RECORD OF SOCIETY OF ACTUARIES
1990 VOL. 16 NO. 4A

HEALTH PROGRAMS OUTSIDE THE UNITED STATES

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- The speakers will discuss the health systems in Australia, Canada, Germany, Japan, The Netherlands, and the United Kingdom. This will be followed by a discussion of the critical issues facing each system and their relative strengths and weaknesses.

MR. GODFREY PERROTT: We are here to solve the health care crisis. Health costs continue to increase relative to the GNP, and there is concern and agitation about access and/or quality. We are going to perform this miracle by considering the health care system of six countries and then discussing the pros and cons of each.

We have an illustrious panel of speakers who have graciously agreed to describe the various systems. Each panelist lives or has lived in the country he will describe. The panelists are: Graham Lewis of AMP in Australia, Henry Essert of Mercer in Canada, Ed Bonach of Allianz in Germany, Hideyuki E. Yoshida of Meiji Mutual in Japan, Jan M. Lokker of Nationale Nederlander in The Netherlands, and Roger Nye of Bacon & Woodrow in the U.K.

To put the different systems in focus, I have gathered a few statistics (Table 1). Most are from the *U.S. Statistical Abstract* and do not appear to be perfect, but they are comparable. The population/doctor numbers come from several sources. It is clear that the U.S. system (which we will not describe) is radically more expensive and less publicly funded than the other six. However, it does not appear on the face of it to produce better results.

MR. GRAHAM P. LEWIS: In Australia, doctors are licensed by state governments after a five to six year university course and one year internship. They usually spend two to three years resident in hospital. Some 77% are in private practice, charging a fee for service; 21% are salaried hospital doctors.

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TABLE 1

Comparative National Data
(shown in percentages)

	Year	Aust.	Can.	Ger.	Japan	Neth.	U.K.	U.S.A.
Health Care Cost (%GNP)	1986	6.8	8.5	8.1	6.7	8.3	6.2	11.1
Public Health Proportion	1986	73.0	76.0	78.0	73.0	79.0	86.0	41.0
Crude Birth Rate	1988	15.1	14.5	11.2	11.9	12.7	13.5	15.3
Life Exp. at Birth	1988	77.1	77.1	75.0	77.8	77.1	75.1	75.3
Population	1988	16.0	26.0	78.0	123.0	15.0	57.0	246.0
Infant mortality per 1,000 live births	1988	8.0	7.0	9.0	6.0	8.0	9.0	11.0
Population per doctor	var	468.0	476.0	407.0	607.0	817.0	647.0	474.0

All currency is expressed in U.S. dollars using the following exchange rates: $1 Can = $.86, $1 Aus = $.77, 130 Yen = $1, 1 Guilder = $.56, 1 DM = $.60, 1 Pound = $1.93.

Health services are the responsibility of state governments, but the bulk of funding is by the federal government, which has the greater taxing powers. Governments fund about 70% of health care spending and own about 80% of hospital beds.

Medicare is a universal health scheme introduced by the federal government in 1984. All taxpayers pay 1.25% of taxable income over a threshold. It is not an insurance scheme however, and true costs would be closer to 7% of income over the threshold.

All medical services are scheduled at a standard fee. Doctors can charge more or less, but the maximum Medicare reimbursement for nonhospital care is 85% of the scheduled fee. Doctors can bill Medicare direct for 85% of the scheduled fee, charging nothing directly to the patient, but only a small proportion do so. "Safety net" provisions ensure that the maximum 15% "gap" medical cost in any calendar year is limited to no more than $240.

Basic hospital accommodation and treatment is free if you use a public hospital and its doctors. If you select your own hospital and doctor, Medicare repays 75% of the scheduled fees, but there is no safety net provision.

Public hospitals are run and financed by state governments with federal financial assistance. Private hospitals receive virtually no government funding, but medical

services performed there continue to be subsidized through Medicare. Federal funding grants for state hospitals are indexed to prices and the population mix by age and sex.

Private health insurance is not allowed for excess medical costs over 85% of the scheduled fee, but is available for private hospital treatment (excess over 75% of scheduled costs). Insurance is also available for ancillary services -- (physiotherapy, dental, optical, chiropractic, naturopathy, etc.) not covered by Medicare.

Health insurance can only be provided by registered benefit organizations (RBOs). These are predominantly nonprofit organizations, and two or three majors (including Medibank Private, run by the federal government) dominate in each state. There are no tax concessions for private health insurance premiums. Private health insurers must use community rating, ignoring age and sex, with family rates twice single rates regardless of family size, and cannot refuse to insure anyone.

The federal government subsidizes drugs and medical preparations. Out-of-pocket medical/hospital expenses exceeding $1,000 in any year attract a tax rebate.

Since the introduction of Medicare, health care costs as a percent of Gross Dominion Product (GDP) have been stable, at around 8%. On the medical side, reliance is placed on fee restraint and inhibiting doctors from charging too much above the scheduled fee. On the hospital side, federal government grants to states have been held far below the rate at which costs have increased, and subsidies to private hospitals have been withdrawn. Restructuring of the retail pharmacy industry is being encouraged. Increasing nursing home costs have been abated by shifting emphasis to hostel-type accommodation.

Lack of facilities in outlying areas denies access to some, e.g., Aboriginals. The number of hospital beds per capita has been falling due to funding squeezes and shortages of nurses and visiting doctors. Waiting lists for elective surgery and other nonessential treatment in public hospitals are growing. This has not caused a shift to private hospitals. Indeed, Medicare has caused a significant drop in membership of private health insurance.

Health care costs are 7-8% of GDP -- little changed in recent years. The estimated cost per person in 1988/89 was $1,415 Aus or $1,090 U.S. -- 40% hospital, 16% medical, 8% pharmaceuticals, 8% nursing homes, 7.5% capital expenditure. That represents about 125 hours of work for a manufacturing worker.

The benefits of Australian health care may be measured as follows:

- Female life expectancy 79 -- 11th in the Organization for Economic Cooperation and Development (OECD)
- Male life expectancy 73 -- 9th in OECD
- Infant mortality -- 13th in OECD

The critical issues facing the Australian system are:

- Growing size of hospital waiting lists, particularly for nonelective surgery.
- Declining private health insurance membership.
- The need for high capital injections to replace obsolete equipment. In the 1960s and 1970s, capital expenditure was 7-8% of current costs. Now it is only 3%.
- The concentration of services in inner areas of capital cities while main population growth is in outer areas and provincial cities.
- The ethics of rationing medical resources.
- Aboriginal health status.

MR. HENRY ESSERT: After a few brief words about Canada and the history of our health insurance program, I will concentrate my remarks on funding and costs and problems and solutions. As much as possible, I will try to use figures from the U.S. to put the Canadian situation into perspective and to provide us with a common frame of reference.

Of the countries represented on our panel, Canada is the largest in land area but among the smallest in population. Only about 26 million people live in our 10 provinces and two territories.

In the Canadian federal system the provinces are considerably more powerful than are the states in the U.S. system. It's not surprising then that the first developments toward a public health program started as provincial initiatives. In 1947 the province of Saskatchewan introduced a hospital insurance program. By 1972, some 25 years later, all provinces and territories had public insurance plans that provided comprehensive coverage of physician and hospital services. The current scene, in terms of the basic structure of the various programs and the manner of federal and provincial cost-sharing was established by the 1984 Canada Health Act.

The Canada Health Act embodies five fundamental principles that characterize the Canadian system. First, coverage is universal. All residents are eligible. Second, access must not be unreasonably restricted. Deductibles and user fees are prohibited; no one may be denied access to medically required services. Third, benefits are portable. That is, services received while the person is temporarily out of the province are covered. Fourth, coverage is comprehensive, it includes all medically required services rendered in hospitals, clinics or doctor's offices. Finally, administration is public and nonprofit.

