Health (care) challenges in Europe – health systems in transition

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Health challenges and successes

Cancer incidence per 100000

Incidence increasing …

+ 15%/ decade

http://mig.tu-berlin.de
SDR, Neoplasms, per 100000

... treatment more successful ...

- 7%/ decade

Cancer prevalence, in %

... prevalence increasing

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

Diabetes prevalence, in %

up to + 50% per decade
Taken together, life expectancy is visibly rising ...

+ 2.4 years/decade

For men more than for women ...

+ 1.6 years/decade
Almost 2/3 of the gain occur in the elderly ...

Life expectancy at age 65, in years, male

+ 1.4 years/ decade

Life expectancy at age 65, in years, female

+ 1.0 years/ decade
Third-party Payer

Population

Providers

Collector of resources

Third-party payer

Steward/regulator

Population

Providers
Third-party payer
Collector of resources

Steward/regulator


Providers

Functions

NHS-principles:
"Universal, comprehensive, free at the point of service"
Third-party payer

Collector of resources

Steward/regulator

Mobilizing resources/funding

Purchasing/contracting/financing providers

Population


Providers

Access to and provision of services

Resource pooling & allocation

Functions

Third-party Payer

Prepaid

Taxes

Social Health Insurance contributions

Voluntary insurance

Out-of-pocket

Population

Providers

European Observatory on Health Systems and Policies
BIG TOPIC 2: Public-private mix in funding health care
The funding mix in 2004

Social Insurance Systems

Private (Out-of-pocket & VHI)

Tax-funded Systems
Countries with major changes in funding mix 1975 - 2004

GDP per capita and public expenditure on health, by country income group

Source: Schieber and Maeda 1997 and OECD 2004
The richer the countries, the more they spend publicly (taxes or SHI) – but is this “better”?

- **Income**
  - 50
  - 500

- **Health funding**
  - 5
  - 25
  - 50

- **SHI contribution**
  - 50

- **Private insurance premium; user fee**

- **SHI contribution**
  - 25
  - 25

- **Regressive = unfair**
  - Proportional = fair
### Distribution: Fairness in Financial Contribution

Fairness in financial contribution is measured on a scale from 0 to 1, where 1.00 = max.

<table>
<thead>
<tr>
<th>Country</th>
<th>1993 Distribution Fairness</th>
<th>Threshold % of Households with Catastrophic Payments (Total)</th>
<th>Threshold % of Households with Catastrophic Payments (Out)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Slovakia</td>
<td>0.941</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>0.921</td>
<td>0.33</td>
<td>0.04</td>
</tr>
<tr>
<td>Denmark</td>
<td>0.920</td>
<td>0.38</td>
<td>0.07</td>
</tr>
<tr>
<td>Sweden</td>
<td>0.920</td>
<td>0.39</td>
<td>0.18</td>
</tr>
<tr>
<td>Germany</td>
<td>0.913</td>
<td>0.54</td>
<td>0.93</td>
</tr>
<tr>
<td>Hungary</td>
<td>0.905</td>
<td>0.96</td>
<td>0.20</td>
</tr>
<tr>
<td>Czech Republic</td>
<td>0.904</td>
<td>0.01</td>
<td>0.00</td>
</tr>
<tr>
<td>Belgium</td>
<td>0.903</td>
<td>0.23</td>
<td>0.09</td>
</tr>
<tr>
<td>Finland</td>
<td>0.901</td>
<td>1.36</td>
<td>0.44</td>
</tr>
<tr>
<td>Spain</td>
<td>0.899</td>
<td>0.89</td>
<td>0.48</td>
</tr>
<tr>
<td>Slovenia</td>
<td>0.890</td>
<td>1.88</td>
<td>0.06</td>
</tr>
<tr>
<td>France</td>
<td>0.889</td>
<td>0.68</td>
<td>0.01</td>
</tr>
<tr>
<td>Lithuania</td>
<td>0.875</td>
<td>1.66</td>
<td>1.34</td>
</tr>
<tr>
<td>Switzerland</td>
<td>0.875</td>
<td>3.03</td>
<td>0.57</td>
</tr>
<tr>
<td>Estonia</td>
<td>0.872</td>
<td>2.47</td>
<td>1.30</td>
</tr>
<tr>
<td>Greece</td>
<td>0.858</td>
<td>3.29</td>
<td>2.17</td>
</tr>
<tr>
<td>Portugal</td>
<td>0.845</td>
<td>4.01</td>
<td>2.71</td>
</tr>
<tr>
<td>Latvia</td>
<td>0.828</td>
<td>4.05</td>
<td>2.75</td>
</tr>
</tbody>
</table>

