

Social Policy and the global crisis: consequences and responses

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Health care reforms in Europe

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Intro

Health care is the most important sector of the welfare state in terms of recipients and the second one in terms of expenditures. Nonetheless, health care has been neglected in traditional scholarship on the welfare state (Esping-Andersen 1990; Pierson 1994). The field was left to economists and public health experts; a special literature on health economics emerged. Health economists concentrate on the varieties of national health care systems and assess the most efficient system.

This paper sets out to analyse why and how health care systems change, by combining the theoretical approaches of the welfare state literature with the extensive knowledge gathered by health economists.

In the first part of this paper, the three classical theoretical approaches functionalist retrenchment, institutionalist path-dependency and the impact of ideas are applied to health care. Although the first two have already been rejected by the mainstream literature, these studies never included health care, which calls for a separate analysis. The time frame for analysis are the years 1990-2009, during which neo-liberal market orientation has been the leading reform idea. In the second part, the theoretical approaches are tested on three most different countries: the Netherlands, Sweden and Germany. The aim is to analyse reform processes, not to assess the most efficient health care system or provide normative guidance.

Framework for analysis

The expansion of the welfare state has been explained as a function of economic development (Wilensky 1975). Inverting the argument, economic slow-down or crisis should therefore lead to welfare state retrenchment. Following the oil-crises of the 70s, a race-to-the-bottom has been expected. However, this retrenchment could not be observed in pension and unemployment. Scholars explained this by institutional inertia and path-dependency (Pierson 1994). The new institutionalism explained persisting differences in the light of common challenges by inherited structures of the welfare state (Hall, Taylor 1996). Especially the continental social insurance systems were regarded as “frozen landscapes” (Esping-Andersen 1996). Among these great theoretical contributions, just one focused on health care and stressed the importance of political institutions for the historical development of health care institutions (Immergut 1992). The newest theoretical approach, concentrates on the power of discourse. The most prominent idea in recent welfare state reforms has been neo-liberalism, arguing for markets as the most efficient allocators.

In the following section, the three theoretical approaches functionalist retrenchment, institutional path-dependency and neo-liberal discourse are brought together with the specific knowledge on health care as a welfare state sector to make them applicable for the country studies. Health care is the most complex of the welfare state areas as a whole economic sector with own interests mediates between contributors and recipients of welfare benefits – instead of a formula, like in pension and unemployment schemes.

Functionalist retrenchment

Health economists traditionally follow a structuralist logic. In a rational-bureaucratic and democratic society, objective problem pressure and societal demands are expected to be met by political responses, the mechanism is somehow automatic, as in all economic rational approaches.

Demographic change and medical-technological innovations are named in all policy documents and preambles to regulations as the reasons for health care reforms. Among health economists there is a broad consensus that cost pressure results from demographic change, increasing demand due to post-modernism, medical-technological innovation and the cost-driving nature of labour intense sectors (Moran 1999; Powell et al. 1999; Freeman 2000; Blank, Bureau 2004).

Out of these, demographic change is the most quoted reason for raising costs. From 1986 to 2006 the life-expectancy within the EU rose by more than four years¹. Older people are more fragile and therefore have higher health care needs. However the life-expectancy for people aged over 65 rose just by two and a half years during these 20 years. The real challenge emerges from the rising share of elderly in the population. The share of people aged 65+ nearly doubled during the time span 1990-2009 in Western Europe. The strongest impact is to be found on long term care. This paper concentrates on acute care, where the impact of demographic change is accelerated by changing expectations. In post-industrial societies increasing levels of education and urbanisation of the population result in higher expectations of the health status and mobility of pensioners and rising demands for quality and availability of services as well as choice and self-determination on behalf of the patient.

These developments on the demand side are met by increasing costs on the supply side. Health care is part of the service sector, productivity increases, like in the industry through automation are nearly impossible. On the contrary, medical-technological innovations, like x-

¹ Data are not available for Estonia, Italy, Cyprus, Latvia, Malta, Poland and the United Kingdom. In Lithuania the life-expectancy fall by 1,2 years during this time span. All data taken from Eurostat.

ray and magnetic resonance tomography, increase personnel costs, as new qualified personal is needed to handle the new equipment. The highly qualified personal, which is needed for modern medicine, requires the same wage increase as equally qualified personal in the industry sector. Apart from a few innovations like key-hole surgery, progress results in increasing costs in health care.

The pressure resulting from demographic change and technological innovations are alike for all countries in this study. From a structuralist point of view, we would therefore expect convergence towards one – most efficient - health care system. This convergence trend could not be observed following the oil crises of the 70s. The welfare state literature offers an explanation for persisting differences: institutional inertia.

Institutional path-dependency

Institutions are defined as the “rules of the game”. Welfare programs are institutionalized historical decisions. Their existence confines and restrains policy options available. Once the path-way is chosen, welfare states become highly path-dependent, because "welfare states create their own constituencies" (Pierson 1996, S. 311). The universal inclusion mature health care systems have reached ensures them universal support by the voters. National institutions also shape their actors and their constellation. The historically grown size of the pharmaceutical industry and the density of doctors are important factors within the reform process. The specific institutional design of national systems is therefore a determinant of the reform process.

National welfare state institutions have long been clustered into “three worlds of welfare capitalism” (Esping-Andersen 1990). However, this work and the majority of its citizens neglected health care. In the literature on public health, just two basic types have been distinguished: National Health Service and Social Insurance Systems. Several ways and methods to classify health care systems have been proposed, but all end up with this basic distinction for Western Europe (Moran 1999; Freeman 2000).

