

The European Experience in Social Health Insurance

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Summarized here are the results of a study, from the European point of view, of the main trends in social health insurance as exemplified by the system of six European countries—from the beginning of the nineteenth century to the present day. The systems are reviewed briefly with respect to their evolution, coverage, benefits, financing, and relationship with the providers of medical care.

THE HEALTH INSURANCE SYSTEMS of the six original Common Market countries—Belgium, Federal Republic of Germany, France, Italy, Luxembourg, and the Netherlands—are studied here. These systems are less well-known to Americans than, for instance, those of Great Britain and Sweden. Yet their experience tells much about the problems of organizing such a system, about the various approaches to financing the program, and about relationships with the providers of care. The health insurance history of these countries may prove helpful to those studying developments in the American system. For each of the six countries discussed, table 1 gives summary information on the administrative body of the health insurance system, the covered population, and the medical benefits provided.

THE SOCIAL SECURITY CONTEXT

Health insurance in continental Europe has taken its structure from the compulsory social insurance plans that developed with industrialization in the second half of the nineteenth century. One should bear in mind the impact of industrialization. It broke up the pattern of family life with its new emphasis on work away

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from the home, and the accompanying high mortality made the nuclear family undependable as a means of economic security. It also greatly increased the risks of illness and injury and left the individual no way to protect himself. Wages were too low to permit sufficient savings or to pay for commercial insurance. The only way to secure some protection against the so-called "social risks" was to share the burden and risks with others by the creation of a mutual aid fund. Such mutual aid societies had already had their beginnings in the first half of the nineteenth century in most European countries, but their membership was small and their benefits limited.

Operating on a local level, these funds raised very small contributions from their members and consequently offered very low benefits. Originally, these benefits were only intended to support the family in case of the breadwinner's illness. No demand for health care benefits existed, as available health services were very limited. After some time the funds started paying small sums for a doctor's services or for medicine—always considered as complementary benefits. Later, such benefits outgrew the original sickness benefits in importance, but they have remained linked together to the present day. Separation of the two types of benefits occurred first in the Netherlands between World War I and World War II because of an organizational dispute. In Belgium, where social security reforms were made in 1963, the two branches were separated financially, although they are still administered by the same funds. In the other European systems discussed here, health care and sickness benefits are still amalgamated.

Health insurance in Europe is thus considered as a specific type of benefit, linked to sickness benefits under the overall social security system. The Italian proposal for a national health service is at present the only attempt in continental Europe to move completely away from this linking of the two types of benefits.

ORGANIZATION OF THE SYSTEMS

The original voluntary mutual aid funds of the midnineteenth century have left their mark on the organization of social health insurance in continental Europe until today. This is a surprising fact, as these funds were small, voluntary, and local societies, and the present insurance organizations are large regional or national compulsory institutions.

The sickness funds of the past century—all of them financially weak—had to protect themselves against the risks of epidemics and of economic depressions—both extremely frequent in the nineteenth century. The funds did this in two ways. First, they formed regional and national federations and confederations, which in the beginning held a purely consultative and representative role but after a while operated as a clearing house of the risks within their field. In some countries (Belgium, France, Italy), the confederations took over the insurance responsibility and reduced the role of the member funds to that of payment offices. In other countries, the local funds gradually merged into larger units.

Apart from this, the funds sought the support of strong and influential organizations such as trade unions and political parties. This trend never developed on an overall basis. In most European countries, however, several of the largest sickness funds are still related to some extent to trade unions or to political organizations.

From Private to Public Institutions

From the midnineteenth century, public authorities started considering health insurance as a matter of public interest. The activities of the sickness funds were officially recognized and governed by legislative statutes. The first statutes—around 1850—failed because the governments sought to control these funds, rather than to encourage them, and few funds actually applied for recognition. Legislation enacted later provided more suitable statutes, and during the 1890's the funds generally received official recognition.

After World War I, the funds were shifted from private organizations to public institutions. Italy was the first country where all sickness funds, created under the *Legge Sindacale* of

1926, were to be considered as public institutions. Shortly afterwards, the German act of July 5, 1935, changed all existing and newly created sickness funds into public institutions. There has been some dispute as to the private or public nature of the French *caisses primaires*, created by the 1928-30 reform, but no one doubts their public character any more. In the Netherlands and Belgium, the funds have preserved their private status. The insurance aspect of the funds, however, has actually been shifted to public institutions originally intended to control them but now bearing the insurance responsibility (the Sickness Funds Council in the Netherlands and the National Institute for Health and Disability Insurance in Belgium).

