

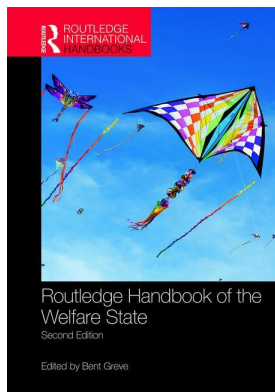
This article was downloaded by: 10.3.98.104

On: 21 Oct 2021

Access details: *subscription number*

Publisher: *Routledge*

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Routledge Handbook of the Welfare State

Bent Greve

Healthcare

Publication details

<https://www.routledgehandbooks.com/doi/10.4324/9781315207049-36>

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Published online on: 02 Jul 2018

How to cite :- Claus Wendt. 02 Jul 2018, *Healthcare from: Routledge Handbook of the Welfare State*
Routledge

Accessed on: 21 Oct 2021

<https://www.routledgehandbooks.com/doi/10.4324/9781315207049-36>

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Introduction

This chapter provides insights into one of modern society's most crucial arenas. Compared with other social policy fields, health policy concentrates less on financial transfers and more on services (see also Chapters 31 and 36). Service provision is of great importance when analyzing healthcare. Furthermore, governance and regulation in healthcare demonstrate major conflicts due to the presence of influential interest groups. While healthcare expenditure, financing and provision can be assessed on the basis of quantitative data, analyzing regulation and governance requires a combination of qualitative and quantitative data and methods. In this chapter, we first discuss core concepts of comparing healthcare policy and politics. We then assess developments in expenditure and healthcare provision. Finally, we discuss regulations in different healthcare systems and how regulation is related to patients' access to healthcare. We provide information for 34 OECD countries and reveal which countries are more successful in controlling costs as well as in translating monetary inputs into healthcare provision.

Core concepts in comparative health policy analysis

Comparative studies of health policy and politics may be distinguished by whether they focus on health policy actors and reform or on healthcare systems (Marmor and Wendt 2011). The first group of studies concentrates on the role of political institutions, health policy decision-makers and organized interests in health reform. The second group of studies analyzes and compares institutions and characteristics of healthcare systems. In the following section, we discuss some of the most influential concepts in both clusters of writing.

Immergut's (1992, 2011) comparison of France, Sweden and Switzerland still sets the standard for studying the role of political institutions and actors in healthcare reform. She focused on the veto potential of interest groups in different settings and showed that veto opportunities arise out of the specific features of political institutions. Her study suggests that the impact of physicians' organizations upon health policy may have been much less decisive than was generally believed until the late 1980s. Immergut concluded that veto points in the political system are of greater importance than veto groups within society. Similarly, but with more emphasis

on process tracing, Hacker (1998) analyzed how political institutions systematically channel the way in which ideas and interests shape political debates and decision-making. His study of the historical sequence and timing of health policy change in Britain, Canada and the United States clearly supports the policy importance of historical legacies and therefore the path-dependence thesis. A country's health policy path, he contended, is significantly influenced, first, by whether a sizable part of the population be enrolled in private plans before national health insurance is on the political agenda; second, by whether public health plans be targeted at residual populations from the outset; and third, by whether medical care be a substantial industry before the universal health insurance is politically salient. The United States fails on all three conditions, a fact that Hacker used to explain the much higher barriers to universal healthcare.

Other concepts have concentrated on governance and regulation (Kuhlmann *et al.* 2015). Tuohy (1999) provides the most theoretical approach to models of governance. She proposed that the dominant model of accountability in healthcare changed from agency to contract models and may currently shift towards complex networks. In the older, trust-based, principal-agent relationship, the state (the principal) delegated authority for the regulation and distribution of healthcare to the medical profession (the agent). As a result of better access to information, the medical profession dominated this model of governance until the end of the twentieth century. New information technologies, however, have provided governments with better information, reducing the information asymmetry between the state and the medical profession. Thus, a transformation from an agency to a contract model has taken place in many countries. In a contract model, the state's role is to purchase rather than to simply finance healthcare. The medical profession's loss of autonomy is due less to cost pressures than to the way in which the provision and verification of detailed medical information strengthens governments' power.

