

HEALTH POLICY AND PUBLIC HEALTH IN SPAIN AND FRANCE: COMPARING EUROPEAN UNION NATIONAL HEALTH SYSTEMS

**Public Health, Comparative Health Policy
and Law in the European Union:
A Transatlantic Dialogue**

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WELFARE STATE

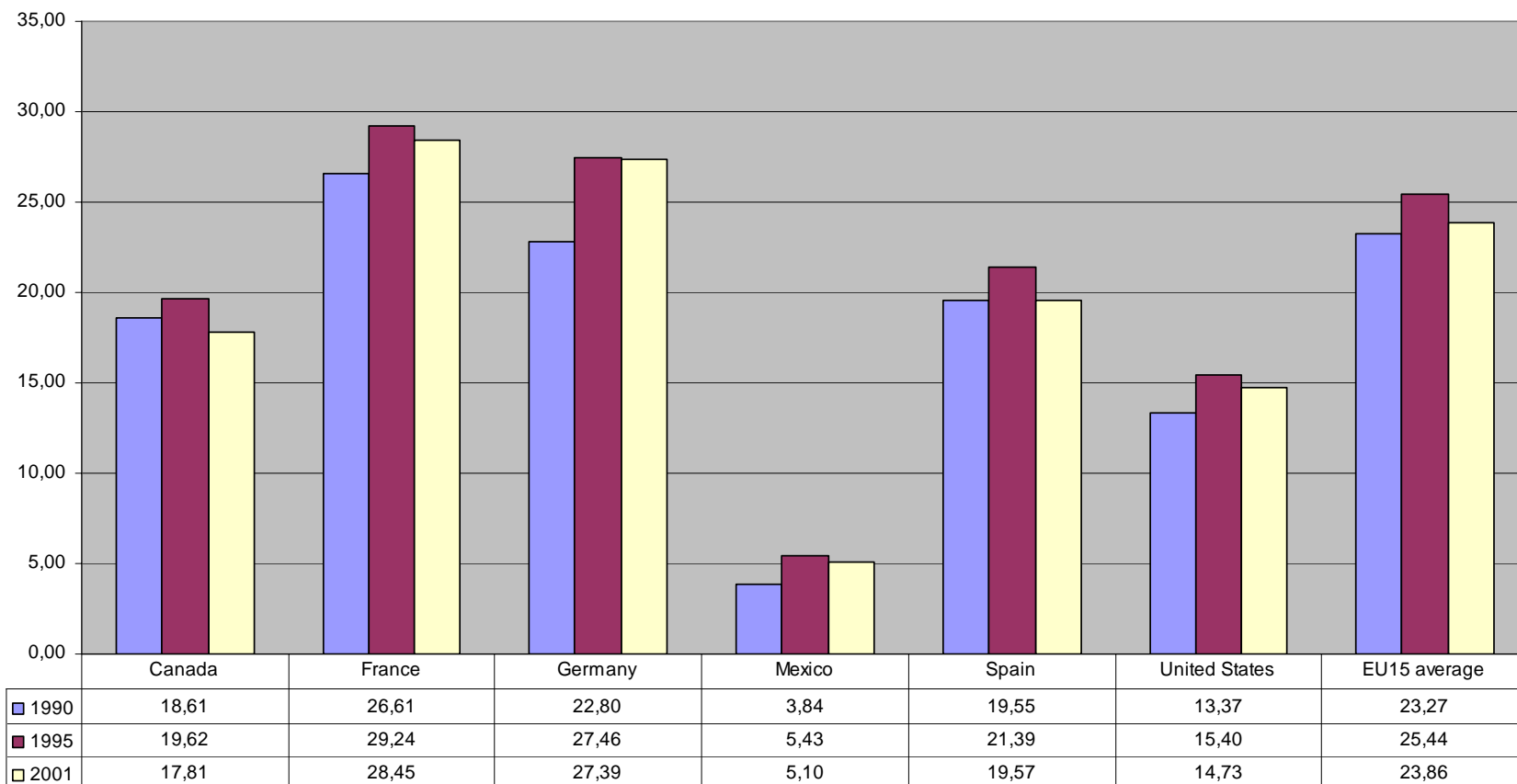
- **“LIBERAL”**
 - MEANS-TESTED ASSISTANCE
 - MODEST UNIVERSAL TRANSFERS
 - (USA, AUSTRALIA)
- **NATIONAL INSURANCE MODELS**
 - **SOCIAL INSURANCE MODEL**
 - RIGHTS ATTACHED TO WAGE-EARNERS
 - UNIVERSAL ACCESS PAID BY STATE
 - PRIVATE INSURANCE & OCCUPATIONAL FRINGE BENEFITS HAVE A MARGINAL ROLE
 - STATE’S REDISTRIBUTIVE ROLE: SMALL
 - (GERMANY, AUSTRIA, FRANCE)
 - **UNIVERSAL MODEL**
 - RIGHTS ATTACHED TO CITIZENSHIP
 - STATE’S REDISTRIBUTIVE EFFECTS: SUBSTANTIAL
 - (SWEDEN, NORWAY, DENMARK)

HEALTH CARE SYSTEMS MODELS

	NATIONAL HEALTH SERVICE	NATIONAL HEALTH INSURANCE	LIBERAL
WELFARE STATE MODEL	UNIVERSAL	SOCIAL INSURANCE	LIBERAL
RIGHT TO SERVICES	YES	YES	NO MEANS-TESTED
FINANCING	TAXES	WAGES CONTRIBUTIONS	INSURANCE POLICIES Direct
COVERAGE	UNIVERSAL	TENDENCY UNIVERSAL	% UNINSURED % UNDERINSURED
BENEFITS	EQUAL	TENDENCY EQUAL	Insurance Policy
USER'S CHOICE	RESTRICTED	PROVIDER	YES
ALLOCATION RESOURCES	ADMINISTRATIVE	CONTRACTS	MARKET
HEALTH CENTERS OWNERSHIP	PUBLIC	PUBLIC/PRIVATE	PRIVATE
CONTROL SYSTEM	ADMINISTRATION	SOCIAL PARTNERS	?

