Who Is the Odd Man Out?: The Experience of Western Europe in Containing the Costs of Health Care

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OVER THE PAST TWENTY YEARS A BROAD consensus seems to have emerged in the United States on two central issues. First, it is now accepted that national health insurance (NHI) is financially out of the question. No longer does an annual rota of very varied NHI proposals get placed before the Congress. Even the most vocal and persistent champions have drifted into silence. And the idea of going further and establishing a national health service has long been off almost anyone's political agenda.

Second, there appears to be a broad consensus that certain instruments which were once expected to help control the cost of health care not only failed to work but could never have worked. Three sets of beliefs underlie this consensus and in turn tend to reinforce it:

1. It is now widely believed that all regulating agencies *inevitably* get taken over by the regulated. Thus, Professional Standards Review Organizations (PSROs), certificate of need (CON), and comprehensive health planning (CHP), were all bound to fail; diagnosis-related groups (DRGs) are doomed to the same fate.
2. It is believed that *no* system of cost control can hold in the long run just as you cannot hope to keep the lid permanently on a boiling kettle: health professionals and health service em-

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ployees are bound to find a way through any attempts to regulate their income. Moreover, the inevitable growing cost of medical innovation must force its way through in the medium term unless quality of care is to be placed at risk.

3. It is believed that while early health maintenance organizations (HMOs) arguably did help to contain health care costs, a general policy of HMOs, even if they could be established throughout the whole nation—which they could not—would not necessarily manifest the beneficial effects of the early pioneers unless strongly directed by market pressures.

Thus, as a result of these beliefs, many of the acronyms of the 1960s and 1970s are being buried to puzzle medical historians when they unearth them in the future.

Other means of controlling health care costs are so impractical and un-American as to be not worth discussion. Budget limits set for each hospital are likely to be out of the question, if historical precedence is any guide, simply because there are so many separate insurers and hospitals. The level of fees charged by health professionals and relative value scales are inevitably matters to be established by the professions rather than negotiated with government, federal or state, or national federations of insurers. The controversy over Medicare fee caps and fee assignment proposed by the Health Care Financing Administration (HCFA) is instructive. It would be impossible to establish federally set quotas for students entering medical schools, let alone quotas for doctors entering clinical practice, specialty by specialty, in each state.

Hence, the thrust toward market pressures is the only way to knock sense into the health care industry. This takes three forms—often at the same time. First, is the reversal of the trend toward more comprehensive insurance by growing *de-insurance*, politely described as "deductibles," "co-payments," and "cost-sharing." Second, is the idea of making those who benefit from insurance actually pay the whole cost of it without any kindly help from employers or income tax concessions to force them to shop more prudently. Third, is the practice of putting services for poor people out to tender so that the contract can be given to the lowest bidder—a development reminiscent of practices abandoned in the face of strong medical opposition in Britain during the nineteenth century under the Poor Law.

While the trend in Europe is also toward a slightly larger use of

direct payment (de-insurance), the main emphasis of policies has been in two different directions. First, there has been increasing regulation and the tougher use of regulation in a whole variety of innovative ways. The choices made in each country vary according to the particular system of health care financing and organization, the pattern of ownership of hospitals and the extent to which it is regarded as politically feasible to interfere, even indirectly, with the practice of medicine. The second development has been the thrust in more and more countries to move over from a compulsory health insurance model to a national health service model of providing health care (as defined later).

The material underlying this article comes from only twelve of the Western European countries which are or are likely to become members of the European Economic Community (EEC)—the ten existing members plus Spain and Portugal. Only the main measures introduced up to the fall of 1983 are included (see Abel-Smith 1984).