In his concept of "the health care state," Moran (1999) classified healthcare systems according to three governing concepts: consumption, provision and production. By consumption, Moran refers to patients' basis of eligibility for access to healthcare and to financing mechanisms. The provision dimension encompasses the control of hospitals and doctors, and the production dimension encompasses mechanisms that regulate medical innovation. Based on these dimensions, Moran constructed four types of healthcare states: the "entrenched command-and-control state" (Scandinavian countries, Great Britain); the "supply state" (United States); the "corporatist state" (Germany); and the "insecure command-and-control state" (Greece, Portugal). "Supply states" are dominated by provider interests in all three dimensions, and this domination of suppliers, not the operation of market principles, is the primary problem with American healthcare. In "command-and-control states," on the other hand, the state is distinctive in all three governing concepts. Although they provide universal healthcare in legal terms, Southern Europe's "insecure command-and-control states" lack the administrative capacities for guaranteeing universal coverage and equal access to care – principles that have characterized the Nordic countries and Great Britain for many decades. In "corporatist healthcare states," finally, public law bodies and doctors' associations are dominant.

Wendt and colleagues (2009a) suggested a conceptual framework that simultaneously measures the role of the state in financing, service provision and regulation compared with private and societal actors (see also Rothgang *et al.* 2010; Böhm *et al.* 2013). Three ideal-type healthcare systems were identified: "state healthcare systems," in which the state is dominant in financing, provision and regulation; "societal healthcare systems," in which societal actors such as social insurance funds are dominant in all three dimensions; and "private healthcare systems," in which all three dimensions fall under the auspices of private for-profit actors. Along with each category of ideal-type, six combinations of mixed types were identified for which state, societal, or private actors and institutions are dominant in two dimensions. Six additional combinations do

not approach any of the three ideal-types. Comparative studies that apply this methodological framework or similar concepts may produce richer descriptive portraits (Böhm *et al.* 2013). Germany, for instance, does not represent an ideal-type societal (or corporatist) model as suggested by Moran (2000), since healthcare services are mainly provided by private actors and institutions. According to this methodology, Central and Eastern European countries (CEE) that have replaced their former socialist healthcare systems with social insurance represent state-based health policy. The social insurance actors in these countries are weak, and healthcare services are in fact largely provided by public institutions (Wendt *et al.* 2013b).

Such studies of health policy decision-making need to be distinguished analytically from the analysis of healthcare systems (Marmor and Wendt 2011). While studies of health policy decision-making focus on political institutions, actors and reform, comparative studies of healthcare systems concentrate on financing and expenditure, regulation, health employment, and the provision of healthcare (Figure 35.1). The focus in the analysis of healthcare systems is on the institutional setting of different types of healthcare systems, and some studies link the analysis of healthcare institutions with the analysis of outcomes such as access to healthcare, satisfaction with healthcare systems and health inequality. Due to the explicit or implicit focus on the living conditions in different institutional settings, the comparative study of healthcare systems is closer to the general welfare state debate than research of health policy decision-making (see Chapters 1 and 23).

Traditional models of healthcare comparison have mainly used the official labels of existing healthcare systems and have contrasted a social health insurance (Bismarckian) type with a National Health Service (Beveridgean) type, Germany being an example of the former and Great Britain of the latter. Analytically, however, it does not make much sense to use these terms for healthcare system comparison. First of all, they do not measure healthcare system change. Despite great changes, the German health insurance system (SHI) of 1883 and the British National Health Service (NHS) of 1946 still carry their labels from the time of origin. Second, and more importantly, the labels suggest a certain mode of financing combined with a certain mode of governance. In the SHI, healthcare is financed by social health insurance contributions and regulated by social insurance institutions through mutual self-governance; in the NHS, tax financing and hierarchical state regulation are used. For empirical comparative studies, however, the labels SHI and NHS are not a useful tool. In Central and Eastern Europe, for instance, SHI schemes have been established in the early 1990s but lack a system of self-governance that is typical for the German or Austrian healthcare system. Southern European