PUBLIC SOCIAL EXPENDITURE

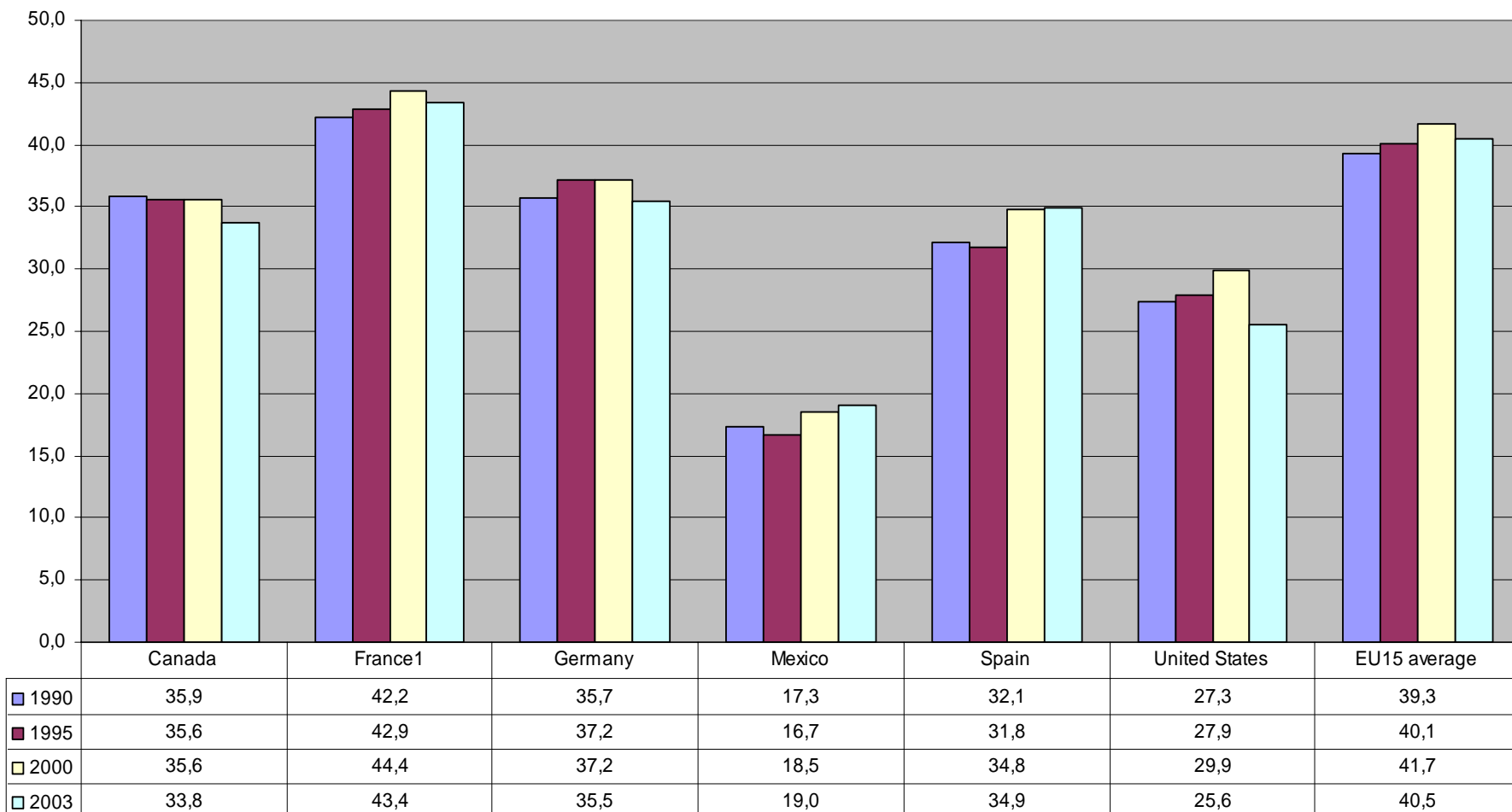
%GDP



Source: OECD Fact Book 2006

TOTAL TAX REVENUE

%GDP



Source: OECD Fact Book 2006



CITIZENS DEMAND

- TAXES
- WAGES CONTRIBUTION
- INSURANCE POLICIES
- OUT OF POCKET PAYMENTS
- FINANCIAL ALLOCATIONS
(Competitive / Cooperative)
- BENEFITS GUARANTEE

Financing/Coverage

Management

- EXPENDITURES
- PURCHASES
- INVESTMENT
- KNOWLEDGE&DEVELOPMENT
- HUMAN RESOURCES POLICIES
- PROFESSIONAL RULES

- EQUITY
- EFFICIENCY
- HEALTH GAIN
- EMPOWERMENT

Results

Organization

- CONTRACTS: Control & Results
- LONGITUDINAL CARE
- QUALITY POLICIES
- CHOICE
- EFFICIENCY CENTERS

SUPPLY

HEALTH CARE SERVICES

SPAIN

- **Health Care System:**
 - Universal, in transition from a Social Security Model
 - Decentralized to the Regional Governments
- **Financing: Taxes**
 - CentralG to guarantee Equity and Solidarity
 - RegionalG to finance Health Care Expenditures
- **Provision:** Mostly public, owned and managed
- **Territorial Organization:**
 - Health Areas: Hospital care
 - Health Zones (less 25.000 inhabitants): Primary Care

SPAIN (2)

- **Access:**
 - Free except Ambulatory Pharmacy
 - Choice of GP inside Health Area
 - No Hospital Choice
- **Health delivery system: Integrated**
 - Primary Health Care: Health Care Centers in a Professional team, Gatekeeper role:
 - Health Promotion
 - Health Prevention
 - Curative care: GPs, Pediatrician, nurses
 - Follow-up patients
 - Hospital Care:
 - Inpatient care
 - Ambulatory specialized care including Ambulatory surgery
 - Emergency care

SPAIN (3)

- **Payment Professionals:** Salary, status similar to civil servants
- **Problems:**
 - Coordination of care
 - Primary-Hospital
 - Health-social care
 - Waiting times for elective surgery
 - Comfort and administrative procedures
 - Staff Satisfaction

FRANCE

- **Health Care System:**
 - Social Security Model
 - UNIVERSAL COVERAGE
 - Centralized:
 - STATE: Regulation, Public Health and “National Expenditure Ceiling”
 - Health Insurance Funds: General (84%), Rural (7,2%), Self-Employees (5%), Others (3,8%)
- **Financing:** Wage Contributions
- **Provision:**
 - Liberal: Ambulatory care
 - Hospitals: Public 25%, Private non profit 35%, for profit 40%

FRANCE (2)

- **Territorial Organization**

- GP's and Ambulatory care Specialists: Freedom of Installation
- Hospital Sector: Regional Strategic Health Plan & Medical Map

- **Access:**

- Direct Payment with reimbursement afterwards (voluntary coinsurance)
- Statutory copayments, exemption is granted (chronic conditions,...)
- Choice of Practitioner
- Choice of Hospital

FRANCE (3)

- **Health Delivery System:**
 - Public Health Services
 - Ambulatory care:
 - Curative care
 - Self-employed professionals: Physicians, Dentists, nurses
 - GP's can play a role of gatekeepers
 - Hospital Care
 - Private: focus on surgical procedures
 - Public: focus on emergency, rehabilitation, long-term and psychiatric care

