Health Policy Challenges in an Era of Prolonged Austerity

Richard B. Saltman
Emory University

European Observatory on Health Systems and Policies
Brussels
www.healthobservatory.eu

Policymaking is an Inherently Political Process

- Options
- Tradeoffs
- Advantages vs disadvantages
- Incremental approaches
- Compromise

Context Influences Politics

Context defines/delimits policy decisions:

- Economic
- Historical
- Cultural
- Geographical

Economic Context Influences Health Policy

- Pre-2008 economic context typically focused on:
  - Ministry of Finance
  - National Health Insurance Agency
- Efforts focused on securing additional funding for health sector

Basic operating assumption was that public funders should find more public money to "invest in health"

The Post-2008 Economic Dilemma

The *reduced carrying capacity of Western economies* has become a key limiting factor for health policy:

- Global trade competition has put constraints on national taxation levels
- Wealth production is shifting from West to Asian Rim countries
- "Lost Decade" of economic growth?

The Shifting Global Wealth Function I

(Figure 3, p. 4)

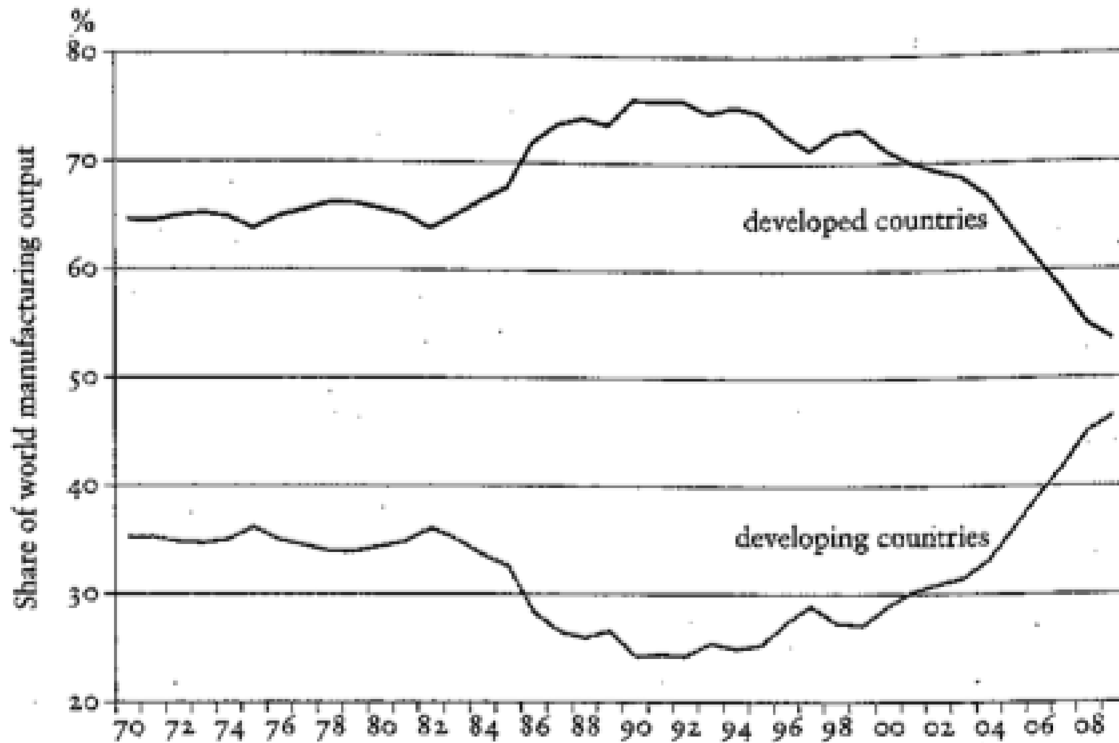

Figure 3. The global shift in world manufacturing.

