Funding health care in Europe: recent experiences

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INTRODUCTION

Discussions about how to fund health care are not new in the UK. Indeed, the Government set up a committee of enquiry into the cost of the NHS as early as 1953. Chaired by C W Guillebaud, its terms of reference were to 'review the present and prospective cost of the National Health Service'. It concluded that if the NHS were to meet every demand that was justified on medical grounds it would require 'very considerable additional expenditure'.[1] Debates about changes to the system of funding the NHS also took place within the Conservative Government in the 1980s. A leaked paper prepared by the right-wing think-tank Centre for Policy Review Studies (CPRS), which proposed replacing the tax-financed NHS with a social insurance scheme, caused cabinet dissent and a public outcry, and led to the decision to concentrate on reforming the structure of the NHS rather than its financing.[2] More recent debates were precipitated by the 'winter crisis' in 1999–2000. The Labour Government has, however, reasserted its commitment to taxation in the *NHS Plan*.[3] In these debates about alternatives, such as social health insurance, or the role of private health insurance and user charges, examples from Europe are often cited. However, many of these are based on anecdote or out-dated perceptions rather than facts.

In this article we review some of the recent and significant changes to health care funding in Europe. We analyse recent trends and draw some tentative conclusions about the significance of these for the debate in the UK.

HOW MUCH IS SPENT ON HEALTH CARE?

One of the main ways in which the UK is compared to other countries is on the basis of how much is spent on health. Despite the fact that such data are often presented as black-and-white facts, they are subject to a number of methodological and interpretative problems.[4] In brief, these include the definition of the boundaries of health care, the way definitions are standardised across countries, data collection methods, and differences in structure and organisation. There are also problems associated with the measurement and reporting of expenditure as a percentage of GDP. These estimates may vary, and no account is taken of the informal sector in the economy. Alternatives such as the use of exchange rate conversions and purchasing power parities (PPPs) when

comparing per capita expenditure on health care have their own difficulties due to the basis of the calculation – the prices and basket of goods used are pharmaceutical-biased. Expenditure data should thus be interpreted with some caution.

Health care expenditure (HCE) as a percentage of GDP has stabilised in the latter part of the 1990s and even declined in some EU countries (*see Table 1*). However, in eight of the 15 EU countries GDP grew faster than HCE between 1995 and 1998, and in Spain, Portugal, Greece and Denmark HCE grew only a fraction more than GDP. Thus, the stabilisation of HCE as a percentage of GDP in some EU countries may not reflect success in controlling HCE growth but, rather, may be a reflection of growth in the economy. Indeed, in Ireland, while HCE grew by 3.4 per cent between 1995 and 1998, the economy grew by 8.8 per cent.[5]

Taking into account methodological limitations, the data show that the UK has consistently spent less in total than most other EU countries throughout the 1990s, ranking in the bottom three countries in any particular year. In terms of public expenditure on health, the UK consistently ranks in the lower half of countries. These data support the criticism that the UK health care system has suffered from chronic underfunding despite a period of economic growth. However, it is by no means certain that higher spending in some EU countries has resulted in more equitable or efficient systems.

WHERE DOES THE MONEY COME FROM?

Health care in Europe relies mainly on public funding; either from taxation or social health insurance. The third significant element is out-of-pocket expenditure. This includes both user charges paid in the public system and also direct payments for services provided in the private sector. The smallest proportion of private expenditure in nearly all countries (with the exception of the Netherlands) is private health insurance. Countries can be clustered into three groups according to the source of funding (*see Figure 1*): those that are predominantly funded through taxation (local taxes in Denmark and Sweden, central taxes in Italy,* Portugal, Spain, and the UK); those predominantly funded through social health insurance contributions (France,** Germany and the Netherlands); and those that are mixed systems (i.e. funded almost equally from tax and social health insurance) such as Belgium, Greece and Switzerland. It is worth noting that due to the organisation of the funding and pooling arrangements and historical origins, Belgium is often classified as a social health insurance system, Greece as tax-funded and Switzerland as privately-funded. Since 1996, Switzerland has moved away from voluntary private health insurance with individual risk-rated premia and variable packages of care, to a system of compulsory insurance provided by both private and public insurers with a guaranteed package of care and community-rated premia.

