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FADING OF THE ROLE MODEL?

Recent developments in Scandinavian health systems and their origins

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Introduction

In the 1990s European social science scholars started discussing and writing about the phenomenon of welfare state more intensively than ever before. It all started with Gøsta Esping-Andersen, a Danish social scientist who wrote the book *The three worlds of welfare capitalism*, published in 1990, where he developed a classification of welfare states. There is hardly any book or article written about welfare state after *The three worlds of welfare capitalism* that does not go back to Esping-Andersen's famous classification. Several authors have developed their own classifications after Esping-Andersen (Castles, 1993; Ferrera, 1993; Bonoli, 1995; Korpi and Palme, 1998; Ólafsson, 1999). What is interesting is that all of them recognized the welfare system in Scandinavian countries as the only one that has high levels of efficiency, inclusion and equity at the same time. An agreement on this has been kept ever since 1990. The so called "Nordic welfare state model" is founded on the ideas of universality and solidarity and has been considered a role-model.

However, this thesis observed that in the past decade the Scandinavian countries went through some changes that show that there is a slowly emerging but constant trend of stepping away from the Nordic welfare state tradition. Analysis of recent developments in Scandinavian social systems can be found in a fair number of newer works, mostly written by scientists and researchers from Nordic institutes for social science such as SFI (Denmark), Fafo (Norway) and Sunstrat (Sweden). It has been observed that the newer reforms of social systems in Scandinavian countries have a neo-liberal character and that they largely follow the tradition of New Public Management, an idea that the public sector should be managed under principles applied to private companies, that there should be more competition between the providers and that the system should strive to achieving more efficiency. Nevertheless, the question on why has a social-democratic type of welfare system started to reform in a neo-liberal kind of way and what are the consequences of this trend has very rarely or never been asked. This is precisely what will be the focus of this paper. It is necessary to examine in which way has the Scandinavian welfare been affected and where did the pressures for the neo-liberal type of reforms come

from in the first place. In order to do so, this paper has been divided into three chapters.

The first chapter brings a theoretical overview of the concept of welfare state in general, and of the Nordic welfare state in particular. The well-known classifications of welfare states, starting with the Esping-Anderson's, are outlined and compared. It is important to start with this theoretical overview in order to get familiar with the features of the Nordic welfare state model and to be able to understand its changes. Besides pensions and unemployment benefits, health sector is one of the biggest parts of the welfare expenditure. Since the scope of this paper does not allow to analyze changes in all three policy fields, the health sector has been chosen for a thorough research. The second chapter is dealing with the reforms of health sectors in Denmark, Norway and Sweden that happened in the 2000s. All the major reforms are outlined for each of these three countries. It is then explained in which way these reforms fall under the New Public Management type of reforms. The end of the second chapter brings a discussion on the consequences of the 2000s reforms in health sectors of Scandinavian countries. The third chapter is trying to find an answer to where did the pressures for the reforms come from. Two possible sources are analyzed – national and the European level. Analysis of the national level is focused on types of governments, while the analysis of the European level is concentrated on the work of the European Court of Justice and the European Commission in period from 2000 to 2010.

The findings of this paper are based on qualitative research and comparative analysis that has been carried out on several levels. The first chapter contains a comparison between welfare state classifications that was based on books and articles written in the 1990s. This period has been chosen because the debate about classifications of the welfare models was at its peak. Based on this debate it is possible to get a picture on how have Danish, Norwegian and Swedish system been seen in the period right before the 2000s reforms. In the second chapter there is a two-level comparison, firstly between initial and final landscape of health sectors, and secondly between the reforms, the exact periods when they were introduced and their flows in all three case-study countries. Based on the OECD data, Fafo research and some other

sources, effects of the 2000s reforms are compared at the end of the Chapter 2. The third chapter brings analysis of government changes in all three Scandinavian countries, of the ECJ case-law established in period from 1998 to 2007 and of all the major Commission's proposals regarding health policy.

Chapter 1

The Nordic model of welfare state

The term "welfare state" in the most general sense means that all citizens are entitled to a minimum standard of living and basic services as a matter of social right (Kananen, 2014). It was introduced around 1930s, but an agreement on the exact definition has not been achieved yet. The term remains to be a point of discussions which are trying to reach an answer on how the state interacts with the market and civil society and how it deals with the social necessities such as employment, housing, health, education (Greve, 2007). "A primary function of the welfare state is to protect its members against social risks" (Kildal and Kuhnle, 2005:16).

Over time, the academic debate produced several models of the welfare state and tried to group different countries under each of them. This paper will concentrate on the Nordic welfare state model with special emphasis on case-studies of Denmark, Norway and Sweden. The Nordic welfare model is considered to be the best one in the world by large part of academia and research milieu because it manages to keep high levels of equity in the society while delivering social services efficiently (Sapir, 2006).

The most famous classification of welfare states was created by Gøsta Esping-Andersen in his capital work *The three Worlds of Welfare Capitalism* from 1990. The notion of Nordic or Scandinavian welfare state existed even before his classification, but it was Esping-Andersen's work that triggered deeper discussions on types, models or regimes of welfare in the research community (Kautto et al., 2001). For the purpose of this paper classifications made by several different authors will be presented in the following section. Since the focus of the paper is on the Scandinavian countries Denmark, Norway and Sweden, special attention will be paid to where have they been placed in each of the classifications.

1.1.Classifications of welfare systems

Gøsta Esping-Andersen starts his explanation of welfare state and types of welfare state by defining two terms: de-commodification and universalism. He wrote: "De-commodification occurs when a service is rendered as a matter of right, and when a person can maintain a livelihood without reliance on the market. (…) A minimal definition must entail that citizens can freely, and without potential loss of job, income, or general welfare, opt out of work when they themselves consider it necessary" (Esping-Andersen, 1990:22-23). Universality means promotion of equality of the status. All citizens have similar rights irrespective of their class or market position and this creates solidarity in the society (Esping-Andersen, 1990:25). Based on these two principles, Esping-Andersen develops his classification of welfare systems and he finds three types: liberal, conservative and social-democratic. He grouped Denmark, Norway and Sweden under the social-democratic type of welfare state. This type of welfare aims to create equality of the highest possible standards for all the citizens, which means that principles of de-commodification and universality are applied to the middle-class as well and not only to the neediest low class. The idea is that everybody benefits, everybody is dependent on the state transfers and everybody is willing to pay for the system to work (Esping-Andersen, 1990).

This classification was a starting point for number of authors who either criticized it or tried to give their contribution to the given classification. One of the first authors to do so was Francis G. Castles. Castles used the OECD data for the same 18 countries that Esping-Andersen analyzed in his research. Castles first grouped the countries based on high and low levels of average benefit equality and welfare expenditure, and then based on high and low levels of taxes and welfare expenditure. Denmark, Norway and Sweden were in both cases grouped together (and together with Belgium) in the quadrant representing high level of both measured parameters. Castles connected these results to another two factors. Those were strength of the trade unions and predominant type of government. Based on this, he came up with four types of welfare system: liberal, conservative, radical and non-right hegemony. Denmark, Norway and Sweden were again grouped together, under the non-right

hegemony (N-RH) model. This means that the welfare model of these countries is characterized by high expenditure, high equalizing instruments, dominance of the Social Democracy in power and strong trade unions (Castles, 1993).

Another author who offered a classification of welfare regimes was Maurizio Ferrera. His classification is based on types of welfare coverage. He differentiates between universal and occupational coverage, where universal means that the entire population is covered by a single scheme and occupational means that different groups of society are covered by different schemes. Under both types of coverage Ferrera finds pure and mixed types. Denmark, Norway and Sweden are grouped together (and together with Finland) under the pure universalist welfare states type (in Bonoli, 1995).

Giuliano Bonoli offered his classification of welfare states in the article *Classifying Welfare States: a Two Dimension Approach* from 1995. His scheme is based on combinations between high and low levels of social expenditure as percentage of GDP and high and low levels of social expenditure financed through contributions. Based on this data, he found four types of welfare system. Denmark, Norway and Sweden (and Finland) belong to the same group which is marked by high levels of both measured parameters. This means that all three countries guarantee high level of coverage for the whole population (Bonoli, 1995).

Another significant classification was made by Walter Korpi and Joakim Palme in 1998. Their types of welfare regimes are based on institutional characteristics of welfare regimes. The authors focused on institutional structures of old-age pensions and sickness benefits and came up with five types of welfare states. Those are targeted, voluntary state subsidized, corporatist, basic security and encompassing. Norway and Sweden fall under the encompassing model, while Denmark belongs to the Basic security model. Pension programs in Norway and Sweden are based on universal coverage with earnings-related supplements from the working population, while in Denmark the supplement part was not noted (Korpi and Palme, 1998).This classification was the only one used for the purpose of this paper where Denmark, Norway and Sweden were not grouped together. However, this should not be taken as such a serious deviation since the difference is based on different types of

financing of pensions systems and not healthcare systems which are in focus of this paper.

The last classification to be presented here is the one made by Stefàn Ólafsson in 1999. He combined high and low levels of generosity of the welfare system with the sources of entitlement to benefits, i.e. employment-based rights and citizenship rights, and he came up with four types of welfare state: minimalist, Bismarck, Beveridge and Scandinavian. Denmark, Norway and Sweden were grouped together under the Scandinavian model. This means that all citizens are recipients of generous social benefits. The state has the central role in welfare provision and the main goal of the system is equality of the citizens. Primary caring services are provided by the public sector (Ólafsson in Kildal and Kuhnle, 2005).

The purpose of this theoretical overview was to show that there is a common understanding among scholars of welfare systems on existence of a separate and distinctive model of welfare in Scandinavian countries. The authors mentioned above have made their classifications of welfare systems based on different parameters, yet all of them, with exception of Korpi and Palme, grouped Denmark, Norway and Sweden under the same model. Some of the characteristics of the Nordic/ Scandinavian model have already been mentioned previously while reviewing the literature on classification of welfare states. At this point it is important to specify all the main features of the model. It will allow us to create a detailed picture on what is actually meant by the term "Nordic welfare state". Based on this understanding it will be possible to continue to the next chapter which will deal in detail with reforms in Scandinavian health sectors. It will enable us to assess whether the reforms went along the traditional idea of the Nordic welfare state or whether they followed some other traditions.

1.2. Features of the Nordic welfare state

Before outlining the main features of the Nordic welfare state, a short storyline on how did Nordic welfare model develop in the first place will be presented here.

The landscape of the Nordic society was from the very beginning different from other European societies. What was unusual in the Nordic society was that the peasants were never excluded from social or political life. On the contrary, this group represented one of the four bases of the society together with clergy, nobility and bourgeoisie. Already at this point it is possible to observe some sort of equality between the citizens and a high level of social inclusion. Historically, there was very little competition between the state and Church for provision of education and health services. Citizens were urged to look for the welfare services from the state and from the lowest possible level of governance, i.e. municipalities. Here are the roots of highly decentralized model of provision of public services and of limited space for market (Kildal and Kuhnle, 2005).

Agriculture was the dominant production sector in the Nordic countries. In the 18th century it started modernizing under pressures of industrialization which was followed by the economic growth and urbanization. The economic activity did not grow only in sense of production, but also in sense of trade. These processes led to rise of importance of education in the 19th century which soon became mandatory in all countries. As more citizens became well educated, there were louder requests for political rights, such as the right to vote, and democracy. As elsewhere in Europe, workers were often exploited while the capital owners were making profits. Therefore, workers had to organize in order to fight for better working conditions and their rights so the labor unions emerged together with the working-class parties – Social Democrats (Kananen, 2014).

Social-democratic parts of society, which were in majority, produced the idea of a special kind of welfare state in the beginning of the 20th century that is still recognized today. The welfare ideology carried a protest element and criticism of capitalism, predominantly because capitalism proved to be inefficient in prevention of poverty and unemployment. The goal was to create a classless society, not through a violent revolution as Marx predicted, but by rising of the economic standards of the working class to the level of the upper class (Heckscher, 1984). It was believed that this kind of model would be more successful than capitalism because it would induce economic growth. More equitable distribution of incomes and expansive economic

policies would increase demand coming from the lower classes of society which would then create more need for employees (Heckscher, 1984). There is a necessity to create the material security for all citizens.

The main and still viable idea of the Nordic welfare state can be summarized in Gustav Möller's (Swedish social reformist, journalist and minister) words: "No citizen should suffer need. We have sufficient powers of production, and it could only be because of bad will or insufficient organization that we should be unable to see to it that what is being created is sufficient for all" (from Möller's 1930 speech, in Heckscher, 1984:44).

The ideal-type of Nordic welfare state model has several goals. Those are: high level of employment, low income inequality, low poverty rates, small differences in standard of living, gender equality (Kautto et al., 2001). The state is supposed to protect the citizens through high transfers and universal coverage for all and the public sector is the main provider of welfare services such as pensions, unemployment benefits, support for families with children, social care for children and elderly and health care. This is why the Nordic welfare states are also described as service welfare states (Greve, 2007). The model is primarily financed through high and progressive taxes while both public and social expenditure on welfare are much higher than in other European countries (Kautto et al., 2001). What is important to emphasize is that the model has a broad support from the citizens which mirrors the tradition of social solidarity in the Nordics.

