Public Health Policies in Europe: Implications for equity

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European Observatory on Health Systems and Policies

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The Observatory supports and promotes evidence-based health policy-making through comprehensive and rigorous analysis of the dynamics of health care systems in Europe.

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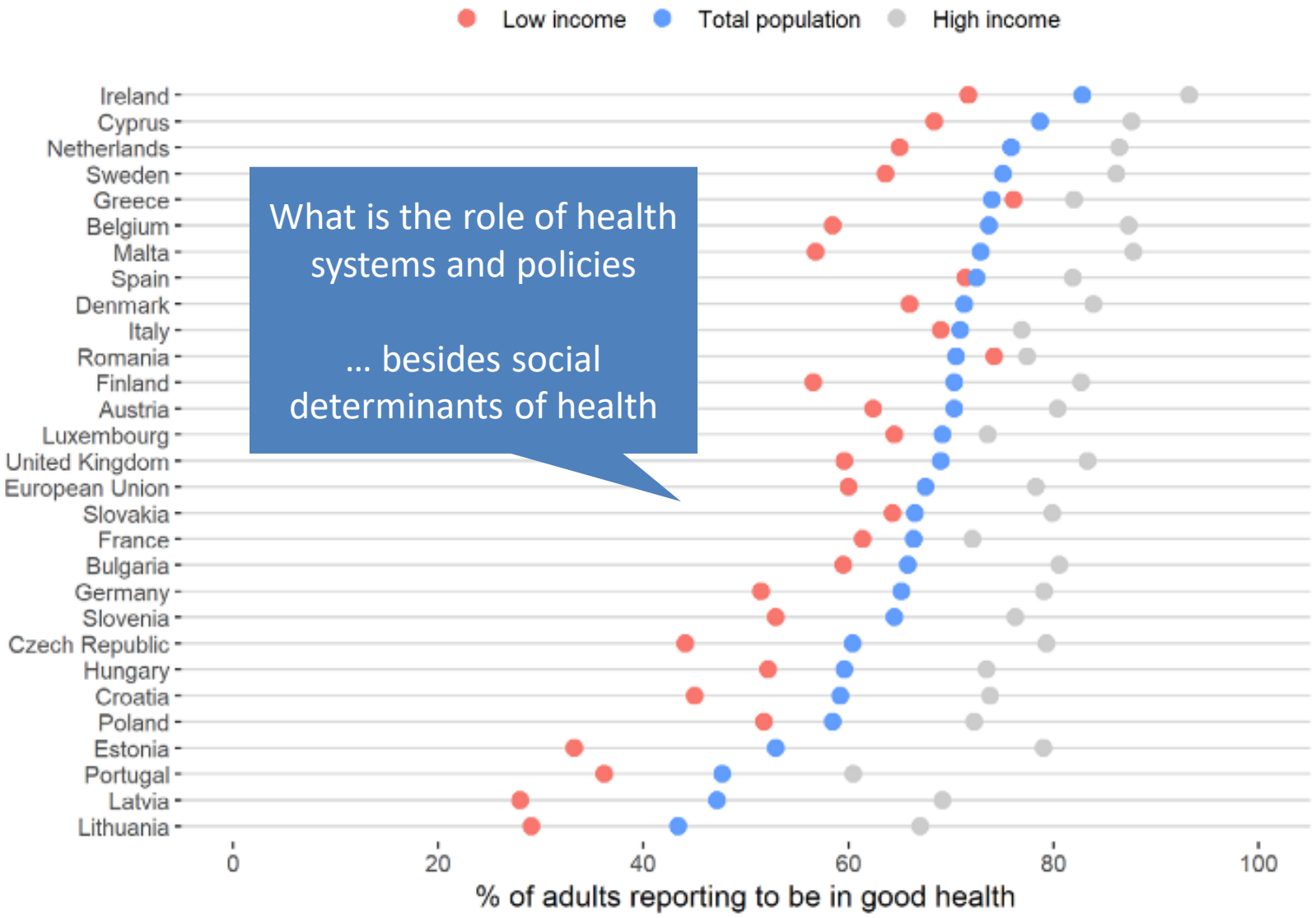
Disparities in Self-Reported Health by Income



Observatory‘s approach to country-monitoring

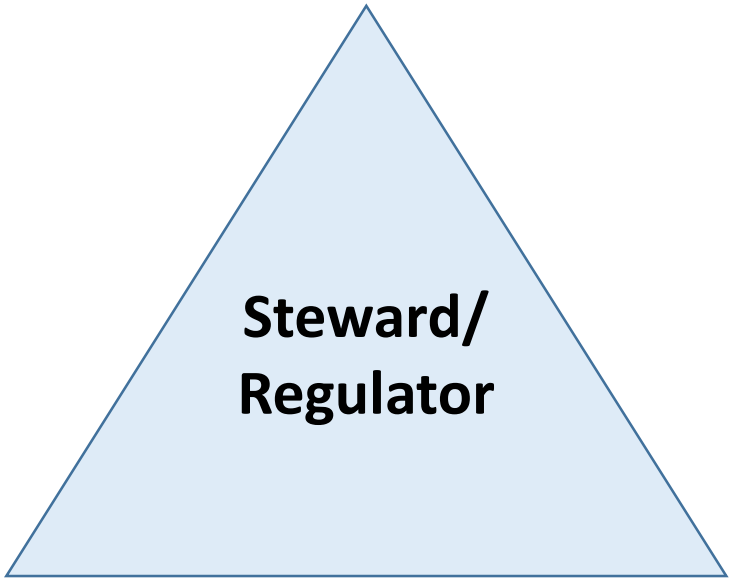
= Health Systems in Transition (HiT)

- Describe and analyze a country’s health system and key reform initiatives
- Based on a common set of questions and follow the same structure, enabling easy cross-country comparisons
- Seek to provide relevant information to support policy-makers and analysts in the development of health systems in Europe and beyond

The health system triangle

Collector of resources

Third-party Payer



Population

Providers

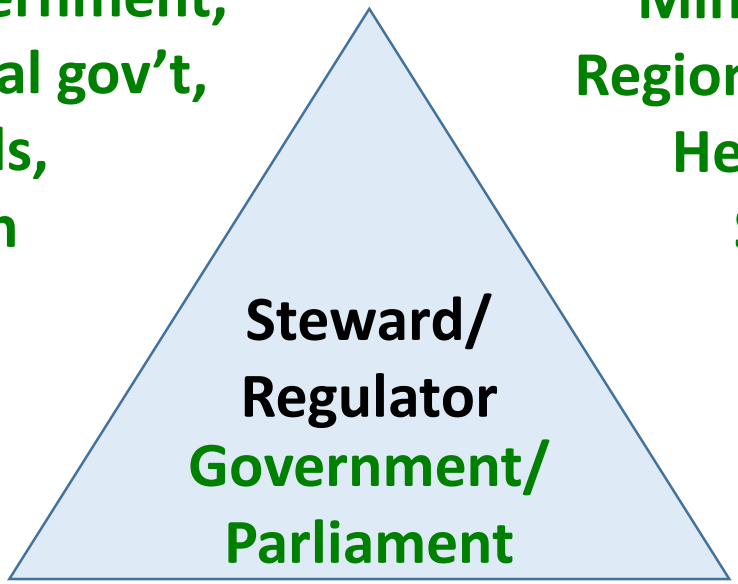
Possible actors

Collector of resources

National government,
Regional/ local gov't,
Sickness funds,
Private health insurers,
MSA ...

Third-party Payer

Ministry of Health
Regional/ local gov't
Health Authority
Sickness funds
HMOs

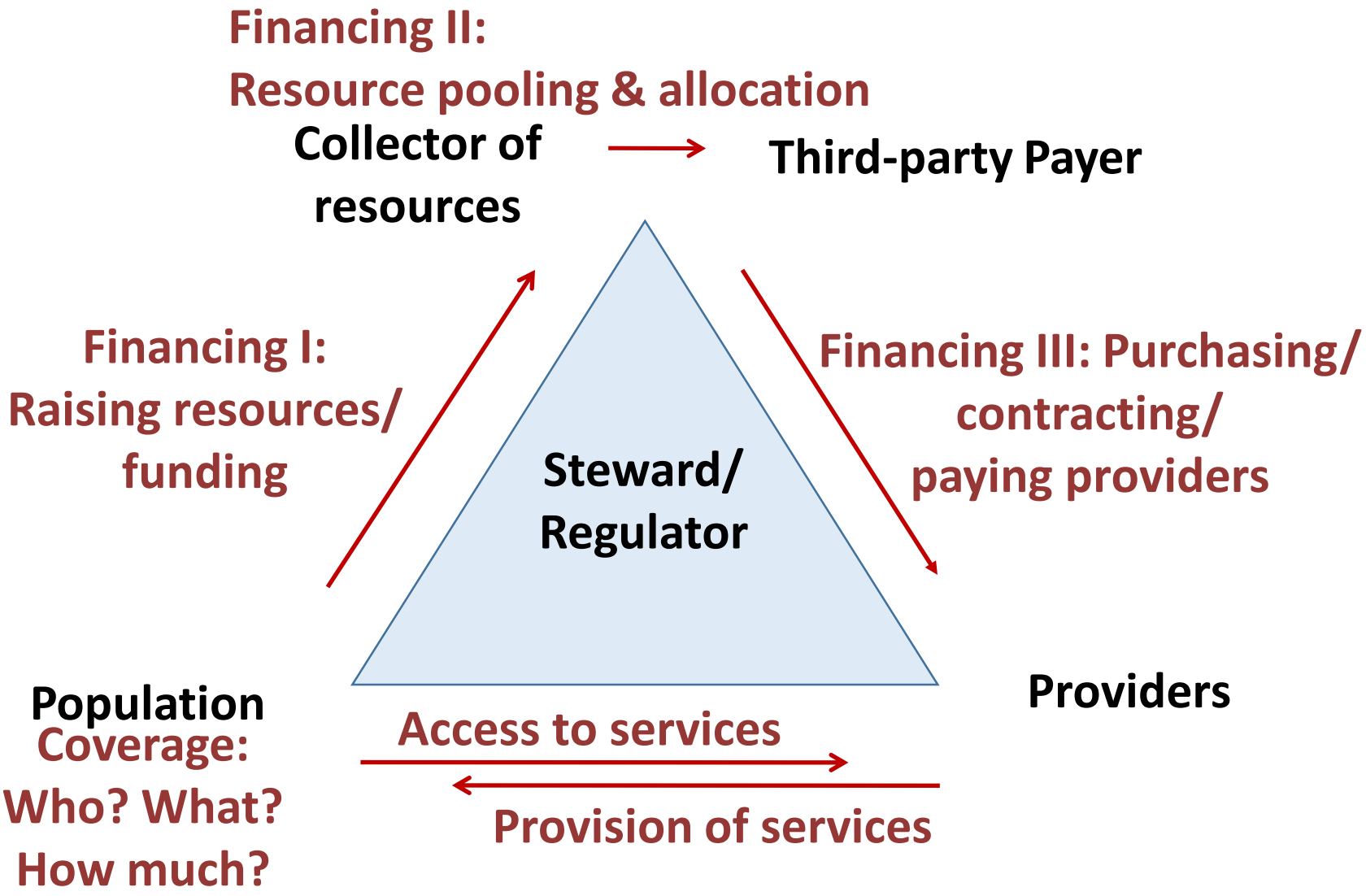


Population

Providers

GPs, specialists, dentists
Ambulatory/ inpatient providers
Public/ private hospitals ...

