Europäische Gesundheitssysteme im Vergleich
Perspective européenne comparée des systèmes de santé et des assurances sociales

Reinhard Busse, Prof. Dr. med. MPH FFPH
Fachgebiet Management im Gesundheitswesen, Technische Universität Berlin
( WHO Collaborating Centre for Health Systems Research and Management),
Charité – Universitätsmedizin Berlin &
European Observatory on Health Systems and Policies
1. Actors and organisation: are Bismarck´s and Beveridge´s grandchildren look-alikes?
2. Financing
3. Ensuring access and quality
4. Services, costs and reimbursement
5. Contribution to health and wealth
Collector of resources

Third-party payer

Population

Providers
Resource pooling & allocation

Collector of Third-party payer resources

Mobilizing resources/funding

Steward/regulator

Regulation

Financing providers: reimbursement/purchasing/contracting

Access to and provision of services

Population


Functions
Resource pooling & allocation

Collector of resources

Third-party payer

Mobilizing resources/funding

Steward/regulator

Regulation

Financing providers: reimbursement/purchasing/contracting

Population

Coverage:
Who? What?
How much?

Providers

Access to and provision of services

System typology
Third-party payer

Mobilizing resources/funding

Social insurance contributions & sickness funds =
social health insurance (SHI)
BISMARCK

Taxes & health authorities =
national health service (NHS)
BEVERIDGESystem typology

http://www.mig.tu-berlin.de
Classical integrated NHS-type systems

Central government

General taxation

Population

Limited choice

Public providers

NHS = payer & provider
Central government

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General taxation

Population

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Limited choice

Public providers

"NHS"

Purchaser – provider split
Central government

General taxation

Population

"NHS"

Purchaser – provider split

Limited choice

Public “autonomous” providers
"NHS"

Central government

General taxation

Purchaser – provider split

Population

Limited more choice (money follows patient)

Public "autonomous" providers
Central Regional governments

General taxation

Population

“NHS”

Purchaser – provider split

Limited more choice

Public “autonomous” providers
Regional governments

General taxation

Population

Purchaser – provider split

"NHS"

Limited more choice

Public "autonomous" and private providers
Social Health Insurance (SHI) systems

Sickness funds

Population

Choice

SHI contributions

Purchaser – provider split

Public “autonomous” and private providers
Social Health Insurance (SHI) systems

Sickness funds

Observation 1:
Basic configuration of actors is now similar across EU member states.

Population Choice

Public “autonomous” and private providers

Prof. Dr. Reinhard Busse
Berlin, 12.5.2007
Third-party Payer

Taxes

Social Health Insurance contributions

Voluntary insurance

Population

Providers

out-of-pocket

Prepaid
Third-party Payer

Taxes
Social Health Insurance contributions
Voluntary insurance

Population

Providers

Out-of-pocket

EU-15
12 new EU members

75% public
71%
5%
2%
18%
26%
Third-party Payer

Taxes
Social Health Insurance contributions
Voluntary insurance

Population
Providers
Out-of-pocket

USA

45% public
75%
71%
5%
2%
37%
18%
26%
14%
Total health expenditure as % of gross domestic product (GDP), WHO estimates.
Observation 2:
There is a distinct European way of financing health care.
Health care outcome: satisfaction, complications etc.

Structures and organisation

Health care system

Environment

Nutrition/agriculture

Other sectors

Needs-based access?

Personnel well qualified? Institutions of high standards? Technologies effective?

High-quality results?

Health gain/Outcome

Population health status (need)

Human resources

Technologies

Financial resources

Patients: demand, access

Process

Health care outcome: satisfaction, complications etc.

Patients receiving appropriate services?

Fair and sustainable funding?

How much? Is it worth it?
Health care outcome: satisfaction, complications etc.

Structures and organisation

Patients: demand, access

Process

Health care outcome: satisfaction, complications etc.

Universal coverage; cost-sharing limits

Professional (re-)certification
Provider (re-)accreditation
Health Technology Assessment
Concentration of services

“Do the thing right“:
Benchmarking/ league tables; registers

Population health status (need)

Human resources

Technologies

Financial resources

Environment
Nutrition/ agriculture
Other sectors

“Do the right thing“: *ex ante* Guidelines/ disease management programmes/ reminders; *ex post* Review
Observation 3: EU health care systems face the same challenges and are choosing very similar answers.

“Do the thing right“: Benchmarking/league tables; registers

“Do the right thing“: ex ante Guidelines/ disease management programmes/ reminders; ex post Review
Costs and reimbursement of European hospitals: *hip replacement*

HealthBASKET project final report (presentation: Berlin, 22.2.07)
Costs and reimbursement of European hospitals: stroke

HealthBASKET project final report (presentation: Berlin, 22.2.07)
Observation 4: Actual treatment and costs differ in the EU - but mainly within, not systematically between countries. Why do countries pretend they need their own specific reimbursement systems?