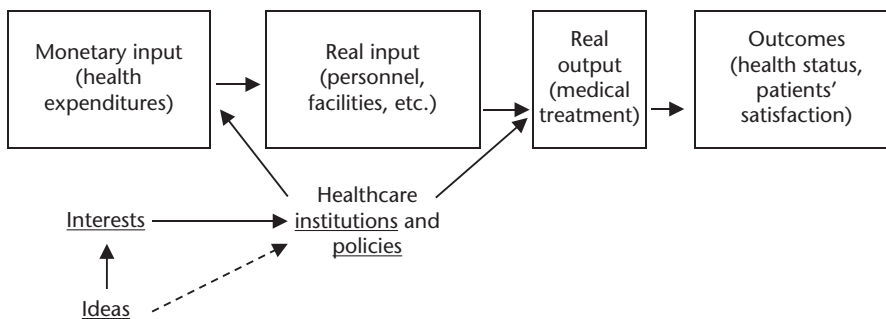


Figure 35.1 Ideas, interests and institutions in healthcare.

Source: Marmor and Wendt (2011: xxv).

countries have established NHS systems that, as Moran (2000) correctly observed, lack the administrative capacities of the British archetype. The Scandinavian countries set up NHS schemes that typically endowed the regional and local levels with much greater responsibilities than was the case in the hierarchical British system.

It is only recently that concepts for comparing healthcare systems have been suggested that do not imply a certain type of governance. Instead, these concepts have introduced a particular focus on patients' access to healthcare (Wendt 2009, 2014; Reibling 2010). According to Reibling (2010: 5), "putting access at the centre of a health typology strengthens a patient's perspective and thereby the impact of health services on individual health." The patient-oriented concepts aim at providing a better understanding of the relationship among healthcare systems, access to healthcare services and health outcomes. They do not, however, directly measure the effects of healthcare systems on health status or other outcomes.

Wendt (2009, 2014) used the following criteria for classifying healthcare systems: total healthcare expenditure, the public–private mix of healthcare financing, private out-of-pocket payment, outpatient healthcare provision, inpatient healthcare provision, entitlement to healthcare, remuneration of medical doctors, and patients' access to healthcare providers. Based on these criteria, three types of healthcare systems were distinguished by cluster analysis: a "health service provision-oriented type," characterized by a high number of healthcare providers and free access for patients to medical doctors (Austria, Belgium, France, Germany and Luxembourg); a "universal coverage – controlled access type" in which healthcare is a social citizenship right and equal access to healthcare is of higher importance than freedom of choice (Denmark, Great Britain, Sweden, Italy and Ireland); and a "low budget – restricted access type," with limited financial resources for healthcare and in which patients' access to healthcare is restricted by high private co-payments and through the regulation that patients have to sign up on a general practitioner's (GP's) list for a longer period of time (Finland, Portugal and Spain). In the 2014 paper, Wendt also analyzes healthcare system change and concludes that the identified healthcare system types are quite robust. Total health expenditure increase and stronger regulation of patients' access to medical doctors were the main changes.

Reibling (2010) focused even more on patients' access to the supply of healthcare services and used the criteria of gatekeeping, cost-sharing, provider density (GPs, specialists and nurses) and medical technology (magnetic resonance imaging units/MRI, computed tomography scanners/CT). Classifying European healthcare systems by these criteria, she arrived at four types: "financial incentives states," which regulate patients' access to medical doctors mainly by cost-sharing (Austria, Belgium, France, Sweden and Switzerland); "strong gatekeeping and low supply states," with no cost-sharing but extensive gatekeeping arrangements for doctors' visits, low numbers of healthcare providers and little medical technology (Denmark, Great Britain, the Netherlands, Poland and Spain); "weakly regulated and high supply states," with weak gatekeeping and a high supply of healthcare providers (the Czech Republic, Germany and Greece); and "mixed regulation states" that combine gatekeeping and cost-sharing arrangements (Finland, Italy and Portugal).

