Financing Health Care

How societies pay for health care, and how many resources they devote to health, affects both the care people can get and its quality.

In most developed countries, health care is paid for largely by the government or an organization associated with it, using taxes collected from citizens. The United Kingdom, for example, has a “single-payer” system in which the government pays directly for care; in France and Germany, the government collects taxes to fund part of the government health care system, and employers and individuals pay for the remainder of the costs directly.

In other countries, such as the United States, a portion of the health care system is market-based, that is, paid for by private entities such as employers and individuals. Even in market-based systems, the government may provide health care to vulnerable people. For instance, in the U.S., federal funds support Medicare, which covers the elderly and disabled, and state and federal funds support Medicaid, which covers low-income people.

These two broad approaches to financing health care – market-based and government financed – offer different advantages and disadvantages and neither is perfect in all aspects. All societies have to make choices between how broadly to provide access to basic and advanced care, how much to pay for health care and how much and which innovations to make available to patients.

Different Approaches to Health Care

In market-based systems, care is generally delivered by private organizations and individuals and all parts of the system are subject to some level of competition. There are many different payers, providers and suppliers, and people with insurance can choose which ones serve their needs best. Doctors may have the benefit of best-practice guidelines that indicate when and for whom different treatments should be used, but they’re free to make care decisions on a case-by-case basis, considering the needs of each individual. One disadvantage of a system where physicians and patients have free choice is that coordination of care can be challenging and some duplication of services can occur.

Because market-based systems offer financial incentives for developing new medical advances, progress is often greater and new advances are available to patients sooner.
But if there are not adequate provisions ensuring a basic level of health coverage, some people may not have access to the care they need. As a consequence, market-based health care systems tend to offer “safety net” programs that provide government-funded coverage to people who cannot afford to buy insurance on the private market, such as the disabled, the poor or the elderly.

Singapore’s 3M programs, Brazil’s Sistema Unico de Saude, and Medicare, Medicaid and the State Children’s Health Insurance Program (SCHIP) in the U.S are examples of safety net programs. Safety net programs may not reach all those without coverage, and in the U.S. there are 47 million people who have no health insurance. Many are lower-wage working people who cannot afford coverage; others are healthy people who choose to go without insurance.¹

Most government-financed systems tend to provide everyone living in the country with coverage that offers access to some basic level of care. Most people pay for these systems through taxes and other charges. In government-financed health care, the government may deliver the care itself, as in the United Kingdom, or they may contract with other providers to do so, as in the German or Japanese systems or in the U.S. government-financed programs, Medicare and Medicaid.

Because of the reach of government-financed health care programs, they typically have more power to place limitations on the care offered to patients and doctors in order to keep costs down. Under these programs, it also tends to take longer for new advances to be accepted and reimbursed by governments and therefore available to doctors and patients²,³. As a consequence, the diagnostics and treatments that are offered may not be the same as what’s available in a market based health care system. For example, in the U.S. market-based system, people have cancer diagnostic tests earlier and more often than do Europeans.⁴ Government-financed systems also tend to offer fewer incentives to encourage new medical advances.

Managing Health Care Costs

Both market-based and government-financed health care systems strive to manage overall health care costs. The difference lies in the way they approach the task. Market-based health care relies primarily on the force of companies competing against each other to bring the best new products to customers. Customers make their choices based on many variables such as quality, convenience and service, not just cost.

Most government-financed health care systems do not use competition, but rather a variety of other tools to keep costs down. Some of these tools harm continued medical progress, others are useful and effective ways to control costs without slowing advances, and the effect of still others depends on how they’re applied.

Approaches that can stifle innovation are:

- firm budget ceilings that limit the resources a government will devote to health care in any budget cycle;
- direct price limits on new treatments;
- profit caps;
- the importing of medicines from lower-priced countries without approval of the relevant authorities or review by the manufacturer;
- the substitution of one product for another;
- highly restrictive formularies, or restricted lists of which medicines will be reimbursed, and
- penalties for physicians who exceed certain levels of spending.

Countries, as well as private payers in market-based health care systems, may use other approaches that, if well designed, can help to constrain health care spending without harming innovation. Among these are the use of generics, where appropriate, as well as reimbursement for care associated with an episode of illness instead of a la carte reimbursement for each individual treatment intervention. As long as the set reimbursement, or capitation, for the episode of care is adequate and outcomes measures are in place, patients can get quality care tailored to meet their particular needs. Episode-based reimbursement also stimulates competition among insurance plans and helps keep health care costs down.

Patient-centric cost control efforts are also important, such as placing a greater focus on
prevention and wellness to reduce the need for acute care later on, or more flexible formularies that permit physicians to prescribe treatments not on the approved list if they conclude they’re better for the patient, or efforts to provide physicians with cost information.

**Advancing the Medical Frontier**

One of the most important differences between government-financed and market-based health care is their ability to generate medical advances that will bring new, effective treatment to patients.

Studies show that innovation tends to suffer under government-financed systems. The combination of price controls, budget ceilings and other restrictions reduces incentives to invest in medical research.

For example, European countries used to discover and develop more new medicines than the United States, but that’s not the case any longer. While there are certainly several contributing factors, including changing tax policies in these markets, the advent of price controls in Europe is one important reason for the change.

From 1993 to 1997, 90 new medications were launched in Europe, compared with just 66 in the U.S. Just a few years later, between 2001 and 2005, as European price controls on medicines took hold, the number of new drugs from Europe dropped from 90 to 55, while the number of new drugs launched in the U.S. stayed about the same as before: 61 vs. 66 drugs.

In market based health care systems, investors are willing to finance medical research because they know they’ll be rewarded for successfully bringing a new advance to doctors and patients. As a result, these systems tend to foster more health care advances, and those advances reach patients and their doctors more quickly.

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