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Governance of health care: converging trends?

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Introduction

During the past few decades social policies have been subject to cost containment and ensuing retrenchment, although to a varying degree depending on the kind of policy, as well as cross-nationally. On the whole however, the space for maintenance, let alone expansion, of social citizenship rights of transfers and services has been gradually decreasing. Behind this development there is a range of causal factors, such as demographic pressures, the increasing trans-nationalization of capital, or "globalization", and the financial policy restrictions of the European Union.

Global market forces as well as the market-enhancing objectives of the European Union are bringing pressures on Western welfare states to create further space for market activities, especially with regard to production of services. National polities have been recommended to exchange the hitherto collective provision of services such as communication systems, telecommunications, postal services, as well as health care, education systems and care services for market production, either by outright sales, or by auctioning out service production, while maintaining state financing (see for ex. Esping-Andersen 2002; Ferrera and Hemerijck 2003; Scharpf 2002). Such pressures are enhanced by the opinions within epistemic communities of neo-liberal theorists and Western business elites extolling the capacity of market forces to select the type of institutions in which the economy is most suitably embedded, as opposed to politically favoured ones (for ex. Majone 1996). This conviction has gained almost hegemonic status in most Western welfare states, especially as it seems to offer a solution to the economic and financial problems of the national polities.

As a result of these developments, the governance of social policies has changed in most Western welfare states during the last decades. The institutions informing the financing and provision of social policies have been transformed in this process; whether any substantial convergence has taken place is still an open issue. Although converging trends have been found in certain dimensions of social policy programmes, the specific institutional set-ups seem so far to be unaltered. Recent convergence research has focussed on changes in transfers, i.e. social insurance and social assistance (for ex. Kenworthy 1997; Montanari et al, 2007, 2008, Nelson 2006). Comparative analyses of changes in services, the other pillar of social policy, have however so far been limited to a few countries.

We will in this paper focus on a core social policy in most developed societies, namely health care service. Our purpose is to perform a diachronical cross-national analysis of health care service. We thus raise the question of convergence, which will here refer to processes generating conformity in the institutional set- up of health care systems across countries. Our hypothesis is that convergence is absent in the latest development of health care systems. Rather we expect national politics to have responded differently to these pressures, resulting in more institutional variation across countries. We limit our analysis to member nations of the European Union, where convergence pressures should possibly be greater than in the entire group of OECD countries. The empirical analysis is based on OECD Health Data. In addition to expenditure data, we do here analyze qualitative aspects of health care systems, such as coverage, health care personnel, hospital beds, and degree of advanced medical equipment.

The paper is organized in the following way. After a survey of the core analytical dimensions in the two components of social rights, namely transfers and services, an outline of the specific dimensions and institutional forms of health care service within a social citizenship perspective is presented. Various convergence pressures are then specified, followed by a section on the data used and a presentation of the results of the empirical analysis. The paper ends with conclusions and a short discussion.

Social citizenship rights

Social policies are central in freeing the individual from exclusive responsibility for her wellbeing via market income. How national economies are governed determines the total degree of encroachment on the organizational and allocative power of the market economy by extending social citizenship rights and labour market regulation. Social citizenship, which is a bundle of rights and duties, has two main components: transfers and services.

Core analytical dimensions in legislated social insurance transfers have been elaborated within the Social Citizenship Indicator Program (SCIP)[1], namely *Coverage*, describing individuals who are insured and eligible for benefits, *Benefit levels* for lost earnings, and

[1] SCIP has been organized at the Swedish Institute for Social Research under the direction of Walter Korpi and Joakim Palme.

Financing sources. On the basis of SCIP data a variety of comparative analyses of the development of transfers have been carried out (Carroll 1999; Ferrarini 2006; Kangas 1991, 2004; Korpi 1989; Korpi and Palme 1998, 2003; Montanari 2000, 2001; Nelson 2006, 2008; Montanari et al. 2007, 2008; Palme 1990, 2006; Sjöberg 1999).

Criteria determining eligibility for transfers (coverage) are often relatively clear-cut, whenever we have to do with a legislated social citizenship right. Thus forms of child benefit, parental leave benefit and basic pension, have clear criteria related to when a family is formed or a person retires. This also holds for unemployment insurance, sickness benefit insurance, work accident insurance and income-related pension, which are tied to labour force participation. Social assistance is instead means-tested. Financing sources for transfers comes from taxation and contributions by the insured and employers, in proportions varying among countries. Taxes may be levied at the state, regional or municipal level. Benefit levels are established by national law or labour market contracts, with the exception of social assistance and home care allowance which are administered and provided at the community level and therefore subject to arbitrariness.

In services, core analytical dimensions are just as in transfers *coverage* (eligibility at the individual level) and *financing.* Formal eligibility to a certain type of social service is easily established, according to national, regional or municipal rules, while the actual use of the service in question also depends on individual knowledge or preferences. To the basic sources of financing relevant for transfers, namely taxes - either state, regional or municipal - and contributions by insured and employers, for services we have to add user fees, i.e. private out-of-pocket financing, which may or may not be means-tested.

Services are provided, be they private or public. While transfers simply are administered, an important dimension of services is *provision*, which in itself harbours several sub-dimensions, most importantly type and degree of service.[2] There is great cross-national variation in the types of services which are offered as social rights. This is so especially with regard to day care for small children, after-school activities for older children, home care for elderly or incapacitated persons and elderly care in special facilities. This can be referred to as social reproduction work, which may be carried out in three different institutional arenas, namely the

[2] Provision is an internationally established dimension of social services. See for example Wendt et al. (2009).

family, the market or a collectively organized, and subsidized, public sector (Montanari 2009). As with all social policies, the choice is political and has consequences not only for gender and class equality but also for the development of the service sector within the national economy.

