch model as an example for the US seem to hope (Nauk 2007; Harris 2007).

The Dutch experience also confirms the need for post-reform maintenance. For example, in 2007, the government abandoned the no-claim restitution (only implemented one year before) and replaced that with a modest mandatory deductible for the basic insurance after critics claimed the no-claim bonus was unfair to insured with higher levels of health expenditure. In several cases, government reinstated entitlements it had de-listed only a few years (e.g. dental care) before because of widespread opposition (Maarse and Okma 2005). Likewise, the rise of numbers of uninsured in 2007 prompted government to take action.

7. Conclusions: Debates, Reforms and Policy Adjustments

This section summarizes our findings on the origins and the fate of the health reform debates in Chile, Israel, Singapore, Switzerland, Taiwan and The Netherlands. Why (and when) did those countries embark on the health reform trail in the 1980s and 1990s? What were the major policy goals and reform options discussed? Was there explicit reference to other countries' reform experience? Who were the main stakeholders and what were their positions? What option became reality? And finally, what were the (intended and unintended, the expected and unexpected) outcomes, and what happened during implementation?

In the 1980s and 1990s, all six countries undertook systematic reviews of their health care. Both endogenous and exogenous factors added to the pressure to change. The oil crises of the mid-1970s, the end of the post-war baby boom and changing ideological views of the role of state and citizens combined to trigger extensive debate about the future of the welfare state. Thus budgetary and fiscal restraints, changing ideology and changing economic conditions played a role in reshaping social policy. The Asian countries faced a unique situation created by long periods of high economic growth. The new prosperity increased the expectations of the populations that government would not only initiate income-protection schemes for old age and illness, but also provide the fiscal means for making sure the entire populations could benefit. In the 1970s and 1980s, periods of phenomenal economic growth, two of the "Asian tigers" Singapore and Taiwan saw the need for a systematic buildup of the income protection schemes that had started in Western Europe after the industrial revolution. They both realized universal

coverage for health insurance. In both countries, expansion, rather than contraction of the welfare state was the main point, though in strikingly different ways.

The goals of the reforms in all six countries were similar: improved access to health services (through expanding public or private health insurance), improved quality and efficiency of services (through a mix of market-oriented and regulatory measures) and greater consumer and patient choice (freedom to switch to another insurer, or to a different plan with different financial conditions, but also, freedom of choice of provider).¹⁵ All countries except Chile realized universal or near-universal health insurance coverage, but their success with other goals, in particular consumer choice, has been more modest. Insured now have a larger choice of health plans in Switzerland, the Netherlands and Israel. In Chile, they can opt out from the public scheme to take out private coverage. At the same time, there is decreased choice of providers because of selective contracting in Chile, Switzerland and The Netherlands. In those countries, insurers gained decision-making power of the contracting with providers. In Chile and Singapore, governments strengthened their role in contracting services by imposing new rules and in Taiwan government itself became the sole health insurer. The expansion of private insurance led to increased risk selection in Chile, Switzerland and The Netherlands. Shifts toward decentralized private governance also increased the administrative complexity and overhead costs in those countries. The goal of cost containment, it seems, has been most successful in the most centralized systems; low overhead costs because of uniform administration and the imposition of country-wide fees and tariffs played an important role (e.g. in Taiwan). The complexity of the Swiss model reflects in its rising costs. Within a few years, Switzerland reached the world top of health expenditure after the US.

At the two extremes of the range of options considered are full privatization of health insurance and provision (considered by Chile, Singapore, Switzerland and The Netherlands) and nationalization (considered by Chile). In the end, no country has fully privatized or fully nationalized its entire health care system. After considering alternatives, Israel extended its Bismarckian model of employment-based insurance to cover the entire population, but left the responsibility for administering the scheme in the hands of the existing of sick funds. It also introduced choice of fund for the insured. Singapore, despite 140 years of British rule and influence, never went Beveridgean but instead emphasized individual over state responsibility and encouraged private sector participation. Taiwan nationalized its health insurance but the provision of health care services remained predominantly private. During the military regime of 1974-1991, Chile shifted towards private health insurance. After the restoration of democracy, it strengthened the public sector and sought to impose strict rules on the private sector to counteract the problems of risk-selection. Over four decades, The Netherlands reform debate shifted from considering a fully nationalized health insurance with state controlled health care provision (based on regional planning) towards market-oriented options. In 2006, it implemented a new insurance model that, like the Swiss one, combines public and private elements. Switzerland took the lead in experimenting with a new health insurance model that combines public rules with private insurance administration (somewhat similar to the Dutch scheme of 2006). The model offers basic coverage to all, with the possibility to opt out to alternative schemes with different financial conditions. It kept the existing mix of public, and both not for profit and for profit providers.