* Italy finances health through general and hypothecated tax, which is currently collected and set nationally. However, reforms are being introduced to decentralise the responsibility for health care funding to the regions.

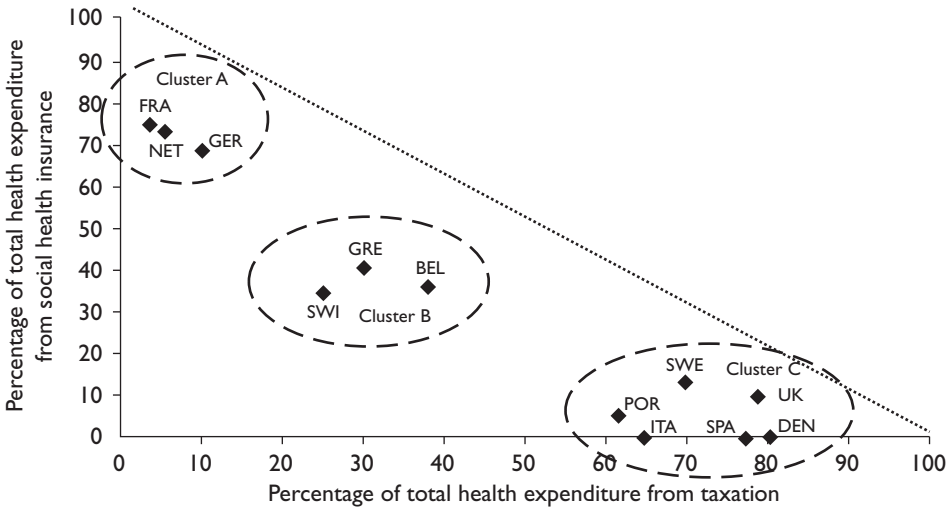
** France is increasing the contribution of taxes to the funding of health care, as we discuss in more detail below.

Table 1: Total health care expenditure (public health care expenditure) as a percentage of GDP in EU member states, 1990–98

	1990	1991	1992	1993	1994	1995	1996	1997	1998
Austria	7.2 (5.3)	7.2 (5.3)	7.6 (5.6)	8.1 (6.0)	8.1 (6.0)	8.9 (6.4)	8.9 (6.3)	8.2 (5.8)	8.2 (5.8)
Belgium	7.4 (6.6)	7.8 (6.9)	7.9 (7.0)	8.1 (7.2)	7.9 (7.0)	8.2 (7.3)	8.6 (7.6)	8.6 (7.7)	8.8 (7.9)
Denmark	8.4 (7.0)	8.3 (6.9)	8.4 (7.0)	8.7 (7.2)	8.5 (6.9)	8.2 (6.8)	8.3 (6.8)	8.2 (6.8)	8.3 (6.8)
Finland	7.9 (6.4)	9.0 (7.3)	9.1 (7.3)	8.3 (6.3)	7.8 (5.9)	7.5 (5.7)	7.7 (5.8)	7.3 (5.5)	6.9 (5.3)
France	8.8 (6.7)	9.0 (-)	9.2 (-)	9.7 (-)	9.6 (-)	9.8 (7.5)	9.7 (7.4)	9.6 (7.3)	9.6 (7.3)
Germany	8.7 (6.7)	9.1 (7.1)	9.7 (7.6)	9.7 (7.5)	9.8 (7.6)	10.2 (8.0)	10.6 (8.3)	10.5 (8.0)	10.6 (7.9)
Greece	7.6 (4.8)	7.9 (4.8)	8.3 (4.9)	8.3 (4.8)	8.3 (4.9)	8.3 (4.8)	8.3 (4.9)	8.5 (4.9)	8.3 (4.7)
Ireland	7.0 (5.0)	7.4 (5.4)	7.8 (5.6)	7.8 (5.7)	7.7 (5.5)	7.4 (5.4)	7.2 (5.2)	7.0 (5.3)	6.4 (4.8)
Italy	8.1 (6.3)	8.4 (6.6)	8.5 (6.5)	8.6 (6.3)	8.4 (5.9)	8.0 (5.4)	8.1 (5.5)	8.4 (5.7)	8.4 (5.7)
Luxembourg	6.6 (6.1)	6.5 (6.0)	6.6 (6.1)	6.7 (6.2)	6.5 (6.0)	6.3 (5.8)	6.4 (5.9)	6.0 (5.5)	5.9 (5.4)
The Netherlands	8.8 (6.1)	9.0 (6.4)	9.2 (6.8)	9.4 (7.0)	9.2 (6.8)	8.9 (6.5)	8.8 (6.0)	8.6 (6.0)	8.6 (6.0)
Portugal	6.4 (4.2)	7.0 (4.4)	7.2 (4.3)	7.5 (4.7)	7.5 (4.8)	7.7 (5.0)	7.7 (5.1)	7.6 (5.1)	7.8 (5.2)
Spain	6.9 (5.4)	7.0 (5.5)	7.4 (5.8)	7.6 (6.0)	7.4 (5.9)	7.0 (5.5)	7.1 (5.5)	7.0 (5.4)	7.1 (5.4)
Sweden	8.8 (7.9)	8.7 (7.6)	8.8 (7.7)	8.9 (7.7)	8.6 (7.3)	8.4 (7.2)	8.7 (7.4)	8.5 (7.2)	8.4 (7.0)
UK	6.0 (5.1)	6.4 (5.4)	6.9 (5.9)	6.9 (6.0)	7.0 (5.9)	7.0 (5.9)	7.0 (5.9)	6.7 (5.6)	6.7 (5.6)

