

Appendix. Description of Nordic Hospital systems 1998-2004 ¹

Background

The providers of the hospital care in the four Nordic countries are regional health enterprises in Norway (after 2002), county councils in Denmark and Sweden while in Finland the services are provided by hospital districts. Since health and hospital care is mainly publicly provided, it is mostly publicly funded, and thus taxation is the main source for financing the hospital care..In all Nordic countries the state, counties and municipalities have right to levy taxes, and they also do so (Figure A1 and Table A1).

The hospital districts or the county councils, own hospitals in all Nordic countries except in Norway after 2002 where the state is nowadays the sole owner. Notably in Denmark the Copenhagen area is an exception as its hospitals are owned and financed by the municipalities of Copenhagen and Frederiksberg and organised as a public company. In all Nordic countries publicly owned hospitals are non-profit. On the other hand, private hospitals do not play significant role in any of the countries

Characteristics of purchaser, and its organization

1.1.1

The responsibility for hospital care in Norway, Denmark and Sweden is given to regional authorities but in Finland to local authorities². In Finland, hospital care is financed mostly by municipalities, which get their income from local taxes and non earmarked state subsidies. In Sweden and Denmark hospital care is financed by county council taxes (added with general grants) while in Norway there have been two public financiers (Counties and the State). After 2002 the state has been the only financier in Norway. .

In Finland, the municipalities are responsible not only hospital care but also primary health care, social services and basic education. In Denmark and Sweden, the role of considerable bigger counties is much more important in health care than lower level municipalities. This difference is also important with respect to resource allocation, since the counties in Denmark and Sweden are usually responsible mainly for financing and delivering health care whereas in Finland, municipalities are, in addition to health care, also responsible for other public services such as social services (including e.g. children's day care and the care for the elderly and disabled persons) and school services. Excluded are only outpatient medicines and private ambulatory services and occupational care (reimbursed partly by NHS). In Denmark health care amounts about 60 per cent of the total expenditures of counties and in Sweden the corresponding figure is nearly 90 % whereas

¹ More detailed descriptions of Nordic Health care systems can be found e.g. from Järvelin, 2002, Annell 2005, Glengård 2005, Häkkinen 2005, Pedersen 2005, Johnsen 2006, Stranberg *et al.* 2007 and Vuorenkoski *et al* 2008 ¹

² In Finland the legislation is somewhat conflicting since the municipalities have the overall responsibility to arrange and finance the hospital services for their inhabitants but also the responsibility for providing hospital care is given to hospital districts that are federations of municipalities.

in Finland health services amounts about 30% of the expenditure of municipalities. Thus, it can be concluded that in Denmark and Sweden the county taxes can be considered more earmarked to the health care than the municipal taxes in Finland. After the reform the Norwegian hospital care is provided by public enterprise and financed by central government

In Finland, there exist compulsory national health insurance (NHI) that covers all the inhabitants and is paid partly by employers, partly by employees and partly by state. Quite similarly, in Norway, there is a National Insurance Scheme (NIS) that is financed by contributions from employees, the self-employed and other members, employers' contributions and state funding.³ In Finland NHI is for reimbursement purposes for private sector utilization and for pharmaceuticals, while in Norway NIS is to cover the costs from outpatient treatments in hospitals as the hospital treatment for inpatients is free of charge. In Sweden, a payroll tax funded national social insurance (NSI) is only to cover expenses from dental care and part of prescribed pharmaceuticals

Private health insurances include mainly health care costs paid out of life and accident insurance schemes. From the perspective of hospital care, the significance and effectiveness of private health insurance is small in all Nordic countries, and hence our analysis omits it.

Vertical integration of provider responsibilities is rather high in Sweden, Finland and Denmark and has been considerably lower in Norway even before the Hospital Reform. In Sweden, counties are responsible for the major part of health services including financing of medicines. In Denmark the counties had the responsibility for most health care activities (hospitals, including is psychiatric and prenatal centers, GPs, funding of medicines.