The Economic Background

The economies of Western Europe have been even more disturbed by the second oil crisis of 1979 than by the first (1973). Low growth and in some years negative growth and attempts to moderate inflation have led to policies to restrict the growth of public expenditure. In Western European countries spending on social security (or social protection, as it is defined in the European Community) represents a massive chunk of public expenditure. Among the ten existing EEC members, excluding Greece, it amounted in 1980 to between 21.4 percent of the gross domestic product (GDP) (in the United Kingdom which was the lowest spender), and 30.5 percent of the GDP in the Netherlands (which was the highest spender). Social protection covers spending on cash social security benefits as well as spending on health care and certain other social services (but not education).

Attention has focused on social protection spending for two essential reasons. First, the massive growth of unemployment has reduced the yield of social security contributions and also of tax rates. Second, social security spending has long been rising faster than the gross national product partly because of the growth in the proportion of aged in the population with its impact on pensions and health care spending, and partly because of increasing demands on health care

systems mainly by providers. It is in this context that governments and health care insurers have set about the task of finding ways of containing the cost of health care. The common objective has been to keep the growth in line with the growth of the gross national product or in line with the contribution income of health insurance funds at given levels of contribution. Such policies have been applied in all of the twelve countries except Greece where services are still held to be underdeveloped.

The regulatory measures adopted by the twelve countries are described below. First are set out short-term measures aimed to have immediate effect. Next, medium-term measures are described—such as hospital closures or mechanisms broadly corresponding to certificate of need. Finally, the long-term control of the output of highly trained health professionals (particularly doctors) is discussed.

Measures with Immediate Impact

Budget-funded Services

In Europe, several countries finance their services by what are called in America "prospective budgets." Europeans do not yet see how a "budget" can be anything other than prospective. It is inevitably easier to control the costs of health care where the body that finances the system also owns all or most of the facilities where health care is provided, finances these facilities on a budget basis, and employs the staff who work in them—particularly the doctors. This body may be the central government with its own hospitals, as in the case of Ireland, Italy, or the United Kingdom, though local decisions may be delegated to health boards or health authorities. It may be local government heavily dependent on general rather than categorical central government grants, as in the case of Denmark. Or it may be the key statutory plans, as in the case of Spain, Greece, or Portugal who also employ general practitioners and specialists as well as having a major role in hospital ownership.

Budget control and the removal of incentives for the provision of excessive services or uneconomical provision of services (e.g., unnecessary use of hospitals) and the promotion of preventive activity are, of course, the central ideas underlying the HMO. Some Americans seem

to write of them as if they were a sudden revelation of the Nixon era. They are, however, certainly as old as European health insurance plans and probably underlay, if in a primitive form, any plans for the health services of the armed forces of any country at any time. The early Austrian, German, and British health insurance funds which preceded the era of compulsory health insurance were HMOs to the extent that technology permitted. This was the rationale of comprehensive capitation payment. Similarly, the multitude of health insurances operating under Bismarck's scheme of 1883 were HMOs. British district health authorities which provide local services under the National Health Service are, in a sense, monopolistic HMOs.

Budgets can be set at predetermined levels and local management forced to do the best it can within its share of the budget limit. The budget determines what numbers of staff can be hired and what purchases of equipment and other supplies can be made. Some of the consequences may seem unacceptable to American readers. For example, about a quarter of physicians in Spain are registered with the Physicians' Association as unemployed because the statutory insurers refuse to hire more physicians than they can afford to pay. Budget controls in any country may result in some patients having to wait for treatment—an issue much commented on in the United States but only in the context of Britain's National Health Service. In this connection it may be worth pointing out three facts. First, the size of waiting lists in Britain is much more a consequence of past strikes of health service employees seeking to break through an anti-inflationary national pay policy than of chronic under-financing of the service. Second, the situation varies enormously geographically. There have always been some hospitals which can admit an elective surgical case (the main waiters) virtually immediately. Third, a survey commissioned by the Royal Commission on the National Health Service showed that 80 percent of patients do not see themselves as inconvenienced or distressed by waiting (Royal Commission on the National Health Service 1978, 26). Moreover, the rise in private health insurance in Britain to cover about 7 percent of the population (almost exclusively for specialist and hospital care) is not correlated over time either with the length of waiting lists or with strikes in the National Health Service. The main factors seem to be initiatives by employers to use fringe benefits as a way around anti-inflationary national pay policy and more aggressive sales promotion by the key insurer.