The degree of service may refer to the quantity as well as the quality of the service in question. The quantity of care for each child and elderly or incapacitated person is rather straightforward a variable, while criteria for quality are harder to establish, but would include, for example, density of personnel as well as educational levels of the carers. With regard to provision of services great changes have taken place during the latter decades. The introduction of the purchaser-provider split, or quasi-markets, in countries with tax-financed social services, has resulted in the appearance of private for-profit firms, as well as non-profit organizations, as the actual providers of services, alongside the traditional exclusive public sector providers (Anell 2005; Blomqvist 2004; le Grand and Bartlett 1993). Where social services are organized as a collective employment related insurance service, for-profit firms have always been the dominant form of providers (Mossialos et al. 2002).

Health care: dimensions and institutional forms

Health care is one of the core social citizenship rights in all European countries. It is most often cherished by an overwhelming majority of the population. Also political opponents to other forms of social citizenship are reluctant to deny health care to co-citizens in need. The reasons may be three: the limited degree of moral hazard involved in health care, as opposed to sickness insurance benefits, the usefulness of a healthy workforce, and the risk of contagion. Public health improvement is therefore generally considered a positive development, and as a result access to at least basic health care is next to universal in all highly developed countries, with the exception of the USA.

The state ultimately decides whether or to what extent health care is to be a social citizenship right. If health care is not provided as a social right, services have to be acquired privately on the market as any other product or service. Specific for private health care services is the private insurance system. Health care institutions are of course influenced by the wider welfare state arrangements (Lundberg et al. 2008; van Doorslaer et al. 2006). We would expect this influence to be especially relevant for the coverage and financing dimensions.

Thus coverage would primarily be of three types, i.e. universal, employment related social insurance model, or mainly market driven (Moran 2000), the former two corresponding to taxes or contributions as main financing sources. Where health care services are offered as a social citizenship right, the main financial sources are in fact the same as those of other social services, namely state, regional or municipal taxes, employer and employee fees via social insurance, and user fees.

The type and degree of health care service depends on one hand on the specific health situation of the citizen, in case the latter puts forward a demand, and on the other on the regulation of the kind and extent of health services offered. The ratio of physicians and nurses to population, the ratio of primary to specialist care, as well as the organization of hospital and convalescent care, are here relevant dimensions. What is included in basic health service also differs between countries, for example dental services, just as certain age groups may be exempted from user fees.

Health care services are however also shaped by dynamics of their own (Moran 2000). Two specific dimensions in health care services are regulation of the medical profession and technology (idem). Regulation of the medical profession regards qualifications, as well as the forms for and conditions of professional performance. The independence of members of the medical profession has gradually decreased during the last century through political intervention circumscribing the range and forms of exercise (Nordgren 2000; Scott 2000). Moreover, standardization pressures from within the profession as well as from financing sources herald Evidence Based Medicine as the one method for diagnosis and care (Goldenberg 2006; Kuhlmann and Burau 2008; Lambert et al. 2006; Mykhalovskiy 2003).[3]

The role of technology, i.e. the medical instruments and devices, as well as pharmaceuticals used in the accomplishment of health services, is an important factor influencing the content and results of health care services. The growth of the biomedical and pharmaceutical industrial sectors has been fast and consistent during the last century, as has the ratio of their products in health care expenditure, public or private buyers' financial resources being the only obstacle to an even faster development (Saltman et al. 2002). Governance lies here in the

[3] Evidence Based Medicine (EBM) is an example of best practice, which however neglects that evidence is socio-culturally constructed and political-economically determined (see especially Goldenberg and Kuhlmann and Barau). Less possibility for the doctor to find a specific solution to the patient's problem, but more power with respect to alternative medicine.

hands of private firms, most often trans-national corporations. Pressures on members of the medical profession to introduce new techniques with new instruments or drugs are often materialized as offers of research and trials. At the same time we may presume that public opinion is generally positive to any improvement in health care which would increase quality of life or life itself.

Convergence pressures

Convergence previsions have been legion within social policy research. Earlier versions of the "logic of industrialism" theory have been succeeded by present-day forecasts of the necessary transformation of social policy institutional structures in a market-enhancing direction, as well as political blueprints of a European Social Model (for ex. Esping-Andersen 2002; Ferrera 1998, 2005; Montanari 2001; Montanari et al. 2007, 2008; Scharpf 2002: Scharpf and Schmidt 2000).

Social scientists recognizing the existence of different welfare state models and social policy institutions as a result of different political choices have mostly been sceptical to a convergence thesis in the field of social policy (for ex. Esping-Andersen 1990, 1996, 2002; Goldthorpe 1984; Huber, Ragin and Stephens 1993; Kitschelt et al. 1999; Korpi 1989; Korpi and Palme 1998; Scharpf and Schmidt 2000). Of course, changes in the direction of a country's polity may reform existing institutional structures (Korpi 2001), and social policy institutions are "path-dependent" (Pierson 2001) only as long as there is political support for them. Piecemeal reforms (Cox 1998:2), as well as subtle conversion of existing institutions and establishment of competing institutional structures (Hacker 2004) should also be taken into consideration. All the same, within this theoretical perspective continuing variation in social policy institutions rather than convergence is predicted.

Although national polities formally are still the main arbiters with regard to the extent of social citizenship rights embodied in social policy institutions, the space for government action has been circumscribed in many ways during the latter decades. The autonomous state has become embedded in a wider economic and political context (Sundström och Jacobsson 2007). Policies aiming at enhancing social rights meet formidable obstacles of implementation, even when a political will is aforehand.

