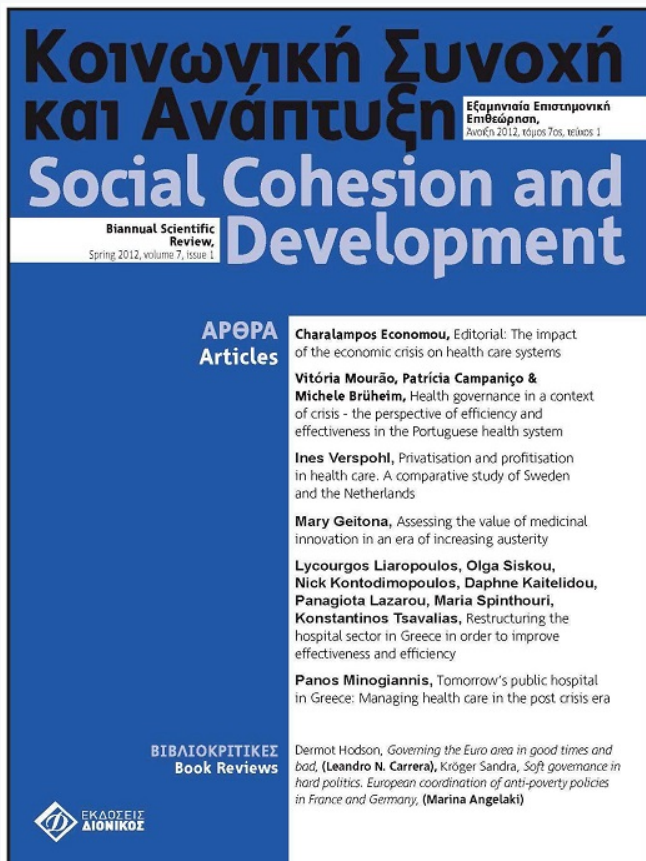


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Ines Verspohl

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Privatisation and profitisation in health care. A comparative study of Sweden and the Netherlands

Ines Verspohl, *Advisory Council on the Assessment of Developments in the Health Care System*

Ιδιωτικοποίηση και επιδίωξη κέρδους στη φροντίδα υγείας. Μια συγκριτική μελέτη Σουηδίας και Ολλανδίας

Ines Verspohl, *Advisory Council on the Assessment of Developments in the Health Care System*

ABSTRACT

During the last 20 years, privatization became an issue in health care. The neo-liberal market idea promised to increase efficiency and responsiveness, while at the same time relieving public budgets. European countries have introduced all kind of market instruments, reaching from internal markets, over DRGs, to increased co-payments. However, the welfare state literature currently lacks a detailed explanation of these different reforms.

All health care systems in the European Union are affected by the same problem pattern: demographic change, raising demand, medical-technical innovations and labour intensive services. Nonetheless, the degree and form of privatization varies a lot. This paper studies the power of ideas within the framework of structural reform pressure and institutional path-dependency. The causes for privatization reforms are studied in two countries representing the two ideal types: the Netherlands for Social Health Insurance and Sweden for the National Health Service.

KEY WORDS: Privatisation, profitisation, healthcare, institutional path-dependency, Netherlands, Sweden

ΠΕΡΙΛΗΨΗ

Κατά τα τελευταία 20 χρόνια, η ιδιωτικοποίηση αναδείχθηκε σε σημαντικό ζήτημα στον τομέα της υγείας. Η νεο-φιλελεύθερη ιδέα της αγοράς υποσχέθηκε να αυξήσει την αποτελεσματικότητα και την ανταπόκριση, μειώνοντας συγχρόνως την επιβάρυνση των δημόσιων προϋπολογισμών. Διάφορες Ευρωπαϊκές χώρες έχουν εισάγει όλα τα είδη των εργαλείων της αγοράς, τα οποία κυμαίνονται από την εφαρμογή εσωτερικών αγορών, μέχρι τις Ομοιογενείς Διαγνωστικές Κατηγορίες (DRGs) και την αύξηση των συν-πληρωμών. Ωστόσο, η υφιστάμενη βιβλιογραφία για το κράτος πρόνοιας δεν διαθέτει μια αναλυτική επεξήγηση αυτών των μεταρρυθμίσεων. Όλα τα συστήματα φροντίδας υγείας στην Ευρωπαϊκή Ένωση αντιμετωπίζουν παρόμοια προβλήματα: δημογραφική αλλαγή, αύξηση της ζήτησης, ιατρο-τεχνολογικές καινοτομίες και υπηρεσίες έντασης εργασίας. Παρ' όλα αυτά, ο βαθμός και η μορφή ιδιωτικοποίησης διαφέρει πολύ. Η παρούσα εργασία μελετά τη δύναμη των ιδεών στο πλαίσιο των πιέσεων για διαρθρωτικές μεταρρυθμίσεις και υπό την οπτική της θεωρίας της θεσμικής εξάρτησης. Οι αιτίες για τις μεταρρυθμιστικές διαδικασίες ιδιωτικοποίησης εξετάζονται σε δύο χώρες που εκπροσωπούν τις δύο ιδεατούς τύπους συστημάτων υγείας: την Ολλανδία η οποία έχει σύστημα κοινωνικής ασφάλισης υγείας και τη Σουηδία η οποία διαθέτει Εθνικό Σύστημα Υγείας.

