

The financial crisis means that Europe will need to look beyond the public sector to provide its healthcare needs

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*The financial crisis has led to public spending cuts across most European countries. **Richard B Saltman** and **Zachary Cahn** write that even if current levels of health spending are maintained, public healthcare systems will increasingly come under strain due to projected rises in healthcare costs. They argue that the only solution left for European governments is to increase the contribution made by other sources of care, such as those in the private and voluntary sectors.*



The present economic crisis in the developed world is now five years old. To date, there has been inadequate public discussion about how health policymakers should respond to these difficult 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, including rising rates of chronic disease, and increased costs created by new clinical, pharmacological, pharmaco-genetic, and information technologies, will all put upward pressure on health spending (for UK projections see [here](#)).

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](#), empirical [evidence](#) that this link exists in practice has been accumulating over the past decade. 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, [others](#) believe that this course is unsustainable in the medium term, reflecting the finite amount of "fiscal space" that countries have to take on new debt. On top of public debt, levels of private debt [remain high](#), further dampening prospects for strong growth that could relieve current fiscal pressures.

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. 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. Thus while a country like Britain was able to weather debts of over 200 per cent of GDP after the second world war without defaulting, its current GDP growth rates are too low to outpace its increasing debt.

A [third reason](#) for Europe's lack of growth is continued high rates of taxation and restrictive state regulation of economic activity. Countries with lower corporate tax rates such as Estonia (10 per cent) and Ireland (12 per cent) have been more successful in recovering growth than have countries with higher corporate tax such as France or Italy. Raising taxes further risks reducing economic demand internally, pushing remaining industry to move abroad, and, in a global economy, damaging export competitiveness.

Health systems under strain

The implications of a prolonged lack of economic growth for the future of European healthcare systems are substantial. Clinical care must compete for funding from stagnant public budgets against other social priorities, such as education and infrastructure, and also with longer term public health and prevention initiatives. 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 marshaled, or providers will need 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 privately funded services, private providers, and/or informal care from family or community caregivers.

Potential restructuring options

Despite substantial structural differences across countries, in Europe the public sector remains 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 have to focus not on re-organising 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.

Latvia, faced with a 19 per cent drop in public funds, [raised](#) patient copayments to 38 per cent of total health sector costs, buffered by a new programme that exempted the lowest 10 per cent of income earners from these charges. Latvia also consolidated its hospital sector, making these new, larger public hospitals semi-autonomous. Ireland, facing massive debt assumed by the state from its banks, reduced some insurance coverage and consolidated its regional health boards into national control.

In both these 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.



Operating theatre in Bytom, Poland (Credit: Piotr Bodzek, CC-BY-SA-3.0)

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 per cent of all primary care provision has been shifted to various types of private provider.

Several Nordic governments have [centralised](#) their administrative mechanisms to make public governance of health systems more efficient. Norway in 2002 brought ownership of its hospitals into state control, while Denmark in 2007 re-centralised fiscal and budgetary decision making for its hospitals. Further, in Sweden in 2012, 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.

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 likely require substantially more systematic efforts to create a consistent, financially viable strategy. In this view, fundamental structural change will need to occur along five inter-related dimensions.

First, a substantial part of healthcare costs will need to be paid by individuals or other non-state collective actors. This could include not just individual co-payments 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).

Second, state regulation will need to be simplified so that it is more targeted, more effective, and less costly. Restructuring state agencies will be essential, along with employing (and making redundant) state personnel according to good private sector management standards.

Third, rapid diversification of service providers will need to be promoted, especially the expansion of not-for profit private as well as small local for-profit actors. Alternatives to state and public providers for physician office and outpatient care can create a barometer for innovation and good practice standards, particularly when reinforced by patient choice. Public hospitals need to become more autonomous in their management for the same reasons.

Fourth, patients, their families, and local communities will need to be made responsible for producing more care. Informal caregivers [already provide](#) the largest portion of home care services for elderly people without public payment, although often with some public support. 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.

Finally, the role of private employers will need to be increased. Employers will need to increase provision and payment for occupational primary care services, again for reasons of innovation and good practice as well as adding to non-state funding sources.

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 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.

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, and some have [rejected them](#) as unacceptable. 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.

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 the restructuring of health systems be handled with the least damage to vulnerable groups and to overall 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 have maintained positive economic growth (Norway, Switzerland, Israel, Sweden) may have more latitude 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, instead the current economic context suggests it is essential 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 skeptical about whether publicly funded health systems are sustainable as presently structured.

There will inevitably be the unintended consequences that 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.

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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Richard B. Saltman – *Emory University*

Professor Richard B. Saltman is Professor of Health Policy and Management at the Rollins School of Public Health of Emory University in Atlanta, Georgia. His research focuses on the behaviour of European health care systems, particularly in the Nordic Region. He has published 20 books and 130 articles and book chapters on a wide variety of health policy topics, particularly on the structure and behaviour of European health care systems.



Zachary Cahn – *Emory University*

Zachary Cahn is a doctoral student in the Department of Health Policy and Management at Rollins School of Public Health, Emory University, Atlanta, USA.

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