Reinhard Busse, Prof. Dr. med. MPH FFPH
Dept. Health Care Management, Technische Universität Berlin
(WHO Collaborating Centre for Health Systems Research and Management)
&
European Observatory on Health Systems and Policies

Development of healthcare in Europe 2006-2016 – a European perspective

Forecasting is difficult – especially regarding the future
Health challenges and successes

Cancer incidence per 100000

Incidence increasing … + 15%/ decade

SDR, Neoplasms, per 100000

… treatment more successful … - 7%/ decade
Cancer prevalence, in %

... prevalence increasing

up to + 50%/ decade

Diabetes prevalence, in %

up to + 50%/ decade
BIG TOPIC 1: Chronic disease

Taken together, life expectancy is visibly rising ...

Life expectancy at birth, in years, male

+ 2.4 years/ decade
Life expectancy at birth, in years, female

For men more than for women ...

+ 1.6 years/decade

Life expectancy at age 65, in years, male

Almost 2/3 of the gain occur in the elderly ...

+ 1.4 years/decade
Integrated public health system 1991

Central government

General taxation

Population

Limited choice

Public providers

NHS = payer & provider

Out-of-pocket

Private providers

Development 1 up to 2006

Central government

General taxation

Population

Limited choice

Public providers

Purchaser – provider split

European Observatory on Health Systems and Policies

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?

Population  
Limited choice  
Public providers
BIG TOPIC 2: Regionalisation

Development 3 up to 2006

Regional governments

Population

Limited

more choice

Public providers

(money follows patient)

General taxation

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

<table>
<thead>
<tr>
<th></th>
<th>Public beds</th>
<th>% share</th>
<th>Not-for-profit beds</th>
<th>% share</th>
<th>Private beds</th>
<th>% share</th>
<th>Total beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990</td>
<td>387207</td>
<td>62.8</td>
<td>206936</td>
<td>33.5</td>
<td>22779</td>
<td>3.7</td>
<td>616922</td>
</tr>
<tr>
<td>2003</td>
<td>265520</td>
<td>53.1</td>
<td>187271</td>
<td>37.5</td>
<td>46994</td>
<td>9.4</td>
<td>499785</td>
</tr>
<tr>
<td>Change</td>
<td>-32.4%</td>
<td>-9.5%</td>
<td>+106.2%</td>
<td></td>
<td>-19.0%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


2005: ca. 14
BIG TOPIC 3: Privatisation

But will we still need hospitals in 2016?

Acute care hospital admissions per 100

- 0.7/ decade
Average length of stay, acute care hospitals only

- 1.2 days/ decade

Acute care hospital beds per 100000

- 80/ 100000
- 0.8/ 1000 per decade
Total inpatient expenditure as % of total health expenditure

The hospital of the past

Source: Edwards & McKee
The hospital of the future?

BIG TOPIC 4:
Role of hospitals

Source: Edwards & McKee
Further developments up to 2016

Regional governments

Choice

Competing insurers?

General

Purchaser – provider split

Insurance contribution

Population

Choice

Public providers: Public-private mix

Who competes for whom?

Third-party payer

= insurer (sickness fund)

Choice of fund

Population

Free access

Providers

Public-private mix

Contracts: collective
Third-party payer
= insurer (sickness fund)

Choice of fund

Population

Contracts: collective

But based on what?
Price, quality, access …

Who competes for whom?

Contracts:
- collective
- selective

Free access

Providers
Public-private mix

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?
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?

BIG TOPIC 5:
Choice & Competition
The first three rulings that changed our perception of the “Free Movement of Patients”

Decker (C-120/95)  
free movement of goods

Kohll (C-158/95)  
free movement of services

Molenaar (C-160/96)  
free movement of service-equivalent cash-benefits; definition of what belongs to health service and what not

The first nine patients sent to France by the English NHS (not shown: the 40 journalists who accompanied them)

ARE THESE DATA REALISTIC?  
ARE THEY REPRESENTATIVE?  
HOW CAN THE DIFFERENCE BE EXPLAINED?  
IS A „CATARACT“ IN ENGLAND THE SAME AS IN FRANCE?
Patient mobility

HOW MANY?

Country A
Benefit Package A using Service Taxonomy A and Fee Schedule A
Accessibility A_x
Quality of service A_x

Country B
Benefit Package B using Service Taxonomy B and Fee Schedule B
Accessibility B_x
Quality of service B_x

WHY?

WHICH SERVICES?

WHAT COSTS?

(SERVICES x REIMBURSEMENT)

• How much do prices/reimbursement rates actually differ?
• Are these differences real (= different input costs)?
• Are they rather explained by systematic differences (e.g. capital costs included/not included)?
• Or by differences in service intensity (e.g. pre-operative tests)?
<table>
<thead>
<tr>
<th>Need for care</th>
<th>Age group</th>
<th>Type of Care</th>
<th>ECHI *</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appendectomy</td>
<td>14-25</td>
<td>In-patient Surgery Emergency</td>
<td>-</td>
</tr>
<tr>
<td>Normal delivery</td>
<td>25-35</td>
<td>In-patient Obstetrics Elective</td>
<td>+</td>
</tr>
<tr>
<td>Hip-replacement</td>
<td>65-75</td>
<td>In-patient Surgery Elective</td>
<td>+</td>
</tr>
<tr>
<td>Cataract</td>
<td>70-75</td>
<td>Out-patient (day case) Surgery Elective</td>
<td>+</td>
</tr>
<tr>
<td>Stroke</td>
<td>60-70</td>
<td>In-patient Medical Emergency</td>
<td>+</td>
</tr>
<tr>
<td>AMI (PTCA)</td>
<td>50-60</td>
<td>In-patient Medical Emergency</td>
<td>+</td>
</tr>
<tr>
<td>Cough</td>
<td>2</td>
<td>Out-patient Paediatrics/GP Emergency</td>
<td>-</td>
</tr>
<tr>
<td>Colonoscopy</td>
<td>60-70</td>
<td>Out-patient Diagnostic Elective</td>
<td>+</td>
</tr>
<tr>
<td>Tooth filling</td>
<td>25-35</td>
<td>Out-patient Dental Emergency</td>
<td>+</td>
</tr>
<tr>
<td>Physiotherapy (knee)</td>
<td>12</td>
<td>Out-patient</td>
<td>Rehabilitative</td>
</tr>
</tbody>
</table>

*ECHI: related to European Community Health Indicators set (+ yes - no)
How will such developments influence health care in Europe? (1)

Initially probably not directly, but

- *Comparability* of services, their access and 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 EU-health insurance card.

How will such developments influence health care in Europe? (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*
- a need for Europe-wide *regulation*, affecting public and private entities equally.
THE 6 BIG TOPICS

- Chronic disease
- Role of hospitals
- Choice & Competition
- Privatisation
- Regionalisation
- Europeanisation

And why was expenditure not mentioned?

Total health expenditure as % of gross domestic product (GDP)

only +0.8 % points/decade
This presentation and more material can be found on the following websites:

http://mig.tu-berlin.de

www.observatory.dk