

# Healthcare Governance in Britain, Germany and Sweden

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## How Differences in Funding and Provision Shape Transformations in the Governance of Healthcare – A Comparison of Britain, Germany and Sweden

### 1. Introduction

Every German student, coming to Britain to spend some time at a university there, will notice rather quickly that there is something different about the way healthcare is organized. “Why do I not have to get insurance? And why do I have to register with a specific doctor?” are the questions that are likely to come to this student’s mind. Not every student will have the time and energy to expand those questions and look more deeply into the related subject matter. Fortunately, this essay gives me the opportunity to do exactly that.

The purpose of this essay is to analyse structural differences between the healthcare systems in Britain, Germany and Sweden and to explore to what extent these differences shape transformations of healthcare governance. I will do this in four steps. First, I will outline the structural differences between the healthcare systems in the three respective countries. Second, I will give a brief overview over reform efforts that led to transformations in the governance of healthcare. Third, I will discuss the connection between the structural differences and the transformations outlined. Fourth, I will conclude the arguments made, and link them to the wider context of healthcare system transformation.

I will argue that structural differences play an important role in transformation processes of healthcare governance and shape these processes in three particular ways. First, they decelerate reform processes through their institutional inertia and make fundamental transformations difficult to implement. Second, they determine the area in which reform pressures arise. Third, they channel reform pressures into certain pathways. However, I will also argue that the structure of healthcare systems, although certainly of great importance, is not the only explanatory factor that shapes the transformation of healthcare governance, and that there are other factors of influence that expand across different structures.

### 2. The Healthcare Systems in Sweden, Britain and Germany

A variety of typological approaches has been suggested in the recent literature in order to categorize the healthcare systems of different countries. As shown in Wendt’s (2009, p. 442), compilation of classification schemes, Britain and Sweden are usually placed in the same group, in spite of the fact that they are located on opposite ends of Esping-Andersen’s (1990) analytical spectrum regarding the welfare state as a whole.

The reason for this is that the healthcare systems in both countries are traditionally state-centred. It is the state that allocates a certain part of its budget to the healthcare system and thus guarantees the provision of healthcare services to all residents. Healthcare service providers are either directly employed by the state or reimbursed for their services with taxpayers’ money on the basis of contracts. Patient access to services is subject to state regulations and restrictions, such as the requirement to use the services of a provider close to one’s place of residence, and also to prioritization schemes and waiting lists for certain services (Burau 2007, p. 380; Baggott 2004; Gløngård et al. 2005; Ham 2009).

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The main differences between the Swedish and the British healthcare system lie in the degree of centralization and the scope of healthcare expenditure. In Sweden, the organisation of healthcare is highly decentralised. It is funded at the sub-national level by county councils which raise their own local taxes for this purpose. In addition to this, county councils have the competence to regulate the provision of healthcare independently within a rather loose general framework outlined by the central government (Burau 2007, p.380; Glengård et al. 2005).

Naturally, a certain degree of delegation of responsibilities to the local level has to occur in Britain as well, since it would be impossible for the central government to regulate every minor detail of healthcare provision in every corner of the country (Glasby et al. 2010). Nevertheless, funds are provided and allocated by the central government and a far stricter hierarchy of command and control is in place. Furthermore, Britain traditionally spends a considerably smaller proportion of its GDP on healthcare than Sweden does (Baggott 2004; Burau 2007, p. 379-380; Ham 2009; OECD 2010a).

Germany, on the other hand, is a classical example of a corporatist healthcare system based on social insurance. Healthcare is paid for by sickness funds which collect a certain percentage of the salary of each person they cover. Employees whose income lies beyond a certain threshold as well as the self-employed have the opportunity to opt-out of the system and get private health insurance. Sickness funds negotiate healthcare provision and reimbursement directly with providers. Patients are generally free to choose a provider. The state acts as a regulator in the background and, through legislation, determines a framework, inside of which sickness funds and providers act autonomously, as well as a comprehensive catalogue of provisions to be covered by the health insurance system (Burau 2007, p. 380; Busse and Riesberg 2004; Haverland and Stiller 2010; Lisac et al. 2010).

