
Financing of Health Care in the Nordic Countries



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Preface

At the plenary session in June 2010, Nomesco decided that the 2012 theme in "Health Statistics in the Nordic Countries" should be the financing of health care in the Nordic countries with a focus on similarities and differences in the countries' various ways of financing health care. Sweden assumed responsibility for the project, and the authors have together with the Nordic reference group unearthed the base of the present report.

Chapter 1 gives a short presentation of the health care systems in the Nordic countries with a focus on organization, responsibility and legislation. In Chapter 2, the international system of health accounts is described, and Chapter 3 provides a description of the expenditure development of the health care sector in 2000-2010. In the main chapter of the report, Chapter 4, the financing of the health care sector in the Nordic countries is described on the basis of the health accounts principles. In Chapter 5, the Nordic reforms as to freedom of choice are presented. Chapter 6 deals with diagnosis-related groups (secondary patient classification). The report is completed by a chapter on factors that may influence future financing of health care with a view to the fact that the need for health care is expected to increase over time.

The purpose of this theme is to provide an overview of the financing of health care. The thematic reports also aim at developing and improving Nomesco's annual statistics.

The economic data in the report derive from national sources in the Nordic countries but above all from the OECD Health database which among other things provides information on the financing of health care in accordance with the system of health accounts. Data from the OECD Health database were at the time of writing only available to 2010 implying that it is not yet possible to see whether or not the financial crisis has affected the operation and financing of the health care system.

Chapter 1

Health Care Systems in the Nordic Countries

Introduction

The health care systems in the Nordic countries are basically alike. They are to a large extent financed and produced by Central Government, but the share of private health professionals has increased in recent years. Comprehensive reforms have been implemented in recent years to improve productivity and effectiveness in the health care sectors.

Legislation, organization and responsibility for health care are further described in Chapter 1, Organization of health services, in the main publication (Health Statistics in the Nordic Countries).

1.1 Health care in Denmark

The Danish health care system includes institutions and activities performed under both public and private providers. Their common trait is that they aim at curing and preventing illness and at improving the health of the Danish population.

Legislation and the Structural Reform in 2007

In the current Danish Health Act that entered into force on 16 June 2005, a number of tasks was in connection with the structural reform (1 January 2007) transferred from the counties to the newly established regions. The Health Act lays down who is responsible for treatment, prevention and health-improving measures in the Danish health care system. The purpose of the Act is to ensure that all citizens with a health insurance card have equal access to the health care system; that treatment is of a high quality; that patients are free to choose health provider and that waiting times are as short as possible. The Act does not specify how short waiting times should be. The Act also provides entitlement to reimbursement of certain medicine costs.

In connection with the structural reform, also called the municipal reform, the number of municipalities was reduced from 271 to 98 and the 13 counties were replaced by five regions. The reform also resulted in a reorganization of the expenditure of the health care system. The five popularly elected regional authorities are responsible for a large part of the hospital care sector and the primary healthcare sector, while municipal authorities are responsible for preventive care and rehabilitation.

Regional health care

The regions are responsible for access to hospital care for all inhabitants in the region and emergency care to everyone staying in the region. They are also responsible for the primary health care sector. Each region provides hospital care in that region and when needed also in other regions or by agreement with private hospitals, primarily specialized hospitals.

By way of the extended option of choosing medical professionals, all patients are entitled to care in a private hospital paid by the public authorities in case when care cannot be provided within 30 days. The waiting time is calculated from the time when the hospital has received notification from the responsible doctor.

Municipal health care

The municipal authorities are responsible for health-promoting and preventive health care; rehabilitation; birth control; child health care; child dental care; treatment of substance abusers; general rehabilitation and home nursing. The municipal authorities are also responsible for the main part of the social services sector, such as housing for the elderly with a responsible nurse and 24-hour-staff available and support to people with reduced capacities. The municipal authorities must also finance the regional hospital care for their inhabitants.

More often than not, the municipalities produce the care for which they are responsible, but they also buy care from private entrepreneurs. Some kinds of care are also bought from the regions, such as rehabilitating care and some institutional care for people with reduced capacities.

Health care in the Faroe Islands

Everyone resident in the Faroe Islands is according to law obliged to be a member of a sickness insurance fund in order to get access to general health care. Everyone over 18 years pays a membership fee to the sickness insurance fund. The tasks of the sickness insurance funds comprise reimbursement of payments for medical visits, such as visits to specialists; dental treatment; retraining and chiropractic treatment; reimbursement of medicine costs; glasses; bandages; transport and funeral support. In the Faroe Islands, medical treatment is carried out by independent practitioners (municipal doctors) and also some statutory tasks such as inoculations and health checks of children and pregnant women. In the Faroe Islands, there are independent dentists.

Health care in Greenland

The Greenlandic home rule assumed responsibility for health care from the Danish State on 1 January 1992. In the Greenlandic legislation (Inatsisartut Act no 27 of 18 November 2010), the responsibility for health care was taken over by the Landsstyre (Naalakkersuisut). In Greenland, the Department of Health is responsible for the actual running of health care at the Queen Ingrid Hospital and in the five health care

regions. The entire health care sector, including dental care, home nursing, etc., is gathered under one and the same administration. There is no private care sector in Greenland, with the exception of independent dentists in Nuuk.

1.2 Health Care in Finland

The primary purpose of the Finnish health policy is to sustain and improve the inhabitants' mental and physical health. The system is based on preventive health care and a well-functioning health care system. Everyone who is registered/ living in Finland is entitled to health care of a good quality within fixed time frames.

Legislation

Central Government's responsibility for advancing welfare, health and safety is deeply rooted in the Finnish constitution (731/1999), which entitles everyone residing in Finland to health care even if they are unable to pay for it. Central Government reimburses the municipalities financially for planning the care for which they are responsible according to law.

The legislation governing primary health care (66/1972 the Public Health Act) and specialized care (1062/1989 the Act on Specialized Medical Care) lays down which kind of health care the municipalities must provide for their inhabitants. Furthermore, there are special laws governing occupational health care (1382/2001 the Occupational Health Care Act), psychiatric care (1116/1990), birth control and treatment of contagious diseases (786/1986) as well as patient rights (785/1992).

The new Health Care Act (1326/2010) that entered into force on 1 May 2011 is a combination of the Primary Health Care Act (66/1972) and the Act on Specialized Medical Care (1062/1989). The new Act is adapted to the municipal governments' health care. One of the purposes of the Act was to improve the operating conditions for primary health care and to increase the collaboration among the actors in the health care system.

Specialized medical care - health care districts

Public health care is divided into specialized health care which is organized by the health care districts and primary health care which is organized by the health care centres. Each health care district consists of a hospital and specialized clinics/units. The hospitals provide specialized in- and out-patient health care. Diseases requiring highly specialized treatment are dealt with by the regional health care units or at the central level in accordance with special legislation.

Municipal primary health care

Each municipality forms part of a health care district. The municipality can run the health care centre on its own or together with other municipalities. Municipalities can also buy health care services from private health care providers.

The municipal health care centres provide medical treatment; dental treatment; basic health care; preventive health care; maternal and child health care; school and student health care as well as in-patient primary health care and ambulance transport. The health centres also provide occupational health care for which the employer is responsible. Apart from at the health care centres, preventive health care is also carried out at children's clinics; school health care; student health care and occupational health care. Another task of the health care centres is to follow the public health situation in the municipality and to monitor health aspects in all municipal enterprises together with Social Services.

Municipal collaboration

Municipal collaboration is a permanent collaboration introduced in connection with the municipal reform in 1993. Municipalities working jointly in a health care district are responsible within their area for the harmonization within the specialized health care in line with the needs of the inhabitants and the primary health care. The collaborating municipality must also provide the health care centres in its area with such specialized health care services that it is not expedient for the primary health care sector to produce. The collaborating municipality must in cooperation with the municipality responsible for the primary health care plan and exchange the specialized health care so that the primary health care and the specialized health care form a functional whole. In cooperation with the primary health care sector, the specialized health care must be provided in an expedient way.

Employers

Employers are responsible for providing their employees with preventive health care and if possible also with basic health treatment.

Private health care

Private health care is provided as a supplement to public health care. A number of private actors in the health care field provide their services in the private market only. The majority of the private providers of health care are located in Southern Finland and in the largest towns. The most common services in private health care are medical and dental treatment; occupational health care; medical rehabilitation and laboratory services. The share of private health professionals and organizations of social and health care has increased continuously in the past decade.

Health care on Åland

According to the The Act on Provinces on Health Care (60/1993), *Landskapslagen om hälso- och sjukvård*, it is the health care service of Åland (ÅHS) that is responsible for the public health care on Åland. The operations differ from those of the rest of Finland in that both primary health care and specialist care are administered by the same organization, which implies that the municipalities of Åland are not responsible

for the primary health care service. Some types of highly specialized health care services are purchased in both Finland and Sweden.

1.3 Health Care in Iceland

Central Government is responsible for legislation, supervision and guidelines and has the overall responsibility for ensuring that all inhabitants have access to the best possible health care services.

Legislation

The Icelandic Health Services Act (No. 40/2007) and the Act on the Rights of Patients (No. 74/1997) entitles all citizens to the best possible health care to protect their mental, physical and social health. The legislation lays down the organization of health care and how it should be divided between the health Centre's and the hospitals. The legislation divides the country into seven health regions.

The Ministry of Welfare (Velferðarráðuneytið) is responsible for the administration and formulation of policies on health, social security and social issues. The Directorate of Health has the overall responsibility for the supervision of the health care institutions; health care personnel; regulations concerning medical products; combating substance abuse as well as managing all public health care services. The Directorate of Health also gathers and adapts data on health and health care. Public health and preventive health care are also parts of the responsibility of the Directorate of Health.

The Icelandic Medicines Agency (Lyfjastofnun) supervises medicines and medical devices. Pharmacies are run by private entrepreneurs and are governed by the Medicinal Products Act (No. 93/1994). Central Government governs the work of the pharmacies and also medicine prices in respect of both pharmacies and consumers. The municipal authorities decide the location of the local pharmacies.

All citizens who have resided legally in the country for at least six months are, irrespective of nationality, automatically covered by the Icelandic health insurance system. The Icelandic Health Insurance (Sjúkratryggingar) Íslands administers health insurance and industrial injury insurance according to the Act on Health Insurance (Act No. 112/2008) (Lög um sjúkratryggingar) and the Act on Social Security (Act No. 100/2007(Lög um almannatryggingar)).

Specialized medical care

Specialist treatment is mainly supplied by private care providers working on contracts with the Icelandic Health Insurance. Specialized out-patient treatment is also carried out at hospitals. There are essentially three different kinds of hospitals: specialist hospitals, regional hospitals and local hospitals. Local hospitals often contain nursing homes and long-term care wards. Most nursing homes are run as independent institutions by the municipal authorities and voluntary organizations. Hospitals providing rehabilitation and clinics for treatment of substance abuse are private in-

stitutions partly financed by Central Government. Most private health care providers have contracts with the national Health Insurance and receive patients with or without referral. Private specialists are most often found in the towns but they also visit the health centres in the less densely populated areas.

Primary health care

The health centres are responsible for primary health care, preventive health care and treatment of common illnesses. Preventive health care includes maternal and child health care; school health care; immunization and family planning. The health centres are also responsible for home nursing, while home help is part of the municipal care scheme. The first contact with health care should take place at the health centres. No referral is usually necessary for treatment in the primary health care sector for visits to a specialist; dentist; emergency ward or for ambulance transport. Dental treatment is performed by private dentists. Physiotherapy is partly performed at health centres and first and foremost by private physiotherapists in the towns.

Employers

According to law, employers are responsible for the occupational health care. In large work places, it is performed by private doctors, enterprises or health care centres.

1.4 Health Care in Norway

Central Government is responsible for the promotion of public welfare and health and for the provision of treatment to everyone on equal terms irrespective of income.

Legislation

As a result of the Norwegian hospital reform in 2002, the public hospitals are now the property of the State. The Norwegian Central Government is responsible for legislation, running and financing of the hospitals and specialist health care services. Specialist health care includes specialist care at hospitals; psychiatric care institutions; treatment of substance abusers; ambulance transport and private specialists on contracts. Specialist health care is governed by the Specialist Health Service Act. The municipalities are responsible for the primary health care sector, including health care for the elderly and people with reduced capacities, governed by the Municipal Health Services Act. Apart from the treatment performed by the above mentioned doctors, the municipalities are free to decide their level of service and also to prioritize the various tasks.

Specialized health care at four regional health providers

Norway is divided into health regions where four regional health authorities (administrative units), owned by the state. Each of these administrative units is in turn divid-

ed into legally independent health trusts for which they have ownership responsibilities. Even though these health trusts are the main producers of health services in the region, the so-called provider responsibility lies with the administrative units. This responsibility can be met either by internal production (i.e. in the respective health region) or through purchases from the other three health regions, private health care providers or abroad.

Central Government supplies the regional health authorities with a global budget so they can meet the political health goals for the specialist health care. In 2008, a new system was introduced for the distribution of grants between the four health regions¹. Each region is allocated an index for the calculation of the resource need. This resource index is used in combination with each region's share of the Norwegian population, thus providing a key for distributing the global budget.

Municipal health care service

The municipalities are responsible for organizing and financing primary health care services, such as the Regular General Practitioner Scheme (RGP); nursing homes, home nursing and practical assistance at home; public physiotherapy; maternal and child health care, etc. Since the transfer of hospital ownership to the Central Government in 2002, municipal expenditure is largely related to health care for the elderly as well as for people with reduced capacities (long-term nursing care, LTC). Between 5 and 10 per cent of the long-term nursing care in the municipalities are bought from private providers.

In 2001, the Regular General Practitioner (RGP) Scheme was introduced. The purpose of the RGP Scheme was to improve the quality of the primary health care service and the population's access to health care. The RGP Scheme entitles all inhabitants residing in Norway to choose a regular general practitioner. The majority of the RGPs are self-employed persons, who enter into a contractual agreement with the municipal authorities. An RGP's list cannot exceed 2 500 patients. 98.5 per cent of the population has registered with an RGP². For each patient on the list, the RGP receives NOK 386 from the municipal authorities³. This per capita component is meant to account for 30 per cent of the RGP's income. The remaining 70 per cent is to be generated from consultation fees, partly user charges, partly charges payable by the National Insurance Scheme.

1.5 Health Care in Sweden

In the Swedish health care system, the responsibility for health care is divided among Central Government, the counties and the municipalities. Central Government has

¹ NOU 2008:2 Distribution of incomes among regional health providers to the Ministry of Health and Care Services

² Evaluation of the GP reform 2001-2005, Summary and analysis of the part-projects of the evaluation (Research Council of Norway)

³ Per 1 July 2011

the overall responsibility for the health care policies. The counties and the municipalities have far-reaching autonomy implying that they can adapt their operations to local and regional conditions. The operations are for the most part financed by regional and municipal taxes. Each county, region and municipality decides how large the tax burden should be and how it should be allocated.

Legislation

According to the Health Care Act (1982:763, HSL), the overall objective of health care in Sweden is to provide good health and treatment on equal terms to the entire population. According to the HSL, treatment should be provided with respect to the equality of everyone and to the dignity of the individual. Those most in need of health care should be given priority. The law also requires that care should be provided with a high degree of patient safety and be of a good quality and that the quality should be improved and ensured systematically and continuously. Health care should be based on transparent priorities and be cost effective. It should also be democratically managed and give citizens influence on all important decisions. The Health Care Act is a responsibility law, which means that society is responsible for ensuring that its citizens are provided with good health care services. On the other hand, patients lack the formal right to request care.

Specialized health care and primary health care

Twenty counties, including the four regions, are the main responsible for the health care and the independent development of it as regards both primary health care and specialized health care within the framework laid down by the Swedish Parliament. The mandatory tasks of the counties/regions are to administer health care according to the Health Care Act, both in respects of in-patient and out-patient treatment as well as dental treatment for people up to 20 years of age.

The municipal health care service

In Sweden, there are 290 municipalities that are responsible for most of the local community services. The municipalities are legally obliged to provide some of the services, but other services are voluntary. Among the municipalities' mandatory tasks is the provision of care and welfare for the elderly and people with reduced capacities as well as some degree of health care according to §18 of the Health Care Act. Each municipality must provide good health care services to those living in special residential housing⁴ for both elderly and people with reduced capacities under both public and private manage-

⁴ People living in special housing refers to individually needs-tested accommodation provided with support under the Social Service Act or the Act Concerning Support and Service for Persons with Certain Functional Impairments. In Sweden, special housing is the common name for several different forms of accommodation that are adapted to the elderly and people with reduced capacities with extensive needs for care. Such accommodation forms differ in the various municipalities

ment. Health care must also be provided to people living in special service housing, staying in short-term care units or in day care units⁵ and sheltered work places⁶.

