

Explaining Convergence and Common Trends in the Role of the State in OECD Healthcare Systems

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There are three major branches in the literature that contribute to the explanation of change in healthcare policy, which are the functionalist perspective, institutionalism and path-dependence explanations, and the theory of power resources.^{1, 2} While all of these approaches have their strengths, they mainly derive from the broader analysis of the welfare state and therefore tend to neglect the specifics of healthcare systems, especially their typology. Yet, the specific healthcare system type – as we argue in what follows – is a crucial factor when it comes to the explanation of change.

In this paper, we outline our theoretical concept for explaining healthcare system change. We do this against the backdrop of information we gathered by qualitative and quantitative analysis of 23 countries belonging to the Organisation for Economic Co-operation and Development (OECD) before the first

oil crisis (Turkey excluded) in conjunction with a detailed focus on the cases of Great Britain, Germany, and the United States.^{3, 4} These cases are taken to represent ideal approximations of state-based National Health Service (NHS) systems, social insurance, and private healthcare system types, respectively.

To briefly summarize these results, in the 1970s, healthcare systems differed greatly in terms of their spending patterns, mode of service delivery, and regulatory structures. Over time, with respect to the role of the state, we find convergence in healthcare financing, and a common privatization trend in service provision. Convergence means that systems grow more similar, which quantitatively can be expressed by a diminution of variance (so-called sigma convergence). Common trends, in turn, describe the fact that indicators move in the same direction, without necessarily approaching each other.

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Convergence also occurs in the regulatory dimension of healthcare systems. By drawing on our qualitative case studies, we find that these healthcare systems have blurred. More precisely, they incorporated structures of regulation they were originally lacking, i.e. which are not characteristic for the respective healthcare system type.⁵ The blurring of healthcare systems and the emergence of mixed types imply increasing similarities and therefore can be considered as specific forms of convergence.

In the following, we start by presenting a general explanatory model for healthcare system change. We continue with a system-type specific account, exemplifying the changes for (1) state-led NHS systems, (2) social insurance schemes, and (3) private healthcare systems. We conclude by suggesting that only mixed structures adequately respond to the common problem pressure caused by globalization, demographic change, and medical-technological progress that healthcare systems must cope with.

Explaining Healthcare System Change

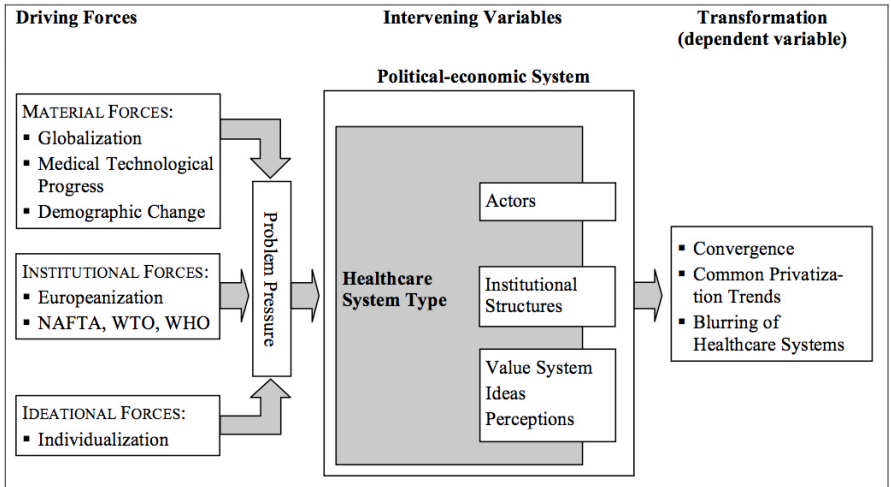
In order to explain the phenomena of convergence and common trends, it is hypothesized that healthcare systems share a common source of problem pressure which forces them to induce change. According to the standard functionalist argument, we should witness a uniform reform path in all industrialized countries.^{1, 6, 7} In contrast to this theory we find that the chosen trajectories vary considerably among the distinct types of healthcare systems. The crucial explanatory variable, therefore, is the healthcare system itself, its defi-

ciencies, and functional requirements as reflected in the specific system type. The direction of change is ultimately subject to the particularities of individual system types (modified problem pressure hypothesis).

