

9 The changing role of the state in healthcare systems

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This article focuses on two major questions concerning the changing role of the state in the healthcare systems of OECD countries. First, we ask whether major changes in the *level* of state involvement (in healthcare systems) have occurred in the past 30 years. Given the fact that three types of healthcare system, each of which is characterized by a distinct role of the state, evolved during the ‘Golden Age’, we discuss how this distinctiveness – or more technically, *variance* – has changed in the period under scrutiny. While many authors analysing health policy changes exclusively concentrate on finance and expenditure data, we simultaneously consider financing, service provision and regulation. As far as financing is concerned, we observe a small shift from the public to the private sphere, with a tendency towards convergence in this dimension. The few data available on service provision, in contrast, show neither signs of retreat of the state nor of convergence. In the regulatory dimension – which we analyse by focusing on major health system reforms in Germany, the United Kingdom and the United States – we see the introduction or strengthening of those coordination mechanisms (hierarchy, markets and self-regulation) which were traditionally weak in the respective type of healthcare system. Putting these findings together we find a tendency of convergence from distinct types towards mixed types of healthcare systems.

The economic recession following the oil price shocks of the 1970s triggered a broad range of cost containment measures in the social policies of all TRUDIs, an acronym for democratic, constitutional, interventionist states explained in some detail in the first essay in this volume. National governments, however, have also shown major difficulties in curtailing public financing as well as provision in the field of welfare policy. This particularly holds true for the healthcare sector, in which the difficulties of cutting back state involvement, among other things,

are particularly related to the fact that the legitimacy of health systems is largely based on their capability to provide a satisfactory standard of healthcare for all citizens, irrespective of their ability to pay for it.

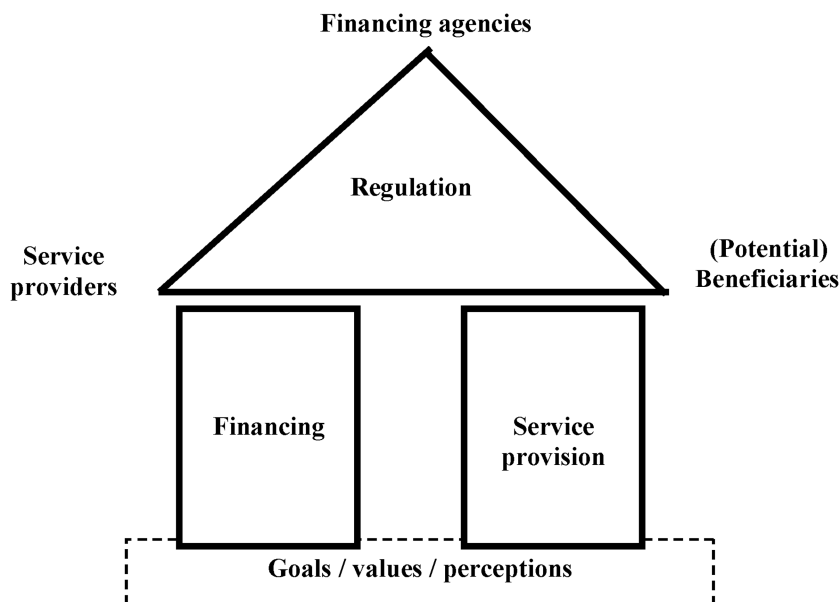
Keeping in mind that the state has played a distinct role in the healthcare systems of all developed welfare economies in times of welfare expansion, this article addresses the changing role of the state in the healthcare systems of OECD countries under the condition of ‘permanent austerity’.³⁰ In doing so, the article focuses on two principle questions. First, it asks whether there are major changes in the *level* of state involvement in healthcare systems. Second, it discusses whether the role of the state in the three types of healthcare systems, i.e. national health services, social insurance systems and private (insurance) systems, has increasingly *converged*.

Taking this twofold focus, the article aims at a more systematic evaluation of the changing role of the state in the healthcare systems of advanced capitalist countries. Hence, in the next section we introduce a three-dimensional framework for analysing the role of the state in the healthcare sector, which is then applied to the healthcare systems of the ‘Golden Age’ of welfare state expansion. In the subsequent two sections the development in the last three decades is analysed with respect to our quantitative and qualitative dimensions. In the final section we draw conclusions on the changing role of the state in financing, providing and regulating healthcare services.

The role of the state in healthcare systems

Conceptualizing and measuring the changing role of the state in healthcare systems

With respect to the role of the state in healthcare, many comparative studies have exclusively concentrated on *financing* and *expenditure*.^{6, 7, 25, 26, 27} Following their line of argumentation, the involvement of the state in a healthcare system can be measured as the ratio of public to total health expenditure. A focus purely on financing, however, neglects whether state agencies also provide healthcare, or whether these services are provided by private entities such as hospitals or self-employed doctors. A second role that the state can play in healthcare systems, therefore, is that of *provider of services*. Thus, the share of public services is a good indicator for measuring this dimension of potential state activity. Even if the state neither finances nor provides services directly, there is a third role it can play: it can be more or less engaged in the *regulation* of the relationships between providers, financing agencies, and users – or it can leave this task to corporate self-regulation mechanisms or to the markets. When considering the bilateral relationships between the three major stakeholders of a healthcare system, i.e.



Source: OECD Health Data 2002.

Figure 1. Financing, service provision, and regulation in healthcare systems.

financing agencies, service providers, and (potential) beneficiaries, at least six major areas of regulation evolve and are subject to potential change (see also Figure 1):

Between (potential) beneficiaries and financing agencies

- (1) Coverage: the inclusion of (parts of) the population in public and/or private healthcare systems.
- (2) System of financing: the financing of healthcare by public (taxes, social insurance contributions) and/or private (private insurance contributions, out-of-pocket payments) sources.

Between financing agencies and service providers

- (1) Remuneration of service providers: the specific system of provider remuneration.
- (2) Access of (potential) providers to healthcare markets: access to financing agencies.

