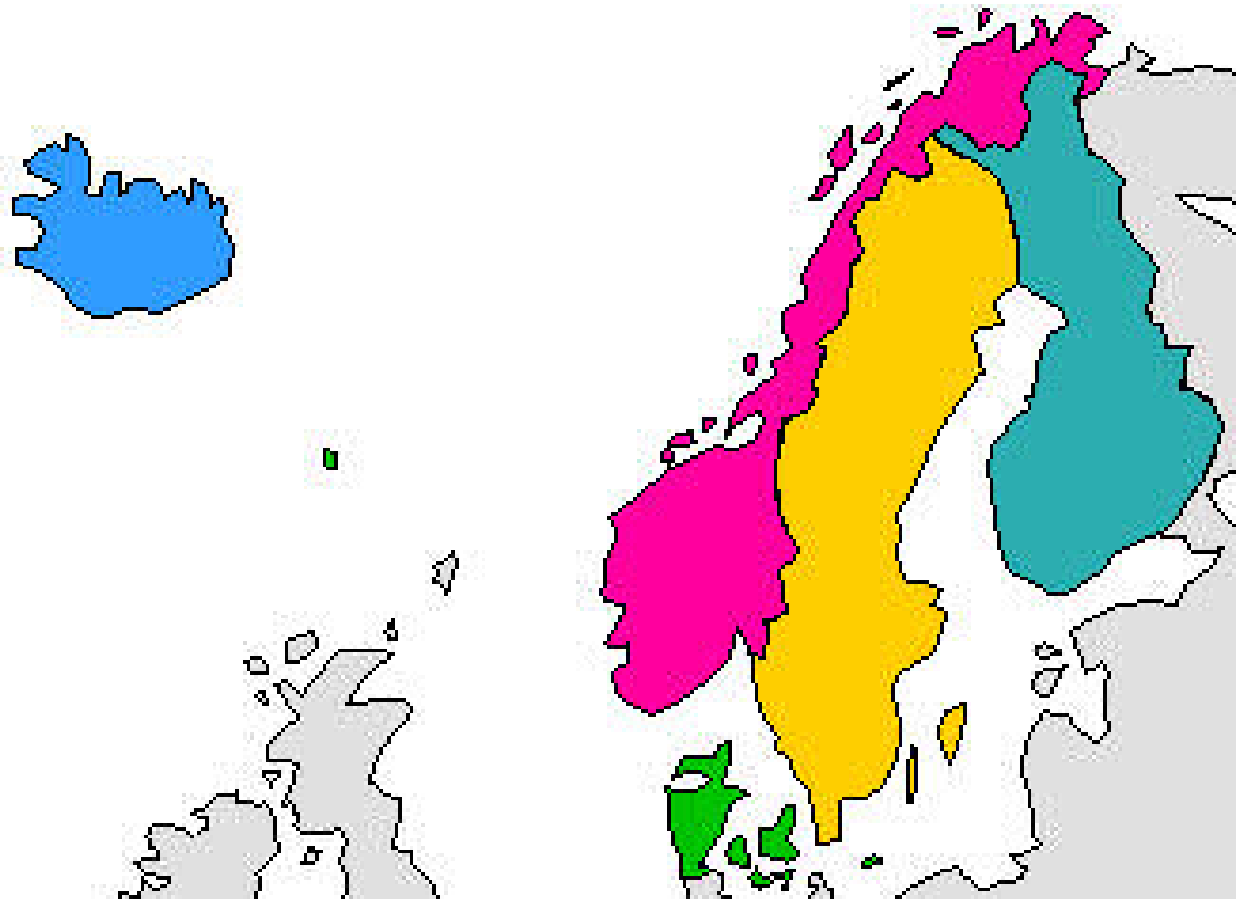
Bending the cost curve: The Nordic countries

Jon Magnussen

Department of Public Health

Norwegian University of Science and Technology (NTNU)



Overview

- Part 1: Health care in the Nordic Countries
- Part 2: Fiscal challenges
- Part 3: Policy initiatives
- Concluding remarks

Part 1: Health care in the Nordic Countries

A “Nordic model of health care”

- Tax funding
- Decentralized public governance
- Elected local governments that can tax
- Public ownership (or control) of delivery structure
- Equity driven, with focus on geographical and social equity
- Public participation.

