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Health care systems in Europe – an impossible overview

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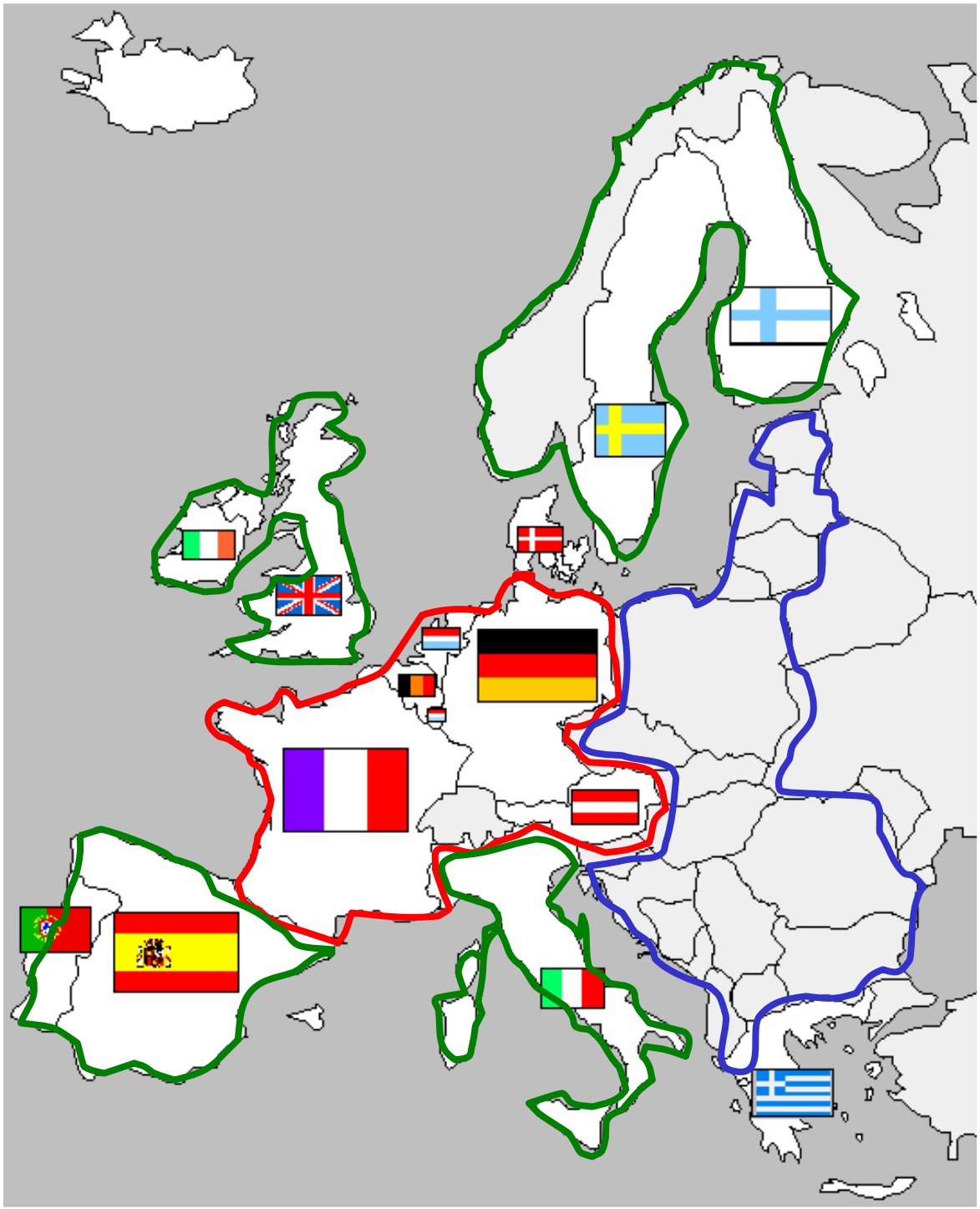
European Observatory on Health Care Systems

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



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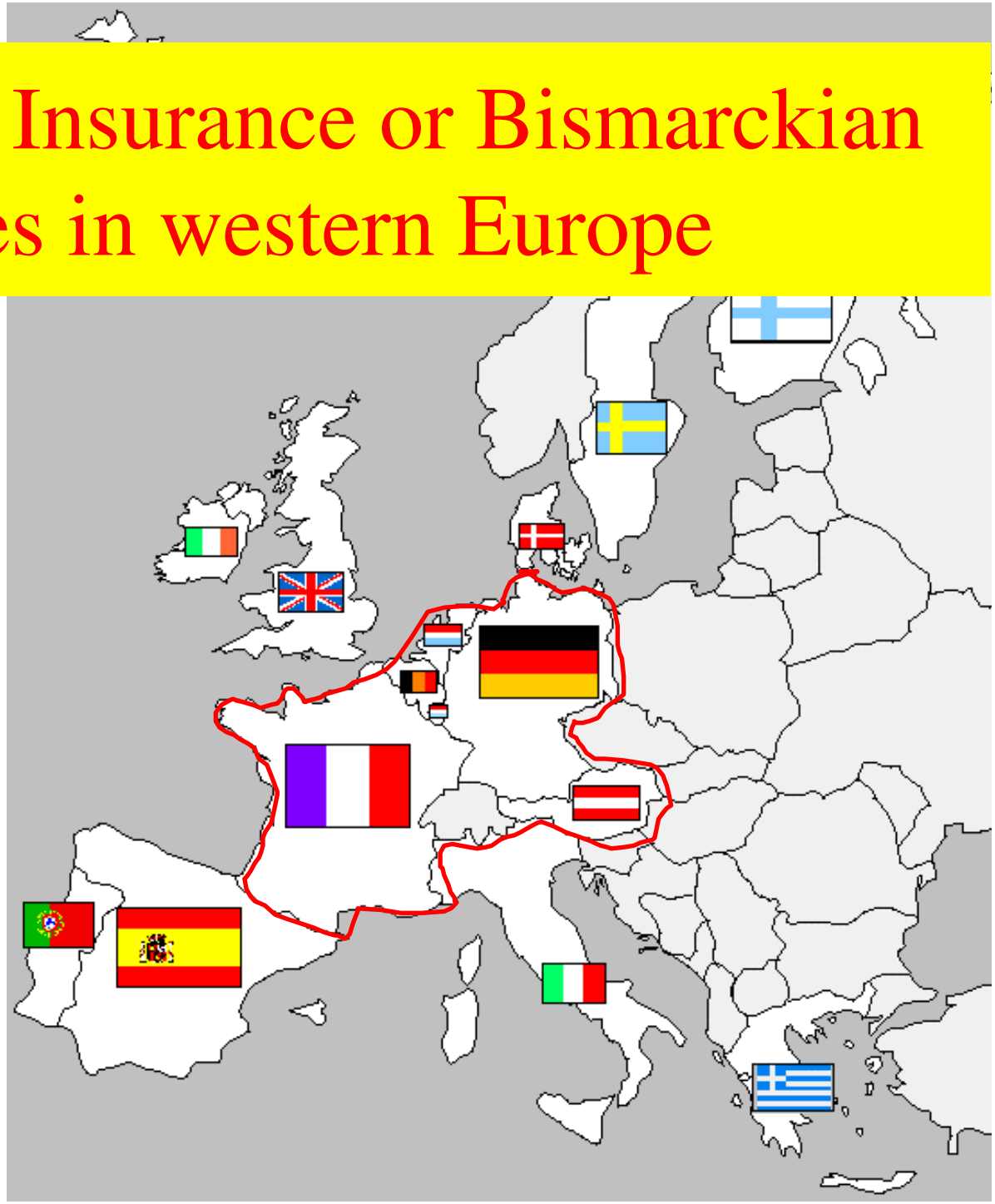
Social Health Insurance or Bismarckian countries in western Europe