## 3. Reform Trajectories

Across the three countries, there are four main target areas of healthcare reforms, which are accessibility, expenditure, efficiency and freedom of choice. In Sweden, various efforts have been made to deal with the problem of long waiting lists, the latest one being a nationwide maximum waiting-time guarantee of 90 days between diagnosis and treatment, introduced in 2005 (Glengård et al. 2005, pp. 76-77). The size of healthcare expenditure as a whole has not been an issue of great urgency since the share of Swedish GDP spent on healthcare has remained comparatively stable over the last 30 years (OECD 2010a). Patients' entitlements have remained largely unchanged with the exception of dental care where government subsidies were reduced significantly (Glengård et al. 2005, p. 103).

Efforts to improve efficiency have focussed on a shift from hospital to ambulatory care. The number of hospital beds has decreased significantly as a result (Burström 2009, p. 272; OECD 2010b). Furthermore, a new authority was established in 2002 to decide whether a new pharmaceutical product should be subsidized and, if so, to negotiate a price with the producer (Glengård et al. 2005, pp. 103-104).

Finally, the conservative-liberal government elected in 2006 has tried to increase the importance of demand-based mechanisms by loosening restrictions on the number of service providers per area, through the inclusion of private service providers and through the patients' right to choose a provider freely (Burström 2009; Dahlgren 2008). At the same time, however, some county councils are introducing so-called integrated health care schemes, which are supposed to provide integrated, cooperative and comprehensive healthcare for local residents. So far, it is not entirely clear to what extent this trend will contradict the freedom of choice objective in practice (Ahgren 2010).

In Britain, waiting times are traditionally a key issue raised in the context of accessibility. Efforts have been made to address the problem but the issue remains contentious (NHS 2010; Robinson and Dixon 1999, p. 36; The Independent 2010). A distinctive feature of the British healthcare system is the comparatively small proportion of GDP that has been used to fund it. In the past, it has been widely perceived that the National Health Service (NHS) was chronically underfinanced (Baggott 2004, p. 134). When the Labour Party came to power in 1997, it promised to raise healthcare expenditure to the European average (Baggott 2004, p. 136). This goal has not quite been reached but spending was increased significantly nevertheless (OECD 2010a).

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Another very important aspect of British healthcare reform has been the attempt to increase efficiency without increasing expenditure. This has been tried through the introduction of an internal market, skill mix policies, and extensive quality management measures. The internal market, a project of the conservative government in the early 1990s, splits the healthcare sector into purchasers and providers. The former mainly consist of local authorities endowed with money from the central government. The latter can be public health trusts or private sector providers. Both sides cooperate on the basis of contracts (Baggott 2004, pp. 105-108). This separation appears to be somewhat artificial in cases where both sides are under public control, but it is believed to increase competition and efficiency. Interestingly, some Swedish county councils experimented with similar models from the late 1980s onwards. The benefits of the system remain debatable in both cases (Siverbo 2004).

Skill mix policy mainly involves the shift of certain medical tasks from doctors to nurses. Britain is the only one of the three countries that has implemented this practice on a considerable scale (Bourgeault et al. 2008). Quality management and public control of healthcare providers were implemented through a variety of measures, the most significant one probably being the creation of the National Institute for Health and Clinical Excellence (NICE) in 1999 (Baggott 2004, pp. 213-244; Blank and Burau 2010, pp. 134, 156; Fenton and Salter 2009). Finally, especially in recent years, considerable attention has been given to demand-based reforms bringing about greater freedom of choice (Baggott 2004, pp. 314-321; Veitch 2010; Vincent-Jones et al. 2009).

In Germany, accessibility of healthcare services was universalised in 2007 when private insurance companies were required to offer a basic insurance plan to everybody who is not covered by the social insurance scheme. However, the number of uninsured people had never been very high in Germany and a previous reform in 2004 had been aimed at limiting rather than widening accessibility. User charges were introduced for the first GP visit per calendar quarter as well as for every specialist visit without referral from a GP (Haverland and Stiller 2010; Lisac et al. 2010).