A municipality may also, upon agreement with the county council, assume full or part responsibility for home nursing of people living in ordinary housing. The county council is responsible for and in charge of all medical measures. Most of all the municipalities in the country have entered into agreements about to assume responsibility for the home nursing service for people living in ordinary housing. The extent of the municipal authorities' assumption of the home nursing service for people living in ordinary housing varies, however. Quite a few municipalities have only assumed responsibility for some parts of the home nursing service for people living in ordinary housing.

⁵ Daily function according to the Social Service Act, SoL

⁶ Daily function according to the Act Concerning Support and Service for Persons with Certain Functional Impairments (LSS)

Chapter 2

The System of Health Accounts (SHA)

The financial information in the present report is based on the international system of health account. The system of health accounts is according to the OECD manual, A System of Health Accounts (SHA, version 1.0), developed in order to enable comparisons among countries with different health care service systems. Now also the EU/Eurostat and the WHO participate in the work of developing and maintaining the system of health accounts. The three international organizations have carried out a revision of the manual of the health accounts (SHA, version 2011) which will be implemented in the member states in the years to come. The three international organizations also work on a harmonization of definitions in the international health statistics and have applied joint questionnaires for the gathering of information on the economy of the health care service and its function.

The health accounts for the health care service measure the total expenditure on health care and are based on established international classifications for the functions of the health care service, providers and financing agents, ICHA⁷ The health accounts are designed on the basis of three dimensions that are consistent with the classifications for the objectives/functions of the health care service (ICHA-HC), the financing agents of the health care (ICHA-HF) and providers of the health care (ICHA-HP). The three classifications are in turn divided into several levels, which can be seen from the appendices.

The three dimensions are based on the questions:

- Which types of services are provided and which ones are purchased in health care? (ICHA-HC)
- How is the health care service financed? (ICHA-HF)
- Who are the health care service providers? (ICHA-HP)

All expenditure on health care is presented in relation to these dimensions and can be combined in various ways to describe different aspects of the health care service expenditure. The health care service expenditure also includes health-related ex-

⁷ ICHA International Classification for Health Accounts

penditure on social welfare in relation to the elderly as well as measures aimed at people with reduced capacities. It has been discussed in the international organizations and also in the respective member states where the boundary is drawn between health care and health-related expenditure and social welfare expenditure. The international organizations have decided that apart from the expenditure on health care, also ADL activities⁸ that are part of the care for the elderly and the disabled should be included in the health accounts as an expenditure on health care. That implies that in at least in respect of Sweden and Iceland the part of the expenditure for care for the elderly and people with reduced capacities that concerns ADL activities should be included in the health accounts.

2.1 SHA in the Nordic Countries

All Nordic countries report their health care expenditure in accordance with the manual for health accounts, SHA 1.0. Denmark introduced the health account system in 2003 and started reporting according to the SHA as from 2003. Finland began reporting according to the SHA manual in 2006 and has revised its accounts from 1995. Iceland introduced the health account system in 2008 and has reported expenditure according to the SHA since 2003. Norway published its first health accounts according to SHA in 2005, with time series covering data from 1997. Sweden introduced the health account system in 2008 and has reported according to the SHA, with time series covering data from 2001.

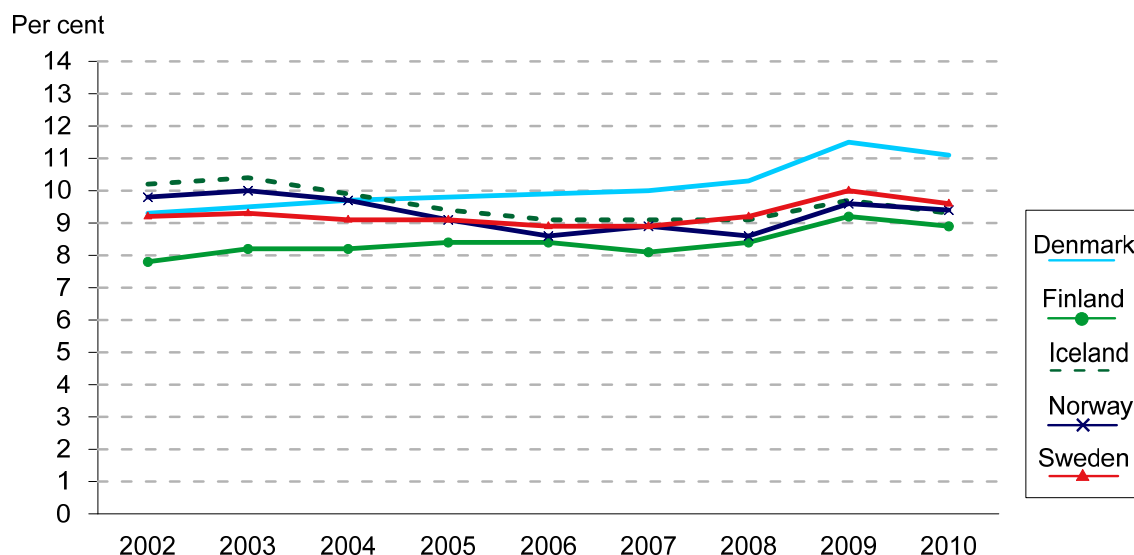
⁸ ADL, Activity of Daily Living

Chapter 3

Health Care Expenditure Development in the Nordic Countries 2000-2010

The health care expenditure as a share of the gross domestic product (GDP) in the Nordic countries varies from 8,9 to 11,1 per cent of GDP in 2010. Denmark has the highest share of health care expenditure of GDP, while Finland has the lowest share. The development since 2000 differs from one country to the next. The shares of the health care expenditure of GDP in Denmark and Finland have continued to increase until 2009. Iceland, Norway and Sweden had increasing shares until 2003 after which they declined until 2006. Since 2006, the share of GDP of the health care has increased even in those three countries. But in 2010 the share of GDP of the health care declined in all the Nordic countries (Figure 3.1).

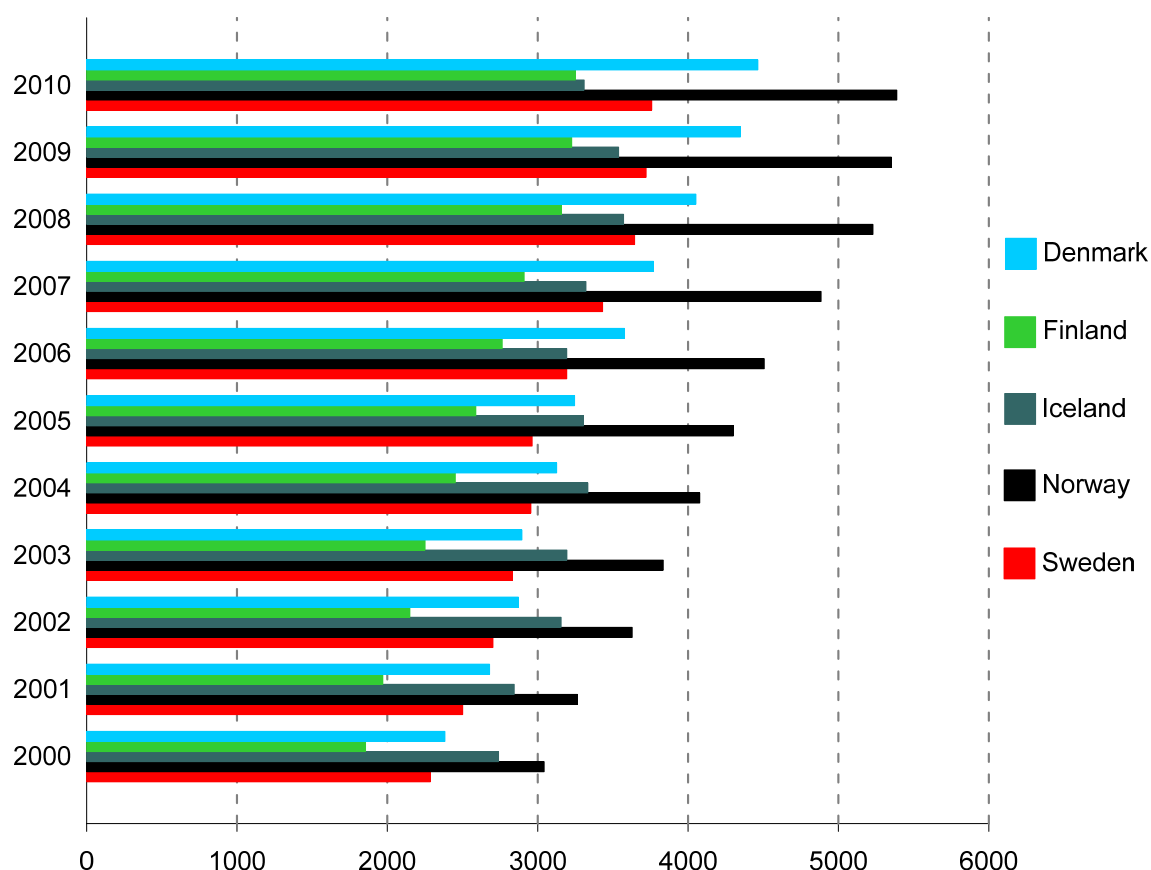
Figure 3.1 ICHA-HC - Total expenditure on health as a share of GDP in the Nordic countries 2000-2010, per cent



Source: OECD Health Data 2013

If one looks at the health care expenditure per capita in 2010 adjusted by the purchasing power parity (PPP)⁹ Norway shows the highest expenditure at USD 5 388 per capita. Denmark comes second at USD 4 464 per capita. Sweden has a health care expenditure per capita with USD 3 758, and Iceland USD 3 309 per capita. Finland has also here the lowest expenditure per capita at USD 3 251 (Figure 3.2).

Figure 3.2 Total expenditure on health per capita in the Nordic countries 2000-2010, USD, purchasing power parity, PPP¹⁰



Source: OECD Health Data 2013

There are big differences between the Nordic countries in how much the countries spend on Long-term nursing care (LTC) for elderly and persons with disabilities. While Norway and Denmark devote approximately one fourth of total health expenditure to health related long-term nursing care (LTC), Sweden's share is 7 per cent (see figures

⁹ Purchasing power parity (PPP) is a measure used in economics in order to compare price levels of goods and services in different countries. PPP is used to calculate the exchange rate used in order for countries with different currencies to have the same purchasing power. By using the PPP, price differences in the various countries are thus taken into account

¹⁰ The PPP Purchasing power parity aims at measuring price differences among comparable goods and services from one country to the next

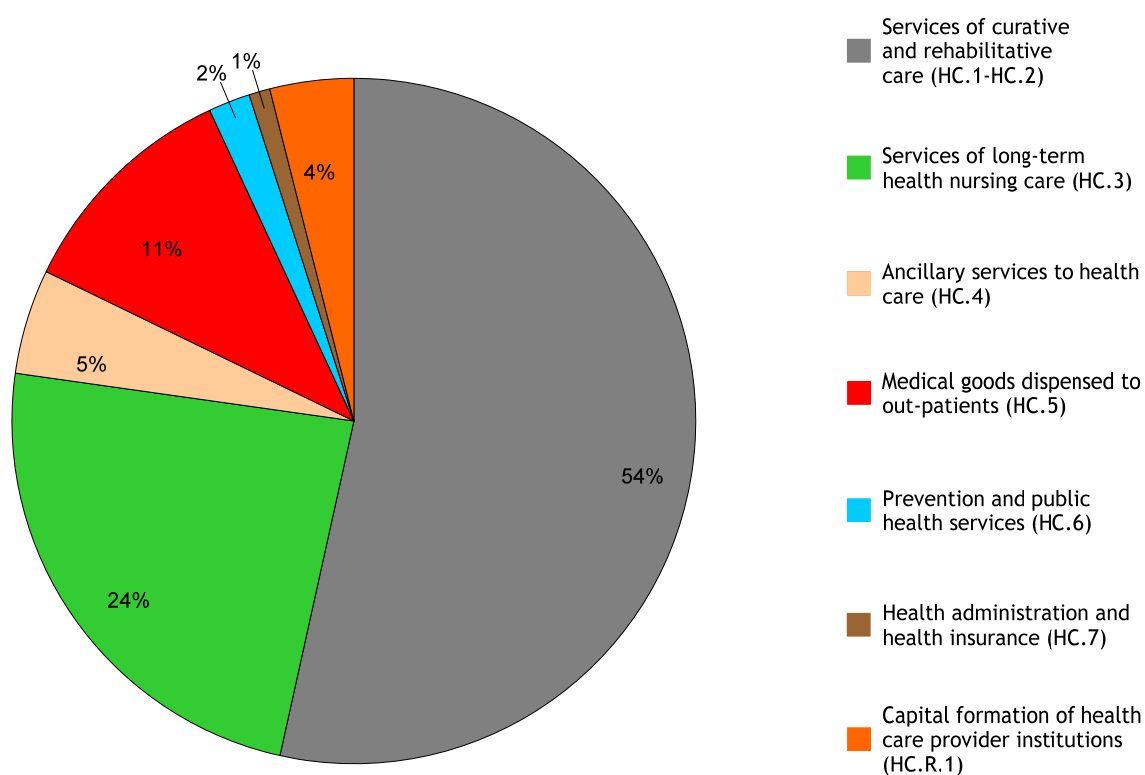
3.3, 3.8 and 3.9). LTC comprises health expenditure and personal care expenditure so-called ADL, i.e. activities of daily living, for the elderly and people with reduced capacities. Both Norway and Denmark include services for personal care and nursing, when calculating LTC expenditure. In 2010 LTC expenditure corresponded to USD PPP 1 497 per capita in Norway, and USD 1 051 PPP per capita in Denmark. The corresponding expenditure for Sweden amounts to USD 268 PPP per capita. In the Swedish health accounts, the item Long-term care (LTC) includes only such health care costs that are classified as health care in the Swedish Health Care Act and which are related to care for the elderly and the disabled. The same applies to Iceland. Only expenditure that is related to health care excluding the disability care services that are included in the SHA report from Iceland under the item Long-term care (LTC), corresponding to USD 594 PPP per capita. In Finland, the expenditure on health care for the elderly and the disabled, including ADL activities, amounts to USD 346 PPP per capita. These differences are mainly a result of the countries' different interpretations of what the concept health care includes. But the differences can also be ascribed to an actual difference in how the countries prioritize. When the new SHA manual 2011 will be implemented ADL activities will be included in the all Nordic countries.

3.1 The Expenditure Development in Denmark

The total health care expenditure in Denmark amounted in 2010 to DKK billion 195 billion corresponding to about 11,1 per cent of GDP. In the years 2000-2010, the total Danish health care expenditure increased by DKK 82 billion in current prices corresponding to an increase of 73 per cent. After a reduction of the share of the health care of GDP in the middle of the 1990s, the share of the health care of GDP has now increased continuously from 2000. GDP has increased by 2.8 percentage points from 2000. The share of the Danish health care expenditure of GDP has increased more than the increase in percentages of GDP. This increase is partly due to Central Government having put priority to health care which has resulted in a steep increase in the consumption of health care, also in relation to the augmentation of the total public consumption. In total, Denmark spent USD 4 464 PPP per person on health care.

When looking closer at what the increased health expenditure has been spent on, it appears that the expenditure is evenly distributed on the entire health care sector. In general, the Danish health care expenditure follows the OECD manual on health accounts. The Danish health care expenditure also includes expenditure on ADL activities for the elderly and the disabled (LTC) giving a somewhat higher share of the health care expenditure. Together with Norway, Denmark also has the lowest share of expenditure on medicines at 11 per cent (Figure 3.3).

