Funding the Health Systems in the European Union Member States

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Abstract

The paper analyzes and compares the funding policy of health care systems in European countries. The study indicates big differences between Member States in health care investment strategies, which conducts to different health care outcomes in terms of life expectancy. New European regulations are necessary in order to ensure the health equity in the European Union.

Key words: health care investment, life expectancy, EU services market

Jel Classification: H75, I18

Introduction

There are significant differences in the funding of the health systems in the countries from the European Union, both from conceptual overview (mostly funded by the budget or by compulsory social security insurance) and from the level of the budget granted to the health system. The continuous increase of European citizens travelling inside EU raised the issue of regulating their rights to trans-border medical care. The paper analyzes and compares the funding for the health systems in the European Union Member States and the effect they have on the population life expectancy, emphasizing the necessity to regulate the legal framework on European citizens’ access to non-discriminatory medical services.

The Trans-Border Medical Care Services within the Internal Market

Regulations of the Services within the Internal Market

Services have likely become the most dynamic area of the European economy considering the extent and the diversity they went through at worldwide level. To state that, we can look to the statistics, currently showing that services generate 65%-70% of the Member States yearly
income, 70% of the EU GDP compared to 35% – industry and agriculture, 20% of the foreign trade, in the external operations and about 70%\(^1\) (2010) of the employment.

Along the other fundamental freedoms of the Internal Market\(^2\), the free movement of services represents an extremely important element in strengthening and properly functioning of it. “Services shall be considered to be "services" within the meaning of the Treaties where they are normally provided for remuneration, in so far as they are not governed by the provisions relating to freedom of movement for goods, capital and persons.” (art. 57 TFUE)

Some of these services are regulated by very strict provisions, due to the implications they have for the credibility of certain sectors, and here we refer to the banks sector and the social and health insurances fields, where the regulation on personal data protection must be strictly obeyed.

The Health Systems in the European Union

Main Characteristics of the Health Systems

There are a large number of applicants for the health services, reason for which the national health systems are huge financial and human resources consumers. Considering the principle of social equity, all EU Member States have a health policy establishing the accessibility to the health services and the ways for funding them. The funding mechanism is practically the tool for implementing these policies. It has two main axes: (1) collecting the resources for health services payments and (2) their distribution.

Considering the financial flow, there are three main players regardless on the type of the health system:

- health services supplier;
- health services consumer (the patient);
- paying third party.

The chosen way of funding, correlated with health care system type of organization are the elements to indicate who is going to have access to the health care services, the price for such services, the efficiency and the quality of the delivered services. Actually, all these results are indicators for any health care system: population health status, financial efficiency and not lately the increase of the satisfaction degree within the healthcare services beneficiaries.

Consequently, we mention that the development of the health care system is differential, depending on the level of economic development for each Member State.

\(^1\) The developed countries show that 60-70% of the employed population is in services, recording some differences given by the particularities of the economic growth patterns specific for each of the Member States, by the customs differences, etc. In the same time, in average developed countries, the third sector weight within the occupied population is of about 50-60%, also average values whilst the low developed countries record levels correspondingly lower (30-40%).

\(^2\) “The single market […] means the right to live and work in another EU country, and to access a wider choice of quality products and services at lower prices. For business, it means operating on a domestic market of 500 million people, based on the rule of law, with mutual respect and trust. The single market is more important than ever […].” (Jose Manuel Barroso, 2007)
Health Care Systems in the European Union – Subject to Subsidiarity

The 10+2 Member States EU accession hyphenated the existent differences with regard to the level of European economy development and claimed for the necessity to intensify the vertical integration process. Insofar, during the various EU extension waves, the geographic area increased thrice while the population doubled. The initial homogeneity (as socio-economic development and territorial distribution) diluted and the social and economic cohesion diminished all this due to accession of some states with less developed economy. Consequently, as result to such factor and considering the “historical heritage” of the respective states, a pentagon of economic increase showed up that involved London, Hamburg, Munich, Milan and Paris, and that imposed itself as a development pole, a “polygon” concentrating 20% of the EU are – 15.40% of the EU population and that generated 50% of the EU richness.

