Project C3: Change in the state of health care systems in OECD-countries

Disciplines

Health economics, health science, health system research, political science

Background

The economic recession of the mid-1970s triggered the implementation of several cost containment measures in the health care sectors of "Democratic Constitutional and Interventionalist States" (DCIS). This, in turn, has stimulated greater activity in the field of international comparative health care system research **(Roemer 1977, Abel-Smith 1984),** that has intensified since 1985 when the OECD published, for the first time, a database of health system related statistics for each member State **(e.g. Alber 1988, Parkin 1989, Immergut 1990, Saltman et al. 1998, Mossialos et al. 1999).** This study builds on the results of these prior research efforts.

Research goals

The research goal of the C3 study is to describe and analyse changes in the state of health care systems in OECD States. This entails the analysis of country-specific and system-specific factors and the investigation of the consequences of change in terms of health care system performance and the legitimacy of States.

Main study hypothesis

The main research hypothesis of the C3 project is that, since 1970, a convergence can be observed in the health care systems of OECD countries. This convergence is characterised by a change from "Idealtypen" health care systems --- namely private health insurance, social insurance, and national health insurance systems --- towards a greater variety of “mixed” health care systems. It is thus hypothesised that the “corridor”, within which the health care systems of DCIS countries are located, is narrowing.

Project phases

The research project is comprised of three main phases:

- Phase 1 from 2003-2006: Description, 29 OECD-countries with macroindicators and three country-studies (Germany, Great-Britain, USA).
- Phase 2 from 2007-2010: Explanation, 29 OECD-countries with macroindicators and six country-studies (Germany, Great-Britain, USA and three more countries).
- Phase 3 from 2011-2014: Evaluation, 29 OECD-countries with macroindicators and six country-studies (Germany, Great-Britain, USA and three more countries).

The focus of phase 1 is the description of welfare state related changes in the health care systems of OECD countries that, since 1970, have been largely driven by profound changes in the

interventionalist dimension of States. This phase of the study will use macroindicators for all OECD States and, in addition, will detail the reform process for three country-specific case studies using quantitative and qualitative methods. Building on this descriptive phase, the analytical approach of phase 2 will focus on the *causes of the changes* in health care systems of OECD States. Important explanatory variables include considerations of efficiency, and of challenges external to the system, such as demographic changes and advances in medical technology. Phase 3 will then focus on the *consequences of the changes* in health care systems, in terms of system performance, including the level of care and the distribution and variation of health services provided, as well as the legitimacy of the system itself, given changes in its ability to fulfil welfare state functions.

The typology of health care systems

In 1970, there were large differences in the health care systems of OECD member States. In particular, the extent of protection against health risks in the specific States depended very much on the gross national product (GNP) of each State. Many analyses have reported a positive correlation between State GNP and the per capita spending for health services **(Alber 1989, Leidl 1999).** In addition to differences in level of health care coverage, there was also marked differences in respect to the institutional frame of health care systems. The health systems of the OECD States can be categorised into three main "Idealtypen" --- private health insurance, social security systems, and national health care systems (Table 1).

Table 1

"Idealtypen" of health care systems in DCIS States.

Idealtyp	leading principal	social policy main goal	function of state	public-private mix			
				finance	provision	regulation mechanism	density
private health insurance	equiva-lency	health services in accordance with financial resources	poor relief, social welfare, regulation of insurance market	private: risk related insurance premium	private	market	Low
social security system	solidarity	equal access to health services	legislation, surveillance of guidelines	public: income related premiums	private and public	bargaining	medium
national health care system	equity	equal access to health services	organisational and financial supporter of health services	public: income related taxation	public	hierarchy	high

These main ideal types of health care systems in DCIS States differ not only with regard to organisational measures, which aim to achieve specific health and social policy goals, but the health care systems themselves are actually driven by very different policy goals. In the British national health care system, higher priority is given to equal access to health services than to measures of efficiency. In the private health care system of the United States, high priority is given to the "fair financing" of health services, which implies risk-dependent health insurance premiums and (unequal)

outcomes based on the type of individual health insurance. The social security system, which is situated somewhere in between these other two "Idealtypen" system, gives high priority to the principle of solidarity. The main differences between these types of health care systems are based on the relationship between the private and public role in protection of health risks ("private-public mix").

A three-dimensional roster of finance, service provision, and regulation enables a systematic evaluation and detection of changes in health care systems, especially with regards to the role of the State, and can thus be used to describe and analyze changes in the state of health care systems of OECD countries.

Description of changes of health systems

Table 2 displays a conceptualisation of the main research hypothesis of the study --- "from ideal to mixed types of health care systems". Three countries, Germany, England and the United States were selected as representative of the three ideal types of health care systems.

Table 2

From ideal to mixed types? Changes in the public-private mix of three OECD health care systems.