Firstly, the total deregulation of capital mobility has eroded political governance at the national level (Pierre 2000). The increasing trans-nationalization of real and financial capital influences national social politics in two ways: it has tilted the power balance to the side of capital at the national level of contest between labour and capital, and it puts pressures on national polities to create and improve the investment environment (Montanari et al. 2007). Supply-side strategies in the form of a functioning technical and logistic infrastructure as well as social investment in human capital have become the foremost objectives of national governments with regard to macro-policy (Scharpf 2002).

Secondly, for the member states of the European Union, there are specific political pressures of at least three types: the established economic and financial policy, competition policy, and the Open Method of Coordination (OMC). The anti-inflationary financial policy and budgetary restrictions of the EU Treaties require strict compliance. Either one considers the EU as the political expression of global or regional capital forces, or as a bulwark against such forces, the basic neo-liberal criteria on which the Union is built can not be neglected. In fact, firm criteria have been specified for the functioning of the product and production market of the European Economic Area (inclusive of Western European countries not yet members of the EU or the EMU). The Broad Economic Policy Guidelines include low inflation, balancing of national budgets and exposure to competition in every field, under conditions of harmonized social regulations (EU 1996).[4] With regard to social policy, the effects from the supra-national level on national policies are indirect results of the established political economy guidelines (Montanari et al. 2008). The exclusive focus on anti-inflationary measures, to the detriment of employment policies, as well as conditions in the form of budgetary balance also in times of economic crises, means that EU member states are supposed to save themselves out of an economic crisis, which may have negative consequences for the substance of social policy programs, both with regard to benefit levels and quality of social services.

Competition law expresses the baseline of the European Union project. In Treaty articles 81 and 82 rules to protect the internal market's neutral playing field are listed (Mossialos and McKee 2002). Apart from cartel building and other anti-competitive behaviour among

[4] EU social regulations, which mainly regard health and safety at the workplace, aim at establishing a level playing field for firms operating in the EU area, and should not be confounded with traditional social policies (Majone 1993, Montanari 1995).

companies, restrictions apply explicitly to any public procurement be it within the transport, education or health care sector. Lately these regulations have come to the forefront of public attention and been reinforced by a series of rulings of the European Court of Justice (idem). A municipality intent on extending elderly care facilities for example, is held to invite firms not only for the construction of the premises, but also for the organization and running of the service, although the whole undertaking is tax-financed.

The Open Method of Coordination was launched at the European Council in Lisbon in 2000 as a new form of governance within the EU (Borrás and Jacobsson 2004; O'Connor 2005; Radaelli 2003). The OMC is a kind of soft law, promoting development of national levels and standards in for example education, employment, poverty alleviation, and health care, with the explicit aim of final convergence (Carson 2004; Falkner 2005; O'Connor 2005). Although the social policy agenda of the OMC principally regards some form of social protection in order to enhance social stability, as well as preventing "social tourism" in view of the enlargement of the union, the continuous exchange of expert-led 'best practices' may lead to discursive consensus on institutional convergence of social policies.

Thirdly, at the national level, there are demographic pressures, reflecting an ageing population and low fertility. Life expectancy is continuously growing, which on one hand entails extended pension payments as well as a greater need for multi-dimensional health care services, especially for very old persons. On the other hand, this increasing dependency ratio means that taxes from gainful employment diminish. Further causes of decreasing tax entries are high unemployment levels as well as limits in achieving high productivity levels in the labour-intensive lower echelons of the service sector.

Finally, governance of many socio-economic activities has been ceded to private firms. Although such activities most often are regulated by the state, which thus retains some control over the situation, public control within the situation is lost (Aronsson 1989). Also, more and more decisions within state agencies have been handed over to experts, in line with Public Management Policy (PMP) or New Public Management (NPM) theories (Clarke and Newman 1997). The result is a fragmentation of steering and organizing national states, which until recently in our Western democracies was the task of the elected government.

All of these factors do in different ways limit national policymaking and we would thus predict some convergence of the various dimensions of a social policy such as health care, especially among the member nations of the European Union. Due to the financial pressures related above, we would expect convergence in a downward direction, especially with regard to the types and degrees of health care services offered as social citizenship rights, and possibly also with regard to coverage. As to financing we would expect an increase in private expenditure, which would also entail a development in a downward direction for the individual holder of a social citizenship right. A formidable counterweight to these pressures is however the role of technology in health care. The development of new techniques, using continuously more sophisticated instruments and pharmaceuticals, is a push factor for convergence of expenditure in an upward direction.

Data

In this paper we will apply the framework of core social citizenship dimensions described above to the area of social service. More specifically, focus is on the financing, coverage, and quality of health care. The empirical analysis is based on the *OECD Health Data 2008*, which includes a large set of indicators on health care systems and where data goes back to the 1960s. In this study we restrict the analysis to the period 1980-2006 for two reasons. The first reason is a contextual one, where we limit the study to a period in which European integration has been significantly strengthened, both in content and space. In this period arguments for a more regulatory social policy of the EU has gradually emerged (Hantrais, 2007). The focus on developments since 1980 also places the study in an era characterized by other pressures for welfare state reform, including both global economic factors, aging societies, and the spread of neo-liberalism. The period 1980-2006 therefore gives excellent opportunities to analyze whether governments in different countries follow the same pattern in the restructuring of social policy. The second reason is data driven, since missing information is more frequent for earlier years in the OECD health dataset. Similarly we choose 2006 as the most recent year since there is a large number of missing values for 2007, which is the most recent year available in the dataset.