Not only the direction, but also the speed of implementation of reforms varied widely. In the mid-1990s, after carefully considering alternatives, Taiwan opted for a nation-wide public health insurance scheme, by far the simplest model for universal coverage and uniform administration (and thus, as experience has shown, with low administrative costs). It implemented the model in a very short time span. With similar speed, Singapore put a complicated mix of private (but mandatory) savings schemes and public safety net funding in place. It successfully implemented an ingenious financing mechanism that, combined with public subsidies for primary care and hospitals, assures that everyone has reasonable access to basic medical services. Singapore first wanted to privatize all of its hospitals, but, faced with public dissatisfaction, the government reversed its course within a few months. It retained the hospitals and other health facilities under government control and integrated hospital and outpatient services under broader governance structures. Quality of care improved, but it came at higher costs. Singapore is an example of a country where a strong central governments can design and implement (and rapidly adjust) major policy change without much opposition from organized interests. Taiwan has seen a rise in political opposition and citizen empowerment in recent years. Governments of countries with “older” models in place, like Chile, Israel or The Netherlands, have had a much harder time change the system in the face of opposing stakeholders. In fact, both Israel and The Netherlands (and to a lesser degree, Switzerland as well) have neo-corporatist policy traditions, the model that assumes that government shares the responsibility for social policy with other organized stakeholders in society. That tradition also provides ample veto power to stakeholders who feel that proposed change will negatively affect their positions. In none of the countries of this study, organized citizens or patients played a dominant role in the reform process even while governments often quoted expanding consumer and patient choice as one of the main reasons for change. In several cases, broad popular support for existing social policy severely restrained governments’ possibilities to shift costs top patients, or forced policy-makers to adjust their course.

All countries have shifted, or are in the process of shifting, payment for hospital care from overall global budgets or per diem payments to some form of diagnoses-related groups (DRG) or case-based payment. The DRG model rarely covers all expenses as hospitals often receive separate funding for their capital investments and certain very expensive treatments. In all countries, self-employed health professionals receive fees for their services, often combined with additional payment for specific activities. Thus instead of a shift from one payment model to another, all countries have shifted to mixed methods.

Some countries studied the experience abroad before deciding on their reform course. Chile looked at the US for inspiration of its earlier reforms. Both Singapore and Taiwan did explicitly “shop around” for health reform models and considered the experience abroad as possible options before finally implementing two entirely different models. In The Netherlands, the 1987 “Dekker Committee” report has no references to other countries’ experience. The 2006 insurance of Holland resembles the Swiss model (but without the restraints of devolved administration). In fact, in the early 2000s Dutch policy-makers and politicians had visited Switzerland and were clearly impressed with what they saw (or wanted to see).

One common experience is that the labels used in the international reform debate do not always reflect reality. For example, Singapore is often quoted as the country that successfully introduced individual savings accounts to pay for medical care. In fact, those accounts only count for a modest share of total health care funding as government subsidy and employers' mandatory contributions are more important. Moreover, there are several forms of cross-subsidies to safeguard access to health care for lower income groups. The Dutch health insurance of 2006 initially was labeled as "private" but for different reasons, it ended as "public".

What are the lessons we can draw from that experience?

First, major change is rare. The cases of this study contain clear examples of "windows of opportunity" for change (Kingdon 1984). For example, the confluence of political willingness to change, popular perceptions of the need to reform and the availability of reform options that fit the national context, created a fertile ground for success in Taiwan and Singapore to implement major reforms. Israel shares some of the neo-corporatist features of the social policy arena with Germany, Switzerland and The Netherlands. This model traditionally provided organized interests veto power to thwart or slow down change proposed by government. In The Netherlands, the erosion of some of the institutions that traditionally dominated social policy-making (and offered ample opportunity for organized stakeholders to block change) combined with a strong position of the new governing coalition dominated by the Christian Democratic Party allowed for a surprisingly rapid passage of reform law in 2006.

Second, values matter. Over time, dominant cultural orientations or values in society have shaped political and other institutions that serve to channel interests, but reversely, such institutions themselves shape values as well (Marmor, Okma and Latham 2006). For example, the Canada Health Act of 1984 (CHA) expresses general support for universal access to health care for all Canadians. Over time, CHA itself has become a symbol of national unity, itself adding to the sense of common values in Canada. In many countries, there is strong popular support for old age pension schemes and health care (perhaps even more than for unemployment and disability benefits). Everywhere, strong popular support for government-sponsored (not necessarily government provided) arrangements that safeguard universal access to health care has limited options for governments to shift too much of the financial burden to families.¹⁶ In a way, Singapore is an exception: an entitlement culture has not taken root. Government has successfully coaxed the highly disciplined, rags-to riches immigrant population to assume greater responsibility for its own health care. Mitigated by government subsidies, health care financing has shifted to private pockets without much fuss. Singapore's Medisave scheme appealed to traditional Asian values by identifying the family rather than the state, as the basic unit of solidarity and risk pooling.