ΛΕΞΕΙΣ-ΚΛΕΙΔΙΑ: Ιδιωτικοποίηση, επιδίωξη κέρδους, φροντίδα υγείας, θεσμική εξάρτηση, Ολλανδία, Σουηδία

1. Introduction

The first reaction to the current economic crisis is a call for cut-backs. The same pattern could be observed after the oil crisis of the 70s. However, the crisis was also the source of a new discourse: neo-liberalism. In the 90s and 2000s the new paradigm was also applied to health care. Privatisation and profitisation should increase efficiency and contain costs. Neo-liberalism as the dominating economic theory and 'cost-explosion' as the major concern of health policy makers emerged simultaneously in the mid-80s on the agenda. Since 1990, the fall of the iron curtain, the Single European Market and afterwards the introduction of the Euro increased the need for structural reforms (Verspohl, 2012). The time frame for analysis spans from 1990 to the recent financial and economic crisis (2009). During these years neo-liberal market orientation has been the leading reform idea on the European stage.¹ However, these privatization/profitization reforms took place in different forms and degrees in different countries. Two forerunners in market oriented reforms are selected as case studies: the Netherlands and Sweden. The two countries represent the two different systems Social Insurance and National Health Service. This paper studies the power of ideas within the framework of structural reform pressure and institutional path-dependency.

2. Structural reform pressure and Institutional path-dependency

The first welfare state researchers explained the expansion of the welfare state as a function of economic development (Wilensky 1975). Inversing 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. While the economic means for welfare are decreasing, costs are increasing. The reasons are demographic change, increasing demand due to post-modernism, medical-technological innovation and the cost-driving nature of the labour intense sector (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 years. Older people are more fragile and therefore have higher health care needs. In post-industrial societies, increasing levels of education and urbanisation of the population result in higher expectations towards health status. Furthermore demand rises 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. Apart from a few innovations like key-hole surgery, progress results in increasing costs in health care.

From a functionalist point of view, we would therefore expect retrenchment and convergence towards one – most efficient - health care system.

However, this retrenchment could not be observed in pension and unemployment. The new institutionalism explained persisting differences in the light of common challenges by inherited structures of the welfare state and path-dependency (Pierson 1994; Hall, Taylor 1996). Especially the continental social insurance systems were regarded as "frozen landscapes" (Esping-Andersen 1996).

Institutions are defined as the "rules of the game". In the welfare state literature 'institution' refers to the rules of redistribution and risk-sharing in a society. Welfare programs are institutionalized historical decisions. Their existence confines and restrains the policy options available. Once the path-way is chosen, welfare states become highly path-dependent (Pierson 1996, p. 311).

For health care, just two ideal types can be distinguished: National Health Service (NHS), invented by Beveridge, and Social Health Insurance (SHI), invented by Bismarck (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 is based on income rather than reflecting health status or risk. Membership is based on employment. Children and spouses have derived rights to care. Contributions are paid both by employers and employees. 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 social insurance funds and the medical profession play a central role in the governance of health care. The government just sets a regulatory framework for the insurances. Goods and services are provided by private and public hospitals 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. 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. The provision of goods and services is governed by central planning. Hospitals are owned by the responsible state level. Ambulatory care is provided in local health centres and 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. Notwithstanding its effectiveness, the NHS has been criticized as unresponsive to individual needs and its bureaucratic style.