Health care coverage measures the share of the population eligible to health care. Contrary to what is common among scholars analyzing social security and where main focus is on publicly mandated programs, both publicly and privately provided services are included here. Financing refers both to levels of health expenditure and sources. We do here distinguish

between total health expenditure and private health expenditure. The latter is measured as share of total health expenditure. Total health expenditure includes activities that are directly related to health care services. Activities such as education and training of health personnel, research and development in health, and administration and provision of health related cash benefits are not included. Private health expenditure is defined in similar terms and excludes the same activities as total health expenditure. Out-of pocket payments are one part of private health expenditure that would have been interesting to analyze in closer detail. The focus onlong-term trends in this paper makes it difficult to use out-of-pocket payments as one distinct dimension of health care financing. The missing values on this indicator increase quite substantially the further back in time we go. This may not necessarily mean that also the private expenditure indicator gets less reliable over time. It may simply mean that out-of-pocket payments cannot be identified as an individual source of health care financing in national statistics, although it is included in national accounts of health care financing.

Research on social entitlements often uses the level of benefits as an essential indicator for the quality of social protection. To measure the quality of health care we have here constructed an additive index comprising three basic parts of the services: health care employment, number of health care beds, and medical technology. Health care employment is subsequently based on three sub-indicators: total health employment, practicing physicians, and practicing nurses. Physicians and nurses in both publicly and privately provided health care are included here. Total health employment includes also administrative staff. The number of health care beds is based on two sub-indicators; total hospital beds and acute care beds. The latter comprise hospital beds that are available for curative care. Finally, medical technology includes five sub-indicators; the number of computed tomography scanners, magnetic resonance imaging units, radiation therapy equipment, lithotriptors, and mammographs. All above sub-indicators are measured as shares of total population.

Since the numerators of the sub-indicators are not strictly comparable they have been standardized to one common scale. Missing values have to the extent possible been estimated. Missing values on one or more sub-indicator does not disqualify cases from being included in the health care quality index. The study includes 19 countries; Austria, Belgium, the Czech Republic, Denmark, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Luxembourg, the Netherlands, Poland, Portugal, Slovak Republic, Spain, Sweden, United Kingdom. Due to missing values the number of countries may differ between indicators and years. No analysis

includes less than 12 countries. Where break in trends are observed to be caused by the inclusion of additional cases in the analysis it is noted in the text.

Results

The health care sector has been subject to several changes in recent decades. Two trends that emerge are raising expenditure and the increased role of private financing for health protection. Several attempts have also been made to explain such trends and differences in health expenditure between countries (for an overview see Gerdtham and Jönsson, 2005). Some studies relate cross-national differences in health expenditure to national income, thus arguing for a positive correlation between expenditure and national income. The structure of health care systems seems to be of minor importance in these studies (Hitiris and Posnett, 2002). Nevertheless, some quantitative and comparative studies have focused on the organization and quality of health care services (for ex. Allen and Riemer Hommel 2006; Saltman and al., 2002; Wendt et al., 2005). Another example is Gerdtham et. al. (1998), who show that primary care "gatekeepers" and capitation systems tend to lead to lower health expenditure.[5] The problem of accountability in general and payment methods in particular are treated in for example Blomqvist (2004) Duggan (2000), Hughes Tuohy (2003), Lindqvist (2008) and Silverman and Skinner (2004).

In this section we analyze how three crucial dimensions of health care have developed from 1980 and up to 2006. We start this exercise by an analysis of financing and expenditure. Thereafter we turn to the equally important issues of quality and coverage. *Figure 1* shows how the financing of health care has evolved in our set of EU countries over the period 1980-2006. The figure shows changes in total health care expenditure as percentage of GDP and changes in private health care financing as percentage of total health care expenditure. Also shown are changes in the health care quality index described above. Only country averages are used and 1980 is indexed to 100.[6]

[5] In capitation systems payments are made for every patient that is cared for. Such a system was recently introduced in Sweden, where also gatekeepers have existed for a long time. At the moment Sweden spends about 6 percent of GDP on health care, which is somewhat below the EU average.

[6] Only un-weighted averages are used here and in the subsequent analyses of cross-country variation. Even though there may exist good arguments to give some countries greater weights in these averages, we do here assign the same country loads for large countries, such as Germany, and small countries, such as Luxembourg, The reason for un-weighted averages is one of simplicity, but also due to the problems involved in assigning differing weights for the various countries included in the empirical analyses, that is, should weights be determined on the basis of population size, GDP, health care expenditure, health care usage and so forth.

[Figure 1 about here]

Total health expenditure fluctuated around 7 percent of GDP in the 1980s, where after it is possible to observe a substantial increase in total expenditure up to nearly 9 percent in 2006 (these absolute figures are not shown). The substantial increase in total health expenditure in 1990 and 1991 is partly due a break in the series and the additional inclusion of three Eastern European countries; The Czech Republic, Hungary, and Poland. However, the long-term trend of increased expenditure is not affected by this enlargement of the study population. A two percentage point increase may not seem that much at first glance. However, in Sweden for example, this increase in health expenditure would have amounted to 2 643 million US$, in the United Kingdom the corresponding increase in expenditure would be 10 752 million US$. In absolute terms the rise in total health expenditure is substantial, and something that places serious strains on public finances. Not the least since population ageing and increased life expectancy is expected to raise the dependency ratio (Institute for Future Studies, 2006), something that probably contributes even more to health care expenditure in the nearby feature. Of course averages conceal variation between countries. For example in 2006 total health expenditure was lowest in Poland with a share of about 6 percent and highest in France having a share of 11 percent of GDP. We will turn to these differences in expenditure levels later on in this empirical section.