Figure 3.3 Structure of health expenditure in Denmark, 2010, per cent



Source: OECD Health Data 2013

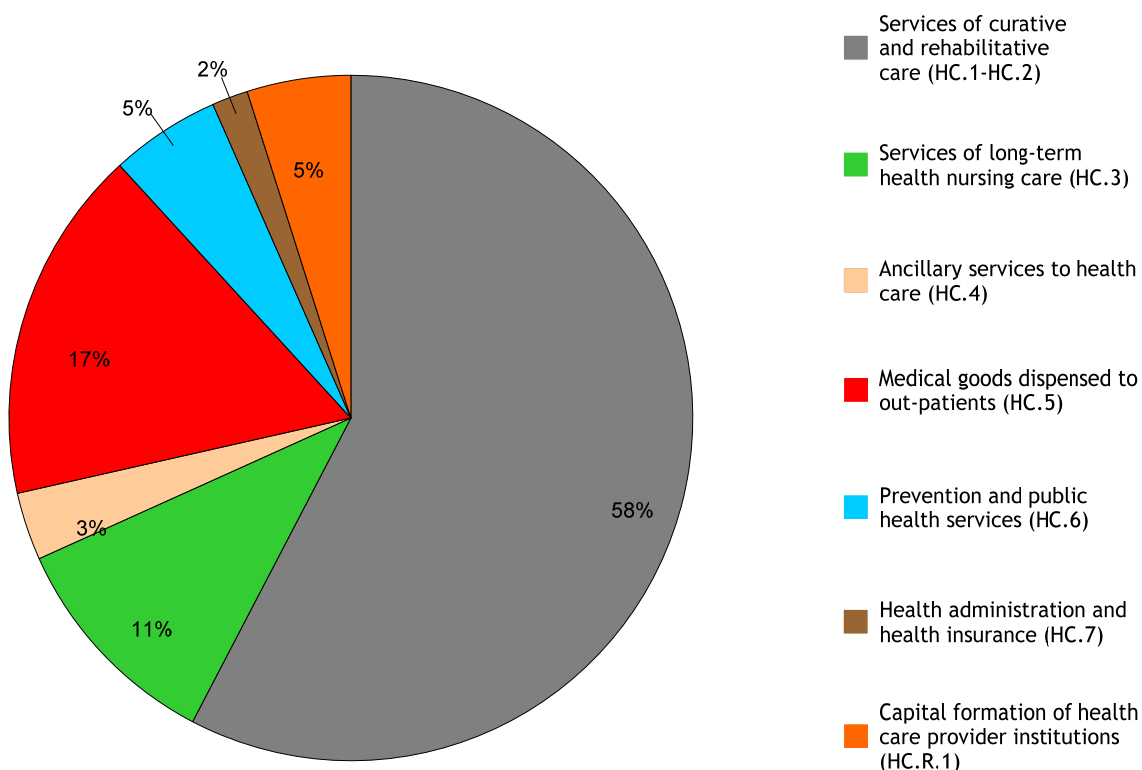
3.2 The Expenditure Development in Finland

In 2010, the Finnish health care expenditure increased to EUR 16,0 billion. The expenditure on health care and its share of GDP increased in 2010 to 8,9 per cent. Between 2008 and 2009 the share of the health care expenditure of GDP increased mainly as a result of a decline in the total Finnish GDP. In comparison with the other Nordic countries, Finland spent a lower share of its GDP on health care.

In total, Finland spent USD 3 251 PPP per person on health care. The health care expenditure per capita has risen in real terms from 2000 to 2010 at about 4 per cent per year.

Figure 3.4 shows how the expenditure is distributed among the various activities/functions in per cent of the total health care expenditure. Curative and rehabilitative care is the largest cost item followed by pharmaceutical costs and costs for health care in the disability care sector. Finland has the largest share of preventive health care expenditure compared with the other Nordic countries.

Figure 3.4 Structure of health expenditure in Finland 2010, per cent



Source: OECD Health Data 2013

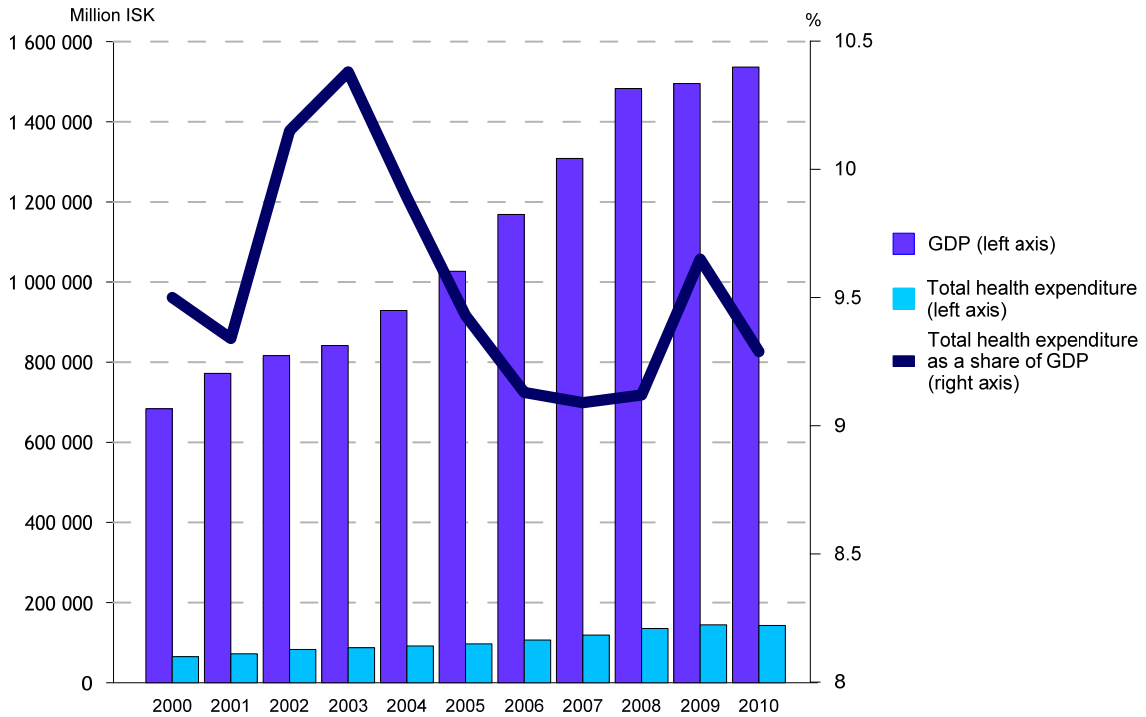
The in-patient expenditure increased in Finland over a period of ten years by 3.4 per cent annually. As regards out-patient treatment, the expenditure increased in that same period by 5.0 per cent. The total public expenditure on health care in the LTC increased to 2.2 per cent of GDP. This level is about the same as the one in Norway and in Denmark. Pharmaceuticals increased by 3.3 per cent. In 2009, the expenditure on pharmaceuticals amounted to USD 452 PPP per capita.

3.3 The Expenditure Development in Iceland

The total health care expenditure in Iceland was 9.3 per cent of GDP and increased to ISK 143 billion. The increase of GDP from 2008 to 2009 was only 1.1 per cent at current prices, or converted into fixed prices a reduction of 6.7 per cent. That explains why GDP increased so drastically in relation to the total health care expenditure in 2008 and 2009. The same applied in 2002 in relation to 2003 when the average increase of GDP from 2000 to 2008 was approximately 10.2 per cent at current prices. At the same time, the total health care expenditure increased by 15 per cent. Figure 3.5 shows the trend at current prices.

The total investments in health care in 2009 increased to 1.7 per cent of the total health care expenditure, corresponding to ISK 2.5 billion. Public investments increased to ISK 1.6 billion, while the private investments increased to ISK 0.9 billion.

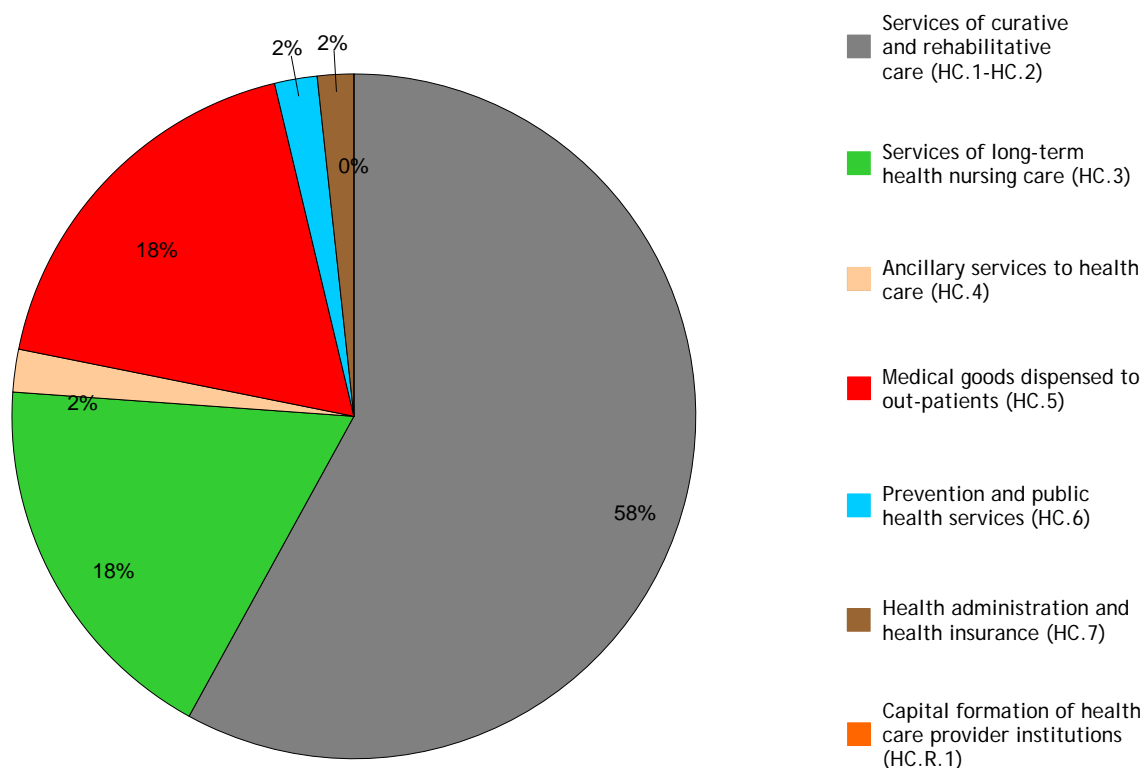
Figure 3.5 GDP and total health care expenditure as share of GDP in Iceland 2000-2010, Million ISK, per cent



Source: National Accounts in Iceland and OECD Health Data 2013

Figure 3.6 shows the distribution in percentages of the total health care expenditure in Iceland in 2010. Curative and rehabilitative care which in total accounted for 58 per cent of the health care expenditure made up the largest part. Expenditure on health care for the elderly and on pharmaceuticals each accounted for 18 per cent. Investments are not shown separately in the figure, but are included in the respective functions.

Figure 3.6 Structure of health care expenditure in Iceland 2010, per cent

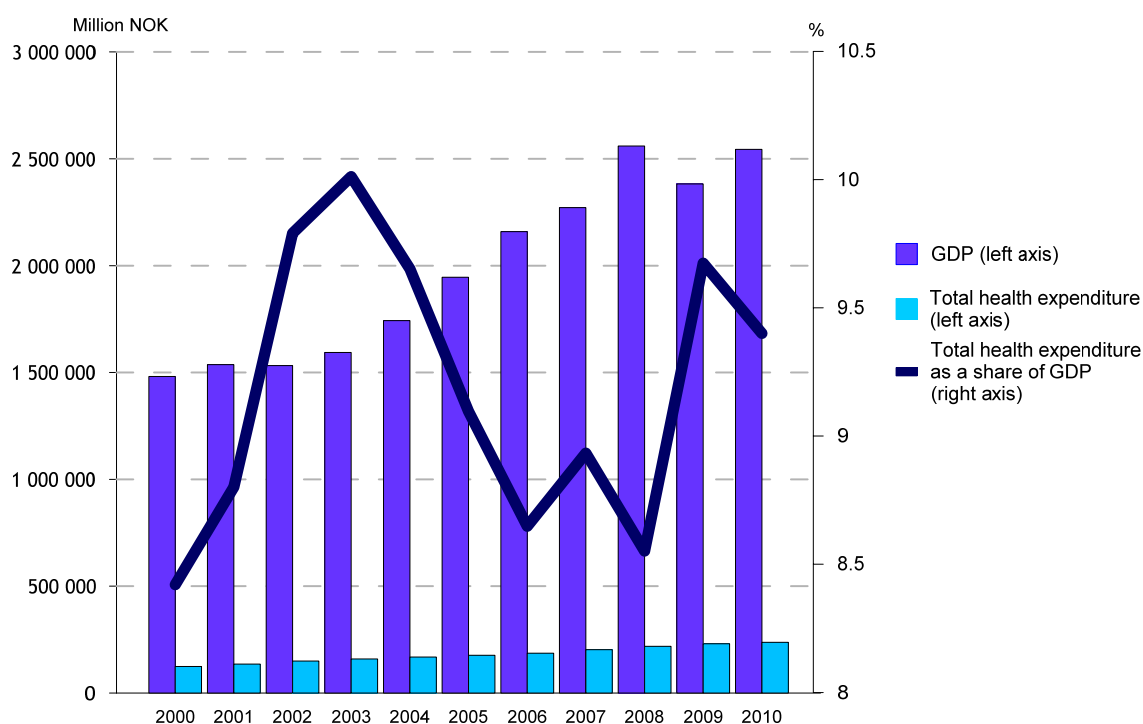


Source: OECD Health Data 2013

3.4 The Expenditure Development in Norway

The total health care expenditure increased continuously from NOK 125 billion in 2000 to NOK 238 billion in 2010. This means that the average increase per year was 8 per cent. Adjusted for inflation/price increases, the average increase was 5 per cent per year. In Figure 3.7, the total health care expenditure is compared with GDP and the share of the total health care expenditure of GDP.

Figure 3.7 Total health care expenditure, GDP and total health care expenditure as a share of GDP in Norway 2000-2010. Current prices, million NOK, per cent

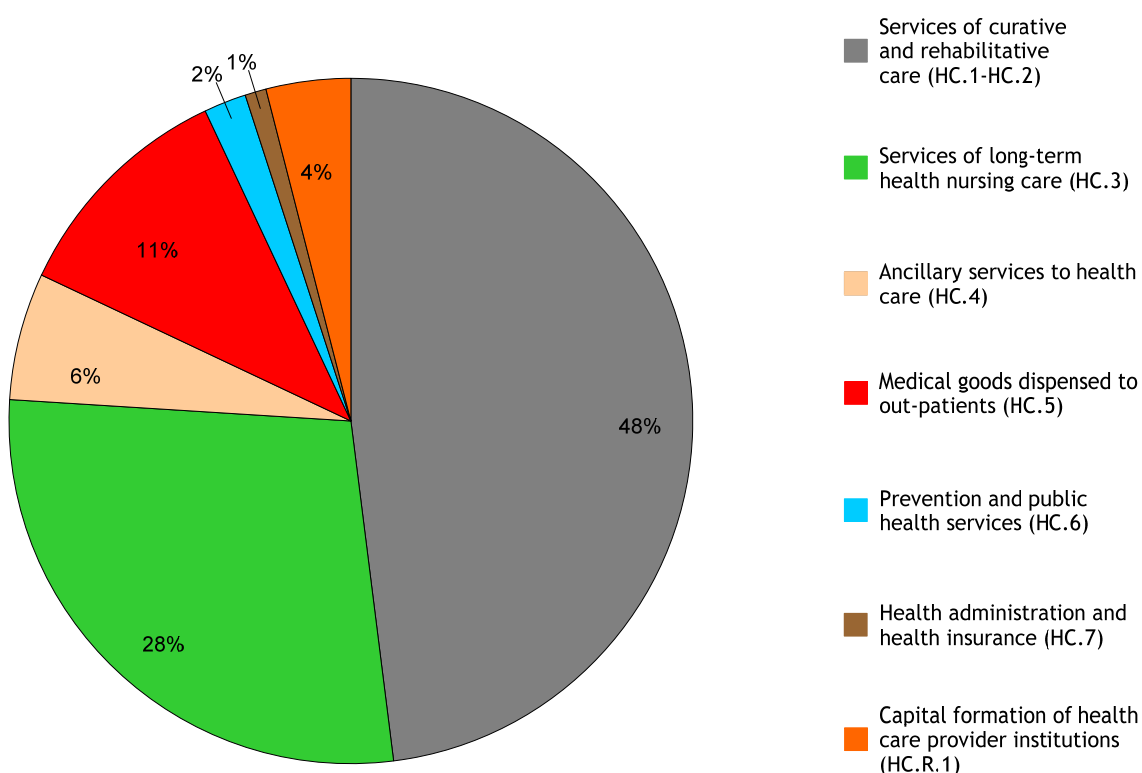


Source: Statistics Norway and OECD Health Data 2013

The relatively low growth rate of GDP from 2000 to 2004 is largely a result of low oil prices which leads to the share of the health care expenditure of GDP increasing from 8.5 per cent to 10 per cent. Since 2004, GDP has increased relatively more than the health care expenditure, and health care expenditure as a share of GDP decreased again to 9.4 per cent in 2010.

The distribution of the health care expenditure on functions has been relatively stable (Figure 3.8). The most significant change is the increase in the expenditure on hospital care and health care for the elderly and people with reduced capacities as well as patient transport. The most significant difference in respect of Norway and Denmark is that health care and nursing for the elderly and people with reduced capacities makes up a larger part of the total health care expenditure compared to Finland, Iceland and Sweden. The Norwegian and Danish health care expenditure includes costs for ADL activities. The share of the pharmaceutical expenditure is low in comparison with the other Nordic countries.

