Best practices of selected EU countries concerning the provision of healthcare services to people not covered by social health insurance

IPA Social Security Co-ordination and Social Security Reforms

Skopje, 9 November 2009

Willy Palm
Dissemination development Officer
A partnership that reflects evidence-based policy-making

- **International agencies**
  - WHO Regional Office for Europe, the European Investment Bank, the World Bank, the Open Society Institute

- **National and regional governments**
  - Belgium, Finland, Greece, Norway, Spain, Sweden and Slovenia, as well as the Veneto Region of Italy

- **Academia**
  - the London School of Economics and Political Science (LSE), the London School of Hygiene & Tropical Medicine (LSHTM)
Country monitoring

- Health Systems in Transition (HiT) profiles are country-based reports that provide a detailed description of each health care system and of reform and policy initiatives in progress or under development.
  - produced by country experts
  - based on a common template
  - covering the whole European region and selected countries elsewhere
Health systems and policy analysis

We run and publish comprehensive, systematic, comparative healthcare systems analysis on a range of topical issues and policy aspects

- Validated evidence – research
- Tailored to policy-making needs
- Freely accessible
Dissemination

- Disseminating generated evidence to decision-makers in the health sector is an essential component of our mission to inform the policy process.

- Publications
- Web
- Personal interaction (policy dialogues)
Observatory Venice Summer school

- Our Summer School brings together high level policy-makers in a stimulating environment where experiences can be openly discussed and information freely exchanged.

- While there is some formal teaching, the emphasis is on a participative approach.

- Human Resources for Health (2007)
- Hospital Re-engineering (2008).
- Innovation and Health Technology Assessment: Improving Health System Quality (2009)
- EU integration and health systems (2010)
Overview

• Framing the problem of uninsurance
• Universal coverage: what do we understand by it?
• Broad approach to universal cover
  – Population coverage
  – Service coverage
  – Cost coverage
• Solidarity vs. financial sustainability?
The uninsured: expelled from paradise

Can we afford universal coverage?

From I. Kickbush
USA: 45 million uninsured (2008)

Number & Percentage of Non-Elderly Americans Without Health Insurance Coverage, 1994-2007

Health insurance premiums outpacing normal inflation

Average Monthly Worker Premium Contribution, 2000-2008

Insurance coverage decreasing

*Distribution of Deductibles for Employee-Only PPO Coverage, 2000-2008*

"If we do not fix our health care system, America may go the way of GM -- paying more, getting less and going broke,"

The AMA agrees with Obama on the need for health care reforms but has reservations about the creation of a "public option" paid for by the government to ensure coverage for the 46 million uninsured Americans.
Social inequalities in health and access to health care

Diabetes mellitus

 poking on...
US - Federally Qualified Health Center (FQHC)

- Health Center Consolidation Act (1996)
- “safety net” providers: community-based health centers providing comprehensive PHC and preventive care to persons of all ages, regardless of their ability to pay
- 20% co-insurance with sliding-fee scale based on patients' family income and size
- Medicare patients, poor (homeless, migrants, non-US citizens, etc.), 40% uninsured
- To reduce the patient load on hospital emergency rooms
Rates of uninsurance in European Union

• 0.3% Germany (but 10% private)
• 1% (+ 2.2% defaulters) Netherlands (previously 35% private)
• 1.6% Switzerland
• 2% Austria
• 2.1% Poland
• 5% Estonia
• 12.9% Bulgaria (1 mln.)
Public funding of total health expenditure
(OECD countries 2006)

1. Data refer to current expenditure.  
3. The OECD average excludes Belgium and Slovak Republic.  

**Increase:** public spending as a % of total expenditure on health

**Decrease:** public spending as a % of total expenditure on health

Source: WHO 2007
The founding fathers of universal coverage in Europe

Otto von Bismarck
1815-1898

Nikolai Alexandrovich Semashko
1874-1949

William Henry Beveridge
1879-1963
Mix of contribution mechanisms, 2005

Source: WHO 2007
Can payroll contributions continue to account for at least 90% of Germany’s SHI revenue? What options to avoid harmful impact on labor market and competitiveness?