Privatization of both financing and provision of health care seems to be one reform measure that European governments have relied on since the beginning of the 1980s at least, although to varying extent. In figure 1 the trend of increased private financing of health care since the early 1980 is clearly visible. At the end of the period 1980-2006 private health expenditure is on average slightly above 20 percent of total health expenditure in the European countries (absolute figure not shown here). The reasons behind this trend of privatization may be multiple and complex. Factors such as neo-liberal ideas, budgetary strain, public failures, and affluence may all have contributed to the increased share of private sources in the financing of health care (Maarse, 2006). Lower expenditure levels for operating health care services and increased quality of services are two arguments that often are used in the political and public

debate to promote an increased privatization of the provision of health care services (Lindqvist 2008).

Although the privatization of health care during the last two decades coincides with increased social expenditure, it is not possible here to make any judgments whether more private elements in health care systems actually do increase health expenditure. Privatization would however not necessarily boost the quality of health care services offered to citizens. The health care quality index in figure 1 is remarkable stable over last two decades. The quality index increased slightly in the early 1980s, until there was a sudden decrease in 1988. During the 1990s when total health expenditure and private health expenditure began to increase substantially, the health quality index only changes one or two percentage points from the level recorded for 1980. At the end of the period and early in the first decade of this century there is a slight increase in the quality index, corresponding to about 9 percentage points above the level for 1980. Whether this increase is due to changes in the level and composition of health care financing is beyond this study to explore in more detail.

The trends in figure 1 add further input to the ongoing debate about welfare state resilience and reform. For example Clayton and Pontusson (1998) argue that there has been a substantial shift in the composition of social spending, which partly involves developments of entitlement programs and the health care sector since the early 1980s. Based solely on expenditure indicators Clayton and Pontusson argue that the service sector has been subject to more substantial cutbacks than social entitlements, such as social insurance and social assistance. Using the same vocabulary as Clayton and Pontusson (1998: 331) retrenchment since the 1980s seems to involve an '…anti-service bias of welfare state retrenchment'. EU enlargement and integration is one reason that is expected to account for this bias in social spending. The issue of social tourism is here predicted to influence more serious cutbacks in social services, such as health care, than in social insurance. The reason being that social insurance entitlements in many European countries are based on gainful employment, something that evades EU legislation in relation to discrimination on the basis of nationality. Typically the use of social services does not have that strong connection to employment income. In an era of welfare state stagnation and decline European governments are therefore expected to turn their retrenchment efforts to social services and health care, rather than to social transfers and benefits.

The results presented here fail to give support to Clayton's and Pontusson's argument. We cannot see any substantial signs of retrenchment in the health care sector. Quite the contrary health expenditure has increased during the last two and a half decades. Basically it is only in the most recent years, the years 2005 and 2006, that health expenditure shows a decline.[7] Furthermore, when focus is on the quality of services provided, the health care sector seems to be rather resistant to cutbacks. The health care quality index is remarkably stable over the period 1980-2006. Compared against recent findings on social entitlements, which show declines of social insurance replacement rates beginning in the mid 1980s (Montanari et.al. 2007, 2008) and curtailments of social assistance benefits since the mid 1990s (Nelson, 2008), health care seems to lean more towards stagnation than retrenchment. This does not necessarily mean that health care systems are unaffected by pressures that currently foster changes in welfare state policies. Shifts in the sources of financing are one such factor which should be investigated further. In this section, however, we raise the question of convergence and whether total health financing, health quality, and health care coverage are becoming more similar across the EU countries.

Figure 2 shows cross-national variation in health care financing (measured as total health expenditure) and the health care quality index in 17 EU countries from 1980 up to 2006. Dispersion is measured by the coefficient of variation. The indicators describe somewhat of a rollercoaster pattern with several ups and downs. The overall trend for health care financing is that the coefficient of variation has decreased slightly, giving some signs of convergence. Similar results of a weak process of convergence in health care financing among OECD countries but for the period 1970-2000 are shown by Wendt et al. (2005). The sharp increase in 1990 is partly due to the inclusion of the Czech Republic and Hungary. If these two countries are excluded from the analysis the increased dispersion for this year yields a level of 17 for the coefficient of variation, instead of a level of almost 19 as in the figure. Thus, there is still an increased variation for this year, albeit not as sharp as now depicted.

The health care quality index does not show this pattern of changes. At the end of the period cross-national variation in the health care quality index is approximately at the same level as in the beginning of the period. This does not mean that dispersion on this dimension has been

[7] Some small declines in health expenditure can be observed also for disparate years in the 1980s and 1990s. However, due to the complex measurement of total health expenditure these small changes in expenditure levels should be treated with substantial caution.

stable over the years. Especially the 1990s is characterized by changes, where cross-national variation in the health care quality index describes a U-turn pattern; that is, decline in the early 1990s and thereafter increase for a few years. This dispersion in the health care quality index started to fall off at the end of the 1990s and subsequently change shape into decreased cross-national variation. Although the few remaining years up to 2006 indicate convergence in the quality dimension of health care, the end result, considering the whole period 1980-1990, is continuity. Cross-national differences in health care quality seem to be at the same level in 2006 as in 1980. This does not mean that cross-national differences are frozen at 1980-levels. Countries may simply have changed place in the health care ranking.