The General Explanatory Model

To structure our argument, we propose a general model of healthcare system change, which serves as a heuristic device (see Figure 1). The explanatory model addresses the interplay of specific driving forces, which cumulatively exert problem pressure on healthcare systems. This system stressor can then be seen to interact with intervening variables, which structure change by veering systems toward a specific direction and by setting the pace; thus accelerating or retarding and even temporarily arresting transformation.

To start with the driving forces, we distinguish between material (e.g. globalization, medical-technological progress, demographic change), institutional (e.g. Europeanization), and ideational forces (individualizationⁱ). Without immersing too deeply into the mechanisms of how these forces act in an isolated manner, it can be said that particularly demographic change, medical progress, and individualization tend to increase demand for scarce resources. Globalization and Europeanization restrict policy makers' discretion and set limits on (public) healthcare spending. For the time being, however, we will argue that their cumulative effects exert problem pressure on healthcare systems.^{6, 8, 9} As a consequence, efficiency has been the catch-word in the political debate since the 1990's, requiring healthcare systems to implement cost-containment strategies while simultaneously achieving (or



Source: own depiction

Figure 1: General Explanatory Model

preserving) responsiveness and choice.⁹
¹⁰ At the same time, institutional forces require the harmonization of national healthcare policies and the compliance with international law.

Regarding the intervening variables, the most crucial factors are the healthcare systems themselves: their value systems and the associated veto points and organized interests, which are also part of the broader political-economic system. In line with the “modified problem pressure hypothesis,” it is both the nature and degree of problem pressure, subsequently mediated by the component factors of the healthcare systems themselves, which can be said to define the direction of healthcare system transformation observed (dependent variable, see Figure 1).

The Modified Problem Pressure Hypothesis: Why do Mixed-Types of Healthcare Systems Emerge?

A widely held belief is that problem pressure necessarily leads to a privati-

zation of social risks, the introduction of market competition, and a retreat of the state in all healthcare systems of the OECD world.ⁱⁱ Yet, by analyzing the empirical data, we find that common privatization trends are solely observed in the service provision dimension. Privatization trends alone, therefore, explain only part of the story. Regarding their financing structure, in contrast, we find that the healthcare systems have approached each other with respect to the role of the state.ⁱⁱⁱ Even more persuasively, convergence in the regulation dimension implies a blurring of systems, i.e. public elements grow in the private US healthcare system, while market competition is considerably enhanced in the state-led UK system and the German social insurance scheme as well.^{3, 4} It is therefore our hypothesis that only mixed structures adequately respond to the common problem pressure healthcare systems are facing, leading to our core theme, the “modified problem pressure hypothesis.”

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This hypothesis suggests that in search of solutions to common problem pressure, systems develop distinct policy responses, thereby quitting traditional paths and taking up new elements that are non-system specific. As system types vary so too do their adaptive responses. By “borrowing” from each other healthcare systems transform into mixed-types.⁵ The modified problem pressure hypothesis takes into account that different lines of adaptation emerge depending upon the specific healthcare system type the observed countries resemble.

Healthcare Systems and their Response to System-specific Deficiencies

According to our argument, the direction of change is indicated depending on the specific features and deficiencies of the healthcare system type. In a somewhat stylized manner, we outline the general characteristics as well as the system-specific deficiencies by examining the system logic of (1) state-led NHS systems, (2) social insurance schemes, and (3) private healthcare systems, which serve as examples of most pure-type healthcare systems.⁵⁻⁷ We thereby draw on the general system logic, as well as on some empirical examples, which may serve as first evidence.

