

POLICY SUMMARY I

# Addressing financial sustainability in health systems

Sarah Thomson, Tom Foubister,  
Josep Figueras, Joseph Kutzin,  
Govin Permanand, Lucie Bryndová

## POLICY SUMMARY 1

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*Policy summary prepared for the Czech European  
Union Presidency Ministerial Conference on the  
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## Authors

**Sarah Thomson**, Research Fellow, European Observatory on Health Systems and Policies, and LSE Health, London

**Tom Foubister**, Research Officer, LSE Health, London

**Josep Figueras**, Director, European Observatory on Health Systems and Policies, Brussels

**Joseph Kutzin**, Regional Adviser, Health Systems Financing, and Head of the WHO Office, Barcelona

**Govin Permanand**, Programme Manager/Technical Officer, Health Evidence Network, WHO Regional Office for Europe, Copenhagen

**Lucie Bryndová**, Adviser to the Minister of Health, Cabinet of the Minister, Prague

## Preface

At the invitation of the Ministry of Health of the Czech Republic, this document is one of three reports produced by the Health Evidence Network and European Observatory on Health Systems and Policies for the Czech European Union Presidency Ministerial Conference on the Financial Sustainability of Health Systems (Prague, 10–12 May 2009):

1. Addressing financial sustainability in health systems – Policy summary
2. How can health systems respond to population ageing? – Policy brief 10
3. How can European states design efficient, equitable and sustainable funding systems for long-term care for older people? – Policy brief 11

These reports reflect key priority areas for European health systems, and ones where learning from comparative experience is crucial to informing future policy choices.

This report (Report 1) is a policy summary which underpins the key theme of the conference – financial sustainability in health systems. The report touches on the myriad elements involved in discussions on financial sustainability, and emphasizes the need for a clarification of the key concepts as a prerequisite to understanding both what is at stake and what is involved, in order to then consider potential policy decisions. Given the high level involvement at the conference, and towards enhancing the empirical relevance of the report and the research evidence it synthesizes, an earlier draft for consultation was presented at the conference. The current version represents the final report, taking into account the feedback received.

Reports 2 and 3 are part of the joint Health Evidence Network-European Observatory on Health Systems and Policies policy brief series. The reports aim to respond to policy-makers' needs through the provision of accessible syntheses of the available research evidence, along with a discussion of the implementation issues around particular policy options.

Earlier versions of the reports were presented during a review workshop hosted by the Czech Ministry of Health on 3 December 2008, involving the authors, representatives of the Czech Ministry, country experts, and key technical staff from the World Health Organization, the European Commission, the World Bank and the Organisation for Economic Co-operation and Development. The feedback and input received from the workshop participants were used in developing the final reports.

# 1 Introduction

The question as to whether health systems will be financially sustainable in the future is frequently raised in health policy debate. The problem is often phrased in terms of the ability of governments and others adequately to finance health care in the face of growing cost pressures, with population ageing, new technologies and consumer expectations around health care coverage and quality being the three most commonly cited challenges. Although the notion of 'financial sustainability' appears to be central to health policy debate, it does not form part of most health system objectives, including those of the World Health Organization's health system performance framework (1). Moreover, there is little clarity or consensus about the term's meaning, beyond it having something to do with 'ability to pay' or 'affordability'. Nevertheless, the underlying 'sustainability' issue – balancing rising cost pressures against limited resources – is a concern across countries, all the more so in the context of the current financial crisis. Inevitably, this means addressing trade-offs, both within the health sector itself and more broadly between the health sector and the rest of the economy.

This policy summary, prepared for the Czech European Union Presidency Ministerial Conference on the Financial Sustainability of Health Systems (Prague, 10–12 May 2009), aims to shed light on the notion of financial sustainability and to examine its policy relevance in practical terms. Without a better understanding of what is meant by financial sustainability and, importantly, without explicitly linking the issue to questions such as willingness to pay for health care, the value of the benefits gained from health spending and how to improve the performance of the health system, policy responses to sustainability concerns may be misdirected and yield unintended consequences. This policy summary shows the limitations of adopting financial sustainability as a 'policy goal', arguing instead that it should be understood as a 'policy constraint', and translating this notion into three key policy-relevant questions. First: 'how much should we spend on health care?' This raises questions about the value of the benefits gained from health spending against other sectors of public expenditure, and the extent to which societies are willing to pay for health care on a collective basis. Second: 'what level of coverage should we provide?' This brings up issues of solidarity and distribution of benefits between population groups. And finally: 'how do we increase value from existing health system resources?' In other words, how can we improve performance while respecting budget constraints?

Following this approach, Section 2 below examines the challenge of financial sustainability, both in terms of unpacking the key elements and thinking, and with respect to the practical implications for policy and policy-making. Sections 3 to 5 correspond to each of the questions above, and thus focus on the three

main ways of addressing the sustainability 'problem'. Section 3 considers how countries might decide how much to spend on health care. Section 4 looks at what level of coverage should be provided and, more specifically, at the implications of different ways of reducing the breadth, scope or depth of health care coverage. Section 5 focuses on improving efficiency and briefly outlines how policy-makers might enhance value in the way in which they finance and provide health services. Section 6 summarizes and concludes.

It is, from the outset, to be noted that this document focuses on health systems, which include the delivery of health services (both personal and population based), the activities to enable delivery (finance, resource allocation and stewardship) and also those stewardship activities aimed at influencing health determinants in other sectors (1,2). However, the discussion puts more emphasis on the sustainability of health care, reflecting much of the current political debate and the availability of expenditure data (mostly coming from curative health services). Nevertheless, this should not be taken as an indication of relative importance. On the contrary, as discussed below, in many instances increasing spending on or reallocating resources towards public health interventions (within the health sector or in other sectors) will maximize health gain and may therefore help to address sustainability challenges.

## **2 Understanding the challenge of financial sustainability in health**

Health system sustainability is frequently debated in policy circles and the media. Yet debate is rarely, if ever, accompanied by a clear idea of what it means for a health system to be financially sustainable or how we might assess a health system's financial sustainability or, indeed, what the policy implications of the problem are. The likely reason for this is that the meaning of financial sustainability is taken to be self-evident: the presence of an imbalance between the obligations that a health system has in respect of entitlements and instituted rights on the one hand, and its ability to meet those obligations on a continuing basis on the other (3). Although this formulation is accurate, it is inadequate. It tells us only how the problem of financial sustainability manifests itself – namely as a problem in accounting. As such, it tells us that expenditure and revenue must be aligned. But it does not tell us anything about the nature of the problem itself – that is, about what causes the imbalance between expenditure and revenue. Nor does it tell us anything about the problem's policy implications; and in particular, it does not tell us anything about the level at which expenditure and revenue should be aligned.

The problem of financial sustainability can be broadly characterized in three ways.

- First, increases in health spending due to factors affecting demand for and supply of health services – among them, technological progress, demographic change and consumer expectations.
- Second, resource constraints relating to government inability or unwillingness to generate sufficient resources to meet its health system obligations – an issue which takes on particular relevance in the current context of financial crisis. This is the issue of fiscal sustainability or fiscal balance.
- Third, health spending is rising as a proportion of gross domestic product (GDP). If this spending grows at a faster rate than spending in other parts of the economy, and therefore consumes an ever greater share of GDP, there is a concern that at some point it will eventually ‘crowd out’ expenditures on other goods and services that provide welfare gain. This is the issue of economic sustainability.

The challenge in each case relates to the ability and willingness to pay for health care in the face of rising costs and resource constraints. Whether or not the economy can sustain higher levels of spending on health care, and how much a country can or should spend, is an issue we discuss in more detail in Section 3. First, however, we look briefly at why health care costs rise, before focusing on fiscal sustainability, which is often put forward as a central objective guiding policy development.

## 2.1 Why does the cost of health care rise?

From the considerable research into why health care costs are rising across Europe (4,5,6,7), the drivers that receive most attention are associated with the increasing volume of services used. These include advances in technology and the associated changing patterns of utilization, and population ageing coupled with rising income and expectations. As each of these factors carries implications for our broader discussion on financial sustainability, we briefly address each one in turn.<sup>1</sup>

Technological innovation is the most important driver of health care costs, estimated to account for between a half and three quarters of all growth in health care spending (8,9). However, the role played by technological change is complex. New technologies can reduce costs through efficiency gains or through health improvements that reduce the need for further and perhaps more costly care. But they can also lead to higher costs: by increasing utilization; by extending the scope and range of possible treatments available;

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<sup>1</sup> See the policy brief by Rechel et al. (2009) (15), also produced for this conference, and Busse et al. (2008) (16,17).



by extending treatment to a wider set of indications and to more people (expansion); by replacing an existing and cheaper technology (substitution) (10); and, even if not more expensive, by being applied more widely within the relevant patient population than the existing technology (a combination of substitution and expansion).

Demographic trends in Europe, which reflect falling fertility rates and rising life expectancy, indicate an increasing proportion of people aged 65 and older. This has fuelled concerns about the future health and long-term care costs of caring for an increasingly older population. However, both past analyses and future projections show that the contribution of population ageing to rising health care costs is relatively small in comparison to technological innovation (less than 10 per cent of the growth in health care costs) (4, 11, 12, 13, 14). Earlier scenarios that predicted an explosion of health costs caused by an ageing population are being challenged by new research, including that based on the 'compression of morbidity' hypothesis (longer life expectancy with less time spent in poor health); 'the costs of dying' which fall as age at death increases; 'utilization rates' being lower among the very old and 'lifetime health costs' reduced in 'healthy ageing'. This underlines a central point in our discussion, namely that increased investment in appropriate health system interventions, such as early prevention or improving the control of chronic diseases, may lower future health care costs and thus contribute to addressing financial sustainability concerns (15).

The role of rising income and higher expectations as factors believed to drive up costs is also complex. First, health care expenditure is closely related to national income: research suggests that health spending tends to rise roughly proportionately with economic growth. However, debate continues about the extent to which health care is a 'normal' good (income elasticity that is close to one) or a luxury good (higher income elasticity), where health care expenditure will increase at a higher rate than income. Second, given that responsiveness is now recognized as a central goal of the health system in its own right, health systems are under greater obligation to respond to people's concerns about quality and access to health services. However, the extent to which expectations can and do actually lead to increased health care costs in practice remains unclear (16, 17).