Source: *OECD Health Data, 2000*

Figure 1



The pros and cons of each method of funding, for example the implications in terms of equity and efficiency, are discussed in detail elsewhere.[6–9] It is important, though, to note that even where a system is predominantly funded through taxation it may be regressive due to the significant use of user charges (e.g. Italy and Portugal).

Private expenditure accounts for as little as 11.4 per cent of total health expenditure (THE) in the UK but over 30 per cent of total health expenditure in Italy, Greece, Portugal and Switzerland. In all EU member states, except the Netherlands, the majority of private health expenditure is out-of-pocket payments and user charges. The smallest private health insurance markets are in southern Europe and Scandinavia. Private health insurance is also only a small percentage of total health expenditure in Belgium (2 per cent) and indeed in the UK (3.5 per cent). Private health insurance is more important in the Netherlands (17.7 per cent of THE), where it is the sole form of cover for those with incomes in excess of a defined ceiling, and in Germany (6.9 per cent of THE), where those with incomes above a defined ceiling are free to opt out of the statutory insurance scheme. In France, private health insurance accounts for 12.2 per cent of THE and is widely purchased to cover the co-payments within the public system. In Ireland (9.4 per cent) and Austria (7.1 per cent), private health insurance is purchased to cover additional services not available through public insurance for all the population. In several of these countries, not-for-profit as well as for-profit insurers are important. In France and the Netherlands not-for-profit insurers account for 64 per cent and 34 per cent of total private health insurance expenditure respectively.

The organisation of health care funding is not static; indeed, there have been a number of significant changes in recent

years. These have not seen convergence between health care systems; indeed, both the objectives and direction of change vary. The main objectives that lie behind the funding reforms in Europe include a reduction in high labour market costs (e.g. France, Germany), a desire to promote choice and encourage competition in order to increase efficiency (e.g. the Netherlands), the provision of universal coverage for the population (e.g. France, Belgium and southern European countries), reduction of public spending either through the exclusion of services (e.g. over-the-counter drugs, dental care in most EU countries) or by increasing co-payments, and decentralisation of the funding of services (e.g. Italy). Here we highlight some of the most significant trends in both the method and organisation of health care funding in Europe:

- a shift from social health insurance to tax funding in France
- the introduction of insurer competition in Germany and the Netherlands
- the lack of significant growth in the private health insurance market in the 1990s
- increases in user charges and direct payments in several countries resulting from the (partial) exclusion of services from public cover.

