European health care systems in transition

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Third-party Payer

Population

Providers
Functions

Collector of resources  Third-party payer  Steward/regulator

Population  Providers

Resource pooling & allocation

Collector of resources → Third-party payer

Mobilizing resources/funding

Steward/regulator

Purchasing/contracting/financing providers


Access to and provision of services

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Resource pooling & allocation

Collector of Third-party payer resources

Mobilizing resources/ funding

Purchasing/ contracting/ financing providers

Steward/ regulator

Regulation

Population

Coverage

Who? For what?

Providers

Access to and provision of services

System typology

The funding mix in 2002

Source: OECD Health Data 2004, 3rd Edition
¹: Data refer to 2001
²: based on calculations of Schreyögg (2000)
Countries with major changes in funding mix 1975 - 2002

Revenue from taxes as % total expenditure on health
Revenue from SHI-contributions as % total expenditure on health

Funding of health care in the new EU Member States: % contributed from three main sources – social insurance, taxes, and private (in 2000)

¹ based on calculations of Prescott, N. and Nichols, L.M. (1998)
² based on calculations of Schreyögg (2003)
Tax-based systems in western Europe

Classical integrated NHS-type system

Central government

General taxation

Population

Limited choice

NHS = payer & provider

Public providers
Development 1

Central government

General taxation

Purchaser – provider split

Population

Limited choice

Public providers

Development 2

Central Regional governments

General taxation

Purchaser – provider split

Population

Limited choice

Public providers

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Development 2
Central Regional governments

Questions arising:
- Funding from national or regional taxation?
- Benefit catalogue uniform?
- Supply density and quality regulated uniformly?
- Access to services across regional borders?

Population Limited choice Public providers

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Development 3
Regional governments

General taxation
Purchaser – provider split

Population Limited choice Public providers

(money follows patient)

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Regional governments

Development 4

General taxation

Population

Limited

Purchaser – provider split

Public providers: Public-private mix

more choice

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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**

**Population**

**Providers**

**Direct tax**

- **progressive = equitable = „good“**
- **proportional = „not so good“**
- **regressive = not equitable = „bad“**

**SHI contribution**

- **progressive = equitable = „good“**
- **proportional = „not so good“**
- **regressive = not equitable = „bad“**

**Private insurance premium; user fee**

**CAVE:** Many tax-funded systems have high indirect taxes = regressive!

**SHI systems have (CH) or will (NL) replace contributions by premiums = regressive!**
<table>
<thead>
<tr>
<th>1993</th>
<th>Distribution: fairness in financial contribution (1.00 = max.)</th>
<th>Threshold</th>
<th>% of households with catastrophic payments (total expenditure)</th>
<th>% of households with catastrophic payments (out of pocket)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Slovakia</td>
<td>0.941</td>
<td>0.00</td>
<td>0.00</td>
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<tr>
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<td>0.33</td>
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<td>0.38</td>
<td>0.07</td>
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<td>0.920</td>
<td>0.39</td>
<td>0.18</td>
<td></td>
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<td>0.54</td>
<td>0.93</td>
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<td>0.96</td>
<td>0.20</td>
<td></td>
</tr>
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<td>0.00</td>
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<tr>
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<td>0.23</td>
<td>0.09</td>
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<td>0.44</td>
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<td>0.89</td>
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<td>4.01</td>
<td>2.71</td>
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<tr>
<td>Latvia</td>
<td>0.828</td>
<td>4.05</td>
<td>2.75</td>
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</table>

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

Bipartite = members/insured + employers

Tripartite = + government

Population  
Providers

Principal organisational forms of sickness funds

- One national monopoly fund: e.g. Estonia, Hungary, Poland
- Several regional monopoly funds: e.g. Latvia, Romania; initially Estonia and Poland
- Several non-choice funds organised on other principles (e.g. occupation): Austria, France, Luxembourg; Germany -1995
- Several funds with choice/competition: Belgium, Germany, Netherlands, Switzerland; Czech Republic, Slovakia

More than one fund raises many questions:

