Constructing Health Security in Europe: Looking Backward to See Forward

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INTRODUCTION

The dynamics of day-to-day policymaking make it difficult to peer very far into the future. Every public decision-maker is familiar with the calculus: "it's not possible to predict A, since it is dependent on B, which is contingent on C, etc." This lack of certainty about future developments, as much as the rigidities in contemporary structures of authority and organization, leads to what Charles Lindblom sought to dignify as "the science of muddling through" (Lindblom, 1959) - that is, to incremental decision-making. This stepwise approach is often described as one of the central strengths of democratic policymaking, in that it involves a process of negotiation and compromise. In this perspective, politics becomes "the art of the possible."

While incrementalism has a number of positive features, it also has inherent liabilities. When it becomes the sole basis for decision making, incrementalist thinking can lead to dangerous levels of policy myopia. One well-known saying about the less savory consequences of incrementalism is that it makes it "difficult to see the forest for the trees". Another, more pungent US saying, speaks less delicately about it being "difficult to develop plans to drain the swamp when you're knee-deep in alligators."

These inherent difficulties in extrapolating from where policy is now to where it ought to go in the mid-term future suggest that, in order to develop robust long-term policy strategies, it is necessary to break out from the regular political cycles that incrementalism creates – e.g. from what political commentators refer to as logrolling, back-scratching, the politics of interest groups, and other patterns of normal if not particularly edifying political behavior. To switch to a nautical metaphor, if they are to successfully navigate over the longer term, policymakers need a different kind of map.

One conceptually valuable technique is to reverse direction and to start not from where policy is today, but from where it should be in the future. This general approach was adopted 100 years ago in the United States by a number of social reform groups that are now called the Progressive Movement, which sought to restore principles of good governance based on the public interest to what had become a corrupt political system run by self-interested and business-dominated politicians (Josephson, 1962; Sinclair, 1981). The classic exercise in this reform effort, written by Edward Bellamy in 1888, was titled Looking Backward: 2000-1887. In it, Bellamy gave a pragmatic twist to the age-old utopian device of describing a static, perfect society. Instead, Bellamy described, from a position some 100 years in advance, the process of how society had evolved to reach a better, more civilized status. It was a device that made it possible to "look backward to see forward."

This paper will adopt Bellamy's device as a means to organize its review of what has transpired to date in European health care systems. It is, ideally, a heuristic device intended not to quibble over the particularities of the present period, but rather to drive the debate forward over the next several decades. It can serve to organize the available evidence about what has already occurred, which is being published in ever-greater streams by health service researchers in Europe as well as in the United States. Lastly, perhaps most usefully, it may be a device which can link back to the major social achievement of the Post-World-War II period – that is, the much-maligned concept of the welfare state – and which can help re-invigorate and re-direct those original normative values that in the 1950s and 1960s inspired its creation.

It is by now a commonplace in European health policy to acknowledge the need to re-vitalize the underlying forces that drive health policy, and to find a new vision for how to move forward over the next period of years. The long erosion of purpose that began in the 1980s with increasing emphasis on cost containment, and which in the 1990s was re-formulated in the soothingly technical notions of "priority setting" and "rationing," reflects the degree to

which European health policy – viewed backward from the future – has been confronted by both external as well as internal pressures (Saltman, 2001a). Demography (the aging of society), technology (the rise of information technology), and economy (regionalization and globalization) have served to establish the outside parameters to which health care systems must respond. Internally, pressures for greater efficiency, greater efficacy, and greater patient/citizen influence have also played their part in pushing national health policymakers to search for new instruments with which to steer their health care systems.

The degree to which European health policy is at an inflection point is matched by the extent to which the broader social project within which European health care systems are embedded – namely the welfare state – is itself confronted by much the same mix of external and internal pressures. The past 20 years have seen a wide range of critiques, assessments, and analyses of the strengths and weaknesses of the welfare state (George and Wilding, 1994; Mishra, 1984; Einhorn and Logue, 1989; Esping-Anderson, 1990). Starting in the United Kingdom in the early 1980s, a variety of attempts have been made to chisel away at various bureaucratic and/or support aspects of the welfare state system that those on the right – and in the late 1990s those on the left as well – found to be both socially and economically constraining. The current debate across Europe about how to re-structure state pensions is emblematic of this long-term battle to reshape (left) and/or diminish (right) the future role of the welfare state. Esping-Anderson (1990) argued that the central battle for the welfare state was not over its elimination but rather over the different types of welfare state regimes in place, and which group will benefit from shifts between these different forms. The present-day welfare state debate may well be not so much about whether the existing system will survive but rather in what form and to the benefit of which social groups (Pierson, 1998).