Cost containment has been a main objective of German health policy in recent years. Numerous services, such as glasses, non-prescription drugs and parts of dental care were removed from the package of services paid for by sickness funds. In addition, the principle of equally shared contribution between employers and employees was abandoned. The employers' share was frozen and an additional fee imposed on employees (Haverland and Stiller 2010; Lisac et al. 2010).

Doctors and hospitals have been obliged to set up quality management schemes. Reimbursement was shifted from payment for each individual therapeutic measure to flat rate payments per diagnosed case. An independent institute for the evaluation of medical practices has been set up and so-called disease management programmes have been introduced in order to treat the chronically ill in a more structured and efficient way (Haverland and Stiller 2010; Lisac et al. 2010). However, in spite of these developments, measures that supposedly enhance efficiency are not pursued with the same vigour as in Britain (Burau, 2009; Kuhlmann and Allsop 2007, p. 182).

The approach to freedom of choice pursued in recent reforms can be described as somewhat ambiguous as well. On the one hand, it has been tried to discourage frequent visits, to specialists in particular, through the introduction of user charges. On the other hand, the freedom to change from one sickness fund to another has been extended and the healthcare reform of 2007 introduced the possibility to choose between different insurance plans within the same sickness fund (Haarmann et al. 2010).

## 4. Discussion

The first important observation that can be made when comparing healthcare reforms in Sweden, Britain and Germany, is the fact that the healthcare system in all three countries retained their basic structure in spite of all changes. The NHS was neither privatised under the Thatcher administration nor are there any plans to change the underlying structure of the healthcare system dramatically under the current liberal-conservative government (Department of Health 2010). In Sweden, the current government's more demand-centred approach to healthcare faces severe criticism although it does not actually question the foundations of the healthcare system that have remained virtually unchanged over the last decades (Burström 2009; Dahlgren 2008). The left-leaning government that was in Power in Germany between 1998 and 2005 did not make any serious move towards abolishing the

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possibility for those with the highest incomes to opt-out of the social insurance system, either.

This rather cautious, slow pace of healthcare reforms under governments on both sides of the political spectrum and the total lack of radical, revolutionary changes support the argument of the “New Politics of the Welfare State” Literature which argues that welfare systems and their institutions are “sticky” and difficult to reform (Pierson 2001).

Nonetheless, even though the underlying structure of each respective healthcare system was not overthrown, the implemented reforms led to a certain degree of structural transformation. The analysis of healthcare reforms carried out above leads to the conclusion that the area and the direction of transformation were to a certain extent again determined by features of the structure itself: In Britain, healthcare expenditure was a core area of reform pressure due to the structural peculiarity that Britain traditionally spent a comparatively small proportion of its GDP on healthcare in combination with the fact that the system was widely perceived as underfinanced. Logically, this pressure was pushing the system towards an increase in healthcare expenditure. In contrast, the structural feature that Sweden’s healthcare expenditure has remained comparatively stable over the last decades, while the healthcare system was perceived as comparatively well-performing, explains the lack of reform impetus in this area there. In Germany, on the other hand, where healthcare expenditure has risen considerably above the European average, reform pressure was pointing towards cost containment. However, due to the indirect influence of the German state on the governance of healthcare, cost containment could not be achieved by simply cutting healthcare expenditure. As a consequence, reform pressure occurred in the area of accessibility and pushed towards the reduction of the number of services covered and the introduction of user charges.

Reform pressure in the area of efficiency occurred in all three countries. Naturally, this pressure was pushing towards more and not less efficient healthcare governance. However, in the case of Germany, the lack of strong hierarchical command and control structures makes the implementation of efficiency enhancing measures difficult (Burau 2009).