- Uniform benefit catalogue? For equity reasons – yes; but for competition?
- Uniform contribution rate (or per capita premium)? A, B, F, L = yes; CH, D = no, NL = mix
- If rate is uniform, should there be one collector? How should the money be allocated to funds? Which risk factors? What happens if that is not enough? Otherwise: re-allocation between funds needed (as in CH & D)!
- Is it worth it to have more than one fund???
### Transferred money through “risk structure compensation”

<table>
<thead>
<tr>
<th>Year</th>
<th>West RSC / SHI expenditure (billion €)</th>
<th>West RSC as % of SHI</th>
<th>East RSC / SHI expenditure (billion €)</th>
<th>East RSC as % of SHI</th>
<th>Germany RSC / SHI expenditure (billion €)</th>
<th>Germany RSC as % of SHI</th>
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<tbody>
<tr>
<td>1995</td>
<td>6.90/ 97.29 7.1</td>
<td></td>
<td>2.36/ 19.70 12.0</td>
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<td>9.23/ 116.99 7.9</td>
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<tr>
<td>1996</td>
<td>7.27/ 100.41 7.2</td>
<td></td>
<td>2.51/ 20.47 12.3</td>
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<td>9.78/ 120.88 8.1</td>
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<tr>
<td>1997</td>
<td>7.71/ 98.23 7.8</td>
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<td>2.63/ 20.05 13.1</td>
<td></td>
<td>10.34/ 118.29 8.7</td>
<td></td>
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<tr>
<td>1998</td>
<td>8.22/ 99.74 8.2</td>
<td></td>
<td>2.80/ 19.97 14.0</td>
<td></td>
<td>11.01/ 119.71 9.2</td>
<td></td>
</tr>
<tr>
<td>1999</td>
<td>8.30/ 102.68 8.1</td>
<td></td>
<td>3.29/ 20.52 16.0</td>
<td></td>
<td>11.60/ 123.21 9.4</td>
<td></td>
</tr>
<tr>
<td>2000</td>
<td>8.30/ 105.05 7.9</td>
<td></td>
<td>3.73/ 20.89 17.8</td>
<td></td>
<td>12.03/ 125.94 9.6</td>
<td></td>
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<tr>
<td>2001</td>
<td>9.06/ 108.89 8.3</td>
<td></td>
<td>4.43/ 21.75 20.4</td>
<td></td>
<td>13.52/ 130.63 10.3</td>
<td></td>
</tr>
<tr>
<td>2002</td>
<td>9.28/ 111.79 8.3</td>
<td></td>
<td>4.66/ 22.54 20.7</td>
<td></td>
<td>13.94/ 134.33 10.4</td>
<td></td>
</tr>
</tbody>
</table>

Source: own calculations based on Ministry of Health and Social Security (27).

Note: RSC: risk structure compensation; a total expenditure of sickness funds without spending on administration and fund-specific benefits as detailed in the funds’ articles (ca. 90% of total).

### What makes a health system a SHI system?

- **Contribution collector**
- **Third-party payer**
  - = sickness funds
  - bipartite self-government

- **Population**
  - Mandatory insurance

- **Providers**
  - Public-private mix

- **Limited government control**
- **Contracts**
- **Free access**
- **Choice of fund**
- **Not (health) risk-, but usually wage-related contribution**

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• SHI traditionally 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

• Universal population coverage in Switzerland (since 1996), Belgium (since 1998), France (since 2000) and in Netherlands (from 2006)
• 75% mandatory and 13% voluntary coverage in Germany (choice between SHI and PHI)
• Currently, 65% coverage in Netherlands (no choice!)
Stewardship and accountability

• Stewardship role for government complicated as major health care responsibilities are in the hands of sickness funds
• Sickness funds should be (and usually are) accountable, but only to their insured and regarding the benefits covered (i.e. no broad public health perspective)

What does this all mean?

• Social health insurance systems with more than sickness fund are close to the actors but complicated to steer and manage!
• We do not have convincing data that it's really worth it in terms of improved health outcomes – especially for the chronically ill who need coordinated/integrated care (disease management programmes) more than competition!
Choice for individuals or collective participation?

