WELFARE STATES AND PUBLIC HEALTH: AN INTERNATIONAL COMPARISON

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ECLAC,Santiago de Chile, Chile,November 3, 2008

Structure of presentation

1. Health care regimes in Europe

2. Financing of health care expenditure in the OECD: Comparing the European Union to Mexico and the USA

3. Focusing on outcomes: Welfare regime matters

4. European health care policy: the open method of coordination

5. Attitudes toward health care in Europe

1. Health care regimes in Europe

Usually, the social sciences see welfare states clustering around a small number of regimes. In the European case we identify five regime clusters:

- Nordic/Scandinavian/Social Democratic
- Continental/Conservative/Corporate
- Atlantic/Liberal
- Mediterranean/Catholic
- East-European

However, when it comes to health care, the EU-countries and OECD-countries cluster somewhat differently

If we cluster the OECD-countries according to "publicness" of health care, we get the following:

I An *American* cluster: Mexico and USA (very low public share)

II Belgium & NL, plus *Greece* and Korea (low public share)

III Australia, NZ & Canada, plus *Continental Europe* (median public share)

IV *Scandinavia* & UK plus Czech and Slovak R (High public share)

2. Financing of health care expenditure in the OECD: Comparing the European Union to Mexico and the USA

This section briefly looks at

a) Total health care expenditure as share of GDP in OECD (relative financial weight)
b) Total health care expenditure per capita (absolute financial weight)
c) Share of public expenditure of total health care expenditure (degree of “publicness”)

Distribution of OECD countries according to share of public expenditure of total health care expenditure in 2006 (EU-countries in italics)

Very low public share, <50 pct.: Mexico, USA

Low public share, 50 – 64 pct.: *Belgium, Greece*,Korea, *NL*, Switzerland

Medium public share, 65 – 80 pct.: Australia, Canada, *Finland, France, Germany, Hungary, Ireland, Italy*, Japan, NZ, *Poland, Portugal, Spain,* Turkey

High public share, > 80 pct.:*Czech R, Denmark*, Iceland, *Luxembourg, Norway, Slovak R, Sweden, UK*

Distribution of OECD countries according to health care expenditure as share of GDP in percent 2006 (EU-countries in italics)

Lower spenders

6 pct: Korea, *Poland*, Turkey

7 pct: *Czech R, Luxembourg, Slovak R*, Mexico

8 pct: *Finland, Hungary, Ireland*, Japan, *Spain, UK*

Middle spenders

9 pct: Australia, *Greece*, Iceland, *Italy*, NL, NZ, Norway, *Sweden*

10 pct: *Austria, Belgium, Denmark, Portugal*

11 pct: *France*, *Germany*, Switzerland

High spender

15 pct: USA

Relatively speaking, all EU-countries are low or middle spenders, while the USA stands out as a big spender

Distribution of OECD countries according to health care expenditure per capita in US $ PPP in 2006 (EU-countries in italics)

Low spenders –

< 1.0 k-$: Mexico, *Poland*; Turkey

1.0 – 1.9 k-$: *Czech R, Hungary*, Korea, *Slovak R*

Middle spenders –

2.0 – 2.9 k-$: *Finland, Greece, Italy*, NZ, *Portugal, Spain, UK*;

3.0 – 3.9 k-$: Australia, *Austria, Belgium*, Canada, *Denmark, France, Germany*, Iceland, *Ireland, NL, Sweden*

High spenders –

4.0 – 4.6 k-$: *Luxembourg*, Norway Switzerland;

> 6.7 k-$: USA

In absolute terms USA is still a big spender, but is now joined by Luxembourg, Norway and Switzerland

While the rest of the EU-countries remain low or median spenders

Hence the correlation seams to indicate that:

the higher the public share of health expenditure

the lower overall expenditure

From a snapshot situation – 2006 – to an historical trend – 1973 - 2006

Relative expenditure on health care has expanded over time, but most so in the USA:

Total Health Care Expenditure as Share of GDP 1973 - 2006

	1973	1980	1990	2000	2006
Denmark	7,8	8,9	8,3	8,3	9,5
France	6,0	7,0	8,4	9,6	11,1
Germany	7,2	8,4	8,3	10,3	10,6
UK	4,6	5,6	6,0	7,2	8,4
USA	7,2	8,7	11,9	13,2	15,3
Mexico	..	..	4,8	5,6	6,6

Relatively speaking health care expenditure increased

22 pct. In Denmark

47 pct. In Germany

85 pct. In France and the UK, and

113 pct. In the USA

From 1973 to 2006

Total Health Care Expenditure per capita in US PPP $ 1973 - 2006

	1973	1980	1990	2000	2006
Denmark	417	897	1.544	2.379	3.349
France	369	669	1.449	2.421	3.449
Germany	410	971	1.769	2.671	3.371
UK	191	470	965	1.847	2.760
USA	426	1.065	2.738	4.570	6.714
Mexico	..	..	296	508	794

In absolute terms total health care expenditure increased:

703 pct. In Denmark

835 pct. In France

722 pct. In Germany

1.345 pct. In the UK, and

1.476 pct. In the USA

From 1973 to 2006

Christian Hagist & Laurence Kotlikoff (2005) 'Who's going broke? Comparing Healthcare Costs in Ten OECD Countries.' Cambridge, Massachusetts: National Bureau of Economic Research: *Working Paper 11833*.

"Growth since 1970 in aggregate healthcare spending by our ten OECD governments reflects first and foremost growth in benefit levels… Indeed, three quarters of overall healthcare expenditure growth and virtually all of growth in healthcare expenditure per capita reflect growth in benefit levels. Although OECD countries are projected to age dramatically, growth in benefit levels, if it continues apace, will remain the major determinant of overall healthcare spending growth…

The fiscal fallout is likely to be particularly severe for the United States. Like Norway and Spain, its benefit growth has been extremely high, but unlike Norway, Spain and other OECD countries, the U.S. appears to lack both the institutional mechanism and the political will to control its healthcare spending”

(Manfred Huber & Eva Orosz (2003) 'Health Expenditure Trends in OECD Countries, 1990 – 2001.' *Health Care Financing Review*, Vol. 25, No. 1: 1-22.)