The concepts discussed in this section provide a sample of ways to comparatively analyze health policy and politics (see also Marmor and Wendt 2011). Conceptual frameworks have been designed that, relative to a specific research question, capture either the relevance of political institutions and political and corporate actors in healthcare reform or the main institutional differences of healthcare systems. Cross-border learning requires fundamentally theoretical comparisons with an analytical framework that captures the relevant institutional characteristics and healthcare reforms on the basis of a standardized set of indicators. However, such sophisticated studies have often covered only a small set of countries and a limited time span (Marmor

et al. 2005). The typologies of health policy and politics presented in this chapter may provide a tool for the inclusion of a greater number of countries in comparative studies. They may also provide the basis for better combining macro and micro research in comparative studies on both the consequences of health policy decision-making and healthcare systems.

Healthcare expenditure, financing and service provision

Conceptual frameworks and studies facilitate the understanding of developments in modern healthcare systems. The important developments described in this section are related to healthcare expenditure, financing and provision.

Healthcare represents a particularly costly part of the welfare state (Wendt 2015). From 1970 to 2015, total healthcare expenditure (THE) as a percentage of the gross domestic product (GDP) increased on average from 5.2 to 10.0 percent in OECD countries (OECD 26; see Figure 35.2). When including countries from Central and Eastern Europe (CEE), the 2015 average is somewhat lower, at 9.7 percent (OECD Health Data 2016; not shown). Due to demographic aging and medical technical innovation, a further increase of healthcare expenditure in OECD countries may be expected, and the US example demonstrates that much higher total healthcare costs are possible.

Turkey has been the country with the lowest level of THE for the entire period. The other side of the spectrum is represented by the United States, with a level of 17 percent of GDP in 2015. The distance between the United States and the OECD average has grown dramatically, from 1.9 percentage points in 1970 to 7.2 percentage points in 2015. In Figure 35.2, three

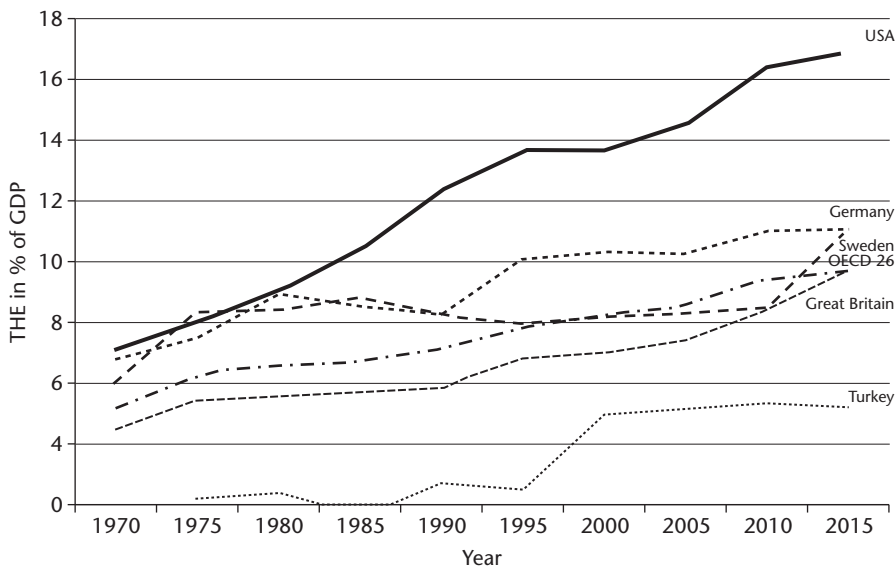


Figure 35.2 Total health expenditure (THE) as a percentage of GDP, 1970 to 2015.