[Figure 2 about here]

Figure 2 also shows the coverage of health care. It is not possible to discern any trend towards an increase or decrease in the dispersion of coverage rates across countries. Cross-national variation in health care coverage is very stable over the whole period with one exception. In 1986 there is a sudden increase in the coefficient of health care coverage, something that is due to developments in the Netherlands and Spain. In the former case the coverage rate decreased by about 4 percentage points, whereas in the latter case there was a slight increase by about 2 percentage points. In a broader comparative perspective we should point out that health care coverage is very high among most of the European countries analyzed here, something that adds to the low cross-national variation observed for this indicator. In figure 2 we can easily see that cross-national variation are greatest for health care financing, followed by the health care quality index and health care coverage. Ten countries had full coverage in 2006. Included in this group are the Czech Republic, Denmark, Finland, Greece, Hungary, Ireland, Italy, Portugal, Sweden, and the United Kingdom. Only Greece made the transition towards full coverage during the observation period. Greece went from a coverage rate of 88 percent in 1983 to 100 percent in 1984. Most of the other countries have nearly full health care coverage. In Austria, Belgium, the Netherlands, Poland, and Spain only 2 percent of the population lacked access to health care in 2006. Corresponding figures for the Slovak Republic and Germany are 4 and 10 percent, respectively. Here we should point out that the Netherlands went from a coverage rate of 62 percent in 2005 to a coverage rate of 98 percent in 2006, as part of a major and nationwide restructuring of health care services. Since 2006 health care coverage is statutory but every one is required to purchase their own health insurance (Hassenteufel and Palier 2007; Palier and Martin 2007). In figure 2 we do not take

this exceptional development into consideration. If so the dispersion of coverage rates drops from a value of 9 to a value of 2.5 in 2006.

In relation to the welfare state regime debate an interesting pattern emerges. Only in the conservative welfare state regimes is it possible to find instances where the coverage rate is below 100 percent. Many of these countries rely on the so-called social insurance model for health care provision elaborated by Schieber and Poullier (1987). It can be debated whether Poland and Spain belongs to the conservative welfare state cluster or if they show more resembles to some kind of transitional or southern European group of welfare states (Ferrera 1998). The purpose here is not to define the belongings of countries into distinct groups of welfare states. Nevertheless it should be noted that both Poland and Spain share distinct features with the corporatist welfare systems in continental Europe, such as the high degrees of fragmentation and the importance of the family as welfare provider.

The health care quality index used above does conceal differences in the development of each composite indicator. *Figure 3* therefore shows cross-national variation for each indicator included in the quality index for the period 1980-2006. The result of this exercise is somewhat different compared to the health care quality index. Both health employment and the number of hospital beds show greater cross-national variation in 2006 than in 1980, indicating an overall trend of divergence. Cross-national variation for the number of beds indicator shows a slow but steady increase over the years. The result for health employment is somewhat different. Health employment converged somewhat in the 1980s and early 1990s, and divergence can foremost be observed as from the beginning of the 1990s. For medical technology, where meaningful comparisons of a large number of countries only can be made from 1990 and onwards, it is not possible to observe any overall trend of either convergence or divergence.

[Figure 3 about here]

So far we have showed that health care financing converged over the period 1980-2006, whereas cross-national variation in the health care quality index was approximately the same for 2006 and 1980. Among the three constituent parts of the health quality index, both health employment and the number of hospital beds show slight signs of divergence over the period. One question that can be raised in relation to the changes described above concerns the issue

of cross-national differences in levels. To put it more blunt: are countries still different in these regards? In *Figure 4* we try to share some light on this question by looking at differences between countries in health care financing and health care quality for the most recent date for which data is available. Coverage is not included in this analysis since cross-national variation is quite limited for this indicator. Each indicator is standardized relative to the maximum score of each indicator. The health care quality index does not show a value of one because standardization was made for each composite indicator.

[Figure 4 about here]

There are sizeable differences between countries both in financing and quality. For example, health expenditure in France is nearly two times the size of Poland. If we restrict the group of countries to the longstanding EU democracies health expenditure in France is approximately one and a half the size of health expenditure in Ireland. Turning to the health care quality index Greece has a score which is four times higher than that of Hungary. Among the longstanding EU democracies the score of Greece on this index is three and a half the size of the health care quality index of the United Kingdom. The other countries fall in between of these countries, making the scatter-plot resemble the pattern of a Christmas tree.

From an ocular inspection of this scatter-plot it is difficult to identify certain groups of countries that resemble each other. We have therefore used cluster analysis to reveal whether countries can be grouped according to their values on the health quality index and total health expenditure.[8] The purpose here is not to engage in the ongoing discussion about welfare regimes and the construction of different forms of typologies of social policy in general and health care in particular (for a recent interesting example see Wendt et al. 2009). Rather the objective is to use cluster analysis as a heuristic device and to bring some order in the patterns described by the scatter-plot in figure 4. The cluster analysis revealed four different groups of countries, which are shown by the dotted lines in the figure. According to this categorization Greece and Finland constitute one group with high scores on the healthcare quality index, but medium scores on health expenditure. Here we should mention that Greece formally has full health care coverage. In practice, however, the development of public primary care does not match the demand for such treatments. For some citizens full coverage in Greece simply

[8] K-Means cluster analysis was used defining four groups of countries.

means access to public hospitals (Cabiedes and Guillén, 2001). A larger group of countries - including Austria, Belgium, Denmark, Italy, Luxembourg, and Italy - score medium levels on both indicators. Another large group includes the Czech Republic, Ireland, Hungary, Poland, Slovakia, Spain, and the United Kingdom. These seven countries have low levels on both indicators. Finally there is Germany, France, and the Netherlands, all of which score high on health expenditure but low on the health care quality index.