Public administration is the feature most often contrasted with the U.S. system, but as we'll see, the differences between the two systems are not as large as you may have imagined.

HEALTH PROGRAMS OUTSIDE THE UNITED STATES

In 1987 Canadians spent $48 billion on health care, about $1,900 for every man, woman and child. What did we buy with this money (Table 2)?

TABLE 2

Expenditures by Category

	Canada	U.S.
Hospitals	40.4%	39.2%
Other Institutions	12.6	8.3
Physicians	15.7	19.5
Dentists	5.5	6.4
Other Professionals	1.4	3.0
Drugs and Appliances	12.4	11.1
Miscellaneous	12.0	12.5

The delivery mechanisms and setting and type of provider of the medical care that we receive are more or less the same as in the United States. Furthermore, these service providers are, for the most part, owned and managed in the same way.

Most physicians, in both countries, are self-employed professionals who charge a fee for the services that they perform. Drugs are manufactured and distributed by for-profit companies.

The only significant difference is hospital ownership. There are virtually no for-profit hospitals in Canada. About half are owned by voluntary organizations; the rest are owned by the government or religious organizations.

The difference between the Canadian and U.S. system is not the nature of the services or the provider of the services. It is the payor of the services. In particular, the difference between the two systems is the difference in the amount of the total bill paid by the government (Table 3). But, the difference may not be as large as you might think.

TABLE 3

National Health Expenditure -- Public Share

	Canada	U.S
1960	42.7%	24.7%
1965	52.1	26.2
1970	70.2	37.0
1975	76.5	42.5
1980	75.0	42.6
1985	75.9	42.0

In both countries, the amount of public funding has increased over the last 25 years. In Canada, it seems to have leveled off at 75%, in the U.S. at about 40%. Canada is not a totally public system and the U.S. is not totally private. In Canada, dentists and some other professionals, drugs, nursing homes, and semiprivate upgrades, are usually not publicly funded. In the U.S., of course, Medicare and Medicaid account for the significant public share.

No discussion of health care costs is complete without the obligatory "as a percent of GNP" (Table 4).

TABLE 4

National Health Expenditure -- Percentage of GNP

	Canada	U.S.
1978	7.1%	8.4%
1979	7.0	8.6
1980	7.3	9.1
1981	7.5	9.4
1982	8.3	10.2
1983	8.5	10.5
1984	8.4	10.4
1985	8.5	10.6
1986	8.8	10.9
1987	8.7	11.2

Although some people have used a table like this to distinguish the Canadian system from the American and to endorse the Canadian system, I'm struck more by the similarities. Both countries spend a lot on medical care -- too much. And for both countries the trend is getting worse.

Now we see the first problem with the Canadian health care system -- cost. It's the same problem the U.S. faces. In fact, from a problem perspective, we have so much in common with the U.S., that I'm going to start with a list of U.S. problems. This was composed by Dr. Arnold S. Relman, editor of the *New England Journal of Medicine.*

1. The system is too costly. The groups that are paying, government and large employers, are saying they cannot afford it.

2. The system is inequitable. Between 35-40 million people are inadequately covered and get inadequate care.

3. The care provided is inefficient and of uncertain value.

In Canada, we have the same problems, save one. Our universal health insurance program has pretty much solved the access to coverage problem. Our universal system isn't perfect -- there may still be some people without adequate care -- but our system looks for them and is structured to include them.

Our biggest problem is the same as yours. And, you may be surprised at this. It's not cost. It's value.

Dr. Relman's comments on the inefficiency, and ineffectiveness applies equally well to Canada. He says that: ". . . there is a growing sense that we're not getting value for our money. We may be wasting a lot of money on procedures that are unnecessary or ineffective. The sad thing is we don't have adequate machinery for deciding what's worthwhile and what isn't."

This is where we need to focus our efforts. Only if we focus our efforts on value will we be able to solve the cost problem. Looking for, and achieving, value in our medical care systems leads to four broad areas of effort -- evaluation, substitution, prevention, and allocation.

1. Evaluation means assessing the usefulness of medical procedures. In their book, *Second Opinion: What's Wrong with Canada's Healthcare System and How to Fix It,* Dr. Michael Rachlis and Carol Kushner estimate that as many as 80% of all treatments, including surgeries, have never been scientifically tested to prove their worth. Medical history is littered with abandoned therapies that were once common practice but are now utterly discredited.

2. Substitution means more than replacing brand name drugs with generics. It means selecting the right care setting from an intensive care unit (ICU), to hospital room, nursing home, walk-in clinic or the patient's home. It means training and selecting the right care giver, doctor or nurse or social worker.

3. On the subject of prevention, a quote by Dr. John Gordon, a Harvard professor of epistemology, is particularly appropriate. He says that: "no mass disorder or condition affecting humankind has ever been eliminated or controlled by treating afflicted individuals."

   Think about what this means. Money spent on medical care is money spent putting out fires. But new fires keep starting, and there are more of them, and they are more expensive to put out. We need to refocus, to look at how we can prevent these fires in the first place.

4. The last idea is, I think, the most powerful. As a society, we are coming to recognize that the economic principle of allocating scarce resources is a reality, not an academic concept. We live on a planet with limited resources. We live in a society with limited means. We need to choose how we will allocate our capabilities and resources.

   Our health is determined by diet, by exercise, by our standard of living and education. When we spend more on medical care, we spend less on these determinants of health. We need to recognize that spending money on new technology is an allocation of finite available resources. Are we making the best allocation?

This session is about comparing health care systems. I'd like to suggest that our comparison of different systems should focus not just on the past, which is more expensive, which has more or fewer of one or the other providers, but on the future. It would be interesting to compare the different systems in terms of how well they are set up to evaluate the services that the system provides, how much opportunity or reward there is for substitution, how much effort is directed toward prevention and finally, how the important question of allocating scarce resources is addressed.

MR. EDWARD JOHN BONACH: My focus will be on what was West Germany. Yet, with the dramatic changes that are taking place with the reunification of the two Germany's, I would be remiss if my comments do not also touch on the East German health system. Even though we now have a united Germany, my presentation will address East and West separately for what I hope will be obvious reasons.

The medical profession in West Germany is college educated, with specialized medical training taking place after the normal college degree, much like in the U.S. The physicians are, however, more specialized in West Germany in that they typically practice either in an office, clinic, or hospital setting, rarely crossing the line and following their patient.

Patients, therefore, are referred among physicians practicing in the different entities. Most doctors are registered under the national health insurance, with patients having the right to consult any doctor registered in the plan. This creates is comprehensive communication among the medical practitioners, along with the absence of one physician who is responsible for the overall coordination and management of care for a specific patient.

Essentially, all physicians practice within this national system, which is the sole avenue most individuals look to for their health care (Chart 1). Physicians are primarily on salaries, which do not vary much between specialties, with limited incentives related to care provided or patients handled.