Between service providers and patients

- (1) Access of patients to service providers, i.e. doctors (and further healthcare personnel).
- (2) Benefit package: the content of the benefit package.

While the financing and the service provision dimension allow quantitative measurement, the concept of regulation is qualitative in nature. Thus, the proposed *three-dimensional framework* for analysing the role of the state in healthcare systems rests on two quantitative ‘pillars’ – the financing and service provision dimension – as well as on a qualitative ‘roof’, which focuses on the regulation of the triangle between providers, financiers, and (potential) users of healthcare services (Figure 1). In the dimensions of financing and service provision, the role of the state is measured as the public share in financing and in service provision. When assessing the changing role of the state in the regulation dimension we also refer to de-regulation and re-regulation. Goals, values, and perceptions, which comprise the *normative foundation* of healthcare systems, are not dealt with in this essay, however.

Types of healthcare systems and the role of the state in the context of welfare state expansion

During the ‘Golden Age’ of welfare expansion, states pushed for the inclusion of more and more parts of the population into the healthcare systems. Thus, with the notable exception of the US, by the mid-1970s almost the whole population had access to healthcare services in OECD countries. Nevertheless, there were considerable differences between healthcare systems: there were such systems that can be characterized as National Health Services (NHS) (such as in the UK); healthcare systems that can be characterized as social insurance systems (such as Germany); and healthcare systems that can be characterized by a high share of private healthcare and health insurance markets (such as the US). Table 1 summarizes the differences among the types of healthcare systems in a stylized and pointed way: *NHS-type healthcare systems* rely on the state more than the other two systems. In this system, the state is responsible for service provision, financing and regulation. Here, financing is based on taxes and regulation is generally executed hierarchically through a comprehensive planning model. By contrast, *social insurance-type healthcare system* services are provided by public providers, non-governmental, not-for-profit organizations, and private for-profit enterprises. Financing is public, not through the general budget, but through social insurance funds which are public para-fiscal agencies, and merely based on social insurance contributions. While social (security) law provides some regulatory framework, in a social insurance system detailed regulation – including access to

Table 1. Types of healthcare systems with respect to the role of the state.

<i>Type of healthcare</i>	<i>Underlying values and principles</i>	<i>Financing</i>	<i>Service Provision</i>	<i>Regulation</i>
<i>National health service</i>	<i>Equity:</i> Equal access to services for everyone	<i>Public:</i> taxes according to income (direct taxes) and consumption (indirect taxes)	Public providers	<i>Dominant Regulatory Mechanism:</i> hierarchy; comprehensive planning and tight control by the state
<i>Social insurance system</i>	<i>Solidarity:</i> Equal access to services for all members of insurance funds	<i>Public:</i> contributions according to income	Private and public providers	<i>Dominant Regulatory Mechanism:</i> collective bargaining; legal framework and some control by the state
<i>Private (insurance) system</i>	<i>Principle of equivalence:</i> service according to ability to pay	<i>Private:</i> premium according to individual risk	Private providers	<i>Dominant Regulatory Mechanism:</i> markets; limited control of insurance and service provision by the state

healthcare markets, remuneration systems and the detailed definition of the benefit catalogue – is, however, left to negotiations between sickness funds and service providers. *Private healthcare systems*, finally, are characterized by private financing (with an emphasis on private insurance), service provision by private for-profit enterprises, and a limited degree of public regulation. The coordination between providers, financiers, and (potential) users is largely left to the market and – to some extent – to the courts.

In order to conduct an empirical analysis, the United Kingdom is considered to be the representative of a national health service system, Germany is assigned to the social insurance system and the United States represents the private insurance system. We assume that during the period of welfare

state expansion, healthcare systems were close to the constructed, stylized types.

A changing role of the state in the healthcare systems beyond the Golden Age?

Starting with the oil price shocks, the last three decades have seen major changes in the context of the healthcare systems of all TRUDIs. First of all, in the course of the recession of the late 1970s and early 1980s, the economic context of healthcare systems changed from growth to stagnation, and from affluence to austerity. Although the economy recovered thereafter, in the healthcare sector the perceived need for cost containment remained, leading to the subsequent introduction of cost containment measures.^{2,3,8,17,22} Besides the changing economic situation, healthcare systems are currently also situated in a context of increasing globalization. Generally speaking, this pushes national governments to compete for ‘global capital, companies and labour especially by lowering taxes, by deregulating the labour markets and by cutting social provisions’.¹⁸ More specifically, the context of health systems has also changed through the accelerating innovation process in the sphere of medical technology on the one hand, and the profound demographic changes in all highly industrialized countries on the other.^{36, 39} Due to the outlined transformations in the context of modern healthcare systems, the pressures on post-war healthcare systems have multiplied. Hence, the major question we focus on in this article is how the role of the state in the healthcare systems has changed since the Golden Age. Using the typology of healthcare systems outlined above we examine both whether the role of the state is growing or declining; and whether the distinct types converge with respect to the role of the state.

Therefore, we first analyse whether the state retreats from healthcare financing and/or service provision, as one might assume. Second, we explore whether retrenchment policies (if existing) have led not only to a reduction in public spending, but also in total healthcare spending and service provision; or whether such a cut is substituted by an increase in private spending and service provision. The third issue we address is whether austerity policies have so far led to more state regulation, e.g. in order to control costs or to guarantee equity in a more privatized system, or whether they are also accompanied by a retreat of the state from regulation.

Given the fact that the three types of healthcare system are characterized by a distinct role of the state, we finally ask whether these three models are equally affected by the changing context of the post-1970s, and whether the differences between distinct ‘families of systems’ remain. Here, our focus is on whether the types move towards each other (convergence), or away from each other

(divergence), or whether they move in the same direction without revealing any changes in the distance between each other (level effects). In the quantitative dimensions these developments are measured by parameters of dispersion (convergence/divergence) and means.