As the program has evolved in some countries the old mutual aid funds have been put aside and entirely new institutions have been created for administering social health insurance. In Germany in 1884, for example, the insurance was administered mainly by newly created official funds. The old mutual aid funds could be maintained under the compulsory system only if they changed their name and complied with certain obligatory rules. In France in 1945, the insurance program was administered only by the new *caisses primaires* and *caisses regionales*, created by the law.

Even in these extreme cases the newly created funds took over the structures of the private mutual funds and their method of operating. The new funds were managed in the old way—by committees with equal representation of the employers and the employees, sometimes elected (as in Germany), most of the time designated by the employers' associations and the trade unions.

In every reform of health insurance and of social security in general the governments have always tried to preserve as much as possible of the existing organizational structures. The insurance institutions of today therefore consider themselves the inheritors of a tradition more than 100 years old. These strongly vested structures form a strong barrier against certain fundamental reforms.

COVERAGE

As already noted, the origin of the European health insurance system lies in the mutual aid

societies of the nineteenth century. These funds were created to care for the most obvious needs of the most needy groups in the population. The group of the poor coincided almost completely

TABLE 1.—Selected provisions on coverage, benefits, and administration of health insurance systems, six European countries, 1971

Country	Coverage	Medical benefits	Administrative organization
Belgium.....	Employed persons (must enroll with mutual benefit society, or else with public auxiliary fund). Pensioners also covered for medical benefits. Special systems for the self-employed, miners, railway employees, and seamen. Also: students, handicapped persons. Voluntary insurance for "all not yet protected persons."	Cash refunds of part or all of medical expenses. Includes general and specialist care, surgery, hospitalization, medicines, laboratory services, maternity care, dental care, nursing, and appliances. Insured normally pays for services and is then reimbursed by society of which he is a member up to 75% of amount listed for such services in negotiated and approved fee schedules. 100% reimbursement for ward care in hospital, specified serious diseases, specialist services, maternity care, appliances; and for invalids and pensioners. Service benefits provide for drugs and hospital care. Unlimited duration.	Ministry of Social Welfare, general supervision. National Social Security Office, collection of contributions. National Sickness and Invalidity Insurance Institute, coordination of program. Agencies paying benefits: (1) about 2,000 approved private mutual benefit societies, federated in 5 national unions and (2) district offices of public auxiliary fund for persons not belonging to mutual society.
Federal Republic of Germany.	All wage earners. Salaried employees with income below certain level. Pensioners also covered for medical benefits. All covered persons required to become members of appropriate sickness fund. Special system for miners. Voluntary insurance for self-employed with incomes lower than a certain level. Voluntary continuation of insurance for salaried employees exceeding the salary limit.	Service benefits provided to patients by doctors, hospitals, and druggists under contract with and paid directly by sickness fund. Includes general and specialist care, necessary hospitalization, prescribed medicines (maximum fee of 2.50 Deutsche marks per prescription), dental care, attendance of midwife or doctor at confinement, specified appliances, and travel expenses (some funds provide additional benefits). Unlimited duration, except for hospitalization (78 weeks in a 3-year period).	Federal Ministry of Labor and Social Affairs, general supervision. State Insurance Office in each State, enforcement of laws and regulations in State. Sickness funds, administration of contributions and benefits for members. Includes about 2,000 local, establishment, occupational, agricultural, and miners' funds. Managed by elected representatives of insured persons and employers, and united in State and national federations.