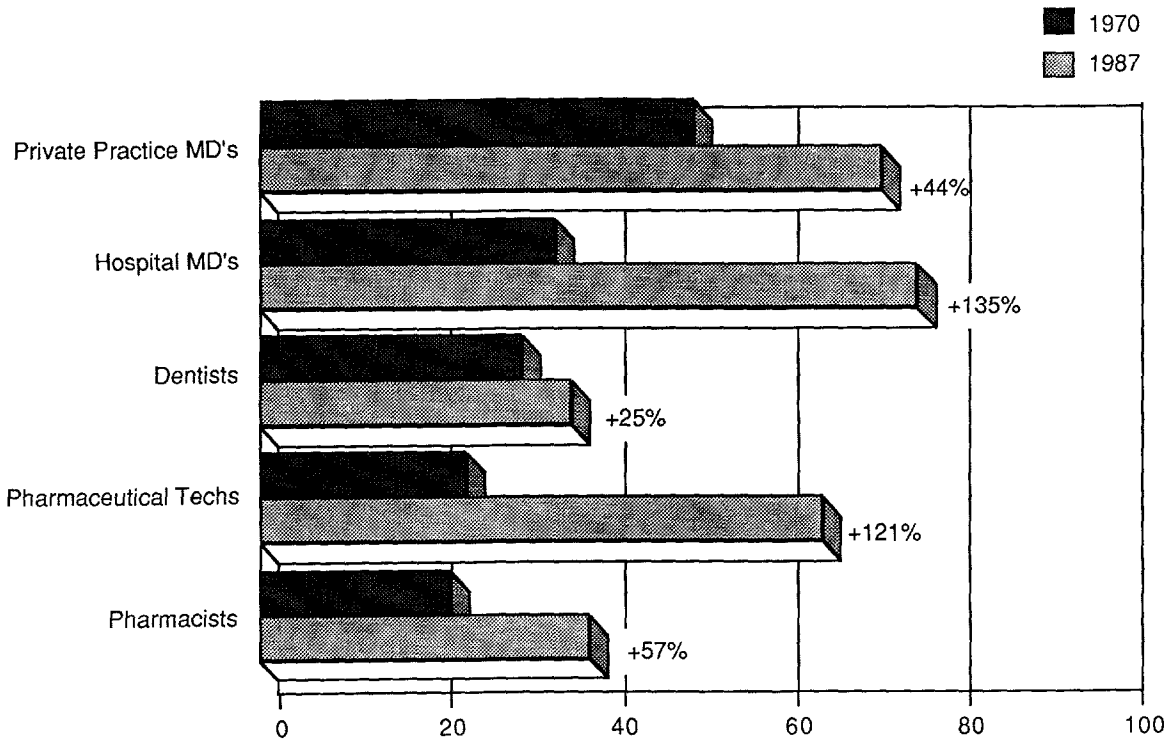
Germany's national health insurance is part of its social security system and is financed jointly on the "pay-as-you-go" basis by employers and employees. All contributions are income related, with certain insurable earnings' limits. Almost all hourly paid and the majority of salaried employees are within these ceilings (1990 was 4,725 DM/month or about $3,000). These are regularly adjusted upward for inflation. Total social security contributions currently represent about 35% of insurable earnings, with approximately 13% going towards health insurance (19% pension, 4% unemployment).

The premiums or contributions are not dependent on the age of the employee or the number of family members who are also covered under the plan.

Contributions or premiums to the national system totalled 130 billion DM ($78 billion) in 1988.

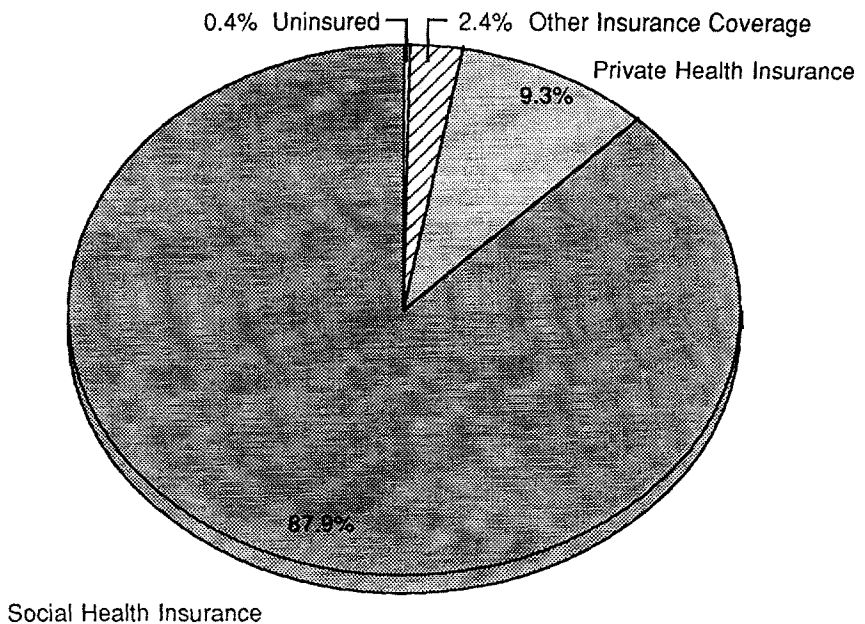
The national health insurance covers over 90% of the population, including unemployed and retired persons (Chart 2). Most of the remaining 10% are privately insured.

EMPLOYMENT IN HEALTH CARE
West Germany



Source: BPI-Statistik

WEST GERMAN POPULATION 1987
Health Insurance Protection – Percent



Source: BPI-Statistik

Private health insurance premiums are differentiated based on benefits offered, age of the insured, and sex. In order to opt out of the national system, an individual must provide proof of comparable private coverage, and the employer is required to pay a portion of the premium, equivalent to that which would have been paid under the national system.

The benefits are quite comprehensive and include medical, dental, hospital and specialist treatment. Also included are short-term disability benefits. Benefit payments in 1988 totalled 133.8 billion DM ($80 billion), exceeding premiums by over $2 billion.

Germany's national health system is undergoing continuing reforms to address the mounting cost problems coming from rising health care costs, a quickly aging and shrinking population, and no reserves due to the pay-as-you-go approach. The demographic changes that we are seeing and forecasting for the U.S. are not nearly as dramatic as those in Germany. Chart 3 and 4 show the decline in population and significant age shift.

Germany's national health system is seeking to control costs through some reductions in benefits; i.e., no death benefits paid for new entrants into the system after January 1, 1989; and increased copayments for medications and incentives through higher insurance benefits for those practicing preventive care, such as semiannual dental checkups.

The reforms at the national level have presented new opportunities for private insurers to offer supplemental coverages.

Chart 5 shows that the number of individuals who are completely insured by private insurers is climbing, as is the number of individuals purchasing supplemental coverages.

Chart 6 shows the payments by benefit category. The distribution of the benefits is monitored to look for areas of over- or underutilization and appropriate reforms.

The national health insurance is operated through over a thousand distinct entities run by independent, self-governing bodies composed of equal numbers of employee and employer representatives. The government's role is only one of overall supervision. The various subgroups are differentiated by categories such as place of residence and occupation. This presents unique challenges in overall control of benefit costs, as well as delicate issues when one subgroup requires additional financing, whereby the other subgroups are looked to for support.

Another problem this splintered approach entails is immense difficulty in obtaining systemwide data, with most of the current information covering only through 1988 experience.

Besides the ongoing reforms in the West German system, the reunification with East Germany is one of the most critical issues facing the national health insurance system. East Germany also has a social health plan which covers all citizens. The coverages and financing are quite similar to the West German scheme.