In order to move towards a more universal conclusion, the last question is of particular interest: similar reactions by distinct types of healthcare systems to the changing context variables would indicate the existence of a best-practice solution for problems caused by a changing environment.^{1, 10} Non-convergent developments or parallel upward/downward trends of the three types of healthcare systems, on the other hand, would indicate the prevalence of distinct solutions^{2,3} due to processes of path dependence and system inertia.

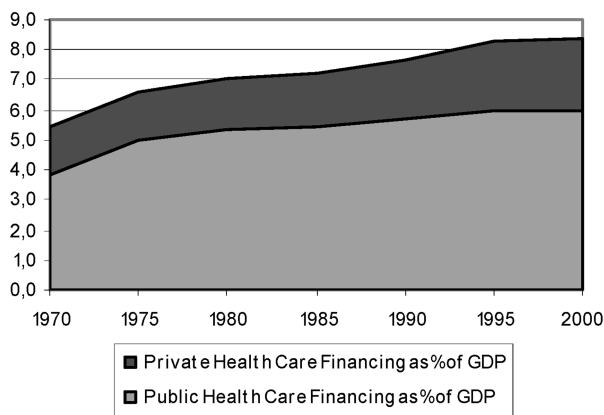
The changing role of the state in financing and providing healthcare

The changing role of the state in healthcare financing

Ever since the OECD published the first edition of its healthcare data in 1985, most international comparisons have centred on the financial dimension. Thus, there is a comparatively rich database for the analysis of the changing role of the state in the financing of healthcare. Based on data of 21 TRUDIs,^a Figure 2 shows a massive growth in total healthcare financing in the early 1970s. This growth process was almost completely fed by an increase in *public* healthcare spending. From the mid-1970s, cost-containment became the prevailing policy in all healthcare systems. Nevertheless, total healthcare financing still continued to grow, although at a much slower pace. This time however, the process was driven by increased *private* healthcare financing: while public healthcare spending increased by 21% (from 5.0 to 6.0% of GDP) between 1975 and 2000, the private complement rose twice as fast, i.e. by 42% (from 1.6% to 2.3% of GDP).

While the slow-down in growth rates of public healthcare financing was compensated by private spending until 1995, total healthcare spending has been stagnating since the mid-1990s. Even if we cannot observe a decrease in public healthcare financing (in relation to the GDP) on the aggregate level from 1975 to 2000, owing to a much higher growth rate of private healthcare expenditure, the *share* of public healthcare financing out of total healthcare financing declined

^a Included are those cases that had already developed a high standard of democratic, constitutional and welfare institutions in the 1960s and early 1970s. Based on this definition, 23 of the 30 current OECD members qualify for inclusion. The Czech Republic, Hungary, Korea, Mexico, Poland, as well as the Slovak Republic are excluded, since they only became OECD members in the 1990s. Turkey is also excluded as it cannot be regarded as a welfare state. France and Belgium, however, are excluded from the group of 23 countries due to a lack of data. Since data are often not available for the 1960s, we concentrate on the period from 1970 until 2000.



Source: OECD Health Data 2002.

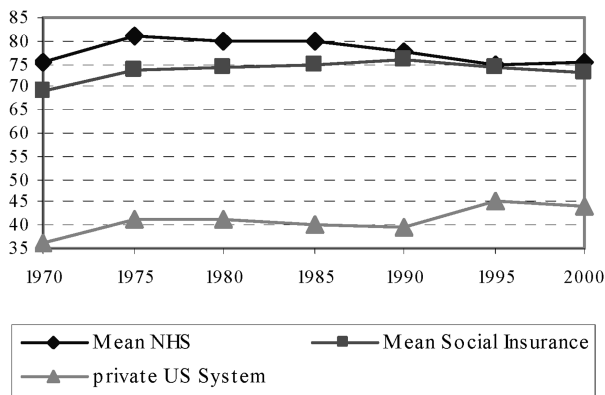
Figure 2. Healthcare financing as a percentage of GDP in 21 OECD countries.

from 75.8% in 1980 to 71.8% in 2000. Thus, there is a *relative retreat* of the state from healthcare financing, but to a very limited extent.

While Figure 2 refers to all countries under consideration, Figure 3 disaggregates the data with respect to the types of healthcare systems.^b Once again checking what happens after 1975, we observe a declining share of public healthcare financing in NHS systems, a growing share of public financing in the private US system, and no clear tendency for social insurance systems. So the role of the state was strengthened where it was weakest and it was weakened where it was strongest before. In short, on the level of ‘families of healthcare systems’ there are at least tendencies of convergence towards more mixed systems.

When ranking the countries according to their share of public healthcare spending (as a percentage of total healthcare spending), we find a similar picture: countries with a below-average share of public financing increase their share to a relatively high extent, while countries with an above-average share of public financing reduce their public spending.⁴¹ This is in agreement with Peter Flora’s¹¹ ‘growth to limits’ thesis, but it is, of course, not sufficient proof. The process is driven by a highly significant closely negative correlation between the average annual growth rate of public health expenditure (as a percentage of GDP) and the

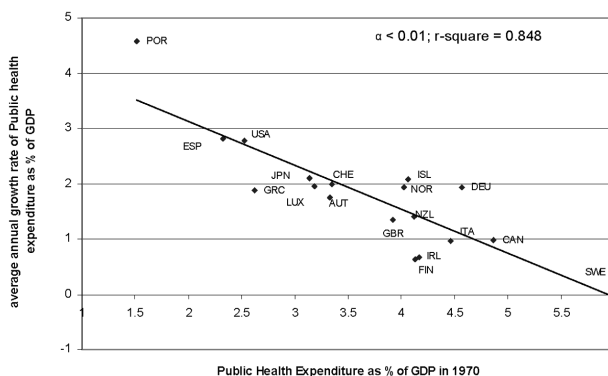
^b In accordance with the respective share of health care financing by taxes, social insurance contributions, and private funds, Austria, Germany, Japan, Luxembourg, Netherlands, and Switzerland are classified as social insurance systems while Australia, Canada, Denmark, Finland, Greece, Iceland, Ireland, Italy, New Zealand, Norway, Portugal, Spain, Sweden, and the United Kingdom are classified as NHS-systems. The private health care system type is represented only by the US.