"Despite a general convergence of countries' experience over the past decade, the U.S. remains significantly different"

Share of public health care expenditure against total expenditure 1973 – 2006 in percent

	1973	1980	1990	2000	2006
Denmark	83,8	87,8	82,7	82,4	82,9
France	78,0	80,1	76,6	78,3	79,7
Germany	77,0	78,7	76,2	79,7	76,9
UK	87,6	89,6	83,6	80,9	83,4
USA	37,9	40,8	39,4	43,7	45,8
Mexico	..	..	40,4	46,6	44,2

In Europe, the share of public health care expenditure has been very stable over time around 80 pct.,

while it has increased some in the USA from 38 to 45 pct.

With some caution it can be concluded that

health care expenditure increase the most the more private it is; and that

health care expenditure is the highest in the most private regime

3. Focusing on outcomes: Welfare regime matters

In a special report on the political and social context of health, Vicente Navarro et al. show how societies' socioeconomic, political, and cultural variables are the most important factors in explaining their populations' levels of health (2003: 743).

For the entire period 1950 – 1998 for the majority of the OECD countries, there is a clear negative relationship between social inequalities and *infant mortality* and life *expectancy* (2003: 744).

The main findings are:

(1) Countries and regions with better distributed economic resources (such as income and employment) and social resources (such as health care, education, and family supportive services) have better health indicators, and

(2) This is the source of the superior health performance of European countries over the United States.

(3) Pro-redistribution policies improve the health of populations not only through their impact on reducing poverty: they improve the health of the most impoverished and of the entire population.

(4) Universal pro-redistribution policies are more effective in improving populations' levels of health than are programs specifically targeted at reducing poverty.

(5) Politics matters: the length of time in government of pro-redistribution parties is, in general, positively related to levels of health in OECD countries.

Vicente Navarro, Margaret Whitehead, Tim Doran, Bo Burström, Uwe Helmert, Giuseppe Costa, and Carme Borrell (2003). 'Summary and Conclusions of the Study.' *International Journal of Health Services* Vol. 33, No. 4: 743-749.

Haejoo Chung & Carles Muntaner (2006) 'Political and welfare state determinants of infant and child health indicators: an analysis of wealthy countries.' *Social Science and Medicine* Vol. 63, No. 3: 829-842.

Variables: low birth weight levels; infant mortality rates; under-five mortality rate

Main result:

Our investigation suggests that strong political will that advocates for more egalitarian welfare policies, including public medical services, is important in maintaining and improving the nation's health

This investigation on the macro-social determinants of population health in wealthy countries found substantial variation attributable to political and welfare state factors.

Thus it seems parsimonious to suggest that economic development alone does not create a healthy society. Political will that serves to implement and institutionalize welfare systems, including public medical services, appears to contribute as well to the health and well-being of its citizens.

Terje Eikemo et al. (2008) 'Welfare state regimes and self-perceived health in Europe: a multilevel analysis.' *Social Science and Medicine* Vol. 66, No. : 2281-2295

Welfare regime characteristics are important factors in explaining the variation of self-perceived health between different European populations, as they explain about half of the between-country variation in health. The main finding is that

People in countries with Scandinavian and Anglo-Saxon welfare regimes were observed to have better self-perceived general health in comparison to Southern and East European welfare regimes

The literature suggests that it is unlikely that there is one particular facet of the Scandinavian welfare model that leads to better health outcome, rather it is the interaction and combination of a variety of policies (e.g. universal access to welfare services, higher replacement rates, higher levels of employment amongst both men and women), over a sustained period of time which has led to a health enhancing reduction in material and social inequality (p. 2090).

Terje Eikemo et al. (2008). ‘Health inequalities according to educational level in different welfare regimes: a comparison of 23 European countries.’ *Sociology of Health and Illness* Vol. 30, No. 4: 565-582.

> We observed that the countries with the lowest average years of education, namely the Southern and Eastern European countries, have the largest overall prevalence rates of ill-health…, whilst the Anglo-Saxon countries have the lowest prevalence rates. This is in keeping with most previous research into variations in population health (such as infant mortality or total mortality) by welfare regimes (p. 577).

4. European health care policy: the open method of coordination

What is the Open Method of Coordination (OMC)?

- Agreeing on a common set of objectives
- Leaving it to the Member States to apply whatever appropriate means
- Evaluating correspondence between goals and means

Method of sanction: Shaming and blaming

Recommendation July 1992 on Convergence:

2. Admit all citizens access to health care institutions irrespective of their ability to pay

Accessible, high-quality and sustainable healthcare and long-term care by ensuring:

a) access for all to adequate health and long-term care and

that the need for care does not lead to poverty and financial dependency;

and that inequities in access to care and in health outcomes are addressed;

b) quality in health and long-term care and by adapting care, including developing preventive care, to the changing needs and preferences of society and individuals,

notably by developing quality standards reflecting best international practice and by strengthening the responsibility of health professionals and of patients and care recipients;

c) that adequate and high quality health and long-term care remains affordable and financially sustainable by promoting a rational use of resources,

notably through appropriate incentives for users and providers, good governance and coordination between care systems and public and private institutions.

Long-term sustainability and quality require the promotion of healthy and active life styles and good human resources for the care sector.

5. Attitudes toward health care in Europe

Frequently the EU populations are surveyed with regard to opinion on various issues. In summer 2007 a representative sample was interviewed on health and long-term care

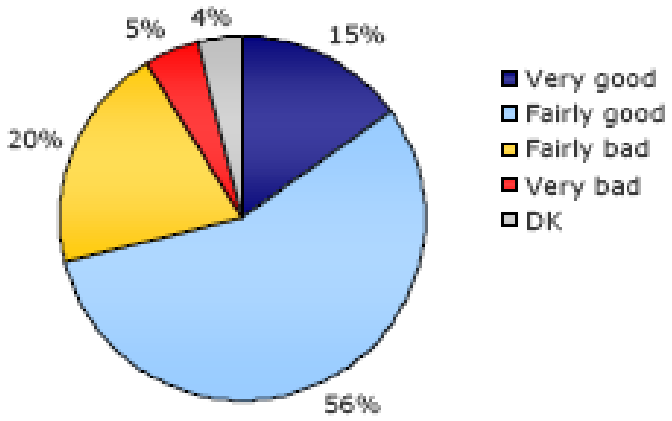
EU citizens were asked to rate

hospitals, dental care, medical or surgical specialists, family doctors, care for dependent people, and nursing homes