It is precisely the degree to which both European health care systems and, more broadly, the welfare state structures within which they sit, are in flux that the process of "looking backward to look forward" can be valuable. This paper will argue that, in the case of European health care systems, a central challenge is the sustainability of solidarity as the structures of these systems evolve over the next several decades. It will make this argument through the presentation and examination of the concept of "health security" which will serve as the central mechanism by which, looking backward, the paper will consider health system development to date both in Western Europe and in the United States. Subsequently, the paper will draw upon the main characteristics of health security as the basis for considering the implications of current European Union decisions upon the likely future of health systems in Europe.

I. A CONCEPTUAL TYPOLOGY OF HEALTH SECURITY

The notion of health security is both simple and far-reaching. Defined simply, it "incorporates those funding and service elements…. that either protect against or alleviate the consequences of trauma, illness, or accident" (Vohlonen et al., 2002 forthcoming). Defined more far-reachingly, it involves coordinating disparate and often fragmented components of curative and preventive health care, social care, rehabilitative care, occupational health services, workman's compensation, sickness pay, and disability pensions such that the individual's need for services and income are met. Providing health security for all citizens does not necessarily mean providing public funding for all services, and it certainly does not necessarily mean providing exclusively publicly operated facilities to deliver those services. Typically, the wide number of health care and income support functions that comprise health security are performed by a range of both national and local public, private not-for-profit, and occasionally, private for-profit entities. What health security clearly does entail is public responsibility to ensure that all citizens have access to appropriate services at a suitable standard; that the funding structure for those services reflects ability to pay; that providers

serve the needs of citizens in a consistent, reliable, and sensitive manner; that adequate replacement income is provided in a non-discriminatory manner; and that the entire structure is integrated and coordinated so as to reduce unnecessary stress on the individual as well as unnecessary or duplicate cost to the society.

Defined in this manner, health security is an important component of the broader, more widely recognized notion of social security. Viewed in this way, health security can be seen as an essential component of a well-functioning structure of social security. This combination of health plus social protection has a long history in Europe, extending back to Bismarck and the mutual aid societies that preceded social health insurance in German (Altenstetter, 1999).

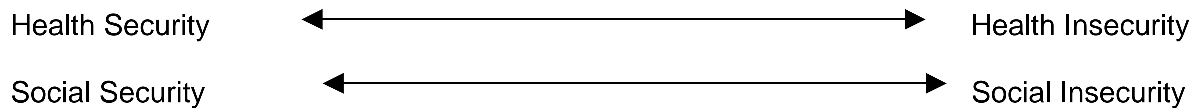
An alternative approach to understanding the notion of health security is to contrast it with its opposite: e.g. health insecurity. The nature and consequences of health insecurity are rather transparent. Citizens worry that episodes of sickness or ill health may place at risk either their physical or mental health, on the one hand, or their financial stability, on the other. Lacking certainty about either the adequacy or availability of needed services, individuals fear that – should they require them – they may not qualify and/or may not be able to afford them. Again, health insecurity forms an important component of a larger concept, that of social insecurity, in which citizens worry that their ability to work, their income, and/or their basic human needs (clothing, food, shelter, education) could be compromised despite their own personal best efforts.

Armed with these key contrasting concepts, it becomes possible to establish two broad policy continuums. One moves from "health security" on the left to "health insecurity" on the right; the second from "social security" on the left to "social insecurity" on the right (Figure 1). Structured in this manner, discussions about health security take on a number of intriguing characteristics. Many current debates appear in a decidedly different light. Among them are the following:

A) Stewardship

Stewardship in the health sector involves the application of both sound normative values and efficient expenditure of revenues to the activities and decisions of the state (Saltman and Ferroussier-Davis, 2000). The role of the state in the formulation and implementation of efficient, efficacious, and responsive health policy, and in the regulation of health sector actors, should also, overall, seek to improve the level of health security of the citizenry. Measures which might improve the technical functioning of health systems according to these three criteria but which move the health system toward greater health insecurity would, arguably, not reflect good stewardship except in the most dire policy circumstances (e.g. war, depression).

Figure 1



B) Cross-sector Coordination

Integrating service provision across health sub-sectors (e.g. primary care, hospital, home care, etc.) is believed to hold considerable potential in reducing aggregate health expenditure while simultaneously improving overall quality of patient care (Saltman and Figueras, 1997). The concept of health security suggests that extending this integration to incorporate social care, occupational health, rehabilitative services, and income transfer programs could have even broader savings. A trial evaluation in Finland found substantial range for future improvement across this broader health security category (Vohlonen et al., 2002 forthcoming). Similar efforts inspired an early 1990s program in Sweden to utilize disability pension funds to speed up the provision of health and rehabilitative services to injured or sick workers.