Following an institutionalist approach, the state governed NHS should be easier to reform than the SHI with their strong position of interest groups.

Immergut stressed the importance of political institutions for health care reforms (Immergut 1992). In some countries, the state had the power to replace existing market or corporatist arrangements by an NHS, while in others, political institutions allowed the medical association to block the introduction of a public system. Hence, taking political institutions and especially veto-points into account is also salient for the analysis of privatization reforms in health care.

3. Neo-liberal ideas

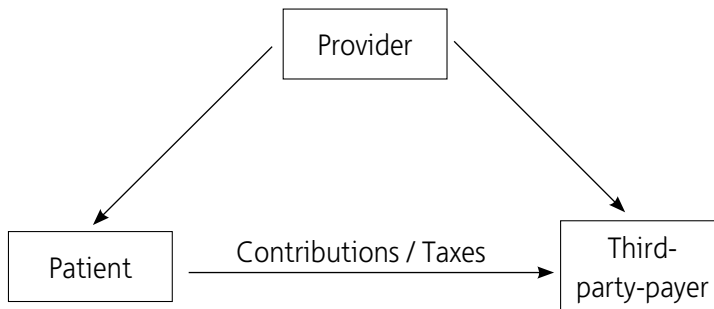
The newest theoretical approach concentrates on the power of ideas. The objective, structurally and institutionally shaped world still leaves a lot of room for uncertainty, where ideas are needed to fully understand the world and formulate legitimate responses (Parsons 2007). Actors follow their personal beliefs about the world and the most suitable action to take. Policy actors, organizations, and the population at large are interpreting facts. The glasses they are wearing are grinded by cognition, experiences and values (Harrison 2004). These interpretations about the world are also labelled policy paradigms or discourse. Ideas play a 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 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 re-adjusted 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. The American public health professor Alain Enthoven developed the concept of “managed competition” for health care maintenance organisations in the US (Enthoven 1978). The providers should not compete for patients, but the insurances for members. The insurances would then contract providers. Although the US generally serve as the example of the least efficient and most unjust system in the western world, his ideas figured prominently in European reform debates.

The modern health care systems have been developed to eliminate direct markets between patients and doctors and to ensure that questions of life and death are not decided by money. All countries introduced third-party-payer systems (see Graphic 1). Theoretically, markets, competition, or market instruments can be introduced in all three sides of the triangle to set economic incentives for rational use.

Graphic 1: Third-party-payer scheme



To categorize health care systems, traditionally three dimensions 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 care systems. In the ideal model of a NHS all four dimensions are dominated by the state, in an ideal SHI by corporatism. Privatisation and profitisation can take place in all of the four dimensions of health care systems (see table 1). By scrutinizing all four dimensions the degree and direction of change can be detected.

Table 1	Social Health Insurance	National Health Service	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"> • <i>private insurance</i> • <i>out-of-pocket payments</i> • <i>charity</i>
Provision	Private	Public employees	<ul style="list-style-type: none"> • <i>Increase of private praxis</i> • <i>Privatisation of public hospitals</i>
Access	Membership	Citizenship	<ul style="list-style-type: none"> • “going private” to skip waiting lists

4. Netherlands

The new Dutch health care system from 2006 often serves as the prime example of a market based system in Europe. 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. However, as shown below, 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 regulation brought the social health insurance de facto closer to a NHS than to a market model.

4.1 Causes for reform: Institutional legacy and ideas

As in all European countries, demographic change and medical-technological innovations were driving up health care costs. Expenditures rose constantly in real terms. In percentage of GDP, they could be maintained during the 90s. Especially the population projections called for reforms. By 2030, every fourth Dutch will be in retirement age. The means to finance the expenditure growth became rare. At the end of the 1970s the Dutch disease was diagnosed. Real economic growth rates were very low. 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 (Andeweg, Irwin 2009). In the early 90s, structural reforms begun. At the turn of the millennium the Dutch economy experienced a boom (4.1 and 5.1 in 2000 respectively 2001) (Eurostat), 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.

The Dutch health care system has not been planed from the scratch, but is rather the result of an organic process. It is separated into three compartments, with different governance and funding principles. The first compartment, the AWBZ, is a universal insurance. It covers the whole population against high risks, especially long-term care. Furthermore, the AWBZ covers public health, and maternity and child care.