Source: OECD Health Data 2002.

Figure 3. Public healthcare financing as a percentage of total healthcare financing.

respective figure at the beginning of the observation period (Figure 4).^c As a result, those countries with the lowest public expenditure on health in 1970 have the highest average (geometrical mean) annual growth rate. Thus, a ‘catch-up’ of the laggards has taken place. With respect to social expenditure, a similar catch-up can be identified (see Obinger et al. in this volume for details). The result is a



Source: OECD Health Data.

Figure 4. Correlation between average annual growth rate in public healthcare financing as a percentage of GDP from 1970–2000 and public healthcare spending in 1970

^c The figure is based on data for 18 countries. Due to missing data for 1970 Australia, Denmark and the Netherlands are excluded.

(tendency of) convergence of the share of public spending in the field of healthcare that is indicated by a decrease of the coefficient of variation^d from 21.6 (in 1970) to 18.5 (in 1975) and to 14.5 (in 2000) for the countries under consideration.

The changing role of the state in healthcare provision

Concerning the *service dimension* of healthcare systems, the OECD provides a wide range of data relating to the quantitative level of health services, such as for example total health personnel, general practitioners, specialists, nurses, or in-patient beds. As in the financing dimension, most indicators – for instance, total health personnel, physicians, or nurses – show an ongoing increase in healthcare services, and a slowdown of the increase only in the 1990s.²⁸ Owing to the decreasing average length of stay, however, the number of in-patient beds per 1,000 inhabitants is declining.³⁷ However, there is hardly any information on the role of the state in healthcare provision. Only for hospital beds is a differentiation between public and private services available. While the number of hospital beds is declining, the public share remains relatively stable. For the 16 countries that the OECD provides data for at some point in time, the public share grew, on average, from 67.1% of all hospital beds in 1970 to 70.4% in 1975. For the rest of the observation period up to 2000, the share remains slightly above this level (72.7% in 2000). When restricting the analysis to those 12 countries for which data are provided for all the years between 1970 and 1995, one obtains even less variation: at any time from 1975 to 1995, the share of public beds remained between 67.7% and 68.9% (OECD Health Data 2002, own calculation).

Distinguishing between the three types of healthcare system, we find a public share in hospital beds of about 80% in NHS systems, a share of about 55% in social insurance systems, and of less than 20% in the private US system, which again emphasizes the distinct role of the state in the respective systems. While there is a slight convergence process in the financing dimension, the differences between the three types of system in the service dimension remain relatively constant. Generally, there is no sign of a retreat of public services – and hence, of the state – from the provision of healthcare in any of the three systems focused on in this article.

Further data are necessary to provide a clear picture of the ‘role of the state’ in the provision of healthcare services. It is, however, remarkable that the reduction of hospital beds has been much higher in NHS systems than in social insurance systems – without a major change of the public–private mix.⁴¹ This

^d The coefficient of variation is calculated by dividing the standard deviation of the distribution by its mean. It is given here as a percentage, i.e. multiplied by 100. Other measurements of dispersion lead to a similar result. So, between 1970 and 2000 the range has decreased from 55 to 37 (reduction of 33%) and the interquartile range is reduced from 25 to 8 (reduction of 68%) (own calculations according to OECD Health Data 2002).²²

indicates that the state has not only reduced public hospital beds, but may also have regulated the reduction of private hospital beds to a similar extent.

The changing role of the state in regulating healthcare systems

When focusing on the third dimension of healthcare systems, i.e. the regulation of the system, in the context of this essay it is not possible to compare the six relations introduced earlier extending to funds for financing, service providers, and (potentially) beneficiaries (coverage, financing, access to the healthcare market, remuneration methods, access of patients to service providers, and benefit package) for all countries. We therefore select three 'representative' countries to sketch changes of regulatory measures in different types of healthcare systems: the United Kingdom (NHS system), Germany (social insurance system), and the United States (private insurance system). In doing so we not only examine whether the role of the state in regulation has increased or decreased, and whether the healthcare systems have converged in this respect; but we also investigate which role the state had in bringing these changes about.

Coverage

Since the introduction of the NHS in 1948, the whole population of the UK is covered. In Germany, nowadays about 89% of the population are covered by the social insurance system. Additionally, about 2% of the population are covered by special systems, and about 9% by private insurance. The latter scheme includes civil servants whose healthcare expenses are partly covered directly by their employers. Consequently, almost the whole population is covered by insurance. In the US, about 70% of the population has private insurance. Private insurance is either employment-based (61%) or privately purchased (9%). The lowest income groups as well as senior citizens and the disabled are covered by the main public insurance programmes, Medicaid and Medicare (25%). In 2002, 15%⁶ of the US population were without health insurance.²³ For the period of analysis from 1970 to 2000, no changes took place in the British NHS since there was no need to include further parts of the population, and since a policy of exclusion (for example, of higher income groups) did not exist. Germany's health insurance system experienced a process of inclusion since its first implementation in 1883. Within the period under consideration, coverage was extended by the inclusion of farmers, handicapped persons, students, and artists, thus further strengthening the role of social insurance.⁴⁰ In the US system, an important extension of public coverage had already taken place in the 1960s, when Medicare was introduced

⁶ Due to double counting, these figures do not add up to 100%.

for senior citizens and opened to the disabled (in 1973). Furthermore, Medicaid was introduced for low-income groups. The most significant process of inclusion in the Medicaid programme since 1970 took place in the late 1980s when the eligibility of pregnant women and infants was mandated by Congress. Additionally, the federal government extended public coverage in 1997 with the introduction of the State Children's Health Insurance Program (SCHIP).

