THE IMPACT OF MACROECONOMIC CRISSES ON NORDIC HEALTH SYSTEM POLICIES
Denmark, Finland and Sweden 1980-2012

Juhani Lehto,
Karsten Vrangbæk and
Ulrika Winblad
DIVISION OF LABOUR

ANA RICO, PH Researcher, NHI Spain (ex-Prof Health Politics Oslo)

➢ Summary Background & Expenditure
  » Background pp. 1-2
  » IVs & DVs pp. 1-4
  » Theory pp. 5-7
  » Expenditure pp. 8-10

➢ Discussion

JUDITH SMITH, Head of Policy, Nuffield Trust, London

➢ Summary Structural adjustment
  » Deinstitutionalization pp.11-3
  » Privatization? pp.13-4
  » Recentralization pp.14-5
  » Entitlements pp.15-6
  » Discussion pp. 17-9

➢ Discussion
1.1.2 Life expectancy at birth and GDP per capita, 2009 (or nearest year)

Source: OECD Health Data 2011; World Bank and national sources for non-OECD countries.

StatLink: http://dx.doi.org/10.1787/888932523272

1.1.3 Life expectancy at birth and health spending per capita, 2009 (or nearest year)

Source: OECD Health Data 2011; World Bank and national sources for non-OECD countries.

StatLink: http://dx.doi.org/10.1787/888932523291
57.2 Life expectancy at birth and total expenditure on health per person (2008)

Source: OECD Health Data 2010.

StatLink &nbsp; http://dx.doi.org/10.1787/888932391735
RESEARCH QUESTIONS

• “How is health expenditure related to macro-economic fluctuations?”
• “Which institutional mechanisms or conscious policies make health systems behave counter cyclically?” = Why CC policy? + BIAS

❖ Real RQ: Are the Nordics still a (SD) Club?
❖ Relevant RQs: Do SD WS buffer crises? Is CC/PC policy efficient (LAGGED IMPACT)? Why Socialdemocrats cut the WS?
GOOD!

- BUT 1: DIFF from INSTITUTIONALISM (=PS?)
- BUT 2: OMMITS key IVs (WS! EQ!)
- BUT 2: NO DATA on PERF. & VALUES
Figure 1
Direct and Indirect Effects on Reduction in Inequality

Bradley Huber Moller Nielsen Stephens 2003
RESEARCH DESIGN

FOCUS
• Present crisis or previous 25 years?
• On similarities? (assumed?) Vs. EU?
• Supply-side (but key impact is on demand/NEED?)

DV1: TOTAL HC EXP., % PUBLIC
  * DETAILS PER EPISODE, PATIENT, SUBSECTOR

DV2: SELF-ASS. MINOR/MAJOR INST. CHANGES
  * E-A DECOMODIFICATION INDEX → Entitlements, coverage, expenditure, generosity, redistribution

IV: KEY ONES OMITTED OR MISSESPECIFIED
  – Income ineq., taxes & cash transfers → WS & SE →
  – Demand and need for HC
  – Years in office of SD + hold of key ministries

METHOD
- Comparative? 1990s/2010s IntraClub, InterClub
MEASUREMENT: EXAMPLES & GOOD PRACTICE
Exhibit 1. International Comparison of Spending on Health, 1980–2009

Average spending on health per capita ($US PPP)

Total expenditures on health as percent of GDP

Note: PPP = Purchasing power parity—an estimate of the exchange rate required to equalize the purchasing power of different currencies, given the prices of goods and services in the countries concerned.

Source: OECD Health Data 2011 (Nov. 2011).

Squires 2012
Exhibit 5. Hospital Spending per Discharge, 2009
Adjusted for Differences in Cost of Living

<table>
<thead>
<tr>
<th>Country</th>
<th>Dollars</th>
</tr>
</thead>
<tbody>
<tr>
<td>US</td>
<td>18,142</td>
</tr>
<tr>
<td>CAN*</td>
<td>13,483</td>
</tr>
<tr>
<td>NETH</td>
<td>13,244</td>
</tr>
<tr>
<td>DEN</td>
<td>11,112</td>
</tr>
<tr>
<td>SWIZ</td>
<td>10,875</td>
</tr>
<tr>
<td>NOR**</td>
<td>10,441</td>
</tr>
<tr>
<td>SWE</td>
<td>9,870</td>
</tr>
<tr>
<td>AUS*</td>
<td>8,350</td>
</tr>
<tr>
<td>NZ*</td>
<td>7,160</td>
</tr>
<tr>
<td>OECD Median</td>
<td>6,222</td>
</tr>
<tr>
<td>FR</td>
<td>5,204</td>
</tr>
<tr>
<td>GER</td>
<td>5,072</td>
</tr>
</tbody>
</table>

* 2008.
** 2007.
Source: OECD Health Data 2011 (Nov. 2011).