The second compartment is a SHI and covers the actual costs of medical care. Just the second compartment was subject to the radical reform. 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. Just employees under the income threshold and civil servants were obliged to have a health care insurance. The rest of the population could be voluntary insured, which resulted in 2% of the Dutch not obtaining health insurance in 2001.

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 dental care, physical therapy, and optic and hearing aids (Helderman 2007).

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.

Even when health care is managed by corporatism, the state has the legal power to change the terms of governance. Traditional pillarization, fluctuate ten party parliament, and coalition governments, often without a majority in parliament, led to a political culture of consent. The bicameral parliament with strong parliamentary committees, decentralisation, corporatism, a society of minorities, and nowadays the increasing policy-making by the courts are further veto-points (Andeweg, Irwin 2009). As a result of the high fragmentation within the parliament the incoming government rarely replaces all the parties from the old coalition. This allows for a great deal of political stability (Vaillancourt Rosenau, Lako 2008). The same few parties are to be found in government continuously: Christian-Democrats (CDA), Labour Party (PvdA), and Liberals (VVD). 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, policies are continued by the following government, which allows for incremental, but radical change.

The idea of competition is the core of the Dutch reform. The health care system was discredited as violating the principle of solidarity, first, by separation into social and private insurances and, second, by differentiated premiums according to age, gender, and health status in by the private insurances (van Ginneken et al. 2006). The new neo-liberal ideas were not presented as opposing the old value of solidarity, but as reinforcing it.

The recession in the early 80s did not just lead to top-down cost-containment measures, but also to the establishment of a committee to propose a new health care system, which assembled in 1986. The choice of the chairman set the direction for the proposed solution: Dr. Wisse Dekker, chairman of the board of Philips was a convinced market proponent. The final plan suggested a system of regulated competition, inspired by the concept of "managed competition" by Enthoven (Commissie Dekker 1987). The Dekker plan served as blueprint for reforms throughout the 90s until its final implementation in 2006. The core elements were:

- One insurance market for social and private funds
- Competition between the insurances on a defined basic package of goods and services
- Expansion of the market for private, complementary insurances
- free market of providers, insurances conclude selective contracts with providers
- insurances and providers are allowed to merge, following the example of health maintenance organisations in the US
- a central fund collects the employer contributions and redistributes them via a risk-adjustment scheme
- additional flat-rate premiums to be paid directly by the insured; the main element for competition among insurances
- strengthening patient rights and their groups to ensure quality

In combination these elements 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. The abolition of the parallel private system increases solidarity, while competition between insurances should render them more efficient. Hence, the plan 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, p. 288). An electoral alternative to privatisation and quasi-markets was not available.

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, p. 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 existing problems, but as a goal in itself. However, the other two goals – the first and the last one – refer to solidarity in the system. The two aims: competition and solidarity co-exist in the discourse and are presented as mutually reinforcing.

4.2 Change: governance, funding, provision and access

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. The corporatist bodies of self-governance have been staffed with crown advisors. As outlined above, the political institutions allow for change in the welfare institutions.

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 corporatist bodies were rather 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 bodies of self-administration and advice were replaced by representatives of the crown. In a second step, the agencies changed their task from governing to market supervision.

For example, social insurances and association of general practitioners negotiated the prices and remuneration system for ambulatory care under the supervision of the National Board for Tariffs in Health Care. The later was merged with the Supervising Board for Health Insurances to the new Dutch Healthcare Authority (NZa). The NZa resembles an anti-trust board and should ensure that prices are found on the free market.

The introduction of markets in health care called for state re-regulation, resulting in a very densely institutionalised framework (Götze et al. 2009).

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. Price negotiations between insurances and individual providers are just allowed for 34% of hospital services. For the remainder of hospital care and for all ambulatory care, the NZa sets the prices by hierarchical state governance (De Nederlandsche Bank 2009). It has to be asked, if the high administrative costs of selective contracting are worth the outcome.

Contrary to the neo-liberal idea, health care costs have not been privatized. Despite the far reaching market-oriented reforms, the burden on private households decreased from 51% to 42% of total health care expenditures. The share of employers increased slightly from 21% to 22%. Expenditures have been shifted to public budgets. The share of state, provinces and municipalities increased from 23% to 32% (Centraal Bureau voor de Statistiek).

