Students of health care systems will greatly benefit from a careful reading of these two volumes which have been prepared on behalf of the Working Party on Social Policy of the Organization for Economic Cooperation and Development (OECD). These books, which are part of the OECD health policy series, focus on the specific structure of the health care financing and delivery subsystems of 24 member countries, most of which are industrial capitalist economies with roughly similar socioeconomic structures. The first book covers seven countries: Belgium, France, Germany, Ireland, the Netherlands, Spain, and the United Kingdom. The second volume surveys health care systems of Australia, Austria, Canada, Denmark, Finland, Greece, Iceland, Italy, Japan, Luxembourg, New Zealand, Norway, Portugal, Sweden, Switzerland, Turkey, and the United States.

Jeremy Hurst, Senior Economic Advisor to the British Department of Health, prepared the first book. It has 12 chapters. The first chapter introduces the main issues: gaps in access, income protection in the face of medical need, macroeconomic efficiency (rapid increases in health care expenditure), microeconomic efficiency (allocative efficiency: enhancing health outcome and patient satisfaction for a fixed cost, and technical efficiency: reduction of costs without any reduction in services), freedom of choice for patients, and appropriate autonomy for providers.

Chapter 2 offers a typology of health care financing and delivery subsystems. Hurst's classification shows how the United States is markedly different from the bulk of OECD countries in its entrepreneurial character. Even Switzerland, which bears the closest resemblance to the United States, has a national health program and important government regulations to ensure that 99% of its population has some kind of health coverage. At the other end of the spectrum are countries with public financing and delivery subsystems. They include the Nordic countries, Greece, Italy, and Portugal. The rest of the OECD countries combine taxation and social insurance for financing, and a mix of public and private arrangements for delivery of health care. The financing and delivery subsystems are further classified according to financial flows, i.e., whether patients or third-party payers pay providers and how patients are reimbursed, the ownership and management of providers, and the structure of referrals. Accordingly, Hurst suggests several models of health care
financing and delivery: private, out-of-pocket model, private and public reimbursement (of patients) models, private and public contract models, and private and public integrated models. The models are listed in the order of greater substitution of markets by non-profit operators including the state.

Hurst discusses the advantages and disadvantages associated with the market mechanism and government intervention. In general, market organization of health care is inconsistent with adequate or equitable care or with income protection and its achievement of macro- and microeconomic efficiency is doubtful. This situation is best represented by the private, out-of-pocket model. In this model, consumers will be fully cost-conscious and will generally enjoy a choice of providers, even though consumer sovereignty or effective competition may not prevail due to the asymmetry of knowledge between patients and physicians. Government financing and delivery of care in any top-down structure, such as the U.S. Department of Veterans Affairs, is distinguished by a lack of effective choice of provider by patients, and incentives for under-service which are not countered by the need to retain customers. Providers are paid by salaries and global budgets. Thus, efficient providers generate more work for themselves but not more resources. However, inefficient providers can maintain a quiet schedule and under-utilize resources. There is no incentive to minimize costs but it is easy for government to control them. However, this model is capable of universal coverage and equity. This situation is best represented by the public integrated model. There are many varieties of mixed (market and non-market), private and public structures of health care financing and delivery subsystems.

Chapters 3-9 outline the health care systems of each one of the seven OECD countries, and their evolution and structural reform. Hurst then returns to the introductory themes of the book to analyze these changes in chapters 10 and 11. The results are summarized in chapter 12. In terms of adequacy, equity and income protection, Hurst finds that public finance is the method of choice to ensure basic health care for the great majority. However, persistent differentials in the health outcome of the population underscore the limits of health care systems. He further finds that all seven countries enjoyed a slower rate of growth of health care expenditure during the 1980s compared to the 1970s. Ireland even registered an absolute decline. All but Spain moved to a greater measure of self-regulation during the 1980s such that the government would be responsible for setting the level of the bulk of health care expenditure, ensuring universal coverage, arranging equity and distributional issues, setting the rules for the operation of the market, and ensuring the adequacy and transparency of information. The market would be responsible for all other matters concerning the local financing and provision of care. Hurst suggests these changes are due to attempts to strike a new balance between the state and the market to enhance the microeconomic efficiency of the health care systems.

The second book has 22 chapters divided into two parts. Brian Able-Smith, a consultant to the OECD, wrote the first part consisting of 5 chapters where he offers an overview of health care reform in the remaining seventeen countries of OECD. The first chapter classifies the health care financing and delivery subsystem of these countries. Chapter 2 touches on the gradual changes in these health care systems: extension of coverage, geographic and outcome equity, cost-containment, hospital financing, the role of primary care, payment of physicians, drug costs, quality assurance, education and training, and patient choice. Able-Smith argues that since universal coverage has been achieved in the great majority of these countries, more attention can be paid to issues of equity and quality. He also notes how tight budgets for all services or for hospitals but not cost-sharing is the method of choice for cost containment in most of these countries. Chapter 3 addresses structural reforms in the 1990s. The most significant of these are reforms in New Zealand in