Source: OECD health data (2016).

Notes

OECD 26: OECD countries excluding Chile, Mexico and CEE countries; USA: country with highest THE; Turkey: country with lowest THE.

additional countries are presented that are often taken as exemplary cases in welfare state and healthcare system research. Great Britain remained below the OECD average for the entire period under study. However, the expenditure level increased to a greater extent compared with the OECD average since the implementation of market principles in the early 1990s. Later, the British government even announced an increase in healthcare expenditure with the goal of reaching the average of OECD countries, which the country achieved in 2015 (Mays *et al.* 2011; OECD Health Data 2016). In Germany, on the other hand, THE has always been above the OECD mean and was even higher than that of the United States in 1975. The period between 1975 and 1990, however, was one of cost containment reforms in Germany, and only following its reunification did the country again face a steep expenditure increase. Other countries have been more successful in stabilizing healthcare costs. THE in percent of GDP was even reduced from 1980 to 2000 in Sweden, Denmark, Ireland and Israel, partly related to a prosperous economic development (OECD Health Data 2016). Sweden joined the group of high-cost healthcare systems in the 1970s and reached the OECD 26 average by the 1990s. Rothgang and colleagues (2010) have observed a catch-up of low-spending nations and therefore a convergence of OECD countries with respect to THE and to public health expenditure (PHE).

Healthcare is mainly financed by public money, which mirrors high public responsibility in the field of healthcare. Despite scarce resources, the state is not on the retreat in real terms. More public resources are invested in OECD healthcare systems every year (measured in percent of GDP and in US\$ per head). However, since public financing has been increased to a lower extent than private financing, a relative retreat of the state from almost 80 percent in 1980 to 75 percent in 2005 has taken place (Rothgang *et al.* 2010). In recent years a further decline of the public share of healthcare financing has taken place and is today at about 73 percent of total healthcare financing in the OECD world (OECD Health Data 2016).

More specifically, the sources of healthcare financing may be categorized into taxes, social insurance contributions, private insurance contributions and private out-of-pocket payments. Thirteen OECD healthcare systems are financed mainly out of taxes, led by Great Britain, Sweden and Denmark with tax financing of more than 80 percent. Eighteen countries are mainly financed out of social insurance contributions, with the Czech Republic, France and the Netherlands having the highest share, more than 70 percent. Among OECD countries, the United States represents the only example in which private insurance is the financing instrument of first choice, and Mexico is the only example in which healthcare is predominantly financed out-of-pocket by patients (OECD Health Data 2016). The overall share of public financing has slightly decreased in tax-financed systems and increased in social insurance-financed systems since the early 1980s (Rothgang *et al.* 2010). Direct private payments have remained relatively stable on average. Most CEE countries, however, have increased direct private payments to a large extent since 1990. In Hungary, the Slovak Republic and (outside the CEE) also in Switzerland, private out-of-pocket payments represent about a quarter of the total healthcare budget and arguably have a negative effect on access to healthcare, particularly for low-income groups and frequent users such as the chronically ill. Other countries, such as Korea and Turkey, have reduced out-of-pocket payments. Despite wide public debates over user charges, we do not see a considerable individualization of social risks in most OECD healthcare systems. However, there is also no evidence that user charges successfully reduce costs without establishing barriers to necessary healthcare, as is often claimed (Marmor and Wendt 2011).

In times of retrenchment, it becomes evident that healthcare systems with a strong role of the state, not user charges, are more successful in stabilizing healthcare costs. The role of the state can be estimated by measuring the public share of healthcare financing (Moran 2000). In the 1970s, there was no correlation between the public share in healthcare financing and the level

of THE in percent of GDP. Countries both with a low share and with a high share of public expenditure increased the overall healthcare budget. Since the 1990s, however, countries with a higher involvement of the state have been much more successful in cost containment, and we find a strong negative correlation of public financing and total healthcare expenditure in the early twenty-first century (Figure 35.3; see also Wendt and Kohl 2010; Wendt 2015). The relative retreat of public responsibility in healthcare financing therefore potentially reduces the state's capacity to successfully control costs, as is shown most prominently by the US example.

