



## Household Health Security

# Adopting Household Health Security as a Health Reform Strategy

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This paper explores the broad concept of household health security as a basis for health system reform. This concept incorporates a range of health and social services that influence the impact of an episode of illness on individual or household finances: curative and preventive healthcare, social care, rehabilitative care, occupational health services, workman's compensation, sickness pay, and disability pension. The paper examines the ability of this approach to refocus ongoing health system change in a manner consistent with both accepted social values as well as the increasing demands of financial stringency. By so doing, household health security may provide a simultaneously broader and more normative strategy with which to carry forward the notion of integrated care.

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## INTRODUCTION

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 healthcare 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 restructure various bureaucratic characteristics of the welfare state system that those on the right – and by the late 1990s many of those on the left as well – found to be both socially and economically constraining. The continuing debate across Europe about how to restructure



state pension arrangements 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).

This paper will argue that, in the case of European healthcare systems, much like the broader welfare states within which they sit, a central challenge is to construct a strategy for change that can reduce rigidly bureaucratic structures while maintaining, if not enhancing, socially responsible outcomes. It will suggest that the concept of 'household health security' could serve as the central strategic mechanism for that developmental process.

## **A CONCEPTUAL TYPOLOGY OF HEALTH SECURITY**

The notion of household health security is both simple and far reaching (Saltman, 2002). 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.*, 2004). Defined more far reachingly, it involves coordinating disparate and often fragmented components of curative and preventive healthcare, 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 healthcare 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, household health security is an important component of the broader, more widely recognized notion of social security and can be seen as an essential component of a well-functioning social security configuration. 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 Germany (Altenstetter, 1999).

A relatively instructive, if somewhat more obvious, approach to understanding the notion of household health security is to contrast it with its opposite: 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 can be valuable to reconsider several standard ongoing health sector debates. For example, integrating service provision across health sub-sectors (eg 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.*, 2004). 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 (see Allebeck article, this issue).

As a second example, an emphasis upon health security can serve to refocus several standard health economic arguments:

- *An analytic basepoint.* In assessing social decision-making processes, economic theory starts from the assumption that the analytic basepoint should be individual-expressed preference (Rice, 2003). Things of value are presumed to be commodities that can be bought or sold in a market structure. Activities of entities that either are not or cannot be accommodated within this market framework are designated as anomalies – for example, ‘market



failures' – which by definition are improperly constructed outliers that inherently have a less optimal form of distribution.

If household health security (or social security) were the analytic basepoint for judging social decisions, they would necessarily start from a different initial premise: 'what makes a socially responsible society, and how do we set about achieving that objective?' In this perspective, markets become only 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, court decisions, or healthcare services.

- *Cost-sharing and co-payments.* Although comprehensive review of the available evidence has demonstrated that cost-sharing is both financially inefficient and socially inequitable (Kutzin, 1998; Robinson, 2002), 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 healthcare 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 healthcare services. A key assumption here is that healthcare services are considered to be a commodity no different from any other market-allocated 'product.'

A health security perspective would take a 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.

- *Rationing/priority setting.* Rationing involves setting criteria for decisions to eliminate certain clinically necessary services from coverage by a third-party payer (Klein *et al.*, 1996). Proponents of rationing argue that there is an infinite demand for scarce healthcare resources, and that only limited access to certain services can be afforded by publicly funded or publicly regulated third-party payers (Ham and Glenn, 2003).

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 would lead to the conclusion that priority setting needs to be restructured if it is to provide a socially acceptable solution to the problem of inadequate health sector resources.



Taken together, the above debates on cross-sector coordination and the limitations of economics in the health sector can serve to demonstrate the potential usefulness of adopting a health security lens in future health policy decision-making.

## TWO CASE STUDIES OF HEALTH SECURITY

The structural dimensions of health security, as sketched out above, suggest that it is a considerably more macro or system-level concept than most contemporary programs of integrated care. Going beyond issues of integration at clinical level (disease management/case-based management), health security seeks to link the multiple service categories that, together, influence the actual ability of the overall social security structure to mitigate financial consequences on individual patient households. As such, health security can not only be a strategy for financial sustainability but also one for continued social accountability.

While the post-World War II welfare state was intended to provide many if not all of these services, it did not conceptualize them as needing to be connected on an integrated basis. The two case studies that follow – Sweden and Canada – illustrate the degree to which efforts currently exist in two well-respected welfare states to integrate this wide range of these health-related services. As initial mapping exercises, the two papers demonstrate the complexity of the elements involved, as well as the types of challenges that exist in taking a more macro-oriented health policy approach to the question of integrating health-related services. As such, they provide a first step toward the more extensive research necessary to explore the potential of the concept of health security as an effective health policy tool.

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