SEEKING A BALANCE?!

The emergence of New Public Management in new hospital payment systems in Germany, the Netherlands and the United Kingdom
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ISBN 978-90-8659349-1

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Cover design by Esther Beekman, www.estherontwerpt.nl
Printed by PrintPartners Ipskamp, Enschede
Seeking a Balance?!
The emergence of New Public Management in new hospital payment systems in Germany, the Netherlands and the United Kingdom

by

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<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>AWBZ</td>
<td>Dutch Exceptional Health Care Expenditures Act (<em>Algemene Wet Bijzondere Ziektekosten</em>)</td>
</tr>
<tr>
<td>BÄK</td>
<td>German doctors organization (<em>Bundesärztekammer</em>)</td>
</tr>
<tr>
<td>BIG</td>
<td>Dutch Individual Health Care Professions Act (<em>Wet op de Beroepen in de Individuele Gezondheidszorg</em>)</td>
</tr>
<tr>
<td>BMA</td>
<td>British Medical Association</td>
</tr>
<tr>
<td>CDA</td>
<td>Dutch Christian-Democratic Party (<em>Christen Democratisch Appèl</em>)</td>
</tr>
<tr>
<td>CDU/CSU</td>
<td>German Christian-Democratic Party (<em>Christlich Demokratische Union</em>)</td>
</tr>
<tr>
<td>D66</td>
<td>Dutch Liberal Party (<em>Democraten 66</em>)</td>
</tr>
<tr>
<td>DBC</td>
<td>Dutch DRG-system (<em>Diagnosebehandelcombinaties</em>)</td>
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<tr>
<td>DRG</td>
<td>Diagnosis Related Groups</td>
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<tr>
<td>EU</td>
<td>European Union</td>
</tr>
<tr>
<td>FDP</td>
<td>German Liberal Party (<em>Freie Demokratische Partei</em>)</td>
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<tr>
<td>GDP</td>
<td>Gross Domestic Product</td>
</tr>
<tr>
<td>GMC</td>
<td>General medical council</td>
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<tr>
<td>KNMG</td>
<td>Royal Dutch Medical Organization (<em>Koninklijke Nederlandsche Maatschappij tot bevordering der Geneeskunst</em>)</td>
</tr>
<tr>
<td>LAD</td>
<td>Dutch union of hospital doctors (<em>Landelijke vereniging artsen in dienstverband</em>)</td>
</tr>
<tr>
<td>LPF</td>
<td>List Pim Fortuyn</td>
</tr>
<tr>
<td>NATO</td>
<td>The North Atlantic Treaty Organization</td>
</tr>
<tr>
<td>NHS</td>
<td>National Health Service</td>
</tr>
<tr>
<td>NPM</td>
<td>New Public Management</td>
</tr>
<tr>
<td>OECD</td>
<td>Organization for Economic Cooperation and Development</td>
</tr>
<tr>
<td>PA</td>
<td>Principal-Agency</td>
</tr>
<tr>
<td>PCT</td>
<td>Primary Care Trusts</td>
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<tr>
<td>PDS</td>
<td>German Socialist Party (<em>Partei des Demokratischen Sozialismus</em>)</td>
</tr>
<tr>
<td>PvdA</td>
<td>Dutch Social Democratic Party (<em>Partij van de Arbeid</em>)</td>
</tr>
<tr>
<td>SHI</td>
<td>Statutory Health Insurance</td>
</tr>
<tr>
<td>SP</td>
<td>Dutch Socialist Party (<em>Socialistische Partij</em>)</td>
</tr>
<tr>
<td>SPD</td>
<td>German Social-Democratic Party (<em>Sozialdemokratische Partei Deutschlands</em>)</td>
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<tr>
<td>VVD</td>
<td>Dutch Liberal Party (<em>Volkspartij voor Vrijheid en Democratie</em>)</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
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ACKNOWLEDGEMENTS

‘Seeking a balance’ does not only refer to policy makers that have to deal with a complex health care sector, but also to the process of writing a PhD. You need to find a balance between complex and clear answers. When people ask about the topic of my thesis, I often answer that is about marketization in health care. This thesis will show that the real answer is more complicated. In addition, you need to find a work-life balance that suits you. In the first years, this was not too difficult; in the last months I often (unnecessarily) doubted whether I would ever finish. Here, I would like to thank all the people that made working on a PhD project a pleasure in the first years and helped me survive the last months.

Although both my supervisors may have doubted this in the end, I enjoyed the years we worked together. Hans, I would like to thank you for many things but in particular for being demanding. You showed me that I can make it even if there are some hurdles on the way. Paul, I thank you for all the support during the process. I am proud that we published an article together.

This PhD project has been part of a multidisciplinary VU sterproject ‘Publiek domein en markten’ that gave me the opportunity to discuss my work outside my own department. I would like to thank, in particular, Kirsten Wilkeshuis and Frank van Ommeren. Kirsten, as you can see, women are the real tough fellows. I wish you all the best in finishing your PhD-project. Frank, you were a perfect copromotor in this project: you never imposed specific arguments or views on me, you were interested in my work and gave me the opportunity to get useful insights in Law studies.

Without comments of people at conferences and other events the manuscript would not be as good as it is now. In particular the insights, ideas and support of Ellen Kuhlmann and Viola Burau were necessary to understand the role of the medical profession in political processes, and to finish the manuscript.

(Former) colleagues of the Department of Political Science, I would like to thank you all for sharing your (PhD) experiences with me. Laura, thanks for being my roommate. I love my new job, but I miss sharing an office with you. Erica, you managed to turn my Dunglish into a readable manuscript. I am very grateful that you were willing to finish it after you moved to Austria. All the remaining flaws are fully my responsibility.

Finally, thanks to my family and friends for the interest in my work, your support and the necessary distraction. Ronald, I know you from the first day of my political science study and you are my best ‘studievriend’, I am grateful that you agreed on being a paranymph. Mam en pap, thanks for the trust in my choices. Coen, your love and conciseness have been necessary conditions to finish this project. And you were right in the end,¹ I should have taken it more easily.

¹ I know, as you always are 😊
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1. SEEKING A BALANCE?

1.1. Introduction

The American College of Healthcare Executives awarded the 2005 James Hamilton book of the year prize to Fred Lee (2004), author of *If Disney Ran Your Hospital: 9 ½ Things You Would Do Differently*. The advantage of running a hospital according to the principles of Disney is that it creates an environment “where people feel they are working with friends who share a common dream of making communities and patients their loyal fans” (Lee, 2005). Though certainly a positive scenario, to what extent can hospitals be compared to amusement parks? And to what extent is it desirable for hospitals to be run like businesses in countries with public health care services? Is there a blueprint for increasing the performance of the health care sector? This dissertation approaches these questions from a political science perspective, focusing particularly on what role institutions and actors play in the emergence of new hospital payment systems, which introduce principles from the private sector, in this case New Public Management (further NPM).

The title, ‘seeking a balance’, refers to several aspects of health care policy reform. First, it refers to specific health care goals: (universal) accessibility, quality and cost containment. As will be outlined in Chapter 2, new hospital payment systems likely change the balance between these goals. Second, it refers to questions about the involvement of the state and the market in the health care sector. Implementing NPM in new hospital payment systems affects the role of the state in health care policy. Third, changes in the former balances alter the interests of actors in the health care and political domains.

This first chapter sets the scene for the dissertation. It provides the background for the research question by describing the health care sector and by comparing how ‘shifts in governance’ – including NPM - are studied in different research traditions, i.e. law, public administration and political science. I argue that health care policy is a particularly sensitive political issue, as it deals with matters concerning life and death. Governments must constantly strive to reconcile quality and costs. Moreover, introducing NPM is likely to change the balance between health care goals and the role of the state according to its degree of ‘stateness’ (Nettl, 1968). For this reason, studying the emergence of NPM in health care policy from a political science perspective is relevant. Finally, this chapter outlines the plan of the book.

1.2. The health care sector

Blank and Burau (2004: 13-14) distinguish three types of care in health care policy: primary care, chronic care, and curative medicine. Primary care includes visits to general practitioners and ambulatory care, as well as health education and promotion. Chronic care includes long-term facilities, nursing homes and home care. This dissertation focuses solely on the third type – curative medicine. This
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covers acute/hospital care, outpatient clinics, technical specialists and intensive care. Reforms in curative medicine provide an excellent avenue of research for three reasons. First, curative medicine encompasses the main institutional settings and actors of the specific health care systems (i.e. health insurers or other organizations that purchase health care services, hospitals, the medical profession, patients and the state). Second, it accounts for the bulk of governmental and medical professional activity in health care (Freeman, 2000: 120). Finally, curative medicine is directly connected to ‘life and death’ issues, which are relevant to all citizens.

Three general sorts of health care systems can be distinguished in western countries: private insurance systems (e.g. in the United States), public(-regulated) insurance systems (e.g. in Belgium, France, the Netherlands and Germany) and national health services (e.g. in the UK, Norway, Sweden, Spain). Specific types of actors and organizational relationships characterize these different health care arrangements. In particular, the form and degree of stateness varies across health care systems. For example, the state acts mainly as a regulator in public health insurance systems, while in national health services the state takes on a more active/visible role. In addition, there is a sharp distinction between the public and private health care sector.

Some of the cross-country differences in financing can also be explained by considering the different health care systems. National health services are financed by taxes, while insurance-based systems have insurance schemes funded by employers and employees. In addition, countries have organized the financing of the health care subsections in different ways. In the Netherlands, for instance, curative medicine is completely financed from the basic insurance and from additional voluntary insurances, while primary care is paid partly from the basic insurance (e.g. in the case of visits to general practitioners) and partly from the Exceptional Medical Expenses Act (further AWBZ) (e.g. in the case of health education). Chronic care is fully financed from the AWBZ\(^1\). In Germany, all health care is reimbursed from the statutory insurance (sickness funds) or from voluntary insurance schemes. In the UK, all health care is paid from taxes.

The different institutional health care settings likely result in different outcomes of similar reform initiatives, since the form of stateness determines a specific starting point and specific relationships between actors. Consequently, this study takes into account the political and health care institutional settings. I argue, however, that neither the political nor the health care system determines variation in health care reforms. Rather, it is the interactions between actors and these institutional settings that is most relevant. I contend that the institutional setting determines the room to maneuver for actors, but not the eventual outcomes.

---

\(^1\) This is the situation in the Netherlands at the end of 2008. There are plans to reform the financial structure.
1.3. Health care and welfare state reforms

Throughout the 1980s and 1990s, there were debates about the size and the role of the state in public sector provision. Inspired by a particular set of economic theories and values mainly focusing on enhancing efficiency, NPM emerged as a reform movement to address such questions (Christensen and Laegreid, 2001). The new pressures on the welfare state have led to the widely held belief that current levels of social provision are unsustainable (Giaimo and Manow, 1999). The welfare state reforms that occurred during the last decades have been the source of extensive research (cf. Huber and Stephens, 2001; Pierson, 1994, 2001; Starke, 2006).

The studies have usually dealt with welfare state retrenchment and less often with welfare state restructuring. I define retrenchment as changes which cut back or reduce social entitlements by, for example, reducing benefit levels, tightening eligibility rules or shortening entitlement periods (Clasen and Van Oorschot, 2002; Green-Pedersen, 2007). Another type of welfare state reform, welfare state restructuring, is defined as changes in the institutional rules surrounding a scheme. These can be changes in the administration or the funding of benefits, but also shifts in the principles which govern the calculation of benefits, e.g. changes in the scope of means-testing (Clasen and Van Oorschot, 2002; Green-Pedersen, 2007).

The cost of health care has emerged as an important policy issue. The reason for this is two-fold: first, health care costs grow faster than GDP (OECD, 2006) and, second, depending on their hospital payment system, countries were confronted with increased public costs (e.g. Germany) and/or waiting lists (e.g. the Netherlands and the UK). Like other western countries, Germany, the Netherlands and the UK introduced comparable types of payment systems to increase the performance of the health care sector in the period 2002-2006. These new hospital payment systems were not developed to redress welfare entitlements (cf. Clayton and Pontusson, 1998; Green-Pedersen, 2001); rather, they were meant to enhance performance. I argue, however, that new hospital payment systems are at the very least a form welfare state restructuring and that they eventually may lead to retrenchment. The rationale for such a statement is that by emphasizing cost containment, other health care goals, as for instance quality, are affected.

In this dissertation, I study NPM to understand the variation in new hospital payment systems in Germany, the Netherlands and the United Kingdom. Many public sector studies deal with NPM, but it is seldom linked to welfare state reforms (see for an exception, Green-Pedersen, 2002b). Interestingly enough,

---

2 Due to devolution in the United Kingdom, reforms in the NHS do not necessarily occur simultaneously in Scotland, Northern Ireland, Wales and England. The new payment system is not implemented in the Scottish and Welsh NHS. Since this study deals with the extent to which NPM has emerged in new hospital payment systems based on DRG, only the reforms of the English NHS are considered. For this reason, this dissertation refers to the British political system as a whole, but to the English policy plans and the English hospital payment system in particular.
however, NPM is addressed in health care policy studies (cf. Dawson and Dargie, 2002; Dent, 2005).

1.4. NPM in health care reforms: a political science perspective

NPM emerged as a reform movement and tends to be viewed as either a major breakpoint in public sector management, the most recent paradigm change on how the public sector is governed (Lane, 2000) or a new international administrative orthodoxy (Christensen and Laegreid, 2001: ix). It is defined as lessening or removing differences between the public and private sector and shifting the emphasis of governance from process accountability towards greater accountability in terms of results to improve the performance of the public sector (Hood, 1995; Pollitt and Bouckaert, 2004: 8). In NPM, elements such as increased competition, devolution, managerialism and the use of contracts occur simultaneously (cf. Christensen and Laegreid, 2001; Hood, 1995; Lane, 2005). Like organizing health care according to the principles of Disney, NPM is frequently presented as a blueprint for solving public sector problems, as if it would be applicable in every situation.

The use of Diagnosis Related Groups (further DRG) types of payment systems became more prevalent in the 1980s and 1990s and has taken on a variety of forms (Fetter and Freeman, 1986; Leister and Stausberg, 2005; Lungen and Lauterbach, 2000). The rationale behind all such systems is that hospitals earn money if they treat patients for less than the (DRG-)tariff (cf. Fetter and Freeman, 1986). In some cases, the systems have been mainly symbolic and included little actual change in the way the hospital sector is governed, while in other cases they have provided the basis for privatization of the hospital sector (Leister and Stausberg, 2005). An important assumption of this dissertation is that NPM may emerge in DRG based systems but that this is not a forgone conclusion. It is possible to introduce a DRG based payment system without the aims and measures characteristic of NPM. The systems are assumed to support specific policy objectives, which are not necessarily NPM (Leister and Stausberg, 2005: 47). This dissertation does not explain NPM, but uses its prevalence in DRG payment systems to study variation in health care reforms.

NPM is often related to governance literature. Governance is a widely used catchall phrase (cf. Pierre and Peters, 2000; Rhodes, 1996; Van Kersbergen and Van Waarden, 2004), which takes on more specific meanings when referring to countries and organizations. According to Rhodes (1996), for instance, at least six meanings of governance can be distinguished: ‘the minimal state’, corporate governance, NPM, good governance, socio-cybernetic networks and self-organizing networks.

Governance is a common research topic in several scientific fields, e.g. law, public administration and political science. The main differences among the disciplines concern the types of questions that are examined. Law scholars address
‘shifts in governance’ from a legitimacy and legal perspective. Important contemporary legal questions include: whether it is legitimate to let societal actors choose the most efficient means to address a policy goal, who decides which aspects must be taken into account in a particular governmental policy, whether specific performance standards can be laid down, how citizens are legally protected and whether performance indicators for public policy can be established by non-democratic actors (Mackor, 2008; Michels, 2001). Legal scholars also consider the consequences that the changing role of the government has in the public and private domains and how this role should be formalized in a changing society (e.g. Vonk, 2003).

Scholars in the field of public administration study the implementation and organization of policy. They focus on questions regarding how NPM has emerged in the public sector and on the effects of the implementation of NPM on the performance of the public sector (cf. Christensen and Laegreid, 2002; Dunleavy and Hood, 1994; Hood, 1995; Pollitt and Bouckaert, 2004). Public administration scholars are particularly interested in descriptive and normative questions (cf. Noordegraaf and Abma, 2003). Moreover, several studies analyze the impact of NPM, i.e. whether convergence can be observed and whether it should be considered a paradigm (cf. Gow and Dufour, 2000; Pollitt, 2001).

Political science is often defined as the study of ‘who gets what, when and how’ (Lasswell, 1958 [1936]). The implementation of NPM in new hospital payment systems addresses the questions: who governs health care – the state and/or the market; for what ends - (universal) accessibility, quality and cost containment; by what means – public governance, private governance or NPM? Studying how NPM has emerged in health care from a political science perspective starts from the idea that outcomes of political processes are useful for understanding variation in reforms. Such a perspective should shed light on what political obstacles might stand in the way. In addition, political processes do not take place in a vacuum, but in a specific institutional setting that affects the choices of political actors. Here institutions are defined as structural features that lead to patterned interactions (Peters, 2005: 18). I contend, therefore, that it is necessary to take the specific setting in which political processes occur into account to explain the variation of a similar policy initiative (i.e. a new hospital payment system) in different countries.

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3 Legitimacy is used differently in political science and law. In the former, it is considered the capacity of the political system to engender and maintain the belief that political institutions are the most appropriate institutions in a specific society (Lipset, 1963 [1960]: 64). In law, legitimacy is based on the Weberian perspective and defined as the general readiness to accept governmental rules and decisions regardless of the specific content (e.g. Schwitters, 2000: 12). Hence, in law the legal basis of governmental authority in health care is discussed, while in political science legitimacy is used as a variable to explain institutional change or stability.
1.5. New institutionalism: actors in their institutional context

To some extent one could see the emergence of new institutionalism as a reaction to theories of rational choice and behavioralism, which were a reaction to the ‘old’ institutionalism that studied institutions in a more (constricted) formal way (cf. March and Olsen, 1989; Peters, 2005; Weingast, 2002). Within new institutionalism several approaches can be distinguished, some of which are more or less compatible with the individualistic approaches of political science (e.g. rational choice) than others (Peters, 2005: 2). The core assumption of all forms of new institutionalism is that rules and systems of rules not only organize and regulate social behavior, but also make it understandable and – in a limited conditional sense – predictable for those sharing knowledge of the rules (Scharpf, 1997: 40).

Several specific forms of new institutionalism have developed that differ in their definitions and assumptions about the role of institutions. In rational institutionalism, institutions are systems of rules and inducements in which individuals attempt to maximize their own utilities (cf. Keman, 1999b; North, 1990; Peters, 2005; Weingast, 2002). In sociological institutionalism, institutions that provide the ‘forms of meaning’ guiding human action, are not just (formal) rules, procedures or norms, but also symbols, cognitive scripts and moral templates (Hall and Taylor, 1996: 947). In historical institutionalism, institutions are, like in sociological institutionalism, more than just formal rules. In addition, they are seen as the outcomes of struggles between actors with unequal resources (Pierson and Skocpol, 2002: 706).

New institutionalism does not provide concrete hypotheses about how institutions and actors affect outcomes; rather, it offers guidelines in search of explanations (Scharpf, 1997: 37) as well as a theory driven framework of reference that enables the researcher to interpret empirical developments, as regards behavior, within a set of formal and informal rules. Scholars of the specific forms of new institutionalism agree that the interactions between institutions and actors are relevant for explaining outcomes, but they start from different assumptions about how and to what extent these are important for explaining outcomes (cf. Keman, 1998). Since new institutionalism provides several ideas about how actor preferences and interests might interact with the institutional setting, it provides useful frameworks for explaining variations in hospital payment systems, as will be outlined in Chapter 2.

Immergut (1992a; 1992b) has provided one of the earlier and influential studies linking new institutionalism and health care policy. In her work, she discusses the outcomes of the development of health care systems in relation to institutionalist theory. She sees institutions as establishing a strategic context for the actions of political actors (Immergut, 1992b: 83). Her study concludes that institutions only become relevant in strategic calculations about the best way to advance a given interest in a particular system. Moreover, her findings indicate that the goals and interests of actors, who are socialized by institutions, do not depend
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on a specific institutional structure (Immergut, 1992b: 84/85). Immergut’s work has shown that more than one course of action is possible in institutions and that events depend just as much on historical accident as on the inventiveness of actors (Immergut, 1992b: 84/85).

Pierson (2004: 64) offers a somewhat different perspective, arguing that initial steps in a particular direction may encourage further movement along the same path. From his viewpoint, courses of actions are more restricted than Immergut (1992a; 1992b) suggests. Hence, change can occur, but it is partly explained from the specific context and the specific ‘path’.

According to Hacker (2004: 722), an important puzzle in the study of health care reforms is the notion of ‘reform without change and change without reform’. Hacker places much weight on specific institutional structures to explain reforms. He concludes from a review of the literature that market reforms tend to occur more often in centralized political and health care systems, while governments in decentralized systems expand the role of the state. In addition, Hacker argues that countries which introduced market-based reforms in health care often have brought the state back in, in essence reversing the original change. Overall, though scholars agree that contexts seem to limit choices for actors, they do not agree on how this mechanism works.

The movement of a pendulum provides a useful illustration of these different ideas about reform. According to Hacker (2004) and Pierson (2004), a specific course of action is more likely than a random course of action. However, seeing processes as swings of a pendulum implies that actors’ choices in specific institutional settings do not matter; the pendulum will always swing in the same direction in similar circumstances. This is in contrast to considering health care reforms as outcomes of political conflict; movements in this case are a result of political conflict between actors in specific institutional settings. Although actor preferences are affected by the specific context, the direction of the reform is not determined by this context. Hence, more courses of action are possible when one takes into account the interaction between actors and institutions.

This dissertation explores to what extent health care reform can be seen as a result of a specific blueprint or as a result of political conflict. The study does not start from a particular form of new institutionalism but uses it as framework of reference to explore the relationship between institutions, actors and policy output and to interpret the outcomes (Scharpf, 1997). The following research question guides therefore this dissertation:

To what extent is the variation between new hospital payment systems of Germany, the Netherlands and the UK a result of preferences about NPM, related behavior of political parties and medical bodies, and institutional characteristics of the political and health care systems?
This study covers one comparable policy reform in three countries that represent distinct political institutional contexts and health care systems: Germany, the Netherlands and the UK. By studying how NPM has emerged in new hospital payment systems in three cases representing meaningful variation in their institutional context, it is possible to obtain explanations that are useful for contemporary welfare state literature. In the subsequent chapters, I show that variation is not determined by specific contexts or path-dependency; instead, explanations for the emergence of NPM are to be found in to what extent actors can further their preferences about NPM elements in their specific institutional setting.

1.6. Plan of the book

Although this dissertation sets out from a comparative case studies design, the chapters are devoted to specific topics rather than to the specific cases. Chapter 2 further outlines the theoretical framework by discussing the development of health care regulation in the three cases. With the literature about principal-agent theories and ‘shifts in governance’, the chapter illustrates why and to what extent NPM represents a public-private shift in health care. It also introduces the actors and specific institutional settings that are taken into account in this study. Subsequently, the chapter describes the research design. It argues why a small-N design is useful for this dissertation and explicates why Germany, the Netherlands and the United Kingdom are considered diverse cases, i.e. cases that represent maximum variation with regard to important independent variables (Gerring, 2007; Seawright and Gerring, 2008). Finally, Chapter 2 briefly outlines the methodological considerations of the analysis.

Chapter 3 provides a detailed account of the various ways and degrees to which NPM has emerged in the new hospital payment systems. It formulates several institutional hypotheses about how NPM might emerge in new hospital payment systems and analyzes whether variation in the way NPM has emerged can be explained without taking ‘politics’ into account. The starting point is the assumption that NPM should emerge to a large extent in the UK, to a moderate extent in the Netherlands and to a small extent in Germany. The chapter shows that the variation between the cases cannot be fully understood from formal institutional settings or path-dependent characteristics.

In Chapter 4, I examine the role that political parties have played in the emergence of NPM. Specifically, I study the interaction between actors and institutions by comparing party positions – in the election phases and the decision-making phases - in the three countries. The role of health care issues in these phases is linked to theories about political competition, e.g. whether health care is a valence or a positional issue (Stokes, 1963) and how parties compete for voters (Downs, 1957; Lewis and King, 1999; MacDonald and Rabinowitz, 1998). The chapter shows that there is a relationship between the attention governmental parties give to NPM and variation in the hospital payment systems. Moreover, it
demonstrates that political processes are affected by specific institutional settings: the importance of health care as political issue varies across countries.

Chapter 5 further explores the interaction between institutions and actors by focusing on the strategies of medical bodies in the policy process. It considers the relationship between preferences, institutions, strategies and outcomes. I show that the preferences and the strategies of the medical bodies and the new hospital payment systems can be only understood if the specific institutional position of the bodies is taken into account.

The final chapter outlines the contributions that this research makes to contemporary comparative welfare state studies, new institutionalism and the literature on NPM. The specific institutional settings or ‘paths’ in a specific policy domain are relatively decisive for how – in this case – NPM can be given shape by actors into policy. Moreover, actor preferences and behavior are crucial features to understand the specific emergence of an ideational feature into policy.
Seeking a balance!?
2. NPM AS PUBLIC-PRIVATE SHIFT IN HEALTH CARE

2.1 Introduction

This chapter provides the theoretical framework and research design of the dissertation. I outline the characteristics of NPM to fully understand why variation is expected among the DRG-based payment systems. In addition, the chapter conceptualizes how NPM emerges in health care reforms and how it is related to preferences of actors, i.e. political parties and the medical profession. It is outlined why a new institutionalist framework is useful for interpreting how actors and institutions will account for the variation in the new hospital payment systems and why the effects of institutions and actors are probably different in comparison to other welfare state sectors.

The main argument of this chapter is that NPM is given shape in health care policy by the interaction of actors and specific institutional settings. The theoretical framework and research design presented in this chapter explicate how the next chapters address the specific sub-questions that are derived from the main research question: To what extent is the variation between the new hospital payment systems of Germany, the Netherlands and the United Kingdom a result of actor preferences about NPM of political parties and medical bodies, related behavior and institutional characteristics of the political and health care system?

In NPM, elements such as increased competition, devolution, managerialism and the use of contracts occur simultaneously (see Christensen and Laegreid, 2001; Hood, 1991, 1995; Lane, 2000; Pollitt and Bouckaert, 2004). There is, however, no agreement in the literature on a precise definition of NPM. It is, on the one hand, seen as a ‘management hybrid’ with a continuing emphasis on core public values, but expressed in a new way (Ferlie, Ashburner, Fitzgerald, and Pettigrew, 1996). On the other hand, it is considered a market-based ideology invading public sector organizations (cf. Laughlin, 1991). This chapter conceptualizes NPM in a way that allows for a comparative analysis. The sub-question: To what extent and how has variation occurred in the emergence of NPM elements in the new hospital payment systems of Germany, the Netherlands and the UK? cannot be answered without a well-founded conceptualization of NPM.

Several researchers emphasize the role of specific state traditions and institutional settings for understanding the different ways in which NPM has emerged (cf. Dent, Howorth, Mueller, and Preuschoft, 2004; Pollitt and Bouckaert, 2004). As argued in Chapter 1, it is questionable whether formal institutions are useful in explaining reform outcomes. This argument is developed further in this chapter. Chapter 3 will verify that actor preferences and related behavior need to be taken into account to explain the variation in the new hospital payment systems by answering the second sub-question:
To what extent is the variation between new hospital payment systems of Germany, the Netherlands and the UK explained by state tradition and the institutional characteristics of the political and health care systems?

Subsequently, I outline in this chapter why focusing on the preferences and the strategic choices of actors in different institutional settings will provide insight into how NPM has emerged in health care reforms. Beside scholars that have focused on the large effects of a specific institutional setting, there are scholars that have considered actors, in particular political parties, more sufficient for explaining welfare state and NPM reforms (cf. Green-Pedersen, 2002b). This leads to the third sub-question of this dissertation is: To what extent and how are policy preferences of political parties about health care and NPM related to the variation in the new hospital payment systems of Germany, the Netherlands and the UK?

The role of the medical profession is by many considered as so important, that the dynamics of health care reform are different in comparison to other welfare state areas. It is, therefore, necessary to analyze whether preferences and related behavior of the medical profession are useful in explaining reforms. The theoretical framework and research design to answer the fourth sub-question: To what extent are the negotiation strategies of the medical profession related to the variation between the new hospital payment systems of Germany, the Netherlands and the UK? are outlined here.

The chapter proceeds as follows. First, the development of state regulation in health care is discussed to illustrate the variation in institutional settings between the countries and to conceptualize the preferences of actors. Second, the chapter explicates the distinction between health care and other welfare state sectors. Third, I conceptualize NPM. Fourth, consideration is given to why the preferences and related behavior of political parties and the medical profession are relevant for understanding how NPM has emerged in health care reforms. Lastly, I develop a research design to answer the research questions.

2.2 Health care sector development and reform

In this section, I first discuss how state involvement in health care regulation has developed. Second, I contend that although health care is part of the welfare state, it has its own dynamics and rationale. Finally, it is demonstrated that quality is a relevant aspect in comparison to other welfare state services and that health care is very important for the individual citizen. In other words, I show the distinctiveness between the health care sector and other welfare state sectors and argue that the way in which ‘politics matters’ in health care reforms, i.e. the extent to which actors can further their preferences, is likely to be different than in other welfare state reforms.
2.2.1 Health care and state intervention

In 1980, almost all European states guaranteed access to health services for all their citizens, while in 1880 none of them did (Freeman, 2000: 14). Before the expansion of the welfare state and public health care in Western Europe, working class users of health services exercised strong bargaining power in contracting physicians into institutionalized third party payers (Heidenheimer, Heclo, and Teich Adams, 1990). Market failures in health care provision were mainly caused by the dominance of these third party payers and by the fact that doctors made decisions about treatments. Due to governmental regulation, however, health care today tends to be organized more publicly than privately in many western countries.

A private health care system works inefficiently since market failures as adverse selection and moral hazard occur (cf. Rothschild and Stiglitz, 1976; Thomson and Mossialos, 2006). Privately insured patients do not pay directly to health care providers, but are instead insured and do not make individual choices. Adverse selection is apparent in several instances. First, insurance companies obtain information about the risks of individuals and can refuse insurance or only offer coverage at high prices to persons with greater risks. Second, people might be able to conceal information about their health status. This will lead to the fact that healthy persons do not purchase full coverage (Rothschild and Stiglitz, 1976; Thomson and Mossialos, 2006). Finally, markets fail to provide health care that is accessible for all citizens, since bad risks are excluded from coverage. Particularly, citizens who need health care and have no income due to their illness cannot access private health care services.

Moral hazard appears when insurers lack information about the appropriateness of refunding treatment. In public and private health care delivery, an information asymmetry occurs since doctors or service providers usually decide what treatment a patient receives. The services are controlled less by the claims of the users than by the judgment of the providers. It is often difficult for insurance companies to estimate whether the costs are correctly measured. In addition, insured persons may use health services more extensively, since they do not pay them directly. Scholars argue that fully insured people spend 40-50% more on health care services than others, while their health status is not measurably improved (e.g. Newhouse, 1992). As the previous discussion has shown, both adverse selection and moral hazard are likely to lead to malfunction of the market provision of health care.

Historically, two routes have been taken to solve the aforementioned market failures. First, in some countries piecemeal expansion of social insurances took place, i.e. more and more citizens could make use of a (public) scheme. The health care systems in these countries have grown, but their organizational frameworks have remained static and ill-defined. They are characterized by complexity and

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1 The so-called sickness funds and sickness fund physicians in Germany (Kassenärzte) are the most well-known example.
relatively low involvement of the state. Strong interests – for instance the medical profession - in these systems were able to resist universalistic reform (Freeman, 2000: 24). This route characterizes the Dutch and German systems. In the Netherlands, private ‘sickness funds’ were formed as far back as the 1820s, but it was only in 1941 that these funds became subject to strict governmental regulation (Companje, 1997: C). In Germany, private ‘sickness funds’ were formed during the mid-19th century and the first legal act was provided in 1883 (Freeman, 2000).

In the second route, radical universal access was instituted in a single stroke by creating national health services. This happened under particular circumstances, i.e. where a failure of existing arrangements occurred, where pro-reform (often social-democratic) parties were governing and where there was a strong executive and a divided medical profession (Freeman, 2000: 24). This route characterizes the UK. The NHS was set up in 1948, though there were some public insurance schemes before. In sum, the cases figuring into this study reflect two general organizational structures. Although both are mainly public, one has more complex relationships between the state and other organizations, while the other is dominated by the state.

Until the 1970s, the welfare state - including health care policies - expanded. The literature points to both political and economic reasons to explain the reforms that started in the 1970s. First, the era was marked by decline in rates of economic growth and by anti-welfare state sentiments (Hacker, 2004). Additionally, cost containment grew in importance. These developments occurred not only in health care, but also in other welfare state sectors. However, another important development in health care policy has been the change in the relationship between the government and the medical profession. According to Hacker (2004), this relationship has shifted from an uneasy cooperation between ‘states and interests’ towards ‘states versus interests’. Governments have often identified the medical profession as a cause of cost containment problems (cf. Ackroyd, Kirkpatrick, and Walker, 2007; Kuhlmann and Allsop, 2008). As further explicated below, this development is one of the aspects that distinguish health care reforms from other welfare state reforms.

2.2.2 Is health care different from other welfare state sectors?

As noted by Pierson (1994), reforming health care has been difficult. Health care is part of the welfare state, but there are three reasons why contemporary reforms in health care cannot likely be explained by the same set of factors that account for other welfare state reforms. First, quality is a separate policy goal. Second, governments have difficulties controlling health care provision,² because physicians decide when and what kind of treatment patients receive. Third, health

² Health care in this dissertation is discussed with regard to solving health problems in curative medicine. The way primary care and chronic care are governed may be significantly different (see also Chapter 1).
NPM as public-private shift in health care

is a matter of life and death for individual citizens making changes that lead to retrenchment more unpopular compared to other welfare services.