FRANCE (4)

- **Payment Professionals**
 - Fee for service: Ambulatory care and Private Hospitals
 - Salary: Public hospitals
- **Problems:**
 - High Health Expenditure
 - No financial risk to Insurance Funds
 - Coordination of care
 - Shortage of Professionals

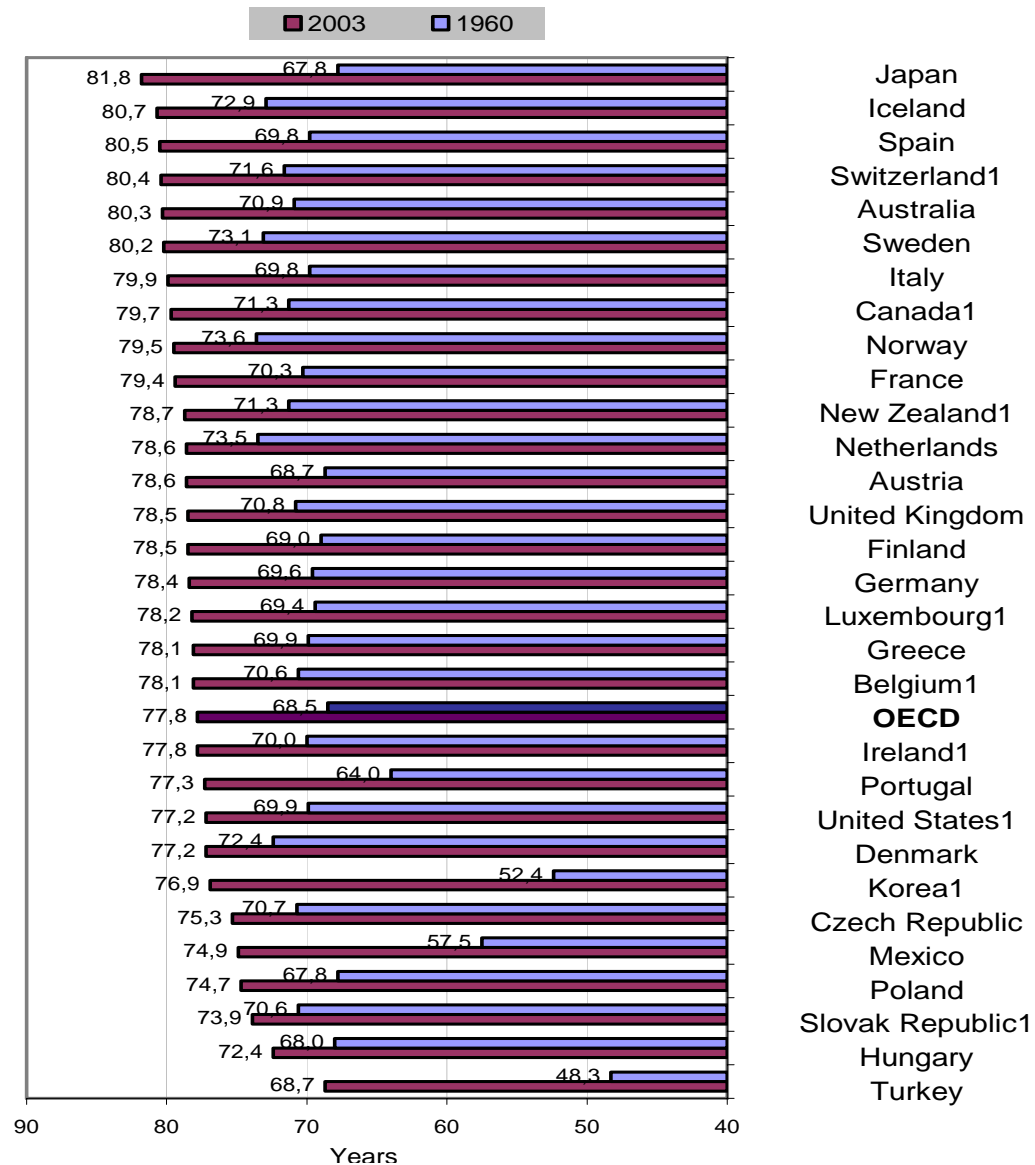
HEALTH STATUS

HEALTH: STATUS

	Life expectancy at birth years			Fertility rate Children per woman 15-49		Infant mortality per 1 000 live births		Tobacco consumption % of population smoking daily		Overweight or obese population	Obese population	
	Women	Men	Total	2003	1993	2003	1993	2003	1993	% total pop. BMI>25 kg/m ²	% total pop. BMI>30 kg/m ²	
	2003									2003	1993	2003
Canada	82,1	77,2	79,7	1,52	1,66	5,4	6,8	17,0	25,5	46,5	14,3	12,1
France	82,9	75,8	79,4	1,89	1,65	3,9	6,5	28,6	29,0	37,5	9,4	6,6
Germany	81,3	75,5	78,4	1,34	1,28	4,2	5,8	24,3	22,9	49,2	12,9	..
Mexico	77,4	72,4	74,9	2,40	3,04	20,1	29,6	26,4	25,1	62,3	24,2	..
Spain	83,7	77,2	80,5	1,29	1,27	4,1	6,7	28,1	32,1	48,4	13,1	8,8
United Kingdom ¹	80,7	76,2	78,5	1,71	1,75	5,3	6,3	26,0	27,0	62,0	23,0	15,0
United States ¹	79,9	74,5	77,2	2,04	2,05	7,0	8,4	17,5	20,4	65,7	30,6	23,3