Inevitably, "prospective" budget-setting is a political process for health services as it is throughout the world—even in the United States—for schools. How tight can you turn the screw before providers use the media to appeal over the heads of politicians to public opinion with allegations that quality of care is suffering or money is insufficient for certain lifesaving cures to be provided? Shroud-waving of this kind can be effective. And it is notable that despite Mrs. Thatcher's attempt to cut public expenditure, the resources available to the British National Health Service have been increased not inconsiderably during her period of office. Tougher has been the government of Denmark which cut central government grants to local authorities by 10 percent in 1983, and persuaded the local authorities to reduce the level of hospital current expenditure back to that of 1980 and reduce expenditure on primary health care by about 0.5 percent in 1983. Similarly, the expenditure allocations to Irish health boards were based on the assumption that staff numbers would be cut by 2 percent between July 1981 and March 1983. The room for cuts without serious damage to quality may have been greater in Denmark and Ireland than in Britain.

It is presumably because of concerns about quality that countries with budget-funded health services do not solely rely on budget cuts when they are in economic difficulties. They also introduce or increase direct charges for certain nonhospital types of health care, or reduce the scope of what these services comprise. Thus, Ireland and Portugal have recently decided to make patients pay the full cost of nearly all or many drugs which could have been bought without prescription. And Italy has heavily restricted the use of free spa treatment, and Denmark payments for transport used to obtain health care. All countries with budget-financed health services now make charges for drugs except Greece (in the case of the scheme for the agricultural population) and Ireland, where free drugs are only available to the lower income groups. Some countries exempt from these charges large categories of the population. What is notable is that *countries with budget-financed health services still provide free hospital care*. Portugal which had tough income-related charges for hospital care from 1982 decided to abolish them a year later. Only Portugal charges for home and office visits and diagnostic tests but there is a wide range of exempted categories of patients.

Contracted Services

In Belgium, Germany, France, and Luxembourg hospitals are paid per day of care, and doctors outside hospital and in some cases inside hospital are paid on a fee-for-service basis. The Netherlands also pays hospitals per day of care, has its own special arrangements for paying doctors for in-patient services, and pays out-of-hospital specialists on a fee-for-service basis and general practitioners on a capitation basis. One of the most ingenious developments of recent years has been to apply prospective budget limits on services financed in these ways.

How can budget limits be imposed on services paid for on any itemized basis? In the case of hospitals an income ceiling can be given to each institution usually based on the real income of a previous year. Any income beyond the target income has to be paid back at the end of the year proportionately to the various insurers funding the care of patients in that hospital during the year. Thus, in the Netherlands the 1985 target income for each hospital has been set at 1 percent below the 1983 real income, and is targeted a further 2 percent lower in 1986. It should be pointed out that only 70 percent of the population of the Netherlands is covered by statutory health insurance and virtually all the rest (the higher income groups) take out private insurance from a large number of carriers. The system applies to the income of the hospital from both types of insurer. In 1983 each general hospital in Belgium will be paid for the number of bed days provided in 1980, less 3 percent in 1983 and less 5 percent in 1984. In France each contracted hospital was given a target income for 1984.

The Netherlands also applies the target income system to specialists working outside hospital. The total income of these specialists is to be held constant between 1983 and 1986 despite an expected increase in their number. Any extra services provided by existing specialists or new specialists will lead to proportionately lower fee payments. The Belgian system is much looser and operates only on fee levels which will no longer be indexed to the cost of living.