Source: Dirk Sauerland, WHL Graduate School of Business and Economics, presentation to 6th European Conference on Health Economics, 6-9 July 2006, Budapest
<table>
<thead>
<tr>
<th></th>
<th>Purchasing side</th>
<th>Provision side</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social health insurance</td>
<td>Semi-public actors</td>
<td>Mainly private actors</td>
</tr>
<tr>
<td><em>(Bismarck)</em></td>
<td>Integrating private insurers</td>
<td>More selective contracting, performance-based payments, integrated care models</td>
</tr>
<tr>
<td></td>
<td>User charges</td>
<td></td>
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<td></td>
<td>Complementary HI</td>
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<tr>
<td>Tax funded</td>
<td>Public actors</td>
<td>Mainly public actors</td>
</tr>
<tr>
<td><em>(Beveridge)</em></td>
<td>Purchaser-provider split</td>
<td>Autonomisation, contracting in private provision, outsourcing, PPP</td>
</tr>
<tr>
<td></td>
<td>More regional and local devolution</td>
<td></td>
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<tr>
<td>CEE and NIS</td>
<td>Public actors</td>
<td>Public actors</td>
</tr>
<tr>
<td><em>(Shemasko)</em></td>
<td>Move to social health insurance and purchasing model (single – multiple)</td>
<td>Private practice</td>
</tr>
<tr>
<td></td>
<td>Informal payments</td>
<td></td>
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</tbody>
</table>
Beveridge or Bismarck?

“It doesn’t matter whether the cat is black or white. As long as it catches mice!”

Deng Xiao Ping
The notion of solidarity

«The very notion of solidarity, on which our social security systems are based, demands an universalisation of its extent. It is contradictory to the idea of solidarity itself, to limit it to a certain group to which one belongs...

When this limited solidarity occurs among the rich, to the exclusion of the poor, it is not solidarity at all. It is protectionism and collective selfishness, not deserving the name ‘social’.

Health financing within overall system

- Resource generation
- Revenue collection
- Pooling
- Purchasing
- Benefits
- Service delivery

How health financing can influence goals

- Equity in utilization and resource distribution
- Quality
- Efficiency
- Transparency and accountability
- Choice

Health system goals (WHR2000)

- Health gain
- Equity in health
- Financial protection
- Equity in finance
- Responsiveness

Core values

- Participation
- Solidarity
- Equity
Reform and public policy objectives

- Cutler (2002): successive waves of healthcare reform
  - Ensuring universal *access* to medical care
  - Centralised regulation-based *cost containment* by various rationing mechanisms
  - Decentralised market- and *incentive-based systems*
Choice and competition in health insurance

- **free choice**
  - variable contributions (premiums)
  - selective contracting

- **no free choice**
  - fixed contributions
  - collective contracting

- Single payer
  - Austria
  - Belgium
  - Germany
  - Czech Rep.
  - Slovak Rep.
  - Luxembourg
  - Poland
  - Estonia
  - Hungary
  - Slovenia

- Multiple payers
  - Austria
  - Belgium
  - Czech Rep.
  - Slovak Rep.
  - Luxembourg

- Fixed contributions
  - Switzerland
  - Netherlands

- Variable contributions
  - Germany
  - Austria

- Single payer
  - Netherlands
  - Switzerland

- Multiple payers
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  - Belgium
  - Germany
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  - Slovenia
Renewed interest in universal coverage

• Move towards more private competition-based health insurance systems

• Non-active and non-contributing groups in universal SHI-systems (problem of defaulters)

• Small but persistent pockets of uninsured

• Depth of universal coverage (cost-sharing)
Universal coverage: what do we understand by it?