Nordic model - similarities

- Common goals and aspirations
  - Equity
  - Public participation
- Common structural features
  - Tax based funding
  - Decentralization – the role of regions, counties and municipalities
  - (Local) Political governance

But: Differences in health policy

- Degree of decentralization
- Models for Financing and contracting
- Degree of choice
- There is a common model but countries differ in how they approach specific issues

Finland

- Role of state: Legislation, guiding role, providing block grants to municipalities
- Organizing, providing and funding health care is the responsibility of 336 municipalities
- Special feature: Occupational health care implying a two tier system

- Trend: Fewer and larger municipalities

Sweden

- Role of state is legislation, monitoring and some control functions (drugs)
- Organization, provision and funding of health care is the responsibility of the counties

- Trend: Unsuccessful attempts to centralize and to introduce national payment systems

Denmark

- Role of state is legislation and distribution of funds to regions. Also national frameworks of health care
- Organization, provision of health care is at the regional level

- Trends: Further centralization of some municipal tasks(?)

	Finland (5.4 mill)	**Sweden (9.4 mill)**	**Denmark (5.5 mill)**	**Norway (5.0 mill)**
Specialist health care	21 districts	21 counties (regions)	5 regions	4 regional health authorities (RHA)
Decentralized political governance?	Yes, through the hospital districts	Yes, thorugh counties	Yes, thorugh regions	No
Primary health care	336 municipalities	21 counties (regions)	5 regions	430 municipalities
Decantralized political governance?	Yes	Yes	Yes	Yes
Role of state in governance	Weak, but increasing	Weak	Strong, but in cooperation with regions	Strong

Norway

- Role of state is legislation and distribution of funds as well as hospital owner.
- Administrative delegation to RHAs, primary health care is devolved to mumicipalities

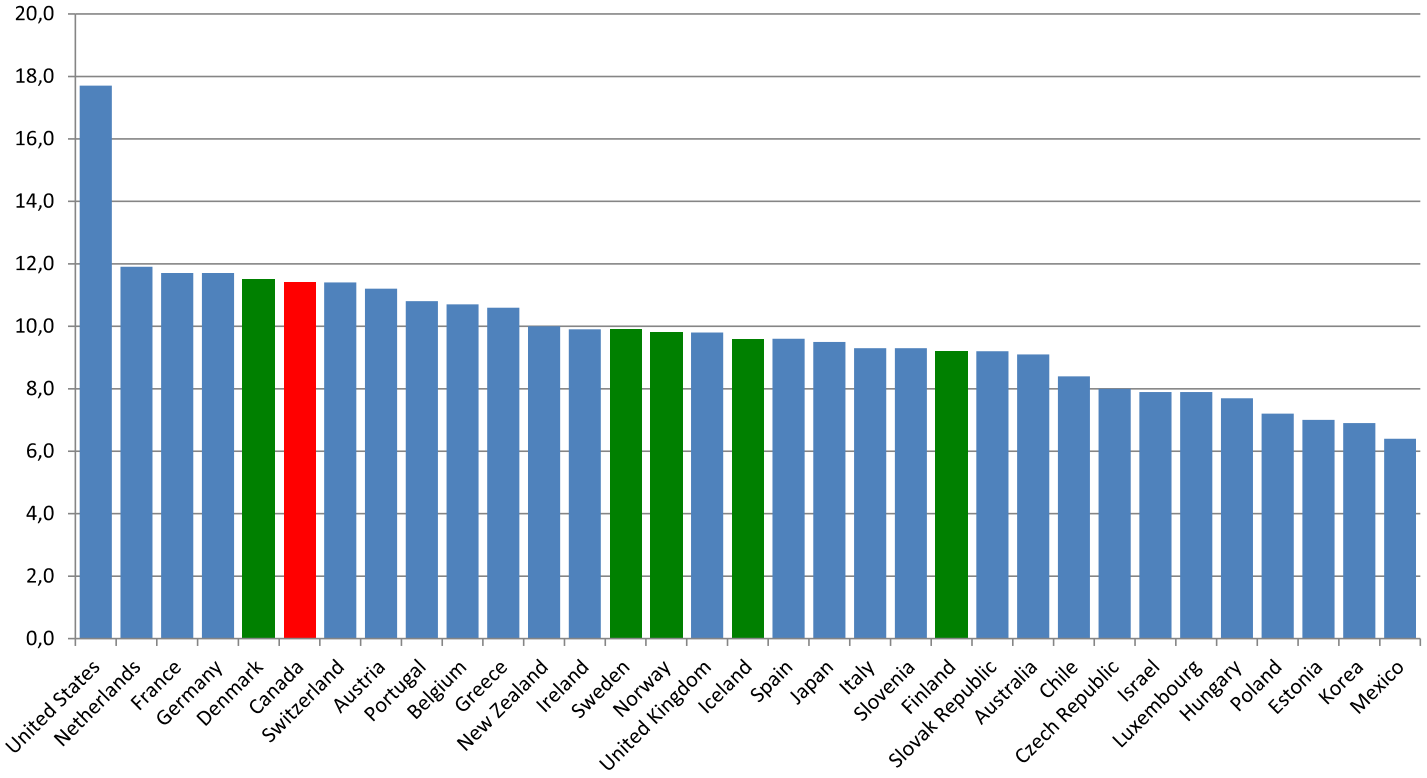
- Trends: Lack of general support for the RHAs. May remove these and thus further centralize

