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European health care systems in transition

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&
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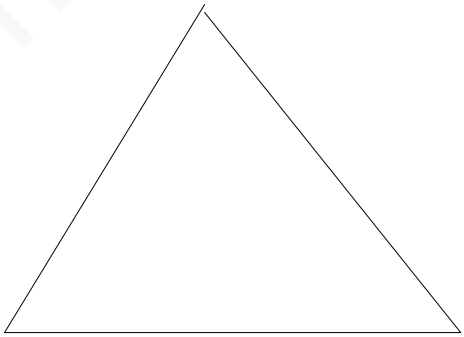
Third-party Payer



Population **Providers**

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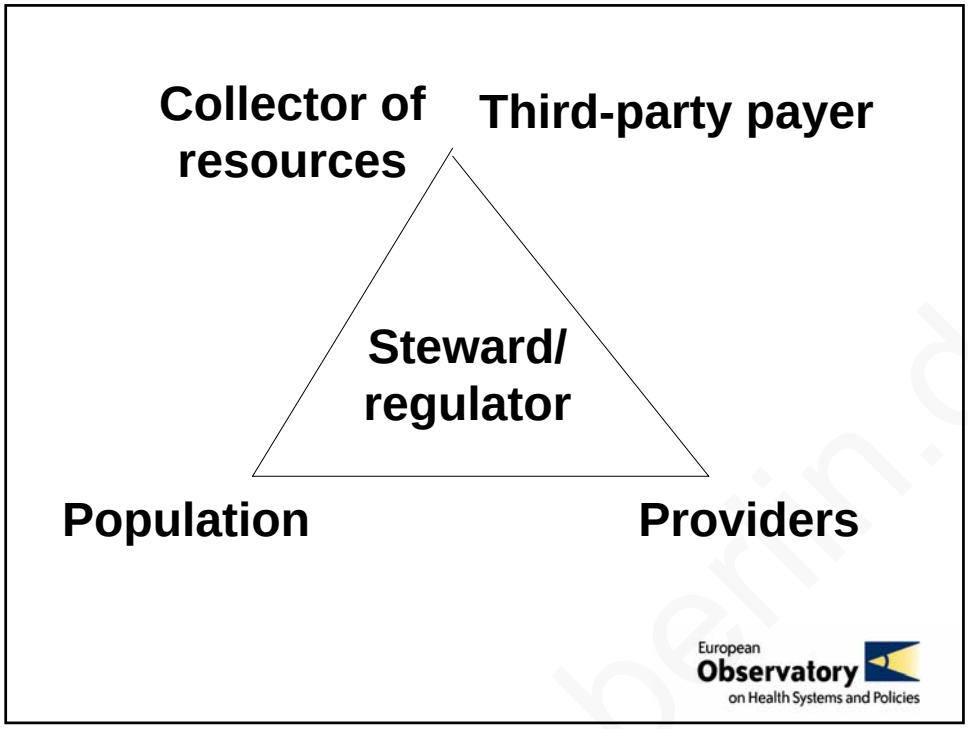

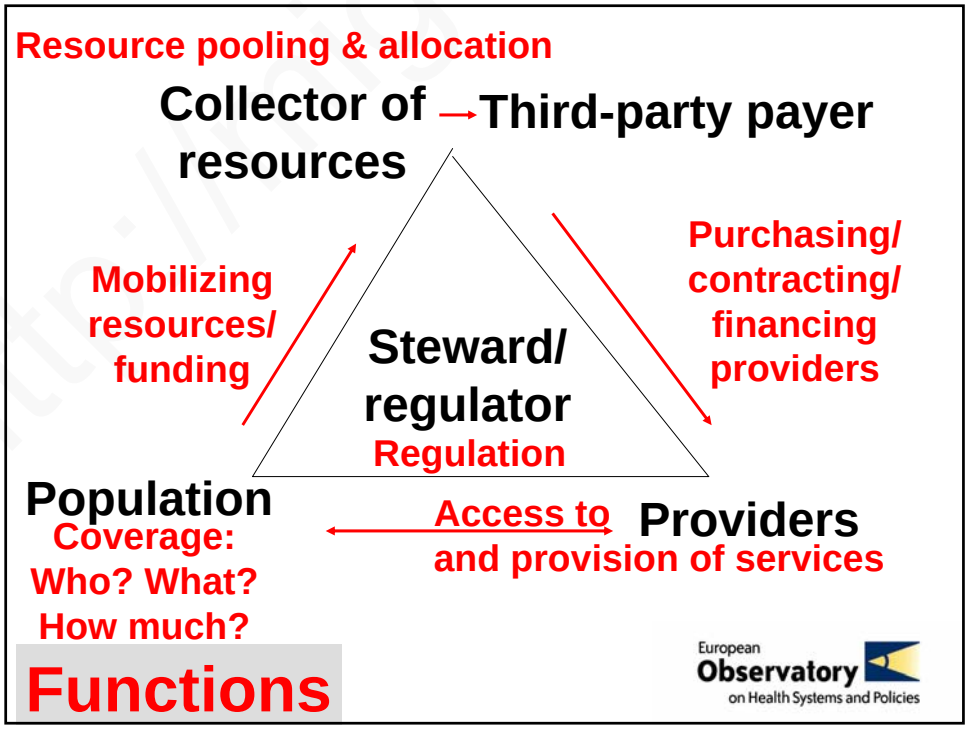

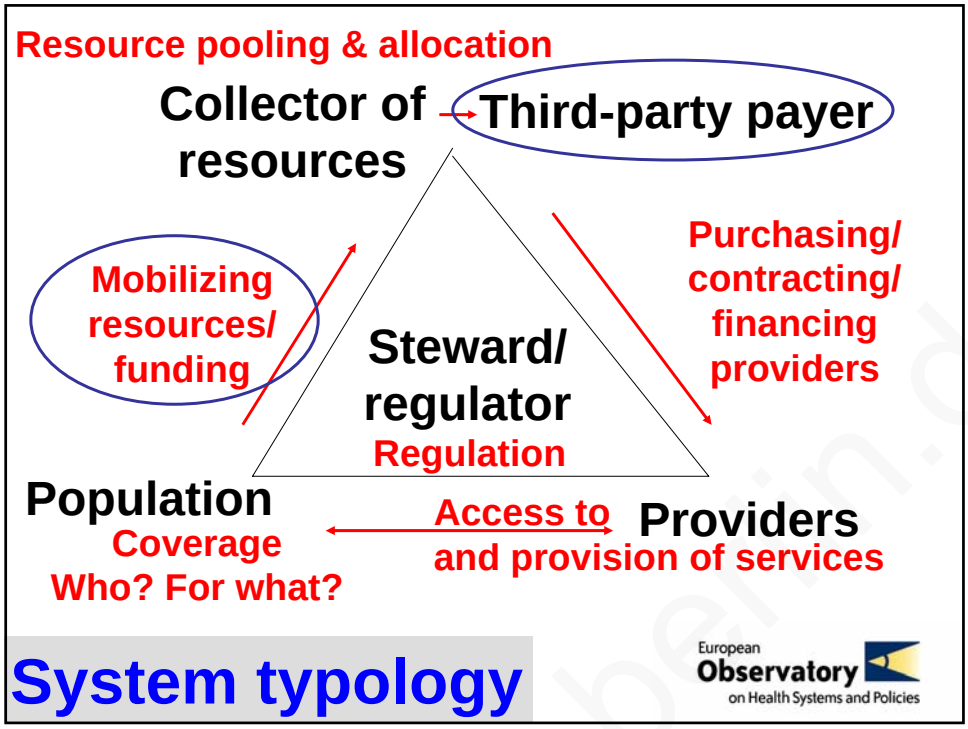
Resource pooling & allocation
Collector of resources
Third-party payer
Mobilizing resources/ funding
Steward/ regulator
Regulation
Purchasing/ contracting/ financing providers
Population
Coverage
Who? For what?
Access to and provision of services
Providers
System typology
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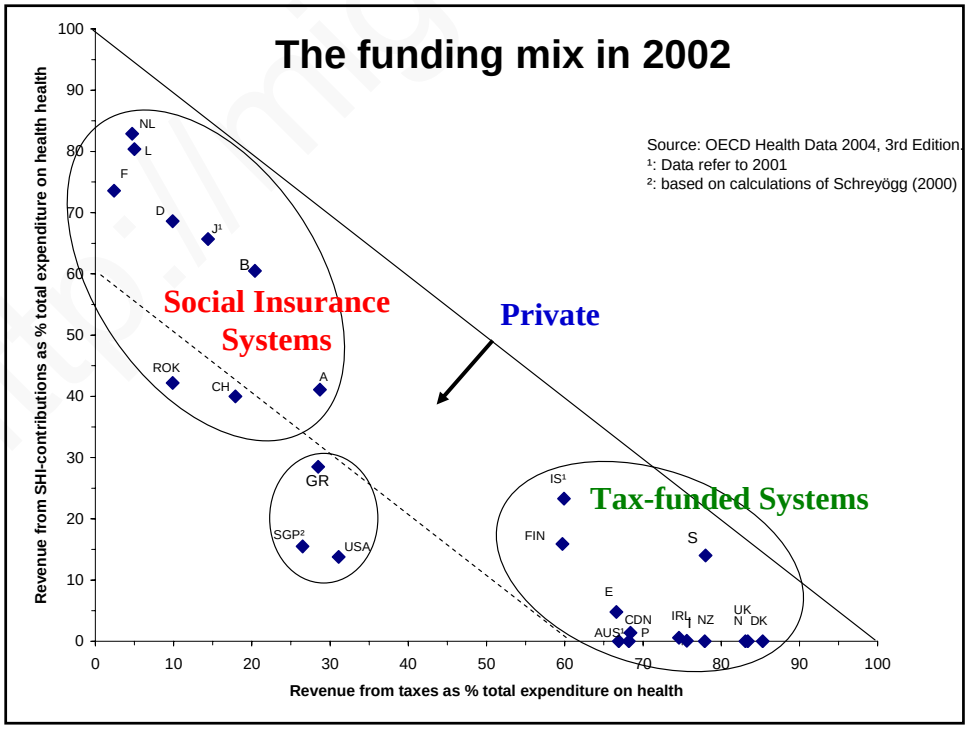
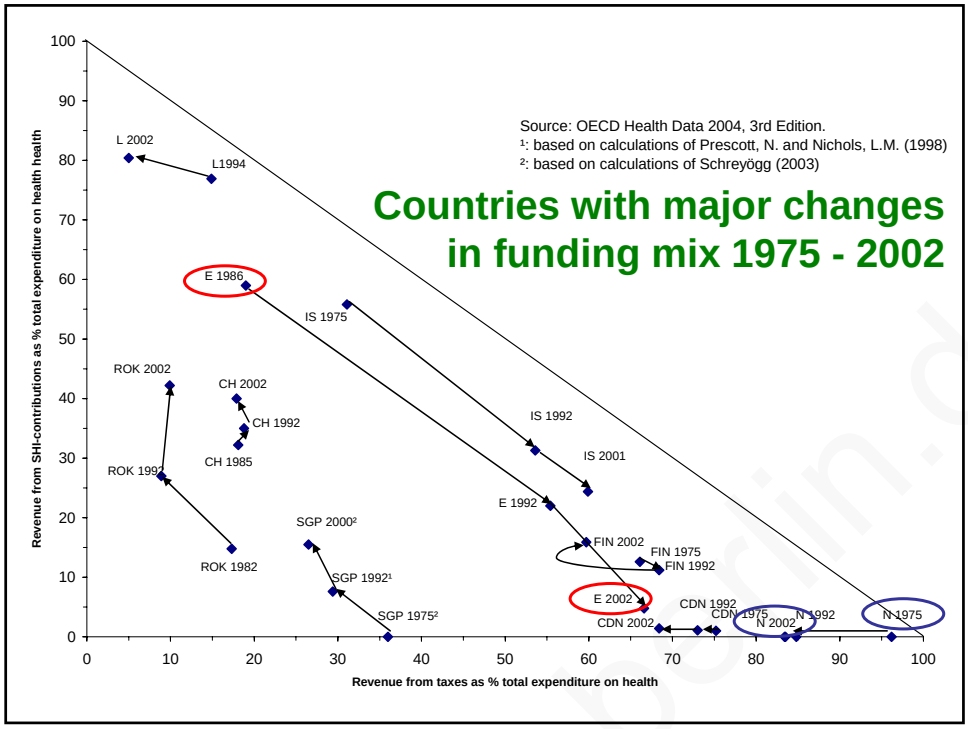
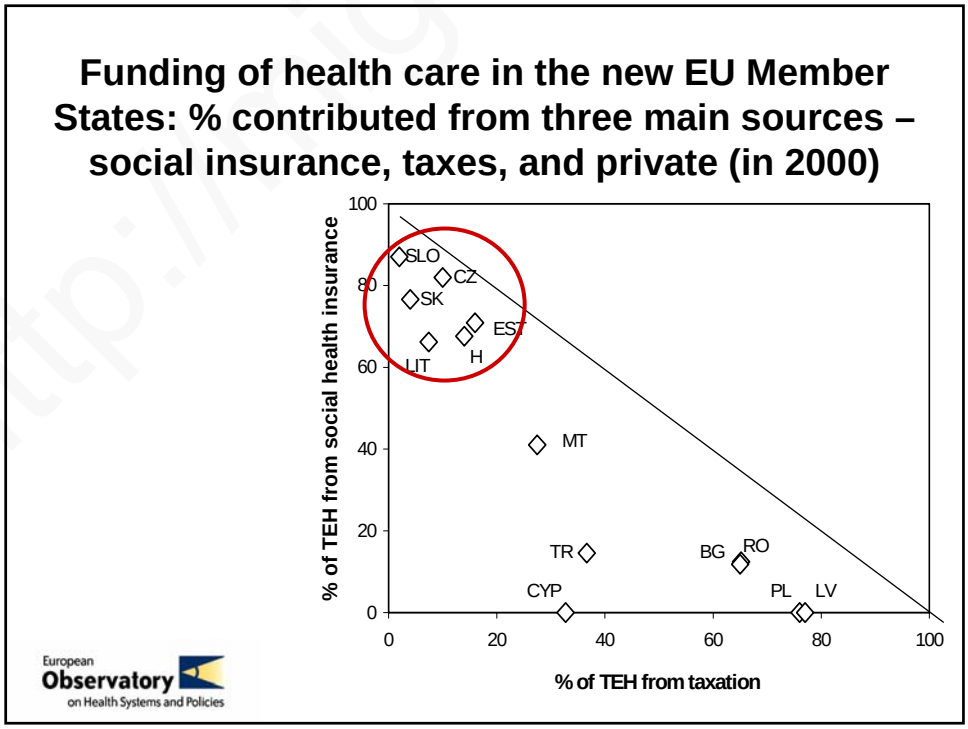
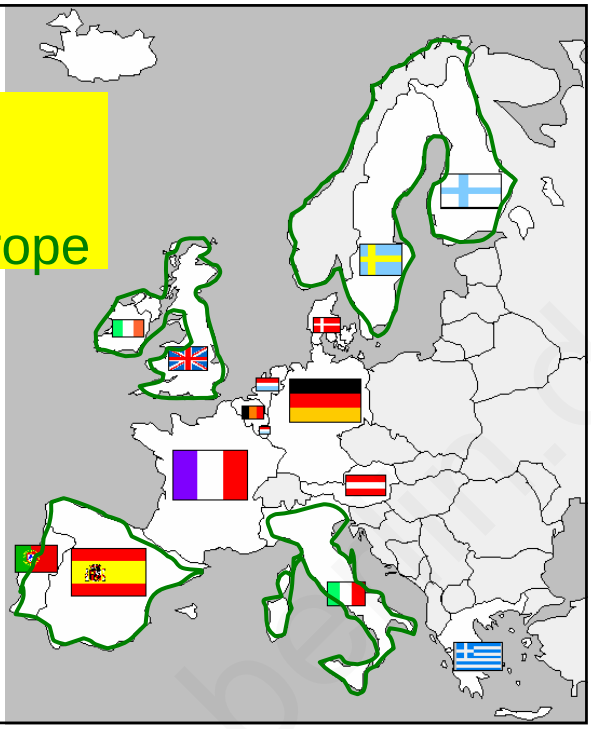