Although quality has become more relevant in contemporary welfare state services, e.g. in active labor market policies, the quality aspects of health care and education have remained more important than those of, for instance, sickness benefits. According to Harteloh (2003: 266), the concept of quality is used, on the one hand, to describe the relationship between possibilities realized and a normative frame of reference and, on the other hand, to prescribe or recommend a certain form of this relationship. While this definition is too vague to judge whether health care has a certain measurable quality, it introduces the concept of quality standards. There are, for instance, clinical standards to which the medical profession should comply, e.g. standards about client-centeredness and hygiene. In the cases under study, state intervention and organizations aimed, aside from solving market failures, at defining standards and monitoring quality standards set by the medical profession. The importance of quality in health care policy thus affects the dynamics of reform distinguishing it from other welfare state sectors.

In addition, the importance of quality complicates health care policy. For the purchasing organizations (i.e. insurance companies or other agencies that distribute money among providers), quality represents a way of evaluating how well money is spent. Patients, in comparison, evaluate care in terms of responsiveness to their individual needs (McGlynn, 1997: 9-10). For them, the quality of health care is a matter of life and death. Finally, physicians are caught between efforts to control costs, their own judgments and the demands of patients. According to physicians, quality erodes if they are less involved in choosing a treatment, since decisions are then made on the basis of costs (McGlynn, 1997: 10).

The second reason why health care is different from other welfare state sectors is that physicians are key decision makers in health care and work in single purpose organizations with strong informal networks (cf. Ackroyd, Kirkpatrick, and Walker, 2007). We can assume, that when making decisions doctors prioritize treating patients within the available budget and that politicians do not seek to influence these decisions (Ham and Alberti, 2002: 839; see also Olson, 1982: 28). Heclo et al. (1990: 58-60) show that the directness of state control has varied more in health care than in education. Physicians’ organizations were able to affect the set up of the public health care sector in different ways. Moreover, these organizations have often been involved in governmental policy processes. Indeed, it is the influence of physicians that distinguishes health care from other welfare state services.

Finally, public health care has traditionally garnered large support (Blekesaune and Quadagno, 2003: ; Houtepen and Ter Meulen, 2000a). Blekesaune and Quadagno (2003) argue that there is overwhelming support for welfare state policies for the sick and the elderly and generally positive attitudes toward welfare policies for the unemployed. Green-Pedersen (2002a) shows, however, that voters are often critical of the economic viability of extensive welfare states. Like in other
Seeking a balance?!

welfare state services, there is a tension between the public costs of health care and solidarity with the people who need services. Houtepen and Ter Meulen (2000b) argue that in areas such as unemployment, broad and fundamental consensus on the value of solidarity gave way to doubts concerning the attainability and desirability of big welfare schemes during the fiscal crisis of the welfare state beginning in the 1970s. Solidarity in health care has remained mainly unquestioned. The distinctiveness of health care implies that the role of ‘politics’ is probably different in this area compared to other welfare state sectors. Health care reforms consequently affect interests and preferences of political actors in specific ways.

2.2.3 Balancing health care goals

Despite different dynamics, health care reforms cannot be completely isolated from other welfare state reforms. The new pressures on the welfare state have led to the common idea that current levels of social provision are unsustainable (Giaimo and Manow, 1999). Reducing the costs of health care has also become an important policy issue since health care costs grow faster than GDP (OECD, 2006). Furthermore, costs are constantly rising since new medical technologies are usually more expensive than the old. The government can only partly affect this, because doctors are important decision makers concerning the treatments patients receive. Finally, while governments have tried to reduce expenditures by introducing shorter periods for sickness and employment benefits, it is difficult to cut down costs in health care without compromising on quality and/or universal accessibility.

Cost containment, quality and accessibility are seen as competing goals in this study (see figure 2.1, Blank and Burau, 2004: 88). A comprehensive, universal health care system with high standards of quality is very costly. For this reason, conflicts among political actors are likely to arise regarding how the different health care goals should be (re-)prioritized and realized. In other words, it is impossible to improve the three elements simultaneously.

(Blank and Burau, 2004)
Figure 2.1 Competing health care goals
Another way of approaching health care goals is to define them as ‘individual’ preferences and interests\(^3\) (cf. Czada, 1998; Keman, 1999b). Actors, for instance various political parties, as well as the individual citizen, might consider each of the health care goals important, but they are likely to rank these goals in a different order. Hence, leftwing parties may view universal accessibility and quality as more important than cost containment, while rightwing parties are more likely to prioritize cost containment over quality and universal accessibility.

Different actors in health care have specific preference orderings. Green-Pedersen and Wilkerson (2006: 1041) argue that politicians seek the proper balance between responding to insatiable public demand for expanding services and controlling costs. In comparison, citizens care about their own health, which is not only seen as the absence of decease or injury but also as a state of complete physical and social well-being (Evans and Stoddart, 1990: 1347). Although people take risks, for instance by smoking, eating unhealthy food or skiing, they want to be healthy (Laver, 1986). Patients can estimate that they need health care, but the medical profession creates the demand by choosing the treatment. Fully insured individuals in Western Europe prefer a high quality and accessible health care service.

Figure 2.2 shows the preferences of government, society, the individual and the medical profession. The government seeks for a balance between health care goals, while in society there is a tension between the interest of solidarity with the sick and cost containment for all. The individual desires individual happiness. Finally, as outlined below the medical profession seeks self-regulation.

<table>
<thead>
<tr>
<th>Government</th>
<th>Society</th>
<th>Individual</th>
<th>Medical profession</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance (equal) accessibility, quality and cost containment</td>
<td>Solidarity versus cost containment</td>
<td>Individual happiness</td>
<td>Self-regulation</td>
</tr>
</tbody>
</table>

**Figure 2.2 Preferences and interests in health care**

In sum, state involvement in health care emerged to solve market failures, but as this section has demonstrated, its development was not uniform across countries. Rather, specific political and institutional circumstances mattered in the way health care became publicly organized. The previous paragraphs have also shown that different sets of preferences can be distinguished in relationships between actors. Welfare state reforms occurred, according to several authors, due to a combination of reasons, e.g. political ideology, perceptions of the welfare state

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\(^3\) Other terms that can be used in this respect are needs (Keman, 1999b), desires (Laver, 1997) and wants. In this dissertation, I use preference to refer to the liking or ranking of one thing before or above another (McLean, 1996), and interest to refer to the ‘instrumental relation between such policies and the individual’s preferences attainment’ (McLean, 1996). If I cite authors, I use their terms.
and fiscal or economic reasons (cf. Freeman, 1998; Pierson, 1994; Pierson, 2006; Vis and Van Kersbergen, 2007). As will be outlined in the following pages, the introduction of NPM in health care reforms will lead to changes in the relationships between actors and, therefore, the preferences of actors.

2.3 NPM as public-private shift

In the former sections, I discussed how state involvement in health care developed, how the health care sector differs from other areas of the welfare state and how preferences and interests are shaped in the system. In this section, I argue that implementing NPM changes both the type of state involvement in health care and the ‘balance’ between the different preferences and interests. In addition, this section shows that new hospital payment systems can be characterized as welfare state restructuring, but that the emergence of NPM in these systems might lead to welfare state retrenchment.

NPM appears mainly in two ‘political science’ literatures: the governance literature (cf. Rhodes, 1996; Van Kersbergen and Van Waarden, 2004) and the Principal-Agency (further PA) literature (cf. Lane, 2005). ‘Governance’ scholars conceptualize NPM as a model of governing situated between the public and private ideal types. Lane (1993: 1) argues that in liberal democracies there is a divide between the public and private sectors of the economy (or society): i.e. different institutions, interests and individual preferences exist. For instance, the way PA-relations are organized differs between the public and private sector (Lane, 2005: 38-40). I use the theories about PA-relations to illustrate that implementing NPM alters the relationships between actors in terms of how things are done, but not the roles of the actors.

The governance literature particularly shows that governing is not necessary done by the government (Rhodes, 1996). Many policy sectors have not a clear distinction between the public and private sector. I suggest that, in liberal democracies, policy sectors have a specific governance mix, which is affect by NPM. Van Kersbergen and Van Waarden (2004) list several contemporary shifts in governance: in forms and mechanisms of governance, in how institutional and organizational societal sectors and spheres are governed, and in the location of governance. They also distinguish vertical and horizontal governance shifts. Examples of the former consist of upward shifts from nation-states to international public institutions (i.e. the NATO, EU) as well as downward shift to regional levels. Horizontal shifts of governance include: shifts from statutory contracts to instruments under private law (contracting), shifts from ‘command to control’ to information management and shifts from public to private organizations (Van Kersbergen and Van Waarden, 2004: 153-155). As it embraces contracting, outsourcing and privatization, NPM can be characterized as a horizontal shift of governance.
Literature about PA-relationships is useful for further conceptualizing the movement from public to private governance in NPM. Lane (2005) argues that PA-models are particularly helpful for understanding the logic of organization of the public sector. Complex PA-relationships among the government, health care providers and other actors (e.g. insurance companies) occur in health care systems. According to the PA-model, providing public services is basically contracting, first, between the leaders of government (principal) and an organization responsible for service delivery (agents), and, second, between the leaders of government (agent) and individuals (principals) (Lane, 2005: 31). As elaborated below, relationships between principals and agents are organized differently in a bureaucracy than in NPM and private sectors. Hence, NPM is characterized by different relationships between actors as the traditional public administration.

In the PA-model, the basic governance problem of public sectors is conceptualized as contractual incompleteness: i.e. it is impossible to fully measure the effort of the agent in terms of money. Consequently, the principal attempts to spend too little and the agent shows little effort (Lane, 2005: 57). However, NPM remains different from private management, because the government is still the main principal (Lane, 2005: 27). This is important to note. NPM changes in health care do not aim at privatizing the whole sector, but at shifting the model of governance and at changing the PA-framework. In other words, the way relationships between actors and principals are organized changes.

In the countries included in this study, the public-private mix in the health care sector is particularly important in determining the structure of a health care system, i.e. whether a system is insurance-based or has a national health service. Several important sets of PA-relationships are distinguishable: government (principal) and health care provider (agent); individual patient (principal) and health care provider (agent); health purchasers (principals) - e.g. insurance companies or fund-raising general practitioners - and health care providers (agents).

Hence, governments deal with a complex network of public and private organizations in health care. The insurance-based health care systems are more complex than national health services, because health insurance developed along the lines of work-based social insurance and, consequently, self-regulation and private organizations are found in the health care sector. In contrast, national health services are state-led and, to some extent, organized as a bureaucracy (see Table 2.1). Despite such differences, PA-frictions will occur in both systems, since governments lack information about whether the effort of health care providers actually contributes to the health care goals (i.e. accessibility, quality and cost containment).
Table 2.1 Differences between national health services and insurance-based systems

<table>
<thead>
<tr>
<th>National health services</th>
<th>Insurance-based systems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Large (overall) state involvement</td>
<td>State as regulator</td>
</tr>
<tr>
<td>Large distinction between public and private system</td>
<td>Public and private organizations provide care for public insured people</td>
</tr>
<tr>
<td>A purchaser-provider split is created within the public system</td>
<td>Insurance companies have a role as purchasing organizations</td>
</tr>
</tbody>
</table>

As argued in Chapter 1, DRG payment systems facilitate specific policy goals, which are not necessarily NPM. This implies that the roles of actors remain similar, e.g. the state remains an important principal for health care providers, but that how such relationships are constituted changes. Hence, if NPM goals emerge in payment systems, it will lead to a public-private shift, since the PA-relationships shift from ‘command and control’ to relationships between principals and agents that are more characteristic of private sectors, e.g. contracting. These changes in the relationships likely affect preferences and interests of actors in this system and might lead to conflict between actors during the policy process.

2.4 NPM as ideational stream

The term NPM is appropriate in labeling the majority of public management reforms that emerged since the 1980s (Lane, 2000). The idea of NPM as a body of managerial thought originates from the observation that management techniques are to a large extent imported into the public sector. NPM is sometimes seen either: as a major breakpoint in public sector management, as the most recent paradigm change on how the public sector is governed (Lane, 2000), or as a new international administrative orthodoxy (Christensen and Laegreid, 2001: ix). Aucoin (1995) states that in the late 1980s policies of bureaucracy-bashing and restraining government were widespread. Bureaucracy was identified as the source of every problem. According to Trubek et al. (2008: 2), governments nowadays struggle to regulate and govern in the face of loss of confidence in the ability of state regulation to produce satisfactory outcomes.

However, one must ask whether a global convergence towards a particular, new style of public management is inevitable (Pollitt, 2001). I argue that the emergence of NPM cannot be considered the solution to the bureaucracy problems, such as those identified by Lane (2005). It is striking that countries have introduced relatively similar hospital payment systems in which NPM can emerge. However, it
might also be that countries just copy what is in fashion, particularly under conditions of uncertainty (DiMaggio and Powell, 1983; Pollitt, 2001).

In this section, I define NPM in health care and explain why NPM should not be seen as a blueprint for reforming the health care sector. It is best viewed as an ideational stream that is given shape in policy by actors and through specific institutional settings. According to Pollitt (2001: 946), agents of reform are not concerned merely with maximizing efficiency but are also interested in keeping up appearances, i.e. convincing stakeholders and appearing to do the right thing. It is selective copying, in which the perceptions and purposes of the reformer reassert a distinctive significance (Pollitt, 2001: 946).

2.4.1 Defining New Public Management in health care

In this study, NPM is defined as lessening or removing differences between the public and private sector and shifting the emphasis from process accountability towards a greater element of accountability in terms of results to improve the performance of the public sector (Hood, 1995; Pollitt and Bouckaert, 2004: 8). This definition shows that there are two different sides of NPM: 1) removing differences in governance between the public and private sector and 2) shifting to performance accountability. As stated above, it conveys both a horizontal shift of governance and changes in the PA-relationships. Since NPM is complex, it can emerge in various ways: i.e. different extents and different emphases. This is studied in Chapter 3.

Accountability is an aspect in the definition of NPM that needs more conceptualization. The essence of accountability in NPM is answerability (Brinkerhoff 2004: 372). Mulgan (2000) list a number of features of this “answerability”. First, it is external, so the account is given to someone outside the body that is being held accountable. Second, it involves social interaction and exchange, since one side seeks answers and rectification, while the other side responds and accepts sanctions and it involves rights of authority, the right to demand answers and impose sanctions (Mulgan, 2000: 555). In NPM social interaction and exchange is molded in contracts that may include sanctions, for instance selective contracting by insurers or patient choice. The latter, for instance, implies that patients can ‘sanction’ a hospital that does not deliver certain quality standards by choosing a different hospital for the next treatment.

Two types of accountability, managerial and political accountability, are distinguished (cf. Christensen and Laegreid, 2002; Ferlie, Ashburner, Fitzgerald et al., 1996). Managerial accountability in NPM means that service providers are held accountable for their performance (cost containment and quality) within a(n) (internal) market. Political accountability deals with ensuring that the government delivers on electoral promises, and responds to ongoing and emerging societal needs and concerns by guarding the accessibility of health care under changing conditions (Brinkerhoff 2004: 374). For the latter type of accountability, it is necessary that governments have insight in how hospital budgets are spent and how
accessibility is safeguarded. I argue that more managerial accountability is introduced with NPM, which focuses on performance instead of the process; i.e. performance accountability.

Hood (1991; 1995) distinguishes seven components related to the two sides of NPM: public-private: unbundling of the public sector into corporative units organized by product, more contract-based competitive provisions, stress on private sector styles of management practice; performance accountability: more disciplined and frugal use of resource, more emphasis on visible hands-on top management, explicit and measurable standards of performance and greater emphasis on output controls (Hood, 1995: table 1). Although these distinctions are useful, Hood’s components do not completely cover the way NPM emerges in the health care sector. For this reason, I use a different set of NPM elements that more accurately shows the variation in the emergence of NPM in health care policy (see Table 2.2).

The elements of table 2.2 are gleaned from the literature. Unlike Hood (1995), I differentiate between aims and measures and do not put all elements in a specific category. This distinction between aims and measures allows one to study variation across countries in a comparative perspective. It may be the case that similar aims are found in policy documents but that the ways to achieve these aims vary (e.g. Pollitt, 2001). Moreover, for some elements that scholars have typified as NPM, it is difficult to assess whether they resemble “shifts in governance” or a change in a PA-relationship. The empowerment of services users, for instance, can be seen as a public-private shift in governance, i.e. a shift in the PA-relationship between the individual patient and the health care provider, as well as a shift from process to performance accountability. Competition is another example. It is clearly a market mechanism introduced in PA-relationships, but it also puts a focus on performance accountability. In Chapter 3, these different elements are further discussed and operationalized to show how the new hospital payment systems facilitate them.
Table 2.2 NPM elements

<table>
<thead>
<tr>
<th>Aims</th>
<th>Accountability of results</th>
<th>Public-private shift</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Accountable for performance</td>
<td>Privatization</td>
</tr>
<tr>
<td></td>
<td>Transparency</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Efficiency</td>
<td></td>
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<tr>
<td>Empowerment of service users</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Competition</td>
<td></td>
</tr>
<tr>
<td>Measures</td>
<td>Standards and measures of performance</td>
<td>The degree to which markets are actually established</td>
</tr>
<tr>
<td></td>
<td>Benchmarking</td>
<td>Deregulation</td>
</tr>
<tr>
<td></td>
<td>Patient Choice</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Contracting in</td>
<td></td>
</tr>
</tbody>
</table>


2.4.2 NPM: a blueprint for health care sector problems?

I argue that NPM should be considered an ideational stream and not as a panacea for problems in the health care sector for two reasons. First, health care policy problems are more complex than bureaucracy problems. Second, though the sector might benefit from NPM under certain specific circumstances, ‘making the government work better’ depends on whose values and perspectives are taken into account (Pollitt and Bouckaert, 2004: 14). The variation in the payment systems likely depends on particular institutional and political circumstances. This also implies that NPM in health care policy probably changes more than would be expected from welfare state reforms that aim on restructuring.

NPM is often seen as a way to tackle the problems of the old public sector in a changing environment. One of the main issues has been the capacity of the state to govern society in an era when the state is cutting back and the global environment is becoming more complex (cf. Aucoin, 1990; Pierre and Peters, 2005). In addition, the attention several international organizations have placed on it makes NPM look like a blueprint. The OECD, for instance, has set up a specific public management committee which states that ‘governments must find effective ways to make responsive policy decisions and to identify the right mix of incentives to implement them’ (OECD, 1995: 9). Some argue that it is possible to develop a framework that is able to determine when and how a specific task should be governed (cf. Cohen, 2001). Indeed, several NPM advocates, notably Osborne and Gaebler (1993), have provided rules and instructions for changing the public sector which and suggested that they are according to them, applicable in every public sector with bureaucracy problems.
I argue that it is impossible to determine which tasks should be undertaken by the government versus the market or which should be subject to public management. It depends on whose preferences and values are taken into account (Pollitt, 2001). Furthermore, Resen (1998: 153) argues that implementing NPM may magnify potential disagreements and stir up dormant issues. Finally, though the welfare state might save the market from its own dysfunctional tendencies, it carries within itself the potential to undermine the market (Cerny, 1997: 261). In other words, a bureaucratic (state-led) health care system has specific PA-problems, as has health care organized by the market. In the former, bureaucracy problems occur, while in the latter information asymmetry, moral hazard and adverse selection are present. This means that by implementing NPM in health care systems, governments are probably exchanging one set of problems for another.

Another important reason why NPM is not a universal blueprint is that old patterns of welfare provision are unlikely to be sustained by the implementation of NPM. Savoie (2006) argues that NPM is better at describing the solutions than at diagnosing the problems of the public sector. Resen (1998) states that many societal problems are of a nested nature and cannot be solved by focusing on limited aspects. In addition, NPM changes the distribution and content of social welfare policy substantively (Brodkin, 2006: 4). Resen (1998) contends that NPM not only changes the governance of social welfare policy, but also substantively changes its distribution and content. Moreover, opportunism, perverse effects and fraud are likely to appear more frequently. Goals are more focused on the performance with concrete (narrow) indicators, for instance admission days.

These arguments suggest that, PA-frictions will inevitably accompany the implementation of NPM. More importantly, it might be that exposing a public sector to ideas of competition, leading to wide spread individualism fosters certain elements at the expense of others (Resen, 1998: 155). Thus, NPM cannot be considered a ‘one-size-fits-all’ solution for public sectors problems, since it may lead to welfare state retrenchment and triggers political questions about the role of the state.

One reason why NPM is sometimes seen as a blueprint stems from its widespread application by different types of governments in various public sectors. Indeed, NPM has been embraced by market liberal parties and (third-way) social democrats alike (cf. Cutler and Waine, 2000; Leys, 2001). However, it is important to note that this finding is somewhat biased towards Anglo-Saxon and Scandinavian contexts (cf. Cohn, 1997; Green-Pedersen, 2002b). It is unclear whether social-democratic parties in continental Europe have supported NPM to a similar extent as their Anglo-Saxon and Scandinavian counterparts or whether they support it only under specific circumstances. It triggers the question whether and under which conditions actors can actively further NPM in health care policy.

Moreover, the preferences of Christian-democratic parties regarding NPM are under researched, making it difficult to discern the extent of their support. Similar to social-democratic parties, they have been big welfare state spenders,
particularly in times of economic prosperity. However, they support a different form of social capitalism, which is less based on universalism (Van Kersbergen, 1994: 42). In this dissertation, the role of Christian-democratic parties is not specifically addressed, but I compare political competition in Germany and the Netherlands, which have important Christian-democratic parties, with the UK.

In sum, NPM is defined as lessening or removing differences between the public and private sector and shifting the emphasis from process accountability towards a greater element of accountability in terms of results. However, this shift is politically vulnerable, since it touches upon questions about the role of the state. In addition, health care policy problems are of a nested nature and therefore cannot be solved by focusing on ‘governance’ or changing PA relationships. I argued that the emergence of NPM in a health care system leads to political conflict, which makes studying actor preferences in different institutional contexts relevant to understand variation in reforms.

2.5 Politics matters: political parties and NPM in health care

Explanations for reform are often sought in the adaptability and structure of the system and not in the choices of political actors in these systems (Hacker, 2004; Harrison, 2004). This way of explaining reforms has been very common in the welfare state and health care reform literatures (cf. Kumpers, van Raak, Hardy, and Mur, 2002; Pierson, 1994; Starke, 2006). For this reason, this argument is taken seriously in this dissertation. However, several scholars have identified the role political actors play in these processes. Vis, Van Kersbergen and Becker (2008) have shown that coalition governments have political motives to pursue reforms. Béland and Shinkawa (2007) argue that institutions explain major differences in policy patterns but that politics of ideas, among other factors, also play a role. Pierson (1994) argues that health care is characterized by heated controversy and a staggering array of powerful interests that compete over policy reform. These studies suggest that studying the choices of actors in the interaction with their specific institutional settings (rather than studying institutional contexts alone) is relevant for understanding reforms.

The notion that actors and institutions should be studied in tandem is no longer novel. New institutionalism (cf. Hall and Taylor, 1996; Immergut, 1998; Pierson and Skocpol, 2002) seeks to elucidate the role that institutions play in the determination of social and political outcomes (Hall and Taylor, 1996: 936) and attempts to explain how institutions affect the behavior of actors. Thus far, new institutionalism has not provided a conclusive answer to how actors and institutions interact in welfare state reforms. The different forms of institutionalism – e.g. rational, historical and sociological institutionalism – respond to this question in specific ways (e.g. Czada, Héritier, and Keman, 1998; Hall and Taylor, 1996; Pierson and Skocpol, 2002; Weingast, 2002). As will be outlined below, new institutionalist frameworks are used to interpret the interaction between actors and institutions.
In the preceding sections, I have argued that implementing NPM influences the interests and preferences of actors in the health care system and is therefore likely to lead to conflicts between different political actors. Analyzing preferences of political parties will provide insight into how governments seek a new balance in health care goals. Several scholars mention social-democratic parties as particularly important for NPM reforms (cf. Green-Pedersen, 2002b; Leys, 2001). Many of these parties in Western Europe have adopted a pragmatic ‘third-way’ policy involving both a positive view of the ability of the market to provide certain outcomes and a strong emphasis on the active ‘social investment’ of the state (Green-Pedersen, Van Kersbergen, and Hemerijck, 2001). Cutler and Waine (2000: 318), for instance, argue that Labour has embraced the changes of the Conservative party while at the same time setting out its ‘own’ managerialist approach.

However, Merkel and Petring (2007) argue that not all social-democratic parties have shifted towards a third-way approach. Besides, they argue that factors such as potential coalition partnerships and specific party competition explain policy patterns to a greater extent than institutional settings do. Hence, it is unlikely that social-democratic parties support implementing NPM in health care under all circumstances across countries. I argue that specific party configurations may accelerate or moderate the extent to which social-democratic parties will take up NPM (cf. Green-Pedersen, 2002b; Kitschelt, 2001; Merkel and Petring, 2007).

In addition, as will be further outlined in Chapter 4, national health services provide better possibilities for controlling costs, but individuals have fewer possibilities to affect the quality of the care they obtain. In contrast, insurance systems offer more choice to patients, but states are less able to offer equitable accessibility and to control costs. Since the preferences of political parties are not exogenous but determined by the specific health care system, actor preferences about NPM may vary across countries.

I argue that specific institutional settings do not determine the outcomes of reform but that they are nevertheless relevant for understanding the choices of governments (cf. Hall and Taylor, 1996; Merkel and Petring, 2007). Political competition and political decision-making about NPM might be affected by the specific party configuration in which parties are embedded and by the specific health care system. In other words, the extent to which parties are able to further their preferences in health care policy depends on the relationships between parties and how the different goals are already embedded in the health care systems. However, health care policy is developed in a complex institutional context in which the medical profession is identified as an important actor in the policy process. To gain a better understanding of how actors and institutions interact in health care reforms, it is necessary to take also the role of the medical profession into account.
2.6 Balancing interests: the medical profession and the government

An important characteristic of health care is the dominance of physicians in its provision. Physicians work in single purpose organizations with strong informal networks (Ackroyd, Kirkpatrick, and Walker, 2007). They are organized by medical organizations that have access to policymaking, albeit in different ways. According to Olson (1982: 28), similar to other small well-organized organizations, these bodies are able to affect the small choices needed to implement policies.

A central argument of this dissertation is that action in health care policy is not determined by institutions alone but that it is also influenced by the preferences of the actors involved (Keman, 1999b: 250/251). While politicians are prone to strive for the proper balance between quality, cost containment and accessibility, patients seek the best obtainable care. The medical profession, in comparison, seeks self-regulation, autonomy and care for patients (e.g. Salter, 2002).

As will be outlined in Chapter 5, actors have a specific preference ordering with regard to NPM (see also Keman, 1999b; Scharpf, 1997). Whether these interests are parallel, conflicting or complementary likely varies across institutional settings (cf. Czada, 1998). I argue that the self-regulation of the medical profession is the most likely source of conflict between actor preferences. Governments have introduced means that reduced self-regulation in the last two decades (cf. Giaimo, 2002; Horner, 2000; Kuhlmann and Allsop, 2008; Lieverdink, 2001), but as Salter (2002) suggests, self-regulation is one of the key interests of the medical profession. The new payment systems, however, do not particularly aim on reducing self-regulation. It may have the result, but not necessarily. As I will show, this depends on the specific governmental preferences and the institutional position of the medical profession.

According to Keman (1999b), there are two possibilities for agreement when two parties compete in the same realm of ‘needs’. If parties have complementary interests or preferences (i.e. separate organizations demand identical measures that meets their respective preferences or interests), they can form strategic coalitions. Otherwise, if parties have parallel interests (i.e. separate organizations have similar preferences or interests) but with a different ordering, they can undertake cooperative strategies (Keman, 1999b: 260).

I argue that the strategies available to medical organizations in decision-making depend on their preferences and interests, on the way they are embedded in the health care and political systems and on the assumptions about the strategies of other actors. Several authors have distinguished different strategies that are used in negotiations between governments and interest organizations: problem-solving, bargaining and confrontation (cf. Scharpf, 1997, 1998; Woldendorp, 2005). In addition, Hood (1995) has theorized which outcomes of NPM reforms are likely under different strategies. In Chapter 5, I outline more precisely the circumstances under which various outcomes can be expected.
2.7 Research design: a comparative approach

This dissertation provides comparative studies of new hospital payment systems. The variation of interest is primarily synchronic, meaning that I focus on variation between cases and not on variation over time (Gerring, 2007). According to Colomer (2002), comparing in political science entails “gathering knowledge about similarities and differences among political structures and at the same time testing theoretical propositions about the real working of political institutions. The research question examined in this study is: To what extent is the variation between new hospital payment systems in Germany, the Netherlands and the UK a result of preferences about NPM, related behavior of political parties and medical bodies, and institutional characteristics of the political and health care systems? The question reveals several specific choices regarding the research design. First, it shows that only one phenomenon is studied, i.e. variation between new hospital payment systems. Second, it explicates which factors are relevant for understanding the phenomenon, i.e. which actors and institutions. Finally, it shows which cases are taken into account.

One of the most prominent questions in social science research is how many cases are needed to gather sufficient knowledge. In King, Keohane and Verba’s (1994: 4) influential book about social research, they distinguish between qualitative and quantitative research but argue that this is primarily a stylistic and methodological differentiation. All social research should derive from the same logic of inference. Hence, a central message of their book is that qualitative researchers can improve their work by adhering to the standards of quantitative research designs (cf. Laitin, 1995). Several authors have opposed this idea (cf. Brady and Collier, 2004; Gerring, 2007). According to Gerring (2007) despite the number of cases, the purpose of a study should be – at least in part – to shed light on a larger class (i.e. a population). In this dissertation, the population constitutes Western European countries with a public health care service that implemented a new hospital payment based on DRG: i.e. systems that remunerate hospitals on the basis of case fees. Hence, I aim on finding conclusions that are not only relevant for the cases of this research.

The number of cases mainly affects whether a study will have more external or more internal validity. Studies with many cases often analyze one observation in each case, e.g. the relationship between economic growth and social expenditures, and are usually a good representation of the whole population. In comparison, studies with one or very few cases analyze several observations at different levels of observation\(^4\). They are typically able to gather better information about how causal relationships work, but they run the risk of overestimating the causal effect.

\(^4\) There is some confusion about this term. What Landman (2000) defines as ‘unit of observation’ is probably similar to what Keman (1999a) defines as ‘unit of measurement’. In this dissertation, unit of observation is defined as the unit of data observations within the object of study (in this research the object of study is a country, but in studies where large numbers of countries are observed, object of study is the population these countries represent)
The advantages of case studies are found in their exploratory and (dis)confirmatory nature (Gerring, 2007: 40; see also Lijphart, 1975).

This dissertation aims on giving more insight in how the interaction of actors and institutions is related to the way NPM has emerged in new hospital payment systems and on arriving at plausible explanations as far as feasible given the data and the cases involved. There are two reasons why a comparative case studies design is the most relevant choice. First, it is difficult to obtain a larger sample of cases given the complexity of measuring the ‘dependent variable’. As will be shown in Chapter 3, the way and extent NPM has emerged cannot be measured in a way that is useful and meaningful in a large-N, quantitative design. Second, I explore the interaction between actors and institutions on different levels of observation to enhance understanding of the relationship between the different variables.

2.8 Research design: new institutionalism as framework of interpretation

New institutionalism provides useful frameworks to interpret the interaction between actors and institutions, but it does not offer a conclusive answer to how institutions affect actor preferences. I do not claim to test institutionalist theory, but use insights from its specific approaches to understand how and to what extent actors and institutions are related to the specific emergence of NPM in the hospital payment systems. Both rational institutionalism and historical institutionalism are relevant as interpreting frameworks. A rational institutionalist approach is useful for interpreting actor preferences and related behavior in specific institutional contexts. It is main argument is that actors act as rational as possible given their specific ‘room to maneuver’ (cf. Keman 1998). Rational institutionalism has however problems with ‘non-rational’ changes (Hall and Taylor, 1996). Hence, it has difficulties in explaining how new payment systems ‘abruptly’ have emerged in relatively rigid policy domains.

A historical institutionalist approach is particularly useful for interpreting punctuations in rigid policy domains. The main shortcoming of historical institutionalism is its unclear assumptions about the interaction between institutions and actor behavior. Some combine the ‘calculus approach’ from the rational institutionalists with a ‘cultural approach’: i.e. actors are bounded in their specific worldview (Hall and Taylor, 1996: 939). The historical institutionalist approach has been particularly used in case studies that employ thick, historical analysis. However, it has been shown to be a useful framework for comparative studies too (Pierson and Skocpol, 2002: 694).

Border crossing between institutional approaches is not new (Thelen, 1999). As noted above, it is argued that historical institutionalists borrow assumptions from both sociological institutionalism and rational institutionalism to interpret actor behavior. In addition, Peters et al (2005) argue that historical institutionalism would gain from some form of agency. Hence, he asks for a stricter way of interpreting actor behavior in their specific settings. He argues that the emergence
30

Seeking a balance?!

of NPM cannot be understood without some form of agency for the neo-liberal ideas (Peters, Pierre, and King, 2005: 1293). Scharpf (2000: 770-771) argues that using a specific institutionalist framework leads to too deterministic results. He states that actor preferences should be treated as a theoretically distinct category: i.e. preferences are influenced, but not determined by the institutional setting in which interactions occur.

Instead of taking one particular type, I consider the institutionalist frameworks complementarily and assess particularly how far the new institutionalist explanations travel by analyzing to what extent and how actors and institutions account for variation in reforms. As outlined above, I explore the preferences and related behavior of political parties and medical profession and compare the emerging patterned variation between the countries. I do not treat preferences as exogenous and given, but relate them to their specific context. Hence, it is analyzed to what extent NPM can be seen as an ideational feature that together with economic problems creates a critical juncture in health care policy and to what extent actors have the capacity to forward their preferences under these circumstances.