C) Limitations of Economics in Health

This is a wide-ranging topic that will be increasingly debated over the next decade. An emphasis upon the importance of health security serves to re-focus several standard health economic arguments:
1. An analytic basepoint. In assessing social decision-making processes, economic theory starts from the assumption that the analytic basepoint should be the particular exchange process that it labels a "market". All things of value are presumed to be commodities which are always bought or sold according to ironclad rules of supply and demand. Those human activities that either are not or cannot be accommodated within this market framework are then designated as anomalies – e.g. "market failures" – which by definition are improperly constructed outliers that require a less optimal form of distribution.

The notion that health security (or social security) ought to be the analytic basepoint for judging social decision starts from an entirely different initial premise: "what makes a good society, and how do we set about achieving those things?" From this perspective, markets are understood as one form of allocative device, useful for distributing commodities, but not the appropriate decision-making logic for human activities that are not commodities – what Walzer (1983) famously referred to as "spheres of justice" - such as family life, courts, or health care services.

2. Cost-sharing and co-payments. Although comprehensive review of the available evidence demonstrates that cost sharing is both financially inefficient and socially inequitable (Kutzin, 1998), many health economists persist in promoting it to policymakers (Barer et al. 1998). One explanation is the surface plausibility of the market-incentive-based argument that co-payments encourage patients to become price conscious shoppers for health care and – not incidentally – to reduce their demand for "unnecessary" services. Co-payments are similarly described as a device to reduce the "moral hazard" that accompanies the provision of third party payment for health care services. One obvious assumption here – referring to #1 above – is that health care services are considered to be a commodity no different from any other market-allocated "product."

A health security perspective takes a very different view of cost sharing. Like Abel-Smith (1985), who labeled all forms of cost-sharing as "partial de-insurance," a health security approach views cost-sharing as intentionally increasing the "health insecurity" of citizens, and

thus as an undesirable instrument in terms of core health policy objectives. Medical Savings Accounts, which seek to return all but catastrophic health services to a fee-for-service basis by removing the third party payer, not only decimate socially responsible risk pooling (Saltman, 1999) but also, at the individual patient level, dramatically increase both financial and clinical forms of health insecurity, and would thus be viewed as unacceptable policy.

3. Rationing/Priority Setting. Rationing involves setting criteria for decisions to eliminate certain clinically necessary services from coverage by a third party payer (Klein and Day, 1996). Proponents of rationing argue that there is infinite demand for scarce health care resources, and that only limited access to certain services can be afforded by publicly-funded or publicly-regulated third party payers (Ministry of Welfare, Health and Cultural Affairs, 1992; Ham and Honigsbaum, 1998).

Focusing on health security would highlight the differential consequences of rationing individuals with high as against low personal incomes. Whereas high-income individuals would be able to privately purchase services no longer covered by a third party payer, low income individuals would be forced to go without the rationed care. Since rationing necessarily increases the health insecurity of only less-well-off individuals, adopting a health security approach leads to the conclusion that priority setting as currently proposed is a socially unacceptable solution to the problem of inadequate health sector resources.

Taking these three debates together – stewardship, cross-sector coordinating, and the limitations of economics in the health sector – serves to demonstrate the potential usefulness of adopting a health security lens through which to assess future health policy decision-making.

II. THE IMPACT OF RECENT REFORMS ON THE LEVEL OF HEALTH SECURITY

During the 1990s, health system reform became ubiquitous throughout the developed world, and a wide range of both national and comparative international assessments have been published (Saltman and Figueras, 1997; Saltman et al., 1998; Ham, 1996; Raffel, 1997; OECD, 1992; OECD, 1994; Robinson and LeGrand, 1993; Schwartz et al., 1996; LeGrand et al., 1998; Powell and Wesson, 1999; Ranadé, 1998; Mossialos and LeGrand, 1999; Altenstetter and Bjorkman, 1997; White, 1995; Jerôme-Forgét et al., 1995). These studies have carefully sifted the available evidence, and have sought to draw policy lessons on the basis of past experience.

Adopting the dual analytic tools of looking backward and the conceptual lens of health security, this evidence and experience can be placed in a wider, more historical perspective, closely linked to current activities and future prospects of the welfare state. This section will apply this dual approach to health reform experience in two key areas of the developed world, the United States and Western Europe.

A) Health Security and Health Reform in USA

The 1990s witnessed the consolidation in the United States of the most far-reaching health sector transformation experienced in any developed country. Viewed from some future historical vantage point, it was the decade in which the world's first fully for-profit health care system was put in place. Not-for-profit hospitals became subsidiaries of for-profit holding companies (Gray, 1997; Claxton et al., 1997); not-for-profit insurers, like Blue Cross, re-incorporated themselves on a for-profit basis (Kane, 1997); and large for-profit corporations were established to purchase and manage physician group practices (Reinhardt, 2000). On Wall Street, shares of hospital, health services, and insurance companies grew to rival those of large multinational pharmaceutical firms, with many senior executives earning tens of

millions of dollars in stock options, buyouts, mergers, and other stock-enhancing maneuvers. Pioneering not-for-profit Health Maintenance Organizations like Kaiser and Harvard Community Health Plans, vestigial remnants of a community-based mission-oriented ethos, found themselves forced by economic realities to expand rapidly and to become equally as ruthless as their bigger for-profit corporate competitors in cutting quality, denying services, and harassing their physicians. A number of these vestigial plans found that they weren't ruthless enough and were merged or absorbed into other competitors or, like Harvard Community Health Plan in 1999, were forced to file for bankruptcy.

