Technische Universität Berlin

Health care systems in Europe

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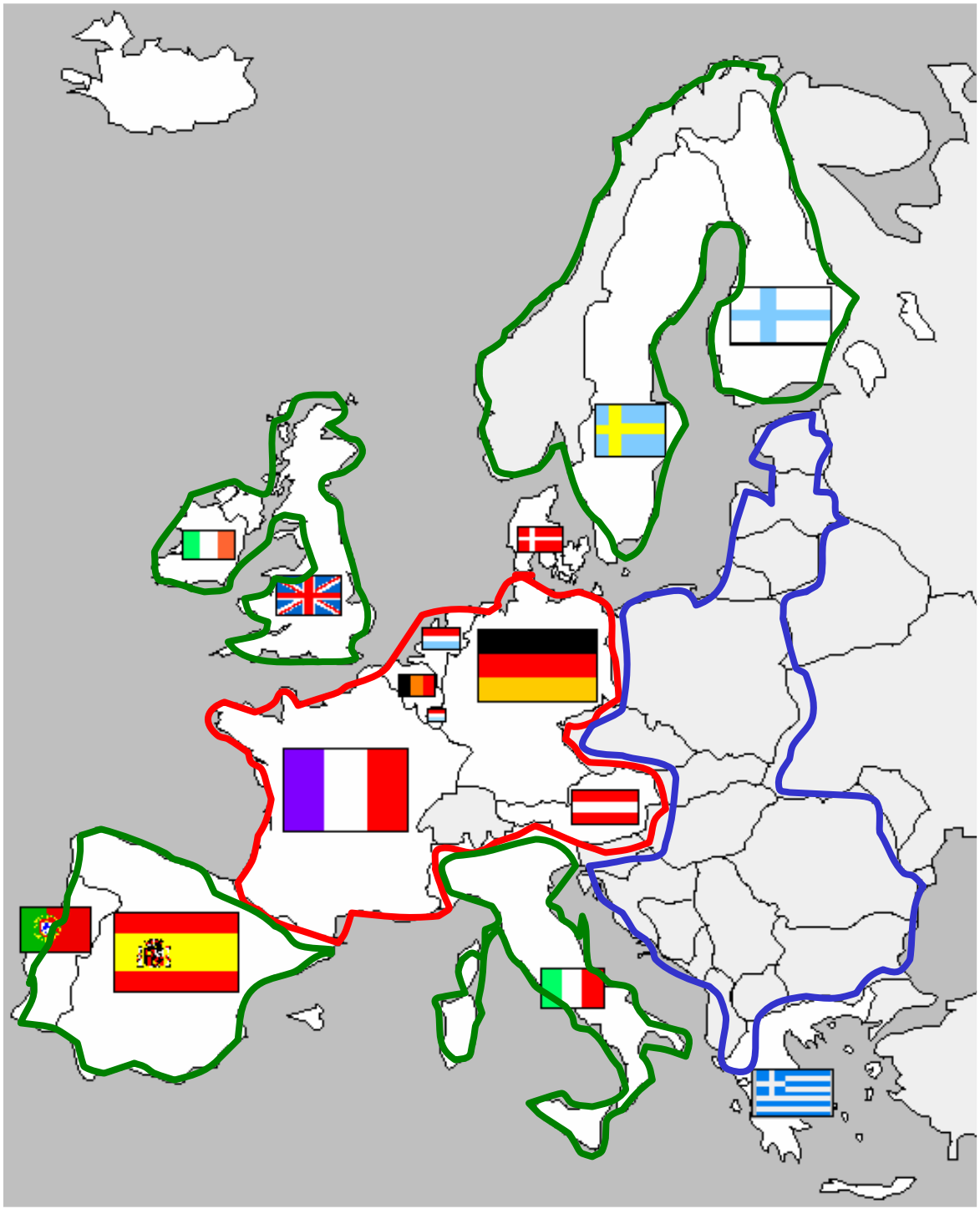
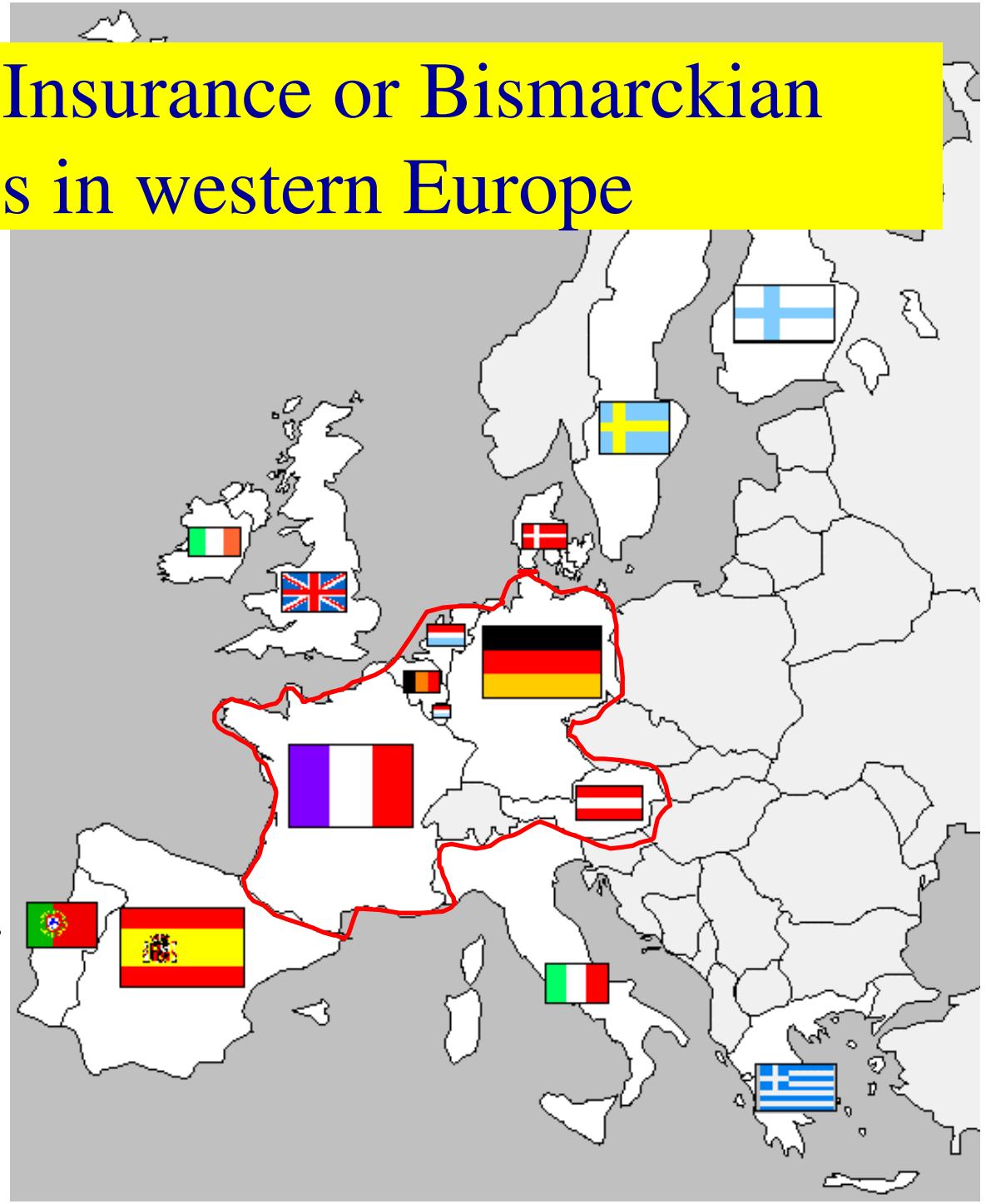
- Social health insurance countries in western Europe
- Central and eastern Europe (Semashko to SHI)
- Tax-based systems in western Europe

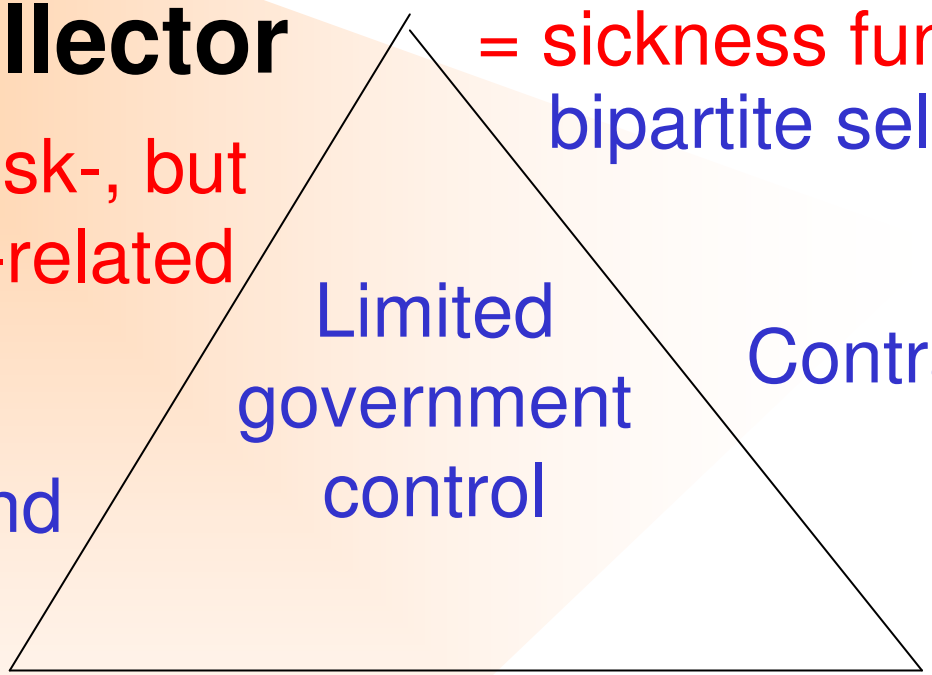


Social Health Insurance or Bismarckian countries in western Europe

- SHI definition
- Commonalities and variations between countries
- Analysis regarding impact on health status, efficiency, equity, satisfaction ...
- Future dynamics and challenges



What makes a health system a SHI system?



Contribution collector

Not (health) risk-, but usually wage-related contribution

Third-party payer

= sickness funds

bipartite self-government

Limited government control

Contracts

Choice of fund

Free access

Population

Mandatory insurance

Providers

Public-private mix

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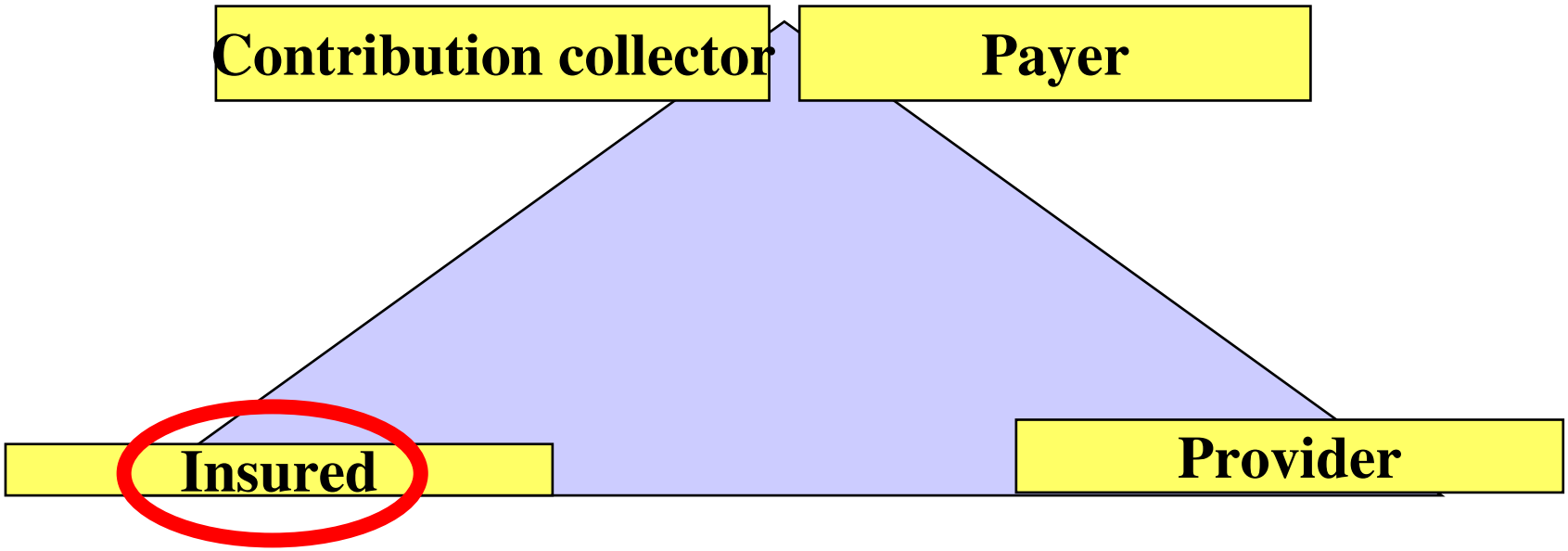
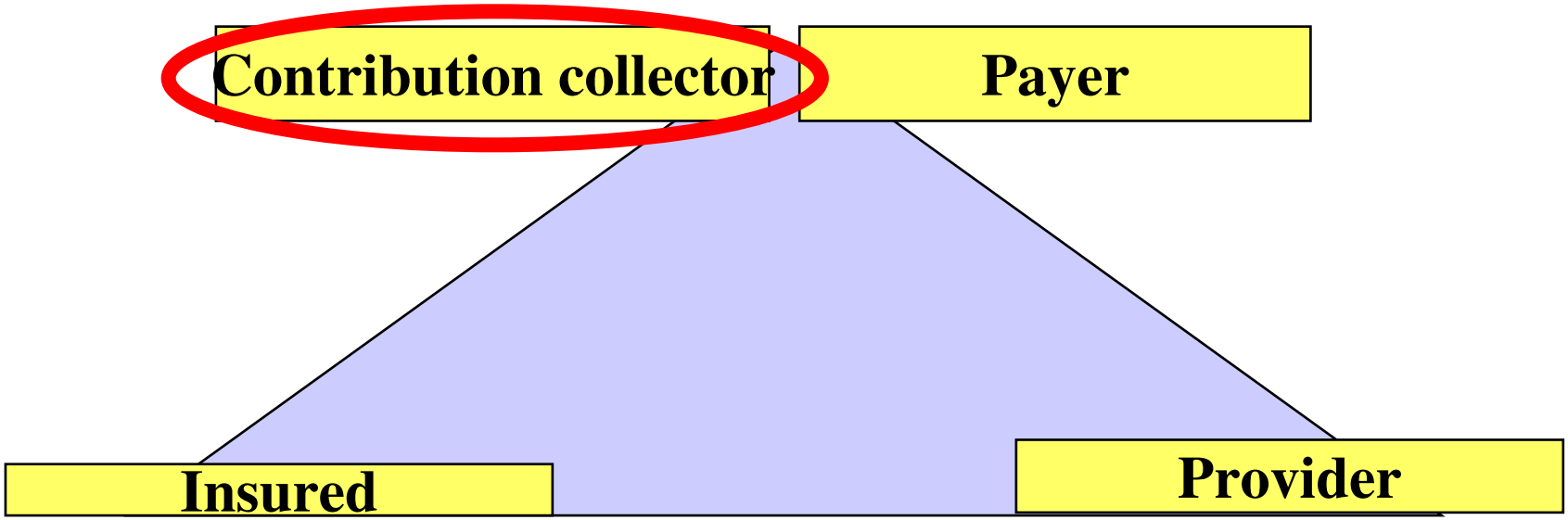
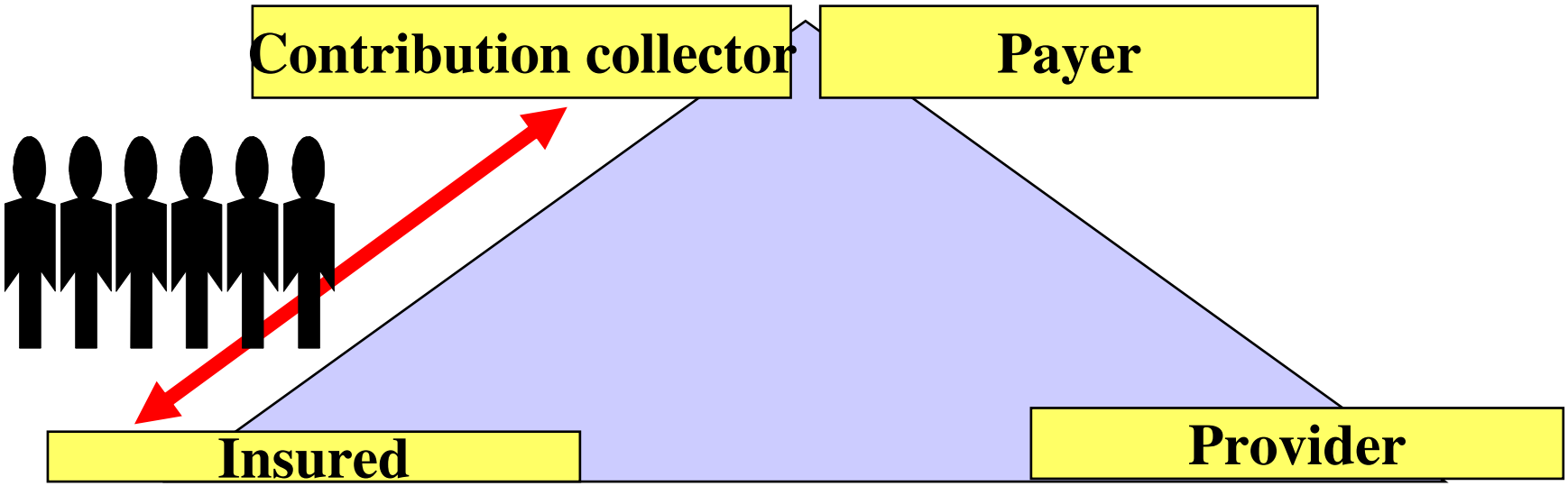
- ***Solidarity*** refers to a set of four cross-subsidies on the funding side (healthy to sick, well-off to less-well-off, young to old, and individuals to families) that provide equal benefits on the entitlements side.
- ***Pluralism*** refers to a complex mix of different public, quasi-public, not-for-profit, and sometimes for-profit actors.
- ***Participation*** refers to shared governance among these actors, sometimes described as "self-regulation".
- ***Choice*** refers to insurees' ability to select among contracted providers and, in four of the eight countries, among different sickness funds.