Figure 3.8 Structure of health care expenditure in Norway 2010, per cent



Source: OECD Health Data 2013

3.5 The Expenditure Development in Sweden

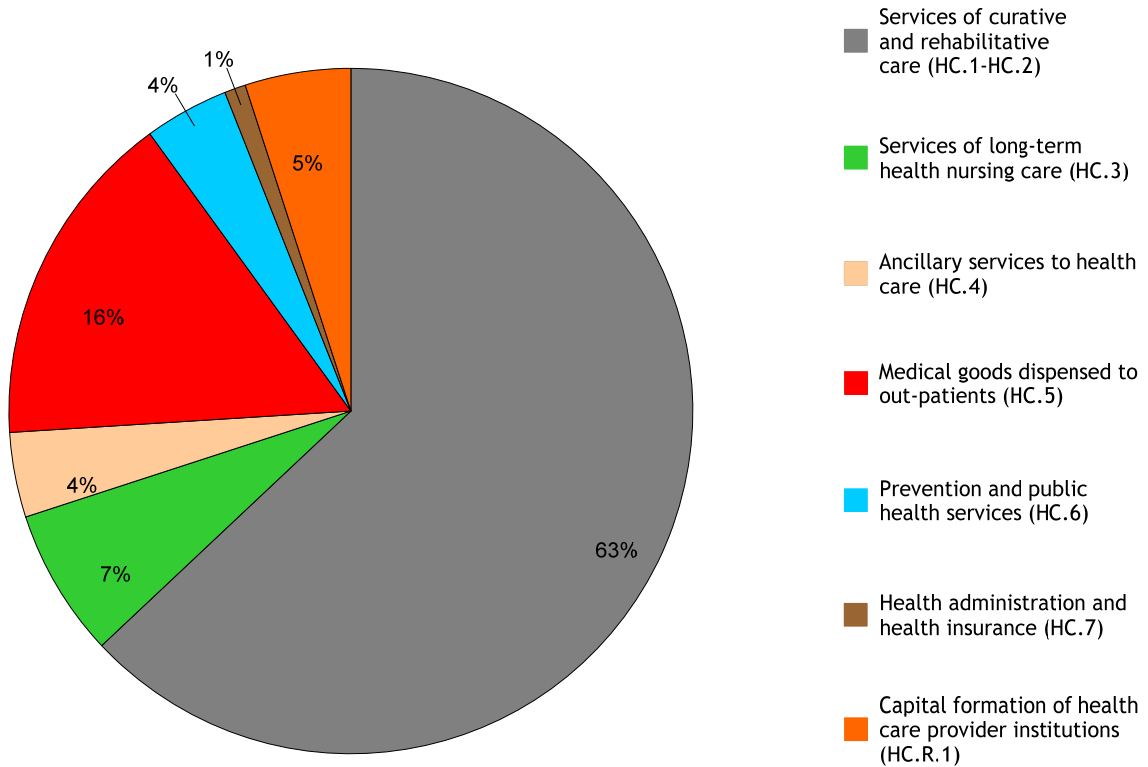
The total health care expenditure in Sweden in 2010 including municipal health care increased to SEK 318 billion. The share of the health care of GDP increased from 8.2 per cent in 2000 to 9,6 per cent in 2010. Between 2001 and 2010, the total Swedish health care expenditure increased by SEK billion110,2 billion at current prices, corresponding to an increase of 53 per cent. In fixed prices¹¹ the increase in that period was approximately 20 per cent. Ancillary services in the health care sector such as laboratories, diagnostic imaging and patient transport as well as curative and rehabilitative home nursing increased the most. The expenditure on administration hardly increased at all.

Figure 3.9 shows how the expenditures are distributed on the various activities/functions in per cent of the total health care expenditure. Curative and rehabilitative care is the largest cost item at 63 per cent of the health care expenditure.

¹¹ Fixed prices implies that the money value is kept constant in the calculations and comparisons of economic conditions at different points in time

Compared with the other Nordic countries, Sweden has the lowest share of expenditure on health care for the elderly and the disabled (LTC) at 7 per cent, as no expenditure on ADL activities is included in the Swedish health care expenditure.

Figure 3.9 Structure of health care expenditure in Sweden, 2010, per cent



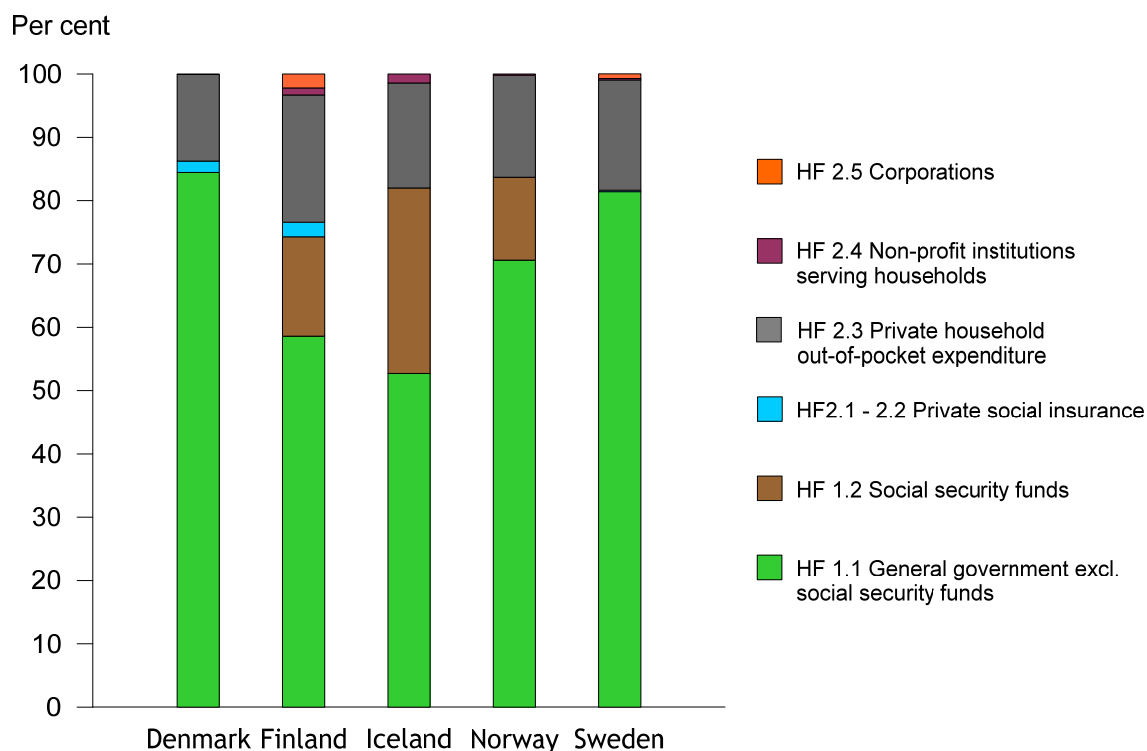
Source: OECD Health Data 2013

Chapter 4

Health Care Financing in the Nordic Countries 2000-2010

Health care is financed in different ways in the Nordic countries. The public financing from Central Government, provincial government and local government makes up the largest part of the financing in all the Nordic countries. Iceland excels by having no less than 29.3 per cent financed by the social security funds. The private out-of-pocket payments make up from 20.2 per cent in Finland to 13.7 per cent in Denmark of the health care expenditure. In Iceland the out-of-pocket payments amount to 18,2 per cent, in Sweden 17,7 per cent and in Norway the, out-of-pocket payments amount to 14,5 per cent. Non-profit organisations finance a very small part of the health care services in the Nordic countries (Figure 4.1).

Figure 4.1 Health care expenditure by financing agent in the Nordic countries, 2010, per cent



Source: OECD Health Data 2013¹²

As the Nordic countries have large public sectors that finance health care, it is interesting to look at the different types of financing agents. In Table 4.1, General Government expenditure (excluding social security funds) has been broken down into Central Government, provincial government and local government. The expenditure has also been broken down into social security funds that are to be considered as public financing agents. There are significant differences among the Nordic countries. Sweden has the largest share with 71.6 per cent of public expenditure on health care that is financed by the regional level (county councils), while Finland has the largest share with 35.1 per cent financed by the local level (municipal authorities). Denmark at 55.2 per cent and Iceland at 50.4 per cent are the countries where Central Government finances the largest share of the health care expenditure. In Finland and Iceland, health care is also to a high degree financed by social security funds, at 14.6 and 29.3 per cent, respectively. Also in Norway, part of the health care services is financed by social security funds.

¹² Norway 2007 figures

Table 4.1 Total health care expenditure by type of public financing agent in the Nordic countries 2010, per cent

| Financing Agent/ Country | HF.1 Public sector | HF1.1: Public sector excl. social security funds | HF1.1.1 Central Govern- ern- ment | HF 1.1.2 Provincial government | HF 1.1.3 Local government | HF 1.2 Social security funds |
|-----------------------------|--------------------------|---|---|--------------------------------------|------------------------------|---------------------------------------|
| Denmark | 85,1 | 85,1 | 55,2* | | 26,0* | |
| Finland | 74,5 | 60,0 | 24,9 | | 35,1 | 14,6 |
| Iceland | 80,4 | 51,1 | 50,4 | | 0,7 | 29,3 |
| Norway | 85,5 | 73,8 | 41,6* | 0,8* | 29,9* | 11,7 |
| Sweden | 81,0 | 81,0 | 1,8 | 71,6 | 7,6 | |

* 2009 for Denmark, and Norway

Source: OECD Health Data 2013 and national System of Health Accounts

4.1 Public Financing - Central Government, Provincial Government and Local Government (HF1.1)

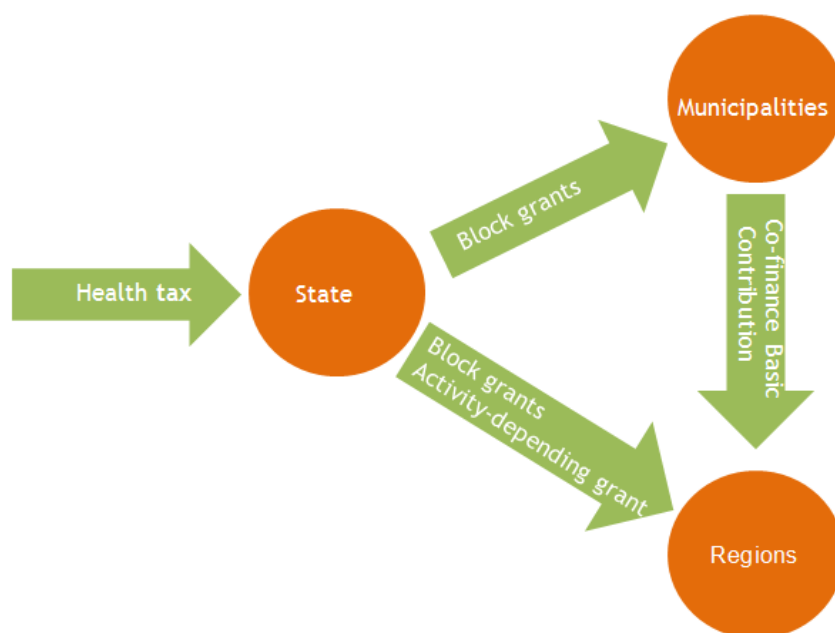
Denmark

85 per cent of the Danish health care expenditure is publicly financed. The remaining 15 per cent of the health care expenditure originate from the private sector, of which 88 per cent encompass patient charges payable for dental treatment and pharmaceutical products.

The distribution between publicly and privately financed treatments has remained relatively stable from 2000 to 2009, but from 2009, the share of the private sector of the health care expenditure declined from 16.9 per cent in 2000 to 15.5 per cent in 2009, i.e. a reduction of 1.4 percentage points.

Unlike the former counties (amterna), the regions are not entitled to levy taxes, so the majority of the financing is made by means of general block grants from Central Government. Such block grants cover about 75 per cent of the regional expenditure on health care. Besides, the regions may be granted earmarked block grants of maximum 5 per cent for specific purposes. The remaining part of the financing of the health care expenditure is payable by municipal authorities depending partly on the type of activity and partly on the size of the population (Figure 4.2).

Figure 4.2 Financing cash flow in the Danish health care system



Source: The Ministry of Health and Prevention

The Danish financial agreements

Each year, the Danish government and the municipal parties (Local Government Denmark and Danish Regions) agree on the overall economy in the so-called financial agreement. The financial agreement is the name for the cooperation between Government and municipalities. The financial agreement lays down the total activity level in municipalities and regions for the coming budgetary year as well as how it should be financed. The basis for the financial agreement is a responsibility distribution in relation to the tasks. The Government and the Danish Parliament (Folketinget) lay down the overall legislation and rules and the overall economic framework for the entire country, while the municipalities and regions are responsible for the actual execution of the tasks and the economy in the individual municipalities and regions. The regions are required to provide free and equal access to hospital care as well as a free and extended choice of hospital. Individual regions and municipalities can within the legal and financial framework adapt their activities to local needs.

Greenland

The financing of the health care expenditure in Greenland is made entirely by tax revenue and government grants from the Danish State. Health care and pharmaceutical products are free of charge. In 2009, the total expenditure for health care in Greenland amounted to 8.6 per cent of GDP.

Faroe Islands

Medical treatment and medically prescribed home nursing are free of charge. Children are entitled to public health care free of charge. School health care is also free of charge. Pregnant women are offered preventive examinations by the doctor and the midwife and other public health care free of charge. Hospital care is free of charge in the Faroe Islands. In some cases, transport charges in connection with illness may be abolished. People with reduced capacities or long-term reduction due to illness or age may be granted contributions towards payment for medicine if the cost exceeds a certain amount. Dental care for children and youth under 16 years is free of charge. Other people are awarded contributions towards their expenditure on dental care.

Finland

Health care in Finland is mainly financed by state and municipal taxes. The private health care sector is supported by the national sickness insurance system which is part of the Finnish social security system. Everyone registered in the population register and permanently resident in the country is covered by the sickness insurance system.

Central Government lays down the charging policy in respect of both health care and social welfare by way of legislation. The purpose of the charging policy is that charges must never be a hindrance to anyone in need of help. On the other hand, endeavors are made to prevent any unsuitable use of the services. The social, health and nursing services are either free of charge (for example visits to mother and child counseling, health care clinics, laboratory and X-ray services at health centres) or cost the same for all clients/patients. The municipal authorities may decide on lower charges or make services free of charge. The municipal charge must not exceed the production costs for the service in question.

The public financing of health care corresponded in 2010 to 74,5 per cent (EUR 11.9 billion) while the private financing corresponded to 25,3 per cent (EUR 4,1 billion) of which the households' share of the total health care expenditure was 19,3 per cent (EUR 3,1 billion). The part of the public financing of health care that is financed by the municipalities has decreased since the beginning of the 2000s. In spite of the declining trend, the share of the municipalities of the financing was 35,1 per cent in 2010 which is the largest share of the public financing. Central Government's share was in 2010 24,9 per cent and has constantly increased since 2002. The share that is financed by the Social Insurance Institution was 14,6 per cent in 2010.

Åland

On Åland, health care is primarily financed by taxes. State tax, duties and charges on Åland are payable to the Finnish Treasury, and Åland is reimbursed its expenses by way of a return of 0.45 per cent of the state revenue. Åland is free to allocate this sum in its budget. In 2009, the Åland budget totalled EUR 318.5 million, of which 23 per cent went to health care, corresponding to about EUR 72 million. Patient charges

amounted to about EUR 2.7 million and the municipalities' reimbursement for care at long-term care facilities to EUR 3.2 million. The Act on Provinces (Landskapslagen) lays down the basis for charges payable to the health care system of Åland while the individual charges are fixed by the Åland Parliament. In accordance with the Act on Provinces on health care, the municipalities are charged for care at long-term care facilities. Financing of the private health care services is made in the same way as in Finland.

Iceland

The Icelandic health care system is largely financed by the public sector. The public sector (Central Government, municipalities and social security funds) financed 81-83 per cent of the health care expenditure in 2003-2010. In 2010, the share was 80,4 per cent. The State financed 51,1 per cent and the social security funds 29.3 per cent of the health care expenditure. The municipal share of the total health care expenditure is only 0.6 per cent. The rest was privately financed.

The Icelandic Health Insurance administers the Icelandic industrial injury insurance scheme. The health insurance scheme is financed by Central Government. Of the Icelandic health insurance expenditure on health care, medical goods dispensed to out-patients made up approximately 60 per cent of the total expenditure, or ISK 18.4 billion. Expenditure on specialized medical care and dental care amounted to ISK 7.4 billion, corresponding to 24.1 per cent of the total expenditure of the health insurance system.

