Financing Health Care Systems in Europe

A study on financial sustainability, its relation to national culture and context and the ‘exportability’ of best practices

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Abstract

Access, quality, and cost are essential components of a health care system. These three umbrella categories are collectively referred to as the three-legged stool of health care, because any changes in one area will inevitably affect the others. The challenge healthcare systems in the developed world face is striking that elusive balance where all three are strong enough to support optimal health. In reality, the healthcare system is perpetually imbalanced and policymakers are constantly over-correcting in the area that is the hot topic of the moment.

In this context, it is not surprising that most of these healthcare systems in Europe, Asia and the United States deal with the issue of financial sustainability. It is one thing to aim for universal coverage, to ensure that all people obtain the health services they need without suffering financial hardship when paying for them (WHO constitution of 1948), but to fulfil all requirements of a strong, efficient, well-run health system has appeared to be challenging for most countries. These features include a system for financing health services; access to essential medicines and technologies; and a sufficient capacity of well-trained, motivated health workers. (WHO constitution of 1948). Clearly, the latter two depend on the first.

To say that there is any system that is financially sustainable, European, Asian or U.S. would be to say that we had found the ideal healthcare system. If this were the case, policymakers around the world would not be struggling to design a system that would be optimal. Indeed, there are differences between health care systems and the way they are financed. This publication summarizes the differences in tax funded healthcare systems and social health insurance systems. It clarifies how culture and context define differences between healthcare systems around the world and the way they deal with an efficient allocation of financial resources, financial sustainability of the healthcare system and risk pooling. It concludes by looking at the question whether any successful healthcare system, or parts of it, can be exported to other parts of the world.
Health Systems Financing

There are three basic principles that guide health system financing. A country should: raise enough revenues to provide individuals with the intended packages of health services; manage these revenues to pool health risks equitably and efficiently; and ensure the payment for health services is carried out in ways that are allocatively and technically efficient.

Raise Enough Revenues

To make sure that policymakers can always raise enough money to finance their healthcare systems, a tax-based health system has some advantages, as the resources increase over time when the economy grows. Reversely, however, revenues decrease over time as the economy shrinks. Added to this, some countries prefer to utilize tax revenues for other ends, such as education or defense. A good example is China, where Mao’s regime built a system of state-sponsored health care, but Mao’s death and the ensuing economic reform dramatically changed the landscape (Yanzhong Huang, 2011). There was a shift in the government’s agenda and local government officials pursued growth at the expense of public health (Yanzhong Huang, 2011). This aggravated some health challenges China already faced: SARS, mental illnesses, smoking pollution et cetera.

So even though tax-based systems have advantages such as fairness (as these systems cover the entire population) and there is a high degree of political accountability, these advantages are not guaranteed in all countries. In fact, in China, increasing public health problems had important implications for political stability (Yanzhong Huang, 2011). In the UK, like China, the NHS has achieved relatively poor outcomes in some areas. For example, rates of mortality amenable to healthcare, rates of mortality from some respiratory diseases and some cancers, and some measures of stroke have been amongst the worst in the developed world (Passim, 2010). So even the original objectives of the British tax-based National Health Service were that it be universal in offering coverage to all members of the population in times of health care need; that it be comprehensive in its provision of health care services; and that it be (largely) free at the point of use (Oliver, 2005), financial sustainability of the system has been challenged.
Tax Funded Versus Social Health Insurance Systems

Social Health Insurance systems (SHI) do not guarantee enough revenues either. Even though SHI schemes have greater potential for providing effective risk protection, these systems deal with equity issues as SHI only covers workers in the formal sector and only pools the health risks of its employees. Another downside, apart from popular acceptance which is largely based on the concept of solidarity, SHI requires adequate fiscal capacity. Especially in Asian countries, where fiscal space constraints limit coverage extension to the poor, SHI schemes can result in higher real cost of labor due to higher social insurance premiums. In fact, newly established SHI schemes in Asian countries should learn from the experiences of different provider payments regarding the strengths and weaknesses of various payment models (Viroj Tangcharoensathien et al., 2011) to guarantee the envisioned extension of affordable primary care services and financial risk protection for the poor, much like the Patient Protection and Affordable Care Act in the United States.

