

# The Scandinavian Healthcare System

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The Scandinavian countries Norway, Sweden, and Denmark occupy the northern part of Europe and are often perceived as quite similar from the outside. There are deep historical reasons for this: The three countries were united in the Kalmar Union from 1397 to 1523, and after its breakup, continued to be united in different constellations before they all gained independence in the 20<sup>th</sup> century. This common history is often used as the major explanation for why the Scandinavian countries have, among other similarities, chosen a common approach to social welfare.

The Scandinavian model of the welfare state has become internationally known. It is characterized by the state playing a dominant role in the formation of welfare policies and a corresponding extensive public sector for the implementation of these policies. Although there are many country-specific attributes, similar features include a broad scope of social policies, universal social benefits, and free or strongly subsidized services. Scandinavian healthcare systems are built on the same principles of universalism,



strongly expressing a goal of equal access to services regardless of social class, income, or place of residence. To reach this goal, the Scandinavian model has relied on public ownership and control, limited use of market-based incentives such as choice or competition, and rationing in the form of (at times long) waiting lists. Out-of-pocket payments play a minor role and are also accompanied by safety nets in the form of maximum annual outlays. Furthermore, the Scandinavian countries have been noted for providing healthcare within a decentralized public model; that is, a model where local – municipal or county – political bodies are responsible for providing both necessary healthcare services to their population and managing the healthcare providers.

However, over the past 20 years, the Scandinavian healthcare model has undergone major changes, though still without rocking its fundamentals. These changes are a response to external factors as well as internal pressures.

First, two of the three countries – Norway being the stubborn exception – became members of the European Union (EU). While healthcare within the EU is still a matter of national discretion, its mere existence puts substantial external pressure on the national healthcare systems. In particular, the EU's tendency to impose

detailed regulations comes in conflict with a Scandinavian model that traditionally has been more laid back, flexible to local solutions and country variations. Secondly, choice, once seen as an unnecessary trait of a market-based system (such as that of the United States), has now been introduced in all Scandinavian countries. This reflects, in part, the fact that the information age has also come to healthcare. Patients today are conscious and demanding consumers – not simply recipients of healthcare. Also, choice implies recognition that increased use of market-type initiatives is an excellent way of correcting inefficiencies in a system that has been characterized by structural as well as managerial rigidity. Notably, though, choice in the Scandinavian setting is still limited to the hospital – choice of physician within the hospital is not high on either the public or the political agenda.

Thirdly, and also in part influenced by parallel developments in other countries, the method of financing services has gradually changed from annual adjustments of historic costs to more sophisticated contracts aiming at improving both performance and quality. Again, mechanisms such as splitting purchasers and providers and using activity-based financing have been implemented with the clear purpose of increasing efficiency.



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sector resource use and efficiency. Frequently consulted by the Norwegian Ministry of Health, he is the lead architect behind the present system of resource allocation between the Norwegian regions. He is the lead editor of a book on the Nordic healthcare systems that will be published by the European Observatory on Health Systems and Policies through McGraw Hill in late fall 2009.

We have also seen significant changes in the way services are provided. Hospitals are increasingly becoming highly specialized treatment centers; simpler cases are dealt with on an outpatient basis. Furthermore, specialized hospital services are delivered in fewer and larger hospitals – the motivation being both cost saving through economies of scale and a higher level of quality through an increased volume of complicated patients seen by each physician. This is a development that regularly faces strong opposition, from both politicians and the population of the areas that lose hospital services. The Scandinavian countries, Denmark being an exception, have large and sparsely populated areas. Maintaining geographical equity and, at the same time, exploiting both medical and economical efficiencies of scale, is thus a challenge.

In two of the three countries, first Norway and then Denmark, the consequence has been a centralization of the responsibility for hospital services from small local governments to the state (Norway) or larger regions (Denmark). Behind this centralization lies the acknowledgement of several factors. For one, the traditional decentralized Scandinavian model has proven costly. This has especially been the case for Norway, who – driven by an oil-induced growth in gross domestic product – has experienced unprecedented growth in healthcare costs in the past 15 years. From being on level with Denmark and slightly below Sweden in healthcare expenditures in the mid-1990s, Norway's level is now more than 50 percent higher than in its neighboring countries. One would think this would curb the pressure for more resources for healthcare, but the opposite seems to be the case. Thus, the state responded by taking control over the entire hospital sector in 2002. The two main arguments were that this would simplify a much needed restructuring and curb costs. Unfortunately, the evidence so far is rather disheartening – costs are still increasing and restructuring still difficult. In Den-

mark, the growth in healthcare costs was not that high, but nevertheless the state decided to merge 14 counties into five regions in 2007, mainly to solve problems with geographical differences in the use of specialized healthcare services, the accompanying hospital structure, and cost efficiency. We have yet to see results, but note that the Danish government has threatened to further centralize if the present reform is not successful. One would expect Sweden to follow on the same path. But the Swedes, who traditionally take more time to ponder the pros and cons of different solutions, have so far chosen to stick to their model of 21 counties – despite the clear recommendations from a government-appointed committee to merge them into larger and fewer health regions. Thus, at present, the Scandinavian decentralized model of local governance has taken three different directions: Norway has abolished local governance altogether for specialized healthcare, leaving the responsibility to the state. Denmark has merged counties into fewer