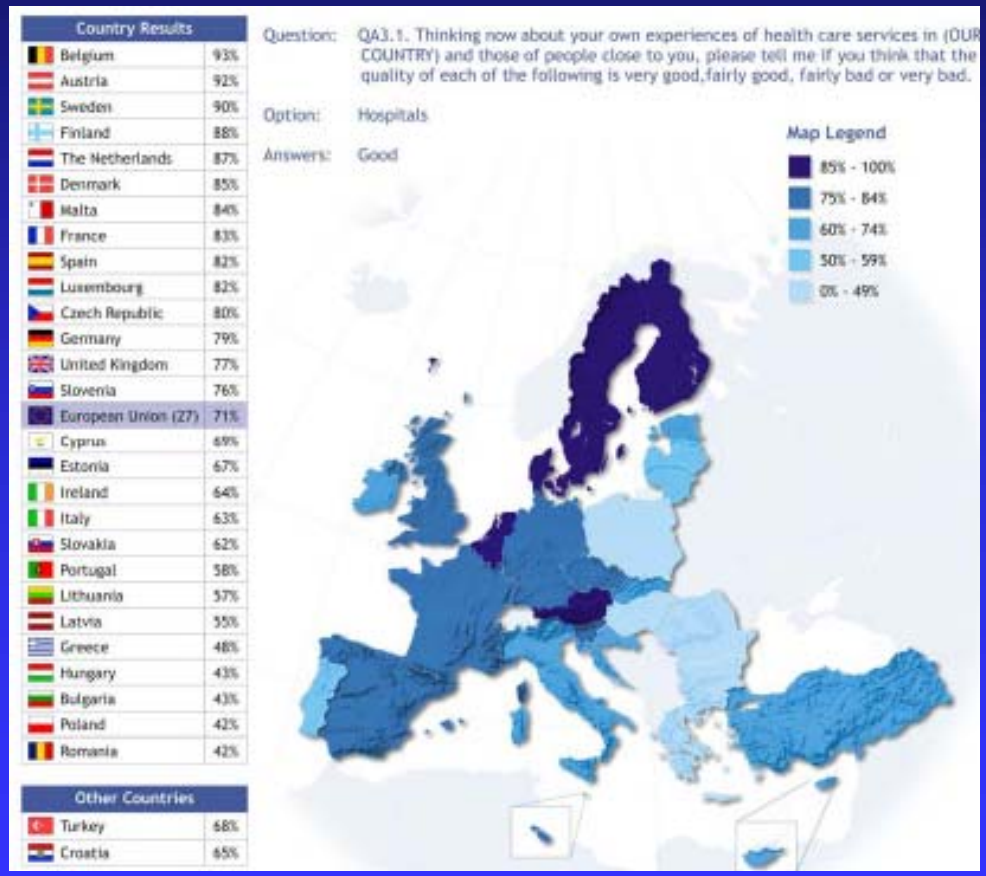
Quality of *hospital care*: EU average

Overall, over seven out of ten European Union citizens rate *the quality of the hospitals* in their country as very (15%) or fairly good (56%). However, a quarter of the European public believes the quality of hospitals is fairly bad (20%) or even very bad (5%)[13].

QA3.1 ...please tell me if you think that the quality of each of the following is very good,fairly good, fairly bad or very bad.
Hospitals - % EU27