HealthBASKET project final report (presentation: Berlin, 22.2.07)
Life expectancy at birth, in years

Life expectancy is visibly rising ...
Today we know that health care does improve health …

<table>
<thead>
<tr>
<th>Time analysed</th>
<th>England &amp; Wales</th>
<th>USA</th>
<th>France</th>
<th>Japan</th>
<th>Italy</th>
<th>Sweden</th>
<th>Netherlands</th>
<th>Spain</th>
</tr>
</thead>
<tbody>
<tr>
<td>1956-1978</td>
<td>15.3%</td>
<td>15.8%</td>
<td>15.3%</td>
<td>33.3%</td>
<td>19.7%</td>
<td>15.8%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1969-84</td>
<td></td>
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<td></td>
<td></td>
<td>18.4%</td>
<td></td>
</tr>
<tr>
<td>1975-90</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>15.5%</td>
<td></td>
</tr>
<tr>
<td>1984</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>11.7%</td>
<td></td>
</tr>
<tr>
<td>1990</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>7.5%</td>
<td></td>
</tr>
</tbody>
</table>

**Share “medically amenable/ avoidable“ mortality of total mortality (cross-sectional analysis)**

<table>
<thead>
<tr>
<th>Time</th>
<th>England &amp; Wales</th>
<th>USA</th>
<th>France</th>
<th>Japan</th>
<th>Italy</th>
<th>Sweden</th>
<th>Netherlands</th>
<th>Spain</th>
</tr>
</thead>
<tbody>
<tr>
<td>1956</td>
<td>17.3%</td>
<td>15.8%</td>
<td>15.3%</td>
<td>33.3%</td>
<td>19.7%</td>
<td>15.8%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1969</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>18.4%</td>
<td></td>
</tr>
<tr>
<td>1975/78</td>
<td>9.6%</td>
<td>6.3%</td>
<td>7.4%</td>
<td>19.6%</td>
<td>11.3%</td>
<td>7.1%</td>
<td>15.5%</td>
<td></td>
</tr>
<tr>
<td>1984</td>
<td></td>
<td></td>
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<td>11.7%</td>
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<td></td>
<td></td>
<td></td>
<td>7.5%</td>
<td></td>
</tr>
</tbody>
</table>

**Change in mortality per year (longitudinal analysis)**

<table>
<thead>
<tr>
<th></th>
<th>„Medically amenable“ mortality</th>
<th>Other mortality</th>
<th>Total mortality</th>
</tr>
</thead>
<tbody>
<tr>
<td>1956</td>
<td>-3.2%</td>
<td>-0.2%</td>
<td>-0.6%</td>
</tr>
<tr>
<td>1969</td>
<td>-3.6%</td>
<td>-0.4%</td>
<td>-0.9%</td>
</tr>
<tr>
<td>1975/78</td>
<td>-4.5%</td>
<td>-1.0%</td>
<td>-1.4%</td>
</tr>
<tr>
<td>1984</td>
<td>-5.6%</td>
<td>-2.5%</td>
<td>-3.4%</td>
</tr>
<tr>
<td>1990</td>
<td>-3.8%</td>
<td>-0.8%</td>
<td>-1.3%</td>
</tr>
</tbody>
</table>

**Share of “medically amenable“ mortality of change in total mortality**

|            | 71% | 59% | 38% | 46% | 45% | 78% | 43% | 41% |

Busse 2006
Rethinking investment in health: A virtuous cycle?

## The return on investment

<table>
<thead>
<tr>
<th></th>
<th>France</th>
<th>UK</th>
<th>Italy</th>
<th>Spain</th>
<th>Sweden</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase in GDP per capita</td>
<td>$5,200</td>
<td>$6,000</td>
<td>$5,420</td>
<td>$5,180</td>
<td>$4,810</td>
</tr>
<tr>
<td>Increase in total health income</td>
<td>$3,302</td>
<td>$4,108</td>
<td>$4,992</td>
<td>$4,498</td>
<td>$4,732</td>
</tr>
<tr>
<td>Increase in health expenditure</td>
<td>$676</td>
<td>$630</td>
<td>$403</td>
<td>$506</td>
<td>$395</td>
</tr>
<tr>
<td>Increase in health income attributable to health care</td>
<td>$996</td>
<td>$1,561</td>
<td>$1,325</td>
<td>$1,780</td>
<td>$1,478</td>
</tr>
<tr>
<td>Return on health expenditure</td>
<td>47%</td>
<td>148%</td>
<td>229%</td>
<td>252%</td>
<td>274%</td>
</tr>
</tbody>
</table>
Spending vs. life expectancy …

$Y = 1.79X + 61.97$

$X$ - Total health expenditure as % of gross domestic product (GDP), WHO estimates, 2002

$Y$ - Life expectancy at birth, in years, Last available

Austria, Belgium, Bulgaria, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, Netherlands, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden, United Kingdom
Observation 5: If health care increases wealth, then it is in our common EU interest that low-spending countries increase their health expenditure.
This presentation and more material can be found on the following website:

http://mig.tu-berlin.de

Deutschsprachige Artikel zu Gesundheitssystemen international:
www.healthcaresystems.de
www.observatory.dk