State-led National Health Services

Healthcare in National Health Services (NHS) is characterized by universal coverage based on citizenship. Ideally, a full range of health services is provided free at the point of delivery. Consequently, services are typically financed through taxes. Health service delivery is characterized by the dominance of pub-

lic provision, i.e. state-owned hospitals as the dominant providers in the inpatient sector and public employees in the outpatient sectors. Moreover, the relations between financing institutions, service providers, and (potential) beneficiaries/patients are mainly regulated through state hierarchy. Within our OECD sample, the Nordic countries (Denmark, Finland, Iceland, Norway, and Sweden), Australia, Ireland, New Zealand, and the UK, as well as Italy, Spain, and Portugal can be counted as NHS systems. However, this large group of NHS countries is heterogeneous and some countries significantly deviate from the ideal type description as the outpatient, dental and/or pharmaceutical sectors are characterized by private providers.⁸

NHS systems are successful in cost-containment, but tend to develop specific malfunctions such as long waiting lists for certain treatments, insufficient investment in healthcare facilities, poor responsiveness, and low productivity of providers. These problems are related to budget cuts which entail forms of rationing, but can also be more generally related to the idea of “state failure.” In short, the notion of state failure assumes that state-organized healthcare may guarantee equal access to services but fails to provide services efficiently.⁹ Therefore, in state-led NHS systems problem pressure mainly translates into remedies for state failure. Driven by the need to produce healthcare services more efficiently (cost-effective and technically efficient), mainly market-based alternatives come under consideration.

The developments in state-led systems with respect to the role of the state in healthcare can be crudely summarized as follows. The role of private healthcare

financing has increased on average, and service provision has been privatized in various ways. Moreover, NHS systems have implemented market elements as modes of regulation. However, the implementation of market-oriented reforms does not necessarily mean a loss of state authority, since markets need to be regulated. Therefore market-oriented reforms tend to go hand in hand with intensified state hierarchy (“seesaw effect”).

The increasing salience of private financing in state-led systems may be simply a side-effect of cost-containment in the public system. It must be considered, however, that this form of privatization may involve high political costs. In the UK, public financing has increased massively from 2003 onwards, after years of continuous decline of the public financing share.¹⁰ Private financing can also reveal dissatisfaction with the public system, e.g. undue waiting times or low standards of treatment provide incentives to choose private alternatives.¹¹ As a further option, the rise of private financing may also reflect attempts to avoid excessive demand. Cost-sharing can be implemented to provide an incentive for using more primary care, as done in Italy and some Scandinavian countries.¹⁷⁻¹⁹

In the service provision dimension we observe diverse forms of privatization. Functional privatization¹² has often been a first step, particularly the outsourcing of non-clinical services to private corporations. Less frequently, health-related functions and hospital management have been outsourced.¹³ The trend to abolish command-and-control management and to grant more autonomy to hospitals goes hand in hand with formal privatization.¹⁴ For-

mal privatization means that hospitals adopt private legal forms and private management structures while remaining in public hands. The sale of hospitals to private owners, however, appears to be rather marginal in most NHS countries. Instead, private providers have often been strengthened implicitly as resources have been shifted towards the outpatient sector, where private providers play an important role.⁸ These diverse forms of privatization can be understood as attempts to increase incentives to provide services more efficiently and to steer resources away from cost-intensive inpatient care.

State hierarchy as the dominant mode of regulation in NHS systems has supported cost-containment policies which can easily be implemented through global budgets.¹⁵ At the same time, hierarchical modes of regulation – often in the form of centralized planning – tended to produce inefficiencies in allocation, which, for example, became manifest in long waiting lists. As a result of system-specific problems, NHS systems have supplemented state hierarchy with market-style modes of regulation.^{16, 17} Several NHS systems such as England, Finland, and Italy have established a purchaser-provider split, though in some cases limited to certain areas, as in Sweden and Spain.¹⁸ Accordingly, providers must compete for purchaser contracts. Furthermore, in Italy managerial behavior has generally been encouraged.¹⁶ Probably the most comprehensive reform steps have been taken by the English NHS through the creation of internal markets.¹⁹

The introduction of market mechanisms, however, provoked new state interventions.⁴ For example, during the implementation of the purchaser-

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provider split UK hospitals ran into difficulties due to massive problems regarding calculating costs and contract models with purchasers. By state interference, cost calculation was standardized through the Healthcare Re-source Groups (an equivalent to Diagnosis Related Groups).¹⁹ Thus, hospital remuneration exemplifies a seesaw effect as the state introduces competition by means of hierarchical intervention and is forced to apply further regulatory measures in order to support the functioning of markets.