Fig. 2. “The Polygon” – the most prosperous areas in the European Union


3 On integration, Jacques Pelkmans considered it as being a „process of cancelation of all types of borders between two or more independent states, so that the respective states work a sole entity”.

Despite the fact that the “new” member states recorded progress on all levels, it is stated the need for greater determination in reforming some systems that are important for the state functioning, among which there is the health care system. In this regard, improving the population healthcare, as well as the increase of the life expectancy, improving the quality of the healthcare service, as well as the trans-border access to these services (patients’ mobility) represent the main aims of the Member States for the next future.

**Chart 1.** Comparative evolution of life expectancy in some EU countries (1995-2010)

Source: OECD, 2011

**Chart 2.** Correlation between life expectancy and GDP / capita in Europe (2009)

Source: OECD, 2011

Ever since the beginning of the European construction health and health care system have been considered as Members States main responsibility and as such submit themselves to the subsidiarity principle. However, there are several related sectors that are legally ruled by the European legislation. Consequently, the legal frame for diversifying the offers for health care services and health care insurances was established in 1992, and implicitly it increased the competition in these fields of activity.
The Member Stated health care systems are a junction of policies and decision based upon universal values, gathering the social justice, responsibility and universal coverage, and they needed to adjust to the demands and to the context of the markets globalization⁴, including the privatization of the healthcare system (see Figure 3, below).

### Fig. 3. WHO health systems framework

Source: De Savigny et Adam (2009)

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⁴ Globalization is the process of expansion, deepening and accelerating the worldwide interconnection, process placed in a changing framework of “tying and expending the human activity over regions and continents” (Held David, 2004, pp. 39).
Healthcare Systems Funding in the European Union

Though the objectives of the healthcare systems are alike in all member states, and we refer to goals such as high quality services, fast capacity of reaction, efficiency, and universal access, the ways to achieve them vary from one country to another and they are the result of the individual specificities related to the national culture, customs, history, political system, and as well the involved institutional stakeholders. (Dubois et al., 2006).

There are two large categories to comprise the European Union healthcare systems:

- those funded mostly from the State Budget (“Beveridge” type);
- those funded mostly through the compulsory healthcare insurance (“Bismarck” type).

The general tendency for funding the healthcare services in the EU is the direct payment, and they represent more than a third of the total expenses for health which vary from 3.9 in Romania to 11.1% in Germany (see Table 2, below).

Table 2. Expenditure on public health in the EU Member States (2010)

<table>
<thead>
<tr>
<th>EU Member States</th>
<th>Population (millions inhab.)</th>
<th>Expenditure on public health (% of GDP)</th>
<th>The main financing source</th>
<th>Physicians /1000 inhab.</th>
</tr>
</thead>
<tbody>
<tr>
<td>EU-27</td>
<td></td>
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<tr>
<td>Austria</td>
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<td>9.6</td>
<td>Social insurance</td>
<td>3.6</td>
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<tr>
<td>Belgium</td>
<td>10.7</td>
<td>9.3</td>
<td>General taxes, Social insurance</td>
<td>4.2</td>
</tr>
<tr>
<td>Bulgaria</td>
<td>7.5</td>
<td>7.7</td>
<td>Direct payment, Social insurance</td>
<td>3.7</td>
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<tr>
<td>Czech R.</td>
<td>10.4</td>
<td>8.6</td>
<td>Social insurance</td>
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<tr>
<td>Cyprus</td>
<td>1.1</td>
<td>6.1</td>
<td>Obligatory and voluntary/private insurance</td>
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<tr>
<td>Denmark</td>
<td>5.5</td>
<td>8.4</td>
<td>General taxes</td>
<td>3.6</td>
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<tr>
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<td>5.5</td>
<td>General taxes</td>
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<td>3.3</td>
</tr>
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<td>France</td>
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<td>11.1</td>
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<td>3.4</td>
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<td>Greece</td>
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<td>General taxes, Obligatory and voluntary/private insurance</td>
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<tr>
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<td>Social insurance</td>
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<td>Irland</td>
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<td>8</td>
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<td>9.2</td>
<td>General taxes</td>
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<tr>
<td>Romania</td>
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<td>Slovakia</td>
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<td>5.7</td>
<td>Social insurance</td>
<td>5.1</td>
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<tr>
<td>Slovenia</td>
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<td>8.2</td>
<td>Social insurance</td>
<td>2.4</td>
</tr>
<tr>
<td>Spain</td>
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<td>7.4</td>
<td>General taxes</td>
<td>3.2</td>
</tr>
<tr>
<td>Sweeden</td>
<td>9.3</td>
<td>9.2</td>
<td>General taxes</td>
<td>3.2</td>
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</table>