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What makes a health system a SHI system?

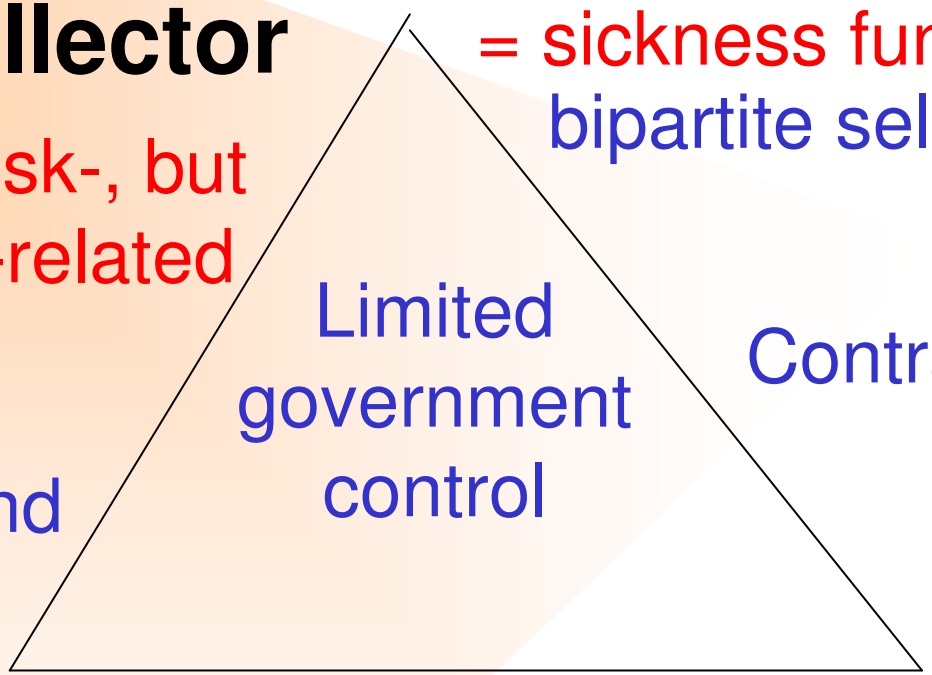
Contribution collector

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

Third-party payer

= sickness funds

bipartite self-government



Population

Mandatory insurance

Providers

Public-private mix

SHI is much more than a funding mechanism – it´s „a way of life“!

