Future threats and opportunities for European health systems

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Health care expenditure

Funding health care: options for Europe

The question of how to generate sufficient revenue to pay for health care has become a serious concern for nearly all European policy-makers. This book examines the advantages and disadvantages of a funding arrangement currently in use across Europe. Adopting a cross-national, cross-disciplinary perspective, it examines the relative merits of the main methods of raising resources including taxation; social, voluntary, and supplemental forms of insurance; and self-pay, including co-payments. Chapters written by leading health policy analysts review recent evidence and experience in both eastern and western Europe. The volume is introduced by a summary chapter which integrates conceptual issues in funding with an overview of the main advantages and disadvantages of each method of funding drawn from the expert chapters.

Funding Health Care: Options for Europe is an important book for students of health policy, health economics, public policy and management, and for health managers and policy-makers.

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The contributors
Expenditure on health care in the EU: making projections for the future based on the past.


Health expenditure in the EU countries has risen faster than GDP,
by 3.2 percentage points in the 1970s, 0.8 in the 1980s and 1.2 in the 1990s.

If future health care expenditure will rise faster than GDP by

• 1 percentage point, the EU average will increase to 11.8% of GDP in 2030
• 1.5 percentage points, it will reach 13.9% in 2030, i.e. the US level with a delay of 35 years.
Demography and ageing

• CAVE: This is the factor with the most myths!
• The common assumption that health care costs rise steeply with age (and that costs are therefore increasing drastically with an ageing population) is based only on current cross-sectional figures, comparing countries or expenditure by age.
• It negates important relationships between life expectancy, health care utilisation and costs!
Usually, our understanding of the correlation between age and acute health care costs looks like this:

... but with increasing life expectancy.

The revised scenario is less threatening – but still leaves the important issue of long-term care.
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<th>Average</th>
<th>Survivors</th>
<th>Persons in their 3\textsuperscript{rd} last year of life</th>
<th>Persons in their 2\textsuperscript{nd} last year of life</th>
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<td>5.1</td>
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Busse R, Krauth C, Schwartz FW. Use of acute hospital beds does not increase as the population ages – results from a 7-year cohort study in Germany. J Epidemiol Community Health 2002; 56(4): 289-293
Health care resources and medical progress

- While there is no clear correlation between health care structures (beds, physicians) or processes (length of stay) and health care expenditure,

- "medical progress" is usually made responsible for majority of increase. It is, however, ill-defined and encompasses a wide range from new technologies/therapies via new indications for existing technologies to changing preferences.
Health Technology Assessment will

• become standard in all countries
• determine benefit basket
• see an increase of non-RCT data
  (“community effectiveness“ instead of efficacy)
Health care provision

Hospitals in a changing Europe

- What roles do hospitals play in the health care system and how are these roles changing?
- If hospitals are to optimize health gains and respond to public expectations, how should they be configured, managed, and sustained?
- What lessons emerge from experiences of changing hospital systems across Europe?

Hospitals of the future will confront difficult challenges: new patterns of disease, rapidly evolving medical technologies, ageing populations, and continuing budget constraints. This book explores the competing pressures facing policy-makers across Europe as they struggle to respond to these complex challenges. It argues that hospitals, as part of a larger health system, should focus on enhancing health outcomes while also responding to public expectations. Adopting a cross-national, cross-disciplinary perspective, the study assesses recent evidence on the factors driving hospital reform and the strategies used to improve organizational performance. It reviews the evidence from eastern as well as western Europe and combines academic research with real-world policy experience. It looks at the role of hospitals in enhancing health rather than simply processing patients. The book concludes that hospitals cannot be managed in isolation from society and the wider health system, and that policy-makers have a responsibility to define the broader health care goals that hospitals should strive to meet.

Hospitals in a changing Europe synthesizes current evidence in a readable and accessible form for all practitioners, policy-makers, academics, and graduate-level students concerned with health reforms.

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Virtual CPs and for private hospitals?

• “By 2020 the first point of contact with health care will be through a ‘virtual‘ cyber-physician (CP). This could increase rather than reduce disparities.“ (UK Foresight Panel on Healthcare)

• Hospitals will still exist but many of them will be comparatively small and specialized – ownership will often be by private for profit companies.

• Linkage between care in hospital, ambulatory offices, pharmacies, other healthcare professionals will be become much more common – and expected.
What should the state do?

Regulating entrepreneurial behaviour in European health care systems

- What have been the major trends in entrepreneurial behaviour and regulation in European health care?
- To what degree do approaches to regulation and entrepreneurship differ amongst subsectors and countries across Europe?
- What does the evidence show about successes and failures, and which successful options are open to policy-makers?

A wide range of entrepreneurial initiatives have been introduced within European health care systems during the last decade. While these initiatives promised more efficient management, they also triggered concerns about reduced equity and quality in service provision. This book explores emerging regulatory strategies that seek to capture the benefits of entrepreneurial innovation without sacrificing the core policy objectives of a socially responsible health care system. It opens with an extended essay on current trends and evidence across health care subsectors and across countries, presenting a wide range of alternatives for policy-makers, and assessing their relative advantages and disadvantages. It then reviews entrepreneurialism and regulation in specific contexts (such as hospitals, primary health care, social services) and considers related issues including the impact of corruption and the potential lessons from deregulation of public utilities.

Regulating Entrepreneurial Behaviour in European Health Care Systems brings together the perspectives of politics, economics, management, medicine, public health and law and will be a valuable resource for students, academics, practitioners and policy-makers concerned with health policy and health reform.

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Stewardship, regulation and entrepreneurialism

“Rowing less, steering more“ – clear division of competencies with role of state = stewardship:

- **Health policy formulation** – defining the vision and direction for the health system
- **Regulation** – setting fair rules of the game with a level playing field (including possibly promotion of entrepreneurial activity!)
- **Intelligence** – assessing performance and sharing information

... but not providing care!
EU: Community instruments affecting health services

233 legal and juridical interventions by community policy or European Court of Justice

(Figure: Wismar, Busse 1999)
At European level, health services have to adapt to market rules, while at national level, health services are seen as part of a social model. To overcome this situation and to ensure the social status of health services, we need – possibly paradoxically – to develop a European health policy.
If we accept that conclusion, the question is:

Should European health policy be based mainly on the “regular” instruments (regulations, directives etc.) or on the open method of coordination?
Which objectives could be relevant?

- to achieve a high population health status for the entire population (healthy life expectancy),
- to design health systems and make them function according to justified population health needs and expectations,
- to ensure access to needs-based and effective health technologies (initially, maybe 15 areas),
- assuring a fair and sustainable financing of health care.
How could the application of such objectives/ indicators influence European health systems? (1)

• **Comparability** of services, access to them and their quality *will increase*, and thereby contribute to the *Europeanisation of health care systems*, already on the way through:
  • mobility of short- and long-term tourists,
  • cross-border contracts/ Euregios,
  • ECJ rulings on Kohll/ Decker, Peerbooms etc.,
  • the planned EU-health insurance card.
How could the application of such objectives/ indicators influence European health systems? (2)

This will in the medium-term probably lead to

- a European *benefit catalogue* (but not equal prices),
- Europe-wide rules/ standards for *accreditation* and *quality assurance*,
- Europe-wide diagnosis/ treatment *guidelines*.

This could make "Europe" more concrete for its *citizens* and help to *ease the conflict between the social model and markets*. 