Third, institutions matter. In a narrow sense, political institutions as defined as the political decision-making structure are crucial for enabling not only reform, but also the speed of change, for example in Singapore and Taiwan. In contrast, the particular institutional configuration of the Swiss federalist tradition has limited the range of options available for policy-makers. In a wider sense, including more organizations in society (and generally accepted practices), institutions have been important in explaining slow policy change in Israel and The Netherlands, with powerful stakeholders thwarting or slowing down reform efforts. Certain policies, once in place, can create their own

constituencies (Pierson, 1994). For example, old age pension schemes and social health insurance have become popular in many countries. The experience in The Netherlands shows that beneficiaries (in the case of health care, patients and their families and providers) will resist shifts in financial burden by increasing patient cost-sharing or delisting entitlements.

Fourth, reforming health care systems is not a one-shot effort. Most countries have adjusted their reform pathways when outcomes did not meet expectations. In all cases, there was a need for “after reform maintenance”. Facing unexpected and unwanted side effects, public dissatisfaction and strong opposition by organized stakeholders, governments had to adjust policy, and in some cases, reversed their policy course or abandoned policies altogether. In fact, “after reform maintenance” seems to be a more or less permanent feature everywhere. Both endogenous and exogenous factors contribute to this process of permanent change. The main actors in the health system anticipate strategically and adjust to new realities. Innovation in medical technology has improved the quality of care and expanded treatment options, but it also has driven up costs. New managerial ideas and information technology affect the organization and governance of hospitals and health facilities. Unexpected and undesired outcomes may force governments to adjust their course of reverse earlier steps. External fiscal strains and budget pressures restrain the availability of public funding.

Sixth, country categorizations do not fit easily. It is hard if not impossible to design or apply any meaningful categorization of countries or entire health care systems. Countries face similar challenges and options, but differ greatly in the direction and speed of implementing social policy change because of country-specific contextual factors. This study shows common problems and policy options, common system elements and a common range of policy instruments and measures considered, but there is no clear pattern of the constellation of those system elements before or after the health reforms. It thus may be more important to focus on system elements than on entire countries or “health care systems”. It is easier to categorize (or characterize) programs and policies than an entire country’s health arrangements. Moreover, the level of programs and policy measures offers a realistic laboratory of policy change rather than (announced) health system reform at the national level. For example, the slow implementation of the DRG-based payment of hospitals in Israel and The Netherlands contrasts with the rapid speed of introducing similar change in Singapore (where DRG payments took only one year to roll out). Israel’s successful experience with defining the entitlements of the social health insurance (or “explicit rationing”) stands out as a policy experience not shared by other countries.

And finally, despite the rhetoric of retrenchment, consumer choice and market competition, there has been more rather than less government action almost everywhere. Nowhere did governments give up their regulatory authority over health care, even in cases where they strongly supported markets and consumer choice as instruments to allocate resources. Some countries developed new instruments for monitoring markets and informing consumers, but kept the old ones for controlling public (and sometimes private) expenditure, for example by delisting of entitlements from social insurance, imposing budgets, user fees and changes in the mix of payment methods.

Tables

Table 1 below shows that surface-wise, Chile is the largest country of the group and Singapore the smallest. Taiwan has the biggest population, Singapore the smallest. Population density is by far the highest in Singapore, followed by The Netherlands and Israel. Switzerland has the highest average income (and the highest mountains), with The Netherlands and Singapore second and third. In the early 2000s, Chile and Taiwan had the highest economic growth rates while the economies of The Netherlands and Switzerland were lagging behind. The large differences between the national income per person measured in current US dollars and in “purchasing power parity” illustrates that it is not easy to compare patterns of health spending across nations without taking real family incomes into account. The PPP amounts show much smaller income differences between the countries than the plain dollar amounts. Similarly, the amounts of health spending per person usually shown in international statistics can underestimate (or overestimate) what those amounts can buy for a family.