France.....	Nonagricultural employees (general system covering about 70% of employees). Pensioners, unemployed, and students also covered for medical benefits. Special systems for agricultural employees, miners, railway employees, public utility employees, seamen, public employees, nonagricultural self-employed, and agricultural self-employed (medical benefits provided under general system for some groups). Voluntary insurance for all other residents.	Cash refunds of part of medical expenses. Includes general and specialist care, hospitalization, laboratory services, medicines, dental care, maternity care, appliances, and transportation. Insured normally pays for services and is then reimbursed by local sickness fund for 75% of amounts provided for such services in negotiated and approved fee schedules (reimbursement rate for some services up to 100%, while actual rate in absence of agreed schedule may be below 75%). Service benefits in public hospitals and for certain pharmacists. Unlimited duration.	Ministry of Social Affairs, general supervision. National Sickness Insurance Fund, coordination of regional funds and financial equalization; bipartite governing body. Regional Sickness Insurance Funds, coordination of local fund; bipartite governing bodies. Primary (local) Sickness Insurance Funds, registration of insured, payment of cash benefits, and refunds of medical expenses; bipartite governing bodies. Contributions collected by joint collection agencies. Private mutual benefit societies may act as local pay offices.
Italy.....	Employed persons. Pensioners also covered for medical benefits. Special systems for seamen, liberal professions, journalists, public employees, self-employed artisans, merchants, tenant farmers, etc.	Service benefits generally provided by doctors and hospitals under contract with and paid directly by Institute. Includes general and specialist care, hospitalization, prescribed medicines, 50% or more of cost of dental care, attendance of midwife or doctor at confinement, specified appliances, and spa treatment; duration limited to 180 days in a year. Tuberculosis care includes curative and convalescent care in sanatorium, post sanatorium care, and rehabilitation: unlimited duration. For certain groups (certain self-employed and civil servants): cash refunds.	Ministry of Labor and Social Welfare and Ministry of Health, general supervision. National Sickness Insurance Institute, administration of sickness and maternity program through regional and district offices; managed by a quadripartite governing body including medical association representatives. National Social Insurance Institute, administration of tuberculosis program. Institute operates own sanatoria. Various specific insurance institutions for different population groups.
Luxembourg.....	Employed persons, with separate systems for wage earners and salaried employees. Pensioners also covered for medical benefits. Persons covered must become members of sickness fund; voluntary membership permitted for certain groups not covered compulsorily. Special systems for railway employees, self-employed artisans, self-employed farmers, and liberal professions.	Service benefits ordinarily provided by doctors and hospitals under contract with and paid directly by sickness funds (salaried employee funds operate mainly on 80% cash-refund basis). Includes general and specialist care, hospitalization, laboratory services, maternity care, transportation, dental care, and prostheses, and 75-85% of cost of medicines (some variation among funds). Unlimited duration, except for hospitalization (26 weeks). Higher coinsurance for higher income groups and for self-employed.	Ministry of Labor and Social Security, general supervision. Regional and establishment sickness funds, administration of contributions and benefits for wage earners. Other funds administer program for salaried employees, civil servants, self-employed, and farmers. Funds managed by elected committees composed of representatives of insured persons and employers.
Netherlands.....	Employees earning not more than a certain wage limit. Must enroll in approved sickness fund. Voluntary coverage for medical benefits available to other persons and pensioners, if annual income below specified levels. Special systems for miners, railway employees, seamen, public employees, and certain other groups. General coverage of all residents for "special medical care costs."	Service benefits provided by doctors, hospitals, and druggists under contract with and paid directly by sickness funds. Includes general and specialist care, hospitalization, laboratory services, medicines, dental care, maternity care, appliances, and transportation. Patient shares cost of sanatorium care, artificial limbs, and transportation. Unlimited duration.	Ministry of Social Affairs and Public Health, general supervision. Approved sickness funds, administration of medical benefits; supervision by tripartite Sickness Funds Council. About 115 funds now operating. Industrial associations, administration of cash benefits within each industry.

with the group of employed workers. The poorness of employed workers was seen as an inevitable structural problem called "the social problem." Even today the term "social" in *social* security and in *social* health insurance still encompasses this problem.

Until the end of the nineteenth century, membership of the health insurance funds was voluntary. With the appearance of compulsory insurance,¹ it was necessary to make it clear who was going to be protected and who was not. Not surprisingly, this new type of insurance applied only to the employed workers of industrial enterprises. White-collar workers were only involved if their wages were below a certain wage limit. Such a limit was not judged necessary for blue-collar workers, as they obviously were all poor.