PROJECTION OF WEST GERMAN POPULATION 1990-2030

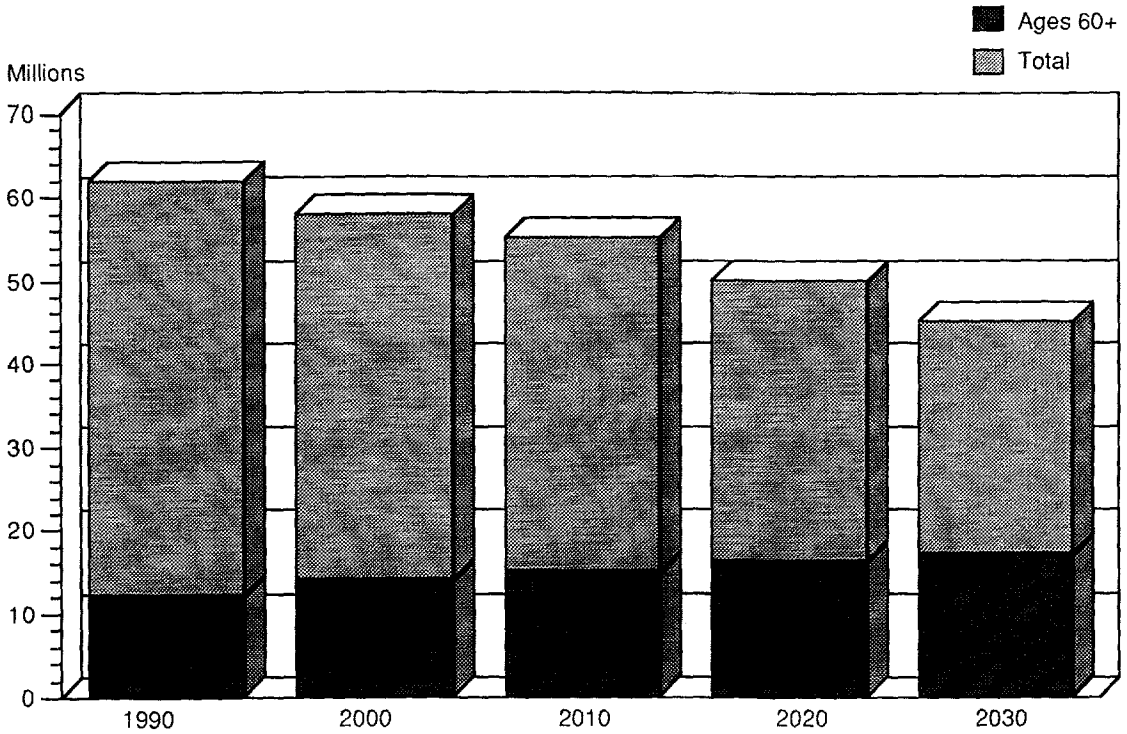


CHART 3

Source: Statistisches Bundesamt

WEST GERMAN POPULATION
Comparison 1990-2030

1990 Projection

2030 Projection

WEST GERMAN PRIVATE HEALTH INSURANCE

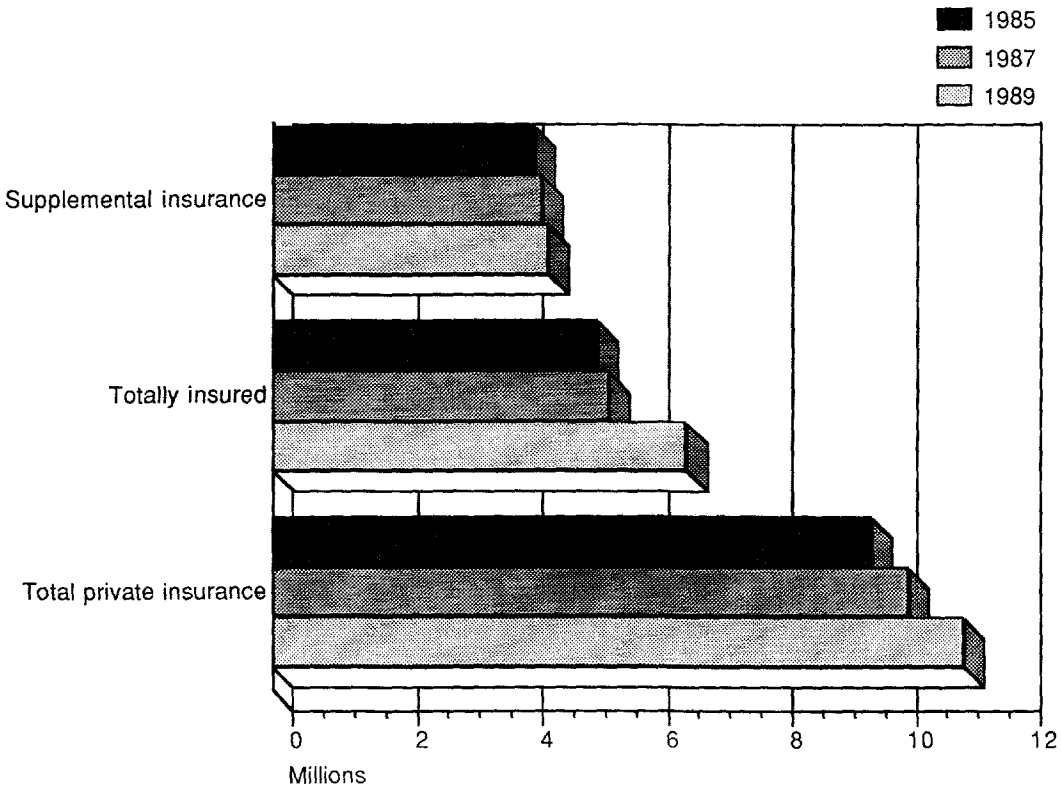
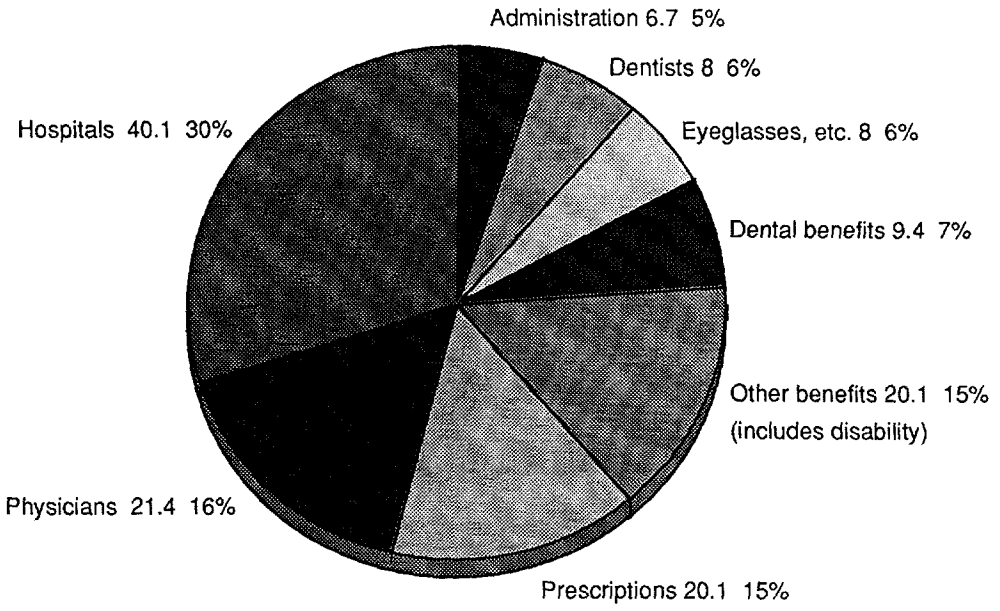


CHART 5

Source: PKV

1988 BENEFIT PAYMENTS
German Social Health Insurance



DM (Billions)

Total Benefits – 133,800,000DM

Source: BPI Statistik

There are, however, differences between the East and West German health plans, with the financial status of the East German plan being critically underfinanced. The anticipated inflation and rise in unemployment due to the reunification will add to the existing problems.

It is planned that beginning with the first of January 1991, that the East German system will be transferred into the West German plan. There will be some transitional provisions in order to control the number and size of any changes.

An important related issue is the status of the health care providers in East Germany. The physicians have not received the same level of education, and the facilities and equipment in East Germany are drastically in need of upgrade. In many cases, they are 10-20 years behind Western technology.

Even though those living in both East and West Germany are Germans, when East Germans will come to the West for health care and cause difficulties in obtaining appointments for West Germans, combined with increased costs, conflicts are bound to arise. Many of these items will, however, take years to develop and appropriately address.