Decentralization

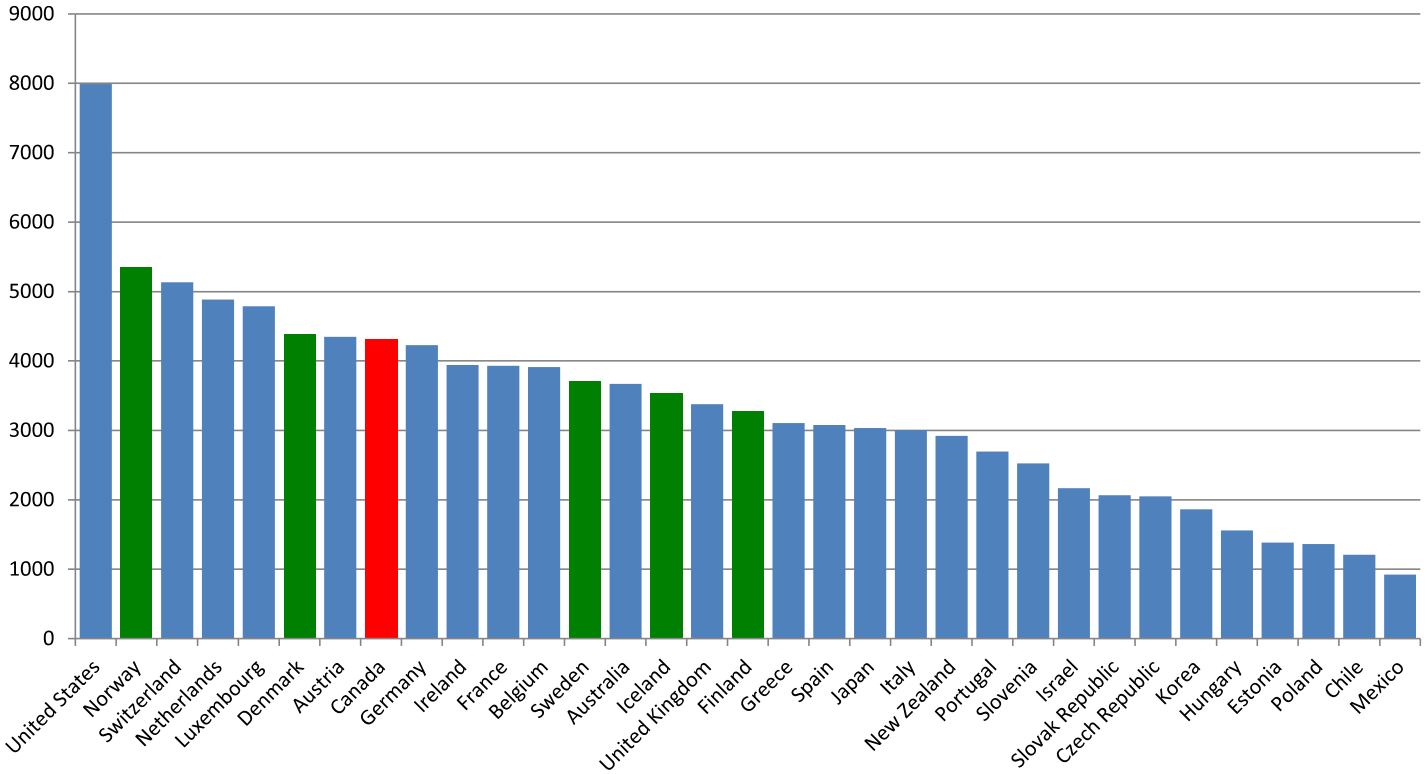
	Long term/ home care	Primary health	Specialised health
Finland	Municipality	Municipality	(Municipality)
Sweden	Municipality	Counties	Counties
Denmark	Municipality	Regions	Regions
Norway	Municipality	Municipality	Regions