Social Health Insurance Systems

Social health insurance (SHI) systems account for the second largest group in our OECD sample, consisting of Austria, Belgium, France, Germany, Japan, Luxembourg, the Netherlands, and, since 1996, Switzerland. The system logic of SHI is characterized by corporatist self-regulation based on collective bargaining between sickness funds and provider associations.²⁰ On the financing side, wage-related contributions play a dominant role. With regard to service delivery, inpatient care mainly relies on public or private non-profit hospitals, whereas the other healthcare sectors (i.e. the outpatient, dental, or pharmaceutical sector) are dominated by private for-profit providers.²¹ SHI schemes usually cover a large part of but not the entire population. Although insurance is generally mandatory, the self-employed, civil servants, and high-income employees often have an exit-option.²²

The eroding financial basis of SHI schemes can be identified as a major system-specific deficiency. First and foremost, the share of wages on overall economies' incomes decreased since the

late 1970s, while capital gains (which are not subject to contributions) became more important in all OECD countries.²³ The decline of standard fulltime employment also decreased the sickness funds' revenue.¹⁰ Furthermore, demographic change negatively affects the ratio between contributors and recipients.²⁴ At the same time, global competition foreclosed the raising of SHI contributions as they represented a (visible) part of labor costs.²⁵ Thus we observed attempts to promote alternative funding sources, such as taxes or private payments. In Germany and the Netherlands, for example, private out-of-pocket expenditures increased since the mid-1990s.¹⁰ In addition, social insurance contributions were transformed from wage-related to per-capita flat-rate contributions. This occurred recently in the Netherlands where almost half of the total healthcare expenditure is financed through income-independent contributions.²⁶

In service provision, trends towards privatization and "profitization," i.e. the growth of private for-profit providers at the cost of private non-profit providers, are mainly driven by permanent fiscal austerity, which limits the state's support for public or private non-profit hospitals. Regarding public hospitals, governments often react with formal privatization to raise incentives for efficient behavior by making them responsible for profits and losses.¹⁴ In addition, private non-profit hospitals must cope with reduced support due to secularization trends. Public and private non-profit hospitals with unfavorable cost structures are vulnerable to acquisition by private for-profit organizations. The advantages of for-profit organizations include more flexible personnel

structures and easy access to the capital market. Since for-profit operators serve investors' interests, they are forced more strictly to provide services efficiently.

Concerning the regulation of SHI systems, we observe a decreasing role of corporatist self-government and an increase of state hierarchy and market competition at the same time. We conclude that this particularly striking change is a reaction to self-inflicted steering failures and the tendency towards deadlock. These phenomena which are commonly labeled "institutional sclerosis," are mainly caused by rent-seeking behavior of corporatist actors.

In a system of mandatory assignment to sickness funds, the insurer has no incentive to reduce contribution rates while the collective arrangements force him, rather, to be responsive to providers' claims. Competition between sickness funds has been introduced in the Netherlands in 1989 as well as in Germany and Switzerland in 1996.²⁷ As soon as the state intervenes with the abolition of fund assignment, competition restrains the funds' freedom to increase contribution rates.²⁸ Yet a considerable side-effect of competition on the financing side is the incentive for risk selection.²⁹ In nearly all SHI systems, the state reacted to this adverse result of market competition with the introduction of risk-compensation schemes.³⁰ As the sickness funds needed different means to unfold competition, the government started to cut back collective bargaining by introducing selective contracting with providers.²⁹ Germany and the Netherlands are examples of this spill-over effect of competition from insurer to provider markets.³¹ Furthermore, market-oriented changes in the reimbursement structure were imple-

mented to improve cost-effectiveness of the healthcare system and to reduce the rent-seeking of providers. In the inpatient sector this is strongly tied to the switch from reimbursement schemes according to incurred cost to flat-rate payment systems, calculated by using Diagnosis Related Groups.²⁹ Generally, the pharmaceutical sector became more affected by hierarchical price control. Nearly all social insurance systems have introduced fixed or reference prices in their pharmaceutical markets.^{32, 33}