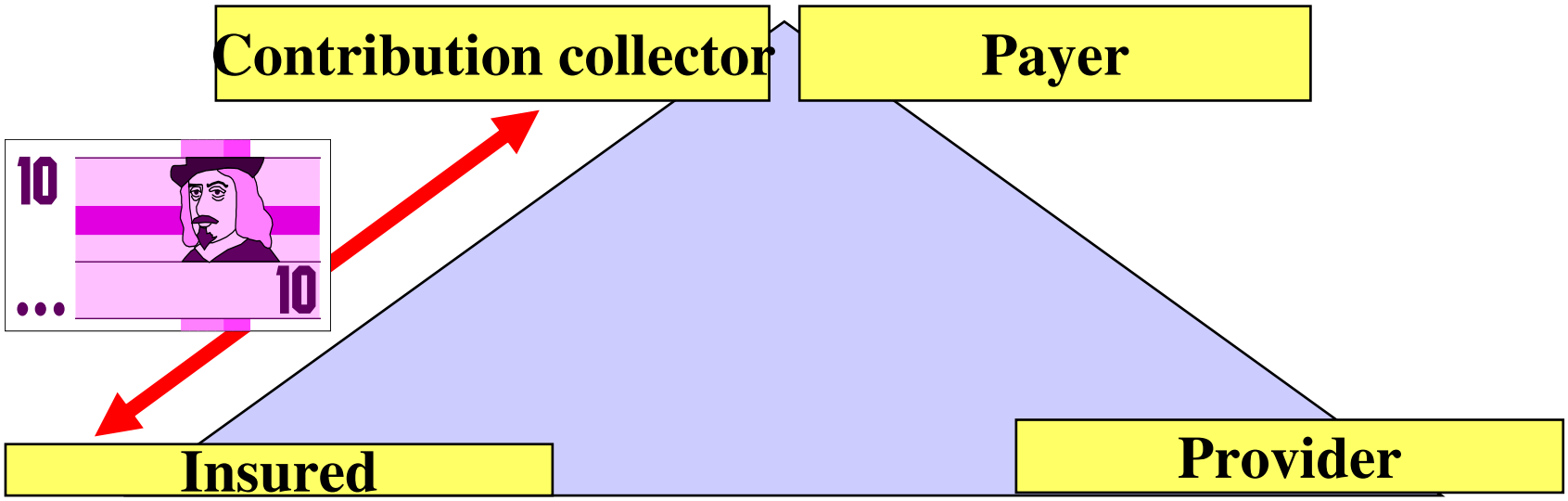
- 100% population coverage in Austria, Belgium, France, Luxembourg, Switzerland (since 1996!)
- 75% mandatory and 13% voluntary coverage in Germany (choice between SHI and PHI)
- 65% coverage in Netherlands (no choice!)



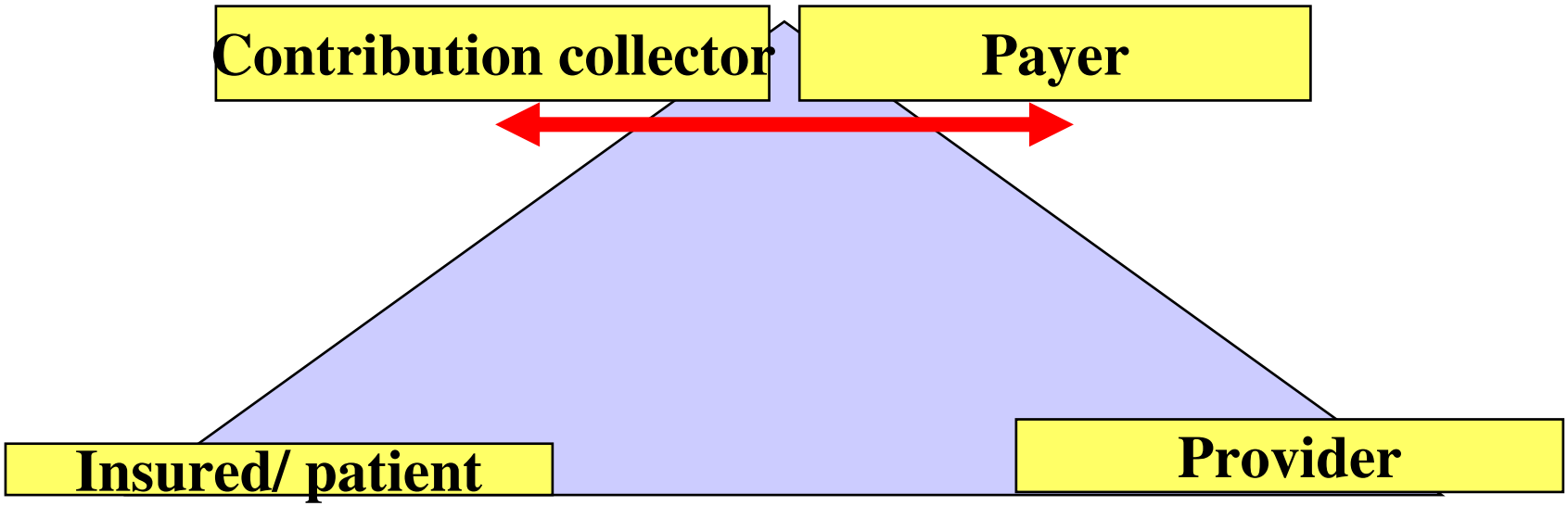
- Government (Belgium, France, Netherlands)
- Union of sickness funds (Luxembourg)
- Individual sickness funds (Austria, Germany, Switzerland)



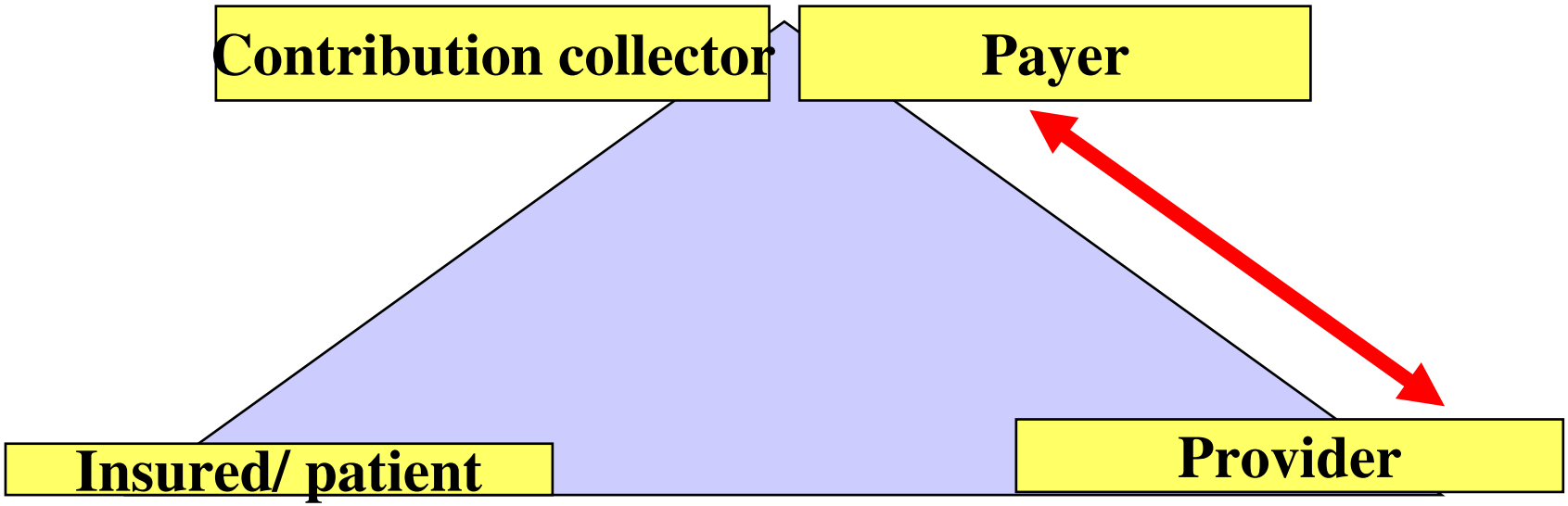
- Pre-determined membership in Austria, France, Germany (until 1995) and Luxembourg
- Free choice of fund in Belgium, Netherlands (1993-), Germany (1996-) and Switzerland



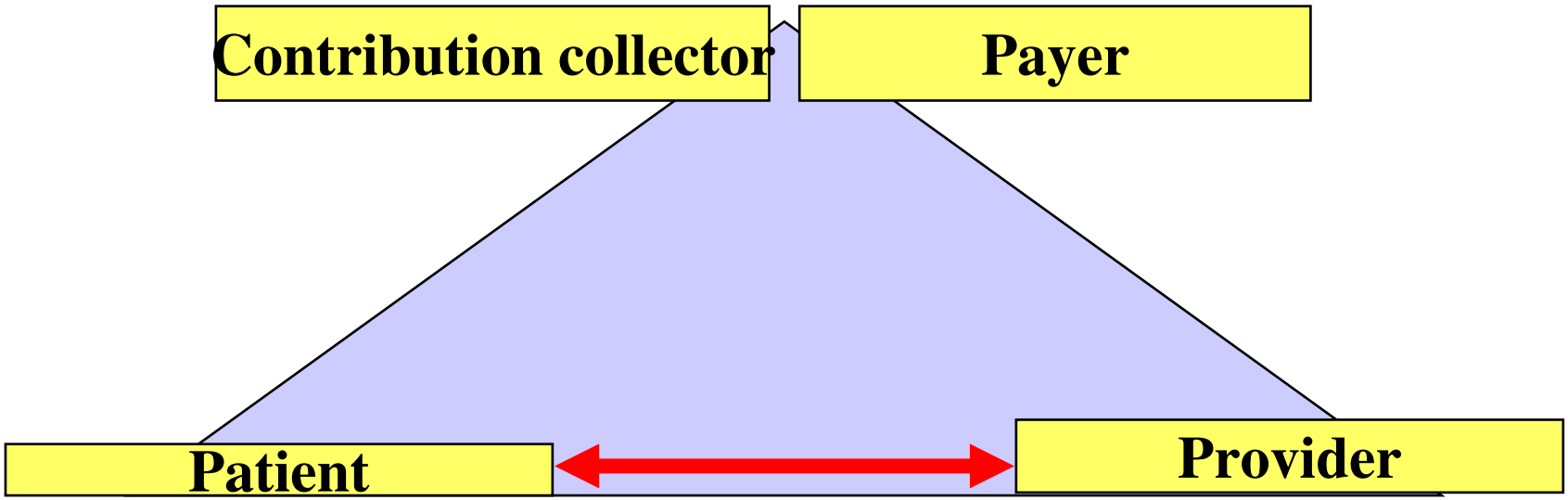
- Uniform rate in Austria, Belgium, France, Luxembourg and Netherlands (+ differing per-capita premium); differing rate in Germany; per-capita premium in Switzerland.
- Contribution cap in Austria and Germany but **not** in Belgium and France.
- France: in 1999 change from income-related contribution (8.9%) to tax on total income (8,25%)
- In the Netherlands, privately insured subsidise SHI, in Germany not.



- allocation (Belgium, Netherlands) or re-allocation (Germany, Switzerland)
- area of allocation: nation vs. region (Switzerland), degree of retrospective compensation (not in Germany and Switzerland), differing factors in the formulas (e.g. region in NL), different types of expenditure included, use of high-risk pool

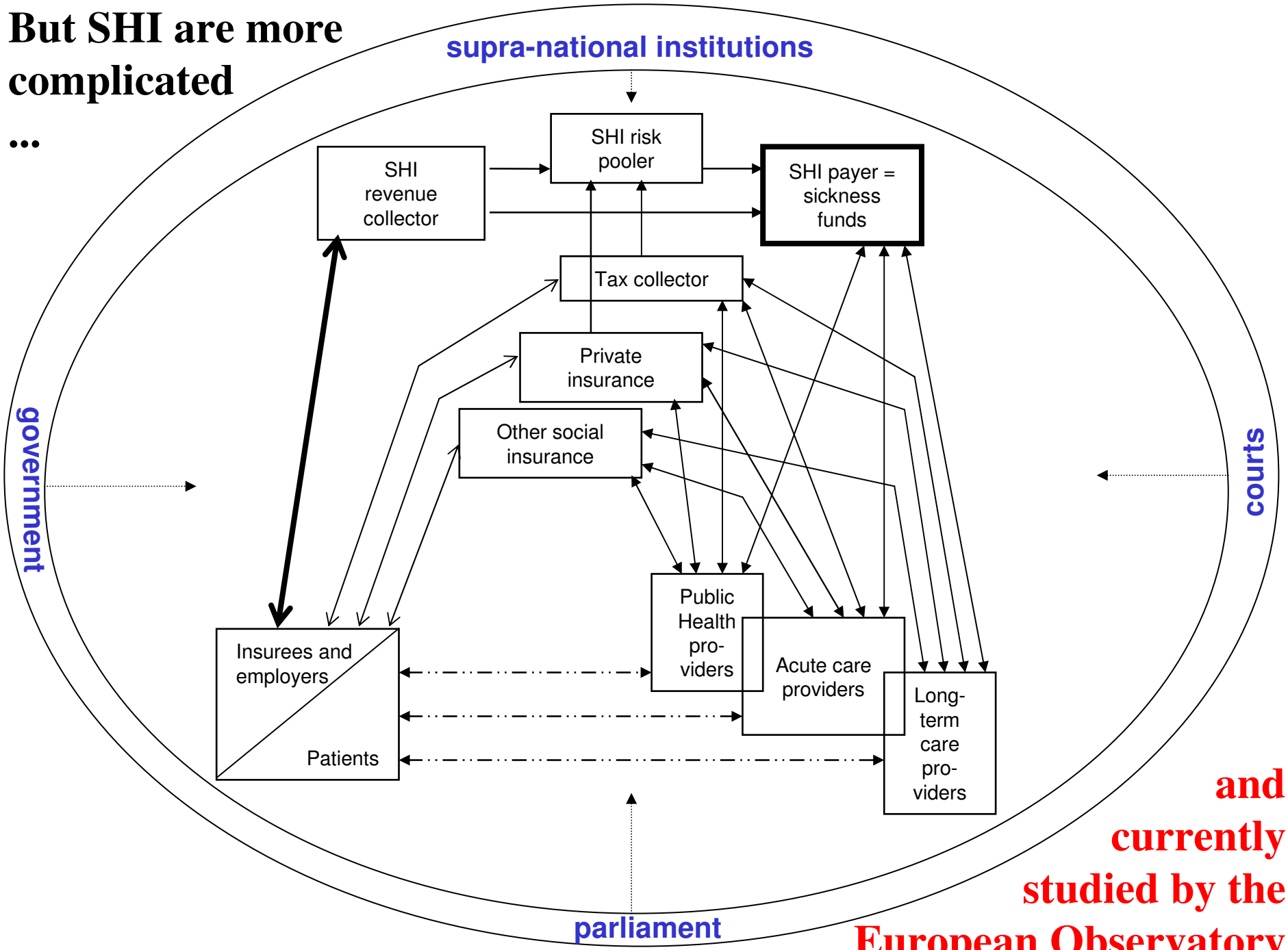


- all SHI systems are traditionally multi-payer systems – problem: weak cost-control
- solutions: budgets – via state (Austria, France) or collective contracts
  (problem: contradict competition between funds)
- Netherlands: collective contracts will be illegal – but: funds hardly use selective contracts and reimbursement at lower than maximum rates



- Free access = feature of SHI systems (except NL): Gatekeeping = more effective, cheaper, but less popular?
- Attempts in the Netherlands to separate “core” benefits from others (to be paid for privately) has failed: dental care was partly re-introduced; not covered services make up only 3% of expenditure

But SHI are more complicated ...