The Nordic welfare state is deeply rooted in values of universality and equality. Those are the bases on which the whole model remains, therefore it is necessary to dedicate some lines to each of these concepts. Universalism is a distributive principle connected to equity and redistribution. Two main dimensions of this principle are membership and allocation, where membership means that people are beneficiaries of welfare schemes because they are members of a specific community, and allocation means rules under which a member of the community is entitled to certain welfare services (Kildal and Kuhnle, 2005). Egalitarian ideas represent another core value of the Nordic welfare model. This means that the system is using social policies for leveling of economic differences between social groups. The main

instrument the state uses to do so is equalization. Alva Myrdal emphasizes that equalization has to be constant. It is not only a tool to fight against the social inequalities that already exist, but also to prevent any new inequalities that may appear in the future (Heckscher, 1984).

Chapter 2

The modern challenge of the Nordic welfare state: example of reforming the health sectors in Denmark, Norway and Sweden

As presented in the previous chapter, there is a general agreement between scholars that a Nordic welfare system as a system with distinctive features exists. In order to show how these general characteristics of the Nordic welfare state are transferred to a concrete welfare sector, this chapter will focus on health care systems in three out of five Nordic countries, i.e. on Scandinavian countries Denmark, Norway and Sweden. Finland and Iceland were not included in the research because it would go beyond the scope of this paper. There are features of health systems that are shared by the three Scandinavian countries, therefore they need to be briefly outlined in order to show the distinctiveness of the model on the sector level as well. In the early 2000s health systems in all three countries started reforming rather rapidly and some big changes have been introduced into what has been considered a traditional model of Nordic health care system. In this chapter the reforms will be presented for each country individually with focus on what has changed in comparison with the previously existing system. Except for this past and present comparative dimension, a comparison between the three countries will be carried out as well. The point of this is to examine if there are similarities in reforms which were introduced in each country respectively, and also to show if after reforming the three countries can still be grouped together according to the features of their health systems. The last point of this chapter is that it is possible to observe some negative trends in development of the health systems of Denmark, Norway and Sweden. The emphasis is on the rising problem of inequalities between the citizens of these countries in access to health care. Can the problem be explained with the introduction of the 2000s reforms? This question will be thoroughly discussed at the end of the chapter.

2.1. A distinctive Nordic health care model

As we can talk about a specific kind of the Nordic welfare state, we can also talk about a specific type of Nordic health care system. The characteristics shared by health systems of all Nordic countries are basic values and organization of the health system. The main principles of the Nordic health care system are equity and universality. That means that "all inhabitants have the same access to public health services regardless of social status or geographic location" (Magnusen et al., 2009:10). Apart from equity, participation of citizens in democratic decision-making in health care is highly valued and for that reason in all Nordic countries local councils, both on municipal and regional level, with elected representatives can be found. In this way health system is closer to citizens' needs and it can be more responsive to them. The division of tasks and responsibilities in health sector has been shared between three levels: national, regional and municipal. Majority of the health services is traditionally delivered to the citizens by the lowest level possible while the center state is in charge of national health policy, regulation and supervision of the whole sector as well as the largest part of financing. This means that the health system in Nordic countries is decentralized. The health systems are primarily financed through high taxes and the revenue is redistributed by the state in forms of different types of grants. Also, every citizen is entitled to coverage for health services through a national insurance scheme. National insurance scheme is a public universal insurance scheme that assures everybody a minimum of social security, regardless of income (Johnsen, 2006:14). Private health insurance and out-off-pocket payments for health services have traditionally been very rarely used by the citizens. Private suppliers have not been numerous in any of the Nordic countries. The health system is largely publicly owned and run with a strong opposition to private expansion. "The common understanding has been that health care should be under the ultimate control of democratically elected bodies, and not left to commercial market forces" (Magnusen et al., 2009:11). The overall responsibility for the health systems in Denmark, Norway and Sweden lies in hands of each of these countries' respective Ministry of Health Affairs (The Commonwealth Fund, 2012). To sum it up, the most important features of the Nordic health system to note are that

it is a predominantly tax-funded system with universal access for all the citizens and public players in decision-making and delivery of health services.

Health care systems in Scandinavian countries are considered to be ones of the best in the world. All the official reports on health systems asses Scandinavian systems as systems of very high quality. For example, the OECD annual reports *Health at a glance*, among other, measure the percentage of people reporting to be in good health. Denmark, Norway and Sweden always score above the OECD average. In all three countries total expenditure on health care is very high and the records show that it has been on the rise since the year 2000 (See the Table 2.1.). "Total expenditure on health is defined by the OECD as the sum of expenditure on activities that – through application of medical, paramedical and nursing knowledge and technology – have the goals of promoting health and preventing disease, curing illness and reducing premature mortality, caring for persons affected by chronic illness who require nursing care, caring for persons with health-related impairments and disabilities who require nursing care, assisting patients to die with dignity, providing and administering public health, and providing and administering health programs, health insurance and other funding arrangements" (CIHI, 2014:65).

Table 2.1.: Total expenditure on health as % of GDP in Denmark, Norway and Sweden

	2000	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**
Denmark	8.7	9.1	9.3	9.5	9.7	9.8	9.9	10.0	10.2	11.5	11.1	10.9
Norway	8.4	8.8	9.8	10.0	9.6	9.0	8.6	8.7	8.6	9.7	9.4	9.3
Sweden	8.2	8.9	9.2	9.3	9.1	9.1	8.9	8.9	9.2	9.9	9.5	9.5

Source: The table was made based on data from www.stats.oecd.org

At the first glance, the traditional model of health care in Denmark, Norway and Sweden might sound too idyllic. Indeed, there are problems that these three countries are facing in their health sectors, the crucial one being the long waiting lists. All three countries went through quite a few reforms since the early 2000s and the official reasoning for the reforms was precisely to reduce the waiting lists and increase efficiency of the health system and access to health care services. It is

necessary to look into the reforms in each of the three countries to determine have they and to which extent changed the traditional health system, as well as what have been the consequences of the reforms for the Scandinavian society.

2.2. The reforms of Danish, Norwegian and Swedish health sector

2.2.1. Denmark

The system of public governance in Denmark has normally been marked by a high level of decentralization, like it is typical for other Nordic countries as well. This means that there is a division of tasks between the three levels of governance, i.e. national, regional and municipal. This changed in Denmark in 2007 when an important structural and organizational reform occurred resulting in mergers of the municipalities and, more importantly for the topic of this paper, mergers of the regions. Denmark went from having 14 counties to 5 regions. The regions were largely stripped of their competences and completely lost their taxation power. The most important responsibility remaining in the hands of the five regions is the health sector so the administrative regions at the same time became the health regions. The health regions are financed by both national and local level, since both of those are able to collect taxes. The national level contributes to the regional budget through grants and activity-based financing, while the municipalities pay per capita and by activity. The health regions use their budget to finance the work of the hospitals (both private and public with which they have contracts signed), general practitioners (GPs) and specialists (Olejaz et al., 2012). Merger of the counties into five health regions is definitely the most significant reform that happened in the Danish health sector because it created a specific frame inside of which all the other previously introduced reforms got a different meaning. Introduction of the health regions gave room for a certain kind of competition between the providers that did not exist before in Denmark.

Activity-based financing has been introduced in Denmark back in 1999 and since then this model of financing went through several adjustments in the 2000s. This is highly important especially if it is understood in combination with purchaser-

provider model, patients' choice legislation and waiting time guarantees, and even more if it is understood in the framework of the new system of health regions. Activity-based financing was an instrument by which the national government tried to increase efficiency and productivity of the health sector. The system works by setting a baseline activity level for the counties, later health regions, and the entities are entitled to extra financial transfers from the state if their overall production of health services goes over that line (Street et al., 2007). In other words, the more activity the more money the given health region can get from the state. The activity-based financing was established not only on the state-region relation, but also on the region-hospital relation. In 2004 mandatory level of activity-based financing of the hospitals was 20% of the overall county budget and it grew to 50% by 2007 (Olejaz et al., 2012).

In 1993 the Act on Free Choice of Hospitals was passed in Denmark as a respond to the problem of waiting lists. This law enabled the patients to choose where, of all possible public providers in the country, they want to be treated after the GP's referral. Even though the law did not have much effect, it was further expanded only in 2002 with the introduction of the so called "extended free choice" (Olejaz et al., 2012). The free choice of providers was combined with a two months waiting time guarantee. If the system failed to give the treatment to the patient in a two months period from his/her referral, the patient had the right to choose where to be treated among the other counties or private facilities having a contract with his/her home-county. The home-county is obliged to carry out the full cost of the treatment (Østergren et al., 2008). Furthermore, the waiting time guarantee was reduced from two to one month in 2007. As can be expected, these reforms created the need for more providers of health services and this led to increase in number of private providers. Much more attention will be paid to this point at a later stage of this paper.

The significance of purchaser-provider model and expansion of its usage in Denmark increased in the 2000s with reductions of the waiting time guarantees and ever more encouraged productivity of the health suppliers through previously explained activity-based financing. As Andrew Street explains it, the main idea of the purchaser-provider model in health care is that there is a split between the actors in

charge of production of services (hospitals, community health centers) and a health authority that buys these services in order to meet the needs of the citizens (Street, 1994:6). The system is based on contracts between the providers and health authorities with the purchasing power. By using this model a country can reduce waiting lists since the system does not rely only on publicly owned hospitals, health centers and other providers, but it increases the number of providers through contracted co-operation with the private providers as well.

Because of the necessity to have a better view over the health sector and respond to the consumers' needs efficiently and with high quality of health services, the system has to be monitored and a regular collection of the data has to be exercised. Danish health care system is being monitored and evaluated by the Danish Institute for Quality and Accreditation in Healthcare. This body was established in 2005 with the purpose of developing certain internal standards of health care and assure high quality of the services. Also, as of the 2000 Danish Ministry of Health collaborates with the health regions in conducting The National Danish Survey of Patient Experiences in order to gather more information on general functioning of the health system and patients' satisfaction (Olejaz et al., 2012).

2.2.2. Norway

In the 2000s the Norwegian health system experienced some significant reforms as well. The largest and the most analyzed reform of the Norwegian health sector is the so called "hospital reform" or "the big-bang reform" from 2002. Through The Regional Health Authorities Act the 21 administrative counties were organized into five regional health enterprises. This means that there is an executive board established in each of the health regions with managers on top. The executive board has the responsibility for day-to-day governance of the health services provision and it is managing the region as if it was a private company (Helsedirektoratet, 2009). Regional health enterprises are organized as corporations fully owned by the state and funded through capitation, activity-based financing and out-of-pocket payments (Lindah, 2012). The three-level organization of the health system was kept and the

municipalities kept the responsibility for the primary care. Later, in 2007 the two biggest health enterprises, Eastern and Southern, were merged into one so that today Norway is divided into four health regions. The "hospital reform" was the biggest change ever introduced into Norwegian public system in general.

Activity-based financing of the health sector was introduced in 1997. This type of financing gained more significance after the 2002 reform and creation of the regional health enterprises. In 2002 the regional level lost the taxation power meaning that it became dependent on municipal and in much larger part on the state finances. Activity-based financing is an arrangement between the central state and the health regions (Street et all., 2007). The budget is set annually. In the beginning the share of activity-based financing was 35%, then rose to 60% in 2005 and was immediately reduced to 40% in 2006. What this means is that today 60% of a single region's finances comes as a fixed sum based on the potential number of patients in the given year and 40% depends on the actual activity of the health sector.

Another significant reform in Norwegian health sector was introduced by the 2001 Patient' Rights Act which gave the possibility to choose their general practitioners (GPs) and hospitals where they wish to be treated after the GP's referral to all the patients. This was the first time that a Norwegian patient could choose his/her GP and the GPs got a list of patients they were responsible for, while hitherto patients were restricted to health care given by the nearest provider. This led to a new phenomenon in the Norwegian health system. The GPs had normally been public employees, but the introduction of patients' choice resulted in increasing trend of self-employment of the GPs. (Magnussen et al., 2009). In other words, the number of private GP offices rose. This also means that the GPs' services have from this point on been to a larger extent financed through out-of-pocket payments by the users and through service contracts with the health regions. In 2003 the patients' choice of hospitals was extended to private hospitals that had agreements with the regional health authorities (Johnsen, 2006).

Norway introduced a 6-months waiting time guarantees for the first time in 1990 and changed it to a 3-months guarantee in 1997. In 2002 The Patients' Rights Act cancelled the 1997 guarantee period. From this point on the waiting time guarantee

has been a combination of a general guarantee for a hospital examination (30 days) and an individual time limit set by the medical professionals according to the needs of the patients. If the time limit has exceeded the hospital has to pay for the patient's treatment in any facility of his choice in other health region or among the private providers his/her home-region has a contract with (Østergren et al., 2008).

"Integrated purchaser-provider relations are dominant feature of the Norwegian health care system" (Johnsen, 2006:49). Purchaser-provider model in Norway is based on contracts between the municipalities and private GPs when it comes to primary care, and on contracts between the regional health authorities and private hospitals or specialists, when it comes to somatic and specialist care. Both the municipal and the regional level need to buy services from the private providers to meet the needs of the citizens and respect the waiting time guarantees as much as possible. The Patients' Rights Act and reduction of the waiting time guarantee enabled more dynamic purchaser-provider relationships because there was an increased number of the providers competing for the contracts with the municipalities and the health regions.