The funding mix in 2002
Source: OECD Health Data 2004, 3rd Edition.
¹: Data refer to 2001
²: based on calculations of Schreyögg (2000)
Revenue from SHI-contributions as % total expenditure on health health
Revenue from taxes as % total expenditure on health
Social Insurance Systems
Private
Tax-funded Systems
NL
L
F
D
J¹
B
ROK
CH
A
GR
SGP²
USA
IS¹
FIN
S
E
CDN
AUS
P
IRL
NZ
UK
N
DK





Tax-based systems in western Europe



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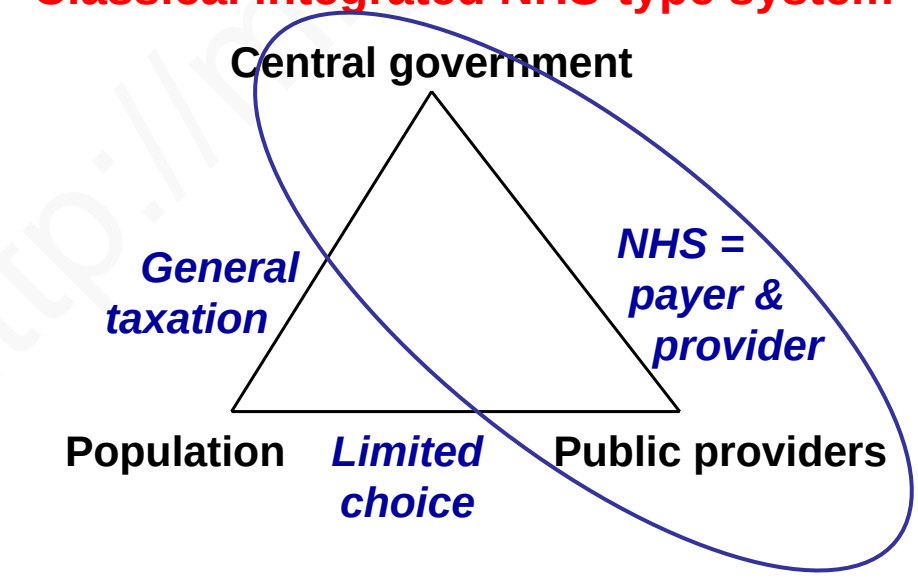
Classical integrated NHS-type system



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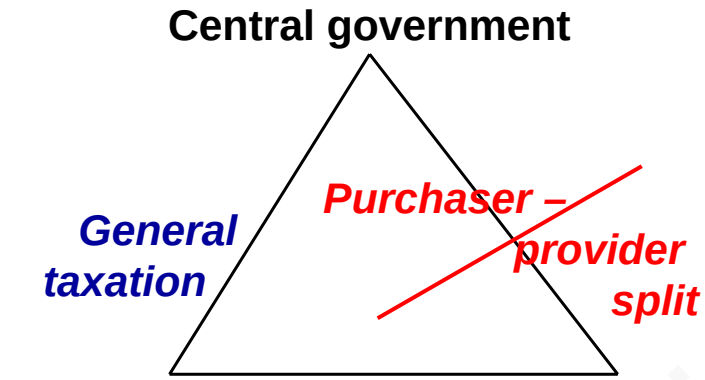
Development 1



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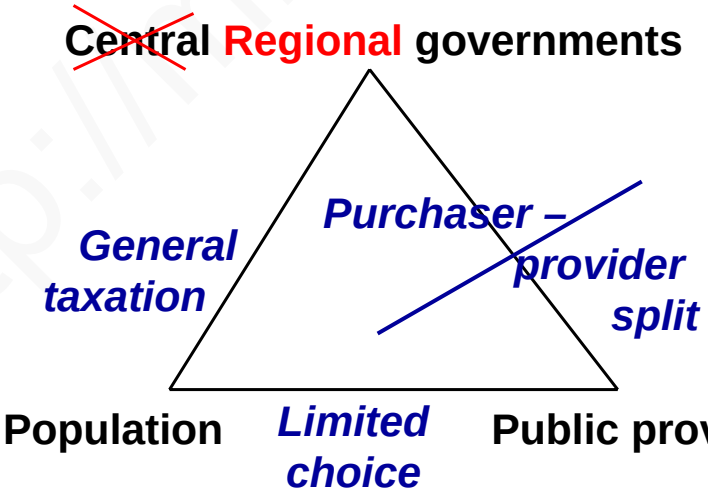
Development 2



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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*~~ — Public providers

more choice
(money follows patient)

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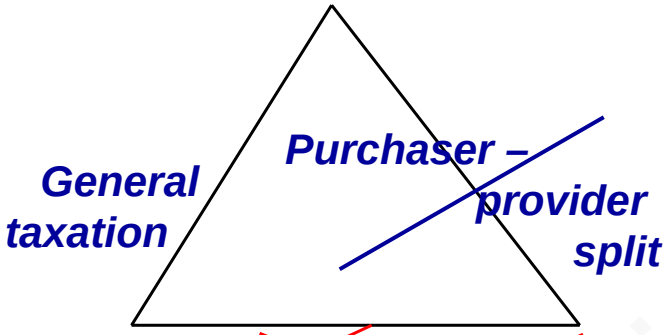
Development 4

Regional governments



Population ~~*Limited*~~ *more choice*

~~Public providers:~~ **Public-private mix**

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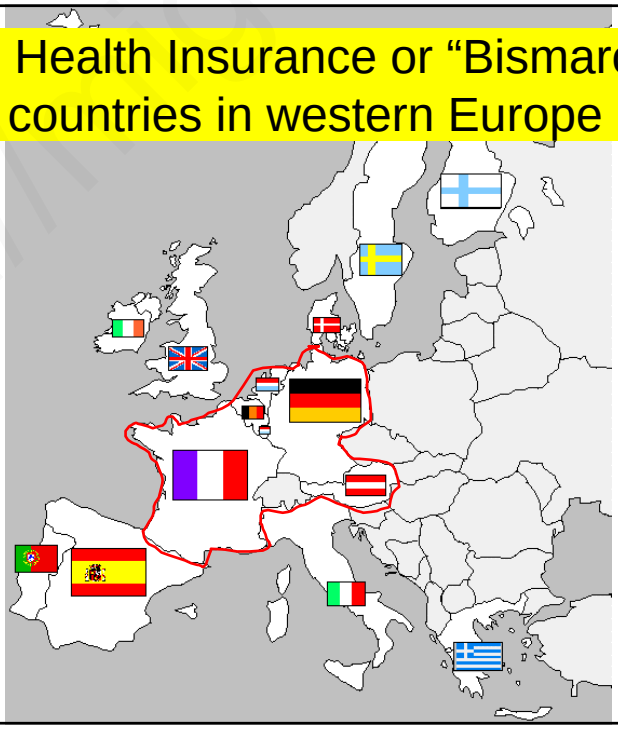
Social Health Insurance or "Bismarckian" countries in western Europe

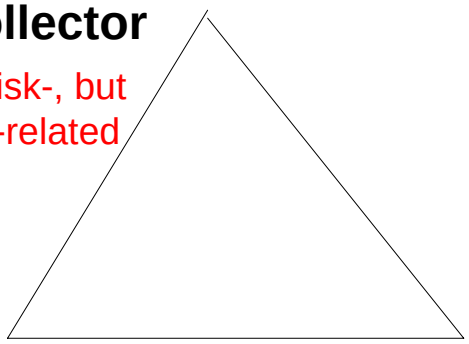


What makes a health system a SHI system?

Contribution collector

Third-party payer

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



Population

Providers

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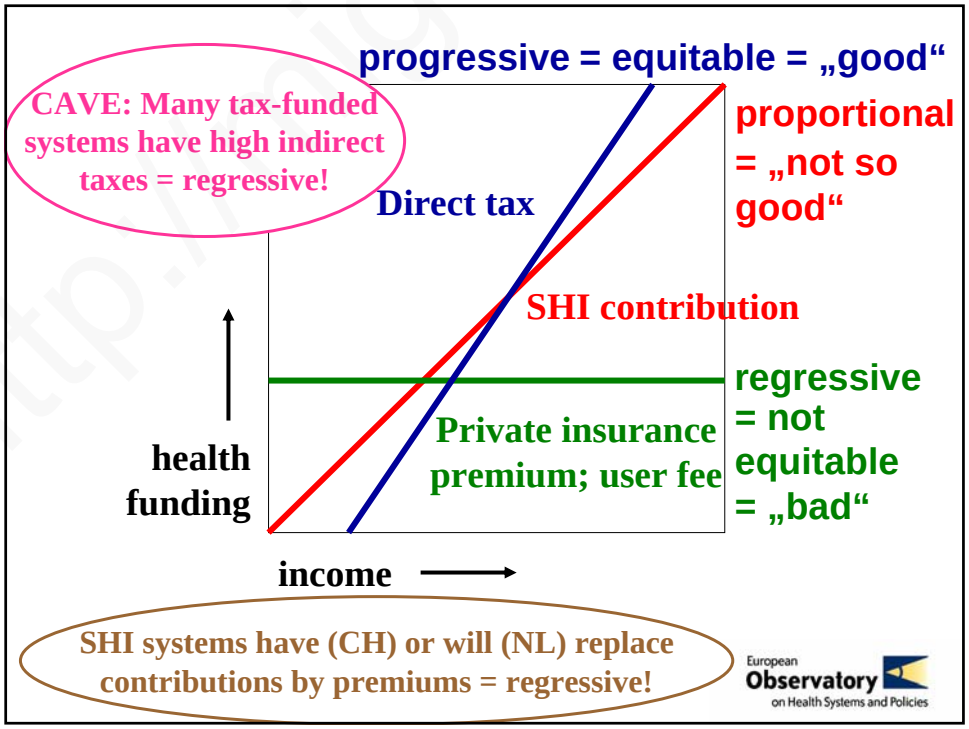

		Distribution: fairness in financial contribution (1.00 = max.)	Threshold	
			% of households with catastrophic payments (total expenditure)	% of households with catastrophic pay-ments (out of pocket)
1993	Slovakia	0.941	0.00	0.00
	United Kingdom	0.921	0.33	0.04
	Denmark	0.920	0.38	0.07
	Sweden	0.920	0.39	0.18
SHI	Germany	0.913	0.54	0.03
	Hungary	0.905	0.96	0.20
1999 →	Czech Republic	0.904	0.01	0.00
SHI	Belgium	0.903	0.23	0.09
	Finland	0.901	1.36	0.44
	Spain	0.899	0.89	0.48
	Slovenia	0.890	1.88	0.06
SHI	France	0.889	0.68	0.01
	Lituania	0.875	1.68	1.34
	Switzerland	0.875	3.03	0.57
	Estonia	0.872	2.47	1.30
	Greece	0.858	3.29	2.17
	Portugal	0.845	4.01	2.71
	Latvia	0.828	4.05	2.75

Data: Murray & Evans „Health Systems Performance Assessment: Debates, Methods and Empiricism“, WHO 2003: 525-6

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

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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"

	West		East		Germany	
	RSC / SHI expenditure[a] (billion €)	RSC as % of SHI	RSC / SHI expenditure[a] (billion €)	RSC as % of SHI	RSC / SHI expenditure[a] (billion €)	RSC as % of SHI
1995	6.90/ 97.29	7.1	2.36/ 19.70	12.0	9.23/ 116.99	7.9
1996	7.27/ 100.41	7.2	2.51/ 20.47	12.3	9.78/ 120.88	8.1
1997	7.71/ 98.23	7.8	2.63/ 20.05	13.1	10.34/ 118.29	8.7
1998	8.22/ 99.74	8.2	2.80/ 19.97	14.0	11.01/ 119.71	9.2
1999	8.30/ 102.68	8.1	3.29/ 20.52	16.0	11.60/ 123.21	9.4
2000	8.30/ 105.05	7.9	3.73/ 20.89	17.8	12.03/ 125.94	9.6
2001	9.09/ 108.89	8.3	4.43/ 21.75	20.4	13.52/ 130.63	10.3
2002	9.28/ 111.79	8.3	4.66/ 22.54	20.7	13.94/ 134.33	10.4
2003	9.87/ 113.14	8.7	4.93/ 23.08	21.4	14.79/ 136.22	10.9

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).