2.9 Research design: case selection

Well-founded case selection is crucial in a comparative case studies design. Indeed, some of the often-mentioned problems of small-N studies relate to the methods by which cases are selected (cf. King, Keohane, and Verba, 1994). Although small-N studies cannot cope with the requirements of statistical models, they nevertheless provide specific opportunities for research. In small-N studies, cases are seen as complex, yet meaningful, configurations of events and structures (Ragin, 2004: 125). In this section, I provide the motivation behind my selection of cases for which I try to trace the processes that have occurred (cf. Rothstein, 2007; Seawright and Gerring, 2008).

Case selection is a much debated topic in the methodology literature. Lijphart (1971) distinguishes six types of case selection and Gerring (2007) an astonishing nine. Lijphart (1971: 687) demonstrates several ways to solve the ‘small-N many variables’ problem. One option is to focus on ‘comparable cases’, i.e. cases that are similar in a large number of important characteristics but dissimilar regarding the key variables that one wants to relate to each other.

My case selection is based on this idea and follows what Gerring (2007) calls a diverse cases design. The cases, which are expected to be representative in the minimal sense, are chosen to capture the full variation in the population on the variables that I want to relate to the variation in new hospital payment systems. This type of case study is particularly relevant for generating and testing hypotheses (Gerring, 2007: 89). As noted, both exploration and hypothesis testing are applied in this study: a direct, simple causal relationship is (dis)confirmed, and subsequently other aspects, i.e. the interaction between actor preferences, related
behavior and institutions, of the cases are studied to gain a better understanding of the variation in the new hospital payment systems.  

The cases Germany, the Netherlands and the UK, represent the population of Western European countries with a public health service in which new hospital payment systems based on DRG are introduced. In these systems, every inpatient care is classified by diagnosis, procedure, age of patient and condition in which the patient left the hospital (Fetter and Freeman, 1986; Lungen and Lauterbach, 2000). Hospitals are rewarded for productivity, as an increase in activity will increase payments. The prices for each case are usually determined irrespective of the real costs (cf. Jegers, Kesteloot, De Graeve, and Gilles, 2002; Schreyögg, Stargardt, Tiemann, and Busse, 2006). DRG systems facilitate NPM in several ways, e.g. by focusing on efficiency, by shifting accountability to the health care providers and by enhancing the possibilities for competitive contracting (see Chapter 3). Table 2.3 shows how the policy processes developed through time in the three cases.
Table 2.3 The implementation of new hospital payment systems

<table>
<thead>
<tr>
<th>Country</th>
<th>Year and decision</th>
</tr>
</thead>
</table>
| The Netherlands | 2000: Request research Diagnose Behandel Combinaties (DBC)  
2001: Project DBC  
2005: official start DBC-system  
2008-9: Budget component (fixed DBC prices) decreased to 60%, competition for 40% of DBCs |
| Germany     | 2001: First design “fallpauschalengesetz’l  
2002: Decision on legislation (start convergence phase)  
2003: Adjustment law (prolongation convergence phase and new rules special hospitals)  
2004: Second adjustment law  
2009: End of convergence phase |
| UK          | 2000: NHS plan  
2002: Reforming the NHS financial flows  
2003: Payment by Results (PbR) consultation preparing for 2005  
2004: Start PbR foundation trusts  
2005: Start PbR (limited amount of services)  
20??: Most services under PbR |

1Fallpauschalen are difficult to translate into English. Common translations are ‘case-based lump-sum’ ([http://www.aok-bv.de/lexicon](http://www.aok-bv.de/lexicon)), and ‘case fee’ (Busse and Riesberg, 2004: glossary). I would translate it as ‘case-based, all-inclusive fee’. Hospitals get remunerated a total sum of money based on cases with a fixed price.  
(source: Ettelt, Thomson, Nolte, and Mays, 2006)

Though NPM elements can emerge in these payment systems, this is no certain conclusion. The assumption allows me to analyze variation in the way NPM emerges in these similar types of hospital payment systems. Furthermore, hospital payment systems incorporate all important institutional settings and actor constellations in a health care system, including health care providers, third actor payments, patients and the state (Busse, Schreyögg, and Smith, 2006). Germany, the UK and the Netherlands introduced new hospital payment systems in the same period (2002-2007) and are therefore likely to be similarly affected by external factors, such as economic conditions and the influence of international organizations (e.g. the OECD, the WHO and the EU), but they have different political and health care institutional settings. My cases illuminate the full range of synchronic variation on ‘the independent variable’.
Figures 2.3-2.6 demonstrate that the countries have had comparable economic positions and the main differences exist in the degree of public health care spending. Germany has spent a large proportion of its GDP on health care in comparison to the Netherlands and the United Kingdom. The large financial constrain of the unification is probably the most likely explanation (cf. Altenstetter, 2003), i.e. it might be an indication that cost containment is a more important health care policy goal in Germany compared to the other cases. However, despite this, Germany’s political and health care institutional setting makes it a relevant case.
Figure 2.3 Age dependency index in OECD countries (OECD, 2007)
Figure 2.4 Public spending on health among OECD countries (OECD, 2007)
**Figure 2.5 Total spending on health care among OECD countries (OECD, 2007)**
Figure 2.6 National income per capita (OECD, 2007)
As argued, the cases represent three specific institutional contexts in Western Europe, i.e. a state-led health care system in a centralized political system, an insurance-based system in a centralized political system and an insurance-based system in a federal political system. The cases differ with respect to several political and health care institutional settings (see Table 2.4), which determine the extent to which the government has to share powers with other actors (cf. Jordan, forthcoming; Lijphart, 1999). The only other useful case would be a state-led health care system in a federal political system. Unfortunately, such a case does not exist.

According to the specific problems in health care policy, one would probably expect that NPM is particularly popular in Germany. However, I assume that if the emergence of NPM is related to the specific institutional setting, it will emerge to the largest extent in the UK, to a moderate extent in the Netherlands and to the smallest extent in Germany. As will be shown in Chapter 3, NPM has emerged differently than assumed by the ‘power-sharing hypothesis’, particularly in the Netherlands. In other words, a direct causal relationship between institutions and the variation in health care reforms cannot be drawn.

Table 2.4 Polity and health care characteristics

<table>
<thead>
<tr>
<th>Polity characteristics</th>
<th>UK</th>
<th>Netherlands</th>
<th>Germany</th>
</tr>
</thead>
<tbody>
<tr>
<td>State structure</td>
<td>Unitary state</td>
<td>Unitary state²</td>
<td>Federal state</td>
</tr>
<tr>
<td>Parliament structure</td>
<td>Asymmetrical bicameralism</td>
<td>Asymmetrical bicameralism</td>
<td>Symmetrical bicameralism</td>
</tr>
<tr>
<td>Majority-consensus system</td>
<td>Majority system</td>
<td>Consensus system</td>
<td>Consensus system</td>
</tr>
<tr>
<td>Party government structure</td>
<td>Single party government</td>
<td>Coalition government</td>
<td>Coalition government³</td>
</tr>
<tr>
<td>Health care system</td>
<td>National health system</td>
<td>Insurance based system,</td>
<td>Insurance based system,</td>
</tr>
<tr>
<td>State tradition</td>
<td>Anglo-Saxon</td>
<td>French-Napoleonic</td>
<td>Germanic</td>
</tr>
</tbody>
</table>

Notes: Characteristics shared between cases are underlined.

¹Although devolution matters for this specific reform and the new hospital payment system has only emerged in England, the decision-making is played out in a unitary context (Budge, 2002: 18).

²Keman (2002: 232) states that the Netherlands is unitary and decentralized at the same time, but that the ultimate regulating powers rest with central authorities. The latter is particularly the case in health care. For this reason, the Netherlands can safely be characterized here as unitary state.

³The German chancellor has – legally – a more powerful position than the Dutch and British prime ministers. I assume that the role of the Chancellor has no specific role in this policy process. (sources: Colomer, 2002; Lijphart, 1999)

As discussed in the theoretical sections of this chapter, scholars of NPM and welfare state reforms have identified (social-democratic) parties as important actors in reforms (cf. Green-Pedersen, 2002b). In all three countries included in the study,
NPM as public-private shift in health care

the social-democratic party has been in the coalition either for the whole policy process (Germany and the United Kingdom) or for a considerable time period (the Netherlands from 1998-2002). For this reason, I argue that the responses of the social-democratic parties affect the outcomes of reform. In addition, I assume that the institutional characteristics are relevant in relating the party preferences to the way NPM has emerged. They determine political parties’ room to maneuver (cf. Colomer, 2002; Keman, 1997). This means that similar party families in different countries might not react in the same manner, since they are embedded in different structures (see Table 2.4)\(^8\).

Table 2.5 shows that the cases depict two specific public health care systems and three specific party system configurations. They do not represent the ‘perfect’ diverse cases design, because other combinations are possible, e.g. a national health service with a ‘Dutch’ party system configuration\(^1\). Although this makes the results less valid for the whole population of countries, there is sufficient variation among the cases to obtain meaningful results. Based on the variation in the new payment systems, one can expect that at least in the Netherlands and probably in the UK, social-democratic parties have been willing to introduce NPM in health care reforms.

Table 2.5 Case characteristics: Health care and political system

<table>
<thead>
<tr>
<th></th>
<th>UK</th>
<th>Netherlands(^2)</th>
<th>Germany</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health care system:</td>
<td>National health service: large tax based financing</td>
<td>Insurance system: public (70%) and (obligatory) private (30%)</td>
<td>Insurance system: public (88%), (voluntary) private (12%)</td>
</tr>
<tr>
<td>purchasers/funding</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Political system:</td>
<td>United market-liberals versus united social-democrats</td>
<td>Three-way divide between liberals, centre and social-democrats</td>
<td>Relatively weak liberals, strong centre and strong social-democrats</td>
</tr>
<tr>
<td>Party configuration</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(sources: Kitschelt, 2001).
Note: Shared characteristics are bold.

Additionally, the cases differ in specific institutional settings that are relevant for understanding the interaction between the government and the medical profession. I contend that negotiation strategies of the medical bodies depend partly on the preferences of the medical profession and partly on the institutional setting, i.e. the rules of the game. The specific institutional settings that are considered important for understanding the negotiation strategies of the medical profession are: first, clinical discretion - the extent to which the medical profession can set its own

\(^1\) See for further details Chapter 4
\(^2\) This describes the situation until 2006 (which was the situation when the new hospital payment system was implemented).
Seeking a balance?!

standards; second, economic autonomy - the extent to which physicians can affect their ‘salary’; and third, joint decision-making - the extent to which the medical bodies are involved in decision-making (see Table 2.6).

Germany and the Netherlands have relatively similar institutional settings in comparison to the UK. Gerring (2007: 89) argues that cases can also be as diverse as possible on the combination X/Y. The cases represent: a case where the medical profession has an important (formal) position in the decision-making process and where NPM has emerged to a large extent (The Netherlands), a case where the medical profession has a formal position and where NPM has emerged to a small extent and in a specific way (Germany), and a case where the medical profession has no formal role and NPM has emerged to a large extent (the UK).
### Table 2.6 Case characteristics: The institutional settings of the relationship between the medical profession and the state

<table>
<thead>
<tr>
<th>Institutional settings</th>
<th>Netherlands</th>
<th>Germany</th>
<th>UK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Economic autonomy</td>
<td>70% of physicians are independent entrepreneurs (mainly in hospitals); the rest are employed by hospitals</td>
<td>Approx. 50% of physicians work in hospitals, mainly salaried employees, with some mixed forms; the remaining 50% works in ambulatory care, mainly office-based physicians</td>
<td>NHS physicians are salaried</td>
</tr>
<tr>
<td>Medical bodies</td>
<td>Corporate body negotiates the (hourly) tariff, but this is determined by the Dutch health authority; hospitals negotiate with insurance companies about DBC’s</td>
<td>Statutory Health Insurance (SHI) bodies negotiate tariffs; unions are also relevant in the hospital sector</td>
<td>British Medical Association (BMA) negotiates about contracts with the Department of Health and NHS, consultant’s contract.</td>
</tr>
<tr>
<td>Decision-making</td>
<td>Joint decision-making: medical profession developed DBC system; involved in the maintenance</td>
<td>Joint decision-making, SHI bodies (including medical profession, sickness funds and Hospital Society) were obliged to choose a new payment system; involved in the maintenance</td>
<td>No (official) joint decision-making</td>
</tr>
<tr>
<td>State-profession relationship</td>
<td>Government depends to a large extent on the corporate bodies</td>
<td>Government depends to a large extent on the corporate bodies</td>
<td>Government only partly depends on the medical profession, e.g. clinical directors</td>
</tr>
</tbody>
</table>


Chapter 5 explores whether the interactions between the medical bodies and the government in different institutional settings are related to the outcomes of the new hospital payment system reform. According to the way NPM has emerged in the payment systems, I assume that medical strategies in the Netherlands focus more on problem solving than in Germany, despite the comparable institutional contexts.
In the UK, medical strategies are less relevant for explaining the outcomes, due to the limited involvement of the medical bodies in the policy process.

In sum, the following empirical chapters explore to what extent and how institutions and actors affect health care policy with a new institutionalist framework. Together, they form a comparative case study to explain variation in the emergence of NPM in new hospital payment systems. As outlined in the next section, the empirical chapters analyze the specific factors at different levels of observation and with different research techniques.

2.10 Research design: Data and methods

There is a frequent confusion regarding types of evidence, data collection and research strategies (Gerring, 2007; Yin, 1981: 58). Although a comparative case study provides the opportunity to garner a complete picture of the cases, this does not imply that the types of evidence and data collection must be qualitative in nature. A case study can also be done with quantitative data (cf. Vietorisz and Harrison, 1970). In this study, both quantitative and qualitative research techniques are used to address the research questions.

A case study allows one to approach the research problem from different units of observation (Gerring, 2007; Mahoney, 2000). Depending on the research question and the number of meaningful observations that can be made within a case, the data collection and the subsequent research techniques are more qualitative or quantitative in nature. In contrast to some comparative case studies which present broad and case-by-case reports, the empirical chapters of this dissertation are devoted to specific sub-questions across all three cases. In this section, I provide a short overview of the data collection and methods; both are further discussed in the chapters that follow.

By means of systematic document analysis, Chapter 3 demonstrates the degree and manner in which NPM has emerged in the policy documents of the new payment systems. The results show that NPM does not emerge in accordance with the state tradition and the way powers are formally shared. The extent to which NPM elements have emerged in the Netherlands, for example, is particularly remarkable. In addition, the focus in the German plans on efficiency, cost containment and the absence of competition is a notable finding.

In Chapter 4, the observations follow from a textual analysis of party manifestos (1986–2006) and parliamentary debates (1998–2004). With Ordinary Least Square (OLS) regression, the saliency to different elements of NPM and health care of parties are compared between and within cases. The limited number of countries allows for a more in-depth study of the role of the different social-democratic parties in specific contexts. However, the limited number also restricts generalizations. The results show that governmental parties can further their preferences. The party configuration and health care system are important to understand how politics is shaped and therefore how NPM has emerged.
Chapter 5 employs different types of sources to get insight how preferences and related behavior of the medical profession matters. By means of an expert questionnaire, document analysis, a close reading of the contributions to professional journals and studying a review of the secondary literature, the perceptions and strategies of the medical bodies are analyzed. The results show that medical strategies are related to the outcomes – politics matters - but depend heavily on the specific institutional position of the medical body. The strategy of the Dutch medical body has facilitated the way NPM has emerged. In Germany and the UK, the medical profession had more aggressive, uncooperative styles, but these strategies resulted in different outcomes. The specific institutional settings have affected whether the strategies have been effective; i.e. actors and institutions are both necessary to explain outcomes of health care reforms.

2.11 Conclusion

This chapter has provided an overview of the research design of this dissertation. I argued how NPM would change the PA-relationships between health care actors and the type of governance. Implementing NPM leads to a public-private shift in the health care sector and is no ‘blueprint’ for enhancing the performance of the health care sector. A public-private shift affects the main preferences of the political and sectoral actors and will lead to political conflict. However, political conflict does not take place in a vacuum, but in a specific political institutional context.

The main argument of this dissertation is that the interaction between actor preferences, related behavior and institutions explain variation between the new hospital payment systems. New institutionalism has provided useful frameworks for interpreting the interaction between actors and institutions. I argued why combining assumptions from the historical institutionalist and rational institutionalist frameworks is meaningful to explain variation between different institutional contexts. Preferences of actors should be studied as a separate category, but not exogenous from their specific institutional context.

Political parties and the medical bodies are the actors that are taken into account in this dissertation. First, I argued that preferences of political parties affect the reforms and these preferences are affected by the specific party configuration and health care system. Second, medical organizations are mentioned as actors that affect health care reforms. I argued that their preferences and related behavior need to be studied in tandem with their specific institutional position in relation to the government to understand the way NPM has emerged.
The comparative design that was presented in the second half of this chapter allows for analyzing the way NPM has emerged in new hospital payment systems in three different cases, i.e. diversity of actors, institutions and outcomes. In the next chapters, first, it is studied whether the variation the new hospital payment systems can be explained without taking actors into account. Second, I explore the preferences of political parties and relate them to the specific institutional settings. Third, the negotiation styles of the medical bodies are studied in tandem with the specific institutional settings.
3. THE EMERGENCE OF NPM IN HEALTH CARE

3.1 Introduction

How can the state preserve or even improve the quality of health care without a huge increase in cost? In the 1980s and 1990s, similar questions about the public sector and welfare state provoked debates about the size and role of the state in public sector provision. Inspired by a particular set of economic theories and values mainly focusing on enhancing efficiency (Christensen and Laegreid, 2001), NPM emerged as an ideational movement to address such questions.

In NPM, elements such as increased competition, devolution, managerialism and the use of contracts occur simultaneously (cf. Christensen and Laegreid, 2001; Hood, 1995; Lane, 2005). Contemporary studies have asked to what extent NPM can be considered a ‘one-size-fits-all’ solution (cf. Hood and Peters, 2004), i.e. is it applicable in every public sector and in different countries? Proponents of NPM consider it the solution for more efficient service provision, offering the possibility for services of equivalent or even superior quality but at lower or equal costs. In short, restructuring health care services by means of NPM holds the potential to fight bureaucracy and to create greater choice. Yet others view NPM as a neo-liberal attempt to dismantle the welfare state, e.g. by disguising cutbacks. According to these critics, NPM results in a decrease in the quality of public services (Green-Pedersen, 2002b). Moreover, Van Kersbergen and Van Waarden (2004) argue that implementing NPM would lead to a horizontal shift in governance, creating a separation between the functions of policymaking, policy implementation, enforcement and control (i.e. a shift from a ‘command-and-control’ state towards information management). This shift has the danger of generating new problems related to governability, accountability, responsiveness and legitimacy in the (welfare) state.

This chapter examines the variation in the new hospital payment systems in different political and health care contexts: the UK, Germany and the Netherlands. One avenue of research would be to compare why rather different countries have converged to a similar type of payment system. Harrison et al. (2002), for instance, question why different actors in different environments (the UK and United States) have converged towards ‘scientific-bureaucratic medicine’. According to these authors ideational convergence, i.e. similar ways of ‘framing the problem’ and similar intellectual underpinnings of the proposed solution, offers a possible explanation.

Nevertheless, there are at least two reasons why it is more interesting to study the variation in payment systems rather than their convergence. First, I argue NPM is not an ‘one-size-fits-all’ solution (cf. Christensen and Laegreid, 2002). This means that variation in the payment systems is more likely than similarity. Second, policy convergence may have quite distinctive explanations, making consensus about what exactly policy convergence entails, problematic, if not
impossible (cf. Heichel, Pape, and Sommerer, 2005; Holzinger and Knill, 2005; Knill, 2005). Furthermore, public sector and welfare state studies have shown that reforms tend to vary enormously among countries rather than being similar.

This chapter has two goals: establishing how NPM has emerged in the new payment systems and to ascertain that the different institutional settings alone cannot account for the variation. It addresses the following sub-questions:

- To what extent and how has variation occurred in the emergence of NPM elements in the new hospital payment systems of Germany, the Netherlands and the UK?
- To what extent is the variation between new hospital payment systems of Germany, the Netherlands and the UK explained by state tradition and the institutional characteristics of the political and health care systems?

The interactions between actors and institutions invoke differences between hospital payment systems although they originate from the same ‘ideational shift’, i.e. NPM (cf. Peters, Pierre, and King, 2005).

The chapter proceeds as follows. In the next section, I discuss what factors might be decisive for reform. The third section outlines why NPM is a relevant concept for analyzing variation in health care reforms. Subsequently, I elaborate my choice for analyzing reforms in hospital payment systems and I outline the conceptual framework and operationalization for comparing the emergence of NPM further. To preview the results, the analysis of policy documents shows that variation is indeed found and it is somewhat different from what one would expect given the particular political systems and health care state organizations.

### 3.2 Institutional settings and reform

Comparative studies on welfare state and public sectors reforms offer several explanations for variance in policy outcomes, focusing on cross-national structural differences. The most important are: variation in political systems (cf. Bonoli, 2001; Immergut, 1992a; Swank, 2001), state traditions, i.e. organizational features and the forms of procedures in state organizations (cf. Peters, 1997; Pollitt and Bouckaert, 2004; Resen, 1998) and welfare state structures (cf. Swank, 2001). Although the explanatory power of actor behavior is discussed by several scholars, many argue that despite political support, structural factors are to a large extent responsible for reforms (cf. Allan and Scruggs, 2004; Lieverdink, 2001). Hacker (2004), for instance, predicts that on the basis of their medical systems and the structure of their decision-making systems (i.e. polities), the UK should experience ‘big legislative breakthroughs and reversals’, Germany more ‘incrementalistic policy making’ and the Netherlands an intermediate outcome.

Given their different state traditions, political systems and health care systems, the three countries provide excellent cases for my analysis. Additionally,
they introduced new hospital payment systems in the same period (2002-2007) and are likely similarly affected by external factors, such as economic conditions and the influence of international organizations (e.g. the OECD, the WHO and the EU). In other words, the countries are similarly exposed to NPM.

In sum, this chapter examines to which extents NPM elements have emerged in the three countries. We expect the emergence of NPM to the greatest extent in the UK and to the least extent in Germany, with the Netherlands experiencing an intermediate outcome. As elaborated above, the reasons for this stem from fundamental differences in these countries state traditions, political structures and health care systems. The UK has an Anglo-Saxon state tradition, which is more receptive for NPM elements, as well as a hierarchical, centralized health care organization and a majoritarian political system. In contrast, NPM elements would emerge to a lesser extent in Germany, which has a Germanic state tradition, a self-regulated health care organization and a political system based on consensus and separation of powers. Finally, this chapter explores whether the Netherlands will have an intermediate outcome because this country has a unitary state structure and asymmetrical bicameralism (like the UK) and a coalition government and a self-governed health care system (like Germany) (see also Table 2.4).

3.3 NPM: The development of a ‘paradigm’

Though NPM continues to be relevant for contemporary research, the term ‘new’ is increasingly a misnomer, as the concept has changed over the years. NPM used to be a ‘new’ approach superseding traditional ‘old’ public administration. But it has shifted to a new logic with specific values and recently to a combination of market oriented philosophy combined with managerial thinking, in contrast to the professional bureaucracy (Hood and Peters, 2004). The emergence of NPM has been widely explored in public sector reforms, but little research has been done with regard to welfare state and health care reforms outside of the UK (cf. Ferlie, Ashburner, Fitzgerald et al., 1996; Green-Pedersen, 2002b).

Hood (1991) defines NPM as two different streams of ideas: new institutional economics and managerialism. Furthermore, Lane (2005) mentions two additional theories that are behind NPM: the Chicago School of Economics and PA-studies, both focusing on the relationship between the state and service delivery and the relationship between the state and its citizens (the customers of the services). Scholars of public choice and the Chicago School of Economics show that bureaucracy does not work and demonstrate why market-inspired mechanisms are needed to run the public sector efficiently (cf. Lane, 2005; Niskanen, 1971; Stigler, 1988).

The specific content of NPM has changed over the years. Ferlie et al. (1996), for instance, illustrate that the concept is comprehensive and unstable, and define four models of NPM in the 1990s. Nevertheless, several elements of NPM form its core and have remained recognizable during the evolution of the concept, namely contracting, decentralization or deregulation, emphasis on outputs and outcomes,
client-centeredness, efficiency, and contestability or marketization (cf. Christensen and Laegreid, 2001; Lane, 2005). The elements show a contradiction between the centralizing tendencies (for instance, explicit measures for performance) that are inherent in contractualism and the devolutionary tendencies of managerialism (Christensen and Laegreid, 2002).

The main criticisms of NPM focus on two aspects. The first is that the underlying normative values, derived from the Chicago School of Economics and public choice, are not universal solutions for problems in the public sector, as outlined in Chapter 2. A more intense focus on the efficiency of health care, as implied by NPM, might make it more difficult to ensure universal access of citizens to high-quality health care services. For this reason, opponents often see the introduction of NPM as a neo-liberal attempt to hollow out the welfare state (Green-Pedersen, 2002b). In Chapter 2, I linked NPM to ‘shifts in governance’ and theories about PA-relationships, and argued that NPM is no blueprint to improve the performance of the health care sector, since it affects the balances between health care goals and leads to different PA-problems. Hence, introducing new hospital payment systems is politically vulnerable.

Second, the tensions that are caused by the dual character of NPM have led to questions about the universal applicability of NPM, since focusing on depoliticization might easily lead to the opposite effect. Since public managers are not totally autonomous from political direction, applying NPM may lead to differentiated roles and to the (contestation of) allocation of risks of blame between public servants and politicians (Hood, 2001; Hood and Peters, 2004). Additionally, although aimed at deregulation, NPM forces the introduction of control mechanisms since political executives fear losing control over the implementation process (Hood and Peters, 2004). Finally, administrative costs do not decrease but increase, as actors have to invest and comply with new rules. In other words, introducing NPM in the health care sector is likely to have unintended negative consequences rather than being the solution to problems such as rising costs and waiting lists.

3.4 Conceptualizing NPM in hospital payment systems

I outline in this section that NPM elements can be expected to emerge in DRG-based hospital payment systems, but not necessarily in similar ways. I focus on the implementation of new hospital payment systems, since these are building blocks of any health care system, introducing powerful incentives for the behavior of actors in the system (Busse, Schreyögg, and Smith, 2006). Moreover, reforms usually involve changes in the relationships between all actors in the health care field, including providers, purchasers, patients and the state. The payment systems are either nation-specific Diagnosis Related Groups (DRG) systems, as in Germany, or systems based on the likeminded ideas but which code hospital episodes in a different way, as the ‘payment by results’ system in the UK and the
so-called DBC system in the Netherlands. The latter, for instance, incorporates outpatient care in its coding scheme.

The use of DRG payment systems became more prevalent in the 1980s and 1990s and has taken on a variety of forms (Fetter and Freeman, 1986; Leister and Stausberg, 2005; Lungen and Lauterbach, 2000). In some cases, the systems have been mainly symbolic, inducing little real change in the way the hospital sector is governed, while in other cases they have provided the basis for privatization of the hospital sector. The rationale behind all systems is that hospitals earn money if they treat patients for less than the DRG-tariff (cf. Fetter and Freeman, 1986). Though NPM elements can emerge in DRG-based payment systems, this is no forgone conclusion. This assumption allows me to analyze variation in the way NPM emerges in these similar types of hospital payment systems.

I argue that NPM can be adopted in DRG based payment systems in three ways. The first and most obvious is that NPM implies enhancing efficiency, particularly by increasing the emphasis on outputs and outcomes (Lane, 2005: 6). In health care policy, more emphasis on outputs and outcomes is usually sought by extending auditing systems, e.g. by introducing more transparent methods of performance review (Ferlie, Ashburner, Fitzgerald et al., 1996: 11). DRG systems are specifically designed to obtain better information about the performance of hospitals. An increased focus on efficiency is likely to emerge if the policy plans contain specific ideas and measures about, for example, the extension of auditing and transparency.

The second way concerns the change in accountability, suggesting that shifting accountability towards service providers and purchasers is a major feature of NPM (cf. Christensen and Laegreid, 2001; Lane, 2005). The government no longer directly controls or governs public sector providers, but instead becomes a contractor (Lane, 2005). It remains the principal in the PA-relation with the health care providers, but its role has changed. DRG-based payment systems might facilitate contracting in several ways, e.g. by allowing hospitals to determine what they actually have to offer to contractors. The increased stress on provider responsiveness to customers is an example of a shift of accountability (Ferlie, Ashburner, Fitzgerald et al., 1996: 11). In addition, a DRG system supports customer orientation by allowing for benchmarking (hospitals can more easily be compared) and patient choice (money can follow the patient).

Finally, introducing NPM might lead to (more) marketization and competition in health care provision. The reason for this is two-fold. First, the introduction of a DRG system might allow hospitals to enter competitive contracts about price, volume and quality with purchasers and might allow competition among patients (money can follow the patient). Second, DRG systems might allow private (or for-profit) hospitals to be paid from public money, i.e. they can “sell” DRGs (a certain hospital episode, e.g. cataract surgery) to insurance companies or public purchasers. Exploration of the variation in the hospital payment systems may reveal that plans have a particular focus on efficiency, competition and/or a
shift in accountability towards service providers. Hence, payment systems may affect the accessibility or quality of health care and the way the state is involved in health care organization.

Table 3.1 NPM elements as conceptual framework

<table>
<thead>
<tr>
<th></th>
<th>Performance accountability</th>
<th>Efficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Aims</strong></td>
<td>Accountable for performance</td>
<td>Efficiency</td>
</tr>
<tr>
<td></td>
<td>Empowerment of service users</td>
<td>Transparency</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Competition</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Privatization</td>
</tr>
<tr>
<td><strong>Measurers</strong></td>
<td>Choice</td>
<td>Standards and measures of</td>
</tr>
<tr>
<td></td>
<td>Bench-marking</td>
<td>performance</td>
</tr>
<tr>
<td></td>
<td>Deregulation</td>
<td>Contracting in</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The degree to which markets are actually established</td>
</tr>
</tbody>
</table>

Notes: Elements based on Flynn (2002), Hood (1991) and Lane (2000), used as examples that possibly emerge in DRG based hospital payment systems.

Table 3.1 presents the conceptual framework of this chapter. The ideas and measures are presented in the rows, while the columns differentiate NPM elements into those focusing on increasing efficiency and those focusing more on performance accountability. The NPM elements that focus on marketization and competition merge both columns, since by introducing competition elements, policy makers simultaneously aim at increasing performance accountability of health care providers for their performance and at enhancing efficiency. The elements mentioned in Table 3.1 are examples of the aims and measures of NPM that one expects to find in policy plans about DRG based hospital payment systems. Placing ideas and measures in the different boxes of the analytical scheme provides a clearer picture of how NPM has emerged. It highlights whether or not variation in aims and measures has developed with respect to new hospital payments systems.

Although in some cases the policy plans do not clearly separate between ideas and measures, I distinguish between them in the conceptual framework. It is possible that governments have had quite similar ideas about the aims of the new payment systems but have proposed quite different measures to reach these. Hence,

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1 Note that Table 3.1 is somewhat different from Table 2.2. In this Chapter I analyze how NPM has emerged in new hospital payment systems, while in Chapter 2, I showed how the NPM elements are related to public-private shifts and shifts in accountability.

2 Please note that not the outcomes of the reforms are studied but the policy plans. Since, this dissertation has been written between 2004 and 2008, the outcomes of the systems were not yet known.
the variation between the ideas and the measures is studied to understand how NPM is given shape in the new hospital payment systems. The next sections shortly outline how the policy processes developed and compare the ideas in the policy plans and, the policy measures of the new payment systems.

3.5 Policy processes compared

The policy processes show variation between the countries, particularly with regard to the way actors have been involved in the processes. This variation mirrors how the political and health care systems constitute the power sharing between political and health care actors. Decision-making in Germany and the Netherlands takes place in close co-operation between the government and interest organizations, while in the UK decisions are taken more hierarchically. In Germany, the medical profession and sickness funds organizations constitute the self-regulated structures that operate the financing and delivering of benefits covered by statutory health insurance (Busse and Riesberg, 2004). These organizations were responsible for developing a new system for hospital remuneration compulsory for all hospitals and other health care providers. They chose to create a nation-specific DRG system which is partly based on the Australian DRG system (Deutscher Bundestag, 2001b).

As in Germany, interest organizations have been involved in defining and implementing health care policy in the Netherlands (Harrison, 2004). Medical specialists started as early as 1994 with the development of the DBC system. This system turned out to be remarkably similar to DRG coding, but it incorporates outpatient care as well as fees for medical specialists. It was not until 2000, however, that the Dutch ministry decided to implement the DBC system (Ministerie van Volksgezondheid Welzijn en Sport, 2006). In contrast, the NHS has more hierarchical forms of decision-making and top-down implementation (Ham, 2004), meaning that interest organizations are likely to be less directly involved in the policy process compared to similar groups in the other two countries.

The new payment systems are either embedded in a general reform plan or emerge simultaneously with other health care reforms. In Germany and the UK, the introduction of the new hospital systems has been clearly part of a larger general reform plan. The German health care reform bill (Gesundheitsreformgesetz), implemented in January 2000, provided the first legal basis for developing a new payment system (Deutscher Bundestag, 1999). And in 2001, the first draft of the new DRG-system was created (Deutscher Bundestag, 2001a). The bill to install the new system was accepted in both chambers of parliament in April 2002. In the UK the white papers – The NHS plan: a plan for investment, a plan for reform (Department of Health, 2000) and Delivering the NHS plan: next steps on investment, next steps on reform (Department of Health, 2002b) – have provided the basis for the country’s new hospital payment system.

In the case of the Netherlands, the new payment system originated from a general reform plan that was already developed in 1994 but that was never fully
implemented (cf. Lieverdink, 2001). Simultaneously with the implementation of the DBC system, the insurance structure was reformed: the dual system of sickness fund and private insurance has been replaced by a compulsory basic insurance executed by voluntary organizations (Ministerie van Volksgezondheid Welzijn en Sport, 2005).