As the definition of the benefit package is a major challenge of a system regulated by collective bargaining procedures, this aspect is especially prone to state intervention. In SHI systems, the failure of corporate actors to define an appropriate scope of medical goods and services to be collectively financed therefore also leads to greater state intervention. Institutions for health technology assessment have been founded in nearly all SHI systems, like in Austria, Belgium, Germany, France, and the Netherlands. Sometimes, hierarchical regulation is covered by integrating self-regulatory structures, but all these measures are implemented and often controlled by the "shadow of hierarchy."

In conclusion, poor cost-containment capacities and the lack of cost-effectiveness in collective bargaining systems provoked the state to intervene hierarchically as well as to introduce competitive market mechanisms, which in turn led to even more hierarchical re-regulation. This seesaw effect squeezed corporatist self-regulation in between and is the key to understanding the blurring of the social insurance systems.

Private Insurance Systems

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The logic of private healthcare systems is characterized by extensive reliance on consumer demand and market competition as a mode of governance.³⁴ In our sample of 23 OECD countries, Switzerland (until 1996) and especially the United States come close to the competitive market model. In private systems, the purchase of insurance is not mandatory, nor are the insurers obliged to accept all applicants. Insurance companies sell a variety of contracts that are contingent upon health status and also reflect consumer's willingness and ability to pay. Service delivery is mainly performed by private providers. This also means that healthcare is an industry where private entrepreneurs respond to the high mobility of capital.^{7,35} In the outpatient sector, physicians are generally self-employed and therefore mainly for-profit providers.

While private healthcare systems in general score relatively high with regards to responsiveness and choice, their ability to achieve social objectives is limited.³⁶ Private health insurance markets suffer from "market failure" caused by adverse selection^{iv} and moral hazard.^v³⁷ Insurers try to avoid problems of adverse selection by risk-rating premiums and by imposing (high) co-payments. This method renders health insurance unaffordable particularly for those population groups who most urgently need it, i.e. sick and poor individuals.⁴ Furthermore, private insurers intend to reduce uncertainty by excluding pre-existing medical conditions from the benefit package or by completely denying coverage for an applicant.³⁸ Private healthcare systems thus hardly achieve full coverage of the population with a comprehensive

benefit package. The result is an increase in the number of uninsured and underinsured persons, as experienced drastically in the US healthcare system. In addition, as long as financing agencies are just payers and do not actively manage service provision, they are particularly prone to moral hazard behavior. Private systems therefore tend to have high healthcare expenditures.³⁹ In fact, the US and Switzerland have the most expensive healthcare systems in the world, consuming in 2005 over 15 percent of the GDP and 11.5 percent, respectively.¹⁰

As a consequence of efficiency pressure, hierarchical elements of regulation have increased in private insurance systems over time. Switzerland even moved away from a private to a social insurance scheme by establishing mandatory insurance for all citizens and thus tackling the problem of uninsurance and underinsurance.⁴⁰ The system change was enabled by state interference in 1996 through the introduction of the New Law of Health Insurance (Krankenversicherungsgesetz, KVG). The main objectives of this law were to contain costs, strengthen solidarity, and to provide access to high quality health services for every individual.⁴¹ Also in the US, public and societal elements grew considerably. On the side of the government, public programs for the aged, the disabled, and the indigent were enacted at a time when many elderly persons faced challenges finding affordable coverage within private markets.^{39, 42} With US Medicare, a social health insurance program was implemented for the aged and the disabled. The considerable increase in public funding also entailed a substantial rise in hierarchical state regulation.^{43, 44} Yet,

in the realm of private insurance, government regulation remained weak especially vis-à-vis service providers.⁴⁵