Norway

Health care in Norway is mainly publically financed. 85,5 per cent of the current health care expenditure is covered by Central Government and the municipalities. The remaining expenditure, 14,5 per cent, is covered by the private sector of which private households' out-of-pocket payments to 99 per cent. The share of the expenditure of the public sector, i.e. both Central Government and the municipalities, was relatively stable between 2000 and 2010. There was a slight increase in the public share from 82 per cent in 2000 to 85,5 per cent in 2010. This is reflected by a decrease by 3,5 percentage points in the share of the private sector

The municipal health care system is partly financed through the national budget by way of general and earmarked contributions and partly through municipal taxes and the patients' out-of-pocket payments. Charges are payable for some services such as care and welfare services, visits with general practitioners and physiotherapists, whereas maternal and child care and school health care are free of charge.

Apart from social security funds, such as the National Insurance Scheme (NIS) and Corporations, all sources of financing have increased between 2000 and 2006. The NIS's expenditure on pharmaceutical products peaked in 2004 at NOK 10 billion up

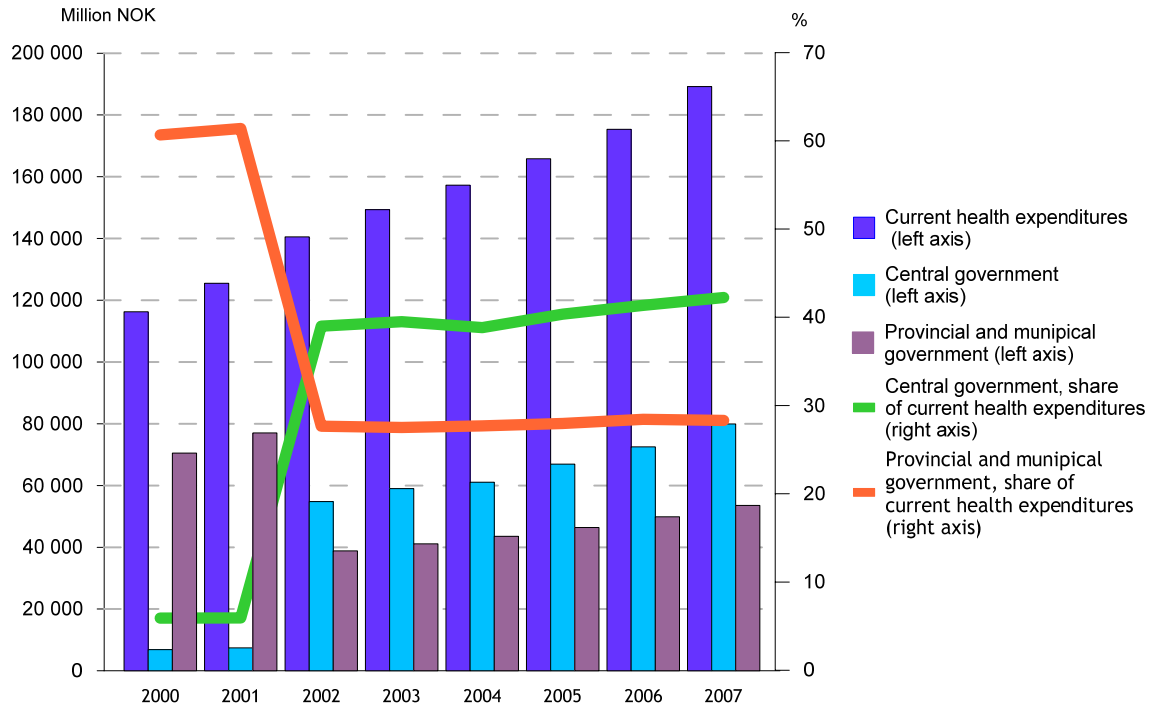
from NOK 7.4 billion in 2000. In 2006, it decreased to NOK 9 billion¹³. This can be explained partly by the transfer of the financing to the regional health authorities of new and often expensive pharmaceutical products, but also by increased consumption of pharmaceuticals due to the competition from generic drugs when the patent has expired, as well as by the Government's price policy. In January 2005 a gradual pricing model was introduced (trinnsprismodellen) for generic drugs. This model reduces the amounts reimbursable by the NIS by as much as 75-80 per cent. According to the Norwegian Medicines Agency, NOK 2.5 billion is saved each year by means of the gradual pricing model.

The hospital reform 2002

In 1997, a system of activity-based financing was introduced in Norway in order to reduce the long waiting times for hospital treatment. It was part of a trend where the public sector gradually increased its control of the specialized health care by increasing the use of regulation, trial projects and Government financing. In 1999, the regional cooperation between the counties became statutory. Finally, in 2002 the ownership of public hospitals was transferred from the counties to Central Government. Private hospitals were not affected by the hospital reform. This transfer of the public sector expenditure, exclusive of social security funds, is clearly shown in Figure 4.3 to lead to an increase. Central Government's share of the current health care expenditure increased from a stable level of about 6 per cent to a new stable level of about 40 per cent, whereas the share of the regional level decreased from 60 per cent to 28 per cent.

¹³ 2009 prices. See Tall og fakta 2010 by The Association of the Pharmaceutical Industry in Norway (LMI)

Figure 4.3 The change of the central and regional health care expenditure, share of current health care expenditure in Norway, 2000-2007



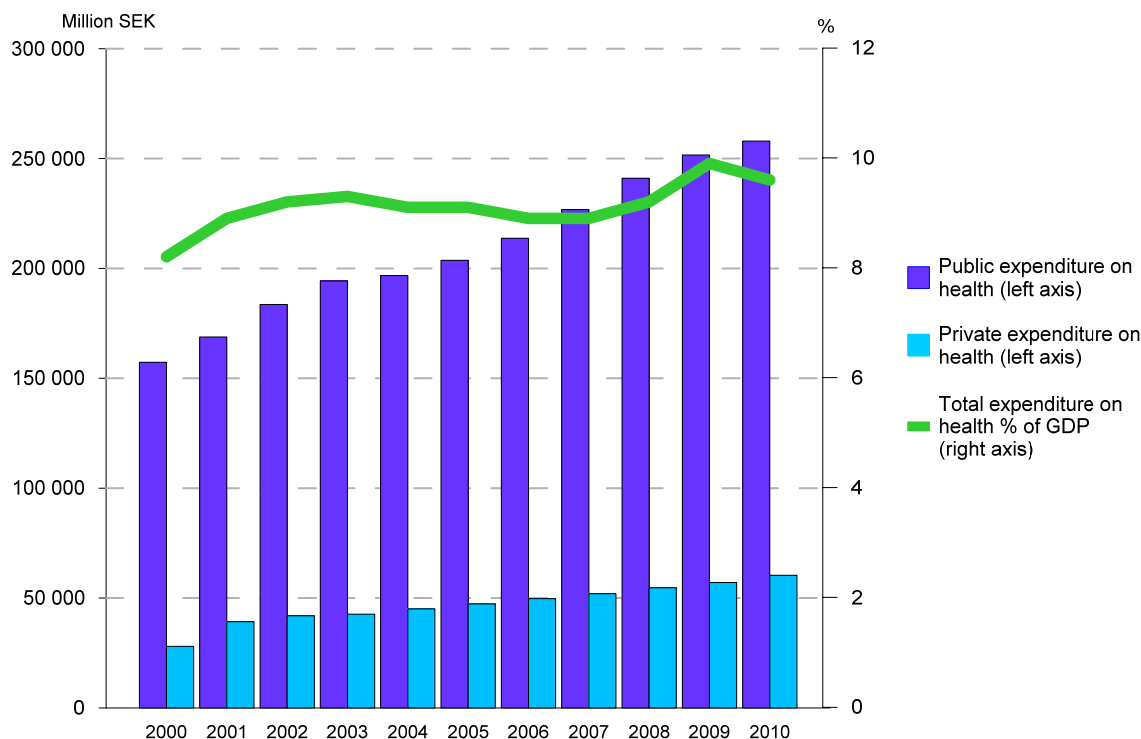
Current health expenditure split between central and regional government. Transfer of ownership of public hospitals in 2002 to Central Government depicted in leap from a 6 per cent to a 40 per cent share of the current health expenditure. ICHA-HF Sources of funding.

Source: Statistics Norway

Sweden

Health care in Sweden is principally financed by taxes. In 2010 71.6 per cent was financed by way of county taxes, 7.6 per cent by way of municipal taxes and 1.8 per cent by Central Government. Private sector financed 18.9 per cent while the private households financed 17.7 per cent. Figure 4.4 shows the development in public and private financing, respectively, of health care and how large a share of GDP is made up by health care. The share of health care of GDP has increased from 2000 to 2010 from 8.2 per cent to 9.6 per cent. Especially after 2007, the share has increased more markedly. The private share of the financing of health care increased by more than 3.8 percentage points from 2000 to 2010.

Figure 4.4 ICHA-HF, Public and private expenditure on health and total expenditure on health as share of GDP in Sweden 2000-2010, Million SEK, per cent



Source: SCB, Swedish health accounts 2012

4.2 Social Security Funds (HF.1.2)

Denmark

In Denmark, there is a public sickness insurance scheme entitling all citizens living in the country to treatment free of charge by a GP, a specialist or at a hospital. The sickness insurance scheme also subsidizes pharmaceuticals; dental treatment; physiotherapy; chiropody; visits with a chiropractor or a psychologist. The insurance scheme is administered by the regions and financed in the same way as the remaining regional health care expenditure by way of government and municipal financing.

Finland

In Finland, there is a mandatory sickness insurance scheme governed by the Sickness Insurance Act (1963)^{14 15}. The sickness insurance scheme is financed by employers' and employees' charges payable to the scheme. The scheme consists partly of income

¹⁴ Sairausvakuutuslaki (1963)

¹⁵ National Health Insurance

insurance to finance daily life, partly of sickness insurance that finances expenditure on health care (medical expenses). The sickness insurance scheme also covers reimbursements of pharmaceuticals. Everyone residing in Finland is covered by the sickness insurance scheme at an individual basis. The Act on Residence-based Social Security¹⁶ defines who is residing in the country and who is consequently entitled to benefits from the sickness insurance scheme. In 2009, the share of the sickness insurance scheme of the health expenditure amounted to about 15 per cent in Finland.

Reimbursement of visits with private medical consultants and dentists is made according to specified rates. On average, 26 per cent of the expenditure on visits to medical consultants and 32 per cent of the expenditure on visits with dentists are reimbursed. The basic reimbursement of medical goods prescribed to out-patients is on average 42 per cent of the expenditure on pharmaceuticals. Patients suffering from severe and long-term illnesses may be granted special reimbursement on pharmaceuticals with 72-100 per cent. In case a patient's pharmaceutical costs exceed to EUR 672.70 in 2010 in a calendar year, the sickness insurance scheme reimburses the entire exceeding amount. Pharmaceuticals provided to in-patients are completely free of charge. They are included in the care charge. The sickness insurance scheme also reimburses part of the expenditure on transport and overnight stays that are made necessary by illness, pregnancy or childbirth.

Employers are by law responsible for providing preventive occupational health care measures for their employees. The sickness insurance scheme reimburses the employers any necessary and reasonable costs for the establishment of occupational health care. Company health care is free of charge for the employers, but employers and employees participate in the financing of the company health care service through their charges payable to the insurance scheme. Costs for statutory preventive occupational health care measures pertain to class 1 at 60 per cent reimbursement, while voluntary visits with general practitioners pertain to class 2 at 50 per cent reimbursement.

Iceland

In Iceland, social insurance, of which health insurance forms part, is financed by the State Treasury. The individual does not pay specific premiums for social protection, but employers pay charges to Central Government on the basis of wage and salary payments. These contributions are used for the financing of the social insurance scheme of which health insurance forms part.

All legal inhabitants in Iceland that have resided more than 6 months in the country automatically become members of the Icelandic health insurance scheme irrespective of nationality, provided no intergovernmental agreements states otherwise. Children younger than 18 years are covered by their parents' health insurance. The Icelandic Health Insurance manages health insurance and industrial injury insurance.

¹⁶ Soveltamisalaki (1993)

Hospitalization is guaranteed according to need, and patients pay nothing for hospital treatment. In special cases, such as treatment of psoriasis, medical assistance at special institutions, care may be payable by the Icelandic health insurance. In case a patient is in need of hospital treatment abroad due to a necessary treatment that is not available at an Icelandic hospital, the Icelandic health insurance scheme defrays the costs for the hospital treatment and also the expenses in connection with convalescence care, such as accommodation, medicine and any necessary medical assistance. In case a patient chooses a more expensive treatment alternative, the health insurance only reimburses the expenses for the care chosen by the insurance scheme.

The Icelandic health insurance covers medical care carried out as out-patient treatment by medical physicians who have concluded contracts with the Ministry. The health insurance also pays 87.5 per cent of unavoidable expenses for transport to a hospital in the country, provided the need for transport is urgent and the patient's health status excludes the use of general means of transport.

Health care in a patient's home due to serious illness or injuries is also payable by the health insurance scheme as well as subsidies towards purchase of nutrients and other special diets for people with reduced physical capacities. The health insurance also pays for training courses or therapy that is made necessary by chronic illness or injuries and also subsidizes the acquisition of technical aids and motor vehicles made for people with reduced physical capacities.

For treatment that is unavailable in Iceland, such as most organ transplants, a patient's physician can apply to the Icelandic health insurance for reimbursement of the expenses for treatment, accommodation and travel to another country for the patient and a companion. As more treatments are now available in the country, the number of treatments payable in other countries has decreased in recent years.

Nursing homes and homes for the elderly are partly financed by charges, but the majority of the financing is made by government funds. Homes for the elderly are often payable by the pension system or by way of the national health insurance where nursing homes are concerned.

Norway

The National Insurance Scheme (NIS) is financed through contributions from employees, self-employed persons and employers, as well as Central Government contributions. The insurance scheme finances government expenditure for pharmaceutical products and medical devices with prior-approved reimbursement dispensed to patients in out-patient treatment, and co-funds out-patient services provided by private practitioners and specialists.

There has been a slight decrease in the share of financing covered by the NIS in the Norwegian health accounts. Its share was around 20 per cent until 2004, after which it has decreased to around 15 per cent. This is largely the result of some responsibilities having been transferred to Central Government, such as the responsibility for

patient transport (2004); part-financing of rehabilitative care; laboratories; diagnostic imaging and financing of new and often expensive pharmaceutical products.

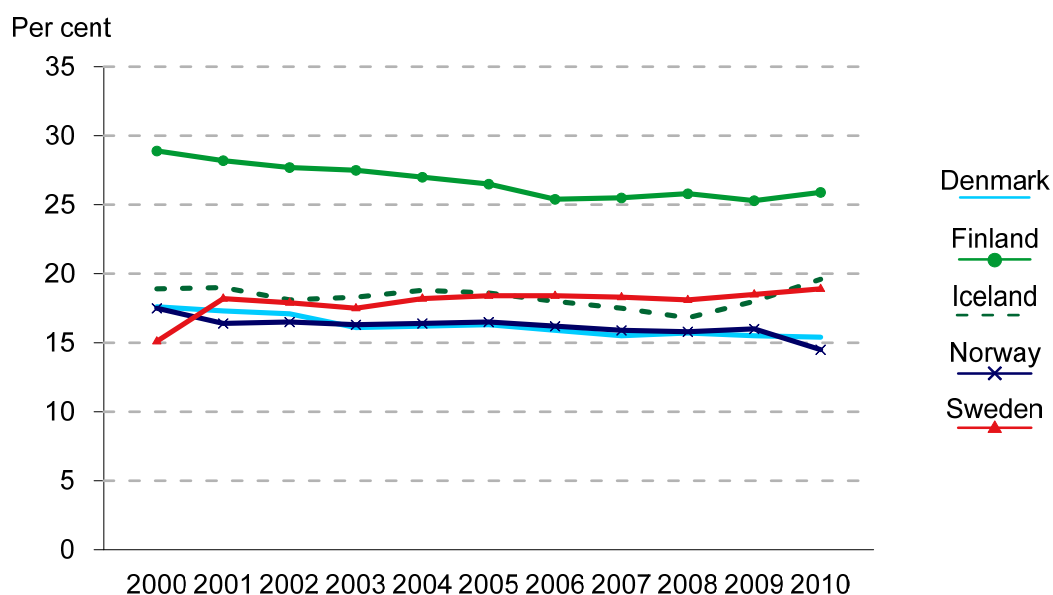
Sweden

In Sweden, financing covering the expenditure on health care does not exist. In Sweden, there is an employer-paid sickness insurance scheme that covers the loss of income in case of illness individually.

4.3 Private Financing - Out-of-Pocket Money (HF 2.3)

There are also large differences among the Nordic countries when it comes to the private share of the total financing of health care. Finland has the largest share of private financing at 25.9 per cent and Norway has the lowest shares at 14,5 per cent. Denmark has a private share of 15.4 per cent while Iceland and Sweden have shares of private financing around 18-19 per cent. The development since 2000 has in respect of Denmark, Finland and Norway tended towards the share of private financing diminishing, while for Iceland and Sweden the level of private financing has increased (Figure 4.5).