To assure better efficiency and quality of health care, Norway introduced monitoring activities and data collection tasks. One of the main national bodies in charge of this are the Norwegian Board of Health and the Norwegian Council for Quality Improvement and Priority-Setting in Health Care. The Norwegian Board of Health was established in 1994, but only in 2002 it became an independent supervision agency (Johnsen, 2006). The Norwegian Council for Quality Improvement and Priority-Setting in Health Care was created by the Norwegian Ministry of Health in 2008. Both institutions are involved in gathering of information about health services, evaluating these information through written reports and giving proposals for improvements in organization and functioning of the health system.

2.2.3. Sweden

Before going through the major reforms that were introduced in Sweden in the 2000s, it is important to emphasize that the case of Swedish health system is in some

aspects different from the Danish and Norwegian one. The main points are first, that the counties did not lose their taxation power after the reforms and second, some reforms were introduced by the national and some by the county level.

In Sweden lower administrative level are in charge of delivery of health services to the citizens while the central state, i.e. the Swedish Ministry of Health has the overall responsibility for the health sector. There is a division of tasks between the municipalities and counties where primary care and secondary care lay on the county level. Municipalities do not have many responsibilities and they mainly handle nursing homes and home care services. As of 2007 counties have been grouped into six health regions in order to increase efficiency of the system and fight against the biggest problem of the Swedish health care system – long waiting lists (Anell et al., 2012). However, counties are still the main players when it comes to the health sector. There is no authority passed onto the six health regions. They are purely functional and serve as a transition form towards the health regions in the sense of Danish and Norwegian ones. In 2007 a common body for representation and collaboration between municipalities and regions at the national level was created and named SALAR (Swedish Association of Local Authorities and Regions).

As for the free choice of providers, it has existed in Sweden since 1991 when patients got the right to choose among public primary care providers and hospitals where they wanted to be treated, but only in 2010 it became mandatory (Anell et al., 2012). What is interesting is that, unlike in other two Scandinavian countries, patients' choice never became a law in itself but was rather incorporated into other legislation and agreements between the state and the counties. The importance of free choice of providers rose dramatically in 2007 when free establishment for accredited private providers was introduced by the government. This meant that patients can register for a free treatment with any public or private provider on the county level, having that the private providers in question have a contract signed with the given county.

The waiting time guarantee was established in Sweden in 2005 and it is based on "0-7-90-90" principle. This means that "the patient is supposed to reach its health care centre by telephone the first day and then be offered an appointment with the GP

within 7 days. If medically needed, the patient has the right to an appointment with a public or private hospital or a private specialist within 90 days and then treatment or operation within another 90 days" (Østregren et al., 2008:8). Besides the waiting time guarantee, the government introduced P4P ("pay-for-performance") mechanism. The counties which managed to respect the targeted time guarantees received extra government grants (Østregren et al., 2008). This can be seen as some sort of a deviation from the regular activity-based financing model. On relations county-local providers, activity-based financing exists but its form varies from county to county.

Activity-based financing is closely related to purchaser-provider model on county levels. Hospital services are paid through global budgets, case-based and performance-based payment. Primary care providers get paid according to number of registered patients and performance as well as through fees-for-service (Anell et al., 2012). Purchaser-provider model is often used in Sweden, especially after the law on free establishment was passed. Again, there are different deals in different counties. The Swedish Institute wrote in 2009 that it became more common for the counties to buy services from the private providers (official Sweden site, last updated November 11, 2013).

The National Board of Health and Welfare is in charge of standard-setting and data collection in Sweden. Also, the information about waiting times and quality of services is available to the citizens on SALAR's web page. These information and evaluation mechanisms gained bigger importance in the 2000s since the number of providers increased significantly and since the patients have more rights and more options to choose from.

One specificity of the Swedish health reforms is the introduction of the so called "Stop Law" in 2000. The aim of this law was to stop privatization of emergency hospitals. This law was abolished in 2007 which enabled the counties to contract with profit-making companies to run the emergency hospitals. The result of the abolition of the "Stop Law" was that six previously publicly owned hospitals became private and entered into contractual relations with the counties.

2.3. Two-level comparative analysis of the reforms

In the beginning of this chapter two questions regarding reforms in health sectors of Denmark, Norway and Sweden were laid out and they will be answered here. Firstly, what changes did the reforms bring into health systems of each respective country? Secondly, can the three Scandinavian countries after the reforms still be grouped together under the same health care model or have they taken their own different and new paths of development?

In Denmark the first forms of free choice of providers, activity-based financing and purchaser-provider model were introduced in the 1990s, but in the 2000s these mechanisms became more frequently used and regulated in a clearer way. Waiting time guarantees were set out in the 2000s as well, starting with the two-months guarantee in 2002 and then reducing it to one month in 2007. However, the most important reform was the organization of the health system into five health regions. This reform created a new framework inside of which all the other reforms got a specific new meaning. Since the regions lost their taxation powers, the importance of activity-based financing rose and consequently, the necessity to attract more patients who now got the right to choose and the guarantee to receive treatments in set times. Having more empowered patients also required higher quality and efficiency in delivering medical services. Information on functioning of the health system, quality of services of individual providers and standards of health care needed to be gathered so more attention was paid to data collection, monitoring and evaluation. The Danish Institute for Quality and Accreditation in Healthcare was formed in 2005 for this purpose and Ministry of Health started collaborating more with the regions on carrying out patient surveys.

Norway experimented with not so ambitious waiting time guarantees in the 1990s, but the matter became more serious in 2001 when the first law on patients' rights was passed. The waiting time guarantee was reduced to one month and the patients got the ability to choose among all public GPs and hospitals, as well as the private ones which had a contract signed with their home-county/region. Activity-based financing

and purchaser-provider model became more heavily used since the efficiency of the health system and respect of the new 2001 legislation (The Patient's Rights Act) depended on competence of the regions to deliver enough services to cover all the citizens' needs. Another reason why activity-based financing gained more importance was the fact that the "hospital reform" stripped the regions of their taxation powers, therefore they became completely dependent on state financial transfers. Same as in Denmark, Norway experienced the biggest change of its health system after division of the state territory into five regional health enterprises in 2002, i.e. four regional health enterprises after the 2007 merger of East and South health regions. Monitoring and data collection activities fell under the National Board of Health and newly established Norwegian Council for Quality Improvement and Priority-Setting in Health Care.

It has been shown that the Swedish case somewhat differs from the other two. There was no establishment of the health regions in the full sense of the word and the counties kept their organizational and financial authority over the health services. Even so, Sweden did introduce all the other reforms that were already noticed in Denmark and Norway. The patients' choice has existed in Sweden ever since 1991, but its real meaning came out only in 2007 with the act on free establishment of health providers. The waiting time guarantee was introduced in 2005 through the "0-7-90-90" principle. Further encouragement for respect of this norm came in form of P4P – "pay-for-performance" mechanism in 2008 which consisted of financial rewards from the state to the counties/regions which managed to respect the established time guarantee. Apart from this kind of activity-based financing, all counties have the right to organize their transfers to the providers that work under their authority which means that the rules vary from county to county when it comes to activity-based financing on the lower level. The purchaser-provider model became more dynamic after the act on free establishment of health providers, abolishment of the "Stop Law" and introduction of "0-7-90-90" principle because more options opened for the counties to choose between the local providers with which they will enter into contractual relations on service delivery. The National Board of Health and new body SALAR took up the tasks of data collection and overall evaluation of the health system.

To have a more organized overview of all the reforms that were introduced in period from 2000 to 2010 in Scandinavian countries, a summary is made in the table below (See Table 2.2.). This makes the comparison easier and it is immediately clear that all three countries went through the same changes of their respective health systems. Since patients' choice and waiting time guarantees existed in some of the given countries even before the 2000s, the table shows only the years in which these norms actually became effective and earned their true value.

Table 2.2. Major reforms of health sector in Denmark, Norway and Sweden in the 2000s

	Denmark	**Norway**	**Sweden**
Health regions	✓ 2007	✓ 2002	Six regions – transitional form
Patients' choice	✓ 2002	✓ 2001	✓ 2007 → 2010
Waiting time guarantee	✓ 2002 → 2007	✓ 2002	✓ 2005
Activity-based financing	✓ increased in the 2000s	✓ increased in the 2000s	✓ increased in the 2000s
Purchaser-provider model	✓ increased in the 2000s	✓ increased in the 2000s	✓ increased in the 2000s
Monitoring activities	✓ new bodies/ new tasks for old bodies	✓ new bodies/ new tasks for old bodies	✓ new bodies/ new tasks for old bodies

To sum up, it is clear that all three Scandinavian countries introduced more or less the same reforms in their health systems. At first glance, the Swedish case deviates from the other two countries. Considering that Sweden did not change the organizational structure of the health sector in the way Denmark and Norway did, i.e. it did not formally introduce the health regions, the possible conclusion could be that Sweden, after reforming, is falling out from the common Scandinavian (Nordic) model when it comes to health care. Division of the state territory into health regions was the "big thing" in Denmark and Norway and in Sweden that is precisely the reform that is lacking. Also, the reforms such as waiting time guarantee and formalized patient choice came rather late comparing to Denmark and Norway. Whereas Denmark and Norway passed the legislation on patients' choice and waiting

time guarantee in the early 2000s, Sweden did so in the second half of the decade. Creation of the six health regions as a transition form is an incremental step towards the eventual creation of real health regions. On the other hand, Swedish reforms brought some new mechanisms such as P4P and free establishment of the health providers, and the "Stop Law" was abolished. This actually produced the same effect as Danish and Norwegian reforms in the sense of increased activity-based financing and utilization of purchaser-provider model. Furthermore, despite lack of mergers of counties into health regions, Swedish counties carry out the same duties as Danish and Norwegian regions – they are in charge of the biggest part of health care services and they participate in negotiations with the local providers when it comes to contracting. Also, as it was explained before, the six Swedish health regions are considered to be a transitional form which means that there is a solid ground for expectation of creation of actual health regions in the future. This is why Sweden can be seen only as a late reformer among the three Scandinavian countries, but it definitely still belongs to the same family with Denmark and Norway.

2.4. New Public Management and increase of private providers of health care

New Public Management is a term that was coined in the 1980s and it denotes public service reform program. The main ideas of New Public Management are shift of public sector to a management based methods along the lines of private companies, introduction of market competition methods into public sector, bigger responsibilities of the single administrative units, more discipline and cost containment in usage of public finances, introduction of standards and evaluation of success, more choice for citizens, the growth of use of contracts for resource allocation and service delivery within public services (Osborne 2006, Pusić, 2002, Stark, 2002). The supporters of New Public Management see it as a tool to make the delivery of services more effective, efficient and economical. The reforms that were carried out in the 2000s in Denmark, Norway and Sweden completely fall under the New Public Management ideology. The exact features of New Public Management in these three countries will be presented in the first part of this subchapter. The second part will deal with the

influence of the 2000s, New Public Management marked, reforms on increase in number of private providers of health care.

Previously outlined reforms of Danish, Norwegian and Swedish health sector were supposed to make the health systems more efficient. In other words, the goal was to get rid of the long waiting lists and also to deliver services of high quality. Introduction of waiting time guarantees meant that the health regions and counties are working on a time frame now and not respecting deadlines means costs that have to be borne by the regional budget. For Denmark and Norway this is an even bigger problem considering that the health regions lost their taxation power. If the waiting time guarantees are not respected, the region loses part of the money that it would usually get from the central state, the money on which it depends. In order to comply with the time guarantees the regions/counties need to make sure that there are enough providers able to respond to the citizens' needs with the highest possible quality of care and in the most efficient way, hence the importance of activity-based financing and purchaser-provider model. Activity-based financing stimulates providers to work more efficiently and respect the time frames because in that way they will be able to treat more patients, meet the set targets and be entitled to always needed more financial means coming from the upper level. This of course leads to competition between the potential receivers of the extra funding, be it the regions or the local providers. "Activity-based funding is a form of "yardstick competition", which is designed to stimulate greater efficiency in contexts where competitive pressure is lacking" (Street et all., 2007:1). Let us be reminded that the traditional Scandinavian health sector, and the welfare system in general, are regulated publicly and by the state's hand, therefore a typical market feature such as competition is definitely lacking. Activity-based financing is intertwined with the purchaser-provider model. As explained before, the purchaser-provider model is based on contracts. The public sector gets a new role. It is not only the provider of the services anymore but under this model it buys the services from the contracted facilities and then delivers them to the citizens. Again, this implies competition. The suppliers are trying to get the deal with the regions/ counties so they are offering competitive prices and good quality of services. In short, "A purchaser/provider separation is designed to use contractual arrangements to introduce competitive elements into what remains essentially a

publicly managed health system" (Street, 1994:5). On the other side, competition was also triggered by the patients' choice acts. The empowered patients got the right to choose the GPs and hospitals where they wanted to receive their medical treatments which means that providers were pushed into a competition ring from the bottom as well. Overall, what needs to be emphasized here is that the reforms brought the market trends into the previously purely state-regulated sector.