In the United Kingdom, there was a considerable increase of subscribers for *private health insurances* in the period from 1979 to 1981 due to a promotion of private health insurance by the new Conservative government.¹⁶ Apart from tax relief for the elderly, however, the government introduced hardly any measures to stimulate the expansion of private coverage to the major part of the population.⁴⁰ Today, about 15% of the British population has a supplementary private insurance. In contrast to the UK, both a supplementary private coverage as well as an exclusive private coverage are possible in Germany. While the inclusion of further groups of the population in the public health insurance system during the 1970s reduced the group of potential subscribers to private health insurance, this group was enlarged again by the introduction of an exit option from social insurance for employees and high-income blue collar workers in 1989 (Healthcare Reform Act). Today, about 9% of the population possess exclusive, and a further 9% supplementary private insurance coverage.³¹ In the United States, the share of people with private insurance has slowly decreased since its peak in 1980. The vast majority of private coverage is employment-based, with a strong linkage of insurance to the workplace. The 1985 Consolidated Omnibus Budget Act (COBRA) gave workers under certain circumstances, such as voluntary or involuntary job loss or transition between jobs, the right to choose to continue group health benefits provided by their group health plan. In 1996, the Health Insurance Portability and Accountability Act (HIPAA)⁵ guaranteed a greater portability and continuation of group health insurance coverage and also limited the insurers' ability to exclude pre-existing conditions.^f

By and large, we observe an increase in public *coverage* by state regulation in Germany and the United States since the 1970s, indicating a strengthening of the role of the state in these countries. At the same time, private coverage has increased in the UK and decreased in the US. While the increase in public coverage in the United States and Germany was the result of state regulation, the increase in private coverage in the United Kingdom was an effect of some financial incentives and promotion by the state.

^f Pre-existing conditions are physical or mental conditions already existing before an individual receives health insurance coverage. Some insurers refuse coverage or increase rates (risk adjustment) due to pre-existing conditions.

Financing

Cost containment has been a core feature of British health policy since the very beginning of the NHS.¹⁹ Although the increase in total health expenditure has been lower than in many other developed healthcare systems, in 1976 the government introduced a so-called cash limits system. ‘This meant that if the cost of providing any particular level of public provision rose faster than assumed by the Treasury [...] there would be no automatic supplementation as in the past’, but a compensatory cut in the input of real resources.^{19:83} Another major change took place when market principles were introduced with the NHS and Community Care Act in 1990. While the central funding and control system remained, the government advocated an improvement of efficiency through the implementation of a purchaser–provider split: health authorities (purchasers of healthcare), GP fundholders[§] (purchasers and providers) and hospital trusts (providers) started to negotiate contracts that were to set the volume and prices of services within the internal healthcare market. The introduction of internal markets has been of the utmost importance for the relation between financing agencies and service providers. Private insurance has been promoted by the government since the early 1980s, but no major changes in regulatory measures can be detected with respect to financing by private insurance.

In the German health insurance system, contribution rates are traditionally fixed by each insurance fund. While this model of self-regulation did not change in the first phase of cost-containment policy that took place in the second half of the 1970s, we find increasing government intervention from the late 1980s onwards, when ‘constant contribution rates’ became a catchword in health policy.³³ Even if the scope for self-regulation remained wide, it increasingly took place in the ‘shadow of (state) hierarchy’ (Fritz Scharpf). During the 1980s and 1990s, the government increasingly intervened in the collective agreements between associations of doctors and insurance funds. The ability of funds to fix contribution rates at their discretion was restricted by the Healthcare Structure Act (1992), the Healthcare Reorganisation Act (1997), and the Healthcare Modernization Act (2003). A second major example of state regulation in the field of healthcare financing is the introduction of free choice of sickness funds for the insured population, and thus the introduction of competition between the main funds of financing. The launch of competition between sickness funds, and of a corresponding risk-adjustment mechanism, established through the 1992 Healthcare Structure Act, for the first time introduced competition as a coordinating mechanism in its own right. While the reduction of the number of sickness funds can partly be seen as an effect of higher competition, neither contribution rates

[§] GP fundholders are general practitioners (GPs) who are responsible for purchasing NHS services for their patients. This includes GPs taking part in the Standard, Community and (pilot) Total Fundholding schemes.

nor total healthcare financing were stabilized in the period following the implementation of competition between funds in 1996. Starting in the 1990s, the German government not only increased direct intervention within the social insurance system but also within the field of private insurance. By and large, the state thus started to use private insurance companies as a means to achieve public social policy goals, thereby inducing some tendencies towards convergence between these systems.³⁸

In the United States, the federal government sets contribution rates, co-payments and deductibles for Medicare enrollees. The contribution-like payroll tax for hospital insurance as part of Medicare has remained unchanged since the early 1980s. The Medicaid programme, by contrast, is tax-financed. In the private schemes, the state governments have the authority to regulate the insurance business, for example by setting the reserve requirements. Additionally, private healthcare financing is heavily regulated by governments' tax policy.¹⁵ While state governments may also regulate premium increases and other aspects of the insurance industry, private insurance premiums are generally set by insurance companies and, in the case of powerful employers, subject to negotiations. Self-insurance, a healthcare financing technique in which employers pay claims out of an internally funded pool, was heavily promoted by federal government and therefore, in 1974, exempted from state regulation. The Employee Retirement Income Security Act (ERISA) of 1974 exempted employers who self-insure their health benefit plans from taxation and control. Although the development of health maintenance organizations (HMOs) was market-driven, HMO Acts of 1970 and 1973 were designed by the federal government to encourage the spread of managed care. From the late 1980s and early 1990s on, federal government has been actively encouraging Medicare beneficiaries to receive their healthcare through managed care organizations, i.e. insurers executing a higher degree of hierarchical control over providers. The states also started to shift Medicaid recipients into managed care plans.³⁵ While we thus witness some public de-regulation, more control of providers was introduced into the private healthcare market through the development of managed care.