SHIFT FROM SOCIAL HEALTH INSURANCE TO TAX FUNDING IN FRANCE

France has recently embarked on reform of health care funding. It is moving away from reliance on social insurance contributions towards a system funded through hypothecated taxes and from a system where eligibility was based on employment to one based on citizenship. The main justification for the diversification of funding sources was the potential negative impact of social insurance on industry. Social insurance contributions were believed to inhibit job creation (international comparisons have shown employment growth in France lagged behind other OECD countries). High wage costs were thought also to deter direct foreign investment.

The proposals, which were announced in November 1995 by the then Prime Minister Alain Juppé, formed part of a broader reform of the French social security system. Economic recession had left the social security budget in chronic deficit since 1991. The reform was therefore also driven by a desire to reduce the deficit and contain public expenditure. The main proposals in the areas of health care funding were as follows:

- reduction in the employee contribution from 5.5 per cent (1997) to 0.75 per cent of income (2000), combined with an increase in the general social contribution (GSC) tax (first introduced in 1991) from 3.4 per cent up to 7.5 per cent (depending on type of income) and earmarking this for health care
- introduction of a new social debt tax (*Remboursement de la Dette Sociale*) of 0.5 per cent on all income except social assistance and invalidity pensions
- parliament to be given the power to set a global budget for health care*

* This required a constitutional amendment and signified a major shift in power from the social partners who managed the social insurance system to the State.

- establishment of universal health insurance to extend the same benefits to all French residents over 18 years old.[10,11]

Known as the Juppé Plan, these proposals were developed secretly by four special advisers and high-level civil servants, the Prime Minister and the President of the Republic, thus by-passing the usual consultation with interest groups and stakeholders such as trades unions and professional groups. The reactions to the legislation were mixed. The main opposition to the reforms came from the trades unions: 'In general we oppose the tendency towards shifting financing from contribution to taxation. The transfer of financial obligations to the state will imply the transfer of decision-making power, and we are against that.'[12] Under the existing system, trades unions had majority representation on the boards of the funds and were in a powerful position vis-à-vis the government and employers. Under the Juppé Plan, membership of the boards would be split equally between the employers and the employees' representatives, namely the trades unions. There would also be a number of government-appointed members. With the change in funding, the link between employment and social benefits is broken and the role of the trades unions within the system less justified, while control by State and government is enhanced. The industrial action and public opposition to the social security reforms, of which the changes to health care funding were a part, led to the surprise defeat of Juppé at the next election. Radical change can have important political consequences.

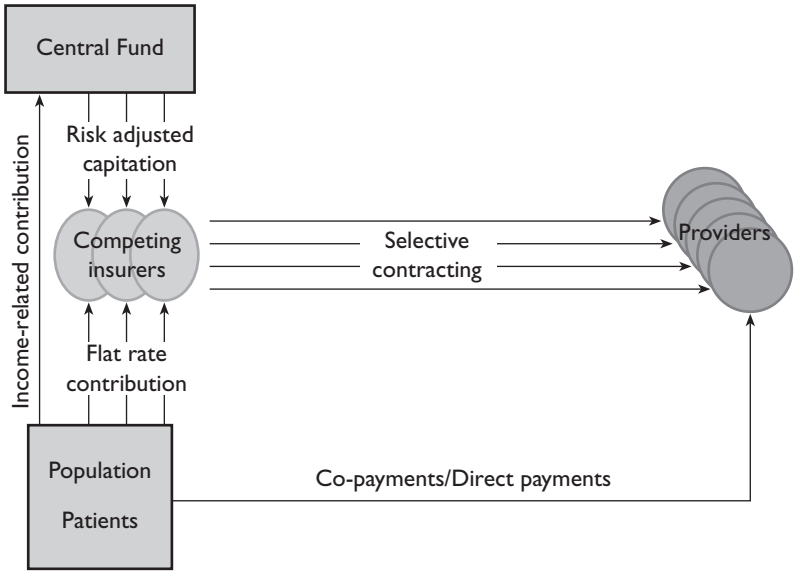
Although the proposals were put forward by a centre-right prime minister, they elicited cross-party support as the principal ideas were social democratic in orientation and they were pursued by a new left-wing government elected in June 1996. The reforms have benefited from sustained cross-party support, as they are seen to be in the economic interests of the country and reduce the burden on labour. Following the introduction and expansion of the earmarked personal income tax, concern in France now centres around the equity implications of such heavy reliance on a proportional rather than a progressive income tax.