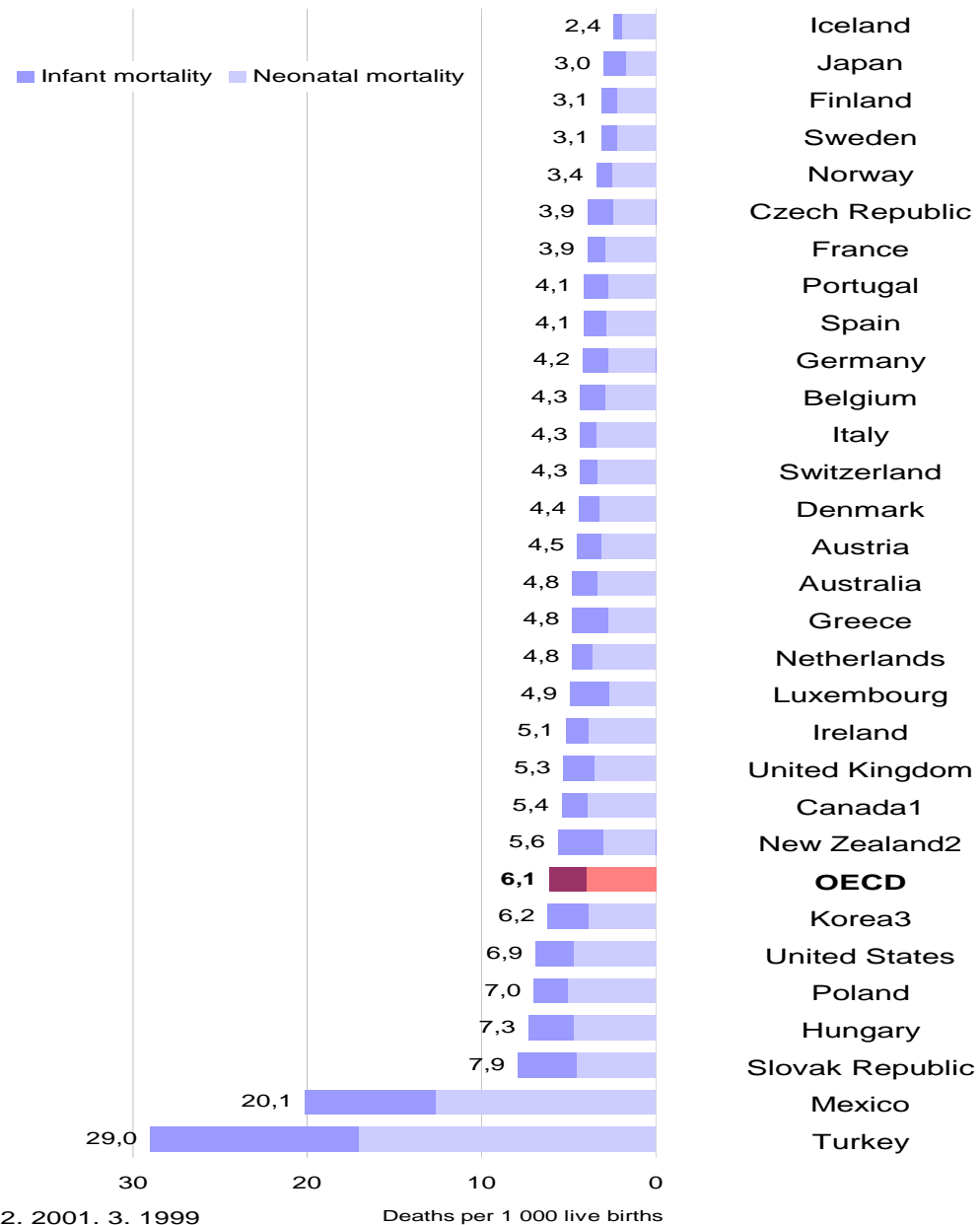
Source: OECD Health Data 2005

LIFE EXPECTANCY AT BIRTH, TOTAL POPULATION



Source: OECD Health Data 2005

INFANT AND NEONATAL MORTALITY RATES, 2003



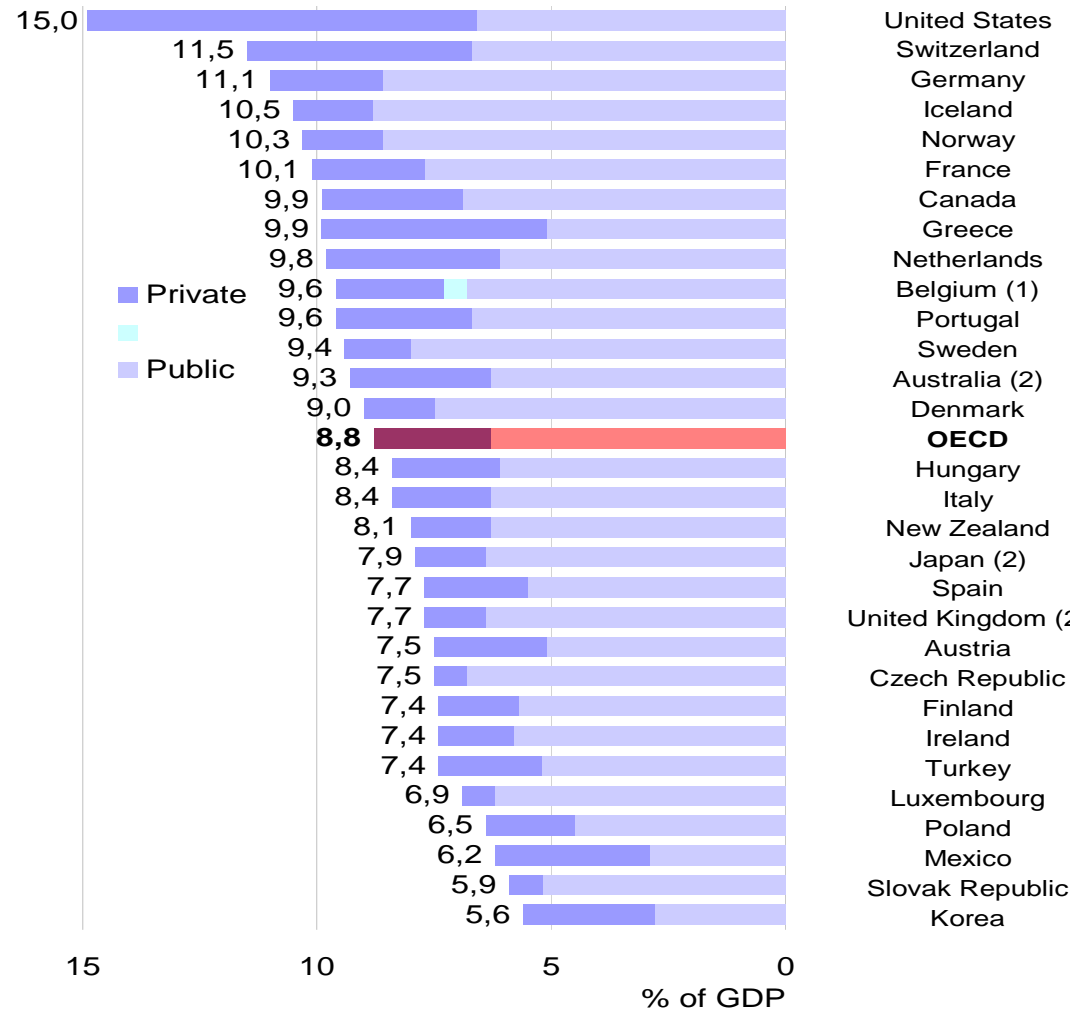
HEALTH SPENDING

HEALTH: SPENDING AND RESOURCES

	Health spending and financing										Acute care beds per 1 000 population		Practising physicians Per 1 000 population		MRI scanner units Per million population	
	Total expenditure as % of GDP		Public expenditure as % of total expenditure on health		Average growth rate	Health expenditure Per capita USD PPP		Pharmaceutical expenditure as % of total expenditure on health		2003	1993	2003	1993	2003	1993	
	2003	1993	2003	1993	1998-2003	2003	1993	2003	1993							