Source: own source, adaptation by the authors, calculations based on the statistical data published by the WHO, „Observatorul european pentru sisteme și politici de sănătate”, Vol. I: Cuprinzătoare tabele, OMS, 2010 and „World Development Indicators database”

5 According to UN, the life expectancy was at 76.1 years old in the EU, in 2009 and the estimates show increase up to 81.5 years old until 2050.
Considering the graphs above (Charts 1, 2 and 3), we can notice the leading group of Member States such as France, Norway, Germany and Austria that record the highest life expectancy (over 80 years old) in EU and Europe overall, states that invest over the European average in their own healthcare systems. At the opposite side, we find states like Ukraine, Moldova and Belarus – outside EU and, unfortunately, Romania with investments in the healthcare system far below the European average value and with 75 years old average life expectancy. Anyhow, comparing ourselves with the other Member States, we can notice Romania is on the last place as for the GDP value allowed for the healthcare system (see Chart 2 and Chart 4, below). As we can notice from Graph 4, this value should be 2.4 times higher in order to reach the European average value and 1.6 higher to reach the next level.

Most of the Member States increase the GDP quota for the healthcare expenses every year, but Romania is the only European state that does the opposite: it reduces the quota by every year: 4.2% (2008), 3.2% (2009) or 3.1% (2010), so the difference between Romania and the rest European countries increases in time.
Patients’ Rights for Trans-border Medical Care

The continuous increase of European citizens movement inside the EU being justified by looking for a workplace, travelling or studies, and, on the other hand, the patients’ movement, the professionals from the healthcare one, claim as a result the continuous improvement of the healthcare systems and services in the EU.

Starting with the ‘70s, more and more concern was shown in the European area for regulating the social security regimes for the employees, for the freelancers and for their families, in a first stage by clarifying some issues related to the way these potential applicants for the healthcare services move in the European area.

Once the European Court of Justice decided for Kohll and Decker (1998), the patients, citizens of the Members States, may prevail the Single Market Principles that grant the right to access medical health assistance in other Member States (trans-border medical care).

Most of the times, the internal services suppliers deliver healthcare services, by internal meaning suppliers from the state where the applicant is resident. Nevertheless there are a lot of applicants that want or need treatment in another country, either being “temporary guests” or long-term residents in another Member State, either addressing to the institutions from the border areas. At the same time there is the option where the healthcare beneficiaries are sent to another Member State by the healthcare suppliers from the national healthcare network either for not having the treatment in the country or as the patient’s medical condition does not allow the delay for a medical intervention.

(1) Temporary guests: temporary/season workers or tourists – the increase of the Member States population with special reference to the EU 12 citizens (with development level lower than EU-15), together with the reduction of the associated costs for travelling inside the European area (transport, accommodation etc.) lead to an increase in the European citizens’ mobility i.e. for tourists, temporary or season trans-border workers. They represent the category which, theoretically, lead to the E111 system drafting, and that allows them when emergency to benefit of medical care in another Member State. Nevertheless, de facto, this solution cannot solve all practical issues related to patients’ mobility. Consequently, there are increased season tourist flows for certain European areas and this may set on one hand the establishment of local specific healthcare services or the occurrence of problems when delivering the sanitary services due to non-adjustment of the responsible authorities in delivering such services in the affected areas.

The procedures for the European card for health insurances apply for citizens requiring urgent medical treatment when visiting another member state. The card is valid for travelling outside the borders of the country of residence that do not last longer than 6 months and that cannot be used for travelling in medical treatment purposes.