Health system functions



Functions

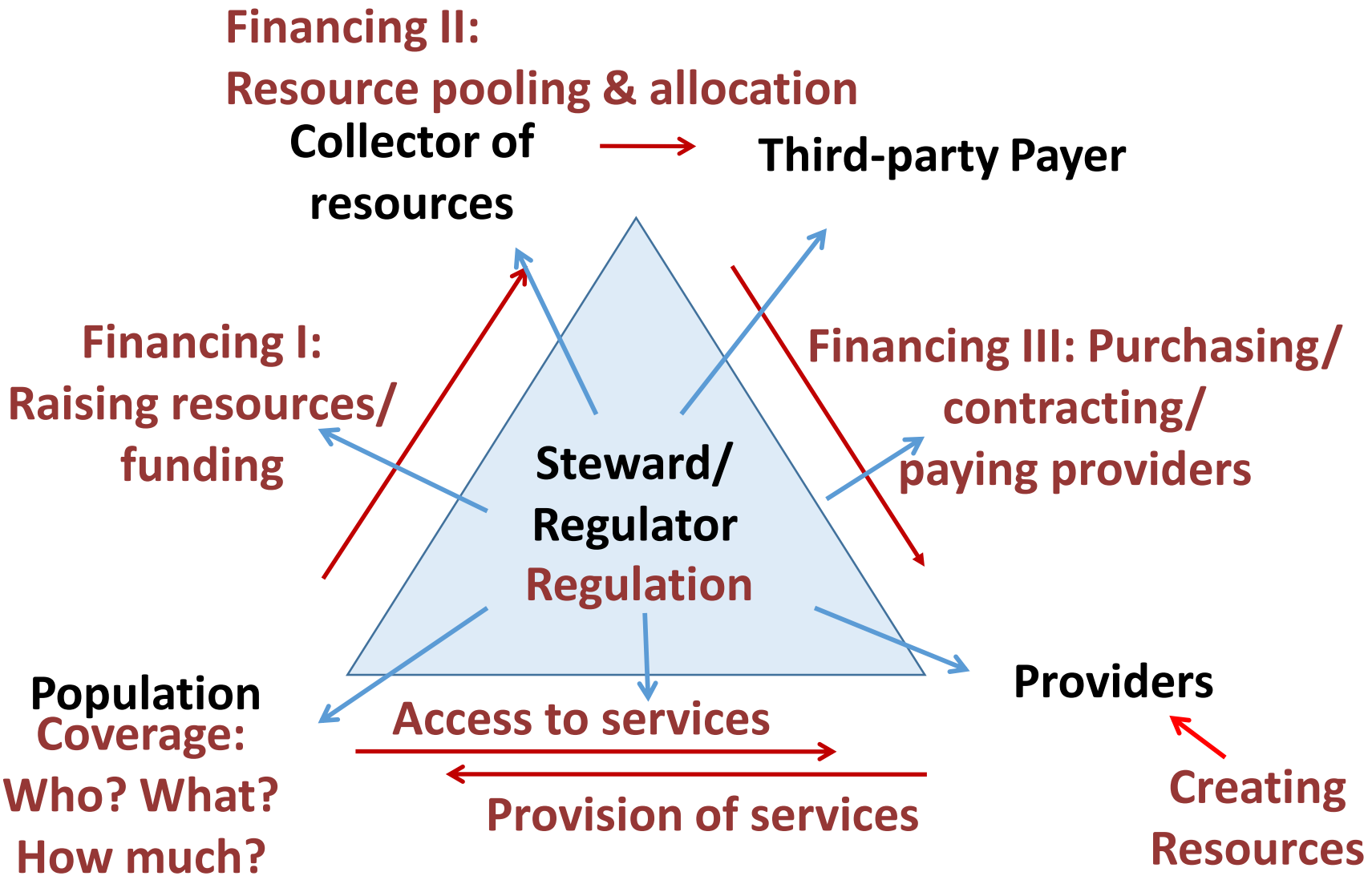
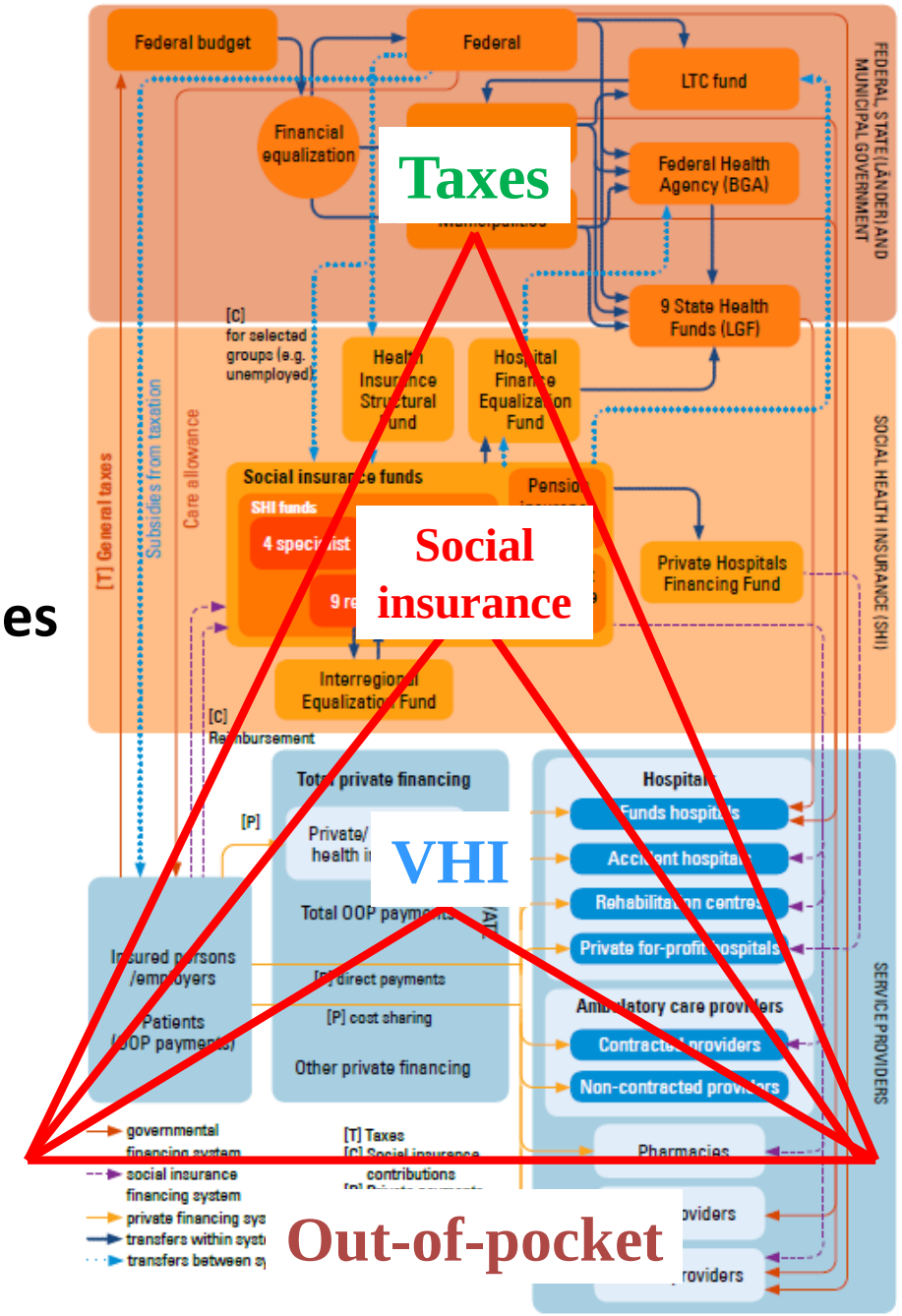

Financing II:
Resource pooling & allocation
Collector of resources
Third-party Payer
Financing I:
Raising resources/ funding
Financing III: Purchasing/ contracting/ paying providers
Steward/ Regulator
Regulation
Population
Coverage:
Who? What?
How much?
Access to services
Provision of services
Providers
Creating Resources

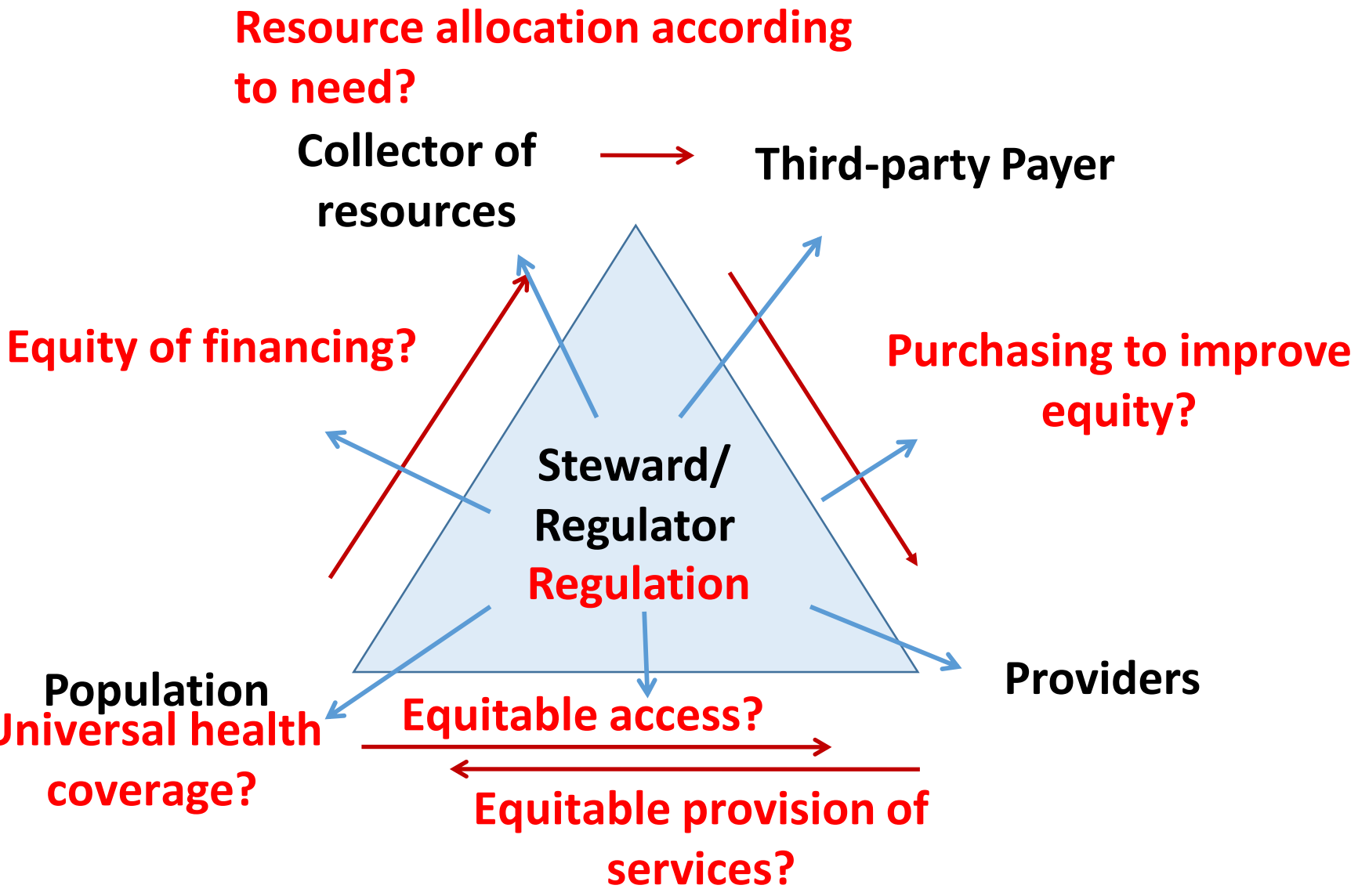
FIGURE 3.5 Financial flows in the Austrian health care system