Solidarity and actuarity are the underlying principles of social health insurances (SHI). The members of the insurance pay a regular contribution, which, in contrast to private or voluntary insurances, is based on income rather than reflecting health status or risks. Membership is based on employment status and obligatory for employees. Children and spouses have derived rights to care. Contributions are paid both by employers and employees, which is often reflected in the board of management of the insurance funds. The variety of social insurance

system reaches from universal, meaning just one public insurance covers all citizens (in the Central and Eastern European Countries) to highly particularized with several occupational funds and substitutive private health insurances for the well-off (in Germany).

The system is self-administered by the social insurance funds and the medical profession. The government just sets a regulatory framework for the insurances. People, who are unable to afford health insurance coverage get government subsidies, however the budget of the social insurance fund(s) stays separate from the general government budget (Jacobs, Goddard 2000, S. 7). Goods and services are provided by private hospitals, often non-for profit ones, and doctors in private praxis. At least some choice is available to patients and satisfaction with the system is generally high.

The typical problems of social insurance systems lie in the inability to maintain costs and the pressure to lower non-wage labour costs. None of the two central actors - social insurance funds and the medical profession - has an overwhelming interest to cut expenditures. The medical profession has a natural interest in maintaining their income, while the insurance funds adjust the contribution rates to the expenditures. Their importance as an institution also increases with increasing budget. Increasing contribution rates, directly translate into higher labour costs for companies, making investment in the country unattractive.

In countries with a national health service (NHS) the right to health care does not derive from contributions, but from citizenship. Health care is a public good and therefore financed by taxes out of the general budget. The responsibility for health care lies with the municipalities, the central government or the regions –but it is always a public obligation. It is ultimately always a political responsibility; health ministers resign in reaction to medical scandals and waiting lists are a central topic in election campaigns.

The provision of goods and services is governed by central planning, which brings NHS close to communism for some critics. Hospitals are owned by the responsible state level. Ambulatory care is provided as well in local health centres as in private praxis – the relation varies among the countries.

The central planning allows for budgetary control and easy cost-containment. However, tight planning tends to result in under-provision and waiting lists.

The publicly provided care is furthermore accused for its bureaucratic style. Notwithstanding its effectiveness, the NHS has been criticized as unresponsive to individual needs.

Following an institutionalist approach, state governed NHS should be easier to reform than SHI with strong positions for interest groups.

Political Institutions

The design of welfare state institutions has figured central in the analysis of their reform capacity. In her analysis of the emergence of contemporary health care systems, Ellen Immergut argues to focus on political institutions (Immergut 1992). The state had the legal power to enact a national health care service and replace existing market or corporatist arrangements. The political instruments available for the medical associations determined, if these were able to block the introduction of a public system. The Swiss referendum allowed the Swiss medical association to block a social health insurance.

Taking political institutions and especially veto-points into account is also salient for the analysis of health care reforms.

Neo-liberal Discourse

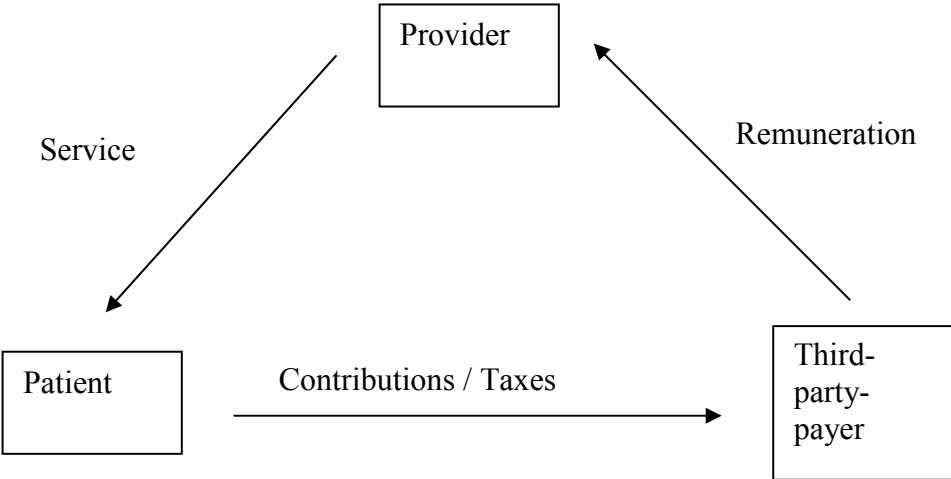
Within the two theoretical approaches describes above, interests are derived out of the position in the economic, social and institutional landscape. The working-class favours higher redistribution, pensioners are interested in higher pensions. Social health insurance managers are interested in maintaining their position. “Irrational” choices are the result of incomplete information. In contrast to this logic of position, interests can also be rooted in logic of interpretation (Parsons 2007, S. 131). The objective, structurally and institutionally shaped world still leaves a lot of room for uncertainty, where ideas are needed to fully understand the world and formulate legitimate responses. Actors follow their personal beliefs about the world and the most suitable action to take. Policy actors, organizations, and the population at large are interpreting facts to make sense out of them. The glasses they are wearing are grinded by cognition, experiences and values (Harrison 2004). The interpretations about the world are also labelled policy paradigms, which offer a coherent “world view” to their parties or communities. Ideas and values have long been neglected as causes for reforms, as they are complicated to study. In “normal times” ideas and institutions should be congruent. Ideas are therefore just made explicit in times of friction and change.

Nonetheless, ideas and ideology can be more powerful than rational logics of position. The historically most persuading example is religion, which lead people to act against their objective, structural interests throughout the centuries.

Ideas are like institutions always just particular explanations. No scientific model can predict human creativity, and therefore solutions and policy paradigms invented by policy makers can just be explained ex-post. Ideas play a role crucial role throughout the whole process of reform. They are needed to recognise a problem, find a solution and organise support for it.