Structures can sometimes be very rigid. Though employed workers are not necessarily poor today and the poor are not necessarily employed workers, compulsory health insurance in the Netherlands and in Germany is still restricted to employed workers under a certain wage limit. In Germany the limit has applicability only for white-collar workers; it has been raised several times in recent years and in 1972 was linked to general wage levels. In the Netherlands the wage limit still applies to all employed workers. In both countries, compulsorily insured workers whose wages come to exceed the wage limit can continue their insurance on a voluntary basis, and public servants and the self-employed whose income is below the wage limit can also enroll voluntarily.

In both Germany and the Netherlands the abolition of the wage limit is strongly opposed by the medical profession, since it might mean the loss of some of their private patients, and by the commercial insurance sector, which sees the possibility of severe restriction of its field of action.

In four other countries, a wage limit for compulsory insurance either never existed (Italy, Belgium) or was abandoned at a certain stage of the development (France 1935, Luxembourg 1951). Yet social health insurance continues to be considered specifically for employed workers in these countries. All of them developed a so-

called "general" scheme especially designed for the needs of the employees of commerce and industry. In the period before World War II, special groups of employed workers were gradually included in the compulsory insurance system. This development often gave rise to the creation of separate schemes, especially in France and Italy, for such groups as seamen, coalminers, and employees of transport industries (railroads and later airways).

The inclusion of the self-employed, who had always been very hostile to the idea of social security, was an important development of the 1950's. The movement started in Italy for some groups even before World War II; it extended rapidly to France, Luxembourg, and Belgium and—in 1972—to Germany. Independent farmers were generally the first to be included (Italy 1945, France 1962, Luxembourg 1962, Germany 1972). Generally, protection was extended to the other self-employed within 10 years (Italy 1960, Belgium 1964, Luxembourg 1964, France 1966).

By the end of the 1960's, practically the entire working population was covered by compulsory health insurance in a number of European countries. Attention was then focused on coverage for those without a connection with employment. The first to be covered were those no longer working—retired workers—who were permitted to join the insurance plan of their previous occupation. Then came those not yet employed (students) and those involuntarily out of the working force (the unemployed and the handicapped); these groups were usually included through special provisions in the general scheme for employed workers.

Basically, health insurance has remained linked to employment, with a number of separate plans for specific occupational groups. Nonemployed persons obtain protection under the system either as members of an employed worker's family or as his dependents or are included under a special provision in the law. Many administrative problems arise from such arrangements that make it difficult to know who is insured under which plan. What is more important, inequitable treatment of some groups is the inevitable consequence. If the same benefits are provided by different insurance plans, with different premium rates and different conditions for obtaining the benefits, one plan is likely to be

¹In Germany, compulsory insurance plans were in existence as early as 1845, well before the National Insurance Act of 1883.

more favorable than the other. If the insured person can choose freely between the plans, an element of competition arises; if the plans are compulsory and the individual is assigned to a plan less favorable than another, injustice occurs.

These problems were already foreseeable to those who were planning the reform of the European social security systems during and after the Second World War under the influence, mainly, of the British Beveridge plan. They proposed that the social security system would provide for every citizen in the same way. Nearly 30 years later, this proposal has not been fully realized in any of these six countries. Only in the Netherlands, and for a limited range of benefits, does a general insurance plan cover all residents (general insurance for special medical care costs). In Italy, plans are being worked out for a national health service that will offer complete protection for all residents on an equal basis from 1980 on.

FINANCING

Health care can be financed from three sources—compulsory savings (contributions or premiums), general tax revenue, and payments for service by the recipients of the care. The early mutual aid societies in Europe were created around the idea of financing benefits out of voluntary savings. The savings of the members of these societies were seldom sufficient, however, to maintain the financial balance of the funds, especially in the nineteenth century. By the end of that century, therefore, the public authorities started to subsidize these aid societies. In most cases, also, part of the cost of care was left for the patient to pay. This mixed structure of financing still stands.