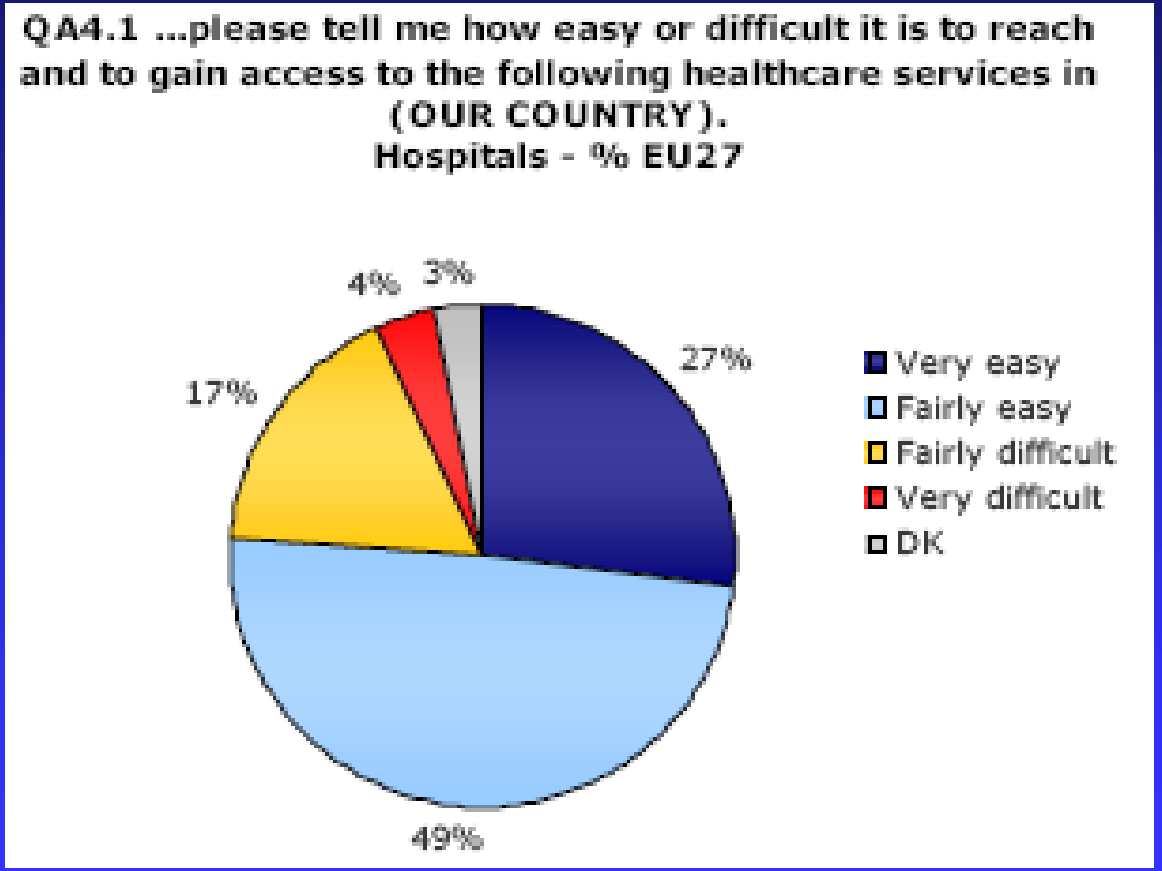
Quality of *hospital care*: EU 27



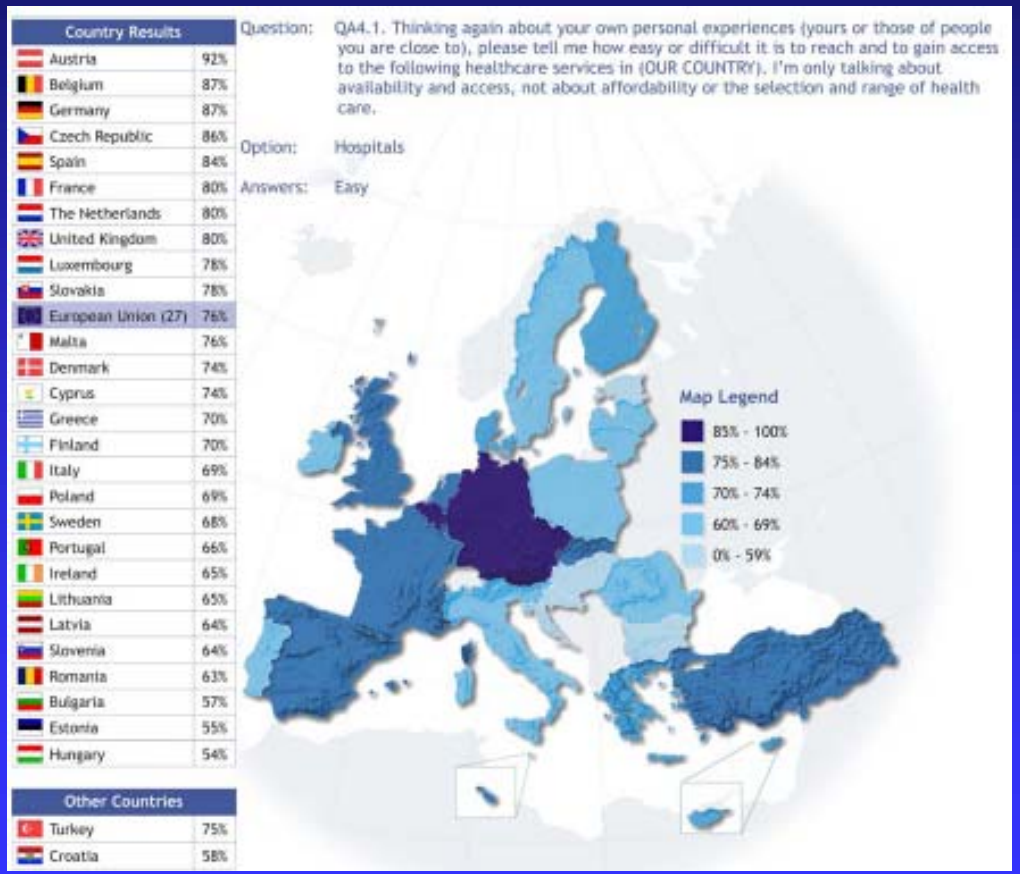
Country Results	
Belgium	93%
Austria	92%
Sweden	90%
Finland	88%
The Netherlands	87%
Denmark	85%
Malta	84%
France	83%
Spain	82%
Luxembourg	82%
Czech Republic	80%
Germany	79%
United Kingdom	77%
Slovenia	76%
European Union (27)	71%
Cyprus	69%
Estonia	67%
Ireland	64%
Italy	63%
Slovakia	62%
Portugal	58%
Lithuania	57%
Latvia	55%
Greece	48%
Hungary	43%
Bulgaria	43%
Poland	42%
Romania	42%