## **2.2 Fiscal sustainability and balance: independent policy objective or constraint?**

Rising health care costs would not present as an acute a problem were resources not limited. Given the reality of resource constraints, rising costs put great strain on government budgets. How policy makers perceive the relation between rising costs and resource constraints has important implications for

how the problem of financial sustainability is viewed. Should financial sustainability be taken as an independent end or policy goal, on a par with other policy goals, or should it rather be seen as a constraint to be respected in the pursuit of health system objectives?

Fiscal sustainability has been defined as “... the capacity of a government, at least in the future, to finance its desired expenditure programs, to service any debt obligations ... and to ensure its solvency” (18). Under this definition, the sustainability challenge presented by a fiscal constraint can be ultimately understood as an accounting problem in which there is a need to align public revenue and expenditure (including debt service). The translation of this concept to the health sector is not straightforward, however. If the need to achieve fiscal balance in the health sector is seen as imperative, then it is easy to see the need to secure financial sustainability as an objective in its own right, independent of and on a par with (or even overriding) other objectives for the health system, for example health gain, efficiency, quality or equity. This approach has the advantage of simplifying policy responses to the fiscal constraint: if governments are unable or unwilling to increase revenue, they will have to cut spending, which means a potential reduction in coverage and in the ratio of public to private spending.

There are, however, three major limitations to viewing the problem in this way. First, it may not make sense to link the financial sustainability of the health system exclusively to fiscal balance or to see it as an independent policy objective – for if this way of thinking is taken to its logical conclusion, the most financially sustainable health system would be no health system at all. Policy-makers are instead concerned about their ability to perpetuate the health system in such a way as to ensure that it continues to meet its objectives in the future.<sup>2</sup>

Second, viewing the financial sustainability of the health system as a policy objective in its own right may place the policy focus on achieving fiscal balance, without regard for the consequences of the methods used to achieve this goal. Policy-makers might be indifferent in choosing between a range of options for reducing health care coverage – even if the options had very different consequences for equity and efficiency – so long as each option offered the potential to achieve fiscal balance. Thus, a health system that managed to achieve fiscal balance by increasing user charges or cutting cost-effective interventions might eliminate its budget deficit, yet significantly undermine the goal of financial protection and health gain.

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<sup>2</sup> Having this ability implies that the expenditure commitments in the health sector will not damage the government’s long-term financial position (19).

Third, a singular focus on achieving fiscal balance may distract attention from other factors contributing to fiscal imbalance, in particular efficiency problems. Coverage reduction aimed solely at securing sustainability by containing costs may not only fail to address underlying efficiency problems, but may actually exacerbate them – whether as a result of the form of coverage reduction adopted (e.g. by cutting cost-effective interventions) or in the form of bringing about an inefficiently low level of spending from an overall social welfare perspective.

It is useful, therefore, to consider the need for achieving fiscal balance as a constraint to be respected rather than as an objective to be pursued for its own sake. Both views give importance to achieving and maintaining fiscal balance, but whereas the latter says it does not matter how this is achieved, the former says that how fiscal balance is achieved does matter. It allows policy-makers to focus on how best to maximize the attainment of the health system's objectives subject to the constraint that the growth of public expenditures and revenues be aligned. Instead of asking 'how much is the government able to pay for health care?' the question becomes 'what level of attainment of the health system's goals is the government willing to pay for?' In other words, the issue is not about sustaining the system overall but about sustaining its performance.

Focusing on the attainment of health system objectives subject to the requirement of fiscal balance provides policy-makers with a range of criteria to assist decision-making. This may clarify the choice of options for addressing the fiscal constraint because the trade-offs can be made explicit – the consequences of choosing one option over another begin to matter. It also enables policy-makers to address fundamental underlying questions about why health care costs rise and whether spending on health care produces sufficient value (both within the health sector and relative to other sectors) to justify its cost.

The level at which expenditure and revenue should be aligned should be that which maximizes the attainment of health system objectives subject to the requirement of fiscal balance, which in turn depends upon what is going on in other areas of government spending, and on the value to be had from spending on health relative to the value to be had from spending elsewhere. To be solely concerned with fiscal balance, on the other hand, is to ignore the necessity of getting the level of alignment right and thereby to risk introducing inefficiency and inequity into the system.

In summary, rising health care costs combined with resource constraints present policy-makers with the challenge of ensuring that the health system continues to meet its objectives in future. Equating financial sustainability with fiscal balance and viewing it as a policy objective in its own right may result in inappropriate policy choices, which may fail to alleviate pressure on the public budget and may have negative consequences for other health system objectives.

The remainder of this policy summary focuses on the three options available to policy-makers to decide how best to meet the health system's objectives in the face of rising health care costs and resource constraints. The first is to increase revenue for the health system and the services it provides, which raises the question of how much to spend on health care. Second, policy-makers can cut spending by reducing services, which addresses the question of what level of health care coverage to provide. Finally, policy-makers can attempt to get better value from existing health system resources (i.e. greater levels of attainment of policy objectives); that is, how best to improve health system performance.

### 3 How much should we spend on health care?

How much a country should spend on health care is not a straightforward question. The decision about the 'right' level of spending is determined by a wide range of factors, most of which are context specific. This section begins with an assessment of country variation in levels of public spending on health care, showing how, to a significant degree, these reflect a political choice about how much to invest in the health sector in absolute terms and relative to other sectors. Next, the section touches on the notion of economic sustainability, discussing a range of arguments about the macroeconomic impact of health care spending. The argument here is that channelling resources into the health system does not need to be a burden on the economy, but rather may result in substantial economic and welfare benefits. Before deciding to increase the level of funding, however, policy-makers need to bear in mind a number of considerations about the degree of benefit from different types of spending and the distribution of benefits across the population. These are addressed in the final component of this section.

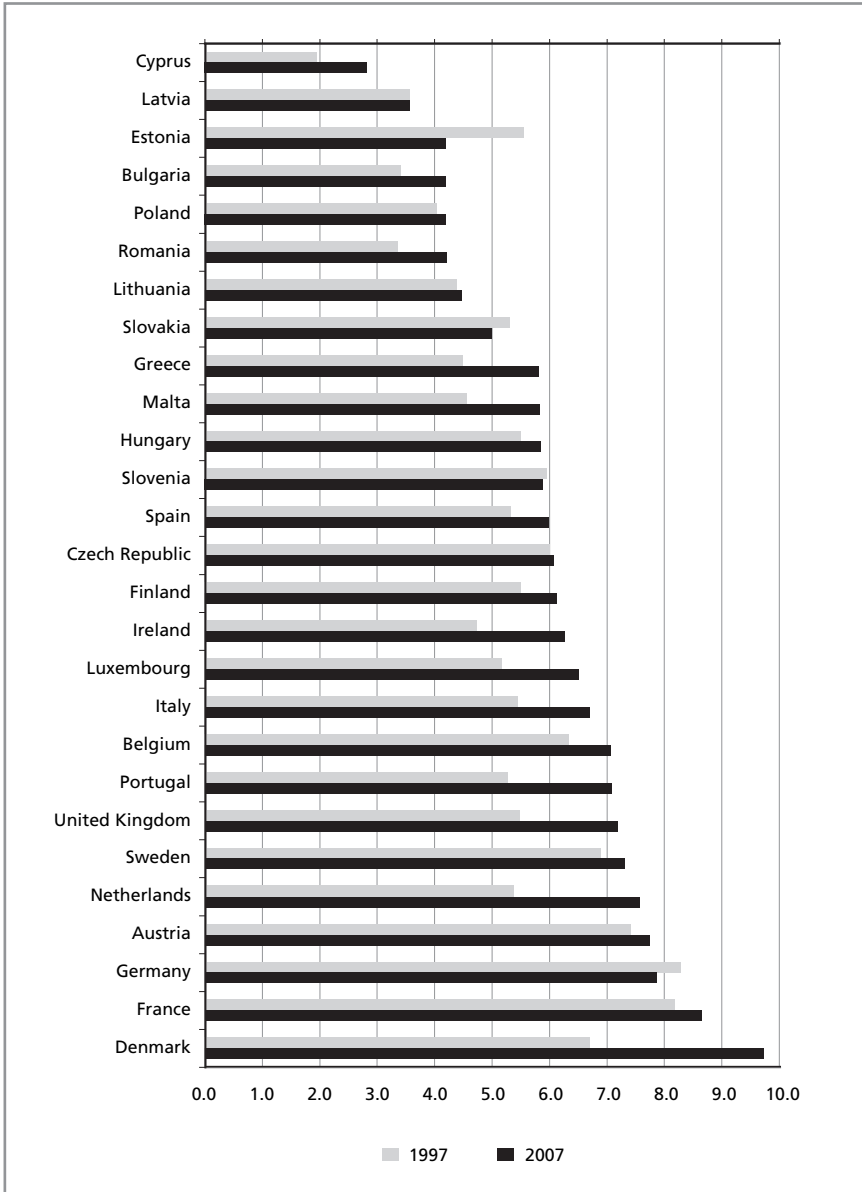
#### 3.1 Public spending on health: a reflection of political priorities

In most high- and middle-income countries the government pays the bulk of health care costs. The extent of government involvement in financing health care is demonstrated in Fig. 1, which shows levels of public spending<sup>3</sup> on health as a proportion of GDP in European Union (EU) countries (1997 and 2007). The graph indicates wide variation in this indicator across countries in each year and shows that public spending on health has increased as a share of GDP in 22 of the 27 countries.

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<sup>3</sup> More precisely, this refers to revenue from compulsory sources, such as government general revenue derived from various forms of taxation, compulsory contributions for health (typically in the form of 'payroll taxes', often referred to as social health insurance contributions), or a combination of these.

**Fig. 1. Government health spending as a percentage of GDP in current EU countries, 1997 and 2007**



Source: WHO 2009 (81).

Total government spending as a percentage of GDP indicates the size of the public sector in the economy. It is one way to capture the 'fiscal context' of a country, although a more complete picture would also incorporate total public revenue and the extent of any deficit. And in many cases, the overall level of public revenue is not simply a contextual factor. It may also reflect political choices about how much tax revenue to collect. Figures for EU countries in 1997 and 2007 are shown in Fig. 2 and again reveal wide variation. The data also indicate that in only seven countries has the size of the public sector increased as a percentage of GDP during this period. The public sector's share of the economy has thus become smaller in most EU countries over the past decade.