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## Facts & Figures

**Medical Care System:** The Scandinavian countries provide universal access to healthcare for their population. The responsibility for healthcare is divided between the state and municipalities in Norway and is decentralized to the regional and county level in Denmark and Sweden, respectively. Decentralized responsibility is accompanied by a distribution of funds that provides each region/county/municipality with the same needs-based amount of resources.

**Financing:** All Scandinavian countries draw their healthcare funding from the general taxation. While Sweden largely uses county-level taxation, both Norway and Denmark have systems where the main proportion of funds comes from the state level. The Scandinavian countries use a slightly higher share of their gross domestic products (GDP) for healthcare than the Organization for Economic Co-operation and Development (OECD) average, but per capita spending was substantially higher at around 25 percent above the OECD average in 2005. Within the Scandinavian countries, there are great differences in per capita spending: Norway's level of spending is more than 50 percent above that of Sweden and Denmark. The main reason for this is a substantially higher, oil-driven GDP in Norway.

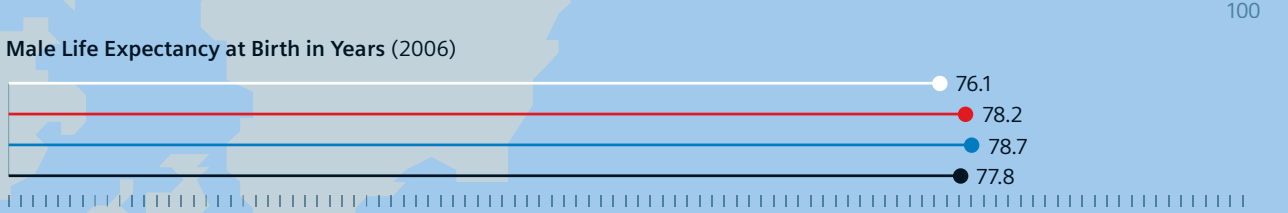