What developed in Denmark, Norway and Sweden in the 2000s was the public-private mix, as Kjeld Møller Pedersen calls it. "(…) the public healthcare systems are not what they used to be. Internal markets have been introduced, hospitals have been corporatized, contracting out has been implemented and free choice of provider has been developed" (Møller Pedersen, 2005:162). The health sector is still predominantly publicly run and financed, but it obviously functions more under the neoliberal New Public Management ideology. This comes clearest in Norway which actually named its health regions regional health *enterprises* and introduced executive boards and managers to lead them. The trend is the same in Denmark and Sweden and it is rooted in the regions', i.e. counties' power to negotiate the contracts with the private providers. The new rules of financing and delivery of health services caused a big demand for more providers, which opened the way for private facilities to be established. The 2000s reforms brought management mechanisms into the public sector. On one side, there is regulation of competition, incentive-based contracts and introduction of private providers to a publicly dominated sector. On the other side, the patients are not only the passive recipients of the medical services. Through the patients' choice acts and waiting time guarantees they became active consumers, like in ordinary markets (Magnussen et al., 2009).

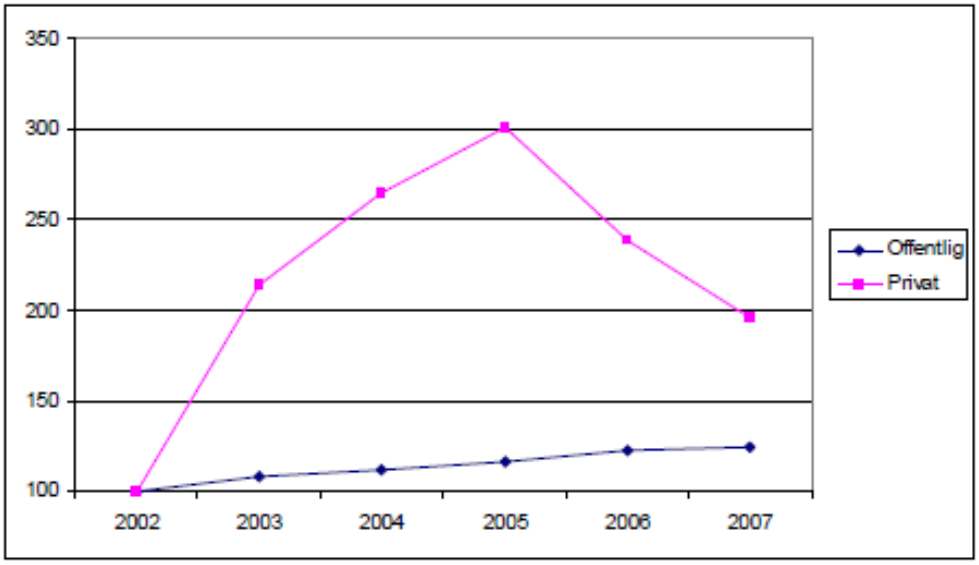
The literature on health reforms in Scandinavian countries is not very rich, especially when it comes to deep analysis of the rising trend of private providers. Therefore, the precise data on number of private providers as well as the measurements of the activity of health sectors is almost completely unavailable. The data that will be presented next is enough to prove the point – that both the number and the activity of the private health sector have increased rather significantly since 2000, even though different parameters were measured in each of the respective countries.

Table 2.3. Denmark – number of public and private hospitals, 2000, 2005 - 2009

In-patient care	2000	2005	2006	2007	2008	2009
No. of hospitals	116	201	210	227	268	271
Classified according to ownership						
– thereof public hospitals	73	59	59	58	58	55
– thereof privately owned hospitals[1]	43	142	151	169	210	216

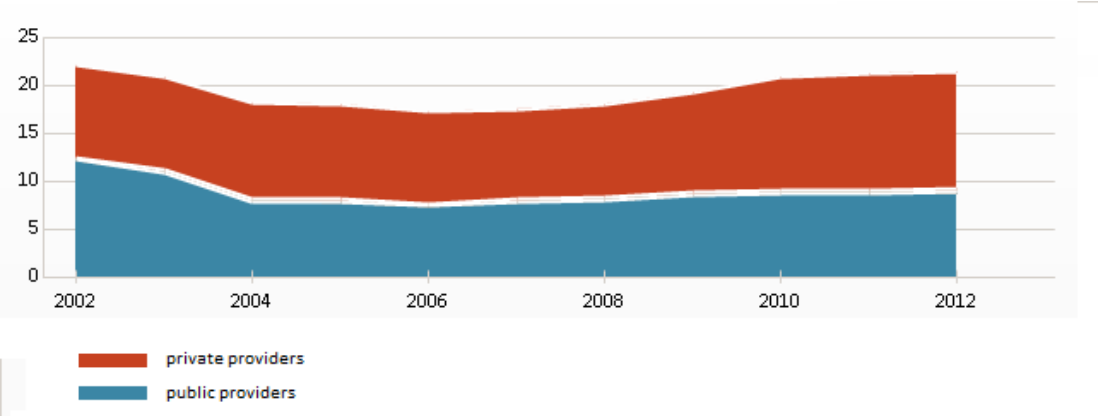
Source: PHIS Pharma Profile 2011: Denmark, 2011:7

Graph 2.1. Norway – activity of private and public sector, 2002 - 2007



Source: Helsedirektoratet: Aktivitetsutvikling og ventetider i somatisk spesialsthelsetjeneste 2002 – 2007, 2008:21

Graph 2.2. Sweden – number of private and public providers, 2002 - 2012



Source: www.ekonomifakta.se , Vården i privat regi

In case of Denmark and Sweden number of providers is measured in the 2000s, for Denmark it is the number of hospitals and for Sweden number of all private and public providers. In both cases there is rise of the private providers and fall of public providers. In Denmark the trend is constant since 2000, but what is important to notice is the big rise in number of privately owned hospitals from 2007 to 2008. This is a strong confirmation of the impact of new organization of the health sector and stricter waiting time guarantees introduced in 2007. In Sweden the number of private providers starts rising around 2007 too, which can be explained by the law on free establishment for accredited private providers. In both countries fall of public providers comes as result of privatization processes and mergers of the facilities.

In Norway the number of private (9) and public hospitals (78) remained unchanged in spite the reforms (PHIS, 2011:7). From the graph it is possible to follow the overall increase of activity of the health sector. However, the rise of activity is much slower in public than in private sector. This implies firstly, that there is a rise in number of private providers other than hospitals and secondly, that the public sector in its current size does not have much room for improvement. Sharp drop of activities in the private sector from 2005 to 2006 can be explained by changes in activity-based financing because the share of it decreased from 60% to 40%. Anyway, if observed for the whole measured period, 2002 to 2007, the activity of the private sector rose by double while the activity of the public sector rose by a quarter.

2.5. Challenging the model – problem of inequity

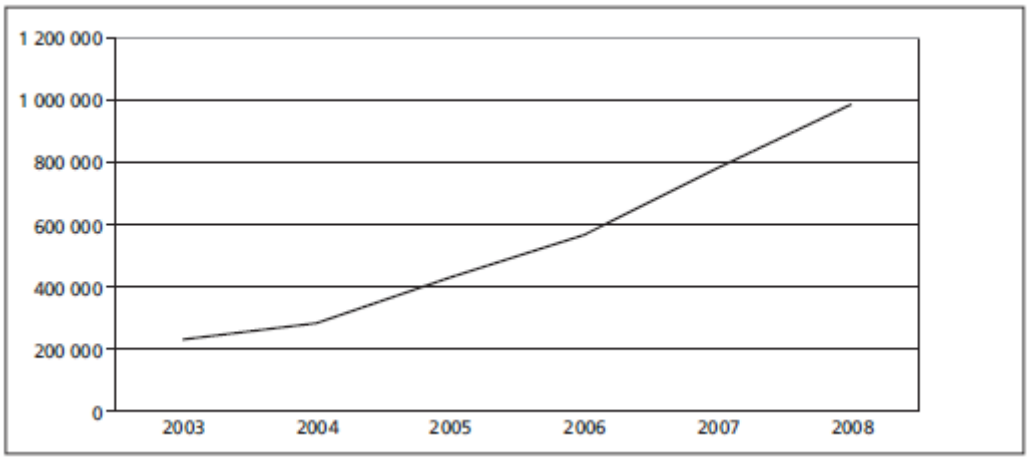
Before continuing to analysis of the consequences the 2000s reforms had on Scandinavian society, it is useful to be reminded of the basic principles of the Nordics welfare state and Nordic health care system. In the beginning of this chapter it was shown that the features of the Nordic welfare state are passed down to the health systems. The top values that the Nordic welfare and health system rest upon are universality and equity. This means primarily that social services, and health services are part of this group, have to be available to every citizen regardless of his/hers social status. "(…) the terms "equity/inequity" have a "moral and ethical dimension and refer to differences which are unnecessary and avoidable and are also considered unfair and unjust" (Povlsen et al., 2011:50). Equity means social justice or fairness and is related to the human right to the highest attainable standard of health. One of the causes of inequity in health is unequal access to health care services (Povlsen et al., 2011).

In the previous pages it has been shown that the reforms that the Scandinavian health system went through in the first decade of the 2000s fall under the concept of New Public Management. Generally, the most significant change was the introduction of market-like relationships in traditionally completely publicly run, owned and financed sector, a sector which is at the same time a major part of the welfare system. The concept of New Public Management is a harsh propagator of "less state and more market", it supports privatization and entrance of more private providers that will compete on the market. This also means that people are left to the market forces to get the products and services they need. If we are talking about health systems, it is not anymore the state that should take care of the people and, sort to say, protect them. The purchasing power of individuals is a decisive factor which enables some people to get services faster or to get services of better quality, while at the same time it unables those whose purchasing power is lower to do the same. Therefore, what follows from the market logic is inequality in terms of people not being able to equally access services or access services of equal quality.

In Scandinavian countries, patients who get the services from public providers or private providers which have contract signed with the health regions/ counties get

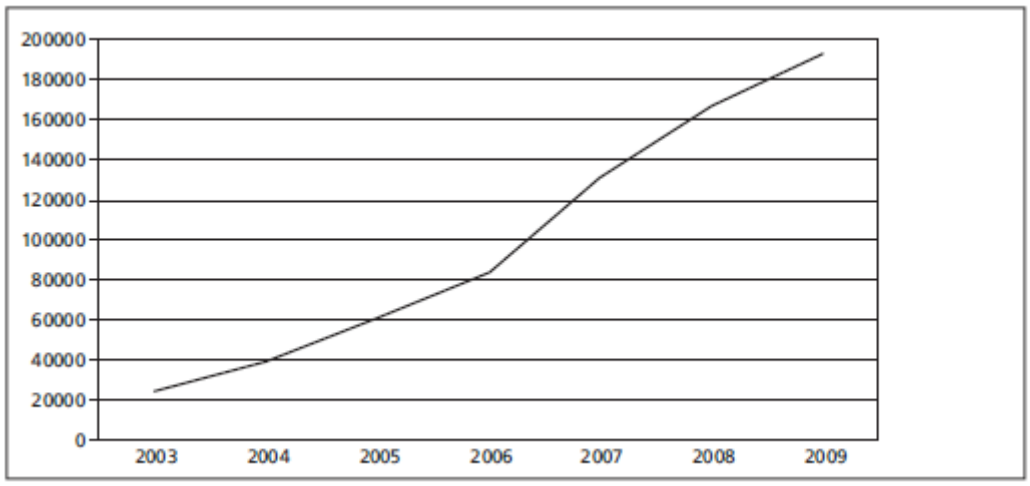
these services either free of cost or through cost-sharing schemes. Cost-sharing scheme means that the patient pays certain amount or money for the treatment, but the biggest part of the cost is covered by the state. For example, in Sweden the fee for staying in a hospital is 80 SEK per day, for GP services 100 to 200 SEK per visit, and for specialist's services maximum 300 SEK per visit. There is also a so called "ceiling" established which limits individual costs. The patient can spend maximum 900 SEK per year through out-of-pocket payments after which all the treatments are free, given that they are received in a public facility or a private contracted one (official Sweden site, last updated November 11, 2013). However, even though the public coverage for health services is very high in all three Scandinavian countries, the available data shows that there is a growing shift from usage of public (and contracted private) providers to private providers of health care.

