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**"HEALTH CARE FINANCING IN THE CONTEXT OF SOCIAL  
SECURITY"**

**Executive Summary  
in English**

**(IP/A/EMPL/ST/2006-208)**

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**Executive summary**  
**HEALTH CARE FINANCING IN THE CONTEXT OF SOCIAL**  
**SECURITY (IP/A/EMPL/ST/2006-208)**

**Introduction**

Health systems in the European Union perform a vital social security function. They mitigate both health and financial risks and make a major contribution to social and economic welfare. In light of various cost pressures, the Council of the European Union has articulated the challenge facing the member states as the need to secure the financial sustainability of their health systems without undermining the values these share: universal coverage, solidarity in financing, equity of access and the provision of high quality health care (Council of the European Union 2006).

Our aim in this report is to contribute to addressing this challenge by examining how strengthening the design of health care financing can help to secure health system sustainability. The report begins by clarifying the nature of the sustainability problem (Section 1). It then explores the adequacy of current financing arrangements and recent financing reforms in respect of their ability to secure sustainability (Sections 2 and 3). Finally, it offers some practical suggestions as to the best way forward.

**The problem of sustainability**

The problem of sustainability presents itself as an accounting problem, where health system revenue is insufficient to meet health system obligations. Two notions are often confused: economic sustainability and fiscal sustainability.

***Economic sustainability***

Economic sustainability refers to growth in health spending as a proportion of gross domestic product (GDP). Spending on health is economically sustainable up to the point at which the social cost of health spending exceeds the value produced by that spending. If health spending sufficiently threatens other valued areas of economic activity, health spending may come to be seen as economically unsustainable.

Growth in health spending is more likely to threaten other areas of economic activity in an economy that is stagnant or shrinking than it is in an economy that is growing. The general consensus, however, is that for the foreseeable future GDP will grow in the European Union at a rate high enough for health spending and other areas of the economy to grow (Economic Policy Committee 2001; Economic Policy Committee and European Commission 2006).

***Fiscal sustainability***

Concern regarding the fiscal sustainability of a health system relates specifically to public expenditure on health care. A health system may be economically sustainable and yet fiscally unsustainable if public revenue is insufficient to meet public expenditure.

There are three broad approaches to addressing the problem of fiscal sustainability: increase public revenue to the point at which health system obligations can be met; lessen those

obligations to the point at which they can be met from existing (or projected) revenue; and improve the capacity of the health system to convert resources into value.

Efforts to increase public revenue face technical obstacles such as institutional capacity, concerns regarding the threat such efforts may present to labour markets, and political obstacles such as the unwillingness of part of the population to continue to subsidise equal access to health care for others. Lessening health system obligations through coverage reduction (de-listing benefits, expanding cost sharing, excluding population groups) may help to secure fiscal sustainability, but will undermine the four values listed by the Council of the European Union. Furthermore, encouraging private financing of health care may exacerbate problems of economic sustainability due to the lower value for money that private markets are able to achieve vis-à-vis public systems.

Improving the ability of health systems to generate value can focus on the reform of service delivery or on the reform of financing systems (although the two are related). Reform over the past two decades has focused on the former. In this report we focus on the latter route to securing sustainability. We argue that improving value through health financing system design should be at the forefront of efforts to secure health system sustainability. But we also note that the problem of fiscal sustainability is a political problem, one that pertains to what has been called the ‘political economy of sharing’ (Reinhardt et al. 2004). Effort to secure population commitment to the four values must accompany any attempt at technical reform to enhance value.

## **Health care financing in the European Union**

Health financing policy encompasses a range of functions: collection of funds for health care, pooling funds (and therefore risks) across time and across the population, and purchasing health services (Kutzin 2001). It also encompasses policies relating to coverage, benefits and cost sharing (user charges). The way in which each of these functions and policies is carried out or applied can have a significant bearing on policy goals such as financial protection, equity in finance, equity of access, transparency and accountability, rewarding good quality care, providing incentives for efficiency in service organisation and delivery, and promoting administrative efficiency<sup>(1)</sup>.