Low premiums have already been introduced in 1989, but insurances seemed to have come to a gentlemen's agreement not to compete on prices. Thus variations in the flat premiums were negligible, and so were the actual switching rates.

Since 2006, premiums completely replaced the employee contribution of former 1.3%. They amount to approximately 1.100€. Although the real price difference just increased slightly, from 200€ to 265€, in the first year of the new health insurance system 18% of all insured changed their insurance. However, this was a one-time effect. Employer contributions and thereby non-wage labour costs decreased from 6.75% to now 6.5%² (de van Ven et al. September 2009).

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).

Health care services are offered by private providers and remunerated by 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 as a result of hierarchical (cost) pressure and technological innovations.

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

In the 1990s, a special fund for the specialities with the longest waiting lists was established to decrease the lists. This was the result of a typical hierarchical regulation, no market solution (Harrison 2004). The gate-keeper system is fully accepted.

4.3 Concluding remarks

The idea of regulated competition was the driver of reform. It linked solidarity and competition. The radical reform was facilitated by the political institutions. Consecutive governments incrementally prepared the basis and implemented the Dekker-Plan. However, more emphasis is laid on regulation, then on competition. Although the new system is widely perceived as market based, the impact of competition is very limited. In the governance and funding dimension, state governance and taxes replaced the corporatist self-administration and wage-related contributions. To sum it up: the Dutch health care system was incrementally transformed to new kind of NHS with competition and private providers.

5. Sweden

In the late 80s, Sweden came closest to the ideal public health care service. Health care is the responsibility of the county councils, which experimented with private providers to increase efficiency and meet societal demands for choice. The political institutions allowed for inconsistent reforms at the national level. As a result, the counties employed different systems and privatization is mainly a Stockholm issue.

5.1 Causes for reform: institutional legacy and ideas

Ageing population, medical-technological innovations, and rising expectations on behalf of the public are also named in the Swedish reform debate (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 and is now the second highest in Europe (Eurostat).

In the welfare state literature, Sweden presents the ideal model of the social democratic welfare state and is the ideal National Health Service, described by state governance, funding by taxes and universal access. In Sweden, even the doctors were public employees. However, since the 90s, 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 and accused the old system of its bureaucratic style.

Although Sweden is not a federal country, responsibility for health care is devolved to the 21 counties and governed by the county council. The counties are in charge of health care, but the national level sets the legal framework and can at any time withdraw competences from the counties. Policy making at the country level is marked by two central features: political responsiveness, as health care reforms are salient issues in the regional election campaigns and pragmatism, as in all regional governments. The decentralised system allows for experimentation at the county level.

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.

Universalism, the core value of the Swedish welfare state, was 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. At the beginning of the 90s "something had to be done" to meet increasing complaints about waiting lists and unresponsiveness. The neo-liberal discourse offered a competing interpretive framework (Enthoven 1989). The market idea promised to render the health care system more efficient, patient-oriented, and at the same time help to decrease public debts.

These new ideas were embraced by both sides of the political spectrum. In their program for the 90s, the Social-democrats favoured 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, favoured 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 emerged.

5.2 Change: governance, funding, provision and access

The change in Swedish health care in the last 20 years is best described by modernisation. The process is market by learning and pragmatism. Free choice has been introduced and private providers challenged the public health bureaucracy. 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, according to regional needs and demands.

Health care policy at the national level was marked by reforms, which were redrawn by the next government. The real privatisation process was driven from below. The mode of governance itself was not changed.

Some county councils had already experimented with purchaser-provider splits in the late 80s. In the early 90s, the Federation of County Council had recommended to fill gaps in the provision with private providers. In 1994, the Moderates obliged the county councils to include private providers into the public system. In the following year, the SAP revoked the reform law.

After the privatization of the first public hospital in Stockholm, the national SAP government prohibited further privatizations in 2004 – the stop-law. In 2006, the new moderate government enacted the start-law, encouraging further privatisations of public hospitals.

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. In 2010, the national moderate government embraced the recommendation (Olsen forthcoming).

Also for quality assurance, we observe a constant rebalancing between regional and national level. Due to the technical developments, health care technology assessment, guidelines for practice and prioritisation became ever more detailed and strengthened the national level. Since 2001, the Federation of County Councils publishes its own quality reports to counterbalance this development (Sveriges Kommuner och Landsting 2002).