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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

Limited government control

Contracts

Choice of fund

Free access

Population

Mandatory insurance

Providers

Public-private mix

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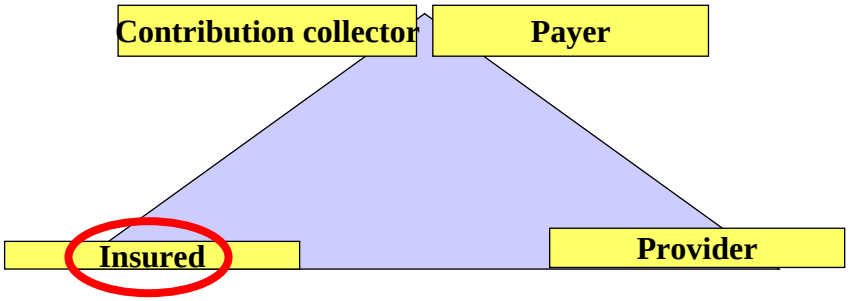
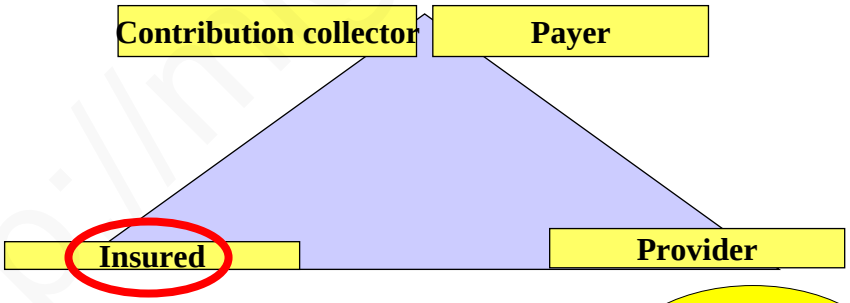


- SHI tradionally tied to employment
- later extended to defined other groups (dependents, pensioners, unemployed, students, self-employed etc.)
- no exclusion due to health status, but
- notion of “universal coverage“
  = very recent phenomenon



- Universal population coverage in Switzerland (since 1996), Belgium (since 1998), France (since 2000) and in Netherlands (from 2006)

In Germany discussed in 2003 – 120 years after SHI introduction!

- 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)

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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!

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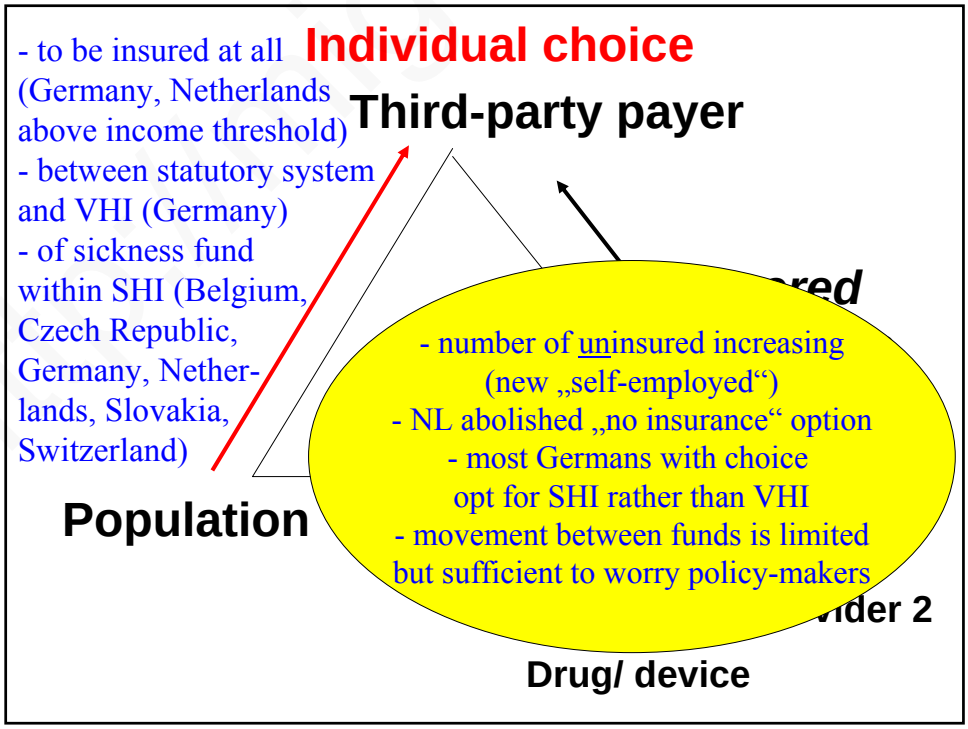
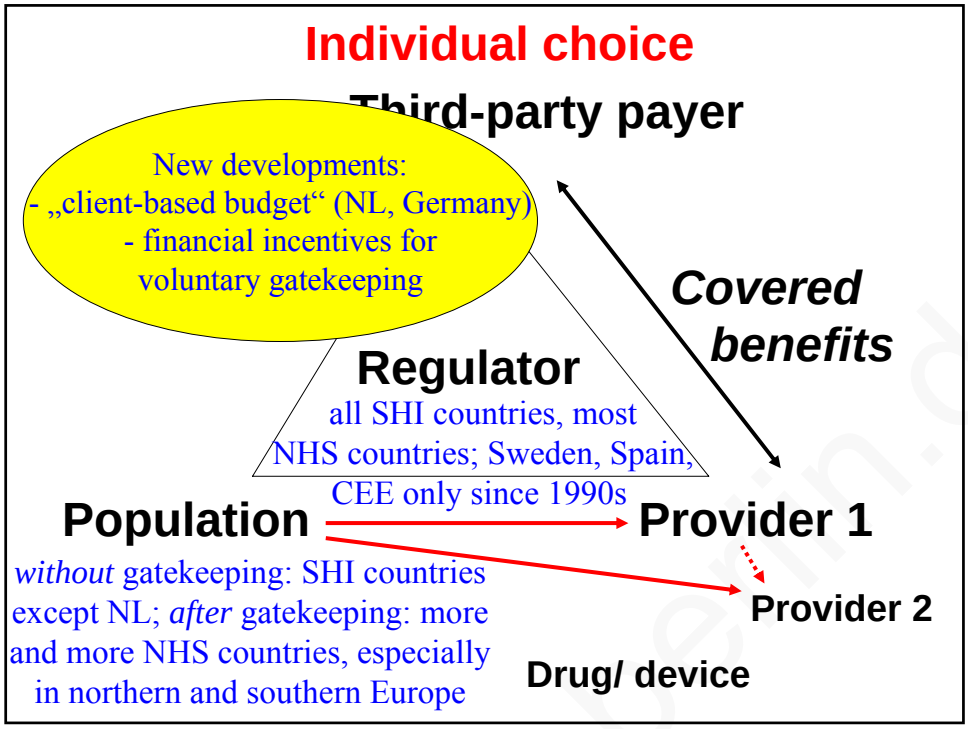
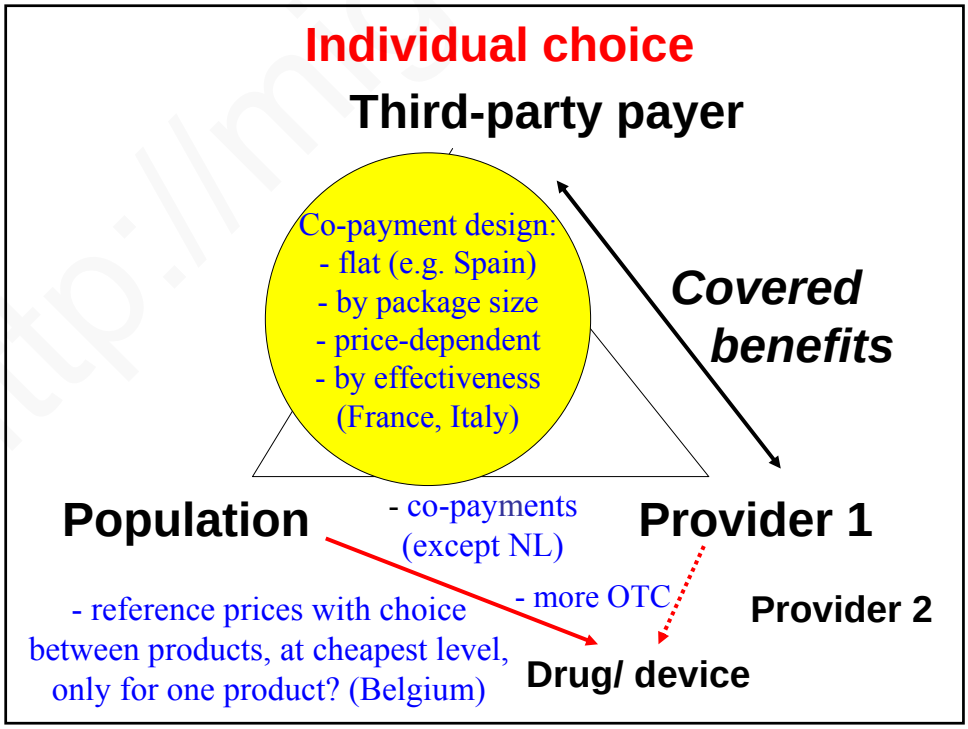
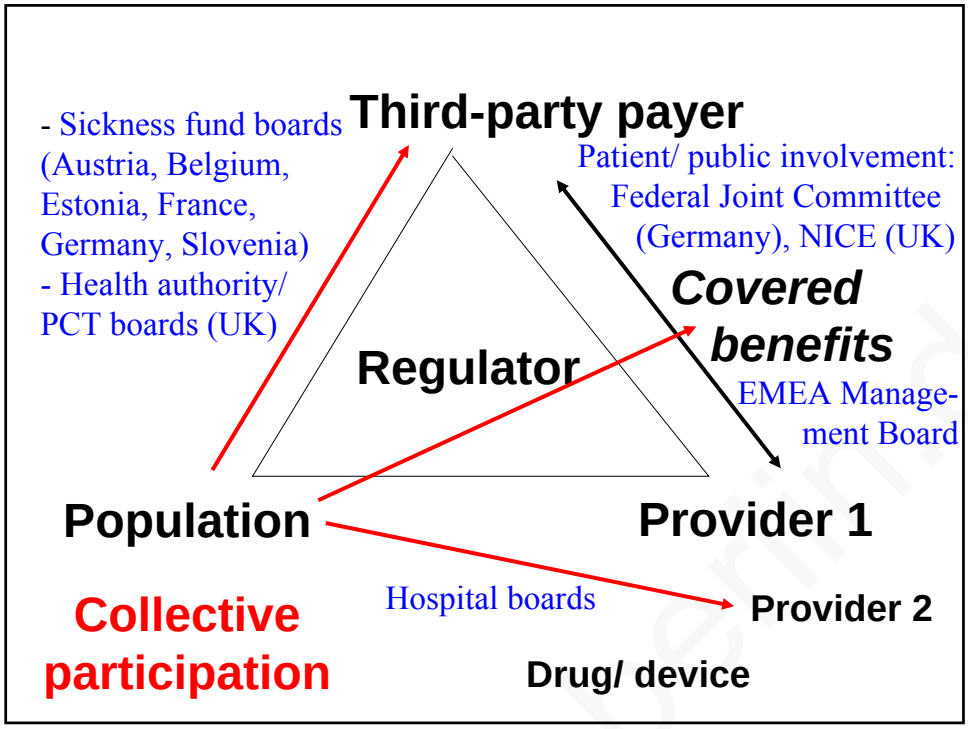
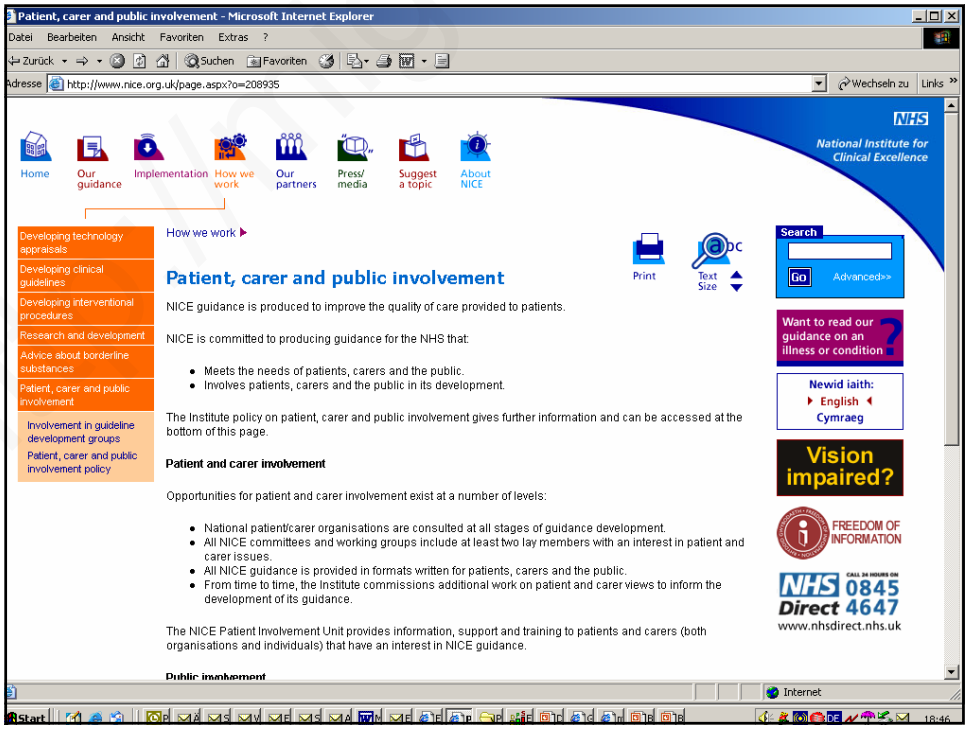
Choice for individuals or collective participation?