Today, cost containment is the main focus of reform in most countries. Healthcare provision, in contrast, is often neglected in the health policy debate. Focusing exclusively on healthcare expenditures, however, misses the point of what health policy is all about. Neither maximizing nor minimizing expenditures is a reasonable policy goal in itself. High levels of expenditure only make sense under the assumption that these monetary inputs will be efficiently converted into real inputs (such as personnel and medical facilities) and eventually into real output (such as medical treatment). Likewise, containing or reducing expenditure would not make much sense if it resulted in cuts in real resources, the quality of services, or both. Expenditure containment (or reduction) only makes sense if it is not accompanied by a proportionate reduction of quality or quantity (Wendt and Kohl 2010). Therefore, the real challenge of health policy is to make effective use of resources in order to meet the patients' needs and demands.

The number of healthcare providers increased in all OECD healthcare systems from 1970 to 2010 (measured in total health employment, medical doctors and nurses; not shown; see OECD

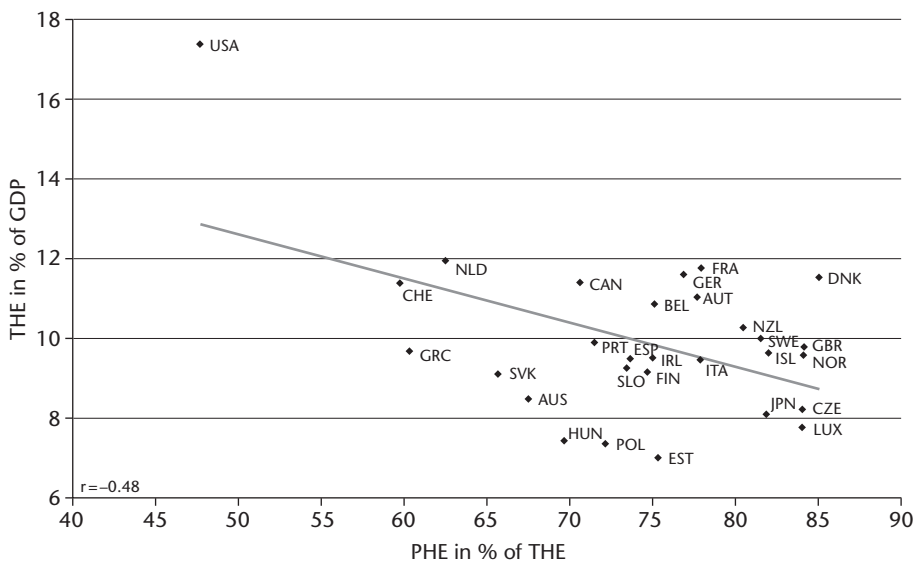


Figure 35.3 Public financing and level of total healthcare expenditure, 2010.

Sources: Wendt (2015); OECD health data (2014).

Notes

AUS: Australia; AUT: Austria; BEL: Belgium; CAN: Canada; CHE: Switzerland; CZE: Czech Republic; DNK: Denmark; ESP: Spain; EST: Estonia; FIN: Finland; FRA: France; GBR: Great Britain; GER: Germany; GRC: Greece; HUN: Hungary; IRL: Ireland; ISL: Iceland; ITA: Italy; JPN: Japan; LUX: Luxembourg; NDL: Netherlands; NZL: New Zealand; NOR: Norway; POL: Poland; PRT: Portugal; SLO: Slovenia; SVK: Slovak Republic; SWE: Sweden; USA: United States.