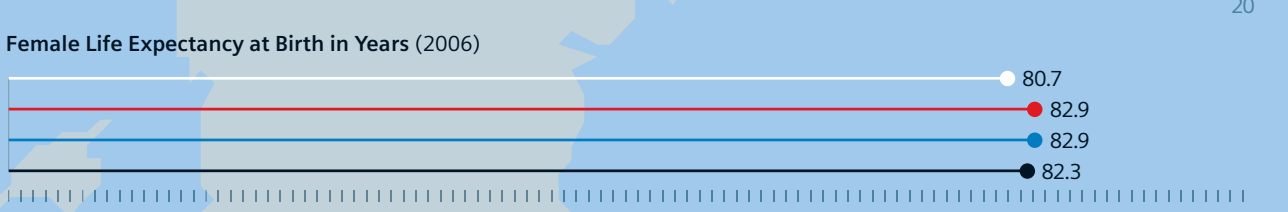
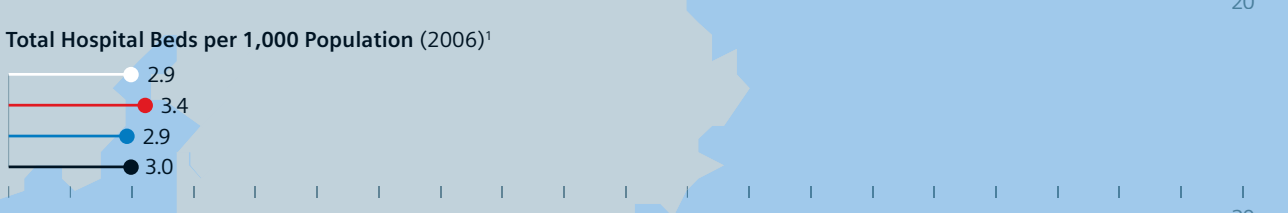
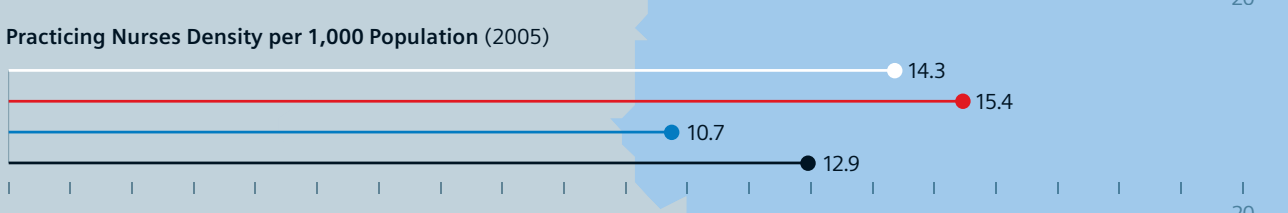
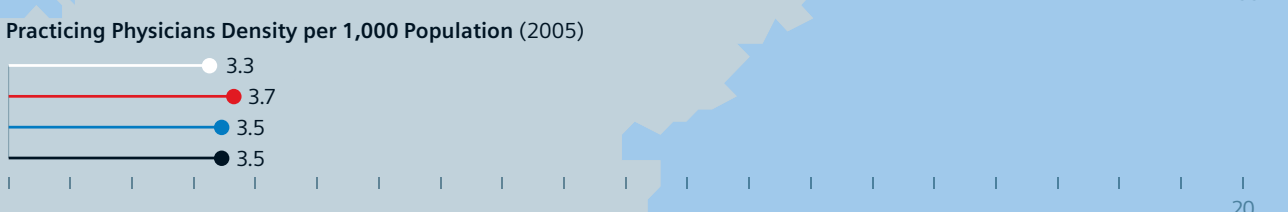
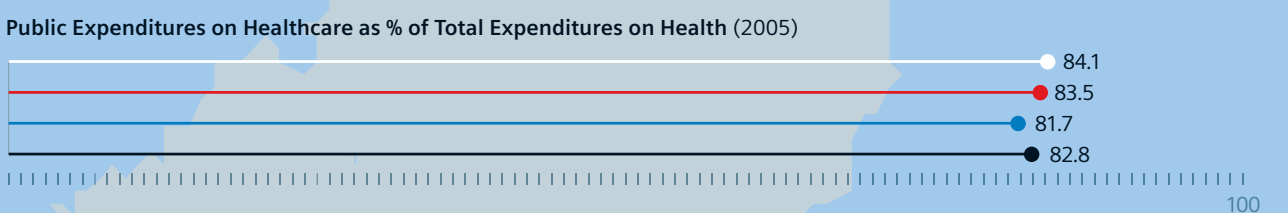
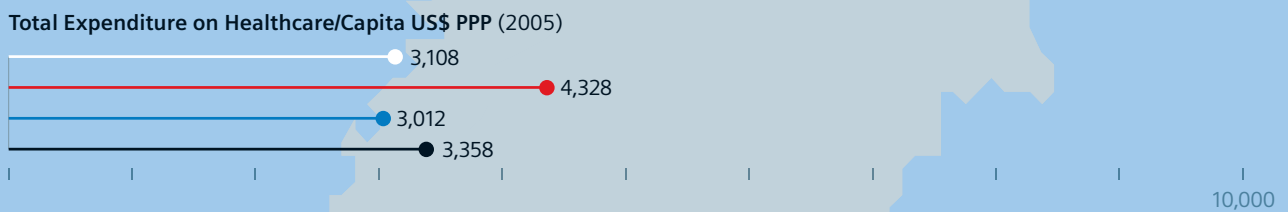
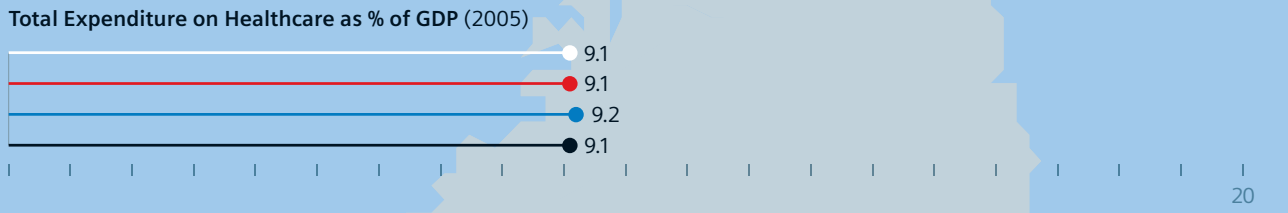
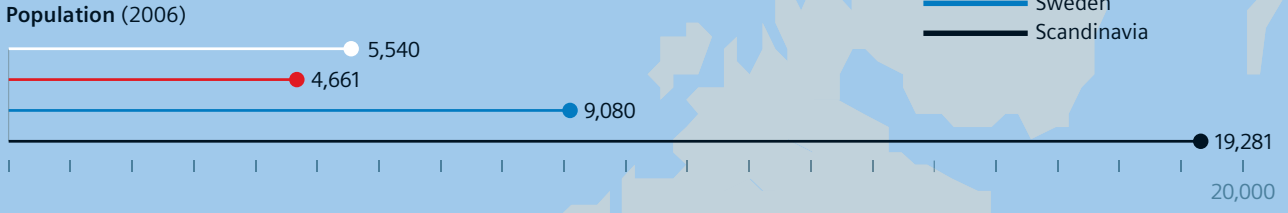
**Governance:** The Scandinavian healthcare systems are publicly governed and, in large part, also publicly owned. There is a distinction between hospitals, where the overwhelming majority are publicly owned, and primary care, where most general practices (GP) are private. Both private and public providers are, however, financed largely from public funds. The share of public financing was among the highest in the OECD at nearly 83 percent in 2005. Also, average tax rates are higher in the Scandinavian countries than in most other OECD countries, reflecting the public responsibility of most welfare services. Voluntary health insurance (VHI) is offered as a supplement to publicly financed healthcare and as a way of beating the lines. VHI is mainly chosen and paid for by employers. The share of the population that is covered by VHI varies substantially between the three Scandinavian countries and was, in 2007, estimated to be two percent in Norway, 4.5 percent in Sweden, and 14.5 percent in Denmark.