Raising resources

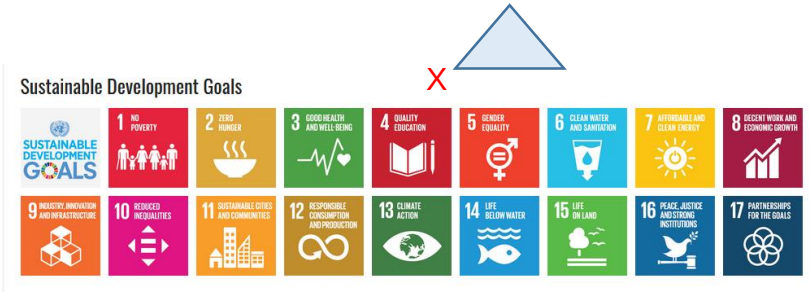
Purchasing and payment

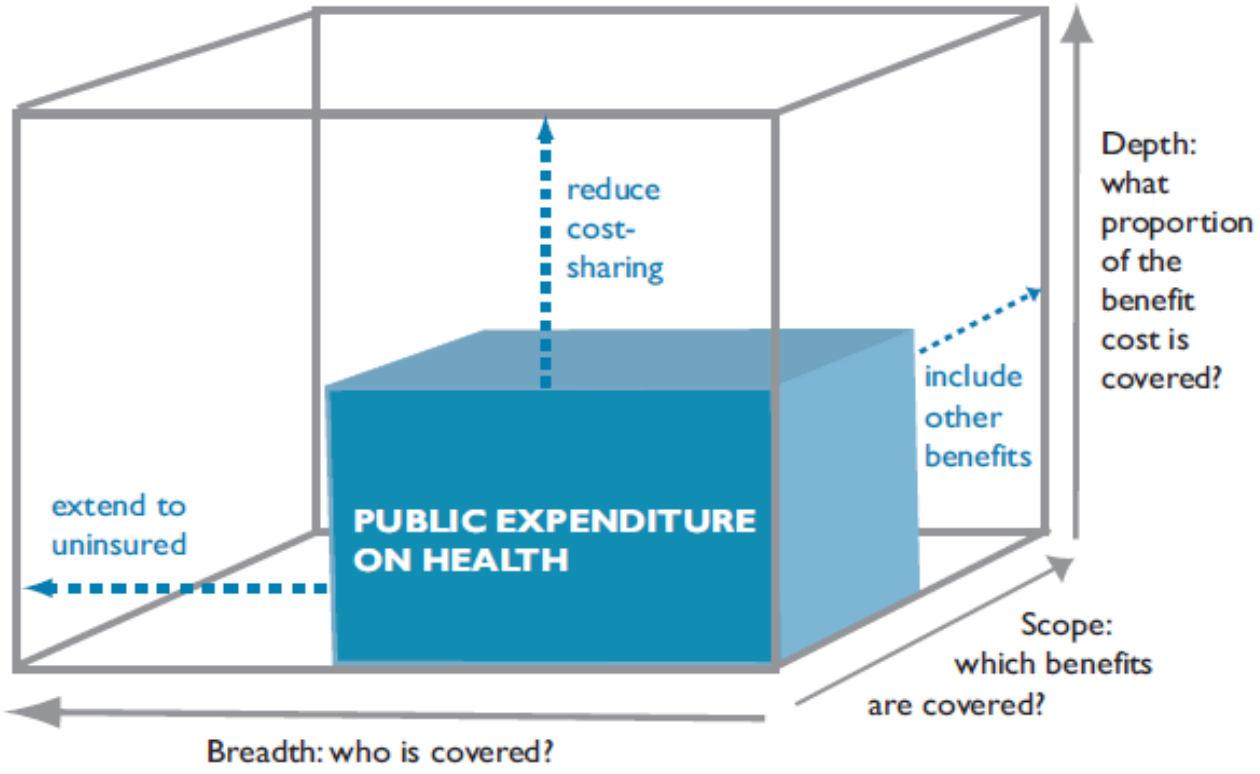
Equity in health systems



SDG 3.8: Achieve universal health coverage (UHC)

Achieve UHC, including financial risk protection, access to quality essential health-care services and access to […] essential medicinces and vaccines for all

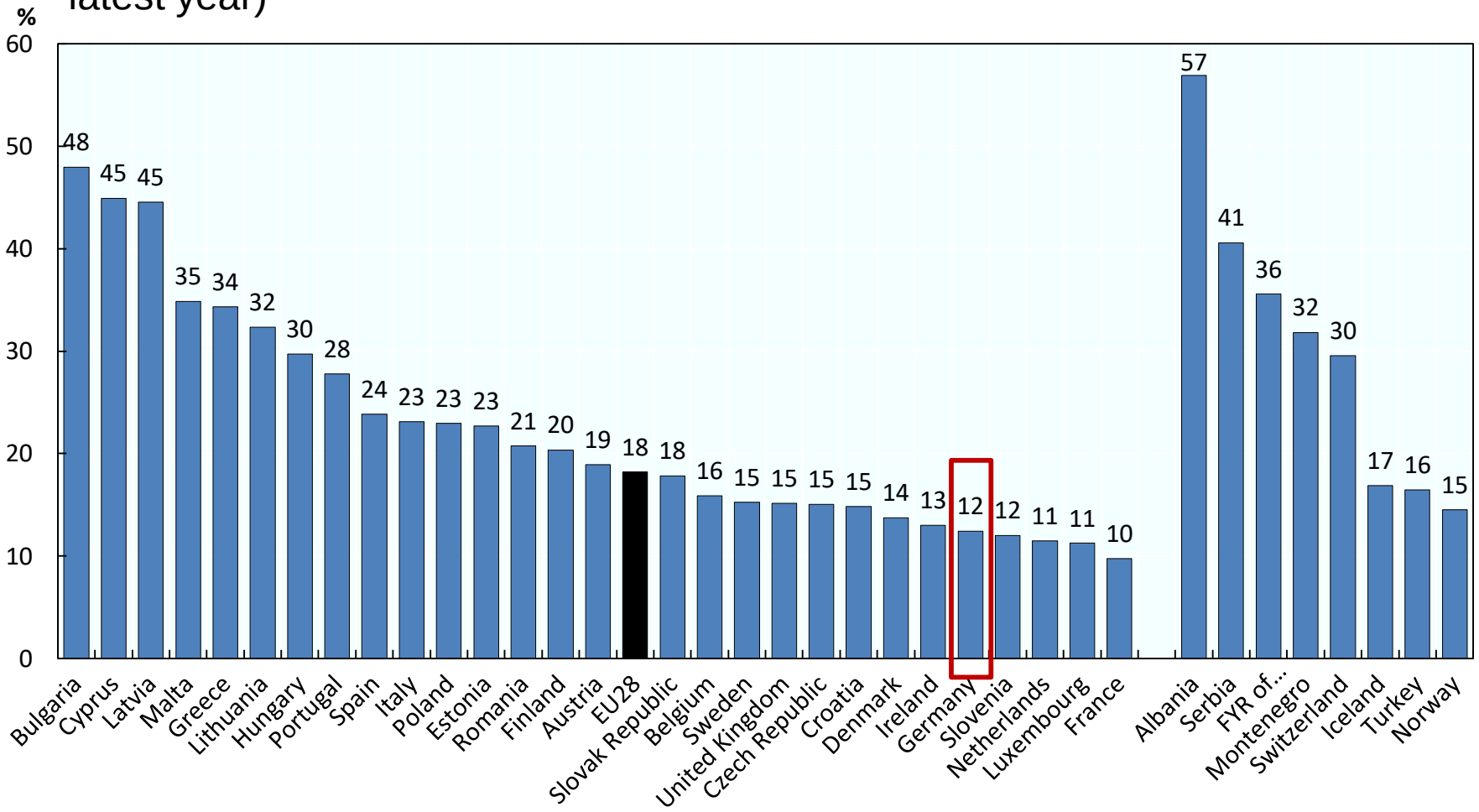




WHO based on R. Busse

Out-of-pocket (OOP) payments indicate gaps in coverage (and lack of financial protection)