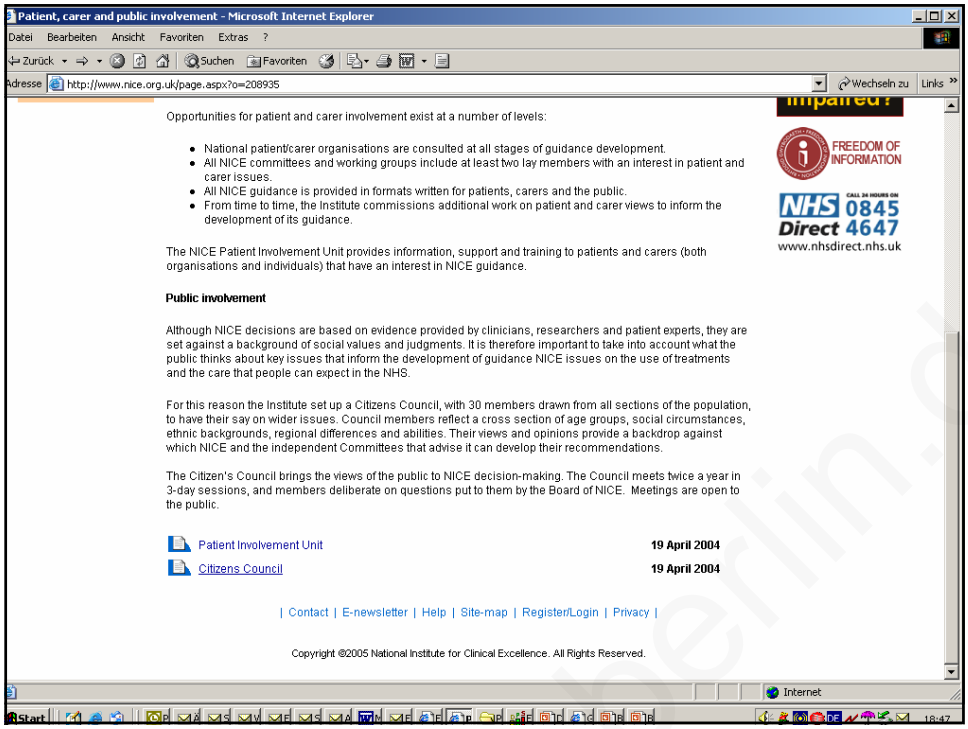






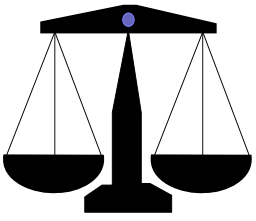






<< Denmark, Sweden

(Belgium), Germany, Netherlands, Switzerland: emphasis on individual choice



UK: emphasis on collective participation

< ? CEE countries ? >

Competition

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'etre: to ensure health care as efficient (cost per quality) and responsive as possible

Health expenditure visible; population willing to pay more

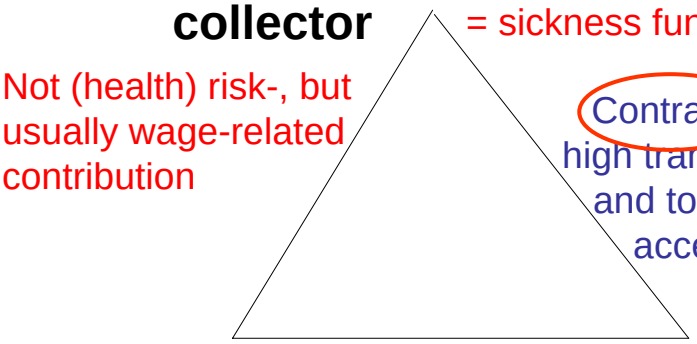
Population

Mandatory insurance

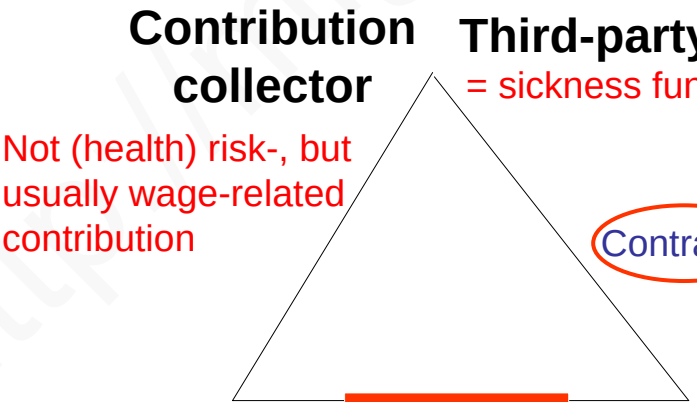
Providers

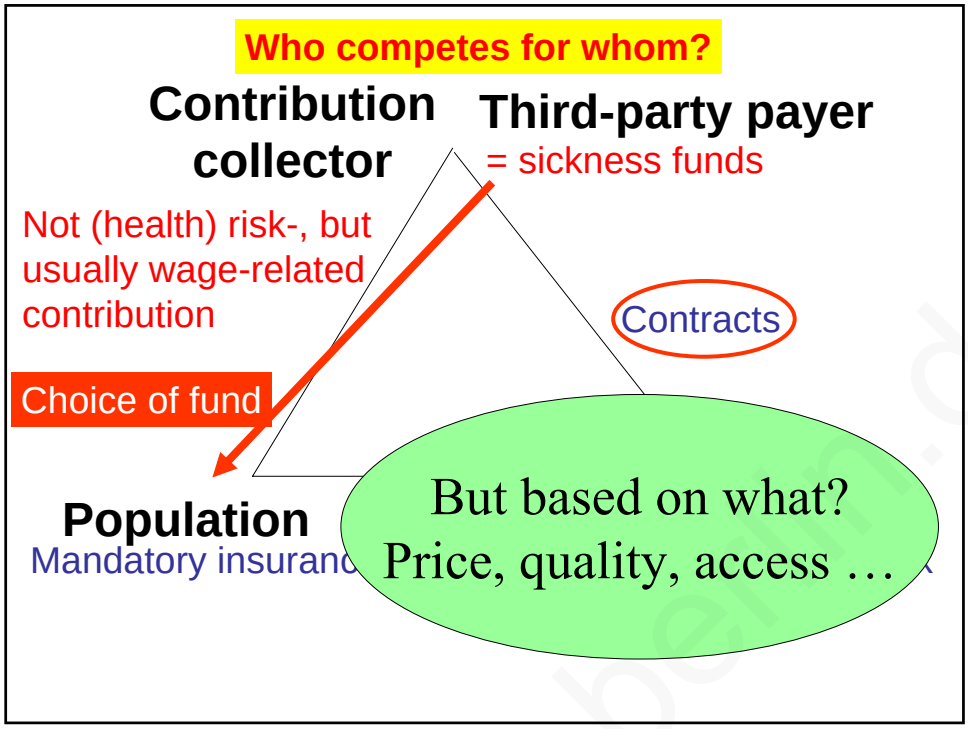
Ability to pay **Solidarity** **Need**

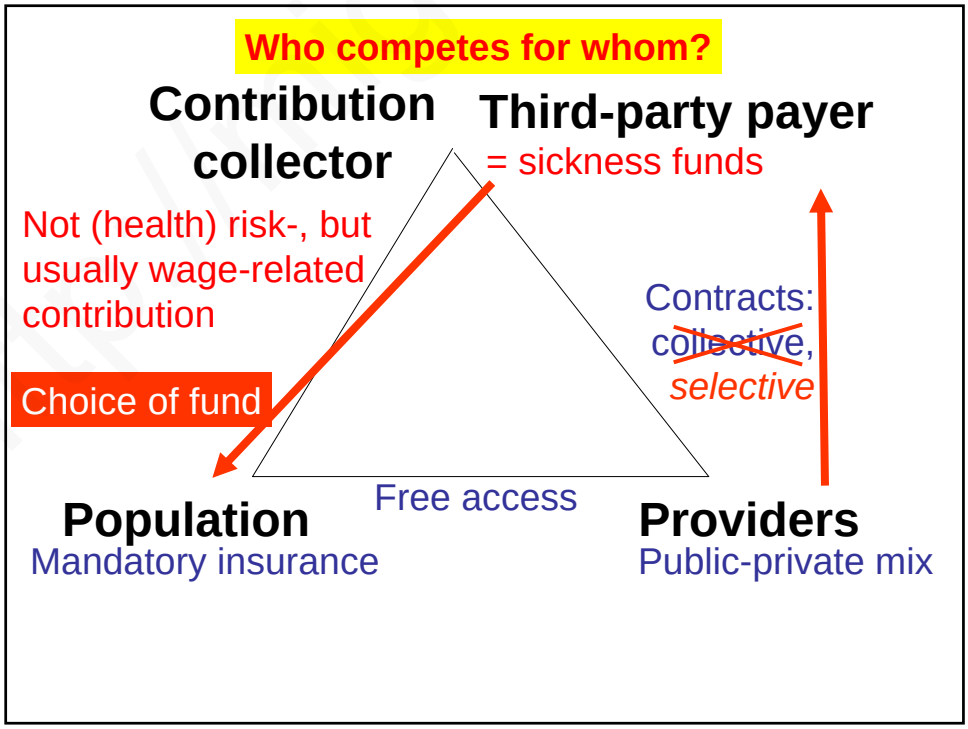
What makes a health system a SHI system?



Who competes for whom?



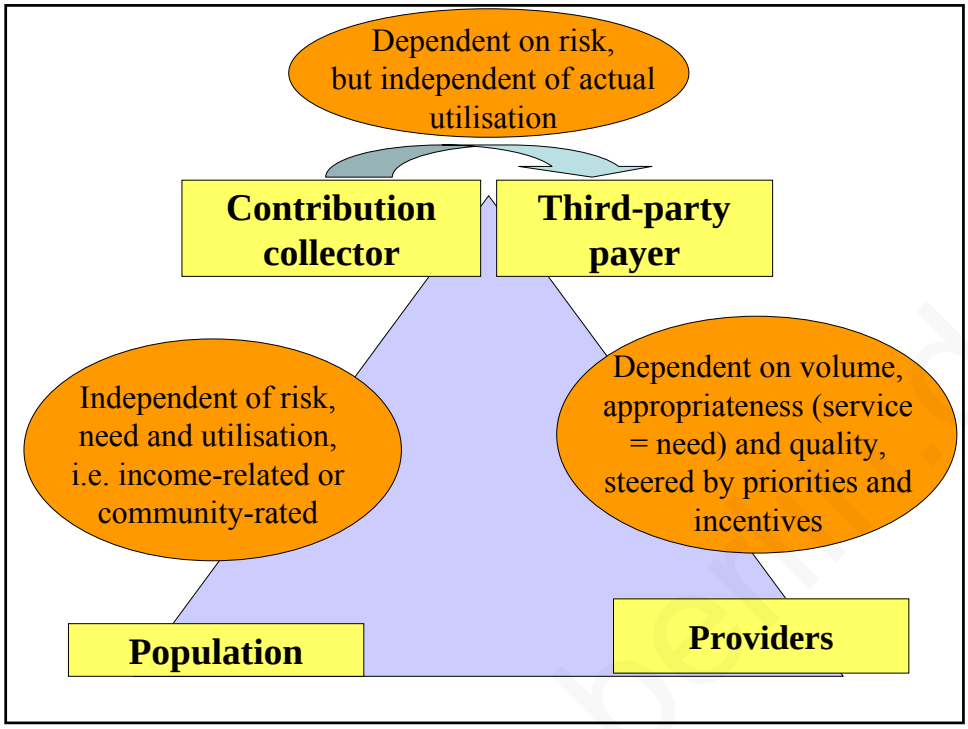


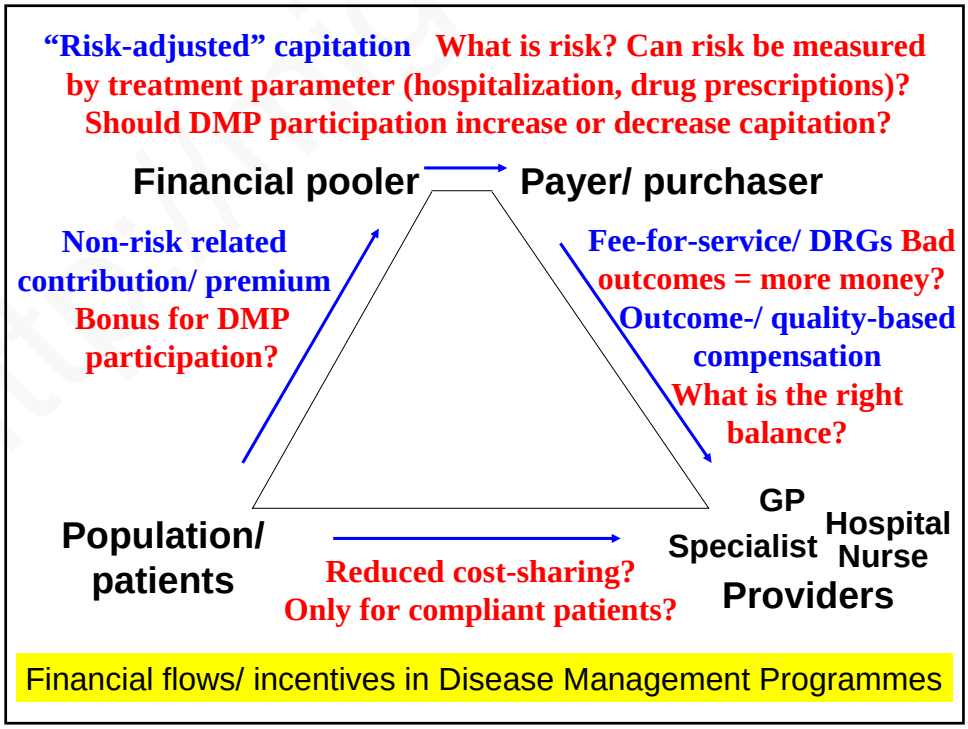


1. Does it work, i.e. does selective contracting/ application of Managed Care instruments produce better outcomes and/or lower costs?
2. For which persons/ indications does it work? For the 75-80% chronically healthy? For the 5% really ill? For the 15-20% chronically ill?