Health Data 2016). Growing demand due to demographic changes and higher expectations by patients has resulted in continuous expansion of healthcare provider numbers per 1,000 of the population. However, not all countries have been equally successful in translating monetary resources into high healthcare provider numbers. As shown in Figure 35.4, countries like Germany, France, Belgium and Austria have invested an above-average share of the GDP in healthcare and achieved an above-average level of healthcare providers (for the calculation of the healthcare provider index see Wendt and Kohl 2010). On the other hand, countries that have placed higher value on cost containment (such as Denmark, New Zealand and Great Britain) have achieved healthcare provider levels below the OECD average. Some countries, in particular the United States and Switzerland, share the unfavorable combination of high costs and low provider levels, and few countries seem to be able to build up a high level of healthcare providers with below-average healthcare expenditures.

When focusing on the public-private mix in healthcare provision, we find that most countries rely to a great extent on private providers. Healthcare providers in the outpatient sector are often self-employed, whereas inpatient healthcare is offered by public, private for-profit and private non-profit hospitals. If specialist healthcare is mainly provided at hospitals and a private hospital market does not exist or holds a very limited market share, public healthcare provision is dominant (more than 60 percent in Finland, Iceland and Great Britain). However, if both GPs and specialists are allowed to open up their own practice and private hospital chains have entered the healthcare market, we find a large share of private for-profit healthcare provision (more than 60 percent in Austria, France, Germany, Switzerland and the United States). The private share of healthcare provision has increased in 11 out of 15 OECD countries analyzed by Rothgang *et al.* (2010).

Few comparative studies have related healthcare systems directly to outcomes such as healthcare utilization (Reibling and Wendt 2011) and health inequities (Beckfield and Krieger 2009). Van Doorslaer and colleagues most prominently pointed towards pro-rich inequity in specialist visits and slight pro-poor inequity in general practitioner (GP) visits. Inequity in medical

Relative level of health expenditures (in % of GDP)	Index of healthcare providers					
	Above average (>100)			Below average (<100)		
Above average (>9.08%)	Germany	10.9	111.4	United States	15.2	96.9
	France	10.4	131.4	Switzerland	11.5	98.3
	Belgium	10.1	148.8	Greece	10.5	93.7
	Norway	10.1	103.2	Canada	9.9	98.1
	Austria	9.6	118.7	Portugal	9.8	84.7
	Australia	9.2	117.0	Sweden	9.3	97.1
Below average (<9.08%)				Netherlands	9.1	74.7
	Italy	8.2	117.6	Denmark	8.9	80.3
	Luxembourg	7.7	115.5	Hungary	8.3	91.4
	Czech Republic	7.5	100.9	New Zealand	8.0	84.6
	Finland	7.4	113.0	Spain	7.9	94.7
				Great Britain	7.9	85.8
				Ireland	7.2	96.7
				Poland	6.5	70.4
			Slovak Republic	5.9	80.3	

Figure 35.4 Health expenditures and healthcare providers, 2003.

Source: Wendt and Kohl (2010: 26).

specialist visits is found in nearly all countries, irrespective of healthcare system characteristics (see, e.g., Van Doorslaer and Koolman 2004). Measuring the effect of regulating patients' access to healthcare providers in European countries, Reibling and Wendt (2011) also found no country differences in inequities among income groups. However, access regulation, such as gatekeeping, affects patients' decision to see a doctor and reduces the extent of specialist healthcare used. At the same time, gatekeeping has favorable effects on reducing inequities among educational groups. Countries with stricter access regulation show lower levels of inequality in specialist visits among groups with different levels of education. Other studies have analyzed outcomes such as trust and satisfaction. The experience of dealing with cost barriers when one is in need of medical care, for instance, reduces a population's trust that necessary healthcare will be provided when one is seriously ill (Wendt *et al.* 2009b). Furthermore, both high levels of healthcare providers in the outpatient sector (but not in the inpatient sector) and the impression that doctors spend enough time with their patients increase satisfaction with the overall healthcare system, while the level of public healthcare expenditure and the degree of access regulation (gatekeeping) have no effect on satisfaction (Gelissen 2002; Wendt *et al.* 2009b).