Finally, the extent to which the new systems differed from the old payment systems varies extensively. In the UK, the change in the payment system mainly involved a shift in the content of contracts between hospitals and purchasers. Hospitals are refunded for work actually done on the basis of a national tariff, with compensation for unavoidable high costs (Department of Health, 2003). In contrast, before the implementation of the new systems, hospitals in Germany and the Netherlands were refunded using a completely different mechanism. The Dutch health care system had a budgeting system in which hospitals received budgets based on specific calculations and fixed costs (Den Exter, Hermans, Dosjlak, and Busse, 2004). In Germany, the DRG system has replaced the mix of reimbursements per diem, per case and for expensive procedures (Busse and Riesberg, 2004). The DRG system is now the sole system for financing recurrent expenditures in German hospitals (Busse and Riesberg, 2004). Although the decisions were taken under different polity structures, the decision-making processes have taken place in a similar period (around 2002) in all three countries, however, the consultation period, as for instance in the Netherlands, could have been rather lengthy.

The implementation phases, i.e. the time it takes for the systems to come into effect, are fairly similar in the three countries. In the Netherlands, the new system quickly began to function as the sole budgeting system for acute hospital care, but a convergence phase has been introduced for price competition. In comparison, the German and British governments have introduced rather extensive convergence phases, i.e. hospitals are still receiving stable budgets and not all hospital episodes are incorporated into the system yet. The convergence phases are supposed to end in 2009 (see also Table 2.3).

3.6 Comparing the aims of the new hospital systems

The main purpose of this chapter is to explore the variation in NPM elements that have emerged in hospital payment systems and to examine whether variation can be explained from the health care and political contexts or whether other factors should also be considered. The characteristics of NPM make it possible to distinguish three types of elements that might emerge in DRG-based hospital payment systems: elements focusing on efficiency by means of governmental control over outputs and transparency, elements aimed at making health care providers and purchasers more accountable for their performance, and elements addressing marketization and competition. Tables 3.2-3.4 present how ideas and measures within the policy plans are divided among the categories.
The emergence of NPM in health care

Table 3.2 Aims and measures of the German DRG-system

<table>
<thead>
<tr>
<th></th>
<th>Accountability of results</th>
<th>Public-Private shift</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Aims</strong></td>
<td>Shift to payment on the basis of achievement</td>
<td>Intensify the integration of care</td>
</tr>
<tr>
<td></td>
<td>Efficient and effective resource use</td>
<td>Specialization of hospitals</td>
</tr>
<tr>
<td></td>
<td>Cost-effectiveness</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Transparency to improve quality</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Shorten hospital stays</td>
<td></td>
</tr>
<tr>
<td><strong>Focus on patient preferences</strong></td>
<td>Public publications on transparency, which are accessible for patients</td>
<td>Hospitals are financed per case-mix, in which the price per case is fixed</td>
</tr>
<tr>
<td></td>
<td>Benchmarking</td>
<td>Quality management developed by hospitals</td>
</tr>
<tr>
<td></td>
<td>If hospitals do not have a minimal number of treatments of certain specialty, they are not remunerated for that specialty next year</td>
<td>Teamwork and optimalization of the workforce (Bundesministerium für Gesundheit, 2007)</td>
</tr>
</tbody>
</table>

(Sources: Bundesministerium für Gesundheit, 2007; Deutscher Bundestag, 1999; Deutscher Bundestag, 2001b, 2001a; Schimmelpfeng-Schütte, 2006)
### Table 3.3 Aims and measures of the 'Payment by Result' system

<table>
<thead>
<tr>
<th>Aims</th>
<th>Accountability of results</th>
<th>Public-private shift</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Strengthen accountability to the public</td>
<td>Rewards efficiency and quality</td>
</tr>
<tr>
<td></td>
<td>Increase transparency</td>
<td>Sharper budget discipline</td>
</tr>
<tr>
<td></td>
<td>Efficient delivery</td>
<td>Fair pay for health care providers</td>
</tr>
<tr>
<td></td>
<td>Improve efficiency and value for money</td>
<td>Underpin the devolution of resources and responsibility to frontline organizations</td>
</tr>
<tr>
<td></td>
<td>Reduction in waiting times</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Reward providers whose services is able to attract patients</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Support patient choice and encourage hospitals to respond to patient preferences</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Facilitate plurality and contestability</strong></td>
<td></td>
</tr>
<tr>
<td>Measures</td>
<td>Providers should provide appropriate and transparent information to patients, so they can make appropriate health care choices</td>
<td>Setting a national price for units of activities based on the average NHS costs</td>
</tr>
<tr>
<td></td>
<td>Risk management arrangements in contracts</td>
<td>Encourage commissioners to focus on costs and volume</td>
</tr>
<tr>
<td></td>
<td>Contract monitoring arrangements</td>
<td>Pay a price that reflects real costs</td>
</tr>
<tr>
<td></td>
<td>Negotiations between PCT’s and providers on quality and innovation</td>
<td>Hospitals have the freedom to use the surpluses they generate for the benefit of the patients</td>
</tr>
<tr>
<td></td>
<td>More freedom for hospitals and PCT’s for delivering to focus on local needs, and by underpinning this, there will be a national framework of standards and accountability</td>
<td>Reward providers for the work done</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Commission service from private and voluntary providers</td>
</tr>
<tr>
<td></td>
<td><strong>Encourage commissioners to provide effective care in the most appropriate setting</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Money flowing to providers in support of patient choices</strong></td>
<td></td>
</tr>
</tbody>
</table>

### Table 3.4 Aims and measures of the Dutch DBC system

<table>
<thead>
<tr>
<th>Accountability</th>
<th>Efficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Aims</strong></td>
<td></td>
</tr>
<tr>
<td>Integration of medical profession in hospital administration</td>
<td>Direct relation between costs and benefits</td>
</tr>
<tr>
<td>Incentives for insurer and health care providers to work in line with the preferences of the patients</td>
<td>Efficacy</td>
</tr>
<tr>
<td>More management information</td>
<td>Shorten waiting times (Ministerie van Volksgezondheid Welzijn en Sport, 2003a)</td>
</tr>
<tr>
<td>Decentralised steering of health care</td>
<td>Decrease of administrative costs</td>
</tr>
<tr>
<td>More responsibility for sickness funds regarding the costs of health care</td>
<td>Awareness of costs for health care providers</td>
</tr>
<tr>
<td></td>
<td>Transparency as the key word of the DBC’s (Ministerie van Volksgezondheid Welzijn en Sport, 2000, 2003a)</td>
</tr>
<tr>
<td><strong>Competition</strong></td>
<td></td>
</tr>
<tr>
<td>Demand-led system</td>
<td></td>
</tr>
</tbody>
</table>

**Measurers**

<table>
<thead>
<tr>
<th>More steering for insurers</th>
<th>Fixed tariffs for 90%, which are based on mean costs per patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction of risks</td>
<td></td>
</tr>
<tr>
<td>Comparison between hospitals</td>
<td></td>
</tr>
<tr>
<td>Negotiation on the basis of volume, price and quality</td>
<td></td>
</tr>
<tr>
<td>Introduction of health authority</td>
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</tbody>
</table>

Contracting of insurers with health care providers (Regulated) competition

  - No fixed tariffs for 10% of the DBC’s (part of the negotiation process)
  - Government creates a transparent market and encourages competition

One of the main purposes of enhancing efficiency in Germany has been to shorten the hospital stays of patients. The government argues that there is a direct relationship between the length of stay and the way hospitals are remunerated (see Table 3.2). The English hospital plans show a clear focus on increasing efficiency by mentioning sharper budget discipline, reduction of waiting times and incentives to increase efficiency (see Table 3.3). The Dutch plans also centre on efficiency, e.g. by means of shortening waiting times, decreasing administrative costs and focusing on efficacy (see Table 3.4).

The three countries demonstrate variation with regard to shifts in accountability. The German policy plans place relatively little weight on this NPM element. Although the plans mention that hospitals and insurance companies are to be held more accountable for their performance by being rewarded on output instead of costs, no explicit ideas are presented in which hospitals or insurance companies are granted more leeway, i.e. the extent to which they are able to make decisions about their budget.

In comparison to Germany, aims focusing on shifts in accountability are more recognizable in the English policy plans, which explicitly focus on improving patient choice and shifting control over resources from the central level to Primary Care Trusts (further PCTs). Hospitals that are able to attract patients and perform better are rewarded (see Table 3.3). In the new Dutch system, shifts in accountability can be seen in goals concerning making insurance companies more accountable for the costs of health care, incentives for insurers to respond more effectively to patient preferences and the installation of a demand-led system (see Table 3.4).

The third way in which NPM can emerge in DRG hospital payment systems, concerns the elements competition and marketisation. The introduction of NPM may have involved an increased market-orientation or more competition in DRG systems, particularly, by means of competitive contracting about price, quality and volume or by means of privatization. The results show that marketization and competition are visible in the UK and particularly in the Netherlands, but they are absent in the German policy plans.

The emergence of NPM elements marketisation and competition highlights the most important difference among the countries. In the UK, goals are set to intensify competition among hospitals for patients. The rationale is that if hospitals are paid per case instead of on the basis of national contracts, they will work more efficiently. In the Netherlands, competition is mentioned as an explicate aim of the implementation of the DRG system. Hospitals are forced to negotiate contracts with insurance companies about quality, volume and increasingly about the specific price of treatments (Ministerie van Volksgezondheid Welzijn en Sport, 2003a).

In conclusion, elements of NPM are prominent in the English and Dutch policy plans and less prominent in the German plans. The latter has a strong focus on increasing efficiency by means other than shifting accountability. However, NPM is recognizable, for example in the argument that transparency in hospital
remuneration will lead to better quality of hospital care (Deutscher Bundestag, 2001b). In addition, despite the variation in each country, the two sides of NPM are visible in the DRG based hospital payment systems and the ideas in the policy plans resemble to a certain extent the problems of the old payment systems.

The results confirm to some extent the main hypothesis that institutions and actors matter for reforms, since institutional settings do only partly shape the outcomes. First, NPM has emerged in the Dutch policy ideas to a larger extent than expected. Second, the ideas in the countries seem to focus on specific NPM elements that can be partly explained from the specific context. The strong focus on efficiency in the German case can be explained from the fact that this country had the most expensive health care sector (see Figures 2.5-2.6). But the relatively strong focus on marketization in the Dutch case and the absence of these elements in Germany cannot be explained. The next section explores the policy measures of the new hospital payment systems to see whether the same variation can be observed.

3.7 Comparing policy measures

The extent to which health care providers and purchasers are held accountable for their performance and have the freedom to control budgets also varies considerably in the three cases. Measures directly aimed at efficiency are clearly visible in Germany. The prices of DRGs, for example, are fixed and adjusted to regional differences. This means that regardless of the effort needed to treat a patient, a certain price is paid to health care providers. The new system enables the government to better control the costs of hospital care than was the case during under the old system with budgets and fixed prices per hospital day. The German plans also reveal measures encouraging hospitals to specialize, i.e. hospitals have to offer a certain amount of specific treatment to stay eligible for funding.

Interestingly, although the Dutch system presented clear goals concerning efficiency and accountability, it is difficult to find actual measures that are directly aimed at improving efficiency, although the majority of the tariffs are still fixed (90% by the introduction of the new system). Similarly, efficiency measures are less common in the English than in the German plans. Nevertheless, the English policy plans do mention some direct procedures to improve efficiency, e.g. stricter budget discipline is mentioned (see Table 3.3).

Although making hospitals and insurance companies more accountable for their performance was a less visible aim in the German plans, the specified measures show that benchmarking, i.e. publishing the performance of hospitals publicly, is an important instrument in making health care providers more accountable for their performance (Deutscher Bundestag, 1999). In addition, German hospitals have obtained some leeway to develop quality management (Deutscher Bundestag, 2001a). In contrast, Dutch hospitals and insurance companies are clearly made more accountable for their performance. However, direct governmental steering in health care is not completely abolished, as
evidenced by the installation of a health authority and the involvement of the government in the health care market (see Table 3.3). The English plans show shifts in accountability that are more comparable to the Dutch plans. This is visible in the change of money flows, the way the new payment system provides more transparent information for patients, and the introduction of more freedom for providers to deliver health care addressing the needs and risks of their patients (see Table 3.3).

The visibility of competitive contracts and marketization in the measures of the new hospital payment systems provides the most noticeable differences among the countries. As mentioned above, the German policy plans did not include any ideas about increased competition or marketization. Therefore, it is not surprising that these kinds of measures are also absent. The Dutch policy plans included the most explicit ideas about competition and marketization, and the measures undertaken are to a large extent based on these ideas (see Table 3.4). In the UK, the possibility for PCTs to purchase hospital treatment from voluntary and private health care providers was introduced to encourage marketization and competition among hospitals. Simultaneously with the introduction of the payment by results system, NHS hospitals received incentives to become more independent from the NHS by becoming foundation trusts and by entering legally binding private contracts with PCTs (Ham, 2004).

It is worth noting that certain measures in the English plans deviate somewhat from the traditional view on NPM. First, contracts between PCTs and hospitals have, according to the plans, a primary focus on quality and volume instead of price (Department of Health, 2005b). Second, in several documents the government has emphasized that collaboration among actors in the health care system is more important than competition (see Table 3.3). Hence, while NPM is clearly visible in the aims of the English payment system, this is less so in the actual policy measures mentioned in the documents. The measures focus on increasing performance accountability and ‘empowering service users’. This focus fits to some extent in the ‘public service management model’ of NPM (Ferlie, Ashburner, Fitzgerald et al., 1996: 15).

In sum, the policy measures resemble the policy ideas. This means that the variation observed in the ideas, remain if the policy measures are taken into account. However, the NPM elements marketisation and competition are absent in the English policy measures. This might be explained from the evaluation of NPM in the ‘public service management’ model, but the explanation is unlikely since marketisation and competition are clearly visible in the Dutch system. The results support the idea that institutional settings are not decisive for the way NPM has emerged in the new hospital payment systems. As will be further outlined in the next chapters, specific preferences of policy-makers and their ‘room to maneuver’ need to be taken into account to explain the way NPM is given shape in the new hospital payment systems.
3.8 Conclusion

This chapter has had two goals: showing how NPM elements are embedded in the DRG based hospital payment systems and testing whether formal institutional settings are sufficient for explaining the variation. Three expectations were formulated. First, one could expect that NPM elements would emerge in the English hospital system most clearly, since this country has an Anglo-Saxon state tradition, a majoritarian political system and a ‘statist’ organized health care system. Second, NPM elements might emerge to a considerable lesser extent in Germany where large policy shifts are less common and the state tradition provides a less receptive environment for NPM. Finally, reforms in the Netherlands were expected to have an intermediate outcome in comparison to the other two cases.

The results have shown that NPM elements are visible in the three payment systems. In Germany, there is a clear focus on efficiency, while the Dutch system focuses on competition and marketisation and the English system focuses on patient choice. Hence, three clear patterns could be distinguished in three different contexts. The way NPM has emerged in the German and British case suggests that path-dependency and ‘power-sharing’ matter, since NPM elements have emerged to a large extent according to the expectations. In addition, the reason that efficiency has been highlighted in the German plans and patient choice in England can be understood from the specific characteristics of the health care systems. However, the focus on specific NPM elements in the ideas and measures of the hospital payment systems, in particular the emphasis on marketisation and competition in the Dutch payment system, can neither be explained from the specific problems in the health care sector nor from the institutional setting. The outcomes reinforce the argument that for explaining reforms not only institutional settings, but also the specific context and actors need to be taken into account (Peters, Pierre, and King, 2005).

The main conclusion of this chapter is that NPM needs to be seen as an ideational feature given shape by actors in a specific institutional setting. A formal institutionalist explanation does not travel far if the variation in the new payment systems is concerned. NPM matters and the results suggest that actors are able to further their preferences. The next chapters explore the specific interactions between actors, i.e. political parties and the medical profession, and institutions to see whether the variation in the new payment systems indeed can be explained by the interaction of actor preferences, related behavior and institutional settings.
Seeking a balance?!
4. COMPARING PARTY COMPETITION ON HEALTH CARE REFORMS

4.1 Introduction

Specific political institutional settings constrain the reform capacities of governments, particularly those of the Netherlands and Germany (cf. Pierson, 1994). However, despite different political and health care contexts, Germany, the Netherlands and the UK have implemented comparable hospital payment systems. The systems classify specific hospital episodes in terms of costs, facilitating the emergence of NPM. As shown in Chapter 3, the extent of power sharing between political and health care actors and other structural factors, e.g. state tradition, cannot satisfactorily explain the variation in the new hospital payment systems. It is necessary to introduce some form of agency (Peters, Pierre, and King, 2005).

A number of scholars have observed that political parties are relevant for welfare state reforms (cf. Green-Pedersen, 2002a; Ross, 2000; Starke, 2006). Green-Pedersen (2002b), for example, argues that the different responses of social-democratic parties explain variation in the emergence of NPM in Denmark and Norway. Hence, the literature to date suggests that party preferences are relevant for welfare state reforms based on NPM. I argue that the interactions between actor preferences and institutional settings do a better job in explaining variation in reforms (cf. Scharpf, 2000). This leads to the following sub-question: To what extent and how are policy preferences about health care and NPM related to the variation between the new hospital payment systems of Germany, the Netherlands and the UK?

Despite their possible relevance for outcomes of reform, party preferences about health care are seldom studied. In addition, although studies about party positions have based their theory and evidence on a wide range of issues, health care issues have typically not been included (e.g. Blendon, Altman, Benson, and Brodie, 2004; Budge, Klingemann, Volkens, Bara, and Tanenbaum, 2001; Laver and Benoit, 2006). This makes it unclear what role health care issues play in political competition and decision-making. For instance, do parties have different preferences about health care goals, i.e. universal accessibility, quality and cost containment? And are political parties able to further preferences in policy decisions? The chapter studies policy preferences in interaction with the

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2 Due to devolution in the United Kingdom, reforms in the NHS do not necessarily emerge simultaneously in Scotland, Northern Ireland, Wales and England. The new payment system is not implemented in the Scottish and Welsh NHS. Since this study deals with the extent to which NPM has emerged in new hospital payment systems, only the reforms of the English NHS are taken into account.
institutional settings, i.e. the specific health care system and the party configuration, to get insight in cross-national differences. In the sections that follow, I discuss health care issues in relation to the characteristics of NPM and formulate assumptions about the role of party competition. It is useful to explore party preferences within and across countries in two stages of the political process, since differences are probably more prominent during the election phase than during the political process. To preview the results, governmental attention to specific NPM elements is related to the variation of the new hospital payment systems and specific party configurations do not determine whether governmental parties are able to further their preferences. In addition, political competition in both political phases has varied considerably between the three cases.

4.2 Theories about party preferences

As noted previously, it is unclear how policy preferences on health care vary among political parties. I contend that preferences on NPM are related to the left-right positions of parties (see Chapter 2). For this reason, it is argued that market-liberal parties and to some extent social-democratic parties are the main supporters of the implementation of NPM. An alternative to this line of argument, however, is that NPM is a universal solution for contemporary health care problems. It is possible that all parties to a large extent support NPM in their manifestos and in parliamentary debates, viewing it as a means to increase the performance of the health care sector. Although, this is unlikely considering the way NPM emerged in the three countries under investigation, it may nevertheless be that no political differences between parties are observable, indicating that other factors have led to variance in the new hospital payment systems.

Though this chapter is not about voting behavior, theories and debates from this literature are useful for exploring party competition. Important insights into party competition can be obtained by questioning whether voters choose a party that is close to them on a specific dimension (cf. Downs, 1957; Lewis and King, 1999; Stokes, 1963), by testing whether parties ‘own’ particular issues in health care and by exploring whether parties distinguish themselves from one another by emphasizing different goals and means (cf. Budge and Farlie, 1983; Budge, Klingemann, Volkens et al., 2001). These ideas originate from theories on proximity and directional voting (cf. Downs, 1957; Lewis and King, 1999), valence (cf. Stokes, 1992; Stokes, 1963), and issue saliency (cf. Budge, Klingemann, Volkens et al., 2001).

This chapter explores whether political competition has ‘path-dependent’ characteristics; whether policy preferences can be related to specific circumstances and/or institutional settings. It is studied whether parties favor solutions in one particular direction and whether this should be related to their specific institutional setting or to their party affiliation. Two types of interactions between actor preferences and institutional settings are studied in this chapter. First, political
Comparing party competition on health care reforms

competition and decision-making about NPM in health care is affected by the position of parties in a party system, i.e. by the specific party configuration, which determines the ‘room of maneuver’ of parties. Governmental parties, for instance, have to compromise between blame for economic mismanagement (e.g. rising costs or extensive waiting lists) and blame for cutbacks that undermine the accessibility or quality of the system. In addition, parties in the Netherlands and Germany must seek consensus with coalition partners. Second, the specific problems and the health care system might affect the attention parties put on health care goals and on the balance between state-market regulation.

4.3 Health care: a valence or positional issue?

To explore political competition regarding NPM elements in health care, I rely on two ideas originating from the literature on voting behavior. Specifically, I examine what role health care plays in political competition by discussing it with regard to positional and valence issues. The former refers to a situation in which parties offer alternatives to voters, and voters have different preferences. Here, parties might offer these alternatives by placing themselves on a certain point on a scale, e.g. more or less universal accessibility in health care. Valence issues, by contrast, are those issues for which parties do not offer alternatives, and for which voters evaluate parties based on their performance.

Downs (1957) argues that parties choose (simultaneously) positions in a one-dimensional space and that voters, who also have a specific position on this dimension, choose a party located close to them in this space. Aspects of this theory have been criticized and extended. For instance, the notion put forward by Downs (1957) that all party competition takes place on one policy dimension, usually the left-right, has been critiqued. Researchers have shown that political competition is located on at least two dimensions, e.g. left-right and conservative-liberal (e.g. Hooghe, Marks, and Wilson, 2004).

Stokes (1963) argues that Downs’ model does not work if voters are simply reacting to parties’ associations with some goal, state or symbol that is positively or negatively evaluated (p. 373). According to him, voters choose a party based both on issues with alternative ends (positional issues) and on issues which relate parties to some condition that is positively or negatively evaluated (valence issues) (Stokes, 1963). Issues in health care may be valence issues if voters are not scattered on the scale but are clustered close together at one point. Voters are aware of how close parties are to that point, but parties cannot rationally change their position as they can on positional issues (MacDonald and Rabinowitz, 1998). In other words, voters evaluate parties on their performance and trust in eliminating, for instance, unemployment and take this into consideration when choosing a party.

There are several reasons to view health care as a valence issue. First, voters cannot predict when they need health care and an individual voter cannot be ‘too healthy’. Health should not be seen as the absence of decease or injury, but as a state of complete physical, mental and social well-being (Evans and Stoddart, 1990:
1347). In addition, voters generally have solidarity with sick people (cf. Blekesaune and Quadagno, 2003). This makes health care, to date, somewhat distinct from other welfare state services. During the fiscal crisis of the welfare state, broad and fundamental consensus on the value of solidarity gave way to doubts concerning the attainability and desirability of the big welfare schemes, such as unemployment, but solidarity in health care has remained largely unquestioned. According to Houtepen en Ter Meulen (2000a):

“Apparently the care of the sick is a strong paradigm for the sort of moral and social responsibility that is commonly acknowledged by members of contemporary western society” (p. 330)

Political parties are thus dealing with voters who cannot be ‘too healthy’, a general support for a society that has a social and moral responsibility for those who are sick and limited financial resources constraining the achievement of these needs. They have to balance three goals: quality, equitable accessibility and cost containment. These health care issues are probably valence, if voters all prefer the same balance between these goals (see also Figure 2.1).

Valence issues are particularly challenging for parties in office. These parties are more vulnerable since their achievements with regard to valence issues are evaluated by voters (MacDonald and Rabinowitz, 1998). If parties perform well they might attract voters (voters consider the party more close to them than before), but if they perform not so well they are likely to lose voters. This demonstrates the difficulties parties face in office, if health care is a valence issue. They are forced to compromise between blame for economic mismanagement, e.g. rising costs or extensive waiting lists, and blame for cutbacks that undermine the accessibility or quality of the system.

Whether an issue is a positional issue or a valence issue varies among countries (Franzmann and Kaiser, 2006). I study whether the different health care goals or health care regulation (state-market) are positional or valence issues; in other words, whether parties offer alternatives to voters or not. Again, we assume that voters have different preferences about what goals should be emphasized in health care policy and reforms and that they will support the party that is closest in line with those goals.

An important question is what different forms of party competition might mean for the variation in health care systems. As argued previously, NPM likely favors cost containment to a large extent, since its elements focus on efficiency (Lane, 2000: 6). Furthermore, universal accessibility may be in danger, since it is difficult to work as a business and still offer equitable and accessible health care service. Hence, parties that emphasize cost containment will support NPM, while

\[\text{Note that cost containment, i.e. reducing (public) costs, is not the same as efficiency, i.e. doing more with less money.}\]
Comparing party competition on health care reforms

Parties that emphasize accessibility will not. If health care is a valence issue, NPM will be supported to the extent that it improves the performance of health care without compromising any of the health care goals.

4.4 NPM as shift from state to market?

Parties can distinguish themselves from one another on health care goals, but also on how to achieve these goals. Implementing NPM is likely to be politically contested among parties, since it implies a potential shift from public service to market regulation of welfare services. As outlined in Chapter 2, NPM can be considered a public-private shift, although it does not aim on complete privatization.

Although heavily criticized, the economic left-right dimension has remained important in understanding political competition. Political contestation regarding lesser versus more governmental regulation tends to be the chief determinant of left-right differences between parties (e.g. Hooghe, Marks, and Wilson, 2004; Huber and Inglehart, 1995). Hence, voters may not differ on the health care goals, but they might differ on how to achieve the goals. While leftist parties emphasize state regulation, rightist parties stress market regulation. If political contestation about NPM mainly reflects the issue of state-market regulation, market-liberal parties are particularly likely to support NPM.

However, recently, social-democratic parties have become more fervent supporters of market regulation. As several studies suggest, social democratic parties in Western Europe have adopted a ‘third-way’ policy pragmatism involving both a positive view of the ability of the market to provide certain outcomes and a strong emphasis on active ‘social investment’ of the state (Green-Pedersen, Van Kersbergen, and Hemerijck, 2001). Cutler and Waine (2000: 318), for instance, argue that British Labour has embraced the changes of the Conservative party, but has also found its own ‘managerialist approach’. Hence, social democratic parties – particularly in the countries under study here – have changed, making them more supportive of greater market regulation in welfare and likely supporters of NPM.

In sum, by exploring whether health care is a valence issue or a positional issue, it is possible to understand how political competition is shaped in a specific institutional context. To understand the relationship between policy preferences and the way and extent NPM has emerged in the hospital payment systems, it is important to study whether political parties attempt to distinguish themselves on the health care goals and on how health care should be regulated (state-market).
4.5 Different party systems and health care organizations

Political competition about introducing NPM elements in health care departs from different starting points, e.g. the current prioritization of the health care goals and the extent to which NPM elements already emerged in the health care sector before the implementation of the new payment systems. Green-Pedersen et al. (2001) argue, for instance, that despite similarities found between the Dutch and Danish labor parties, different starting points have led to important disparities in the outcomes of the reforms. As noted previously, the responses of social-democratic parties towards health care and NPM may be important in explaining the variation in new hospital payment systems. However, different starting points are likely to affect how political competition takes place in the election and decision-making phases. Parties, not operating in a vacuum, have different strategic positions (Green-Pedersen, 2002a)

4.5.1 Party configurations: Policy preferences of social-democratic parties

One reason for selecting Germany, the UK and the Netherlands is their different party configurations, i.e. “weak liberals, strong centre and strong social-democrats” (Germany), “three-way divide between liberals, centre and social-democrats” (Netherlands), and “united market-liberals versus united social-democrats” (UK) (Kitschelt, 2001). As several authors have argued, each party configuration has its own possibilities for reform (Green-Pedersen, 2002a; Kitschelt, 2001). In Britain, the Labour party, when in government, can reform more easily than the Conservative party. In the Netherlands and Germany, the combination of the Christian-democratic party and the social-democratic party have the best possibilities for pursuing welfare state reforms, although more difficult than in the UK (Green-Pedersen 2002a; Kitschelt, 2001). In addition, it can be assumed that coalition governments in general have fewer possibilities to reform, but as shown above some coalitions have better possibilities than others.

The specific party configurations during the decision-making processes of the new hospital payment systems have seldom conformed to the ‘ideal reform’ configurations as outlined above. Aside from in the UK, where Labour was in government during 1997-2006, the governments in the other countries did not reflect the ‘ideal’. During 1998-2002, the Netherlands had a ‘purple cabinet’, formed by the market-liberal party (VVD), the liberal party (D66) and the social-democratic party (PvdA), followed in 2002 by centre-right cabinets; i.e. List Pim Fortuyn (LPF) (replaced by D66 in 2003), Christian Democrats (CDA) and VVD. Germany had a left-wing cabinet with the social-democratic party (SPD) and the Green party (Bündnis 90/Die Grünen) from 1998-2005.

As noted before, if NPM is primarily related to the left-right differences of parties, its supporters should be market liberal parties and third way social democratic parties. However, this does not necessarily mean that social democratic parties can no longer be distinguished from more rightist parties. Indeed, it is unlikely that social-democratic parties would move considerably to the right, as
such a move would be irrational. According to theories of proximity voting, voters would go to other parties, i.e. switch their votes from social democratic parties to Christian-democratic parties for instance.

Merkel and Petring (2007) combine the changed role of social democratic parties with the specific party configurations of the late 1990s and early 2000s. According to these scholars, Labour and the PvdA have been forced more towards the liberal approach than the SPD. In the UK, party competition gave great leeway to the right, while in the Netherlands coalitions partners, ‘demanded’ a movement to the right from the PvdA. In contrast, the German party system – namely the Green-Left coalition and a second big welfare party, the CDU/(CSU) – the limited new programmatic approaches (Merkel and Petring, 2007).

In sum, differences in party preferences and political competition may help to explain the variation in the new hospital payment systems and should show how actors and institutions interact. Moreover, the specific party configuration in a given country is likely to moderate or strengthen the supportive role of social-democratic parties toward NPM.

4.5.2 The role of different health care systems in political competition

A second reason for cross-national differences in political competition is the different health care systems found in the three countries. The Netherlands and Germany have social insurance systems in which payment is shared among the government, employers and citizens. This system has relatively large out of pocket payments and a distinction between a group that relies on obligatory insurance (e.g. a basic insurance or a ‘sickness’ fund) and a group that is able to insure itself (additionally) with private insurance (Busse and Riesberg, 2004; Den Exter, Hermans, Dosjlak et al., 2004). This type of insurance system is only partly redistributive. The total share of payments comprises an income related payment, an employer contribution, and an individual flat rate contribution to an insurance company or association. Such a system creates difficulties for offering universal, equitable access to health services (Hussey and Anderson, 2003). If you earn more, you are able to obtain better health care services by taking better insurance schemes.

In contrast, the British system is mainly redistributive, since it is paid from general tax revenues, meaning that citizens who earn more pay more for the National Health Service (NHS). It is possible to take private insurance, but not instead paying for the services provided by the state, as was to some extent the case in Germany and in the Netherlands until 2006 (cf. Ham, 2004; Robinson and Dixon, 1999). The single-payer structure of the NHS also allows for strict cost containment. The government can control health expenditures more easily than in multi-payer systems. Some argue that this is the reason for the under-investment in the NHS. Indeed, the UK has spent the least on health care per capita in western Europe (Hussey and Anderson, 2003; OECD, 2006).
The differences between the health care systems reflect how various health care goals are prioritized. This suggests that political competition concerning health care and NPM originates from different institutional settings and contexts; it has path-dependent characteristics. Health care in the UK is equitably distributed – citizens have, irrespective their incomes, access to the same package of services. However, the overall quality is questionable; for instance, more individual payment does not positively affect the quality of the service nor does it increase patient choice within the NHS. In the Netherlands and Germany, accessibility and choice depend to a certain extent on the type of insurance, while costs are more difficult to control by the state. Hence, the way health care goals are prioritized in a certain system is often disputed, and parties may offer alternatives to voters. In addition, whether and which goals of health care are valence or positional issues may vary between countries (Franzmann and Kaiser, 2006).

4.6 NPM: a coherent issue in party competition?

Up until this point, NPM has been seen either as a blueprint or, more likely, as a ideational stream that together with specific problems brought about a critical juncture. As demonstrated in Chapter 3, however, NPM elements have not emerged in similar ways in the specific payment systems. In the UK and the Netherlands, the emphasis has been on (price) competition and shifting accountability to non-governmental actors, while in Germany the emphasis was put on efficiency, transparency and quality measures (see Chapter 3).

It might be that party manifestos do not emphasize NPM, but its specific elements. Since NPM is often seen as a paradox between centralizing and decentralizing tendencies (cf. Hood, 1995), it is likely that parties only partially support NPM. For instance, parties emphasizing cost containment and quality as health care priorities will support efficiency and shifts of accountability to health care providers, while parties that consider accessibility and quality more important than cost containment will support centralizing tendencies, e.g. transparency and quality standards. This idea is supported by the results of Chapter 3; countries have implemented different forms of NPM in their hospital payment systems. Furthermore, cross-national differences may occur. In the UK, for instance, costs are relatively easy to control by the central government, which would be more difficult if accountability were to shift. Hence, patterned variation across parties, i.e. the extent to which NPM elements are stressed, is likely to occur.

To understand this variation clearly, it is necessary to explore whether political competition can be found with regard to the use of NPM in health care policy. By disaggregating NPM, I examine the relationship between party preferences and the emergence of NPM in three ways. First, I explore whether different elements of NPM are relevant in political competition. Second, I study whether variation is observable between party families. Third, I consider whether political competition in the separate countries focuses on different elements of NPM, i.e. whether cross-national differences can be found. It is expected that the
attention of social-democratic parties towards NPM, which is given shape by the specific party configuration and health care system, is particularly relevant to understand the variation in the way NPM has emerged in the new hospital payment systems.

4.7 Method and data

In recent years, lengthy discussion has taken place about which resources are most valid and reliable in obtaining policy preferences. The main resources are party manifestos and expert surveys (Budge, Klingemann, Volkens et al., 2001; Laver and Benoit, 2006). The latter are less relevant for this study since the existing surveys do not include (specific) questions about health care. With the manifesto database, however, the original texts and party preferences can, if necessary, be retrieved back to the 1950s.

