Oxford Handbook of Danish Politics

Synopsis for chapter on Danish health policy

Title:

HEALTH POLICY
THE SUBMERGED POLITICS OF FREE AND EQUAL ACCESS

Lars Thorup Larsen
Associate Professor, PhD
Department of Political Science
Aarhus University
lars@ps.au.dk

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CHAPTER OUTLINE

1. Introduction: Overview of main argument

- Broad political consensus about universal, single-payer health care system
- Broad popular support for the national health care system and for increased health spending
- 'Free and equal access' as core value
- Submerged political conflict and party competition. Parties compete for issue ownership, small differences between party positions
- What is to be explained?
- Presentation of chapter structure: Sections on health care financing, regulation and delivery in the Danish health system followed by a discussion of the 'politics' structuring the development of Danish health policy in recent decades.

2. Financing: Expansion of Access and Tax-financed Health Insurance

- Historical development from sickness funds to national health insurance (1971)
- Centralized, state-based financing
- Combination of fee-for-service and activity-based (DRG)
- Key indicators of health costs (OECD data), large cost increase since 2000

3. Regulation: Regulation of medicine and doctors

- The National Health Board (Sundhedsstyrelsen)
- Regulation of health professionals

4. Delivery: The Organization of the Danish Health Care System

- Privately based primary physicians as gatekeepers to public hospitals
- Regional organization of and delivery of health services
- Major reforms since 2000, structural reform, centralization
- Health Act of 2007: Free and equal access
- Increased use of (publicly funded) private providers and insurers
- 'Voucherization' of health care as citizen right and regulatory mechanism
- Rise in prevention and public health policies since late 1970s

5. Health politics: Party politics, competition for issue ownership

- 1990s-: Increased salience of health policy, 'waiting lists' perceived as result of underfunded public system (or efffective cost control)
- 2000s: Centre-right challenge to Socialdemocratic issue ownership, increased voucherization and subsidized private health care
- 2010s: 'Downsian' party competition over expansions of health services and quality, but also new (submerged) attempts to control cost
- Instead of broad 'prioritization' of scarce resources, cutbacks are targeted toward less deserving minorities (obesity, fertility treatment)

6. Conclusion: The Impact of Party Competition on a consensus Issue

- Competition on popular consensus issue inadverdently leads to cost increases

7. References

1. Introduction

No parts of the Danish welfare state are supported as strongly by both voters and political elites as the health care system. There may be disagreeements about how health care should be organized and regulated, or how much autonomy should be granted to health professionals, but few politicians, if any, would dare to show anything but unequivocal support for the 'beveridge style' or universal national health insurance. The broad consensus about universal health insurance particularly stands out as significant, because most other forms of social citizenship in the Danish welfare state such as unemployment insurance and pensions have been reformed with elements of means-testing, work requirements or qualification periods. These areas are also often the topic of contentious political debates about the deservingness of recipients. In health care, however, universalism seems to be largely intact given that all legal residents in Denmark have socalled 'free and equal access' to health care services from both general practitioners (GPs) and hospitals. Just as there are relatively few barriers to get free access to health care, it is also rare – but not totally unprecedented – that health policy debates degrade into 'targeted' (Schneider & Ingram 1997) moral accusations against recipients' use of public resources.

Given the broad political and popular consensus about universal health access, it would be easy to brush off health care as entirely depoliticized and irrelevant to 'politics' and party competition. This would be a mistake, however, because the area is in fact characterized by significant party competition between government and opposition parties. A testament to this status is the fact that the major political parties often put health care plans into their election manifestos, not least when it comes to advertise their willingness to allocate more funds to health care. The core objective of this chapter is to demonstrate that there is in fact a 'submerged' (Mettler 2011) political dynamic hidden underneath the broad consensus around Danish health policy. This was not always the case, since health policy received significantly less attention prior to the 1990s where it gained salience and where popular demands for increased resources for the public health care sector became a permanent feature of Danish politics.

The central ambition of the following chapter is thus to analyze the intersection between health policy and health politics. This involves discussions about which factors contribute to the broad consensus on universal health access, but also some considerations about the likely consequences of this political dynamic. In order to substantiate the main argument, however, it is also necessary to give a somewhat detailed account of how the Danish health care sector is organized and describe the principal characteristics of Danish health policy more broadly. In some situations, it is similarly necessary to describe some of the development behind the present state, although it is not the ambition to analyze the history of health care institutions in its own right (Jacobsen & Larsen 2017). The current health care system in Denmark is a rare combination of some very old and stable instutional structures on one hand and an ongoing modernization of regulatory mechanisms on the other hand. For example, the central agency for medical governance, the Danish Health Authority, is built on the remains of the original Royal Health College established in 1803, and the fundamental principle of 'equal' treatment regardless of income was formulated as far back as 1806 (Petersen & Blomquist 1996). These two features, centralized medical governance and the principle of equal treatment for all citizens have been substantiated by a variety of different institutional underpinnings since the early 19th century. It is thus important to understand the dynamic between stable and changing elements in Danish health policy, also for health policy in the present state.

The chapter begins with three largely descriptive sections covering the main features of health policy financing, regulation and delivery in Denmark. It is customary in health policy scholarship to distinguish between these three (Freeman & Rothgang 2010; Blank et al. 2018) dimensions, although they can be difficult to separate in a Danish context because the state plays such a central role in all three. Section two below gives a brief overview of health care financing in Denmark, whereas section three describes the regulation of medical practice, treatment technology and pharmaceuticals (also known as medical governance). Section four describes the key organizations responsible for health care delivery in Denmark including some of the major reforms of this large field in recent decades.

Based on the three descriptive dimensions of Danish health policy, section five brings back the issue of politics and aims to analyze, albeit in relatively short form, how the political dynamic over health care has developed from the late 1980s to the present day. Finally, section six ties the various ends together and offers a conclusion to how Danish health policy and politics are connected in a 'submerged' political conflict between centre-left and centre-right. The conclusion also discusses the implications of the submerged political conflict for the development of health care costs in comparison with both earlier periods and other health care systems. Public spending on health care has increased significantly in recent decades in Denmark, about 43% since the year 2000, and much more than all other welfare sectors (Ministry of Finance 2018), and yet many voters and observers in public debate seems to think that the area is constantly starved by dramatic cutbacks and rationalization. Some of the reasons for this discrepancy are of course generic to public perception of government and some reasons behind the cost increases are generic to health care, such as price hikes on pharmaceuticals and treatment technology. Nevertheless, my argument in the following is that structural and apolitical explanations such as these tend to drastically underestimate the role of politics in health policy expansion.

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8. Outstanding questions and dilemmas in writing this chapter:

a) Balance between: 1) a descriptive overview of the Danish health care sector that is both detailed and still understandable for non-Danish readers, and 2) a coherent and original argument.
b) Balance between policy and politics: Health policy is the main topic, but in order to make an original argument I feel it is necessary to discuss the political dynamic also
c) Balance between historical development and the current state. The latter is of main interest, but due to the long-term stability of the sector, the present explains very little of why Danish health policy looks the way it does.