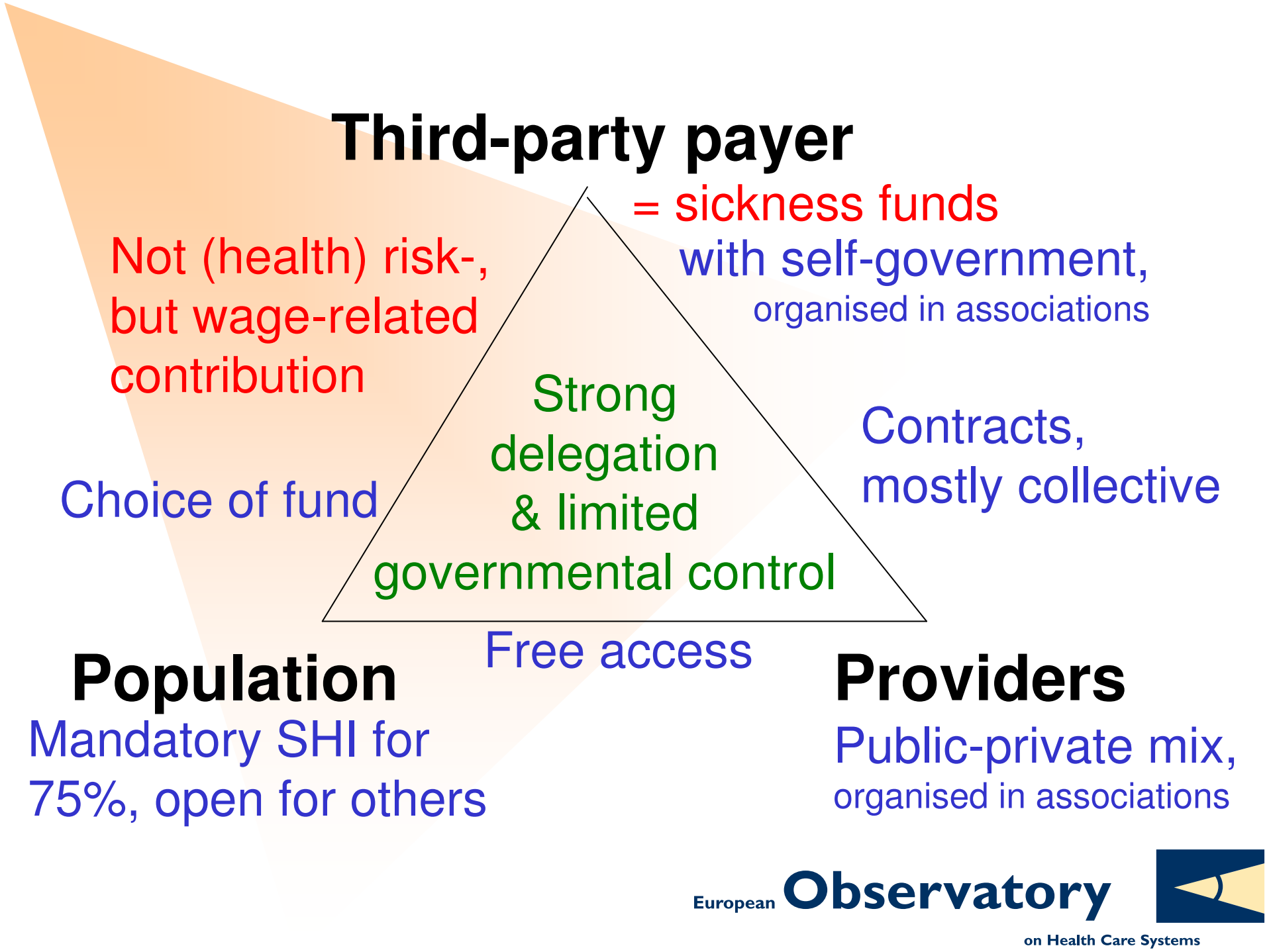


and currently studied by the European Observatory

Case study

Germany

More information and full report available at:
www.observatory.dk



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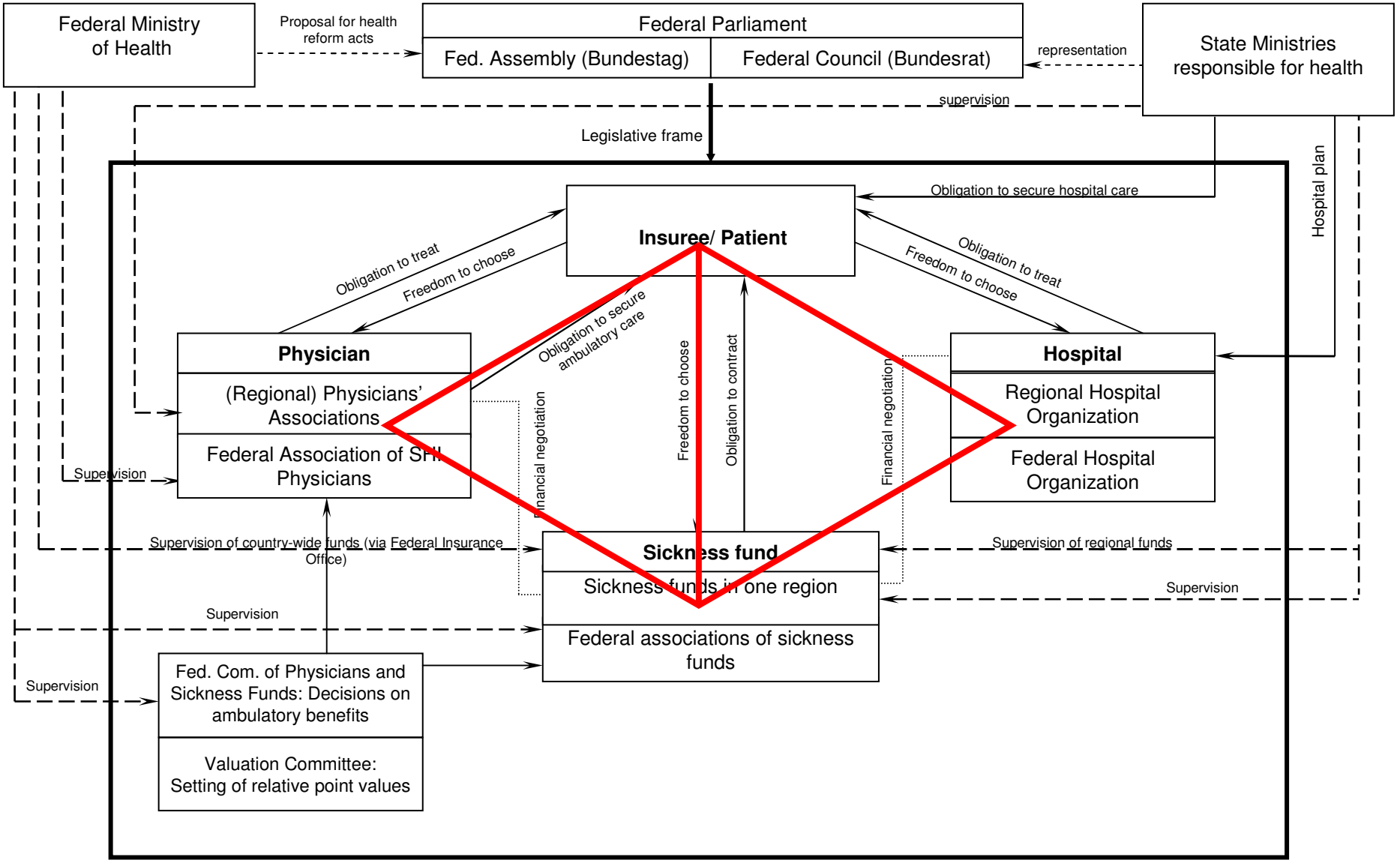


Statutory health insurance 1998

Problem 1: sectorisation of health care delivery

- state-run public health service: decreasing as many activities (immunizations, screening ...) have moved to ambulatory sector
- office-based ambulatory care: powerful and still growing with full range of specialties
- hospitals concentrating on inpatient care (no regular out-patient departments)
- plus rehabilitation etc.

Why this separation?

different history, development and legislative framework:

- ambulatory care = “battle-field“ between physicians and sickness funds resulting in delivery monopoly for physicians´ associations but joint decision-making under federal law
- hospitals = originally not included in constitution, i.e. in responsibility of states, later transferred into joint federal-state responsibility

Differences in planning, regulation and financing

- Benefits: A = decided jointly by physicians and sickness funds, H = not explicit
- Capacity planning & accreditation: A = jointly by physicians and sickness funds, H = by states
- Reimbursement: A = according to uniform fee schedule but depending on overall utilization, H = mainly by per-diems, differing from hospital to hospital (DRGs from 2003); both under separate budgets

Problem 2: Rising expenditure and attempts to solve the problem

- Attempt 1: budgets and spending caps (1989-1996/7 and 1999ff)
- Attempt 2: regulated competition among sickness funds (1993ff)
- Attempt 3: higher co-payments, exclusion of benefits, “privatisation“ of patient-provider-relationship (1997/98; then abolished)
- Attempt 4: health technology assessment (HTA), guidelines etc.

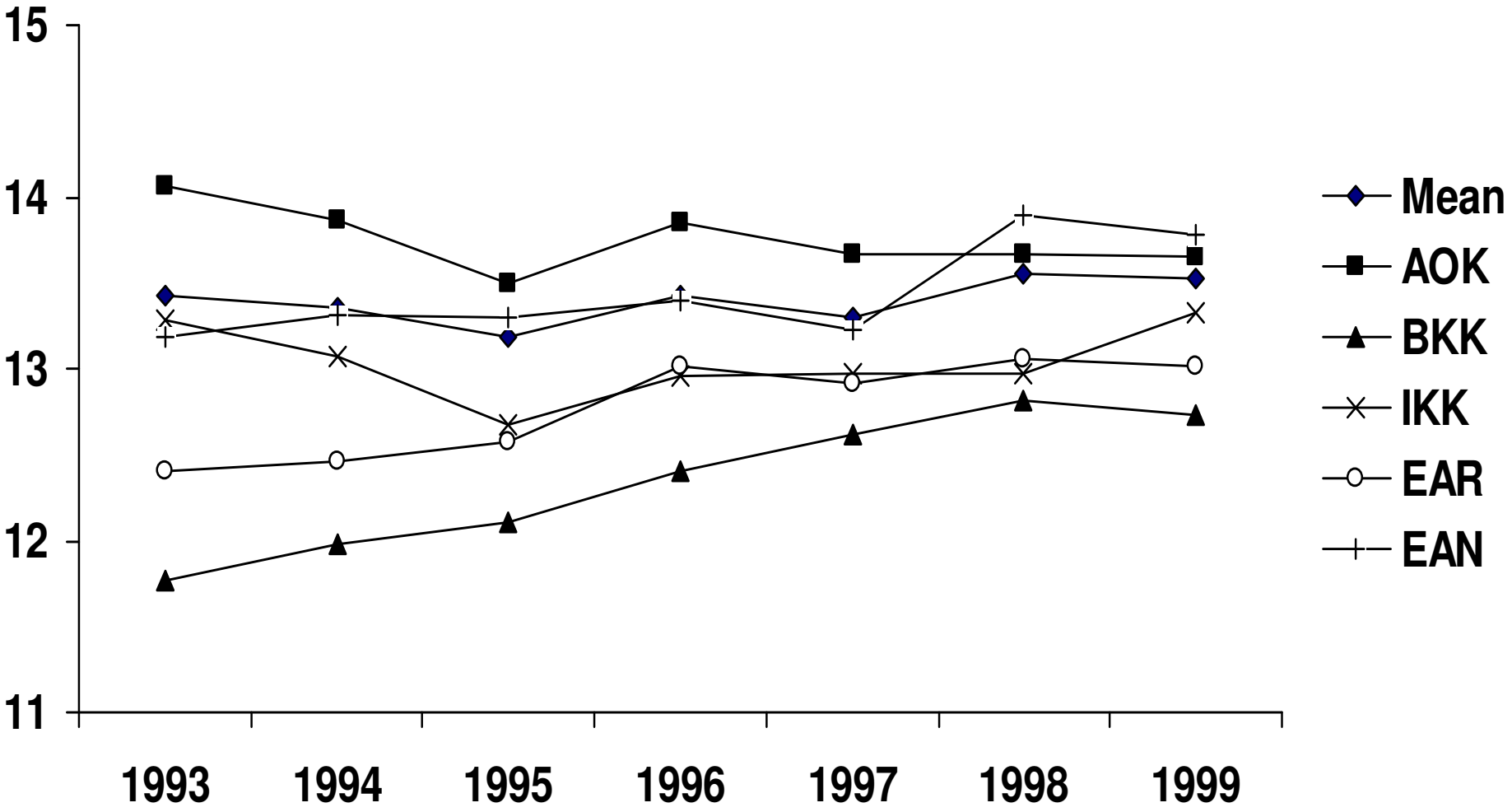
Budgets and spending caps since 1989

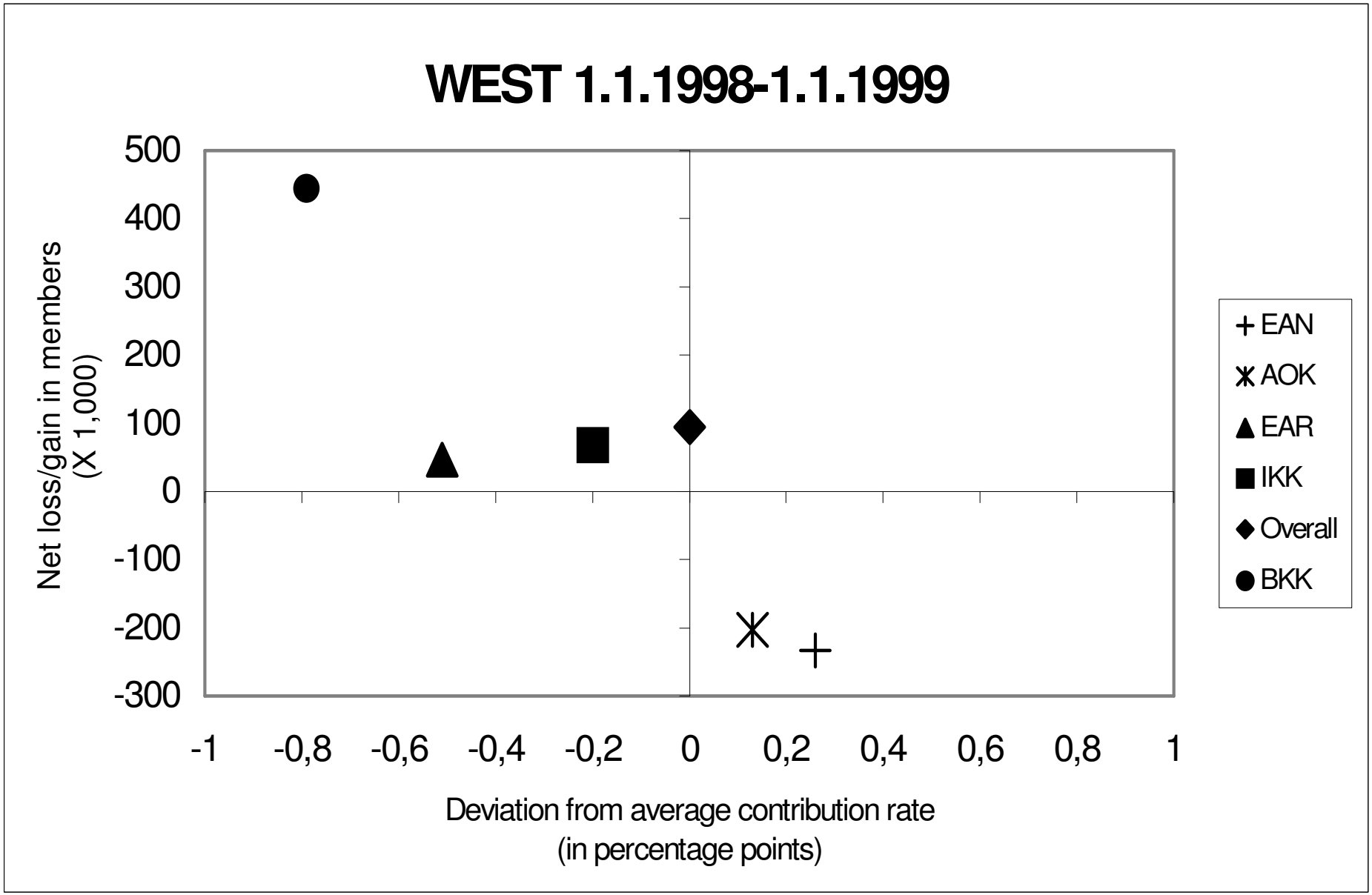
	Ambulatory care	Hospitals	Pharmaceuticals
1989 to 1992	negotiated regional fixed budgets	negotiated target budgets at hospital level	no budget or spending cap
1993	legally set regional fixed budgets	legally set fixed budgets at hospital level	legally set national spending cap
1994			negotiated regional spending caps
1995			
1996	negotiated regional fixed budgets		
1997		negotiated target budgets at hospital level	
1998	(target volumes for individual practice)		negotiated target volumes for individual practices
1999	**Failed attempt to introduce global budget**		legally set regional spending caps
2000	negotiated regional fixed budgets with legally set limit	negotiated target budgets at hospital level with legally set limit	negotiated regional spending caps
2001			negotiated target volumes for individual practices

Free choice among sickness funds but “risk structure compensation“

- sickness funds = contribution collectors;
- therefore re-distribution of money is more difficult than in all other countries as
- 1. funds look at contributions as “theirs“
- 2. both income of funds and “standardised“ expenditure (by sex, age and incapacity to work) vary.

Development of contribution rates in the West (in %) before and after the introduction of the risk structure compensation in 1994/95





Gains/ losses in sickness fund membership

in the western part of Germany in relationship to contribution rate

Transferred money through "risk structure compensation"

	West		East		Germany	
	RSC[1]/ exp.[2] (billion DM)	RSC as % of expenditure	RSC/ exp. (billion DM)	RSC as % of expenditure	RSC/ exp. (billion DM)	RSC as % of expenditure
1995	13.49/ 190.29	7.1%	4.61/ 38.53	12.0%	18.05/ 228.82	7.9%
1996	14.22/ 196.39	7.2%	4.90/ 40.03	12.2%	19.12/ 236.42	8.1%
- 1 January 1997: First opportunity to change between funds -						
1997	15.07/ 192.13	7.8%	5.15/ 39.22	13.1%	20.22/ 231.35	8.7%
- 1 January 1998: Second opportunity to change between funds -						
1998	16.07/ 195.07	8.2%	5.47/ 39.06	14.0%	21.54/ 234.13	9.2%
- 1 January 1999: Third opportunity to change between funds -						
1999	16.24/ 200.83	8.1% (8.7%)*	6.44/ 40.14	16.0% (13.0%)*	22.68/ 240.97	9.4%
- 1 January 2000: Fourth opportunity to change between funds -						
2000	16.23/ 205.46	7.9% (9.2%)*	7.29/ 40.86	17.8% (11.1%)*	23.52/ 246.32	9.6%

The dilemma of equality vs. competition

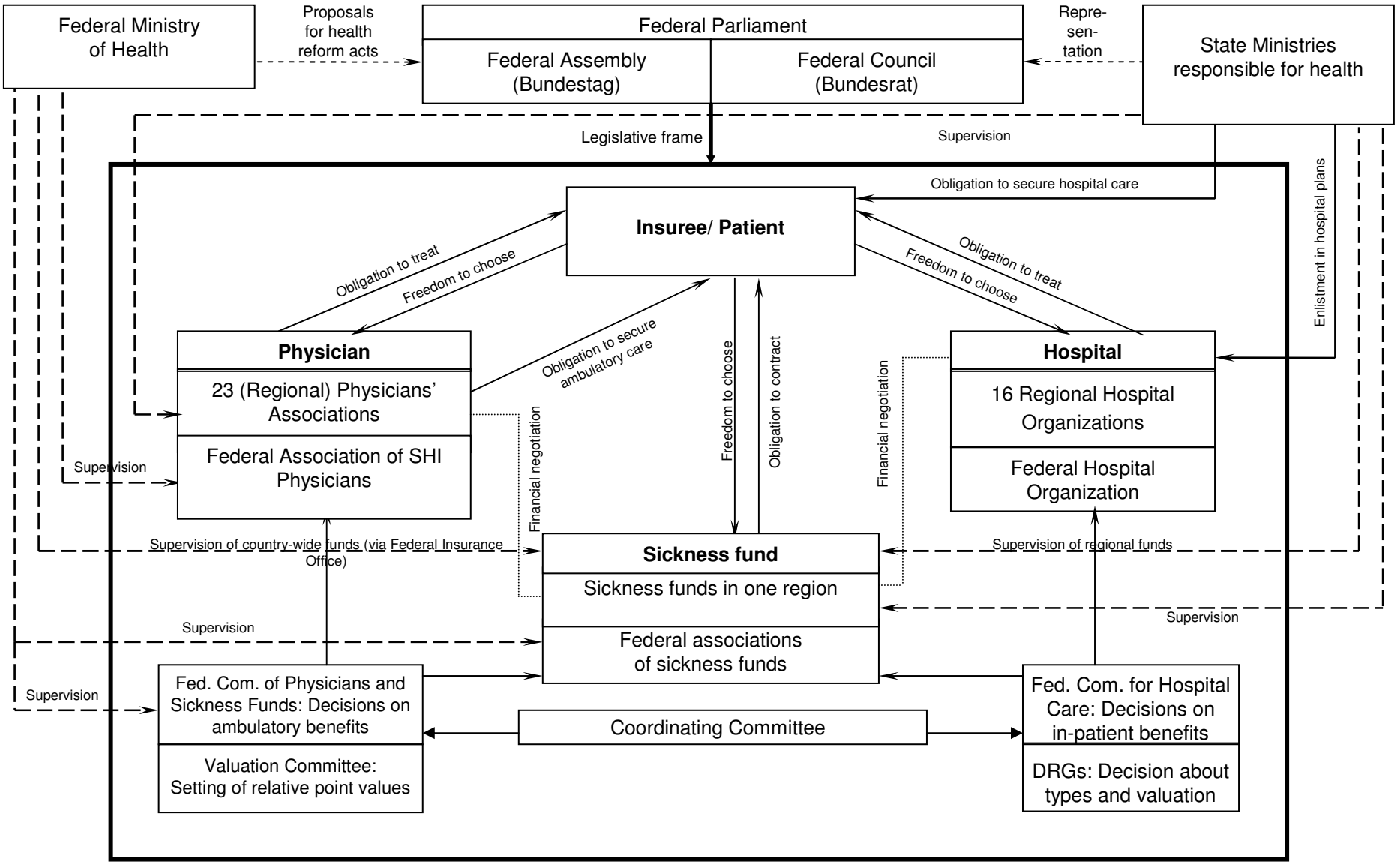
- **1989:** equalisation of benefits and health care provision between sickness funds
- **1994/95:** minimisation of contribution rate differences through ”risk compensation scheme”
- **1996:** free choice of sickness fund for (almost) everybody

> How to compete with (almost) identical benefit baskets, an (almost) identical system of health care provision and similar contribution rates?