Graph 2.3. Denmark – purchase of private health insurance, 2003 - 2008



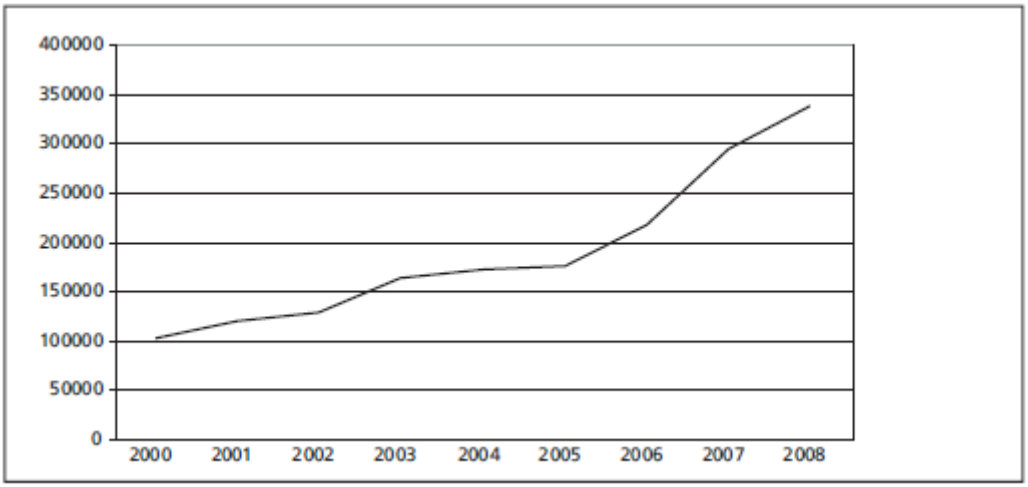
Source: Berge and Hyggen: Framveksten av private helseforsikeringer i Norden, 2010:25

Graph 2.4. Norway – purchase of private health insurance, 2003 - 2009



Source: Berge and Hyggen: Framveksten av private helseforsikeringer i Norden, 2010:16

Graph 2.5. Sweden – purchase of private health insurance, 2000 - 2008



Source: Berge and Hyggen: Framveksten av private helseforsikeringer i Norden, 2010:20

What can be observed from the given graphs is a rather fast increase in number of people purchasing a private health insurance. In Denmark there were approximately 5 times more people buying a private health insurance in 2008 than in 2003. In Norway there were approximately 10 times more people in 2009 than in 2003, and in

Sweden approximately 3.5 times more people in 2008 than in 2000 purchasing a private health insurance. The rise was obviously slowest in Sweden, but if the final number of the privately insured people is observed, there is more people with a private health insurance in Sweden than in Norway. However, if we observe the given numbers as part of the total population, in Denmark there is approximately one fifth of all Danes covered by private health insurance. In Norway and Sweden 4 out of 100 citizens are covered by private health insurance. What is important to notice is that increase in purchase of private health insurance follows the rise in number of private health providers that occurred as a consequence of the 2000s reforms.

The rising number of private providers means that overall there is more providers of health services in the market and that the citizens have more alternatives to choose from. In general, when we talk about private services two things are implied: that those services are of higher quality than the public ones and that the consumers get them faster than the public ones. The quality of health care in Scandinavian countries has been perceived as one of the best in the world, which can be found, for example, in the OECD reports. Therefore, it is hard to imagine that the shift from public to private healthcare providers in Denmark, Norway and Sweden is a consequence of people not being satisfied with the quality of public health care. Thus the main assumption is that consumers are switching to private health care to avoid the long waiting lists and get their treatments faster. Some experts agree, which is shown in Table 2.4. of quoted comments. They also see the emergence of a so-called two-tiered system in health sector, where there is a division between people getting services from private and people getting services from public providers.

Table 2.4. Comments on increasing purchase of private health insurance in Denmark, Norway and Sweden
This table contains some of the comments gathered by the author of this paper on reasons for increase in purchase of private health insurance in Denmark, Norway and Sweden. The comments are found in scientific and newspaper articles.

Vrangbæk, Karsten: Going private? The growth of voluntary health insurance in Denmark (2009)
„*In considering equity, it is hard to deny that some inequity is introduced as VHI is mostly purchased by private sector employers whereas individuals outside the work force, or those employed in the public sector, are largely excluded. This has led some observers to argue that Denmark is developing a two tier system of people with and without VHI. Those with VHI have quicker access to practicing specialists and private hospitals, at least for certain conditions*“ (Vrangbæk, 2009:7)

Increasing private healthcare insurance in free healthcare country, Norway (2014) (www.tnp.no)
„ *I do not think people really want a twin-track health care system. (…) He adds that reduced sickness absence, less queuing time and better care of sick employees are the main reasons why Norwegian companies buy health insurance for employees. The waiting time in the public health system is the main reason that makes people purchase a private insurance*“

Private healthcare insurance in Sweden: a clash of cultures (2011) (www.thelocal.se)
„*Long queues are one of the main complaints for consumers of Sweden's public healthcare services, with patients sometimes forced to wait as much as fifteen times longer for treatment compared to private options*“
„*But Andersson argues that traditional objections from egalitarian Swedes to a two-track healthcare system are diminishing as people's priorities shift. (…) As a result, private healthcare remains in demand, despite some objections that the development results in a two-track system in which wealthy, employed patients receive better, faster care*“

The prices of the services in private facilities are naturally higher from the ones in the public facilities. More providers on the market means more competition which should lead to lower prices of services, but even if so, there is a significant difference between the prices of public and private services. Again, the example of Sweden can be useful. While the annual cap on individual spending for health services in public

facilities in 900 SEK, the average cost of a private health insurance is around 4000 SEK per year (www.thelocal.se). If taken that indeed the quality of the services is equal in private and public facilities and that patients are opting out for the private ones because of the long waiting lists, this implies that fast private health services are available only to the patients who are able to pay for them or for the private health insurance. In other words, the inequity appears. The core value of the Nordic welfare state and health system is deteriorating in Scandinavian countries.

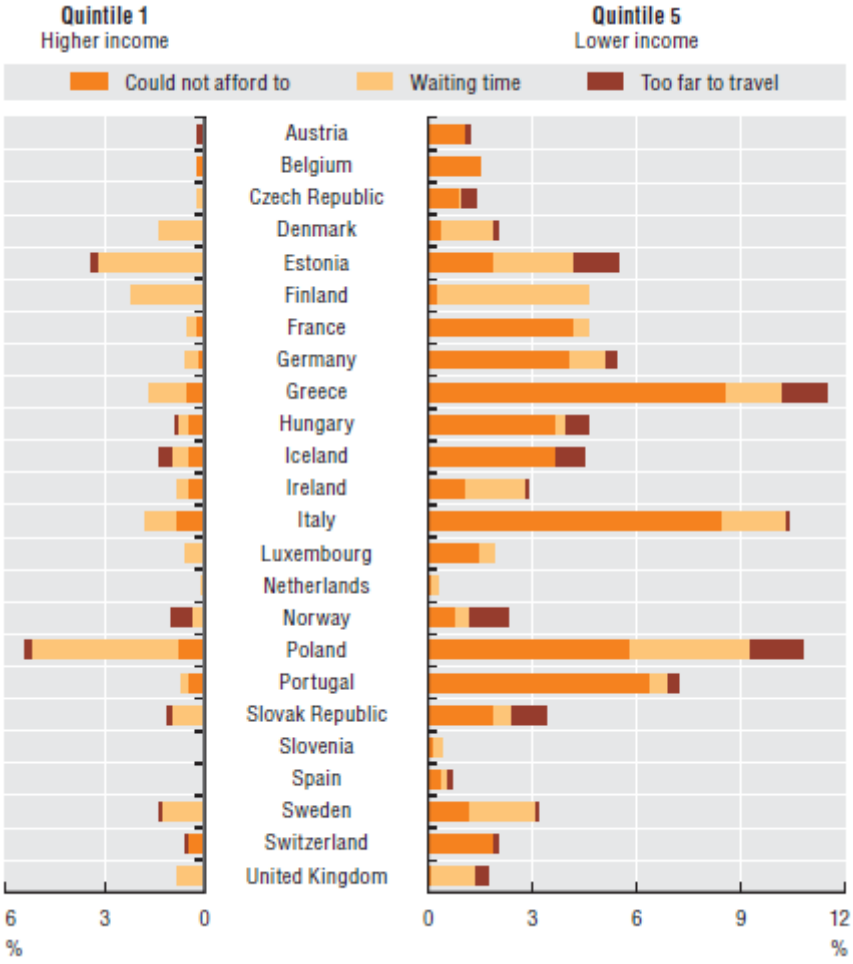
To move away from these normative explanations, let us examine the OECD data. The first group of data shows the percentage of low and high income citizens in all three Scandinavian countries reporting the unmet need for a medical examination in 2007, 2009 and 2011. The second group of data shows the percentage of people in the highest and the lowest income quintile who reported their health to be very good.

Graph 2.6. Unmet need for medical examination per income group in 2007

Source: OECD, Health at a Glance 2009, pg. 143

From the graph, we can observe for all three Scandinavian countries that there are approximately twice as many people of lower income group reporting unmet need for a medical examination than those in the higher income group. In Denmark and Sweden people from higher income group reported “could not afford to” as a reason for the unmet need, while people in lower income group reported “could not afford to” in all three countries.

Graph 2.7. Unmet need for medical examination per income group in 2009

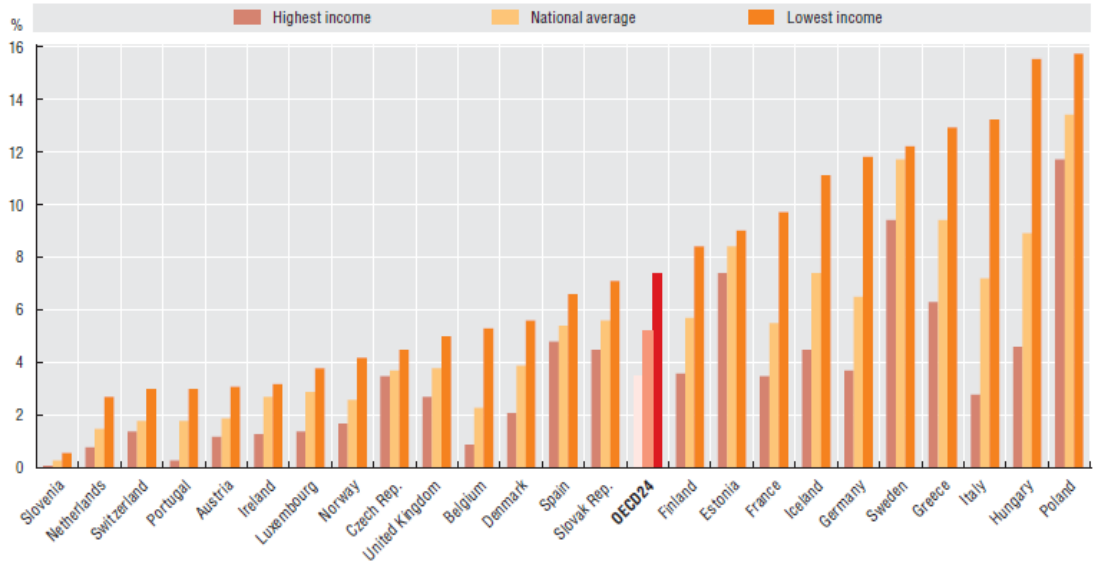


Source: OECD, Health at a Glance 2011, pg. 131

In 2009 the difference between the number of people in the lower income group reporting unmet need for medical examination was again approximately double from the number of the higher income group reporting the same. However, in none of the three countries can it be observed that the higher income group reported “could not

afford to" as a reason for unmet need for medical examination, while in the lower income group things stayed pretty much the same as in 2007.

Graph 2.8. Unmet need for medical examination per income group in 2011



Source: OECD, Health at a Glance 2013, pg. 145

In 2011 the differences between the high and low income group remained. In Denmark and Norway the difference between groups reporting unmet need for medical examination were a bit more than double (around 2,5 percentage points, while before it was around 1,5). In Sweden the difference was also bigger than in the previous years (around 3 percentage points, while before it was around 2), but the number of people in reporting unmet need for medical examination rose in both income groups. The key for this is most probably in the waiting time parameter, since that is still one of the biggest problems of the Swedish healthcare system.

At the same time it is possible to observe how people from lowest and highest income group perceive their health. The table below shows that in all three Scandinavian countries number of people from the lowest income group who perceive their health to be good is lower that the number of people from the highest income group who perceive their health to be good. Given that these countries have very small Gini coefficients (a measure for inequalities level in income distribution

among the citizens of certain country), the differences between the income groups presented in Table 2.5. have to be understood as significant.

Table 2.5. Percentage of people perceiving their health to be good by income group, 2004 - 2011

	Country	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**
Income quintile 1 (lowest)	Denmark	69,6	69,1	68,1	66,3	68,5	64,9	65,1	67,5
	Norway	63,5	63,2	65,6	70	69	68,2	67,4	65,6
	Sweden	61,6	67,7	69,2	70,9	67,3	67,5	68,3	68
Income quintile 5 (highest)	Denmark	84,7	85,8	83,4	84,9	85	83,2	82,2	81,1
	Norway	83,1	82,1	83,1	85	84,7	85,5	86	85,4
	Sweden	83,4	85	83,9	86,5	88,6	90,1	88,7	88,8

Source: The table was made based on data from www.stats.oecd.org

True, the numbers in the presented graphs are not very high, which means that majority of the patients, no matter which income group they belong to, is getting the treatments they need. Inequalities in access to medical services are not dramatically big in Scandinavian countries, but a trend of their rise can be observed. What is problematic about this is the following. If the trend of rising inequalities in access to health services continues or speeds up, there is, theoretically, a risk of health services transforming from a common good (available to everyone without exceptions) to a club good (available to the ones who can pay for the good) after certain period of time. In short, that means that people who are not able to pay for the services can be excluded from their use. This kind of development is unacceptable in health sector. The services people are getting from the health sector are way too important for them individually and for the society as a whole because good health is a precondition for any human activity. All citizens should be able to get high quality care on time. Scandinavian societies have already managed to implement values of solidarity, equity and high standards of social services for all their citizens, therefore any trend that would imply deterioration of these values should be worrying.

Chapter 3

Where from the neo-liberal reforms in social-democratic system?