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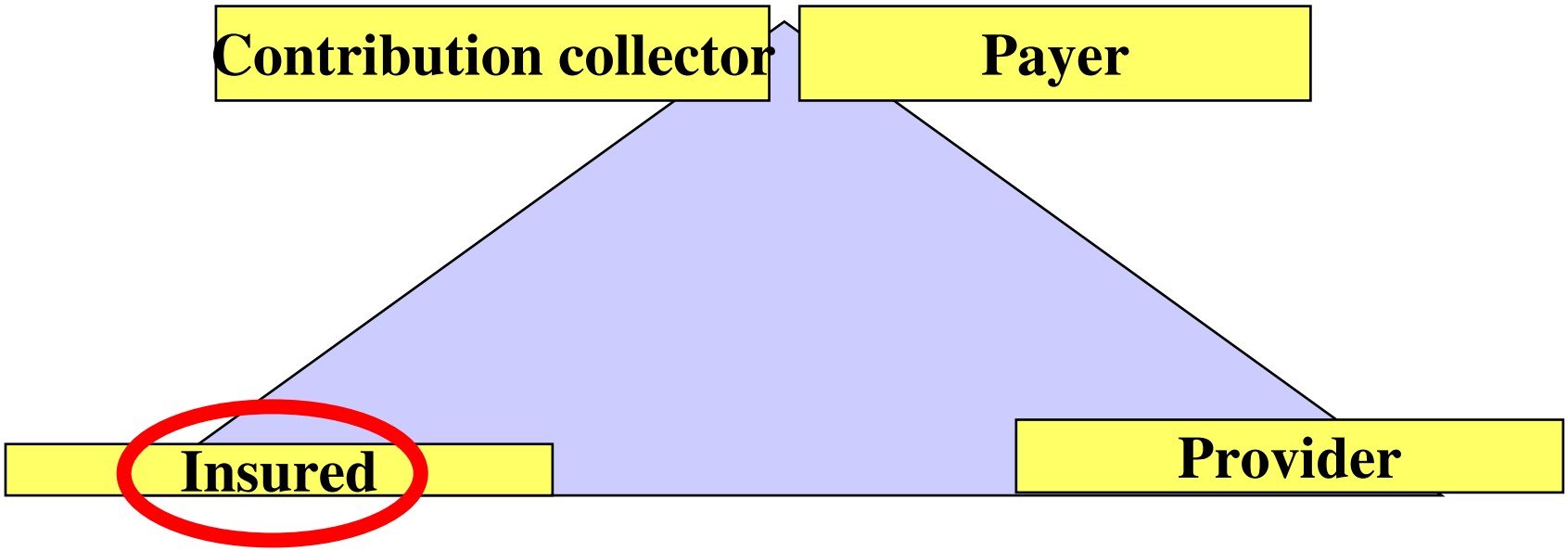
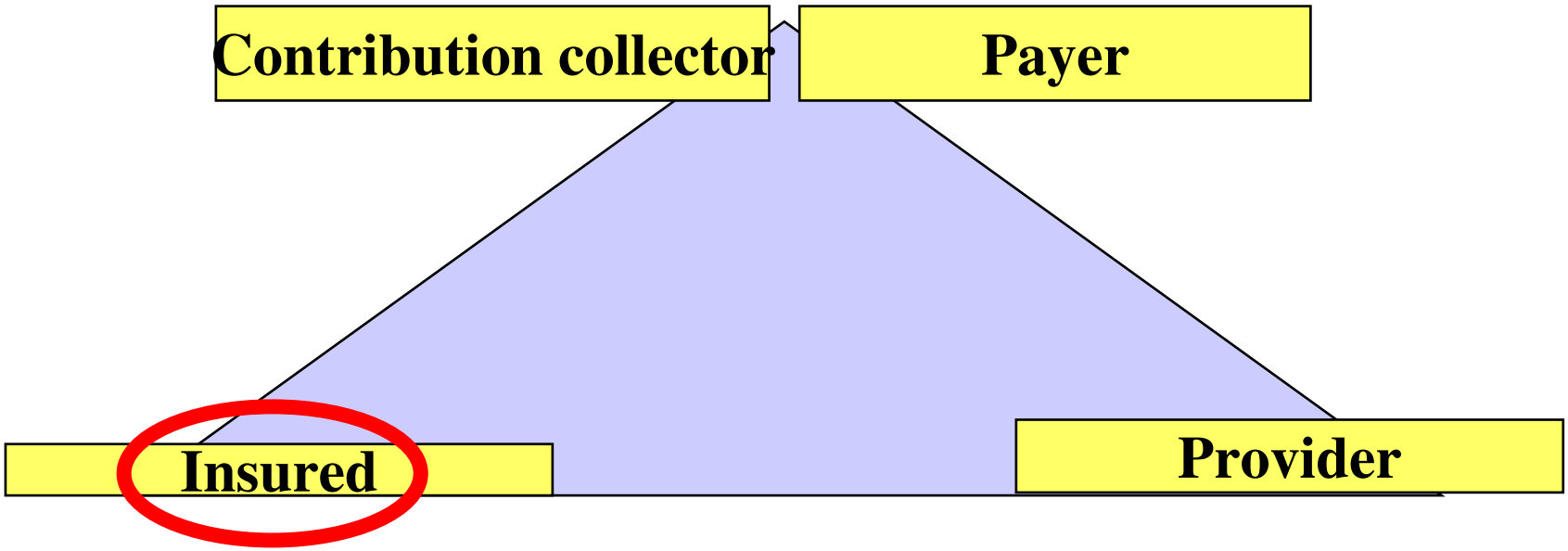
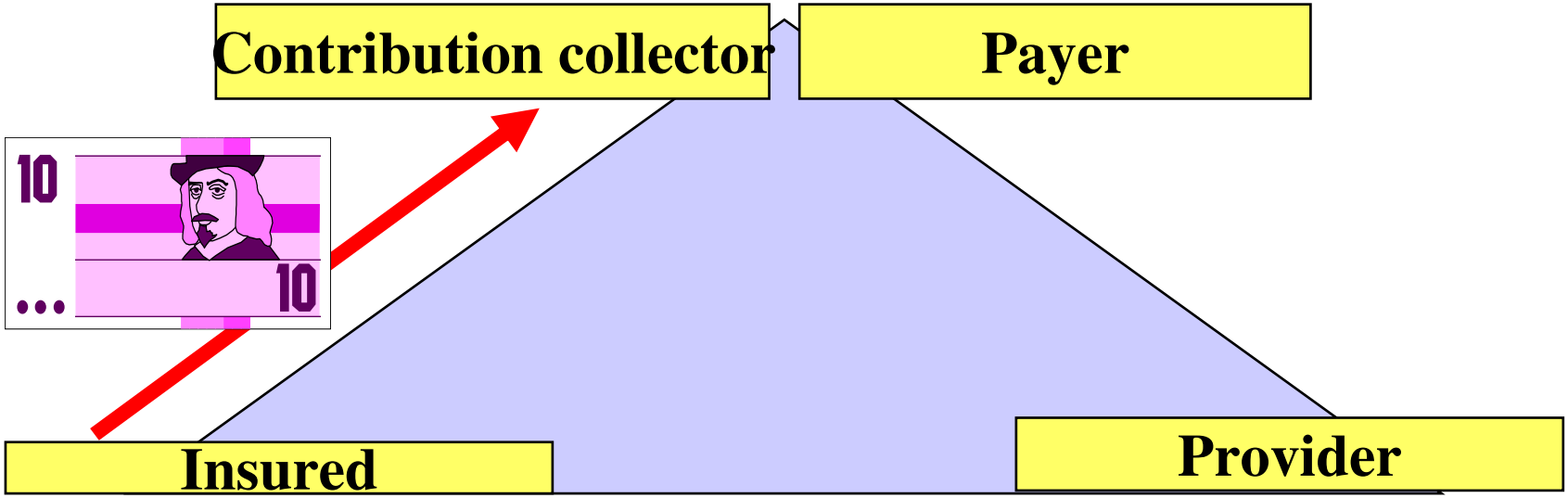


- SHI tradionally tied to employment
- later extended to defined other groups (dependents, pensioners, unemployed, students, self-employed etc.)
- no exclusion due to health status, but
- notion of “universal coverage“ = very recent phenomenon