Following the oil crisis, neo-liberalism replaced Keynesianism as the dominant global idea. In this interpretation, reducing state spending, in particular welfare state spending, was not just commanded by raising public deficits, but also morally necessary to liberate entrepreneurship and welfare state dependents. The new market ideology was first translated into labour market and pension reforms. In health care reforms, the balance between “freedom” and “solidarity” is readjusted under the influence of the new policy paradigm. Markets have not just been promoted to ensure freedom, but also to increase efficiency in the delivery of health care. However, direct market relations between patients and doctors do not exist in Europe. The modern health care systems have been developed to eliminate these markets and to ensure that questions of life and death are not decided by money. Graphic 1 illustrates the relations between providers, patients and third-party-payer.

Graphic 1: Third-party-payer scheme



Theoretically, markets, competition, or market instruments can be introduced in all three sides of the triangle to set economic incentives for rational use or increase efficiency. The American public health professor Alain Enthoven developed the concept of “managed competition” for health care maintenance organisations in the US (Enthoven 1978). Not the providers should compete for patients, but the insurances, which could provide their own services. Although the US generally serve as the example of the least efficient and just system in the western world, his ideas figured prominently in European reform debates. Studying the impact of the neo-liberal policy paradigm in health care offers the change to detect the impact of ideas, as there is no scientific proof that market systems are more efficient. Within these debates the term privatisation is used in the limited meaning of profitisation.

Country studies

To categorize health care systems, traditionally three dimension have been suggested: finance, provision, including remuneration, and regulation. Ferrera adds the category of access (Ferrera 1996). These four dimensions provide also the adequate framework to study change in health policies. Early efforts to cluster health care system focuses on the supply side, e.g. funding and governance of health care. Wendt calls to focus more on the demand side: provider structures and access, beyond the pure right to health care (Wendt 2009). All four dimensions could be under state, corporate regime, or market regime. Traditionally the market system is not to be found in Europe, but as outlined above, market mechanisms are the predominant reform direction. By scrutinizing all four dimensions the degree and direction of change can be detected.

Privatisation and profitisation can take place in all of the four dimensions of health care systems. Table 1 summerizes the four dimensions for the ideal SHI and the ideal NHS and contrasts them with possible market solutions.

Table 1	corporate	state	market
	Social Health Insurance (Bismarck)	National Health Service (Beveridge)	Privatisation
governance	Self-administration	Hierarchical state governance	Competition rules
Funding	Social contributions	taxes	Decrease of public funding, increase of either <ul style="list-style-type: none"> • private insurance • out-of-pocket payments • charity
Provision	Private	Public employees	<ul style="list-style-type: none"> • Increase of private praxis • Privatisation of public hospitals
Access	Membership	Citizenship	<ul style="list-style-type: none"> • “going private” to skip waiting lists • parallel private health insurances

The complexity of health care systems and the independent variables presented above, prevent a regression analysis. Analysing indicators as they are provided by international organisations like the WHO or the OECD, does allow us to estimate the degree of change, but it says nothing about the causes and the process. Historical process tracing in selected case studies is therefore the selected method for this study.

For the case studies, two countries have been selected, who introduced market elements into their public system: the Netherlands and Sweden. Despite the same ideas, the reform

processes and the new system vary significantly. The Netherlands replaced their Bismarck model by “regulated competition”, based on competition between private health insurances. Sweden introduced competition among providers in its public health service, however with great differences between the regions.

The study covers the years 1990 – 2009 to assess the impact of Europeanisation. In 1992, the Single market has been completed, increasing pressure on non-wage labour costs in SHI countries. In the same year, the Maastricht criteria regulating access to the Single Currency, the Euro, have been agreed upon. Especially, the 3% budget deficit rule limits the scope for NHS.

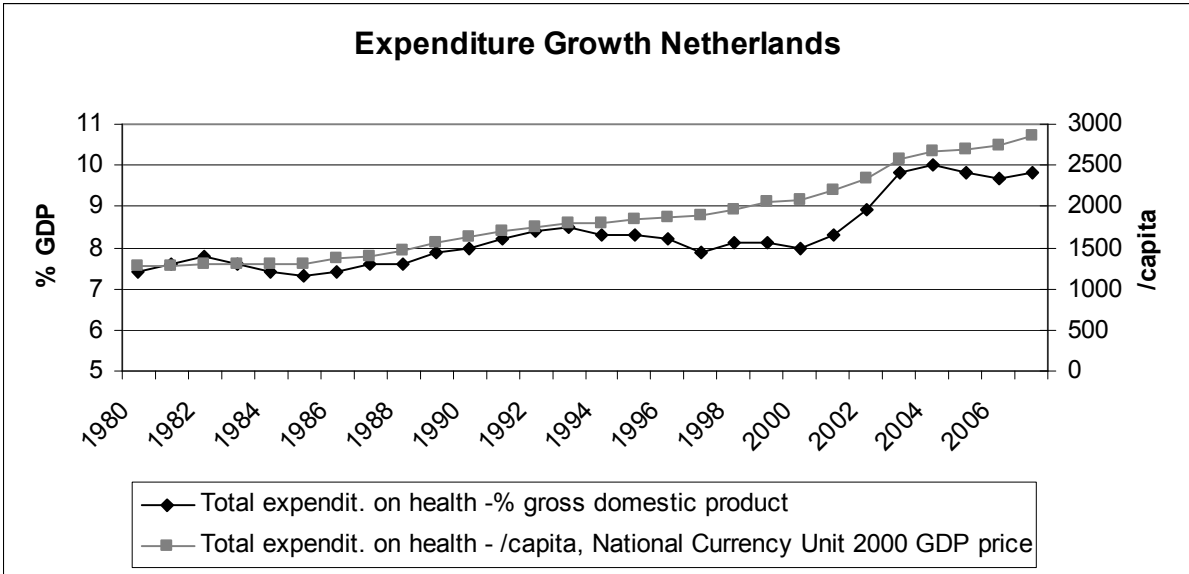
Netherlands

The Dutch health care reform of 2006 serves as the prime example of a market based system in Europe. However, in the following I will argue, that the radical path-break took mainly place on a discourse, not on an institutional level. That means, the system is officially based on competition between private insurances, but tight regulations brought the social health insurance de facto closer to a NHS then to a market model. The transformation was enabled by a coherent policy paradigm. All parties agreed in principle to a plan drafted in the 80s and implemented the “regulated competition” in incremental steps.