Canada	9,9	9,9	69,9	72,7	4,2	3 003	2 014	16,9	13	3,2	3,6	2,1	2,2	4,5	1,0	
France	10,1	9,4	76,3	76,5	3,5	2 903	1 878	20,9	17,5	3,8	4,9	3,4	3,2	2,8	1,4	
Germany	11,1	9,9	78,2	80,2	1,8	2 996	1 988	14,6	13,2	6,6	7,7	3,4	2,9	6,0	1,4	
Mexico	6,2	5,8	46,4	43,2	4	583	397	21,4	..	1,0	..	1,5	1,4	0,2	..	
Spain	7,7	7,5	71,2	76,6	2,6	1 835	1 089	21,8	19,2	3,1	3,5	3,2	2,5	7,3	2,1	
United Kingdom	7,7	6,9	83,4	85,1	5,7	2 231	1 232	15,8	14,8	3,7	3,9	2,2	1,7	5,2	..	
United States ²	15	13,2	44,4	43,1	4,6	5 635	3 357	12,9	8,6	2,8	3,5	2,3	1,9	8,6	5,9	

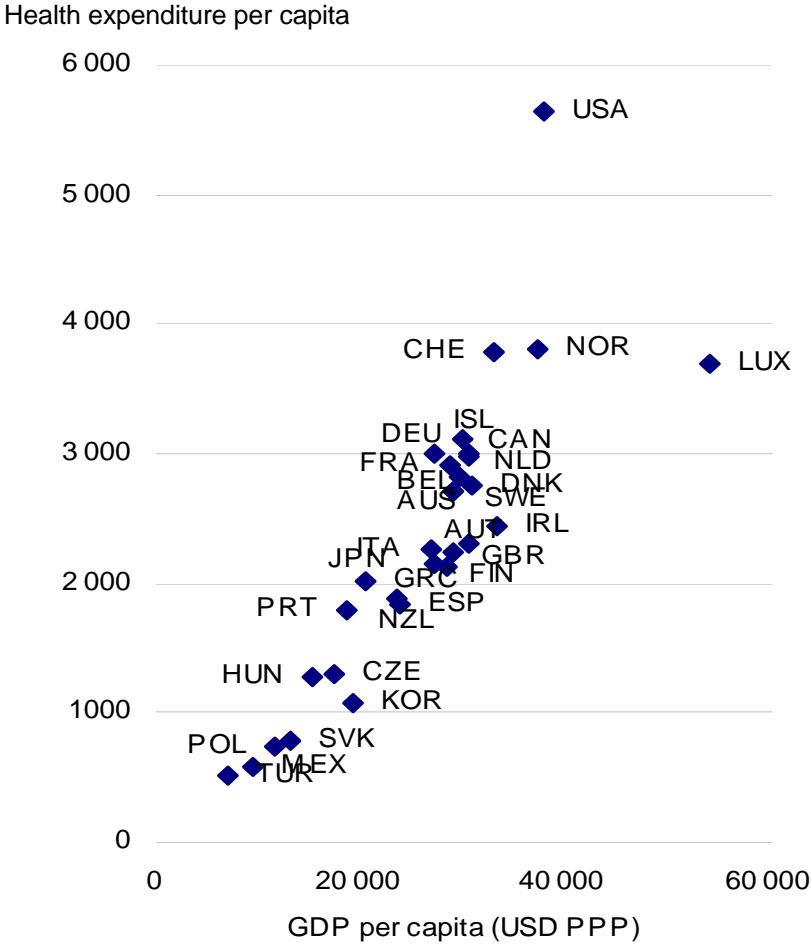
Source: OECD Health Data 2005

HEALTH EXPENDITURE AS SHARE OF GDP, 2003



1. Public/private data refers to current health expenditure. 2. 2002.

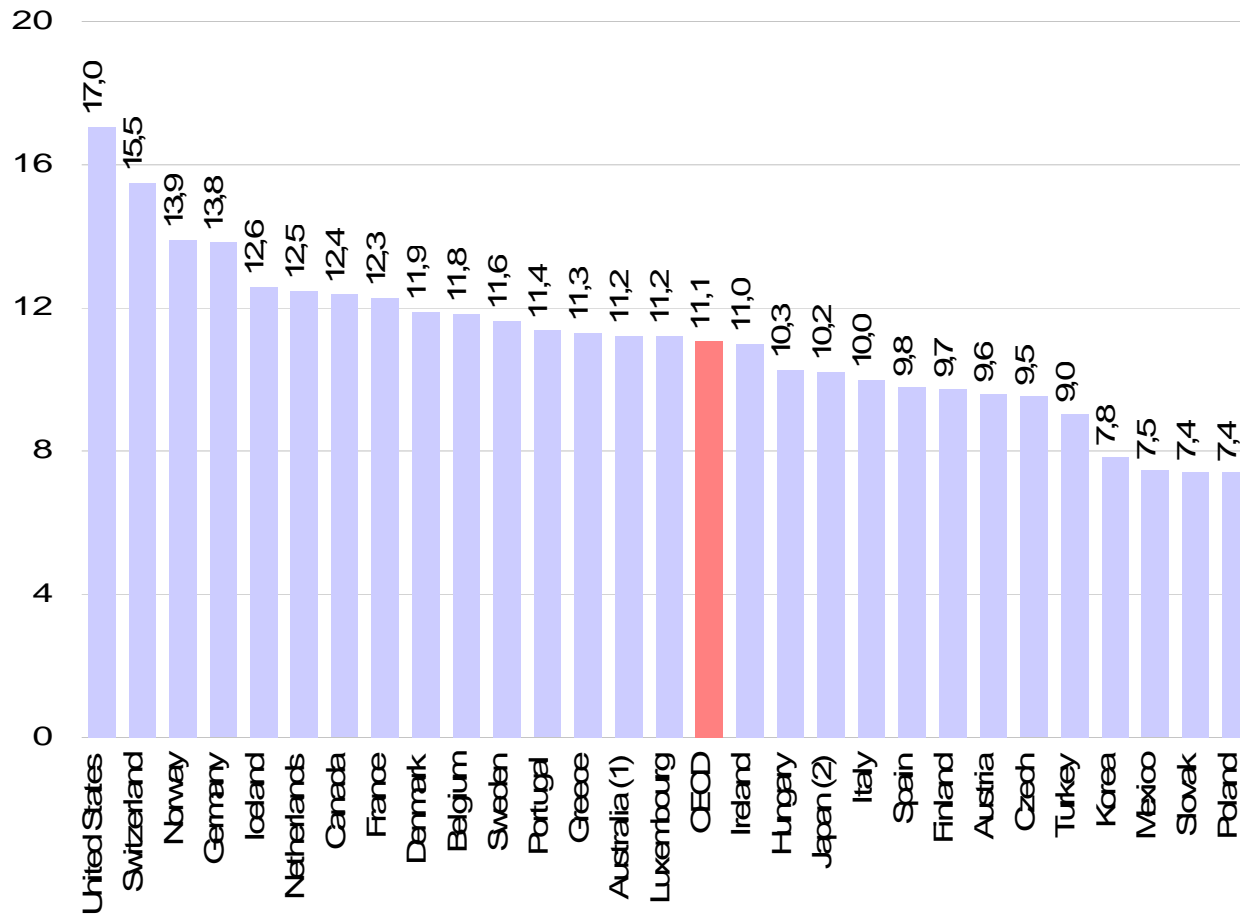
HEALTH EXPENDITURE AND GDP PER CAPITA, 2003