Table 1: Size, Population, Income and Economic Growth in Chile, Israel, Singapore, Switzerland, Taiwan and The Netherlands, early 2000s

Statistic	Chile	Israel	Singapore	Switzerland	Taiwan	Netherlands
Size (1000 square km)	757	22	0.7	41	36	42
Population, 2005 (millions)	16.1	6.8	4.2	7.4	22.9	16.3
Population density, 2005 (people/sq. km)	21.8	319.9	6301.6	185.9	63.6	483.2
Share of population in urban area, 2005 (%)	87.6	91.6	100	75.2	63.2	80.2
Economic growth 1990-99 (%)	6.6	5.3	7.7	1	8.7	2.9
Economic growth 2000-04 (%)	3.7	0.8	2.9	0.6	3.5	0.5
GDP per capita, 2005 (US\$)	6,040	18,580	26,620	55,320	15,036*	39,340
GDP per capita, 2005 (PPP)	10,610	23,770	27,370	35,660	28,552	29,500

* 2004

Source: World Bank, *World Development Indicators 2006*, Washington: The World Bank, 2006. Central Intelligence Agency, *CIA World Factbook 2005*. <https://www.cia.gov/library/publications/the-world-factbook/index.html>. Department of Health, Republic of China, 2005 Taiwan Public Health Report, Department of Health, R.O.C. (Taiwan), 2006. Department of Health, Republic of China, 2005, Health Care Statistical Trends, Department of Health, R.O.C. (Taiwan), 2006.

Table 2 shows large variations in health care spending, inputs (as an example, the numbers of health professionals and hospital beds) and health outcomes (life expectancy and child mortality) across the six countries of this study. Switzerland has the highest GDP share of health expenditure as well as the highest amount per capita, followed by The Netherlands. The lowest is Singapore, followed by Chile and Taiwan. Thus Singapore is the “exception” of the close statistical relation that seems to exist in the OECD world between income level and health spending. There is not that much variation in life expectancy; clearly, as many other studies have shown, health spending does not explain variations in health outcomes. The data also illustrates that life expectancy or child mortality—commonly taken as measures of the quality of health care—are not closely related to spending levels or numbers of health professionals. All countries saw the average life expectancy of the population go up and child mortality go down in the 1990s. The share of public spending in total health expenditure ranges between thirty-for (Singapore) and seventy (Israel). But the terms “public” and “private” are sometimes misleading as government regulation severely restricts private actors in several countries.

Table 2: Health Expenditure, Health Care Professionals and Health Profile of Chile, Israel, Singapore, Switzerland, Taiwan and The Netherlands, 1980-2004

Statistic	Year	Chile	Israel	Singapore	Switzer-land	Taiwan	Netherlands
Total health expenditure (% GDP)	2000	6.3	8.5	3.6	10.4	5.7	8.0
	2004	6.1	8.7	3.7	11.5	6.2	9.2
Health expenditure per capita (current US\$)	2000	307	1,605	820	3,562	794	1,925
	2004	359	1,534	943	5,572	908	3,442
Public expenditure as share of total (%)*	2000	47.9	71.8	35.4	55.6	60.6	63.1
	2004	47.0	70.0	34.0	58.5	64.2	62.4
Physicians per 1,000 people**	2000-2003	1.1	3.8	1.4	3.6	1.4	3.1
Physicians, nurses and midwives per 1,000 people**	2000-2003	1.7	10.3	5.6	12.1	5.8	16.7
Life expectancy at birth (years)	1980	69.3	73.9	71.5	75.5	n.a.	76.7
	1990	73.7	76.6	74.3	77.2	74.5	76.9
	2000	76.9	79.0	78.1	79.7	75.6	78.0
	2005	78.2	79.7	79.7	81.2	77.6	79.3
Infant mortality rate (per 1000 births)	1980	35.0	16.1	11.7	9.1	n.a.	8.7
	1990	18.0	9.9	6.7	6.8	8.0	7.2
	2000	10.0	5.8	2.9	4.9	5.7	4.6
	2005	8.0	5.0	3.0	4.0	5.0	4.0

*Although financed by means of (income independent) community-rated premiums for private health insurance, in international comparisons mandatory health insurance expenditure is usually included for Switzerland and The Netherlands in the share of public expenditure.

** most recent year available

Sources: World Bank, *World Development Indicators 2006*; OECD Health Data 2005; Taiwan Department of Health, Office of Statistics, National Health Expenditures 2004, Taiwan, R.O.C.: Department of Health, 2006; Department of Health of Republic of China, 2005 Taiwan Public Health Report, Department of Health, R.O.C.(Taiwan) 2006; Department of Health of Republic of China, Health Care Statistical Trends, Department of Health, R.O.C. (Taiwan), 2006; Cheng, 2003.