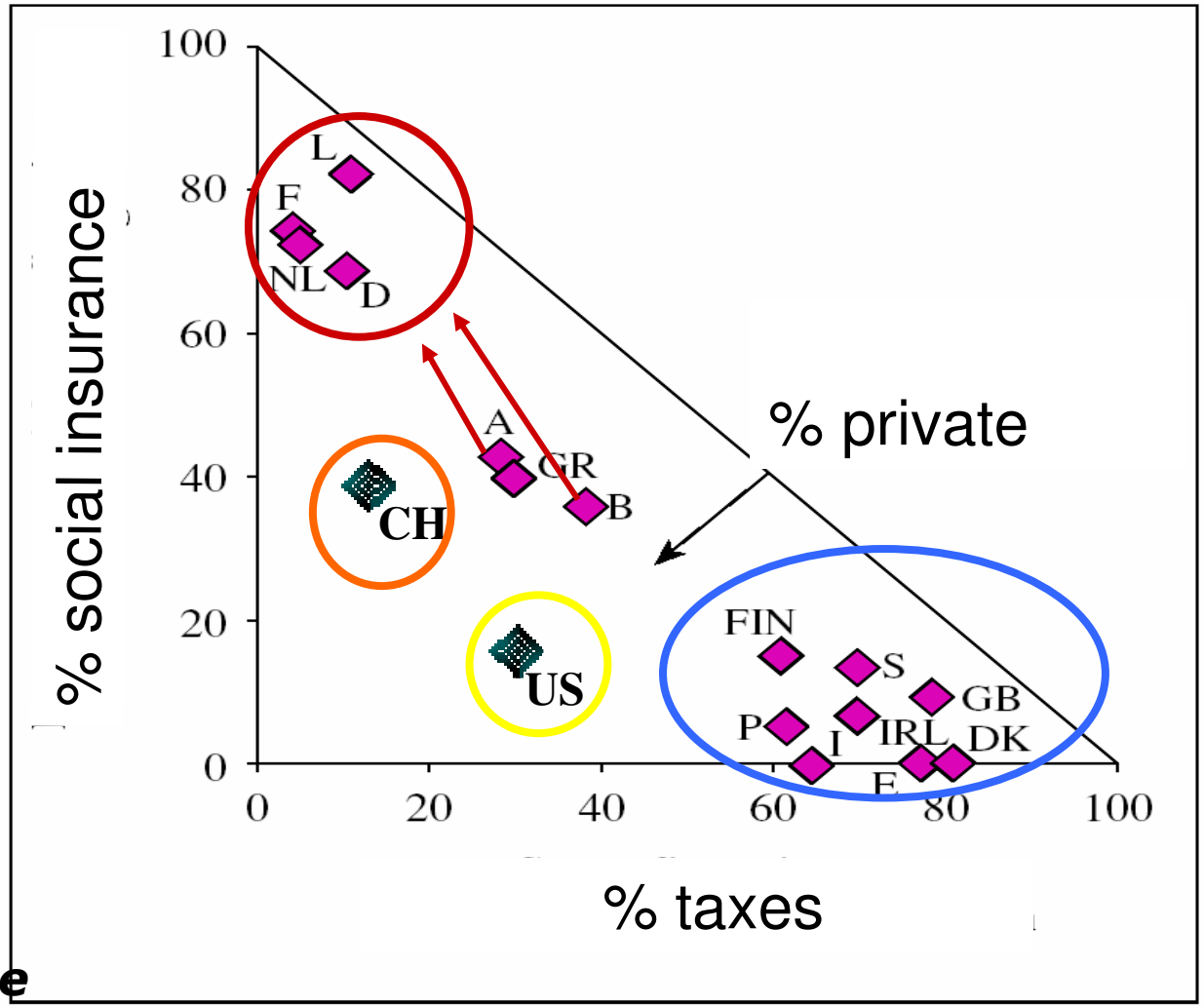


- 100% population coverage de facto in Austria and Luxembourg, legally in Belgium (since 1998), France (since 2000) and Switzerland (since 1996)
- 75% mandatory and 13% voluntary coverage in Germany (choice between SHI and PHI)
- 65% coverage in Netherlands (no choice!)



- traditionally based on wages only (with an upper limit)
- in France change from wage-based contribution of 8.9% to tax of 8.25% on all income of insured + taxing of pharamaceutical advertising ... *i.e. relief for wage-earners*
- in Netherlands plan to introduce community-rated per-capita premia (similar to Switzerland)

Funding of health care in EU countries, Switzerland and US: % contributed from three main sources – social insurance, taxes, and private