INSURER COMPETITION IN SOCIAL HEALTH INSURANCE SYSTEMS

In contrast to France, the Netherlands and Germany continue to rely predominantly on social health insurance. However, they have implemented significant changes to the organisation of social insurance. Up until the 1990s, in all western European countries with social health insurance systems there was more than one sickness fund but little choice, since people were assigned to funds on the basis of their geographical location, occupation or both. The latest trend, most notable in Germany and the Netherlands, has been to expand choice of funds.

In the Netherlands, the introduction of competition was part of an evolving debate on the role of competition that began as early as the 1940s. It mainly centred on concerns to increase the efficiency of the funds and it was expected to lead to rationalisation within the social health insurance system. The concrete proposals were put forward in the report of a government committee, chaired by W Dekker, former Chief Executive of Philips. The changes to the health insurance sector formed part of a wider restructuring of sick leave and disability insurance. Not all of the

Figure 2: Funding flows in the Dutch health care system



committee's recommendations were adopted, owing to doubts about the ability of the new system to contain costs and strong opposition from interest groups such as the private insurers and employers. However the following proposals were adopted:

- insurers were able to directly levy a flat-rate contribution set by them, in addition to the proportional income-based contribution, collected by the central fund, and the same for everyone regardless of insurer (Figure 2 illustrates how this operates)
- regional restrictions on sickness-fund activity (that had resulted in natural monopsonies) were abolished and new entrants, including private insurers, were allowed into the market
- insurers were allowed to contract selectively with providers and negotiate reimbursement prices lower than those set by the Central Tariff Authority (no insurers were able to do this due to the collusion and strength of the providers)
- insurers were able to restrict the purchase of supplementary insurance products to those subscribers who already had their main insurance from them.[13,14]

In practice, it is not clear from initial assessments to what extent insurer competition is having the desired impact. Because the value of the flat-rate contribution is relatively small (about NLG216, equivalent to £62 per year) and does not reflect the true costs of the

insurance, price competition is very limited. It is likely that other factors such as a conveniently located insurance office or choice of fund of other family members will have more impact. The number of people who exercise their right to move funds is very small but has been increasing since the introduction of competition.[15]

One effect of the changes has been the emergence of private insurers who are active in the statutory insurance market. The established sickness funds, however, continue to dominate regional markets for statutory insurance. Choice of fund has prompted an accelerated process of mergers and acquisitions, and between 1985 and 1993 the number of insurers fell from 53 to 26. By 1999, there were 30 funds operating nationwide, with an average membership of about 300,000 persons (with a large variation in membership, ranging from less than 1000 to over 1 million). This suggested that when faced with competition, multiple insurers merged to benefit from economies of scale.[16]

Prior to 1996, German social health insurance was partly segmented according to occupation, and thus there were large differentials in contribution rates between the sickness funds (e.g. high-risk occupational groups were subject to the highest rates).* The Health Care Structure Act (GSG), which was passed in 1992 and came into effect in 1993, marked a major structural change in social health insurance. It granted equal legal status to manual and salaried workers (i.e. extended the right to change funds) and introduced cross-subsidisation between funds. In Germany, the expansion of choice of sickness fund to all workers was partly motivated by a desire to reduce labour costs and to reduce the variation in contribution rates. However, the reform proposals also formed part of the political negotiations surrounding unification. Choice of fund for blue-collar workers was a prerequisite for the Social Democrats to accept the Solidarity Pact between West and East Germany.