1. _
2. _
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?





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

	Public		Not-for-profit		Private		Total
	beds	% share	beds	% share	beds	% share	beds
1990	387 207	62.8	206 936	33.5	22 779	3.7	616 922
2003	265 520	53.1	187 271	37.5	46 994	9.4	499 785
Change	-32.4%		-9.5%		+106.2%		-19.0%

Source: own calculations based on Federal Statistical Office 2004 (*9;52*).

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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 …

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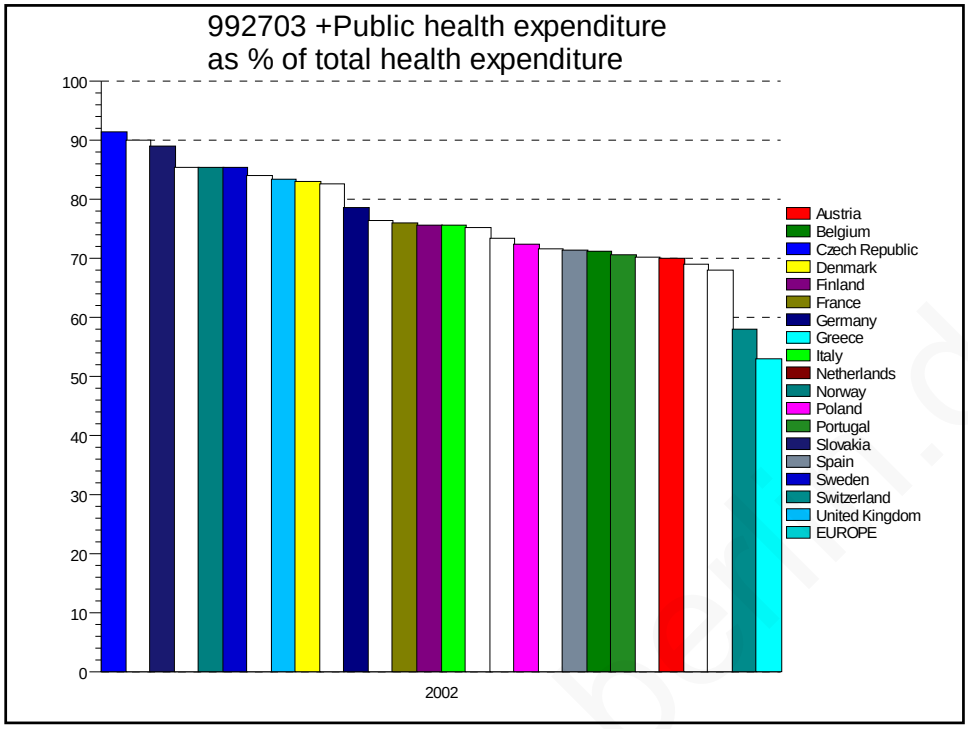
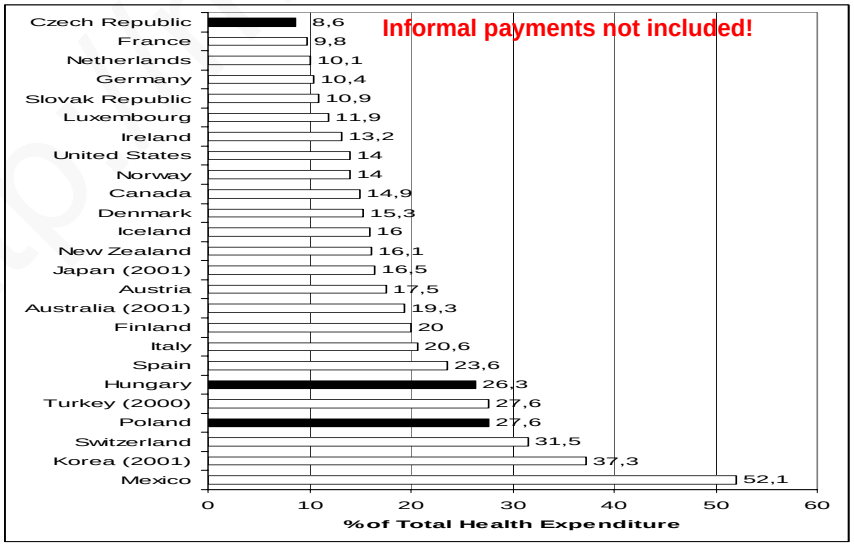
What is public, what is private?

			Funding		
			“public”		“private”
			pub -lic	Statutory Health Insurance	private insurance, out-of-pocket
Deli-very	“pub-lic”	public			
	“pri-vate”	not-for-profit			
		for profit			



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



Source: OECD Health Data 2004.

Private financing of health care and financial fairness

	% of private finance of total health care expenditure	
	2002	1990
Greece	47.1	46.3
Switzerland	42.1	47.6
Austria	30.1	26.5
Portugal	29.5	34.5
Belgium	28.8	n.a.
Spain	28.6	21.3
Poland	27.6	8.3
Netherlands	26.7	32.9
Italy	24.4	20.7
Finland	24.3	19.1
France	24.0	23.4
Germany	21.5	23.8
Denmark	16.9	17.3
United Kingdom	16.6	16.4
Norway	14.7	17.2
Sweden	14.7	10.1
Slowakia	10.9	n.a.
Czech Republic	8.6	2.6

Sources: OECD Health Data, first ed. 2004, WHO Health for All Data base 2004, Murray & Evans 2003: pp. 525-6

Private financing of health care and financial fairness

	% of private finance of total health care expenditure		Fairness in financing (max. 1.00)	% of households which spend >40% of income on health	% of households which spend >40% of income on health out-of-pocket
	2002	1990			
Greece	47.1	46.3	0.858	3.29	2.17
Switzerland	42.1	47.6	0.875	3.03	0.57
Austria	30.1	26.5	n.a.	n.a.	n.a.
Portugal	29.5	34.5	0.845	4.01	2.71
Belgium	28.8	n.a.	0.903	0.23	0.09
Spain	28.6	21.3	0.899	0.89	0.48
Poland	27.6	8.3	n.a.	n.a.	n.a.
Netherlands	26.7	32.9	n.a.	n.a.	n.a.
Italy	24.4	20.7	n.a.	n.a.	n.a.
Finland	24.3	19.1	0.901	1.36	0.44
France	24.0	23.4	0.889	0.68	0.01
Germany	21.5	23.8	0.913	0.54	0.03
Denmark	16.9	17.3	0.920	0.38	0.07
United Kingdom	16.6	16.4	0.921	0.33	0.04
Norway	14.7	17.2	0.888	1.22	0.28
Sweden	14.7	10.1	0.920	0.39	0.18
Slowakia	10.9	n.a.	0.941	0.00	0.00
Czech Republic	8.6	2.6	0.904	0.01	0.00

Sources: OECD Health Data, first ed. 2004, WHO Health for All Data base 2004, Murray & Evans 2003: pp. 525-6

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

	Public	Not-for-profit	For profit
Austria	69%	26%	5%
Belgium	60%	40%	
France	65%	15%	20%
Germany	53%	38%	9%
Luxembourg	50%	50%	
Netherlands	14%	86%	

European Observatory on Health Systems and Policies

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)?

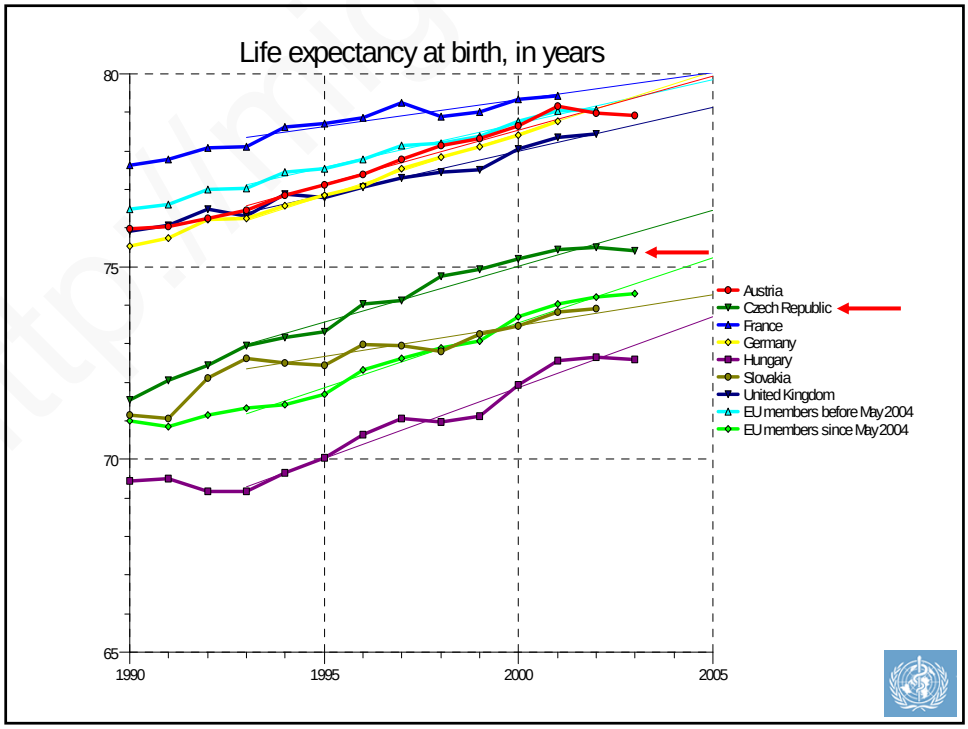
	Core public bureaucracy		Private organization
Autonomy	Few decision rights	→	Full autonomy
Market exposure	None	→	At full risk for performance
Residual claimant	Public purse	→	Organization
Accountability	Hierarchical direct control	→	Regulation and contracting
Social functions	Unfunded mandate	→	Explicitly funded mandate

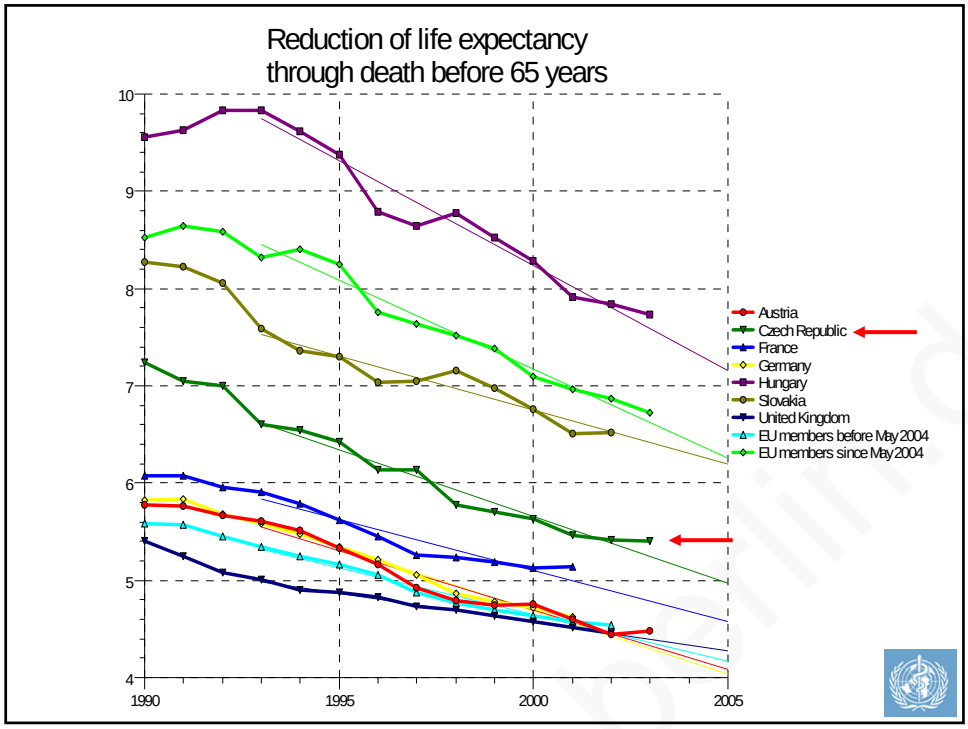
Which system is "best"?