Figure 4.5 Private financing as share of total health expenditure in the Nordic countries, 2000-2010 per cent



Source: OECD Health Data 2013

Denmark

Health care is primarily publically financed. 15,4 per cent of the health care expenditure is, however, privately financed, of which approximately 90 per cent are financed by the patients' out-of-pocket money. The majority of these patient pay-

ments consist of payments for dental care (HC.1.3.2 - out-patient dental care); private home care (HC.3.3 - long-term nursing care) and pharmaceuticals (HC.5 - medical goods dispensed to out-patients). No charge is payable in connection with medical visits if one sees the physician with whom one has registered. The amount of pharmaceutical subsidies depends on the extent of the expenditure on pharmaceuticals. The compensation thresholds for medicines are revised annually according to specific rules (rate-adjustment percentage).

Table 4.2 Reimbursement thresholds for medicine per 1 January 2011

| Annual expenditure per person on reimbursable medicine before deduction of reimbursement, DKK | Reimbursements for medicine to people over the age of 18 years, per cent | Reimbursements for medicine to people under the age of 18 years, per cent |
|---|--|---|
| 0 - 865 | 0 | 60 |
| 865 – 1 410 | 50 | 60 |
| 1 410 – 3 045 | 75 | 75 |
| More than 3 045 | 85 | 85 |

Source: Danish Health and Medicines Authority

Apart from the thresholds shown in Table 4.2, reimbursements to chronically ill people with a permanent and documented need may be granted. The reimbursement to the chronically ill is limited to DKK 3 555 in excess of the patient's out-of-pocket money. After an amendment to the law, also private patient charges are payable for treatment concerning artificial insemination, sterilization and refertilisation.

Finland

In Finland, the private share of the financing of the health care expenditure declined at the beginning of the 2000s, but began to increase again in 2006. In 2010, private households financed approximately 20 per cent of the expenditure on health care (about EUR 3 billion). Of the private households' expenditure on health care, patients' out-of-pocket payments accounted for 49.7 per cent, pharmaceuticals and other medical non-durable articles for 33.1 per cent and 17.2 per cent for therapeutic treatment; appliances; travel costs; etc.

The municipalities decide the amount of the patients' out-of-pocket payments, but in practice there are only minor differences from one municipality to the next. The patients' out-of-pocket payments in the municipal health care system were fixed at a maximum of EUR 663 per calendar year in 2011. Charges payable for children under the age of 18 years are included in the legal guardians' expenditure threshold. In the charge threshold, charges for medical treatment carried out at a health centre's out-patient clinic; physiotherapy; day surgery; short-term care at a convalescent facility within the health care system; night or day nursing; rehabilitation and polyclinic charges payable at a hospital. The charge threshold excludes charges payable for dental care; transport in connection with illness; medical certificates and laboratory and screen tests referred by a private physician. The charge threshold also excludes income-related charges or charges for which a patient has been compensated, for

example in the form of income support or by an accident insurance scheme. When the charge threshold has been reached, patients usually get out-patient treatment free of charge. A care charge of no more than EUR 15 is payable for short-term care at a convalescent facility.

Medicine costs have a charge threshold of their own which was EUR 675.39 in 2011. When the charge threshold has been reached, a customer pays no more than EUR 1.50 per pharmaceutical product. The Social Insurance Institution defrays the rest. Patients' expenditure on prescribed medicines is reimbursable. The reimbursement is deducted from the price of the product on purchase. Reimbursement is only payable for necessary products. In order to qualify for reimbursement, the purchase must cover three months' use in the most economic packaging.

There are three different levels of reimbursement:

- Basic level 42 per cent of the price
- Low special level 72 per cent of the price
- High special level 100 per cent of the price

However EUR 3 will always be charged for each product bought at one time.

Åland

Charges payable for health care at Åland are laid down by the Act on Provinces (Landskapslagen). The protection against high costs covers treatment in out-patient and in-patient facilities at different threshold amounts for different age groups per calendar year:

- A maximum of EUR 120 for children under the age of 18 and people drawing sickness pension or having reached the age of 65+ years
- A maximum of EUR 375 for people between 18 and 65 years

Iceland

According to the SHA, the private sector in Iceland consists only of two components: HF.2.3 private household out-of-pocket expenditure and HF.2.4 non-profit institutions serving households (HIO). The private household out-of-pocket expenditure has in recent years increased to about 17-19 per cent of the total expenditure on health care.

Of the total patient charges in 2010, pharmaceuticals accounted for 31 per cent of the charges, dental care for 27 per cent, out-patient care for 23 per cent, specialized medical care for 15 per cent and hospital care for 2 per cent.

The patient charges for out-patient treatment have by and large remained at the same level since 1998 and amounted to approximately ISK 42 000-43 000 per person annually at 2009 prices. The private expenditure on medicines and medical products

increased from 1998 by 40.7 per cent to ISK 38 400 per person at 2009 prices. Of the private expenditure on medicines and medical products, 66.4 per cent consisted of medicines and 33.6 per cent by other medical products and equipment.

Maternal, child and school health care are free of charge. Medical visits with primary health care providers are free of charge for children under the age of 18 years. Reduced charges for visits within the primary health care sector are available to retirement pensioners, people with reduced capacities and the long-term unemployed. For visits within the specialist health care system, patient charges are higher, and also children under 18 years are charged a fee. No charge is payable for children with reduced capacities or chronically ill children. At the out-patient clinics at hospitals, the same charges are payable as for specialist care, but children under 18 years are charged no fee.

High cost protection

Medical care

In the current system of high cost protection, visits with general practitioners or specialists; home visits by a physician; out-patient care at a hospital; emergency care at a hospital; laboratory and x-ray tests are covered. People between 18 and 66 years are reimbursed any costs in excess of ISK 28 000 in one calendar year. For people between 67 and 69 years drawing no or a reduced pension, the threshold is ISK 22 400 and for the 70+-year-olds and for people with reduced capacities, the threshold is ISK 7 000. For children and youth under 18 years, the corresponding amount is ISK 8 100, irrespective of the number of children in the family. When the threshold amount (the cost maximum) has been reached, all or part of the costs are reimbursed for the remainder of the year according to specific rules.

The high cost protection does not, however, cover reimbursement of expenditure on test tube insemination and infertility. These are subject to special reimbursement rules. Treatment by a psychologist who is not connected with an institution is not reimbursable, with the exception of treatment of children under the age of 18 years, nor is optician treatment reimbursable.

Pharmaceuticals

The health insurance reimburses all pharmaceuticals for certain diseases. The patient pays the entire cost for other pharmaceuticals. The reimbursement of the expenditure on pharmaceuticals is calculated according to a reference pricelist. For generic products of the same type, strength and number, a reference price is calculated on the basis of the lowest price for the respective groups of generic products on which the patient's will be reimbursed. The current reference price list covers 24 per cent of registered products.

Dental care

In the Icelandic public dental care system, patient charges are fixed by the Ministry of Welfare in accordance with a national rate. Private dentists fix their own charges. The national dental insurance scheme reimburses the costs for some parts of the treatment for children under 18 years and for adults over the age of 67 years. The dental insurance scheme reimburses 75 per cent of the basic dental care for children under the age of 18 years. People with chronic illnesses, retirement pensioners and disability pensioners are reimbursed at 50, 75 or 100 per cent according to the dental care rate. Gold and porcelain crowns, bridges and various implants may be reimbursed by up to ISK 80 000 per year. The rest of the population is not reimbursed for dental costs, with the exception of treatment due to serious consequences of congenital defects, accidents or illnesses that are covered by the Icelandic health insurance scheme. There is no private dental insurance scheme.

Norway

According to the SHA, the private sector in Norway consists of only two components: HF.2.3 private household out-of-pocket expenditure and HF.2.5 corporations.

Private financing of the health care system consists primarily of out-of-pocket payments for out-patient curative care, particularly dental care, pharmaceuticals and health care in the care sector for the elderly and for people with reduced capacities. Private households' share of total current health care expenditure was approximately 14.5 per cent in 2010.

Prior-approved reimbursement for pharmaceuticals on prescription ("blue prescriptions") is the most comprehensive system in the Norwegian reimbursement system¹⁷. Patients are required to pay 38 per cent of the prescription costs with a cap of NOK 520 per prescription¹⁸. The physician decides whether the patient satisfies the criteria for reimbursement laid down by the Norwegian Medicines Agency (Legemiddelverket).

There are two thresholds for out-of-pocket payments by private households; exemption cards for user fee groups 1 and 2. The exemption card for user fee group 1 covers treatments and medical services from doctors, psychologists; out-patient clinics (hospitals) x-ray institutes; travel in connection with medical examinations and treatments, and pharmaceuticals and medical products available through the "blue prescription" scheme (prior-approved reimbursement). The exemption card for user fee 2 covers examination and treatment by physiotherapists, certain forms of dental diseases, stays at approved rehabilitation clinics and treatments abroad arranged by Oslo University Hospital¹⁹. Once you have received an exemption card you can avoid

¹⁷ Report No. 18 to the Storting (2004-2005) On course towards more correct use of medicine

¹⁸ Per 1 January 2010

¹⁹ A full overview of the different rates for out-of-pocket payments can be found at <http://www.helfo.no/privatperson/egenandeler/Sider/default.aspx>

paying user fees for the remainder of the calendar year. The thresholds are normally price adjusted every year. In 2011 the thresholds were NOK 1880 and NOK 2 560 for user fee group 1 and 2, respectively.

Sweden

The county councils in Sweden decide the charges payable for the various activities. The charge payable in the primary health care sector to general practitioners varies from SEK 100 to SEK 200 per visit. Additional charges are payable for home visits of SEK 0-200 per visit and for prescription per telephone between SEK 0 and SEK 100 per prescription. The charge payable to specialists in out-patient care varies from SEK 230 to SEK 320 per visit, but if the visit to a specialist takes place as per a referral from the primary health care sector, the charge will be between SEK 80 and SEK 300 per referred visit. Charges payable for emergency visits vary from SEK 200 to SEK 300. Almost all county councils have decided that children and youth under the age of 20 years should be exempt from paying charges in the out-patient care sector. As from the 20th birthday, this exemption ends.

The charge payable for in-patient care is in most counties SEK 80 per day of treatment. Some counties have reduced the charge for the elderly over the age of 65 years and patients drawing sickness or activity benefits. In-patient treatment of children and youth until the ages of 18 and 20 years, respectively, is free of charge in all counties. Furthermore, five counties have lower charges after 15, 31 and 91 days of treatment, respectively. There are exceptions for some groups of patients.

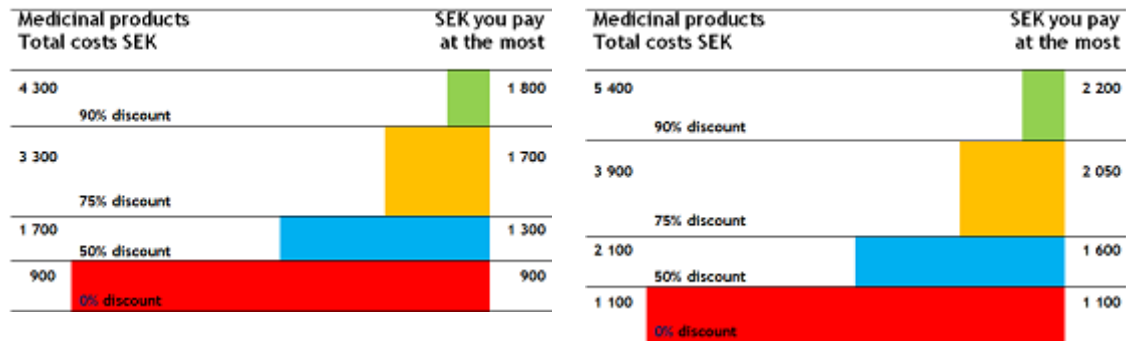
Charges for home help in ordinary and special accommodation, day nursing and municipal health care must in 2010 not exceed SEK 1 696 per month. Charges for accommodation in special housing units that are not governed by the Rent Act may in 2010 amount to as much as SEK 1 766 per month.

High cost protection

In Sweden, high cost protection was introduced in the health care system in 1981. As from 1997, the current system applies with separate high cost protection for medical visits in out-patient care (SEK 900) and medicine (SEK 1 800) with a successive gradual reduction of the patient's share of the medicine expenditure. The period starts on the day the first purchase is made. In a family, medicine costs for all children under the age of 18 years count as one. As to medicine and medical products, the patient charges are according to the reimbursement system in Figure 4.6. The high cost protection is fixed by the Health Care Act and applies in all counties. As from 1 January 2012, new thresholds apply as to the high cost protection scheme. The new thresholds for out-patient care is SEK 1 100 and for medicines SEK 2 200. During 2012 there will be two parallel reimbursement systems.

Dental care is at present not covered by the high cost protection in the health care scheme. Some aspects of dental care treatment is reimbursable, while the majority is payable by the patients.

Figure 4.6 The reimbursement system for medicine in Sweden



This figure is the reimbursement system that ended by 31 December 2012

This figure is the reimbursement system that was introduced by 1 January 2012

Source: www.Lif.se The Research-Based Pharmaceutical Industry

4.4 Private Insurance (HF.2.1 and HF 2.2)

Denmark

The expenditure of private health insurance schemes amounted according to the health account system to about DKK 3.14 billion 2010, which was 1.8 per cent of the health care expenditure in Denmark. In Denmark, there were in 2009 101 general insurance companies and 96 life insurance companies, of which 26 were horizontal pension funds and 37 business pension funds. There were among other things 2.8 million policies covering so-called specific illnesses. One insurance company particularly relevant when mentioning Danish health insurance schemes is a company called Sygesikring Danmark (Health Insurance Denmark). Sygesikring Danmark reimburses a share of the patient charges for example dental treatment and pharmaceuticals. One may apply for membership just as one may choose which level of insurance coverage one wishes to pay for. The share of the Danish population who has taken out private health insurance is about 20 per cent²⁰.

Finland

The share of the Finnish population that has taken out private health insurance is about 11 per cent²¹.

²⁰ International benchmarking of the Danish hospital sector – A summary, February 2010

²¹ OECD Data

Iceland

Private medical care insurance plays an insignificant part in the Icelandic health system. A small share of the population has private sickness insurance to cover the expenditure on basic health care in periods when one is not entitled to public health care insurance. First and foremost, people from other countries staying in Iceland for a short or long period of time are excluded as well as Icelanders who have lived abroad. It takes six months to become entitled to the public health insurance scheme in case no inter-governmental agreement stipulates otherwise.

Norway

Private sickness insurance plays a relatively insignificant role in the Norwegian health system. The share of the population that has taken out private health insurance is about 3.5 per cent in Norway ²².

Sweden

Private sickness insurance plays only a minor part but has increased over time in the Swedish health care system. Private sickness insurance schemes aim at providing fast access to treatment in case of illness or injury. It can be regarded as a complement to the public health care scheme. In 2012, 522 000 policies were taken out. As from 2007, the number of private sickness insurance policies has increased by 77 per cent²³. The majority (81 per cent) of the private sickness insurance policies has been paid by employers. Insurance may be taken out either as a group policy or as an individual policy. The majority of the group policies are taken out through employers but paid by the employees. There is also a private rehabilitation insurance scheme. The share of the Swedish population having private health insurance amounts to about 3.9 per cent²⁴.

²² International benchmarking of the Danish hospital sector – A summary, February 2010

²³ Source: Insurance Sweden

²⁴ International benchmarking of the Danish hospital sector – A summary, February 2010

Chapter 5

Freedom of Choice Reforms in Health Care

5.1 Freedom to Choose Treatment and Care Providers in Denmark

Since 1993, Danish citizens in need of hospital treatment have had freedom to choose at which public hospital they would like to be treated. The free choice of hospital has now also been extended to comprise private hospitals and hospitals abroad that have concluded agreements with the regions, in respect of patients that must wait more than a month for an examination or treatment. Also patients who have waited more than two months for a psychiatric examination and treatment at a hospital are free to choose. Rules of maximum waiting times apply to patients suffering from life-threatening cancer or heart disease. In some cases, patients are entitled to reimbursement of expenditure on hospital treatment abroad.

5.2 Freedom to Choose Care Providers in Finland

The new Health Care Act (1326/2010) has increased patient's options in Finland, in that they may now choose care providers and in some cases also the professional in the health care service by whom they would like to be treated. The freedom to choose place of treatment is being gradually widened.

In the first stage of the reform, patients' may choose which health centre should be responsible for their treatment within their own municipality or the collaborating municipality (collaboration area). If a physician or dentist considers it necessary for a person to receive specialized health care, that person gets to choose care providers in his/her municipal specialized health care system in the area where the home municipality is placed. The care-providing unit may also be chosen from another area, if necessary, in order to consider language rights.