Independent variables

The Netherlands are a relatively small country. As in all European countries, demographic change and medical-technological innovations were driving up health care costs. Expenditures rose constantly as shown in graphic 2. Especially the population projections call for reforms. In 1990, 12.8% of the population were aged 65+, increasing to 15.3% in 2010. The projections expect 19.7% for 2020 and: 24.1% in 2030. Every fourth Dutch will by then be in retirement age.

Graphic 2



The means to finance this expenditure growth became rare. At the end of the 1970s the Dutch disease was diagnosed. Real economic growth rates were rather modest, ranging around 1-2% throughout the 80s and 90s, in the crisis year 1987, even negative. Social insurance contributions rose to 45% of wage costs, and the competitiveness of Dutch companies in the open economy became a serious issue of debate. In the early 90s, structural reforms began. At the turn of the millennium the Dutch economy experienced a boom (4.1 and 5.1 in 2000

respectively 2001), which allowed for the final step of the radical reform in 2006. In reform debates it is often forgotten, that all reforms are expensive, as consent has to be bought.

Institutional inertia

The Dutch health care system has not been planed from the scratch, but is rather the result of an organic process. Thus, it is separated into three compartments, with different governance and funding principles. The first compartment, the Algemene Wet bijzondere ziektekosten (AWBZ), is a universal insurance. It covers the whole population against high risks, especially long-term care. The main task of the AWBZ is to cover illnesses, lasting longer then one year. Next to long-term care, the AWBZ covers public health, and maternity and child care.

Just the second compartment was subject to the radical reform. It takes care of the actual costs of medical care and equals the German health insurance system. In the old system, social and private insurances existed parallel to each other. As the income threshold was relatively close to the average income, a third of the population was privately insured. Civil servants were insured in a special system of private insurances. Just employees under the income threshold and civil servants were obliged to have a health care insurance. The rest of the population could be insured voluntary, which resulted in 2% of the Dutch not obtaining health insurance in 2001 (Bieling).

The third and tiniest compartment includes the private complementary insurances, which cover medical care excluded from the standard insurance. The reasoning for supplementary care is that it is either affordable or a luxury good. Over 90% of the population are covered by supplementary insurance for further dental care as well as physical therapy, which plays an important role in the Netherlands, and optic and hearing aids.

Table 2: The Dutch health care system prior to the reform		
Private complementary insurances (90%)		
ZfW (social insurances) (66%)	Private Insurance Voluntary (27%)	civil servants (5%)
AWBZ (100%)		

The insurances, social as well as private, and the medical association had a strong role in the management of the second compartment, which allowed them to block reforms. The health care insurances and in particular the private companies constituted the main opposition against any structural reform.

Political institutions

Even when health care is managed by corporatism, the state has the legal power to change the terms of governance. In the Netherlands, this was both enabled and slowed down by a culture of consensus. Reforms have to be negotiated between two parliamentary chambers and a minority government and the opposition.

The Dutch party landscape has traditionally mirrored the pillarization of the society into Protestants, Catholics, Socialists and Liberals. Since the end of the pillarization following 1968, the party landscape has become very fluctuate. On average the parliament is composed by ten parties, fostering the concordance democracy.

A dominant characteristic of Dutch policy making is the high fragmentation, as a combined effect of multi-party-system, coalition governments, weak position of the prime minister, strong parliamentary committees, a bicameral parliament, decentralisation, corporatism, a society of minorities, and nowadays the increasing policy-making by the courts (Andeweg, Irwin 2009). As a result of the high fragmentation within the parliament, allowing for many, small, radical parties, the same few parties are to be found in government continuously: the CDA, PvdA, and the VVD. Even following earth-quake election results, the incoming coalition government, rarely replaces all the parties from the old coalition. This allows for a great deal of political stability (Vaillancourt Rosenau, Lako 2008).

This enforces a continuous strive for consensus. On the one hand, the compulsion for compromise offers a variety of veto-points, on the other hand, are policies continued by the following government, which allows for incremental, but radical change.

Ideas

The success of the Dutch path-breaking reform is rooted in the consensual public debate. The new neo-liberal ideas were not presented as opposing the old value of solidarity, but as reinforcing it. A broad consensus existed on the problem definition: top-down planning and regulation had failed. Next to the line of argumentation of economic necessity, the health care system was also discredited as violating the principle of solidarity, as the private insurances differentiated premiums according to age, gender, and health status, which (van Ginneken et al. 2006).

In the spirit of the '83 recession a committee to propose a new health care system was convened, assembling in 1986. The chosen chairman was already a sign for the proposed solution: Dr. Wisse Dekker, chairman of the board of Philips, a convinced market proponent. The final plan suggested a system of managed competition, inspired by the concept of

“managed competition” by Alain Enthoven (Enthoven 1978). The Dekker plan served as blueprint for reforms throughout the 90s until its final implementation in 2006. The core elements were:

- Insurance market without differentiation between social and private funds.
- a defined basic package of goods and services, competition should take place via the price not the content of the insurance
- creation of a market for private, complementary insurances²
- free market for provider, insurances conclude selective contracts for services
- following the example of health maintenance organisations in the US, insurances and providers are allowed to merge
- continued funding via contributions, but these are to be selected by a central fund and distributed to the funds based on a risk adjustment scheme, to fore come risk selection
- additional flat-rate premiums to be paid directly to the insurer; this is the main element for competition for insured
- strengthening patient rights and their groups to ensure quality