	Germany	England	United States
Regulation	introduction of competition of health insurance companies	introduction of internal quasi-markets	private government via managed care
Financing	higher deductibles, co-payments, increase of percentage of private health insurance	strong increase of the percentage of private health insurance coverage	increase of public systems (Medicare and Medicaid)
Providing	no general changes	purchaser-provider split	still private, but vertical integration by health maintenance organisations

Causal explanations for changes of health care systems

A variety of causes play an important role in the changes outlined for the health care systems of OECD countries. A major task of the C3 research project is thus to detect “successful” and “unsuccessful” reform strategies that have been used in the specific countries selected and to consider the interplay of major actors in this change process. Two primary causes that are of special interest include the attempt to achieve greater efficiency by adopting measures “successfully” implemented in other countries, and, for European countries, the process of the European Integration.

The performance of health systems

The performance of health care systems can only be evaluated in terms of the pre-determined policy goals of specific reforms. In the World Health Report 2002 **(WHO 2002)**, the World Health Organisation defined the following health system goals: level of population health, social equity in access to health services, adequate responsiveness of health services, low social inequalities in the level of population health, and fair distribution of financing measures and resource use in health care system. Health system evaluation should also include measures of efficiency and effectiveness.

The impact of health care system on the legitimacy of the State

The health care system plays an important role in terms of the general legitimacy of the State. Yet no systematic internationally comparative research has been done to investigate whether the reduction of resources for public health services have reduced the legitimacy of the national state ("Nationalstaat").

Selection of countries

For an in-depth evaluation of changes in OECD health care systems, a "double-strategy" is planned. In phase 1, the array of public-private mixtures of health care systems will be investigated using macro-data from international organisations (OECD, WHO, European Commission) for all OECD member States. In addition, comparative country-specific case studies for systematically selected countries will be conducted. This research strategy, to include all OECD States based on the level of macro-data available and to glean more intensive insights from selective country-specific studies, will be used in both phase 2 and 3. In phase 2, at least three more country case studies will be added. At the moment, Italy, Switzerland and the Netherlands are thought to be interesting countries to include. The final decision for the selection of more country-specific case studies will be made when the proposal for phase 2 is formulated.

Another task of the country-specific case studies in phase 1 is to describe the process of reform for changes in the state of health care systems. A detailed investigation of the policy reform process will also be a profound basis for more in-depth studies of the explanatory variables and the relative importance of independent and intervening variables in phase 2. Specific tasks in this regard include the analysis of documents and interviews with professionals and experts. The mix of methods ---quantitative analyses of all OECD member States and more intensive qualitative country-specific case studies ---will undoubtedly prove insightful for the research project as a whole.

Independent, dependent and intervening variables

The task of explaining changes in the state of OECD health care system aims to reconstruct the reform process in country-specific case studies. Operationalisation of the explanatory model implies use of the following set of variables.

- independent (explanatory) variables: increasing financial needs of the health care systems, relative decreasing financial resources, political pressure to decrease health care costs, pressure to adopt the European integration policies, promise of increased efficiency via institutional learning based on international comparisons of the performance of health care systems.
- dependent variables: amount, extension and direction of the change of health care systems and changes of the role of the State in the health sector.
- intervening variables: institutional framing of statehood (i.e. number of veto-players), institutional framing of the health care system (i.e. belonging to an "Idealtypus", framing of the sectoral policy-networks), cognitive perceptions of political parties and other actors).

Suggested explanations for change are based on the theoretical approaches of the new political economy **(Frey 1977)** and the new economy of institutions **(Richter/Furubotn 1996)**, which in political

science corresponds to the actor-centered institutionalism of the "Cologne School" **(Mayntz/Scharpf 1995)** and has a sociological counterpart that is found in rational choice theory **(Coleman 1990, Esser 1993, Lüdemann/Rothgang 1996)**. The integration of economics and political science oriented approaches and theories aims to contribute to social theory in general.

Tasks for Phase 1 (2003-2006)

	2003		2004		2005		2006	
Analysis of changes in health care systems in the OECD								
Construct indicators for statehood regarding financing, providing and regulation								
Gather comparable and standardised data								
Describe changes in statehood based on the indicators; Test of the starting hypothesis								
Country-studies								
Establish more specific indicators for changes in statehood in the health care sector								
Gather more quantitative data from national databases								
Describe changes in statehood based on the adopted indicators; test of the starting hypothesis								
Chronologically describe the reform steps from 1960 onwards in selected countries								
Identify and describe the major reform steps which have induced the changes in statehood								
Synopses								
Edit the monograph of basic results from Phase 1								

Cooperating scientists

For the country-specific case studies it is very important to build co-operative relationships with scientists each from specific countries. Existing co-operative relationships include:

- England: Julian Le Grand, Elias Mossiolas, Anna Dixon, Joseph Kutzin, Bleddyn Davis, Adelina Comas-Herrera (London School of Economics, Dep. Health and Social Care)
- USA: Theodore Marmor (Yale University), James Marone (Brown University), Uwe Reinhard (Princeton University)
- Italy: Cristiano Gori (Institute for Social Research, Milan), Giovanni Lamura (INCRA Dep. Ricerche Economico Sociali, Ancona)
- Netherlands: Peter Groenewegen (Netherlands Institute of Health Service Research, Utrecht)
- Switzerland: Peter Zweifel (University Zuerich).

Research team

Dr. Heinz Rothgang (Economist), Dr. Uwe Helmert (Health Scientist), Mirella Cacace (Economist), Simone Grimmeisen (Political Scientist), Dr. Claus Wendt (Sociologist).

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