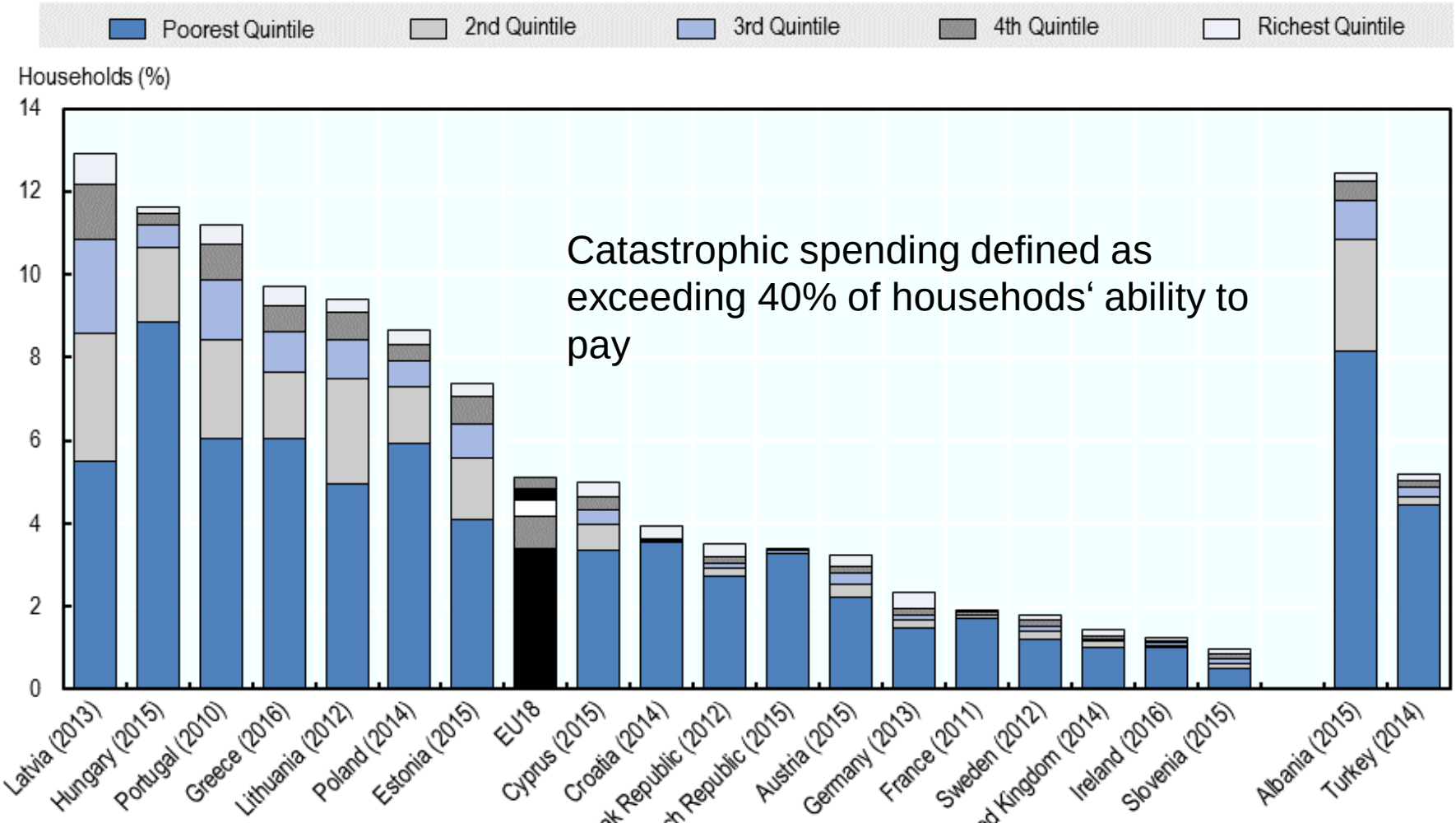
Share of total health spending financed by out-of-pocket payments, 2016 (or latest year)



Source: OECD Health Statistics 2018.

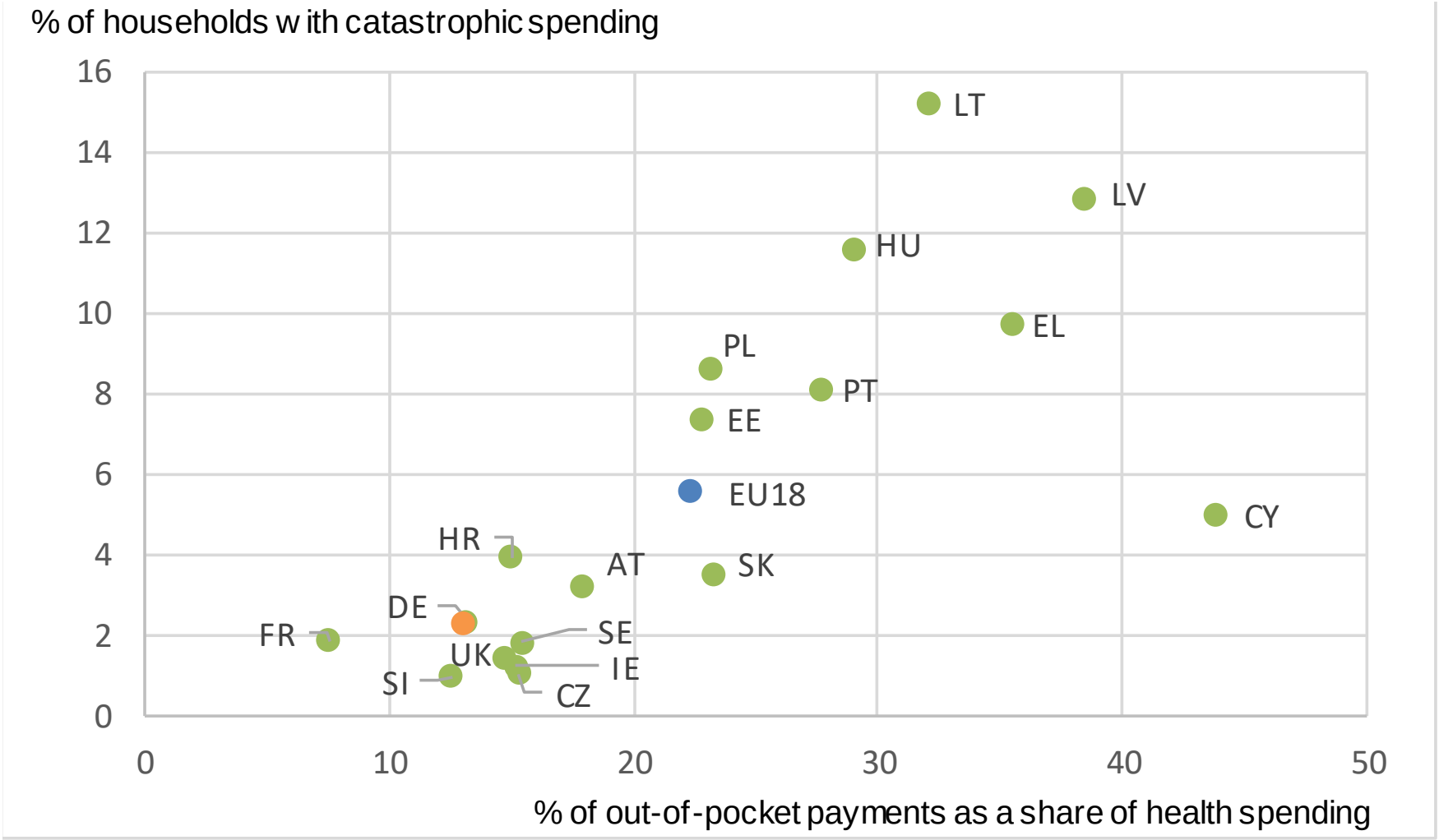
OOP payments are catastrophic for lower income households

Share of households with catastrophic spending on health by consumption quintile, latest year available



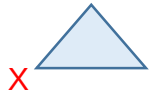
Source: WHO Regional Office for Europe 2018.

Countries with higher OOPs have more catastrophic expenditures

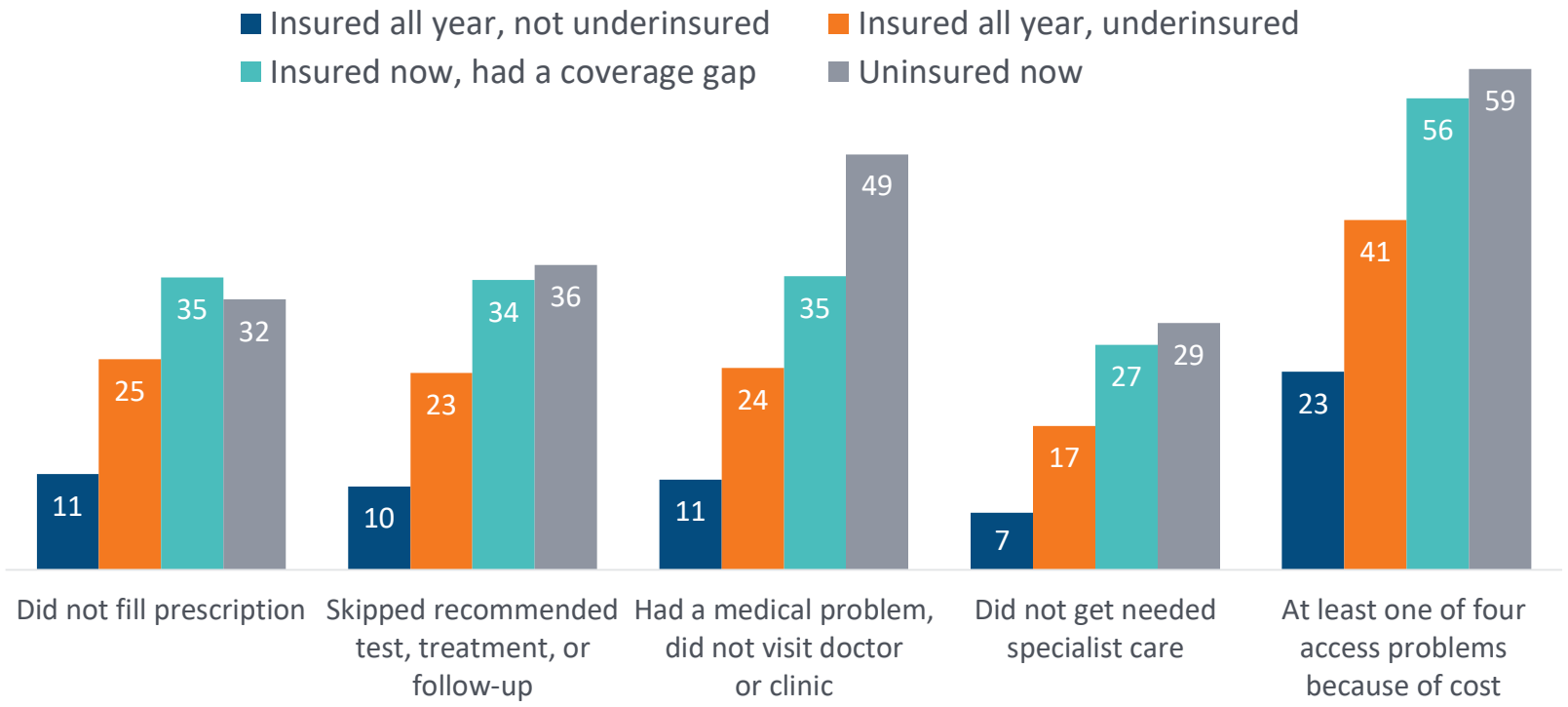


Source: WHO Regional Office for Europe (data refer to 2015 or nearest year).