An advantage of expert surveys is that experts can base their opinion on a wide range of party behavior and not solely on written (and strategic) party manifestos and interventions in debates. However, it is unclear on what bases experts judge parties (cf. Budge, 2000). Moreover, Marks et al. (2007) show that different sources for obtaining party preferences on the left-right scale correlate highly.

The manifestos of the main parties in the Netherlands, Germany and the UK (1986-2006) have been recoded with a predefined coding scheme in Atlas.ti (Muhr, 2004). This was necessary, since the original coding scheme (Budge, Klingemann, Volkens et al., 2001) did not include health care. I decided to only analyze (quasi) sentences that are coded with at least one of the forty-two codes (usually the health care parts of the manifestos dealing with hospital care). These codes include NPM elements, the goals of health care policy, the actors in the health care field, prevention and home care (see appendix A).

The party manifestos that are included in the analysis have a time span of twenty years. I chose 1986 as a starting point since there is a consensus in the literature that NPM became relevant beginning in the 1980s. As noted, this study particularly focuses on synchronic variation between cases, it does not take time into account, which does not affect the results since parties hardly change their party preferences over the years (see also Van Essen and Pennings, 2009).

The parliamentary debates about the new hospital payment systems are recoded with the same scheme. The total time span is six years (1998-2004). In each country, the debates are coded from the first policy proposal until the start of the implementation of the system. To overcome the problem that one intervention of a party in a debate may overestimate its focus on a specific code, I only include party interventions in a specific debate in the analysis if at least five sentences were coded. This allows enough space for parties to emphasize several elements and provides a relatively fair representation of the different parties in the debates.

In total, 14 parties are included from which 80 manifestos were coded, resulting in 2748 quotations (coded sentences): 1524 for the Netherlands (36
manifestos), 594 for Germany (29 manifestos) and 630 for the UK (15 manifestos). From 60 debates, 2124 quotations (coded sentences) are included in the analysis: 694 for the Netherlands (50 interventions), 900 for Germany (35 interventions), 530 for the UK (34 interventions).

My rationale for employing two types of resources is to explore whether differences in party preferences are more visible in the manifests than in the debates. It may be the case that parties offer alternatives in their manifests but that these differences are not found in the debates (cf. Keman, 1997). This would suggest that health care is a positional issue during the election phase but that these differences do not play a role during parliamentary debates. Analyzing two sources provides another way of studying policy preferences to establish whether specific interactions between actors and institutions take place.

4.8 Political competition about health care

In this section, I compare the attention that parties and countries pay to specific elements of health care. I assume that the proportion of attention to a specific code determines the importance of that issue for a party. Using OLS regression, I am able to show to what extent a specific party or country can explain attention to a particular issue (Franzmann and Kaiser, 2006). The regression analysis shows in a relatively simple way how parties differ from each other. It is used to describe variation between parties, countries and issues. The regression equation is as follows:

\[ Y = S_i = C_i + P_1K_{i1} + P_2K_{i2} + P_3K_{i3} + \ldots + P_nK_{in} + \varepsilon_i \]

where \( S_i \) is the saliency score of a category (for instance, the health care goal of accessibility), \( P_n \) is the dummy-coded variable for the party analyzed, \( C \) is the value of the constant in category \( i \) (always the mean attention of the reference party to category \( i \)), \( K_i \) is the difference in attention of party \( n \) to category \( I \) compared with the reference party (e.g. Franzmann and Kaiser, 2006).

The reference party in the analyses is (usually) the social democratic party, i.e. Labour, PvdA and SPD. These are chosen to examine whether their salience on issues differs from rightwing parties and/or other leftist parties. Where countries are compared, the Netherlands is the reference country, since NPM has emerged to a larger extent in its new payment system than in German one and, as shown in Chapter 3, comparable to the English payment system.

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4 See appendix B for more detailed figures.
5 All models deal with some multicollinearity. For this reason the R-squares are published but not discussed. I present here a regression analysis, since it gives very readable output.
4.8.1 Health care as positional or valence issue?

I begin by exploring whether health care is a positional or valence issue, i.e. whether parties offer alternatives to voters during the election phase. Health care is a valence issue, if political parties do not devote significantly different degrees of attention to the goals (equitable accessibility, quality, cost containment). However, there is good reason to believe that specific goals are emphasized due to the specific ‘starting position’ of a country; equitable accessibility might be a positional issue in the Netherlands and Germany and that quality might be a positional issue in the UK. To examine this, I use regression analysis in order to compare the degree of attention to the various policy issues between the parties and countries.

The results show that parties allocate different proportions of attention to accessibility (see Table 4.1). In the Netherlands it is particularly an issue for party far to the left, i.e. a left-positional issue (Franzmann and Kaiser, 2006). The SP devotes almost twice the attention to accessibility in its manifesto compared to the PvdA. The results also show that the PvdA does not distinguish itself from other parties. In Germany, accessibility is a positional issue, i.e. multiple differences between parties. The SPD distinguishes itself both from the FDP, by devoting more attention to accessibility, as well as from PDS. The latter devotes on average 16% more attention to accessibility than the SPD (see Table 4.1).

In the UK, parties dedicate significantly different proportions of attention to accessibility. Here, the Liberal Democratic Party devotes on average 8% of the sentences to accessibility, in contrast with the Conservative party which devotes on average 3% to the issue. Despite such significant discrepancies, however, the relatively low percentages show that accessibility is not really an important issue in the UK; parties devote relatively little attention to it. This calls into question whether varying degrees of attention to accessibility is really relevant in this case. On the two other health care goals no party differences can be observed within countries (see also Appendix B). These goals also receive – in general - less attention in the party manifestos.
As expected, there are cross-national differences among the three countries. In the German manifestos, on average more attention is devoted to accessibility compared to what we find in the UK and the Netherlands. The Dutch parties dedicate little attention to quality compared to the UK, and parties in the UK devote less attention to cost containment than parties in the Netherlands and Germany.

Table 4.2 shows how political competition on health care goals is related to the specific context. First, the attention to cost containment and quality in the manifestos reflects the differences between the health care systems, but not between parties. Overall, the party manifestos reflect different starting points for political competition and decision-making about implementing NPM in health care across the countries (see Table 4.2). The finding that cost containment is no issue in

**Table 4.1 OLS regression of attention to accessibility in health care paragraphs in party manifestos (1998-2006)**

<table>
<thead>
<tr>
<th>Netherlands</th>
<th>Unstandardized Coefficients</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>(n = 36)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reference party: PvdA</td>
<td>B</td>
<td>Std. Error</td>
<td>t</td>
</tr>
<tr>
<td>(Constant)</td>
<td>7.840</td>
<td>2.417</td>
<td>3.244**</td>
</tr>
<tr>
<td>dummy SP</td>
<td>14.553</td>
<td>3.418</td>
<td>4.258**</td>
</tr>
<tr>
<td>dummy Green Left</td>
<td>5.934</td>
<td>3.585</td>
<td>1.655</td>
</tr>
<tr>
<td>dummy CDA</td>
<td>-0.323</td>
<td>3.418</td>
<td>-0.095</td>
</tr>
<tr>
<td>dummy D66</td>
<td>-3.090</td>
<td>3.418</td>
<td>-0.904</td>
</tr>
<tr>
<td>dummy VVD</td>
<td>-3.898</td>
<td>3.418</td>
<td>-1.140</td>
</tr>
<tr>
<td>R² = 0.59</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Germany</th>
<th>Unstandardized Coefficients</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>(n = 29)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reference party: SPD</td>
<td>B</td>
<td>Std. Error</td>
<td>t</td>
</tr>
<tr>
<td>(Constant)</td>
<td>22.544</td>
<td>5.041</td>
<td>4.472**</td>
</tr>
<tr>
<td>dummy Grünen</td>
<td>-7.183</td>
<td>7.129</td>
<td>-1.007</td>
</tr>
<tr>
<td>dummy PDS</td>
<td>16.131</td>
<td>7.477</td>
<td>2.157*</td>
</tr>
<tr>
<td>dummy FDP</td>
<td>-14.603</td>
<td>7.129</td>
<td>-2.048*</td>
</tr>
<tr>
<td>dummy CDU</td>
<td>-9.587</td>
<td>7.129</td>
<td>-1.345</td>
</tr>
<tr>
<td>R² = 0.45</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>UK</th>
<th>Unstandardized Coefficients</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>(n = 15)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reference party: Liberal Democrats</td>
<td>B</td>
<td>Std. Error</td>
<td>t</td>
</tr>
<tr>
<td>(Constant)</td>
<td>8.071</td>
<td>1.274</td>
<td>6.336**</td>
</tr>
<tr>
<td>Labour</td>
<td>-3.381</td>
<td>1.801</td>
<td>-1.877</td>
</tr>
<tr>
<td>Conservatives</td>
<td>-5.197</td>
<td>1.801</td>
<td>-2.885*</td>
</tr>
<tr>
<td>R² = 0.42</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(***p < 0.01, **p < 0.05)
Comparing party competition on health care reforms

the British debates and quality is most stressed, has been expected since the UK is one of the lowest spenders on health care (8.3% of GDP in 2004) and at the same time one of the biggest growers in Real Health Care Spending per capita in the period 1994-2004 (being 4.2%) (Cylus and Anderson, 2007; Klein, 1998).

The patterned variation shows that trade-offs exist, since health care goals get varying degrees of attention in the countries. In addition, in Germany, accessibility reveals large party differences, while in the other countries these differences are smaller. According to voting theories, this means that voter positions vary in the countries. While in Germany voters are scattered about health care issues, they are less so in the UK and the Netherlands. It can be expected that actors attempt to use their ‘room to maneuver’ to affect political decisions. The fact that health care is a positional issue in Germany might affect the way political parties are able to further their preferences in the new hospital payment systems.
Table 4.2 OLS regression of attention to health care goals in party manifestos (1986-2006)

<table>
<thead>
<tr>
<th>(n = 79)</th>
<th>Universal accessibility</th>
<th>Cost containment</th>
<th>Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Unstandardized Coefficients</td>
<td>Unstandardized Coefficients</td>
<td>Unstandardized Coefficients</td>
</tr>
<tr>
<td>(Constant)</td>
<td>B</td>
<td>Std. Error</td>
<td>t</td>
</tr>
<tr>
<td>The Netherlands</td>
<td>9.929</td>
<td>1.873</td>
<td>5.302**</td>
</tr>
<tr>
<td>dummy Germany</td>
<td>8.906</td>
<td>2.782</td>
<td>3.201**</td>
</tr>
<tr>
<td>dummy UK</td>
<td>-4.717</td>
<td>3.419</td>
<td>-1.380</td>
</tr>
</tbody>
</table>

R² = 0.19

R² = 0.11

R² = 0.09

(** p < 0.01; * p < 0.05)
Comparing party competition on health care reforms

As indicated, two resources – party manifestos and parliamentary debates – are used to explore party preferences about NPM in health care. Both sets of data are coded in a similar way, but OLS regression makes less sense in the latter. Party manifestos throughout the years have a similar structure. In contrast, party interventions in debates are more difficult to compare, because not all debates deal with every aspect of the new payment system. In other words, while most codes are mentioned in a single manifesto, only a subset is used in an intervention in a debate. Though they are less useful for regression analysis, the debates nevertheless provide a good overview of party preferences. I therefore explore to what extent these preferences are reflected in the debates. For example, the manifestos show that parties far to the left put more emphasis on the accessibility of health care, making it a left-positional issue. Are these parties distinguishing themselves from other parties in the debates as well?

In addition, I compare the saliency of various health care goals in party manifestos versus parliamentary debates. The results show that attention to health care goals in manifestos and debates differ. In the UK, attention to cost containment is more prominent in the debates, while accessibility also remains relatively important (see appendix B). This is in contrast to the Netherlands where accessibility – being very important in the election phase - almost disappears in the debates. Hence, though debating a similar type of reform, the degree of attention each of the goals receives, varies.

While accessibility does not seem to be an issue in the Dutch debates, all British parties dedicate considerable attention to it. In Germany, parties that devote a relatively large degree of attention to it in the manifestos also do so in debates. Thus, leftist parties devote more attention to accessibility than rightist parties, both in their manifestos and in parliamentary debates.

This attention is, however, moderated by the specific health care system (Hussey and Anderson, 2003). In the NHS universal accessibility is a key feature of the system and hardly questioned among political parties, while in Germany accessibility is a positional issue and not completely guaranteed by the insurance-based system. Remarkably, although the Dutch health care system is comparable to the German system, accessibility is not as political sensitive neither in the manifestos nor in the debates.

The results show that the saliency of issues in parliamentary debates is not necessarily related to the saliency in the party manifestos. One possible explanation for this discrepancy is that parties compromise about issues during the decision-making process (Keman, 1997). The results also show that there is variation between countries in the attention to health care goals which can be partly explained from the type of health care system. This shows that preferences are related to a specific institutional setting, but not determined by it, since other contextual factors seem to play a role.
4.8.2 NPM in health care as shift from state to market?

In this section, I show to what extent party preferences on NPM are related to their positions on state and market regulation in health care. NPM entails the shift from a public service organization towards market regulation of welfare services. According to several scholars, it is only supported by neo-liberal parties and possibly by third way social democrats. If NPM is a blueprint, it is unlikely to be related to party preferences about state and market regulation. As in the previous section, here I examine to what extent saliency regarding state and market regulation in health care can be explained by the ‘variables’ party or the country.

In each of the three countries, parties differ significantly in their attention to state and market regulation of health care in the election phase. In Germany and the UK, state regulation is a left party issue, and market regulation is a positional issue (i.e. parties farther to the left differ significantly form social-democratic parties, and rightist parties differ from social-democratic parties) (see Table 4.3, Franzmann and Kaiser 2006). In the Netherlands, these differences are less prominent. The PvdA differs from the VVD, but not from other parties.

In sum, social-democratic parties are more supportive of market regulation than parties more to the left, though not as supportive as rightist parties. Moreover, parties more to the left than social-democratic parties are more supportive of state regulation than all other parties, meaning that social-democratic parties do not distinguish themselves from rightist parties on this issue, except in the UK. This is in line with the results that Harrison and Calltorp (2000) find in the Swedish case. Social-democratic parties support marketisation; however, according to the findings presented here, the extent of this support appears to vary across cases.
Comparing party competition on health care reforms

Table 4.3 OLS regression of attention to state and market regulation in the party manifestos (1986-2006)

<table>
<thead>
<tr>
<th>Netherlands (N = 36)</th>
<th>State regulation</th>
<th>Market regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reference party: PvdA (Constant)</td>
<td>B</td>
<td>Std. Error</td>
</tr>
<tr>
<td>13.320</td>
<td>3.210</td>
<td>4.150**</td>
</tr>
<tr>
<td>dummy SP</td>
<td>7.160</td>
<td>4.539</td>
</tr>
<tr>
<td>dummy Green Left</td>
<td>-4.010</td>
<td>4.761</td>
</tr>
<tr>
<td>dummy CDA</td>
<td>-4.163</td>
<td>4.539</td>
</tr>
<tr>
<td>dummy D66</td>
<td>1.236</td>
<td>4.539</td>
</tr>
<tr>
<td>dummy VVD</td>
<td>-9.726</td>
<td>4.539</td>
</tr>
</tbody>
</table>

R² = 0.36
(**p < 0.01; *p < 0.05)

<table>
<thead>
<tr>
<th>Germany (N = 29)</th>
<th>State regulation</th>
<th>Market regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reference party: SPD (Constant)</td>
<td>B</td>
<td>Std. Error</td>
</tr>
<tr>
<td>dummy PDS</td>
<td>5.643</td>
<td>2.187</td>
</tr>
<tr>
<td>dummy Grünen</td>
<td>0.357</td>
<td>2.085</td>
</tr>
<tr>
<td>dummy FDP</td>
<td>-3.216</td>
<td>2.085</td>
</tr>
<tr>
<td>dummy CDU</td>
<td>-2.866</td>
<td>2.085</td>
</tr>
</tbody>
</table>

R² = 0.46
(**p < 0.01; *p < 0.05)

<table>
<thead>
<tr>
<th>UK (N = 15)</th>
<th>State regulation</th>
<th>Market regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reference party: Labour (Constant)</td>
<td>B</td>
<td>Std. Error</td>
</tr>
<tr>
<td>9.613</td>
<td>2.047</td>
<td>4.696**</td>
</tr>
<tr>
<td>dummy Liberal Democrats</td>
<td>-7.576</td>
<td>2.895</td>
</tr>
</tbody>
</table>

R² = 0.49
(**p < 0.01; *p < 0.05)

R² = 0.46
Dutch parties, by comparison, devote considerable attention to state regulation in health care (see Table 4.3). This might be explained by the limited role the central government plays in controlling health care. While the NHS consists of state agencies, the Dutch health care system is characterized by private organizations, on which the government imposes rules (Saltman, 2002: 1678). This might also explain why no significant differences are found between social-democratic and other leftist parties concerning state regulation. Furthermore, it sheds light on why the Christian-democratic party devotes extensive attention to state regulation, particularly compared to its German counterpart (see appendix B). In contrast to state regulation, no cross-national differences are found with regard to attention to market regulation. In this respect, party affiliation is more important than the specific context.

Compared to the manifestos, differences between parties are less visible in the parliamentary debates. In Germany and the UK, parties generally refer more often to state regulation in debates than in their manifestos. The extensive attention the Conservative party and the VVD devote to it is particularly remarkable. Turning to the content of the debates, the VVD and the Conservative party focus on how the minister can regulate the health care market and whether the government is able to implement the new regulation. In contrast, Labour and the Dutch Green party had a more traditional view on the role of the government. They related it to creating patient choice and support to patients (cf. Parliament of the United Kingdom, 2003; Tweede Kamer, 2004). Hence, a qualitative approach is sometimes necessary to unravel unexpected results (cf. Van Essen and Pennings, 2009).

A key question is whether parties that devote a relatively large degree of attention to market regulation (or relatively little attention to state regulation) also focus more on NPM elements. The results show that NPM in the Netherlands seems a positional issue, even more so than market regulation, since the attention of the PvdA differs significantly from the attention of VVD and the SP. VVD puts significantly more attention to NPM elements than the PvdA, while the SP puts significant less attention to it than the PvdA. In Germany, NPM is mainly a right positional issue, since the FDP distinguishes itself from all other parties by putting more attention to NPM elements. In the UK, no significant differences are found, meaning that in contrast to market regulation, NPM is not a positional issue in the election phase (see Table 4.4). This means that countries depart from different starting points with regard to political competition about NPM. However, no cross-

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6 In exploring this pattern, we should be aware that market regulation is coded as part of NPM, making it probable that political differences follow the same patterns (see Appendix A). Including marketisation in NPM may bias the results, but excluding it would not provide a fair representation of NPM. The results show that marketisation matters for attention to NPM, but it does not necessarily determine it. For instance, the PvdA pays twice as much attention to NPM than it does to marketisation. Hence, parties can give attention to NPM without putting much emphasis on marketisation (see also Appendix B).
Comparing party competition on health care reforms

national differences are observed in the saliency of the issue, suggesting that the importance of NPM in the election phase is similar in the three countries.

Table 4.4 OLS regression of NPM in party manifestos (1986-2006)

<table>
<thead>
<tr>
<th>Country</th>
<th>Unstandardized Coefficients</th>
<th>T</th>
</tr>
</thead>
<tbody>
<tr>
<td>Netherlands (N = 36)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reference party: PvdA</td>
<td>B = 12.826, Std. Error = 2.761</td>
<td>4.646**</td>
</tr>
<tr>
<td>dummy D66</td>
<td>3.557, Std. Error = 3.904</td>
<td>0.911</td>
</tr>
<tr>
<td>dummy VVD</td>
<td>9.746, Std. Error = 3.904</td>
<td>2.496*</td>
</tr>
<tr>
<td>dummy CDA</td>
<td>6.005, Std. Error = 3.904</td>
<td>1.538</td>
</tr>
<tr>
<td>dummy Green Left</td>
<td>-0.268, Std. Error = 4.095</td>
<td>-0.065</td>
</tr>
<tr>
<td>dummy SP</td>
<td>-10.472, Std. Error = 3.904</td>
<td>-2.682*</td>
</tr>
<tr>
<td>R² = 0.52</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Germany (n = 29)

| Reference party: SPD | B = 13.448, Std. Error = 3.443 | 3.905** |
| dummy Grünen | -4.204, Std. Error = 4.870 | -0.863  |
| dummy PDS | -5.308, Std. Error = 5.107 | -1.039  |
| dummy FDP | 23.337, Std. Error = 4.870 | 4.792** |
| dummy CDU | -1.212, Std. Error = 4.870 | -0.249  |
| R² = 0.65 |

UK (n = 15)

| Reference party: Labour | B = 12.041, Std. Error = 3.030 | 3.973 |
| dummy Liberal democrats | 0.367, Std. Error = 4.286 | 0.086 |
| dummy Conservatives | 7.907, Std. Error = 4.286 | 1.845 |
| R² = (F- test is not significant) |

Note: The regression of the standardized residuals is not completely normally distributed in the German model.

Unlike in the manifestos, cross-national differences are discernable in the debates. NPM receives less attention in Germany than in the other countries (see Table 4.5). It has to be stressed that the variable country does not explain attention to NPM very adequately according to the low R². In addition, we must take into account that in these analyses it has been assumed that the specific NPM elements are of equal importance to parties.
However, it can be stated that the following pattern occurs: while in the UK, NPM elements obtain more attention in the debates than in the manifestos, the opposite is true in Germany where parties devote greater attention to it in the manifestos than in the debates and the attention to NPM elements particularly comes from the FDP and the SPD. Parties in the Netherlands exhibit more consistency, devoting considerable attention to NPM in both the manifestos and the debates (see also appendix B; Table 4.10). This shows that NPM elements are relevant in political processes, but that they are not similarly relevant for the election and decision-making phases, since parties further NPM in the political process in different ways.

Table 4.5 OLS regression: NPM in parliamentary debates

<table>
<thead>
<tr>
<th>Reference country:</th>
<th>Unstandardized Coefficients</th>
<th>t</th>
</tr>
</thead>
<tbody>
<tr>
<td>B</td>
<td>Std. Error</td>
<td></td>
</tr>
<tr>
<td>Netherlands</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Constant)</td>
<td>22.144</td>
<td>2.503</td>
</tr>
<tr>
<td>dummy Germany</td>
<td>-7.942</td>
<td>3.846</td>
</tr>
<tr>
<td>dummy UK</td>
<td>6.226</td>
<td>3.910</td>
</tr>
</tbody>
</table>

R² = 0.09
(* p < 0.05; ** p < 0.01)

4.8.3 Party competition about NPM and the party configuration

The results provided above support the hypothesis that NPM matters in the political process. At least in Germany and the Netherlands political competition concerning NPM largely follows left-right differences. However, remarkable cross-national differences do exist in attention to health care goals and the table shows between which political parties differences are observed. While attention to NPM elements in health care distinguishes parties in the Netherlands and Germany, it does not in the UK. Indeed, in the UK, party competition appears to be different since NPM is not (a rightist) positional issue in this country, but a valence issue.

The possibilities for reform may depend on party configurations. Social-democratic parties in government, particularly those in block party systems (like the UK) or governing with a Christian-democratic party in pivotal systems, have the best possibilities for reform (Kitschelt, 2001). In this portion of the study, I compare the attention social-democratic ministers allot to NPM elements in parliamentary debates verses the attention paid by ‘back benchers’ from the same party. Since several characteristics may affect the behavior of backbenchers, the results are mainly used to explore how political competition takes place. For instance, British MPs represent a certain constituency and have to be re-elected by that constituency. However, if NPM is a general solution supported by third way social democrats, it would be particularly remarkable if significant differences were to be found between the MPs and the minister.
Comparing party competition on health care reforms

The results show that in the UK significant differences are visible between the minister and backbenchers (F = 13.14; p < 0.01). In Germany, the differences are not significant, but the ministers devote on average more attention to NPM (see Table 4.6). However, the two social-democratic ministers do not devote a significantly different proportion of their debate time to NPM elements than the Dutch social-democratic party.

Overall, the findings indicate that political competition regarding NPM elements differs among the countries and that these elements also seem to matter in the decision-making phase. Table 4.6 shows that particularly social-democratic ministers put much attention to NPM elements. However, the variation between the payment systems cannot be explained from these results, it is necessary to explore which NPM elements get attention from the different parties.

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Mean</th>
<th>Std dev</th>
<th>Minimum</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Germany SPD</td>
<td>9</td>
<td>16.28</td>
<td>20.19</td>
<td>0.00</td>
<td>66.67</td>
</tr>
<tr>
<td>Minister</td>
<td>4</td>
<td>35.17</td>
<td>24.62</td>
<td>15.38</td>
<td>66.67</td>
</tr>
<tr>
<td>UK Labour</td>
<td>6</td>
<td>23.15*</td>
<td>7.26</td>
<td>12.05</td>
<td>33.33</td>
</tr>
<tr>
<td>Minister</td>
<td>7</td>
<td>45.37^</td>
<td>13.36</td>
<td>30.00</td>
<td>60.00</td>
</tr>
<tr>
<td>Netherlands PvdA</td>
<td>6</td>
<td>26.07</td>
<td>20.38</td>
<td>7.14</td>
<td>57.14</td>
</tr>
</tbody>
</table>

Party* differs significantly (p<0.05) from party^

4.9 Party preferences on NPM elements

Thus far, I have shown that parties offer alternatives to voters with regard to the health care goal “accessibility” and that the saliency of NPM elements in manifestos is related to the left-right positions of parties in the Netherlands and Germany. Additionally, the type of health care system seems to influence the attention particular issues receive in the debates. Lastly, I have shown that political competition differs among the countries and that NPM has mattered in both political phases.

Although NPM can be recognized in all three countries, the new hospital payment systems have emphasized different elements. Hence, it can be questioned whether certain parties emphasize only specific elements of NPM. In addition, I study whether differences in the attention dedicated to specific elements of NPM between countries are caused by the health care system and/or party configuration.

I employ factor analysis to test whether NPM consists of one dimension or several. The factor analysis (including both the manifestos and the debates in all countries) indicates that there are 5 dimensions, which together explain more than 60% of the variance (see Table 4.7). This is sufficient to conclude that the different

---

A Likert analysis shows (including both the manifestos and debates in all countries) that the different elements are no comprehensive scale (Cronbach’s α = 0.147).
dimensions form one concept, but also shows that the specific dimensions are important. Depending on the country and/or the party, each of these dimensions may have received more or less attention. This provides a clearer picture of how political controversy concerning NPM varies between the countries.

Table 4.7 Dimensions of NPM in health care debates and manifestos

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Description</th>
<th>Atlas.ti codes</th>
<th>Eigenvalues</th>
<th>Total</th>
<th>Cumulative %</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>‘Individual responsibility’</td>
<td>Patient choice, privatization_p</td>
<td>1.494</td>
<td>14.94</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>‘Competitive contracting’</td>
<td>Contracting, Managerial</td>
<td>1.330</td>
<td>28.24</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>accountability_p, Marketisation_p</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>‘Sector accountability’</td>
<td>Political accountability_n,</td>
<td>1.263</td>
<td>40.87</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Benchmarking</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>‘Transparent quality’</td>
<td>Transparency, Quality</td>
<td>1.150</td>
<td>52.38</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>‘Efficiency’</td>
<td>Efficiency</td>
<td>1.022</td>
<td>62.60</td>
<td></td>
</tr>
</tbody>
</table>

Extraction method: Principal Component Analysis

Dimensions 1 and 2 are positional issues in the election phase in the Netherlands and Germany (see Table 4.8). In the Netherlands, the leftist parties devote less attention to these categories. In Germany, the FDP distinguishes itself from the other parties by emphasizing these elements to a larger extent. The dimension sector accountability is not relevant in the countries, and transparent quality shows no differences among parties. In other words, political controversy surrounding NPM focuses on the dimensions pertaining to the shift from public service to market regulation of health care.

In contrast to MPs in other leftist parties, those in the German PDS place considerable weight on efficiency in the debates. The attention of the German PDS is most likely a result of Germany’s transition from an Eastern to a Western orientation (cf. Marks, Hooghe, Edwards, and Nelson, 2007). Another interesting finding is that in the UK, parties do not position themselves on either of the dimensions, since no significant differences can be observed.
Comparing party competition on health care reforms

Tables 4.8 OLS regression: individual responsibility and competitive contracting in Dutch and German party manifestos (1986-2006)

<table>
<thead>
<tr>
<th>Individual responsibility</th>
<th>Competitive contracting</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Netherlands (N = 35)</strong></td>
<td><strong>Unstandardized Coefficients</strong></td>
</tr>
<tr>
<td>Reference party:</td>
<td>B</td>
</tr>
<tr>
<td>VVD (Constant)</td>
<td>8.202</td>
</tr>
<tr>
<td>dummy Green Left</td>
<td>-4.206</td>
</tr>
<tr>
<td>dummy PvdA</td>
<td>-5.419</td>
</tr>
<tr>
<td>dummy CDA</td>
<td>-2.718</td>
</tr>
<tr>
<td>dummy D66</td>
<td>0.407</td>
</tr>
<tr>
<td>R² = 0.37</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Individual responsibility</th>
<th>Competitive contracting</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Germany (N = 29)</strong></td>
<td><strong>Unstandardized Coefficients</strong></td>
</tr>
<tr>
<td>Reference party:</td>
<td>B</td>
</tr>
<tr>
<td>party: FDP</td>
<td>15.411</td>
</tr>
<tr>
<td>(Constant)</td>
<td>-14.697</td>
</tr>
<tr>
<td>dummy SPD</td>
<td>-11.525</td>
</tr>
<tr>
<td>R² = 0.41</td>
<td></td>
</tr>
</tbody>
</table>

(* p < 0.05 and ** p < 0.01)
The positions of parties in their manifestos are only partly reflected in the debates. As was the case with the general concept of NPM, significant party differences within countries can only be observed in the manifestos and not in the debates, since political parties seek to compromise in the decision-making phase. Dimension 1, individual responsibility, appears to be somewhat important during the election phase. However, it is remarkable how much attention Labour pays to this dimension in the debates compared to the other British parties. Since it is a valence issue, introducing patient choice in the British health care system would be highly appreciated by voters and does not directly affect health care goals.

Competitive contracting - the second dimension that shows positional differences among parties – gets much attention in the manifestos and remains important in the debates. Social-democratic parties in the Netherlands and Germany give relatively more weight to this category. With regard to the Dutch case, it seems that the policy preferences of the government explain why competitive contracting emerged in the Netherlands. One could argue that this issue is a (negative) left positional issue, meaning that the SP can be distinguished from other parties. However, the PvdA cannot be distinguished from the VVD by its amount of attention to the issue. Transparent quality is a relevant valence issue in all three countries. Only in the UK, the relevance drops significantly in the parliamentary debates. The dimension efficiency is more important in the British debates than in the manifestos, which can probably be explained by the potential effect the new payment system could have on cost control.

Next, I test whether there are differences between and within social-democratic parties. As shown in section 4.8.3, social-democratic ministers devote significantly more attention to NPM than their backbenchers. The results from the analysis show that in Germany significant differences between the minister and the ‘backbenchers’ are found on the dimension of transparent quality (F = 8.49; p<0.05, see Table 4.9). The minister devotes more attention to this dimension than the backbenchers. As Chapter 3 demonstrated, this type of NPM elements is heavily stressed in the policy plans. Hence, the degree of attention to certain issues by the coalition in the debates is reflected in the reform plans. In contrast to Germany, significant differences are found on the dimension of competitive contracting in the UK, where the minister devotes far more attention to this dimension than the backbenchers (F = 9.20; p < 0.05). In comparison, the German and British social-democratic ministers do not place more weight on these categories than the Dutch social-democratic party (see Table 4.9).
Comparing party competition on health care reforms

Table 4.9. NPM dimensions 'transparent quality' and 'competitive contracting' and social-democratic actors in the parliamentary debates (comparing means with one-way ANOVA)

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Mean</th>
<th>Std dev</th>
<th>Minimum</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Competitive contracting</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Germany</td>
<td>9</td>
<td>10.31</td>
<td>15.54</td>
<td>0.00</td>
<td>50.00</td>
</tr>
<tr>
<td>SPD</td>
<td>9</td>
<td>10.31</td>
<td>15.54</td>
<td>0.00</td>
<td>50.00</td>
</tr>
<tr>
<td>Minister</td>
<td>4</td>
<td>17.45</td>
<td>16.04</td>
<td>0.00</td>
<td>33.33</td>
</tr>
<tr>
<td>UK</td>
<td>6</td>
<td>5.70*</td>
<td>5.74</td>
<td>0.00</td>
<td>14.85</td>
</tr>
<tr>
<td>Labour</td>
<td>6</td>
<td>5.70*</td>
<td>5.74</td>
<td>0.00</td>
<td>14.85</td>
</tr>
<tr>
<td>Minister</td>
<td>7</td>
<td>23.89^</td>
<td>13.62</td>
<td>0.00</td>
<td>45.45</td>
</tr>
<tr>
<td>Netherlands</td>
<td>4</td>
<td>12.67</td>
<td>12.73</td>
<td>0.00</td>
<td>30.77</td>
</tr>
<tr>
<td>PvdA</td>
<td>4</td>
<td>12.67</td>
<td>12.73</td>
<td>0.00</td>
<td>30.77</td>
</tr>
<tr>
<td><strong>Transparent quality</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Germany</td>
<td>9</td>
<td>6.76*</td>
<td>8.62</td>
<td>0.00</td>
<td>25.86</td>
</tr>
<tr>
<td>SPD</td>
<td>9</td>
<td>6.76*</td>
<td>8.62</td>
<td>0.00</td>
<td>25.86</td>
</tr>
<tr>
<td>Minister</td>
<td>4</td>
<td>22.80^</td>
<td>10.48</td>
<td>15.38</td>
<td>38.10</td>
</tr>
<tr>
<td>UK</td>
<td>6</td>
<td>6.19</td>
<td>4.21</td>
<td>0.00</td>
<td>11.90</td>
</tr>
<tr>
<td>Labour</td>
<td>6</td>
<td>6.19</td>
<td>4.21</td>
<td>0.00</td>
<td>11.90</td>
</tr>
<tr>
<td>Minister</td>
<td>7</td>
<td>7.87</td>
<td>10.39</td>
<td>0.00</td>
<td>30.00</td>
</tr>
<tr>
<td>Netherlands</td>
<td>4</td>
<td>5.71</td>
<td>9.04</td>
<td>0.00</td>
<td>20.00</td>
</tr>
<tr>
<td>PvdA</td>
<td>4</td>
<td>5.71</td>
<td>9.04</td>
<td>0.00</td>
<td>20.00</td>
</tr>
</tbody>
</table>

Party* differs significantly from party^ (p < 0.05)

In sum, parties in Germany and the Netherlands, emphasize specific elements of NPM, while in the UK these elements are valence issues. Competitive contracting, the dimension with the most important cross-national differences (see Chapter 3), shows the greatest political controversy. It also reveals clear differences between the Netherlands and Germany. In the latter, it principally remains a right positional issue, i.e. the FDP parties devote significantly more attention to these dimensions than other parties. However, in the Netherlands, only the SP is not a supporter. In the case of the UK, the minister devotes significantly more attention to it than the backbenchers.