Figures 1 and 2 present a contrasting picture: the size of the public sector in the economy of most EU countries has shrunk, but public spending on health as a share of GDP has increased. What accounts for this? The answer is found in Fig. 3, which depicts health as a percentage of total public spending. This indicator is a reflection of the priority<sup>4</sup> that governments accord to health (or more precisely, to health spending) in their resource allocation decisions. In 24 of the 27 EU countries, this 'priority for health' increased between 1997 and 2007, and in some countries (e.g. Denmark, Ireland, the Netherlands, Lithuania) substantially so.

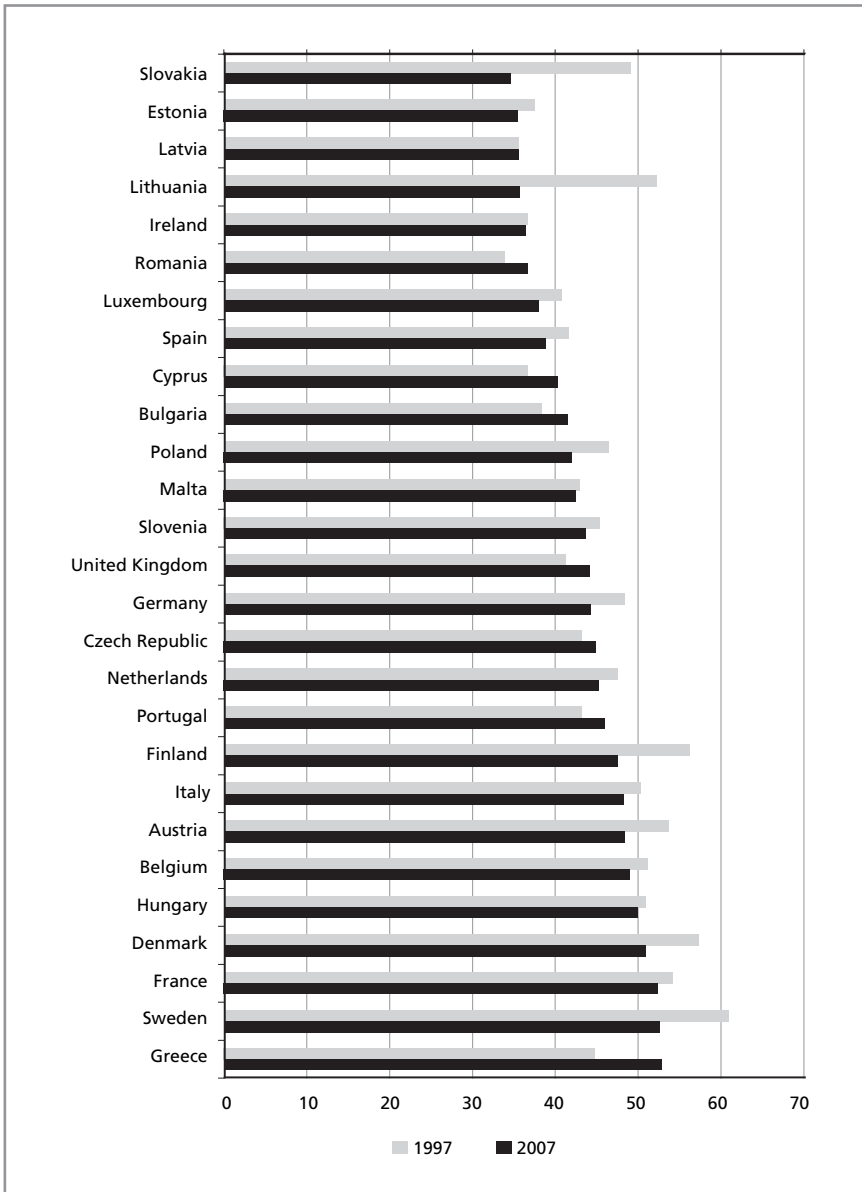
The challenge of applying the concept of fiscal sustainability to the health sector (21) is reflected in the fact that the 'budget constraint' implied by the need to maintain fiscal balance can be altered by political choices. In this regard, the expenditure data portrayed in the three figures suggest that most EU governments, at least over the past decade, have chosen to increase their level of public spending on health, presumably with the intention of sustaining increased attainment of health policy goals, even as their overall fiscal constraints tightened.

Another way of demonstrating the political dimension of sustainability is to examine trends in the size of the public sector and budget allocations within a given country. In Estonia for example, public spending on health declined from 5.9% of GDP in 1996 to 4.1% of GDP in 2003 (21). This was partly due to an overall fiscal contraction, with total government spending falling from more than 42% of GDP to slightly less than 37% of GDP over this period. At the same time, health fell from 14% to 11% of total government spending, and

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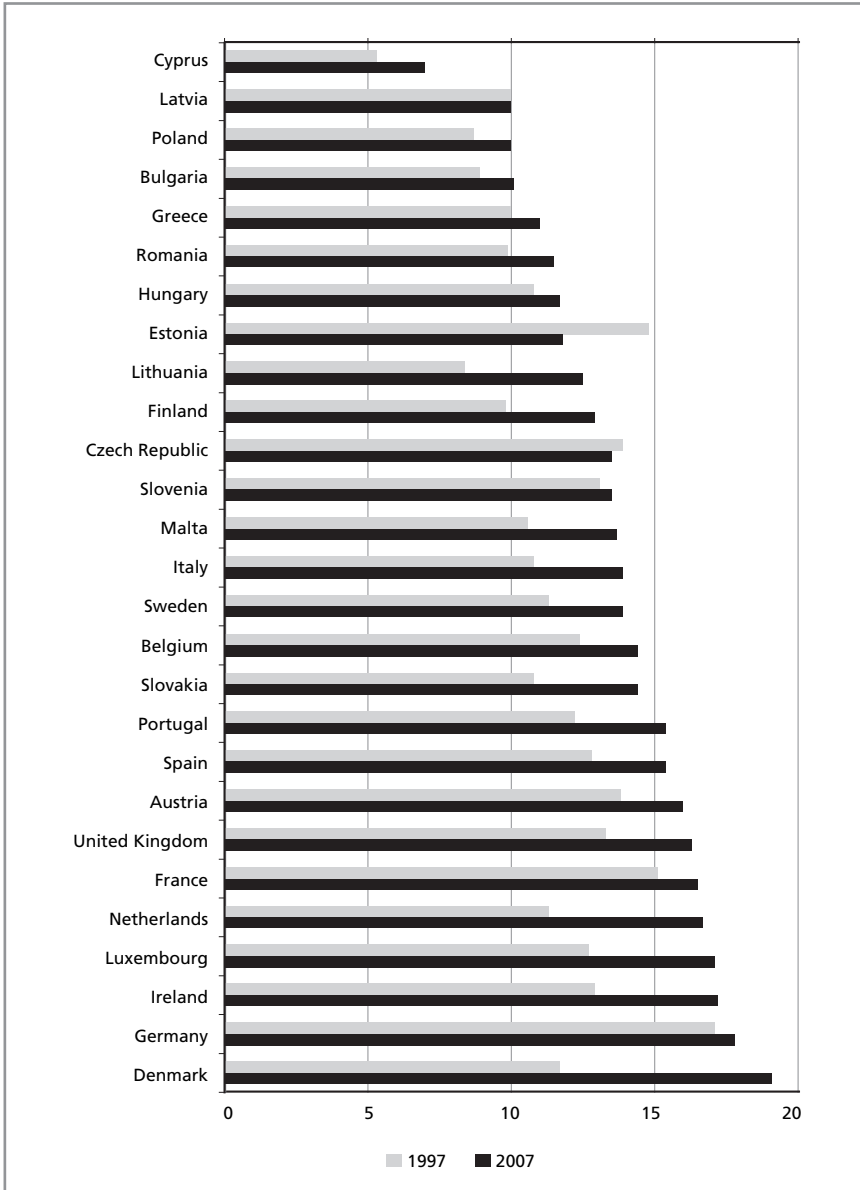
<sup>4</sup> The *ex post* observation of public expenditure levels may not reflect explicit *ex ante* decisions about priorities. This is demonstrated by a non EU example: Switzerland. Public spending on health has been consistently more than 18% of total public spending since 2002. While some of this reflects explicit decisions such as increased public subsidies to ensure universal health insurance coverage, it also reflects decisions of local government authorities to cover the deficits of their public hospitals (20).

**Fig. 2. Total government spending as a percentage of GDP in current EU countries, 1997 and 2007**



Source: WHO 2009 (81).

**Fig. 3. Health as a percentage of total government spending in current EU countries, 1997 and 2007**



Source: WHO 2009 (81).



out-of-pocket spending rose from 11.5% to over 20% of total health spending. If spending on health as a share of total public spending had remained at the 1996 level, then government health spending as a share of GDP would have equalled 5.1% in 2003. In effect, the government chose to sustain a lower level of financial protection by reducing the priority accorded to health in total public spending.

The issue of whether or not public spending on health care is financially sustainable mainly arises in the context of unwillingness to pay more for health care through taxes. There are many reasons why fiscal policy varies across countries, and reluctance to introduce higher taxes for health care may be underpinned by valid technical and political considerations. For example, if taxes for health care are primarily levied on wages, there may be concerns about the effect of raising taxes on the labour market. More generally, there may be concerns about the effect of higher taxes on economic incentives (productivity) and competitiveness. Voter preferences also influence fiscal policy. People may resist paying higher taxes to finance health care if, for example, they are unwilling to further subsidize the health care costs of others, or they are not satisfied with the quality of publicly financed care and would prefer to pay more privately, or if they are concerned about waste in the health system.