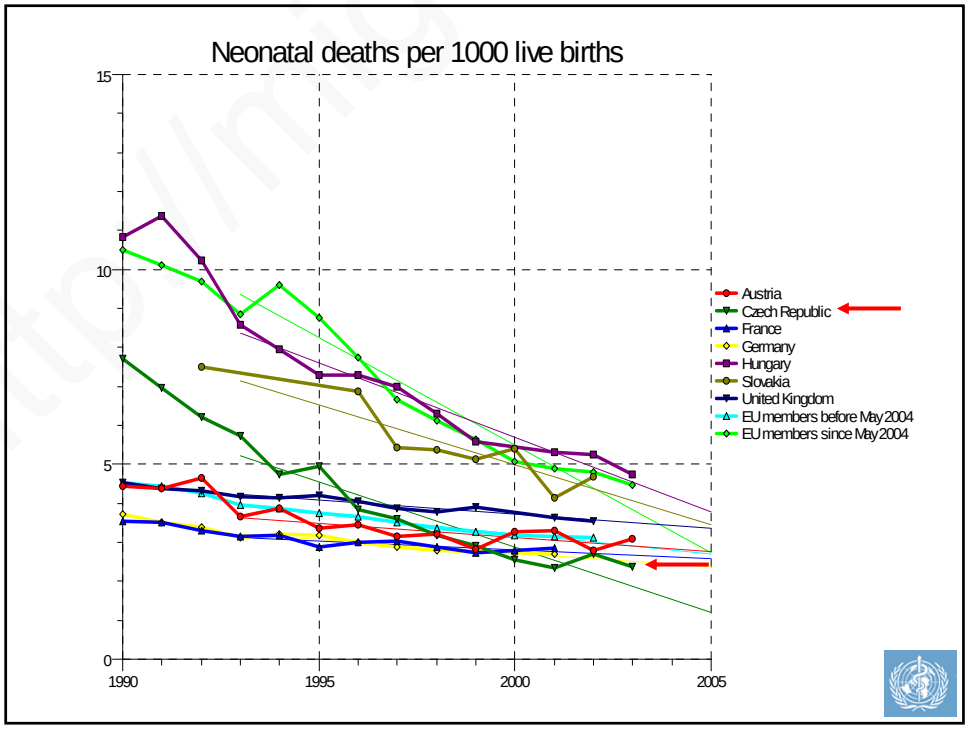
Answer depends on goals, i.e.

- **Health gain/ improvement**
- **Responsiveness to population needs**
- **Sustainable funding**
- **Equity in health, responsiveness and funding**
- **Efficiency (reaching goals : resources)**

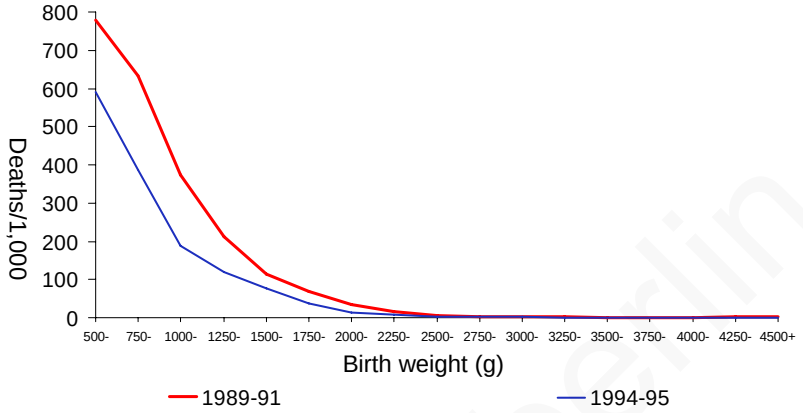
Health gain/ improvement



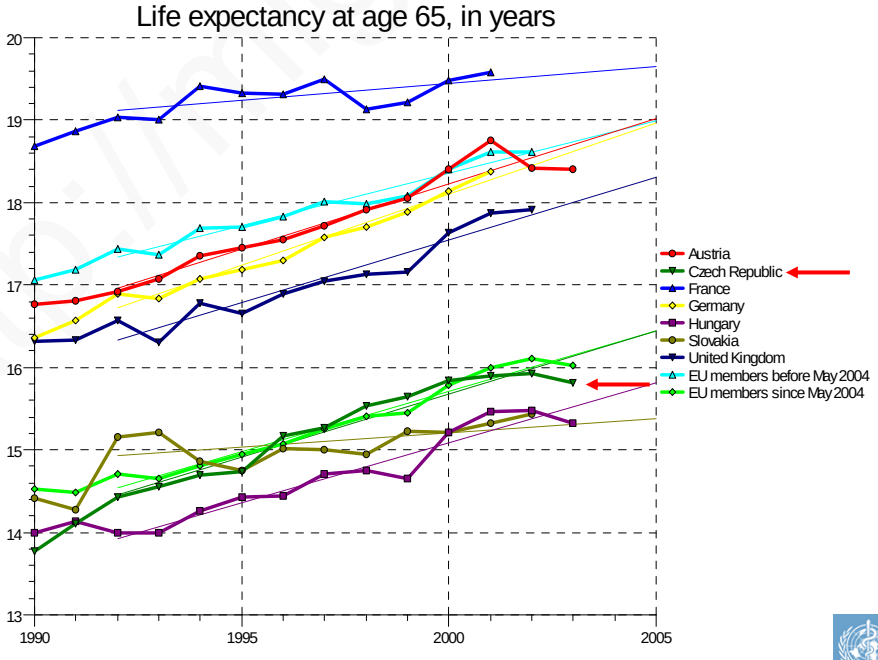


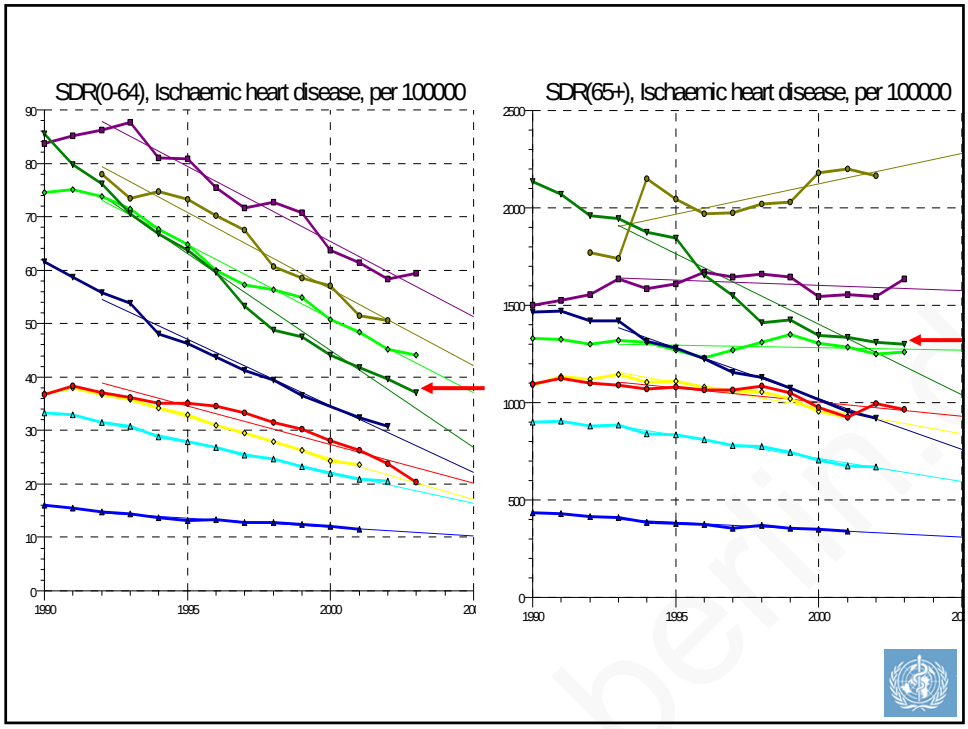


Birthweight specific infant mortality: Czech Republic

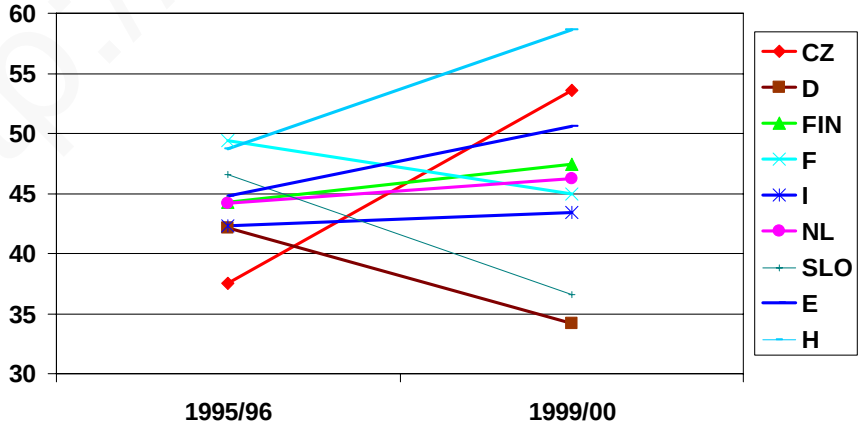


Koupilová, McKee & Holčik. Health Policy, 1998

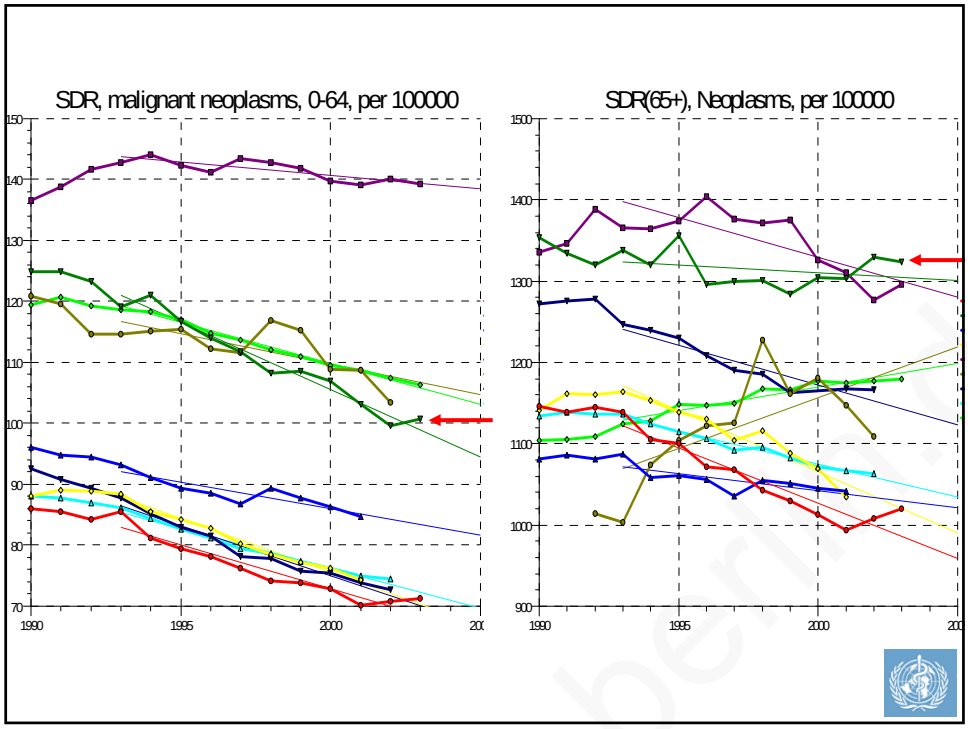




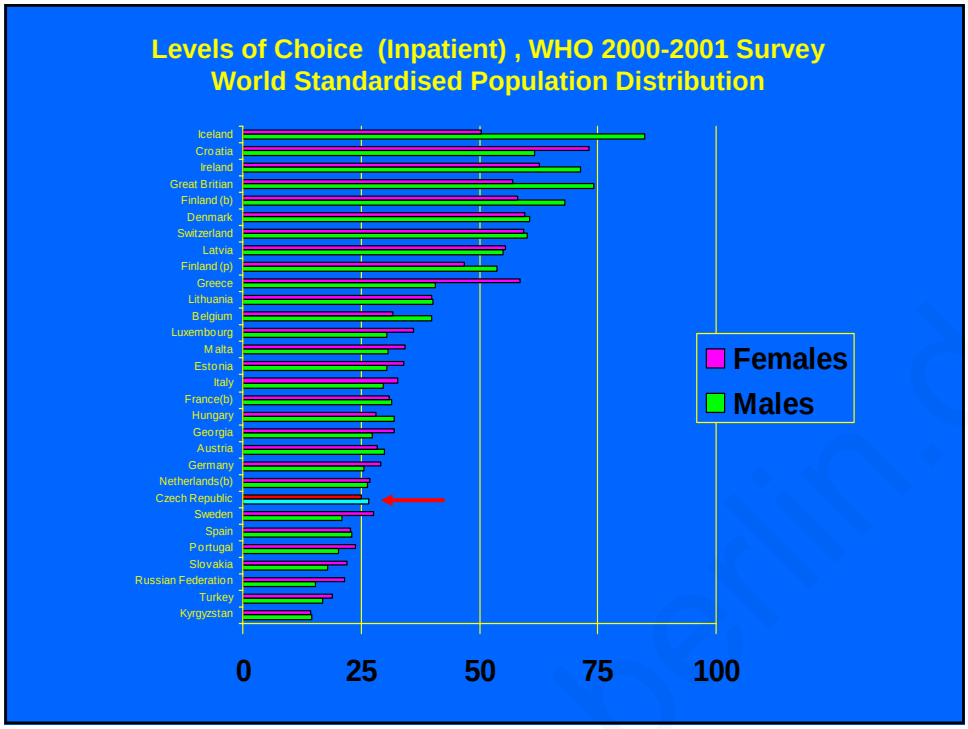
Sufficient blood pressure control 6 months after a CHD hospitalisation