Based on US data: Inadequate coverage is associated with more cost-related access problems

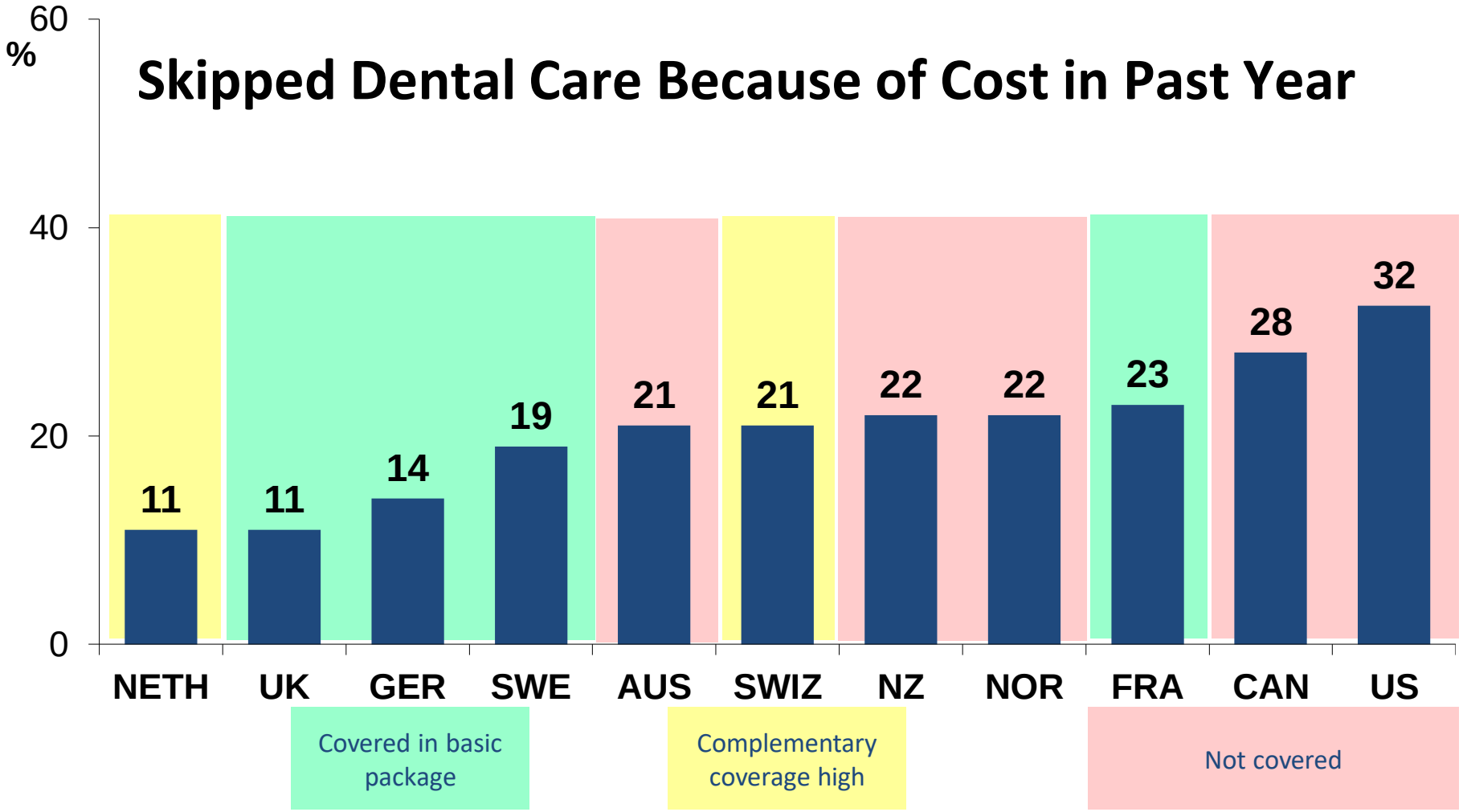


*Percent of adults ages 19–64 who had any of four access problems in past year because of cost**



- Data: Commonwealth Fund Biennial Health Insurance Survey (2018).

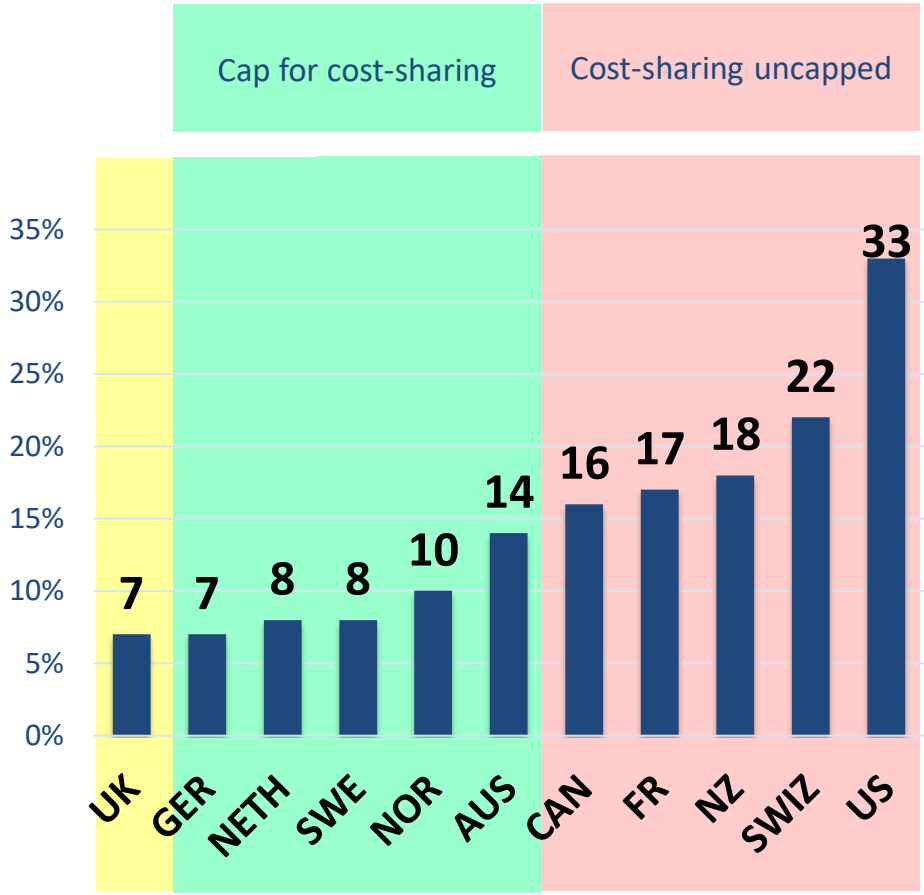
The benefit basket also matters: e.g. dental care



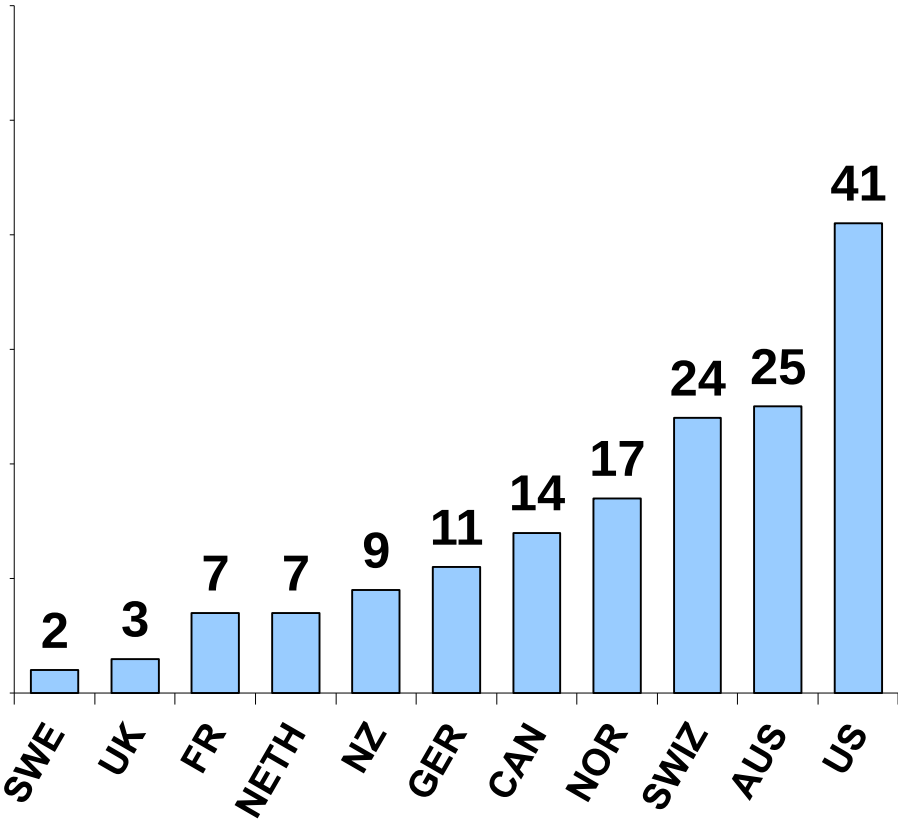
Own elaboration based on data from 2016 Commonwealth Fund International Health Policy Survey in Eleven Countries.

User charges: size and protection mechanisms are important

Experienced cost-related access problem*



Spent US$1,000 or more out-of-pocket

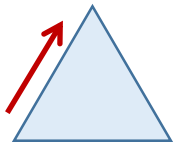


* Had a medical problem but did not visit doctor; skipped medical test or treatment recommended by doctor; or did not fill prescription or skipped doses because of cost.

Source: modified from 2016 Commonwealth Fund International Health Policy Survey in Eleven Countries.

Source: 2013 Commonwealth Fund International Health Policy Survey in Eleven Countries.