> Selective contracting!?

Reform Act of SHI 2000

- change to a uniform, DRG-based reimbursement system for hospitals from 2003/04 - thereby also making the benefits catalogue explicit
- introduction of a coordinating committee, e.g. to pass guidelines for care across sectors
- GP role strenghtened: budget separated from specialists and option for gatekeeping
- possibility for sickness funds to contract with trans-sectoral groups of providers which receive their own budget



Statutory health insurance 2000

• Act to Newly Regulate Choice of Sickness Fund • Act to Introduce the Residency Principle for Physicians' and Dentists' Reimbursement • Act to Reform the SHI Risk Adjustment Mechanism • Act to Adjust Reference Price-Setting Regulations • Pharmaceutical Spending Cap Lifting Act	2001 **Health care Reform a la Ulla Schmidt**
• Act to Limit SHI Pharmaceutical Spending • Act to Introduce a Case Fees-System in Hospitals	2002

Case study – the Netherlands

- Segregation into compartments
- With very different regulatory frameworks, decision-making and financing mechanisms
- Reform attempts have aimed at
  1. increasing equity
  2. introducing market mechanisms/ competition to sickness funds and providers (necessitating new financing and supervision mechanisms)
  3. while exempting other areas from it.

SUPPLEMENTARY HEALTH INSURANCE (voluntary) **Third compartment (3% of health expenditure)**	
SICKNESS FUNDS **(compulsory)**	**PRIVATE HEALTH INSURANCE** **(mostly voluntary)**
Second compartment (53% of health expenditure)	
NATIONAL HEALTH INSURANCE FOR EXCEPTIONAL MEDICAL EXPENSES (compulsory) **First compartment (44% of health expenditure)**	

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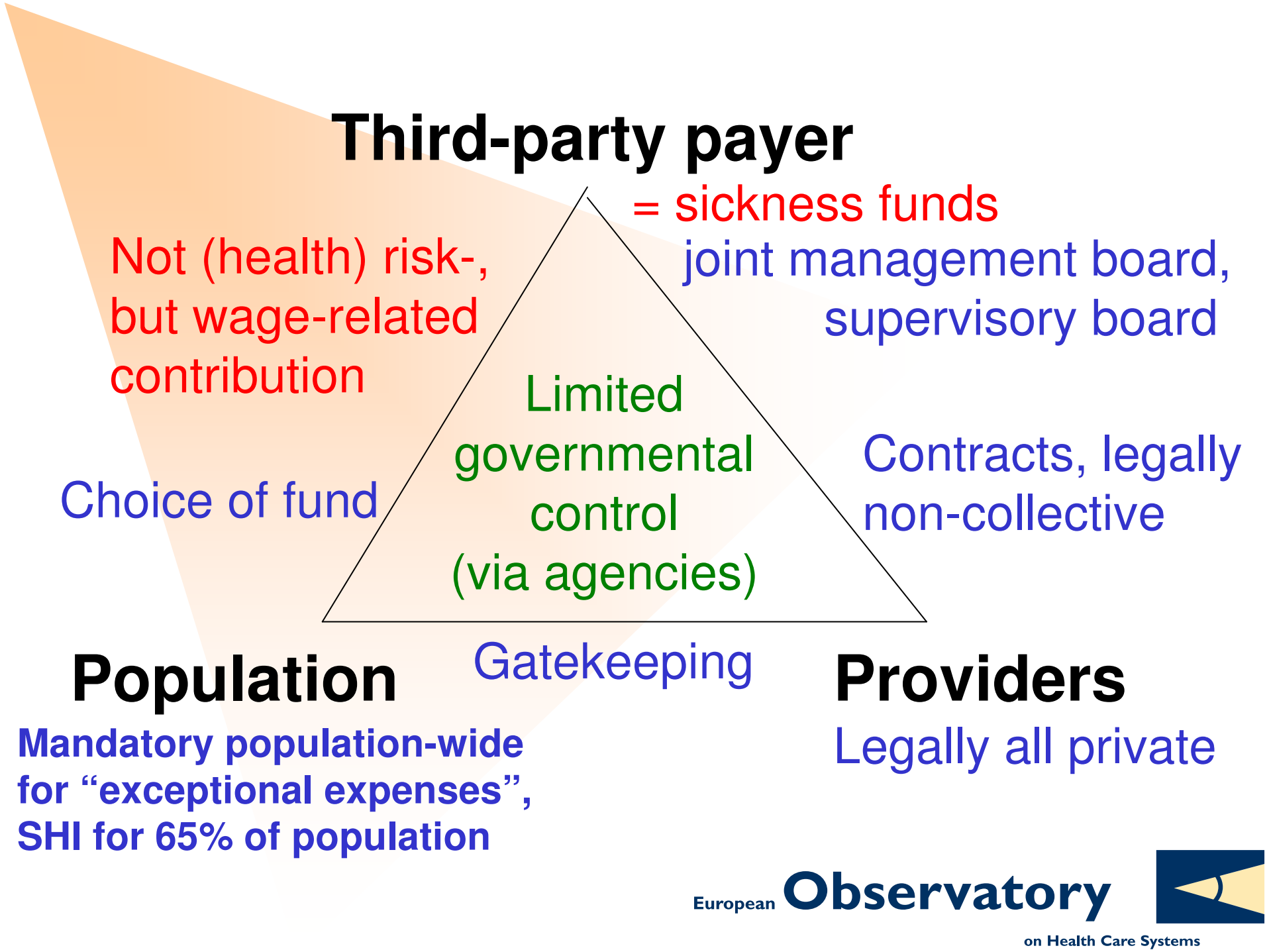

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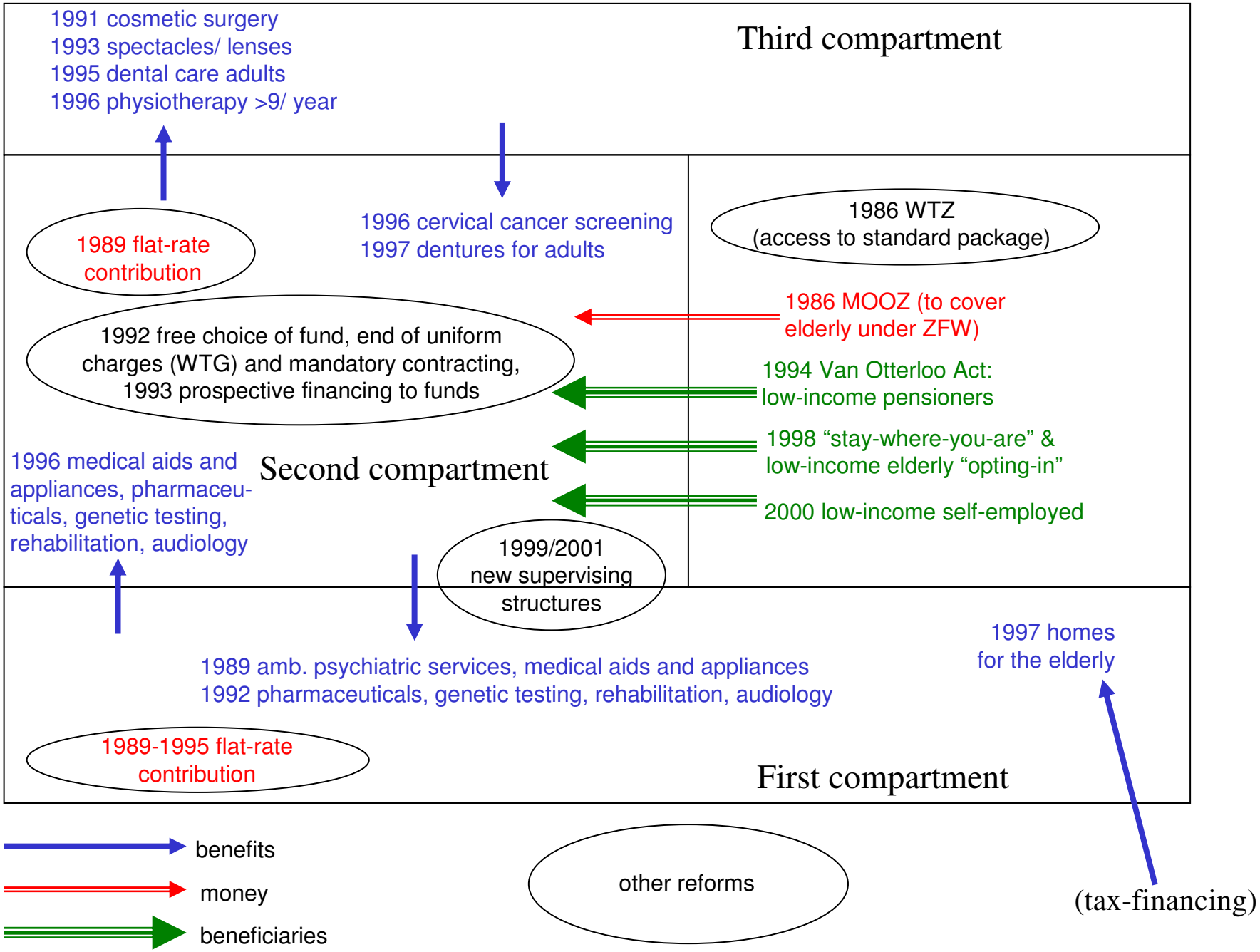
1991 cosmetic surgery
1993 spectacles/ lenses
1995 dental care adults
1996 physiotherapy >9/ year
Third compartment
1989 flat-rate contribution
1996 cervical cancer screening
1997 dentures for adults
1986 WTZ (access to standard package)
1986 MOOZ (to cover elderly under ZFW)
1992 free choice of fund, end of uniform charges (WTG) and mandatory contracting, 1993 prospective financing to funds
1994 Van Otterloo Act: low-income pensioners
1998 "stay-where-you-are" & low-income elderly "opting-in"
2000 low-income self-employed
1996 medical aids and appliances, pharmaceu-ticals, genetic testing, rehabilitation, audiology
Second compartment
1999/2001 new supervising structures
1997 homes for the elderly
1989 amb. psychiatric services, medical aids and appliances
1992 pharmaceuticals, genetic testing, rehabilitation, audiology
1989-1995 flat-rate contribution
First compartment
benefits
money
beneficiaries
other reforms
(tax-financing)

Actors and their tasks 1

- **Ministry of Health, Welfare and Sport**
- **Ministry of Finance**
- **24 sickness funds**
- **Board for Health Care Insurance** (*College voor zorgverzekeringen, CVZ)*
- **Supervisory Board for Health Care Insurance** *(College van toezicht op de zorgverzekeringen, CTZ)*
- **Private health insurers (often under one roof with sickness fund)**

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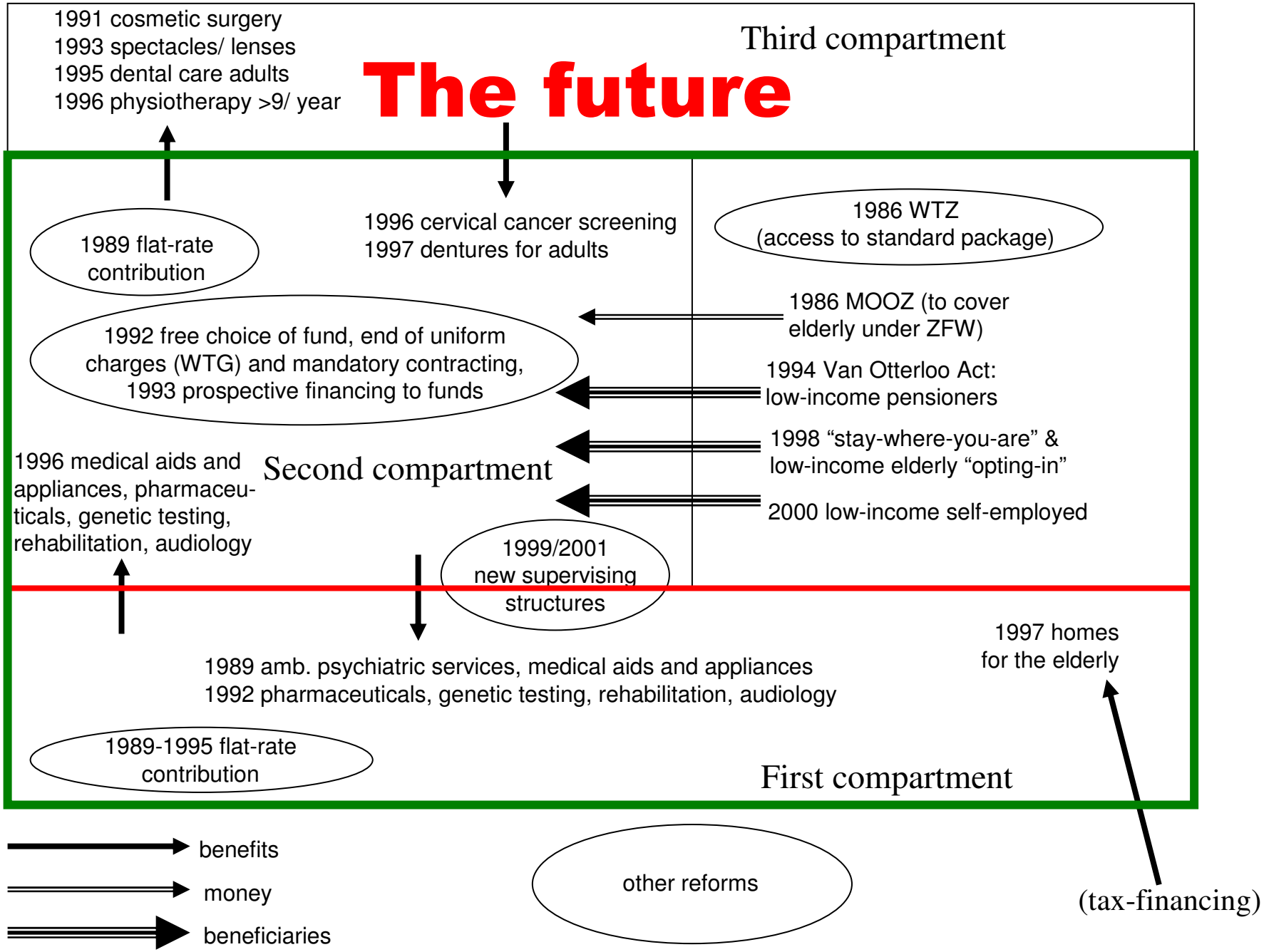
Actors and their tasks 2

- **The Health Council** *(Gezondheidsraad)*
- **Council for Public Health and Healthcare** *(Raad voor de Volksgezondheid en Zorg, RVZ)*
- **Board for Tariffs in Health Care** (*College Tarieven Gezondheidszorg, CTG*)
- **Board for the Evaluation of Pharmaceuticals** *(College ter Beoordeling van Geneesmiddelen, CBG)*
- **Board for the Construction of Hospital Facilities** *(College bouw ziekenhuisvoorzieningen, CBZ)*
- **National Institute for Health and Environmental Hygiene** *(Rijksinstituut voor de Volksgezondheid en Milieuhygiëne, RIVM)*
- ...

