Negotiating a One Payer System - Copenhagen, Denmark 1403-2000

TEK ÖDEYENLİ SİSTEMİN TARTIŞILMASI-KOPENHAG, DANİMARKA 1403-2000

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Summary

The health care systems we have today are the result of long historical developments. Developments which profoundly influence both the structure of our present systems, and the societal values underlying and supporting these systems. This paper presents a historical and social analysis of the health care system in the Danish capital Copenhagen from 1403 to 1990, with special emphasis on the development of the present one payer system in the primary care sector. The analysis aims at explaining both the structure of the system and its value base. Based on this analysis it is concluded that structure and value base developed together, and that a transfer of health care systems between societies with different societal values is not likely to succeed.

Key Words: One Payer System, Copenhagen

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Özet

Bugünkü Sağlık Bakımı Sistemlerimiz uzun tarihi gelişmelerin sonucudurlar. Bu bildiri, Primer-bakım sisteminde tek ödeyenli sistemin gelişimindeki özel önemle 1403-1990'da Danimarka'nın başkenti Kopenhag'da sağlık bakımı sisteminin sosyal ve tarihi analizini değerlendirir. Çalışma, hem sistemin yapısını ve hem de onun temelini açıklar. Bu inceleme yapının ve temelin birlikte geliştiğini ve farklı toplumsal değerlerle toplumlar arasındaki sağlık bakımı sistemlerinin transferinin başarılı olmadığı sonucuna varmaktadır.

Anahtar Kelimeler: Tek ödeyenli sistem, Kopenhag

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The present Danish health care system is a paradigmatic example of what Americans use to call "socialized medicine". Except for small co-payments on prescription drugs all medical expenses are paid by the public from revenue generated through the general taxes. Almost all hospitals are publicly owned, and all hospital physicians employed in salaried full-time positions.

In the primary care area general practitioners are in principle in private practice. They are reimbursed through a combination of a yearly small capitation fee for each patient on their list of patients and a larger fee-for-service component. The fee-schedule is however set by national negotiations between the Danish Medical Association and the Danish State and counties, and it is illegal to charge patients directly. There are further restrictions on the number of patients a general practitioner can have on his or her list, and public advertisements by medical doctors are in general prohibited. The government therefore controls the primary sector almost as efficiently as if general practitioners had been salaried employees.

The Danish health care system was never consciously designed in this way, and there is, in contrast to the establishment of the British National Health Service in 1948, no specific point at which one could say that this marks the establishment of "socialized medicine". This paper tries to explain the historical development of the Danish health

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care system, and to explicate the development of the values that are supporting the system. From this analysis some tentative conclusions will be drawn concerning the feasibility of "grafting" the health system of one country on to the values held in another.

Although Denmark is a small country, there has been differences in the historical development in different parts of the country. This paper will therefore primarily be concerned with the developments in the Danish capital Copenhagen. It will further be restricted in the sense that only the developments in the primary care sector is covered. This restriction was chosen because the hospital sector has been almost exclusively a public enterprise since around 1750.

Early developments

In early med review times health care in Denmark was the responsibility of families and friends and the church would step in only in the cases where no relatives could be found. A few hospitals were established by religious orders that also had special "institutions" for persons with leprosy and for the insane.

The transition from a tribal to a feudal society during this period was accompanied by the creation of a new class of people, the skilled artisans, and the break up of traditional large-family structures.

The artisans soon formed guilds after the German model, and one of the tasks of these guilds was the support of members in need. The first mention of health insurance in Denmark is found in the preserved annals of the bakers guild of Copenhagen which in 1403 decided to pay illness benefits to its members, and to put this provision in a prominent place as the second paragraph in the constitution of the guild. The previous provisions had not given any financial aid, but had simply stated that if a member was ill, and without any family, the apprentices of the guild should sit by him at night and make sure that he was fed and kept comfortable .(1) Many other guilds followed the example of the bakers and by the 1700s most guilds had some kind of mutual health insurance for their members. At the same time benefits were extended from simple income support to the payment of physician fees and later also hospitalisation. In this extension the bakers guild again took the lead when, in 1780, they bought the right to utilize a number of beds at the Royal Frederiks Hospital. (2)

Around the same time freestanding mutual health insurance funds began to emerge, but none of these had a long life.

The first official regulation of medical fees was issued by king Christian V in 1672 and was never revoked. It specified minimum fees for a range of medical services, but also contained an important final provision establishing a legal duty incumbent upon physicians to provide *pro bono* care:

"But the poor, who are not able to pay, shall they serve, according to the demands of their profession and their oath, and not deny or withhold their help from any who is poor and in need." (1)

Originally the various guilds and mutual health insurance funds paid fee-for-service or paid benefits directly to their members, but in the early 1800s a new capitation system began to develop, where a guild would secure the services of a specific physician for its members, and pay a fixed yearly fee for these services.