Part II: Fiscal challenges

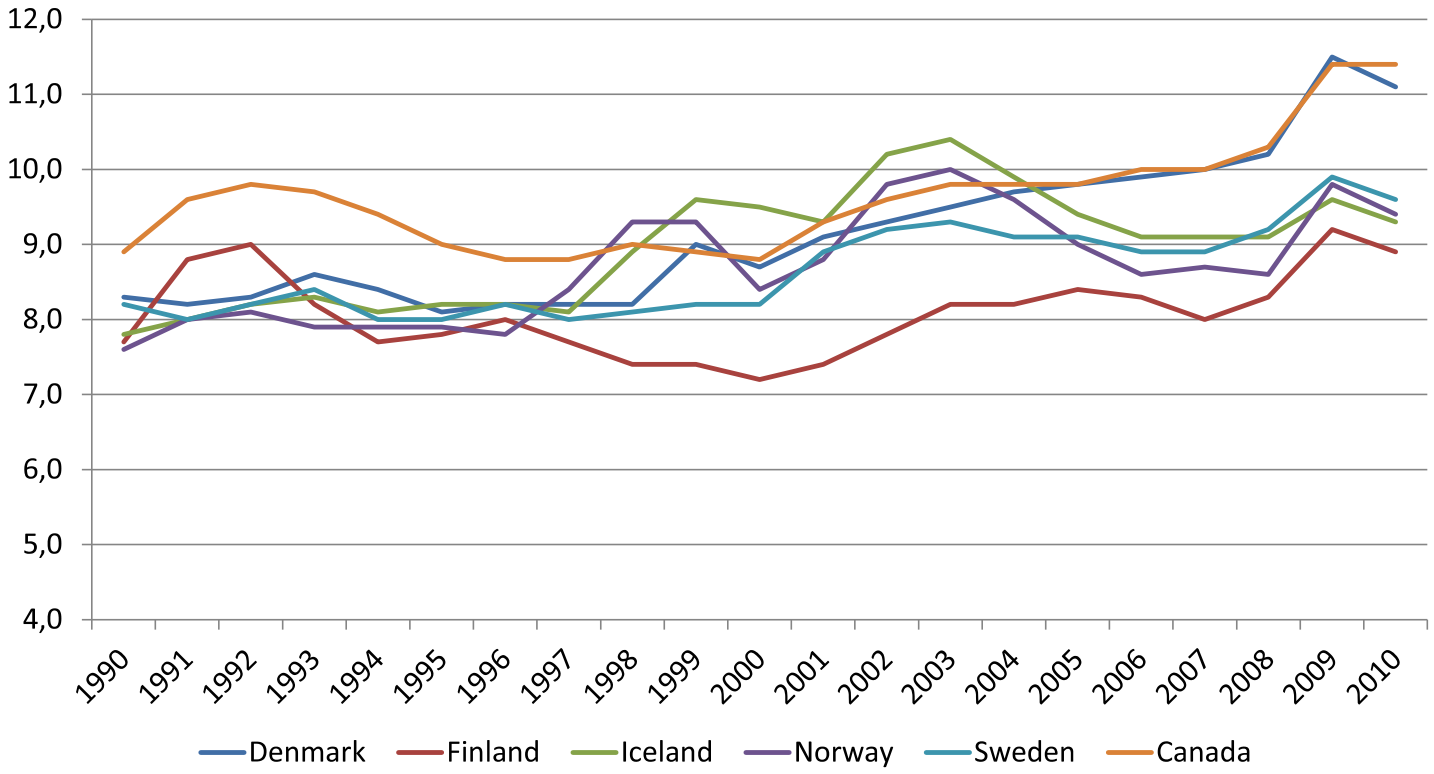
Share of GDP to Health - 2009



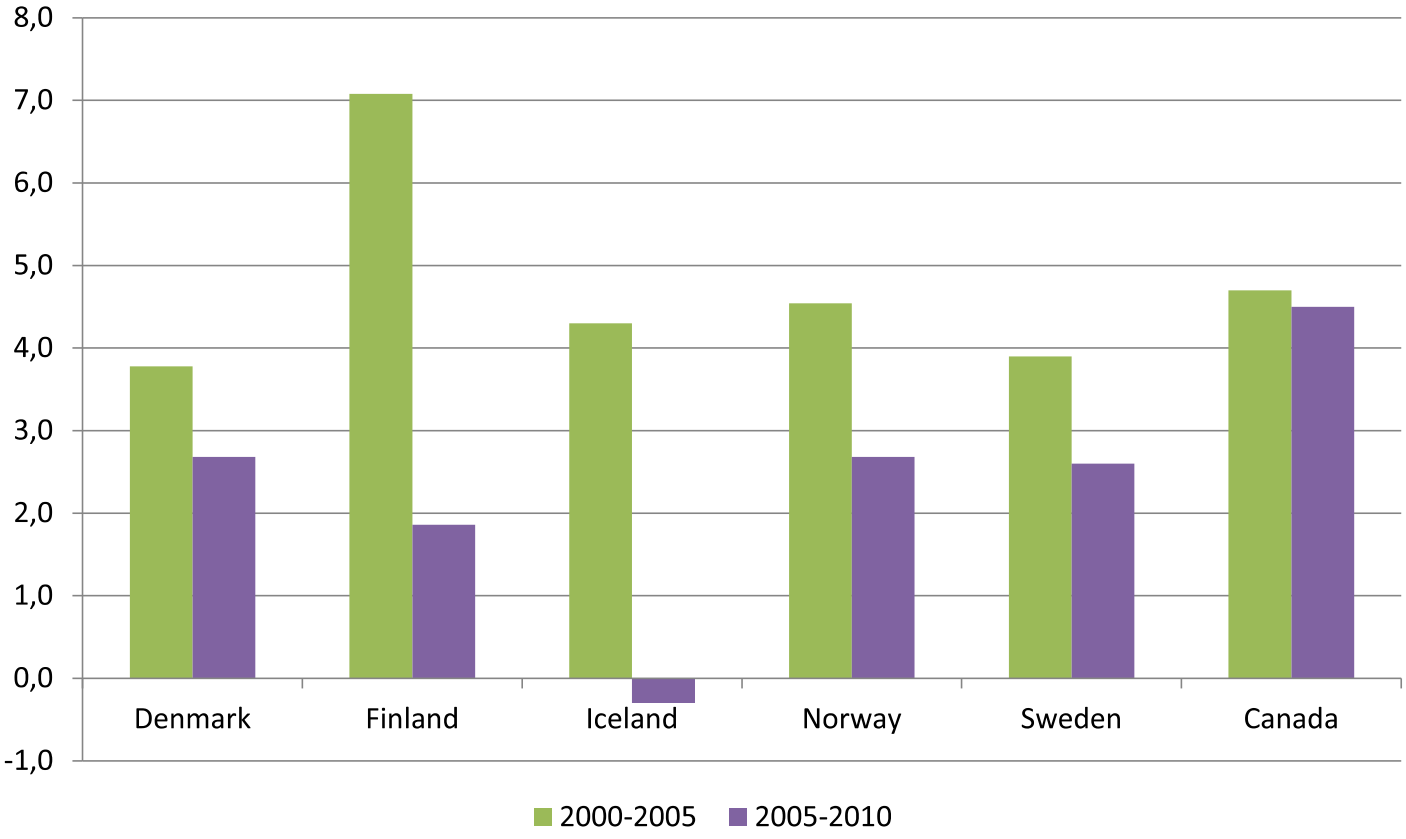
USD PPP Per capita spending - 2009



Share of GDP to Health – 1990/2010



Real growth in public expenditures



Fiscal challenges

- Finland; ageing population combined with low retirement age
  - Fiscal challenges (4,5 % of GDP)
- Sweden; fiscal discipline and surpluses
  - No immediate threat
- Denmark; high tax rates, sub national «slippage»
  - Possible concern (3 % of GDP)
- Norway; oil surplus, net saver
  - No concern on short or medium term

- No "immediate fiscal threat" – this also affects policy

Part III: Policy

Policy initiatives

- Demand side
  - Co-payments (user charges)
  - Gate keeping
- Supply side
  - Re-organization of system
  - Regulate capacity
  - Reduce coverage