- to be insured at all (Germany, Netherlands above income threshold)
- between statutory system and VHI (Germany)
- of sickness fund within SHI (Belgium, Czech Republic, Germany, Netherlands, Slovakia, Switzerland)

Individual choice

Third-party payer

- number of uninsured increasing (new "self-employed")
- NL abolished "no insurance" option
- most Germans with choice opt for SHI rather than VHI
- movement between funds is limited but sufficient to worry policy-makers
Third-party payer

Regulator

Population

Provider 1

Provider 2

Drug/ device

Individual choice

Covered benefits

New developments:
- "client-based budget" (NL, Germany)
- financial incentives for voluntary gatekeeping

all SHI countries, most NHS countries; Sweden, Spain, CEE only since 1990s

without gatekeeping: SHI countries except NL; after gatekeeping: more and more NHS countries, especially in northern and southern Europe

Co-payment design:
- flat (e.g. Spain)
- by package size
- price-dependent
- by effectiveness (France, Italy)

- co-payments (except NL)
- reference prices with choice between products, at cheapest level, only for one product? (Belgium)

- more OTC

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- Sickness fund boards (Austria, Belgium, Estonia, France, Germany, Slovenia)
- Health authority/PCT boards (UK)

Collective participation

Population

Third-party payer

Regulator

Provider 1

Drug/device

Provider 2

Covered benefits

Patient/public involvement:
- Federal Joint Committee (Germany), NICE (UK)
- EMEA Management Board

Hospital boards

Collective participation

- Sickness fund boards (Austria, Belgium, Estonia, France, Germany, Slovenia)
- Health authority/PCT boards (UK)
Belgium, Germany, Netherlands, Switzerland: emphasis on individual choice

UK: emphasis on collective participation

<< Denmark, Sweden

< ? CEE countries ? >
What makes a health system a SHI system?

**Contribution collector**
- Not (health) risk-, but usually wage-related contribution
- separate from taxes

**Third-party payer**
- sickness funds
- Sole raison d’être: to ensure health care as efficient (cost per quality) and responsive as possible

**Population**
- Mandatory insurance
- Ability to pay

**Providers**
- Solidarity
- Need
What makes a health system a SHI system?

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

Third-party payer
= sickness funds

Contracts – to avoid high transaction costs and to ensure equal access: collective

Population
Mandatory insurance

Providers
Public-private mix

Who competes for whom?

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

Third-party payer
= sickness funds

Contracts

Population
Mandatory insurance

Providers
Public-private mix

Free access
Third-party payer
= sickness funds

Population
Mandatory insurance

Choice of fund

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

Contracts

Who competes for whom?

Who competes for whom?

Third-party payer

Providers
Public-private mix

Free access

Price, quality, access …

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1. Does it work, i.e. does selective contracting/ application of Managed Care instruments produce better outcomes and/or lower costs?
2. For which persons/ indications does it work? For the 75-80% chronically healthy? For the 5% really ill? For the 15-20% chronically ill?

3. Does it have adverse effects on somebody else’s access?
4. Is it financially successfull because of cream-skimming?
5. Is it quality-wise so successfull that it leads to adverse selection?

Can risk-adjustment balance both cream-skimming and adverse selection?
Contribution collector

Independent of risk, need and utilisation, i.e. income-related or community-rated

Third-party payer

Dependent on volume, appropriateness (service = need) and quality, steered by priorities and incentives

Population

Providers

Dependent on risk, but independent of actual utilisation

Financial pooler

Non-risk related contribution/premium

Financial flows/incentives in Disease Management Programmes

"Risk-adjusted" capitation

What is risk? Can risk be measured by treatment parameter (hospitalization, drug prescriptions)? Should DMP participation increase or decrease capitation?

Payer/purchaser

Fee-for-service/DRGs

Bad outcomes = more money?

Outcome/-quality-based compensation

What is the right balance?

Population/patients

Reduced cost-sharing?

Only for compliant patients?

GP

Specialist

Nurse

Providers
1. Assuming it works – i.e. there are more benefits than harm, and assuming risk-adjustment can get us over the negative aspects –, who should benefit?