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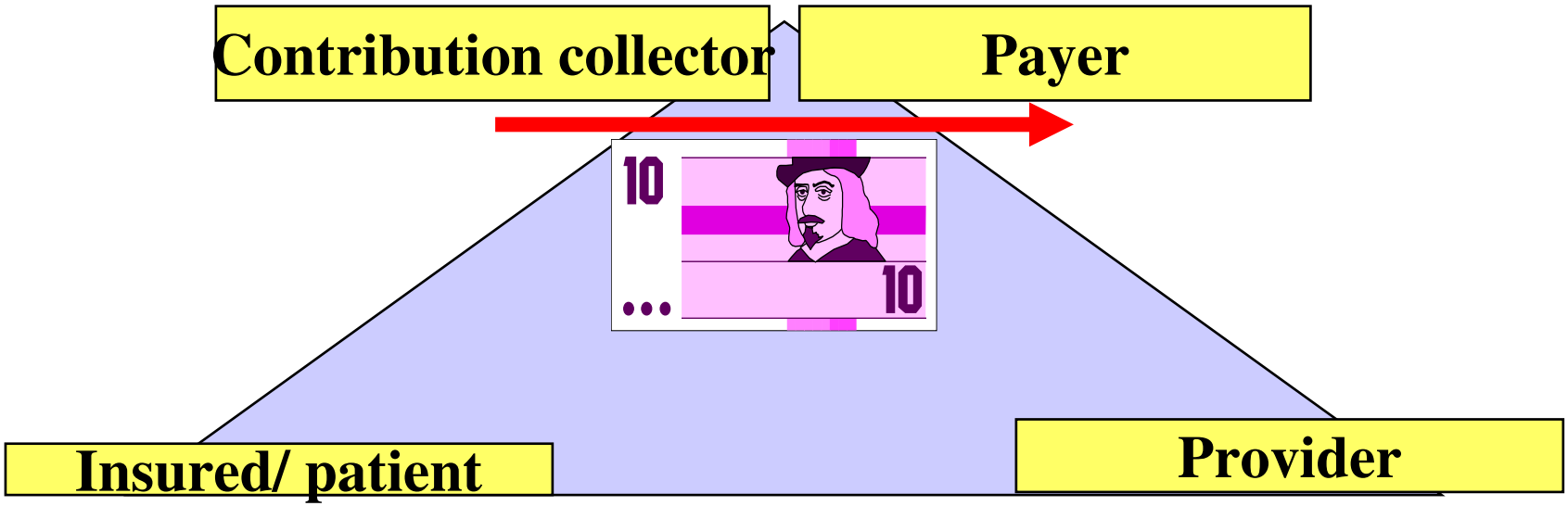
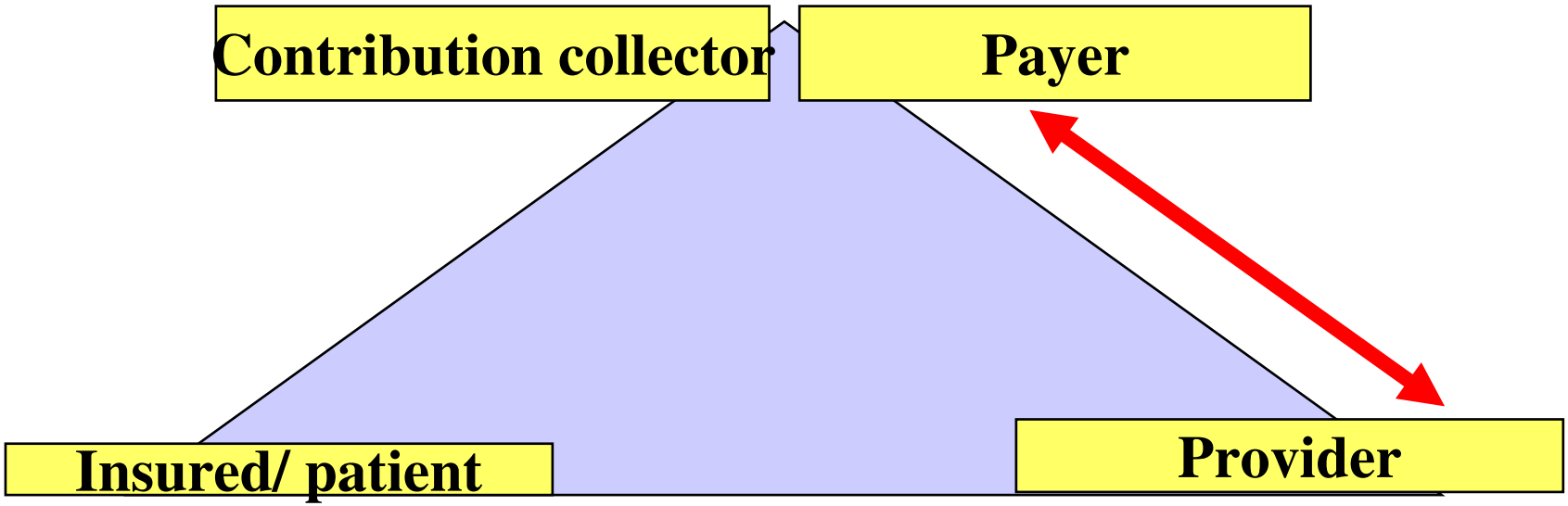
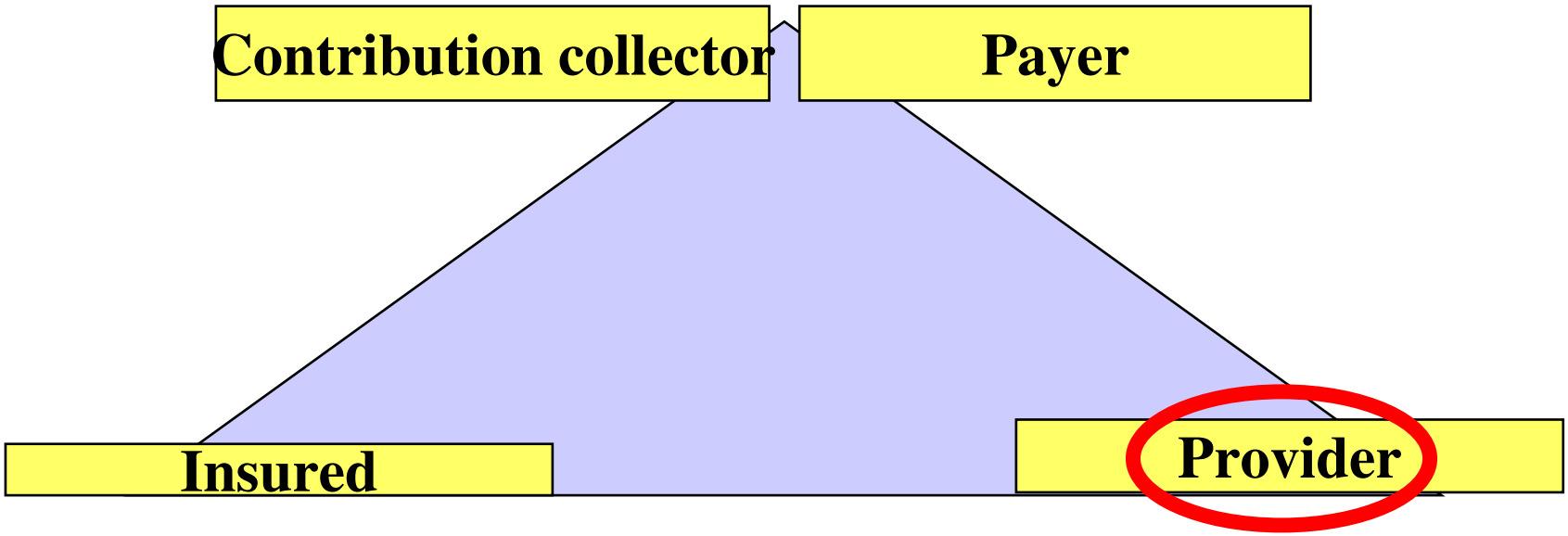


- new approach: prospective allocation of resources (Belgium, Netherlands) or re-allocation (Germany, Switzerland) – *the latter is more difficult as sickness funds view money as "theirs"*
- differences in: area of allocation - nation vs. region (Switzerland), degree of retrospective compensation, factors in the formulas (e.g. region in NL), 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