By the time the 1990s had ended, the US health care system had entered a truly new world. Health services were just another commodity for sale, regulated by federal and regional (state) governments on that basis. "Charity" and "free care" had all but disappeared from hospitals, along with the now quaint notion of meeting community need. Patients became "customers," physician groups became "vendors," community service activities were reconfigured to become "marketing," and hospitals that could not attract enough adequately insured (e.g. non-Medicaid) patients closed their doors. The nature of this transformation can be symbolized in one trenchant example: in Chicago, a well-respected Catholic chain of non-profit hospitals named the "Sisters of Charity" came to be disparagingly referred to by health sector analysts as the "Sisters of Currency."

In looking back at this transformation, it is important to recognize its corrosive effects on the social and cultural expectations of the population. At the same time that Americans now viscerally hate their health insurers (a valuable comment itself on the social consequences of the current system), the vast majority of citizens have no meaningful interest in establishing a universal public system. In health care as in social security generally, they understand "fairness" to be an actuarial term (Stone, 1993), guaranteeing that what they pay in to the system is what they receive back for their use only. A powerful combination of the myth of the individual, personal self-aggrandizement, and the intellectual justification provided by neoclassical economic theory all lead the majority to reject the European notion that "fairness" involves a set of four cross-subsidies (young to old, wealthy to poor, healthy to sick, and individual to family). In practice, the vast majority of US citizens broadly accept the unequal social character of the current for-profit health system. The only changes that command substantial popular support would further reinforce that for-profit character – for example, the right to sue one's health insurer, which is a directly commodity-oriented mechanism.

How then, looking backward, does one assess the changes in the US health care system in terms of health security? The answer is that health security deteriorated substantially in direct proportion to the consolidation of the new for-profit regime. The number of uninsured citizens is rising by approximately one million citizens per year, in 1999 to some 43 millions (Feder et al., 2001). The number of those who are "partially de-insured" due to increased cost-sharing and co-payments (particularly for pharmaceuticals) is considerably larger and has increased even more rapidly. So-called "first dollar coverage" – i.e. full coverage – has all but disappeared except in the few remaining industries that have strong unions. New forms of health insecurity have been created for citizens whose hospital or health insurer is allowed to file for bankruptcy (a normal event in competitive commodity-based markets). Insurance remains tied predominantly to employment and employers must approve both the insurers and the range of services provided. The small and, on balance, insignificant increase in publicly funded programs at both federal and state level during this same period has been an inadequate response to what is a worsening situation.

Regarding transfer payments, the provision of sick pay in the United States remains wholly at the discretion of the employer (many small, low-wage, or construction companies choose to provide no sick pay at all), and disability payments under the federal Social Security program have been substantially scaled back. Initially inadequate federal occupational health

protections have been continuously weakened under a succession of both Republican and Democratic administrations.
Lastly, in terms of co-ordination and integration of health and income transfer payments, there has been little improvement across the several sectors, which still remain isolated each from the other. Inside the health sector itself, despite the development of new programs such as "clinical audit" and "disease management," there has been little major change. After nearly 30 years of rhetoric about health maintenance organizations and "managed care" (Brown, 1983), the large preponderance of for-profit insurance companies still engage only in "managed cost" and have demonstrated little serious interest in the provision of coordinated health care services.

Overall, it is hard to assess the stewardship of the US national government in the health sector in anything other than negative terms. Misled by the false promise of an only marginally relevant ideology – market economics (Rice, 1998; Arrow, 1963) – there have been few notable improvements in the citizenry's health security, while large and thoroughgoing deterioration has occurred for most citizens for most services. Expenditures are high and increasing, coverage and access is falling, administrative and other transaction costs are skyrocketing, quality of care has eroded, and regulation is weak and inadequate. Without doubt, a major and unique contributor to this deterioration has been the conscious decision of government (supported, as noted earlier, by a large majority of the population) to allow and in many cases nurture the transformation of both funding and provision onto a fully market-based, for-profit basis.

B) Western Europe

Looking backward at the balance between health security and health insecurity in Western Europe over the past decade generates a decidedly mixed picture. There has been a widespread policy debate and numerous national-level reform programs have sought to increase the degree to which market-based incentives are incorporated into health sector structures. Despite considerable ferment, what one sees in practice has been careful adjustments to the broad overall organizational pattern, in some instances with marginal erosion of health security for particular groups under particular circumstances in one or more particular countries.