2. Is it worth it? Do we need less competition (unite sickness funds)? More self-responsibility?

Public and private health services: can they co-exist effectively?
What a question …
if you come from a country like this:

- Ambulatory care, dental care, pharmacies: >99% private delivery
- Acute care beds: 53% public, 38% not-for-profit, 9% private for profit
- Rehabilitative beds: 17% public, 16% not-for-profit, 67% private for profit
- Nursing home beds: 11% public, 62% not-for-profit, 28% private for profit

Development of the public-private mix in ownership of general hospitals, 1990–2003

<table>
<thead>
<tr>
<th></th>
<th>Public</th>
<th></th>
<th>Not-for-profit</th>
<th></th>
<th>Private</th>
<th></th>
<th>Total</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>beds</td>
<td>% share</td>
<td>beds</td>
<td>% share</td>
<td>beds</td>
<td>% share</td>
<td>beds</td>
<td>% share</td>
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<tr>
<td>1990</td>
<td>387 207</td>
<td>62.8</td>
<td>206 936</td>
<td>33.5</td>
<td>22 779</td>
<td>3.7</td>
<td>616 922</td>
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<tr>
<td>2003</td>
<td>265 520</td>
<td>53.1</td>
<td>187 271</td>
<td>37.5</td>
<td>46 954</td>
<td>9.4</td>
<td>499 785</td>
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<tr>
<td>Change</td>
<td>-32.4%</td>
<td>-9.5%</td>
<td>+106.2%</td>
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<td></td>
<td></td>
<td></td>
<td>-19.0%</td>
</tr>
</tbody>
</table>

However, the debate is often …

- Biased
- Confused by inconsistent terminology
- Missing concepts (and therefore data)
- Prejudice & Ideology (in both directions)

The European Observatory’s aim is to provide evidence, not ready-made solutions …

What is public, what is private?

<table>
<thead>
<tr>
<th>Funding</th>
<th>“public”</th>
<th>“private”</th>
</tr>
</thead>
<tbody>
<tr>
<td>“public” Statutory Health Insurance</td>
<td>public</td>
<td>private, out-of-pocket</td>
</tr>
<tr>
<td>“private” not-for-profit, for profit</td>
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</tbody>
</table>

Delivery

- “public”
- “private”
Out-of-pocket health care expenditure as a percentage of the total health expenditure for the OECD Region, 2002

<table>
<thead>
<tr>
<th>Country</th>
<th>% of Total Health Expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Czech Republic</td>
<td>8.6</td>
</tr>
<tr>
<td>France</td>
<td>9.8</td>
</tr>
<tr>
<td>Netherlands</td>
<td>10.1</td>
</tr>
<tr>
<td>Germany</td>
<td>10.4</td>
</tr>
<tr>
<td>Slovak Republic</td>
<td>10.9</td>
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<td>Luxembourg</td>
<td>11.0</td>
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<td>Ireland</td>
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<td>United States</td>
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<tr>
<td>Norway</td>
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<td>Denmark</td>
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<td>Iceland</td>
<td>16</td>
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<tr>
<td>New Zealand</td>
<td>16.1</td>
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<td>Japan (2001)</td>
<td>16.5</td>
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<td>Austria</td>
<td>17.5</td>
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<td>Australia (2001)</td>
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<td>Ireland</td>
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<td>Spain</td>
<td>22.6</td>
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<tr>
<td>Hungary</td>
<td>26.3</td>
</tr>
<tr>
<td>Turkey (2000)</td>
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<td>Switzerland</td>
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<td>Korea (2001)</td>
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<tr>
<td>Mexico</td>
<td>52.1</td>
</tr>
</tbody>
</table>

Informal payments not included!