• as a situation in which the entire population of a country has access to appropriate health care services when needed and at an affordable cost, irrespective of sex, ethnic, social or any other background nor financial or health status.

• Primary coverage
• Predominantly public funding
• Compulsory (opting out not allowed)
• Broad benefit basket
• Access (and resource allocation) based on need (not capacity to pay)
<table>
<thead>
<tr>
<th>Minimum level of care</th>
<th>Equality in access to care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency care</td>
<td>Basic benefit basket</td>
</tr>
<tr>
<td></td>
<td>Positive selectivity measures</td>
</tr>
</tbody>
</table>
Access to healthcare services (the filter model)

1. Population coverage
2. Content of the benefit basket
3. Cost-sharing arrangements
4. Geographical factors
5. Choice among available providers
6. Organisational barriers
7. Preferences

Busse et al. 2007
The well-known 20/80 distribution – actually the 5/50 or 10/70 problem

How can we predict who these 5 or 10% are?
Fragmentation of pooling limits insurance potential of public funds

Source: J. Kutzin, WHO EURO
Private health insurance as a proportion of total expenditure on health, 2005

Source: WHO 2007
The new Dutch basic health insurance: a social insurance with private mechanisms or a private insurance with social safeguards?

- **Employer**: Income-related contribution 50%
- **Government**: Tax contribution 5%
- **Insured**: Healthcare allowance (means tested)
- **Pooling fund**: Flat-rate premium 45%, average: 1000€ p.a.
- **Insurer**: Risk equalisation payment
- **Annual deductible of 150€**
### The basic health insurance in the Netherlands: balancing between competition and solidarity

<table>
<thead>
<tr>
<th>Competition</th>
<th>Solidarity</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Nationally operating private health insurers (profit – not-for-profit)</td>
<td>• Insurance obligation</td>
</tr>
<tr>
<td>• Free choice of insurer</td>
<td>• Uniform basic package</td>
</tr>
<tr>
<td>• Nominal premium</td>
<td>• Obligation to insure</td>
</tr>
<tr>
<td>• Collective contracts (-10%)</td>
<td>• Prohibition of risk rating</td>
</tr>
<tr>
<td>• Product choice:</td>
<td>• Premium subsidy for lower incomes</td>
</tr>
<tr>
<td>– In kind – reimbursement</td>
<td>• Income-related (employers)contribution + public funding of aged -18</td>
</tr>
<tr>
<td>– Deductibles (150-500€)</td>
<td>• Statutory system of risk structure compensation</td>
</tr>
<tr>
<td>• Complementary insurance</td>
<td>• Catastrophic illnesses excluded (AWBZ)</td>
</tr>
</tbody>
</table>
Universalisation of SHI systems

- From mandatory insurance to mandate to insure (NL, D)
  - Corollary: obligation to accept subscribers
  - Operating choice?
- Increasing solidarity-base
  - Lifting contribution ceilings, extending scope, restricting opting out (F, D)
- Abolishing waiting periods
- Aligning cover for different schemes, groups (B, IRL)
- Eligibility based on residence (F, LTV, etc.)
  - F – basic universal coverage (CMU): residual category
- State-funding of certain groups (non-active)
  - Children, pensioners, unemployed, students, social assistance, etc.
Defaulters

- Stabilising SHI right (D, F, B): annual right, revert to last insurance
- Collection: monitoring payment of contributions
- Small insurance base may impede on willingness to contribute (BLG, ROM)
- Enforcement policies (CH, NL)
  - Administrative fines, claim back premium subsidies
  - Suspend cover, deny care
- Disentangling entitlements to care from payment of contributions (HUN)
  - Recuperation through taxes
Migrants (assylum seekers, illegal residents, internal migrants)

- Special schemes (D, F for illegals): Often restricted to emergency - essential care
- Integration in general scheme (F for assylum seekers after 3 months)
- Socially excluded groups
  - Administrative as well as language and cultural barriers, discrimination
  - Special health centres
  - Use of health mediators
  - Important role for local authorities, social assistance bodies
Service and cost coverage