This pattern in the health sector is consistent with the argument that Esping-Anderson (1990) and others have made about general developments in the structure of the welfare state overall during the last several decades. Regardless of individual interpretations of the available evidence, however, few would suggest that a radical re-alignment between health security and health insecurity has occurred anywhere in Western Europe. In former Soviet Bloc countries, however, health insecurity increased dramatically during the 1990s, in part due to a drastic drop in available resources, and in part due to adoption of several socially inappropriate market mechanisms (Saltman and Figueras, 1997; McKee and Bojan, 1998).

The broad process of health sector reform over the past 10 to 15 years in Western Europe can be captured in two major themes (Saltman, 2001a). The first has been to add micro-efficiency at the institutional level – e.g. managerial efficiency – to the broad macro-efficiency at the health system level which had already largely been attained with regard to overall health system expenditures (Abel-Smith and Mossialos, 1994; Andersen and Hussey, 2001). The second theme has been the addition of a degree of entrepreneurial behavior – that is, independent managerial decision-making driven by market-based incentives – to what has remained the central policy value of solidarity (Chinitz et al., 1998). These two major themes draw together numerous strands in the health policy process across health care systems (e.g. hospitals, primary care, social care, pharmaceuticals) as well as across a substantial number of countries.

When one looks more closely at the evidence regarding the introduction of entrepreneurial behavior into European health care systems, one finds a consistent pattern about what has and – at least as yet – has not occurred (Saltman and Figueras, 1997; Saltman et al., 2002 forthcoming). If one employs a rudimentary three-way typology to describe health care systems (Figure 2) (Saltman, 1994), the evidence indicates that a substantial number of publicly operated health systems have adopted a measure of entrepreneurial behavior on the production side of their health systems – particularly between hospitals (Busse et al., 2002 forthcoming). Whether these are called "self-governing trusts" (UK); "public companies (offentlig bolaget)" (Sweden), or "public hospitals under private law" (Andalucia, Spain), they all have similar characteristics in that they are independently managed but remain publicly owned and publicly accountable (Saltman, 2002 forthcoming). While the results attributable to these changes are often subject to intense debate (Saltman, 2001a), the available evidence leads to the conclusion that these supply-side uses of entrepreneurial incentives have been reasonably successful in reaching a number of the organizational and financial objectives set for them (Saltman and Figueras, 1997; Saltman and von Otter, 1995). Most governments who have introduced this type of reform have been broadly satisfied with the outcomes achieved by them, particularly their ability to reduce waiting lists and to respond more directly to patient concerns about quality and timeliness of care.

Conversely, those few Western European governments that sought to introduce competitive incentives on the funding side of their health care systems became decidedly disenchanted with the outcomes. Indeed, only two, social-health-insurance-based health systems sought to pursue this approach – Germany and The Netherlands. Neither government succeeded in putting these changes into place, both pointing to severe structural flaws in the assumption that competitive incentives could be utilized on the funding side of health systems without undermining solidarity (Chinitz et al., 1998). Germany dropped large components of its proposed 1993 reform in 1998, and in The Netherlands, 14 years after the 1987 Dekker proposals, only a small portion of the proposed changes have been implemented (Okma and Poelert, 2001).

A review of the policy evidence thus suggests two central points of relevance to the issue of changes in Western Europe in the level of health security. First, those structural reforms utilizing entrepreneurial incentives that have gone ahead have been predominantly among health service providers, have focused on making these providers more flexible in their day-to-day management, and have not dramatically affected the overall equity or accessibility with which health services have been delivered. Second, conversely, those (few) reforms that were intended to utilize entrepreneurial incentives on the funding side – where there potentially was substantial danger to the health security of lower income and/or vulnerable groups – were stopped and/or severely truncated by national policymakers. From a health security perspective, then, the various organizational reforms implemented over the past decade have had little impact on the previously existing balance.

Looking beyond health care services to the various additional programs that compose health security, there again appears to be a generally mixed picture. The one area in which health security appears to have been notably improved in Western Europe has been in the area of long-term care. Germany, for example, in 1995 introduced a separate social insurance scheme for long-term care (Wasem, 1997). In the UK, efforts toward what was termed total fundholding and, subsequently, the responsibilities of the newly introduced Primary Care Groups (PCGs) involve considerable emphasis on improving access to and quality of community care services (Forder, 2002 forthcoming). Similarly, in Sweden in 1993, the Adel reform achieved substantial improvements in the timeliness and coverage of long-term care services (Johansson, 1997).

