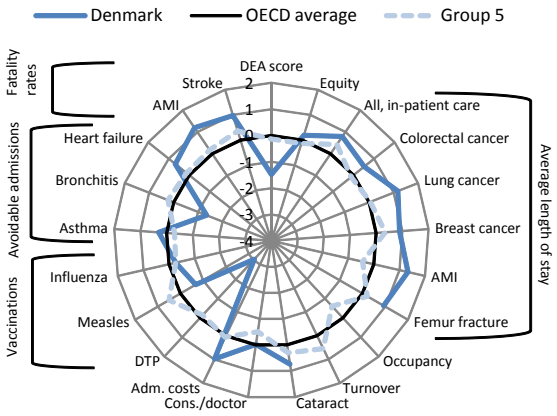
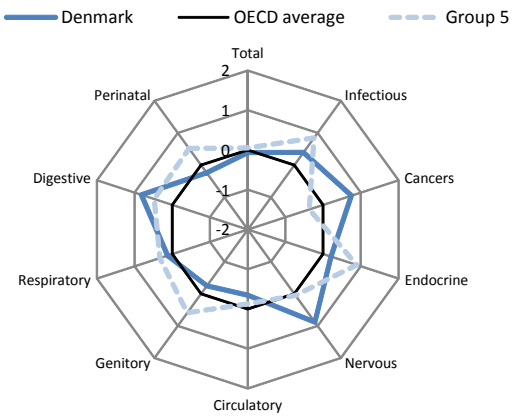
Denmark: health care indicators

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

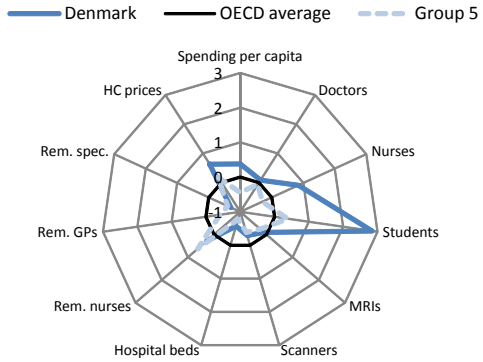
A. Efficiency and quality



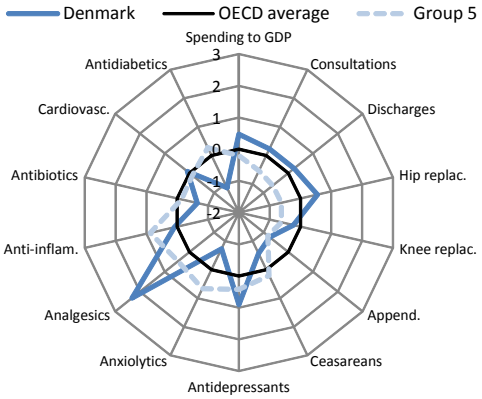
B. Amenable mortality by group of causes



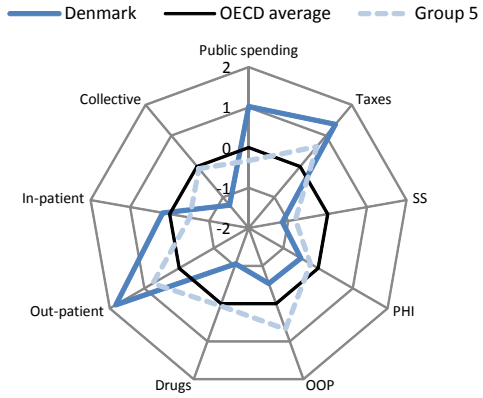
C. Prices and physical resources



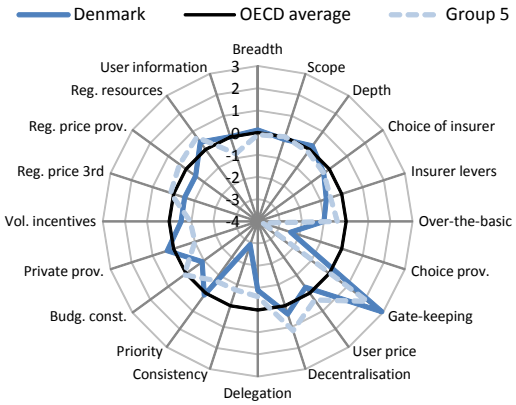
D. Activity and consumption



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 (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.

Source : OECD Health Data 2009; OECD Survey on Health Systems Characteristics 2008-2009; OECD estimates based on Nolte and Mc Kee (2008).

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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.

Efficiency and quality	Prices and physical resources	Activity and consumption	Financing and spending mix	Policies and institutions	Weaknesses and policy inconsistencies emerging from the set of indicators
Lower DEA score but slightly below-average health inequalities	Spending *per capita* and as a share of GDP stand above the OECD and group averages		Higher tax-financed shares	Less market for the "over-the-basic" segment	
Rather high output/hospital efficiency	More nurses and medical students *per capita*. Less acute care beds *per capita*	More hospital discharges	Higher in-patient share	Less price signals on users	
Mixed scores on the quality of preventive and out-patient care	Lower income level for specialists, high income level for nurses	More doctor consultations	Higher out-patient share	More private provision	Introducing co-payments for visits to GPs could help avoid excessive demand
Lower administrative costs				Less decentralisation and consistency in responsibility assignment, less regulation of resources	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