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### Total Health Expenditure as % of GDP

- Funding mix is more important than % of GDP!
- Only +0.8 % points/decade
CEE health care systems in 1990

Central government

Population Limited choice Public providers

General taxation

“NHS” = payer & provider

Central government Sickness funds

Population Limited choice Public providers

SHI contributions

General taxation
Central government  Sickness funds

Population  Limited choice  Public providers

SHI contributions  General taxation  Purchaser – provider split

http://mig.tu-berlin.de

Central government  Sickness funds

Population  Limited more choice  Public providers

SHI contributions  General taxation  Purchaser – provider split

(money follows patient)
Development of the public-private mix in ownership of general hospitals, 1990–2003

<table>
<thead>
<tr>
<th>Year</th>
<th>Public</th>
<th>Not-for-profit</th>
<th>Private</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>beds</td>
<td>% share</td>
<td>beds</td>
<td>% share</td>
</tr>
<tr>
<td>1990</td>
<td>387 207</td>
<td>62.8</td>
<td>206 936</td>
<td>33.5</td>
</tr>
<tr>
<td>2003</td>
<td>265 520</td>
<td>53.1</td>
<td>187 271</td>
<td>37.5</td>
</tr>
<tr>
<td>Change</td>
<td>-32.4%</td>
<td>-9.5%</td>
<td>+106.2%</td>
<td></td>
</tr>
</tbody>
</table>


2005: ca. 14
BIG TOPIC 3: Public-private mix in providing health care

Who competes for whom?

Third-party payer
= insurer (sickness fund)

Choice of fund

Contracts: collective

Free access

Population

Providers

Public-private mix
BIG TOPIC 4: Choice & Competition

Who competes for whom?

Third-party payer
= insurer (sickness fund)

Contracts: collective

Choice of fund

Population

But based on what?
Price, quality, access …
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?
Health care: really necessary for relatively few (here in France 2001)

Source: CNAMTS/EPAS

Contribution collector

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

CRUCIAL!

Dependent on risk, but independent of actual utilisation

Third-party payer

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

Population

Providers
BIG TOPIC 5: Balancing ability to pay, need and solidarity

The first three rulings that changed our perception of the “Free Movement of Patients”

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

Kohl (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
Quality of service A

WHICH SERVICES?
(SERVICES x REIMBURSEMENT)

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

HOW? WHY?
• 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)?

Case vignettes

<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</td>
<td>Surgery Emergency -</td>
</tr>
<tr>
<td>Normal delivery</td>
<td>25-35</td>
<td>In-patient</td>
<td>Obstetrics Elective +</td>
</tr>
<tr>
<td>Hip-replacement</td>
<td>65-75</td>
<td>In-patient</td>
<td>Surgery Elective +</td>
</tr>
<tr>
<td>Cataract</td>
<td>70-75</td>
<td>Out-patient (day case)</td>
<td>Surgery Elective +</td>
</tr>
<tr>
<td>Stroke</td>
<td>60-70</td>
<td>In-patient</td>
<td>Medical Emergency +</td>
</tr>
<tr>
<td>AMI (PTCA)</td>
<td>50-60</td>
<td>In-patient</td>
<td>Medical Emergency +</td>
</tr>
<tr>
<td>Cough</td>
<td>2</td>
<td>Out-patient</td>
<td>Paediatrics/ GP Emergency -</td>
</tr>
<tr>
<td>Colonoscopy</td>
<td>60-70</td>
<td>Out-patient</td>
<td>Diagnostic Elective +</td>
</tr>
<tr>
<td>Tooth filling</td>
<td>25-35</td>
<td>Out-patient</td>
<td>Dental Emergency +</td>
</tr>
<tr>
<td>Physiotherapy (knee)</td>
<td>12</td>
<td>Out-patient</td>
<td>Rehabilitation -</td>
</tr>
</tbody>
</table>

* ECHI: related to European Community Health Indicators set (+ yes - no)
BIG TOPIC 6: Europeanisation

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.

This presentation and more material can be found on the following websites:

http://mig.tu-berlin.de

www.observatory.dk