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¹ This contribution is the result of an international collaborative effort. The authors share the introduction and general conclusions, but the country experts wrote the country pictures. Thus Kieke Okma and Hans Maarse wrote the section on Dutch health reform, Tsung-Mei Cheng on Taiwan, David Chinitz on Israel, Luca Crivelli on Switzerland, Meng-Kin Lim on Singapore and Maria Eliana Labra on Chile.

² One important methodological issue is the need to carefully define terms and concepts. That seems to be a superfluous and self-evident remark, but many policy debates (and studies) are clouded by fuzzy terms. For example, in the last decades the term “health care reform” has appeared in numerous articles, journals, papers, books, conferences and academic meetings. However, few if any clearly define the term “reform” (Marmor and Okma 2003). 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.

³ “Governance”, another example of a conceptually fuzzy term, is a rising star in the terminology of today. Basically, the term refers to the administration of health insurance and health care. Interestingly, it has traveled from government to the corporate sector and back again to the public sector (Okma 2002, see footnote 14 and 18). During this migration, it also shed its neutral meaning and took on a normative connotation under the label of “good governance”. In this contribution, we take “governance” in a neutral sense: administration (both public and private) of health services and health insurance. We characterize governance styles by looking at the ‘dominant cultural orientation’ and dominant welfare orientations that affect the style of social policy making in each country.

⁴ One question we have not addressed extensively in this paper is what counts as “small” or “medium” country. Most international comparative studies take one or more of the world’s large countries as the main comparator: the US, the UK, Canada, Germany, France and sometimes other large OECD member states. We use the term “small and medium sized” to indicate countries that clearly do not belong that group. In the introduction of his grand oeuvre *Rich Democracies*, Harold Wilensky addresses the issue of the size of countries. He argues that rather than actual size in terms of population or geography, it is the complexity of administration that matters (Wilensky, 2002).

⁵ Qualitative research by Chinitz indicates that Israeli physicians spend up to 10% of their time engaged in quarrels with sick fund managers over these points. The physicians often win the argument, but the organizational consequences in terms of efficiency and morale are significant.

⁶ For an updated general presentation of the Swiss health care system see OECD 2006.

⁷ It is important to note that until the Revised Health Insurance Law of 1996, health insurance was optional at the federal level. Before 1994, four cantons had made affiliation to a health plan mandatory for the entire population, and eight cantons for special population groups like low-income families or foreigners.

⁸ As they are private (and governed by private law), the supplemental insurances face less government control than the basic coverage. Insurers can impose more restrictions. In practice, however, most people do not clearly distinguish the two and the supplemental coverage may influence the choice of basic plan.

⁹ Those low overhead costs compare to other programs run by government, for example the Medicare or Veterans’ health Services in the US. Those expenses are generally much higher for private health administration –some studies even suggest that those overheads cause twenty-four percent of total health spending in the US (Woolhandler, Campbell, and Himmelstein 2003).

¹⁰ Until 2006, eligibility to social health insurance was limited to about 60 percent of Dutch population; almost all of the remaining 40 percent of population insured with either work-related group insurance or individual health insurance.

¹¹ There is some dispute over the question whether it should be labeled public or private --that question has not yet been tested by the European Court of Justice, the only authority that can decide on that matter.

¹² Interestingly, for this purpose, over 40% of the Dutch population qualifies as 'low income'. In 2005, the Tax Department hired over 600 extra staff to administer the subsidies including a monthly income check of all applicants. In 2007, the Health Ministry announced plans to simplify that administration.

¹³ Since national competition law based on European law prohibits market collusion, Dutch health care providers have had to abandon their long tradition of collective bargaining between national associations of insurers and providers over fees and tariffs (in Germany, that traditional neo-corporatist model is still in place). Nowadays, hospitals, general practitioners and other independent providers have to sit down and negotiate individually with all the health insurance they seek contracts with; and health insurers no longer have to contract with every provider.

¹⁴ Actually, it is more correct to say that the reforms increased choice of health insurer and decreased choice of provider; selective contracting means that not all providers will get contracts, and some patients thus face a restricted choice.

¹⁵ Paradoxically, the introduction of market competition has in some cases actually reduced patients choice of provider. For example, after the abolishment of mandatory contracting in the Dutch sick fund system in 1991, the funds no longer had to contract all independent health professionals. Thus, while the Dutch citizens have more choice of health insurer, their choice of provider may be curtailed because of selective contracting by their health insurer.

¹⁶ As we have observed elsewhere, values can direct policy-making into a certain direction, or exclude certain options, but they do not tell policy-makers exactly what to do (Marmor, Okma and Latham, 2005).