Other Countries	
Turkey	68%
Croatia	65%

Access to *hospital care*: EU average

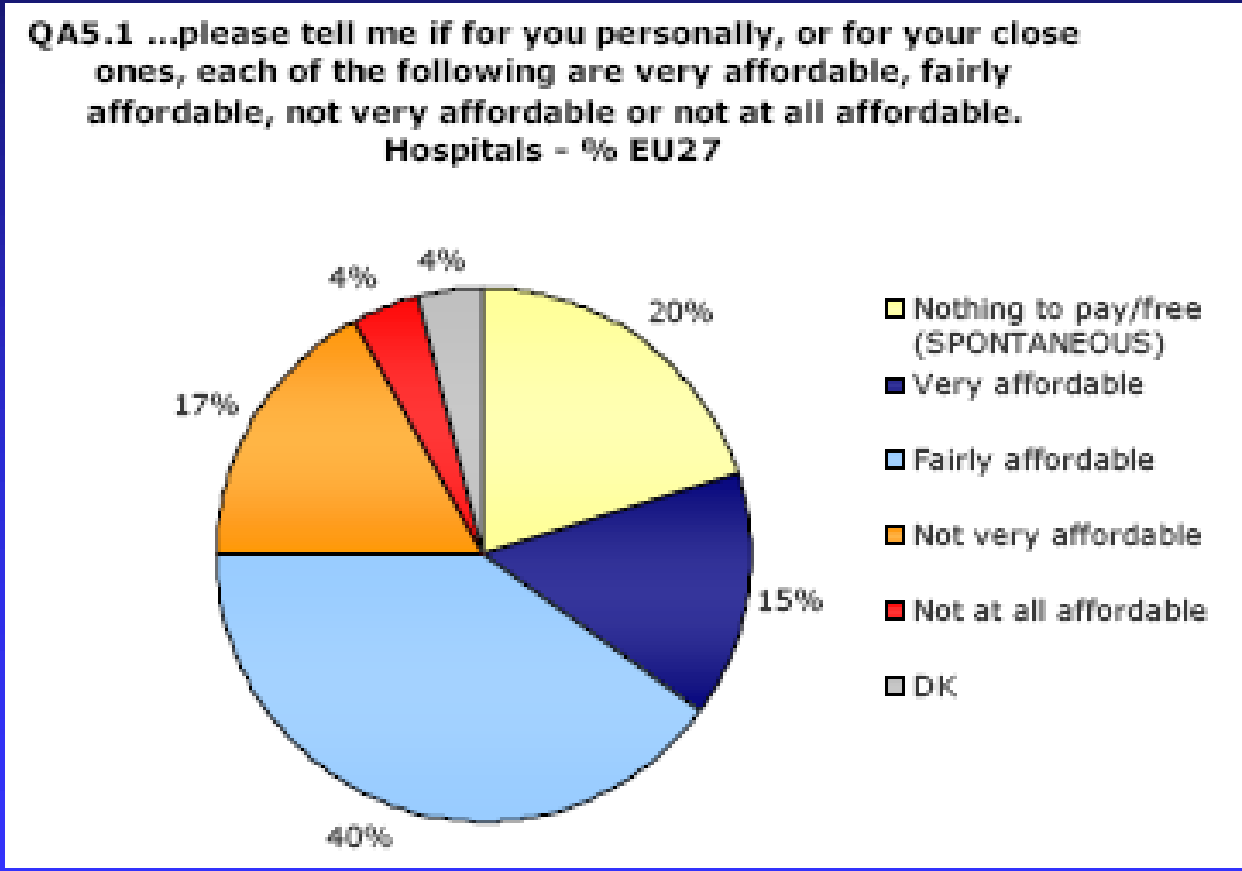


Access to *hospital care*: EU 27

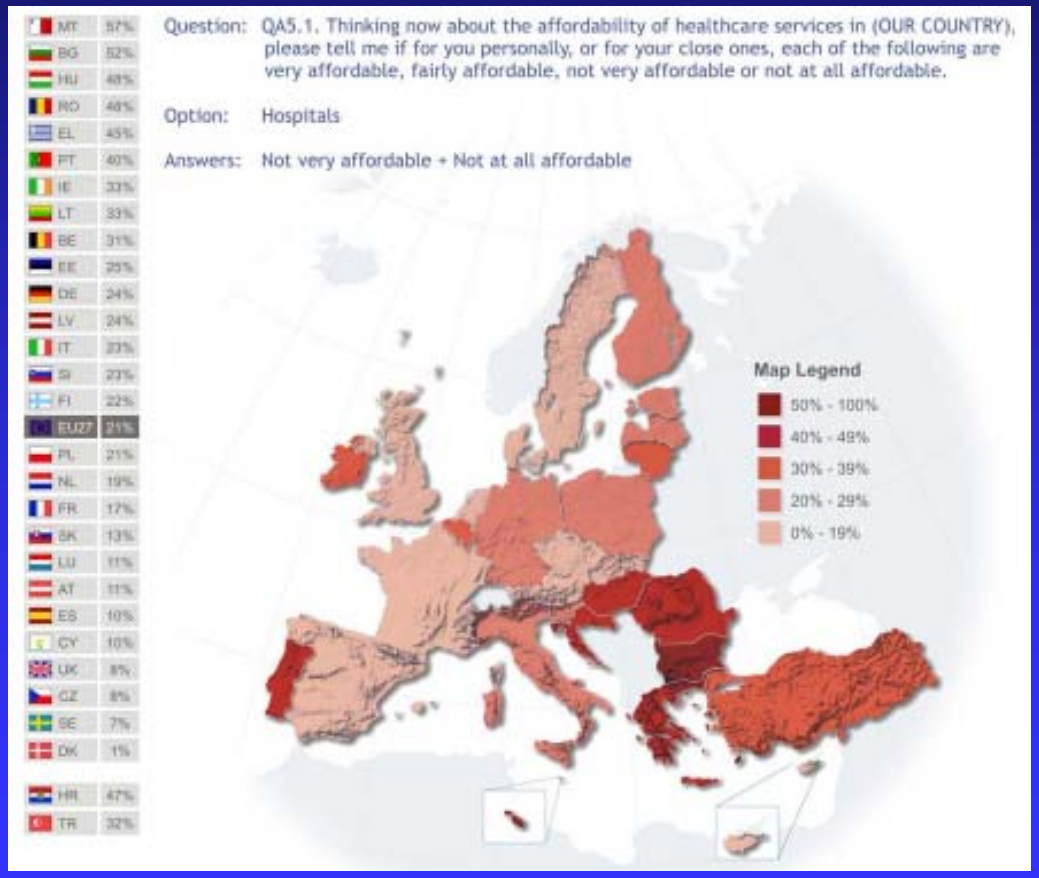


Country Results	
Austria	92%
Belgium	87%
Germany	87%
Czech Republic	86%
Spain	84%
France	80%
The Netherlands	80%
United Kingdom	80%
Luxembourg	78%
Slovakia	78%