Making sickness funds financially responsible

Year	Share prospective payment in total sickness fund expenditure (%)	Risk-adjusters	High-risk pool
-1992	0	-	-
1993-95	3	Age, gender	-
1996	15	Age, gender, region, disability status	
1997	27	Age, gender, region, disability status	90% of annual expenditure above DFL 4500
1998	29	Age, gender, region, disability status	90% of annual expenditure above DFL 4500
1999	35	Age, gender, region, employment/ social security status	90% of annual expenditure above DFL 7500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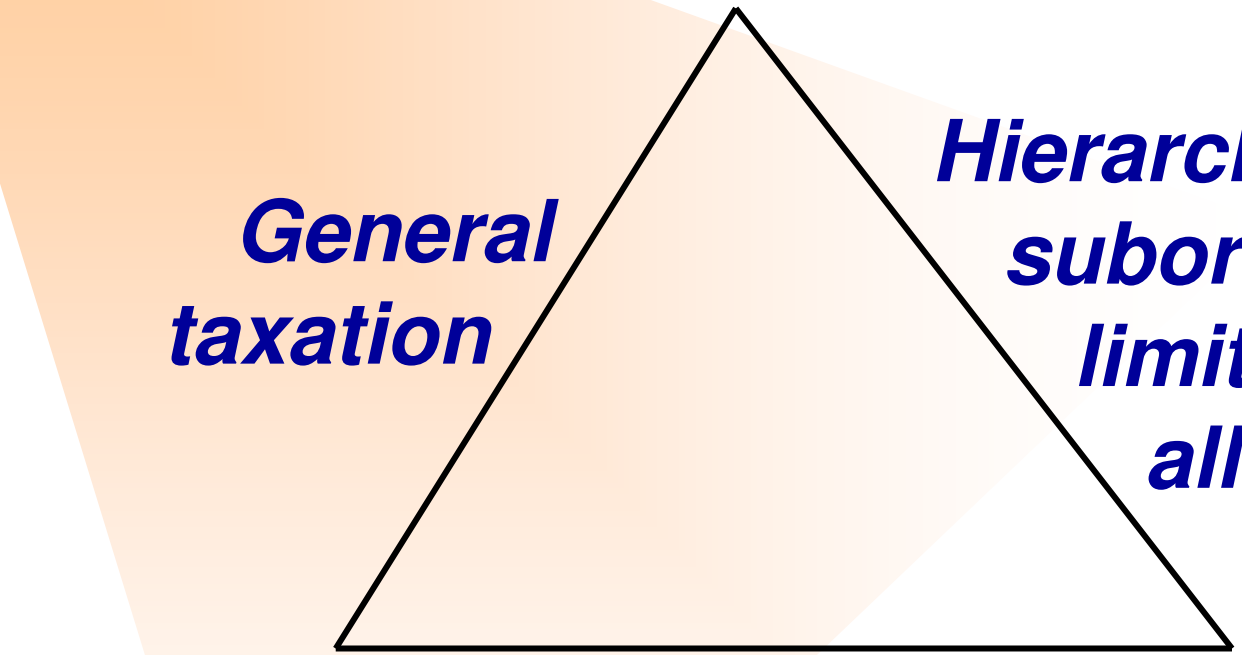
First compartment
benefits
money
beneficiaries
other reforms
(tax-financing)

Central and eastern Europe

Bulgaria
Czech Republic
Estonia
Hungary
Latvia
Lithuania
Poland
Romania
Slovakia
Slovenia

The health care systems in 1990



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Reform strategies in the 1990s

- Dezentralization and privatization
- More money for health care,
  especially through introducing health insurance
- Planned reduction of capacities

No country has successfully tackled all three!

- Often overlooked: population health

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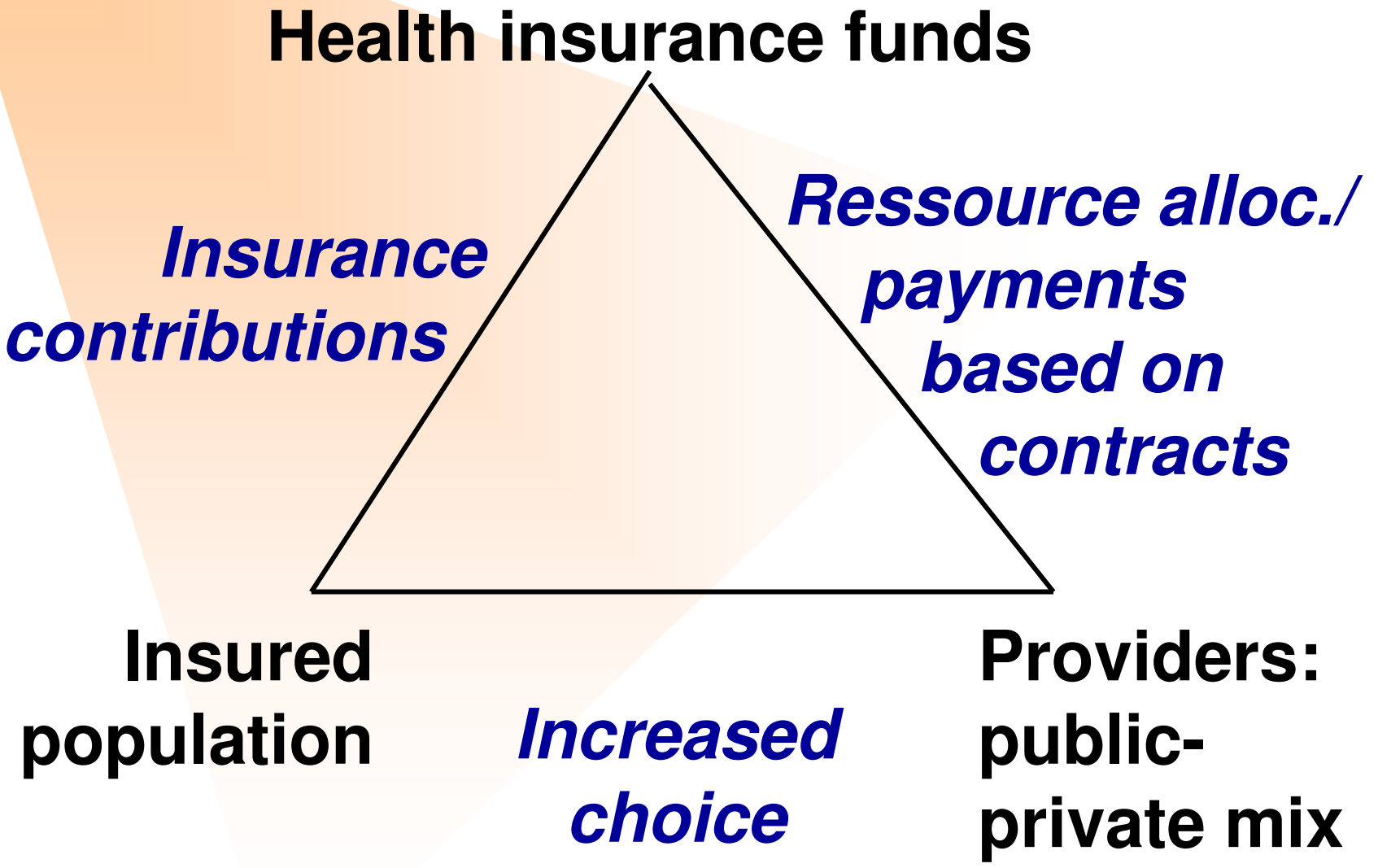
Dezentralization and privatization

- devolution to - newly created - regional levels (which often became responsible for hospitals)
- delegation to physician chambers, health insurance funds etc.
- privatization especially of ambulatory physicians, dentists and pharmacies
    - Problem: physicians were quite powerful in several countries, pushing for privatization, forgetting public health

From Semashko to Bismarck

- "Early wave" 1991/93: Czech Republic, Estonia, Hungary, Slovakia, Slovenia *("Back to Europe - back to Bismarck")*
- "Late wave" 1998/99: Bulgaria, Lithuania, Poland, Romania
- not yet (funds are still tax-funded): Latvia

The health care systems in 2000



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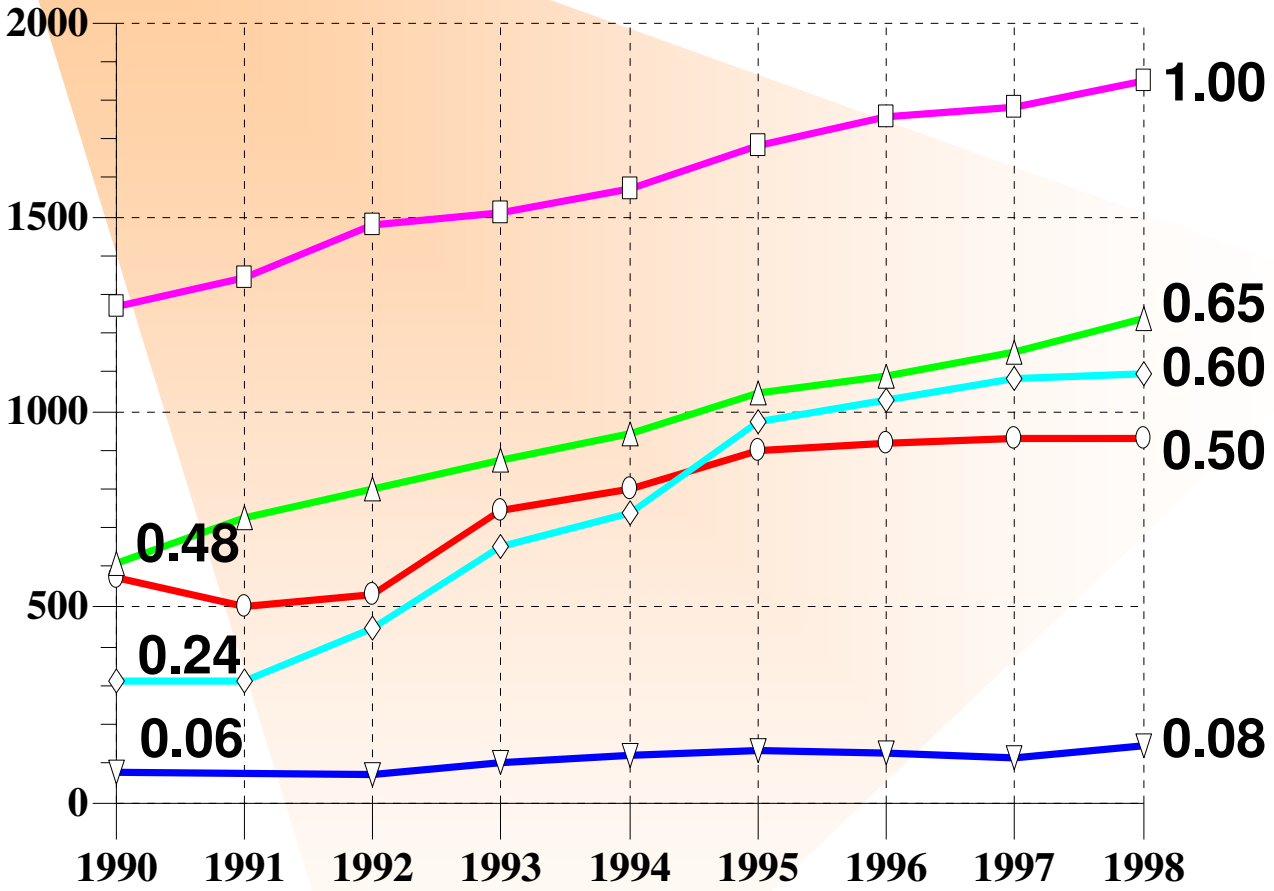
Health insurance variation

- Organization of funds (single, regional monopolies, competing)
- Governance: no board (Hungary), boards with limited to substantial powers
- Contributions: collection (state vs. funds), coverage of non-wage earners (free, reduced contribution, by state)



Successes

Introduction of insurance system and of funds was generally smooth

and expenditure did go up!

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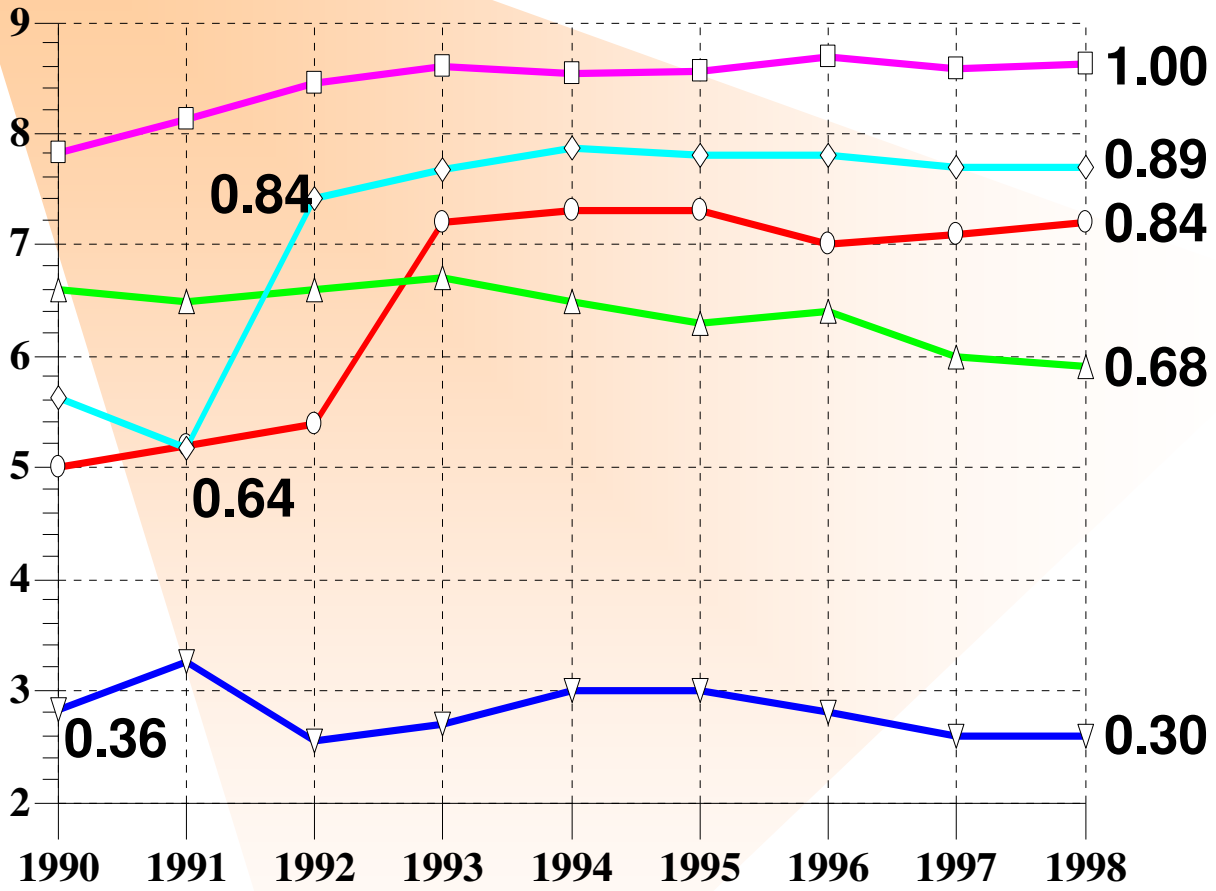
340102 Total health expenditure as % of GDP



Czech Republic
Slovenia
Luxembourg
EU average
Romania

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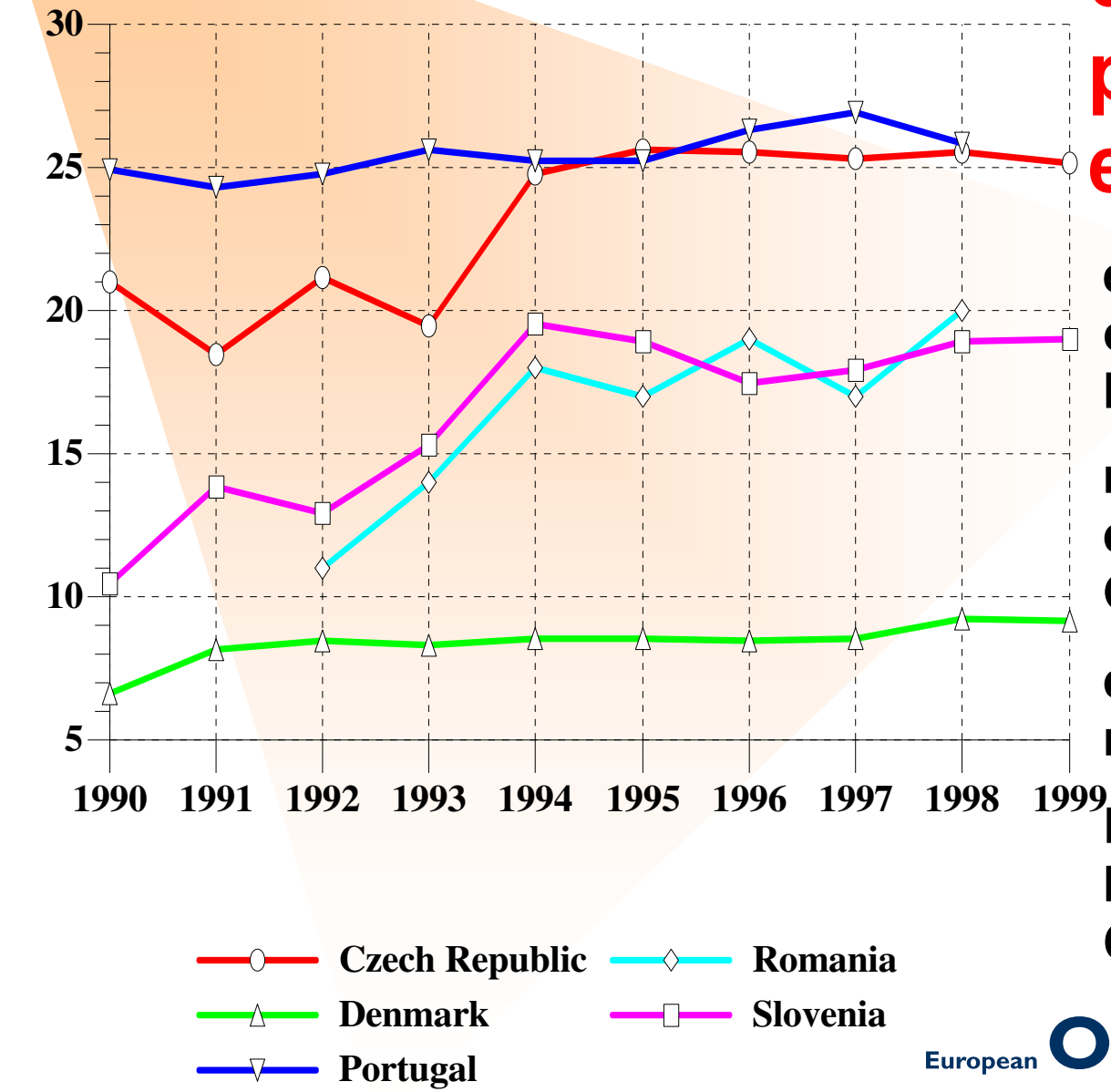
… and problems

- funding expectations partly not met due to evasion of employers and self-employed as well as government
- (re-)allocation of funds still insufficient
- competition among funds in CZ and SK - in conjunction with loose regulations - led to bankruptcies and deficits