In combination they should ensure universal access, quality and efficiency. In the public debate the new market system could successfully be linked to the old and the new values of health care discourses. The abolition of the parallel systems increases solidarity, while competition between insurances should render them more efficient. The plan therefore presents a classical Dutch compromise. The Dekker-plan constitutes the common basis for all following health care reforms, surviving all changes of government. Among the three major parties, CDA, PvdA, and VVD "it was the normative conviction that liberalizing reform was necessary and appropriate, regardless of the electoral consequences for party self-interest" (Castles 2000, S. 288). An electoral alternative to privatisation and quasi-markets was therefore unavailable. The coherent discourse among succeeding governments is facilitated by the single structure of political think tanks. They are governmental advisory bodies, in contrast to party affiliation in other countries³.

In 2006 a reform clearly based on the Dekker-Plan was finally ratified. The ministry named as the main maladies of old system:

- Too many different schemes: social health insurance, private health insurance, civil servants
- Little or no choice for insured parties
- Ineffective or no competitive incentives for insurers
- Little or no pressure on suppliers to achieve better performance
- Unfair premium and income effects (Ministerie van Volksgezondheid, S. 7)

The problem interpretation already frames the solution, three out of the five points are to be solved by market elements. Competition is not presented as a remedy to exiting problems, but as a goal in itself. This reveals a third order change in the terminology of Hall (Hall 1993).

However, the other two goals – the first and the last one – refer to solidarity in the system.

² The Dekker-plan foresaw 15% of all costs for this market, the Simons plan just 5%.

³ Raad voor de Volksgezondheid en Zorg, Wetenschappelijke Raad (WWR), Sociaal en Cultureel Planbureau

That the dualised system is unfair is taken for granted. This is a clear contrast to the public debate on private insurances in Germany. The two aims: competition and solidarity co-exist in the discourse and are presented as mutually reinforcing. Competition is not regarded to increase inefficiency and inequality - the core effects of the market in the US – but to enhance solidarity.

Change

The first attempt to introduce the Dekker-plan failed in 1994. Despite contrary interests, private and social insurances, as well as trade unions and employers had aligned in a veto-coalition. To allow for the radical reform in 2006 to succeed, the institutional patterns of the health care system had to be altered. Over the course of the 90s, the regulatory framework of social and private health insurances has been converged. Already in 1992, free choice of health care insurance within the ZfW was introduced, but it took until 2006 for people to change their insurance. Furthermore, the corporatists bodies of self-governance have been replaced by crown advisor. As outlined above, the political institutions allow for change in the welfare institutions.

Governance

The old system was a Bismarck-system with self-administration. However, the government had always obtained a role in the governance of health care. Several bodies were mere advisory councils for the government, then regulatory bodies. The reform of the governance dimension took place in two steps: during the 90s, the social partners, insurances and medical associations in the several bodies of self-administration and advise were replaced by representatives of the crown. In a second step, the agencies changed their task from governing to market regulation.

For example, social insurances and association of general practitioners negotiated the prices and remuneration system for ambulatory care in the Centraal Orgaan Tarieven Gezondheidszorg. It was merged with the College van Toezicht op de Zorgverzekeringen (CTZ) to the new Dutch Healthcare Authority (De Nederlandse Zorgautoriteit – NZa). The NZa resembles an anti-trust board and should ensure the free market prices. However, this does not function yet. Price negotiations between insurances and individual providers do not take place. Right now, the NZa sets the prices for 90% of all services by hierarchical state governance. The introduction of markets in health care called for state re-regulation, resulting in a very densely institutionalised framework (Götze et al. 05.09.2008). To sum it up, self-

administration has been replaced by state governance. The new institutional set-up resembles rather a national health service than a market.

Funding

Competition was just introduced in the second compartment. The AWBZ is financed by taxes, the private supplementary insurances by risk adjusted premiums.

To allow for competition between the insurances, they have to be able to set their own prices. Already in 1989, flat premiums of 170 Gulden (€ 77) have been introduced, a first implementation step of the Dekker-plan. The premium has been raised in small steps, in 1999 to 356 Gulden (€ 160). Nevertheless, the share of the premiums of the overall funding had just reached 10% in 2000, also the Dekker-Plan envisioned 25%. For the first half of the 90s insurers seem to have come to a gentlemen's agreement not to compete on prices. The variations in the flat premiums were negligible, and so were the actual switching rates.

Since 2006, premiums completely replaced the employers contribution of former 1,3%. They amount to approximately 1.100€. Employer contributions and thereby non-wage labour costs decreased from 6.75% to now 6.5%⁴.

While the real price difference just increased slightly, from 200€ to 265€, in the first year of the new health insurance system 19% of all insured changed their company. However, this was a one-time effect as the majority of changes has to be attributed to the new collective contracts, insuring whole companies. These collective agreements offer 10% discount and were prior just available to private insured. In 2006 already 56 % were covered by these collective agreements. Since then, switching rates decreased again to negligible rates.

Despite contrary expectations, the premiums made the system more equal. 38 percent of the population receive allowances to finance their health insurance premiums. Furthermore, the state directly pays the premiums for children up to 18 and students (circa 20 percent of the population). Military personal is covered by the ministry of defence and imprisoned people by the ministry of justice, respectively (Ministerie van Volksgezondheid 2005).The financial allowance constructs a quasi-markets: the money follows the patients, which is hoped to result in higher responsiveness on behalf of the insurances.