- Definition of services (benefit basket)
  - Most cited gaps: dental and mental care

- Level of coverage (cost sharing)
  - Generalisation of user charges (D)
  - Regressiv: increasing inequalities in access
  - No evidence of efficiency gains or LT cost savings
  - Different types: co-insurance, co-payment, deductibles, extra billing, informal payments

- Conditions and modalities (incl. type of provider)

- Procedure for inclusion of new treatments (e.g. HTA)

- Margin for purchasers?
  - Package and co-pay design
  - Treatment models
  - Complementary insurance
Access problems due to financial difficulties in Poland (2000-05)

<table>
<thead>
<tr>
<th>Service</th>
<th>2000 r.</th>
<th>2003 r.</th>
<th>2005 r.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>23</td>
<td>14</td>
<td>17</td>
</tr>
<tr>
<td>Sanatorium</td>
<td>36</td>
<td>30</td>
<td>34</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>7</td>
<td>10</td>
<td>11</td>
</tr>
<tr>
<td>Medical examinations</td>
<td>9</td>
<td>13</td>
<td>15</td>
</tr>
<tr>
<td>Physicians visits</td>
<td>15</td>
<td>17</td>
<td>22</td>
</tr>
<tr>
<td>Dental prosthetics</td>
<td>15</td>
<td>17</td>
<td>22</td>
</tr>
<tr>
<td>Dental care</td>
<td>31</td>
<td>30</td>
<td>31</td>
</tr>
<tr>
<td>Medicines</td>
<td>34</td>
<td>33</td>
<td>36</td>
</tr>
</tbody>
</table>

% gospodarstw domownych
Latvia (2005): even with universal coverage access problems can persist

Figure 1. Unmet need for health services by quintile, 2005

Figure 2. Reasons for non-use by quintile, 2005

Out-of-pocket expenditure: protection mechanisms

- User charge exemptions
  - Age (children, elderly)
  - Social status
  - Health status (e.g. pregnancy, chronic illness)
  - Income level
- Exemption threshold (OOP ceiling), but
  - Scope?
  - Uniform or income-related?
- Preferential reimbursement
- Extra billing prohibition + third party payer
Latvia (2006): average household OOP per month per quintile

Catastrophic expenditure
Changes in financial protection following a change in priorities (Estonia)

Private health insurance

- **Substitutive insurance**
  - Life-insurance rules (age-at-entry rating) + transferability of age reserve (D)
  - Legally fixed substitutive basic tariff (D)
- **Complementary insurance**
  - Open enrolment/life-long insurance/premium regulation (IRL, SVN, B)
  - Risk adjustment system (IRL, SVN)
  - Free complementary health insurance + voucher system (F)
  - Tax credits only for contracts with social safeguards (F)
- **Prohibition of re-insurance** (D, F)
- Informal payments?
- Solidarity with statutory system?
Comparison of health status and access to health care among privately and publicly insured people in Germany, 2001-2005

<table>
<thead>
<tr>
<th>Prevalence of:</th>
<th>Public (%)</th>
<th>Private (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>People aged 65+*</td>
<td>22</td>
<td>11</td>
</tr>
<tr>
<td>Chronic disease**</td>
<td>23</td>
<td>11</td>
</tr>
<tr>
<td>Self-reported poor health**</td>
<td>21</td>
<td>9</td>
</tr>
<tr>
<td>GP contact**</td>
<td>81</td>
<td>55</td>
</tr>
<tr>
<td>Specialist contact (OP)</td>
<td>47</td>
<td>45</td>
</tr>
<tr>
<td>Difficulties in paying for OP prescription drugs**</td>
<td>26</td>
<td>7</td>
</tr>
</tbody>
</table>

Sources: Mielck and Helmert 2006 and *Schneider 2003

** Statistically significant after controlling for differences in age, gender and income.
Total health expenditure as % of gross domestic product (GDP)

Financial sustainability?
Solidarity vs. sustainability?