With respect to the regulation of *healthcare financing* we thus see an increased role of the state in regulating healthcare financing in Germany, where direct state intervention can be observed in private and in social health insurance. In Britain, the central role of the state was even strengthened through the introduction of cash limits. Only in the US do we observe some de-regulation in the private insurance sector through the introduction of ERISA. However, on the other hand, a more hierarchical control was introduced through managed care, which was initiated by private entrepreneurs but later on promoted by favourable state regulation.

Remuneration

In the United Kingdom, general practitioners are traditionally paid by a combination of general allowances and a certain amount of money for each person enrolled on their 'list' (capitation). In 1990, new contracts were implemented through state regulation, and the proportion of GPs' income that was derived from capitation payments was increased from 46% to 60%. The introduction of the GP fundholder status further increased the influence that GPs had on their income, as it gave fundholding practices the opportunity and the incentive not only to buy services from the cheapest service provider, but also to provide certain services such as diagnosis tests in their own practice. Most hospitals that, for many years, had received a fixed budget per year, in the early 1990s opted out of direct control of NHS health authorities. Instead, they chose the status of hospital trusts as this granted them higher autonomy to develop their own management structures, allowed them to decide on the number and structure of hospital personnel, or to negotiate individual labour contracts.^{13, 32}

In Germany, levels of remuneration in the outpatient sector are traditionally negotiated between the regional associations of panel doctors as monopolist, on the one hand and a wide range of sickness funds on the other. In a number of subsequent reform steps, the state gradually reduced differences between sickness funds and forced them to negotiate together, thus transforming the monopoly into a bilateral monopoly, which mobilized some countervailing power.⁴ In the 1990s, the federal government intervened directly in the corporatist self-regulating structure by introducing a (partial) flat-rate payment system for family doctors, fixed budgets for drug prescriptions etc. (Healthcare Structure Act 1992). In the hospital sector on the other hand, the state tried to initiate some corporatism by assigning power to formally private hospital associations.⁹ In effect, the state intervened in the self-regulating negotiation system, intending to strengthen it by changing the rules of the game.

In the United States, physicians who under traditional indemnity insurance schemes were usually paid on a fee-for-service basis were confronted with completely changed incentive schemes in managed care systems. Depending on the respective managed care model, primary care physicians and specialists may either be employed by the managed care organization (staff model) or are contracted by the managed care organization (group models). Physicians can be paid on the basis of salary, a (discounted) fee-for-service, or a capitation fee.²⁴ Until the 1970s and early 1980s, hospitals in public as well as in private health insurance schemes were paid on a retrospective cost-reimbursement basis. Public insurers were the first to implement major payment reforms during the 1980s to overcome these negative incentives for cost containment. In 1983, the prospective

payment system on DRG (Diagnosis-Related-Groups) basis was introduced, initially exclusively for Medicare treatment, but later it was extended to all plans.

Summing up the developments in terms of the regulation of *remuneration*, we see that methods were modified in the US managed care system from a previously dominant fee-for-service method to payments by salary, discounted fee-for-service, or capitation. In Germany, the fee-for-service method of remuneration was maintained for self-employed medical doctors, but a flat-rate component was introduced for family doctors in the 1990s. GPs in the United Kingdom are still financed on a per capita basis. As GP fundholders, however, self-employed doctors gained a higher influence on their income. We therefore observe a development from highly diverse methods of remuneration in the three types of healthcare systems to a more common 'mixed model of remuneration'. With respect to hospital financing, a first prospective payment system on a DRG basis was introduced in the United States in 1983, and Germany is currently following the US example. In the UK, too, fixed budgets for hospitals were abolished, and today hospital trusts negotiate with health authorities and GP fundholders on the number and price of hospital treatment based on healthcare resource groups (HRGs), a classification scheme similar to DRGs. As far as the role of the state is concerned, the introduction of internal markets and competition in the NHS has led to the establishment of independent NHS Trusts. Consequently, there is less state control on service provision. In Germany, the state invested a lot of effort into making corporatist self-regulation mechanisms more effective, while in the US the state took no active part in promoting changes in the remuneration systems.

Access of service providers to the healthcare market

Within the British NHS only general practitioners but not specialists have the freedom to establish a practice for ambulatory medical care, thus becoming independent contractors – specialists, however, are free to provide services for private patients in private practice although they are employees of a health authority or a hospital trust. Access for general practitioners, too, is strictly regulated by government-determined limits on their number and location, and by financial incentives to increase the number of practices in under-doctored areas.¹² While the number of general practitioners is still closely controlled by central government, the method of access changed dramatically in the last decade of the 20th century. Since the status of a GP fundholder depends on a certain number of patients on the practice list, most GPs today work in group practices, a few even as salaried employees. In the hospital sector, a similar development took place. While the number and location of hospitals are still highly controlled by state authorities, the number of beds and health personnel can increasingly be decided

by semi-independent hospital trusts that have to earn their revenue from contracts won with district health authorities or GP fundholders.^{13,16}

In Germany, the constitutional court overruled the restriction of access for medical doctors to the healthcare market in 1960. Within the self-regulated corporate system, only indirect control of the number and location of general practitioners and specialists as well as the restriction of access to medical schools was possible for many years. In 1992, however, a retirement age for doctors in office practice was introduced for the first time, and the association of panel doctors gained the power to refuse the entry of new doctors to office practice if the region was judged to be oversupplied with self-employed doctors. For hospitals, however, the Länder were always in control of capacity planning. Although, since 1989, hospitals have formally contracted with sickness funds, de facto public 'hospital plans' are actually still in place. Up to now, all attempts to strip the Länder of this power have failed.