The second stage of the reform enters into force on 1 January 2014 and implies that the freedom of choice is extended to include health centres and units in the specialized health care system in the entire country. The gradual widening of the freedom to choose enables a systematic development of the compensation system among the municipalities.

When it comes to emergency health treatment, including emergency mouth and dental treatment; psychiatric treatment; treatment of abusers as well as psychosocial support, such treatment must be available to a patient irrespective of his or her place of residence. In respect of emergency treatment, the municipality or collaborating municipality in a health care district is responsible for provision of treatment around the clock. In connection with decisions regarding emergency teams; the emergency treatment available in the area; the distance between the emergency teams and the population's need for treatment must be taken into consideration.

Health care service vouchers

The use of service vouchers/a check system furthers the freedom of choice and the options of those using social and health care services from private service providers. Service vouchers can be used for the social and health care services that are covered by the public responsibility. The service voucher option offers an alternative to the publically provided care services. Service vouchers are, however, not intended for use in connection with emergency treatment and other treatment that is independent of one's own free will. The municipalities and the collaborating municipalities decide whether or not they will make use of service vouchers and for which services. Service vouchers are obtained according to entitlement to support. The value of the service voucher may be fixed or income-related. For services that according to the legislation on client charges payable in social and health care are free of charge for clients, a voucher must cover all costs. The municipal authorities approve the service providers, also private ones, in social and health care that provide such services as can be obtained by the use of service vouchers. A private service provider must as a minimum provide the same standard as the municipal providers.

5.3 Free Choice of Care Providers in Iceland

In Iceland, there is freedom of choice of care providers of some health care services. This freedom is, however, rather restricted in comparison with the other Nordic countries as many kinds of surgical treatment are only available at hospitals, but there is some freedom of choice in connection with childbirth. According to the Health Care Act, patients are entitled to consult the physician of their choice. Patients are also entitled to have a second opinion. In case a patient has to wait for treatment, a reason must be given and information provided about the estimated waiting time. Information must also be provided in case a patient can be treated in a shorter time at a different care centre in accordance with the Act on Patients' Rights No.74/1997. There is no limit to the waiting time. The Directorate of Health gathers data on waiting times for surgical treatment.

5.4 Free Choice of Hospital care in Norway

In Norway, patients are free to choose which hospital they want to receive treatment at. To facilitate patients' right to choose an information system (Free Hospital Choice Norway) has been established containing updated information on patient rights, waiting times, etc.

5.5 Free Choice of Care in Sweden

According to Act (2008:962) on System of Choice (LOV) that entered into force on 1 January 2009, all county authorities are obliged to introduce the system of choice in the primary health care sector as from January 2010. The Act entitles all citizens, irrespective of county, to choose care providers in the primary health care sector. The county councils do not have the authority to turn down care providers who wish to set up business and be reimbursed by the county council in question. It is, on the other hand, optional for the municipal social services whether or not they want to introduce the system of choice. Several municipalities plan to introduce the system of choice according to LOV.

The county councils that have already introduced the system of choice in the primary health care sector have developed models for how the population can choose care centres and how a care allowance that follows an individual's choice should be formed. It is the ambition that the allowance should follow the population's choice of care provider and to boost the competition by the setup of more private care providers. The way in which the care units get paid is of immense importance to the orientation and extent of the business. The fixed reimbursement varies from 40 to more than 80 per cent of the total reimbursement in the counties that have already introduced a choice system model. Moreover, the care units are granted a visit compensation depending on which occupational category is responsible for the medical visit. The large change ensuing from the care choice reform is the right of free establishment of the care providers.

Chapter 6

Diagnosis-Related Groups (DRG)

Diagnosis-related groups, DRG, are a system to divide patients in homogeneous groups (patient-classification system) and are used activity descriptions in order to follow up on and analyze the health care sector. The DRG system implies that patients with homogeneous diagnoses and resource consumption are grouped in one and the same group. The DRG is a transparent way of describing the patient composition ("case mix") in the care sector which makes it relatively simple to make comparisons over time or to compare the quality of the care and treatment. As the DRG system takes into account the resource consumption, i.e. expenditure, it can also be used to compare different hospitals regarding cost effectiveness.

The NordDRG was developed in a cooperation of the Nordic authorities and is owned by the National Board of Health and Welfare and its sister organizations in the other Nordic countries. The Nordic collaboration on the DRG aims at enhancing the usage of expertise and resources and at a better coherence and quality in the description system for health care in the Nordic countries. An annual update is made of the logic in the NordDRG at the Nordic level and of the individual countries with a view to adapting the system to the changes that continuously take place in health care.

The DRG can also be used as a resource allocation system. The DRG can then form the basis for the allocation of funds to the hospitals or as a basis for the hospitals' internal budgets. In the counties applying performance remuneration instead of allocation-financing, the DRG is also used as a billing record in connection with provided treatment. The NordDRG was developed for in-patient treatment; psychiatry; rehabilitation; day surgery and out-patient treatment at hospitals.

Denmark

In Denmark, the DkDRG is used in connection with in-patients (the Danish version of the NordDRG) and DAGS (Danish Out-Patient Grouping System) for out-patients. The Danish grouping of the DkDRG is based on the classification system (SKS) of diagnoses of the National Health Service that are used in the reporting to the Danish patient register (National Patient Register).

As from 2000, the DRG is used in connection with both in-patient and out-patient somatic hospital treatment and in the settling of accounts among various regional care providers, calculation of municipal co-financing as well as management of the

amount of the expenditure. The rates are calculated by combining the activities with the expenditure.

As from 2004, the counties use activity-based compensation (charge-based management of the hospitals) which expanded the use of the DRG. The system went from being an administrative system for the handling of minor financial flows to being a system for the running of the hospital care sector. As from 2007, the DRG has also been used in connection with the municipalities' co-financing.

Finland

In Finland, two different DRG systems are used: the NordDRG Classic for in-patient treatment and day surgery and the NordDRG Full System used for in-patient treatment and out-patient treatment at hospitals. At present, 13 out of 21 hospital districts use the DRG to various degrees for invoicing. The Finnish version of the DRG is based on patient data from the Helsinki and Uusimaa hospital districts which account for about 30 per cent of Finland's specialized health care sector. Large university hospitals often treat more severe cases by means of more costly treatment methods, and consequently each hospital has its own calculated price system in the DRG.

Iceland

The NordDRG FULL System has been in use in Iceland since 2001, and Iceland participates in the Nordic DRG collaboration. The system is primarily used in the Landspítali (University Hospital, LUH) but also the hospital at Akureyri in Northern Iceland has used the DRG for some years. Together, these two hospitals covered approximately 78 per cent of all hospital treatment in the country in 2009. The health care authorities are planning to extend the use of the DRG in years to come. As from 2003, all treatment of in-patients as well as medical visits to the specialized outpatient clinics at the Landspítali has been classified according to the NordDRG. This also includes psychiatry, geriatrics and rehabilitation. The NordDRG FULL is used in combination with a "cost per patient" system developed by the hospital in order to calculate production costs for treatment at the Landspítali. By way of monthly reports on production and costs, the decision process, the strategic planning and the budget planning is facilitated. The DRG is not yet used as a reimbursement system with the exception of the invoicing of patients outside of the Icelandic social security system. Other application areas for the DRG are for example as a basis for quality indicators; cost analyses; comparisons and in research. Cost weights are calculated annually on the basis of expenditure from the Landspítali and of unit prices. The price list for the DRG is published annually on the website of the Landspítali as a reference to actual expenditure.

Norway

The NordDRG was introduced in Norway in 1999. The DRG system is used to classify patients and as a basis for activity-based financing. The DRG system distinguishes between in-patient and day-cases of curative care. This information is used to break

down expenditure for curative in-patient treatment and curative day treatment (HC.1.1 and HC.1.2) in the health accounts. In 2009 out-patient curative care (HC.1.3) was also included in the DRG system. This is a new source of information for identifying out-patient expenditure. The state-owned hospitals receive a global budget that makes up 60 per cent of their financing, and the remaining 40 per cent is covered through activity-based financing.

Sweden

The NordDRG was introduced in Sweden at the beginning of the 1990s. There was a pressing need in the health care sector for an improvement of productivity, a reduction of patient queues and to provide patients with the freedom to choose hospital. The DRG is used in measuring hospital performance and as a charging basis in connection with reimbursement of health care. The system is also used for efficiency and productivity measuring in health care at different levels, everything from national level to individual clinics. Furthermore, the DRG forms the basis of foreign reimbursements. The National Board of Health and Welfare administers and maintains the Swedish part of the NordDRG.

All county councils in Sweden use the DRG system to some extent. Half of the county councils use the DRG system for both follow-up on and reimbursement of health care while other county councils use the DRG system only for cross county reimbursement. In those counties where health care is reimbursed by the DRG system, the DRG reimbursement varies between 20-60 per cent of the expenditures. The rest is reimbursed by the budget.

The NordDRG in Sweden includes all the somatic and psychiatric specialized in-patient treatment including developed groups in respect of neo natal care and rehabilitative treatment as well as somatic groups in day surgery, day care and visits to specialized out-patient treatment. The expenditure data are used to validate the NordDRG, carry out exchanges and to calculate the relative weights. Sweden's municipal and county councils are responsible for the gathering and development of the expenditure data per patient (KPP data), and each year an expenditure database is set up containing data from the hospitals that are able to supply KPP data, which in 2011 was 70 per cent of the country's in-patient treatment and 55 per cent of somatic specialized day care.

Chapter 7

The Future challenges of the Financing of the Health Care Sector

The economic growth will play a decisive part in the future development of the health care sector. The economic development sets a limit to the resources to be allocated to the health care sector. The higher the economic growth is in the entire economy, the larger the possibility of prioritizing publically financed activities. The demographic development is an important factor to the economic development.

7.1 The Demographic challenge

The number of elderly people is increasing successively in the Nordic countries. The demographic development until 2050 indicates that there will be both more young people and old people in relation to the number of people of working age that are to support the increasing number of young and old people (the so-called support quota). Especially after 2020, the share of those aged 65 years and older in relation to the share of the population in work shall increase considerably. The share of elderly people in the population in 2050 shall increase to between 23.1 per cent in Iceland and 25.7 per cent in Finland. The increase rate is highest in Iceland where the share of elderly is expected to increase by 90 per cent between 2010 and 2050. The increase rate is lowest Sweden, about 35 per cent (Table 7.1).

The average life expectancy is in 2050 estimated to increase the least in Denmark to 83.3 per cent and the most in Iceland to 85.8 per cent (Table 7.1). As it in particular is the older share of the population that is in need of health care, the demands for financing of the public health care might increase, but also for the public care for the elderly.

Table 7.1 Development in the share of elderly in the population in the Nordic countries, 2010-2050

| | The share aged 65+ years of the population 2010, per cent | The share aged 65+ years of the population 2050, per cent | Increase in per cent | Remaining average life expectancy from birth 2050 |
|---------|---|---|----------------------|---|
| Denmark | 16,5 | 24,1 | 45 | 83,3 |
| Finland | 17,2 | 25,7 | 49 | 84,5 |
| Iceland | 17,2 | 23,1 | 90 | 85,8 |
| Norway | 14,7 | 23,7 | 60 | 85,2 |
| Sweden | 18,2 | 24,6 | 35 | 85,7 |

Source: United Nations, Department of Economic and Social Affairs, World Population Prospects, the 2010 revision

The future expenditure development for health care and care for the elderly and for people with reduced capacities is not affected by demographic changes alone. Historically, other factors have had more significance, such as the wealth of the country and the income development; the medical-technological development; altered treatment patterns; increased expectations to and demand for the contents and quality of the services as well as the increase in personnel with various qualifications. Changes in the medical technology allow new ways of treatment that were previously impossible. The diagnostic methods are developed, and more people can be diagnosed correctly or get shorter waiting times which in turn can increase the number of people getting treatment. In some WHO studies, the technological development is estimated to account for 50-75 per cent of the increase in the health care expenditure.

7.2 How to Manage the Future Financing of Health Care?

More working hours

The employment development in society plays a significant part for how much health care a country can afford, i.e. how many resources (as a share of GDP) are needed or how high a tax level is required to finance it. The public financing can be enhanced by way of measures that increase the number of hours worked in the economy and encourage increased efficiency in the production of health care. The long-term trend towards a shorter working life can also be stopped by getting more people in work and/or by each person working more and for a longer period of time. The number of hours worked can also be increased by an increase of the participation rate of among others foreigners living in the country and by way of immigration of labour. A permanent increase in the birth rate would also result in a more favourable age distribution.

In order to make the future pension system viable in the long run, Denmark, Norway and Sweden have reformed their pension systems. In the Danish system, the population gets to gradually retire later while the pensions remain intact. Denmark has decided to introduce an automatic adaptation of the pensionable age to the average life expectancy. The reform will be implemented in several steps and begins with the age limit for early retirement gradually rising by a total of two years. The period of time as a pensioner is anticipated to increase to 19.5 years. The pension terms will be fixed ten years in advance so that they are known relatively early. An adaptation will be made every fifth year and becomes in force in 2027.

In the Swedish system, pensions will be altered in line with the economic development and with the anticipated average life expectancy. In Sweden, a reform of the retirement pension scheme was implemented and entered into force in 1999. In May 2001, a balancing mechanism was introduced, the so-called "automatic balancing" to guarantee that the system remains stable irrespective of economic or demographic developments. This mechanism eliminates the risk of any permanent deficit and consequently guarantees a long-term financial stability in the pension system. The reformed pension system is a contribution-defined system where pensions are based on the individual's paid contributions (pension entitlement) during his or her life time. The new system follows the general income development and the pensions are adapted to the increased life expectancy in that the pension is calculated on the basis of the life expectancy for each individual cohort. This implies that the new pension system is designed better to cope with future economic and demographic changes, such as an increased number of pensioners in relation to the number of people in work.

In principle, all the Nordic countries have some way of adapting their pension systems to the average life expectancy. Further information on the Nordic retirement pension systems can be seen in the Nososko report *Ålderspensionssystem i Norden*²⁵ (The Retirement Pension Systems in the Nordic Countries).

A more effective use of resources

A high degree of effectiveness in the functions is necessary in order to curb the need for financing of different health care services and to maintain the legitimacy for the tax burden that is necessary. An effective publically financed function implies per definition that the resources are used in such a way that they to the highest possible degree contribute to the consideration of the needs in accordance with the legislative requirements and objectives and guidelines. It is both a question of how resources are used and for what they are used. With an improved effectiveness, an increasing need can be met without the resources having to increase correspondingly.

²⁵ <http://nososco-da.nom-nos.dk/filer/publikationer/pensionsystem.pdf>

A number of measures could be introduced to improve the effectiveness, such as avoidance of unnecessary expenses, the so-called quality deficiency expenses such as medical injuries and treatment-related infections. Approximately 9 per cent of all hospitalized patients are estimated to catch a treatment-related infection²⁶. The extra bed-days in relation to avoidable medical injuries in the somatic in-patient care is estimated to be a little over SEK 5 billion annually in Sweden only. A more effective use of resources could also be obtained by way of among other things a knowledge-based health care and social service; a systematic improvement by way of awareness and open priorities and comparisons; a more effective distribution and an appropriate organization. In a long-term perspective, early, preventive and rehabilitative measures both in health care and social services can improve the usage of resources and reduce the costs. In health care, there is an improvement potential in the medico-technical progress implying that more types of treatment can now be carried out at out-patient clinics instead of as previously in hospitals. Telemedicine and web-related health care can further improve the productivity in the health care sector. Furthermore, collaboration among the various sectors of society can be highly significant to a better use of resources.

In Denmark, one of the large challenges in the future will be to ensure an expedient management of the health care expenditure. This can be done by focusing on productivity improvement in the health care sector, e.g. by improving working time schedules and a more effective use of current resources both in respect of health care staff and technical equipment.

Finland has decided to implement a municipality reform to guarantee the financing of the municipalities' expenditure on health care²⁷. According to the Act on Restructuring Local Government and Services (169/2007), the population in each municipality must count at least 20 000 inhabitants. To reach this level, municipalities can either be amalgamated with the neighbouring municipalities or form a collaboration area for the service. Consequently, the number of municipalities declined from 416 in 2005 to 328 in 2010 (Åland not included). A municipality or collaboration area that meets the population requirement must commence its service no later than at the beginning of 2013. Another way of increasing the effectiveness in the health care system, according to the financial objectives in Finland, is to reduce the overlapping of services, especially for occupational health care and primary health care, to reduce the inequalities among the regions and among population groups as well as to monitor the expenditure for inappropriate use of the health care services.

In Iceland, the responsibility for people with reduced capacities was transferred from Central Government to the municipal authorities in 2010. It has also been planned to

²⁶ Sveriges Kommuner och Landsting. Punktprevalensmätning av vårdrelaterade infektioner. 2009

²⁷ PARAS-project since 2005

transfer the care sector for the elderly and the primary health care from Central Government to the municipal authorities. Due to the fact that the municipalities are small, they have to cooperate in order to provide such services. The health care authorities will in years to come investigate the future organization of the Icelandic health care system.