Allocation of Resources

Another point to bear in mind is the economic context within which most of these healthcare systems in Europe and Asia operate. Not only do Western European countries spend more of per capita GDP on healthcare (ranging from $44,000 in Germany to $57,110 in Sweden compared to, for example $4,950 in Thailand and $5,450 in China), the percentage of GDP that are due to health expenditures is also a lot higher (10% and more on average compared to 5% on average in Asia). (2014, The Economist “Pocket World”)

Indeed, most reforms in European countries have been directed to the allocation and production of healthcare. Examples of these are the DRG-based reimbursements for hospitals in Sweden and the quality-outcomes framework in England. This central concept of allocation results in narrowing the gap between an individual's need for a service and his awareness of that need (demand) as well as their use of that service (access); and maximizing health gains from the use of the service available (quality). (Duran et al, 2012, CH2). Whether it be partly performance-tied payment systems (UK); PHC control over hospital budgets (Netherlands, UK, and others); a system of contracting and purchasing power (Netherlands); or price controls; these are all merely allocation mechanisms.
Some reform has also focused on the production-side, such as the semi-autonomous hospitals in England and the shifting of primary care to the private sphere. Politically important issues of greater efficiency in service production and delivery – along with growing patient demands for more timely access, higher quality services and choice over where and from whom they received their medical care – combined to produce a wide range of new governance strategies in tax-funded health care systems across Europe (Saltman, Duran, Dubois, 2011).

Asian countries, on the other hand, have focused their attention mostly on funding their health care system. The most striking example is the system in Singapore, a country that has not reformed its healthcare system since the 1980s, has created Medifund, Medisave and Medishield to fund the system. Singapore has achieved extraordinary results both in the quality of its healthcare system and in controlling the costs of care. In per capita terms as a percentage of gross Domestic Product, its healthcare expenditures are the lowest of all the high income countries in the world (Haseltine, 2013) South-Korea has increased the insurance coverage and reduced co-payments and has recently also shifted total pharmaceutical payments away from office-based MDs.

All these reforms were directed to improve the funding mechanism of the health care system as the government is responsible for health care services, and it subsidizes a substantial portion of health care funding. (Chang Bae Chun et al., 2009) In Thailand, healthcare is decentralized and local governments always come up with locally tailored funding solutions. Financial risk protection, which was initially introduced to protect the poor and vulnerable, was extended to achieve universal coverage and nine successive five-year national health plans ensured continuity over four decades of health system development. (Patcharanarumol et al, CH7 Thailand, 2011)

**Pool Health Risks**

In both European and Asian health systems, risk pooling has become an essential element on the way to universal coverage. In the Netherlands, for example, any losses that private insurances incur on the regulated 2006 reform policies are compensated from a pool that is filled by mandatory cross-subsidies
paid for by all those privately insured. (Helderman et al., 2005) Risk pooling is naturally related to the European “promise” of solidarity. While healthcare reforms in Sweden seemed to have shifted to more "market mechanisms", keeping with traditional Swedish commitment to universal access, predominantly public ownership, single source financing and expanded primary and preventive services (Saltman, 1992), the reforms were still largely directed to the ubiquitous Swedish promise of solidarity.

In fact, both the Dutch and German reforms illustrate that even though a country can implement system changes, the primary principles on which they operate remain the same. In these two countries, the main policy objective was to improve equity in contributions or entitlements, by introducing choice and risk adjustment in systems in which people were formerly assigned to funds on the basis of their occupation or other criteria (Saltman et al., 2012), but risk pooling remains to be an important tool for the allocation of resources to approach universal coverage.