Inequality in access to health services is a major cause of inequity of a given health system. The previous chapter analyzed occurrence of this phenomenon in three Scandinavian countries. Denmark, Norway and Sweden, all three known for success of their welfare systems, are experiencing deterioration of the principal values of the welfare - equity and universality. As it was demonstrated in Chapter 2, it can be understood that the rising inequity of Scandinavian health systems is a consequence of the recent reforms introduced in their health sectors in period from 2000 to 2010. At this point, the question to be asked is why were these reforms introduced in the first place. Is it the question of Scandinavian governments becoming more prone to neoliberal models of governance or is it possible to trace these reforms back to some other sources? This question will be discussed in the following pages.

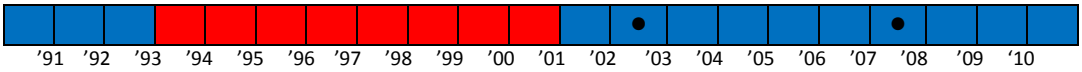
3.1. National level

Governance of social systems is purely a matter of a nation-state. Therefore, the states have the full responsibility for managing their health systems for well-being of their citizens. The governments are expected to reform and run their health systems in a way which would enable high quality of care and efficiency in its provision. Health systems of Denmark, Norway and Sweden are considered to be ones of the best quality in the world. However, all three countries are facing a problem of too long waiting lists. The reforms presented in the previous chapter were in all three countries seen as a solution to the problem of waiting lists and the goal was to make the whole health system more efficient. The question is how come that the countries which are considered to be the welfare role models, which have conspicuously high coverage of social services for their citizens and which are nourishing the tradition of social democracy, opted for a neoliberal model of the reforms.

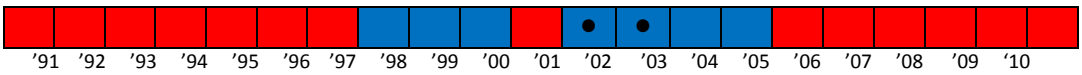
Traditionally, all three Scandinavian countries are run either by a centre-right or a centre-left minority government. This implies moderate politics and consensual

decision making since in most cases the position parties alone do not have the required majority to take decisions and they need support from the opposition parties in order to pass them. The centre-right governments are more prone to neoliberal types of governance and reforms. Therefore, the first hypothesis is that the reforms in Denmark, Norway and Sweden can be assigned to centre-right governments when it comes to the health system. A very simple chronological scheme was created for the purpose of testing this hypothesis. For each country a timeline was made for period from 1990 to 2010, so that it can include both the period when the major reforms were introduced in Danish, Norwegian and Swedish healthcare systems and the decade before that. Each year is marked with either red or blue color, where red color represents the rule of centre-left government and blue represents the rule of centre-right government. For each country years in which major reforms were introduced are marked with "●". The scheme can be found below.

Denmark



Norway



Sweden

Centre-left government Centre-right government

Source: The timeline is based on data from Christiansen et al., *The Nordic Model of Welfare: a Historical Reappraisal*, 2006:364-380

Going back to the Table 2.2. from Chapter 2, let us be reminded that the major reforms occurred in Denmark predominantly in 2002 and 2007, in Norway in 2001 and 2002 and in Sweden in 2005, 2007 and 2010. Obviously, in Denmark and

Norway the reforms were introduced exclusively in the period of centre-right governments, while in Sweden it varies and the reforms were introduced in periods of both types of governments. Overall, it is possible to conclude that indeed, the centre-right governments are more prone to New Public Management-like reforms in the health sector. However, this does not explain why did the reforms occur in the 2000s and not before. "When Sweden introduced the internal market for hospital services in the early 1990s, no other Nordic country followed. When Norway introduced a prospective activity-based financing system in 1997, no other country followed" (Magnussen et al., 2009:16). It also does not explain the fact that exactly the same reforms were introduced in all three countries in more or less the same period of 10 years. Thus, there is a necessity of going beyond the governments to be able to explain the origins of the 2000s reforms. The uniformity and timing of the reforms imply that the pressures for reforming of the health systems must have come from the outside of the national borders for each of the three countries. The timeline scheme and nature of the governments are not sufficient explanations, thus the first hypothesis must be rejected.

3.2. European level

Since the first hypothesis was rejected in the previous section, it is logical to search for the pressures for the health reforms on a higher level than national. Therefore, the second hypothesis is that these pressures are coming from the EU level. Denmark and Sweden are member states of the European Union, Denmark since 1973 and Sweden since 1995. Norway, on the other hand, is not an EU member state, but it has a very close co-operation with the EU, predominantly through the EEA agreement that was signed in 1994. In order to examine if there were some significant developments going on on the EU level as regards to health sector, the following section will look into activities of the European Court of Justice (ECJ) and the European Commission in the period from 2000 to 2010. This period has been chosen for the obvious reason – because the reforms of health sector that have been analyzed in the Chapter 2 had occurred in the same period. Out of five main EU institutions, only two have been chosen for deeper analysis in this chapter. There are two simple

reasons behind this. Firstly, the European Parliament and the Council of the European Union are legislative and decision-making bodies. Since social systems, and thus the health systems, do not fall under the competences of the EU, these two institutions remain irrelevant for this field as their powers cannot be applied. Secondly, the European Council was excluded from this analysis because it can only give very broad guidelines on what could possibly be done to achieve greater co-operation between the member states in the field of health. It is the European Commission which works on creation of concrete policies and proposals, and it is the ECJ which sets the standards of appropriateness through the preliminary procedures.

In order to examine if these two institutions did have an impact on the reforms of health sector in Denmark, Norway and Sweden, this section will present the content of the key documents produced by both the ECJ and the European Commission in relation to the health sector. The end of the chapter brings a thorough discussion on this matter.

3.2.1. European Court of Justice

The European Court of Justice was rather active in the field of health care in the 2000s. Quite an impressive collection of case-law was created specifically in this period. It is crucial to go over all significant rulings to be able to understand how the role of the ECJ grew in the examined period as regards the health sector, as well as to observe the concrete steps in which this institution managed to subordinate the national law to the European law, particularly to the principle of the freedom of movement. The ECJ has referred to the Articles 59 and 60 of the EC Treaty (Treaty of Maastricht, 1992), i.e. Articles 49 and 50 of the EU Treaty (Treaties of Amsterdam and Nice, 1999/2002) in most of its judgments that will be summarized below, thus it is important to deliver their full texts at this point.

Article 49 (ex Article 59)
Within the framework of the provisions set out below, restrictions on freedom to provide
services within the Community shall be prohibited in respect of nationals of Member States

who are established in a State of the Community other than that of the person for whom the
services are intended.
The Council may, acting by a qualified majority on a proposal from the Commission, extend
the provisions of the Chapter to nationals of a third country who provide services and who are
established within the Community.

Article 50 (ex Article 60)
Services shall be considered to be "services' within the meaning of this Treaty where they are
normally provided for remuneration, insofar as they are not governed by the provisions
relating to freedom of movement for goods, capital and persons.
"Services' shall in particular include:
(a)Activities of an industrial character;
(b) activities of a commercial character;
(c) activities of craftsmen;
(d) activities of the professions.
Without prejudice to the provisions of the Chapter relating to the right of establishment, the
person providing a service may, in order to do so, temporarily pursue his activity in the State
where the service is provided, under the same conditions as are imposed by that State on its
own nationals.
(TEU, 1997)

The cases examined for the purposes of this paper start with the Kohll and Decker case from 1998 because this ruling is considered to be a turning point in discussion about access to health care abroad. It was the first time that the principle of freedom of movement of goods and services, and not freedom of movement of people, was introduced into this discussion (Mossialos et al., 2001).

Cases C-158/96. Kohll and C-120/95 Decker (1998)

Mr Kohll, a Luxembourg national, requested an authorization from his national health insurance for a dental treatment in Germany for his minor daughter. According to the national law, a patient needs to get a recommendation from a Luxembourg doctor to get a treatment abroad in case it is not possible to get the treatment in the home country. Only under these conditions can a person get an authorization to get a medical service abroad and the national insurance would reimburse the costs in accordance with the social security scheme applied in the state where he/she is getting the treatment. For Mr Kohll the authorization was refused on the grounds that the treatment is not urgent and that it can be obtained in Luxembourg. Mr Decker had purchased a pair of spectacles from an optician in Belgium without a prior authorization from his home insurance, which was the basis for refusal of the reimbursement of costs that he had later on asked for. After Mr Kohll and Mr Decker appealed, the ECJ ruled that the Articles 30, 36, 59 and 60 of the Treaty are precluding the national law under which the reimbursement of the costs of a medical treatment abroad is subject to authorization by the national insurance institution.

Case C-368/98: Vanbraekel and others (2001)

Ms Deschamps, a Belgian citizen, underwent an orthopaedic surgery in a hospital in France. She got this treatment even though she was not given the authorization for it from her national insurance institution. After the operation in France Ms Deschamps asked for an expert's opinion on her case who concluded that the required hospital treatment could be provided in better medical conditions abroad. Based on this, Ms Dechamps asked for a reimbursement of the costs from the national insurance. By using the formula for calculating reimbursement of medical costs, under the French legislation Ms Duschamps would be entitled to FRF 38 608.99, while under the Belgian legislation she would get FRF 49 935.44. The ECJ has ruled that under the Article 59 (later on Article 49) and the settled case-law (it is referring to the Kohll case) the national social security rules cannot exclude application of Article 59 of the Treaty. If the national insurance scheme is not guaranteeing to the person that takes a medical treatment that it would reimburse the costs in the level equivalent to the cost

the person would be entitled to if he/ she underwent the treatment in the home country, it is considered to be a restriction of freedom of movement. The Court ruled in favor of Mr Vanbraekel, Ms Duschamps' husband, and their six children since Ms Duschamps had passed away during the course of the trial.

Case C-157/99: Geraets-Smits and Peerbooms (2001)

Mrs Garaets-Smits, insured under a Dutch scheme, underwent a treatment for Parkinson's disease in Germany. She did not ask for an authorization. Mr Peerbooms fell into a coma after a road accident in the Netherlands and was transferred to a clinic in Austria. The treatment that he received was at that time only experimentally used in the Netherlands and available only for patients who are not older than 25. The reimbursement of the costs of the treatment for both patients was refused based on the grounds that the underwent treatments cannot be considered as normal within the medical professional circles and that the satisfactory treatments for their conditions were available in the Netherlands. The ECJ ruled that based on articles 59 and 60 of the Treaty medical services fall under the freedom to provide services and there is no need to distinguish between care provided in a hospital environment and care provided outside such an environment. Also, the insurance fund cannot favor a non-contracted provider in the home country over providers in another member state. As for the consideration of a treatment as normal within the medical professional circles, the Court said that a definition of a treatment as such has to come from international medical circles and not only national.

Case C-385/99: Müller-Fauré and van Riet (2003)

Ms Müller-Fauré was insured under the Dutch national insurance scheme. While on a holiday in Germany, she underwent a dental treatment and asked for the reimbursement upon returning to the Netherlands. The reimbursement was refused on the grounds that Ms Müller-Fauré underwent the treatment voluntarily, without authorization. It was not an emergency case and equally good treatment could have been given to her in the Netherlands. In case of Ms Van Riet, also covered by the Dutch national insurance scheme, the patient underwent an arthroscopy treatment in Belgium. It was partly a hospital and partly a non-hospital treatment since it included

care before and after the treatment. Ms Van Riet's requirement for reimbursement was refused with reasoning that there was neither emergency nor medical necessity to receive treatment abroad. Also, an appropriate treatment was available in the Netherlands within a reasonable period. The ECJ ruled that the national insurance fund is to reimburse the expenses of a non-hospital care provided in another member state even if the treatment was provided in an establishment that does not have a contract with the fund, even if the patient did not get the authorization for the treatment and even though the patient could have gotten the same treatment in the home country free of charge.

Case C-145/03: Keller (2005)

Ms Keller, a German national, was a resident in Spain and was covered by Spanish national insurance scheme. Prior to leaving to Germany for family reasons, she got the E 111 form (a form for urgent health care during a temporary stay in another member state) issued from the Spanish national insurance institution. During her stay in Germany, Ms Keller was diagnosed with a malignant tumor of the nose, the nasal cavity, the eye socket and the base of the skull. It was diagnosed that the illness is serious enough to cause the patient's death at any time. Since the transfer back to Spain was not advisable, Ms Keller obtained the E 112 form (for those seeking planned health care in another member state based on authorization) from the Spanish national insurance authority on that grounds and wished to continue receiving her treatments in Germany. However, after further examination the doctors in Germany considered that a special expertise is needed, which could have only been gotten in one private clinic in Switzerland. After the surgery Ms Keller asked for reimbursement from the Spanish insurance and was refused because she did not get the authorization to get a treatment outside national/Community public health scheme. If she had been insured under the German national scheme, she would have been reimbursed the full cost of the treatment. The ECJ ruled that the state issuing E 111 and E 112 forms is bound by the decisions taken by the authorized doctors of another member state, even if they consider that the patient should be further treated in a non-EU member country. Also, the institution issuing these forms is obliged to reimburse the patient for whom it had issued the forms.