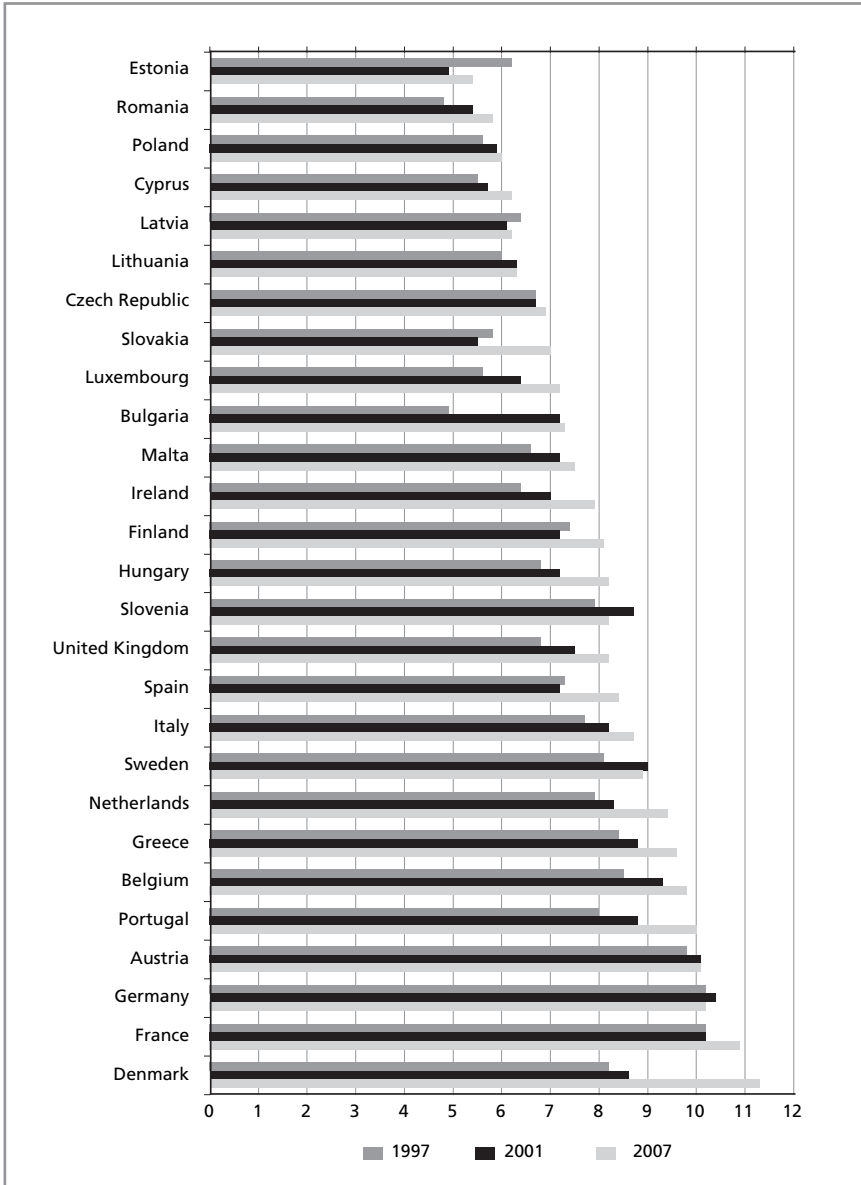
The extent to which public choice reflects concern about higher tax burdens or reduced opportunity for tax cuts is an empirical question that may not be easy to answer. But it is one that is worth considering. For if higher spending on health care is seen to be affordable for the country as a whole, and if it is seen to be desirable because it enhances social welfare, then the question of whether or not this spending is financially sustainable only really arises if there is unwillingness to pay for it, collectively, through government spending. In this sense, it may be said that "the debate over health care is less a pure macroeconomic issue than an exercise in the political economy of sharing" (22).

This section has argued that to a large extent the level of public spending on health reflects a political choice or government willingness to pay. Such choices can be influenced by the evidence on and perception of the impact of health spending on the economy, to which we now turn.

### **3.2 The economic impact of health spending**

When commenting on the share of the economy devoted to spending on health care (Fig. 4), people frequently question the economy's ability to sustain what is seen both as a high level of spending and a high rate of growth in spending (i.e. economic sustainability). Central to understanding this concern is the concept of 'opportunity cost'. Although health spending contributes to social welfare, so too do things such as food, education and leisure. Since

**Fig. 4. Total health spending as a percent of GDP in current EU countries, 1997, 2001 and 2007**



Source: WHO 2009 (81).

resources are finite, at a given point in time, the resources we allocate to health care cannot be spent on these other welfare-enhancing activities: allocation to health care has an opportunity cost, which is equal to the value that would have been gained from allocating those resources to their best alternative use. Thus, when people say that growth in health spending is not sustainable, they may be arguing that the opportunity cost of this spending is too high and that more value would be gained from directing resources away from health care towards other uses. Put simply, people may assume that if health care consumes an ever greater share of national wealth (GDP), there will not be enough left to spend on other valued activities.

There are scenarios in which continued growth in health care spending seems less likely to be harmful in this sense. In others, a negative impact may be more likely. In situations of economic growth, even if health care spending is growing as a proportion of the economy, spending on other activities can continue to grow in absolute terms. People will still have more to spend, year on year, on non-health care activities – just not as much as they would have had in the absence of growth in health care spending. In a shrinking economy on the other hand, growth in health care spending as a proportion of the economy will mean an absolute contraction in other areas of economic activity. Non-health activities will not only decline as a proportion of the economy, there will actually be less to spend on them. In this regard, not only is economic recession likely to compound the technical factors affecting fiscal policy, it may also increase voter resistance to growth in health care spending. But we should not assume an automatic link between economic recession and resistance to higher health care spending. People might be willing to spend more on health care and less on other things if they value health care sufficiently or if they see spending on health care as a tool for economic recovery. The question remains therefore: is spending so much on health worth it?

### **3.3 The contribution of health and health care to wealth and societal well-being**

Health contributes directly to societal well-being and wealth creation which justifies spending on health and, to the extent that health care improves health, on health care. The evidence underlining this proposition can be grouped into three main categories: the direct contribution of health to societal well-being; the effects of ill health on economic productivity; and the impact of health on health care expenditure (23). These are summarized below.

Any decision on health spending is underpinned by the value that individuals and societies attribute to better health, independent of the consequences of ill health on the economy. Quantifying this, or comparing it to the value attached to other components of societal well-being, is not straightforward. A number

of approaches, such as 'willingness to pay' methods, may, however, help to attribute an explicit economic value to health and compare it to standard economic measures such as GDP. In spite of significant methodological complexities, studies introducing the value of mortality reductions into national income accounting ('full income' measures) show the very substantial impact that health improvements have on societal welfare, even when using cautious scenarios and wide sensitivity analysis. This approach has already been used to show that, in a selected number of western European countries, the social welfare gain from increases in life expectancy between 1970 and 2003, when measured in monetary terms, was equivalent to between 29% and 38% of the nominal GDP increase over this period (24).

There is sound theoretical and empirical support for the argument that human capital contributes to economic growth (24,25,26,27). Since health is an important component of human capital, it follows that health is linked with economic outcomes at both individual and country levels, and contributes via four pathways: securing labour supply – healthy people are more likely to be employed than those in poor health; higher productivity – when at work they are likely to be productive, and through skills and the savings that become available for investment and physical and intellectual capital; investment – because healthy people can expect to live for a long time, they might invest time and money in their education (itself a driver of economic growth); and saving – longer lives allow more savings for retirement, providing money for capital investment.

It is suggested that spending on health now will save money in the future – that is, healthier people will need less care and cost less. This thinking underpinned the influential 2002 Wanless report, which recommended increased investment in prevention to address the future financial sustainability of the National Health Service (NHS) in the United Kingdom (28). Other authors have suggested the opposite – better and longer life expectancy will increase future health care spending. As noted earlier, however, the latter view is undermined by recent evidence on compression of morbidity and on the impact of prevention on lifetime costs through lower morbidity and lower costs of dying at older ages.

These three lines of argument support the proposition that societies should spend on health. However, if policy-makers are to make this case effectively, they need to demonstrate that health systems merit investment because they improve health and do so cost-effectively. While there are difficulties in attributing population health gain to health care interventions, the evidence is fairly consistent in showing that around half of the life expectancy increases in recent decades can be attributed to improved health care. This is further underlined by reductions in 'mortality amenable to health care' (see below). On

average, amenable mortality still accounts for a quarter of all mortality, and thus highlights the scope for health care and the role that further spending could play in achieving mortality reductions, with all the associated economic benefits.

A further challenge revolves around providing definitive evidence on cost-effectiveness and on which interventions represent the 'best buys' to guide allocation decisions. National health technology assessment (HTA) agencies and international initiatives such as the WHO CHOICE programme are examining these issues and provide, for instance, assessments based on cost per Quality-Adjusted Life Year (QALY) obtained from alternative interventions, which can help guide spending decisions (29). There is evidence to show that health care is very good at producing value, and that the returns on health care spending are high enough to make this spending 'worth it'.

While the focus of this report is primarily on the health care component of the health system, policy-makers will need to look across care boundaries and at public health interventions across sectors. There is considerable evidence that public health interventions on a series of core issues such as tobacco, alcohol, obesity, mental health or traffic accidents compare very favourably with clinical and curative services in terms of effectiveness and cost-effectiveness. In addition to considering the economic and welfare impact of health and health care, and the appropriate allocation of resources to justify health spending, policy-makers must also demonstrate the performance of the various functions of the health system. We turn to the issue of performance in the last section of this document.

Finally, health systems have an additional and direct impact on national economies: they are a major economic sector, have an impact on research and development and constitute a significant source of employment in their own right, thus acting as a motor for economic growth. While these may not be sufficient grounds to justify health spending, in periods of economic recession they may offer an important alternative for public investment to reactivate the economy.

Since research shows that it can make good economic sense to channel resources into health care (i.e. that such spending can yield important direct and indirect welfare gains), it is mistaken to think of health care spending simply as a burden on the economy. This does not mean that there is no reason to be concerned about how much we spend on health care, now or in the future: not all spending produces the same degree of benefit or value; the benefits of spending on health care may not be evenly distributed across the population; and different ways of generating resources for health care may have differing effects on the economy and on the distribution of benefits. These issues suggest that how a country generates resources for health care

and how it uses those resources are as important a consideration as how much it spends on health care.

### *The degree of value from health spending*

There is no immediate correlation between levels of spending on health care and the degree of value obtained from this spending. Studies from the United States find considerable variation in health care spending across the country, but that higher spending often has no discernable impact on access to care, quality of care or health outcomes; in fact, it may actually result in worse outcomes (30,31). Cross-country comparisons in Europe (and with the United States) reveal a similar picture. Looking at major measures of health system performance such as mortality amenable to health care<sup>5</sup> (Table 1) confirms that there is no consistent relationship with health care expenditure (32,33).