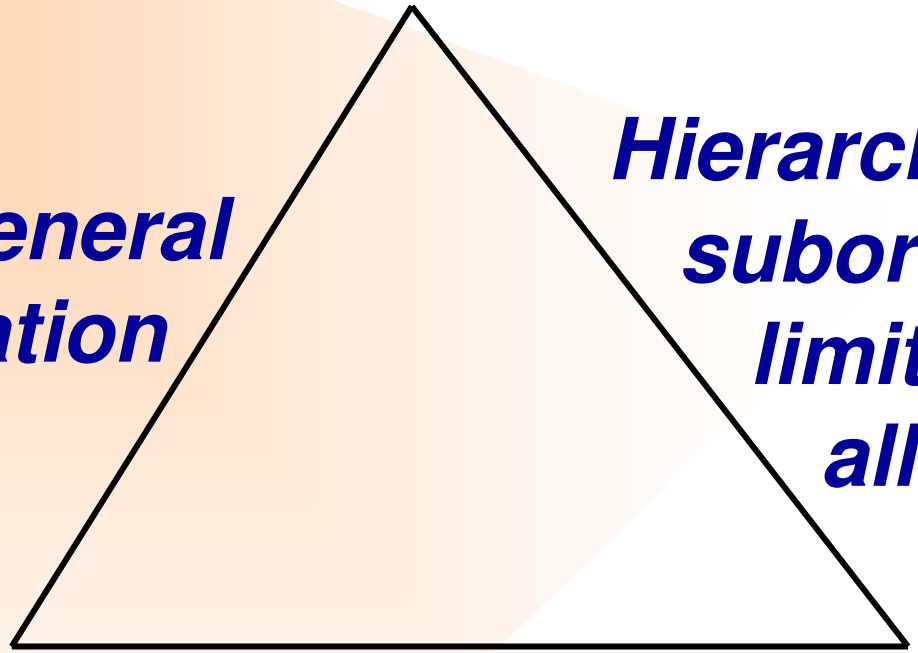


	Public	Not-for-profit	For profit
Austria	69%	26%	5%
Belgium	60%	40%	
France	65%	15%	20%
Germany	55%	38%	7%
Luxembourg	50%	50%	
Netherlands		100%	

Central and eastern Europe

Bulgaria
Czech Republic
Estonia
Hungary
Latvia
Lithuania
Poland
Romania
Slovakia
Slovenia