6 Council Regulation (EEC) No 1408/71 of 14 June 1971 on the application of social security schemes to employed persons, to self-employed persons and to members of their families moving within the Community.
7 E 111 and E111b – „Legal certificates for deliveries in nature during a stay in another state”. E111 form is released for temporary stay of the worker, of the retired persons, of the insured person on the territory of a Member State other than the competent state but also it is given to family members, benefitting as such of healthcare, maternity services in case of immediate necessary care. E111 related forms for ulterior procedures are: E 112 (generates basic reimbursement on invoices), E 113 (for hospitalization, the institution from the resident place must notify the entry and exit data using this form), E 114 (prosthetics), E 115 and E 116 (if the worker ceases his activity, the institution from the place of residence must fill in the forms), E 117 and, eventually, E 118 (the competent institution is responsible for the use of the forms).
8 In Romania, the legal framework for the European Healthcare Card is the Law no 95/2006 on the healthcare system reform, updated.
(2) Retired persons – another category of citizens requiring medical care abroad is more and more the category of persons retiring in another country. For this category, the persons needing healthcare services will not benefit from any family support so that their social assistance rights are to be transferred to the country of residence.

(3) Citizens from the border areas - A special situation where applicants of healthcare services are directed to a medical unit from another Member State is the one of the European citizens from border regions. For Romania, such an example of joint use of the infrastructure at trans-border level is the tele-medicine project from County Hospital Oradea in cooperation with the Regional Szeged Hospital or such as the split town Valka (Latvia) / Valga (Estonia).

(4) Patients with emergencies - some member states adopted special policies to send patients from another member state for treatment. This can be considered either short term policy (for developed member states) meant to remove the monopoly of the private healthcare services suppliers and, consequently, to make a change in the own healthcare system, either as long term policy (for small states such as Malta, Cyprus, or of those less developed, such as Romania), in order to send the patients abroad to highly specialized treatments such as cardiac surgery or spinal, heart transplant etc.

(5) Though few in numbers, we can also talk of patience travelling independent for treatment abroad. Examples include spa, cosmetic and surgical interventions, dental treatment. The new Member States, especially those from the ex-communist bloc, identified opportunities in this area as they have low costs and attract the patients from Western Europe.

Based upon the necessity of regulating the legal framework for the European citizens’ access to safe and high quality medical trans-border services, a draft of Directive on applying the patients’ rights for trans-border medical assistance has been issued. This draft gives new dimensions to the cooperation between EU Member States, the most important regulations aiming at:

- The reimbursement of the expenses on trans-border medical assistance: the expenses are eligible if the treatment type or its costs are on the list of medical services to which the insured person is entitled to receive in the respective Member State;
- The situations for which preliminary certification of the treatment is required: the refuse to grant this preliminary certification has to be justified by the member state to which it is appealed for the treatment, based upon a list of specific criteria and conditions, that include clinic evaluation of the highly identified risks for the patient or the audience.

Conclusions

1. National healthcare systems are large consumers of financial and human resources, the funding policies and mechanisms presenting significant differences between EU member countries with obvious effects on the life expectancy of the population.
2. The Single Market Principle grants European citizens the right to free movement and to access trans-border medical care in the EU Member States.
3. Supplementary regulation of the legal framework on putting into practice patients’ rights imposes itself, regulation based upon new policies on the investment repartition in the healthcare system.

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9 It is also the situation of the Romanian immigrants reaching the retirement age in countries such as Spain, Germany, and Italy etc.
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Finanțarea sistemelor de sănătate în statele membre ale Uniunii Europene

Rezumat

Articolul analizează comparativ politicile de finanțare a sistemelor de sănătate în ţările membre ale Uniunii Europene. Se evidențiază mari diferențe între ţările europene în ceea ce privește nivelul investițiilor în sistemul de sănătate și, corespunzător, în speranța de viață. Se concluzionează necesitatea revizuirii cadrului juridic în vederea asigurării nediscriminatoare a asistenței medicale trasfrontaliere.