Sources of Financing and Their Differing Roles

“Compulsory savings” (contributions or premiums) vary greatly in the countries that use this method of financing the health insurance system. These differences are illustrated by the figures in table 2 for the general scheme for employed workers in industry. For the principal plans for the self-employed, similar or even greater differences between the premiums appear. The maximum premiums for French farmers and

TABLE 2.—Social health insurance contributions, six European countries, January 1, 1972¹

Country	Contributions as percent of gross wages			Wage limit
	Total	Employer	Employee	
Belgium.....	5.75	3.75	2.00	306,600 BF
Federal Republic of Germany ²	7.00	3.50	3.50	18,900 DM
France ²	12.30	9.45	2.95	21,960 F
Italy ²	12.91	12.78	0.13	-----
Luxembourg ²	4.90	1.60	3.30	235,500 Lux F
Netherlands.....	9.70	4.95	4.75	15,860 f.

¹ Under general scheme for employed workers in industry.

² Contribution figures calculated from amalgamated contributions covering more than one branch of social insurance.

other self-employed persons, for example, are at least 10 times higher than the corresponding Italian premiums.

The role of general revenue in financing health care through social health insurance has expanded with time in most European systems. Only France and Germany have held to the idea that the insurance systems should be self-supporting. In these countries the government pays only for the care of specific groups, such as students, unemployed workers, and farmers.

In the other countries, government subsidies have gradually come to play an increasing role. This source accounts for more than 40 percent of the program costs in Belgium and for 15–20 percent in Italy and the Netherlands.

The share of the cost of care paid directly by the patient also varies widely in these European systems. The countries fall into three patterns. In the Netherlands and Germany the program finances nearly all of the costs of care: German insured patients pay extra for only a small part of the cost of drugs, appliances, and prostheses; in the Netherlands the patients pay something for transportation, dental care, and prostheses.

Belgium and France represent the opposite situation, where the cost-sharing is rather heavy in both the regular and the special systems. Health insurance finances only 75–80 percent of the cost of current medical care (with a few exceptions). In many cases, moreover, the physicians are not obliged to use the insurance rates and the patient must pay the difference between the rates and the actual fee.

In Italy, the first type of financing is the one chiefly used in the schemes with “direct assist-

ance." In Luxembourg, except under the system for blue-collar workers, substantial deductibles or coinsurance payments are customary.

It is interesting to note that, with respect to this point, the present situation is like that when compulsory insurance was being introduced. The German act of 1883 already provided fully for medical care. Before the 1941 legislation in the Netherlands, physicians under contract with the funds were already providing care free of charge. When the program began in France in 1930, the rule was established that it would reimburse the patients for 80 percent of the fees charged; in 1945, Belgium adopted the principle that the patient must pay 25 percent of the fee himself. In all these countries, such provisions are practically unchanged today.

Yet fluctuations have occurred in the provisions on cost sharing, especially in the field of pharmaceutical products. For some reason—probably because drugs are bought directly by the consumers as food and other products are—the fear of overconsumption in this field has resulted in a tendency to increase the insured person's share of these costs. At the same time it was feared that high charges at the time of service would impose too heavy a burden on those who must use large quantities of costly pharmaceuticals. The European systems have thus changed the rules of the supply of pharmaceutical products frequently and in various ways. Certainly none of these six countries has found a satisfactory system as yet.

Problems of Program Deficits

In general, financing of these European health insurance systems cannot be regarded as successful, whatever the structure, since program deficits calling for emergency measures are common, occurring regularly if not every year. Whether the system is financed through general revenues or through compulsory premiums appears to be immaterial. Both are in fact income taxes, the one rising with the national income, the other with the level of wages (if not limited by the wage base). The cost of medical care rises quicker than both the national income and the level of wages. This phenomenon appears to be a movement that cannot and should not be stopped. The financing system generates its own deficits.

Many people, especially physicians, want to take care of the deficits by raising the patients' payments at the time of service. The advocates of such proposals suggest that this action would provide not only an additional source of finances but also control the abuse and overuse of care that are considered one of the causes of the program deficits. It is, however, very difficult to define abuse and overutilization. In addition, these phenomena account only for a very small part of the rise in the cost of medical care. At the same time, all thorough investigations have shown that increases in cost-sharing do not affect the consumption of medical care in a significant way. There is even reason to believe that high personal payments are considered by the patients as a mark of high quality of care—a reaction that reverses the role of price in the market economy. Insistence on such increases could prove a threat to the health of the public if it encouraged self-medication and kept the poorest groups of the population from making use of the available health care facilities when they need to do so.

