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The question I would like to address today is a very topical one: how sustainable is the European health care model? In many European countries health care systems are deep into deficits, in others complaints have been mounting over the lack of adequate spending.

When you start talking about the economics of health care, even the most placid and stoic people start getting nervous or passionate. I expect this general rule to apply again with my presentation. I would be disappointed otherwise.

What does it mean for a health care system to become unsustainable? It means reaching a point where spending becomes too high for comfort. One more euro spent on health care reduces the overall social and economic well-being of society. Because it is crowding out other important expenditures: productive investment, education, environmental protection, etc.

This lack of sustainability can show up, for instance, when taxpayers start resisting calls to increase the funding of the system.

When asking ourselves about the sustainability of European health care, we are in fact facing two separate issues:

- First, the general issue of health care sustainability OECD-wide; health care spending is also growing very fast, outside Europe;
- Second, the specific issues facing European systems. Where the funding has more than elsewhere an important redistributive function. Redistribution is a legitimate objective. But it generally means health funding will be more costly from an economic point of view by dissuading individuals' and firms' initiatives. This high economic cost of funding may depress the "sustainability threshold" of health systems. Excess redistribution means less spending is affordable.

That health spending will increase fast, as a share of GDP, in the future is a safe bet. We just have to look at available OECD projections of the consequences of ageing. It is expected that ageing itself would push up the share of health and long-term care from 6% of GDP today to 9% in 2040 OECD-wide.

There will be, of course, many other spending pressures arising from technological advances and rising living standards.

After this preamble, I'd like to ask and tentatively answer, two questions which matter most for policy-makers:

- Is the European health model “spontaneously” sustainable, that is within existing institutional arrangements?
- If not, what should we be doing about it? What structural changes on the spending and the funding sides?

On this sustainability issue you find not surprisingly two schools of thought: the optimists and the pessimists.

The optimists are telling us that health is a “superior good”: the richer we are the more we want to spend on health as a share of GDP. *Prima facie*, this is indeed a plausible assumption.

You have all seen this famous chart relating health expenditure and GDP per capita. (Figure 1). There is indeed an incredibly strong correlation between the share of health spending and GDP. It explains alone 70% of the variations of health spending across countries. And if you dropped the US you would get close to a 100% fit!

Looking at this chart, Europeans may feel reassured and conclude the pattern of spending is just following a general law of nature, with no sign of overspending in sight. From this perspective, even the US, with its very large share of spending, could be deemed normal. Being more than elsewhere a private-based system, it could be seen as allowing a more spontaneous expression of the real needs of health users (cf Figure 2).

Then come the pessimists. Warning us against complacency on at least two grounds:

- This graph doesn't tell us anything in truth, about overspending;
- It only tells us about past trends. But this trend towards a greater share of health spending could be for good or bad reasons.

I won't inflict on you the long list of factors that could lead to overspending. When health systems are insurance-based you encounter this nagging problem of asymmetric information. Once insurance is paid, provider and patient feel relatively unrestrained in prescribing and using health services. The insurance company, or authority, being imperfectly informed finds it difficult to keep this behaviour in check.

In truth, in those systems, suppliers always face the temptation to provide health care beyond what is needed. Rent seeking and income maximisation are all too natural inclinations to be discarded from the analysis.

To be exhaustive, public health services may lead, to the contrary, to rationing, which is also suboptimal.

Looking now at the dynamics of health spending over time, econometricians and statisticians tell us that there is yet no firm consensus around the view that health is a superior good.

The share of health spending may not increase because demand is spontaneously growing faster than incomes. But for more autonomous reasons such as a trend towards increasingly costly medical technology and the phenomenon of supplier-induced demand in health care. For instance when a higher number of doctors induce an increasing demand of health care.

Technological developments are probably the greatest source of uncertainty in assessing the future of health spending. Advances in medical research can bring cost increases because of the development of new treatments. But medical progress can be cost-saving too. New treatments can indeed reduce medical costs if they replace more resource-intensive practices. Or, research may find ways of performing the same treatment in a more cost-effective way.

On balance it seems that so far technical change has been cost increasing. This feature may not be however a natural fact of life. It may also reflect skewed incentives and ineffective arrangements.

The optimists would then argue that, at least, researchers have found surprisingly little connection between the age structure and health care spending. So that we can afford to be more optimistic about the future impact of ageing.

Pessimists would reply that the most rapid increases in elderly populations are yet to come. Hence, evidence based on historical data may be an unreliable guide into the future.

What lessons should a prudent policy-maker then derive from this rather inconclusive discussion? The main lesson is, in my view, that there is no guarantee that there will still be a willingness to pay in the future should the share of health spending increase at the present sustained pace.

In this context, Europeans should watch with some care developments on the funding side. Making sure the degree of redistribution of health systems remains acceptable should be an important objective.

As you know, redistribution within public funded systems can prove relatively strong and the public component of total funding is indeed large in Europe.

My own country, France, gives a good example of a somewhat redistributive system. Health care is principally funded by social charges at a rate of 13.5% in gross salary. And no ceiling is set to the contribution. Hence, high income earners and their employers can make contributions to health care that are transparently way in excess of the average value of medical services consumed. My concern here is essentially one of practical policy-making. Attempts to increase charges may be met by increasing opposition from high and middle income earners and their employers.

If funding arrangements prove inadequate, unwanted consequences may ultimately follow: greater use of less transparent methods of funding, excessive pressure to reduce levels of services, increasingly two-tiered health care systems.

If we are at risk, what then should be done to ensure the sustainability of European health care systems?

Since I have no magic remedies, I will try to be brief.

On the funding side it would be good, as I said, to maintain the degree of progressivity of the system within reasonable limits. Having health users to meet directly some of their own costs would also help. Empirical evidence tells us it can reduce the demand for health care.

Reforming health systems and their supply side would also be of utmost importance. This effort can take many forms like improving gate keeping in primary health care or achieving a wider diffusion of cost-effective medical practice.

More fundamentally, there is still a need to tilt financial incentives towards greater cost saving. This is true for doctors' remuneration schemes and also for research activities.

As you know, the amount of research and its focus are strongly influenced by regulations and incentives. In this context, it would be good to encourage medical research to devote more attention to medical advances that are also reducing costs. My perception is that there is indeed room for manoeuvre here. If you allow me a car-making analogy: health care research strikes me as more concerned about developing formula one racing cars than family saloons. In short, I suspect, cost and productivity concerns rank at present a little bit too low in the priority list.

If I understand correctly, there are already policies attempting to tilt the balance of medical research towards cost saving. For example in a number of countries so-called pharma-economic assessments have been introduced. However, my colleagues at the OECD tell me these are controversial. For instance, it seems that there are concerns about the delays these assessments cause in bringing products to market, controversies over the costs covered in the assessment, and difficult-to-resolve tensions between individual and societal perspectives.

To conclude my presentation, I would say I am not an expert but I have a strong suspicion that despite the deep attachment Europeans show for their health care systems, sustainability is not guaranteed. In this context, policy makers should be working harder at reforming health care.