An often quoted problem: pharmaceutical expenditure



expenditure is high - and often rising - but not higher than in Portugal

main problem: many drugs are imported and OECD-priced

delisting & co-payments not without dangers

EUROASPIRE: good hypertension control in Czech Rep. & Hungary

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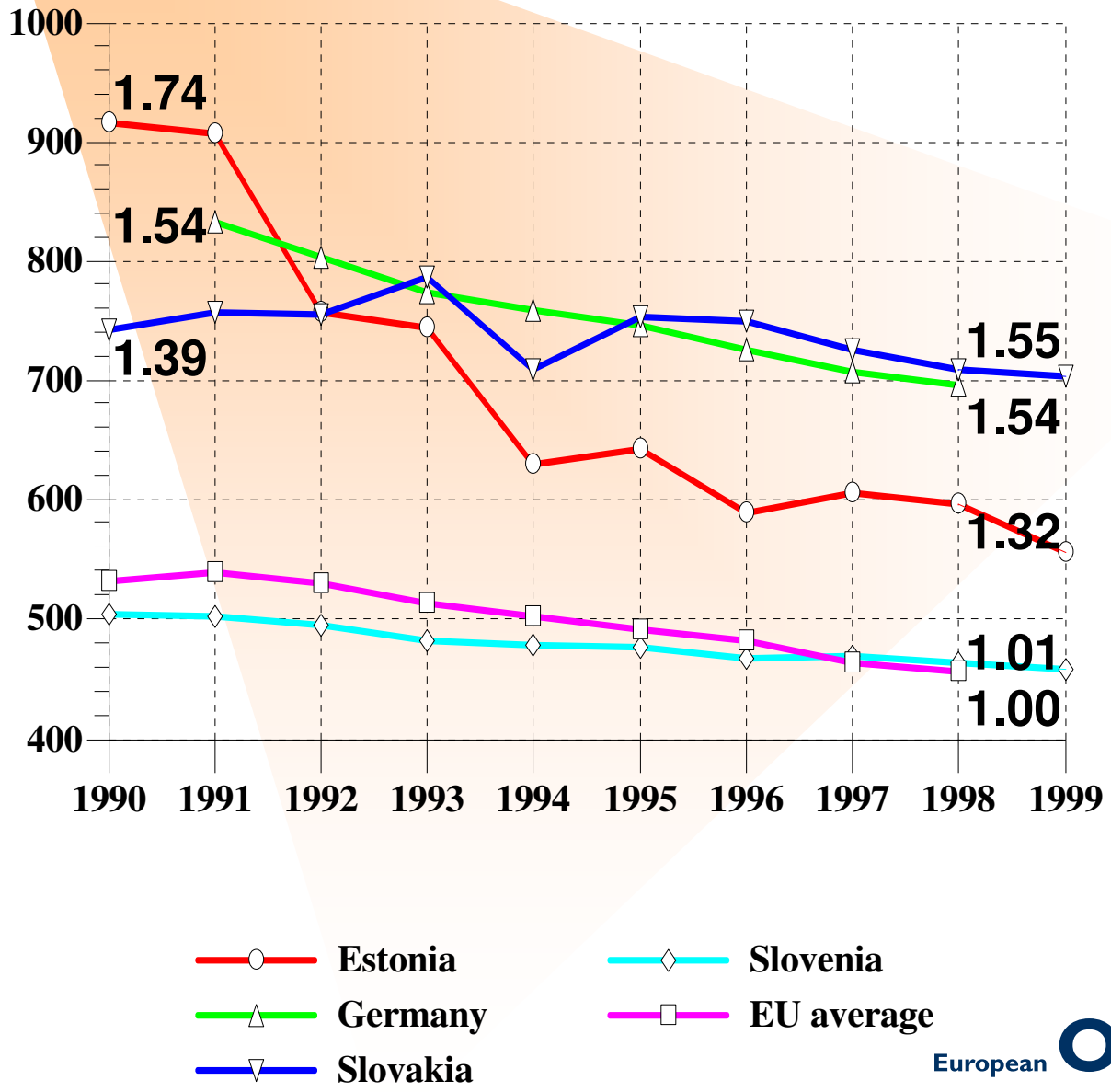
Hospital capacity reductions



early capacity reduction only in Estonia and Romania (1992/93)

in Czech Republic only in mid-90s after belief in markets had failed

no substantial reduction in Poland and Slovenia

as well as Slovakia (with German level capacities)

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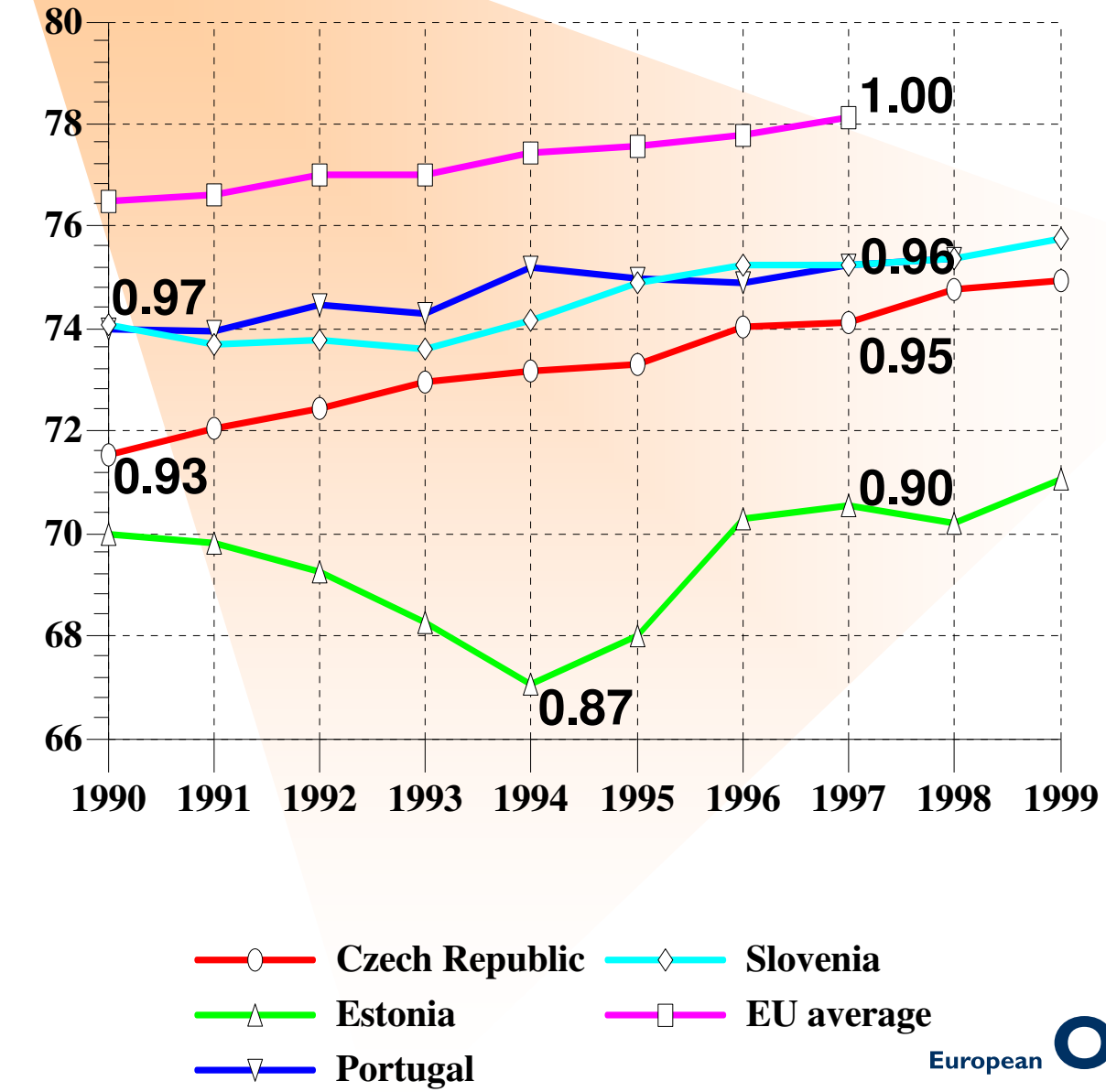
Usually overlooked: population health



1990: gap to EU
2.4 to 6.9 years

drop in Baltics by up to 4 years until 1994,

by ca. 1 year in Romania and Bulgaria in 1996/97

1997: gap up to 8.9 years

only CZ improved vs. EU

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Another approach to analysing health care reforms

- Pressures for change
- Health system/ health care reform goals
- Health system developments

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Pressures for Change

- **Demographic change**
- **Health challenges**
- **Technological developments**
- **Increased citizen expectations**
- **Financial pressures**
- **Macroeconomic constraints**
- **A widening and deepening EU**

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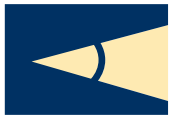
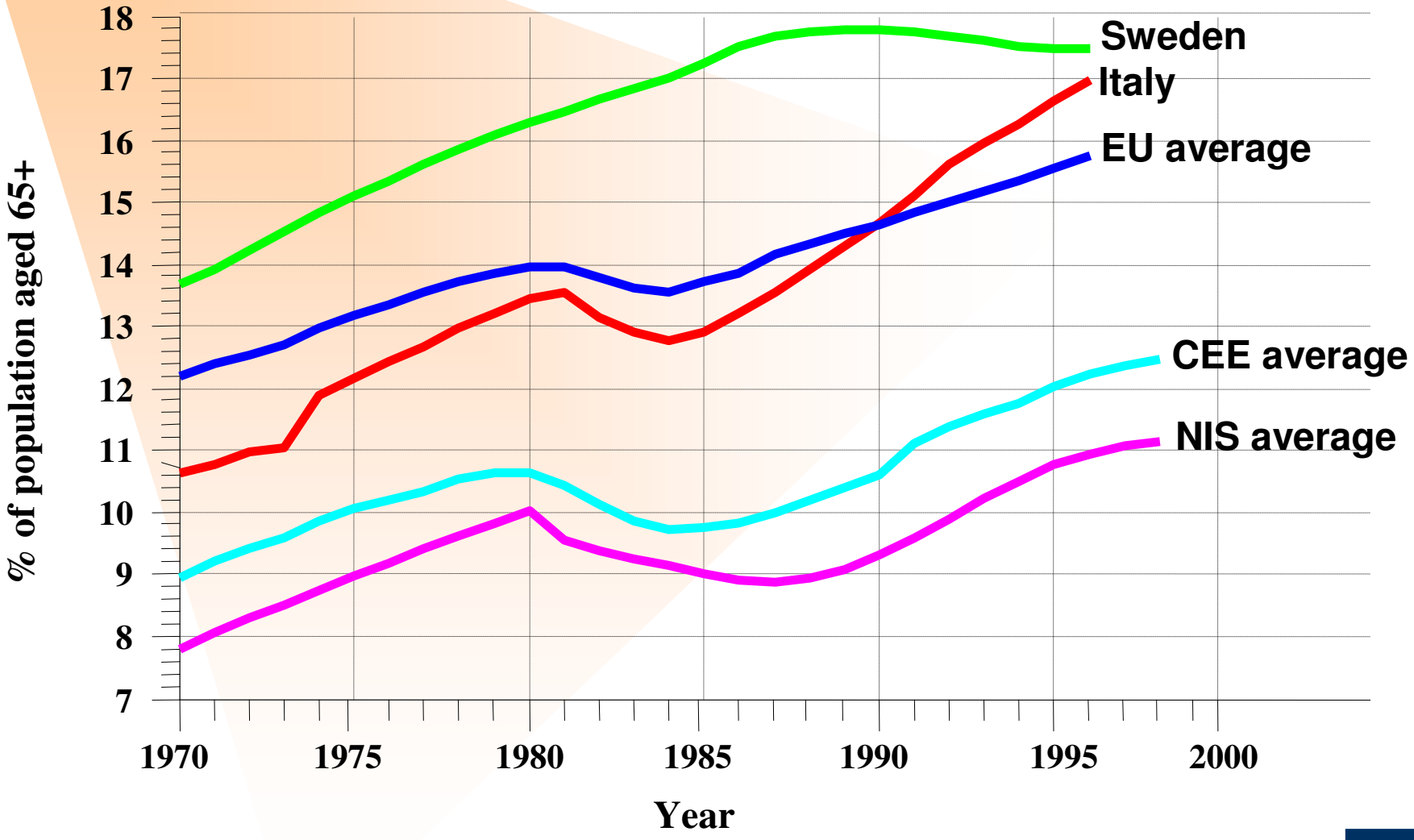


Trends Population aged >65
European subregions, 1970 - 1999



Source: WHO Health For All Database 2000

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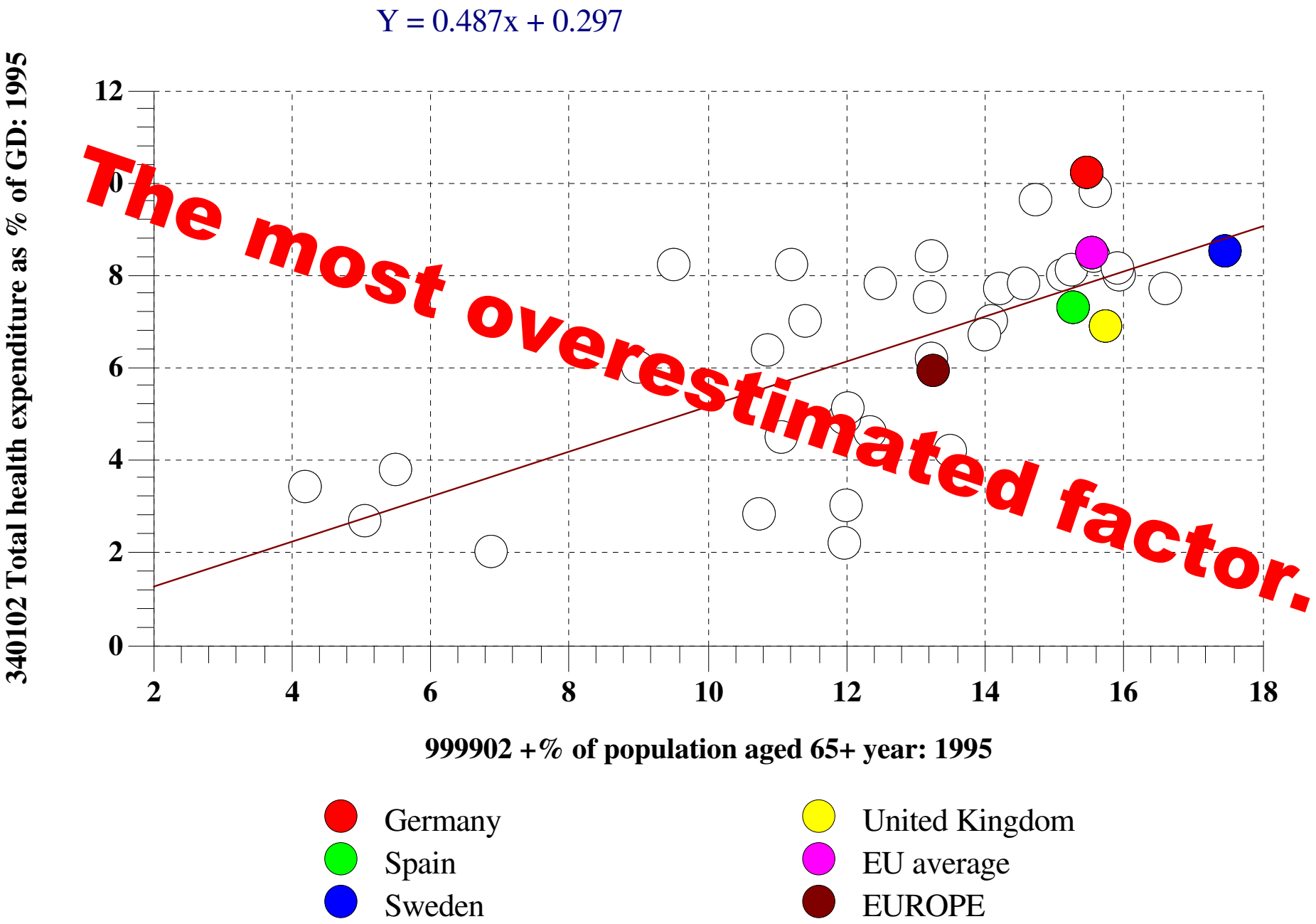
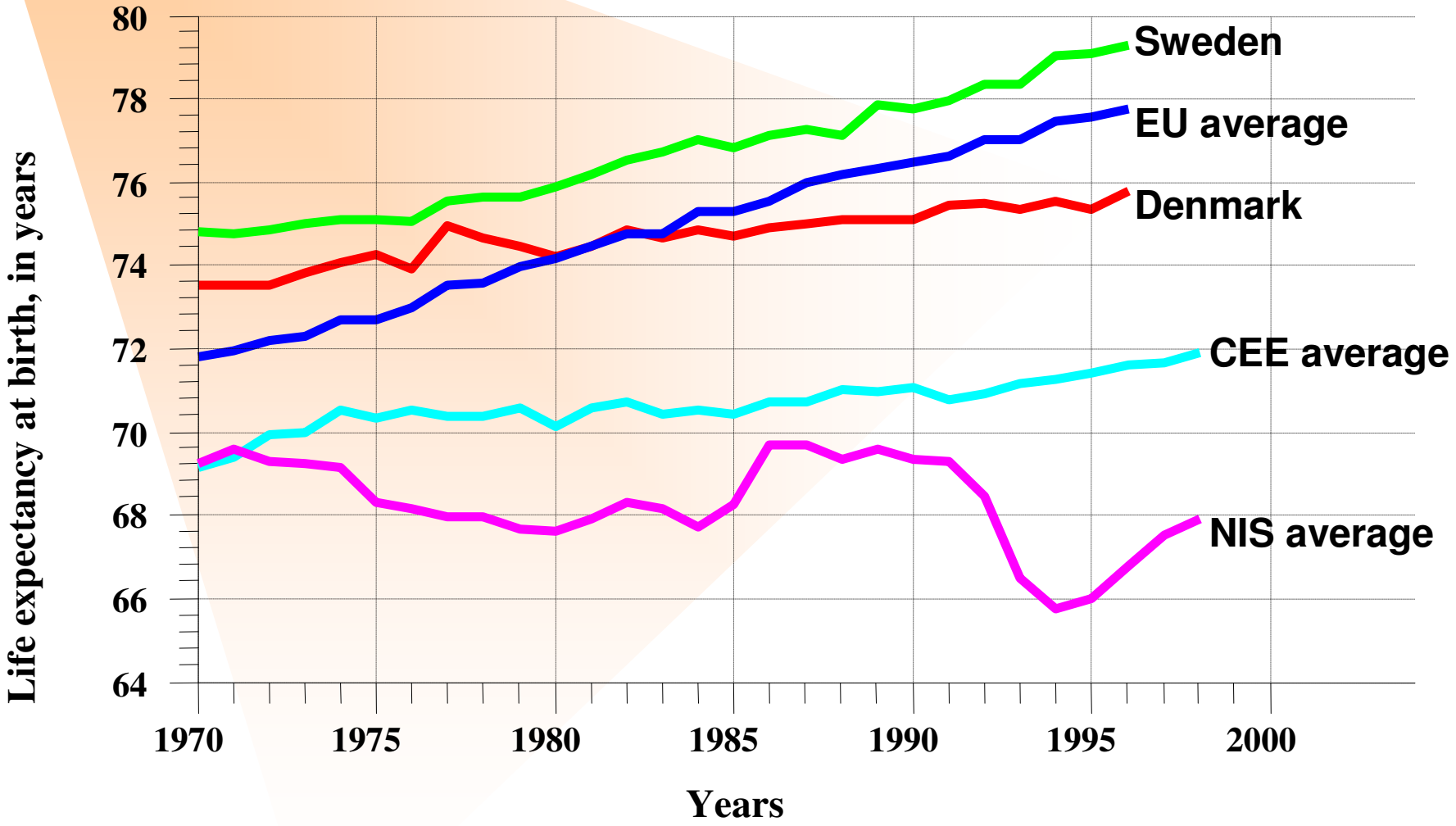