Health insurance is an instrument to make the healthy pay for the sick. Cost-sharing makes the sick pay for their own expenses. It is contrary to the idea of health insurance itself. One should not speak of coinsurance but of non-insurance. Proposing an increase in these charges is admitting the failure of the health insurance system. This is more and more acknowledged in Europe now, and the trend is toward abolition of cost-sharing.

Trend Toward National Uniformity in Financing

The trend toward national solidarity in financing health care is also noteworthy. In the oldest of the systems—those of Germany and Luxembourg—regional as well as occupational barriers in the solidarity have been maintained, with the sickness funds conserving their financial autonomy. The systems of France and Italy have largely abolished limitations in financing but have maintained occupational schemes. The newer compulsory systems of the Netherlands and Belgium (1941–45) based the financial solidarity on larger groups of the population but maintained the principle of financing health care by

occupational groups. The most recent reform movements all point in the direction of abolishing divisions in the financing systems. The Dutch system of general insurance for special medical care costs (1967) was the first to introduce a financing system that imposes the same premiums on all individual incomes for the same benefits. The Italian proposal for a national health service by 1980 goes in the same direction.

BENEFITS

In the nineteenth century the European sickness funds were not institutions for organizing and financing health care. On a more or less regular basis, they granted health care benefits to their members, either by contracting with physicians and pharmacists or by paying small amounts of money when a member incurred medical expenses. They did not provide for all types of medical care. As a rule, however, the funds could supply as complementary benefits what was not provided under the compulsory scheme. Eventually, after these benefits were supplied for a long period, they were included in the compulsory insurance. Thus, today, most compulsory insurance schemes in Europe provide in fact a full range of medical care services.

In the 1950's, when the systems for the self-employed started to develop, a divergent evolution was apparent. Most compulsory schemes for self-employed workers at first covered only the so-called "heavy medical risks," leaving the current types of medical care to be financed by the insured person himself out of pocket or by private insurance. These systems have developed, however, in the same direction as the systems for employed workers. Protection for current care has been supplied by the funds as a complementary benefit and most of the members have subscribed to it. Gradually more and more types of care are being included in the "heavy" medical risks of the compulsory insurance program, and there is little doubt that eventually the systems for self-employed will provide the same complete protection as those for the wage earners.

In the light of the recurrent financial deficits of the insurance systems, proposals have been made to abolish the protection for "small risks." It has been argued (1) that the general level of income has become high enough to enable the

vast majority of the population to pay for current medical care out of their own means, and (2) that substantial financial resources would thus be freed to take care of the really serious needs that are in general insufficiently covered (long-term illness, rehabilitation, etc.). The tendency for program change in Europe is not in this direction. In all schemes where the small risks were not covered, they have gradually been included under compulsory insurance. One important factor is the actual impossibility of determining what exactly are "small risks." Every criterion used—the price of the individual service, the type of care, the type of supplier of care, the degree of inability to work, the cost of the treatment as a whole, etc.—leaves room for cases of hardship that preclude the use of the designation "small risk."

Limitation on Benefits

Will then the insurance in the future have to finance all types of care at any time by any supplier of care? Such an eventuality is obviously impossible. In the European area the tendency appears to be toward a limitation of the benefits according to standards of "rationalization" of the supply of medical care—that is, the insurance program will organize the financing of the medical services in such a way that services will not be paid for unless there are grounds for believing that they are reasonable and beneficial. Most systems, for example, will pay for specialists' care only if it has been prescribed by the family doctor. Pharmaceutical products or prostheses and appliances, and hospital care as well, will be paid for only if they have been prescribed by a qualified physician. Specific types of care (hospital care, orthodontia, prostheses, etc.) will have to be authorized by a second doctor, generally an appointed medical adviser of the funds. At the same time benefits will cover the complete cost, unless a supplemental payment is made when the patient calls for special requirements as a matter of his own comfort—if, for example, without medical necessity, he asks for a private room in the hospital or wants attendance at his home.

Rationalization in medical care is not yet clearly defined. The funds are being oriented, however, toward rationalizing health care through com-

puterized profiles of production and consumption of care, by type of provider and patient, as discussed more fully later.