The health care systems in 1990



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

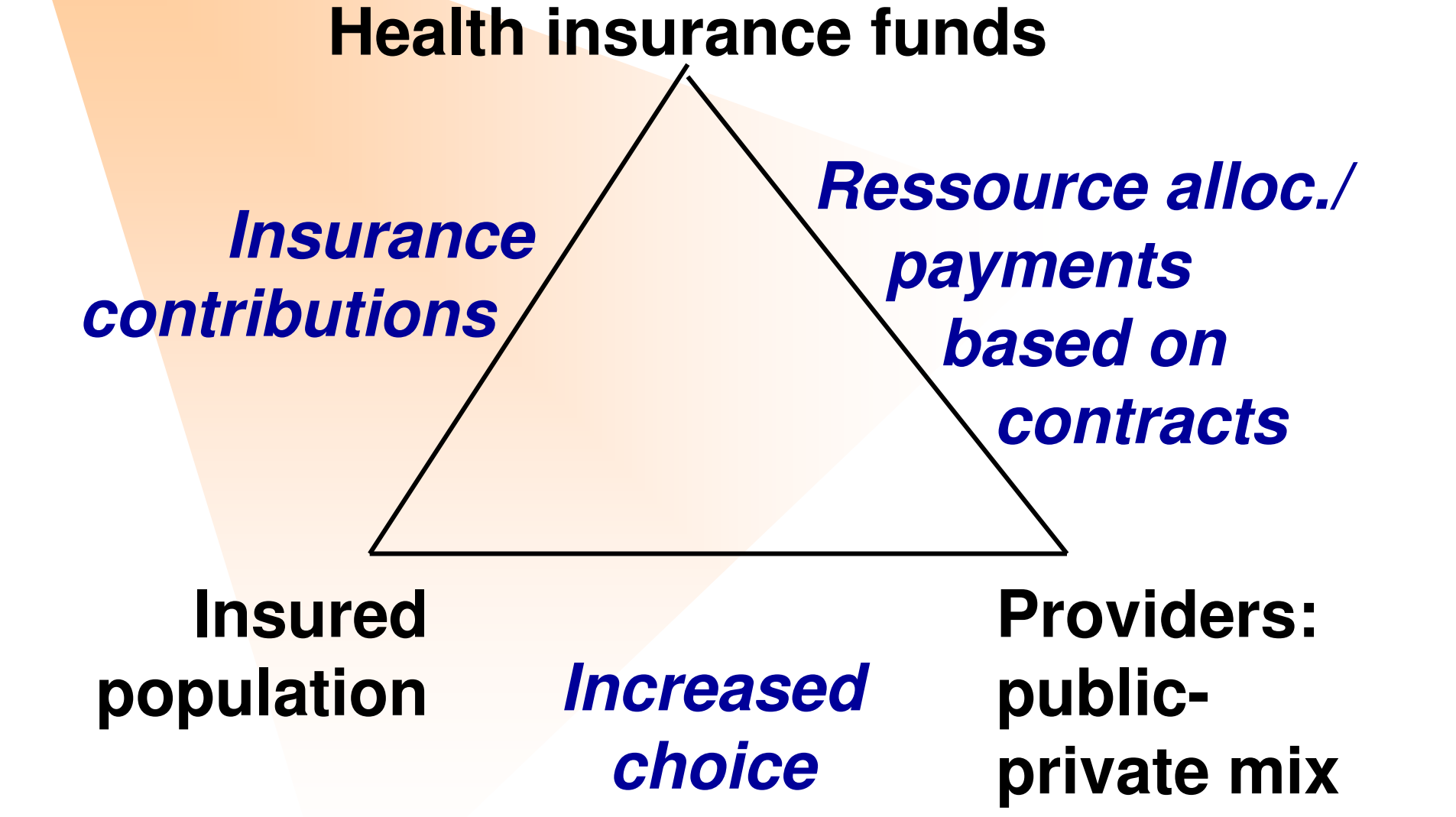
Dezentralization and privatization

- 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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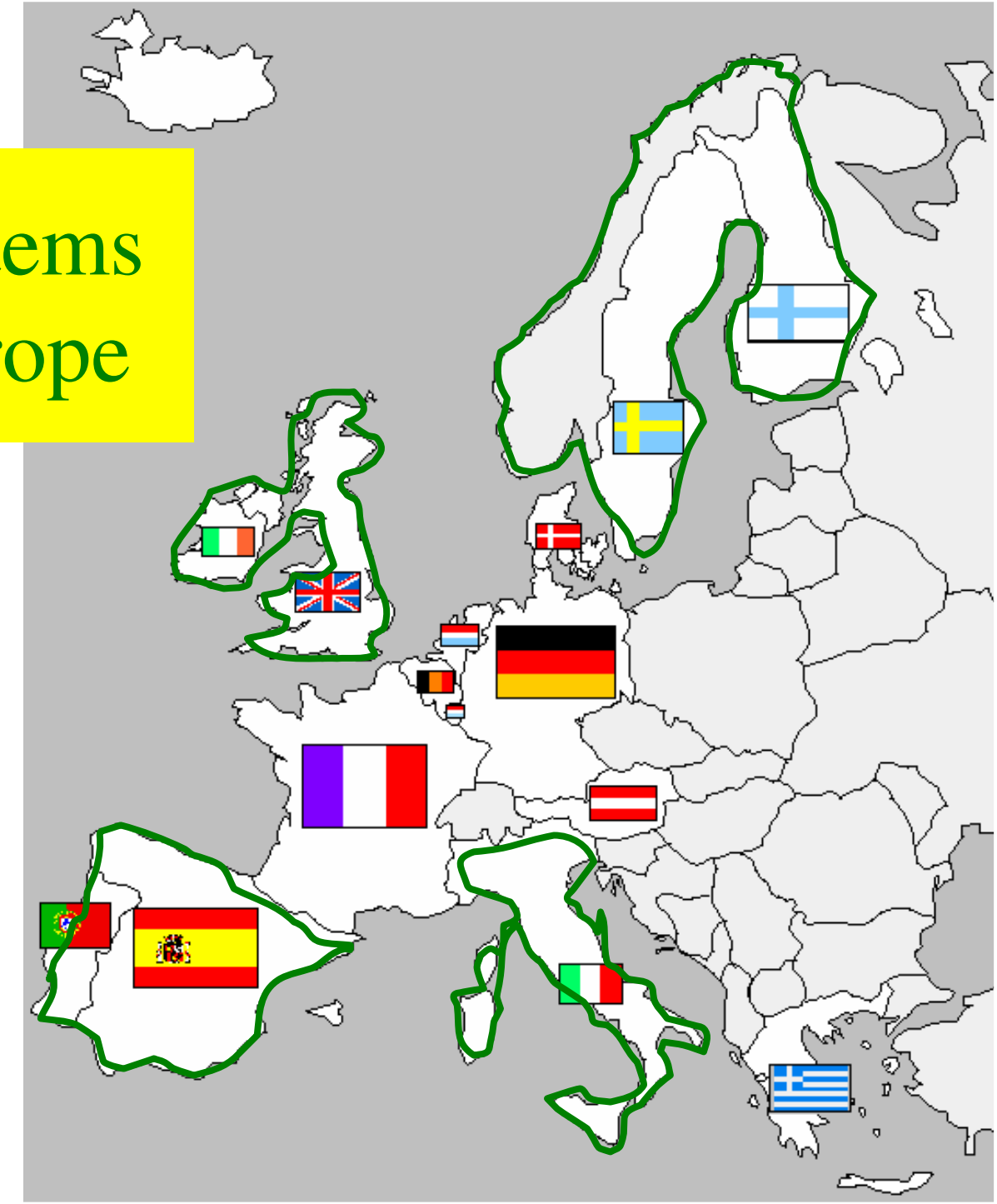
Tax-based systems in western Europe