The German system of ceiling control is voluntary rather than mandatory but it has, on the whole, been reasonably effective. At an annual conference of all concerned parties (including health insurers and providers), separate targets are laid down for physicians' incomes, for dentists' incomes, for dental supplies, for drugs, for hospitals, and

other items. The system works as well as it does because the key provider groups are well aware that if the system does not work reasonably well over the years, more drastic compulsory action would be likely to follow. Such action might even go so far as a salaried national health service. France has also tried to use voluntary targets but with less success. The 1980 agreement with the profession "envisaged" that the level of fees and number of services would keep total costs in line with the gross domestic product. The French medical profession has always been much less cooperative and more militant than the German.

A second method of controlling the costs of contracted services has been by altering the incentives operating on physicians. Changes in relative value scales have been negotiated in both Belgium and Germany with the aim of containing costs. In the former, relative payments for diagnostic tests were considerably reduced in both 1980 and 1983. In the latter, there has been a steady increase in the payment for the consultation as compared with fees for technical procedures—again, particularly, diagnostic tests.

Both Budget-funded and Contracted Services

Medical profiles or systems of monitoring the activities of doctors in the case of out-of-hospital drugs have a long history in Europe (e.g., Germany, Denmark, Ireland, and the United Kingdom). A similar system has recently been introduced in Spain under the main health insurance scheme. PSROs, though more comprehensive, were no new invention. Belgium and France have recently introduced monitoring systems for all medical acts of doctors. The Netherlands is planning a system for out-of-hospital specialists, and Portugal for doctors working in ambulatory care. Regulating systems of the PSRO type are expanding in Europe despite their abolition after brief experience of them in the United States.

Out-of-hospital pharmaceuticals are a fertile field for different measures of cost-containment. More and more countries are developing *positive lists* of what doctors may prescribe under health insurance, with an increasing emphasis on cost-effectiveness in choosing which items to include on the list. Such lists are, for example, to be found in Belgium, Denmark, and Portugal, and are being developed in Spain and Greece. An alternative approach is to develop a *negative list* of products which

doctors are asked not to prescribe (the Netherlands) or may not prescribe under health insurance (certain minor drugs in Germany). *Inclusive lists*, which can give preference to generics, thus ensuring effectiveness at lower cost, are a less controversial approach to increasing generic prescribing than by, e.g., pharmacist substitution. The prices of drugs, including retail margins, are being controlled in more and more countries. In 1983 pharmacists were required to pay back 4 percent of turnover in France and 5 percent of the official price in Luxembourg.

It will be noted that the more draconian measures of cost-containment, such as budget ceilings, are very recent. They have only been imposed after extensive debate about how far, and for what, patients should be made to pay direct charges for health care. What is notable is that, in general, countries with daily payments for hospitals and fee-for-service systems of paying doctors have gone somewhat further with direct charges than countries with built-in budget financing. France has always left patients themselves to pay 20 to 25 percent of most medical bills except for major hospital bills. But France now requires patients to pay 60 percent of the cost of certain minor drugs. Belgium and Luxembourg have recently extended or introduced charges for consultations with doctors. Belgium, Germany, France, and Luxembourg now require all or most patients to pay a charge or "deductible" for hospital care, though only at the rate of around $2.00 to $4.00 per day. The arguments generally used to justify such charges are "home savings" (e.g., food). All these countries now require patients to make payments for drugs—either a flat rate charge (Belgium, Germany, the Netherlands) or a proportion of the cost (Luxembourg and, of course, France). Flat rate charges are small by American standards—around $1.00 to $2.00 per item. There has been an interesting switch of policy in Germany from charging 20 percent of the cost of all dentistry to charging 40 percent but only for work done by dental technicians. This is to discourage the over-provision of dental prostheses—an area where costs had been rising rapidly.