HEALTH INSURANCE AND THE PROVIDERS OF CARE

There are three types of health insurance arrangements that affect the relationship with the providers of care:

(1) The first pays out specified sums of money to the members when they prove that a certain risk has been realized. This is the simplest type. In such countries as Belgium, Luxembourg, and France, the health insurance funds from the nineteenth century on had nothing to do with the medical profession, with the hospitals, or with the pharmacists. All providers of care were left entirely free to organize their profession or their trade in the way they preferred.

This type of arrangement has proved unsatisfactory in the field of health care. The insurance payments were of course meant to cover to a certain extent the usual fees and prices. The providers, however, knowing that their patients received certain reimbursements, tended to increase their fees and prices by about the same amount. This forced the funds to raise the rate of their payments in their turn, giving rise to a similar reaction with the providers of care. Under this system, a serious gap eventually arose between what the insured person had to pay for his care and what he received from the insurance system, with the result that the member could not be assured of reasonable protection for his premiums.

(2) Under the second type of insurance arrangement, the system, without interfering with the organization of the medical services, concludes agreements on payment rates with the providers of care. The insurance system wants to make certain that its benefits will cover all or a given percentage of the fees and the prices the insured person has to pay. It therefore must know what the costs are and make sure that a sufficient number of providers of care will apply these rates.

Establishing such a system is not an easy matter. Before a more or less generalized and workable plan can be worked out, a considerable length of time is needed (from 1930 to 1960 in France and from 1945 to 1970 in Belgium). The struggle to set up these systems went on in the midst of bitter conflicts between the medical profession and the government, including fairly large-scale strikes. A generation of doctors had to pass before opposition died down.

This kind of arrangement is not entirely satisfactory. Certainly, it is appreciated by the medical profession, since it permits a large degree of freedom for the profession while providing the economic

security of public financing. It does, however, tend to raise program expenditures, if the physicians are free to deliver any number of services of any type and to prescribe medical care and medicine without restriction.

(3) The only way for the system to acquire real control over expenditures and at the same procure real protection for its members is to have direct or indirect control over the organization of health care services. This third method is used by the kind of insurance system that organizes medical care for its members. The administrators of the fund do not, of course, make the diagnoses and prescribe treatment but either employ or contract with physicians and other health personnel. In addition, they own or contract for the facilities needed to provide all necessary care for the members.

Under this system, benefits do not consist of sums of money but the right of access to all essential medical care, either free or for a limited price. The agreements with the providers of care bear primarily not on the rates for fees and prices but on the care to be supplied by the system. This is an important difference. Suppliers in the second type of arrangement can sign agreements on rates of payment but can still refuse to treat insured patients; in the third type the supplier who contracts with the system commits himself to give all necessary care to its members. The agreements in the latter type of system also cover arrangements for paying for the care, and a variety of methods can be used. The important factor for this kind of system, however, is not the method of payment but the patient's guaranteed access to the care promised him.

The *third* type has been the concept of health insurance prevalent in the Netherlands, Germany, and Italy. Even in the period of voluntary insurance the funds provided their members with direct access to the care provided by the physicians and the pharmacists they employed or contracted with. The payment of insurance premiums was seen as a subscription, entitling the beneficiary to all possible and necessary care when he needed it. This kind of insurance system is not unlike the American prepaid group health care plans. Throughout their development, the systems of these three countries have maintained such arrangements.

In Belgium and France, as already noted, the original form of health insurance was the simple payment of sums of money to the insured when they incurred medical expenses. It took a long time and the solving of certain problems to switch over to the *second* type of insurance now predominant in these countries. But in the sectors where the increase in expenditure was

strongest, particularly for pharmaceutical products and for hospital care, both countries already in fact now apply the *third* type of insurance. For these sectors, special "third-party payment" agreements are arranged. Under such agreements, the bills of the pharmacists and the hospitals (in France including the doctors in public hospitals) are paid directly by the insurance fund to the provider of care; the patient has nothing to do with the payment, except for any supplement chargeable to him. The system in fact guarantees that the insured person will receive hospital care and pharmaceutical products free or for a limited payment at the time of service if he goes to a hospital or to a pharmacist that has an agreement with the fund.