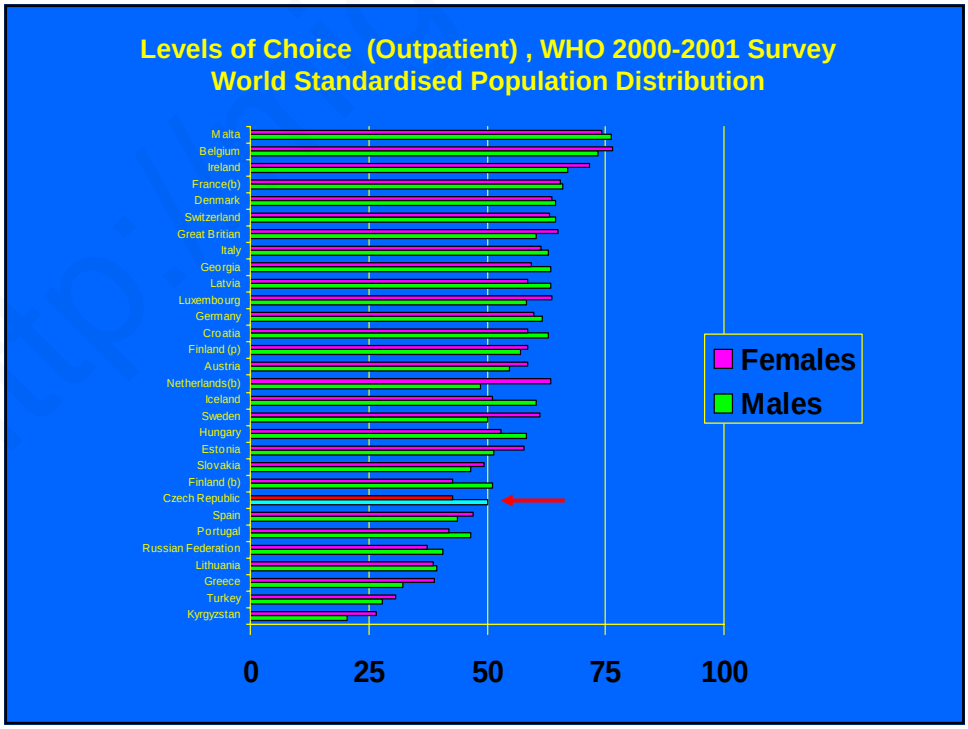


Data: EUROASPIRE „Clinical reality of coronary prevention guidelines“, Lancet 2001; 357: 998



Responsiveness/ satisfaction


Levels of Choice (Inpatient) , WHO 2000-2001 Survey
World Standardised Population Distribution
Iceland
Croatia
Ireland
Great Britian
Finland (b)
Denmark
Switzerland
Latvia
Finland (p)
Greece
Lithuania
Belgium
Luxembourg
Malta
Estonia
Italy
France(b)
Hungary
Georgia
Austria
Germany
Netherlands(b)
Czech Republic
Sweden
Spain
Portugal
Slovakia
Russian Federation
Turkey
Kyrgyzstan
0
25
50
75
100
Females
Males


Levels of Choice (Outpatient) , WHO 2000-2001 Survey
World Standardised Population Distribution
Malta
Belgium
Ireland
France(b)
Denmark
Switzerland
Great Britian
Italy
Georgia
Latvia
Luxembourg
Germany
Croatia
Finland (p)
Austria
Netherlands(b)
Iceland
Sweden
Hungary
Estonia
Slovakia
Finland (b)
Czech Republic
Spain
Portugal
Russian Federation
Lithuania
Greece
Turkey
Kyrgyzstan
0
25
50
75
100
Females
Males

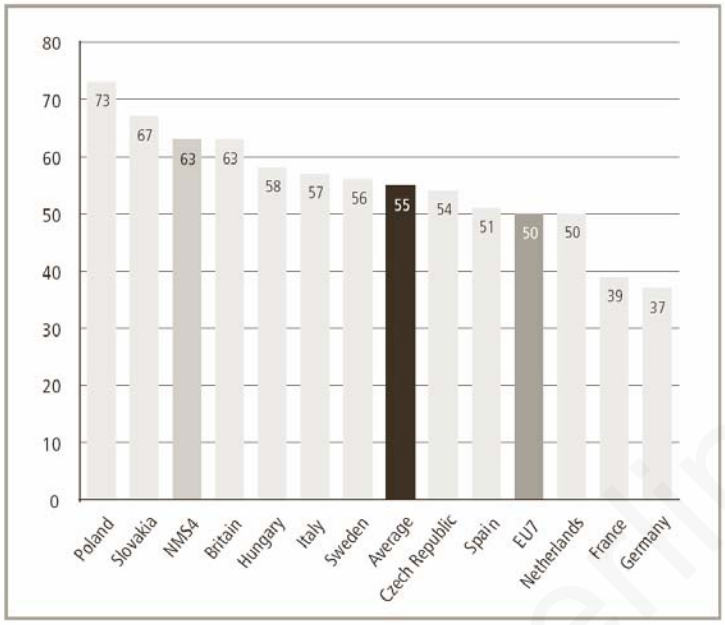


Figure 1 Delivery Deficit

Difference between what people want from healthcare and what they get

Stockholm Network 2005

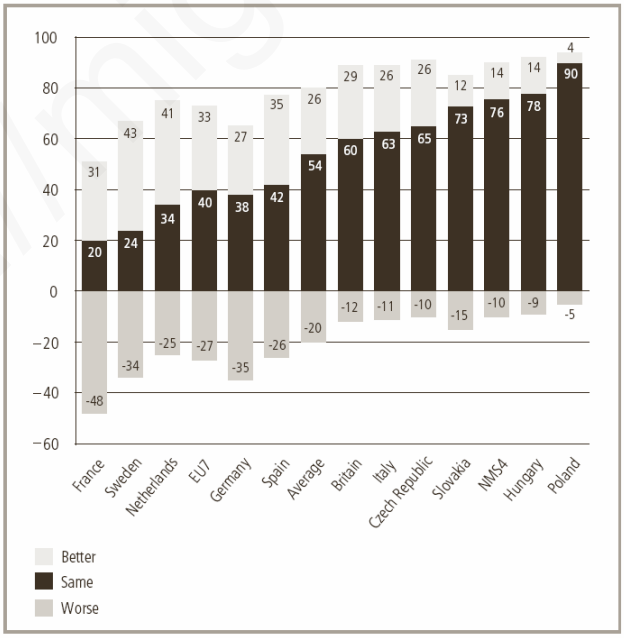


Figure 2 Inferiority Complex

How do other European health systems perform compared with your own?

Stockholm Network 2005

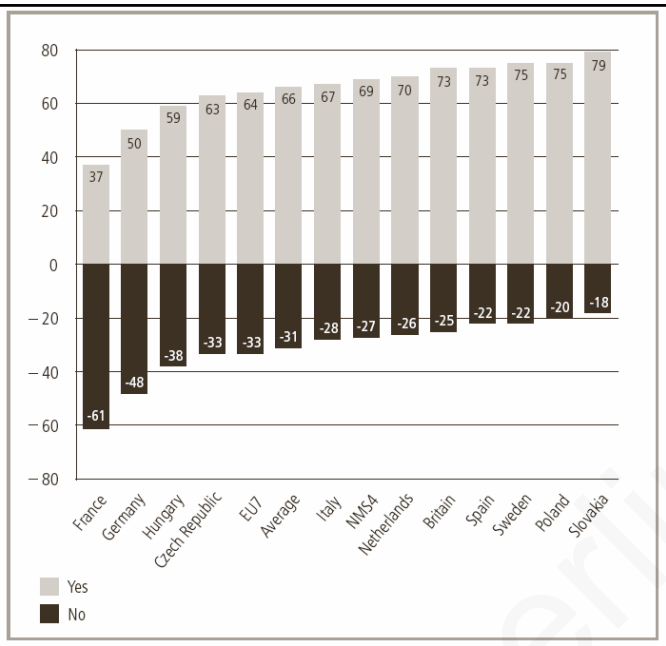


Figure 5 Travel for treatment

Would you travel abroad for treatment if your health system paid?

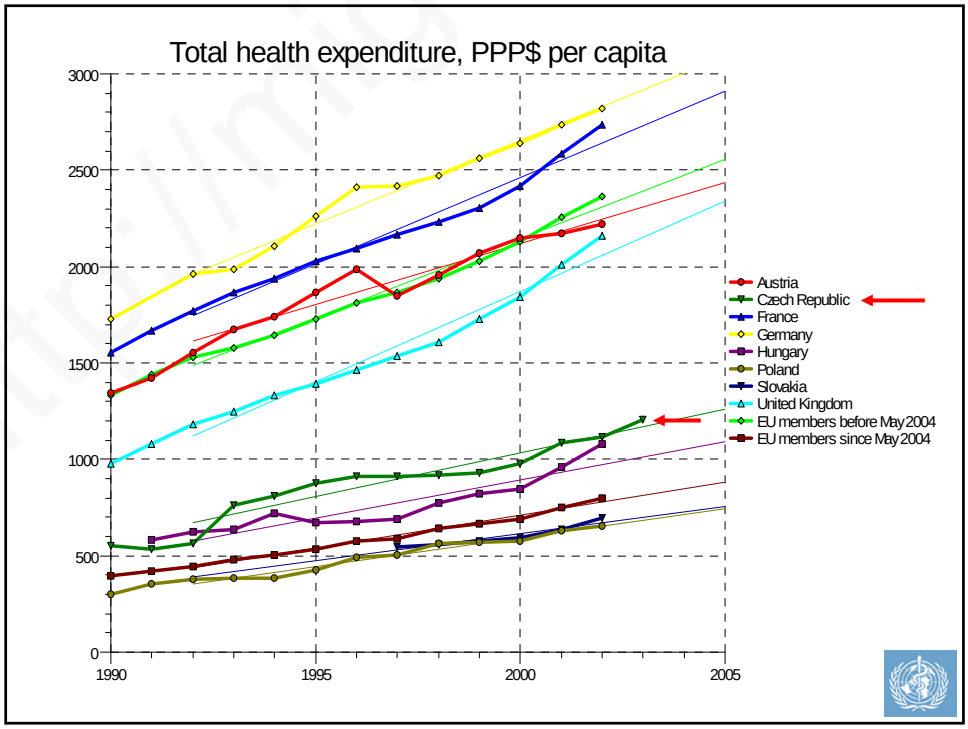
Stockholm Network 2005

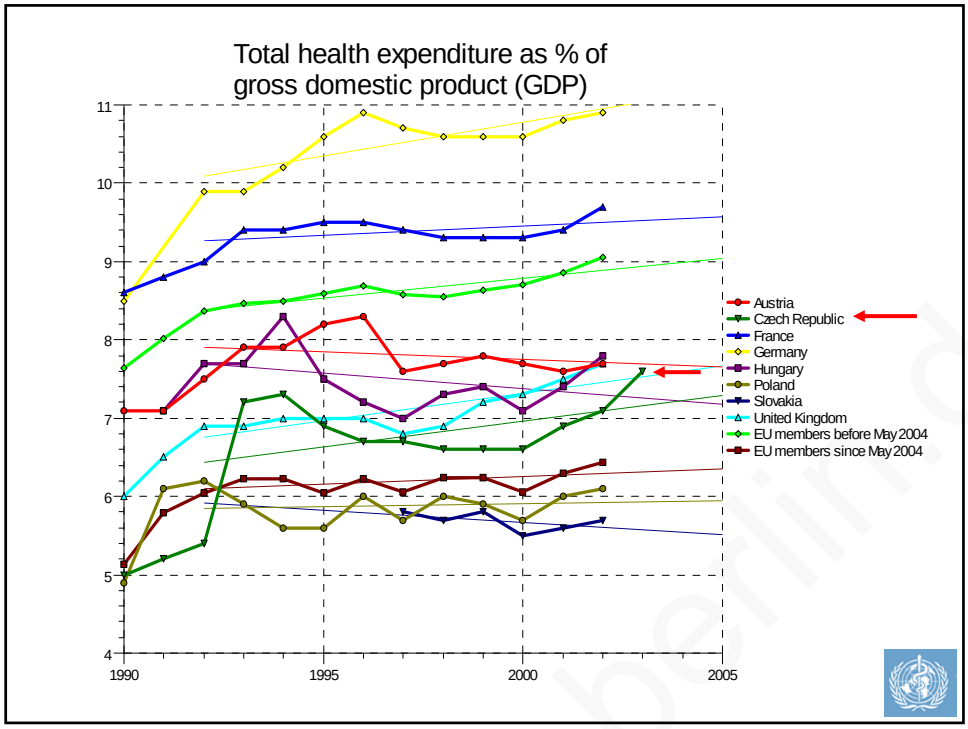
Reforms most likely to increase the quality of care

	Likely	*Not likely*	*Net*
Giving patients more information about their illness	76	21	55
Increasing number of medicines and treatments	67	29	38
Giving patients more control over public spending on health	67	30	37
Making it easier for patients to spend their own money on health	66	30	36
Increasing range of doctors and hospitals	43	53	-10