Measures with Medium-term Impact

These measures are aimed at facilities. All twelve countries have mechanisms to control hospital developments. In nearly all countries

there is a recognition that hospitals have been over-developed if not nationally at least in some regions. Certificate-of-need systems, under a variety of different names and jurisdictions, were generally introduced too late. These are, however, now being rigidly applied on new developments. A special system of authorizing purchases of listed "heavy medical equipment" is also applied in Belgium and France. Countries with planned systems in the public sector can control hospital construction and equipment by budgets and other measures. The problem that has been extensively debated is how to deal with hospital facilities, particularly general hospital facilities, in excess of what are believed to be current requirements. "Roemer's Law" operates in Europe as elsewhere: hospitals once provided tend to be used.

One minister, responsible for health in the Netherlands, boldly announced in 1982 that 27 substantial hospitals were to close. Inevitably this encountered fierce opposition in a country where choice had to be made between denominational and nondenominational hospitals as well as the usual issue of loss of local employment. The policy finally adopted by a later minister, that of squeezing all hospital budgets, if less economically efficient, was more politically realistic. The alternative or complementary approach of trying to change the functions of certain hospitals from short-stay to long-stay is obviously less politically sensitive from the employment point of view than closure.

The only country of the twelve to get far with a policy of hospital closure is the United Kingdom, with about 300 hospitals (mainly small) closed during a ten-year period. The policy has been easier to apply because Britain still has a legacy of old, small hospitals. But more important is the fact that hospital staffs are employed not by the hospital but by the health authority which has several local hospitals under its control. Staff can be offered jobs at neighboring hospitals rather than be made redundant. A further favorable factor has been the existence in each district of a body, representative of consumers (the Community Health Council), which must be consulted on closure. In over 90 percent of closures this Council comes to be persuaded that the proposed closure will provide a better use of the money provided for the district.

In Belgium, the limit on the number of short-stay beds which the social security system will pay for encourages the transfer of beds for use for long-stay cases where the number of bed days paid for is not limited, though the rate of payment is lower. In the Netherlands,

also, the budget limits on hospitals are being accompanied by plans to finance an increase in the capacity of nursing homes and day centers and home nursing. In Denmark the reduction in expenditure on hospitals is being accompanied by action to encourage the development of less costly alternatives, such as day surgery, day hospitals, five-day hospitals, nursing homes, residential homes, and home care. Similarly, in Luxembourg some general hospitals or parts of general hospitals are being transferred for the use of long-term patients. In Germany, on the other hand, it is feared that the financing of nursing homes would become an extra service rather than a substitute for hospital care. But, it will be recalled, the target for hospital expenditure is not mandatory nor does it normally represent a reduction in expenditure. In Italy, private hospitals under contract with the health system can be forced to suffer the curtailment of provision: fewer bed days may be purchased from the private sector.

Measures with Long-term Impact

These are aimed at the production of highly qualified manpower, which under European Community law must be allowed to move freely between member states. Only two of the twelve countries do not now have some system of quotas operating in medical schools. These are Belgium and Italy. Particularly exposed to the immigration of doctors from other member countries is Luxembourg (which has no medical school)—notably from Belgium (which has no quota). The Greek quota has limited effect because many Greek students go to study in Italy, which has no quota, and return to practice in Greece.

Some reductions in medical student entries have been large. The number of entering students was cut from 2,000 to 800 when the quota system was introduced in Portugal in 1977. Entry of Irish medical students was cut from 500 in 1978 to 300 in 1983. In France the cut has been from 8,726 to 6,000 over roughly the same period. On the other hand, the United Kingdom has been increasing its annual quotas of entry to medical schools to enable it to replace foreign medical graduates, mainly from India and Pakistan, with British graduates as the former retire in view of the tighter controls on immigrants from outside the Common Market. Doctors from continental European countries tend not to move to Britain, partly because

of language and partly because physicians' incomes (like other incomes) are lower in Britain.