European Union (27)	76%
Malta	76%
Denmark	74%
Cyprus	74%
Greece	70%
Finland	70%
Italy	69%
Poland	69%
Sweden	68%
Portugal	66%
Ireland	65%
Lithuania	65%
Latvia	64%
Slovenia	64%
Romania	63%
Bulgaria	57%
Estonia	55%
Hungary	54%
Other Countries	
Turkey	75%
Croatia	58%

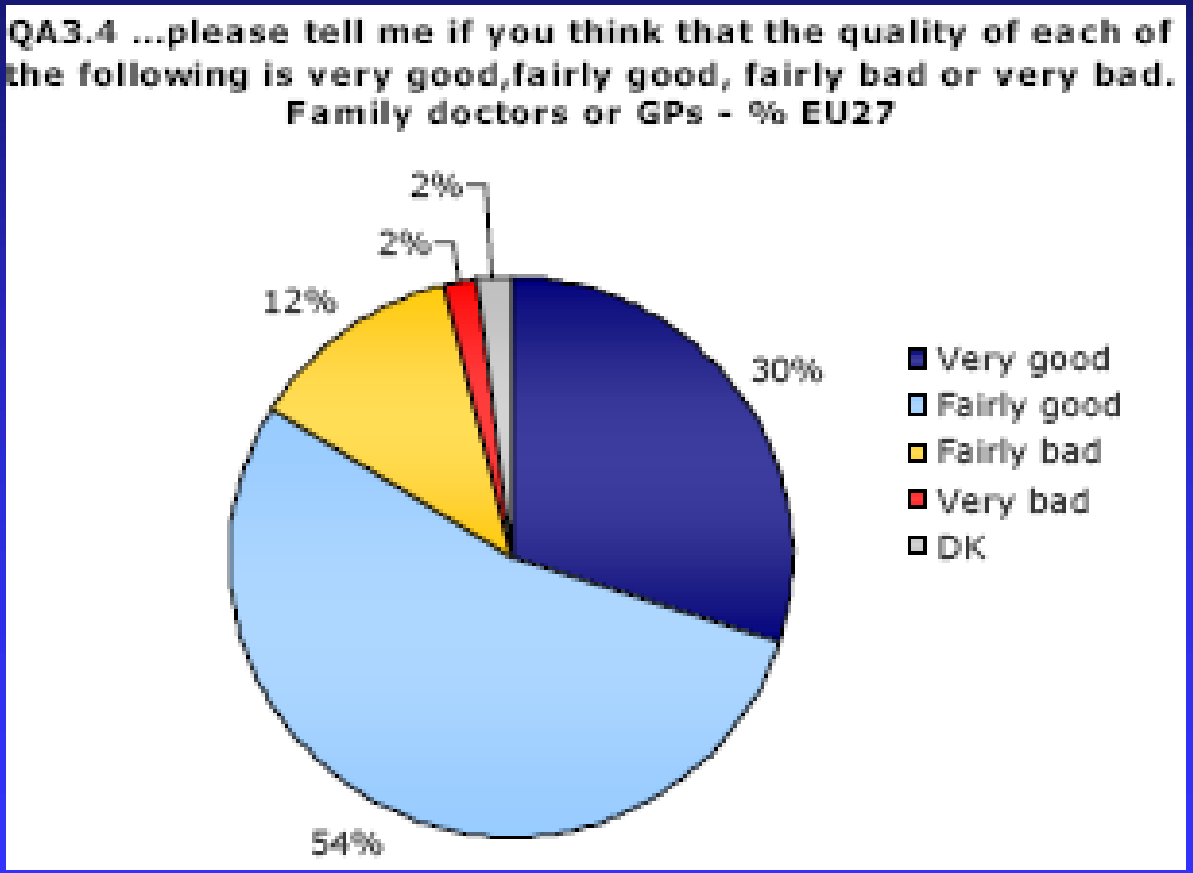
Affordability of *hospital care*: EU average