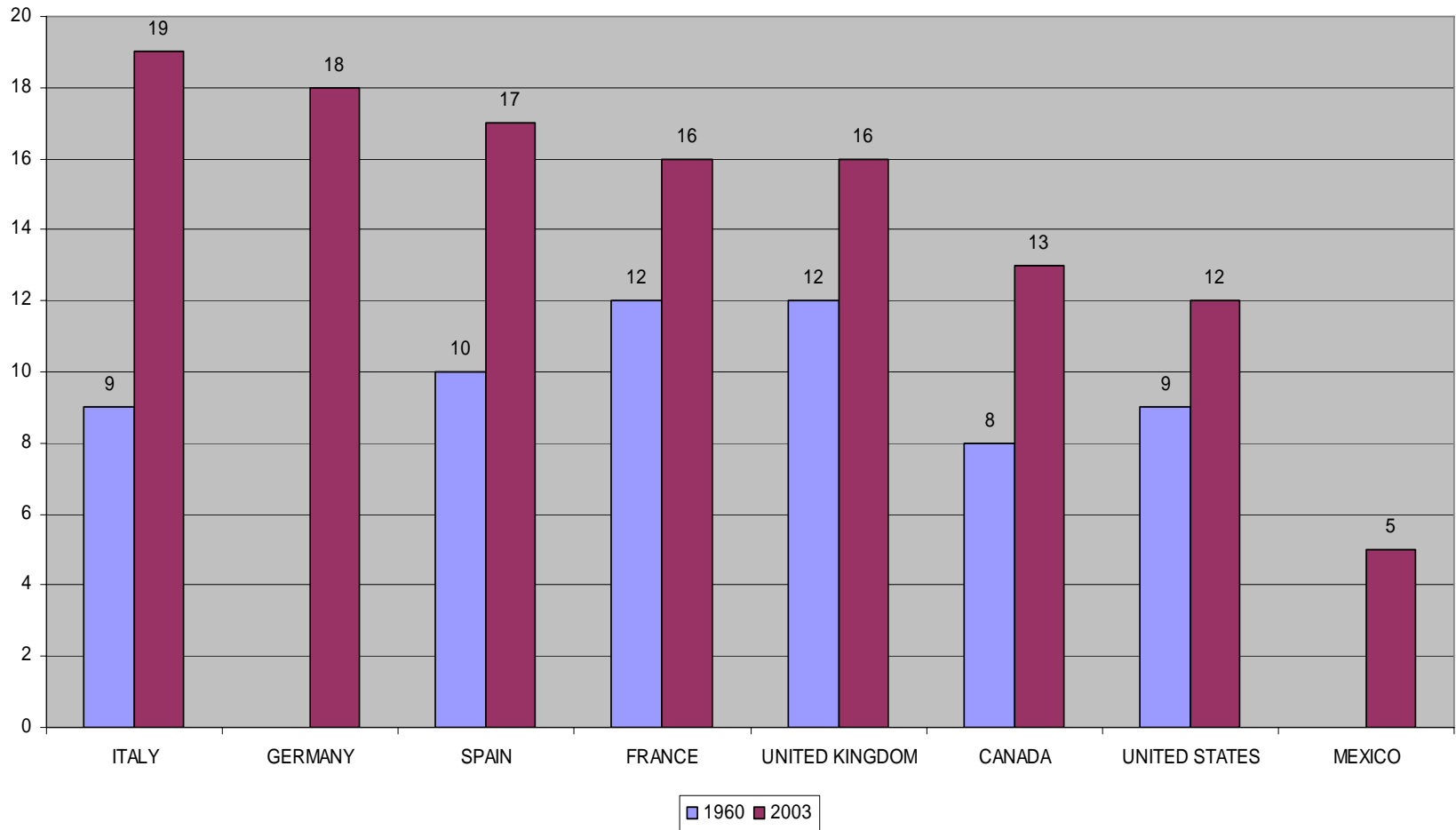
Source: OECD Health Data 2005

CURRENT HEALTH EXPENDITURE, 2003

Share of final consumption



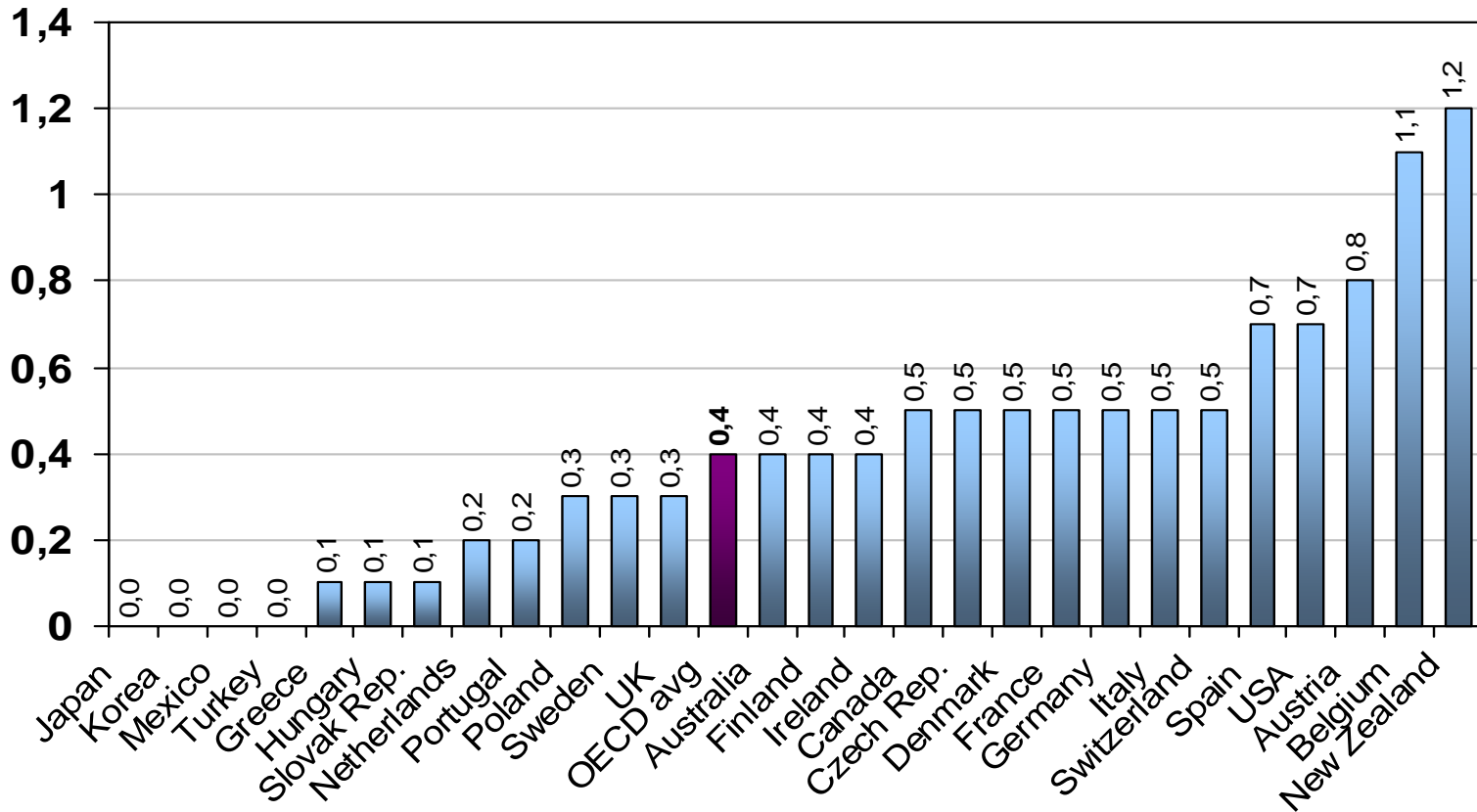