### *Population distribution of benefits*

The extent to which individuals are able to benefit from health care is closely linked to their access. If access depends on ability to pay, those less well off will find a high standard of health care increasingly unaffordable should health care costs rise. Economic growth may also disadvantage those whose incomes are growing too slowly to permit higher spending. And while it is often artificial to talk about individuals with budget constraints – since paying for health care (particularly in the EU) usually involves a system of subsidies – the logic of the individual budget constraint may apply in two contexts: where financial protection is limited and people must pay for health care out of their own pockets; and where financial protection comes from voluntary private health insurance and people must decide how much cover they can afford to buy. The degree to which the benefits of economic growth should be redistributed is ultimately a political choice.

EU countries generally provide people with a significant degree of financial protection since levels of public spending as a proportion of total spending on health care are generally high and levels of out-of-pocket payments are generally low. Nevertheless, this is not always the case, as Fig. 5 shows. In countries that rely more heavily on out-of-pocket payments to finance health care, some people may face financial barriers to access, which may in turn limit their ability to benefit from health care. Thus, focusing solely on the overall level of spending, without paying attention to the way in which resources are generated, masks important distributional issues.

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<sup>5</sup> The concept of avoidable mortality permits comparison of health systems in terms of their relative impact on health and can be used to identify which health systems perform less well and why.

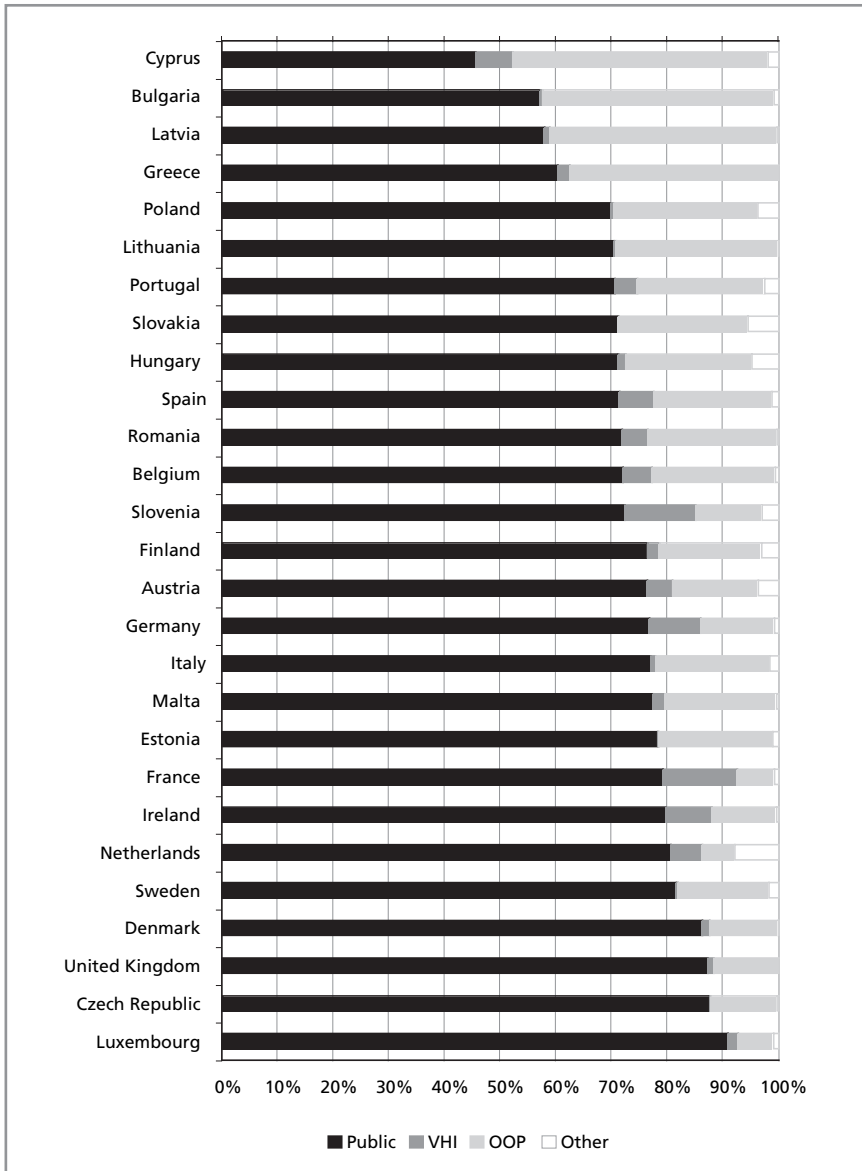
**Table 1. OECD countries ranked by level of age-standardized mortality from causes amenable to health care, 1997–98 and 2002–03**

Country	Amenable mortality (SDR, ages 0–74, per 100 000)		Rank in 1997–98	Rank in 2002–03	Change in rank
	1997–98	2002–03			
France	75.62	64.79	1	1	–
Spain	84.26	73.83	2	2	–
Sweden	88.44	82.09	3	5	-2
Italy	88.77	74.00	4	3	+1
Netherlands	96.89	81.86	5	4	+1
Greece	97.27	84.31	6	6	–
Germany	106.18	90.13	7	8	-1
Austria	108.92	84.48	8	7	+1
Denmark	113.01	100.84	9	10	-1
United States	114.74	109.65	10	14	-4
Finland	116.22	93.34	11	9	+2
Portugal	128.39	104.31	12	13	-1
United Kingdom	129.96	102.81	13	11	+2
Ireland	134.36	103.42	14	12	+2

Source: adapted from Nolte and McKee (33).

Notes: Amenable mortality is deaths before age 75 that are potentially preventable with timely and appropriate medical care; SDR: standardized death rate; Denmark 2000–01; Sweden 2001–02; United States 2002.

Fig. 5. Sources of health finance by country, 2007



Source: WHO 2009 (81).

Notes: VHI: Voluntary health insurance; OOP: out-of-pocket (payment).



### *The impact of financing sources*

The mix of mechanisms used to finance health care may also affect both a country's ability to generate sufficient revenue and the impact of health care spending on the economy. For example, countries that use employment as the basis for financing health care may find that changing demographic and labour market conditions prevent them from generating sufficient revenue through payroll taxes. A growing informal economy (34,35), rising levels of self-employment and unemployment and shifting dependency ratios are all likely to shrink this particular revenue base. The problems associated with employment-based finance extend to voluntary private health insurance, which is partly financed by employers in many EU member states (36).

### **3.4 Summary**

How might a country decide whether to spend more (or less) on health? The way in which policy-makers regard the sustainability challenge presented by a fiscal constraint has some bearing on this question. If allocating more resources to health care is intended to address the accounting problem we referred to earlier – in other words, the need to achieve fiscal balance is seen as imperative and an objective in its own right – then it may not matter how additional resources are generated or spent. But if the aim of spending on health care is to contribute to the attainment of health system goals, then policy-makers will need to think carefully about how best to use existing resources as well as how best to generate and use extra resources.

The opportunity cost of spending on health care plays a central role at the level of the economy, at the level of the government budget and at the level of the individuals. In each case, the 'right' level of spending would be the point at which the benefit of spending further on health care would be less than the benefit to be gained from spending on something else (that is to say, it is right to spend on health care up to the point at which the allocation in question would be better spent elsewhere). Since most health care costs are borne by government (at least in the EU), it is the government that bears the greatest share of the responsibility for making this assessment, based on the performance of the health system and on the values of the population as a whole.

Not all health care spending results in the same degree of benefit. Consequently, it is important to find ways of ensuring that the health care we pay for produces sufficient value to justify existing and further investment. Similarly, the distribution of health spending should reflect population needs. Policy-makers must therefore ensure that there are mechanisms in place to generate and allocate resources equitably. Allocating resources on the basis of

needs is one means of enhancing the value of spending on health care. Finally, focusing on both value and distributional issues may involve greater scrutiny of the mechanisms currently used to finance health care, since some mechanisms may have a more harmful effect than others on access to health care, as well as on the labour market and the economy more broadly.

#### 4 What level of health care coverage should we provide?

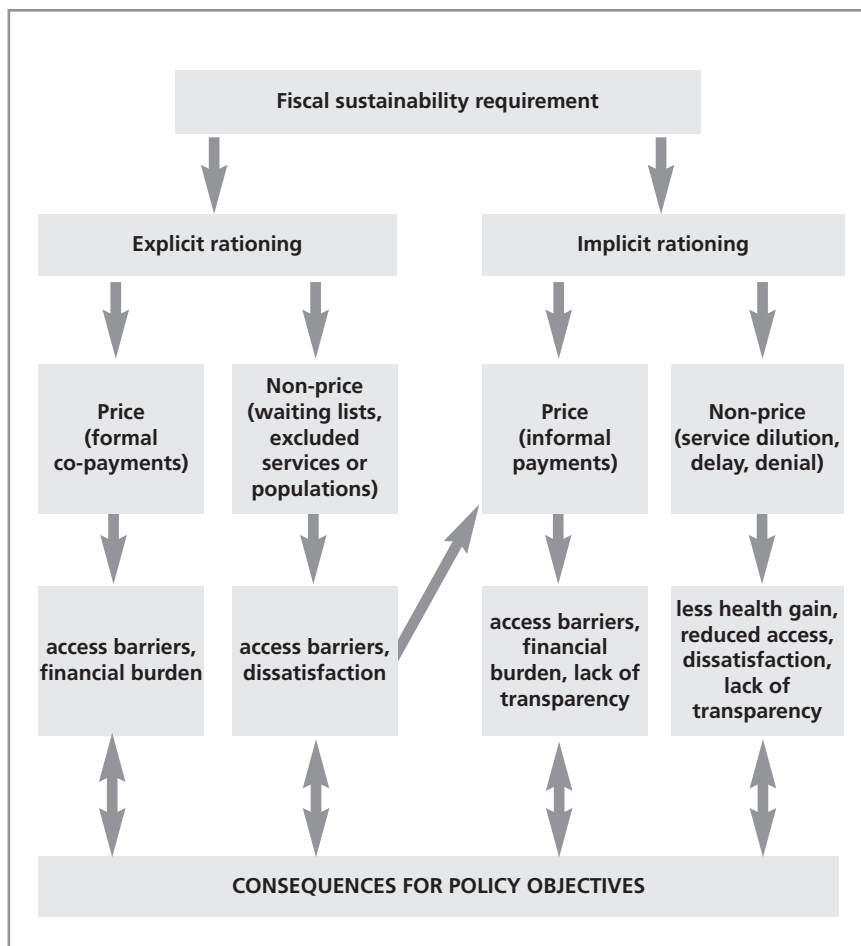
When government does not increase revenues for the health sector to keep pace with rising costs, it may have to cut entitlements to health care services. Rationing implies the existence of trade-offs between policy objectives and the need to respect budget constraints. Taking financial sustainability as an obligation suggests that such consequences for policy objectives can be referred to as sustainability trade-offs. The magnitude and type of rationing can have implications for the kinds of trade-offs that will be made (Fig. 6).

