Social and health care reform

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Economic Policy Council seminar 23.1.2019

Introduction

- Aims of the reform
  - Improved access to services
  - Reduced inequality in access
  - Costs savings of 3 billion €
- Social and health care reform & fiscal sustainability
  - Justification for 3 bn € savings target?
  - Mechanisms for productivity improvements?
  - Proposals contain elements that tend to increase costs

  → Reform unlikely to bring savings to the public sector

Issues that require further attention

- Public-private mix in health care
- Reimbursement rule for providers
- Occupational health care
- Experimentation and implementation

Public-private mix in health care

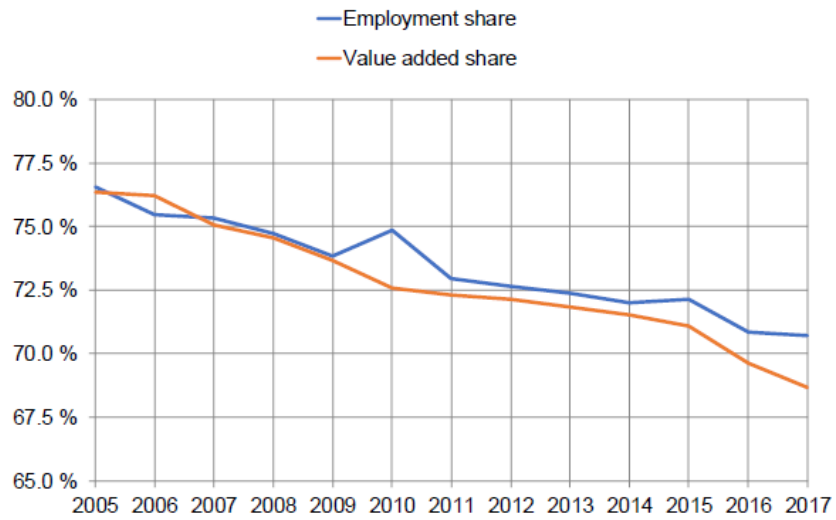
- Freedom of choice in the current Finnish system
  - In general: Competition ≠ private provision
  - In this reform: Increasing freedom of choice effectively means increasing the role of private providers

- Three roles for the public sector in health care
  (i) Organizing health care
  (ii) Funding
  (iii) Provision

Public-private mix in health care

Service provision

Figure 5.2.1. Public sector's share of employment and value added in Finland in the social and health care sector, 2005-2017.



Source: Statistics Finland (National Accounts and Labour Force Survey)

Table 5.1: The projected increase in the share of private provision in publicly funded social and health care.

	Private sector share		Expenditure in 2016, EUR billion
	2016 (realized)	2024 (projected)	
All publicly funded social and health services	17%	24%	18.5
Social services	32%	39%	7.9
Health services	6%	13%	10.6
Primary health care	7%	26%	3.7
Specialised health care	5%	6%	6.9

Source: Ministry of Social Affairs and Health (2018a). Item "All publicly funded social and health services" does not include environmental health services.

Public-private mix in health care

Service provision

- Health care as a credence good
  - Health care quality: right treatment for a given condition
  - 1st and 2nd degree moral hazard
- Empirical research does not find big differences in costs or quality between private and public providers
  - Potential caveats to applicability of this evidence to Finnish reform
- There is strong evidence from many countries that health care providers react to financial incentives

Reimbursement rule for providers

- Provider reimbursement potentially affects costs, quality and equality of access
- Based (at least 2/3) on capitation
- First results on designing the capitation model in the THL-VATT background report
- Exercise based on predicting health care usage and costs at the individual level
- Needs adjustment:A balancing act between
  (i) eliminating incentives for patient selection
  (ii) ensuring incentives for cost efficiency
- Selection depends on how much risk remains unpriced in the model: under/over-compensation of certain groups
- Data problems: e.g. sickness indicators, occupational health care

Public-private mix in health care

Funding

- One aim in government programme was to reform the funding system for health care
  - Public funding to health care through 3 channels
  - Funding through partial reimbursement of private health care visits to be discontinued
  - Occupational health care left ouside of the reform

- Not much discussion of public-private mix in health care funding in the context of the reform

Duplicate coverage and occupational health care

- Approx. 85 % of employed individuals covered by occupational health care and 1,2 million Finns have private insurance
- Potential effects in the freedom of choice model

  (i) Mechanical effect: duplication of costs if lower need for care not taken into account in reimbursement rule

  (ii) Behavioural effects on supplier side: cream-skimming and info rents

  (iii) Behavioural effects on customer side:
    - Duplicate coverage increases demand for health care (unnecessary visits?)
    - Shifts away from privately funded services increase public sector costs
- (i) and (ii) can potentially be partially tackled via reimbursement rule, but information is lacking

Occupational health care

- Taking into account occupational care in reimbursement rule
  - Ideal: coverage of occupational health care at employer level
  - A possible proxy: occupational health care costs per emloyee

Table 5.2: Distribution of employees by average occupational health costs of the employer.

Average occupational health costs, € per year per employee	Number of employees
0-100	109 972
100-200	108 351
200-300	175 064
300-400	368 182
400-500	435 890
>500	638 486
Total	1 835 945

Source: Kela

Overall outcomes?

- Will cost savings be achieved? What will happen to health care access?
  - Tension between cost savings & better access remains unresolved
    - Constitutional law committee required that sufficient funding for health care has to be guaranteed
    - New provisions make the counties' soft budget constraint vis-a-vis the central government explicit
  - Queues likely become shorter if there's sufficient entry, quality depends on incentives
  - Reliance on markets + role of occupational health care – unclear effects on equality of access

Experimentation and implementation

- Current service voucher experiments provide little guidance on potential effects of the reform
  - No clear control group
  - Lack of controlled variation in the policies being tested
  - Potential for strategic behaviour by providers
  - May still be useful for administrative development
- Risks and uncertainty associated with effects of the reform could be alleviated with phased-in implementation
  - e.g. extending freedom of choice more gradually