A clearer public obligation

Predictability is a key aspect. People must be given a chance to know what they may expect in the form of public service in order to plan their future accordingly. A predictable and well-defined public obligation should at least exist guaranteeing that everyone has access to good treatment on equal terms. If one is not content with the public commitment, for example if one wants access to treatment faster than the public guarantees or an extra examination which is not considered medically essential, it should be possible to purchase such services on the private market.

Higher charges

One way of meeting an unknown demand for various services in health care is to increase the aspect of private financing. Charges contribute to the financing and to control the demand to the "right" level of treatment. Charges also have the function of curbing the demand for treatment and care in order to prevent overutilization. If treatment were provided free of charge or at a low price, the risk would arise that a demand would be created for care services that are superfluous seen from a medical perspective. A sufficiently high charge, so that a patient must weigh treatment against other consumption, will reduce such overutilization.

Higher taxation

Increasing taxes through increased tax rates is another way of financing the future expenditure on health care. A way of increasing the financing via taxes in the long run is to increase the number of tax bases from which tax may be payable. A Swedish survey from 2008 shows that there was a strong will to pay for health care and care for the elderly.

Reduced expenditure

The expenditure may be reduced by improving public health and reducing ill health which will lower the need and consequently the expenditure on health care. This can be obtained by preventive and health-promoting measures. The expenditure can also be decreased by way of effective remedies, streamlining activities or reduced public obligation.

To avoid future erroneous and superfluous expenditure in health care, Norway has from the 1 January 2012 introduced a reform, the Coordination Reform, for treat-

ment at the right treatment level and at the right time²⁸. The reform aims at improving the collaboration between the primary health care sector and the specialized health care sector and so reduce the increase in future expenditure on health care. The effects of this reform remain to be seen.

In Finland, the expenditure on pharmaceuticals have increased fast in recent years. To control this, various reforms have been implemented. In 2009, Finland started using a reference price system for pharmaceuticals that comprises almost all replaceable pharmaceutical products. The purpose of the reform is to curb both the patients' medicine expenses and the reimbursement expenses of the sickness insurance scheme. The reference price system is designed in such a way that products sold under different trade names but containing the same active substance and corresponding to one another are divided into reference price groups. The reference price is the price for the most inexpensive product in the group with an extra EUR 1.50 or EUR 2 depending on the price for the most inexpensive product. The reference prices are fixed on the basis of the prices quoted by the pharmaceutical companies. If a customer wishes to buy a product that is more expensive than the reference price, the customer will have to pay the difference himself. The part that exceeds the reference price is not included in a person's annual threshold for medicine costs. The reference price system is a complement to the medicines exchange system that was implemented in 2003. The medicines exchange system enables patients to exchange a prescribed pharmaceutical product for a different product and so influence their expenditure on medicine. The consolidation of two Finnish Acts into the new Health Care Act (1326/2010) aims also to reduce the expenditure of the specialized health care system by increasing the collaboration of the primary health care sector and the specialized health care sector.

New insurance solutions

In the past decades, the international trend has pointed to an increase in the importance of private insurance. Usually, employers choose to insure a number of key staff that is not expendable to the employer. Compulsory charges payable in an insurance solution could also be an alternative to taxes.

The health savings account

A financing alternative that unites patient charges and insurance is the so-called health savings accounts. They could be a tax-subsidized voluntary system as in the USA or a system with compulsory saving. The health savings accounts are often designed so that the individual continuously saves up into a special account, often with a tax subsidy. The amount on the account must only be used to finance health care. In return, the patient charges are relatively high. The account is combined with an

²⁸ Report No. 47 to the Parliament (2008-2009)

insurance system that accounts for the expenditure on expensive treatment and in cases of serious illness. The savings are stimulated by the tax subsidies. The health savings account contributes to equalizing the financing of health care at different levels over time, but unlike the insurance system, however, not amongst individuals. In excess of the part that is covered by the insurance policy connected with the account, everyone pays for his/her own treatment. The insurance protection covers expensive health care but not the risk of having to use treatment often. It is in the nature of the system that it involves a lesser degree of risk equalization than in an insurance scheme.

Health care costs in the insurance scheme

Part of the need for health care is caused by injuries occurring in connection with traffic accidents, at the work place or in one's spare time. There are insurance schemes for most injuries covering the individual's expenditure in connection with an injury, first and foremost loss of income. A proposal that during the years has been presented in several different forms is that health care costs should also be covered by such insurance schemes. A basic economic principle is that a cost should as far as possible be a burden on the activity that causes it. It could be an incentive if the obligatory traffic insurance is responsible for the health care expenses in connection with traffic injuries. Similarly, the household insurance could be responsible for the health care expenses that accrue as a result of leisure activities and a work place insurance for injuries occurred at work. In that way, the health care sector would be provided with resources that cover the costs for this part of the health care. In addition, financial incentives would be created for insurance companies, road users, employers, etc. to try to prevent accidents from happening, as less accidents result in lower premiums payable to the insurance scheme.

Chapter 8

Recommendations for further work

This report provides an overview of the financing of the Nordic health care systems. As it can be difficult to draw the line between health care and social security, it can result in differences in the presentation of the expenditure depending on what is covered by the respective items. In the Nordic collaboration on health accounts, the Nordic countries have met to discuss problems and possible solutions as to how the dissimilarities can be reduced and to improve the quality of the Nordic health accounts. The OECD also participated in the collaboration with its knowledge of the international accounts system. In order to improve Nomesco's statistics and enhance the comparability among the Nordic countries, it is proposed to:

- Develop better descriptions and analyses of similarities and differences among the Nordic countries in Nomesco's statistics. The development should be made on the basis of the health accounts system (SHA 2011). Furthermore, it is as a first step suggested that the present chapter on resources is supplemented by a presentation of the expenditure on health care by financing agent (cf. Figure 4.1)
- Resume the Nordic SHA collaboration prior to the transition to SHA 2011
- Develop a joint description of the health care financing agents in the Nordic countries prior to the future international development
- Analyze the differences among the Nordic countries in respect of what should be covered by the item Long-term care (LTC) as well as how the presentation should be made in the SHA
- Analyze the differences among the Nordic countries as to how preventive health care should be presented in the SHA

References

Denmark

International benchmarking of the Danish hospital sector - A summary, February 2010, Ministry of Health and Prevention, Denmark

Finland

Vitikainen K, Häkkinen U. DRG Country Report. Finland. In Book on DRGs in Europe. Open University Press Nov. 2011 (Draft).

Health at a Glance 2011. OECD indicators. OECD 2011 (Draft).

Health Expenditure and Financing 2009. National Institute for Health and Welfare (THL), Statistical Report 14/2011. Official Statistics of Finland. Helsinki 2011.

OECD Health Data 2013.

Sosiaali- ja terveydenhuollon monikanavaisen rahoituksen edut, haitat ja kehittämistarpeet (Advantages, Disadvantages and Developmental Challenges in the Multisource Financing of Social and Health Care). National Institute for Health and Welfare (THL), Report 4/2011. Helsinki 2011.

Vuorenkoski L, Mladovsky P, Mossialos E. Finland: Health system review. Health Systems in Transition. 2008; 10(4):1-1168.

Iceland

Eggertsdóttir, G. Heilbrigðisútgjöld á Íslandi 1998-2010. Health Care Expenditure in Iceland 1998-2010. Statistics Iceland, Reykjavík, 2011.

Halldorsson M. Health care systems in transition: Iceland. Copenhagen, WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, 2003.

Health Statistics in the Nordic Countries with data from 2008. Helsestatistik for de nordiske lande med data fra 2008 Nordisk Medicinalstatistisk Komité: København 2010.

Health Statistics in the Nordic Countries with data from 2009. Helsestatistik for de nordiske lande med data fra 2009 Nordisk Medicinalstatistisk Komité: København 2011 (2012?).

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NOU 2008:2 Fordeling av inntøker mellom regionale helseforetak til Helse- og omsorgsdepartementet
 Evaluering av fastlegereformen 2001-2005, Sammenfatning og analyse av evalueringens delprosjekter (Research Council of Norway).
 Tall og fakta 2010 by The Association of the Pharmaceutical Industry in Norway Legemiddelindustrien, LMI
 Report No. 18 to the Storting (2004-2005) On course towards more correct use of medicine
 A full overview of the different rates for out-of-pocket payments can be found at <http://www.helfo.no/privatperson/egenandeler/Sider/default.aspx>
 Report No. 47 to the Storting (2008-2009)
<http://nososco-da.nom-nos.dk/filer/publikationer/pensionsystem.pdf>

Sweden

Hälso- och sjukvårdslagen 1982:763
 Socialtjänstlagen 2001:453
 SOU 2008:105 Långtidsutredningen 2008 - Huvudbetänkande
 Socialdepartementet, Den ljusnande framtid är vård, Delresultat från LEV- projektet Stockholm 2010.
 Socialstyrelsen. Att förebygga vårdrelaterade infektioner - Ett kunskapsunderlag. 2006
 Socialstyrelsen, Hälsa- och sjukvårdsrapport 2009. Västerås april 2009.
 Sveriges Kommuner och Landsting. Svenska folket om finansiering av välfärden. 2008
 Sveriges Kommuner och Landsting, Hälsa- och sjukvården till 2030- Om sjukvårdens samlade resursbehov på längre sikt. Borås 2005
 Sveriges Kommuner och Landsting. Utveckling av ersättningssystem inom hälso- och sjukvård. En översikt av tillämpning, erfarenheter och utvecklingslinjer. September 2007.
 Sveriges Kommuner och Landsting. Framtidens utmaning - Välfärdens långsiktiga finansiering. Klippan 2010
 Sveriges Kommuner och Landsting, Kommer vi att ha råd med sjukvården? - Ett diskussionsunderlag om hälso- och sjukvårdens framtida finansiering. 2005
 Sveriges kommuner och landsting. Punktprevalensmätning av vårdrelaterade infektioner. 2009.
 Sveriges Kommuner och Landsting. Patientavgifter fr.o.m. den 1 januari 2010. PM 2010
 Försäkringsförbundet. www.forsakringsforbundet.com
 Statistiska centralbyrån. Hälsoräkenskaper 2011-03-31
 OECD A System of Health Accounts, Version 1,0 OECD 2000
 OECD Health Data 2013
 ICHA-HF-klassifikationer: www.oecd.org/dataoecd/47/37/1896289.pdf
<http://www.oecd.org/dataoecd/47/37/1896289.pdf>.
<http://nomesco-eng.nom-nos.dk/filer/publikationer/Helsestatistik2010.pdf>

Appendices

Health Care Classifications According to ICHAⁱ

ICHA-HC classification of functions of health care

ICHA-HP classification of health care providers

ICHA-HF classification of health care financing

ICHA-HC classification of functions of health care: three-digit level
SHA 1,0

ICHA code Functions of health care

HC.1 Services of curative care

HC.1.1 In-patient curative care

HC.1.2 Day cases of curative care

HC.1.3 Out-patient curative care

HC.1.3.1 Basic medical and diagnostic services

HC.1.3.2 Out-patient dental care

HC.1.3.3 All other specialized health care

HC.1.3.9 All other out-patient curative care

HC.1.4 Services of curative home care

HC.2 Services of rehabilitative care

HC.2.1 In-patient rehabilitative care

HC.2.2 Day cases of rehabilitative care

HC.2.3 Out-patient rehabilitative care

HC.2.4 Services of rehabilitative home care

HC.3 Services of long-term nursing care

HC.3.1 In-patient long-term nursing care

HC.3.2 Day cases of long-term nursing care

HC.3.3 Long-term nursing care: home care

HC.4 Ancillary services to health care

HC.4.1 Clinical laboratory

HC.4.2 Diagnostic imaging

HC.4.3 Patient transport and emergency rescue

HC.4.9 All other miscellaneous ancillary services

HC.5 Medical goods dispensed to out-patients

HC.5.1 Pharmaceuticals and other medical non-durables

HC.5.1.1 Prescribed medicines

HC.5.1.2 Over-the-counter medicines

HC.5.1.3 Other medical non-durables

HC.5.2 Therapeutic appliances and other medical durables

HC.5.2.1 Glasses and other vision products

HC.5.2.2 Orthopedic appliances and other prosthetics

HC.5.2.3 Hearing aids

HC.5.2.4 Medico-technical devices, including wheelchairs

HC.5.2.9 All other miscellaneous medical durables

HC.6 Prevention and public health services

HC.6.1 Maternal and child health; family planning and counseling

HC.6.2 School health services

HC.6.3 Prevention of communicable diseases

HC.6.4 Prevention of non-communicable diseases

HC.6.5 Occupational health care

HC.6.9 All other miscellaneous public health services

HC.7 Health administration and health insurance

HC.7.1 General Government administration of health

HC.7.1.1 General Government administration of health (except social security)

HC.7.1.2 Administration, operation and support activities of social security funds

HC.7.2 Health administration and health insurance: private

HC.7.2.1 Health administration and health insurance: social insurance

HC.7.2.2 Health administration and health insurance: other private

ICHA code Health-related functions

- HC.R.1 Capital formation of health care provider institutions
- HC.R.2 Education and training of health personnel
- HC.R.3 Research and development in health
- HC.R.4 Food, hygiene and drinking water control
- HC.R.5 Environmental health
- HC.R.6 Administration and provision of social services in kind to assist living

**ICHA-HP classification of providers of health care: three-digit level
SHA 1,0***ICHA code Health care provider industry***HP.1 Hospitals**

- HP.1.1 General hospitals
- HP.1.2 Mental health and substance abuse hospitals
- HP.1.3 Specialty (other than mental health and substance abuse) hospitals

HP.2 Nursing and residential care facilities

- HP.2.1 Nursing care facilities
- HP.2.2 Residential mental retardation, mental health and substance abuse facilities
- HP.2.3 Community care facilities for the elderly
- HP.2.9 All other residential care facilities

HP.3 Providers of ambulatory health care

- HP.3.1 Offices of physicians
- HP.3.2 Offices of dentists
- HP.3.3 Offices of other health practitioners
- HP.3.4 Out-patient care centres
 - HP.3.4.1 Family planning centres
 - HP.3.4.2 Out-patient mental health and substance abuse centres
 - HP.3.4.3 Free-standing ambulatory surgery centres
 - HP.3.4.4 Dialysis care centres
 - HP.3.4.5 All other out-patient multi-specialty and co-operative service centres

HP.3.4.9 All other out-patient community and other integrated care centres

HP.3.5 Medical and diagnostic laboratories

HP.3.6 Providers of home health care services

HP.3.9 Other providers of ambulatory health care

HP.3.9.1 Ambulance services

HP.3.9.2 Blood and organ banks

HP.3.9.9 Providers of all other ambulatory health care services

HP.4 Retail sale and other providers of medical goods

HP.4.1 Dispensing chemists

HP.4.2 Retail sale and other suppliers of optical glasses and other vision products

HP.4.3 Retail sale and other suppliers of hearing aids

HP.4.4 Retail sale and other suppliers of medical appliances (other than optical glasses and hearing aids)

HP.4.9 All other miscellaneous sale and other suppliers of pharmaceuticals and medical goods

HP.5 Provision and administration of public health programmes

HP.6 General health administration and insurance

HP.6.1 Government administration of health

HP.6.2 Social security funds

HP.6.3 Other social insurance

HP.6.4 Other (private) insurance

HP.6.9 All other providers of health administration

HP.7 Other industries (rest of the economy)

HP.7.1 Establishments as providers of occupational health care services

HP.7.2 Private households as providers of home care

HP.7.9 All other industries as secondary producers of health care

HP.9 Rest of the world

ICHA-HF classification of health care financing: three-digit level SHA 1,0

ICHA code Sources of funding

HF.1 General Government

HF.1.1 General Government excluding social security funds

HF.1.1.1 Central government

HF.1.1.2 State/provincial government

HF.1.1.3 Local/municipal government

HF.1.2 Social security funds

HF.2 Private sector

HF.2.1 Private social insurance

HF.2.2 Private insurance enterprises (other than social insurance)

HF.2.3 Private household out-of-pocket expenditure

HF.2.3.1 Out-of-pocket excluding cost-sharing

HF.2.3.2 Cost-sharing: central government

HF.2.3.3 Cost-sharing: state/provincial government

HF.2.3.4 Cost-sharing: local/municipal government

HF.2.3.5 Cost-sharing: social security funds

HF.2.3.6 Cost-sharing: private social insurance

HF.2.3.7 Cost-sharing: other private insurance

HF.2.3.9 All other cost-sharing

HF.2.4 Non-profit institutions serving households (other than social insurance)

HF.2.5 Corporations (other than health insurance)

HF.3 Rest of the world

ⁱ © OECD 2000 The System of Health Accounts