Provision

Health care services are offered by private providers under a common fee schedule. The 2006 reform had no significant impact on the provision of care. The important changes – reduction of beds, hospital mergers, group praxis for general practitioners – happened already in the 90s

⁴ officially all contributions are paid by the insured, however the reimburseable wage-related contribution is in reality a employer contribution.

as a result of hierarchical (cost) pressure and technological innovations. The legal scope for competition for selective contracts with insurances has constantly been improved since 1992 but remains still small. It is further limited by the shortcut of providers. Some insurances now offer reductions for patients, who undergo treatment by selected providers. However, free choice and local provision have to high a value for this instrument to work (De Nederlansche Bank 2009, S. 47). To conclude: competition between providers is foreseen in the reform laws, but hampered by the short cut of doctors. It has to be asks, if the high administrative costs of selective contracting are worth the low outcome.

Access

Although not directly visible to the patient, the 2006 reform fundamentally changed the underlying logic of access to care. Whereas the ZfW was an employee insurance with derived rights for spouses and children, the new ZVW is based on citizenship, not on income classes. Health care insurance is an individual right and obligation. The reform therefore adopts to the changing social realities, praising individuality.

Tackling the waiting lists was not an aim of the Dekker-plan, but it was assumed, that market reforms would solve the allocation problem. In the 1990s the problem became politicized and a special fund for the specialities with the longest waiting lists was established. This was the result of a typical hierarchical regulation, no market solution (Harrison 2004). Cross-boarder health care is already an important issue in the Netherlands, also to tackle waiting lists – especially by sending patients to Belgium.

The gate-keeper system is fully accepted. Changing the family doctor is nearly impossible, due to the short cut of doctors.

Conclusion

Ideas were the drivers of reform. Structural factors like increasing costs and the future demographic change were pressing for reforms, but the short-comings of the old institutional design were at the heart of the reform. The parallel insurances were the result of the hierarchical structures of the old noble Netherlands and did not fit the new society after 1968 any more. The radical reform was just possible in small steps. These were facilitated by the political institutions. Constant governments incrementally prepared the basis and implemented the Dekker-Plan. This plan successfully linked solidarity and competition under the heading of “regulated competition”. However, more emphasis is laid on regulation, then on competition. The impact of the market elements is very limited, although the new system is widely perceived as market based. Markets were fashion in the discourse and on the very

same level, competition was introduced. In the governance and funding dimension, the state governance and taxes replaced self-administration and wage-related contributions.

Sweden

In the late 80s, Sweden came closest to the ideal public health care service. During the last 20 years, private providers and internal markets have been introduced. As shown below, these reform processes were not driven by the national government, but by pragmatic reforms on the county level. As a result, the counties employed different systems and market elements are predominantly to be found in Stockholm.

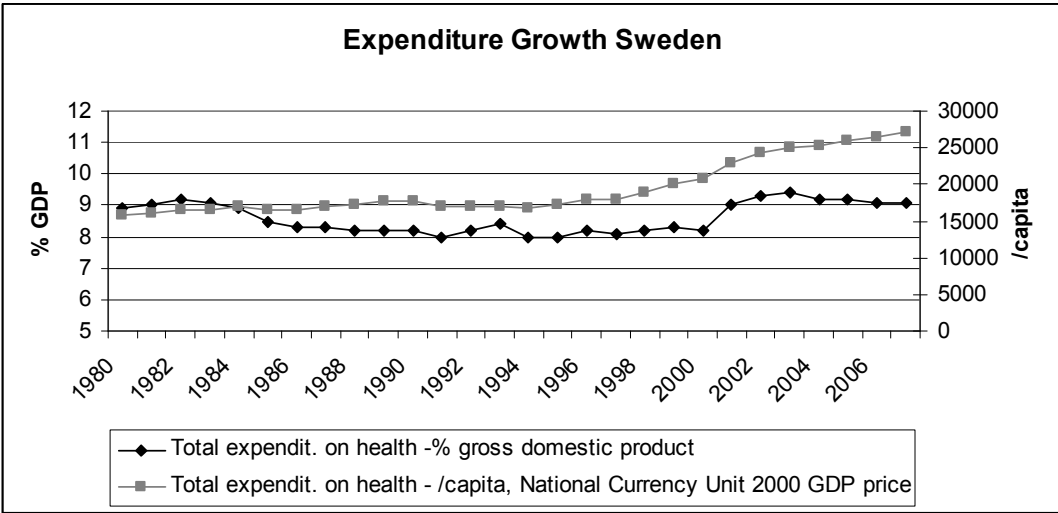
Causes

In the Swedish debate, reforms are explained by the standard causes of health economics: Ageing population, medical-technological innovations, and rising expectations on behalf of the public (Federation of Swedish County Councils 2002).

In the early 90s, Sweden experienced an economic crisis, which was met by tight state and county budgets. Sweden managed to maintain its health care costs as share of GDP during the 90s, during the 2000s they slightly rose from 8% to 9% of GDP.

The share of the population aged 65+ was 17.3 in 2006 and is expected to further increase. The share of the very old, aged 80+, rose to 5.3% of the population. Just Italy has a higher share with 5.5% (Eurostat).

The Swedish society and thus its expectations changed over the last 20 years. Increasing levels of education and urbanisation resulted in demands for choice, self-determination, and higher standards of health.



Institutional inertia

In the welfare state literature Sweden presents the ideal model of the social democratic welfare state. Also in health care, Sweden comes closest to the ideal of a national health service, although devolved to the county level. State governance, funding by taxes and universal access describe the ideal of the Nordic model. Sweden went furthest in nationalising providers. In the late 80s, nearly all doctors were public employees, a feature of the NHS no other country implemented so radical. Inherent problems of the health care institutions, induced reform pressure. The Swedish health care system had been designed for the post-war period. During the modernisation of health care it offered the perfect framework for an efficient system, however this induced the accusation of unresponsiveness. The socialist system, allocating patients by post-code to their doctors and hospitals did not fit the new post-modern values any more. People demanded choice.