Source: M. Jacques, When China Rules the World, Penguin, 2012

The Shifting Global Wealth Function II

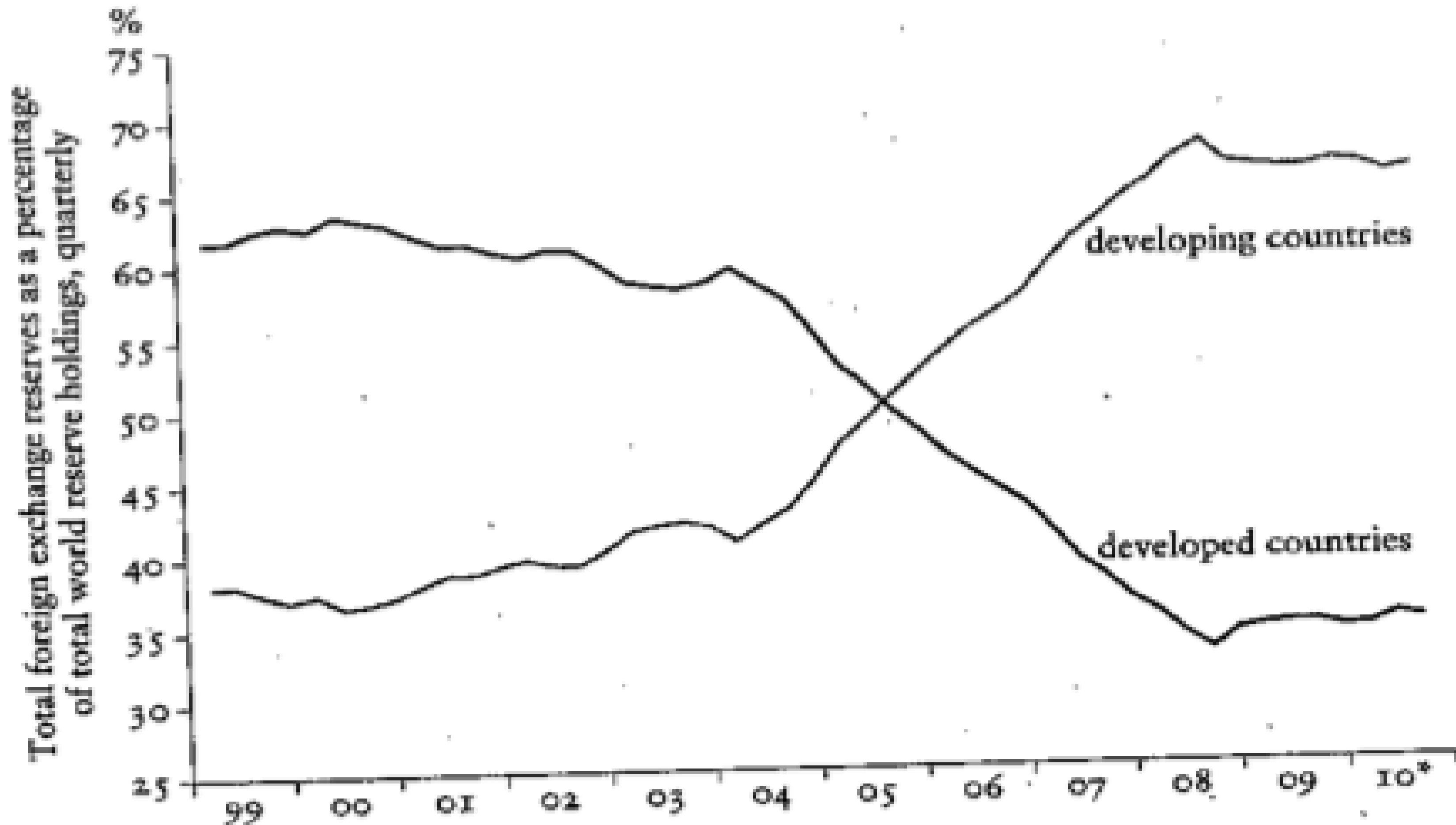

Figure 1. Savings in the East, debt in the West.

Source: M. Jacques, When China Rules the World, Penguin, 2012

Major Challenges for Health Policymaking

- On-going process of structural reform
- Shrinking range of policy alternatives
- Pressure to re-think previously
  unacceptable alternatives
  (search for “least worst options”)

Three-Part Presentation

Part I: The Changed Context for Health Policy

Part II: Prior Policy Changes (1990s – 2000s)

Part III: Potential Policy Options 2010s

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Part I: The Changed Context for Health Policymaking

An Historical Perspective

- Health systems reflect social/economic history
- Current Western health sector architecture:
  - product of post WWII experience
  - ***reflects strong economic growth of post-war period***
  - strong public role
    - funding/owning providers
    - central/decentralized steering
  - rooted in post WWII social welfare state

Health Systems Depend on the Economic Context

- *Operating funds are pre-dominantly publicly raised and/or regulated*
- Range and quality of services is tied to core carrying capacity of private sector economy
- Higher levels of per capita income associated with higher levels of health expenditure

  (R. Maxwell, 1981)

Problem #1:
The economic context has changed

- 3rd Industrial Revolution: electronic/computer chip
- Globalization/rise of Asian Rim countries
- **Slowing/falling Western economic growth?**
- Fading national “tax sovereignty” ?
- Permanently high unemployment?