In sum the empirical analyses have showed that the period 1980-2006 is characterized by increased total health expenditure and an increased share of private health expenditure. The health care quality index used in this paper remained quite stable over these years, all of which seem to go against influential arguments for privatization. We find some evidence of convergence in total health expenditure, but not for the health care quality index. It is also evident that differences between countries in expenditure and the quality of services are still substantial. The convergent trend in health care financing does not alter the large amount of cross-national differences that do exist in relation to the governance of health care.

Discussion

In this paper we have made a preliminary analysis of health care developments in a large number of EU member states. In addition to the same reform pressures as non-European OECD countries are facing, such as economic globalization and the ageing of populations, intrinsic pressures for reform of social transfers and services are building up also within the increased European cooperation. Although many of these pressures do not directly involve the organization of social policy, one can assume that they at least indirectly create pressures for a reformation of health care services. Since these pressures affect all EU countries, albeit to differing extent, it is plausible that long-term developments in the organization of health care services describe patterns of convergence. In the empirical section we analyzed three core dimensions of health care services; financing, coverage, and quality. Here we did only find evidence of slight convergence for health care financing. Variation in health care coverage is largely absent since most EU countries either have full coverage or close to full coverage. For the health care quality index there has been periods of both convergence and divergence over the years 1980-2005, and at the end of the period we are back at the same levels of dispersion that were recorded in the early 1980s.

Differing results such as these show the importance not to only analyze expenditure data, but also to consider the quality of entitlements and services. Of course, the latter is much more complicated to measure and particularly in the area of social services also less investigated by comparative welfare state scholars. The health care quality index presented in this paper may be one way forward to more closely and accurately study the quality dimension of health care.

Cross-national developments of health care services differ in important aspects from that of social entitlements, where the quality of transfers and benefits in major programs often have diverged over the period analyzed here. Furthermore, whereas social insurance replacement rates and social assistance benefit levels often have been curtailed during the last two decades, health care systems seem to have resisted any major retrenchment efforts. This preliminary finding brings new input into the discussion about welfare state developments in eras of welfare state retrenchment and decline. Contrary to previous claims about the vulnerability of transfers and services, health care services do not seem to be more vulnerable to retrenchment than social insurance and other cash benefit programs. There are many factors that may explain the greater resistance to cutbacks of health care services. One factor may be that health care services often receive strong popular support. Remember that even the conservative Prime minister Thatcher in the 1980s failed to basically change health care in the United Kingdom. Another factor may be that health care systems are less affected by economic downturns than social transfers and benefits. The demand for health care may be less influenced by business cycles than that of social transfers and benefit, which means that the need for reforms due to movements in caseloads are less apparent for health care services.

The lack of greater heterogeneity in the quality of health services, as here measured, in spite of the different points of departure of the countries in the sample, may be due to opposite trends of development. While relative newcomers to the European community have increased their use of technology, and possibly employment in the health care sector, many of the earlier member nations have actively strived to decrease employment as well as beds, in order to contain expenditure. The local community or the family have to a greater extent been appointed as providers of convalescent care, similar to the development of elderly care.
The quality index here used may of course be constructed differently, using additional dimensions. Most important is however to proceed with an analysis of the changes in the public-private divide of provision. How are these changes related to the quality of services?

Great political interest is presently shown for the possible effects of patient mobility. Formally, citizens are free to demand health care services anywhere in the European Union, a freedom which is actively promoted by the EU Commission. The issue is if permission has to be granted aforehand by the home country local authorities, which are responsible for payments. We do not consider this to be a prominent cause of future convergence of any of the dimensions of health care services which we have analysed. The possibility to demand health care in foreign environments will probably also in the future be an option only for well educated and well situated persons. Language, cultural values and epistemic identity are of paramount importance in the relationship between patient and medical professionals, especially if your condition is a serious one.

Finally, the coverage variable should be qualified. The OECD data indicates the percentage of the total population which formally has the right to health care services. Neither the types nor the degree of health care is however specified. Are all citizens, or holders of social insurance, eligible for every kind of treatment, or are especially costly services reserved for those with an additional private insurance? The earlier consensus on health care as an inalienable social right is in the present political debate often substituted by demands of differentiation of services according to ability of cost participation.

A further dimension of coverage should also be considered. To be formally eligible for a health care service does not entail that a need is transformed into a demand for such a service. Difficult or lacking access to care is one obstacle; the private economic situation, cultural factors and earlier kind of reception is another. Class and gender inequalities are present in health care services both with regard to the ability of the individual to make the step from need to demand, and subsequently with regard to the kind of service offered, especially if the trend of privatization of both financing and provision increases.