### 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 on health out-of-pocket</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2002</td>
<td>1990</td>
<td></td>
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<td>47.1</td>
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<td>30.1</td>
<td>26.5</td>
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<td>24.5</td>
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<tr>
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<td>28.8</td>
<td>n.a.</td>
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<tr>
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<td>Italy</td>
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<td>Finland</td>
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<td>United Kingdom</td>
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<tr>
<td>Czech Republic</td>
<td>8.8</td>
<td>2.6</td>
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</tr>
</tbody>
</table>

Public-private ownership of acute care hospital beds in SHI countries

<table>
<thead>
<tr>
<th></th>
<th>Public</th>
<th>Not-for-profit</th>
<th>For profit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Austria</td>
<td>69%</td>
<td>26%</td>
<td>5%</td>
</tr>
<tr>
<td>Belgium</td>
<td>60%</td>
<td>40%</td>
<td></td>
</tr>
<tr>
<td>France</td>
<td>65%</td>
<td>15%</td>
<td>20%</td>
</tr>
<tr>
<td>Germany</td>
<td>53%</td>
<td>38%</td>
<td>9%</td>
</tr>
<tr>
<td>Luxembourg</td>
<td>50%</td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td>Netherlands</td>
<td>14%</td>
<td>86%</td>
<td></td>
</tr>
</tbody>
</table>

But reality is more complex:

- public hospitals encompass wide range from “budgetary“ via „autonomous“ to „corporatized“
- public hospitals may be under public or private law
- public autonomous = private not-for-profit?
- what about “public enterprises“ with partly private ownership?
- big differences between contracted and other private for-profit hospitals
What differentiates public from private (if not ownership per se)?

<table>
<thead>
<tr>
<th>Core public bureaucracy</th>
<th>Private organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Autonomy</td>
<td>Few decision rights</td>
</tr>
<tr>
<td>Market exposure</td>
<td>None</td>
</tr>
<tr>
<td>Residual claimant</td>
<td>Public purse</td>
</tr>
<tr>
<td>Accountability</td>
<td>Hierarchical direct control</td>
</tr>
<tr>
<td>Social functions</td>
<td>Unfunded mandate</td>
</tr>
</tbody>
</table>

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)
Health gain/ improvement

Life expectancy at birth, in years

- Austria
- Czech Republic
- France
- Germany
- Hungary
- Slovakia
- United Kingdom
- EU members before May 2004
- EU members since May 2004

http://mig.tu-berlin.de
Reduction of life expectancy through death before 65 years

Neonatal deaths per 1000 live births
Birthweight specific infant mortality: Czech Republic

Koupilová, McKee & Holčík. Health Policy, 1998

Life expectancy at age 65, in years

http://mig.tu-berlin.de
Sufficient blood pressure control
6 months after a CHD hospitalisation

Data: EUROASPIRE „Clinical reality of coronary prevention guidelines“, Lancet 2001; 357: 998
Responsiveness/ satisfaction
Figure 1 Delivery Deficit
Difference between what people want from healthcare and what they get

Figure 2 Inferiority Complex
How do other European health systems perform compared with your own?
Reforms most likely to increase the quality of care

<table>
<thead>
<tr>
<th>Reform</th>
<th>Likely</th>
<th>Not likely</th>
<th>Net</th>
</tr>
</thead>
<tbody>
<tr>
<td>Giving patients more information about their illness</td>
<td>76</td>
<td>21</td>
<td>55</td>
</tr>
<tr>
<td>Increasing number of medicines and treatments</td>
<td>67</td>
<td>29</td>
<td>38</td>
</tr>
<tr>
<td>Giving patients more control over public spending on health</td>
<td>67</td>
<td>30</td>
<td>37</td>
</tr>
<tr>
<td>Making it easier for patients to spend their own money on health</td>
<td>66</td>
<td>30</td>
<td>36</td>
</tr>
<tr>
<td>Increasing range of doctors and hospitals</td>
<td>43</td>
<td>53</td>
<td>-10</td>
</tr>
</tbody>
</table>
Sustainable funding

Total health expenditure, PPP$ per capita
Figure 3 Underfunding at home
How much money does your health system have?
Equity

Health Financing Contribution Distribution Graph

http://mig.tu-berlin.de
Czech Republic
Level for Choice by sex and age categories (Outpatient)

Age

Efficiency?
If asked, the public wants reforms in every country – but which?

Figure 4 Reform Index
Does your healthcare system need reforming?

http://www.observatory.dk

European Observatory on Health Systems and Policies

Social health insurance systems in western Europe

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