Political Institutions

Sweden is not a federal country, but responsibility for health care is devolved to the 21 counties. The counties have their own parliament and government – the county council. Although the counties are in charge of health care, the national level sets the legal framework. The decentralised Swedish system has no clear delineation of competencies. Policy making at the country level is marked by two central features: political responsiveness and pragmatism. The high responsiveness of political actors is enabled by the institutional design of the health care system: the ultimate responsibility lies with politicians, not with the physicians as in continental Europe. Health care reforms are salient issues in the regional election campaigns. The decentralised system allows for experimentation at the county level. As all regional government, also the Swedish councils are characterised by a high level of pragmatism: “Good is what works”.

Elections are held simultaneously at the national and the county level to ensure some degree of consistency between the politics of the two levels. At the national level, the complete absence of veto-points allowed rapid course changes and partisan politics can be observed. The shift to a one-chamber system in 1970 increased responsiveness, but undermined institutional stability.

Discourse

The core value of the Swedish welfare state - universalism - was sided and challenged by the new value of self-determination. Post-modern individualism also found its way into the Swedish culture. Standardised procedures and paternalistic decisions were no longer accepted, challenging the traditional health care system. At the beginning of the 90s “something had to

be done” to meet increasing complaints about waiting lists and unresponsiveness. During the 80s, the world wide neo-liberal discourse entered the stage in Sweden as well and offered a competing interpretive framework. The ideas of Enthoven were also widely received in Sweden. The general strive to internationalise the health care system and the huge public debts, favoured neo-liberal ideas. Enthoven even published a special paper, in which he adopted his ideas to the Swedish model (Enthoven 1989).

These new ideas were even feasible under the budgetary constrains. They were embraced by both sides of the political spectrum, although to different degrees. In their program for the 90s, the Social-democrats favour internal markets in health care to give the individual health care centre or clinic incentives to increase efficiency and responsiveness. The Moderates, on the contrary, favour private provision in competition to the public system. They furthermore embraced the ideology of markets on an ideological level, whereas the SAP saw it just as a tool to rescue the universal welfare state. Out of these conflicting views no coherent discourse could emerge during the 90s. Health care policy at the national level was marked by laws, which were redrawn by the next government.

Change

The change in Swedish health care in the last 20 years is best described by modernisation. The paternalistic and hierarchical public health service has been challenged by private providers and thus responsiveness increased and free choice has been introduced. The new times called also for new forms of governance and management: global budgets for hospitals, capitation for family doctors and DRGs, as well as health technology assessment and prioritisation guidelines, replaced the traditional planning.

Change took place on the county level, which diverged significantly over the years. “The” Swedish health care system does not exist any more. The process is market by learning and pragmatism.

Governance

The privatisation process is driven from below by the 21 county councils. In the early 90s, the Federation of County Councils recommended to fill gaps in the provision structure by private contracts. The rise of private practice was also favoured by an inherent social-democratic feature of the public sector: the standard working week, which allowed publicly employed doctors to practice privately in their extensive free-time. This institution allowed the counties to conclude short-term contracts to fill the gaps in their provision structure. Some county councils already experimented with purchaser-provider splits in the late 80s. At the national

level private provision was made mandatory for the counties by the 1994 Family Doctor Reform. It established competition within the public system and allowed patients to choose their family doctor, instead of being treated by the doctor on duty. Remuneration by capitation set incentives to increase the number of patients inscribed. The counties had to introduce a remuneration system, where money follows the patient. Private and public providers have to be treated on equal terms. In 1995, the social democratic government revoked the reform, as it accelerated costs and threatened the new approaches of integrated care. However, already before the 1994 elections the market experiments in Stockholm and Dalarna were restructured by conservative county councils (Harrison, Calltorp 2000). Some counties maintained the capitation for family doctors, others returned to salaried doctors in public health care centres. The regional systems became more diverse.

In 2005, the Federation of County Councils recommended to offer free choice in the whole country, including private and public providers alike. With the exception of the Northern region, all county councils followed the recommendation. Back in office, the conservative national government re-installed the right to choice of primary care physician – the vårdval reform. From 2010 on, patients again have full freedom to choose their family doctor. The national legislation followed developments already implemented in most counties.

Privatisation takes place within the public health care system, not parallel to it. The fear of a private alternative for the rich and a delegitimation of the universal system was for sure one reason for this development.

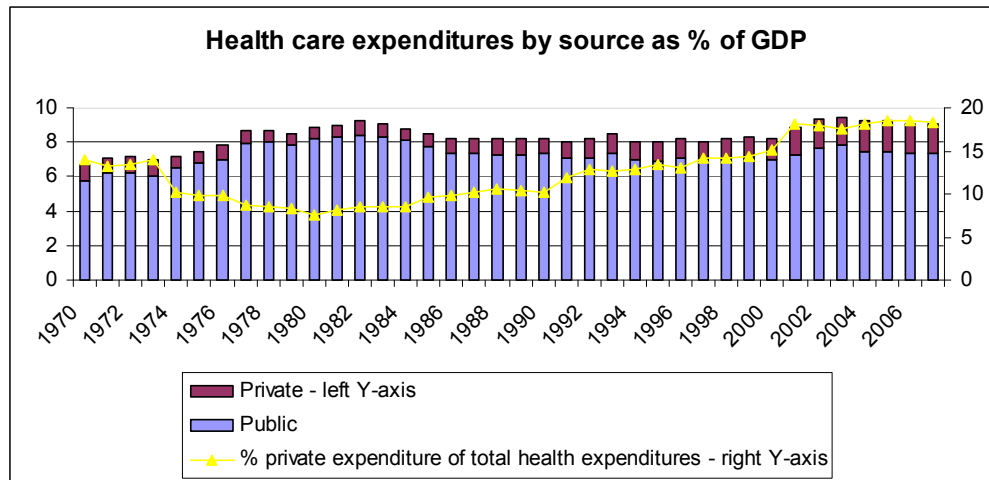
State governance remained the core principle of governance; shifts took place in the balance between the national and the county level. Health care technology assessment, guidelines for practice and prioritisation are not issued by the Medical Association, but by a governmental agency. Due to the technical developments, they became ever more detailed. The national level is strengthened to ensure an equal level of quality in the whole country. Since 2001, the Federation of County Councils publishes its own quality reports to counterbalance this development.