The Trend toward National Health Services

The term "national health service" is loosely used throughout the world. In the United States it has come to be used almost as a term of abuse—synonymous with "socialized medicine." This gradually replaced "teutonic medicine" as the main bogeyman among foreign medical care systems after the First World War when the Russian Revolution led public opinion to replace Germany with the U.S.S.R. as the potential oppressor of Europe. If the idea of medical services being provided by doctors both employed by some level of government and working in publicly owned hospitals and clinics is the essence of socialized medicine, then historically the concept owes more to the Czars than to the Soviets, who massively expanded and developed the Russian system. Perhaps it would be more historically correct to describe this model as "Czarist medicine."

But is this the essence of a "national health service"? If it is, then Finland or Sweden (countries which are not members of the European Community) are nearer to having a national health service than Britain because a considerable part of primary health care is provided by salaried doctors in publicly owned facilities in those countries, while virtually all general practitioners are self-employed contractors in Britain, most of them working in their own premises, in much the same way as in Denmark or the Netherlands. (Salaried doctors in primary care are far less frequently to be found in these countries than in the United States.) Do Sweden and Finland, or for that matter Denmark, fail to have a "national health service" because it is run mainly by local authorities and thus is not "national"?

Is the provision of free care to all comers by central government the essence of a national health service? If it is, then it is hard to think of any examples in the world except perhaps Sri Lanka. Or is the key feature financing from taxes rather than from social security contributions? If it is, then Italy was quite wrong to call its 1980 reform "the creation of a national health service." If it is not, why is Canada not described as having a national health service rather than

having health insurance? Is it because it is run by each province and not the federal administration, or is it because general hospitals are voluntary, nonprofit rather than public, although receiving annual budgets from "the system," however it is described?

In Europe the essential feature of a national health service is coming to be seen as universal entitlement for all citizens rather than entitlement to the benefits of the main system, or different funds being determined by whether social security contributions have been paid. The precise mix of publicly owned and privately owned facilities (large U.K., small Canada), of salaried professionals (large Sweden, smaller Italy), the roles of central, regional, or local government (centralized U.K., highly decentralized Finland), the degree of charging at time of use, and whether the system derives part of its finances from social security contributions (small U.K., large Italy), are matters of detail which inevitably vary between different "national health services." Sweden, Norway, and Finland have national health services but do not choose to use the term. Similarly, Canada has a national health service. But it was presumably because the term had acquired pejorative connotations in North America that health insurance was the preferred description for purposes of political rhetoric when the system was established.

This discussion of nomenclature has been necessary to explain to the North American reader what lies behind the trend in Europe toward the establishment of national health services. Thus, when Portugal established its national health service in 1978–1979, everyone became entitled to use the main structure of health services. This does not mean that moving over to universal standard entitlement was the only reason for establishing it. In addition, the curative and preventive services were brought together and social security contributions for health insurance purposes were abolished. The motives of the Italian reform of 1980 were even more complex. While it is true that some two million (mainly poorer) Italians obtained rights they were previously denied, the change had two further objectives—cost-containment and a fairer distribution of health care resources among the regions of Italy. How could the substitution of a national health service for many different health insurance funds help to contain costs? First, the costly bureaucratic processes of determining entitlement to separate funds and of billing—processes which consume a growing proportion of U.S. health expenditure—were abolished. Second, all

general practitioners became paid on a capitation basis where previously many had been paid on a fee-for-service basis. It had been found that the prescribing of drugs had been much higher by doctors paid on a fee-for-service basis. Third, many specialists became paid on a full- or part-time salaried basis rather than on a fee-for-service basis with its incentives to overprovide services. Fourth, funding public hospitals and other services on a budget basis rather than each insurance fund paying per day of care reduced financial incentives for prolonged acute hospital stays. Fifth, the government could control future hospital capital expenditure in view of its implications both for current costs and for geographical equity.

In Spain, a law is currently being drafted for a national health service. This will give entitlement to about 10 percent of the Spanish population not covered by the existing three health insurance funds, particularly those who have never worked, to the unemployed and the self-employed who have not joined the statutory scheme. It will also bring together the curative services and preventive services at the local level. Finally, it will enable control over services to be handed over to the elected parliaments of the nineteen regions with budgets provided from the center. Again, the concern is to secure a more equitable distribution of health resources.