**Fiscal Sustainability**

The way countries are changing to deal with their fiscal sustainability can be summarized by the words “individual responsibility”, although there is confusion about the concept of responsibility, especially when comparing this in a European context to an Asian context. Obviously, there are differences between tax funded and Social Health Insurance (SHI) countries on this issue and countries also change in how they deal with their fiscal sustainability. Tinhong et al (2010) describe a conceptual framework for exploring the suitability of private financing in a publicly funded health care system and describe individual responsibility connected to health care as “a heterogeneous group of commodities, which allows policymakers to make decisions on rationing by design rather than default”.

One of the central questions, indeed, remains how to reduce the seemingly inherent structural tension between the socially embedded character of social health insurance systems and even tax-based systems, and the challenges of efficient economics on the other (Saltman, Busse, Figueras, 2004) Especially in an era of increasing patient mobility around the world, the nationally run health care systems will be under increased financial pressure.
Exportability of Health Care Systems

The major issue remains whether it will be possible to bring about a ubiquitous shift in the policy making process, moving from the deeply rooted cultural values of solidarity and social cohesion and belief system of European citizens to a merely Anglo-Saxon model in which low taxes and individual responsibility prevail as the driving forces behind economic and policy reform. In this respect European and Asian various cultures and historical contexts differ largely from the United States, where individual responsibility has a long history as a means for health care sustainability. Indeed, we can say that now that we see the U.S. move towards increased awareness of the redistribution of wealth; European and Asian countries are shifting more and more towards individual rather than collective responsibility to safeguard financial sustainability.

Countries and their health systems are constantly changing and the key word to any reform is policy “incrementalism”. Policymakers will have to negotiate an intricate combination of incremental, partial, and marginal improvements on a number of health, social, and economic indices, which together may help manage or mitigate the demand for health care services and the overall cost of providing those services (Saltman, Dubois, Chawla, 2006). Haseltine (2013) described three compelling qualities enabling Singapore to achieve the outstanding successes in healthcare, which can be applied to many other nations, European, Asian or American: long-term political unity, the ability to recognize and establish national priorities and the consistent desire for collective well-being and social harmony of the country. So even though healthcare systems as a whole cannot be applicable from one country to the other; the universal successes in healthcare can be incrementally implemented in other countries.

Indeed, at a wider system level, each healthcare system is a result of its unique heritage so that none of the system is replicable. (Gauld et al., 2006) So it is indeed a key lesson that policymakers should not necessarily look to emulate the health systems of Europe or advanced Asia, as the problem exists in classifying the diverse systems. Yet the systems face common pressures; and there are considerable opportunities to enhance primary care, service quality and system integration, so policymakers should study how each of the systems has dealt with generic issues such as funding, equity and quality. (Gauld et al., 2006) As Haseltine (2013) described, the answers are bigger than just the process of putting a
healthcare system together. There are larger factors that have to do with the spirit and philosophy of a country itself, and the way it is governed, how the government approaches domestic issues, and how it deals with the world, such as a country like Singapore where health savings accounts are guaranteeing a minimal of financial sustainability.

Lee Kuan Yew said in an interview with Foreign Affairs that the Asian “model” may prove to be a transitional phenomenon. “It is not just mind-sets that would have to change but value systems”, he said. The interviewer, Fareed Zakaria, reacted in his concluding remarks that cultures change. “Under the impact of economic growth, technological change and social transformation, no culture has remained the same. (...) But to be modern without becoming Western is difficult; the two are not wholly separable.” The interview underlines the challenges to transfer European or Asian financing arrangements directly to the U.S.

As noted in the first part of this publication, a healthcare system is perpetually imbalanced and policymakers are constantly over-correcting in the area that is the hot topic of the moment. The reforms that reflect the corrections are tied to the culture and the context in a country’s health system. These elements are already different when comparing health systems in various European countries, but they seem to have more in common than do Asian countries. Lee Kuan Yew made it clear that healthcare reform in Asian countries is always part of a different set or mix of reforms of which healthcare is only one piece. This different set relates to culture, context and norms and values inherent to a countries system.