With this as background, the remainder of the section discusses the implications of rationing along three dimensions of health care coverage:

- limiting the *breadth* of population coverage by instituting means-tested access to publicly financed health care (excluding richer people), by excluding other groups (for example, self-employed people) or by allowing people to 'opt out' (effectively giving them a choice between public and private coverage);
- limiting the *scope* of publicly financed benefits to which people are entitled by rationing the quantity and/or quality of health care (including rationing by waiting lists); and
- limiting the *depth* of publicly financed coverage by introducing or increasing price rationing (for example, user charges).

If fiscal balance is taken as an independent objective, then the impact of spending cuts on other objectives may be less important than their success in aligning (public) expenditure and revenue. In this case, the main technical criterion guiding policy is the potential for coverage reduction to lower public expenditure on health care. If, however, the objective is to maximize the attainment of health system goals within a fiscal constraint, the technical criterion guiding policy will be slightly different. The potential for coverage reduction to lower public expenditure on health care remains a consideration, but the overriding aim is to achieve this in ways that are least likely to undermine other objectives. This brings additional criteria to the fore – notably efficiency and equity.

**Fig. 6. Summarizing sustainability trade-offs**



Political factors inevitably play a role in either case, since reducing coverage implies a shift in the ratio of public to private spending on health care and may have a direct financial impact on patients, providers and producers of medical goods. However, an exclusive focus on achieving fiscal balance may give political factors greater opportunity to influence the coverage reduction process and encourage policy-makers to cut spending in areas of least resistance (for example, services provided by allied health professionals such as physiotherapists and dentists). One potential advantage of using additional

criteria to guide policy is that it may increase the visibility of the trade-offs involved in reducing coverage, which may in turn increase public understanding and acceptance. This is more likely to be the case if the process of coverage reduction is seen to be based on explicit criteria, informed by evidence, transparent and protected to some degree from political interference (37,38).

#### 4.1 Breadth of coverage

Reducing the proportion of the population eligible for publicly financed coverage can be achieved in various ways, each with potentially different implications for policy. Income is the most common criterion used to define eligibility for public coverage, with two variants: those above the means-tested threshold may be excluded from public coverage (the Netherlands prior to 2006) or they may be able to choose between public and private coverage (Germany). In a third scenario, the whole population may be given this choice (Chile). Lowering the breadth of coverage creates a role for substitutive private health insurance. This discussion is largely informed by the experience of Germany, which is the only EU country in which substitutive private health insurance plays a significant role (39). It is important to note that the German system was introduced to give richer workers and their families the opportunity to benefit from public coverage, not to reduce public coverage (opting in rather than opting out) (40). Any learning from the German experience must therefore be interpreted with this difference in objective, which not only shaped the original policy's design but also has influenced subsequent developments.

Reducing eligibility for public coverage may lead to a reduction in the overall level of public expenditure on health care, but because it also results in an immediate reduction in public revenue (if those who are no longer covered are no longer required to contribute)<sup>6</sup>, the net 'gain' for the public budget may be small – or may even constitute a loss. German researchers have calculated that the public system loses about €750 million a year as a result of people changing from public to private coverage or from private to public coverage (41). In addition, the loss of contributions from a predominantly richer group of people has been shown to increase the financial regressivity of public coverage (42).

Allowing richer people to opt out has the effect of segmenting the risk pool, which increases the average level of risk in the public pool. In Germany people with private coverage are on average younger, healthier, have higher earnings and use fewer health services than people with public coverage. Table 2 indicates differences in age, health status and health care use between the two groups. Between 2000 and 2004, more than half of those leaving the public

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<sup>6</sup> Or, in a system with universal residency- or citizenship-based entitlement, if they are compensated with tax relief for choosing voluntary health insurance.

**Table 2. Comparison of age, health status and health care use among publicly and privately covered people in Germany**

Indicator	Mandatory publicly covered	Voluntary publicly covered	Mandatory privately covered*	Voluntary privately covered
People aged 65+	22%		11%	
Been ill during the last three months	46%	42%	47%	28%
Chronically ill	47%	33%	45%	23%
Regularly take medication	50%	35%	54%	21%
Number of visits to a doctor in a year	6.6	4.4	6.2	3.2

Source: Leinert (43) (health status and health care use) and Schneider (44) (age).

Notes: the age data are for 2002; the health status and health care use data are for 2006; \*those who are no longer permitted to return to the German opt-out system of statutory health insurance (GKV) because they are aged 55 and above.

system were low risks in terms of age, family status and income, while most of those joining the public system were high risks (41).

The German experience suggests that reducing the breadth of coverage offers some, albeit limited, potential to lower public expenditure. However, in the German case it does not appear to relieve pressure on the public budget due to the loss of contributions from richer households on one hand and the ensuing risk segmentation on the other. Rather, the reverse may be true: the public budget may experience greater pressure because its resources must cover a disproportionately high-risk pool.

#### 4.2 Scope of coverage

Scope of coverage can be reduced by delisting certain items from the publicly financed 'benefits package' or by not including new items as these become available. Rationing the quantity of care available acts to shift excluded services to the private market, where access is determined on the basis of ability to pay (directly out of pocket or via premiums for complementary private health insurance).

Excluding individual benefits systematically on the basis of explicit criteria such as effectiveness (or even cost-effectiveness) can prevent this form of coverage reduction from undermining the goal of improving health. It can also enhance quality and efficiency in service delivery. Thus, carefully reducing coverage of benefits that are ineffective or offer a low level of cost-effectiveness is a viable option for attaining policy goals within a fiscal constraint.

HTA is a tool that has been adopted in several EU countries in the last twenty years (45). Its contribution to systematic priority setting is often limited, partly because it presents a number of technical and political challenges, and partly due to resource constraints (29,46). Instead, governments generally find it easier to exclude whole areas of service (notably adult dental care) or limit access to services such as physiotherapy or in vitro fertilization (37,38). Nevertheless, several countries have successfully used HTA to lower the use of ineffective services, either through direct exclusion from the benefits package or (more commonly) dissemination of practice guidelines (29).

Many health systems also ration nonclinical aspects of quality, often by allowing waiting lists to develop (47). There may be potential for further reduction of coverage here. However, the desirability of further reducing coverage of nonclinical quality is limited by legitimate user expectations regarding acceptable standards of care provision. There also comes a point when reduction in the coverage of nonclinical quality will have an adverse impact on clinical quality, which would undermine the goal of improving health. More broadly, implicit rationing of one kind or another (see Fig. 6 on p.22) – in some ways a consequence of policy omission rather than positive policy action – might be allowed to become more extensive. It is often health professionals who act as 'bedside' rationers, and this may have certain advantages in ensuring that knowledge of individual medical need plays a part in rationing decisions. However, implicit rationing decreases transparency and accountability, and may also undermine fairness requirements, so policy-makers need to be aware of the trade-offs involved.

### 4.3 Depth of coverage

Depth of coverage can be reduced by introducing or expanding user charges for publicly covered services. User charges shift some of the costs of coverage to households and have been shown to lower the use of appropriate health care, particularly among poorer people and older people, even when the level of charges is relatively low (48,49,50,51). This policy therefore requires careful design to prevent undermining goals such as improving health, financial protection, equity in finance and equity of access to health care.

The effect of this form of coverage reduction on policy goals will depend on various context-specific factors, including: the current level of out-of-pocket

spending on health care; the extent of informal payments; the type of service to which charges are applied; the level of charges; and the availability of protection mechanisms such as exemptions, reduced rates or complementary private health insurance. For example, countries with a very low level of out-of-pocket payments may be able to accommodate more private spending without serious damage to policy goals, particularly if the level of charges is low and there are mechanisms in place to protect poorer households and people who frequently use health services (although the experience of Wales and Scotland demonstrates that even where user charges are already low policy-makers may opt instead to abolish them altogether).

Similarly, selectively applying charges to services of limited effectiveness, to discourage their use, may prevent user charges from undermining the goal of improving health. This approach to directing patients (and, indirectly, providers) away from using certain services is sometimes referred to as ‘value-based cost sharing’ or ‘value-based insurance’ (52,53). However, value-based approaches can lead to administrative complexity (in particular, where patient characteristics determine what is of high or low value) and there remains uncertainty around the value associated with many interventions.

High expectations about the ability of user charges to contain overall health care costs (not just public spending on health care) may not be met for three reasons. First, there is no published evidence to show that user charges help to contain health care costs in the long term. Research shows that in some cases, short-term savings to the public pharmaceutical budget were outweighed by increased spending in other sectors such as emergency and long-term care (54). Second, the distribution of health care spending across the population tends to be highly concentrated (55). Consequently, a policy tool aimed at the 90% of the population that collectively accounts for under a third of total spending on health care may have a limited effect on costs. In addition, many of these ‘high spenders’ are patients with multiple and/or chronic conditions, and in many EU countries such patients are exempt from user charges on equity and health grounds (54,56). Third, it is now widely recognized that the way in which health care is provided has more influence on health care costs than the extent to which use is initiated by patients. Efforts to curb expenditure are therefore more likely to be effective if they focus on health care supply.

#### **4.4 Mitigating the effects of reduced coverage**

Coverage reduction – along with its corollary, greater reliance on private finance – may be seen as a necessary step in the context of a fiscal constraint. In many cases, however, it not only has the potential to lower the attainment of health system goals, but may also fail to relieve pressure on the public budget. In weighing up the options and deciding how and what form of coverage to

reduce, policy-makers can consider the following issues.