In private insurance, vertically integrated private managed care organizations gained a foothold. Due to their hierarchical structure, they were able to impose instruments for steering patients and providers. Private managed care arrangements, therefore, operated as a functional equivalent to government regulation. Health Maintenance Organizations (HMOs) achieved considerable savings, especially in the first decade of their spread. As a consequence of the backlash against HMOs, “virtually” integrated provider networks emerged, giving some leeway for bargaining procedures in the interaction between insurers and service providers.^{46, 47} Managed care was introduced in Switzerland as well, yet in this case, it was a consequence of state legislation (KVG 1996) and therefore not initiated by private actors. Nevertheless, the managed care instrument was adopted in order to bring more hierarchy into the delivery system.

On the side of service providers, the system logic of private, market-based healthcare systems led to the expectation that most providers are private for-profit. We find this assumption affirmed only for the outpatient sector, where most physicians are self-employed. In inpatient care, by contrast, non-profit providers (public or private) prevail, as they are either part of the safety net (US) and/or because they are subsidized by the state (Switzerland).^{48, 49} In the US, public inpatient care provision decreased as a direct consequence of the growth of managed care. Here the government sold its municipal hospitals in light of increasing market competi-

tion.⁵⁰ Functional privatization through outsourcing activities is advanced, especially in the US. For example, hospitals commission the service industry not only with catering and laundry services, but also with management functions, such as human resources management and payroll accounting. Most of these highly specialized suppliers are private for-profit businesses.

In coping with system deficiencies, hierarchical elements have increased considerably in private healthcare systems, emanating from the side of public and private actors as well. More collective financing too is observed, either through the introduction of social health insurance or by an increase in public funding. At the same time, profitization tendencies in the health service sector are clearly to be discerned, but are limited in their extent as the state subsidizes the non-profit industry.

Conclusion

Healthcare systems once differed largely with regards to spending patterns, the mode of service delivery, and their regulatory structures. Over time, we have observed convergence (financing and regulation dimension), common privatization trends (service provision), and a blurring of healthcare systems (regulatory dimension).

In this paper, we have shown that convergence and the common trends we observed in the healthcare systems of OECD countries can be explained by the reaction of distinct system types to the common problem pressure. Evidently, only mixed structures adequately respond to common problem pressure healthcare systems have to cope with.

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In our examination of the changes for state-led NHS systems, social insurance countries and private healthcare systems, we have demonstrated that the system types themselves – their functional requirements and deficiencies – lead the direction of change. The “modified problem pressure hypothesis” we put forward, therefore emphasizes that problem pressure is mediated by the component factors of the systems themselves. As systems integrate features that are non-system specific, they blur in their composite features and ultimately converge.



Notes

- i. Individualization trends have two major consequences. On the one hand, changing life patterns require new forms of risk protection. On the other hand, increasingly informed and self-conscious patients successfully demand the responsiveness of healthcare services.
- ii. For a general critique see ⁶.
- iii. Here we observe common privatization trends mainly during the 1980s and the 1990s and a tendency towards higher public spending levels for the rest of our observation period. We also show evidence for convergence when comparing public expenditure growth with its baseline in 1970, as countries with low public financing caught up with the leaders.⁴
- iv. *Adverse selection* occurs when an insurer is not able to rate the health risk of the applicants. In this case he will calculate a premium based on average risk expectation. This premium will attract mostly individuals with relatively unfavorable risk structure. As a consequence, the insurer will be forced to increase the premium in the next period and more favorable risk groups will be further deterred. This process can repeat itself with the consequence of a break-down of the insurance market. At best, good risks accept co-payments and co-insurance thereby signaling that they are good risks. As a result good risks only get partial insurance. If insurance (on part of the insured) and underwriting (on part of insurances) are not mandatory, however, it may even lead to the ruin of the market.
- v. *Moral hazard* refers to a change of behavior once insurance exists. It includes reduced prevention (ex ante moral hazard) as well as over-utilization (ex post moral hazard), which can be induced by suppliers and consumers as well.

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