Where recent changes have raised concerns regarding health security have been in the areas of workman's compensation, in occupational health services, and also in certain cases

to disability pensions. All three instances reflect changes encouraged by economists seeking to reduce what they typically term “labor market rigidities,” which they contend add unnecessarily to the cost basis for labor and contribute to stubbornly high unemployment rates of the 1990s across much of Continental Europe. The country that has seen the largest changes in this area – the UK – is also the country that is seen by union advocates as having most increased the financial burden shifted from companies to individual workers and their families. While the UK has not put restrictions in place that are as severe as those found in the United States, the contrast with France, Germany, and a number of Southern European countries is notable.

The picture is broadly similar with regard to enhanced co-ordination, both within the health sector itself and also between health and income transfer programs. While there are pockets of improvement, the majority of activities in both tax funded and social insurance funded systems remain independently generated and operated (Vohlonen et al., 2002 forthcoming).

Among the more interesting departures have been programs in Denmark and Sweden that move “finished” elderly hospital patients (who have completed their clinical treatment) more rapidly into less expensive and more clinically appropriate settings in nursing homes and home care services (Johansson, 1997). Notably better coordination between what in Nordic countries are two separately budgeted and administered public services has been achieved by creating market-style incentives between their budgets. Prior to 1993, some 25% of hospital beds in Sweden were occupied by elderly “bed blockers” who had finished their clinical course of treatment, but whom the municipalities refused to accept for nursing home or home care, due to lack of adequate facilities. Under the new, nationally-imposed arrangement, if the municipally run nursing home and home care services cannot accept a “finished” patient back from the hospital within five days, then their budget must pay the hospital the full cost of each additional day of care. This powerful market incentive dramatically changed the behavior of the municipally run services, who in the first year in Sweden (1993) took back fully 85% of all patients (Johansson 1997). A side benefit of this better coordination was that it released what was substantial over-capacity in hospital beds, which could then, in turn, be progressively reduced through closures and space re-allocations.

Overall, then, it seems fair to conclude that the prior balance between health security and health insecurity in Western Europe – which due to prior welfare state structures was well articulated and broadly favorable to health security – has remained, in the main, unaltered over the past decade. This reflects what has been the continued good stewardship of numerous national governments who have been vigilant about threats to health security and have reversed policy once these dangers became visible (and thus a potential political liability). This is not to conclude that all issues regarding health security have been resolved in Western Europe, nor that the existing means of funding, providing, and regulating health services need no further improvement (Mossialos et al., 2002 forthcoming; Saltman et al., 1998; Saltman et al., 2002 forthcoming). Rather, looking backward, it is an assessment of how the broader swath of health security change appears in long-term perspective.

C) A Comparative Assessment

The degree of health security that a society provides to its citizenry can be judged from a variety of different perspectives: social, economic, psychological, philosophical, historical, even anthropological. It also is embedded in the configuration of the society’s broader commitment to social security generally, as reflected in the nature and character of its welfare state – a configuration that can also be evaluated along the same broad range of disciplinary perspectives.

Independent of the disciplinary perspective one takes, however, or of the normative values that necessarily underlie such assessments, the relative position of different countries in terms of the health security they provide is a relatively straightforward comparative exercise. The level of health security provided by the United States as against that in Western European countries, and the impact of the past decade's health reforms, largely reflects easily available and widely agreed evidence.

Drawing on the discussion in sections A and B above, two almost entirely uncontentious observations can be made. The first is that, now as in the entire post-World War II period, Western Europe has considerably higher levels of health security than does the United States. Alternatively, one can phrase it that the United States continues to have notably higher levels of health insecurity than do its Western European counterparts. To a degree, this observation reflects the relative broader distinction that has long been acknowledged between what has been termed the "reluctant welfare state" of the United States (Rodwin, 1987) as against the more robust forms that emerged in Western European countries in the 1960s and 1970s. Nevertheless, the unique character of health care and its standing as a social good makes this broad disparity on specifically health care services notable and, from most normative perspectives, disquieting.
The second uncontentious observation concerns the impact that the past fifteen years of reforms in the funding and delivery of health services have had on relative levels of health security. Despite a broad range of sometimes contradictory interpretation that divides some European health economists from their public health peers (Saltman, 2001a), both groups would undoubtedly join most other commentators in agreeing that Western Europe did not experience the dramatic decline in health security that has occurred over the same period in the United States. Stated more pointedly, health sector reforms over the past 15 years in the United States have generated a much greater increase in health insecurity than have reforms implemented during that time period in Western European nations.

Once one agrees to these two assertions, several important health policy conclusions necessarily follow. The first is that the health security profile in Europe has not substantially been changed, in either direction, by the last period of health sector reforms. Looking backward from a macro-perspective, measures implemented to date to create planned markets/quasi-markets in the health sector, measures to restrict workers' occupational-health-related benefits, as well as measures to improve coordination and integration between health and income transfer services, have been introduced without appreciably increasing the levels of health insecurity among the citizenry. Thus, while not necessarily improving health security, what can be said is that they have not worsened it.