Squires 2012
### Exhibit 11. Quality Indicators in Select OECD Countries, 2009

<table>
<thead>
<tr>
<th>Country</th>
<th>Asthma mortality among ages 5 to 39 per 100,000 population</th>
<th>Diabetes lower extremity amputations per 100,000 population</th>
<th>In-hospital fatality rate within 30 days of admission per 100 patients&lt;sup&gt;c&lt;/sup&gt;</th>
<th>Acute myocardial infarction</th>
<th>Ischemic stroke</th>
<th>Hemorrhagic stroke</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia</td>
<td>0.13</td>
<td>11.0</td>
<td>3.2</td>
<td>5.7</td>
<td>17.2</td>
<td></td>
</tr>
<tr>
<td>Canada</td>
<td>0.17&lt;sup&gt;b&lt;/sup&gt;</td>
<td>9.5</td>
<td>3.9</td>
<td>6.3</td>
<td>20.6</td>
<td></td>
</tr>
<tr>
<td>Denmark</td>
<td>0.08</td>
<td>18.1</td>
<td>2.3</td>
<td>2.6</td>
<td>16.4</td>
<td></td>
</tr>
<tr>
<td>France</td>
<td>—</td>
<td>12.6&lt;sup&gt;b&lt;/sup&gt;</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td></td>
</tr>
<tr>
<td>Germany</td>
<td>0.17&lt;sup&gt;b&lt;/sup&gt;</td>
<td>33.7</td>
<td>6.8</td>
<td>4.0</td>
<td>13.8</td>
<td></td>
</tr>
<tr>
<td>Japan</td>
<td>—</td>
<td>—</td>
<td>9.7&lt;sup&gt;a&lt;/sup&gt;</td>
<td>1.8&lt;sup&gt;a&lt;/sup&gt;</td>
<td>9.7&lt;sup&gt;a&lt;/sup&gt;</td>
<td></td>
</tr>
<tr>
<td>Netherlands</td>
<td>0.09&lt;sup&gt;a&lt;/sup&gt;</td>
<td>12.0&lt;sup&gt;b&lt;/sup&gt;</td>
<td>5.3&lt;sup&gt;b&lt;/sup&gt;</td>
<td>5.7&lt;sup&gt;b&lt;/sup&gt;</td>
<td>22.5&lt;sup&gt;b&lt;/sup&gt;</td>
<td></td>
</tr>
<tr>
<td>New Zealand</td>
<td>0.43&lt;sup&gt;b&lt;/sup&gt;</td>
<td>7.0</td>
<td>3.2</td>
<td>5.4</td>
<td>21.1</td>
<td></td>
</tr>
<tr>
<td>Norway</td>
<td>0.27</td>
<td>9.9</td>
<td>2.6</td>
<td>2.8</td>
<td>11.6</td>
<td></td>
</tr>
<tr>
<td>Sweden</td>
<td>0.01&lt;sup&gt;a&lt;/sup&gt;</td>
<td>5.7</td>
<td>2.9&lt;sup&gt;b&lt;/sup&gt;</td>
<td>3.9&lt;sup&gt;b&lt;/sup&gt;</td>
<td>12.8</td>
<td></td>
</tr>
<tr>
<td>Switzerland</td>
<td>—</td>
<td>7.4&lt;sup&gt;a&lt;/sup&gt;</td>
<td>4.5&lt;sup&gt;a&lt;/sup&gt;</td>
<td>—</td>
<td>14.8&lt;sup&gt;a&lt;/sup&gt;</td>
<td></td>
</tr>
<tr>
<td>United Kingdom</td>
<td>0.27</td>
<td>4.8</td>
<td>5.2</td>
<td>6.8</td>
<td>19.3</td>
<td></td>
</tr>
<tr>
<td>United States</td>
<td>0.40&lt;sup&gt;b&lt;/sup&gt;</td>
<td>32.9&lt;sup&gt;a&lt;/sup&gt;</td>
<td>4.3&lt;sup&gt;a&lt;/sup&gt;</td>
<td>3.0&lt;sup&gt;a&lt;/sup&gt;</td>
<td>21.0&lt;sup&gt;a&lt;/sup&gt;</td>
<td></td>
</tr>
<tr>
<td><strong>OECD Median</strong></td>
<td>0.09</td>
<td>9.9</td>
<td>4.6</td>
<td>4.9</td>
<td>19.3</td>
<td></td>
</tr>
</tbody>
</table>

**Note:** Rates are age–sex standardized.

<sup>a</sup> 2008.

<sup>b</sup> 2007.

<sup>c</sup> Figures do not account for death that occurs outside of the hospital, possibly influencing the ranking for countries, such as the U.S., that have shorter lengths of stay.

Source: OECD Health Data 2011 (Nov. 2011).
Gráfico 1. Relación entre el gasto sanitario y la satisfacción de la población con el sistema (año 2008).