The specific governmental preferences are visible in the new hospital payment systems. These preferences have interacted with the institutional setting in specific ways. In the Netherlands, the government focused on traditional rightist NPM issues, i.e. marketization and competition. However, it has been expected that the specific Dutch coalition has not the best possibilities to further its preferences. The fact that its preferences are reflected in the payment systems shows that a multiparty system has not hampered the reforms.

The way NPM has emerged in the English payment system shows a different interaction between preferences and institutions. Here, NPM has been seen as a way to solve waiting lists, i.e. increase spending without compromising on efficiency. Voters evaluate the British government on its performance on health care policy, since means and goals do not differ across political parties. The Labour party has the best possibilities for reform and could further its specific preferences. In Germany, leftist parties emphasize transparency and quality instead of individual responsibility and competitive contracting. This is likely related to the fact that accessibility and state regulation are left positional issues. The social-democratic party and green party are unlikely to distinguish themselves too far from the PDS. Particularly, since health care and NPM are positional issues.
4.10 Conclusion

The aim of this chapter has been to relate policy preferences to the variation in the DRG-based hospital payment systems. I argued that in the interaction between actor preferences, related behavior and the institutional setting is necessary to explain variation. The main conclusion of the chapter is that governmental preferences have strongly affected the variation in the new payment systems. Governments seem to be able to further their preferences irrespective of the party system.

Table 4.10 summarizes the results. It illustrates that attention to health care goals is distributed quite differently among the countries in the two phases of the political process. As noted, accessibility to health care is a positional issue in party competition in the Netherlands and, particularly, in Germany. State regulation is a left positional issue in the Netherlands and not relevant in the two other countries. Political competition about NPM in the election phase is comparable between the Netherlands and Germany, but the British parties do not distinguish themselves on the NPM dimensions which are positional in Germany and the Netherlands.
Comparing party competition on health care reforms

Table 4.10 Summary of political competition in two stages, i.e. election and debates

<table>
<thead>
<tr>
<th></th>
<th>Netherlands</th>
<th>Germany</th>
<th>United Kingdom</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Accessibility</strong></td>
<td>Left</td>
<td>Positional</td>
<td>Lib dem</td>
</tr>
<tr>
<td><strong>Quality</strong></td>
<td>Valence</td>
<td>Valence</td>
<td>Valence</td>
</tr>
<tr>
<td><strong>Cost containment</strong></td>
<td>Valence</td>
<td>Valence</td>
<td>Valence</td>
</tr>
<tr>
<td><strong>State – market</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>State regulation</td>
<td>Left</td>
<td>Left</td>
<td>Left</td>
</tr>
<tr>
<td>Market regulation</td>
<td>Right</td>
<td>Positional</td>
<td>Right</td>
</tr>
<tr>
<td><strong>NPM</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual responsibility</td>
<td>Right</td>
<td>Right</td>
<td>Valence</td>
</tr>
<tr>
<td>Competitive contracting</td>
<td>Left (negative)</td>
<td>Right</td>
<td>Valence</td>
</tr>
<tr>
<td>Sector accountability</td>
<td>Valence</td>
<td>Valence</td>
<td>Valence</td>
</tr>
<tr>
<td>Transparent quality</td>
<td>Valence</td>
<td>Valence</td>
<td>Valence</td>
</tr>
<tr>
<td>Efficiency</td>
<td>Valence</td>
<td>Valence</td>
<td>Valence</td>
</tr>
</tbody>
</table>

**Bold**: issue gets more than 5% attention in the health care parts of the manifestos

**↑**: attention in the debates is at least 5% more than in the manifestos

**↓**: attention in the debates is at least 5% less than in the manifestos
The findings show that governmental attention in the decision-making phase to the specific NPM health care goals is related to the variation in the new hospital payment systems. In the Netherlands, individual responsibility, competitive contracting and transparent quality are supported by parties in coalition. In Germany, in comparison, individual responsibility and competitive contracting – which are missing in the DRG payment system - get much attention from a party that is in opposition. The results also reveal large support for NPM from social-democratic ministers in contrast to relatively low support from the British and German social-democratic backbenchers, indicating that the position of political actors matters.

Though the strength of the market-liberal parties – the key proponents of NPM – is relevant to understanding variation in the hospital payment systems, the party system affects the extent to which social-democratic parties will prefer NPM in health care reforms. Social democratic parties seem to support NPM in accordance with their coalition parties. In the Netherlands, PvdA probably gives more attention to NPM since it formed a coalition with the VVD, while in Germany, the SPD did not want to distinct itself too much from its coalition partner.

Preferences about NPM are not completely related to left-right party differences and need to be understood in their specific context. In the UK, NPM in health care is a valence issue that is particularly supported by the government. The extent to which the centre-right cabinets in the Netherlands were able to implement NPM elements shows that governmental parties are able to further their preferences even if they do not form the ‘ideal reform coalition’ (Kitschelt, 2001). This might be explained from the fact that health care policy goals and NPM are hardly positional and therefore political consensus for the rightwing view on NPM could be easily found.

In sum, the specific political and health care system might not have a direct effect on hospital payment system, but affect the preferences and the distinctions between parties with regard to health care. These institutional settings are important to understand the different preferences of political parties about the new payment systems. It can be expected, for instance, that in the German decision-making phase parties cannot find consensus easily, since the health care goals and the means to achieve them are more positional.

As argued, the federal and corporatist institutional settings limit the ‘room to maneuver’ of the German government to a large extent. However, despite the political sensitiveness and power-sharing between actors, the preferences of the German governmental parties are recognizable in the new hospital payment systems. It is therefore interesting to consider the role of the medical bodies, since they are regarded as important actors in the process of reform.
5. COMPARING STRATEGIES OF GOVERNMENTS AND MEDICAL BODIES

5.1 Introduction

A central argument of this dissertation is that action in health care policy is not determined by institutions alone but is also influenced by the preferences of the actors involved (Keman, 1999b: 250/251). Politicians will strive for the proper balance between responding to public demand for expanding services and controlling costs (Green-Pedersen and Wilkerson, 2006: 1041). The medical profession, in comparison, seeks self-regulation, autonomy and care for patients (cf. Salter, 2002). To understand strategies and outcomes, one must ascertain whether the interests of the government and medical profession are parallel, conflicting or complementary in different institutional contexts (cf. Czada, 1998).

As noted in Chapter 2, decision-making in health care is often complex, since it involves many political and sectoral actors and since the medical professionals dominate provision. This distinguishes health care from other welfare state services in which the state, often in collaboration with social partners, controls both provision and distribution. For this reason, variation in the payment systems is better understood by taking into account the interaction between actors and the specific institutional setting (cf. Ross, 2007). In addition, agency is mentioned as important for understanding specific reforms. Klein (1990: 700) argues that it is possible to understand what is happening in the NHS today and over the last forty years by viewing it as a stage on which tensions are acted out. He points particularly to the conflict between the medical profession and the state. Other countries have also encountered conflicts, especially concerning the economic position of the medical profession (e.g. Lieverdink and Maarse, 1995).

Chapter 3 underlined that actor preferences and related behavior are necessary to understand the variation in the new payment system. Despite comparable institutional settings, NPM has emerged to a large extent in the new Dutch payment system and to a smaller extent in the German one. Furthermore, the payment systems of the UK and the Netherlands are more similar than expected given the institutional settings. Chapter 4 demonstrated that the variation in the new hospital payment systems cannot be understood without taking party politics into account; the preferences of the governmental parties are recognizable in the policy output. To improve our understanding of how actor preferences have affected the variation in new hospital payment systems, the preferences of the medical bodies and their related behavior is studied.

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1 Another version of this chapter is published as: Van Essen, A.M (2009). ‘New hospital payment systems: comparing medical strategies in the Netherlands, Germany and The UK’ Journal of Health care Organisation and Management. vol. 23(3), 304-318
The sub-question posed in this chapter is: *To what extent are the negotiation strategies of the medical bodies related to the variation in the new hospital payment systems of Germany, the Netherlands and the UK?*

The next sections conceptualize how the medical profession and the government might interact in different institutional contexts, i.e. in contexts with different rules of social practice. The formal political system and the health care institutions produce different ‘rooms to maneuver’ for the medical profession and the government. I conceptualize the interaction between governments and medical bodies from a game theoretical perspective. Subsequently, this chapter explores the preferences and related behavior of the medical profession by using different data sources: official documents, professional publications, secondary studies and an expert questionnaire. Subsequently, the game-theoretical conceptualizations are compared with preferences and related behavior of medical bodies and governments. Finally, the strategies are related to the variation between the payment systems.

To preview the results, the strategy of the Dutch medical body in interaction with the government facilitated the emergence of NPM in an institutional setting with comparatively little room to maneuver for the government. The German and British medical bodies used more offensive negotiation styles. In the German case, this made a smooth-running new hospital payment system more difficult. In the UK, the government could further its preferences in the payment system despite the offensive strategy of the medical body. In all cases, the interaction between the preferences, related behavior and the specific institutional settings do a better job in explaining variation than the institutional settings or preferences alone.

### 5.2 Centralizing and decentralizing tendencies in payment systems

Payment systems are the building blocks of any health care system, as they introduce powerful incentives for the behavior of actors in the system (Busse, Schreyögg, and Smith, 2006). Furthermore, NPM elements are likely to emerge in new hospital payment systems, but will do so differently, in particular the extent to which hospitals have to compete for funding, the extent to which process accountability shifts to performance accountability, and the extent to which efficiency is considered an important policy goal.

As noted in Chapter 2, The new hospital payment systems are either nation-specific forms of DRG, as in Germany, or systems based on likeminded ideas, such as the ‘payment by result’ system in the UK and the Dutch DBC (*Diagnosebehandelcombinaties*) system. Differences in the way health care products are categorized are apparent, but the three systems all reward providers for productivity, as an increase in activity will subsequently increase payment (Jegers et al, 2002). In other words, the reform initiatives are similar across the countries, while the policy ideas and measures vary (see also Chapter 3).

The main similarity in how NPM has emerged in the payment systems concerns the notion of transparency. Particularly in the Netherlands and Germany,
transparency is frequently mentioned as one of the key ideas of the system. Differences are found in two areas. First, how accountability has shifted from process to performance, i.e. the extent to which non-governmental actors have been made accountable for the performance of the system instead of governmental actors alone, varies. Second, differences are observed in how and to what extent the system facilitates marketization and competition. In Germany, contracting out and competition are seldom emphasized or mentioned in the policy plans and legislation, while competitive contracting is a key method in the British and Dutch plans (see Chapter 3). This indicates that NPM can emerge in various ways in the new hospital payment systems.

Table 5.1 Divergence of NPM elements in hospital payment systems

<table>
<thead>
<tr>
<th>Netherlands</th>
<th>Germany</th>
<th>UK</th>
</tr>
</thead>
<tbody>
<tr>
<td>NPM to a large extent recognizable; focus on competition and marketization</td>
<td>NPM to some extent recognizable; focus on transparency, efficiency and performance</td>
<td>NPM to a large extent recognizable; focus on patient choice and contracting</td>
</tr>
</tbody>
</table>

(source: Chapter 3)

The contradiction between the centralizing tendencies, e.g. explicit performance standards and measures, and the devolutionary tendencies (i.e. managerialism) in NPM is relevant (Christensen and Laegreid, 2001). Table 5.1 shows that in the Netherlands and the UK both centralizing and decentralizing elements are present, while in Germany the system prioritizes centralizing elements, such as monitoring and transparency. Other studies have confirmed the latter finding (cf. Dent, Howorth, Mueller et al., 2004). This shows that preferences are probably complex and relevant in understanding the specific policy processes in the countries.

As argued previously, the variation in hospital payment systems needs further empirical investigation, as institutional and state traditions do not provide sufficient explanations. These structural factors have been, for instance, unable to explain the remarkable ease with which NPM emerged in the Netherlands. Hence, it is interesting to study the impact of strategic behavior on similar types of reforms, e.g. the implementation of new hospital payment systems, in different institutional contexts.

5.3 Medical bodies and interest representation

Medical bodies are interest organizations. Similar to other political actors, they represent an aggregate of individual preferences and a collectively shared and rank-ordered set of urgent needs (Keman, 1999b). Their key interests are self-regulation, autonomy and care for patients (e.g. Salter, 2002). The selective principle of most medical bodies is coercion, i.e. doctors are obliged to become members. Medical
bodies act in many cases according to the closed shop principle (Olson, 1982: 21). German doctors, for instance, must be members of the Statutory Health Insurance (further SHI) doctor association to be allowed to treat SHI patients, who constitute a majority.

all are interest organizations, medical bodies are organized in different ways. In the UK and Germany, the bodies that represent doctors in policy processes and those who organize self-regulation are separate: the British Medical Association (further BMA) and the General Medical Council (further GMC) are separate entities; the German SHI doctors’ associations and are distinct from the German doctors’ chambers. Moreover, in Germany voluntary unions represent the interests of certain types of doctors (e.g. Hartmann and Marburg union). In the Netherlands, by contrast, the body that represents the physicians (Orde van medisch specialisten) is part of the organization of self-regulation (further KNMG). All recognized medical specialist organizations are members of the representing body. Dutch doctors who are employed by the hospital have a specific interest organization for collective working agreements (Landelijke vereniging artsen in dienstverband, LAD).

It is important to understand the role of the medical bodies as interest organizations and their role in health care policy. Olson (1982: 28) argues that medical bodies, similar to other small well-organized organizations, are able to affect the small choices needed to implement policies. As an example, he points to the US, where physicians were able to increase their income by the setting up Medicare and Medicaid. Moreover, Klein (1990) argues that there is mutual dependency between the state and medical bodies. In the UK, for instance, the state has become a monopoly employer but is dependent on the medical profession for running hospitals. Although this mutual dependency differs in Germany and the Netherlands, which do not have national health services, some form of dependency is nevertheless present, since most patients are part of public schemes. The government is thus the main sponsor and/or regulator, while physicians provide health care (in private organizations).

Many scholars contend that health care is different from other welfare state sectors since a professional group, rather than the state, dominates provision (cf. Heidenheimer, Heclo, and Teich Adams, 1990). According to Ham and Alberti (2002), in the past, physicians had a large degree of autonomy and control over their work. In return, doctors accepted the governmental right to determine the budgets and the broad national political framework. Typically when making decisions, doctors prioritize treating patients within the available budgetary constraints, and politicians do not seek to influence these decisions. However, individual professional discretion has eroded over time. On the one hand, it is constrained by external pressures, namely the organizations within which professionals work and governmental regulation. On the other hand, clinical autonomy rests more and more in elite-set rules (Armstrong, 2002; Freidson, 1984).
Comparing strategies of governments and medical bodies

As noted in Chapter 2, three main health care priorities – quality, cost containment and universal accessibility – compete with each other (see also Figure 2.1). Either a particular treatment for an individual patient is done at the expense of other patients who may require equally urgent treatment, or public expenses must rise. Doctors are not able to solve this dilemma, yet they are expected to resolve conflicts between their interests and the patient’s interest in favor of those of the patient (Blumenthal, 1996). For this reason, health care reforms in the 1980s and 1990s aimed at reducing the decision-making power of medical bodies and individual physicians (Ackroyd, Kirkpatrick, and Walker, 2007; Giaimo, 2002; Horner, 2000; Kuhlmann and Allsop, 2008; Lieverdink, 2001).

Klein (1990) sees the mutual dependency between the medical profession and the government as the politics of a double bed. When determined to weaken the medical profession, the state has the power to breach the accommodation (Klein, 1990). The power of the state in this regard is particularly relevant in studying NPM reforms. NPM does not always reduce medical self-regulation, but it certainly has the possibility to do so. A central question to understand the preferences is therefore whether individual physicians gain from the shifts in accountability (i.e. its devolutionary tendencies of NPM) or lose from the enhanced scrutiny of the government into their performance and the expenditures of health care resources (i.e. its centralizing tendencies).

The preceding discussion underlines the complexity of the interaction between the medical profession and government. They are in a mutual relationship with each other. The medical bodies are able to affect minor choices in policy, but the government has the ability to breach the accommodation with the medical profession by implementing a specific form of NPM, i.e. by focusing on the centralizing tendencies. As will be outlined in the next section, the strategies of the medical bodies depend on whether they expect the government to influence their position in the health care organization and on how the new payment system may affect the care for patients.

5.4 Conceptualizing ‘politics’ in the interaction between the government and medical bodies

In this section, I apply a game theoretic approach to illustrate the relationship between the strategies of the government and those of the medical corporate bodies in the policy process under study. The aim is to discern whether strategies tell us something about the outcomes of reform. In other words, how does politics matter in different institutional settings?

I compare the hypothetical game situation with the actual policy processes to gain insight into how institutions and actors interact. Woldendorp (2005: 278) distinguishes three types of interaction that may occur between different actors:

---

2 As will be outlined below, this is a different interplay than what Scharpf (1998) and Woldendorp (2005) refer to as ‘the battle of the sexes’. In the battle of the sexes, the preference to preserve the relationship is more important than fulfilling self-interest.
confrontation, bargaining and cooperation. These forms of interaction are useful for conceptualizing the strategic choices actors can make under specific circumstances in various institutional settings. To understand the strategies of actors as they interact with one another, it is important to understand the overall environment: what are the preferences of an actor regarding a specific decision; what is the status quo, and what are the behavioral assumptions about the strategies of other agents (Dion, 1992)?

5.4.1 Conceptualizing preferences and interests

Conflicts over competing interests often occur as a ‘zero-sum game’ to actors, i.e. political actors may either win or lose at costs of the interests of others (Keman, 1999b: 251). In health care, conflicts between the government and medical profession are explained by the tension between health care as a political decision and as a technical medical decision (Starr and Immergut, 1987). As already noted in Chapter 2, private interests in health (of patients, for instance) are different from the public interests regarding health care (which is a compromise between quality, equitable accessibility and costs). However, it is unclear whether these varying interests and preferences are always conflicting or whether they might also be parallel or complementary (Czada, 1998; Keman, 1999b).

I assume that neither the government nor the medical bodies have an interest in keeping the status quo in the three cases. Under the old payment systems, either a particular treatment for an individual patient was done at the expense of others who may have required equally urgent treatment (fixed budgets), or public expenses were pushed up (fee-for-service or payment per hospital day). The result was either long waiting lists (as in Netherlands and the UK) or high public costs (as in Germany). The old payment systems thus directly limited the care patients received, particularly in the Netherlands and UK. Moreover, a new payment system might be attractive to both parties. The medical profession is likely to gain from the decentralizing tendencies, since these expand their autonomy. In addition, governments generally favor more effective and transparent spending of resources.

Three aspects are important in conceptualizing the interests or preferences of physicians and the government: self-regulation and autonomy of the medical profession, an efficient health care system and care for patients. Whereas self-regulation is likely the most important (self-)interest for physicians, contemporary reforms introducing measures to reduce self-regulation of physicians and medical bodies suggest that governments prefer the opposite (cf. Ackroyd, Kirkpatrick, and Walker, 2007; Kuhlmann and Allsop, 2008). Implementing NPM, however, does not particularly aim on reducing self-regulation. It may have this result, but it is not a certain outcome. For this reason, (reducing) self-regulation of the medical profession is not considered a very important preference the government.

As shown in Chapter 4, parties place varying degrees of attention on the different health care goals. Since cost containment has consistently been a salient issue in political debates, a more efficient health care system (i.e. more value for
Comparing strategies of governments and medical bodies

money) is more important for the government than either the self-regulation of the medical profession and care for patients (i.e. quality and accessibility) in this reform (see also Table 4.10). Table 5.2 shows the hypothetical ranking of actor preferences.

**Table 5.2 Hypothetical ranking of preferences and interests**

<table>
<thead>
<tr>
<th></th>
<th>Medical body</th>
<th>Government</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-regulation medical profession</td>
<td>1 or 2 [+]</td>
<td>3 or 2 [-]</td>
</tr>
<tr>
<td>Efficient health care system</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Care for patients</td>
<td>2 or 1</td>
<td>2 or 3</td>
</tr>
</tbody>
</table>

(1 = very important, 2 = important, 3 = indifferent)

The strategies actors adopt are not only determined by their own interests and preferences, but also the strategic choices of other actors and the specific institutional context. According to Keman (1999b: 249), there are two possibilities to come to an agreement when two parties compete in the same realm of ‘needs’. If parties have complementary preferences, i.e. separate organizations demand identical measures that meet their respective interests, they can form strategic coalitions. Otherwise, if parties have parallel interests, i.e. separate organizations have similar interests but with a different ordering of these interests, they are likely to employ cooperative strategies (Keman, 1999b: 260).

5.4.2 Conceptualizing governmental and medical strategies

The implementation of new payment systems is here considered as a micro-macro paradox (Keman, 1999b: 251). Strategies can be defined as pursuing self-interest by means of social interaction whilst being dependent on others. Actors must act strategically within the rules of the game to achieve their individual preferences and interests, e.g. self-regulation and an efficient health care system. Woldendorp (2005) distinguishes three strategies.

The first strategy is **confrontation**. Actors consider their conflicting interests more important than the common interest and are therefore unwilling to cooperate. With regard to the hypothetical preference ordering, the medical profession and/or the government hold opposite views on the importance of self-regulation of the medical profession (see Table 5.2). Otherwise, parties might agree on the fact that a new payment system is important for the efficiency of health care, but they are aware of potentially different self-interests, such as self-regulation. This second strategy is **bargaining**: actors will support a common solution, but only if their other interests are safe-guarded. As noted by Keman (1999b), actors might come to a solution in instances when the interests and preferences that compete are not very important. Finally, a strategy can be described as **problem solving** when actors deal with the same concerns and present comparable solutions. The necessity of a new payment system is so important for medical bodies that they are willing to give up their other interests to solve the conflict (Keman, 1999b; Scharpf, 1998; Woldendorp, 2005).
Game theory is a useful method for relating preferences to strategies and outcomes. Building on Scharpf’s framework (1987) - describing the interaction between governments, unions and central banks - Hood (1995) has constructed a game for public sector workers and politicians (see Figure 5.1). The outcomes and possible strategies that he describes provide insight into the way NPM might emerge in new hospital payment systems. Figure 5.1 shows that outcome 1 needs the cooperation of both political actors. Outcome 2, 3 and 4 are so-called Structure-Induced Equilibriums (further SIE), meaning that actors cannot change their strategy without making the outcome worse (in terms of individual utility) (Hood, 1995; Keman, 1999b; Shepsle, 1995).

Table 5.3 Hypothetical outcomes of in the interaction between politicians and profession

<table>
<thead>
<tr>
<th>Profession</th>
<th>Politicians</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Cooperative</strong></td>
<td>Outcome 1: smooth running medium cost NPM/payment system</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Outcome 2: politicians exploit self-regulation ethos for cheap and effective NPM</td>
</tr>
<tr>
<td></td>
<td><strong>Non-cooperative</strong></td>
<td>Outcome 3: medical profession can expand self-regulation, probably leading to high costs public management</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Outcome 4: large transaction costs by the implementation of the new hospital payment systems (i.e. bureaucracy)</td>
</tr>
</tbody>
</table>

(sources: Hood, 1995; Scharpf, 1987)

Table 5.3 relates the strategies of actors to different outcomes, but it fails to provide insight when different strategies in interactions are expected; in other words, the strategies are described without taking the specific context into account. Depending on the different modes of interaction, three pay-off matrices can be distinguished in Table 5.3. The pay-off matrix chicken game will occur if at least one party opts for the confrontation strategy. The prisoner’s dilemma will be played if one or both parties opt for the bargaining strategy, while none of the parties opt for confrontation. Finally, the battle of the sexes will occur if both parties opt for problem solving (see table 5.4c Woldendorp, 2005: 278). The hypothesized relationships between interactions and outcomes described here apply to scenarios in which two equal, isolated actors play the game once.

To be useful for assessing outcomes between actors, the battle of the sexes pay-off matrix needs to be conceptualized in a somewhat different manner. In the

Seeking a balance?!
original game, the least preferred outcome is for the couple to go out separately. With regard to the options specified under Hood’s (1995) scheme, outcome 4 would be the least preferable option, since in this cell no agreement is reached. Outcomes 2 and 3 reveal that an agreement serving the interests of one actor is reached. Lastly, outcome 1 prevails if both actors strive for the best common solution (Woldendorp, 2005: 68).

Which cells can be SIEs according to Hood’s (1995) scheme depends on the interaction between the government and the medical bodies, i.e. a chicken game results in a different SIEs than a prisoner’s dilemma. SIEs are equilibriums in which actors are not likely to change their strategy since their individual utility will not increase. If one actor acts offensively in the chicken game, the other actor cannot act offensively, as this would lead to outcome 4. In a (one-shot) prisoner’s dilemma, both actors have the incentive to act uncooperatively, since if one actor does act cooperatively, it will lead to the best individual outcome for the non-cooperative actor.

Note, however, that cooperation can also be a dominant strategy in a prisoner’s dilemma. First, an outside enforcement could punish players for breaking the deal, in which case free riding is less rational. Or second, an infinite or indeterminate number of repetitions of the game could occur, in which case actors tend to use the same strategy as in the last game (Axelrod, 1984; Laver, 1997). Since the game is repeated over the years, outcome 1 is possible. This is conditional cooperation: remaining the cooperation is more useful than free riding and breaching the contract (Laver, 1997: 47-48).

---

3 In the original game, a couple wants to go out. The woman prefers to go to the Opera, while the man wants to see a ball-game. Going out separately rather than together is the least preferred option regardless the venue (see for instance Scharpf 1998).
Table 5.4a-c Hypothetical pay-off matrices between government and medical bodies

a. Chicken game

<table>
<thead>
<tr>
<th>Medical bodies</th>
<th>Government</th>
<th>Cooperative</th>
<th>Non-cooperative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cooperative</td>
<td>0,0</td>
<td>-1, 1</td>
<td></td>
</tr>
<tr>
<td>Non-cooperative</td>
<td>1, -1</td>
<td>-2, -2</td>
<td></td>
</tr>
</tbody>
</table>

b. Prisoner’s dilemma

<table>
<thead>
<tr>
<th>Medical bodies</th>
<th>Government</th>
<th>Cooperative</th>
<th>Non-cooperative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cooperative</td>
<td>0,0</td>
<td>-2, 1</td>
<td></td>
</tr>
<tr>
<td>Non-cooperative</td>
<td>1, -2</td>
<td>-1, -1</td>
<td></td>
</tr>
</tbody>
</table>

c. Battle of the sexes

<table>
<thead>
<tr>
<th>Medical bodies</th>
<th>Government</th>
<th>Cooperative</th>
<th>Non-cooperative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cooperative</td>
<td>2,2</td>
<td>0,1</td>
<td></td>
</tr>
<tr>
<td>Non-cooperative</td>
<td>1,0</td>
<td>-2, -2</td>
<td></td>
</tr>
</tbody>
</table>

Ordinal pay-offs are ranked from worst (-2) to best (2), SIEs are **bold**.

→ Conditional cooperation

(source: Scharpf, 1998: figure 3.2)

5.4.3 ‘Playing games’ in three different institutional settings

The simple game theoretic scenarios presented in the last section do not take the specific institutional context into account. It compares the hypothetical setting with the empirical situation to get insight in the interaction of actors and institutions. I argue that it is unlikely that the ‘power relations’ of the medical bodies and the government are similar across cases, meaning that the specific institutional settings influence strategies and interactions.

The three cases are relevant. They are comparable with regard to context - international organizations and economic situation - but the medical bodies and the individual physicians are embedded differently in the political and health care systems. As noted in Chapter 2, the countries represent diverse cases (Gerring, 2007). They signify variation on the independent and dependent variables. As outlined below, in the Netherlands and Germany the medical bodies can be considered veto players, while in the UK the medical body is not a veto player (cf. Immergut, 1992a; Tsebelis, 2000).

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4 Several studies have taken institutional settings in games into account, e.g. Ostrom (1998), Norgaard (1996), Greif and Laitin (2004).
The organization of the medical self-regulation is not completely similar across cases. As shown in Chapter 2, two general trajectories of health care system development can be distinguished. The first trajectory is characterized by the radical institutionalization of universal access, i.e. the UK (Freeman, 2000: 24). State control and power are accepted and embedded in this structure (cf. Kuhlmann and Allsop, 2008). The second trajectory is characterized by piecemeal expansion of the public insurance scheme (Freeman, 2000: 24). The relationships between health care providers and the state have remained more complex in the latter. In Germany, self-governing powers developed parallel with the setting up of the welfare state. Social health insurance was introduced much earlier alongside a corporatist and federal political system (Kuhlmann and Allsop, 2008). The Dutch system shows a somewhat mixed form; self-regulation of the medical profession (1865) existed before the installation of the social health insurance system (1941), but in a centralized political system. However, in the Netherlands most organizations that operate on the health care market are private (not-for-profit).

As noted in Chapter 2, the dissertation does not follow a configurative approach, but it studies the interaction between actors and specified institutional settings. This chapter focuses on specific institutional settings that are considered theoretically important for understanding the interplay between the government and the medical profession: first, clinical discretion - the extent to which the medical profession can set its own standards; second, economic autonomy - the extent to which physicians can affect their income; and third, joint decision-making - the extent to which the corporate bodies are involved in decision-making (see Table 5.5). Clinical discretion is organized most comparably across countries, since evidence-based medicine has become the rule. It remains, however, very difficult for third parties, e.g. the government, to break the clinical monopoly of medical bodies. Financial incentives, as the new payment systems, are usually not able to change this (Timmermans, 2005: 490). For this reason, governments recognize medical bodies in the three cases despite the specific ‘power balances’.
**Table 5.5 Institutional context of the medical profession**

<table>
<thead>
<tr>
<th>Institutional settings</th>
<th>Netherlands</th>
<th>Germany</th>
<th>UK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Economic autonomy</strong></td>
<td>70% of physicians are independent entrepreneurs (mainly in hospitals); the other 30% are employed by hospitals</td>
<td>Approx. 50% of physicians work in hospitals, mainly salaried employees, with some mixed forms; the remaining 50% work in ambulatory care, mainly office-based physicians</td>
<td>NHS physicians are salaried</td>
</tr>
<tr>
<td><strong>Corporate bodies</strong></td>
<td>Corporate body negotiates the (hourly) tariff, but this is determined by the Dutch health authority; hospitals negotiate with insurance companies about DBC’s</td>
<td>Statutory Health Insurance (SHI) bodies negotiate tariffs; unions are also relevant in the hospital sector</td>
<td>British Medical Association (BMA) negotiates about contracts with the Department of Health and NHS, consultant’s contract.</td>
</tr>
<tr>
<td><strong>Decision-making</strong></td>
<td>Joint decision-making: medical profession developed DBC system; involved in the maintenance</td>
<td>Joint decision-making, SHI bodies (including medical profession, sickness funds and Hospital Society) were obliged to choose a new payment system; involved in the maintenance</td>
<td>No (official) joint decision-making</td>
</tr>
<tr>
<td><strong>State-profession relationship</strong></td>
<td>Government depends to a large extent on the corporate bodies</td>
<td>Government depends to a large extent on the corporate bodies</td>
<td>Government only partly depends on the medical profession, e.g. clinical directors</td>
</tr>
</tbody>
</table>

Comparing strategies of governments and medical bodies

In all three countries, medical bodies register doctors and carry out disciplinary punishment. These bodies also control the basic standards and outcomes for medical education. However, some legal acts, for instance the health professions act (BIG) in the Netherlands, make it impossible for the medical bodies to close the shop completely, i.e. they cannot act unilaterally. The government is able to affect the self-regulation of the medical profession by deciding who can work as a physician.

To understand the degree of economic autonomy, it is relevant to compare how physicians are employed. In the Netherlands and Germany, more than 50% of the physicians are individual entrepreneurs (Kuhlmann and Allsop, 2008; Lombarts and Klazinga, 2001). This means that, in contrast to the British physicians, a large proportion of Dutch and German doctors have been able to affect their individual income, although medical bodies or interest organizations negotiate (hourly) tariffs for hospital doctors. Since 2000, however, Dutch hospitals rather than the medical bodies negotiate about the budget and tariffs with insurance companies (Integration Act, 2000). Hence, medical organizations are no longer necessary for the negotiations. National differences in salaries are also important. Dutch physicians (particularly independent entrepreneurs) have very high incomes, and British doctors are similarly amongst the peak earners. Salaries are on average much lower in Germany and this remains a source of conflict, as demonstrated by the recent hospital strikes (Janus, Amelung, Gaitanides, and Schwartz, 2007; Maynard and Street, 2006; OECD, 2006).

Finally, the medical bodies have been involved in the implementation of the new payment systems in different ways. Although the UK does not have a corporatist tradition, the health care sector is probably an exception (cf. Giaimo, 2002). The medical profession is still involved in all layers of the Department of Health (Ham, 2004). However, the implementation of the new hospital payment system in the UK did not involve the medical bodies to the same extent as in the Netherlands and Germany, where medical bodies have contributed considerably to the content of the new payment system.