Two social developments facilitated this change. The early decades of the 19th century was a prolonged period of recession in Denmark. The country had sided with the losing side in the Napoleonic wars and consequently lost all of Norway to Sweden in 1814. This meant that the number of poor people in the cities grew rapidly. At the same time the number of physicians graduating from the University of Copenhagen, which was the only Danish university, also increased, thereby expanding the number of physicians, especially in Copenhagen. Taken together these two developments increased the competition for the patients who could pay and increased the amount of *pro bono* work expected from each physician. Many physicians were therefore willing to sign capitation contracts with guilds and health insurance funds in order to recoup at least some income from their treatment of the poor.

The market for such contracts was totally unregulated, and the contents and terms varied widely.

Industrialization

In the 1830s and 40s Denmark started its transition from a feudal/agrarian society to an industrial society. The old guilds representing both employers and employees lost their importance and were replaced by separate organizations for workers and employers. Most of the emerging labour unions were ideologically aligned with the social democratic political movement (i.e. revisionist socialist), and were not only interested in wages, working conditions and revolution, but also in a wider range of social issues, including health care.

It was from these unions the mutual health insurance funds in emerged which would be the backbone of health care in Copenhagen for the next 110 years.

The Danish Medical Association was formed in 1857 and at the annual meeting in 1875 it discussed the worsening conditions for the medical profession, especially in Copenhagen. It was documented that physicians who had no private patients, but only patients on capitation contracts, would be unable to sustain themselves and their families at a standard of living suitable for a physician and a gentleman. The association therefore resolved to empower the regional associations to conduct collective negotiations with the insurance funds.

Likewise the insurance funds in Copenhagen formed a negotiation consortium in 1884. This development was aided by the close ideological connection between different funds and the fact that they were all not-for-profit enterprises.

In the years between 1884 and 1892 the Copenhagen Association of Physicians (KL) and the Collaborating Health Insurance Funds of Copenhagen (DSS) had an ongoing series of negotiations aiming at a standard contract for physicians employed by members of the DSS.

In 1892 the Danish parliament passed the first law recognizing the health insurance funds as important parts of the social security system. The funds could now apply for registration and all registered funds received a state subsidy equivalent to the administration costs and 25% of the payments made to or on the behalf of members below a certain level of income, which was set at approximately the level earned by an unskilled labourer.

Later in 1892 KL and DSS finally reached agreement on a standard contract specifying capitation fees for families and single members as well as the range of services the physician was required to offer for this fee. This standard contract created uniformity in the contractual relationships between physicians and insurance funds, but each physician still contracted separately with a number of insurance funds.

It is interesting to note, that whereas a full capitation model was implemented in Copenhagen, similar negotiations elsewhere in Denmark led to systems that were combinations of a large fee-for-service component, and a small capitation component. This difference was probably caused by the difference in bargaining power held by the physicians. In Copenhagen many physicians were in competition for the few patients able to pay out of pocket, and the amount of unpaid *pro bono* work was large, whereas physicians were scarce in the countryside, and the individual physician there could still lead a good life on his paying patients. So the Copenhagen physicians needed the insurance patients, and in the end they got a worse deal than in those regions of the country, where the physicians were able to take a more relaxed view of the negotiations.

This interpretation of the relative bargaining positions in Copenhagen and in the provinces is further reinforced by the fact, that even while there were a number of organized withdrawals from the contracts in the provincial counties, the Copenhagen physicians never took any kind of industrial action.

In the regular contract renewals between 1892 and 1908 the physicians only managed to insert minor changes protecting physicians against summary dismissal, but they had to wait until 1909 to negotiate the first small rise in the capitation fee after 17 years on a constant fee schedule.

The next major changes in the relationship between physicians and insurance funds came with the agreements of 1921 and 1925, which established a mutual exclusive employment agreement specifying that only members of KL could be employed by the insurance funds, and that members of the KL were only allowed to sign contracts with insurance funds that were members of DSS. The

1925 agreement further specified that all posts as general practitioners within the insurance system should be publicly advertised, and that a committee with representatives from DSS and KL should choose between the applicants.

By 1925 Copenhagen had thereby achieved a one payer system for a very large part of the population, with physicians who were in reality the direct employees of the insurance funds.

This system continued basically unchanged even when the Danish counties in 1973 took full responsibility for health care, and the system became fully financed by taxes. For 17 more years the special Copenhagen system with virtually no fee-for-service components continued to operate, but in 1987 Copenhagen moved to the national system with a small capitation component and a large fee-for-service component. This, not surprisingly, led to an increase in the number of consultations and procedures, and it finally brought the income of physicians in Copenhagen up to the level of the rest of Denmark. (3).

The value history of Danish health care

Running in parallel with the structural and political history of the Danish health care system outlined above is a value history concerned with the developments of the values supporting this system.

At the same time as the insurance funds developed, and the Danish health care system was slowly constructed and negotiated, the *raison d'etre* and the value base of the health care system gradually changed.