SHARE OF POPULATION AGED 65 AND OVER



Source: OECD Health Data 2005

Heart transplants 2003

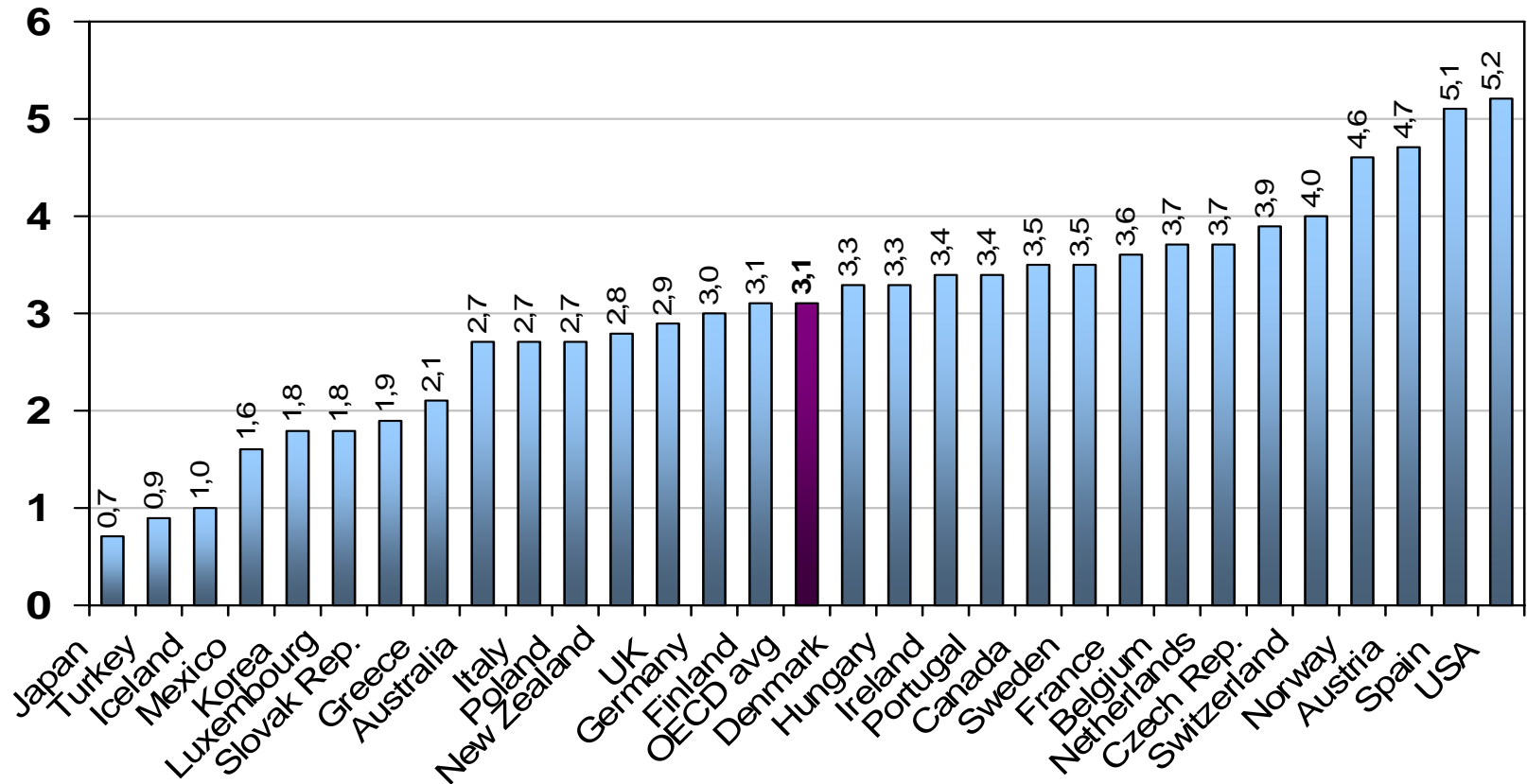
Number of transplants per 100 000 population