- i) To what extent are these measures used, ii) do we see any recent changes motivated by «fiscal concern»?

Cost-sharing

- Co-payments are in general not fiscally motivated, but rather intended at regulating (unnecessary) demand
- No major shifts in policy in order to increase co-payments

- This is not where the road to fiscal sustainability lies

Gate–keeping

- An integral part of the system in Norway, Finland and Demark
- In Sweden direct appointment with specialist is possible, but co-payments are higher
- No major shifts in policy expected

- Probably keeps costs down (and possibly leads to better coordinated care)

Re-organization of system

- Re-centralization
- Increased reliance on activity (DRG) based financing
- Shifting activity from specialized care to primary care
- Increased focus on prevention

Re- centralization

- Primarily Norway and Denmark
- (Partly) central funding – local provision
  - Soft budgeting
  - Regional differences (equity concerns)
- Structural issues
  - Duplication of services (inefficiency)
  - Quality concerns (low volume)

Fiscal decentralization

- When local authorities cannot tax freely they will dip into the ″common pool″ of resources
- To the single authority this will be practically free in terms of the pressure on national tax rates

- Thus there is an argument for centralizing governance when financing is centralized

Lessons from decentralized models

- Soft budgeting is difficult to avoid
  - And affects the behavior of the hospitals
- Administrative decentralization is more difficult than political decentralization
  - "deficit of democracy"
- Health policy goals and tools need to be internally consistent

