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ANALYSIS

ESSAY

Restructuring health systems for an era of prolonged austerity: an essay by Richard B Saltman and Zachary Cahn

Richard B Saltman and **Zachary Cahn** argue that efficiency savings are unlikely to enable health systems to cope with long term budget constraints and suggest that countries need to shift responsibility for substantial parts of health activity away from the public sector

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The present economic crisis in the developed world is nearly five years old. Since the autumn of 2008, governments in Europe have struggled with flat growth rates and soaring unemployment. The European Commission has now forecast that the Eurozone's gross domestic product (GDP) will drop a further 0.3% in 2013.[1] In the UK, the British economy is 3.3% smaller in 2013 than it was in the first quarter of 2008[2] and the US bond rating service Moody's forecast in early 2013 that deterioration in the British government's balance sheet was unlikely to be reversed before 2016.[3]

To date, there has been little public discussion about how health policymakers should respond to these straitened circumstances. Even if current levels of health spending are maintained there will be effective cuts in services because the costs of current levels of provision are projected to rise considerably. Demand for services from an ageing population and increased costs created by new clinical, pharmacological, pharmacogenetic, and information technologies, will all put upward pressure on health spending (for UK projections see Appleby[4]). Below we review the reasons behind Europe's lack of growth and examine some of the policy options that health systems may need to adopt.

Why isn't Europe growing?

Europe's failure to grow has multiple economic and structural causes. One reason is that many European countries have large annual budget deficits as well as high and growing levels of national sovereign debt. Though one high profile report making this connection has been disputed,[5] empirical evidence that this link exists in actual practice has been accumulating over the past decade.[6] While some academics remain convinced that massive stimulus purchased with higher taxes or borrowed money can restore long term growth and thereby permanently relieve pressure on the provision of welfare state services,[7] others (for example, economists at the International Monetary Fund) believe that this course is unsustainable in the medium term,[8] reflecting the finite amount of "fiscal space" that countries have to take on new debt.[9]

A second reason for the slowdown in European growth is globalisation. The financial crisis of 2008 exacerbated several longer term structural forces that have shifted economic growth and wealth production from developed countries (especially in Europe) to the countries of east Asia.[10] In addition, developed world economies are increasingly service oriented, and productivity growth rates in the service sector are not high enough to replicate the manufacturing led growth of the postwar period.[11] Thus while a country like Britain was able to weather debts of over 200% of GDP after the second world war without defaulting, its current GDP growth rates are too low to outpace its growth of debt.

A third reason for Europe's lack of growth is continued high rates of taxation and restrictive state regulation of economic activity.[12] Countries with lower corporate tax rates such as Estonia (10%) and Ireland (12%) have been more successful in recovering growth than have countries with higher corporate tax such as France or Italy. Taxes cannot be raised further without damaging economic demand internally, pushing remaining industry to move abroad, and, in a global economy, reducing economic competitiveness externally.

Health systems under strain

The implications of a prolonged lack of economic growth for the future of European healthcare systems are severe. Faced

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with increased demand and fixed or decreasing public resources, health sector actors will find themselves forced to rethink many previous financial and institutional assumptions. Either non-public sources (of which there are several) will have to be marshalled or providers will have to deliver a growing number of services for substantially less money. If recent improvements in quality, safety, and access are to be maintained, however, it is unlikely that increased efficiency alone will be sufficient. New non-public money will have to be found, and some publicly delivered services will have to be supplanted by informal care from family or private services.

Potential restructuring options

Despite substantial structural differences across countries, in Europe the public sector has become the main source of health funding and, in many cases, service delivery. Previous reforms aimed at providers, such as those based on a purchaser-provider split, are insufficient for dealing with the current financial difficulties. Future policy options will thus have to focus not on reorganising existing elements within publicly operated health systems but on shifting some health related activity out of direct political and financial (but not regulatory) control by the public sector. How this will work can be expected to vary greatly between countries.