Still No Economic Growth in Europe

Eurozone GDP: -0.2% for 1st Qtr 2013

-0.6% for 4th Qtr 2012

France GDP: -0.2% for 1st Qtr 2013

Italy GDP: -0.5% for 1st Qtr 2013

Spain GDP: -0.5% for 1st Qtr 2013

Germany GDP: +0.2% for 1st Qtr 2013

Britain GDP: +0.6% for 1st Qtr 2013

Netherlands GDP: -1.7% for 1st Qtr 2013

Sources: Thomson Reuters Datastream/Ecomomist

European Economies Continue to Shrink

By End of 2013:

Spain GDP – 6% below 2008 peak

Italy GDP - 8% below 2008 peak

Portugal GDP – 8% below 2008 peak

Greece GDP - 23% below 2008 peak

Estimates by IMF (20 May 2013)

1st Qtr 2012:

Britain GDP - 3% below 2008 1st Qtr peak

European Sovereign Debt Continues to Rise

Eurozone: 96% GDP by 2014

Greece: 175% GDP by 2014

Italy: 132% GDP by 2014

Portugal: 124% GDP by 2014

Ireland: 120% GDP by 2014

Forecast Economic Growth 2013

- Mediterranean Europe:
  continuing contraction
- Continental Europe/UK:
  falling into recession
- Denmark/Finland/?Sweden
  slowing to zero
- USA:
  slow growth (quantitative easing)

- Japan:
  some growth (devaluation)

Health Funding Consequences to Date

- Greece/Portugal/Ireland:
  Continuing cuts in wages/prices/funding, some services but few posts (or administration cars in Iberia)
- Continental Europe:
  Minimal cuts in wages/services/funding
  (Mladovsky et al, April 2012)
- Nordic countries:
  No cuts to date
  (Lehto et al, September 2012)
  (1990s showed "1-3 year lag time")
- USA:
  Dramatic expansion of public expenditures w/ borrowed money ($2.6 trillion/10 years+)
  (prevention, coverage, access – 2010 Act)

Problem #2:
The policy context is changing rapidly

- More technical/clinical complexity
- Higher international clinical standard (procedures/drugs/outcomes)
- More diversity of providers (end of public sector hegemony)
- More information capacity (IT, internet)
- Higher patient/citizen expectations (ECJ rulings)

The Fiscal "Black Hole"

What happens to the health sector if current welfare state infrastructure, workforce, wages, pensions and taxes are not fiscally sustainable?

How long can public spending for health be "protected?"

Part II: Prior Policy Changes (1990s – 2000s)

1990s Provider-Side Changes (Tax-funded health systems)

Purchaser-provider split

a) Provider diversification

- different ***public*** providers
  (public firms/trusts/foundations)
- different ***private*** providers
  (not-for-profit MD cooperatives)
  (for-profit small and large firms)

b) Purchaser shift to primary care providers

- ***Public*** sub-district Boards (Sweden)
- ***Private*** GPs/PCTs (England)

1990s Provider-Side Changes (primary care)

Primary care holds hospital budget

- Elective care (sometimes all care)
- Different national actors (***private*** and ***public***):
  - **England**: Fundholding GPs (1991)
    Primary Care Trusts (2000)
    GP Consortia (2013)
  - **Finland**: Municipal Health and Social Boards
  - **Sweden**: sub-county districts (Stockholm County)
- Similar goals:
  - reduce unnecessary referrals
  - raise primary (health) care's importance
  - increase hospital responsiveness to patients
  - increase hospital quality of care
  - reduce centrality of hospital in health systems

1990s System-Level Objectives (Funding and Provider Sides)

- introduce contract-based payment
- create contestability/competition for public monies
- create conditions for patient choice of public/private providers
- create conditions for more efficient use of public operating funds/capital
- create conditions for higher quality/more appropriate care

Impact of 1990s Structural Changes

- Melted public-private boundaries
- Mixed public-private provider markets
  (particularly primary and home care)
- Centralized funding (**Norway/Denmark)**
- Consolidated (larger) health system districts
  (**Norway/Denmark/?Sweden/?England**)
- Semi-autonomous public hospitals
  (Self-governing trusts/Foundation trusts/
  State enterprises/ Consortios/PEEH)
  (**England, Estonia, Norway, Czech Republic,
  Spain, Portugal)**

Emerging/New Structural Changes 2000s

Consolidating State Role:

- State IT monitoring of clinical outcomes/financial performance
- State setting/regulating clinical/financial standards with incentive payments/clawbacks (**Italy, Norway, Sweden, Denmark**)

More Individual Patient Responsibility:

- Co-payment/top-up for extra services
- Co-management of care (cellphone budgets/**NL/England**)
- Co-production of services
- Responsibility for compliance/personal behavior

