

After decades of decentralisation, the state now has a growing role in Nordic health systems.

by Blog Admin

*The onset of the financial crisis has forced many European governments into reforming public services, including healthcare. Despite this economic turmoil, the Nordic states have so far been insulated from some of the pressures faced in other European countries. **Richard Saltman, Karsten Vrangbaek, Juhani Lehto and Ulrika Winblad** look at how the Nordic countries have moved to decentralise the control of healthcare provision over the last fifteen years. They suggest that despite their insulation from the crisis, Nordic governments may be moving towards more centralised models of healthcare provision.*



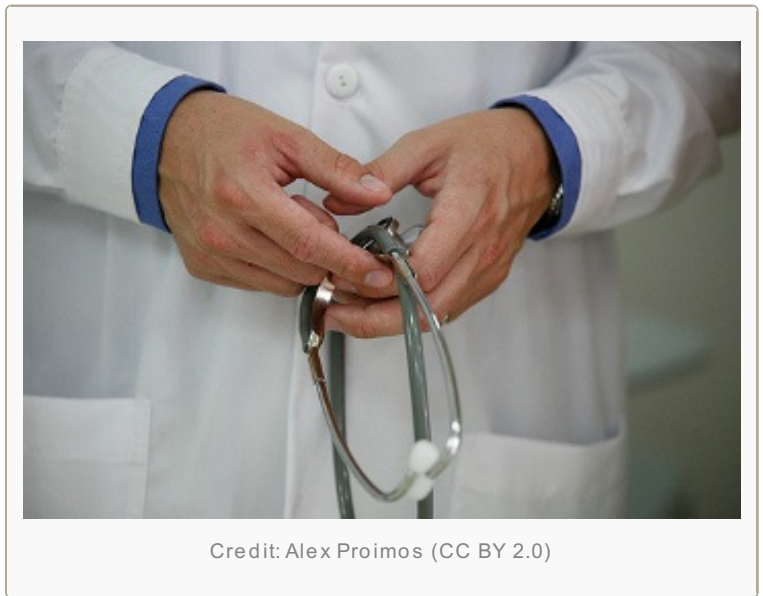
Decentralisation has [long been seen](#) as an attractive health sector strategy in Europe, and proponents of decentralised health care systems have turned in particular to the Nordic countries for support. In countries such as Norway, Denmark, Sweden and Finland, health systems have been based on local political control over most policy and administrative decisions, with locally elected representatives setting their own tax rates in order to finance those decisions. In the Nordic region, this decentralised model has been [viewed](#) as an important mechanism to ensure broad popular participation, responsiveness to patient and citizen needs, and efficient care production, all while still preserving equity among the different groups in the citizenry. Moreover, these four health care systems that are built on decentralised models (though with varied structures) have wide acceptance among their citizenry, regularly garnering high levels of support in national opinion surveys.

From a European perspective, it is notable to find that all four European Nordic countries now appear to be centralising the balance of healthcare decision-making away from the local and the regional level towards the national. This shift occurred initially in Norway and Denmark, and it now appears that a similar, though slower process, is underway in Sweden and Finland. While these changes are deeply rooted in on-going dilemmas within Nordic health systems, the emergence of this new pattern of consolidation carries important implications for other decentralised health systems elsewhere in Europe and beyond.

While formal administrative structures have given certain powers to different levels of government in these countries, power over important core elements of health care governance has been, and continues to be, centralised and uniform in all four countries. This includes macro-economic policy regulations that set tight frameworks for local/regional government taxation; bargaining and contracts for health care employee wages; setting the general rules for inhabitants' entitlements to health services; as well as preparing and adopting clinical guidelines and a number of other standards.

Denmark and Norway –decentralisation and centralisation

In the 2000s, both Norway and Denmark restructured their health care systems, abolishing the prior elected county council system of local control and replacing this with new regional governments at the county level. These regional governments can no longer raise taxes, but are directly financed by the central government, eliminating a key lever of power and credibility for regional administration, and making these new actors directly dependent on national government decisions for their funding. At the same time, both countries have strengthened the role of the municipal authorities in delivering long-term care, prevention and rehabilitation services. This shift was backed by economic incentives in the form of municipal co-payments if their citizens were hospitalised, thereby encouraging municipalities to develop services and strengthen their efforts to prevent unnecessary hospitalisation.



Now, a new financial stability law in Denmark will impose sanctions on regions and municipalities that do not keep within their budgets – which are agreed with the national government. This reinforced budgeting supervision creates a de facto national veto on the ability of Danish municipalities to set their own expenditure levels – dramatically reducing their level of authority downward such that, in practice, the national government is now making the essential fiscal decisions for both regional and municipal levels of local government.

A second arena in which the Danish national government has exerted new authority is in the design and building of new public hospitals. Since the majority of the capital funds now come directly from the national government (as the regional governments have lost their right to tax), the national government has placed tight requirements on these new “super hospitals” regarding the specialised services that they must include, to the point of dictating that at least 20-25 per cent of the total hospital expenditure must be devoted to new technologies. The goal appears to be to continue the on-going centralisation of hospital services into much larger units in order to increase the quality of the technical services offered, and to thereby respond to citizen demands for more modernised and effective services. The Danish state also has mandated that the municipalities and regions must enter into comprehensive health agreements to create more efficient interaction between primary care, municipal health and social care, and hospital care.