In the United States, the increase in the number of medical doctors was promoted by large federal outlays for the training of medical school students in the 1960s and 1970s. The number of private practices also increased steadily. In 1997, however, the total number of outpatient practices for which Medicare makes direct payments was limited by the Balanced Budget Act.²⁰ Further restrictions were set by government (in the case of Medicare or Medicaid) or by self-regulation in managed care plans.²⁴ In the inpatient sector an important regulatory measure was introduced by the National Health Planning Act in 1974, which created a system of state and local health planning agencies, largely supported by federal funds. The law required all states to adopt certificate-of-need (CON) laws by 1980, subjecting expansion as well as new entry into the hospital market to certification. Although federal funding of the programme was eliminated in 1986, about 30 states have partially continued the CON process.²¹

Concerning the regulation of *access of service providers to the healthcare market*, Germany and the United States increased state control, while the United Kingdom eased state restrictions by introducing fundholding models. On the one hand, in the US, hierarchical control mechanisms to channel the access of medical doctors were introduced through managed care systems. On the other hand, in Britain, the hierarchical planning and control system of the British NHS has been extended by the introduction of partly independent fundholding settings and NHS trusts. The British government still controls the number and location of general practitioners, but the means of access has changed dramatically. Just like GP fundholder practices, most general practitioners, today cooperate with other health service providers in group practices and negotiate on contracts with health authorities and hospital trusts. Thus, negotiation partly replaced hierarchy.

Finally, in the German system, only in the 1990s were some limits for the entry of new doctors for office practice introduced by state regulation.

Access of patients to healthcare services

In the national health system of the United Kingdom, access to healthcare services is constrained by a reliance on primary care physicians as health system gatekeepers. As a rule, patients are only permitted to select or change their primary care physician once per year, and for access to specialists, patients need a referral from their GP. For British patients it is therefore hardly possible to track multiple physician contacts. Apart from the proliferation of medical practices and the decline of average list size, patients' access to service providers has been facilitated by allowing patients under certain circumstances to change their GP more than once a year. This new rule was introduced in 1990 to increase competition between doctors and make them more responsive to their patients' needs. Since the average size of practices has been increased through the introduction of GP fundholding practices, the access of patients to different service providers in group practices (GP fundholding practices, total fundholding practices etc.) has been improved.

In the German health insurance system, access to health services and the right of patients to choose their own doctor (general practitioner and specialist) has always been an important feature. While the de facto possibilities for 'doctor hopping' increased in the late 1980s and early 1990s, in the second half of the 1990s the government introduced legislation that allowed various types of managed care elements as gate-keeping models, as well as for provider networks and other forms of integrated care. Providers and sickness funds, however, only hesitantly seized these opportunities. With the US experience in mind, in the latest piece of legislation the government even extended possibilities for managed care through the introduction of disease management programmes as well as through the improvement of models of integrated care. When effective, these models will strengthen funds that want to become players rather than payers. On the other hand this will lead to selective contracting between funds and groups of doctors, thus introducing elements of competition and market coordination.

In the United States, the access of patients to healthcare providers is restricted in several ways. Generally, in managed care, the choice of healthcare provider is limited to a pre-selected network of providers. For further investigation, three different forms of managed care organizations have to be considered according to their difference in regulating access to patients. In health maintenance organizations (HMOs), enrollees have no choice of provider and receive access to specialists only through the primary care provider. In preferred provider

organizations (PPOs) there is no such gatekeeper. Members may also choose to opt out of the network of providers but at the cost of higher out-of-pocket payments. In case of point-of-service (POS) plans there is a primary care provider as gatekeeper, and again members have the freedom to opt out when choosing a higher co-payment.²⁴

As far as the regulation of the *access of patients to service providers* is concerned, our preliminary analysis shows developments towards a similar model in all three countries. In the British NHS, general practitioners have been the first-contact service providers since the introduction of the NHS. In Germany, however, patients still have free access to general practitioners but sickness funds are encouraged to implement gate-keeping models and other forms of managed care. In the US, access of patients to services and the choice of providers has also been restricted under managed care plans – by state regulation (in the case of Medicare/Medicaid) or by self-regulation measures in managed care programmes. The role of the state varied in bringing about those changes: in Germany, funds were given more control through legislation; in the UK, the state induced internal markets; while in the US, once again, markets were the driving force in bringing about more hierarchy.

Benefit package

In the United Kingdom, there has never been a benefit catalogue on the macro level. Health authorities and service providers are free to decide about appropriate services within given budgets. Since cost-containment can be executed through budgets, there is no need for cuts in a formal benefit catalogue to limit expenditure. Consequently, restrictions of benefits through waiting lists as well as through the denial of certain services on a local and/or regional level are the result. The effect, however, was described as ‘postcode prescription’, alluding to the fact that access to certain services depended on the area in which the patient lived. In order to improve (regional) equity, the National Institute for Clinical Excellence (NICE) was introduced in 1998. The NICE is an independent institute, consisting of representatives from all stakeholders of the healthcare system, that provides guidance on all types of services, but with a strong emphasis on pharmaceuticals. The NICE appraisal process for services follows a well-publicized, standardized procedure, including a health technology assessment (HTA) report, normally commissioned from a university or a research institute. NICE guidance is fairly binding, although regional health authorities still have some discretion and providers may follow a different course if they argue their case. Although cost control is still guaranteed through budgets, NICE places a higher relevance on cost-effectiveness than, for example, the respective German bodies do.³⁴ The establishment of NICE limited the power of managers and the medical profession.

In Germany, cuts in the benefit package have been a constantly used measure of cost-containment. During the 1970s and 1980s, numerous deductibles and co-payments were introduced through legislation.²⁹ Although there was some rhetoric claiming that they were introduced in order to limit moral hazard behaviour, they were in fact just aiming at cost-containment. Only in the 1990s did efficiency considerations become more prominent, and the design of the benefit package started to follow the methods of evidence-based medicine and HTA. In the Healthcare Reorganization Act of 1997, the Federal Committee of Physicians and Sickness Funds was given the power to evaluate existing and new technologies and services with respect to effectiveness and cost-effectiveness, and to decide whether they should be part of the publicly financed benefit package.¹⁴ In the latest healthcare reform, taking effect in January 2004, these powers were consolidated and formalized with the new Joint Federal Committee, representing doctors, hospitals and sickness funds. In its decisions about benefit catalogues the Committee is advised by a newly founded independent German Institute for Quality and Efficiency in Healthcare. Thus, once again the state intervened in order to strengthen corporatist self-regulation following publicly decreed goals.