Stockholm Network 2004

Sustainable funding





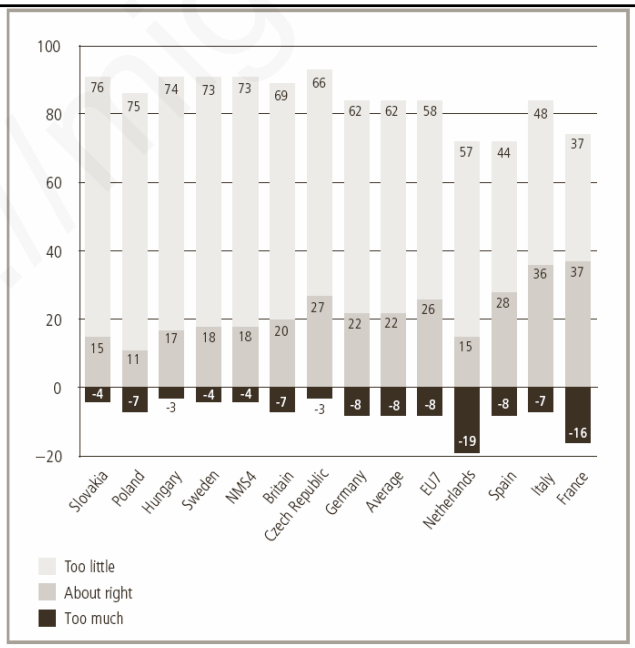
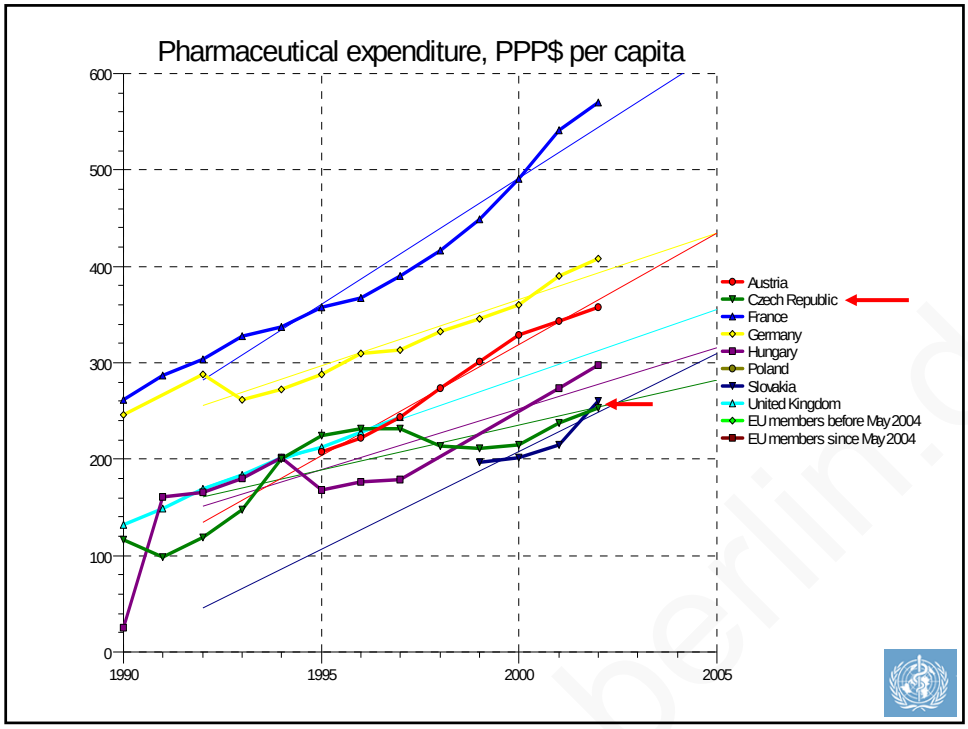
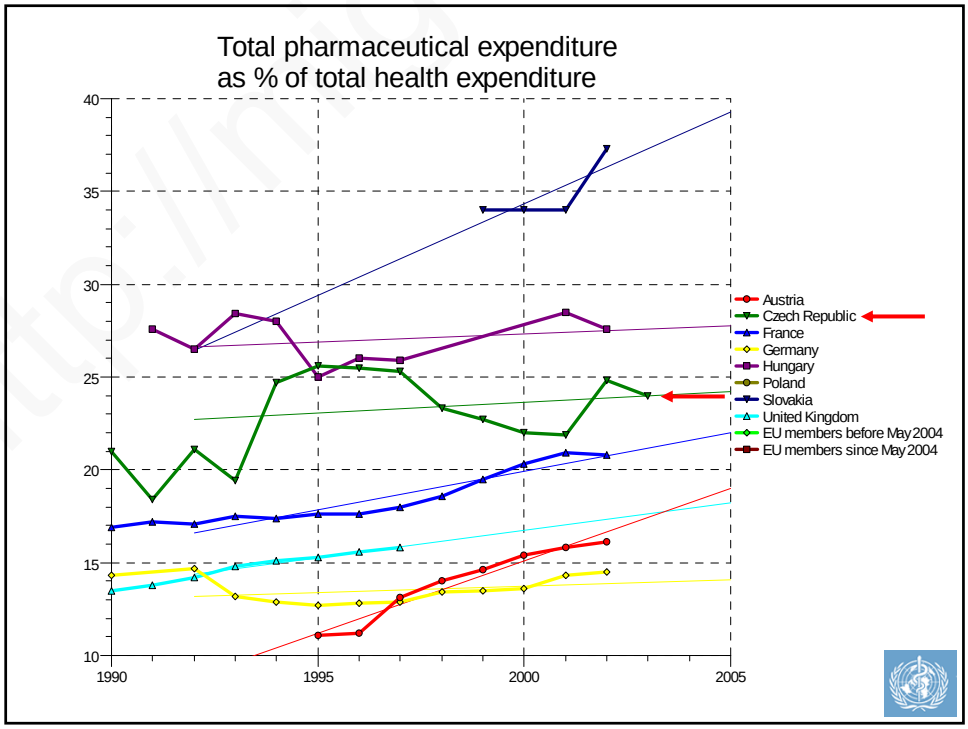


Figure 3 **Underfunding at home**

How much money does your health system have?

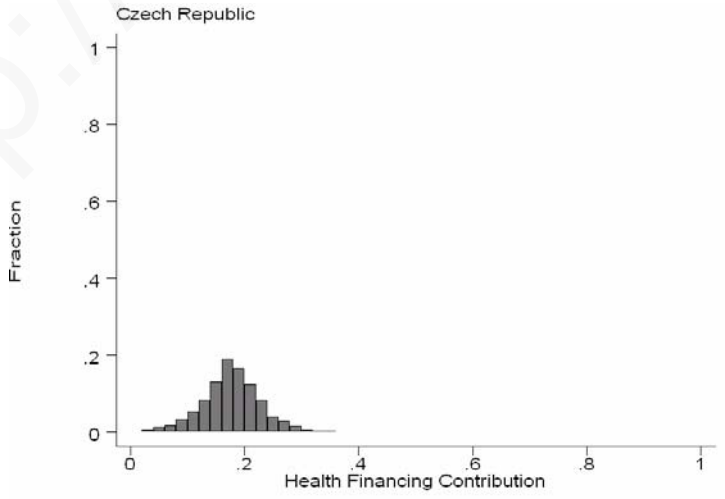
Stockholm Network 2005

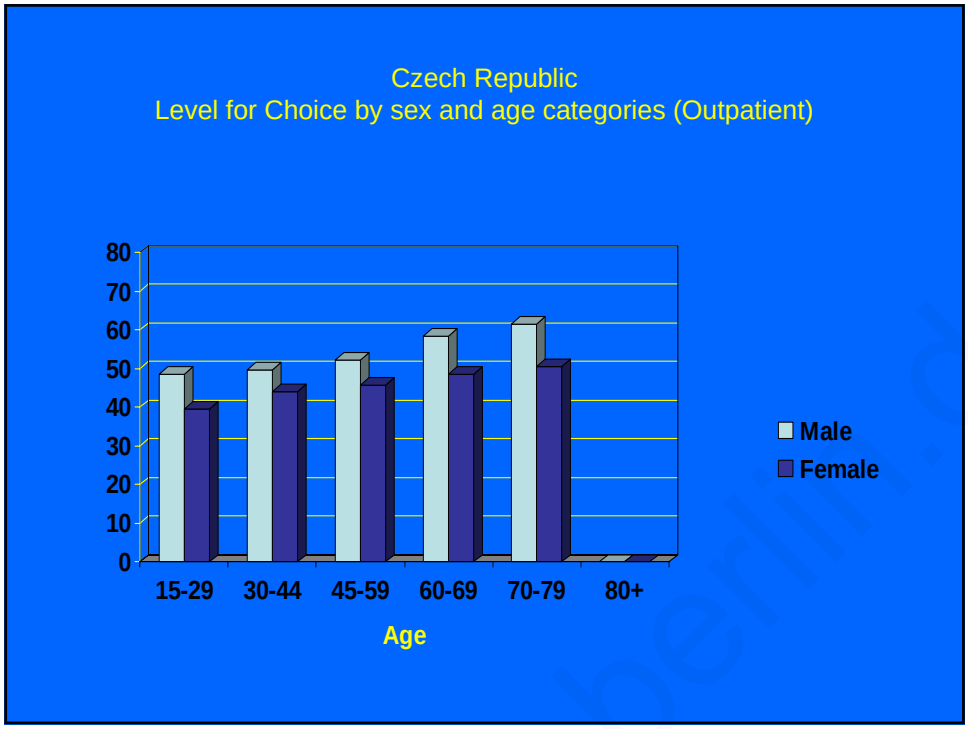




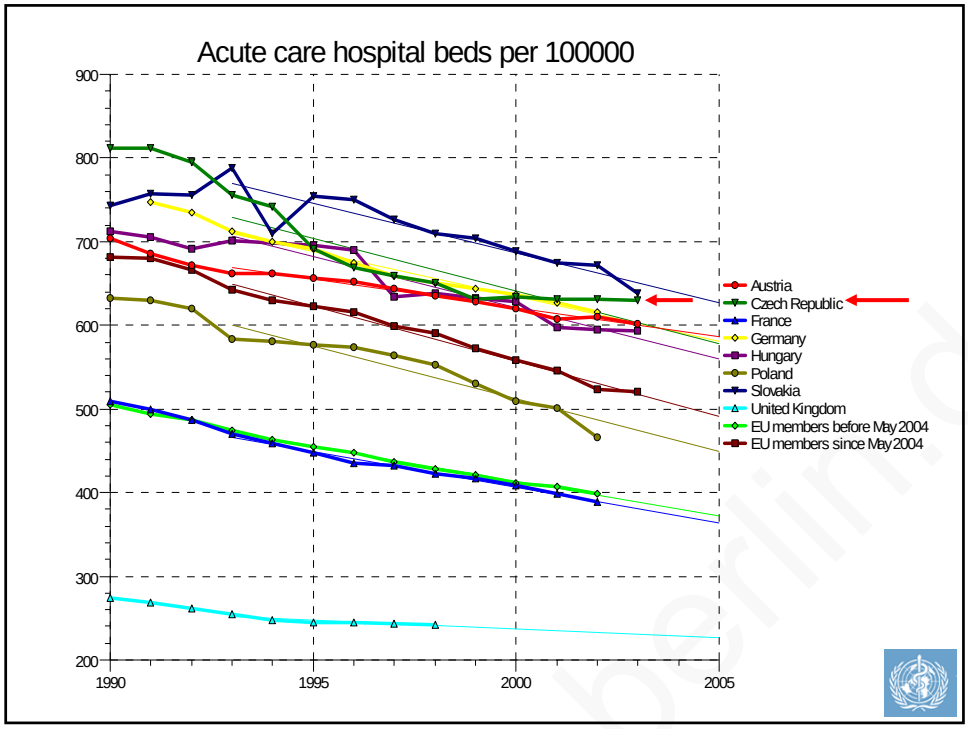
Equity

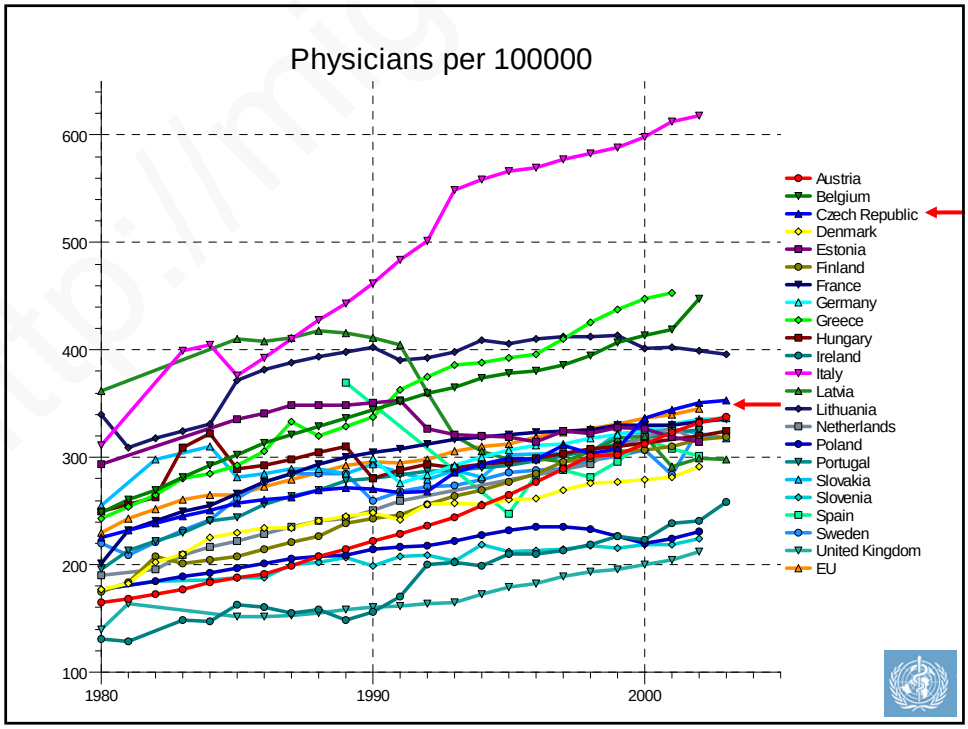
Health Financing Contribution Distribution Graph





Efficiency?





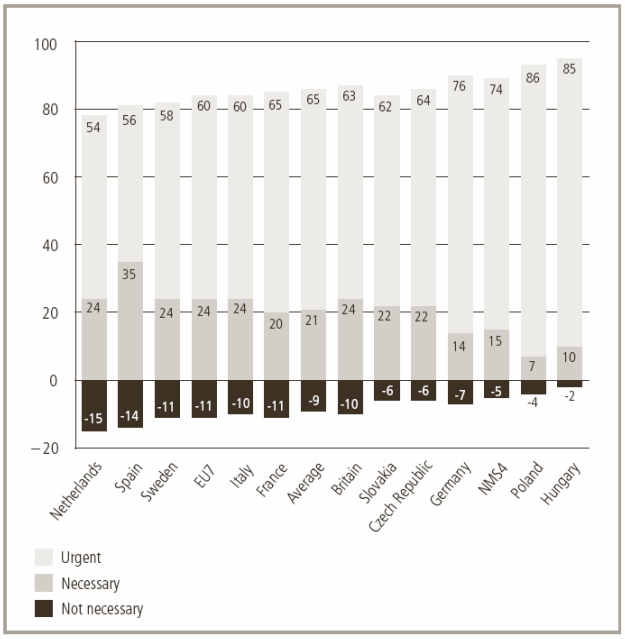


Figure 4 **Reform Index**

Does your healthcare system need reforming?

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

Stockholm Network 2005

http://www.observatory.dk

European Observatory on Health Systems and Policies

Technische Universität Berlin

http://
mig.tu-berlin.de