### ***Collecting funds***

All member states use a range of contribution mechanisms to finance health care: public (tax and social insurance contributions) and private (private health insurance, medical savings accounts (MSAs)<sup>(2)</sup>) and out of pocket payments in the form of direct payments for services not covered by the statutory benefits package, cost sharing (user charges) for services covered by the benefits package and informal payments). A major change since the early 1990s has been the shift from tax to social insurance as the dominant contribution mechanism in many of the newer member states of central and Eastern Europe.

Public expenditure on health dominates in every country except Cyprus, although it has fallen, as a proportion of total expenditure on health, in many member states since 1996. Private expenditure is largely generated by out of pocket payments, which have risen as a proportion of total health care expenditure since 1996, but still account for less than a third of

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<sup>1</sup> These are the health financing policy goals adopted by the World Health Organization.

<sup>2</sup> Although none currently uses MSAs on a statutory basis.

total expenditure in most member states. In 1996 private health insurance was non-existent or made only a very small contribution to total expenditure on health in most of the newer member states and in several of the older member states. While it has grown as a proportion of total expenditure on health in many member states, in most it still accounts for well under 5%. However, its effect on the wider health system may be significant, even in member states where it plays a minor role.

### ***Pooling funds***

Pooling (the accumulation of prepaid funds on behalf of a population) allows the contributions of healthy individuals to be used to cover the costs of those who need health care. It is an essential means of ensuring equity of access to health care. In general, the larger the pool and the fewer in number, the greater the potential for equity of access and administrative efficiency. In most member states, all publicly-collected funds for health care are pooled nationally, which means there is a single pool. The exceptions are member states in which local taxes are used to finance health care and those in which individual health insurance funds are responsible for collecting their own social insurance contributions. In both cases, systems are usually in place to re-allocate resources to compensate poorer regions with smaller tax bases or to compensate funds with poorer members and/or members at higher risk of ill health. Competition among pooling agents (usually also purchasing agents) is relatively rare in EU health systems (see below).

### ***Purchasing health services***

Purchasing refers to the transfer of pooled funds to providers on behalf of a population. The way in which services are purchased is central to ensuring efficiency in service delivery and quality of care. It may also affect equity of access to health care and administrative efficiency and is likely to have a major effect on ability to control costs and financial sustainability. Key issues involve market structure and purchasing mechanisms (for example, contracting, provider payment and monitoring).

Where health care is financed mainly through social insurance contributions, the relationship between purchaser (health insurance fund) and provider has traditionally been contractual. In member states where health care is financed mainly through tax, the purchasing function is usually devolved to territorial entities (regional or local health authorities or specially-created purchasing organisation such as Primary Care Trusts in England). Purchaser-provider splits have been introduced throughout England, Italy and Portugal and in some regions of Spain and Sweden.

Competition among purchasers is relatively rare in EU health systems. It exists in Belgium and during the 1990s it was introduced in the Czech Republic and Slovakia and extended to the whole population in Germany and the Netherlands. Allowing health insurance funds to compete for members gives them incentives to attract favourable ‘risks’ (that is, people with a relatively low average risk of ill health) and avoid covering high risk individuals, which may affect equity of access to health care. Risk adjustment mechanisms aim to address this by compensating health insurance funds for high risk members. However, risk adjustment is technically and politically challenging and often incurs high transaction costs. A recent review concluded that most risk adjustment mechanisms in the Europe fail to prevent risk selection, and that the benefits of competition were therefore likely to be outweighed by the costs (van de Ven et al. 2007).

In EU health systems, primary care providers are most commonly paid through a combination of capitation and fee for service. Where health care is financed mainly through social insurance contributions, specialists are more likely to be paid on a fee for service basis, whereas in predominantly tax-financed health systems, specialists are often salaried employees. Hospitals are most commonly allocated budgets, but case-based payment is increasingly used either to define budgets or as a retrospective form of payment (with or without a cap on payments).