Y = 0.487x + 0.297
The most overestimated factor.
340102 Total health expenditure as % of GD: 1995
12
10
8
6
4
2
0
2
4
6
8
10
12
14
16
18
999902 +% of population aged 65+ year: 1995
Germany
Spain
Sweden
United Kingdom
EU average
EUROPE

Life expectancy at birth, European subregions, 1970 - 1999



Source: WHO Health For All Database 2000

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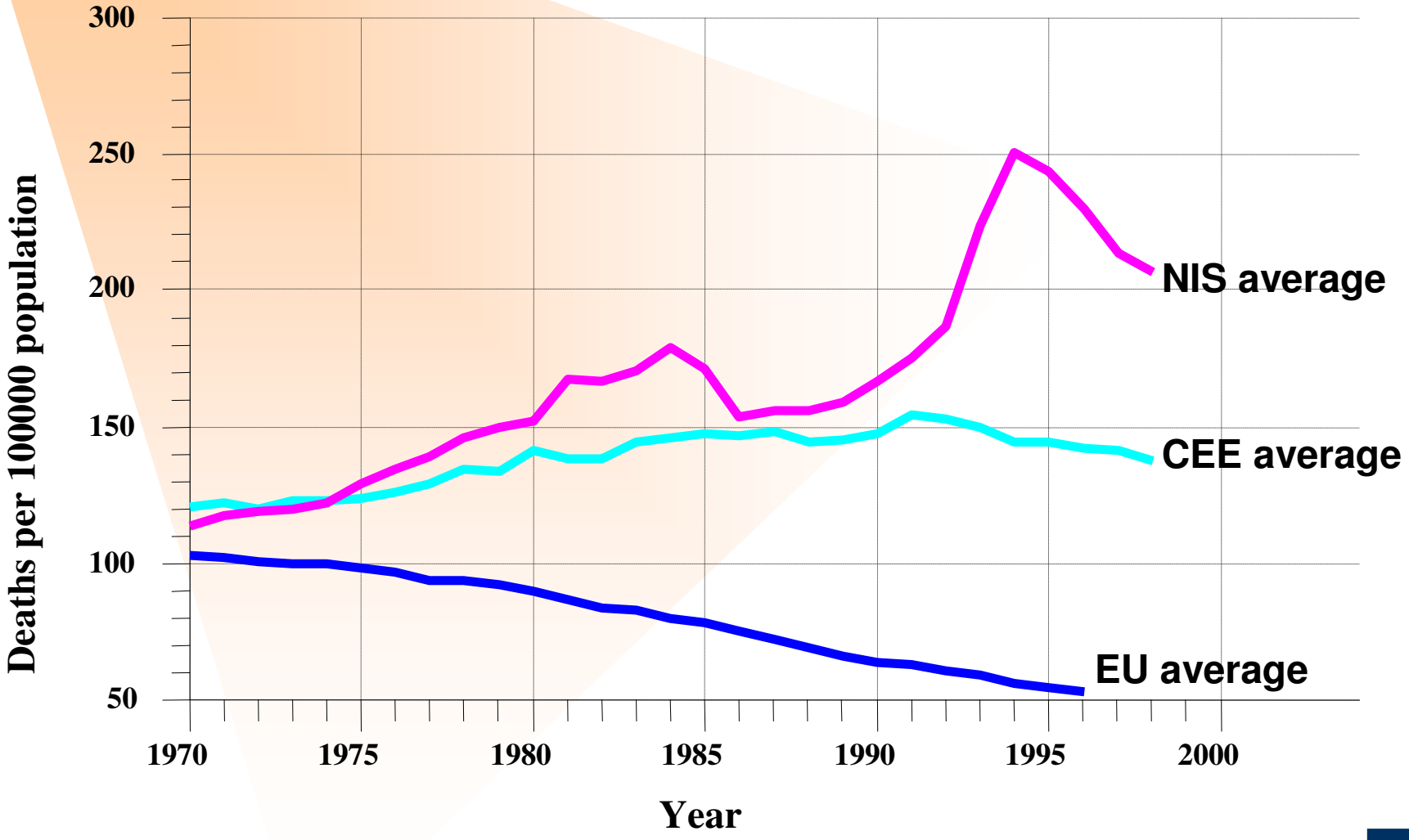
SDRs from diseases of the circulatory system, 0-64, European subregions, 1970 - 1999



Source: WHO Health For All Database 2000

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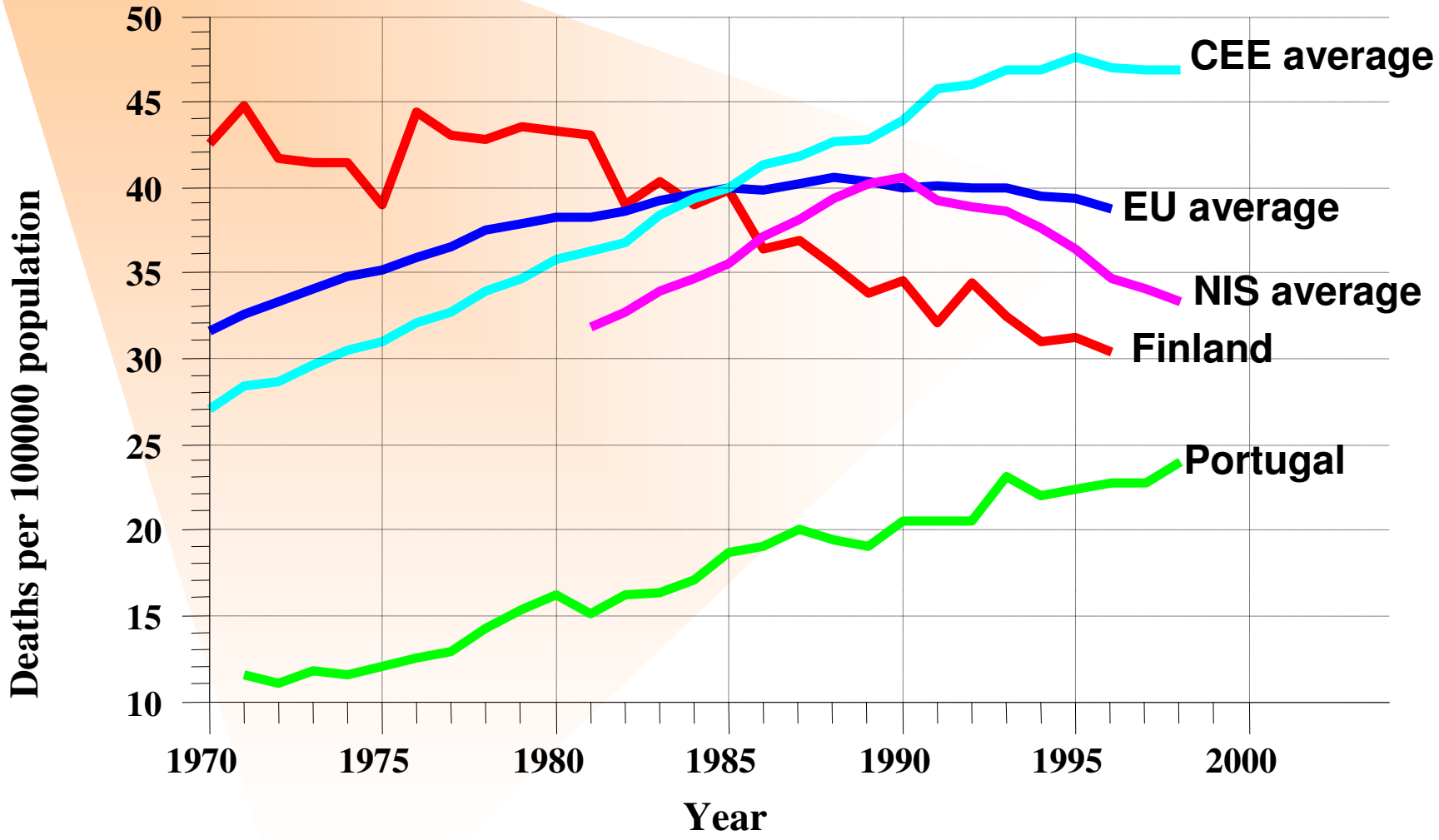
SDRs from cancer of the trachea, bronchus and lung, all ages, 1970 - 1999



Source: WHO Health For All Database 2000

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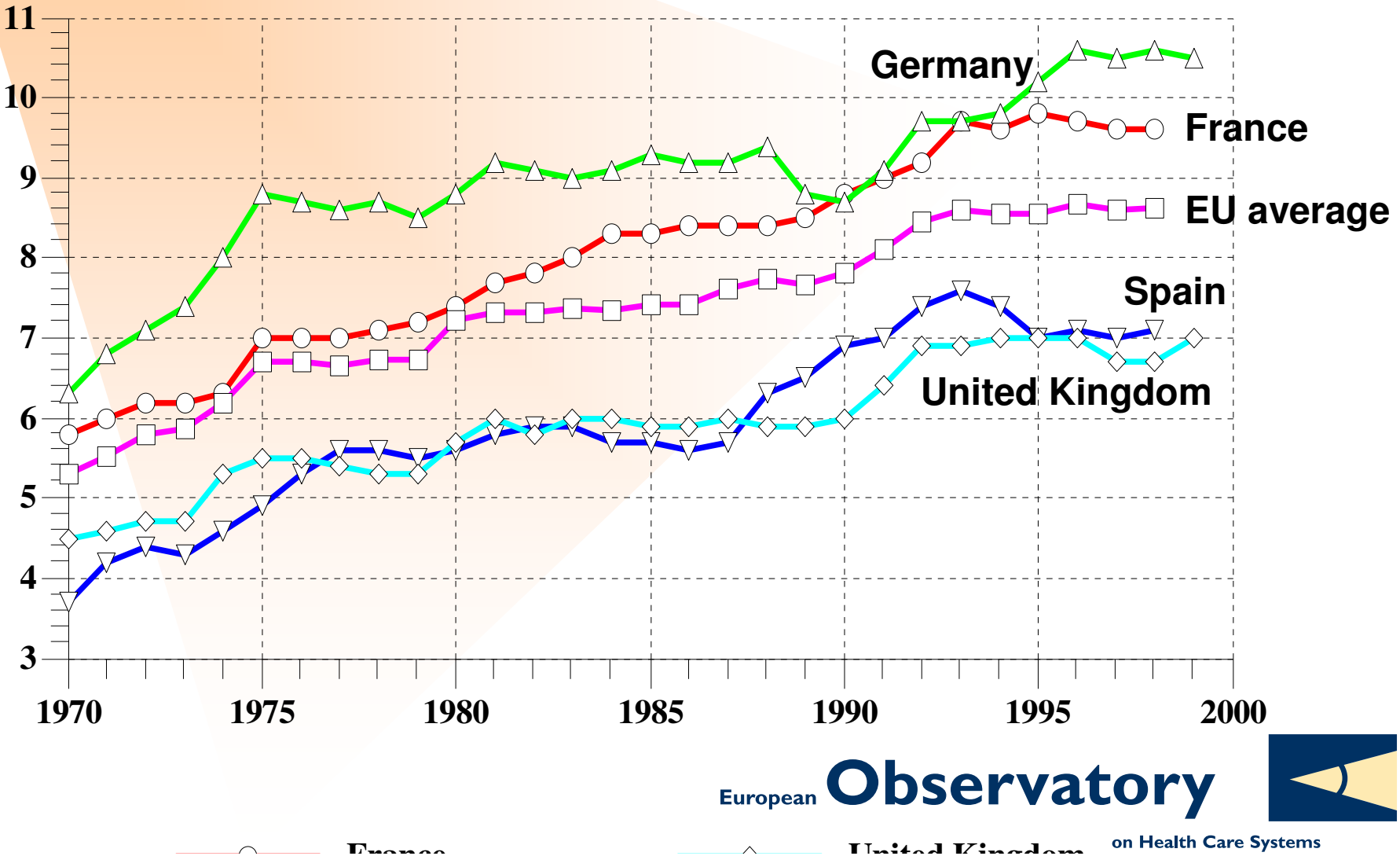
Trends in total health expenditure as % of GDP, 1970 - 1999



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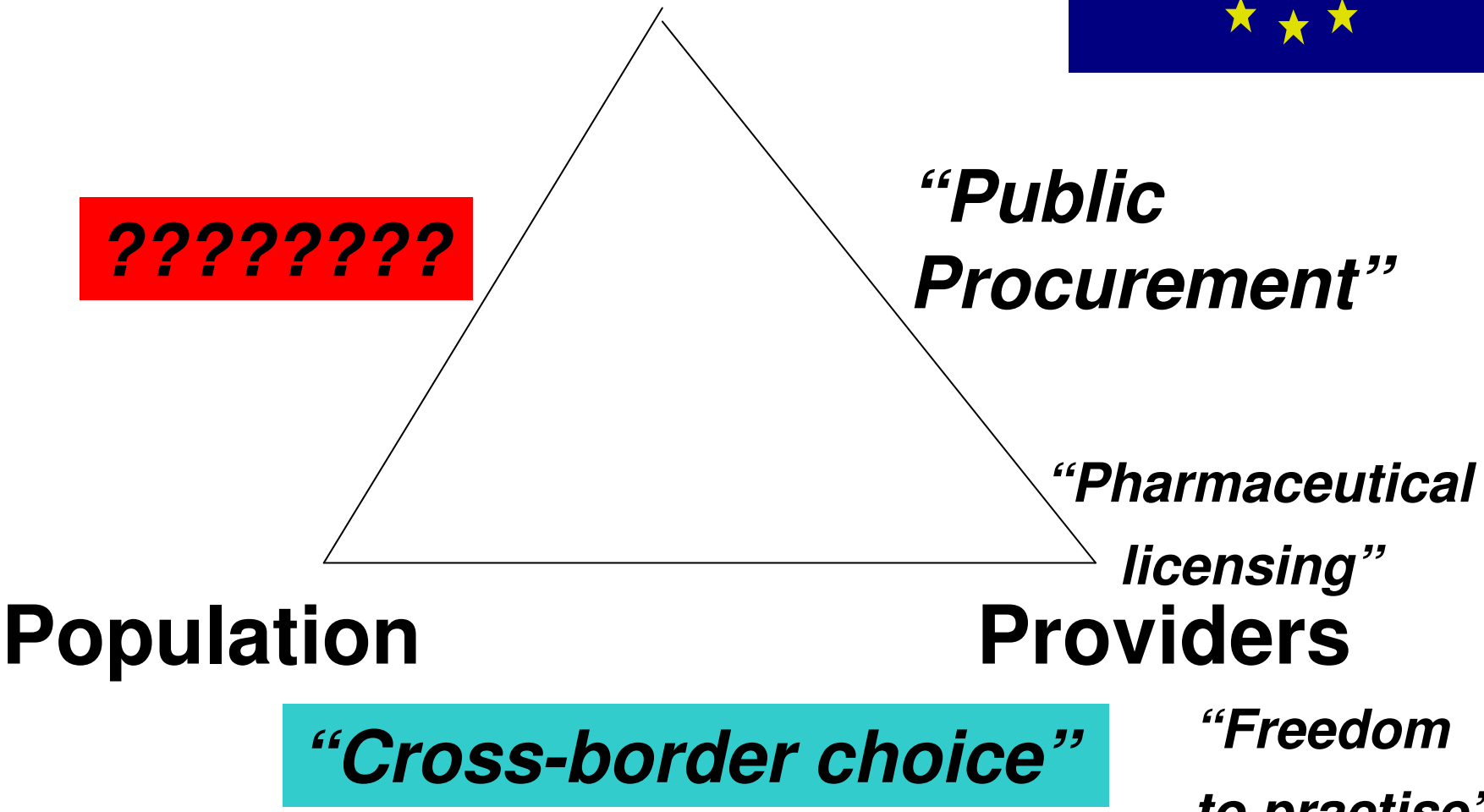
A widening and deepening EU



Three ECJ rulings that changed our perception of health services in the EU Member States

Decker (C-120/95)