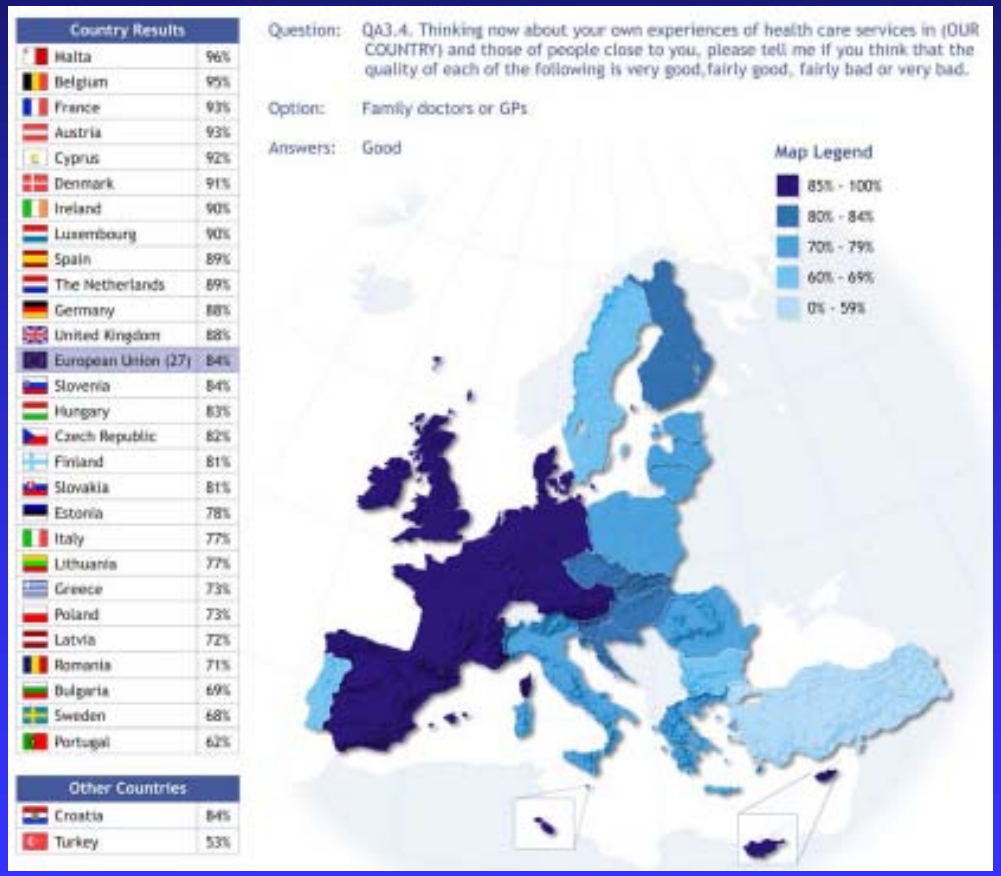
Affordability of *hospital care*: EU 27



Quality of *family doctor*: EU average



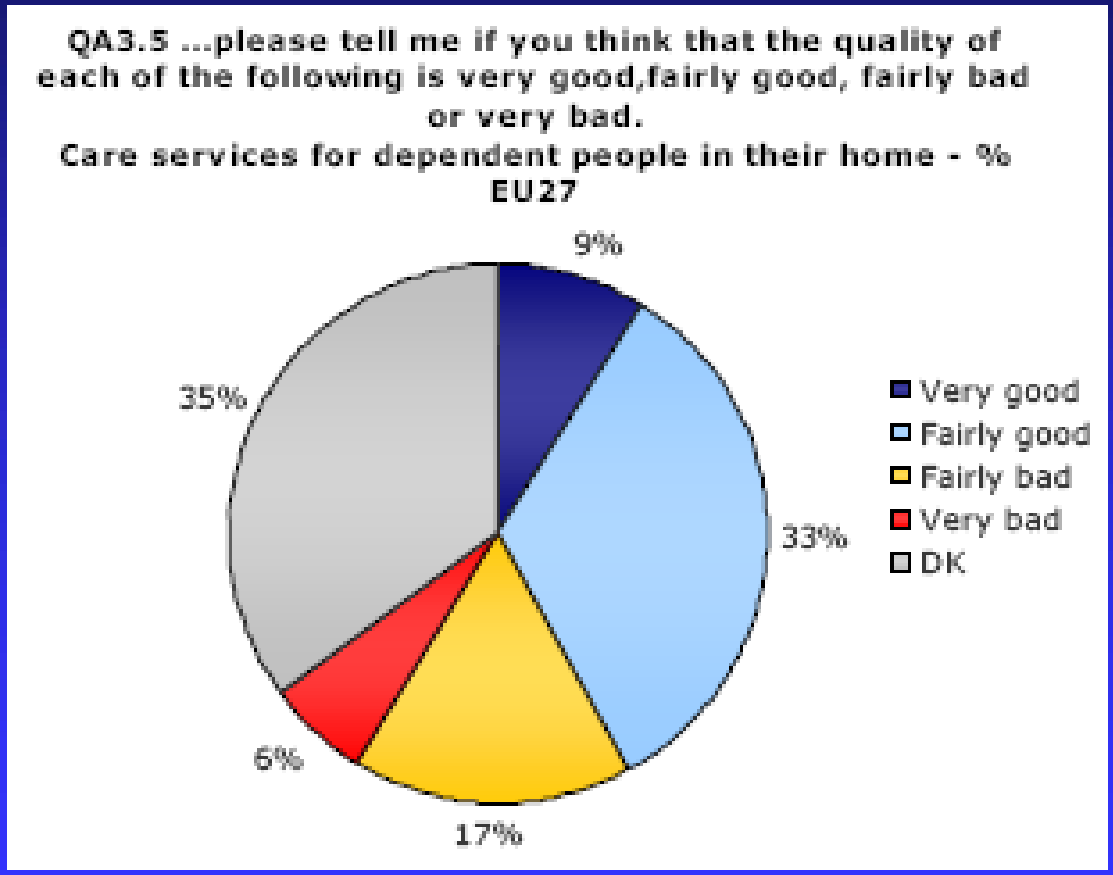
Quality of *family doctor*: EU 27



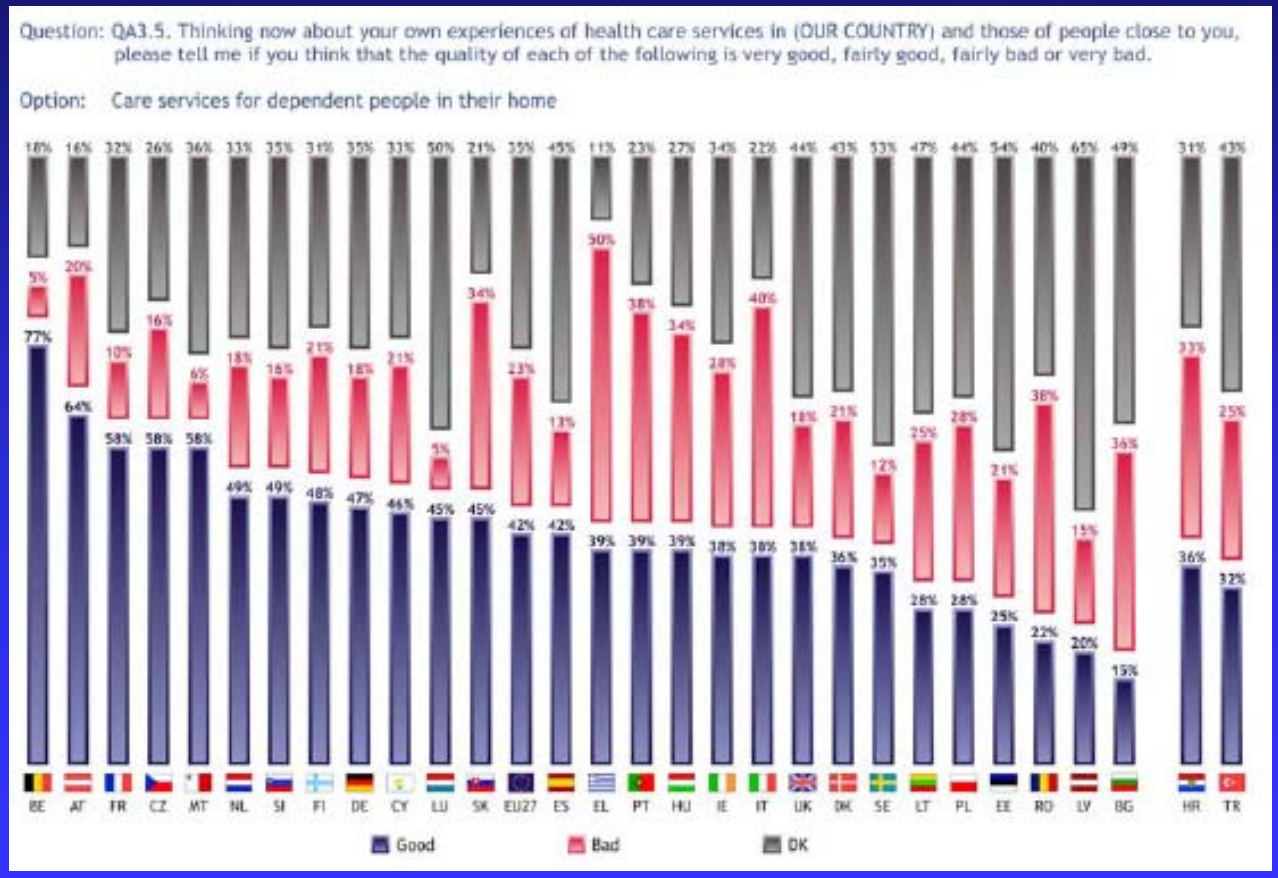
Country Results	
Malta	96%
Belgium	95%
France	93%
Austria	93%
Cyprus	92%
Denmark	91%
Ireland	90%
Luxembourg	90%
Spain	89%
The Netherlands	89%
Germany	88%
United Kingdom	88%
European Union (27)	84%
Slovenia	84%
Hungary	83%
Czech Republic	82%
Finland	81%
Slovakia	81%
Estonia	78%
Italy	77%
Lithuania	77%
Greece	73%
Poland	73%
Latvia	72%
Romania	71%
Bulgaria	69%
Sweden	68%
Portugal	62%