### ***Coverage, benefits and cost sharing***

Residence in a country is the most common basis for entitlement to health care in the European Union, resulting in universal or near universal (98-99%) population coverage in most member states; the main exception is Germany, where statutory coverage is around 88%. EU health systems provide broadly comprehensive benefits, usually covering preventive and public health services, primary care, ambulatory and inpatient specialist care, prescription drugs, mental health care, dental care, rehabilitation, home care and nursing home care. Across member states there is some variation in the range of benefits covered and the extent of cost sharing required. In some member states there may be a gap between what is 'officially' covered and what is actually available in practice. All member states impose cost sharing for services covered by the benefits package, most commonly to outpatient prescription drugs and dental care. In some member states, the prevalence of informal payments to supplement or in lieu of formal cost sharing has posed a challenge to health reforms (Balabanova and McKee 2002; Lewis 2002; Murthy and Mossialos 2003; Allin et al. 2006).

### **Which financing reforms are most likely to enhance sustainability?**

Many who draw attention to the gap between what we currently spend on health care and other forms of social security and what we may need to spend in future conclude that the only way of bridging this gap is to increase reliance on private finance (Bramley-Harker et al. 2006). We question the validity of this approach. Private financing undermines health system values and presents poor value in comparison to publicly-financed health care. In what follows we summarise some of the key findings of Section 3.

**Centralised systems of collecting funds** seem better able to enforce collection (in contexts where this is an issue) and may therefore be better at generating revenue than systems in which individual health insurance funds collect contributions. In part, however, this reflects the nature of the collection agent – tax agencies may be more difficult to evade (with impunity) than health insurance funds. Centralised contribution rate setting may be resisted where funds have traditionally had the right to set their own rates, but it is not impossible, as recent Germany reforms show. It is an important step towards ensuring equity and may lower the transaction costs associated with risk adjustment, as the risk adjustment mechanism no longer has to compensate for different contribution rates. It may also help to address resistance to risk adjustment on the part of health insurance funds.

Some of the older member states have taken steps to boost public revenue by **broadening revenue bases** linked to employment. Both France and Germany have increased their reliance on non-earnings-related income through tax allocations, a move that is likely to contribute to fiscal sustainability in the context of rising unemployment, growing informal economies,

growing self employment, concerns about international competitiveness and changing dependency ratios. In contrast, during the 1990s, many of the newer member states of central and eastern Europe moved away from tax financing and introduced employment-related social insurance contributions. Unfortunately, the economic and fiscal context in many of these countries is particularly unsuited to employment-based insurance due to high levels of informal economic activity and unemployment. Consequently, governments have usually continued to rely on tax allocations to generate sufficient revenue. In some cases, this has been seen as a failure of the social insurance ‘system’. However, it should probably be seen as an advantage. The potential benefits of creating new purchasing entities at arm’s length from government and from providers can be maintained, even if tax financing continues. In fact, finding ways to safeguard tax allocations when new contribution mechanisms are introduced might be essential to ensuring sufficient revenue and to addressing some of the limitations of employment-based social insurance.

The clear trend towards creating a **national pool** of publicly-generated health care resources witnessed in newer and older member states is a welcome one. A single pool of health risks is the basis for equity of access to health care. It also enhances efficiency by counteracting uncertainty around the risk of ill health and its associated financial risk. In addition, minimising duplication of pooling may improve administrative efficiency.

Another welcome trend related to pooling is the move away from allocating pooled resources (to health insurance funds or to territorial ‘purchasers’) based on historical precedent, political negotiation or simple capitation towards **strategic resource allocation** based on risk-adjusted capitation. This move can address some of the inequalities associated with local taxation or collection by individual health insurance funds and is a major step to ensuring that resources match needs and that access to health care is equitable.

Some newer and older member states have introduced **competition among purchasers** (health insurance funds). This may seem like a good way to stimulate active purchasing. In practice, however, the costs of this form of competition may outweigh the benefits due to the incentives to select risks it creates. Evidence from Belgium, France and Germany shows how risk adjustment mechanisms may weaken these incentives, but fail to eliminate them (van de Ven et al. 2007).