Case C-372/04: Watts (2006)

Mrs Watts, a British national, was suffering from hips arthritis and therefore asked her national insurance institution for authorization of a surgery in France. Under the national insurance scheme, the patients are provided with the necessary treatments free of charge and in accordance with the urgency for receiving the treatment. The decision on type, timing and location of provision of medical services is decided upon by national health system. Also, the national health insurance does not cover the expenses of treatments in private sector facilities in England and Wales. Mrs Watts was at first supposed to get her hip surgery in a one-year period since her case was considered to be a routine case. After appealing, she was re-examined and the waiting time was reduced to three- four months. Even with this reduction, Mrs Watts underwent the surgery in France without an authorization and asked for a reimbursement upon returning to her home country, which was refused. The ECJ ruled that the medical treatments received in another member state should be reimbursed by the national insurance even though the treatment would be free in the home country. The home institution may not refuse to authorize a treatment abroad based on the existing waiting lists and priorities if an objective medical assessment of patient's condition has not been carried out.

Case C-444/05: Stamatelaki (2007)

Mr Stamatelaki, a Greek citizen, underwent a treatment in a private hospital in United Kingdom. Under the national law, the costs of an abroad treatment can be reimbursed only if a person got the authorization from the national health insurance. This can be applied for private hospitals only if they are connected to the national health system by a signed agreement or if a patient is not more than 14 years old. Based on this, the reimbursement of costs was refused for Mr Stamatelaki. When his case reached the ECJ, the Court ruled that the Article 49 of the Treaty precludes the national legislation in this case and that the patient should be reimbursed even if he/ she got a treatment in a private hospital abroad without prior authorization.

In all examined cases, according to the national laws of the respective countries the reimbursement of costs for a medical treatment abroad for persons insured under

national schemes can be obtained if a treatment was provided as an immediate answer to an unpredicted and urgent condition of the person in another country or if the condition of a patient needed an urgent treatment which was not available in country where he/ she is insured. Also, a person can be reimbursed if he/ she obtained a prior authorization from the national health insurance, which is possible if the waiting lists are too long, if the needed treatment is not available or it is of a lower quality than the one a patient could get abroad. The ECJ rulings showed how the EU internal market and the freedom of movement can be used to supersede the national law and to justify reimbursements even for the non-urgent treatments. An impressively fast and progressive trend can be followed in the given judgments in course of only 9 years. The ECJ managed to put more and more cases under the effect of freedom of movement based on Articles 49 and 50 of the EU Treaty. It starts with the ruling that authorization is not needed even for the non-urgent cases, then goes to approval for reimbursement of the costs of treatments received in the hospital facility as well as a non-hospital facility, to ruling that the costs should be reimbursed for the patients under the national scheme even if they would be reimbursed less in the country of treatment, and later that the costs should be reimbursed even if a person could undergo the treatment in their home country free of charge. The ECJ goes on to including the treatments received in a non-member state and in private facilities under the freedom of movement of services, based on which the patients' costs should be reimbursed by the national insurance. In this way the ECJ turned the preliminary ruling procedure from a mechanism to allow individuals to challenge the EU law to a mechanism to allow individuals to challenge national laws (Alter, 1998). The clear message is that the health services are part of the European Single Market. They have to be available to the citizens and the rules of competition apply in their provision since the competition contributes to quality and efficiency of the provision.

3.2.2. European Commission

The European Commission became more active in the field of health in the 2000s. It had produced several law proposals, working plans and policy strategies with an overall goal of greater co-operation of member states, but also the EU partner states,

on health matters. What is important for this paper is to see how the Commission's work progressed in this field, therefore the main ideas of the most important documents will be summarized here.

In 2000 the Commission produced a *Proposal for Action in the Field of Public Health* where it had outlined three goals for further action of the Union. Those were improvement of information systems, rapid reactions to health threats and health promotion with the emphasis on inter-sector action. It was stated in the proposal that the member states cannot achieve these goals alone and that it would be much easier to reach them through a Community action in co-operation with the EFTA countries and the candidate countries. Later on, in 2002, the Commission published the first health policy for period 2003 to 2008. It was a call for a greater co-operation between the member states and their commitment in implementation of Community actions in the field of health. The emphasis was also put on collection and evaluation of data on health, as well as co-operation with the EFTA states. An important point was that the other Community policies should incorporate health aspect. In 2003 the Commission produced a document *High Level Process of Reflection on Patient Mobility and Healthcare Developments in the European Union*. It emphasized the need for more co-operation in the field of medical care, which will enable that the patients' needs are met more efficiently. There is a necessity of giving the patients more freedom to choose the providers of health services. Also, it is argued that an appropriate place should be given to private non-profit organizations providing health services. In other words, this was an open call for contractual relationships between the healthcare providers which corresponds to purchaser-provider model that was already thoroughly discussed in this paper. Another important document was the 2005 *Commission proposal for establishing a Programme of Community Action in the Field of Health and Consumer Protection 2007 – 2013*. This proposal called for numerous actions in health sector. It further encouraged integration of health and consumer concerns into the other EU policies. The member states should work on developing new ideas and sharing the best practices among themselves, which will enable the implementation on the national levels. The EU as a whole should have a bigger role in the international health. Also, the Commission stated that in order to realize the full potential of cross-border purchase of health services

the remaining barriers to trade should be eliminated. The consumers must be able to make free and informed choices, which will further boost competition and responsiveness to consumers' needs. Finally, one of the last documents with relevance for health sector was the Commission's white paper *Together for Health: a Strategic Approach for the EU 2008 – 2013*. The content of this document is also known as the second European health policy. It was a step further from the existing health strategies and it emphasized the necessity of cross-sectoral work and implementation of "health in all policies" approach into the external EU policies as well, including development policy, external relations and trade. The main new idea brought by the white paper was that the European health policy should be based on shared values.

The progressive trend can be followed in Commission's work as well as it was possible for the work of the ECJ. Approximately the same period is crucial, 2000 to 2007. The Commission's proposals start with a call for inter-sectoral co-operation on health, then continue to inclusion of health aspects into all EU policies, call for more space for private non-profit organizations providing health services, eliminating the remaining barriers to cross-border purchase of health services, and finally, calling for creation of a common set of values in health policy. Another important thing that the Commission has put a lot emphasis on in all the documents it produced was the necessity to create an information and evaluation system.

What we are dealing with here is a clear case of neo-functionalism. The Commission and the European Court of Justice come as classical supranational promoters of the European integration (Greer, 2006) and defenders of the European Single Market. The market is precisely the starting point of the spillover to the health sector. This comes the most obviously in the ECJ rulings which were based on the freedom of movement principles. As it was shown previously, usage of this principle enabled the ECJ to interfere with a very national thing, social and health systems. The Kohll and Decker rulings established clearly for the first time that the economic rules regarding the free movement of goods and services in the EU can be applied to social security systems and that if something is connected to social security it does not mean that it is beyond the grasp of internal market (Nickless, 2001). It also made it possible for

the ECJ to create a line of case-law in a very short period of time. Another track of spillover effects can be followed in the ECJ judgments, going from the question of prior authorization of a non-urgent treatment, to hospital and non-hospital treatments, and eventually to the treatments in private facilities. Each new ruling came as an upgrade to the previous one and at the same time a new case was interpreted through the principle of freedom of movement. As for the Commission, it took advantage of opportunities created by the ECJ to promote the idea of the European health policy (Greer, 2006). The European Commission is a purely supranational body and the main promoter of "more Europe", therefore it should not come as a surprise that it has tried to encourage creation of a common European health policy. Going over the crucial documents produced by the Commission in the period 2000 to 2007, it is possible to notice the same trend as for the ECJ. Each new document spreads the scope of what is supposed to become a common health policy so the spillover effect can be followed in the Commission's work as well. The call for co-operation between the member states and especially the call for creation of common values in the field of health show how the Commission tries to use the basic principles of functioning of the EU to promote a new common policy field.

3.3. The effects of the Court's and Commission's work on Scandinavian health systems

How can then the ECJ rulings and the Commission's documents be seen as the external pressure that pushed the Scandinavian countries to reform their health systems in the way they did?

Table 2.2. from the Chapter 2 shows that the reforms that were introduced first in all three Scandinavian countries were the patients' choice of providers and waiting time guarantees. This can be understood as a reaction to the first ECJ rulings, i.e. Kohll, Decker, Vanbraekel and Gaerets-Smiths. The ECJ ruled in favor of the patients who got their treatments abroad without authorization, whose conditions were not urgent and who could have gotten the same quality treatments in their home countries. Introduction of more freedom for the patients to choose among the providers of

medical services can be seen as the way for a state to comply with the freedom of movement of services, as the patients can choose any public GP and a hospital or a private GP and hospital which have contracts signed with the government or health regions. On the other hand, even if the country has given a lot more freedom to the consumers, it has still kept the control over the financing of the health system and contracting with the non-public providers. As for the waiting time guarantees, what can be found in texts of all ECJ judgments is a reference to a "*time normally necessary for obtaining the treatment in Member State of residence*" from Article 22, paragraph 2 of the Council Resolution 1408/71. The ECJ has not defined what this should mean exactly, so creation of a waiting time guarantee is a tool to specify what a given country understands under "time normally necessary for a treatment". A waiting time guarantee means that a patient can freely choose any provider for his/ her treatment in case the guarantee is not being respected by the public health system, which again goes along the freedom of movement of services.

The introduction of patients' choice and waiting time guarantees created new challenges for Denmark, Norway and Sweden. By reforming in this way, all three countries created new quests for themselves. In order to respect the guarantee for patients' choice and the waiting time, it was necessary to ensure that there are enough providers and that these provide high quality care. Public providers alone do not have enough capacities to meet the patients' needs under the limiting conditions, therefore what the health system requires is firstly, more providers, and secondly, better organization of the provision of medical services. The importance of purchaser-provider model as well as health regions rises here. In the previous chapter it was emphasized that in period from 2000 to 2010 it is possible to follow the increase in number of private providers and purchase of private health insurance in all three countries as a consequence of the purchaser-provider model. The health regions in Denmark and Norway and counties in Sweden facilitate the purchaser-provider model in practice since they are the authorities to negotiate the contracts with the providers. The contracting can be seen as a response to the later ECJ rulings like Watts and Stamatelaki. It is not only that by including more providers the state can guarantee to respect the new laws, but the health system gives more freedom of

movement of services by including the private providers. At the same time it also fully covers the patients who are using the contracted providers.

Organization of the health system as a set of working units, i.e. health regions and counties, encourages competition and more activity of the health sector. This is why the combination of health regions/ counties with the activity-based financing is crucial. A significant part of funding comes from the central state to a certain region if the region manages to meet the set targets. Moreover, since the region/ county decides on contracting with the providers, more activity is in the interest of these providers as well. The whole system clearly goes along the EU idea on competition. Another way in which the introduction of health regions made compliance with the EU requirements easier is that the collection of data and monitoring of the health system became more organized. In this way the three countries satisfied the Commission's call for more information and evaluation of health systems.

The offered explanations can confirm the hypotheses that the work of the EU institutions, namely the European Court of Justice and the European Commission, came as an external pressure that caused Denmark, Norway and Sweden to introduce analyzed reforms in their health sectors. However, there is one more question to be answered to make this explanation fully valid and that is: why were there multi-speed reforms in these three countries? What can be followed from the Table 2.2. and the timeline in subsection 3.1. is that Norway was a fast reformer. Basically the whole process of reforming happened in the first years of the 2000s. This is surprising since Norway is not an EU member state, thus it would be more logical that Norway is more protected from the EU influence and most reluctant to the possible pressures coming from the EU. On the other side, Sweden started reforming rather late in comparison to other countries. The waiting time guarantee was introduced only in 2005 while the patients' choice was formally introduced in 2007. Only the reforms in Denmark seem to fully follow the developments on the EU level, since they occurred in 2002 and later in 2007. In 2002 Denmark introduced the patients' choice and waiting time guarantee as a response to Kohll, Decker, Vanbraekel, Gaerets-Smiths and Peerbooms rulings.In 2007 the waiting time was reduced and the country was divided into five health regions with activity-based financing and purchaser-provider

model applied. This came as a response to the ECJ rulings which expanded the influence of the freedom of movement of services on non-hospital and private providers.

As it was shortly mentioned before, Norway has had a very close co-operation with the EU through the EEA agreement. The Agreement enables these three countries to be parts of the European Single Market while at the same time not being members of the EU. The aim of the Agreement is to strengthen trade and economic relations between the EU member states and three EFTA states, Norway, Iceland and Lichtenstein. In order to achieve this aim the states of the Agreement bound themselves to respect the freedom of movement of goods, persons, services and capital, to ensure that the competition is not distorted and to co-operate in fields of research and development, environment, education and social policy (Article 1, The EEA Agreement). The body which is in charge of making sure that the three EFTA countries respect the EEA Agreement is the EFTA Court. Its role is equivalent to the one of the ECJ in the EU. In order to understand what may have given Norway the extra push to reform its health system faster than the other two Scandinavian countries, it is necessary to present the case that was brought up against Norway before the EFTA Court in 1999.

Case E-6/98: EFTA Surveillance Authority against The Government of Norway

Under the Norwegian National Insurance Scheme, all persons residing or working in Norway are covered by a compulsory insurance scheme for benefits such as pensions, rehabilitation, medical care, unemployment benefits. The contributions to this scheme are paid by both employers and employees, where employees pay certain percentage of their gross salary income. This percentage varies from 0% to 14,1%, depending on person's residence (for example, people with residence in Oslo county will pay maximum of 14,1%, while people residing in the far north county Finnmark will pay 0%). The EFTA Surveillance Authority assessed this social security scheme as State aid, which meant that it presents a threat to competition within the EEA and is therefore against the EEA Agreement. The EFTA Court ruled in favor of the EFTA Surveillance Authority.