Only time will tell how successfully Germany can address the significant health care issues it faces.

MR. HIDEYUKI E. YOSHIDA: I would like to start with some statistics relating to Japan's total medical costs.

According to the latest statistics of the Ministry of Health and Welfare, the nation's total medical care costs for fiscal year 1988 amounted to $144.6 billion, which is a 3.8% increase over the last year, and as a result, medical care cost per capita reached $1,175. The national income of Japan for fiscal 1988 reached $2.2 trillion, which is a 6.8% increase over the last year. So, the medical care cost as a percent of national income was 6.42%. While the growth rate of medical care cost for fiscal 1988 was lower than that of national income for fiscal 1988, it normally exceeded the growth rate of national income for the past several years. Causes for such a rise include:

1. The extension of hospitalization and treatment periods due to the increase in number of cancers, heart diseases and cerebrovascular diseases.

2. The rapid increase in medical care costs resulting from the application of advanced technology to the medical care field.

3. The increased demand for medical care created by the aging of the population.

Basically there are three categories of public health insurance programs in Japan excluding public employees and seamen.

1. "Employees' health insurance scheme": covers all employed persons across all industries.

This category is further divided into two subcategories depending on who administers the plan.

a. Government administered plans: 34.7 million people are covered including dependents.

b. Large corporations' self-administered plans (health-society-based plans in government terminology): 31.1 million people are covered including dependents.

2. "National health insurance scheme": covers all self-employed persons and those who were transferred from the employees' health insurance scheme after retirement. Some 44.6 million people are covered. Administration is performed by local communities such as cities, towns, or villages.

3. "Health and medical services for the aged": This program was introduced in 1983. The scheme covers those people who are 70 years old and over and those between 65-70 with designated disabilities. The costs for this program are shared by the above-mentioned two health insurance schemes, national government, prefectures, cities, towns, and villages.

The benefits for each of these schemes are as follows:

1. The employees' health insurance scheme covers 90% of the actual medical costs for the insured person and 70-80% for family dependents.

2. The national health insurance scheme covers 70% of the actual medical costs for the whole household.

For both of these schemes, if the total out-of-pocket money an insured paid exceeds a certain predetermined amount (currently $438 per month), the excess is reimbursed later.

3. The benefits for the old age medical care plan is basically 100% with a very minor deductible (currently $6.15 per month.)

FINANCIAL STRUCTURE OF THE PLAN

The average contribution rate for the government administered health scheme is 8.3%. Contribution is, in principle, shared by the employer and insured person in equal proportion.

The large corporation's society-managed health insurance scheme's average contribution rate is 8.2%, again shared by employer and employee). National subsidy for the government-administered health scheme is 16.4% of the total benefits and a fixed amount of $60 million for the society-managed scheme. The average contribution amount for the national health scheme is $1,062 per household. It also receives government subsidy of 30-50% of the total benefits.

Now let me go to the products offered by private companies. Although a part of covered medical expenses must be borne by covered persons under the public health insurance programs, needs for private health insurance coverages offered by life insurance companies are relatively limited in Japan. Thus far, life insurance companies have been offering hospitalization benefits as riders attached to basic life insurance plans or as stand-alone products for dread diseases such as cancer, in order to supplement public health insurance coverages. Hospitalization riders provide fixed amount benefits such as $38 per day if the insured becomes hospitalized for more than five days by accident or sickness. If the sickness is due to dread disease, the benefit amount normally triples. Some cancer policies offered by a foreign insurance company have achieved a remarkable success because of its low premium rates and the unique distribution system.

Based on the recommendation of the insurance council in May 1985, life insurance companies sell a "Medical Expense Insurance Plan" starting in April 1986, which is designed to supplement the public health insurance program and to provide four types of packaged medical expense benefits (physician's fee, hospital cost, nursing care cost and nominal death benefit).

This policy is underwritten on a group basis and has a one-year renewable feature. And, since April 1988, a similar individual medical expense plan has been marketed. Thus far sales results have been very discouraging because of the complicated features of the products and relatively high premium rates compared to nonpackaged products.

Dental expenses are also covered under the public health insurance schemes. However, some heavy treatments like crowns and bridges are not fully covered by the public health program. The development of dental expense insurance was a long-awaited dream in Japan. And it was finally realized by Meiji and Nissan in September 1988. Meiji's product is sold as a rider attached to a basic plan, and Nissan's product is as a packaged savings plan.

Due to the combined influence of the aging population and the increasing number of families, a great deal of attention is being paid to the issue of the elderly who need nursing care services. While nursing care services or benefits may come from various sources such as social insurance, families, communities and voluntary groups and private companies, it is expected that private companies, especially life insurance companies, will play a major role in this area. Some companies have already developed products for nursing care that provide annuity benefits when the insured becomes bed-ridden. A product offered by one company became the industry's standard in 1988, and other companies soon followed that design. This product essentially is a whole life insurance plan convertible into a nursing-care-type coverage after a certain duration (a very innovative product design by Japanese standard).

MS. JAN M. LOKKER: As of January 1, 1988, these were the numbers of health professionals in The Netherlands:

General Practitioners	6,300
Specialists	11,900
Dentists	7,600

At that time the population was 14.6 million. It takes six to eight years of study at a university to become a doctor, including two years of practical training. The entrance requirement is completion of secondary school education, but only a limited number of students are selected. The selection procedure is based on a choice from among those applying who satisfy the entrance criteria. The system is weighted such that candidates with higher marks have a higher chance of being selected.

After graduation one is qualified to specialize. A further two to six years of study are needed: for example two years to become a general practitioner, six years to become a heart specialist, and so on.

There are approximately 200 hospitals in The Netherlands with some 68,000 beds excluding psychiatric hospitals and nursing homes. They may be classified as teaching, general and specialist hospitals.

Teaching hospitals, which are attached to universities, train doctors, conduct medical research and provide medical care, especially that involving advanced treatment. General hospitals provide various forms of specialist treatment. Specialist hospitals include ophthalmic or children's hospitals for example.

Psychiatric hospitals, institutions for the mentally handicapped and nursing homes make up an additional 100,000 beds.

In general, hospitals are established and maintained by voluntary religious organizations active in the field of health care. A few hospitals are maintained by municipalities, provinces or the state (e.g., seven of the eight teaching hospitals).

The health care system in The Netherlands is complex. An elaborate system of government regulation exists, which is currently the subject of many proposed changes.

Every resident of The Netherlands is entitled to medical insurance, and in practice almost 100% of the population is covered (Table 5).

GENERAL LAW EXTRAORDINARY HEALTH COSTS
(in Dutch: Algemene Wet Bejzondere Ziektekosten AWBZ)
This law covers expenses for stays longer than one year in hospitals, nursing homes or institutions for the mentally handicapped for all Dutch citizens. The costs were about $5.8 billion in 1988. Premiums are income related. The AWBZ comes into effect after one year of illness. The changeover from insurance to AWBZ is unseen by the insured as amounts are paid and then reclaimed by the insurance company or national health insurance scheme.