Equity of financing



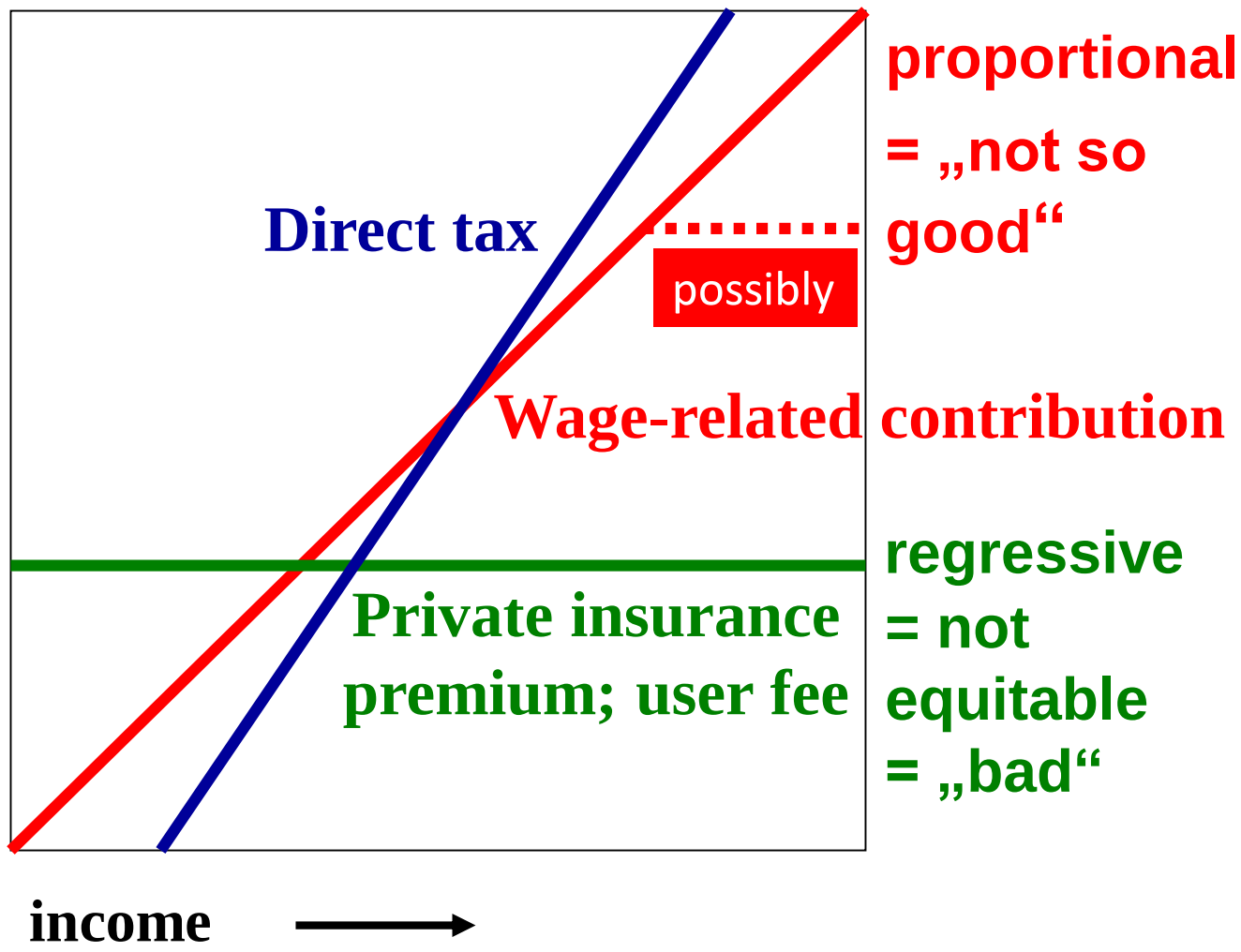
- World Health Report 2000: „health care [financing] is perfectly fair if the ratio of total health contribution to total non-food spending is identical for all households, independently of their income, their health status or their use of the health system."

- **Two concepts are important:**
  - Vertical equity: people with a greater ability to pay should pay more
  - Horizontal equity: individuals with similar resources should contribute similarly to the health system

Vertical equity

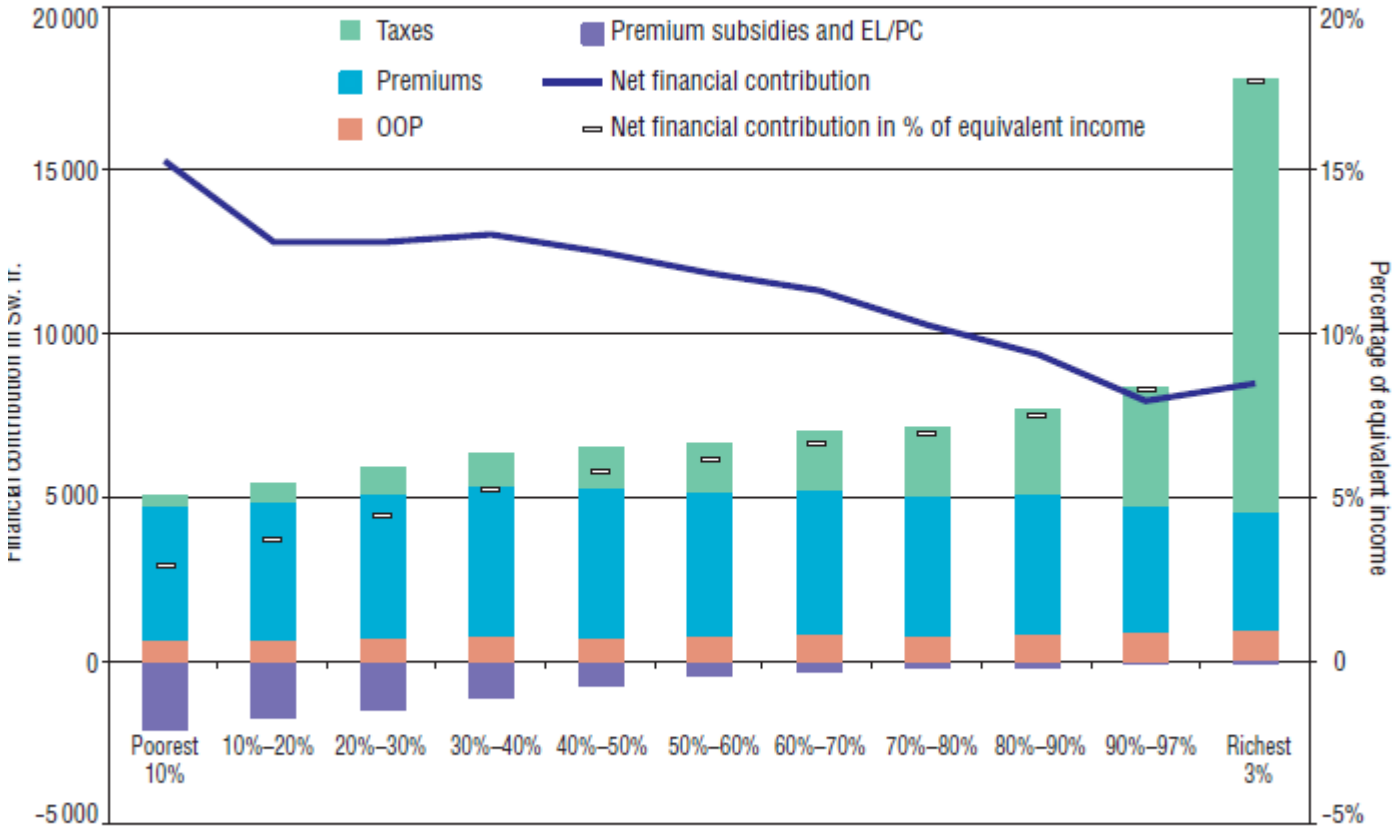
Progressive:
individuals with greater ability contribute a larger proportion of their income than do individuals with lower ability to pay

Regressive:
individuals with greater ability contribute a lower proportion of their income than individuals with lower ability to pay

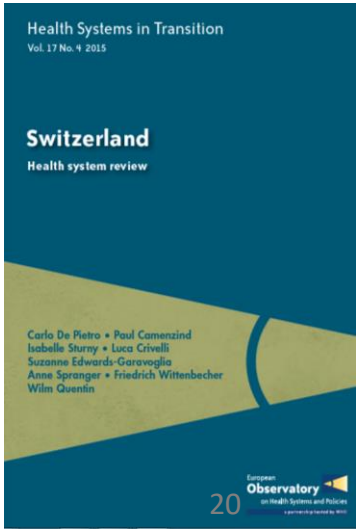


Equity in financing in Switzerland

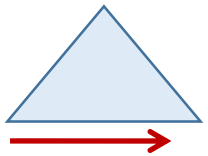
Financial contributions to health of different income groups by type of contribution and in percent of equivalent income, 2010



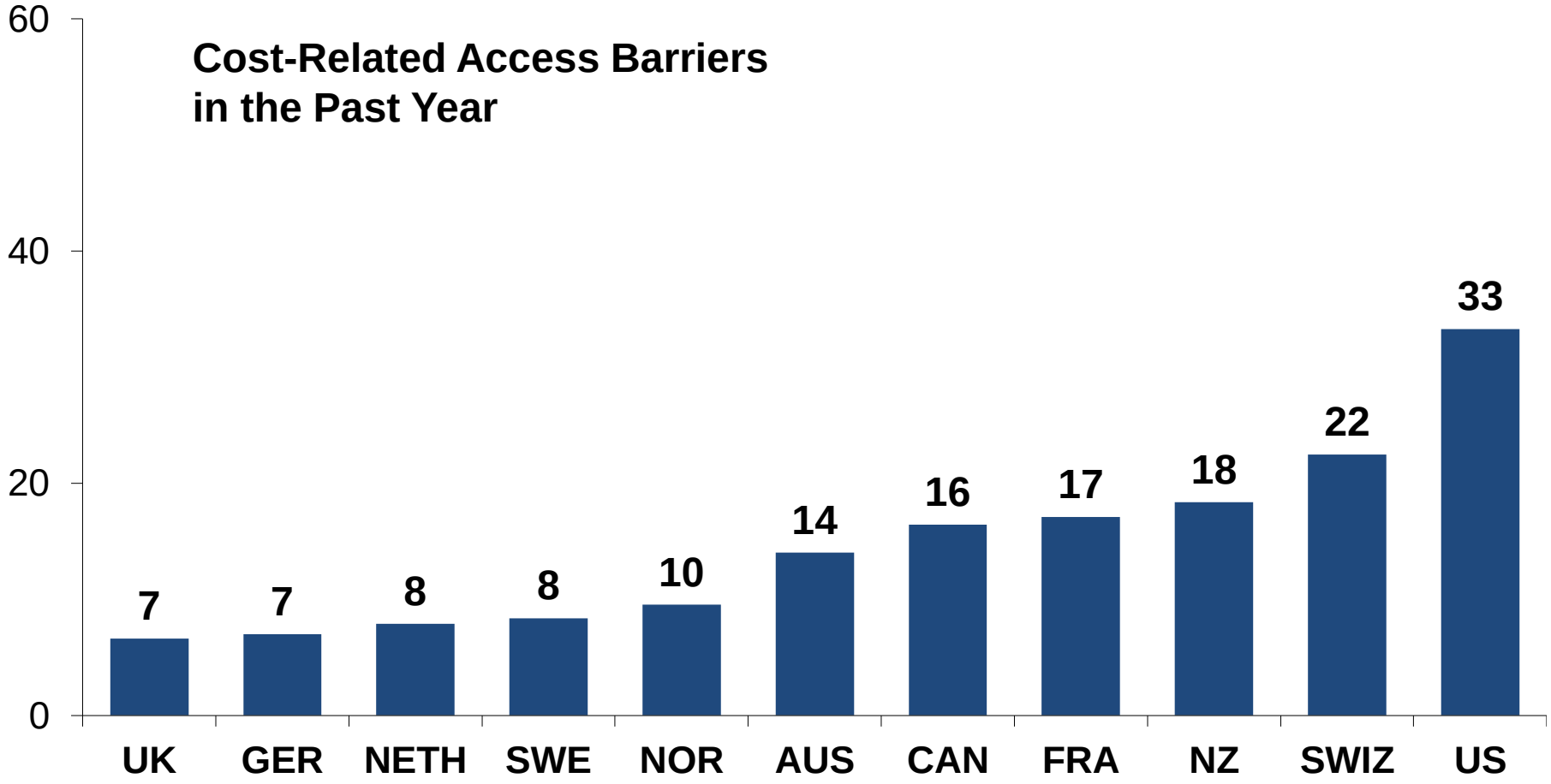
Source: Ecoplan, 2013, with modifications.