Belgian and French physicians have always strongly opposed the third-party payment system. They see in it a limitation of the free choice of supplier of care for the patients. A closer consideration of the problem reveals that, in the countries with the other two types of insurance, limitation of the free choice of supplier also exists. In the group of systems that provide for direct access to medical care the limitation is formal in nature: The regulations of the funds oblige the insured person to choose his provider of care from among the contractants of the funds and stick to his choice for a certain period of time, unless a serious reason for changing exists. In the countries with reimbursement of medical expenses there is an economic limitation on the free choice: Since not all suppliers of care respect the set rates of the insurance system, the insured individual may pay more for receiving the same amount of reimbursement if he goes to one physician instead of another.

In reality, the freedom of choice is greatest in the countries where it seems to be formally limited. In Germany, the Netherlands, and Italy the vast majority of physicians cooperate with the social insurance systems; in Belgium and France, even if all physicians were to sign the agreements (and some do not), they have in many cases the right to exceed the fixed rates.

CONCLUSIONS

In the early days of health insurance in Europe, organization of the work of the medical

profession and other providers of medical care was scarcely affected by the existence of the funds. The insured were only a small minority of the patients—the traditionally poor—whom the physicians and the hospitals had to treat free of charge in any case. At the same time, the structure of the supply of medical care had very little influence upon the funds. The price of medical care and the demand for it were low.

With the rapid rise in the number of insured patients, as well as medical care costs, especially during the last decades, the problems of financing medical care through health insurance were sharply delineated. It became increasingly clear that no health insurance system could go on paying for all the medical care its members could want without raising expenditure levels beyond what the community was prepared to pay for.

As a first step the funds established certain conditions for entitlement to benefits, in order to prevent abuse. To what extent cases of abuse are prevented or found out by the control mechanisms is difficult to say. Certainly abuses still occur and the control of abuses has proved to be an unsatisfactory way to hold down rising medical care expenditures.

In addition, the funds undertook to restrict their commitments as far as possible to those essential to providing all necessary care, with the patient permitted free choice of the providers. Thus in certain countries, as already stated, the funds would pay only for the care given by providers who are under contract with the fund; in other countries the funds have limited their commitment to fixed fees and prices. In nearly all of the six countries a list of recognized drugs was drawn up, and previous authorization by a medical control officer of the fund became necessary for financing hospital care and prostheses.

As far as actual rationalization of the supply of medical care is concerned, some solutions have already been tried. Germany, which has the longest experience with compulsory health insurance, worked out a system of regularization of health care as early as 1930. All physicians wishing to cooperate with the funds had to be members of an association of the funds' physicians.

This association works out with the funds the total amount to be paid for the supply of all necessary care to the insured patients in a given period of time. When the agreement is concluded,

the fund knows how much it has to raise premiums to achieve its financial balance; the association knows how much it can divide among its members. The members bring in their bills for the services rendered to insured patients and copies of the prescriptions written. Special control committees of the association compare these accounts. Members who show remarkably high scores for the nature and cost of their services and/or prescriptions must justify their actions before the committee. If they cannot do so satisfactorily their share in the money is reduced accordingly.

A recent national agreement in France between the medical profession and the social health insurance system is a step in the same direction. Under that agreement the funds will assemble data on the average practice (services and prescriptions) of various types of physicians; control committees will then compare the data per physician with these averages and notify the physician if his activity diverges significantly from the average. If the physician fails within a certain period to justify this difference or to adapt his practice he may be struck out of the agreement sys-

tem. The agreement goes further: The medical profession will see to it that in every region a reasonable supply of all necessary types of services is assured; if this is done, the insurance funds will refrain from creating or subsidizing their own health centers and institutions of care; if not, the funds will feel free to fill in the gaps.

The German system has worked to a certain extent. Germany has the lowest cost per insured in Europe (much lower than that in France), yet it finances a larger share of health care costs than the French system does. This experience indicates that it is possible to influence rising costs of care through the method of financing used by the health insurance system.

Yet in this field the actual rationalization of the supply of care is still far away. The most serious problems remain in the area of hospital care, drugs, laboratory tests, etc. Health insurance developments in the United States will be closely observed by other countries in the expectation that, on the basis of more extensive research, the way to a workable and efficient system of rationalizing the supply of medical care will be found.