In the Netherlands, the physician organizations of the different specialties developed the health care products in collaboration with the hospital and insurer organizations (Borst, 2000). In Germany, key organizations of the medical profession, hospitals and insurers were legally obliged to develop the system (Lauterbach and Lungen, 2000). In both countries, institutions representing members of key health organizations continue to maintain the system (DBC Onderhoud, 2007; InEK, 2009). In the UK, the case mixes of the new payment system have been based on historical data. Hence, the degree of clinical and economic autonomy varies across cases, and the medical profession has been involved in the policy processes in several ways. In the Netherlands and Germany medical bodies have had significant leeway, while in the UK individual physicians

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5 These are the General Medical Council (GMC) and the Royal Dutch Medical Association (KNMG)
are more integrated in the hospital organization and the medical bodies have not been involved in joint decision-making with other political actors.

As argued, actors attempt to pursue their self-interests but remain dependent on others to achieve this. It is clear from the institutional context that the German and Dutch governments are unable to act unilaterally in their interactions with the medical profession. In contrast, the British government seems better able to pursue its individual utility unilaterally, irrespective of the medical strategy. This can be explained by the large state involvement in the NHS. Although (weak) corporatism can be observed (cf. Giaimo, 2002), the state has a stronger position than in the other two cases, since the medical profession is less involved in the policy process. The different new institutionalist approaches, i.e. historical institutionalism and rational institutionalism do not agree whether institutions are only affecting the formal 'room to maneuver' or are more decisive for actor preferences and related behavior. The next sections show how the preferences and strategies in the policy processes interact within institutional settings and whether these mirror the hypothetical game-theoretical situations.

5.5 Method and data
To analyze the specific interests underpinning the medical profession’s strategies, it is necessary to study the stances that the medical profession adopted in relation to the introduction of the new hospital payment systems. More specifically, I analyze the preferences of the medical profession regarding how the new system might affect care for patients and self-regulation. The analysis is based on a systematic review of articles, the positions of the medical bodies (retrieved from reports and statements published on medical bodies’ websites) and an expert questionnaire.

The systematic review of articles centers on three key resources – the ‘BMJ’ (edited by the British Medical Association, BMA), ‘Medisch Contact’ (edited by the Royal Dutch Medical Association, KNMG) and ‘Das Deutsche Ärzteblatt’ (edited by the German Medical Association, Bundesärztekammer, BÄK). It covers a time span of 1996-2007, with a focus on 2002-2006. The articles included in the review were selected from the digital archives in January 2008 using the following key words: 'DBC', 'Fallpauschalen/DRG' and 'payment by results'. All articles selected have the new payment system as their main topic or relate the payment system to the medical bodies and/or individual physicians. A total of 286 articles were reviewed: 138 for Germany, 59 for the Netherlands, and 99 articles for the UK.6

Note that the nature and scope of the resources differ in some respects. The Dutch and German publications are both non-refereed with opinion and policy articles, and generally written by physicians. The BMJ, by contrast, is a refereed

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6 Note that the number of articles vary significantly among the journals: 962 articles that refer to the new payment system were found in the German journal, 347 in the Dutch journal, and 108 in the British journal. See for a complete overview of the articles taken into account in this research Appendix C (January 2008)
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journal with a more international scope, and contributions include articles by
policy-makers as well as scholars of health policy and management. Moreover, the
total number of articles addressing the new payment systems in the BMJ is
somewhat lower. All of the journals, however, provide a broad basis for analyzing
the views of the medical profession.

In addition to the analysis of secondary sources described above, an expert
survey was carried out in the three countries. The questionnaire was administered
between January and March 2007 to experts selected on the basis of their function,
e.g. academic, author of professional or scientific publication, or key lecturer at a
professional conference. Twenty-six experts completed the survey – five from
Germany, seven from the UK and fourteen from the Netherlands. The primary
purpose of the survey has been to uncover selection bias and biased reporting of the
journals. It is thus used in a qualitative manner, i.e. as a form of triangulation of
data sources.

There are two potential risks of focusing mainly on the views of the medical
bodies. First, the aggregated preferences and interests of individuals might not be
similar to those of the medical bodies. Second, disagreement within the bodies
might affect the ranking of their preferences. The present study, however, focuses
primarily on the views of the medical bodies and the debates presented by the
journals, since they are involved in the policy process and are assumed to act in the
interests of their members (Scharpf, 1997).

5.6 Results

The purpose of this section is three-fold. First, I analyze the preferences and
interests of medical bodies across cases. Second, I determine which strategies were
likely used and which interactions between the government and medical bodies
occurred. Finally, I consider how such strategies and interactions are related to the
way NPM has emerged in the policy of new hospital payment systems. This section
explicates that the tactics employed by a specific actor are not determined by the
institutional settings alone; rather, an actor’s ‘room to maneuver’ is also affected by
other political actors, preferences and the assumptions about the strategies of other
actors (Dion, 1992).

It is important to note that this research does not present a thick analysis
through time (cf. Woldendorp, 2005). As indicated in Chapter 2, I study synchronic
variation among cases. The expert survey does not allow for comparison over time
and the resources consulted in the systematic review of articles are also limited.
The study is however, useful in determining whether politics matters, for instance,
since preferences of medical bodies seldom change much over time. The German
and British bodies, for example, did not modify their preferences during the
reforms of the 1990s (cf. Giaimo, 2002: 56-60, 132-135). Of course, there are some
instances in which strategies have changed (Giaimo, 2002; Woldendorp, 2005).
Evidence of such changes in this study is indicated whenever possible.
5.6.1 Complementary and parallel interests

Table 5.6 summarizes the preferences of the medical bodies as found in the three data sources. The first row shows the general (aggregated) opinions. The next rows indicate opinions regarding how the new payment system will affect care for patients, position in the health care system and bureaucratization. The last row presents the preferences of the governmental parties (as extensively discussed in Chapter 4).
Table 5.6 Overview of the views of the medical bodies about policy of the new hospital payment systems

<table>
<thead>
<tr>
<th></th>
<th>Netherlands</th>
<th>Germany</th>
<th>UK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General standpoints</strong></td>
<td>All resources show that the corporate body has supported the development of the system.</td>
<td>Corporate bodies are in general negative about the system.</td>
<td>Corporate body is negative about the system.</td>
</tr>
<tr>
<td><strong>Care for patients</strong></td>
<td>Fear that accessibility to hospital care might become more difficult.</td>
<td>Competitive elements will lead to fragmentation of care</td>
<td>Cherry picking of private centers, which can be funded through Payment by Results (further PbR)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Fear of fragmentation of care</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>New clinical practices cannot be taken into account immediately in tariffs</td>
</tr>
<tr>
<td><strong>Self-regulation:</strong></td>
<td>An extended role for insurance companies</td>
<td>Physicians get more financial responsibility.</td>
<td>Authors focus on other role of Primary Care Trusts. Own position not really discussed.</td>
</tr>
<tr>
<td>Clinical and economic</td>
<td>More influential role of the state</td>
<td>Shift from clinical priorities to economic priorities.</td>
<td>Shifts in accountability are discussed with regard to hospitals instead of individual physicians</td>
</tr>
<tr>
<td>autonomy**</td>
<td></td>
<td>More influential role of the state</td>
<td></td>
</tr>
<tr>
<td><strong>Bureaucratization</strong></td>
<td>Administrative workload is the most negative aspect of the DRG system</td>
<td>The way health care products are described is unfair</td>
<td>PbR does not taken into account differences</td>
</tr>
<tr>
<td></td>
<td>The way health care products are inadequately described</td>
<td></td>
<td>Health care products inadequately described</td>
</tr>
</tbody>
</table>
Table 5.6 continued

<table>
<thead>
<tr>
<th>Summarized standpoints of government and profession</th>
<th>Netherlands</th>
<th>Germany</th>
<th>UK</th>
</tr>
</thead>
<tbody>
<tr>
<td>The governmental parties emphasize competition.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dutch profession more positive about competition than other countries, particularly at the start</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Governmental parties emphasize efficiency and transparency</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Profession points to more centralized role of government and the shift to economic priorities</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Governmental parties focus on all elements of NPM and all important parties support payment system</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Profession fears competitive elements, e.g. competition with private centers</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(For a complete list of sources see appendix C, details about the questionnaire can be obtained from the author)

1 This perception is only found in the questionnaire
Comparing strategies of governments and medical bodies

The most remarkable finding is the relatively sizeable support of the Dutch medical body. One of its campaigns has been ‘The DBC system is a necessity, but needs to be done well’ (DBC moet, maar dan wel goed, http://orde.artsennet.nl). Several articles also point to the support of the system (cf. Bolhuis, 2005; Dofferhoff, 2005). Finally, the evidence from the questionnaire shows that the Dutch medical body has been more positive than its German and British counterparts.\(^7\)

It is striking that the preferences of the medical bodies are fairly similar to their general reactions to the reforms of the 1990s. Giaimo (2002) argues that both the German and British medical bodies were extremely negative about the market-oriented governmental plans in the 1990s. Lieverdink (2001: 1191) shows that Dutch medical practitioners, in contrast, underlined the importance of demand-led organization of care in the 1990s. Such findings support the notion that preferences about governmental plans are relatively stable over time.

As noted in Chapter 2, quality and accessibility of health care are likely impacted when reforms focus on containing costs and/or introducing competition and marketization. Resen (1998: 155), for instance, argues that including competition in public sectors will lead to a focus on specific goals. However, the extent to which competition is implemented in the systems seems to have little influence on the preferences of the medical bodies concerning care for patients. In the Netherlands, for example, neither the journal discussion nor the official publications of the medical body highlight the probable effects on quality or accessibility of care.\(^8\)

In contrast, the views reflected by the British and German medical bodies suggest that they consider the new payment system to be at odds with their ideas about care for patients. As illustrated in Table 5.6, their concerns about the consequences of the new payment systems on care for patients are comparable. The British medical profession points to the influence of the system on fragmentation of care (i.e. when money would move out of the NHS to private providers) (Black, 2004; McGauran, 2004). Similarly, German physicians fear the fragmentation of care (Flintrop 2006) and are moreover concerned about the effects of NPM on the quality of care (Rieser, 2006; Scherlitz, 2002).

The evidence also suggests that self-regulation is important for all medical bodies. The Dutch and German bodies emphasize the centralizing tendencies of NPM. In the Netherlands, the extended influence of insurance companies is also a key issue (Crommentuyn, 2005, 2006). German articles, in comparison, focus heavily on the growing economic responsibility of health care providers (Flintrop, 2006). Hensen et al. (2004), for example, stress the key role of physicians nowadays in the economic survival of hospitals.

\(^7\) Means on a five points scale (1 = very positive, 5 = very negative): NL 1.71 (N=14, std: 1.07), GER 4.40 (N = 5, std 0.55), UK 3.86 (N = 7, std 1.07).

\(^8\) Not one article in Medisch Contact (search June 2008) contained both Dutch words for accessibility (toegang/ toegankelijkheid) and DBC. However, the results from the expert survey show that experts state that accessibility may decrease with the implementation of the new system.
According to these authors, the new payment system will especially deteriorate the clinical autonomy of the physicians. In the UK, the expanded roles of PCTs and hospitals are important points of discussion. In the British case, the economic autonomy of physicians has been so severely eroded in earlier reforms that preferences tend to focus more on possible job losses when hospitals have to close down and on decreased funding for training and working conditions (Eaton, 2007). It confirms the idea that a national health care system has less economic autonomy for physicians than the public-regulated systems in the Netherlands and Germany where physicians are often employed in private (not-for-profit) hospitals or self-employed.

To summarize the preferences of the medical bodies in the three countries, the Dutch medical body supported the new payment system to a large extent, believing that it would have little negative effect on care for patients. The expectation is that self-regulation might decline due to the new responsibilities and measures for health insurers. In contrast, the German and British medical bodies did not support the new payment system. These organizations argue that the system will have adverse effects on care for patients. Although bureaucratization is cited as a problem by the medical bodies in all countries, the German bodies are particularly apprehensive of the consequences of the new payment system for their self-regulation; they fear a loss of autonomy.

5.6.2 From preferences to related behavior

As stated above, the strategies of medical bodies are affected by their preferences and interests, their assumptions about the strategies of the government and their room to maneuver. Section 5.4.3 demonstrated that power dependencies vary across cases. While in Germany and the Netherlands, the medical bodies are veto players in the process – i.e. the government needs their cooperation to implement the system, the British government is able to act to a large extent unilaterally (Immergut, 1992a; Tsebelis, 2000).

Section 5.3 employed game theory to outline three possible medical strategies. First, parties are likely to act in a problem-solving manner if their main interest is to cooperate. Second, if actors are aware of their self-interest but are nevertheless willing to cooperate, their strategy is likely to bargain. Finally, actors focused only on defending their own interests are expected to take on an offensive strategy (Scharpf, 1998; Woldendorp, 2005).

Tables 5.7a-c delineate the interests and preferences of the medical bodies and governments in each of the countries on the basis of the preferences reflected in the different resources. Conflicting strategies are more likely to occur in the UK and Germany. In these countries, the medical bodies view the new payment systems as negatively affecting care for patients and self-regulation and rank these preferences relatively high. In the Netherlands, medical bodies evaluate the effect the new payment system has on care for patients in a more positive way, and the government is relatively indifferent about self-regulation of the medical bodies.
Comparing strategies of governments and medical bodies

Tables 5.7 Lists of needs of medical bodies and governments based on the resources

a. The Netherlands

<table>
<thead>
<tr>
<th></th>
<th>Medical body</th>
<th>Government</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-regulation medical profession</td>
<td>1 +</td>
<td>3 -</td>
</tr>
<tr>
<td>Efficient health care system</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Care for patients</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

b. Germany

<table>
<thead>
<tr>
<th></th>
<th>Medical bodies</th>
<th>Government</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-regulation medical profession</td>
<td>1+</td>
<td>2 -</td>
</tr>
<tr>
<td>Efficient health care system</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Care for patients</td>
<td>2-</td>
<td>3+</td>
</tr>
</tbody>
</table>

c. United Kingdom

<table>
<thead>
<tr>
<th></th>
<th>Medical body</th>
<th>Government</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-regulation medical profession</td>
<td>2+</td>
<td>3-</td>
</tr>
<tr>
<td>Efficient health care system</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Care for patients</td>
<td>1-</td>
<td>2+</td>
</tr>
</tbody>
</table>

The governmental ordering of preferences is based on the information provided in Chapter 4. Governments focusing on the centralizing tendencies of NPM consider reducing the self-regulation of the medical profession paramount. From its focus on centralizing elements of NPM, it can be argued that the German government has an offensive strategy with regard to the medical profession. Other scholars have underlined this; they have recognized the re-emergence of the Ministry of Health as key player in contemporary reforms (Altenstetter and Busse, 2005; Hassenteufel and Palier, 2007). The scholars consider the DRG reform as a dramatic change in the system. The minister even planned a federal ordinance in the implementation of the new payment system (Altenstetter and Busse, 2005: 138).

Regarding the strategies of the medical bodies, the British and German medical bodies have taken a more offensive approach compared to the Dutch one. In 2006, the BMA supported the pressure group ‘Keep our NHS public’ (www.keepournhspublic.com, October 2008), which particularly opposes the new hospital payment system. The situation concerning the power dependencies in Germany is somewhat more complex, as the SHI body has to orient its behavior toward the common good (gemeinwohlorientierte). In other words, it not only has to implement governmental policies but also has to make sure that its members are in compliance (Giaimo, 2002: 99). The strategies of the voluntary bodies have tended to differ from those of the SHI body, with the former usually adopting a more offensive posture (cf. Giaimo, 2002). Demonstrations by doctors and protests
against the governmental plans during the DRG reforms underline this (Rabbata, 2002).

Self-regulation has played an important role in the Dutch strategy. The medical body has focused particularly on the income of medical specialists. In 2004, for example, it had to set a specific hourly tariff for independent entrepreneurs. However, the tariffs varied to a large extent among specialties, and it was not until 2007 that members of the body finally compromised on the tariff. Meanwhile, tensions have occurred in the medical profession since the new payment system does not affect physicians in a similar way. Ophthalmologists and orthopedists, for instance, have many treatments that are subject of price negotiation, while other medical specialists have to get along with fixed prices for treatments (Medisch Contact, 2004).

Chapter 3 revealed that NPM was able to emerge relatively easily in the Dutch payment systems. According to the preferences of the medical body, it has employed a less offensive strategy than its counterparts in Germany and the UK. Other studies indicate that the medical body has hindered decision-making processes concerning new medical specialists fees (e.g. Lieverdink and Maarse, 1995) yet supported decisions about demand-led care (e.g. Lieverdink, 2001). I argue that the medical body supports the course of the Dutch government, but it defends its self-interest. This corresponds with a bargaining strategy.

In sum, conflicting interactions - including strikes and federal ordinance - took place in Germany and the UK, while a bargaining interaction – small conflicts and cooperation - is evident in the Dutch policy process. Studies on previous reforms suggest that the strategies of medical bodies in the current reforms are comparable to those of the past. The German and British medical bodies have used more offensive strategies, while the Dutch had been more cooperative with regard to demand-led care (Giaimo, 2002; Lieverdink, 2001). Hence, preferences and related behavior have path-dependent characteristics. The next section shows how such strategies can be related to the variation of the new hospital payment systems.

5.6.3 From strategy to outcome

The main aim of this chapter is to address whether ‘politics matters’ by focusing on the interaction between medical bodies and the government. It compares the game-theoretical interaction with the preferences and strategies actors used in the policy process of the new hospital payment system. Hood (1995) shows that four outcomes are possible in NPM reforms regarding the different interests of public service workers and the government (see Table 5.3): 1) the NPM system runs smoothly, 2) the government exploits the public sector, 3) the public sector exploits the government; or 4) implementation of NPM induces high transaction costs. The ‘chicken game’ pay-off matrix can be applied in the German and British case, while in the Dutch case the ‘prisoner’s dilemma’ matrix shows the payoffs of the outcomes (see Tables 5.4a-c).
Comparing strategies of governments and medical bodies

Outcome 2 (the government exploits the medical profession) is the most likely result in the British case. Although the medical body is not a veto player and a top-down challenge seems to have an ongoing place in British health reforms, the government must embrace a professional ‘conscience’ and cannot simply focus on contracting and oversight (Stevens, 2004: 41-42). However, due to the power dependencies, the medical profession might even adopt an uncooperative strategy (e.g. go on a long strike) without risking outcome 4 and the government can further – particularly in comparison to the other counties - the new payment system to a large extent unilaterally.

As in Britain, the medical bodies in Germany have used offensive strategies. A key difference, however, is that the German medical bodies are veto players. Hence, if both the government and the medical bodies employ offensive strategies, there will likely be a shift to outcome 4 earlier than in the British case. As noted, the German government has used a remarkably offensive strategy, making it unlikely that the German SHI body will adopt a strong posture, since it cannot breach the accommodation with the government. Furthermore, an offensive strategy might lead to a larger individual utility loss, making outcome 2 likely. Thus far, the government has been able to reduce the self-regulation of the medical profession. However, transaction costs are relatively high as many complain about bureaucratization. In addition, the law has been altered several times to adjust to the problems that occurred (see Table 5.6)

One possible explanation for the somewhat unexpected finding that NPM emerged relatively easily in the Dutch payment system is the conditional cooperation between the government and the medical bodies. The prisoner’s dilemma pay-off matrix most accurately represents the Dutch situation. As outlined above, none of the actors in the Dutch case used an offensive strategy, but the medical body did not act completely cooperative. They have consistently defended their self-interests, which has led to conflicts. The Dutch government, however, has not breached its contract with the medical bodies nor has it threatened to use a form of ordinance, as in the case of the German government. This can be explained by the involvement of the medical profession in the development of the new hospital payment system which makes it difficult for the medical body to defect the bargaining with the government. Interaction between the medical bodies and government does not take place in isolation. Since the game is repeated over several years, a smooth running hospital payment system (Outcome 1) is possible.

However, this does not necessarily mean that the system is a complete success in the Netherlands. Indeed, all of the sources indicate that bureaucratization is a prominent problem of the new system, suggesting that it is less ‘smooth running’ than Hood (1995) anticipated in a scenario in which two parties cooperate. In addition, several respondents to the expert questionnaire stated that the Dutch payment system is a typical compromise; it serves the specific interests of the government and the medical bodies. The ordering of preferences of the medical

---

9 See table 2.3
body and the government confirm that cooperation could be expected (see Table 5.7a). The need for self-regulation is important for the medical body, while the government remains relatively indifferent on this issue during the policy process of the new hospital payment system. In addition, the medical profession has not considered that the care for patients is affected by the new system, as the German and British bodies.

5.7 Conclusion
Chapter 3 illustrated that the political and health care system cannot sufficiently explain variation in the hospital payment systems. To what extent can the strategies of the medical profession in the specific institutional settings explain the variation? Scholars studying the interactions between governments and interest groups (e.g. unions) have distinguished three negotiation styles based on game theory. These negotiation styles are related to specific policy outcomes (cf. Scharpf, 1997, 1998; Woldendorp, 2005).

In the Netherlands, NPM elements have been able to emerge to a greater extent and in a specific way in the new payment system because the medical body and the government had a bargaining strategy based on conditional coordination. The interaction between actors and institutions show why the government could further its preferences in the new payment system in a “veto-ridden” environment. The British government acted unilaterally, irrespective of the medical strategy, thus furthering its preferences in the new payment systems. In comparison, complaints about bureaucratization suggest that the more confrontational strategy adopted by the medical profession in Germany has led to a sub-optimal outcome and delays.

Moreover, the strategies of SHI bodies seem not in accordance with their preferences. Although I have characterized the German situation as a chicken game, the institutional context of the SHI body suggests that an outside enforcement probably played a role as well. It shows that the government can use the specific ‘room of maneuver’ provided by the specific institutional context to further its preferences in the payment system.

The fact that Dutch medical bodies support the course of action taken by the government and the British and German medical bodies do not, shows, that it is important to study actors within their institutional context rather than focusing on the specific characteristics of the health care and political system. In addition, the confrontational position of the German medical profession is in accordance with the controversy of health care policy in the political arena. As noted in Chapter 4, the red-green government demonstrated little to no support to the decentralizing elements of NPM. Its primary focus was on the shift to transparent quality. Hence, it does not come as a surprise that the medical profession felt especially threatened by the focus on cost containment and the influence of the federal government. This fear was further exacerbated when the government threatened the medical bodies with an ordinance. It seems that in Germany health care is a more politically sensitive policy domain than in the other countries.
Comparing strategies of governments and medical bodies

In sum, this study has clearly highlighted that medical strategies are embedded in specific institutional and interest configurations typical of individual national states. It has illustrated that medical strategies matter in health reforms, but only if related to the specific context. The results have also shown that specific institutional settings influence the preferences of medical bodies. However, it is important to note that the specific institutional position does not determine the preferences of actors. However, institutions affect preferences in a more complex way than argued by rational institutionalists in their ‘calculus approach’ (cf. Hall and Taylor, 1996).
Seeking a balance?!
6. TOWARDS A NEW BALANCE IN HEALTH CARE?

6.1 Introduction

The focus of this dissertation has been on how actors and institutions have intervened in reforms that introduce principles of the private sector to improve the performance of health care policy, i.e. the emergence of NPM in DRG-based hospital payment systems. This chapter, first, provides a summary of the findings, arguing that actor preferences in interaction with institutional settings are necessary to explain variation in how NPM has emerged in new hospital payment systems. Chapter 3 has shown that formal political institutions appear to be relevant only indirectly. Moreover, the preferences of political parties in interaction with their specific institutional setting, i.e. the party system and the national health care system, on the one hand, and the negotiation strategies of the medical bodies in relation to their specific (veto-)position, on the other hand appear to do a better job of explaining variation in the payment systems.

Second, I relate my findings to welfare state reforms in general. As noted in Chapters 1 and 2, many contemporary welfare state studies have focused on retrenchment, i.e. changes which reduce social entitlements, for example, by lowering social benefits, tightening eligibility rules and shortening entitlement periods (Clasen and Van Oorschot, 2002; Green-Pedersen, 2007). However, health care reforms are rarely taken into account in these welfare state studies. One reason for this is that health care reforms are often characterized as restructuring and not as retrenchment. I have argued, however, that a new hospital payment system may result in retrenchment, since the balance between the main health care goals – accessibility, quality and cost containment – shifts to the latter. For this reason, I contend that any answer to the question of whether politics matters in welfare state reforms is incomplete if health care reforms are ignored.

Third, I elaborate how my findings contribute to claims found in the NPM literature. The aim of this study has not been to explain NPM, per se, but to show which factors account for variation in its emergence in health care policy reforms. The analysis has demonstrated that NPM matters, but that it does not emerge as a ‘one-size-fits-all’ solution. I contend that actors ‘pick and choose’ among the various elements of NPM. This study has also provided a relatively detailed account of political competition in Germany, the Netherlands and the UK, which is useful to better understand cross-national variation in NPM driven reforms.

Finally, I outline how this dissertation is related to other studies that employ a new institutionalist approach. The main argument driving this study was that the interaction between actors and institutions is necessary to explain variations. I use institutionalist theory, but as a framework of interpretation to understand how and to what extent the interaction between actors and institutions is related to the specific emergence of NPM in the hospital payment systems. This study appears to confirm the ideas set forth in the institutionalist approaches of Scharpf (1997) and
Peters et al. (2005). I have demonstrated by means of comparative case studies design – allowing for in-depth analysis – that actor preferences should be studied as a separate category and evaluated in conjunction with the formal political institutional context and health care system.

6.2 Summarizing the findings

Since the 1980s, NPM has been considered a solution for many public sector problems, particularly for problems between the government (principal) and public service providers (agents). NPM has been defined as lessening or removing differences between the public and private sectors and shifting the emphasis of governance from process accountability towards a greater element of accountability in terms of results to improve the performance of the public sector (Hood, 1995; Pollitt and Bouckaert, 2004: 8). NPM is a fascinating topic to study since it is an ideational stream close to neo-liberalism, which affects the health care sector. Though it has been studied extensively, it is seldom related to welfare state politics.

The aim of this dissertation has been to explain variation in the DRG based payment systems. I have argued that the emergence of NPM in the new hospital payment systems would demonstrate how and to what extent public governance has shifted to private governance and how (institutional) relationships between health care actors have changed in curative medicine. By exploring to what extent and how NPM elements have indeed emerged, it is possible to ascertain this variation. As outlined in Chapter 3, NPM can take shape in DRG-based payment systems but this is not a forgone conclusion. In some cases, the systems have been mainly symbolic, inducing little real change in the way the hospital sector is governed, while in other cases they have provided the basis for the privatization of the health care sector.

Studying the variation in new hospital payment systems from a political science perspective starts from the idea that to understand reforms it is necessary to understand political processes. Moreover, as many scholars of new institutionalism have shown, these processes do not take place in a vacuum. There is a certain system of rules in any historically-given society that not only organizes and regulates social behavior, but also makes it understandable – and in limited conditional sense – predictable for those sharing knowledge of the rules (Scharpf, 1997: 40).

Health care systems and health care policy and are known for their tremendous rigidity in the countries in this study. The dominant structures have existed since the Post-War Era. Consequently, similar to studies of other welfare state sectors, health care policy studies are frequently analyzed in a historical institutionalist perspective (cf. Immergut, 1992a). However, historical institutionalism has difficulties explaining small, but often relevant, changes. Peters et al. (2005: 1277) suggest that historical institutionalism would gain from introducing some form of agency. This dissertation has assessed how far new institutionalist explanations can travel by analyzing to what extent and how the
interaction of actors and institutions account for variation in reforms. As outlined further below, I have explored the preferences and related behavior of political parties and the medical profession within specified institutional settings and compared these across three countries. In doing so, I have not treated preferences as exogenous and given, but I have derived them from their specific context. Hence, this study has analyzed to what extent NPM can be seen as an ideational feature that, with pressing economic problems, creates a critical juncture. Furthermore, it has analyzed the extent to which actors have the capacity to forward their preferences in similar reform initiatives in different institutional contexts.

The research question driving this dissertation was: To what extent is the variation between new hospital payment systems in Germany, the Netherlands and the UK a result of preferences about NPM, related behavior of political parties and medical bodies, and institutional characteristics of the political and health care systems? The study was designed as a comparative case study to understand which interactions between actors and institutions are instrumental for explaining changes in different institutional settings. Such an approach facilitated a study of interactions at different levels of analysis and an examination of variation in the payment systems, i.e. the emergence of NPM elements, in a qualitative way. The main conclusion is that the preferences of governmental parties and the negotiation strategies of the medical bodies in interaction with the specific institutional setting are particularly relevant for understanding variation in the emergence of NPM in DRG-based payment systems. Though constrained by their specific room to maneuver, actors are able to further their preferences, which are shaped by specific national contexts.

To map the variation in new hospital payment systems, the first sub-question addressed in this dissertation was: To what extent and how has variation occurred in the emergence of NPM elements in the new hospital payment systems of Germany, the Netherlands and the UK? The results have shown that elements of NPM are visible in each of the new hospital payment systems. However, NPM does not emerge as coherent ‘one-size-fits-all’ solution. Variation is particularly visible in the specific focus of the policy measures of the new payment systems in the three countries. The focal point is on transparency and efficiency in Germany, on competition and marketization in the Netherlands, and on patient choice and contracting in the UK.

Explanations for variation in outcomes of reforms are often sought in specific institutional settings. I have argued that if institutional settings are decisive for the way NPM emerges, institutions that determine the extent of formalized ‘power-sharing’ between actors will be most decisive. Hence, the following hypothesis was put forward: NPM emerges to the largest extent in the English payment system, which has the fewest veto-points; it emerges to a moderate extent in the Netherlands, and it emerges to a smaller extent in Germany, which has a federal and corporatist political system. In addition, I have argued that the state tradition in the UK, i.e. the organizational features and the forms of procedures in
state organizations, is particularly receptive to NPM (cf. Resen, 1998). This made it likely that NPM would emerge more extensively in the UK than in the Netherlands or in Germany.

The findings indicate that NPM did indeed emerge to a large extent in the UK. However, the fact that NPM also developed extensively in the Dutch payment system and the fact that different elements of NPM are emphasized in the two countries demonstrate that institutional settings provide an insufficient explanation of variation in the payment systems. Some variation could be explained from the specific institutional context, for example the introduction of ‘patient choice’ in the English payment system and the focus on efficiency in the German case. This is in accordance with Peters et al.’s (2005: 1296) argument that a historical institutionalist framework is useful but that it needs some form of agency to understand how ideas, as embodied in NPM, are shaped in policy domains. In addition, Scharpf (2000) has argued that preferences of actors must be analyzed as a separate factor in comparative research. For this reason, I have examined the preferences of political parties and the medical bodies in interaction with specific institutional settings, i.e. the way the health care system and political system regulate their ‘room to maneuver’.

The first category of actors examined was political parties. Several welfare state scholars have discussed the role of political parties in reforms (cf. Keman, Vis, and Van Kersbergen, 2006; Starke, 2006; Vis, Van Kersbergen, and Becker, 2008). The preferences and behavior of political parties are also identified as factors for explaining NPM reforms (Green-Pedersen, 2002b). In this dissertation, I have studied policy preferences in two phases of political competition, electoral competition and parliamentary decision-making, in order to analyze the interaction of preferences within these specific institutional settings, i.e. party configuration and health care system. The second sub-question considered in this dissertation was: To what extent and how are policy preferences about health care goals and NPM related to the variation in the new hospital payment systems of Germany, the Netherlands and the UK?

I argued that the preferences of social-democratic parties are related to the variation in the hospital payment systems. However, the results have shown that governmental parties’ attention to specific NPM elements better explains the emergence of these elements in new hospital payment systems. This demonstrates that ‘politics matters’, since governmental parties are able further their preferences into policy. In addition, Chapter 4 illustrated a clear interaction between actor preferences and the specific institutional setting.

Party configurations and health care systems are central to understanding the preferences of political parties concerning the new payment systems. The role that health care has in political competition is different across the countries: it is far more of a positional issue in Germany than in the Netherlands or the UK. In addition, the German federal and corporatist political system may not have a direct effect on the hospital payment system, for instance, but it influences the preferences
Towards a new balance in health care?

and the distinctions between parties with regard to health care. The expectation is that in Germany parties cannot find consensus easily during the decision-making phase, since the health care goal accessibility is positional.

The results have also shown that NPM is influential in the three payment systems but that its elements take on different shapes given the variation in political processes. In both the Netherlands and Germany, NPM is a positional issue in the political phases, while it is a valence issue in the UK. The strong focus on the quality dimension in the German case can be explained by the fact that the SPD had less ‘room to maneuver’, since, for instance, the SPD formed a coalition with the Green-Party and since there has been greater political controversy surrounding the implementation of NPM in health care in Germany. Substantial support for NPM in the Dutch political arena has resulted in more ‘room to maneuver’ for governmental parties, facilitating political consensus for the NPM ‘dimension’ marketisation and competition. In the UK, health care goals and particularly NPM are valence issues, meaning that specific governmental preferences are less contested and thus more easily shaped into policy. The significant support of the Labour party for NPM, however, concentrates less on marketisation and competition than in the Dutch case.

In sum, the results have shown that NPM elements are supported insofar as they fit into the political ideologies of parties. The support can be understood partly from left-right differences between parties and partly from the specific institutional setting in which parties operate. Party preferences and related behavior seem particularly relevant for variation in the new payment systems. Despite specific party configurations and different forms of political competition, governmental preferences are furthered in the new hospital payment system in all three countries. This is a somewhat remarkable finding, since in Germany and to some extent in the Netherlands, governments share decision-making power with other actors, i.e. medical bodies.

The influential role of the medical profession is often cited as important in health care policy-making (Freeman, 2000; Freeman and Moran, 2000). Hence, I have studied medical bodies to gain better insight into how their preferences and related behavior are connected to variation in the new hospital payment systems. The specific sub-question considered was: To what extent are the negotiation strategies of the medical bodies related to variation in the new hospital payment systems of Germany, the Netherlands and the UK? The results indicate that strategies and preferences, in interaction with the specific institutional position of the medical profession, explain variation in payment systems. Chapter 5 has shown, for example, that the Dutch medical strategy of ‘cooperation’ resulted in a change in the hospital payment system, i.e. a shift towards private governance. The institutional position of the medical profession and its large involvement in the development of the new payment system made it less ‘rational’ to take another negotiation strategy. Moreover, the preferences of the medical bodies and the
government were parallel in this case (cf. Czada, 1998). Hence, conflict was not the game to play.