Simply reducing coverage may not address underlying inefficiencies in the use of resources. Where these inefficiencies are partly responsible for the pressure facing the public budget in the first place, indiscriminate reductions in coverage may actually heighten rather than alleviate pressure. Moreover, indiscriminate coverage reduction may create new inefficiencies. For example, limiting access to effective health care could lead people to forego the use of health services that are relatively cheap to provide, such as primary or preventive care (or indeed services that are more expensive to provide but which produce a high 'return' in terms of health gain). Sooner or later, however, the same people might be forced to use more resource-intensive forms of care such as emergency or inpatient care. Again, the result would be a failure to alleviate pressure.

If, however, policy-makers are able to take a more discerning approach to reducing coverage, with a focus on enhancing value (discussed further in the following section) and avoiding harmful effects on equity, they may be more successful in alleviating pressure on the public budget. This in turn would contribute to achieving a higher level of attainment of health system goals (or at least prevent them from being further undermined). In this respect, systematic exclusion of ineffective and non-cost-effective interventions from the benefits package, informed by HTA, would be a good starting point. Although this form of coverage reduction may encounter resistance from entrenched interests, if it is applied with transparency it seems most likely to improve efficiency without jeopardizing equity and health.

To some extent, the potentially negative effects of reducing the breadth, scope and depth of public coverage may be mitigated by factors such as careful policy design and the availability of substitutive or complementary private health insurance. However, the market failures that characterize voluntary health insurance, in particular problems relating to information, mean that those forced to rely on private cover may be placed at risk (57). Ensuring access to private cover for older people and people in poor health requires significant government intervention and there are limits to what can be done (as well as resource implications) (36,40). For example, EU internal market legislation makes it difficult to shape and regulate voluntary markets for private health insurance (58), even where there are political will and capacity to do so.

## **5 How can we enhance value in the health system?**

A more useful approach to attaining health system goals within a budget constraint is to think about how to enhance the value the health system produces. This has two dimensions: doing more with the resources already devoted to health care, and ensuring that the benefits gained from any



additional spending on health care outweigh the opportunity cost implicit in not spending those resources on other things. Focusing on value is constructive for the following reasons. First, it is acknowledged that health systems often waste resources, and in different ways. Thus there is likely to be room for improvement in every health system. Second, efficiency gains (i.e. greater value from a given level of spending) effectively reduce the severity of sustainability trade-offs, potentially alleviating pressure on the public budget, which in turn may lessen the need for reducing coverage. Third, if people can be persuaded that the health system is effective in producing value, it might be easier to overcome resistance to paying more, collectively, for health care.

Health systems in the EU have over thirty years of experience in containing health care costs. Building on the advantage of having universal health systems, many have already developed successful mechanisms to control spending growth and address underlying inefficiencies. In this respect they are well placed to manage health policy within fiscal constraints. The challenge now is to move away from a narrow focus on cost containment as an end in itself and embrace the potential for enhancing value in the health system. This shift in approach is realistic because it recognizes how much governments can do to improve health system performance, even when faced with a limited budget. It is also responsible because it brings health system goals to the fore and aims to maximize rather than undermine them. Consequently, whether health budgets will be cut in an effort to relieve pressure on the public budget or if there is willingness to divert more resources to health care, health system performance objectives drive health policy. This is particularly the case when governments are considering reductions in coverage.

The starting point for enhancing value is to draw on policy analysis and research evidence to identify the sources of a health system's cost pressures and underlying efficiencies, its strengths and weaknesses and its options for reform. This can be facilitated by a clear understanding of different health system functions and their implications for health system goals (21,59).

### **5.1 Health financing reform (revenue collection, pooling and purchasing)**

The way health care financing is organized has important implications for efficiency and hence for the potential for health systems to mitigate the severity of sustainability trade-offs. Because coverage reduction tends to arise from a reduction in the level or growth of public spending on health, policy attention is typically concentrated on revenue sources. However, there is far greater potential for enhancing the value that the system produces from its available resources from reforms in the pooling of funds and the purchasing of services. While the appropriateness of any particular reform measure is country-specific,

fruitful directions for efficiency-enhancing change in EU health financing systems are identified here. A cross-cutting conceptual point relevant to all countries is essential to emphasize: improving efficiency needs to be seen as a means to obtain more value – more attainment of health system performance objectives – from available resources. If instead efficiency-oriented reforms are treated as the means or rationale to reduce government spending on health, such that the ‘savings’ are extracted from the health sector (for example, for deficit reduction), they will fail. Performance will suffer, and any savings will only arise in the short run. Such expropriation of efficiency savings by forces outside the sector serve to undermine the efficiency-enhancing incentives within the sector, and as a result, the gains cannot be sustained.

### *Revenue sources and collection measures*

Faced with tight spending limits, governments are interested in finding new contribution mechanisms that generate revenue more successfully than existing mechanisms or tap a broader revenue base. While not necessarily meant to enhance value, these options may offer potential to offset the financial constraints in some settings. Arguably, the measures have more to do with tax policy than health policy, but they can have important implications for sectoral objectives.

For countries that rely predominantly on employment-based compulsory health insurance contributions, getting more revenue from existing contribution rates can be achieved by lifting any existing income or earnings ceilings or caps (a step taken in Estonia and Hungary), or by broadening the income base for contributions beyond wages. Diversifying the sources of public revenue for health may be a particularly relevant option for governments that are simultaneously concerned to stimulate employment while maintaining or increasing public spending on health. France replaced most of the employee share of the payroll tax earmarked for health with an income tax in the mid-1990s (60) and Germany followed suit in 2007, allocating (for the first time) general tax revenue to finance the public coverage of children (61). After moving to a unified national contribution rate of 15.5% of wages at the start of 2009, Germany injected additional general tax revenues into the health insurance system to enable this rate to be reduced to 14.9% as part of its economic stimulus package, with plans gradually to increase the budget subsidy by 2012 (62).

### *Reforms in the pooling of funds*

Pooling prepaid revenues for health care enables the redistribution of resources across the population (or a defined subgroup), allowing the contributions of relatively healthy individuals to be used to cover the costs of those with greater

health care needs. It is therefore a vital means of promoting financial protection as well as equity of access to health care. In addition, the organizational arrangements for pooling also have implications for the efficiency of resource use within the sector. For a given level of revenues, fragmentation into many small pools (e.g. local governments, multiple health insurance funds) reduces the scope for redistribution as compared to fewer, larger pools. Fragmentation into many pools also entails higher administrative costs and reduces the purchasing power of any single fund. Hence, reforms to reduce fragmentation or mitigate its consequences offer the potential to improve risk protection and equity of access for a given overall level of public spending.

European countries with quite different systems have undertaken efforts to address fragmentation. For example, both Norway and Denmark have recently reduced the number of territorial health authorities responsible for pooling funds for the purchase of health care services (63,64). Since the early 1990s in Estonia, Latvia, Lithuania and Poland, separate health insurance funds have gradually been consolidated into single national funds (65). And in countries with multiple competing insurers such as the Czech Republic, Germany, the Netherlands and Slovakia, an important intent of improvements in risk adjustment methods (66,67,68) has been to reduce the incentive for insurers to invest in risk selection – investments that had a private return but no public benefit. In the Czech Republic, for example, refinements to the risk adjustment system introduced in 2003 reduced the incentives for insurers to engage in risk selection and shifted their competitive energies towards improved cost management and overall quality of their services (65,69). To the extent that efforts to reduce the incentives for risk selection are successful, they enhance value because non-productive investments (from an overall sectoral perspective) are reduced as a consequence.

### *Purchasing better value for money*

Changes in how health care is purchased offer perhaps the greatest potential for enhancing value as compared to other aspects of health financing policy. The way in which health services are purchased is central to ensuring efficiency in service organization and 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 impact on ability to control costs. Reforms in many EU countries have attempted to move from passive reimbursement of providers to active or strategic purchasing, which aims to improve health system performance by explicitly linking decisions and methods of resource allocation to information on population needs and provider performance (70).

Reforms in purchasing involve decisions about which health services to fund, at what level and in what incentive environment. In particular, purchasing permits

closer scrutiny of a major source of health care spending growth: technological innovation. Effective purchasing will consider how best to encourage the discerning incorporation of new technology into the health system. Inevitably, this will involve greater investment in and use of HTA to determine the range of benefits and services that should be publicly financed. For some EU countries, this is nothing new. Several have engaged in HTA for many years now (45). Rather than simply viewing HTA as a rationing mechanism, policy-makers should see it as a means of increasing the value to be had from any given level of health care spending.

Since purchasing encompasses provider payment methods, it presents a good opportunity to develop payment methods that reinforce the work of HTA agencies; for example, by creating financial (and non-financial) incentives to encourage the provision of effective, cost-effective and high quality health care. A major area for development is to link payment to provider performance measured in terms of both processes and outcomes, sometimes called Payment for Performance (P4P). Growing attention to P4P reflects concerns about the lack of evidence for some procedures as well as the wide variation observed in certain clinical practice patterns, combined with optimism about the scope for improvement through financial incentives. A recent review of the P4P experience, with particular focus on the efforts made to date in the United Kingdom and the United States, suggests that while the attention being given to the subject is welcomed, it is too early to reach strong conclusions about the potential gains from this. Most P4P reforms have emphasized process rather than outcomes, and their potential to induce 'gaming' behaviour that ultimately damages the interests of patients and taxpayers is high. A critical part of national efforts to enhance value through better purchasing practices is to integrate evaluation and feedback into the reform process and incorporate patient-reported outcome measures into the system (71).

## **5.2 Reforming delivery**

The nature of demand for health care is changing as a result of ageing and the growing prevalence of chronic illness (72). This presents a challenge to health care delivery systems. If delivery systems are to function effectively and efficiently, they must adapt to meet this challenge. Failure to do so will mean unnecessarily high costs and reduced quality, which present health risk to the patient and lower patient satisfaction.

The following should be priorities if value is to be enhanced through delivery system reform, in particular given this changing environment: care should be delivered in lower cost settings where possible and where appropriate; the scope of what can be provided in lower cost settings should be expanded; and intra-system coordination should be improved to address the inefficiency effects

of fragmentation in delivery and to improve quality (23). These approaches to delivery system reform will also make it easier to position prevention and health promotion activities at the heart of health care delivery. An independent reform focus – although not unrelated – should be to improve our understanding of the nature of waste in health care delivery, and to develop methods for identifying and eliminating such waste.