What is also important to mention here is that the Articles 36 and 37 of the EEA Agreement, concerning the freedom of movement of services within the EEA, are almost in full taken from the EU Treaty and correspond to the Articles 49 and 50 of the EC Treaty. Let us be reminded that these are the articles on which the ECJ based its rulings in cases presented previously in this chapter. This fact together with the EFTA Court ruling against Norway on its social security system had to have an influence on fast reforming of Norwegian health system, especially on introduction of health regions in 2002. Health regions in combination with activity-based financing completely comply with the EU/EEA competition policy.

Sweden, on the other hand, came as a rather slow reformer. The Swedish Government believed that the Kohll and Decker rulings did not apply to its health system. However, in 2004 two national rulings were carried out based on the ECJ case law (Baeten et al., 2010). Besides this, in 2005 the ECJ ruled against Sweden in the Hanner case. Prior to this ruling private pharmacies were forbidden in Sweden and there was only one pharmaceuticals provider in the state ownership – Apoteket AB. The ECJ ruled that the Apoteket monopoly was illegal under the EU law by discriminating against foreign goods and by restricting the free movement of goods in the EU (C-483/02), which later on led to a complete privatization of the Swedish pharmacy system. Interference of the ECJ into something that was considered a Swedish tradition together with the two national rulings in 2004 can be seen as the push Sweden needed to start reforming its health system.

Conclusion

There is a number of authors that wrote about the reforms of the Nordic welfare state and health sector in Scandinavian countries. What can be found in the literature is to some extent similar to what has been done in the Chapter 2 of this paper. Various authors have shown the course of the reforms and some of them have connected the reforms to New Public Management features (Johnson, 2006; Østergren et al., 2008; Anell et al., 2012; Olejaz et al., 2012). On the other hand, there is also a number of authors who wrote about the ECJ rulings that were presented here in the Chapter 3 and about the influence on national systems of the EU member states in general (Mossialos et al., 2001; Nickless, 2001; Newdick, 2009). Mostly, these authors talk about the rulings as part of the "increasing Europeanisation of health" (Greer, 2006) and rising power of the ECJ. The Court is seen as a new important actor on European stage which can influence convergence of policies even though the states did not explicitly agree to that. This paper has brought something new into the debate by connecting the Scandinavian health reforms with the ECJ rulings and Commission's work on health matters. Since an extensive research on possible influence of the European institutions on Scandinavian health system and Nordic/ Scandinavian welfare state has not been done so far, that is the main contribution of this paper in this field of social science.

Three points have been made in this paper, each of them in one chapter. Firstly, it has been shown that it is possible to clearly define the features of a traditional model of the Nordic welfare state and, furthermore, that the same characteristics can be found in a specific sector of welfare, i.e. it is possible to talk about a distinctive model of Nordic health system. The values of universality and equity lay at the core of the Nordic welfare/ health system, which means that everyone, regardless their economic and social status, can equally access services. Secondly, the presented 2000s reforms of health sectors in Denmark, Norway and Sweden were proven to fall under a neo-liberal model of New Public Management. Furthermore, it has been demonstrated that these reforms have led to increase in numbers of private health care providers as well as in purchase of private health insurance. This is not the only anomaly of the normally publicly run sector. Another observed phenomenon is the rising inequalities

in access to health care. It was argued in this paper that this phenomenon is a consequence of the introduced reforms and that, even though the trend of rising inequalities is slow, it represents deterioration of the core values of the Nordic welfare state. Finally, an explanation was offered on where did the pressures for the reforms of Nordic healthcare systems come from. These pressures were found on the European level, more precisely in the work of the European Court of Justice and the European Commission in the 2000s.

The fact that the Nordic model of welfare has been seen as the best performing one and it has been considered a role-model which other countries should strive for, does not mean that the model is not facing some negative trends and that these trends should be disregarded. Sure, comparing to other European and world countries the negative trends in development of the Nordic welfare state do not seem dramatic, but they may lead to decadence of a model that has proved to work perfectly fine. Therefore, there should be further research carried out on this matter and not only in health sector. This paper did not offer a solution to the observed problem so this is another direction in which work on this topic should be continued.

Bibliography

Action for annulment of a decision of the EFTA Surveillance Authority - State aid - General measures - Effect on trade - Aid schemes, E-6/98 (EFTA Court May 20, 1999).

Agreement on the European Economic Area. (1994).

Alter, K. J. (1998). Who are the Masters of the Treaty? *International Organization, Volume 52, number 1* , str. 121 - 147.

Anell, A., Glenngaard, A. H., & Merkur, S. (2012). *Sweden: Health System Review.* European Observatory on Health Systems and Policies.

Baeten, R., Vanhercke, B., & Coucheir, M. (2010). *The Europeanisation of National Health Care Systems: Creative Adaptation in the Shadow of Patient Mobility Case Law.* Observatoire social européen.

Berge, Ø. M., & Hyggen, C. (2010). Framveksten av private helseforsikringer i Norden. Fafo.

Bonoli, G. (1997). Classifying Welfare States: A Two-dimension Approach. *Journal of Political Science* , pp. 351 - 372.

Briggs, A. (2014). The welfare state in the historical perspective. In C. Pierson, F. G. Castles, & I. K. Naumann, *The Welfare State* (pp. 14 - 27). Polity Press.

Castles, F. G. (1993). *Families of Nations. Patterns of Public Policy in Western Democracies.* Dartmouth Publishing Company Limited.

Christiansen, N. F., Petersen, K., Edling, N., & Haave, P. (2006). *The Nordic Model of Welfare: a Historical Reappraisal.* Museum Tusculanum Press.

CIHI. (2014). *National Health Expenditure Trends, 1975 to 2013.* Canadian Institute for Health Information.

Council Regulation 1408/71 on the application of social security schemes to employed persons, to self-employed persons and to members of their families moving within the Community (1971)

Decker v Caisse de Maladie des Employés Privés, C-120/95 (European Court of Justice April 28, 1998).

Einhorn, E. S., & Logue, J. (2007). The Scandinavian Reform Model and the European Union. The Lisbon Agenda and the Scandinavian Model(s). *European Union Studies Association meeting.* Montreal.

European Commission. (2005). Commission proposal for establishing a Programme of Community Action in the Field of Health and Consumer Protection 2007 - 2013.

European Commission. (2003). High Level Process of Reflection on Patient Mobility and Health Developments in the European Union.

European Commission. (2000). Proposal fo Action in the Field of Public Health.

European Commission. (2007). Together for Health: a Strategic Approach for the EU 2008 – 2013.

Ferrera, M. (2005). *The Boundaries of Welfare. European Intergation and the New Spatial Politics of Social Protection.* Oxford University Press Inc.

Flora, P. (1986). *Growth to Limits: The Western European Welfare States Since World War II* (Vols. Volume 1. Sweden, Norway, Finland, Denmark). Walter de Gruyter.

Geraets-Smits and Peerbooms, C-157/99 (European Court of Justice July 12, 2001).

Greer, S. L. (2006). Uninvited Europeanization: neofunctionalism and the EU in health policy. *Journal of European Public Policy, Volume 13, Number 1* , pp. 134 - 152.

Greve, B. (2007). What Characterise the Nordic Welfare State Model. *Journal of Social Sciences* , pp. 43 - 51.

Grøholt, E.-K., Dahl, E., & Elstad, J. I. (2007). Health inequalities and the welfare state. *Norsk Epidemiologi, Volume 17, Number 1* , pp. 3 - 8.

Hanner, C-438/02 (European Court of Justice May 31, 2005).

Heckscher, G. (1984). *The Welfare State and Beyond. Success and Problems of Scandinavia.* University of Minnesota Press.

Helsedirektoratet. (2008). *Aktivitetsutvikling og ventetider i somatisk spesialisthelsetjeneste 2002 - 2007.*

Helsedirektoratet. (2009). *Norway and Health. An Introduction.* Oslo: Norwegian Directorate for Health.

Johnsen, J. R. (2006). *Health Systems in Transition: Norway.* European Observatory on Health Systems and Policies.

Kammer, A., Niehues, J., & Peichl, A. (2012). Welfare regimes and welfare state outcomes in Europe. *Journal of European Social Policy* , pp. 455 - 471.

Kananen, J. (2014). *The Nordic Welfare State in Three Eras: From Emancipation to Discipline.* Ashgate Publishing Limited.

Kautto, M., Fritzell, J., Hvinden, B. K., & Uusitalo, H. (2001). *Nordic Welfare States in the European Context.* Routledge.

Keller, C-145/03 (European Court of Justice April 12, 2005).

Kildal, N., & Kuhnle, S. (2005). The Nordic welfare model and the idea of universalism. In N. Kildal, & S. Kuhnle, *Normative Fundations of the Welfare State. The Nordic experience* (pp. 13 - 33). Routledge.

Kohll v Union des Caisses de Maladie, C-158/96 (European Court of Justice April 28, 1998).

Korpi, W., & Palme, J. (1998). The Paradox of Redistribution and Strategies of Equality: Welfare State Institutions Inequality, and Poverty in the Western Countries. *American Sociological Review, Vol. 63, No. 5* , pp. 661 - 687.

Lindah, A. K. (2012). The Norwegian Health Care System. In T. C. Fund, *International Profiles of Health Care Systems.* The Commonwealth Fund.

Magnusen, J. V. (2009). *Nordic Health Care Systems. Recent Reforms and Current Political Challenges.* New York: Open University Press.

Møller Pedersen, K. (2005). The public-private mix in Scandinavia. In A. Maynard, *The Public-Private Mix for Health* (pp. 161 - 191). RADCLIFFE MEDICAL PRESS.

Mossialos, E., McKee, M., Palm, W., Karl, B., & Marhold, F. (2001). *The influence of EU law on the social character of health care systems in the European Union.* Report submitted to the Belgian presidency of the European Union.

Muller-Fauré and Van Riet, C-385/99 (European Court of Justice May 13, 2001).

Newdick, C. (2009). The European Court of Justice, transnational health care, and social citizenship - accidental death of a concept? *Winsconsin International Law Journal* , pp. 843 - 867.

Nickless, J. (2001). The Impact of the EU Internal Market on Social Health Care. *European Integration and Health Care Systems: A Challenge for Social Policy.*

OECD. (2009). *Health at a Glance 2009.* OECD.

OECD. (2011). *Health at a Glance 2011.* OECD.

OECD. (2013). *Health at a Glance 2013.* OECD.

Official Norwegian Reports NOU 2012:2. (2012). *Outside and Inside. Norway's agreements with the European Union.*

Ólafsson, S. (2005). Normative foundations of the Icelandic welfare state. On the gradual erosion of citizenship-based welfare rights. In N. Kildal, & S. Kuhnle, *Normative Fundations of the Welfare State. The Nordic experience* (pp. 214 -236). Routledge.

Olejaz, M., Juul Nielsen, A., Rudkjobing, A., Okkels Brik, H., Krasnik, A., & Hernandez - Quevedo, C. (2012). *Denmark: Health system review. Health Systems in Transition.* Copenhagen: WHO Regional Office for Europe.

Osborne, S. P. (2006). The New Public Governance? *Public Management Review* , pp. 377 - 387.

Østergren, K., Vrangbaek, K., & Winbald, U. (2008). *Waiting time guarantees in the Scandinavian countries - symbols or reality?* IJPSM.

PHIS. (2011). *PHIS Pharma Profile 2011: Denmark.* PHIS.

PHIS. (2011). *PHIS Pharma Profile 2011: Norway.* PHIS.

Povlsen, L., Borup, I. K., & Fosse, E. (2011). The concept of "equity" in health-promotion articles by Nordic authors - A matter of some confusion and misconception. *Scandinavian Jornal of Public Health* , pp. 50-56.

Pusić, E. (2002). Modernizacija velikiheuropskih upravnih sustava.

Sapir, A. (2006). Globalization and the Reform of European Social Models. *JC MS, Volume 44, Number 2* , p. 369 390.

Stark, A. (2002). What Is the Nwe Public Management? *Journal of Public Administration Research and Theory, Volume 12, Number 1* , pp. 137 - 151.

Stråth, B. (2005). The normative fundations of the Scandinavian welfare states in historical perspective. In N. Kildal, & S. Kuhnle, *Normative Fundations of the Welfare State. The Nordic experience* (pp. 34 - 51). Routledge.

Street, A. (1994). *Purchaser/Provider and Managed Competition: Importing Chaos?* Centre for Health Program Evaluation.

Street, A. V. (2007). *Introducing activity-based financing: a review of experience in Australia, Denmark, Norway and Sweden.* Centre for Health Economics, University of York.

Vanbraekel and others, C-368/98 (European Court of Justice July 12, 2001).

Vrangbæk, K. (2009). Going private? The growth of private health insurance in Denmark. *Eurohealth, Volume 15, Number 2* , pp. 5 - 8.

Vrangbaek, K. (2012). The Danish Health Care System. In T. C. Fund, *International Profiles of the Health Care Systems.* The Commonwealth Fund.

Watts, C-372/04 (European Court of Justice May 16, 2006).

www.sweden.se, Official Sweden site (2013)

www.thelocal.se (2011).

www.tnp.no (2014).