In Finland, the central government has not actively taken part in financing of hospital services. Exceptions are earmarked money to hospitals for children's psychiatric care in 2001 and activities to reduce of waiting time in 2002 in surgery. In Denmark, the overall budget is negotiated each year in a Budget Cooperation between state government and the local governments represented by the County Council Association and the Association of Municipalities. In this co-operation an overall ceiling of the growth in the local tax rate is agreed on upon and the level of state block grants is negotiated. In Sweden, central government allocates financial assistance and acts as supervisor of activities in the county councils. The government may legislate temporarily ceilings on the county councils and municipal tax rates. In Norway after 2002, the hospital care is financed directly from the state budget as the state owns the public hospitals, reflecting the lowest possible decentralisation level.

Relationship between purchaser and provider/producer

In general, the “classical” purchaser–provider model does not exist in the Finnish public health care system. Municipalities own through municipal federation's hospital districts, which provide hospital services. Also here competition is restricted by the fact that a hospital district is a local monopoly in its area, and according to the law a municipality must be a member of a hospital district. Hospital districts are governed by member municipalities and they can also influence on hospital district by their representatives in executive board and the council of hospital district. This governance is most important in situations of major investments or major changes of policy or direction. Steering and

³ Hospital services are financed by general taxes in Norway. The remuneration of outpatients is partly done by NIS, but departing from Finnish system there is no national health insurance paid to NIS. Thus, NIS is funded from the general taxes.

governance of hospital care is under constant strain and also change. A more formal contract (so called Steering by Contract model) has been developed in Pirkanmaa Hospital district. The model has been seen as an application of the purchaser-provider model and thus a market steering procedure. However, the purpose of model is to promote co-operation with view of partnership, instead of simply separating the roles of purchasers and providers. The municipalities did not use the service agreements to implement target-based health policy. The model worked well in the steering of service production of hospital services and also a co-operation forum for the municipalities and the hospital district (Ihalainen 2007).

The split is most developed in some regional authorities in Sweden. Most hospitals in Sweden today get their money from the county councils, with some fixed prospective per case payments and activity contracts, complemented with price or volume ceilings and quality components. County councils negotiate with hospital health care providers and establish financial and activity contracts that are based on e.g. DRG and fee-for-service grounds. Growing voluntary regionalisation of government (Skåne and Gothenburg), and hospitals mergers further reconfigured acute care and limited opportunities for competition. In the 2000's, during the time when national and a majority of local governments were run by Social Democrats, interest in the purchaser-provider split was marginalised (Anell, 2005). More generally, the organizational structures (such as role of political bodies in provision and purchasing) among the county councils are in continuing change. Stenberg (2007) classified counties between high frequently changers (counties that changed governance structure for health care after each election) and still dominant low frequency changers (counties that do not change organizational model often, but do continual changes). The change of political governance structure has effects on organizing structure of purchasers and providers in Sweden. As by today, minorities of the counties /regions apply purchaser-provider models, but these areas anyhow cover approximately half of the Swedish population.

In Denmark, resource allocation through global budgets from county council to hospitals was fixed on negotiations with hospital administrators. Although the counties and municipalities are responsible for providing the majority of health services, they must do so within the targets for health care expenditure agreed at the annual budget negotiation. The negotiation is between Ministry of Health, Ministry of Finance and the county and municipal councils with joint representatives. Since 1993 some counties introduce contracts with hospitals. Later these explicit not binding contracts are widely used in counties. These soft contracts supplemented the global budgets and were intended to raise awareness of the relationship between costs and activity and create incentives to activity, not to introduce competition.

In Norway, the Health Enterprise Act 2002 changed crucially the hospital care system. Hospital ownership was transferred from counties to the central government, and currently there are five Regional Health Enterprises (RHEs) that are reporting to the Ministry of Health and are responsible for delivering health services in their regions. RHEs are then responsible for monitoring costs and quality of services of 33 local health trusts (Magnussen *et al.* 2006). Organizational systems have mainly favored cooperation rather than competition model. However, RHEs devote 2-3% of their budgets to tendering services to private clinics. Health trusts can also, at least in principle, compete with each other. When need of specialized care, patients are allowed to choose self-employed physician instead of hospital outpatient care. The payment for hospitals is through block grants and DRG-prices. The health enterprise are to a certain degree based on a purchaser-division, since the regional authorities purchase health services and the health enterprises provides the specialist health services. But health authorities also own their health enterprises. In addition, they have a contractual relationship with many radiology/laboratory