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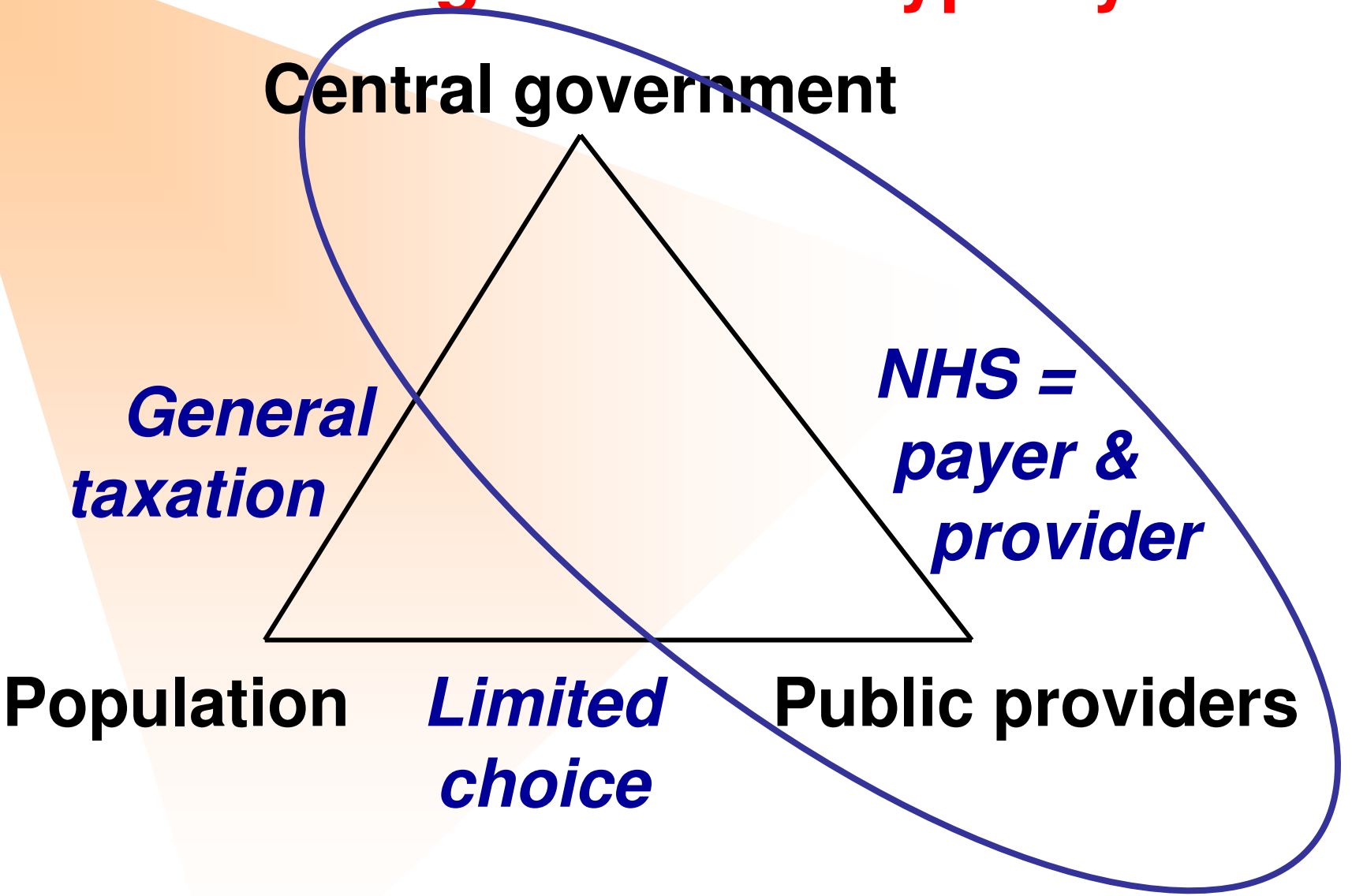
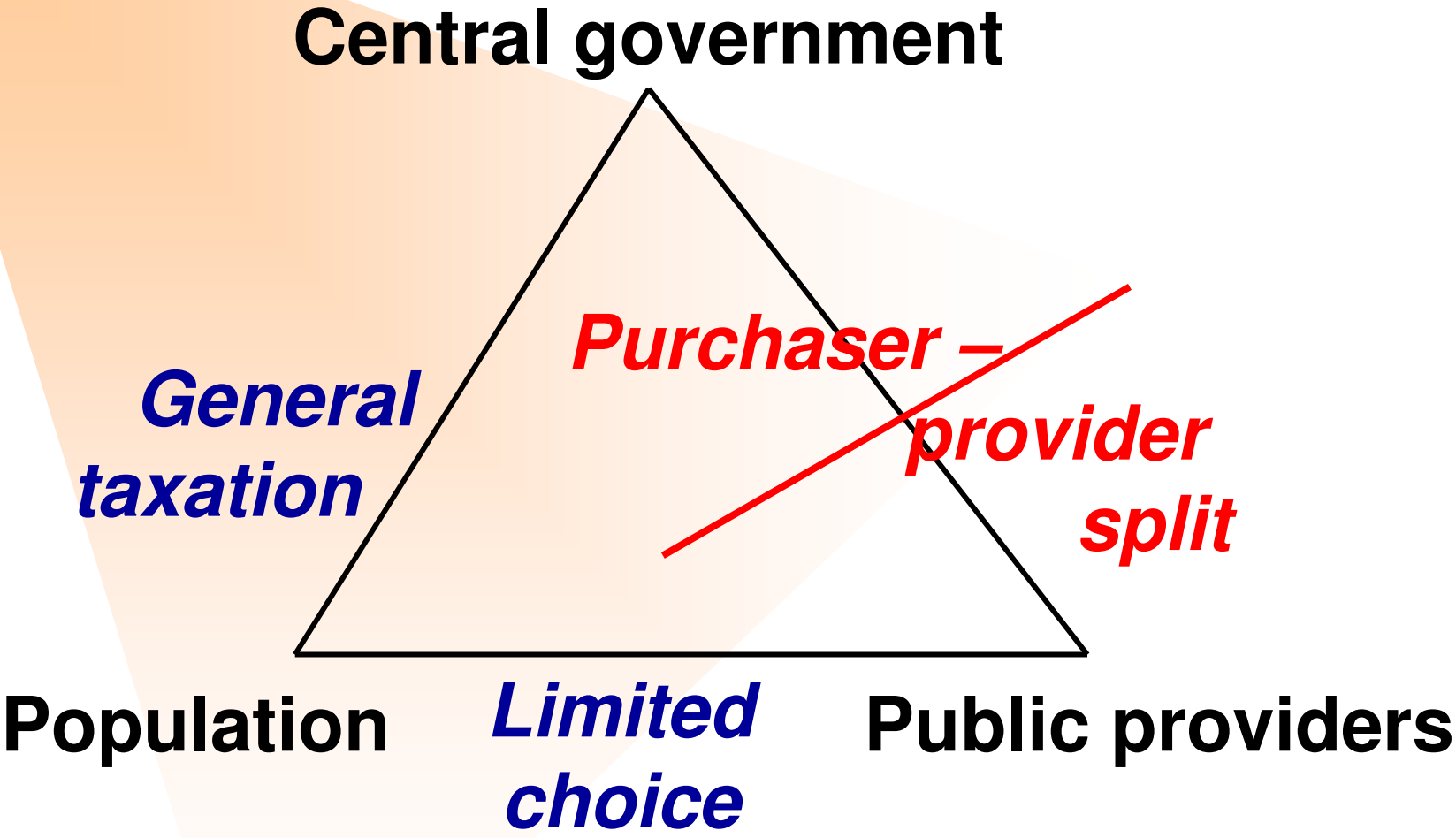
Classical integrated NHS-type system

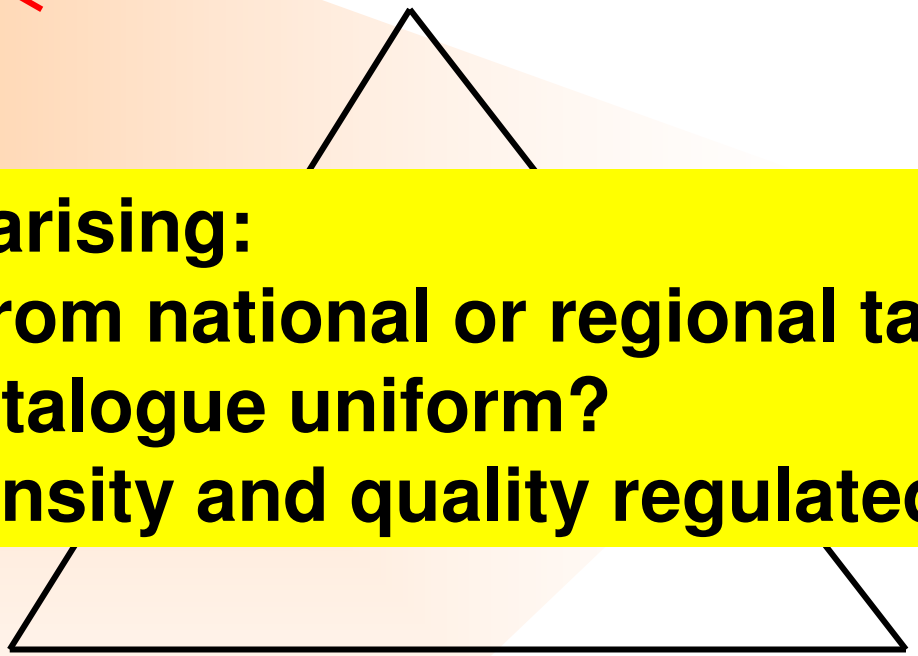


Development 1



Development 2

~~Central~~ **Regional governments**



Questions arising:
- **Funding from national or regional taxation?**
- **Benefit catalogue uniform?**
- **Supply density and quality regulated uniformly?**

Population ***Limited choice*** **Public providers**

Development 3