Inherited divisions between primary care and secondary care can function as an obstacle to low cost delivery. Much care which could be provided in a primary care setting continues to be provided in secondary care settings (73). There are various ways of addressing this, including giving primary care providers financial responsibility for the patient's care pathway, leading to a more discerning use of referral; and strengthening the role of primary care within first contact care more generally, including limiting direct access to specialists and improving the accessibility of primary care providers (in particular for unplanned contact, thereby reducing the use of resource-intensive settings such as accident and emergency departments and hospital outpatient departments).

The transfer of care delivery to lower cost settings would be further enhanced by expanding the scope of what lower cost settings can provide. If more can be provided within primary care, less needs to be provided in more resource-intensive settings. This ties in with the particular requirements of chronic illness patients, although other patients stand to benefit too. Patients with chronic illness and (often) with co-morbidities regularly require access to a broad range of services within primary care and within secondary care. The division between primary and secondary care means that many of these patients have to move among multiple providers. The burden of coordination rests either with the patient's general practitioner (GP) or with the patient himself or herself. This burden represents a severe strain – for the GP because of the growing number of such patients, and for the patient because of the information demands the burden places on them. There are two approaches to addressing this problem. One is to increase the comprehensiveness of what can be provided within primary care, with the formation of multidisciplinary teams (including specialists) at primary care level, often based in a single facility. This does not dispense with the need for external coordination, but it does reduce that need. The second approach is to improve the infrastructure of coordination by developing effective information technology (IT) systems and by introducing care coordinators who can focus on coordinating the patient's care pathway among multiple providers and relieve the GP or the patient of this burden. Either approach – increase comprehensiveness within primary care or improve coordination – can work to enhance efficiency and quality of care, but the approach chosen (or the nature of the combination of the two approaches chosen) will relate to initial conditions, including the interests of the wider

patient population who may prefer more traditional models, and the financial interests of health care workers, which may be threatened by such changes. Also important is whether primary care does or does not already play a central role. Thus where it is customary to consult specialists directly rather than to register with a GP or other family practitioner, the emphasis is likely to be on the development of coordination, whereas where there is a strong primary care sector expanding the scope of what primary care can offer is likely to receive greater emphasis.

To adapt delivery systems to the changing nature of demand has considerable potential to enhance value in delivery over the medium to long term (costs – for example those associated with developing an effective IT infrastructure – may rise in the short term). Another area where there is significant potential for enhancing value in delivery is in eliminating waste. The amount of waste in delivery is impossible to quantify, but it is generally accepted that there probably remains a great deal. Most delivery reform has sought to eliminate waste in one way or another, but there are areas where the nature of waste remains poorly understood. Among these, and perhaps promising the greatest gains, is waste deriving from variation in clinical practice. Recent years have seen the Dartmouth Health Atlas project in the United States identify differences in the ways physicians practise in different part of the country, with some following much more resource-intensive practices than others, yet without attaining better outcomes (sometimes the outcomes are worse) (30,31). The Dartmouth research has focused on care delivered within the national Medicare system, so it may be difficult to transfer the Dartmouth model (or models used for comparable intra-country studies elsewhere) to the study of pan-EU practice variations. But this is an area whose investigation could lead to substantial efficiency gains. If physicians are practising differently in different countries, why is this so? Is it due to local medical cultures and education? Or can it be explained by the design of the delivery system? By addressing these questions, it might be possible to learn more about why practice varies and about what can be done about it if such variation has no strictly medical rationale.

The human resources dimension of delivery is an important parallel function too, and reform here can also help enhance value. There are three key problems in this area. The first relates to problems of staff shortage generally, and the second to the distribution of staff – particularly between urban and rural settings. The third relates to changing skill mix requirements given the kind of developments outlined above. All these problems can be addressed in part by adjustments in the content and structure of health professional training and through the use of incentives (in particular for attracting health professionals to rural or deprived inner city areas).

### 5.3 Strengthening stewardship

The stewardship function is defined as the responsible and careful management of the well-being of the population and constitutes the very essence of good government. It is arguably the most important function of the health system because it influences the way other functions are undertaken and how they affect health system goals (71). Stewardship sits at the heart of many health reform strategies and is central to improving health system performance.

The challenges to stewardship are distinct and strategies will not transfer easily from one country context to another, but there are some common general strategies that will strengthen stewardship and improve performance. First, if reforms are to succeed and contribute to policy goals, then stewards must track how these reforms are progressing and monitor their impact. Yet, many countries in Europe lack good systems to monitor performance. Moreover, they are not necessarily making use of all governance initiatives outlined above, such as the systematic assessment of new technologies. Assessing performance (including tracking how financial resources are used) and embedding performance assessment in health system governance (so the measurement and analysis lead to ongoing improvements) are central to improving health systems and to making a case for resources for health (74).

The second key strategy is to put in place an adequate system of effective but flexible government regulation. New regulation may be needed in light of the increasing role of the private sector, the growing assertiveness of patients and other reform initiatives such as multidisciplinary working and cross-disciplinary coordination. Good stewardship demands that countries re-regulate before they deregulate, so avoiding lacuna in governance, as evinced by numerous examples of late or ineffective regulation in European countries (75).

Finally, while this report primarily focuses on health care services, the stewardship function goes well beyond health care to influencing the determinants of health in other sectors. If health stewards, in particular ministries of health, are to maximize health gain from scarce financial resources and to improve performance, they need to be able to exercise stewardship in other sectors towards ensuring that health objectives are considered in their policies – what has been termed Health in All Policies (HIAP) (76). The HIAP movement embodies WHO policy (i.e. the ‘Health for All’ movement), guides the new EU health strategy (77) and was recently championed by the Finnish presidency of the EU (76) and endorsed through the Rome Declaration on Health in All Policies in 2007 (78).

There is a range of approaches to implementing HIAP, including: the use of intersectoral government targets (France, Lithuania, Sweden, the United Kingdom) (79); the use of health impact assessment units at local authority,

parliamentary and inter-ministerial levels (Sweden, Wales, the Netherlands and Lithuania, respectively) (80); or passing 'shared' public health legislation, such as bans on smoking in public places. There is also a range of structures and processes to facilitate intersectoral action, including horizontal public health committees (England, Sweden), formal consultations and communication between sectors (Wales) and public health reporting with other sectors (Finland, the Netherlands, Wales) (76).

## 6 Conclusion

As this policy summary has suggested, the concept of financial sustainability has many facets. For our purposes here, however, we have interpreted the concept primarily as a question concerning ability to pay (more) for health. If governments can generate additional resources to finance health, and if the welfare gains derived from higher spending on health outweigh the opportunity costs of not spending those resources on other things, then societies may well choose to devote more resources to health in order to sustain these greater welfare gains. In this regard the pertinent issues also involve questions about willingness to pay more for health care on a collective basis and the value and distribution of the benefits gained from higher spending on health care.

The report has stressed the importance of how policy-makers understand the sustainability challenge presented by a fiscal constraint. If it is seen solely as an accounting problem, in which the imperative is to achieve fiscal balance by aligning revenue and expenditure, then to secure financial sustainability becomes an objective in its own right independent of other objectives for the health system. In this case, the obvious policy response is to lower public spending by reducing coverage, and the guiding criterion will be the potential for coverage reduction to lower public expenditure on health care. However, indiscriminate cuts do not address underlying inefficiencies in the use of resources, which may be partly responsible for the pressure facing the public budget in the first place, and furthermore may reduce care that has a high benefit to cost ratio. As a result, they may heighten rather than alleviate pressure. They may even create new inefficiencies and are likely to undermine the attainment of goals such as improved health, financial protection and equity.

Rather than as an objective to be pursued for its own sake, it is more useful to see the requirement of fiscal balance as a constraint to be respected. This allows policy-makers to consider how best to maximize the attainment of the health system's goals subject to the constraint of aligning revenue and expenditure. Instead of asking 'how much is the government able to pay for health care?', the question becomes 'what level of attainment of its goals for



the health system is the government willing to pay for?’ Spending may still need to be cut, but the overriding aim will be to reduce coverage in ways that are least likely to undermine other objectives, which brings additional criteria to the fore. If policy-makers are able to take a more discerning approach to reducing coverage, with a focus on enhancing value and avoiding harmful effects on equity, they may be more successful in alleviating pressure on the public budget. This in turn would contribute to achieving a higher level of attainment of health system goals (or at least prevent them from being further undermined).

Since health care produces substantial benefits for individuals and for the economy, there may be a case to be made for spending more on health care, particularly in countries where levels of spending are relatively low. Again, however, it would not be appropriate to increase spending without considering the opportunity cost of doing so. Moreover, not all spending results in the same degree of benefit. Some countries spend much more on health than others and still achieve lower outcomes. It needs to be ensured that the health care paid for produces sufficient value to justify further investment. Key mechanisms for achieving this include the systematic assessment of existing and new technologies using explicit criteria such as effectiveness and cost-effectiveness, and needs-based or risk-adjusted resource allocation. A further element involves looking more closely at the mechanisms used to generate resources for health care. Some mechanisms may have a less harmful effect than others on access to health care, as well as on the labour market and the economy more broadly.

Attempting to enhance value by doing more with the resources being devoted to health care ought to be the first choice for government. Because this task involves identifying and addressing underlying inefficiencies, it is most likely to lessen the pressure facing the public budget at the same time as it places the emphasis squarely on improving the health system’s performance. If it is carried out in a transparent way, with effort to convince the population of its worth, and if improvements are visible, then it might also lower resistance to paying more, collectively, for health care.

The ‘problem’ of financial sustainability is, as we have argued, inherently political. In many cases the fiscal constraint governments face is created by political choices about the priority accorded to the health sector in relation to other sectors and the size of the government budget. The question of how much people are willing to pay to sustain a given level of attainment of health system goals is also a political one. And there are political challenges to be faced in each of the areas outlined in this report: how much to spend on health care, what level of health care coverage to provide and how to enhance value in financing health care. Part of the ‘solution’ must therefore be to acknowledge this underlying dimension of political choice.

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