Inequities of access can be related to costs (and coverage → see above)



Percent*



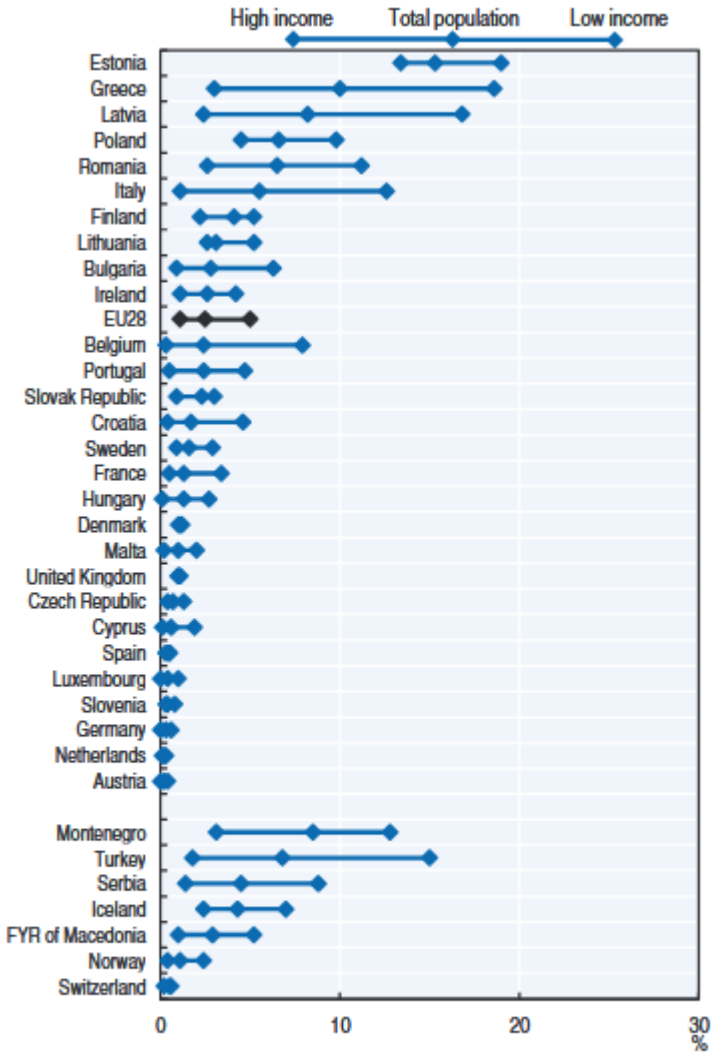
*Had a medical problem but did not visit doctor; skipped medical test, treatment or follow up recommended by doctor; and/or did not fill prescription or skipped doses

Source: 2016 Commonwealth Fund International Health Policy Survey

Unmet need often depends on type of care

→ related to scope of coverage (see above)

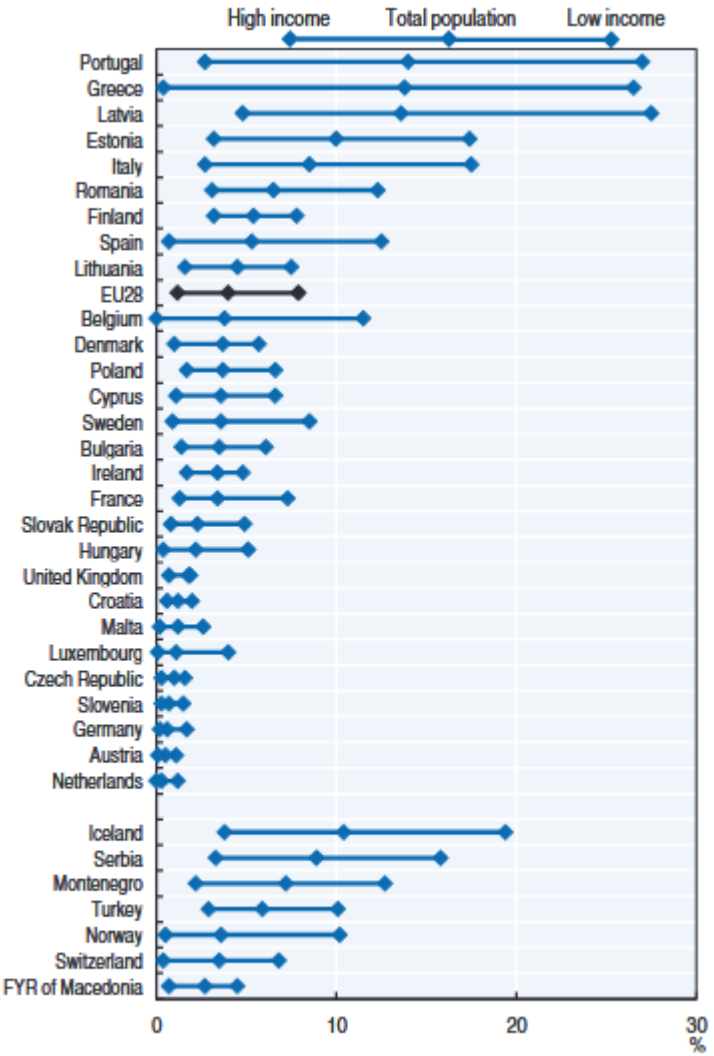
Medical care



Source: Eurostat Database, based on EU-SILC.

StatLink http://dx.doi.org/10.1787/888933836200

Dental care

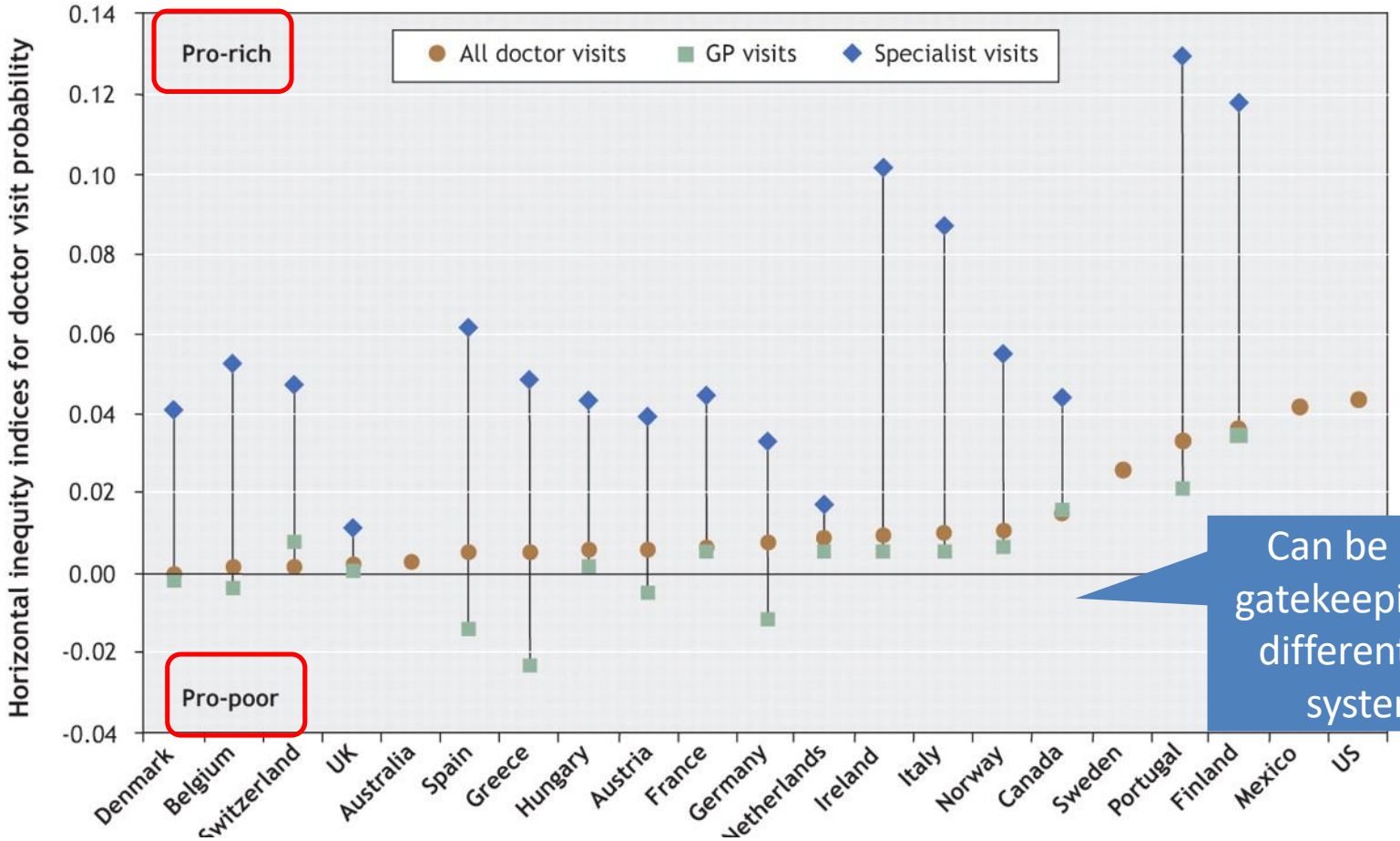


Source: Eurostat Database, based on EU-SILC.