Additional Changes 2000s

Locally managed integrated care/chronically ill

- Municipal (**public**) responsibility for prevention **(DK**)
  - All (private) GPs need contract w/ municipality
  - GPs paid extra for new patient workup (diabetes in DK - 7000: DKK)
  - Muni pays 20% of hospital budget (incentive for better prevention)
- **Private** integrated care company in SHI systems
  - Cordaan in **NL**
- West London Imperial College Trust Pilots in **England** (public /NHS)

Parallel Changes in SHI Countries

- Competitive/selective contracting (**NL, DE, CH**)
- Consolidated State role in funding **(NL, DE, FR, IL)**
- More patient responsibility (**NL**)
- Greater diversity of public/private providers (**NL,IL**)
- Greater state monitoring/steering role (**NL, DE**)
- Innovative public/private strategies for integrated care (**NL, DE**)

Part III: Potential Policy Options 2010s

Will Past Change Be Enough? Challenges for National Policymakers

- Growing demand for services/care
- Higher standards/expectations
- Continuing workforce wage/pension demands
- Shifting centralized/de-centralized/delegated/privatized configuration of health sector governance

How to provide more/higher quality services with slowing/reduced public money?

Options for Further Structural Change

Reducing Organizational Rigidities:

- Less direct politician decision-making/more managerial autonomy
  - (problem: less “democratic” control)
- Smaller union role/create P4P for personnel
  - (problem: less guaranteed jobs/pay/work rules)
- More innovative/cross-boundary providers
  - (problem: less institutional stability)
- More individual/less collective responsibility
  - (problem: reduced social equity)

Policy Trade-offs in a Post-Austerity World

- Higher co-payments/cost- sharing vs needs of lower income groups
- More institutional flexibility vs. less organizational stability
- More flexible staff vs. less job security
- More hospital semi-autonomy vs. less political control
- More managerial professionalism vs. less political control
- More national/state control vs. less local political control (political control shifting upwards)

Potential Options I

New Policy Tools:

- Tied to innovative cross-sector and cross-specialization strategies
- A mix of upstream/preventive and downstream/curative measures
- Prioritizing efficiency, effectiveness (quality and safety), and personal responsibility
- Re-configured expectations re: equity and equality ("Fair equality of opportunity" not "right to equal outcomes" - Rawls/Daniels)

Potential Options II

Shifting Status of State-based financial responsibility for paying for health care?

- From “defined benefit” to
  “defined contribution” (as in pensions)
  (Netherlands; Ryan “Medicare” Plan USA)

Can citizens assume the long-term financial solvency of universal State-funded health systems?

Potential Options III

Central Challenge:

Will the next generation of health policies have to find a "new balance" between

- publicly paid services vs. individual obligations?
- collective vs. individual responsibilities?

Potential Options IV

Re-consideration/re-design of numerous funding tools with inherent regulatory and equity concerns?

- Role of co-payments/co-insurance
- Role of private top-up for public insurance
- Role of supplemental/private insurance
- Role of private not-for-profit and for-profit insurers

Potential Options V

End of welfare/health benefits based on comprehensive automatic entitlements?

New "social compact" between citizens and the State based on "individual duties as well as rights"?

Future models that look more like Singapore than Sweden?

Potential Options VI

New Austerity-driven Policy Objectives:

Will patients still have considerable collective cover/funding/services, but will there be major incentives to change behavior and/or choose less expensive/less comprehensive/more self-production-based forms of services/providers/care?

Not "no collective coverage" but more individual and less collective responsibility: eg smokers, obese, etc pay more/receive fewer services

Two Contrasting Views of the Future I

"Even preserving the amount of government functions the U.S. had before the financial crisis will require substantial increases in the share of the economy devoted to the public sector."

"…for the next three decades, the [USA] will confront the reality that major structural changes in the economy will compel an increase in the public sector's fraction of the total economy…"

Larry Summers, Obama Administration Economic Advisor, USA (Financial Times, 19 August 2012)

Two Contrasting Views of the Future II

"The time has come for you to administer the same bitter medicine you prescribed to us: stop living beyond your means."

"…Western leaders are still unwilling to tell their populations the hard truth – that the world has changed. Their nations must now experience the pain of readjustment they once prescribed to others."

Kishore Mahbubani, Dean, Lee Kuan Yew School of Public Policy, Singapore (Financial Times, 25 January 2011)

Key Policy Questions

- How far can Western countries reduce/re-design existing public health funding and services?
- At what point do changes damage health service outcomes?
- If austerity is the "new normal," will a new balance be necessary between individual and collective responsibility?