Findings indicate that healthcare reforms would win public support if they concentrated on the provision of outpatient healthcare and that most people would accept reforms that introduce gatekeeping. Over the past three decades, however, healthcare reforms have focused on other, partly opposite, issues. Pro-market reforms have been on the political agenda in many countries, and patients' choice of healthcare providers has been extended. Moreover, new financing models, such as diagnosis related groups (DRGs), have strengthened competition among hospitals. The Netherlands and Germany have also introduced and strengthened choice among sickness funds and thereby also competition on the financing side. In most cases, however, market elements are quickly diminished.

Competition [...] perhaps the signal term in the international discourse of reform, may well turn out to have been one of the more transient. In the U.K., where it was promoted most vigorously, and in Sweden, competition has turned relatively quickly into collaboration between larger units with more clearly defined functions of planning and providing care.

(Freeman and Moran 2000: 55)

More importantly, Marmor (2000: 165) pointed to a fundamental theoretical weakness in the concept of market competition:

Ironically, procompetitive advocates propose a variety of detailed government programs, laws, and regulations designed to address and eliminate the "market failures" that occur in any unregulated medical environment. This points to the dilemma that has not been faced in most American discussions of competition in medical care markets. What is one to make of the logic of procompetitive proposals when government incompetence makes impossible the effective reform of medical market failures?

If governments are capable of organizing a healthcare market, why should they lack the competence to organize a non-competitive healthcare system?

Another important issue in health reform is the improvement of information technology (Gauld 2009). Healthcare information technology greatly impacts upon the relationship between policy-makers, funders, healthcare providers and patients who have been empowered via better access to information. Interestingly, the tax-funded British NHS seems to be particularly innovative with regard to information technology. New forms of governance with more clinician and

patient involvement in healthcare decision-making and planning have been developed as a result of better information technology. These new forms of governance, most visible in Great Britain and New Zealand, are seen by Gauld (2009) as a social democratic response to preceding neoliberal arrangements.

Conclusion

This chapter has revealed the continuous increase of healthcare expenditure in OECD countries. At the same time, however, the countries covered in this chapter offer various examples of successful cost containment. For instance, the Scandinavian countries of Denmark and Sweden reduced total health expenditure as a percentage of GDP in the 1980s and 1990s. The United States represents the only healthcare system that has great difficulties in bringing healthcare costs under control. Since the US system is mainly based on a private insurance market, it contradicts the assumptions of politicians who still believe that privatization may serve as a solution for stabilizing healthcare costs. On the contrary, data in this chapter indicate that healthcare systems with a higher share of public funding are more successful in bringing healthcare costs under control. Studies on the role of the state, however, show a relative retreat of the state in healthcare financing, indicating that public cost-containment capacities may decrease in the future. When analyzing the relationship between healthcare expenditure and healthcare provision, it becomes evident that some countries are more successful at translating monetary resources into high levels of healthcare provision than others. Countries with a high market percentage of private health insurance share the unfavorable combination of high costs and below-average healthcare provider levels.

Recent studies demonstrate the potential when bridging the macro–micro divide in healthcare research and analyze the importance of the institutional set-up for healthcare utilization and health outcomes. Regulating patients' access to healthcare providers (gatekeeping) has the potential to reduce both the utilization of healthcare services and inequalities in specialist visits among higher educated groups with better access to specialist care than those with lower education (when controlling for health status). These studies see state regulation, not market-based reforms and financial incentives, as the solution for modern healthcare systems and as a method to increase patient involvement (through the use of improved information technology). For some studies, concepts are still required that would allow for measuring and classifying not only specific regulations but the overall healthcare system. For instance, we still need to learn more about health policies and healthcare systems that successfully translate healthcare expenditure into high healthcare provision levels, not to mention those countries that are better at achieving equal access to necessary healthcare services.

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