The impact of the expansion of choice of fund in Germany was a reduction in variation in contribution rates. In 1994, 27 per cent of all members paid a contribution rate differing by more than 1 per cent from the average. This has reduced to only 7 per cent of all members in 1999 following enactment of the legislation. Data shows a shift away from the AOKs (general funds) (a net loss of 1.2 million members from 1997–99) to BKKs (occupational funds) (a net gain of 1.8 million members over the same period), which correlates with contribution rates.[17] Population surveys showed that in Spring 1999 only 7.3 per cent of the population had changed funds since 1996. Those who switched are more likely to have no dependants, to be from the former East Germany, under 40 years old and without chronic conditions. Price was mentioned most frequently by respondents as the reason for switching fund. Other reasons mentioned frequently were changing job, recommendation of a friend or acquaintance, unhappiness with the service and better coverage through the new fund.[18] However, it was not the explicit intention of the reform to encourage as many members as possible to change sickness funds but, on the contrary, that funds should be made to act

* In Germany, choice of funds already existed for white-collar workers but not for the majority of blue-collar workers.

more decisively in the interests of the insurees, above all by actively influencing the quality and efficiency of health care services. Their success in achieving this is more difficult to measure.

Multiple competing insurers may engender greater efficiency but may also bring potential difficulties in ensuring equal access to care for all. Therefore, in order to protect equity, insurers are required to accept all applicants. To stop some insurers from bearing a disproportionate part of the risk or adopting covert forms of cream-skimming, a mechanism for adjusting for risks is required. Risk adjustment in the Netherlands is performed by the central fund, which collects contributions from employers and employees. It then makes adjusted capitation payments to the funds. In Germany, where contributions are collected directly by the sickness funds, the adjustments are made by low-risk funds giving money to high-risk funds. Thus, the transfers are more visible in the German system.

PRIVATE HEALTH INSURANCE

The structure of private health insurance markets varies considerably between EU member states but growth in the private health insurance market has been stagnant in recent years. There are several reasons why this might be the case:

- the State continues to provide comprehensive benefits
- participation in the statutory health sector is compulsory in all countries (with some exemptions for some income/professional groups in Germany, the Netherlands and Spain)
- governments have tended to rely more on user charges as a method of shifting health care costs onto consumers, rather than promoting and subsidising private health insurance
- consumers' preference to pay their doctor or hospital directly, rather than entrust a third party in southern Europe.[19]

Growth has mainly been in the group insurance sector, where premiums are usually cheaper (partly because of the greater purchasing power of an employer but also because risks are spread across all employees, i.e. there is group rating). There is no deliberate or explicit policy of encouraging individuals to take out private health insurance through the use of tax subsidies in seven of the EU member states. Voluntary health insurance receives generous tax relief in Ireland. Given at the standard rate of income tax (27 per cent), tax subsidies of VHI cost the Government £50 million a year (2.5 per cent of public expenditure on health in 1997). However, some countries have removed such incentives, especially for wealthy/high-rate taxpayers. Examples include Austria, where since 1996 private health insurance premiums are no longer tax deductible for those with annual incomes over SCH700,000 (equivalent to about £32,000), and in Spain where the 15 per cent tax deduction on premiums for medical expenses insurance was abolished in 1999.[19]

The role of the private health insurance market is more significant in Germany and the Netherlands, where it is the sole form of cover for a section of the population. This is not a recent change but has been the character of health insurance for a long time. In Germany, those who are eligible (i.e. with annual income over DM77,400 (£25,000) for those living in western Länder and DM63,900 (£21,000) for those in eastern

Länder) may choose to opt out of the statutory scheme and purchase private health insurance. In the Netherlands, all those people whose annual income exceeds NLG64,600 (around £19,000) are excluded from the statutory health insurance scheme. Nearly 98 per cent of them purchase private health insurance; the remainder choose to pay out of pocket.