In the UK and Germany, the non-cooperative negotiation strategies have affected the payment systems in different ways, which can be explained by taking both actors and institutional structures into account. In both countries, the non-cooperative strategy resulted from conflicting preferences between the medical body and the government. However, in the UK the negotiation strategy has done little to constrain the government’s ‘room of maneuver’ in furthering its preferences. In Germany, the ‘confrontation’ negotiation strategy has led to severe measures by the government to preserve its preferences in health care policy. It has curtailed the medical bodies’ ‘room to maneuver’ and resulted in delays in the policy process and multiple policy adjustments.

The confrontational position of the German medical profession is in accordance with the controversy surrounding health care policy in the political arena. In Germany, health care seems to be a more politically sensitive policy domain compared to the other two countries. Yet, retrospectively, the strategy of the German medical bodies is difficult to understand given their powerful position in the system. When one considers the preferences of the government and the medical bodies as well as the specific ‘room to maneuver’, it seems irrational for the actors to act non-cooperatively. I contend that alone Germany’s veto-ridden political system cannot explain the small extent and the specific way NPM emerged; rather, one must consider the interaction between preferences, behavior and the specific institutional setting (cf. Schmidt, 2002). Similarly, the extensive emergence of NPM in the Dutch case is better understood by taking into account governmental preferences and the strategies of the medical bodies as they interact with the specific institutional setting.

In conclusion, this dissertation has shown that NPM elements emerge in DRG-based hospital payment systems. However, the variation of these payment systems across countries demonstrates that the extent to which NPM develops and how it matters varies considerably across the cases. As with other ideational streams, NPM is shaped by the particular political and economic circumstances occurring at critical junctures. The extant political and health care institutional settings and the self-interested behavior of political and health care actors account for the variation in new hospital payment systems; in other words, institutions and politics matter. In addition, my results have shown that institutions are central to explanations of variation in payment systems and cannot simply be considered rules/inducements influencing individuals’ attempt to maximize their own utilities (cf. Keman, 1999b; North, 1990; Peters, 2005; Weingast, 2002). The particular institutional settings or ‘paths’ in a policy domain are relevant for understanding how – in this case – NPM has emerged in policy. Moreover, actor preferences and behavior are crucial features for understanding the specific emergence of an ideational feature in policy.
6.3 Relating this study to contemporary welfare state studies

Welfare state studies and health care policy studies have developed along separate paths. While comparativists studying reforms in income maintenance tend to link their work to the broader welfare state literature, health care scholars seldom relate their findings to research on other welfare state reforms. According to Hacker (2004: 724), health care should have a more prominent place in comparative political analysis. He argues that much of the work on health care reform is too focused on policy details to be helpful for welfare state research, which tends to center on income-replacement programs (i.e. social security programs) or on labor market incentives (cf. Huber and Stephens, 2001; Pierson, 2006; Starke, 2007; Vis, Van Kersbergen, and Becker, 2008).

A number of scholars have criticized the recent focus on retrenchment in the reform literature, and several have suggested alternatives to concentrating solely on the traditional sectors when studying the welfare state (cf. Bonoli, 2007; Jessop, 1999; Sol and Westerveld, 2005). Giaimo and Manow (1999), for example, argue that three types of reform should be examined to understand changes in the welfare state: shifts in social provision, the introduction of market forces in the welfare state and the privatization of social (if not ‘new’) risks. Others have distinguished between welfare state retrenchment, i.e. reducing welfare state generosity, and restructuring, i.e. changing institutional rules (cf. Clasen and Van Oorschot, 2002; Green-Pedersen, 2007).

This study contributes to the broader literature on welfare states by considering whether explanations for reform differ when health care policy reforms are taken into account. As noted, NPM shifts the balance among health care goals to cost containment and leads to a public-private shift in health care affecting health care entitlements. Applying NPM ideas to the welfare state is thus a means of welfare state restructuring and may result in retrenchment. This implies that health care reform is as politically sensitive as other welfare state reforms. I argue that health care policy is part and parcel of welfare state studies and therefore must be taken into account when addressing the question of whether ‘politics matters’ in explaining developments (whether positive or negative) in the welfare state.

An important discussion in the contemporary welfare state literature is to what extent specific institutional characteristics, path-dependency and political actors should be taken into account in explaining reforms. As argued in Chapter 2, the health care sector differs from other welfare state sectors in three respects: the quality aspect, the role of the medical profession and the large public support. Accordingly, one would expect explanations to be different as well.

Explanations of welfare state retrenchment often point to institutional characteristics and path dependency (cf. Pierson, 1994); such factors are also mentioned in explanations of health care reforms (Hacker, 2004). Others have stated that actor preferences and strategic behavior within contexts are more relevant for explaining welfare state reforms (cf. Green-Pedersen, 2002a; Vis, Van Kersbergen, and Becker, 2008). The results of this research confirm the latter.
Governmental parties can further their preferences in health care reforms. In addition, this study indicates that the strategies of medical bodies vis-à-vis governments matter. Hence, explanations of health care reforms are not altogether different from those of other welfare state reforms, although the specific interaction between the medical bodies and the institutional context is characteristic of the health care sector. I contend that health care should be included more often in welfare state studies.

This dissertation has also shown that the political controversies related to health care are weaker than sometimes argued (cf. Pierson, 1994). Health care seems to be politically sensitive only in the German case, where there were significant differences between parties’ positions. In the other cases, health care policy appears to be a valence issue. The implication is that governmental parties will be evaluated on their performance in health care policy and not on their specific preferences. This may explain why consensus over NPM could be found among Dutch parties and why patient choice and quality have been particularly emphasized in the UK.

As argued in Chapter 2, comparative case studies have advantages and disadvantages. Many scholars argue that qualitative studies should not only analyze many aspects of one phenomenon in a single case but also aim to provide knowledge over variety of cases. For this reason, I selected cases that were as diverse as possible in their political and health care institutional settings. A qualitative research design has been an excellent choice for this study from a theoretical and conceptual point of view, but how useful are the findings for the general welfare state debate? The main contribution of this study to the broader welfare state literature is to establish the relationship between governmental preferences and reform. A key finding is that in similar initiatives (each triggered by cost containment problems and an ideational stream), governmental preferences in interaction with a specific institutional setting were quite relevant for the reforms.

6.4 Studying NPM from a political science perspective

In Chapter 1, I mentioned the book “If Disney Ran Your Hospital: 9 ½ Things You Would Do Differently” (Lee, 2004) as an example of the search for the ultimate solution to challenges in health care services. Although several contemporary studies have shown that NPM is not a panacea for problems in the public sector, I have shown that it nevertheless matters, since elements of NPM are recognizable in the new hospital payment systems in the three cases.

As mentioned in Chapter 3, one avenue of research would be to compare why rather different countries have converged to a similar type of payment system. I have argued that similar ways of ‘framing the problem’ and similar intellectual underpinnings of the proposed solution offer possible explanations (cf. Harrison, Moran, and Wood, 2002). In a review article, Common (1998) lists several reasons for the international diffusion of NPM: 1) NPM as a missionary goal; 2) the
intervention of privatization; 3) the role of international relations, and 4) increasing policy transfer activity. Policy transfer has been particularly well-studied (cf. Dolowitz and Marsh, 2000; Greener, 2004; Heichel, Pape, and Sommerer, 2005). Common (1998) also emphasizes the idea that NPM can be viewed as a product of ‘modernization’, i.e. the international pressures and changes in corporate governance make a reorganization of the public sector inevitable. Finally, the focus on NPM in the international field (e.g. OECD) could also explain its popularity.

However, others argue that NPM is already outdated. Several contemporary articles, for instance, deal with post-NPM changes in public sectors and other forms of shifts in governance (cf. Dent, 2005). I would argue that NPM is indeed no longer a missionary goal for consultants and policy advisers, but its elements remain influential for new hospital payment systems (cf. Ferlie and Steane, 2002). First, as I have argued NPM usefully characterizes the public-private shift in the different hospital payment systems. Second, this study had highlighted the paradox of considering NPM as an apolitical toolkit that emerges in the wake of specific socio-economic pressures versus viewing it as a conscious choice of political parties. I have shown that NPM elements have not only become part of the policy options available to political parties but are also shaped by political parties. Third, it is noteworthy that, according to the existing NPM literature, NPM does not emerge as a coherent package and that policy-makers, i.e. governmental parties, tend to ‘pick and choose’ among NPM elements. The political ‘translation’ of NPM is important to understand its heterogeneous introduction.

Although researchers have demonstrated that there is cross-national and temporal variation, most have attributed it to specific national characteristics or to the evolution of NPM (cf. Christensen and Laegreid, 2001; Ferlie and Steane, 2002). I, however, have provided a detailed account indicating that there is a linkage between specific partisan preferences and NPM. Political parties do not see NPM as a ‘one-size-fits-all’ solution, but emphasize specific elements as shown in Chapter 4. In other words, they have incorporated NPM in their ‘party ideologies’ but in a way that seems to fit their overall political complexion.

6.5 New institutionalism and health care reforms

I have argued that including agency and preferences into a historical-institutionalist framework is useful to understand health care reforms. In addition, I relate my findings to the new institutionalist literature by discussing the interpretations of Hacker (2004), Immergut (1992) and Pierson (2004). As outlined in Chapter 2, I have used historical institutionalism and rational institutionalism as complementary frameworks to interpret my findings. A rational institutionalist perspective is helpful but insufficient for understanding reforms in health care policy, while a historical institutionalist perspective suffers from overly broad assumptions about the relationship between preferences and institutions. Hence, I have chosen to study preferences as a separate category (Scharpf, 2000) and to relate them to specific
in institutional contexts. I have also drawn from rational institutionalism to conceptualize the negotiation strategies of the medical bodies.

The results of this study have shown, first, that preferences of actors are only understandable if their specific institutional context is taken into account. As argued above, this is visible in the NPM preferences of social-democratic parties and even more clearly in the preferences of the medical bodies. Second, although governmental attention towards centralizing or decentralizing tendencies seem to explain the negotiation strategy of medical bodies to a certain extent, it is difficult to understand why the German and British medical bodies feared that the new hospital payment system would affect care for patients, while the Dutch medical bodies did not. Third, I found that the strategies of the medical bodies were relatively similar compared to earlier health care reforms in these countries, indicating that systemic features are important. Fourth, retrospectively, it is questionable whether strategies of the medical bodies have optimal given their specific ‘room to maneuver’.

By reconstructing the policy processes, I have shown that preferences have not been formed exogenously and that actors have not always acted as rationally as would be expected. The German bodies, for instance, had a conflicting strategy, which ran counter to what should be expected from their specific position in the decision-making process but which is understandable with regard to their specific preferences. This is likely related to the particular role health care plays in the political process. Hence, this study has underlined the ideas advanced by Peters et al. (2005) and Scharpf (1997; 2000) that agency and preferences are relevant to understanding outcomes of reform and that these elements should be analyzed in tandem with the specific institutional settings.

In Chapter 1, I compared different views on how changes might occur. Three possibilities were distinguished: 1) Reforms depend as much on historical ‘accident’ as on the inventiveness of actors (Immergut, 1992b), i.e. actors and context interact. 2) Market reforms tend to occur more often in centralized political and health care systems than in decentralized systems, where governments often ‘bring the state back in’ (Hacker, 2004). This perspective emphasizes the specific institutional setting for an instrumental explanation for reform outcomes. 3) Initial steps in a particular direction may encourage further movement along the same path (Pierson, 2004). This last perspective argues that reforms often continue in the same direction as the original setting. I outline below that although I find evidence that the specific context is important for understanding reforms, my findings are most in line with Immergut’s (1992) conclusions.

The present study does not confirm Hacker’s (2004) observation. I find little evidence that the emergence of NPM can be sufficiently explained by the way the health care sector was organized previously. In addition, variation in party support for NPM indicates that party preferences matter and are obviously not completely shaped by the health care system as such. Yet, I agree with Hacker’s (2004) assumption that market failures are likely to compel governments to bring the state
Towards a new balance in health care?

back in, while bureaucracy problems are likely to provoke reforms through marketisation. Moreover, political actors would continue to seek optimal health care performance by implementing public-private shifts. However, my study has shown that large waiting lists and high costs together with a neo-liberal ideational stream, can be seen as critical junctures, but are also given shape by political parties and consequently lead to different results in different institutional contexts. Though such results are affected by the old institutional settings, they cannot be sufficiently explained by them.

Pierson’s (2004) idea that initial steps in a particular direction may encourage further movement along the same path has been proven to be relevant in this study. Indeed, the way NPM has emerged in the new payment systems is related to the existing systems, and none of the countries has demonstrated a clear cut preference for either a private health care sector or a system-wide reform, i.e. a preference for a shift from national health service towards a (private) insurance-based scheme or vice versa. As argued in Chapter 2, the relationships between actors (principal-agent) have been altered by the shift to more performance accountability. However, Pierson’s (2004) view cannot explain why similar reforms take place in diverse health care systems. This dissertation has shown that similar reforms can take place in different health care systems and that such reforms will have varying results, as the initiatives are mediated by the interaction between actors and specific institutions.

Finally, Immergut’s (1992) view coincides with the idea that agency should be introduced into new historical institutionalism. Immergut is known as a historical-institutionalist with a clear ‘calculus approach’ with regard to the relationship between actors and institutions (Hall and Taylor, 1996). The inventiveness of actors is indeed as relevant as the institutional settings to understand how a critical juncture is given shape in specific contexts. However, this dissertation has demonstrated that the emergence of NPM - although a critical juncture – is not an historical accident, since it is to varying extents embedded in the preferences of political parties. To understand variation in the way NPM has emerged in the new hospital payment systems, it is therefore necessary to consider the interaction between actors and institutions.

6.6 Has a balance been found?

The title of this dissertation, ‘seeking a balance’, refers to three things: 1) a balance between specific policy preferences and interests of political actors in the health care sector; 2) a balance in public-private governance, and 3) a balance between different health care goals. As I have shown, different balances are discernable in Germany, the Netherlands and the UK. Moreover, these differences can be explained by the interaction between the preferences of political parties and the medical profession and the institutional setting. The implementation phases of the new payment systems took place during the time period when this dissertation was written. Numerous newspaper articles have questioned whether the performance of
the health care sector has indeed improved. Hence, in a speculative way: What do the results of this dissertation mean for health care policy more generally?

There is no easy answer to this question. First, it is debatable whether the different policy ideas and measures that I distinguished in Chapter 3 will ever be met in their full extent. It is also too early to establish whether the new payment systems should be characterized as ‘reform without change’ (Hacker, 2004). Although the new payment systems appear to be functioning poorly at the moment, it is important to recall that the old payment systems had serious problems as well. However, the longer the convergence phases of the new payment systems take, the greater the chance that no structural reforms will emerge. Indeed, the systems may not change the financial outcomes of the health care sector at all.

A possible explanation is that introducing NPM elements does probably not lead to an ‘optimal solution’ for the specific PA-problems that occur in health care policy. Based on the results of this dissertation, one could argue that policy-makers are unable to choose the most optimal solution for two reasons. First, a bounded rationality, i.e. their choices are formed in a complex setting affected both by the specific (problems of the) health care system and by the ideological features of their particular political party. This means that their choices are neither driven by purely rational nor purely ideological considerations alone. Second, every change in health care policy, even those presented as ‘more value, less money’, will have its trade-offs and therefore will be limited in scope. In addition to its potential effects on accessibility and quality, NPM has triggered questions about the role of the state and the market in health care. Hence, the extent to which NPM elements are the perfect solution depends on the institutional context and the political will and skill exhibited by the actors (cf. Scharpf, 1997).

The fear of being punished by voters might also explain why reforms often do not induce real change. Particularly in the Netherlands and the UK where health care and NPM are mainly valence issues, political parties are at the end of the day ‘punished’ or ‘awarded’ for their choices. For instance, voters will decide whether or not the trade-offs of NPM are acceptable as a new balance in health care. It will then become clear whether regulating health care in a NPM way affects citizen’s individual preferences about the accessibility and quality of health care, which is a highly valued good, and about the specific public-private balance.

This latter preference points to a larger political and scholarly debate about the relationships between the government, public services and the individual citizen. While introducing choice and competition in health care enables patients to vote with their feet, it may actually reduce their influence via the democratic process on health care state services. This relates to two topics frequently addressed by political scientists and law scholars, i.e. democratic accountability and responsiveness (e.g. Budge, Hofferbert, Keman, McDonald, and Pennings, 2002; Vonk, 2003). As I have shown in this dissertation, NPM elements matter in health care reforms, involve public-private shifts and are, in some cases, wholeheartedly supported by the main political actors.
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Seeking a balance?!
A. ATLAS.TI PREDEFINED CODING SCHEME

1) Accessibility/Equity
Direct reference towards accessibility, equity,
Reference to negative consequences of co-payments
References to health status of different groups of citizens (for instance social-economic classes)
Reference to geographical spreading of health services
References to solidarity of the health care system

2) Benchmarking (part NPM)
Direct reference to benchmarking (for instance ‘star rating system’)
Reference to ways of compare hospitals or insurance companies on performance

3) Bureaucracy
Direct reference to bureaucracy
Reference to high administrative costs
Reference to ‘too many regulation or rules’

4) Contracting (part NPM)
Direct reference to agreements and contracts between government, health care providers, insurance companies, PCTs
Reference to ‘commissioning’

5) Corporatism
Reference to agreements of government with other partners in health care
Reference to consultation of interest organization by government

6) Cost containment_N
Reference to negative consequences of cut backs
Reference to the need of more resources in health care (for instance ‘investments needed, more personal needed)

7) Cost containment_P
Reference to the need of cutbacks in health care
Reference to direct means of cost saving

8) DRG_N
Direct reference to negative consequences of DRG based hospital payment system
9) DRG_P
Direct reference to the need of a DRG based hospital payment system
Reference to the need of new hospital payment system based on rewarding output and demand-side demands instead of a payment system based on budgets or supply-side demands

10) Primary care
References to primary care/general practitioners

11) Efficiency (part NPM)
Direct reference to efficiency or equivalents (e.g. doelmatigheid, value for money)

12) Fraud
Direct reference to fraud
References to ‘perverse incentives’, gaming, lack of integrity, upcoding

13) Hospitals
Direct reference to health care providers

14) Hospitals_small
Direct reference to small-scale health care provision

15) Information MA
Reference to the gathering of information in the hospital sector
Reference to the need of public information about the performance of organizations in the health care sector

16) Insurance companies
Direct reference to insurance companies

17) Managerial accountability_n (part Pro State)
Reference to the negative consequences of more authority, control or freedom of health care organizations (usually hospitals, medical profession, insurance companies, pct’s)
Reference to lower the authority, control, freedom of health care organizations

18) Managerial accountability_p (part NPM, pro Market)
Reference to the positive consequences of more authority, control or freedom of health care organizations (usually hospitals, medical profession, insurance companies, pct’s)
Reference to strengthen the authority, control, freedom of health care organizations
19) Informal care
Direct reference to care of patients by family

20) Marketisation_n (part Pro State)
Direct reference to the negative consequences of concurrence, marketisation or competition in health care
Reference to means to reduce competition, concurrence and marketisation

21) Marketisation_p (Part NPM and proMarket)
Direct reference to the positive consequences of concurrence, marketisation or competition in health care
Reference to means to increase competition, concurrence and marketisation in health care

22) Medical profession
Direct reference to medical profession without value judgment about their role

23) Medical profession_n
Direct reference to the medical profession in a negative way (for instance in relation to costs and effectiveness or power)

24) Medical profession_p
Direct to the medical profession in a positive way (for instance their knowledge, quality, opposite to management etc)

25) Old system
References to health care system in historic perspective

26) Patient choice (part NPM)
Direct reference to patient choice
References to demand-side (for instance money should follow the patients)

27) Patients
Direct reference to patients or citizens in health care system

28) Political accountability
Reference to the role of government/state in health care without value judgment

29) Political accountability_n (part NPM, part pro Market)
Reference to the negative consequences of state involvement in health care
Reference to means how to reduce the role of state/government in health care
30) Political accountability_p (part pro State)
Reference to the positive consequences of state involvement in health care
Reference to means how to increase the role of state/government in health care

31) Prevention
Direct reference to prevention
Reference to different prevention programs

32) Privacy
Reference to consequences of medical technological development for privacy

33) Privatisation_n (pro State)
Reference to negative consequences of privatization of health care organizations
Reference to direct means to reduce profit-making or privatization

34) Privatisation_p (part pro Market, part NPM)
Reference to positive consequences of privatization of health care organizations
Reference to direct means to increase profit-making or privatization

35) Quality (part NPM)
Direct reference to quality
Reference to qualifications as ‘improvement of service’

36) Regional/decentralization
Reference to decentralization or devolution
Reference to the regional organization of services
Reference to means of decentralization

37) Home care
Direct reference to home care workers or institutions

38) Transparency (part NPM)
Reference to transparency of health care organization or performance
Reference to means to improve transparency

39) Triangle
Reference to the dilemma to improve accessibility/equity, quality and efficiency at once

40) Insurance package_n
Reference to downsizing the services provided by the health care system (in sickness funds, basic insurance or national health service)
41) **Insurance package**
Reference to expand the services provided by the health care system (in sickness funds, basic insurance or national health service)

42) **Waiting lists**
Reference to waiting lists
Seeking a balance?!
## B. MEANS AND MEDIANS IN PARTY MANIFESTOS AND PARLIAMENTARY DEBATES

Table B.1 Attention to health care goals in party manifestos and parliamentary debates

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<td>Equitable accessi</td>
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<td></td>
<td>CDU</td>
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<td></td>
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<td></td>
<td>SP</td>
<td>6</td>
<td>22.39*</td>
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<td>PvdA</td>
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<tr>
<td></td>
<td>D66</td>
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<tr>
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## Appendix B Means and medians in party manifestos and parliamentary debates

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Party* differs significantly from party^ (p < 0.05)
N = interventions of party in debates (at least five sentences coded), statements of minister are not coded
Table B.2 Attention to health care goals in party manifestos

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Country* differs significantly (p < 0.05) from country^ in specific type of resources.

^N = interventions of parties in debates (including interventions of the minister)
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Party* differs significantly from party^ (p < 0.05) within a country on a specific code.

* N = Intervention of a party in a certain debate excluding the minister (at least five sentences coded)
### Table B.4 Attention to NPM in the party manifestos and parliamentary debates

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Party* differs significantly from party^ (p < 0.05) within a country on a specific code.
Country* differs significantly from country-.

^N = party interventions in debates (excluding the interventions of ministers
Table B.5 NPM dimensions in party manifestos and parliamentary debates

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## Appendix B Means and medians in party manifestos and parliamentary debates

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Seeking a balance?!

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### Appendix B Means and medians in party manifestos and parliamentary debates

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Party\(^*\) differs significantly from party\(^^\) (p < 0.05) within a country on a specific code.
Country\(^1\) differs significantly from country-
\(^1\)N = party interventions in debates (excluding the interventions of ministers)
C. SOURCES CHAPTER 5

Germany


Seeking a balance


Netherlands


(2004). Ontbrekende prikkels: DBC-systematiek is een obstakel bij honorering. *Medisch Contact*, 59(4), 118-121

(2005). Orde: 'Nauwelijks uitspraken over DBC's'. *Medisch Contact* 60(38), 1499.


The United Kingdom


Seeking a balance


BIBLIOGRAPHY


Bibliography


Bibliography


Bibliography


Seeking a balance ?!


Ministerie van Volksgezondheid Welzijn en Sport (2005). Wet tot invoering van de Zorgverzekeringswet en aanpassing van overige wetten aan die wet
Seeking a balance ?!


OECD (2007). Selection of OECD social indicators: How does your country compare? http://www.oecd.org/LongAbstract/0,3425,en_2649_34637_38138104_1_1_1,00.html (March 2009)


SAMENVATTING

Op zoek naar balans?! De doorwerking van Nieuw Publiek Management in nieuwe ziekenhuisbetalingssystemen in Duitsland, Nederland en het Verenigd Koninkrijk

Bestaat er een perfecte oplossing die zowel zorgt voor kortere wachtlijsten in de zorg, als bijdraagt aan de garantie voor een betaalbare, toegankelijke en kwalitatieve zorg? Nieuw Publiek Management (NPM) wordt sinds de jaren tachtig gezien als een oplossing voor uiteenlopende problemen die zich voordoen in de publieke sector, maar voornamelijk voor problemen tussen de principaal – de overheid, en de agent – de zorgverlener. Problemen die vooral ontstaan doordat er geen duidelijke informatie is over de prestatie van de zorgverlener en de kosten daarvan. Door een pakket aan sturingsinstrumenten, afkomstig uit de private sector, dat enerzijds de verschillen tussen de publieke en private sector opheft en anderzijds de nadruk legt op de verantwoordelijkheid van de dienstverlener, zou de ‘performance’ van de gezondheidszorg moeten verbeteren. Het primaire idee is dat sturingsmechanismen uit de private sector beter werken dan bureaucratische controlemechanismen.

Vaak wordt gesuggereerd dat administratieve veranderingen – zoals een ander ziekenhuisbetalingssysteem – niet van politiek belang zijn. De vraag of politieke voorkeuren er toe doen voor verschillen of overeenkomsten in gezondheidszorghervormingen is dan ook niet bevreemdend beantwoord in eerder onderzoek. In mijn proefschrift beargumenteer ik dat invoering van NPM principes geen ultieme oplossing is voor de problemen van de oude ziekenhuisbetalingssystemen in de gezondheidszorg. Wel kan het zorgen voor meer nadruk op kostenbeheersing wat waarschijnlijk leidt tot versobering van ofwel de kwaliteit dan wel de toegankelijkheid van de zorg. Beleidsmakers moeten op zoek naar balans tussen efficiëntie, kwaliteit en toegankelijkheid van de zorg. De implementatie van NPM in de gezondheidszorg verandert dan ook het antwoord op de belangrijke politieke vraag ‘who gets what, when and how?’. Een nieuw ziekenhuisbetalingssysteem met NPM principes is geen pure administratieve verandering.

De onderzoekspopet van dit proefschrift is vergelijkend. Het heeft niet als doel om per casus precies uiteen te zetten hoe de hervormingen tot stand zijn gekomen, maar het zoekt naar factoren en patronen die de hervormingen kunnen verklaren voor meerdere casussen. Er zijn drie landen onderzocht die een nieuw ziekenhuisbetalingssysteem hebben ingevoerd dat gebaseerd is op het zogenaamde ‘DRG principe’. Ziekenhuiszorg wordt ingedeeld in zorgproducten die ieder een eigen prijs krijgen. In dit betalingssysteem kunnen NPM sturingsmechanismen voorkomen, maar niet noodzakelijkerwijs. Daarnaast verschillen de landen in hun formele politieke instituties en gezondheidszorgsysteem.
De belangrijkste hypothese is dat zowel actoren en instituties moeten worden onderzocht om variatie tussen casussen te verklaren. Op basis van de bestaande literatuur, zijn ‘politieke partijen’ en ‘de medische professie’ als centrale actoren gekozen in het onderzoek. In de welvaartsstaatliteratuur is er geen eenduidig beeld van de rol van politieke partijen in hervormingen. Daarnaast hebben juist gezondheidszorgbeleidwetenschappers de rol van de medische professie in de beleidsvorming benadrukt. Om deze redenen is de hoofdvraag van dit onderzoek “In welke mate kan variatie in de nieuwe ziekenhuisbetalingssystemen van Nederland, Duitsland en het Verenigd Koninkrijk worden verklaard door preferenties van actoren over NPM en de formele politieke instituties en het gezondheidszorgsysteem?”

De variatie die wordt onderzocht is vooral variatie waarin sturingsmechanismen, die typerend zijn voor NPM, zichtbaar zijn in de nieuwe ziekenhuisbetalingssystemen. De eerste deelvraag van dit proefschrift is: In welke mate en op welke manier is er variatie waarneembaar in de wijze waarop NPM elementen zijn doorgedrongen in de ziekenhuisbetalingssystemen in Duitsland, Nederland en het Verenigd Koninkrijk? Dit onderzoek laat zien dat NPM zichtbaar is in de drie betalingssystemen, maar in verschillende gradaties en met verschillende nadrukken. In Nederland, ligt de focus duidelijk op competitie en marketisering; in Duitsland op transparantie en efficiency; en in de UK, op de sturende rol van de patiënt en kwaliteit.

De tweede deelvraag van dit onderzoek is: In hoeverre kan de variatie in nieuwe ziekenhuisbetalingssystemen worden verklaard vanuit de staatstraditie, formele politieke instituties en het gezondheidszorgsysteem? Vaak wordt gesuggereerd dat het aantal ‘veto-punten’ of de mate waarin macht wordt gedeeld door actoren de mate van verandering bepaalt. Vanuit de NPM literatuur is ‘staatstraditie’ als belangrijke verklarende factor aangedragen. Volgens deze onderzoeken zou NPM het meest herkenbaar zijn in het Engelse betalingssysteem en het minst in het Duitse. Deze conclusie zou betekenen dat mijn hypothese dat actoren ook nodig zijn om verschillen te verklaren moet worden verworpen. Hoofdstuk 3 laat echter zien dat de variatie waarin NPM terug te vinden is in de nieuwe betalingssystemen niet door formele instituties kan worden verklaard. Nederland lijkt daarvoor te veel op de UK, en te weinig op Duitsland.

In hoeverre politieke partijen een rol spelen in de welvaartsstaats- en gezondheidshervormingen is onduidelijk. In vergelijkende studies zijn er verschillende antwoorden gegeven. Case studies laten vaak wel een effect van politieke partijen zien, kwantitatieve studies leggen meer nadruk op formele instituties. De deelvraag die is beantwoord in hoofdstuk 4 is: In welke mate en op welke manier zijn partijpreferenties over NPM gerelateerd aan de variatie in de nieuwe ziekenhuisbetalingssystemen? De resultaten laten zien dat de variatie in de betalingssystemen gerelateerd is aan de nadrukken die regeringspartijen geven aan NPM. In Nederland krijgen de NPM elementen competitie en marketisering veel
Samenvatting

aandacht van de (rechtse) regeringspartijen. In Duitsland is vooral de liberale FDP een voorstander van NPM, de Duitse regeringspartijen benadrukken vooral het element 'transparantie'. In vergelijking met Nederland en Duitsland is de politieke gevoeligheid van NPM anders in de UK. Tussen de Britse partijen zijn geen significante verschillen te vinden in de aandacht die wordt besteed aan de verschillende NPM elementen. De mate waarin de regering de verschillende NPM elementen benadrukt is in grote mate terug te vinden in het nieuwe Britse ziekenhuisbetalingssysteem.

Hoewel in alle landen partijpreferenties terug te vinden zijn in het specifieke ziekenhuisbetalingssysteem, verschilt het politieke debat tussen de landen. Mijn onderzoek heeft laten zien dat deze verschillen samenhangen met de positie van de sociaaldemocratische partij in de partijconfiguratie, en met het type gezondheidszorgsysteem. Het blijkt dat actoren en instituties beiden nodig zijn om de variatie in ziekenhuisbetalingssystemen te begrijpen.

De rol van de medische professie is vaak aangehaald als belangrijke verklaring voor de mate waarin hervormingen konden worden doorgevoerd. De formele machtsverdeling tussen de overheid en de medische professie kan, zoals aangetoond in hoofdstuk 3, de variatie waarin NPM doorwerkt kan verklaren. In hoofdstuk onderzoek ik of de variatie wel verklaard kan worden als er gekeken wordt naar de interactie tussen actoren en instituties. De deelvraag die beantwoord wordt, is: In welke mate en op welke manier zijn de strategieën van de artsenorganisaties te relateren aan de variatie in de nieuwe ziekenhuisbetalingssystemen? Hoofdstuk 5 laat zien dat strategieën van artsenorganisaties niet direct gerelateerd zijn aan de hervormingen in de nieuwe betalingssystemen, maar dat deze strategieën samen met de positie van de artsenorganisaties in het systeem en de preferenties van de overheid de variatie in de ziekenhuisbetalingssystemen kunnen verklaren.

De coöperatieve strategie van de Nederlandse artsenorganisaties kan worden verklaard uit de nadruk van de regering op deregulering en competitie. Door deze nadruk werd de interesse van de artsen niet per se negatief geraakt door het nieuwe ziekenhuisbetalingssysteem. De coöperatie tussen de Nederlandse regering en medische professie heeft ervoor gezorgd dat in een systeem met redelijk wat veto-momenten en deling van macht, de regeringpreferenties over NPM zichtbaar zijn in het de hervorming. Zowel in Duitsland als de UK, waren artsenorganisaties in conflict met de regering, de uitkomsten zijn echter verschillend door de institutionele omgeving. In Duitsland leverden de conflicten aanpassingen en vertraging op in de implementatie van het betalingssysteem door de gedeelde macht. In de UK kon de regering de starre houding van de medische organisatie juist naast zich neer leggen vanwege de gecentraliseerde macht.

Dit onderzoek laat zien dat zowel actoren en instituties van belang zijn om variatie te verklaren. Instituties kunnen belemmerend of bevorderend werken voor bepaalde actoren. Preferenties van zowel politieke partijen en artsenorganisaties
kunnen niet volledig los worden gezien van de context waarin ze worden gevormd, maar kunnen niet worden verklaard door het type gezondheidszorgstelsel. De vorming van preferenties is complexer.

Hoe een bepaald ziekenhuisbetalingsysteem er uiteindelijk uit komt te zien en in welke mate kostenbeheersing ten koste kwaliteit en toegankelijkheid zal gaan, moet gezien worden als een politieke keuze. Of deze keuze moeilijk of makkelijk zal kunnen worden doorgevoerd in een politiek systeem wordt bepaald door de formele instituties, zoals de verdeling van macht tussen artsen en de regering en het politieke systeem. De politieke keuze zelf wordt echter niet bepaald door het politieke stelsel of het gezondheidszorgsysteem. ‘Politics matters’.

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