A second health policy conclusion is that the reform measures introduced in the United States did appreciably increase health insecurity. Whatever other interpretation different academic disciplines might choose to put on them, whatever other advantages such reforms may have produced, and however much one may choose to attribute the blame to poor or half-hearted adoption of otherwise ostensibly positive principles, the particular type of for-profit market created over the last 15 years in the United States has, in fact, further and substantially damaged the level of health security among the citizenry. One critical policy lesson which can be drawn, then, from this comparison is that, in practice, the introduction of a full-scale for-profit market in health care undermines what is a basic tenet of a good society, namely access for all citizens to a high level of health security.

III. THE IMPACT OF EUROPEAN UNION DECISIONS ON HEALTH SECURITY

Thus far, this paper has discussed the concept of health security in Western Europe within the context of the nation-state. This approach reflects the formal position inside the European Union treaties that health care issues are, under subsidiarity, a responsibility of national governments and that only nations concerned with public health fall under the responsibilities of the EU (Amsterdam Treaty, Article 152).

In practice, of course, it is a commonplace to acknowledge that the European Union has had considerable and growing impact on the management of member states' health care systems for some time. It is also widely assumed that this EU role will continue to grow, and that the process of EU decision-making will have a critical impact on the future funding and delivery of clinical health care services.

Reflecting this picture, the driving force of the growing EU role in the health sector has not been the development of explicitly health policy. Rather, it has been as a byproduct of the Union's drive to forge a single European market – that is, its concern to generate a strong regionalized response to the ongoing globalization of the world's economic activity. As noted earlier, these economic developments are a key external pressure that has had considerable influence on the evolution of health sector decision-making.

This explicitly economic policy process has already raised several difficult questions for the formulation of what remains nation-state driven health policy (Wismar and Busse, 2000; European Healthcare Management Association, 2001). The reality that the EU Single Market policy has been driven by a number of different administrative bodies within the EU – both executive and judicial – has further complicated the picture. A central issue concerning the long-term sustainability of health security in Western Europe is the likely consequence of economically-driven (hence commodity and market-oriented) EU policymaking on the social good character of health care services.

While some aspects of the Single Market like a common labor market appear relatively uncontroversial, there are specific areas of EU decision-making that have raised important concerns for health care systems. The first is the contentious issue of member state regulation of pharmaceutical availability, pricing, and public-sector reimbursement. Since the mid-1990s, large pharmaceutical firms have sought to have drugs treated as just another commodity within the EU's single market rules, and to force the removal of member state formulary and pricing controls (Furniss, 2000. Eurohealth). The drug companies have also sought to ban parallel imports, which they view as undermining their ability to differentially price their products in different markets (itself an interesting permutation on the single market argument). While the so-called Bangemann Round did not result in member states losing their ability to regulate pharmaceuticals, this head-on clash between the commodity-oriented EU Single Market versus social-good-oriented, member-state-based health care services established an unstable framework for important health security issues over the next period of years.

The second area of EU decision-making concerns open bidding on contracts. Single Market regulations that require opening contracts to bid from across all 15 EU countries have raised profound questions for a number of tax-funded member states with planned markets, in which public agencies act as purchasers within an all but exclusively public market of providers -–typically for hospital services. At one point early on in its accession the EU in 1995, Swedish county council authorities believed that they would be required to subject all such public market arrangements to politically unpalatable private market competition. More recently, an EU funded study of market forces concluded that, if Single Market regulation is fully extended into the health sector, some member states will have little choice but to shut down their planned market arrangements entirely unless they are willing to turn both health

system funding and delivery over to private for-profit firms (Paton et al., 2000). Similarly, a Dutch sickness fund association report has raised fears that current contracting procedures between Dutch sick funds and hospitals face the same problem, and that the current contracting process cannot be sustained (cite – Busse review).

A third problematic area concerns commercial insurance companies. In their view, exclusive public sector control over health care financing, either via tax-funded or social-insurance-funded arrangement, is simply monopoly control over a particular commodity – one that they also sell – and therefore is prohibited under Single Market rules. In this view, the notion of solidarity or the collective responsibility it implies has no standing, and member state efforts to pursue it are no more than interference with the market place. Several commercial insurance companies have now brought a case to this effect in Belgian courts, which, undoubtedly, will end up for final decision in the European Court (Hermesse, 2001)

This mention of the European Court leads to the fourth and, by many measures, most problematic manifestation of the conflict between economic and health sector regulation within the EU. In a series of recent rulings, including the Kohll and Decker cases in 1998 and the Smit/Peerbooms and Vanbraekel cases in 2001, the Court has established case law that elevates Single Market issues over most member state subsidiarity concerns. Under the guise of protecting individual rights, the Court's decisions require member states to allow citizens to seek a variety of health care services across national boundaries, and to pay for those services from public funds. Despite recognition in these decisions of the importance of maintaining sound financial management of health service funds, their central impetus is to lower previously existing boundaries between national health care systems in the name of Single Market convergence.