The move away from passive reimbursement of providers towards **strategic purchasing** of services also represents a step towards matching resources to needs and ensuring value for money. Health care providers are ultimately responsible for generating a large proportion of health care expenditure, so ensuring that their services are delivered equitably, at an appropriate level of quality and for an appropriate cost is central to securing both economic and fiscal sustainability. However, in many member states reform of purchasing has been under developed. In some cases, purchasing agents have not been given sufficient incentives or tools to attempt strategic purchasing. With regard to provider payment, the move away from pure fee for service reimbursement towards more sophisticated, blended payment systems that account for volume and quality is promising. Again, however, reforms have not always been implemented appropriately and more needs to be done, particularly in terms of linking payment to performance in terms of quality and health outcomes.

Several countries have made efforts to expand **population coverage**. Consequently, most member states now provide universal coverage. However, the scope and depth of coverage are as important as universality, and the trend in some countries to lower scope and depth

undermines financial protection. Efforts to define the scope and depth of coverage should be systematic and evidence based to ensure value for money. Health technology assessment is beginning to be used more widely to assist in reimbursement decisions and defining benefits. However, its application is still limited in many member states. In some cases this is due to financial and technical constraints. In others, implementation is limited by political constraints such as opposition from patient groups, providers and product (usually pharmaceutical) manufacturers.

**Cost sharing** has been introduced and expanded in many member states and reduced in others. Although cost it may be used to encourage cost-effective patterns of use, overall there is little evidence of efficiency gains and, where it is used to curb direct access to specialists, there is some evidence of increased inequalities in access to specialist care (as those who can afford the user charges have better access). There is no evidence to show that cost sharing leads to long-term expenditure control in the pharmaceutical or other health sectors. Additionally, due to the information asymmetry inherent in the doctor-patient relationship, patients may not be best placed to ‘purchase’ the most cost-effective care. Given that the bulk of health care expenditure (including pharmaceutical expenditure) is generated by providers, efforts should focus on encouraging rational prescribing and cost-effective provision of treatment. One lesson from the reform experience is that cost sharing policy should be carefully designed to minimise barriers to access. In practice, this means providing exemptions for poorer people and people suffering from chronic or life-threatening illnesses. With careful design, cost sharing can also be used to ensure value for money.

Markets for **private health insurance** in EU health systems generally serve richer and better educated groups and present barriers to access for older and unhealthier people. They are also often fragmented, resulting in weak purchasing power. Due to the fact that many of them exist to increase consumer choice (or to reimburse cost sharing), insurers have limited incentives to engage in strategic purchasing and link provider pay to performance. However, they may have strong incentives to select risks, to the detriment of equity and efficiency. In general, private systems incur substantially higher transaction costs than public systems and may therefore be accused of lowering administrative efficiency.

Overall, we identify two broad reform trends. First, member states have made significant attempts to promote equity of access to health care – by expanding coverage, increasing regulation of private health insurance, improving the design of cost sharing and making the allocation of resources more strategic. Second, there is a new emphasis on ensuring quality of care and value for money – for example, through increased use of HTA, efforts to encourage strategic purchasing and provider payment reforms that link pay to performance. While cost containment remains an important issue, in many member states policy makers are no longer willing to sacrifice equity, quality or efficiency for the sake of curbing expenditure growth. Several of the reforms introduced more recently are in part an attempt to undo the negative effects of prioritising cost containment over health financing policy goals.

### **Is there an optimal way of financing health care?**

We argue that public finance is superior to private finance. This is not surprising given the need to secure sustainability without undermining values such as equity in finance or equity of access to health care. However, our argument is based on efficiency grounds too. Publicly-generated finance contributes to efficiency and equity by providing protection from financial risk and by detaching payment from risk of ill health. In contrast, private contribution



mechanisms involve limited or no pooling of risks and usually link payment to risk of ill health and ability to pay. Public finance is also superior in its ability to ensure value for money which, as we have argued, is central to securing both economic and fiscal sustainability. Overall, the experience of the United States suggests that increasing reliance on private finance may exacerbate health care expenditure growth, perhaps due to the weak purchasing power of private insurers and individuals against providers. Among the older member states of the European Union, those that have relied more heavily on private finance, either through private health insurance or through higher levels of cost sharing, are also those that tend to spend more on health care as a proportion of GDP (notably, Austria, Belgium, France, Germany and the Netherlands).

