Health care systems in Europe

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Third-party Payer

Population Providers
Functions

Population Providers

Collector of resources Third-party payer Steward/ regulator


Mobilizing resources/ funding Purchasing/ contracting/ financing providers

Access to and provision of services

Regulation
System typology

Collector of resources
- Main funding source: contribution on wages (= SHI), taxes (= NHS), premium (= PHI)

Steward/regulator
- Regulation

Third-party payer
- Mobilizing resources/funding
- Access to and provision of services

Population
- Coverage
- Who? For what?

Providers
- Purchasing/contracting/financing providers

System typology

Collector of resources
- Type of third party payer: Sickness funds (= SHI), government/health authorities (= NHS)...}

Steward/regulator
- Payer-provider relation: integrated (“classical” NHS), contractual (SHI, “new” NHS), none (PHI)

Third-party payer

Providers

System typology

SHI = Social health insurance
NHS = National Health Service
PHI = Private health insurance
The funding mix in 2002

Social Insurance Systems

Private

Tax-funded Systems

Countries with major changes in funding mix 1975 - 2002

¹: Data refer to 2001
²: based on calculations of Schreyögg (2003)
⁴: based on calculations of Schreyögg (2000)

Revenue from SHI-contributions as % total expenditure on health

Revenue from taxes as % total expenditure on health
Tax-based systems in western Europe

Classical integrated NHS-type system

Central government

General taxation

NHS = payer & provider

Population

Limited choice

Public providers
**Development 1**

Central government

- General taxation
- Limited choice
- Public providers
- Purchaser – provider split

**Development 2**

Regional governments

- General taxation
- Limited choice
- Public providers
- Purchaser – provider split

http://mig.tu-berlin.de
Questions arising:
• Funding from national or regional taxation?
• Benefit catalogue uniform?
• Supply density and quality regulated uniformly?
• Access to services across regional borders?

Development 2
Central Regional governments

Development 3
Regional governments

General taxation

Purchaser – provider split

Population Limited choice Public providers

Limited more choice
(money follows patient)
Regional governments

Purchaser - provider split

General taxation

Limited more choice

Public providers: Public-private mix

Social Health Insurance (SHI) or „Bismarckian“ countries in western Europe

Commonalities and variations between countries
What makes a health system a SHI system?

**Contribution collector**
- Not (health) risk-, but usually wage-related contribution
- [Choice of fund]

**Third-party payer**
- = sickness funds
- bipartite self-government
- Limited government control
- Contracts

**Population**
- Mandatory insurance

**Providers**
- Public-private mix

- **Contribution collector**
- **Payer**

- **Insured**
- **Provider**

- SHI traditionally tied to employment, later extended to defined other groups (dependents, pensioners, unemployed, students, self-employed etc.)
- 75% mandatory and 13% voluntary coverage in Germany (choice between SHI and PHI)
- 65% coverage in Netherlands (no choice!)

• pre-determined membership in Austria, France and Luxembourg

• free choice of fund in Belgium, Netherlands (1993-), Germany (1996-) and Switzerland - the young, well-educated and healthier are changing funds more often, i.e. risk-structure de-mixes!
• Traditionally based on wages only (with an upper limit)
• Problem 1: increasing burden on labour costs as other income is rising faster - Solution: broaden income base, e.g. by abolishing upper limit (Belgium, France)
• in France change from wage-based contribution of 6.8% to tax of 6.0% on all income of insured + taxing of pharamaceutical advertising ... *i.e. relief for wage-earners*

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**Figure 4.2** Contributions at different income levels according to contribution rates in the four countries

- **France (18.8%)**
- **Germany (14.3%)**
- **Netherlands (20.75%)**
- **Japan (8.5%)**
- **Japan (8.3%)**
Problem 2: inequity of contributions as income and risk profiles differ between funds

Traditional approach: complete pooling of contributions and passing money to funds according to expenditure

= conflict with efficiency goal and instrument “competition"

uniform contribution rate in A, B, F, L and NL (but differing per-capita premium on top); differing rate in Germany; differing per-capita premium in Switzerland

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
### Number of sickness funds

<table>
<thead>
<tr>
<th></th>
<th>A*</th>
<th>B*</th>
<th>CH</th>
<th>D*</th>
<th>F*</th>
<th>L*</th>
<th>NL</th>
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<td>26</td>
<td>127</td>
<td>191</td>
<td>1223</td>
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* typical bi-partite government

### Diagram

- **Contribution collector**
- **Payer**
- **Insured/ patient**
- **Provider**

- 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 are 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 (also in NL)
• 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
Which system is “best“?

Answer depends on goals, i.e.

- Health gain/ improvement
- Responsiveness to population needs
- Sustainable funding
- Equity in health, responsiveness and funding
- Efficiency (reaching goals : resources)
060204 +Life expectancy at age 65, in years

1. France

1. Austria

Netherlands

Latvia

Data: WHO-EURO HfA-Data Base 1/2004

Sufficient blood pressure control
6 months after a CHD hospitalisation

Data: EUROASPIRE „Clinical reality of coronary prevention guidelines“, Lancet 2001; 357: 998
### Private financing of health care and financial fairness

<table>
<thead>
<tr>
<th>Country</th>
<th>% of private finance of total health care expenditure</th>
<th>Fairness in financing (max. 1.00)</th>
<th>% of households which spend &gt;40% of income on health</th>
<th>% of households which spend &gt;40% of income out-of-pocket</th>
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