In Hospital care an increased use of activity based financing (ABF) is a common theme in Nordic countries. Activity based funding started Norway in 1997 when a fraction of the block grants from central governments to county councils were replaced by a matching grants dependent upon the number of patients treated in each DRG group. The share of activity based funding was decided by parliament. By the year 2003 the share of activity based has increased from 35% to 60 %. The regional health authorities are allowed to change the reimbursement rates to their enterprises. For example, the ABF-was decreased from 60% in 2003 to 40 % in the 2004. In Sweden, the introduction purchaser provider split in 1990s increased the role of activity based funding. In the 2000s about half of county councils, payment to both hospitals and primarily care centres are based on global budgets. A smaller group of about five county councils continue to develop per case payment with expenditure ceilings to some hospital services.

During the 2000s activity based has increased mostly in Denmark. In the year 2000 so called 90/10 rule was agreed: in this budget structure 10 percent of the counties funding were to be dependent on activity measures such as DRG and the rest 90% on base budget.

In Finland hospital pricing there has been a trend away from the bed-per-day price towards case-based prices and presently most hospitals use some kind of case-based payment. In 2005, 9 out of 21 hospital districts and 15 out of 42 hospitals used diagnosis-related groups (DRGs). These 9 hospital districts produced about 50% of all specialist services in the country. In these districts 43–75% of total payments are based on DRG. Thus, about 30 % of the expenditure on somatic specialist care in Finland is based on DRG payments (Häkkinen and Linna 2005).

It should be noted that activity based payments methods have different incentive effects. In Denmark and Norway and in Sweden it has been used as a financing method, which may increase productivity and utilisation. The situation is quite different in Finland where the major purpose of hospital pricing systems has been to cover the costs of production and to allocate hospital costs fairly between the municipalities financing the provision of services within a hospital district. The actual prices (for municipalities) for hospital services are based on the total budget and the predicted use of services. If the hospital budget is exceeded, the municipalities must pay the deficit, usually by higher municipal prices for services. In the case of a budgetary surplus, municipal prices can be lowered. Thus the current Finnish hospital pricing system does not create any incentives for improving efficiency.

In all Nordic countries the central government regulates the markets. In Sweden, the special government department, National Board of Health and Welfare, has supervisory function over county councils. Its role includes supervising, monitoring and evaluating developments in all areas of social policy. Its most important duty is to follow up and evaluate the services provided to see if they corresponds the goals laid down by central government. The central government also has the regulatory power in contracts between municipalities and counties: they determine the per diem level that local municipalities must pay to county councils for fully treated disabled and elderly patients. In Finland the state has the weakest regulatory power. Only in few special cases has the Finnish state involved in administrative or organisational questions of health care provision.

The relationship between producer and patient

In Finland everyone has right to health services regardless of ability to pay or place of residence. A referral is needed from health centre or private doctor in order to get an access to the outpatient or

inpatient department of a specialised care hospital. In general, a patient has no possibility to choose a hospital or his doctor when treated in public hospital.

A characteristic of the Swedish health care system is that the patient does not necessarily need a referral to obtain specialist hospital care: the patient can go directly to the hospital without visiting primary services. For inpatient care a referral is quite often needed. Patients are free to choose between health care centre and hospital outpatient departments within the county council. On the other hand, while patients may choose the specialist and the outpatient department in hospital, they cannot choose the level for a treatment. However, these free health care seeking agreements are not regulated by law but it is up to each county council to decide their procedures (Glenngård *et al.* 2005).

In Denmark, GPs act as the gate keepers to hospitals, specialists and physiotherapists. However, for visiting ear, nose and throat specialist as well as ophthalmologist referral not needed. Patients have free choice of hospital and access to GPs and hospital care is free at point of utilisation. A nice nuance is that waiting times with supplement information e.g. on number of operations and average length of stay for different hospitals are announced on the Internet.