Of course, public finance is not without its problems. Where social insurance contributions dominate, there are likely to be concerns about the high cost of labour and the difficulty of generating sufficient revenue as informal economies and self employment grow, and as population ageing leads to shifts in dependency ratios. Concerns may also focus on generating sufficient revenue where capacity to enforce tax and contribution collection is weak. The reluctance of certain groups to pay collectively for social goods and to subsidise the costs of care for others may exacerbate resistance to paying higher taxes or contributions. However, these problems can be addressed – for example, by broadening the revenue base to capture non-employment-based income, by investing in efforts to strengthen public sector capacity, and by making the social and economic case for collective financing. Equity in finance may be compromised if health systems become increasingly dependent on consumption taxes (VAT), if ceilings on contributions are lowered, or if tax and contribution evasion is rife. On balance, however, these concerns are outweighed by gains in terms of equity of access to health care. In some countries, public sector resource allocation has contributed to inequalities in access, while purchasing has been non-existent or weak. Nevertheless, there are few cases in which private health insurers have been able to demonstrate better purchasing skills (in part due to their need to enhance consumer choice).

In determining an optimal way of financing health care we might ask what type of financing system is best placed to adjust to changing priorities. In recent years there has been increased demand for some types of health services, notably mental health care, long-term care and care of chronic illnesses. Demand for these services, and for integrated forms of delivering care, is likely to grow as populations age. The type of financing system best able to respond to shifts in demand is one with the ability to enhance pooling, co-ordinate and direct strategic resource allocation, match resources to need, shape the nature of supply and create incentives to enhance provider responsiveness. We suggest that systems based on public finance stand a much greater chance of rising to this challenge than alternatives such as private health insurance.

### **Policy recommendations**

Reforms that aim to secure the economic and fiscal sustainability of health care financing in the context of social security should focus on ensuring equity of access and value for money. Our recommendations are based on the analysis of health financing arrangements and reforms in Section 2 and Section 3. We should point out that evidence about the impact of some arrangements and reforms is lacking, so we cannot be sure of all outcomes. Nor can we be sure whether a reform will have the same effect in different countries. With this caveat in mind, we make the following recommendations.

- The starting point for any reform should be careful analysis of the existing health (financing) system to identify weaknesses or problem areas, combined with understanding of the contextual factors that may contribute to or impede successful reform.
- Policy makers may find it worthwhile to try to communicate the aims and underlying rationale for reforms to the wider public.
- Policy makers should consider the whole range of health financing functions and policies, rather than focusing on collection alone (contribution mechanisms).
- Find ways to enforce collection to ensure sufficient revenue and to restore confidence in the health financing system.
- Health systems predominantly financed through employment-based social insurance contributions may benefit from broadening the revenue base to include non-earnings-related income.
- In addition to contributing to efficiency and equity, enhancing pooling by lowering the number of pools or (better still) creating a single, national pool can facilitate strategic direction and co-ordination throughout the health system.
- Limit reliance on private finance (private health insurance, MSAs, user charges) and ensure that there are clear boundaries between public and private finance so that private finance does not draw on public resources or distort public resource allocation and priorities.
- If user charges are imposed, pay careful attention to the design of cost sharing policy, which should be systematic and evidence based.
- Avoid introducing MSAs as they do not involve any pooling across groups of people. They also suffer from many of the limitations of user charges.
- Tackling informal payments is central to increasing public confidence in the health system. Informal payments may present a major challenge to successful implementation of other reforms.
- Encourage strategic resource allocation to ensure that health resources match health needs.
- Encourage greater use of HTA, particularly in decisions about reimbursement and in defining the benefits package, but also in improving clinical performance.
- Design purchasing and provider payment systems to create incentives for efficiency, quality and productivity.
- Encourage administrative efficiency by minimising duplication of functions and tasks.
- Avoid confusing efficiency with expenditure control. Spending on health care should not be unconditional – rather, it should always demonstrate value for money.