Greece is also in the process of establishing a national health service to give every citizen "the same rights to equal and high level treatment and social care" (Abel-Smith 1984, 102). The present different schemes now cover about 96 percent of the population. In this case, the government does intend "the gradual substitution of private clinics and private beds by public hospitals and public beds" (Abel-Smith 1984, 102).

Thus, if the European Community is enlarged by the two prospective new members, six out of the twelve countries will have national health services—Spain, Greece, Italy, Portugal, the United Kingdom, and also Denmark, which has long given every citizen equal rights to health care though it does not call its system "a national health service." It excludes Ireland because full rights are only available to the poorest 40 percent of the population even though the bulk of its services are controlled by governmental health boards. The concept of a national health service, which is dead in the United States, is very much alive in Europe.

Conclusion

There are three main messages of this article. First, in Europe regulation is being used effectively to contain the cost of health care. It can, moreover, take a whole variety of ingenious and innovative forms. Countries which had very high rates of growth of health care spending in relation to national resources have succeeded in moderating them (see table 1). Data is only available for eight countries. It is not true in Europe that any system of regulation gets taken over by the regulated.

Second, budget-funded systems of financing health care—the national health service model—need to rely less on direct charges payable by users as a means of cost-containment.

Third, the trend toward the establishment of national health services

TABLE 1
Average Annual Rates of Growth in Percentage of National Resources Devoted to Health Care—EEC Countries and the United States

	1966–1975	1977–1982
Belgium	N.A.	1.7
Denmark	6.7	0.0[3]
France	3.5	3.8
Germany	7.4	1.2
Greece	N.A.	N.A.
Ireland	9.3	5.7
Italy	6.9	2.3
Luxembourg	7.4	4.6[4]
Netherlands	6.1[2]	2.6
United Kingdom[1]	2.8	3.1
United States	4.6	3.9

Sources: Adapted from Abel-Smith 1984. Figures for the United States calculated by Tom Buchberger, Congressional Budget Office, from R.M. Gibson, D.R. Waldo, and K.R. Levit, National Health Expenditures 1982. *Health Care Financing Review.* 1983. 5(1): 4–5.
N.A. Data was not available for Belgium for 1966–1975. Greece was not at these times a member of the EEC. Spain and Portugal have not yet been admitted as members; their applications are still under consideration.
[1] England and Wales 1966–1975; United Kingdom 1977–1982
[2] 1970–1976
[3] 1979–1982
[4] 1978–1982

in Europe has as its essence the provision of universal entitlement to all citizens. But it also may aim to establish more effective control over costs and a fairer distribution of health care resources between geographical regions.

This is not in any way to suggest that the experience of Europe can be transferred to the United States, which has its own special political, cultural, constitutional, and organizational constraints. What it does bring out is the need to analyze these constraints. How important is the complex legislative process in which subtle amendments can be inserted into bills establishing regulatory mechanisms with the deliberate intention of stopping them from working as originally intended? Why, more fundamentally, are pressures so strong on politicians of certain interest groups in a pluralistic system that what turn out to be paper tigers come to be established? How significant are issues of states rights? How relevant are the career expectations of administrators in any agency given the task of regulating? How important is it to continue at the same time a ritualistic and largely symbolic pursuit of the conflicting goals of social equity, patient and provider autonomy, and cost-containment? How necessary is it to continue to subscribe to the illusion that regulation is the enemy of competition when in reality it is essential to secure cost-containment, quality, and, above all else, equity? How deeply felt is the apparent distrust of government of the people, by the people, actually also being government for the people?

These, and a whole host of other questions, arise in any attempt to explain why the experience of the United States is so different from that of Europe. Moreover, as one looks at trends and experiences throughout all highly industrialized nations—not just Europe but also Canada, Japan, and Australia—one is left asking the question, "Who is the odd man out?"

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