Funding

Swedish health care is funded by taxes raised on the county level. A national income and risk equalisation scheme evens out regional differences. In 1994 the national subsidies covered 15%, in 2006 19% and in 2009 already 20% of the counties income. However, these are average numbers, the percentage per county varies widely.

Nevertheless, tax-funding is not the only source of income. High co-payments and a social insurance contribute as well. The share of private funding out of total health expenditure even

rose from 10% in 1990 to 18% in 2007. The Social Health Insurance traditionally reimbursed pharmaceuticals and private care – especially dental care. Private praxis has been replaced by public providers during the 80s and the funding channelled into the national equalisation scheme. The Social Insurance finances nowadays just sick-leave and dental care subsidies for adults.



Provision

Already in 1994, Sweden ranged among the countries with the highest density of doctors per inhabitants. Sweden is now the country in the EU with the second highest number of physicians per inhabitant (5.57 per 1000 inhabitants) (OECD 2009). However, these doctors have a standard working week with a fixed salary, which results in a low overall volume of services provided.

Health care in Sweden is still predominantly provided by public employees. In 2006, just 16% of all physicians, 12% of the nurses, and 10% of midwives worked in the private sector (Socialstyrelsens 2010). Privatisation is concentrated in ambulatory care. Nationwide, in 2005, already 30% of primary care visits were paid to private practitioners. However, the degree of privatisation differs widely between the counties. Stockholm had 129 private practitioners within the public system per 100.000 inhabitants, in contrast to an average of 31 in the other counties.

The differences between the counties are explained by different degrees of modernisation: the urban middle class was the driver behind reform increasing self-responsibility and responsiveness, which are therefore predominantly to be found in Stockholm. Competition between private and public providers can not be established in villages, which are just served by one doctor. The pattern is repeated in the hospital sector. Out of the 941 private hospital beds, 645 were under contract in Stockholm in 2008 (Sveriges Kommuner och Landsting 2009). In 2008 there were 21 private hospitals in Sweden, six of them in Stockholm and three

in Göteborg. However, also the sparsely populated region Gävleborg has three private clinics (Sveriges Kommuner och Landsting 2009). The huge public and political debate obscures the negligible significance of private clinics within the public system.

Access

Access to health care goods and services has been and still is universal in Sweden. The slight tendencies to a dualisation of the system, with a parallel private market for insurances and private clinics, could be kept at a very low level.

The most dominant issue in the public debate are the waiting lists for elective surgery. Different approaches have been tried to cut them down. Investments in specialities and hospitals with the longest lists were combined with financial penalties. Under the waiting time guarantee, the patient can seek care in a private clinic or in another county, if the hospital of the catchment area is unable to provide the treatment within the three months. The costs are born by the home hospital. This guarantee was first introduced in 1992, withdrawn in 1997 due to scientific critic and reintroduced in 2005, to meet the public demand.

The particular challenge of the Beveridge model is that some kind of rationing has to take place as demands from providers and patients are unlimited. In Sweden, rationing takes place, but it is made explicit and clear guidelines for prioritisation are followed.

Conclusion Sweden

Reform pressure in Sweden stemmed mainly from increasing demands of a new urban middle class. The neo-liberal discourse offered an alternative. The pragmatism and simple institutional design of the county councils allowed for market oriented reforms and their abolition following first scientific evaluations.

The national level is market by a higher degree of politization. Also on the national level, the political institutions with very few veto-points allowed for change. However, as shown above, the counties were most of the times one step ahead of the national regulations. The devolved responsibility resulted in pragmatic, but also fragmented solutions. Markets were introduced as instruments and maintained in counties, where they provided added value to meet societal demands.

Conclusion

Both the Netherlands and Sweden introduced market elements into their public systems. However, the detailed analyses revealed, that these took place in different dimensions of the systems. Whereas the Netherlands established a market in the funding dimension, Sweden

went for competition between providers. In the governance dimension, Sweden experimented with internal markets, without questioning the supremacy of state governance. The Netherlands replaced their corporatists bodies under the heading of “markets” by state agencies. State governance seems to be the most efficient mode to maintain costs, as hypothesised in the theoretical outline. Table 3 gives a comparative overview of the two systems. The changes are highlighted in *italian*.

Table 3	Netherlands	Sweden
Governance	<i>Market with tight regulations</i>	State (counties)
Funding	<i>Premiums + taxes</i>	Taxes + co-payments
Provision	<i>Private; state sets fees</i>	<i>Public and private; price competition</i>
Access	Membership; gate-keeper	Citizenship; co-payments; <i>free choice</i>

The structural challenges were quite similar between the two small countries: both are faced with demographic change and a post-modern society. However, the reform processes differ between the countries, as a result of their institutional heritage. Whereas Swedish county councils could already in the late 80s experiment with internal markets and private providers, the Netherlands first had to alter the institutional framework of the private insurances and of health care governance.

The reform outcomes differ as a result of the different impact of the neo-liberal ideas. Whereas the concepts of Enthoven were prominent in both countries, in the Netherlands, competition became a value itself. Speaking with Hall, change took place on the third order. In contrast in Sweden, competition was just employed at the instrument level. Markets are seen in concurrence to solidarity, whereas the two are conceptualised as mutually reinforcing in the Netherlands.

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