Other Countries	
Croatia	84%
Turkey	53%

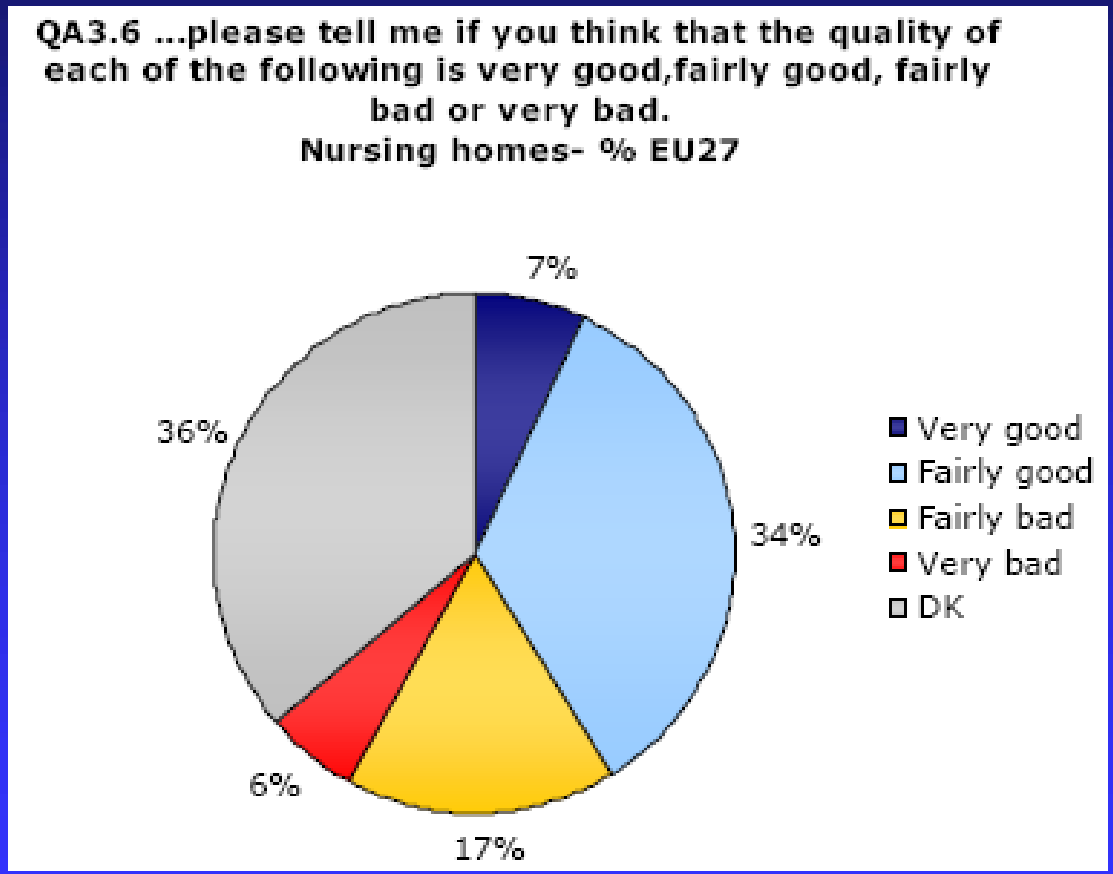
Quality of *care services for dependent people*: EU average



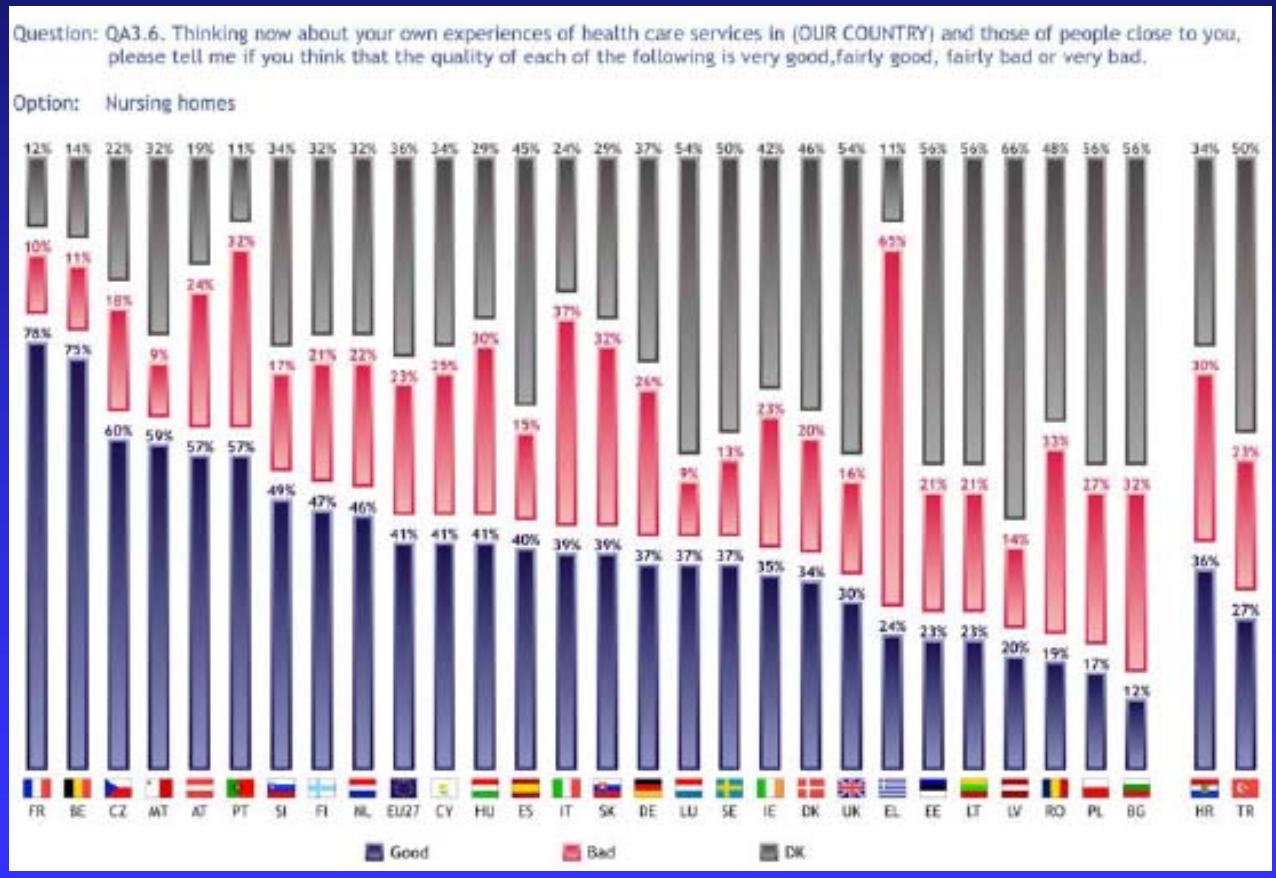
Quality of *care services for dependent people*: EU 27



Quality of *nursing homes*: EU average



Quality of *nursing homes*: EU 27



Summing up the Eurobarometer survey

Quality and accessibility of core health care services are rated good or fairly good in most EU countries;

and they are viewed as free of charge or affordable in the North and the in West

Long-term care services are rated less favorable in Scandinavia and the UK, and in general there are less knowledge about these services

European Commission (2007). *Special Eurobarometer: Health and long-term care in the European Union*. 283/Wave 67.3 – TNS Opinion & Social

Conclusion

Good health is a function of well being and strongly associated with “welfare state-ness”

A public, universal, tax financed health care system seems to be the most effective; it is relatively cheap, and most efficient

Whatever you do in Latin America and the Caribbean, ***DON’T*** do as in the United States

Thank you very much for your attention!