TYPES OF INSURNACE
Types of insurance for the cost of medical care (treatment in hospital, general practitioner's [GPs] fees). The following three types of insurance schemes can be distinguished:

TABLE 5

Financing Health Care in The Netherlands

(Dfl Bln)	1987	1988	1989 Est.
1. General Law Extraordinary Health Costs	5.8	5.9	7.2
2. National Health Insurance	8.6	8.7	8.3
3. Private Health Insurance and Insurance for Persons in Public Service	4.0	4.1	3.9
4. Out of Pocket Payments by Insureds (National Health Insurance and Private Insurance)	1.6	1.6	1.6
5. Social Care	3.4	3.4	3.5
6. Government Subsidies	1.2	1.2	1.1
Total	24.5	24.9	25.6
% of GNP (Incl. Social Care)	10.0	9.9	9.6
% of GNP (Excl. Social Care)	8.8	8.6	8.3

a. The National Health Service Law: This is a compulsory national health insurance scheme for employees with an income below a certain level (in 1989: about $28,000). It covers 62% of the population of The Netherlands. Premiums are mainly income-related and are shared between the employer and employee. The 1988 costs were $8.7 billion. The national health service is partly subsidized by extra premiums charged to private insureds. Once a person reaches the age of 65, the category of insurance does not subsequently alter irrespective of changes in income levels relative to the salary limit after retirement. Disabled and unemployed persons are insured under the national health insurance scheme.

b. Private Insurance Schemes: This is optional insurance for self-employed people and employees with income above $28,000. Some 32% of the population is privately insured. In 1988 costs were $4.0 billion. Premiums are generally age related for individual contracts and are fixed for all ages under group contracts (but the overall level depends on the age structure of the group). Premium increases were previously controlled by the government, but this is no longer the case. The income limit is annually determined by the government. In 1988, there was an underwriting loss, but this was reversed in 1989.

c. Insurance for People in Public Services: Premiums are income related. The costs are included under the private insurance costs. Some 6% of the population is insured this way.

d. Social Care: The areas covered by social care are family care and old people's homes. It is partly paid from the government subsidies, partly out-of-pocket payments. In 1988 costs were $3.3 billion.

The market shares of the top 10 private insurers in terms of net premium income are shown in Table 6. (Note that the figures Table 6 include both accident and health.)

TABLE 6

Market Share of Accident and Health Insurance in The Netherlands

Company	Market Share
Zilveren Kruis	14.7%
Nat-Ned	8.2
OHRA	6.4
VCZ	5.6
AFGON	5.0
VGNN	4.9
Nutsziekiekovlen	4.9
Interpolis	4.4
UAP	3.7
Delta Lloyd	3.4
All Others	38.8
(Total 1988 Premiums = $3.5 billion)	

There is a tendency towards concentration in this market: small insurers either merge or are taken over, and there are partnerships formed by the larger players in the field. Nationale-Nederlanden, AEGON, and Delta-Lloyd, which are three of the top four insurance composites in The Netherlands, and the numbers 2, 5, and 10, respectively, in the accident and health market, have announced the intention to study the possibility of forming a partnership in the health care market. This might involve a complete merger of the health portfolios of the companies, which would offer economies of scale with respect to the heavy administration load for this type of business. There are other groups which have formed alliances, for example Gadanis is a group of seven insurers, which jointly negotiate contracts with doctors and hospitals.

The private insurers are organized in the National Organization of Health Care Insurers (in Dutch: KLOZ -- Kontaktorgaan Lanelijke Organisatie van Ziektekostenvezekeraars). This organization negotiates with representatives of the government, the national health service and the medical profession. Further, the KLOZ Health Care Information System (in Dutch: KISG -- KLOZ Informatie Systeem Gezonheidszog) provides statistical data in analyses. Although participation in KISG is voluntary, most insurers do participate.

These data are used by companies to calculate risk premiums. The method used by Nationale-Nederlanden is as follows: KISG provides risk premiums for 5-year age classes; the company compares these to the experience and factors for costs and commission are added. For group contracts, the premium that is found can then be divided to obtain either a fixed premium for every insured or an age-related premium.

Private insurers had an underwriting loss in 1988, but it was turned around into a gain in 1989. Split of number of insureds by type is as follows:

Individual	55.2%	
Group	31.2%	
Pooled	13.6%	(Standard and standard package policies)

Standard policies are for those private insureds who moved from voluntary national health service to private insurance in 1986. Standard package policies are for private insureds -- mostly over 65 -- who opted for this type of policy on January 1, 1989. Both are subsidized (pooling) from the remainder of the private insureds.

The national health service is also subsidized by MOOZ payments from privately insured persons.

COST CONTROL

Cost containment is one of the main aims of present health policy and is one of the reasons for the broad review of the structure and financing of the health care system.

Until 1986 cost control was mainly attempted through the use of government regulation. Some examples are reductions in the number of beds, limits on the budgets for intra-mural care and on investments in new health care facilities and regulation of doctor's income.

Hospitals are subject to budget constraints. An expected turnover for the year is agreed upon between the government and the hospital. If the hospital has a higher turnover than expected, the tariffs charged by the hospital are lowered (and vice versa) the following year.

A license must be obtained to build a hospital, the granting of which depends on need and building costs.

The intention of the government to reduce the number of hospital beds per 1,000 inhabitants to 3.4 by the end of 1990 has not been entirely successful. Number of beds per 1,000 was roughly 4.6 in 1988.

Doctors in private practice bill the patients themselves. The amounts they charge are controlled, but the number of patients they see is not.

Attempts are being made to change the system to a function-related budgeting system.

Hospitals are nonprofit organizations.

The number of nursing home beds is showing a generally increasing trend, whereas the number of hospital beds has generally decreased.

ACCESS PROBLEMS
People are insured under the national health service, by a private insurer, or by a special scheme for people in public service. Since 1986, it is not possible to choose between these three types of insurance.

Access is extremely good; in fact almost 100% of the population is insured. Financially health care insurance is affordable to all residents.

For certain procedures, waiting periods are common, for example, open heart surgery. The reason for this is a shortage of funding due to budget constraints.

There are three classes of inpatient (hospital) treatment. The medical treatment is the same in all classes, but class I patients have their own room, class II patients share rooms with one other patient, and class III patients are in wards. There is a medical selection of coverage under classes II and I, and high-risk applicants are not granted class I or II coverage. As every resident of The Netherlands is entitled to health care coverage, an insurer cannot refuse to issue class III coverage to an applicant.

OBLIGATION TO INSURE
An obligation by insurers to accept applicants who come from the national health service (reach the income limit) or who can prove that they were already insured privately.

If the life is substandard, the applicant will have no choice as to type of policy, but will be offered a "standard package policy."

The coverage and premium are determined by the government. Premium level is f181 ($101) per month.

CHOICE OF COVERAGE
There is a choice as to extent of coverage within a scheme:

- National Health Insurance -- The people who are insured under the national health service are entitled to services such as treatment GPs and specialists, some dental treatment, medicines and nursing care in a hospital.

  Extra dental coverage is paid for by an additional fee, and flat-rate additional fees may be charged for certain services not included in the basic package. The basic premium is 3.15% of income up to a maximum.

  A person who is insured under the national health service can take optional covers in addition to the compulsory standard cover given by the scheme. The standard cover provides the lowest class (III) for inpatient treatment, no deductible, inclusion of GP. For an extra premium, higher classes (II and I) can be covered, but insureds rarely choose this.

- Private Insurance -- A person who is not insured under the national health service may take out private insurance with an insurance company, selecting the type of coverage best suited to his or her personal circumstances.

The premiums paid vary considerably according to the kind of cover given. General practitioners and prescription costs are not always included; sometimes they are reimbursed above a given amount. About 80% choose the lowest class (III) for inpatient treatment cover, about 20% choose a deductible of about f750 ($420) or more, and about 80% choose inclusion of GP cover.

Chart 7 shows the development of the health care cost/gross national product ratio for the years 1963-89.

The ratio grew rapidly in the 1960s and the 1970s, remained largely constant at about 8.5% in the 1980s, as a result of measures taken by the government for cost reduction.

The favorable growth of the economy during 1989 meant that health care expenditure as a percentage of GNP decreased from 8.6% in 1988 to 8.3% in 1989 (estimated). (All figures in Table 7 exclude social care.)