The choice to remain in the statutory system or to purchase private health insurance is open for about 21 per cent of the German population (the self-employed are excluded from the statutory scheme, as are permanent public employees). In total, 7 per cent of the population (or 7.1 million people) choose full-cover private health insurance,* while 14 per cent of the population are voluntary members of the statutory scheme. In other words, only a third of those who are eligible to go private choose to do so. Private schemes are likely to be more attractive, particularly for single people or couples where both partners work. However, for most of those who are free to choose, the statutory scheme is both cheaper and less risky – dependants are covered 'free' in the statutory scheme and there are restrictions on re-entering the statutory scheme once the right to opt out has been exercised.

SHIFTING COSTS TO PATIENTS

There has been a significant increase in the amount of health care funded directly by patients, either in the form of user charges in the public/private sector or direct payments for services. The direct purchase of services is a significant consequence of rationing policies that exclude services or treatments from cover. These are significant in the areas of dental care and pharmaceuticals, where drugs may be de-listed (negative list) or else authorised for sale over the counter.

User charges in the public system are a direct result of policy to expand private funding for health services. For example, in Germany the government increased user charges when global budgets were abolished, with the hope of compensating for loss of expenditure control. In Finland and Denmark, user charges were increased following economic recession when national and local funding from taxation was squeezed. There are no randomised control trials of the effect of user charges on utilisation in Europe; most studies trace the effect of a policy change. The evidence from Sweden, France and Denmark does suggest, however, that user charges increase inequalities in access to health care.

Research in Sweden found that in the 1960s high-income groups had higher utilisation of health services. Following a reduction in user fees, results from the 1970s and 1980s showed there were no socio-economic differences in the proportion of the population who visited a doctor, after health status was controlled for. The analysis using data from the 1990s shows the re-emergence of inequalities in utilisation in Sweden favouring the better-off following the major increases in user charges.[20]

In France and Sweden, one in four and one in five people respectively declared they had been put off seeking care for financial reasons. In both countries, women, older people and the unemployed form a large proportion of those not seeking care. Elofsson, Unden and Kradau

* Another 2 per cent who are self-employed or public employees have private health insurance.

have shown in the Stockholm area that patient charges were a hindrance to financially and psychosocially disadvantaged groups seeking care. Those who assessed their financial situation as poor were ten times more likely to forego care than those who assessed their financial situation as good.[21,22]

In Denmark, significant increases in user charges for dental care between 1975 and 1990 showed that despite an overall increase in demand, since 1990 household income has been a positive factor in determining the probability for regular dental care, i.e. utilisation was higher at higher incomes.[23] There is little evidence as to how user charges affect health outcomes, but despite the limitations of the research it seems that user charges cause problems for some socio-economic groups in accessing health care services.

CONCLUSIONS

It seems that, at least for the time being, there is a consensus in favour of taxation as the main source of funding for the UK NHS. It has been argued that as long as equity remains of paramount concern, taxation will be favoured over other alternatives.[24] However, experience from the rest of Europe suggests that even when other concerns, such as the economy, are given priority, taxation fares well. Debates in France and Germany centre around the negative impact of social health insurance on the economy. Through the introduction of a health tax and by setting an annual global budget for health, the French state has recently adopted a more interventionist approach. In Germany, the introduction of insurer competition was aimed at reducing contribution rates.

In no country in Europe, with the exception of the Netherlands, does private health insurance account for more than 10 per cent of total health care expenditure. Public policy tends to favour the use of public revenues to ensure universal access to a comprehensive range of services rather than promoting the purchase of private health insurance.

Other countries with traditional welfare approaches to the funding and provision of health care, such as in Scandinavia, did increase the role of user charges. Nonetheless, there is some evidence to show that user charges have acted as a barrier to access, and this policy has attracted criticism and is likely to be reconsidered, at least in Sweden.

If the debate on funding in the UK is closed for the time being (at least until there is a downturn in the economy), we must go beyond questions of how much to spend on health care or how to generate resources. It is also important to examine how the money is spent and what outcomes are achieved.

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