In the US, decisions about benefit packages are as fragmented as the whole system. There are some federal and state regulations concerning benefit packages for private insurances. For the part of the population relying on private health insurance through their employer, decisions about benefit packages are mostly up to employers and insurance companies. Even for public programmes, namely Medicare and Medicaid, procedures and criteria for benefit decisions vary between programmes and states. Evidence-based medicine and health technology assessments were established through the public Agency for Healthcare Research and Quality (AHRQ), which was founded in 1996, and which offers services to public and private bodies. For Medicare and Medicaid, Centers for Medicare and Medicaid Services (CMS) evaluate services on the basis of HTA reports. Private insurance companies quite regularly follow the CMS's decisions. Maybe the most interesting development in the context of decisions about benefit packages, however, is the development of health maintenance organizations (HMOs) and other forms of managed care. HMOs provide a high degree of vertical control over providing units and professionals, also with respect to the benefit catalogue. Thus, managed care gives room for a hierarchical element in privately managed care.

With respect to the regulation of the *benefit package* we observe another 'meta-trend': the heralding of health technology assessment as a standardized procedure for the determination of benefit packages. While responsible institutions vary between countries, the criteria and procedures for determining benefit packages became more similar. Interestingly, in the UK, the respective responsibilities were not given to state agencies but to an independent institute that represented all stakeholders of the system in a quasi-corporatist structure, thus

strengthening the bargaining mode and marking a partial retreat of the state. In Germany, we once again observe state intervention to strengthen corporatist self-regulation. The US case, finally, is more difficult to judge, due to the high level of fragmentation.

Conclusion: towards a ‘mixed model’?

In this essay we have developed a conceptual framework for the description of the role of the state in healthcare systems as it pertains to financing, service provision, and regulation. Utilizing this underlying framework, we then presented some tentative evidence to answer the two major questions raised in this contribution: first, is there an overall retreat of the state and, second, is there some convergence between the three types of healthcare systems, i.e. the national health system, the social insurance system, and the private system?

The analysis of the *financing* dimension of all countries under consideration showed that public health expenditures increased at a higher rate than GDP even after 1975. Moreover, we observed a decreasing share of public health expenditures in total health expenditure, leading to a partial shift from public to private financing. Since this relative retreat of the state is the highest in NHS countries, which had the highest public share at the beginning, and since there is an increase of public financing in the US, this leads to a limited convergence based on a ‘catch-up process’ of laggards. However, major differences in the role of the state with regard to healthcare financing remain between the three types of healthcare systems.

OECD healthcare data provide very limited information on the public–private dichotomy of *healthcare provision*. The data that are available, however, show neither signs of a retreat of the state nor do they point to a convergence of systems. The average share of public hospital beds as a percentage of total hospital beds, for example, remains above 80% in NHS-systems, at about 55% in social insurance systems, and at about 20% in the private US system.

As far as our third dimension, *regulation*, is concerned, we find a general tendency to introduce into each type of healthcare system such modes of coordination that are unfamiliar to that type. More specifically, internal markets and thus an element of market competition and negotiation were introduced into the traditionally hierarchical mode of Britain’s NHS, while competition was also introduced into the German social insurance system, which traditionally rests on bargaining and self-regulation by the stakeholders of the system. In the US, the dawning of managed care introduced an element of hierarchical coordination into a market system. While in the UK and Germany, those major developments were promoted by the state, the US development was introduced by market forces and only later fostered by government. In effect, the role of the state in regulation

Table 2. The changing role of the state in healthcare systems.

<i>Type of healthcare system of data</i>	<i>Financing (all countries)</i>	<i>Service Provision (all countries)</i>	<i>Regulation (UK, Germany, US as representatives for distinct types)</i>
National health service	Decreasing share of public health expenditure on total health expenditure	No clear tendency can be found, possibly due to lack of data	Still high degree of state control but amended by the introduction of competition via 'internal markets' and some corporatist elements through NICE
Social insurance system	Constant share of public health expenditure on total health expenditure		Still predominance of collective bargaining, but complemented, in the 'shadow of hierarchy', with competition as a new principle
Private (insurance) system	Increasing share of public health expenditure on total health expenditure		Introduction of hierarchy through managed care, higher state potential through increase in public coverage
All countries	Slight reduction of public share after 1980; slight convergence tendencies	Distinct patterns of different types remain	Convergence to mixed modes of regulation replace 'pure types'

decreased in the United Kingdom in favour of more market coordination, while in Germany the state continues to act as a referee who intervenes whenever deemed necessary. For example, it was the state that supplemented still powerful self-regulation mechanisms by some element of competition. In the US, finally, we see some retreat of the state from direct intervention, but at the same time, a strengthening of hierarchical regulation, which is executed through the private sector.

These changes should not, however, lead to the conclusion that system-specific characteristics have disappeared. The British NHS is still based upon a hierarchical planning and control system, for example when setting cash limits or deciding on the number and location of general practitioners. In Germany, the corporate structure of the social insurance system was even strengthened with respect to the access of service providers to the healthcare market, or with respect to the regulation of the benefit package. The private US system, lastly, experienced some de-regulation for the private insurance sector.

In Table 1, the role of the state in different types of healthcare systems was outlined. Table 2 sums up which changes happened from the early 1970s onwards.

By and large, we see a slight reduction in public healthcare financing, combined with a tendency towards convergence in this dimension. With respect to regulation, convergence is even more prominent, but we do not have sufficient data to evaluate changes in service provision. Although these observations are based on preliminary data analyses, they lead to the hypothesis that a shift occurs from distinct types of healthcare systems to mixed types. This shift and the spread of gate-keeping, managed care and DRG models around the world would indeed emphasize the role of policy learning and best practice as a yardstick of reform, while the still remarkable differences between the types of healthcare systems point towards inertia and path dependency as the main reasons for the slow pace of this convergence process.

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