Has Austerity Moved the Goalposts? The New Context for Making Health Policy

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Agreed Health System Objectives I

European health policy researchers have developed (since 1980s) a common set of health system objectives:

- Equity
- Efficiency
- Effectiveness
- Accountability
- Stewardship/“Good Governance”

Agreed Health System Objectives II

New proposals and initiatives are often measured against these objectives,
and their usefulness is assessed in terms of their impact on achieving these health system goals

Agreed Health System Objectives III

The central question European policymakers confront:

How to make progress toward these broad health system objectives

In a time of prolonged austerity?

Has Austerity Moved the Goalposts?

Agreed Health System Objectives IV

If the goalposts have in fact been moved:

- Are there alternative ways to reach the same objectives?
- Do some or all of the objectives have to be modified to reflect economic realities?
- Are these temporary or long-term changes?

Onset of Financial Crisis
14 September 2008

USA/Bush Administration did not bail out Lehman Brothers Investment Bank:

- Banks stopped trusting counterparties
- Financial markets froze up
- Central Banks poured in liquidity
- National government deficits and debt skyrocketed
- GDP dropped precipitously in many European countries
- Unemployment rose dramatically across Europe

Almost Five Years Later: Still Little Economic Growth in Europe

Eurozone GDP:	**-0.2% for 1st Qtr 2013**	**0.3% 2nd Qtr**
	-0.6% for 4th Qtr 2012	
France GDP:	-0.2% for 1st Qtr 2013	0.5% 2nd Qtr
Italy GDP:	-0.5% for 1st Qtr 2013	-0.2% 2nd Qtr
Spain GDP:	-0.5% for 1st Qtr 2013	-0.1% 2nd Qtr
Germany GDP:	+0.2% for 1st Qtr 2013	0.7% 2nd Qtr
Britain GDP:	+0.6% for 1st Qtr 2013	0.6% 2nd Qtr
Netherlands GDP:	-1.7% for 1st Qtr 2013	-0.2% 2nd Qtr

Sources: Thomson Reuters Datastream/Economist/Financial Times

European Economies Remain Smaller than 2008

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

Sovereign Debt Continues to Rise

As of 1 January 2013:

Eurozone: 90.6% GDP

Greece: 156.9% GDP

Italy: 127.0% GDP

Portugal: 123.6% GDP

Ireland: 117.6% GDP

France: 90.2% GDP

UK: 90.0% GDP

Source: Eurostat 2013

National Budget Deficits Remain Unsustainably High/Adding to Debt

2012 Budget Deficits:

Spain:	-10.6% GDP
Greece:	- 10.0% GDP
Portugal:	- 6.4% GDP
UK:	- 6.3% GDP
France:	- 4.8% GDP
Netherlands:	- 4.1% GDP

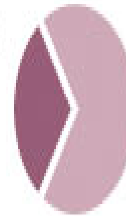
Source: Eurostat 2013

1982-87

A traditional textbook world economy: growth is concentrated in the US, Japan and Europe. Living standards in the countries that industrialised 100 years earlier are still pulling away from what is still known as the third world. Rapid growth in China is only beginning to make its mark

Share of world growth

Emerging
31%



Advanced
69%

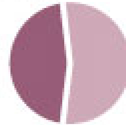
Canada 2.6
UK 4.2
Germany 3.5
S Korea 3.1
Japan 10.3
US 29.8
Italy 2.9
China 9.9
Brazil 4.1
India 3.8

1992-97

Weakness in Europe demotes Germany and Italy from the top 10. Japan's importance also wanes as it embarks on the first of its lost decades. Mexico and Indonesia enter the top 10 as a demonstration of the importance of fast-growing middle-income populous countries

Share of world growth

Emerging
46%



Advanced
54%

2.0 Canada

UK 3.8

Germany

Italy

S Korea 3.7

Japan 3.8

US 24.2

China 18.9

Indonesia 3.0

Mexico 2.1

Brazil 3.7

India 6.1

Key

1.7 Top 10 1992-1997

Top 10 1982-1987

2002-07

By the turn of the millennium, China's consistent 10 per cent annual growth rates have put it on top of the list of countries contributing to growth. Indonesia temporarily leaves the top echelon, still recovering from the Asian crisis of the late 1990s. Russia has learnt how to exploit its commodity riches

Share of world growth

Emerging
67%

Advanced
33%

Canada

Russia
4.7

UK
2.2

S Korea
1.7

Turkey
1.8

Japan
2.6

US
12.6

China
23.6

Indonesia

Mexico
1.6

Brazil
2.3

India
7.7

Key

1.7 Top 10 2002-2007

Top 10 1992-1997

2012-17

The future of world growth is increasingly dominated by China, soon to be the world's largest economy. Only the US and India provide any rivalry and, so weak is prospective European growth, that the EU accounts for less than 6 per cent of the global total. Only Latin America and India are increasing their share

Share of world growth

Emerging **74%**

Advanced **26%**

Health Policy Quandary I

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?"