TABLE 7

Total Health Care Costs					
	GNP ($ billions)	Costs inc. Social Care	% of GNP	Costs exc. Social Care	% of GNP
1987	241.0	24.5	10.0	21.1	8.8
1988	252.0	24.9	9.9	21.6	8.6
1989	266.0	25.6	9.6	22.1	8.3
Total Health Care costs per inhabitant per annum (inc. social care)					
1987			$1,637		
1988			1,667		
Expenditure per privately insured individual					
1987			$578		
1988			668		
1989			665		

The quality of the medical treatment given in The Netherlands is high and is comparable to that in other Western European countries. Table 8 shows demographic data related to live births and mortality. The mortality rates are low and the life expectancy is high.

Prior to 1986, the National Health Service Law encompassed three segments:
1. Compulsory insureds
2. Retired persons (Elderly Fund)
3. Voluntary insureds (approximately 800,000 lives)

In 1986, a modification to the National Health Service Law led to the small structure change. The voluntary insureds were moved to private and the national health service on a 50/50 basis. The people aged over 65 were divided in accordance to their

CHART 7

HEALTH CARE IN THE NETHERLANDS
Total Cost of Health Care (excluding social care)

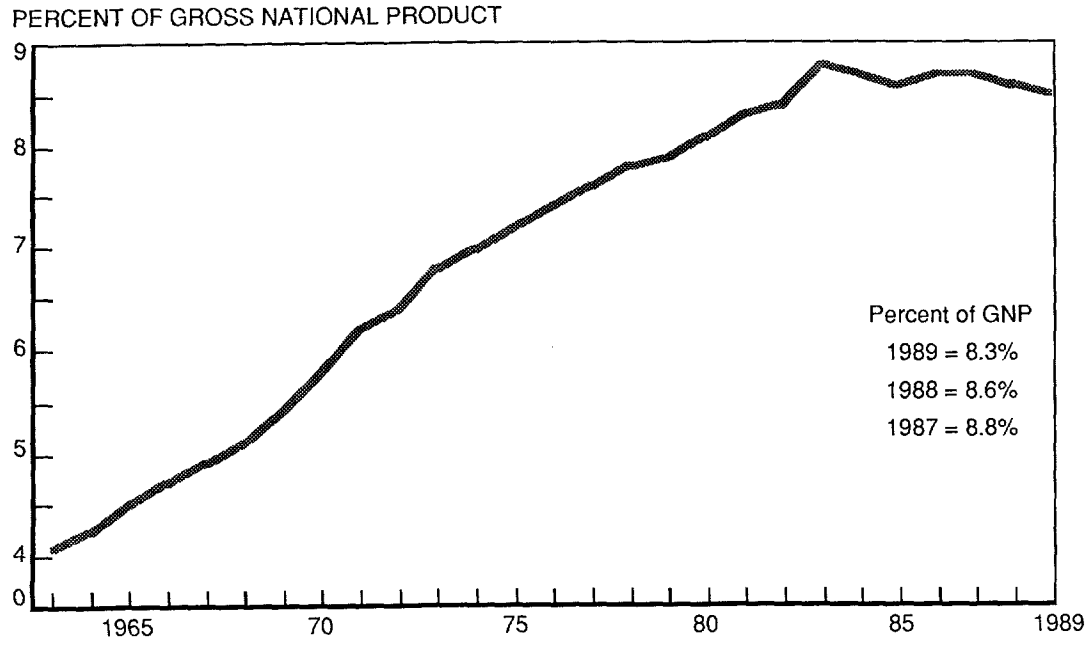


TABLE 8

Measurement of the Benefits of Health Care

Health Care in The Netherlands	1986	1987	1988
Live Births: Per 1,000 Inhabitants	12.7	12.7	12.6
Deaths: Total Per 1,000 Inhabitants	8.6	8.3	8.4
Males Per 1,000 Males	9.3	9.0	9.0
Females Per 1,000 Females	8.0	7.7	7.9
Excess of Births: Per 1,000 Inhabitants	4.1	4.4	4.2
Population (Millions)	14.6	14.7	14.8

income between the national health service and the private insurers, with relatively more ending up in the national health service.

To compensate the national health service for overrepresentation of elderly persons, a law was implemented (MOOZ) requiring an extra premium to be added to the premium for the privately insured persons. Extra premiums collected in this manner are reallocated to the national health service.

The overrepresentation of elderly persons in the national health service is not expected to continue, however, because from now on there will be no movement between type of insurance after the age of 65.

The people who were transferred to the private insurers were issued a standard policy, which the private insurers were obliged to offer. The coverage and premium for this policy were determined by the government. Note this is a closed group of insureds.

From January 1, 1989, all privately insured persons above 65 are able to obtain a standard package policy, which offers the same coverage as the standard policy. The premium and coverage is specified by the government. Ninety percent of the privately insured persons over 65 switched to the standard package policy in 1989.

Additionally the premiums paid for the standard policy and the standard package policy are not sufficient to cover the costs. To pay for this deficit all insureds (private and through the national health service) are charged an extra premium by law (Subsidization WTZ).

In 1986, the Committee on the Structure and Financing of Health Care (Dekker Committee) was set up to advise on strategies for volume and cost containment against the background of an aging population and developing medical technology. To be considered were:

- replacing inpatient with outpatient care
- improving incentives to control costs on the supply side
- improving incentives to control costs on the demand side
- a review of the finance and insurance system
- the possibilities for deregulation and streamlining within the health care system.

HEALTH PROGRAMS OUTSIDE THE UNITED STATES

In 1987, the Committee published a report "Willingness to Change." On the basis of this report, there was discussion with representatives of the national health service, private insurers and political parties, and this led to a government policy document entitled "Change Assured."

"Change Assured" proposes the following:

- o No distinction by type of insurance, namely national health service, private insurers and public service insurers.

- o Reduction of the fragmentation of the system within health care and between health care and social care providers (integration and coordination of provisions).

- o Combination of most health and social care facilities into a single basic compulsory insurance scheme, covering about 85% of the total cost of health and social care facilities. The AWBZ General Law Extraordinary expenses would be used for this purpose.

- o Optional supplementary insurance to cover the remaining 15% (e.g., physiotheraphy, dental care, medicines) in addition to the basic insurance. To be covered by private insurance.

- o The basic insurance paid for mainly by an income-related premium (75% of total costs) paid as a tax to a central fund. The remainder of the premium for the basic insurance will be a fixed premium not related to income (10% of total costs) paid directly to the insurance company.

- o Reallocation of funds from the central fund to the insurance companies according to objective and normative criteria.

- o The supplementary insurance (15% of total costs) paid for by a fixed flat-rate premium. Insurance companies would be free to compete with regard to the level of the flat-rate premium.

- o A shift from government-imposed rules (regulation by directive) to regulation by the market (regulation by incentive). There would be a lower level of political involvement in determining charges and prices.

- o Consumers free to choose their insurance company (but must choose the same company for the basic as for the extended cover).

- o Obligatory acceptance.

- o The same fixed premium to all policyholders for a particular level of coverage by an insurer. Variations of premium by company are not prohibited.

In 1989, the cover for psychiatric treatment and prostheses was transferred from the national health service and the private insurers to the AWBZ (General Law

Extraordinary Health Costs). This reallocation can be seen as a first step to increase the basic coverage and decrease the extended coverage.

Since the fall of the cabinet, no further action has been taken to implement "Change Assured."

There has now been another proposal by Simons. It is similar to Dekker but with a higher percentage of the total falling under basic. The latest plans even propose that up to 96% of the total expenditure be included in the basic coverage. The outcome of the discussions is uncertain.

STRENGTHS & WEAKNESSES OF THE CURRENT SYSTEM

Strengths:

- The system provides good-quality care, in terms of both the level of medical knowledge and technology and the treatment of patients.