Mixed signals creates escape routes and makes governance more difficult

From specialized to primary care

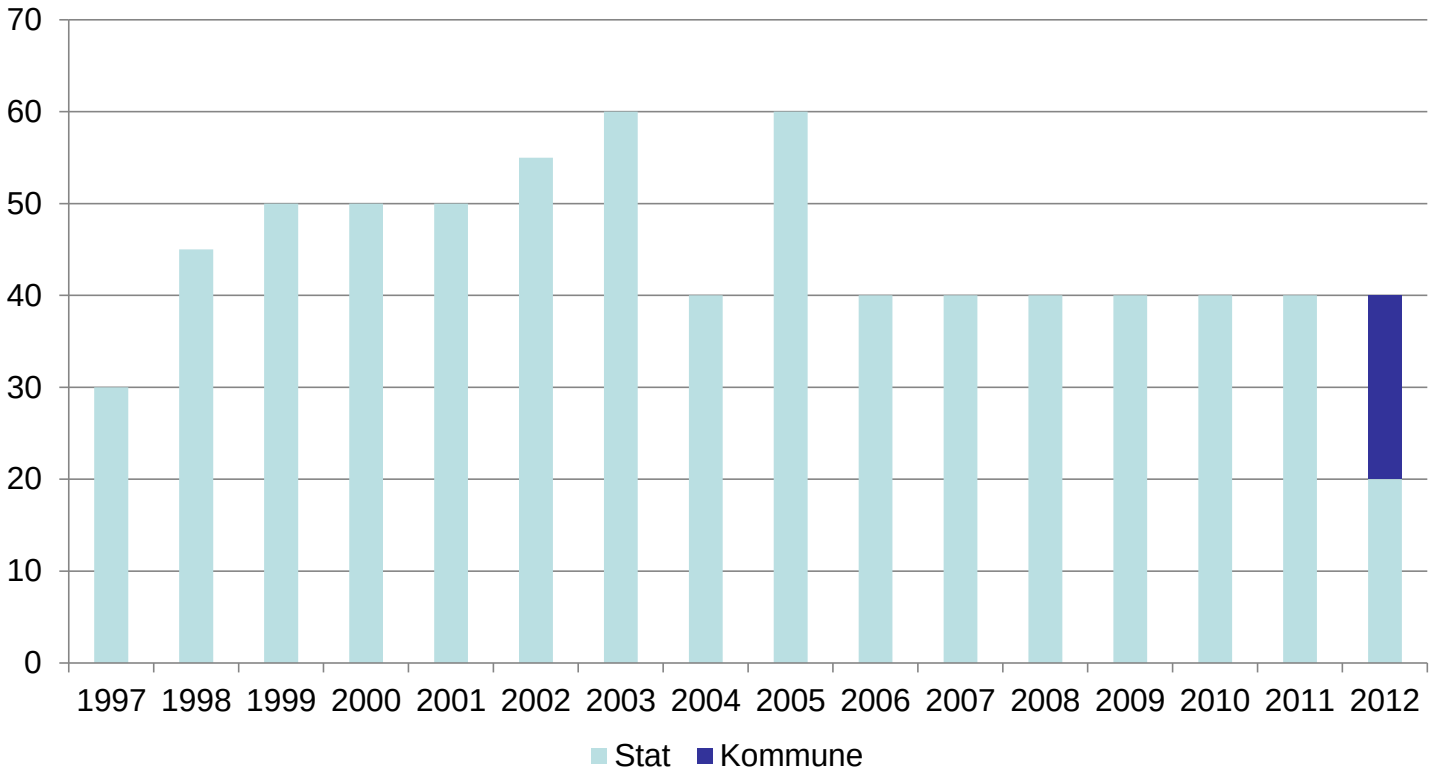
- Municipal co-payment for hospital services
  - Norway and Denmark
- Coordination reform
  - Norway
- Larger municipalities
  - Denmark, Finland

- Shifting activity from specialized to primary care is a trend

Hospital payment

- DRG-based payment in Norway and Denmark
  - But more controversial in Norway
  - And primary motivation is increased cost-efficiency and reduced waiting lists, not necessarily cost-containment
- No national system in Sweden – and not really that much focus on payment systems related to cost-containment
- Finland use DRGs as a budgeting tool – which is probably more efficient in terms of cost-containment

Norway: Share of ABF1997-2012



Payment and sustainability

- Trend towards «open-ended» activity (e.g. DRG) based systems
- These systems are likely to drive costs up because activity increases
- But may lead to higher levels of efficiency, thus curbing costs

- Cost-volume contracts are more likely to curb costs, while also improving efficiency

Reducing coverage

- Today coverage is limited for some prescription drugs and for dental care
- Need for: Stricter priority setting rather than general reduction of coverage
- Also: Limiting the use of new drugs and new costly technologies

- Limit future growth rather than reduce existing coverage

Concluding comments

Bending the cost curve – The Nordic way

- Systems are not especially costly
- No immediate threat of a fiscal crisis (but warning for Finland)
- Lack of manpower may pose a larger threat than lack of public funding (speculation)
- Restructuring of services is the most prominent policy measure to curb costs
  - Centralization
  - Shifting activity to primary care + prevention
- Regulating the introduction of new (costly) drugs and therapies is a challenge

Thank you!