Health Policy Quandary II

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

Health Policy Quandary III

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

Health Policy Quandary IV

How should health systems be re-structured to

- **Meet the new financial situation**
- **Minimize the damage to agreed health system objectives**
- **Create sustainable institutions for the forseeable future?**

Responding to Prolonged Austerity I

Re-considering prior health policy debates:

- Rationing debate
- Efficiency debate
- Decentralization/Re-centralization debate
- Co-payment debate
- Governance/Stewardship debate
- Role of primary care debate
- Hospital semi-autonomy debate
- Co-production of services/informal caregivers debate
- State/civil society debate

Responding to Prolonged Austerity II

Re-framing social responsibility:

- The upstream/prevention argument
- The public health/population health argument
- The social cohesion argument
- The social determinants of health argument
- Primary Care: GP as community advocate argument

Responding to Prolonged Austerity III

Many caveats:

- Some countries still have some growth
  (Norway, Austria, Germany, Sweden)
- Southern Europe/Northern Europe differences
- Broad health system objectives adjusted for national context and culture
- Slow growth could return (European Central Bank efforts)

Responding to Prolonged Austerity IV

The European policymaker's dilemma:

Wouldn't it be irresponsible <u>not</u> to think about how to finance and deliver needed health services if in fact austerity is long-term?

Facing Major Challenges for Health Policymaking

- On-going process of structural reform
- Inadequacy of “improving efficiency”
- Shrinking range of policy alternatives
- Pressure to re-think previously unacceptable alternatives:
  - re-considering “least worst options”

Previous European Structural Reforms 1990-2012

- Purchaser-Provider Split (tax-funded countries)
- Semi-autonomous providers (hospitals)
- Private primary care (GPs, group practices)
- Revised payment systems (DRGs, contracts, primary care holds hospital budget))
- Re-centralized state controls (funding, delivery)
- De-centralized local controls (prevention, home care)
- Patient choice of provider/insurer
- Quality/safety/re-engineering production

Will Past Change Be Enough?
Challenges for National Policymakers

- Growing demand for services/care
- Higher standards/expectations
- Continuing workforce wage/pension demands
- **Prolonged Austerity**: slow/no economic growth or new revenues for next period of years

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

A Harsh Appraisal of the Current Situation

"Stop living beyond your means."

"…Western leaders are still unwilling to tell their populations the hard truth – that the world has changed."

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

Next Stage Policy Options I

Shift significant part of health care cost away from State onto individual and collective civil society actors:

- Shift State-based financial responsibility from "defined benefit" to "defined contribution" (as in pensions in UK/US)?
- Increase co-payments/co-insurance?
- More supplemental/private insurance?
- More private sector (not-for-profit and for-profit) insurers?

Next Stage Policy Options II

New state legislation to encourage diversified private sector health providers:

- Create secure legal status for not-for-profit private providers
- Simplify contracting requirements for new private providers (profit and non-profit)
- Encourage community cooperatives that provide services (home care/nursing home)

Next Stage Policy Options III

Simplify State regulation to make it

- More appropriate for diverse public/private system
- More technically effective/coordinated across diverse provider groups
- Less heavy handed/bureaucratic
- Simpler less costly (will require redundancies)

Sweden's 2012 Inquiry: "Gor det Enklarer!"
Consolidate National Regulators from
12 to 4 agencies

Next Stage Policy Options IV

Patients, families and local communities should take more responsibility for care provision:

- Wellness incentives/value-based cost sharing
- More informal caregivers
- More co-production of clinical services
- More local non-state elderly care
  (community centers, church groups, etc)

Next Stage Policy Options V

Expand role of private employers and work-site provision of medical services:

- Expanded occupational/primary care services
- Tied to lower social charges on wages

What These Changes Imply: Major Shift in "Balance" between State and Civil Society in Health Sector

- New "social compact" between individual and State: individual has "duties" as well as "rights"
- Greater individual/civil society responsibility for both funding and provision
- *Re-create non-state service sector* (mutual associations, community groups)

State role: minimize social inequities/support less well off

Not "US-style Privatization"

Not an ideologically driven program, but pragmatic reality:

If there's not enough money, policymakers' choice is either

- over-stretched poor quality public services, or
- new non-state actors and responsibilities

Not: multiple overlapping, unplanned
providers and insurers

Rather: intentionally developed parallel sources of
provision and funding in the face of
state resource/delivery constraints

Implementation Dilemmas

- Greater/new inequities between social groups?
- Reduced "upstream" prevention/public health?
- State regulation of private sector actors is expensive and complicated
- Private sector actors (especially for-profit) not necessarily more efficient or higher quality (depends on regulatory framework)

Need to develop more targeted strategies

Possible Implications for Finland I

- How can State policy frame equity goals as public service delivery shrinks?
- How can more new doctors be attracted to work in the public primary care system if it has less money?
- Can having three competing primary care systems become a strength rather than a weakness?
- Will production of primary care be further diversified? Will state regulation view private providers as partners (as “vardval” did in Sweden in 2006)?

Possible Implications for Finland II

- Will state regulatory reforms stimulate more non-state provision of care (family members/community groups/non-profit private groups/etc)?
- Will individuals be held responsible financially for their health-related behavior (smoking, obesity, cholesterol)?
- Will the new regional administrative regions (SOTE) earn additional non-public revenue to continue to provide high quality/new clinical services?