• Financial protection and equity of finance are key
  – Universal access and solidarity central in most European systems
  – Solidarity (integration, financing, benefits)

• Trade-off: macro-economic context (constraints)
  – Collecting capacity
  – Health as priority in public financing
  – Increasing financial pressure (cost, public finances)
  – Looking for efficiency gains/savings

• Issues
  – Increasing role for out of pocket (with exemptions and ceilings) and for private voluntary insurance
  – Fragmentation of pools
Public health expenditure as % of GDP

Source: WHO
General public expenditure as % of GDP

Source: WHO
Health expenditure as % of total public expenditure

Source: WHO 2007
Different health priorities in a similar fiscal context

<table>
<thead>
<tr>
<th>Country</th>
<th>Total public spending as % of GDP</th>
<th>Public health spending as % of total public spending</th>
<th>Out-of-pocket spending as % of total health spending</th>
</tr>
</thead>
<tbody>
<tr>
<td>France</td>
<td>52.4</td>
<td>16.5</td>
<td>6.7</td>
</tr>
<tr>
<td>Czech Republic</td>
<td>44.9</td>
<td>13.5</td>
<td>11.9</td>
</tr>
<tr>
<td>UK</td>
<td>44.1</td>
<td>16.3</td>
<td>11.6</td>
</tr>
<tr>
<td>Cyprus</td>
<td>40.3</td>
<td>7.0</td>
<td>45.9</td>
</tr>
<tr>
<td>Ireland</td>
<td>36.4</td>
<td>17.2</td>
<td>11.6</td>
</tr>
<tr>
<td>Estonia</td>
<td>35.5</td>
<td>11.8</td>
<td>20.4</td>
</tr>
</tbody>
</table>

Source: adapted from Kutzin 2008; WHO data for 2007
Priority to health in the government budget

Source: WHO estimates for 2004
Why it’s important: public spending on health matters (for our objectives)

The more that governments spend on health, the lower the burden of out-of-pocket spending on their population (with variation: policy matters too!)

Source: WHO estimates for 2003, European Member-States w/ population > 600,000
Out-of-pocket payments as % of total health expenditure (2002)

- Albania, 61
- BIH, 50
- Bulgaria, 46
- Russia, 44
- Moldova, 42
- Serbia, 38
- Romania, 34
- Turkey, 34
- Ukraine, 29
- Belarus, 26
- Croatia, 19
- FYROM, 15

WHO / WB estimate 2005
Poverty still widespread in large parts

**Absolute poverty rates (%), around 2003**

- Above US$ 2.15 but below US$ 4.30
- Below US$ 2.15 a day

Source: Alam et al. (2005)
Monitoring and analysis

Emphasis on vulnerable populations

- Homeless
- Irregular employment
- Migrants
- Ethnic minorities
- Refugees
- Addicts (alcohol, narcotics)
- Sex workers
Strengthening social safety nets

- Ensuring protection from catastrophic expenditure
- Tackling informal payments, especially where they are regressive
- Ensuring benefit systems respond rapidly when people become unemployed

- Ensuring affordability of pharmaceuticals
  - Especially where currency depreciations increase price
  - Especially for people with chronic illness
  - Tackling profiteering and counterfeit drugs
  - Transferring taxes on drugs to taxes on tobacco (or airline tickets?)
HiAP: intersectoral action on health determinants

• The entry point for Health in All Policies
  – The so called determinants of health influence the health of the population and individuals
  – Changes in the determinants may result in changes in the health of the population and individuals
  – Some determinants are amenable to policy changes!

(Dahlgren and Whitehead 1991)
Health is wealth: the virtuous circle

sickness

poverty
Thank you for your attention

Analysing Health Systems and Policies