Within the old guilds health insurance funds were established as a logical extension of the various other services intended to support a feeling of togetherness among an elect group. No member of the group should be left destitute, as long as he kept his part of the bargain and did not reveal the secret elements of the craft to outsiders.

When the guilds were abolished and mutual health insurance funds began to emerge three fundamentally different ideologies or value systems supported this development. In the cities the health insurance funds were closely connected to the emerging labour movement and the social democratic party, whereas outside of the cities they were connected to the agricultural cooperative movement, which had strong ties to the liberal party. The conservative government, after some hesitation, also supported the health insurance funds but for quite different reasons. They wanted a healthy population as the basis for a healthy army, so that the devastating defeat in the war against Prussia and Austria in 1864 should not be repeated.

This divide in motivation was clearly demonstrated in a debate about the proper scope of the funds and the proper criteria for membership which ran continuously between the 1860s and the early 1930s. The social democrats wanted to extend membership to all citizens, whereas the cooperativists, liberals, and conservatives only wanted membership to extend to the poor and needy, since they believed that those who could take care of themselves ought to do so.

Initially the conservative and liberal wing had the upper hand, and the 1892 legislation set fairly stringent income limits for membership in state recognized insurance funds, but gradually the climate changed, and the old dividing lines disappeared. Income limits were gradually raised, and more and more politicians spoke in favour of a comprehensive health care system for all. The parties moved from their partisan views towards a common vision of "The Good Society". In 1933 this slow change in value base was so far progressed that a large majority in the parliament, including the social democrats, the conservatives, and the radical liberals, supported what came to be known as "the Great Social Reform". A comprehensive bill changing the official justification of social security from a principle of charity to a principle of citizens' rights with a first paragraph which stated that the state had a duty to care for those citizens who could no longer care for themselves. Part of this reform was compulsory membership in a health insurance fund. Persons with an income below the level of the average skilled worker could obtain full membership, whereas persons above this level of income could only obtain passive membership, with reduced membership fees and no present benefits but a right to obtain full membership at a later time irrespective of health status. This meant that from the 1930s and onwards more than 60% of the Danish population had full health insurance coverage in a not-for-

profit mutual insurance system. For persons above the income limit several of the mutual health insurance funds created special funds giving the same benefits, but at a higher premium since this group was not eligible for the state subsidy. These subsidiary health insurance funds picked up most of the persons not eligible for membership in the regular funds, and by the 1940s more than 90% of the Danish population had comprehensive health insurance coverage. (4)

The mutual nature of the insurance system in itself gave further nourishment to a sense of obligation or solidarity between Danes with respect to health care, and the German occupation during the 2nd World War and the sense of cohesion of Danes as Danes fostered by the oppression finally forged the notion of solidarity into a firm structure upon which the present comprehensive welfare state could be erected. No Danish post-war politician, and very few others for that matter, has dared to express the belief that comprehensive health care is not the responsibility of the community. There have been discussion about exactly how this responsibility should be discharged, but there has not been any doubt about its existence and its grounding in an ideal vision of the good community and a basic value of solidarity between fellow members of this community. (5)

In recent years there have been signs indicating that this value base may be slowly eroding, but whether this will actually happen cannot be predicted at present. A few private hospitals doing fee-for-service medicine has appeared, but they are still struggling with great economical problems. (6).

Various proposals for radical restructuring has been put forward through the years. As early as 1908 the social democratic party suggested in parliament that all general practitioners should be salaried employees of the state, and as late as the 1930s some doctors suggested that an unregulated fee-for-service market was the only way forward. Both proposals diverged widely from the consensus of the time and were never seriously considered.

It is probably true to say, that apart from the period before 1909, were the relative bargaining power of physicians and insurance funds was the main determinant of the development of the Danish health care system, the structure of the system and its value base has developed together. Sometimes with changes in one preceding changes in the other by a few years, but never with any radical split between structure and value base. Political intervention has been limited, and has mainly served to embed present structures, negotiated between consumers and providers, in the law.

Conclusion

What can be learned from all this, and does it have any relevance today?

It seems that at least three important features can be extracted:

a. Although Denmark now has a fairly monolithic tax-based health care system , i.e. what Americans like to call "socialized medicine" , this came about through a long historical development, and not primarily as a result of conscious design.

b. If the relative negotiation position of physicians and insurance funds had been different, Denmark might have ended with a very different health care system.

c. The societal values presently supporting continued public health care were themselves brought into being during the slow emergence of the health care system they now support. Values and system grew together.

Although these features are based on an analysis of the historical development of one specific health care system, they can be further generalized to support the contention, that the health care system and the prevalent values in a given society must attain some form of congruence. New health care systems cannot be designed and expected to survive, if the values forming the societal foundations are at variance with the values built into the new system. As an example we can look at the the present discussions of health care reform in the United States. Given the values underpinning American society it might be prudent to look to countries achieving universal coverage through some form of non-government controlled insurance system. This would exclude Denmark, Canada and England as models, but would include countries like France, Germany or The Netherlands. (7)

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