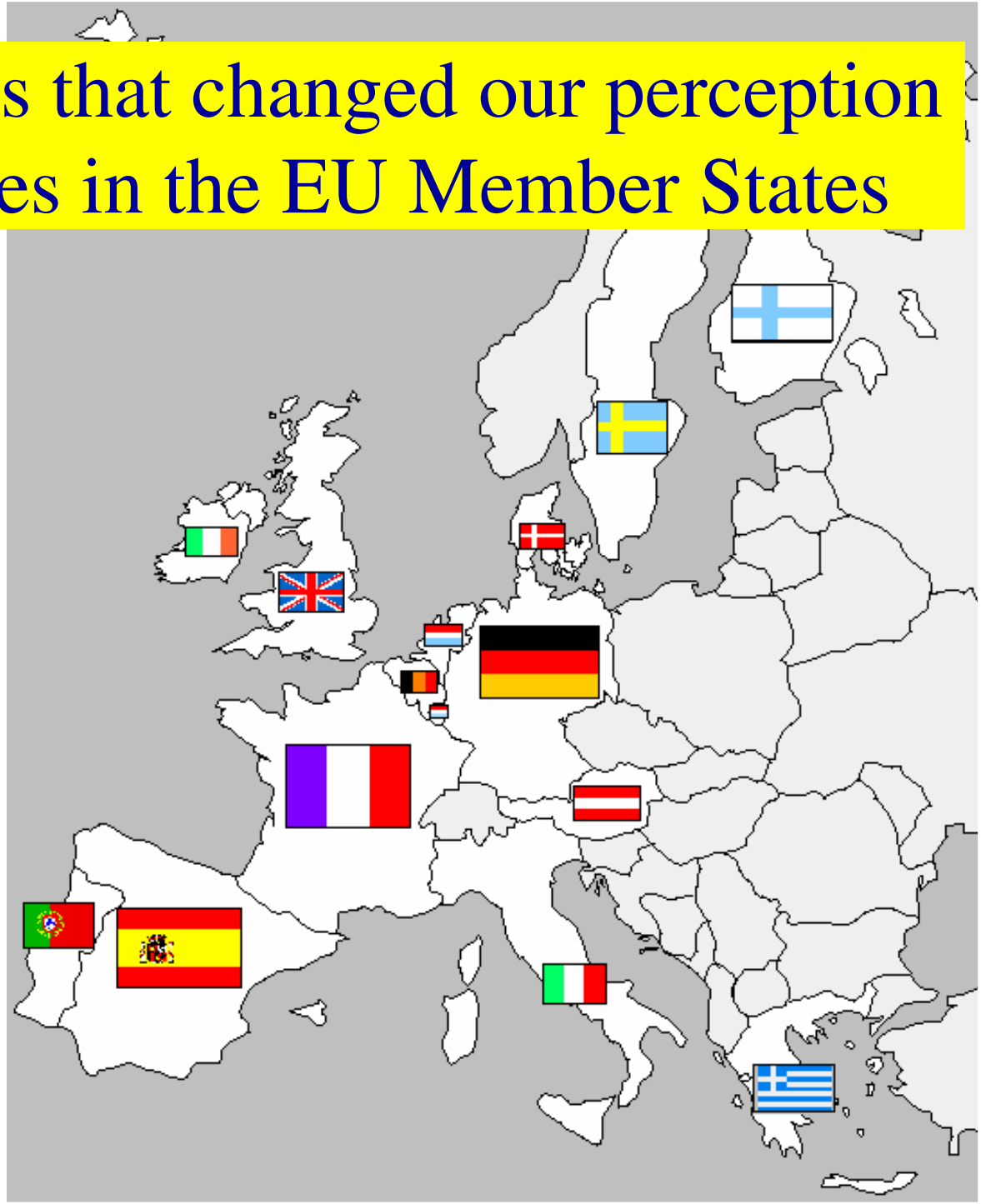
free movement of goods

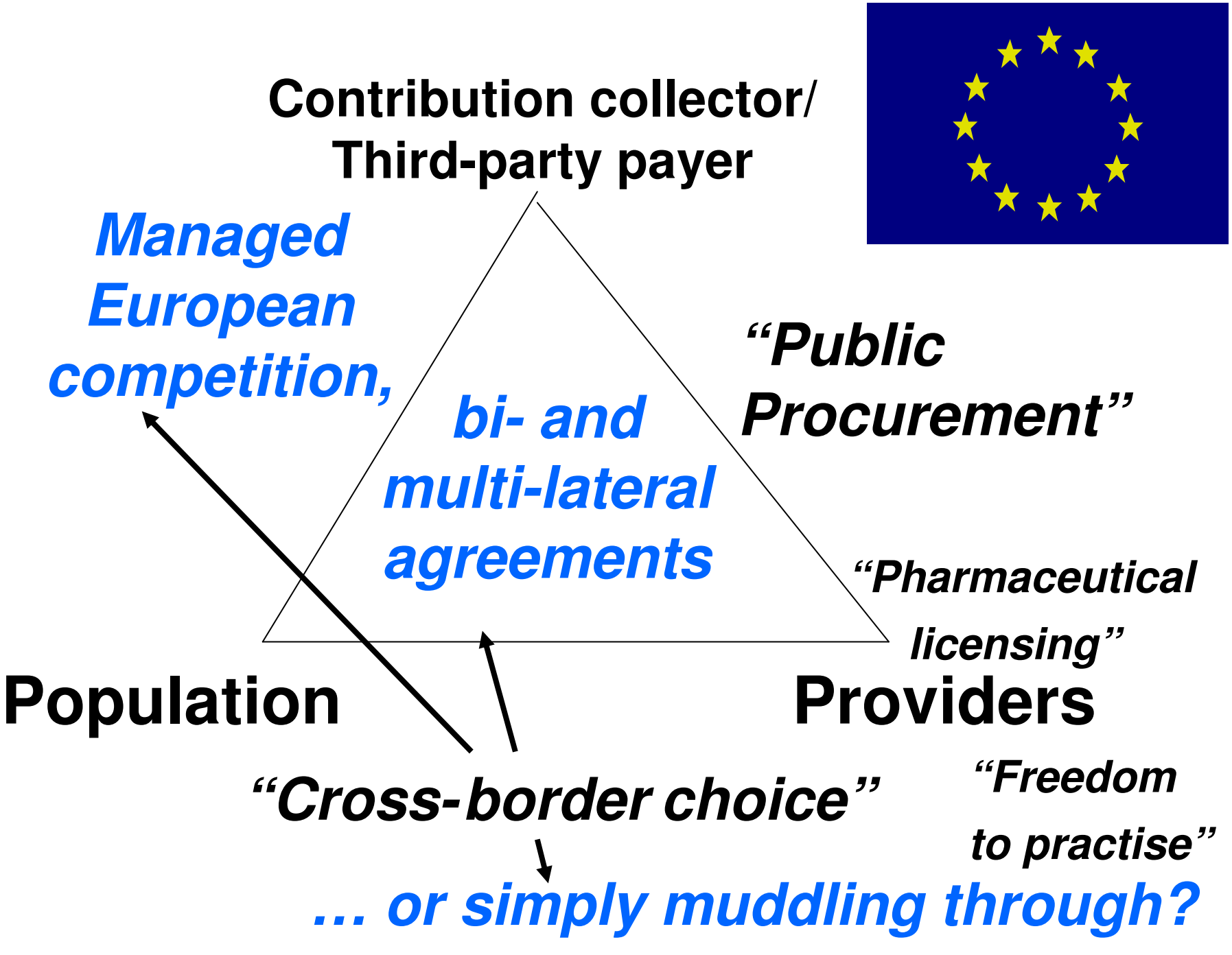
Kohll (C-158/95)

free movement of services

Molenaar (C-160/96)

free movement of service-equivalent cash-benefits; definition of what belongs to health service and what not




Contribution collector/
Third-party payer
Managed European competition,
"Public Procurement"
bi- and multi-lateral agreements
"Pharmaceutical licensing"
Population
Providers
"Cross-border choice"
"Freedom to practise"
… or simply muddling through?

Health System Goals

- **Better health**
- **Efficiency (macro and micro)**
- **Quality**
- **Equity**
- **Responsiveness**

financial sustainability

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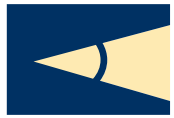

Health System Developments

- Balancing state and market
- Empowering the citizen
- Shifting costs to the consumer
- Strengthening the role of public health
- Increasing cost effectiveness of service provision
- Measuring health systems performance

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Balancing State and Market

- Limited role for market-oriented mechanisms (due to concerns for solidarity and equity)
- Melting borders between public / private provision
- Enhanced stewardship role of government
  - formulating health policy - vision
  - exerting influence - approaches to regulation
  - collecting and using knowledge

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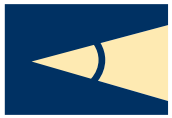

Empowering the citizen
'The raise of the patient'

- Patient's rights legislation
- Participation in priority setting
- Choice of providers
- Participation in clinical decision-making

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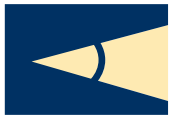
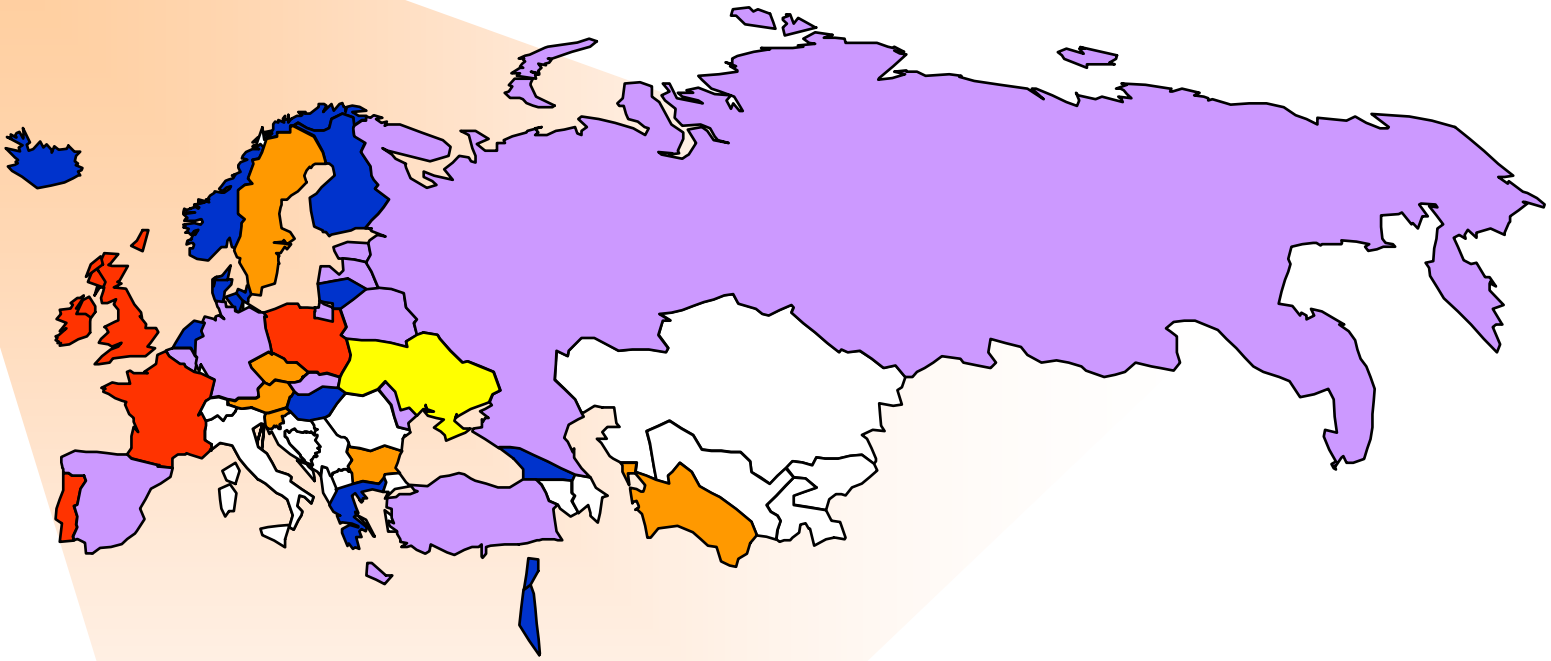


Patients' Rights in Europe



- Patients' rights legislation in force – 10 countries
- Legislation or charter on patients' rights under preparation – 9 countries
- National Charter or code of patients' rights – 5 countries
- Patients' rights in various legal texts - 6 countries
- Patients' rights explicitly defined in health services legislation – 1 country

Source: WHO-European Partnership on Patients' Rights and Citizens' Empowerment

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Shifting costs to the consumer

- **Cost sharing**
  - Limited (but increasing) role for cost sharing (WE)
  - Consensus on limitations as a cost containment tool
  - Limited formal cost sharing in CEE/NIS but wide use of informal payments

- In EU countries with **SHI systems**, total private expenditure is only around 20% of total expenditure - excluding full-cover private insurance (D, NL) it is only around **18%**.
- In others, mainly with **NHS systems**, private funding (= out-of-pocket & supplementary health insurance) accounts, on average, for **>25%.**

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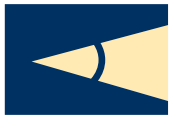

Shifting costs to the consumer

- **Rationing through priority setting**
  - Wide debate on the need for explicit priority setting
  - Development of national guidelines
  - But only marginal exclusions of the package of care
  - Some implicit rationing, widespread in CEE/NIS

- **Increasing complementary (private) insurance**
  - Especially in NHS and CEE countries

Strengthening Public Health

- From health services to broad health determinants
- Developing / implementing a HFA based strategy
  - cost effective intersectoral strategies
  - setting / monitoring health targets
- Developments in control of communicable diseases
- Commission/plan/evaluate health services

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Towards supply based strategies
Increasing cost effectiveness of services

- Decentralized provider management
- Purchaser / provider split: strategic purchasing
- Performance-related payment systems
- Shifting care boundaries: substitution policies
- Restructured hospitals & integrated models
- Strengthened Primary Health Care
- Outcomes based movement / technology assessment
- Human resources policies

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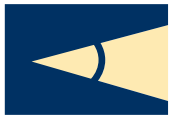
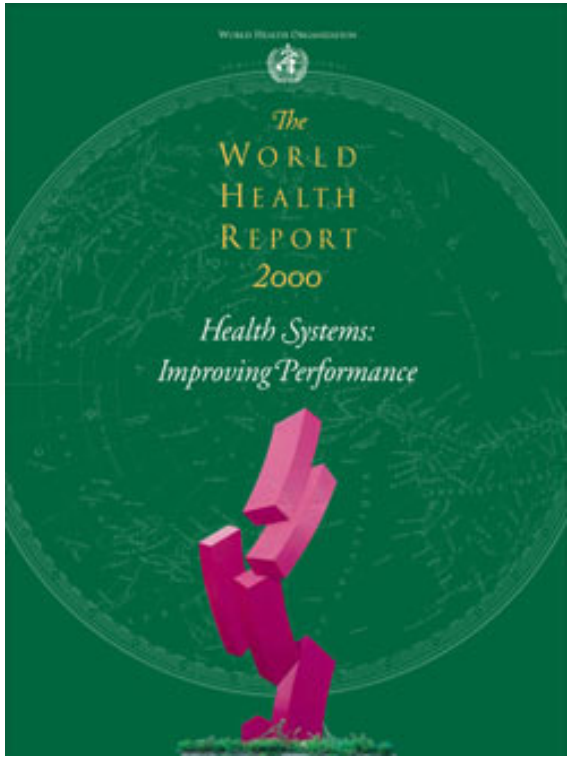


Measuring health system performance

- **Performance measures/goals**
  - Level and distribution of health
  - Responsiveness
  - Fair financial contributions
- **Use of benchmarking & country ranking**



- **Need for data & methodology improvements BUT performance needs to be measured**

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	Gesundheit		Personenorientierung („Responsiveness")		Faire Finan-zierung (25%)	Zieller-reichung insgesamt	Gesund-heitsaus-gaben/ Kopf	Leistung („Performance")	
	Ausmass (25%)	Verteilung (25%)	Ausmass (12,5%)	Verteilung (12,5%)				Ausmass Gesundh.	insgesamt
A	17	8	12-13	3-38	12-15	10	6	15	9
B	16	26	16-17	3-38	3-5	13	15	28	21
DK	28	21	4	3-38	3-5	20	8	65	34
D	**22**	**20**	**5**	**3-38**	**6-7**	**14**	**3**	**41**	**25**
FIN	20	27	19	3-38	8-11	22	18	44	31
F	3	12	16-17	3-38	26-29	6	4	4	1
GR	7	6	36	3-38	41	23	30	11	14
GB	14	2	26-27	3-38	8-11	9	26	24	18
IRL	27	13	25	3-38	6-7	25	25	32	19
I	6	14	22-23	3-38	45-47	11	11	3	2
L	18	22	3	3-38	2	5	5	31	16
NL	13	15	9	3-38	20-22	8	9	19	17
P	29	34	38	53-57	58-60	32	28	13	12
E	5	11	34	3-38	26-29	19	24	6	7
S	4	28	10	3-38	12-15	4	7	21	23
SHI	14-15	17	10	20-21	12	9	7	23	16-17
other	16	17	24	24	24	20	20	24	18

Linking rankings to functions

- What can Germany learn, using France as benchmark? *People live longer in France (weather? pharmaceuticals? diet?) but responsiveness and fair financing are better on this side of the Rhine – at a price, however.*
- What can Sweden learn, using France as benchmark? ***Life expectancy is same** but unevenly distributed (face validity?); **responsiveness, fair financing and goal attainment are all better** and **expenditure is lower** – performance can therefore be disregarded (due to lower edecation in France?) and nothing is to be learnt.*
- What can France learn about it‘s system? *It‘s expensive but worth it? Should the financing be changed – but what **effects on other indicators**?*

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Satisfaction with EU-Health Care Systems 1996-98

1996		Änderung 1996-98	1998			
	Zufrieden			Zufrieden	Weder-noch	Unzufrieden
DK	90,0	+0,6	DK	90,6	3,5	5,6
FIN	86,4	-5,1	FIN	81,3	18,5	10,2
NL	72,8	-3,0	A	72,7	18,5	6,7
L	71,1	-4,5	NL	69,8	8,4	20,9
B	70,1	-7,3	L	66,6	18,7	12,0
S	67,3	-9,8	F	65,0	18,5	15,5
D (*West/Ost*)	66,0 (*65,8/66,5*)	-8,5 (*-6,8/-14,6*)	B	62,8	21,6	14,7
F	65,1	-0,1	IRL	57,9	25,0	24,3
A	63,3	+9,4	D (*West/Ost*)	57,5 (*59,0/51,9*)	17,6 (*16,6/21,5*)	23,5 (*23,0/25,4*)
IRL	49,9	+8,0	S	57,5	14,3	26,1
GB	48,1	+8,9	GB	57,0	11,0	31,4
E	35,6	+7,5	E	43,1	30,1	26,1
P	19,9	-3,5	I	20,1	25,0	53,3
GR	18,4	-2,9	P	16,4	16,0	66,5
I	16,3	+3,8	GR	15,5	24,6	59,6
Mittelwert GKV	68,1	-2,3		65,7	17,2	15,6
Mittelwert andere	48,0	+0,8		48,8	18,7	36,7