The impact of these various EU-related decisions on the health security of the Union's citizenry has been, to date, only marginally apparent. In two areas of dispute – pharmaceuticals and private insurance – there has as yet been no inroad on national health policy decision-making. In a third – open bidding – the feared damage remains potential not actual. Hence, only in the fourth area – the European Court – have there been decisions made which can be construed as adversely affecting health security in the sense of influencing good stewardship of health funds by national governments. Moreover, these decisions to date have only affected national health care systems at the margin, and some could well argue that – by giving citizens the right to obtain care which their own health system was slow or unable to provide – these decisions could be construed as improving individual health security in the face of unresponsive public bureaucracies.

Thus, the consequences of these measures for health security in Western Europe must be necessarily viewed far more as a future challenge than a present danger. Once again, with regard to EU actions as well as to the overall impact of national decision-making, the 1990s appear as an era in which the pre-existing balance between health security and health insecurity in Western Europe remained remarkably stable.

IV. LOOKING BACKWARD TOWARD FUTURE CHALLENGES

While the concept of health security is a relatively simple one, it is comprised of a wide range of components that are decidedly difficult to successfully structure, fund and coordinate. Precisely this organizational complexity highlights the potential future vulnerability involved in sustaining current levels of health security, or even more, in improving those levels. A diverse combination of geopolitical, technological, demographic, social, and economic factors can all generate new managerial needs and/or dilemmas.

Within this wide range of factors, however, it would seem prudent to extrapolate certain potentially more pressing issues from past and present experience. In particular, by drawing on the earlier mentioned advantages of looking backward, it becomes easier to identify those factors which are controllable by national policymakers, as against those which endanger their ability to sustain and/or improve the health security of their citizenry. Based on the above review, three key concerns would appear to deserve particular attention.

The first is that Western European health policy should continue to be based on the premise that the funding and delivery of health services is a social good, subject to normative values and concerns. The experience in the United States indicates that allowing health care to become just another commodity, to be bought and sold on the open market, is a formula for dramatic reductions in the level of its citizens' health security.

The second key concern (directly related to the first) is to put in place explicit measures to prevent national health care systems from disappearing – salami slice by salami slice – into the economic maw of the European Single Market. It will likely not be easy to prevent such a descent, in the face of existing European Court decisions combined with the economic and political clout of the pharmaceutical and insurance industries. Opposition to such a counterproductive outcome should not, however, undermine the judicious use of carefully constrained market style incentives specifically on the production side of European health systems, e.g. between hospital and doctors (Saltman and Figueras, 1997; Saltman and von Otter, 1992). These are and remain essential tools in efficient and effective institutional-level management of publicly operated health care systems.

The third key concern picks up the point raised by the positive and necessary role played by planned markets in European health care systems. As elegantly argued by de Roo, publicly financed and/or publicly operated health care systems have little choice but to provide roughly the same level of health security - in all its dimensions – as for-profit private arrangements that are on offer to economically well-off subscribers. This reflects the common-sense observation that the long-term stability of publicly funded and/or publicly delivered services is contingent on the continual acceptability of the public system's service level vis-à-vis the level of care available in the fully private sector. This notion of providing adequate health security runs contrary those voices demanding explicitly political rationing and priority setting in publicly funded health care systems. The point raised by de Roo implies that publicly funded health care arrangements that cannot or will not deliver what better-off citizens can purchase themselves in the private sector will put their own future at serious risk in a democratically governed developed society. In any event, the damage that explicit rationing does not only to health security but to the fundamental political legitimacy of a universal health care system suggests that, in the future as in the past, few if any Western European policymakers will actually implement such measures. Instead, a variety of alternative measures will have to be found, including renewed efforts to improve efficiency, to reduce the profit margins of health equipment and pharmaceutical suppliers, and to find innovative new sources of solidaristic funding.

Taken together, one can argue that the continued maintenance of a high level of health security will require active measures to ensure that an inappropriate balance between public and private does not emerge in Western European health care systems. The health security consequence of allowing such an imbalance to develop is clearly visible in recent developments in the United States. Moreover, as can also be seen in the US, the shift to a fully for-profit health care system is a "one-way-street": should some future national administration seek to rectify the structural consequences of this change, the ensuing process will likely will be equally as messy as the health sector transition currently underway in former Soviet states. Given current high levels of health security, Western European policymakers would seem wise to ensure that future conditions never deteriorate to levels that require such truly radical efforts.

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