Denmark: health care indicators

Group 5: Denmark, Finland, Mexico, Portugal, Spain

A. Efficiency and quality
B. Amenable mortality by group of causes
C. Prices and physical resources
D. Activity and consumption
E. Financing and spending mix
F. Policy and institutions

Note: Country groups have been determined by a cluster analysis performed on policy and institutional indicators. In all panels except Panel A, data points outside the average circle indicate that the level of the variable for the group or the country under scrutiny is higher than for the average OECD country (e.g. Australia has more scanners than the OECD average country).
In Panel A, data points outside the average circle indicate that the group or the country under scrutiny performs better than the OECD average country (e.g. administrative costs as a share of total health care spending are lower in Australia than on average in the OECD area).
In all panels except Panel F, data represent the deviation from the OECD average and are expressed in number of standard deviations.
In Panel F, data shown are simple deviations from the OECD average.

DENMARK

GROUP 5: Mostly public insurance. Health care is provided by a heavily regulated public system and the role of gate-keeping is important. Patient choice among providers is limited and the budget constraint imposed via the budget process is rather soft.

<table>
<thead>
<tr>
<th>Efficiency and quality</th>
<th>Prices and physical resources</th>
<th>Activity and consumption</th>
<th>Financing and spending mix</th>
<th>Policies and institutions</th>
<th>Weaknesses and policy inconsistencies emerging from the set of indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lower DEA score but slightly below-average health inequalities</td>
<td>Spending per capita and as a share of GDP stand above the OECD and group averages</td>
<td>Higher tax-financed shares</td>
<td>Less market for the &quot;over-the-basic&quot; segment</td>
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<td>Rather high output/hospital efficiency</td>
<td>More nurses and medical students per capita. Less acute care beds per capita</td>
<td>More hospital discharges</td>
<td>Higher in-patient share</td>
<td>Less price signals on users</td>
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<tr>
<td>Mixed scores on the quality of preventive and outpatient care</td>
<td>Lower income level for specialists, high income level for nurses</td>
<td>More doctor consultations</td>
<td>Higher out-patient share</td>
<td>More private provision</td>
<td>Introducing co-payments for visits to GPs could help avoid excessive demand</td>
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<td>Lower administrative costs</td>
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<td>Less decentralisation and consistency in responsibility assignment, less regulation of resources</td>
<td>Enhanced priority setting (in particular the definition of the benefit basket and the monitoring of public health objectives) and greater consistency in the allocation of responsibilities across levels of government could deliver efficiency gains</td>
<td></td>
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