For the case of Sweden, Fredriksson and Winblad (2008) argue that due to the highly decentralised, communal structure of the healthcare system, transformations in the governance of healthcare tend to be comparatively fragmented and heterogeneous as well. In the area of patients’ choice, reform pressures also appeared in all three countries. Both in Sweden and Britain – where healthcare systems are traditionally state-centred and pay comparatively little attention to the forces of the market and the choices of the individual – the structure provided room for manoeuvre towards a more demand-based policy. Due to this, reform pressure was pushing towards the implementation of measures to increase freedom of choice. In Germany, where the freedom to choose a provider was firmly established in the structure of the healthcare systems and has led to high costs which the state is unable to control directly for structural reasons, the direction of pressure was more contradictory. While reforms in the organizational structure of the social insurance system were clearly pushing towards greater freedom of choice, the cost containment pressures discussed further above were dominant as far as the choice of providers was concerned and were pushing towards a decrease in accessibility there.

What this discussion shows is that the distinct structural characteristics of the healthcare systems in Britain, Germany and Sweden are useful to explain in which areas transitions of healthcare governance occurred and in which direction the arising pressures for reform were likely to push. However, there are two questions of great importance that have not been discussed so far: When does reform pressure occur and why does it occur? Structural differences in the governance of healthcare between different countries fail to provide an answer to these questions.

Blank and Burau (2010, pp. 1-31) argue that the healthcare systems of all industrialized nations basically face the same main challenges. These challenges are increasing demand due to ageing populations as well as increased public expectations on the one hand, and rising costs due to the introduction of more and more advanced technologies on the other. If we accept Blank’s and Burau’s claim that these challenges are indeed universal to all industrialized countries, they explain convincingly for which reasons and at what particular time the reform pressures described above appeared. They also explain similarities in the transformations of healthcare governance that can be observed across all three countries in spite of all structural differences. In none of the three countries, reforms were able put an end to the salient debate about equity and accessibility of healthcare services: In Britain waiting times remain an issue; in Sweden, dental care leads to high costs for individuals, and in Germany, the recent reduction of

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services covered by the sickness funds as well as the new user charges are a potential cause of concern. In all three countries, efforts have been made to increase the efficiency of the system. The independence and professional freedom of physicians and other healthcare service providers has been reduced significantly in favour of stricter control and management (Kuhlmann and Allsop 2007; White 2009). A third common trajectory has been the move towards patient empowerment and greater freedom of choice. Although slightly compromised in some aspects by cost containment measures in Germany, this development has played a key role in reform processes across all three countries.

The existence of universal challenges and similarities in governance transformations in spite of structural differences does not render the institutional configurations of individual national healthcare systems irrelevant and does not suggest a total homogenisation of reform pressures. Even if a challenge is universal, the specific response in each country will still be shaped to a certain extent by the structure of the respective country's healthcare system. Thus structural differences between countries are not a sufficient but still a necessary explanatory factor for transformations in the governance of healthcare.

## 5. Conclusion

This essay analysed structural differences between the healthcare systems in Britain Germany and Sweden and discussed the question how those differences shape transformations in the governance of healthcare. I have shown that the structures of healthcare systems differ significantly across the three countries and that these structural differences shape transformations in the governance of healthcare in three different ways. Structural differences have a self-preserving effect that reduces speed and scope of transformations due to institutional inertia. Structural differences determine the area, in which reform pressure arises. They explain, for example, why reform pressure focused on healthcare expenditure in Britain while it was largely absent from this area in the case of Sweden. Structural differences channel reforms pressures by making some pathways for change more viable than others. Measures aimed at increasing efficiency, for example, are easier to implement in the state-centred, hierarchical British system than in the corporatist German one.

However, structural characteristics of healthcare systems are not the only factors that shape transformations in the governance of healthcare. Other drivers of change exert reform pressure regardless of structural circumstances and lead to common reform trends across very different healthcare systems. It remains to be seen whether this will lead to an international convergence of healthcare governance. By all means, significant structural differences remain at this point in time and play an important role in shaping transitions of healthcare governance in each respective country, even though these transitions might have been caused by universal pressures originally.

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