Choice of provider was only recently (early 1990s) introduced in the Scandinavian countries. While choice of GP has been possible in Norway and Denmark, and in practice in Sweden, for quite some time, choice of hospitals was previously limited to those within the same county or region. All three countries now allow for free choice of hospitals, including private hospitals, but significantly not for choice of physician within the hospital.

**Manpower and Capacity:** Scandinavian countries have slightly more physicians and nurses than the OECD average, but fewer acute-care hospital beds. The number of hospital beds is steadily decreasing, reflecting a change away from inpatient treatment towards same-day care and outpatient treatment.

Out-of-pocket payments play a minor role in all three Scandinavian countries. All have copayments for pharmaceuticals provided outside hospitals and dental care. Norway has additional copayments for outpatient specialist healthcare and primary care, and Sweden also imposes a small copayment for inpatient hospital stays. All three countries have a maximum annual amount that can be charged in copayments, thus providing a safety net for people with chronic illnesses.

Denmark  
Norway  
Sweden  
Scandinavia



<sup>1</sup> Nordic Medical Statistics (NOMESCO) <http://nomesco-eng.nom-nos.dk/default.asp?side=88>. last accessed March 5<sup>th</sup>, 2009. All other data: OECD Health Data, May 2008

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and larger regions, strengthening central control, but still leaving regionally elected politicians in charge. Sweden has stuck to its model of 21 counties, less state involvement, and no immediate plans of centralization.

What are the major challenges facing the Scandinavian countries? As in the rest of the world, the fiscal sustainability of the system is under pressure. Within the framework of the welfare state, this can be handled by three measures: reducing benefits, increasing taxes, or increasing efficiency. So far, there has been little tradition or willingness for looking at the content of the benefit package. With rapid pharmaceutical and technological developments, it is increasingly clear that universal access to (almost) free healthcare no longer can imply access to any healthcare. Therefore, a more explicit rationing in terms of what is and what is not covered by the public sector is necessary. How the three countries will deal with the introduction of new and costly technologies in the future will signal how well they will be able to cope with the necessity for rationing.

It is hard to envisage a tax-funded expansion of the healthcare sector. The Scandinavian countries are already among the countries with the highest level of taxation, and there is no political climate for increasing taxes. In Denmark, the conservative government introduced a law in 2002 prohibiting municipalities from increasing taxes.

This implies that the only way of avoiding more rationing of services is to increase efficiency. While still firmly founded on the principles of the Nordic welfare state, healthcare systems are gradually putting more weight on economic incentives, looking for more diversity in the provision of services and, at the same time, seeking models of governance that handle the challenges of a more dynamic and market-oriented system.

Healthcare in the Scandinavian countries is, as many other welfare services, regarded as a citizen's right. When this is combined with a strong tendency to oppose any arrangement that leads to geographical or social inequalities, we also understand why a parallel private market is rarely viewed as an alternative to public rationing. In this respect, the Scandinavian countries differ also from the culturally similar UK. Neither in education nor health is a two-tier private/public system the Scandinavian way. But it is difficult to see how Norway, Sweden, and Denmark can support their present systems without allowing for more diversity in how services are financed and provided. We already see that the market for private supplementary health insurance is growing rapidly in all three countries. As the pressures from the EU are likely to increase and make way for a rights-based use of foreign hospitals, the likely development is a tightening of the public benefit package combined with a loosening of the restrictions on the use of private healthcare. Whether this also implies an end to the Scandinavian model as we know it today remains to be seen.

The opinions expressed in this article do not necessarily reflect those of Siemens Healthcare.