Fuente: elaboración propia a partir de los datos de la OCDE y de la Gallup World Poll 2008

JM Rivera Otero, PhD Thesis 2011
Correction for DIF leads to a... decrease in... people satisfied with `time to wait for treatment` from 20.9% to 17%...; while the... unsatisfied... climbs from 35.5% up to 39.5%... → heterogeneity in reporting overestimate[s]... satisfaction"
Satisfaction by utilization rate in Spain

Gráfico 39. Valoraciones de los servicios sanitarios públicos según el tipo de usuario

JM Rivera Otero, PhD Thesis 2011
The impact of macro-economic crises on Nordic health system policies: 1980-2012

Discussant:
Dr Judith Smith
Head of Policy
The Nuffield Trust, UK

European Health Policy Group
London, 20 September 2012
Overview of paper

• Examines macro-economic crises of a) the late 1980s and early 1990s and b) after 2007

• Considers how Denmark, Finland and Sweden responded to these respective economic recessions

• A particular focus on the response in terms of health policy

• Considers how far such responses are directly related to the economic context

• Examines the role of the wider political context

• Analyses responses in terms of their ‘conservative’ or ‘reformist’ nature
Overview (2)

- Sets out analysis of patterns of public health expenditure
- Considers the response of each health system in relation to structural changes made
  - moving care out of institutional settings
  - privatisation of care provision
  - centralisation of financial and quality control
  - cutting of health entitlements
  - summary of ‘crisis reactions’
Responses by health systems – care settings

- A downward trend in hospital beds over the period, in all three countries
- This is often due to other factors such as reform of model of care (e.g., mental health in the community, older people’s care at home)
- Move to day case and ambulatory care in acute settings
- Associated rise in productivity in the last decade (especially Denmark)
- Also seen a rise in number of doctors and senior nurses
- Need to be cautious however – how cost-effective are the new care arrangements?
Responses by health systems: privatisation of care provision

- Privatisation of health care provision is often suggested as an option at a time of financial constraint.
- Some move towards more private provision of primary and long-term elderly care (Sweden and Finland).
- Elderly home care services in Denmark also increasingly privately provided.
- Some Swedish regions actively encouraging greater use of private provision.
- In earlier economic crisis, private provision in Finland fell – people less willing to pay, and state preferred to halt private contracts rather than lose state employees.
- Private provision increased again in Finland when economy grew.
Responses by health systems: centralisation of control

- These three countries have been trying to decentralise power and management control to regions and municipalities, since the 1970s
- However, a tendency to strengthen national level control at the economic level: national standards, guidelines and quality control (Sweden and Finland)
- Tougher approach adopted in Denmark in budget negotiations between government and the regions/municipalities – expenditure targets and levels of local taxes
- This central control tightened in latest recession
- Increased use of budget control systems using DRG measures (all 3 countries) – various incentive schemes
- Trend towards larger municipal and regional authorities
Responses by health systems: cutting of health entitlements

- Finland’s debate has been about cuts in supply and availability of services
- Productivity targets for Danish hospitals
- Swedish county councils use differing reimbursement methods
- In decentralised (or all?) systems, effects on service availability of budget cuts is quite hard to measure
- Changes to coverage of older people for home care services, waiting lists for some procedures – sort of mechanisms used
- Trend to reduce public share of health funding and increase private contributions – drugs, dentistry, older people’s care
- Legal rights to health coverage largely unchanged – often clarified further (Finland and Denmark)
Overview of Nordic experience

- The three countries seem to be getting through the recent crisis more easily than in the 1990s
- Less unemployment, stable tax income, low levels of public debt
- More moderate responses this time round – is this possible due to what was done in the 1980s and 1990s?
- Common approaches this time:
  - restricting wage increases
  - increase in some co-payments
  - curtailing capital schemes
  - focus on control of management costs
  - continuing to move elderly care out of hospitals
  - cuts in staffing of national bodies
Points for discussion

• Changes such as community care for older people are not a function of economic crises (technology, drugs, societal views)

• Some evidence that crises present an opportunity for ‘creative destruction’ of old and ineffective organisations and care

• After the crisis, space for new providers and care models to be developed, as expenditure grows again

• It seems that these countries were better prepared for the current crisis – what exactly was it that helped them?

• The recent crisis has accelerated changes that were already in train – carrying on with what was started in the 1990s
Points for discussion (2)

• What are the specific health policy lessons that were learned by Finland, Sweden and Denmark in the 1990s?
• What would be your ‘top tips’ for policy makers in other European countries now?
• To what extent do national or Scandinavian culture and politics play a part in this story of measured response and adjustment?
• Could you mention briefly what has happened with other public services, e.g. education? Is health special in any way?
• And a brief summary (in boxes?) of each country, its system and funding, and ‘crisis stories’ would be helpful