StatLink http://dx.doi.org/10.1787/888933836219

Equity of access: probability of seeing (different kinds of) physicians

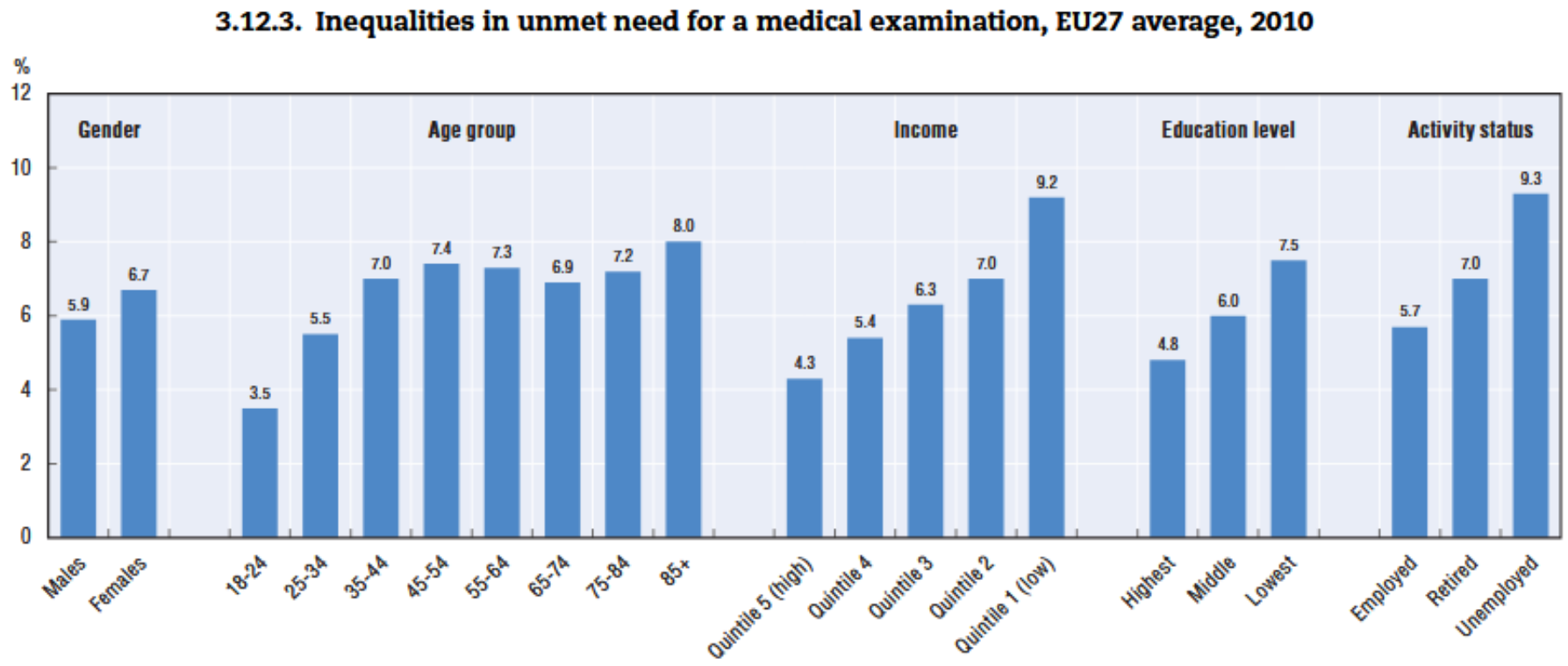
Inequity of physician visit probability by income (standardised for need)



Can be related to gatekeeping policies, different coverage systems, etc.

Equity of access: unmet need

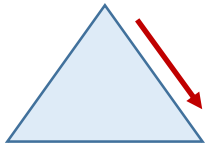
Inequities across multiple dimensions



Source: *Eurostat Statistics Database*, based on EU-SILC.

StatLink http://dx.doi.org/10.1787/888932704779

The inverse care law (early 1970s) – still true today!?



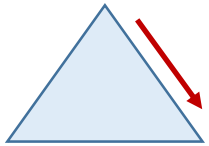
- *[Doctors] tend to gather where the climate is healthy… and where the patients can pay for their services.*

(Ivan Illich)

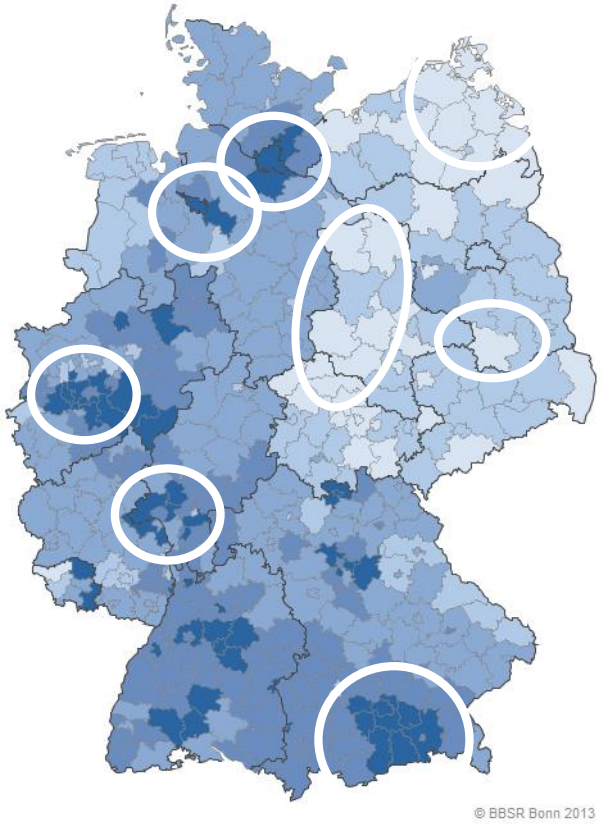
- *[T]he availability of good medical care tends to vary inversely with the need for it in the population served.*

(Julian Tudor Hart)

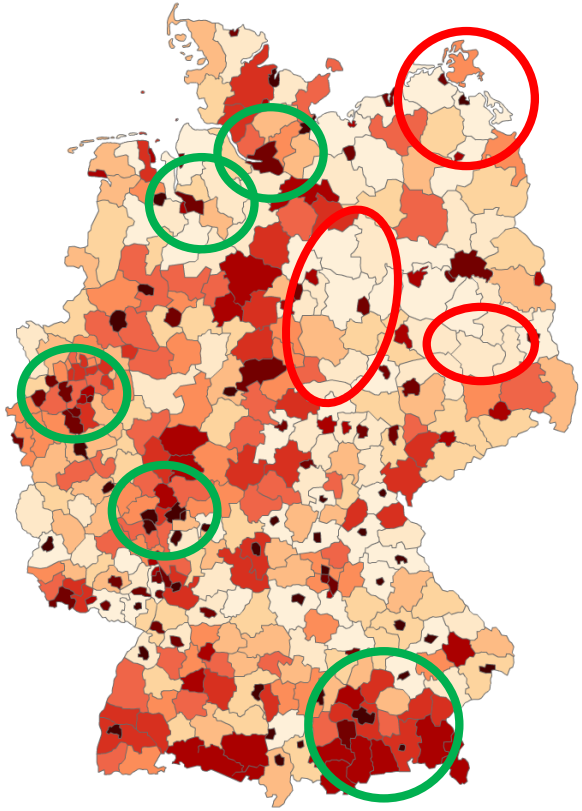
Germany as an example: Areas with higher/lower income → more/fewer physicians



Median household income



Physician supply (PCP) 2010

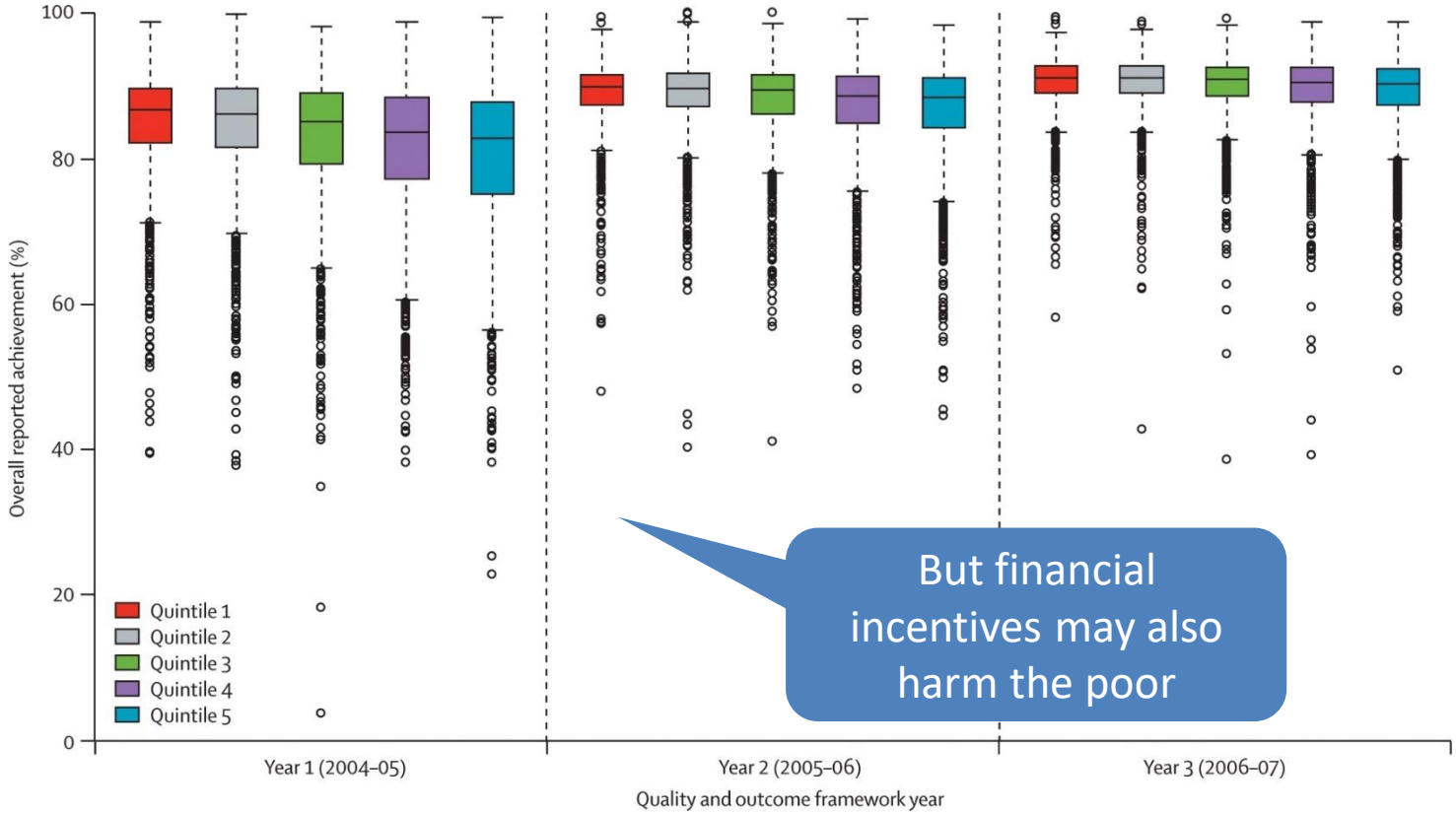


Source: www.versorgungsatlas.de

Financial incentives to improve quality can contribute to reduced inequalities

Quality improvements through “Quality and outcomes framework (QOF)” by deprivation, England 2004/05-2006/07

Figure 1. Distribution of scores for overall reported achievement by deprivation quintile for year 1 (2004–05) to year 3 (2006–07)



Source: Doran T et al. (2008) Effect of financial incentives on inequalities … Lancet 372: 728-736

Conclusions

- Inequities in health systems are related to a range of system factors and policies (besides social determinants), including (amongst others):
  1. Coverage: how well is the population protected from the costs of ill health?
  2. Raising resources: Is the burden of health care financing equitably distributed across the population?
  3. Access: do people have equal access according to need?
- A range of policies is available to reduce inequities by:
  1. Improving coverage, e.g. insuring uninsured, reducing cost-sharing (and protecting the poor), increasing the benefits package
  2. Changing the financing system, e.g. by increasing the role of progressive taxes in financing health care
  3. Improving access, e.g. by assuring more equitable distribution of resources
- Finally, disaggregated data (by income and education) should be much more readily available and be included in research