If we look beyond countries with externally imposed cuts like Greece and Portugal, there are several examples of more self directed structural change in response to the crisis.[13] Latvia, faced with a 19% drop in public funds, raised patient copayments to 38% of total health sector costs, buffered by a new programme that exempted the lowest 10% of income earners from these charges. Latvia also consolidated its hospital sector, making them semiautonomous. Ireland, facing massive debt assumed by the state from its banks, reduced some insurance coverages and consolidated its regional health boards into national control.

In both cases, major restructuring took place on both the funding and the production sides of the health system. On the funding side, the state implemented a new arrangement that, in practice, would reduce its overall financial responsibility for paying for health services. On the delivery side, the national government consolidated management of provider institutions in search of greater efficiency and lower operating costs. These structural changes have been substantial and are seen as important (although controversial) steps toward long term stabilisation of these countries' health sectors.

Beyond these two crisis driven examples, there are other recent instances of major structural change, mostly initiated before the crisis began. The Netherlands in 2006 shifted its sickness fund system to a regulated market structure, with individuals becoming responsible for a substantially larger segment of the cost of insurance. In Sweden since 2007 about 50% of all primary care services have been shifted to various types of private provider.[14]

Several Nordic governments have restructured their administrative mechanisms to make public governance of health systems more efficient. Norway (2002) brought ownership of its hospitals into state control, while Denmark (2007) recentralised fiscal and budgetary decision making for its hospitals. Further, in 2012 in Sweden, a state appointed investigatory commission recommended that the national government's 12 health sector agencies should be consolidated into four somewhat smaller and less expensive agencies, each with a single well defined oversight function.[15]

All these reforms are important in that they seek to redefine the day to day operating role of the public sector in their health systems. However, meeting the challenge of austerity will probably require substantially more systematic efforts to create a consistent, financially viable strategy. Extrapolating from these country examples, we can develop an initial typology of measures needed to lower public sector expenditures for the long term. In this view, fundamental structural change will need to occur along four inter-related dimensions:

Shifting the cost of care away from the state—A substantial part of healthcare costs will have to be paid by individuals or other non-state collective actors. This could include not just individual copayments as in Latvia (with protection for the lowest income group) but also expanded forms of complementary and supplemental insurances originating in the not for profit and for profit sectors, and potentially in local communities (as in the older notion of mutual associations).

Simplifying state regulation so that it is more appropriate, more effective, and less costly. Restructuring state agencies is never easy, and considerable political capital will need to be expended.

Making patients, their families, and local communities responsible for producing more care. Primary care advocates regularly remind us that patients generate much of the basic primary care they receive.[16] Informal caregivers already provide the largest portion of home care services for elderly people without public payment, although often with some public support.[17] Other types of "coproduction" and "self production" of care will be needed as state funded primary and social services can no longer keep up with growing demand from elderly people with chronic illnesses.

Increasing the role of private employers—Employers will need to increase provision and payment for on-site primary care services. Although at first glance this seems counterproductive, in that it raises employer costs at a time when overall economic policy needs to focus on lowering those costs, many employers will be able to provide expanded occupational services more cheaply than current state funded primary care services. Employers offering such services could pay lower social charges to the state for each employee.

Implications of restructuring

The central premise of these new measures is to rebalance public sector versus other forms (individual, community, civil society, private sector) of responsibility for both providing and, increasingly, funding health services. The goal is to maintain the core "social insurance" function of welfare state institutions[18] while relieving fiscal pressures associated with service provision. Thus support for the lowest income population will be maintained but everyone else will find they have to carry considerably greater responsibility for their own care.