**Culture; Norms and Values**

Lee Kuan Yew summarized the differences between Europe and Asia very clearly: “I don’t think there is an Asian model as such. But Asian societies are unlike Western ones. The fundamental difference between Western concepts of society and government and East Asian concepts is that Eastern societies believe that the individual exists in the context of his family. He is not pristine and separate. The family is part of the extended family, and then friends and the wider society. The ruler or the government does not try to provide for a person what the family best provides”.


Indeed, in Europe the way that institutions affect reform is very different. Since many European countries have developed a deeply rooted principle of solidarity that goes back to the day when countries were still largely divided (think about the pillarization society in The Netherlands that gradually ceased to exist), this and other norms and values are more often than not the central objective of reforms of the healthcare system. Indeed, the diffusion of ideas can sometimes be a causal force in political decision-making, implying that if a sense of altruism or collectivism exists throughout society, institutions that embody this societal principle will be reinforced in these European nations. (Oliver and Mossialos, 2005; borrowed from Saltman and Bergman) Equity is the central objective of European health care reform, driven by the ubiquitous principle of solidarity, not family norms and values. Asia, on the other hand follows family principle: “There is a little Chinese aphorism which encapsulates this idea: Xiushen qijia zhiguo opingtianxia. Xiushen means look after yourself, do everything to make yourself useful; Qijia, look after family; Zhiguo, look after your country; Pingtianxia, all is peaceful underheaven. We have a whole people immersed in these beliefs.” (Lee Kuan Yew)

**Context**

As a consequence, many Asian countries have decentralized healthcare systems which is the opposite of most European countries where healthcare is largely organized by the national or central government. Socioeconomic inequalities that persisted within populations of all European countries since the start of the twenty-first century have acted as a catalyst for a shared value of solidarity. (Mackenbach and Kunst, 2012) Sweden with its tax-based health care system and The Netherlands with its system of Social Health Insurance are examples of countries that have developed plans for tackling health inequalities. The fact that even Margaret Thatcher - still an exception to the rule of European spendthrift politicians - did not attempt to reform the tax-financing structure of the NHS illustrates this point. Apparently, the forces of solidarity and equity are dominant in most European countries and the "tyranny of the majority" (Tocqueville) prevails.

Even though the U.S. shares Western values with many of the European nations, it is not feasible to transfer European financing arrangements directly to the United States. In Sweden, for example, it is apparent that the Swedes over the long term have had considerable success in attaining cost
containment for health services. In 1980, Sweden actually spent a greater proportion of its gross domestic product (GDP) on health services (9.4%) than did the US (8.9%). (Anderson, 2001 from Levit et al) However, the situation changed dramatically after that so that by 1990 the US was spending 12.1% while the Swedish proportion had dropped to 8.9% and by 1994 the proportions were 13.5% in the US and about 7.5% in Sweden. (Levit et al., 1996). Both in the case of Sweden, and the same for the tax-based system in the UK, it is hotly debated whether and how much additional funding is needed to keep the system running. The fact that Sweden spends a smaller percentage of GDP does not imply that that was a major consideration in shaping a system that was largely defined by traditional Swedish values of jamlikhet (equality) and trygghet (security). (Saltman and Bergman, 2005)

In summary, where the concept of efficiency in a U.S. context usually refers to financial or economic gains, in Europe it often has a different connotation related to concepts of equity and responsiveness of the healthcare system. The major issue remains whether it will be possible to bring about a ubiquitous shift in the policy making process, moving from the deeply rooted cultural values of solidarity and social cohesion and belief system of European citizens, and the family connections in Asian societies, to a merely Anglo-Saxon model in which low taxes and individual responsibility prevail as the driving forces behind economic and policy reform.

According to Lee Kuan Yew, the liberal, intellectual tradition that developed after World War II claimed that human beings had arrived at this perfect state where everybody would be better off if they were allowed to do their own thing and flourish. According to him, Westerners have abandoned an ethical basis for society, believing that all problems are solvable by a good government, which in the East people never believed possible. The U.S. with an historical mix of both might borrow from European or Asian financing arrangements and efficiently working elements of various countries around the world, but the central question remains:

“Who is going to pay for it?”