Source: OECD Health Data 2005

Kidney transplants 2003

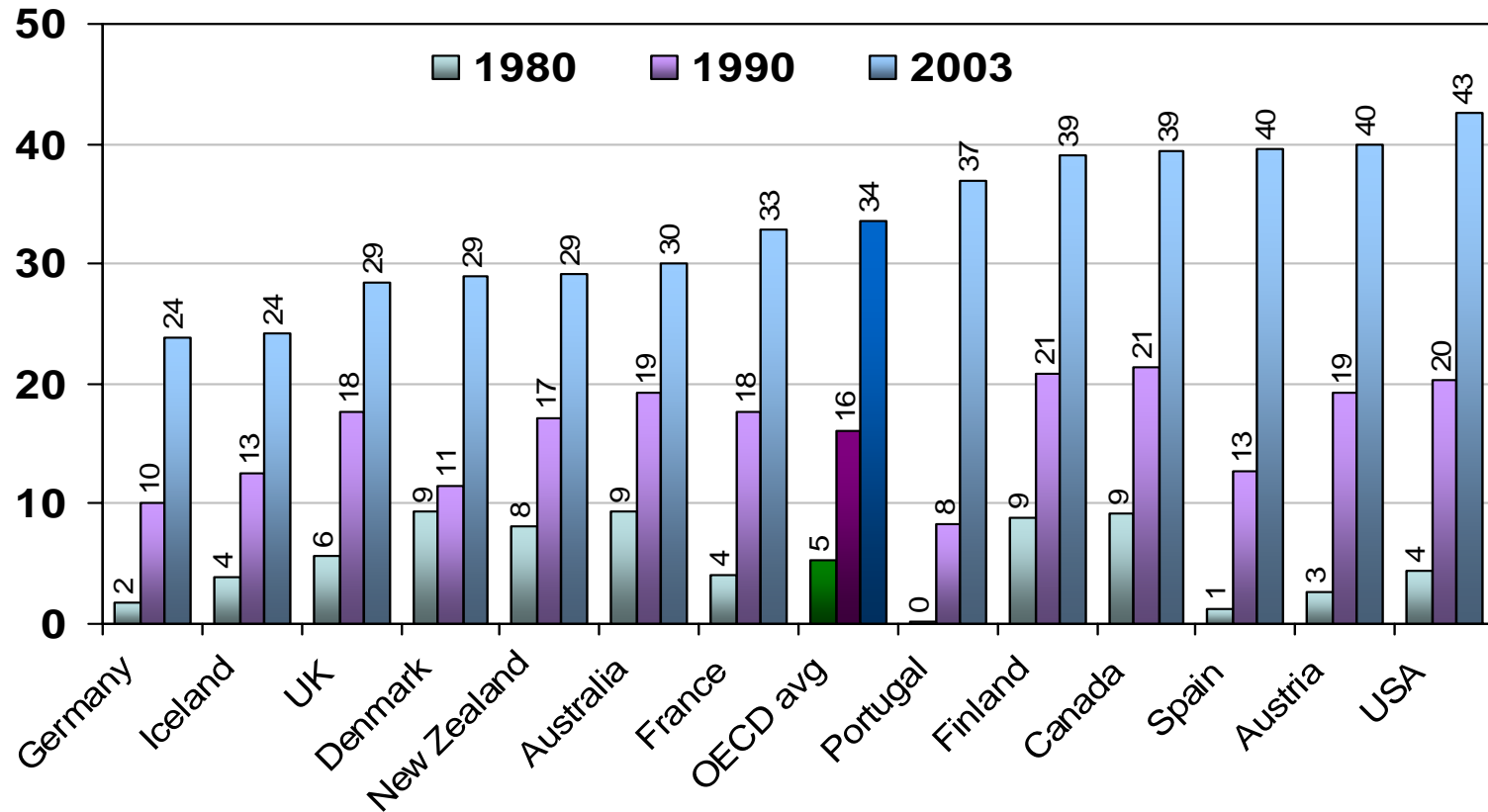
Number of transplants per 100 000 population



Source: OECD Health Data 2005

Functioning kidney transplants, 1980, 1990 and 2003

Number of patients per 100 000 population



EUROPEAN SOCIAL MODEL VALUES

- SOLIDARITY AND EQUITY
- REJECTIONS OF ALL FORMS OF DISCRIMINATION
- GENDER EQUALITY
- UNIVERSAL ACCESS TO EDUCATION AND HEALTH CARE OF GOOD QUALITY
- EMPLOYMENT, PROTECTION AGAINST UNEMPLOYMENT
- PENSIONS

EUROPEAN SOCIAL MODEL CHARACTERISTICS

- EUROPE IS DEFINED BY ITS DIVERSITY
- THE EUROPEAN SOCIAL MODEL IS NOT MONOLITHIC
- THERE ARE DIFFERENT MODELS AND POLICY CHOICES TO DEVELOP THE COMMON VALUES
- SUBSIDIARITY: POLICIES MUST BE DESIGNED AND IMPLEMENTED AT THE LEVEL WHICH IS THE MOST EFFECTIVE
- EMPLOYMENT AND SOCIAL POLICIES ARE ESSENTIALLY OF THE DOMAIN AND COMPETENCES OF MEMBER STATES
- SOCIAL POLICY IS SEEN AS A PRODUCTIVE FACTOR IN THE MOST DYNAMIC COUNTRIES

EU HEALTH CARE: LEGAL FRAMEWORK

- **PRINCIPLE OF TERRITORIALITY AND SUBSIDIARITY:** The responsibility lies with the Member States
- **SOCIAL SECURITY COORDINATION:** a mechanism was set up in 1958 to ensure workers mobility. No discrimination. Recognition of Social Security benefits elsewhere in the Union
- **EU'S ROLE IS MAINLY SUPPORTING, COORDINATING AND COMPLEMENTARY**
- **EUROPEAN COURT OF JUSTICE:** to make compatible the national systems and the free movement. Only barrier to hospital access and only in case of similar treatment at home

WHO MIGHT SEEK HEALTH CARE ABROAD?

- **TEMPORARY VISITORS:** E-111 scheme -enables to obtain care abroad in the event of an emergency- / health care insurance card
 - TOURISM: Young, Active Life
 - BUSINESS TRAVEL
- **LONG-TERM RESIDENTS ABROAD:** Health care entitlement is transferred to the new residence country
 - TOURISM: Retired, social care
 - WORK
- **“EUROPEAN CONMUTERS”:** There is not yet mechanisms to link two health care entitlements
- **PEOPLE USING FACILITIES LOCATED IN BORDER REGIONS:** Hospital of Puigcerda (Spanish-French Border); double-access eligibility of frontier workers
- **PEOPLE SENT ABROAD BY THEIR OWN HEALTH FUNDER:** E-112 scheme, Highly-specialized facilities, pre-authorization required