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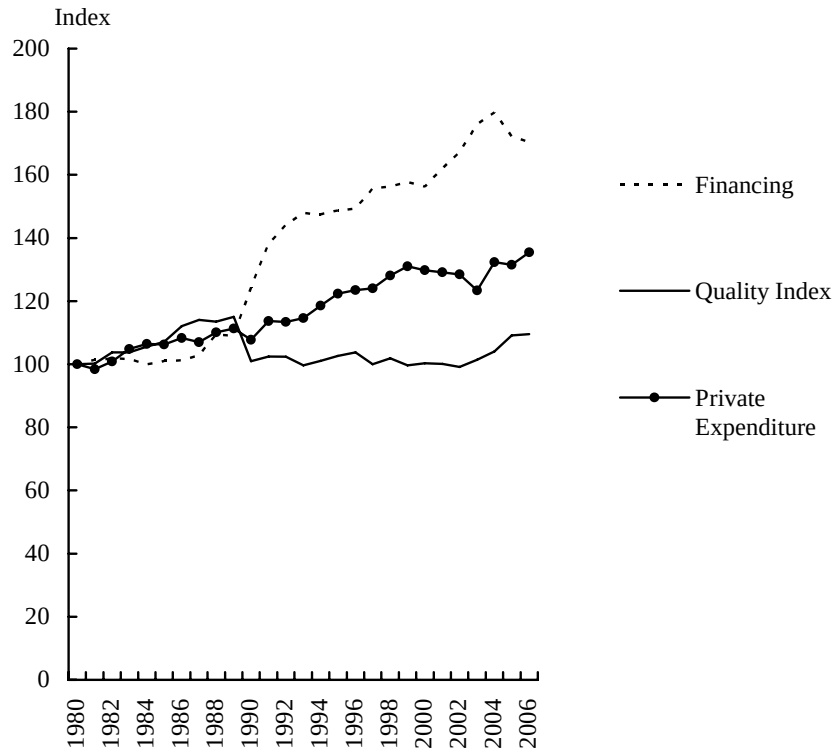
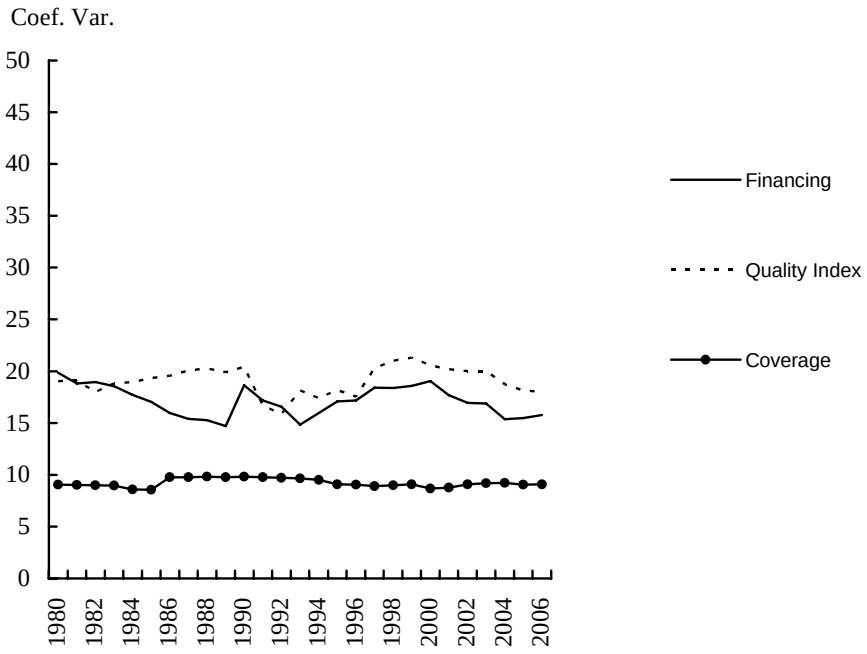
Figure 1. Health Care Financing (Total Health Expenditure as percentage of GDP), Private Health Expenditure as Percentage of Total Health Expenditure and Health Care Quality Index 1980-2006 (Index 1990=100). Averages of up to 19 EU Countries.



Source: OECD Health Data 2008.

Figure 2. Cross-national Variation in Health Care Financing (Total Health Expenditure as percentage of GDP), Health Care Quality Index, and Coverage of Health Care, up to 19 EU countries 1980-2006 (Coefficient of Variation*100).

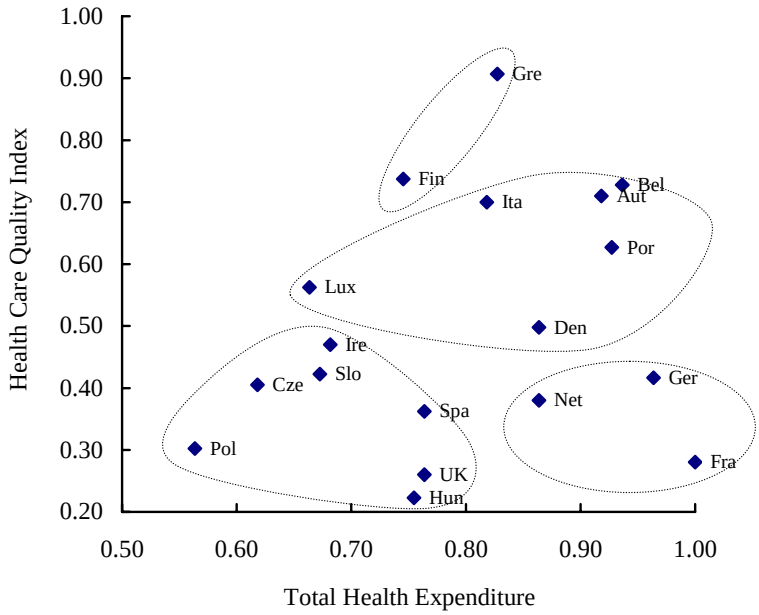


Source: OECD Health Data 2008.

Figure 3. Crossnational Variation in Three Health Care Quality Indicators, up to 19 EU Countries 1980-2006 (Coefficient of Variation*100).

Source: OECD Health Data 2008.

Figure 4. Health Care Quality Index and Total Health Expenditure in 18 EU Countries 2006.



Note: The scores are standardized according to the maximum value on each indicator. The health care quality index have no maximum value of 1 since standardization was made only for each indicator included in this index.

Source: OECD Health Data 2008.