Norway also fits the pattern of increasing national authority. For example, the five regional state enterprise councils initially envisioned in the 2002 reform were reduced to four in 2007, when two regions were amalgamated into one. The general expectation among policy analysts is that on-going inadequacies in the performance of the existing structure will likely lead to future changes in the direction of yet greater national control.

The simultaneous strengthening of the state and the municipal authorities within health care has changed the balance of power within the Danish and Norwegian health systems. Regions are still important for making operational decisions and for developing strategic plans, but now within a more constrained environment. While directly elected politicians remain in power in the Danish regions, the Norwegian councils' members are appointed from Oslo, largely eliminating the democratic participation and legitimacy that had previously accompanied having their predecessor county councils directly elected.

Finland and Sweden – indirect consolidation

Finland and Sweden too are now beginning to restructure their local and regional governments in a way that may lead to a consolidation of more health sector authority in national political hands. In both countries, the national decisions behind this strategic shift appear driven primarily by long-term concerns about quality

of care and equal access to health care services regardless of where one lives in the county. There is also concern about the growing need to re-structure health service delivery in the face of new technologies and rapid population ageing, with an accompanying desire to achieve these objectives more efficiently and effectively.

In the mid-2000s, Finland's government began a process of consolidating municipal governments (which are the owners and operators of the Finnish health system, typically through federations with neighbouring districts) into fewer, larger, more administratively and financially capable units. For its five million people, Finland now has 339 local governments, reduced from over 450, with the on-going consolidation process aiming to result in 70 municipalities or less. By comparison, Denmark re-structured its municipalities from 271 to 98 as part of its structural reforms in 2006-2007. This process of municipal consolidation could well be a preview to consolidating the twenty hospital districts (made up of federations of municipalities) and the existing public hospital structure into five regional hospital consortiums built around the five university hospitals.

Finland is also debating again the potential consolidation of its two different sources of public funding for health care, which would involve folding parts of the national health insurance fund (KELA) into the existing publicly financed, municipally operated health system structure. If this occurs, it would remove a source of funding that has been used to provide partial public funding for Finns to use private medical services, in effect further consolidating the position of the public authorities in the health care system. It may not reduce private health care provision, however, as the public authority-run system is itself increasingly outsourcing the provision of health services that it funds.

In Sweden, since its election in 2006 the national Conservative-led government has sought to exert more strategic authority over the officially independent 21 county councils. For instance, since 2007, the Ministry of Health has required permits from the National Board of Health and Welfare for certain advanced specialisations, and is seeking to consolidate them in only a few locations in the country. There are also examples of increasing state monitoring and supervision. For instance, starting in 2006, the national government began publishing yearly comparative data showing the quality of key clinical services provided by each county. Another example has been the National Guidelines, developed by the National Board of Health and Welfare in order to govern clinical prioritisation as well as resource allocation within the counties. These National Guidelines are also [used](#) as an instrument for the national government to exercise control over local political decision-making. Similar developments of monitoring systems and national guidelines have also been introduced in Denmark in recent years, although Denmark has chosen to back this with mandatory accreditation of all health care providers (including municipal and primary care) at regular three-year intervals.

These efforts at service consolidation in Sweden are being made in the context of a 2007 [national commission](#) which proposed that the existing 21 counties be combined into six to eight regional governments to run health services. While the commission's recommendations were not adopted, efforts to encourage voluntary mergers between counties have been intensified lately (the three large metropolitan areas are already large merged counties).

The economic crisis has had minimal impact on Nordic healthcare reform

Unlike many other European countries, the Nordic countries have weathered the post 2008 economic crisis relatively well. Both Finland and Sweden had suffered severe economic contractions in the early 1990s, complete with collapsing real estate prices and nationalisation of major banks, and had had to re-engineer their financial systems more than a decade before the 2008 wave broke. As a result, neither country was particularly vulnerable in this latest downturn. Norway, buoyed by oil revenues and relatively tight national economic management, suffered little economically either in the early 1990s or in the post-2008 period. Denmark had a strong economy going in to the financial crisis and has maintained relatively strong exports of diverse manufacturing, pharmaceuticals, and consumer goods. This has reduced the effects of the crisis in spite of a drop in the housing market of 22 per cent since 2007.

Certainly, concerns about the potential economic slowdown among other European trading countries (only Finland is a member of the Eurozone) have intensified health sector costs and efficiency pressures in all four countries, and all four countries reduced their health care expenditure to GDP ratios after 2009. However, general public budgets have not been as severely affected as in many other European countries.

In the debate over the relative benefits of decentralised versus centralised health system strategies, evidence from the Nordic countries has traditionally been strongly supportive of decentralised approaches. This has been backed by social values about local control, as well as financial mechanisms that included only a small national government apparatus to steer health system decision-making, emphasising “framework legislation.”

However, recent evidence indicates that this Nordic commitment to a reduced role for their national governments in the health sector may be weakening. In these countries, and elsewhere in Europe, it would seem that a combination of rapidly changing technology, growing pressure from patients, and stark, if as yet unrealised, fears about the cost consequences of an ageing population have led Nordic countries to considerably increase the steering and supervisory role of their national governments. The degree to which this shift appears to be relatively independent of on-going economic problems in Europe can only serve to strengthen the broader implications of the structural shift that appears to be underway.

A longer version of this article appeared in [Eurohealth](#), a quarterly publication produced by the [European Observatory on Health Systems and Policies](#) at [LSE Health](#).



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