In Norway, while it is the responsibility of the RHE to provide health services to all residents of their region, the patient has nevertheless free choice of all public and private hospitals through a GP referral. Again the GP acts as a gatekeeper, since specialised care is not available without referral. The only limitation is that the hospital must have contract with RHE.

Cost-sharing is very moderate in Nordic countries and mainly exercised in primary health care if at all. In Norway, there are no user charges in hospitals for inpatients but for outpatient visits and to private specialists, and in Denmark user charges are mainly for pharmaceuticals. In Finland and Sweden there are user charges also for hospital treatments but those are constrained with ceilings for maximum charges per calendar year and 12 month period, respectively.

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Figure A1 . Financing flows of Hospital care in Denmark (Figure A1 a). Finland (Figure A1 b) Norway before the reform (Figure A1 c) , Norway after the reform (Figure A1 d) and Sweden Figure A1.a Denamrk

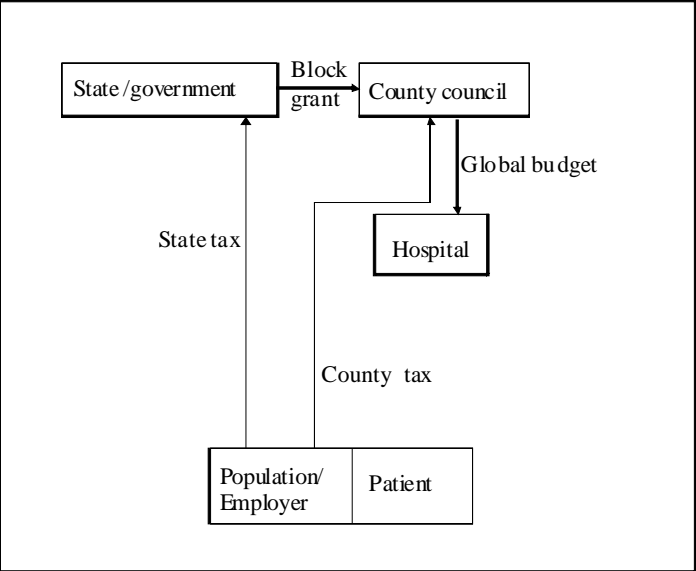
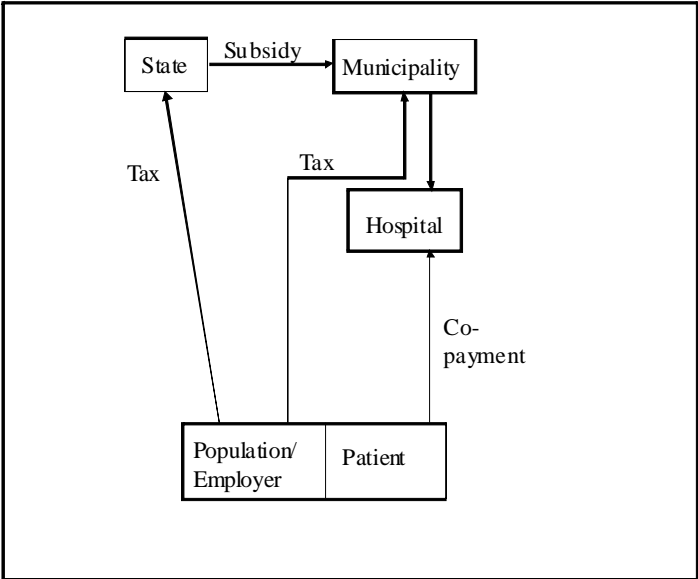
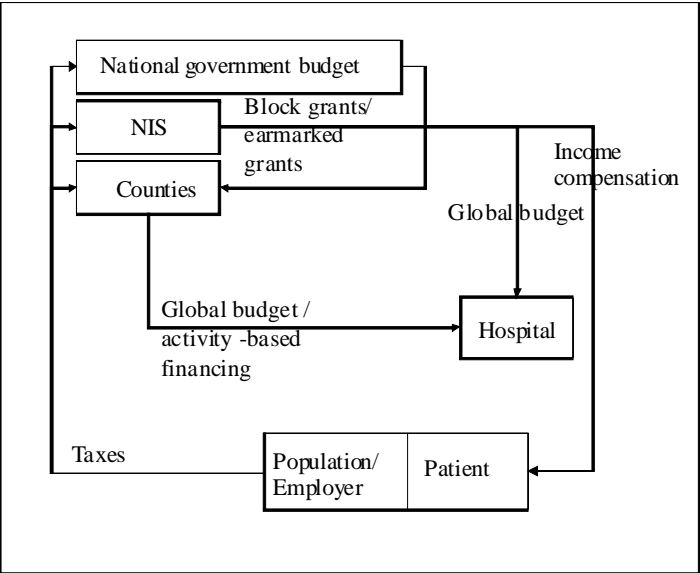