- There is an even distribution of care facilities and ease of accessibility to these facilities.

- There is good attention to prevention, health promotion, health protection and intersectoral action in the health field.

Weaknesses:

- The diversity of the present system has raised barriers for substitution, both within the health sector and between health care and related social service facilities.

- The partition of health insurance into a social insurance system and private insurance schemes gives rise to inefficiencies. The national health service generally provides insurance for people with a higher risk than those insured privately. This, together with the principle of equity (income solidarity) in the health insurance system, has led to a need for financial compensation from the private to the social sector.

- The system offers no incentives for the national health service to improve efficiency and cost-effectiveness, as insureds have no choice; private insurers have stronger incentives to be cost conscious.

- The government feels that much of the present relevant legislation is insufficiently effective to make reduction of costs by state regulation possible.

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MR. ROGER NYE: The national health service in England has been in existence for 42 years. This means that I and many millions like me have never known anything else. We have come to expect free medical treatment as a right. When I say free it is paid for through taxes, but it is free at the point of treatment.

This means that the decision whether or not to consult a medical professional is not a financial one! This is true regardless of means.

There is one fundamental feature of the national health service which is seen in very few other areas -- and that is the GP.

Everyone in the U.K. is allocated to his own GP who is the first port of call for most medical problems. The GP is a screening device to separate small problems (those that will get better by themselves or those that are easily dealt with) from larger problems (those that need referral to specialists). So as a screen GPs control the number of cases reaching the specialists and ensure that patients reach the appropriate experts.

The national health service aims to provide a comprehensive medical service. It provides a complete service that is an alternative to private provision, not a complement.

In spite of this, the cost of the national health service is a lower proportion of GNP than the state health provision of most other countries.

There is a fundamental conflict between the aim of providing a comprehensive service and minimizing the cost to the taxpayer.

PANEL DISCUSSION

In a recent opinion poll, 97% of those asked would like to see improvements to the national health service, but only a little over half would be willing to pay more tax to fund it.

There is general agreement that the national health service is underfunded for its objective of a comprehensive health service, but when it comes to increasing the funding, nearly half the population would look elsewhere.

There are a number of symptoms for the disease of underfunding:

- Some junior doctors in training work 120 hour weeks.
- Hospitals have to resort to charitable sources for equipment.
- Above all there are unacceptably long waiting lists for nonemergency procedures and elective surgery.

The national health service offers one of the best emergency medical services in the world, but because of its limited budget it is limited in the nonemergency services it can provide.

In England as a whole, around 25% of those in need of treatment have to wait over a year. For instance, hip operations have a three- to four-year waiting list in many areas.

This year the government passed the National Health Service & Community Care Act 1990. The national health service was set up 42 years ago and has been little changed since then. As I have said, the people of Britain want a better national health service but are less keen on paying for it. The national health service Reform Act aims to provide just this.

The national health service is a state-run system. It is a fundamental maxim of any capitalist economy that competition increases efficiency. There are two main methods proposed for introducing competition into the state-run system.

- Within the national health service -- national health service hospitals will have the right to become self-administered trusts to offer their services freely in the market. If one area has a long queue for hip operations and another can perform these cheaply and efficiently, then the patients, and an appropriate fee, can be transferred.
- Between the national health service and private sector -- similarly, queues can be reduced if private hospitals offer quick cost-effective treatment, or national health service hospitals could tender for private patients.

The hope is that this competition will produce greater productivity without the need for substantial increases in funding. The government talks about sending money where it is needed and most effective.

In addition to competition, the government has proposed other ways of improving service without increasing costs. Education and awareness is a major area of development. Each household received a copy of "NHS Reforms and You" explaining the basics of healthy eating, the need for exercise, the perils of smoking, etc., as well as the principal features of the Act. The principle, rightly or wrongly, is that by educating the people, you can improve their health and reduce the cost of medical treatment.

Screening programs are being expanded so that potentially serious conditions can be identified and dealt with before they become dangerous.

Finally the present regime has created an environment which encourages private provision. In 1970, around 4% of the population had private medical insurance, now nearly 11% are covered. With the introduction of tax-relief for those over age 60, the government is showing its understanding that an expansion of the private sector provision takes some of the burden off the state and contributes to the overall aim, namely a better service for minimal extra cost.

MR. THOMAS P. EDWALDS: How does the tort system in your country interact with the medical profession? Here in the U.S. a major component of the professional's annual budget goes towards malpractice premiums. Is this a problem in the other countries?

MR. LEWIS: In Australia the same rights apply -- for malpractice, one can sue. The major difference between there and here is a distinct difference in litigiousness.

MR. PERROTT: Does anyone have any idea of what malpractice insurance costs are for a doctor in the other countries we have described?

MR. ANTHONY D. MASON*: In the U.K., the average cost per year for doctors in private practice is about $1,930. The state health service meets the claims against doctors who work for the national health service. Ireland is the most expensive outside the U.S. with rates from $1,930-17,370 per year.

In Holland, the cost of malpractice insurance is approximately $290-386 per year.

Germany has a wide range of rates which vary depending on the specialty of the doctor. The range is from $290-3,860 or $5,790 per year.

In Australia costs vary from state to state and are between $772-1,930 per year.

MR. JOE P. STERNFELD: I'd like to ask two questions about the German system.

1. Who actually pays the doctors their salary?

* Mr. Mason, not a member of the Society, is a Partner of Lane Clark & Peacock in London, England.

2. Is there any advantage in having these 1,000 different societies and how did they come into being? Is there any move to get rid of them or are they firmly entrenched?

MR. BONACH: The various 1,000 entities or accounts are the ones that pay the doctors. They, in effect, contract with the doctors and determine their salaries from their regional accounts.

I would say it is quite entrenched in the system, and that a lot of these different accounts are union motivated. German economy is quite unionized compared to the U.S. economy. That is why there are all these various accounts around Germany, and until that unionization changes, I don't think that there will be a dramatic change in this rather cumbersome administrative system.

MR. SPENCER KOPPEL: I'd like to ask the gentleman about the Australian plan, specifically about the private insurers that have only a single rate, a community rating standard, one rate for individuals, and another for families. How do the private insurers compete for customers? Is it guaranteed issue, etc.?

MR. LEWIS: There's not a single rate throughout the country. Each provider of these coverages can set his own rate, but the rate that it sets must be a single rate, or at least one for single people and one for families. And so, providers compete primarily on price and they can, in effect, change their ability to compete on price by the way in which they go about their marketing.

MR. KOPPEL: That was really my question. How do they get the lowest price product if they can't underwrite, for example?

MR. LEWIS: Careful marketing is the thing, and the government is not particularly happy about this situation, particularly insurers that go for the young, health, single market, rather than those people who are producing babies by the dozen or older people. The rules that have come in recently try to deal with this. You can't refuse coverage to anyone, and there are provisions whereby everyone has to contribute to a reinsured's pool in respect of the over 65 years olds and so on. These are aimed to prop up a system which is basically unsound. In a system where insurance is voluntary, I really can't tell you how long it will last.

MR. DAVID W. REIMER: In the U.S. we have a rather complex method with the American Medical Association (AMA) and Federal Drug Administration (FDA), etc. for determining whether or not something is approvable, and therefore commonly used and then covered under insurance, which I believe is what most insurance companies use as the criteria. I'd be curious in some of the other countries what mechanisms are in place for determining whether procedures, drugs, etc. are covered under your particular method of providing benefits?

MR. LEWIS: Drugs and so on in Australia have a system of approval similar to that of the U.S. We don't necessarily approve something your FDA has already approved. We

probably spend an extra few years working out whether we'll accept that approval. And indeed, state by state there are differences as well.

MR. NYE: The situation is pretty much the same in the U.K. as well.