Swedish health care is funded by income taxes on the county level. A national income and risk equalisation scheme evens out regional differences. The national subsidies rose from 15% in 1994 to 20% in 2009. However, these are average numbers, the percentage per county varies widely (Swedish Association of Local Authorities and Regions 2008).

Next to tax-funding, high co-payments and a social insurance finance health care. The share of private funding out of total health expenditure nearly doubled from 10% in 1990 to 18% in 2007(OECD 2010). This is mainly the result of the complete privatisation of dental care. The Social Insurance finances just sick-leave and dental care subsidies for adults. Just 4 percent of the population obtain a private health insurance (OECD 2004). Hence, increasing co-payments increase the risk of social imbalances.

In the late 80s, nearly all doctors were public employees. In the early 90s, the Federation of County Councils recommended to fill gaps in the provision structure by private contracts. The counties concluded contracts for private practice with their own employees. The standard working week allowed the public employees to practice privately in their extensive free-time.

In 1994, the Family Doctor Reform established competition within the public system and allowed patients to choose their family doctor, instead of being treated by the doctor on duty. Private and public providers have to be treated on equal terms. The counties had to introduce a remuneration system, where money follows the patient. The result was provider induced demand. In 1995, the social democratic government revoked the reform, as it accelerated costs and threatened the new approaches of integrated care. Some counties maintained the capitation for family doctors, others returned to salaried doctors in public health care centres. The regional systems became more diverse (Harrison, Calltorp 2000).

Despite the privatization reforms, health care 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 (Sveriges Kommuner och Landsting 2010). Privatisation was the answer to the quest for self-responsibility and responsive providers by the urban middle class. In rural areas a natural monopoly exists.

In the hospital sector, the huge public and political privatisation debate obscures the negligible significance of private clinics within the public system. So far, just one public hospital was sold to a private investor. Furthermore 20, private non-profit clinics exist. Out of the 941 private hospital beds, 645 were under contract in Stockholm in 2008 (Sveriges Kommuner och Landsting 2009).

The only exception to the principle of public provision is dental care. More than 40% of the dental care personnel work in private for-profit practice.

Access to health care goods and services has been and still is universal in Sweden. In a public system demands from providers and patients are unlimited and some kind of rationing has to take place. In Sweden, clear guidelines for prioritization are followed. 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, competition between counties is established. 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.³

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.

Again, dental care is the exception. Costs and risk are born by the patient. As a result, patients from lower income classes visit the dentist less often, despite higher needs (Calltorp, Larivaara 2009; European Commission 2007, p. 396).

5.3 Concluding remarks

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 allowed for reform by the county councils. The most salient shift was the introduction of private providers – although in international comparison still at a low level. 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.

6. 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 competition in the funding dimension, Sweden between providers. In the governance dimension, Sweden experimented with markets, without questioning the supremacy of state governance. The Netherlands replaced their corporatist bodies under the heading of “markets” by state agencies. State governance is the most efficient mode to maintain costs. Table 3 gives a comparative overview of the two systems. The changes are highlighted.

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

The structural challenges were quite similar between the two small countries: demographic change and a post-modern society. The institutional heritage determined in which dimensions they introduced choice and competition. In the Netherlands the provision dimension was already market by competition – also in a corporatist setting. In Sweden, choice between third-party-payers is inhibited by the regional principle. The governance structure of health care determined the pace of reform. 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 health care governance.

The reform outcomes differ also as a result of the different impact of the neo-liberal idea. Whereas the concept of Enthoven was prominent in both countries, in the Netherlands, competition became a value itself. In Sweden, the conservatives could not establish such a common discourse, and 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. To sum it up, a coherent neo-liberal idea is the precondition for market oriented reforms. The welfare state institutions define the dimension, in which competition is the easiest introduced and the political institutions define the feasibility. For the future, research in countries with more veto-point is needed.

Notes

1. During the first years of the crisis, there seemed to be the possibility of a new paradigm shift Hemerijck, 2009.
2. Officially all contributions are paid by the insured, however the reimburseable wage-related contribution is in reality a employer contribution.
3. This guarantee was first introduced in 1992, withdrawn in 1997 due to scientific critic and reintroduced in 2005. However, since 2005 nearly all counties offer free choice of provider in the whole country.

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