A key element of such a transformation will need to be a new social contract between citizens and government, in which the "duties" of citizens and civil society institutions will play a substantial role alongside a patient's "right" to receive care. This shift toward less state dominated funding and delivery systems reverses the social logic of post-second world war Europe, where an increased state role was typically believed to be associated with greater stability of finance and also greater equity of access. In a slow or no-growth world, over-reliance on state financing risks reducing the levels of service and quality as cash starved providers, pressured by large numbers of chronically ill elderly people, fall behind the constantly increasing international standard of care. Substantial non-state activity in financing and provision of care can become a bulwark

to prevent decreasing public spending capacity from leading to inadequate care. This point echoes a recent *Financial Times* editorial regarding copayments in the UK: "if the alternative is worse provision, charging looks the better option."[19]

Several of these new measures deserve further comment. Reflating or recreating not for profit civil society providers runs contrary to the direction of health policy in tax funded health systems. Recapitalising this civil society component of the health sector will need to be done through tax advantaged foundations, philanthropy, and other private capital flows. Thus the state will have to consciously set out to recreate the non-profit segment of the new private institutions that will replace existing public arrangements and staff.

Most European health systems have not seriously considered financial incentives for individuals to engage in healthy behaviours,[20] and some have rejected them as unacceptable.[21] This contrasts with the United States, where it has become common for private companies to require that employees who smoke pay substantially higher health insurance premiums. Conversely, employees who join free employer provided programmes to reduce weight, blood pressure, and cholesterol levels receive a rebate on their insurance premiums. While the US health system is not normally seen as a suitable or efficient model for other countries, moderate attempts at actuarial fairness with regard to behavioural risk factors are a potent way of reducing overall health costs. More extreme policies, such as denying care to people who engage in risky behaviours, raise ethical problems.

Patient copayments, if carefully constructed, can enable higher income patients increased access to expensive new technologies without decreasing access to older technologies for lower income patients. Administrators at a hospital in Vancouver, facing insufficient funds to purchase a da Vinci robot to practise state of the art prostate surgery, convinced provincial officials (who fund care in Canada) to allow them to charge patients the cost difference between regular surgery and surgery using the robot. This solution enabled the hospital to provide wealthier patients with the international standard of clinical care without increasing financial obstacles to needed elective procedures for lower income patients.[22]

Inaction is not an option

This initial discussion of how health policymakers might respond to the new economic reality leaves many questions unanswered. How can restructuring of health systems be handled with the least damage to vulnerable groups and to overall population health? How can funding and provision be structured to encourage more preventive behaviour and intervention? How can the state continue to engineer overall health sector goals but at the same time structure its own operational retreat?

Moreover, the urgency of action varies considerably among countries. Those with predominantly tax funded systems face more immediate challenges than do those with social health insurance systems. Countries that still have positive economic growth (Norway, Switzerland, Israel, Sweden) also may have more latitude (at least in the near term) in how they address these structural issues.

The argument that European countries structured and funded their publicly driven health systems when they were much poorer—for instance the UK in 1948—conflates multiple distinctions. Compared with today, healthcare could do much less and was much less costly, governments already (in the UK) administered many private hospitals, there was rapid economic growth (albeit from a lower base), citizens were willing to accept uniform instead of personalised medical attention, and elderly people comprised a far lower percentage of the total population.

The structural changes we have discussed are more nuanced than the reflexive for-profit privatisation that some fear. The goal is not to create a US-style health system with its multiple overlapping, inconsistent, and often inadequate levels of publicly unplanned funders and providers. Rather, the objective is to develop parallel sources of funding and provision in situations where public sector resource constraints mean that the real alternative is likely to be no provision.

While our discussion will be labelled by some as ideologically driven, it is important to consider the practical consequences of not conducting a realistic assessment of the emerging fiscal situation in European health systems. Given current macroeconomic realities, it would be irresponsible not to question whether sufficient revenue growth will return and not to be sceptical about whether publicly funded health systems are sustainable as presently structured.

There will inevitably be the unintended consequences that typically accompany major health system reform. State regulation of private sector actors is complicated and expensive. Private sector providers (especially for-profit) are not uniformly more efficient or of higher quality than well funded and well managed public institutions.[23]

These potential disadvantages will need to be weighed against positive outcomes that can be achieved in terms of long term sustainability as well as quality and access. The challenge to health sector policymakers will be to reduce the financial and operational burden of the public sector while minimising undesirable inequality.

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