Social and health care reform

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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

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

<table>
<thead>
<tr>
<th></th>
<th>Private sector share</th>
<th>Expenditure in 2016, EUR billion</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2016 (realized)</td>
<td>2024 (projected)</td>
</tr>
<tr>
<td>All publicly funded social and health services</td>
<td>17%</td>
<td>24%</td>
</tr>
<tr>
<td>Social services</td>
<td>32%</td>
<td>39%</td>
</tr>
<tr>
<td>Health services</td>
<td>6%</td>
<td>13%</td>
</tr>
<tr>
<td>Primary health care</td>
<td>7%</td>
<td>26%</td>
</tr>
<tr>
<td>Specialised health care</td>
<td>5%</td>
<td>6%</td>
</tr>
</tbody>
</table>

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 outside 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 employee

<table>
<thead>
<tr>
<th>Average occupational health costs, € per year per employee</th>
<th>Number of employees</th>
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<tbody>
<tr>
<td>0-100</td>
<td>109 972</td>
</tr>
<tr>
<td>100-200</td>
<td>108 351</td>
</tr>
<tr>
<td>200-300</td>
<td>175 064</td>
</tr>
<tr>
<td>300-400</td>
<td>368 182</td>
</tr>
<tr>
<td>400-500</td>
<td>435 890</td>
</tr>
<tr>
<td>&gt;500</td>
<td>638 486</td>
</tr>
<tr>
<td>Total</td>
<td>1 835 945</td>
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</table>

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