Figure A1.b Finland



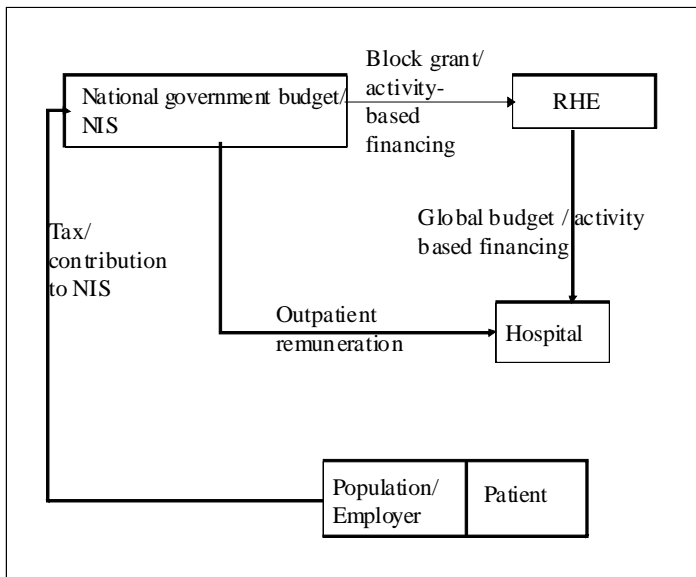
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Figure A1 c Norway before the reform



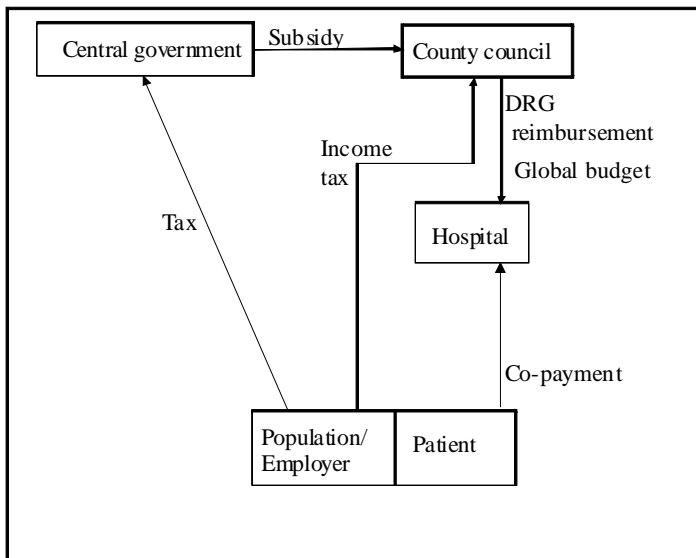
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Figure A1 d Norway after reform



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Figure A1 d. Sweden



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Table A1 Hospital systems in Nordic countries

		Denmark	Finland	Norway Before R	Norway After R	Sweden
Governance	<i>Provider/purchaser</i>	County	Municipality	County	RHE	County
	<i>Number of purchasers/providers</i>	20 (after 1.1.2007 15)	432	19	5	20
	<i>Hospital Ownership</i>	County	Hospital district (federation of municipalities)	County	State	County
Financing	<i>Main source of funds</i>	County	Municipality, Patient fees	County, NIS	State, NIS	County, Patient fees
	<i>Payment method</i>	Global budget	Activity based	Activity based	Activity based	Activity based contracts
Size	<i>Number of acute hospitals</i>	~60	~50	~50	~50	~70

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