Constructing Health Security in Europe: Looking Backward to See Forward

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A 3-Part Perspective

Part I: Defining "Health Security"

Part II: Assessing "Health Security" in USA and Western Europe

Part III: Looking Backward Toward Future Challenges

Part I: Defining "Health Security"

<u>Policymaking I</u>

The promise of incrementalism:

- "the science of muddling through"
  - Charles Lindblom
- "the art of the possible"

Policymaking II

The reality of incrementalism:

- "can't see the forest for the trees"
- "hard to think about draining the swamp when you're waist-deep in alligators"

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Policymaking III:

Beyond incrementalism and fire-fighting:

- Taking a long-term perspective
- "Looking backward to see forward"

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Policymaking IV

The Central Challenge:

Sustaining solidarity as the

Welfare State evolves

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Policymaking V:

The Health Policy Tool:

Assessing changes in
"Health Security"
over the past decade

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Defining “Health Security” I:

“incorporates those funding and service elements . . . that either protect against or alleviate the consequences of trauma, sickness, or accident”

Vohlonen et al., 2002 forthcoming

Defining “Health Security” II:

- Curative medical care
- Preventive medical care
- Nursing home and home care
- Rehabilitative care
- Occupational health services
- Workman’s compensation
- Sickness pay
- Disability pensions

Defining “Health Security” III:

A long history in Europe:

- Mutual Aid Societies
- Bismarck’s Germany
- Post-World War II Welfare State

Defining “Health Security” IV:

A Policy Continuum:

Health Security ↔ Health Insecurity

Health Security:

- Stewardship
- Cross-sector coordination

Health Insecurity:

- Cost-sharing and co-payments
- Rationing/priority setting

Part II:

Assessing "Health Security"
In USA and Europe

Health Security in USA I

Reforms in the 1990s:

- Fully for-profit hospital system
- Fully for-profit insurance system (managed care)
- Health care became a commodity
- Disability payments scaled back
- Occupational health weakened
- Workman's Compensation reduced

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Health Security in USA II

Non-Reforms in the 1990s:

- Sick pay remains at employer's discretion
- No new Medicare Programs (Elderly):
  - No outpatient drugs
  - No MD office visits
  - No nursing home care
  - No home care
- Uninsured rose to 43 million
  (1 in 5 children, after CHIP)
- Poor intra-sector coordination

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Health Security in USA III

Key Tracer Variable:

Medical expenditures remained
the most common reason for
filing bankruptcy in 2000

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Health Security in USA IV

Overall assessment:

- Coverage and access fell
- Administrative/transaction cost skyrocketed
- Quality of care eroded
- Regulation further weakened
- Premiums rising dramatically
  (20% in 2001; 20% in 2002)

Health Security in USA V:

Overall Impact on "Health Security" in 1990s:

Sharply reduced from previous modest level

Health Security in Western Europe I:

Reforms in the 1990s:

- Pursue production-side efficiency
  (entrepreneurialism at micro/institutional level)
- New long-term care programs (Germany; Sweden)
- Limited reduction in workmen's compensation
- Limited reduction in occupational health
- Limited restrictions on disability benefits

Health Security in Western Europe II:

Non-Reforms in the 1990s:

- No funding-side entrepreneurialism (e.g. continuing public control)
- Hospitals remain in public sector
- Health care remains a social good
- Sickness pay remains mandatory
- Some improvement in intra-sector coordination (Denmark, Sweden for "finished inpatients")

Health Security in Western Europe III:

Overall Assessment:

- Coverage and access remained high (higher: France; Germany)
- Administrative/transaction cost grew somewhat (particularly UK)
- Quality of care mildly improved
- Regulation mildly weakened
- Premiums/taxes increasing mildly

Health Security in Western Europe IV:

Overall Impact on "Health Security" in 1990s:

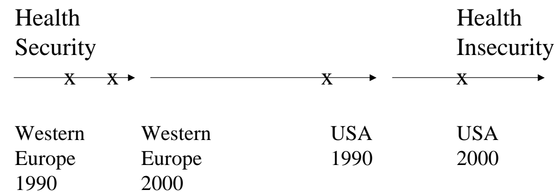
Broadly stable at high level

Part III:

Looking Backward Toward Future Challenges

Comparative Assessment I:

The impact of 1990s reforms:



Comparative Assessment II:

High levels of “health security”

- Are compatible with treating health care as a social good
- Are compatible with well-designed planned markets/quasi-markets among providers only
- Are compatible with public-sector-imposed, macro-level measures to increase efficiency
  - Technology assessment
  - Global budgets
  - Case-based payment
  - Intra-sector coordination

Comparative Assessment III:

High levels of “health security”:

- Are not compatible with treating health care as a market commodity
- Are not compatible with full-scale for-profit competitive markets, especially among funders
- Are not compatible with individual-level measures to increase efficiency: (cost sharing, rationing)

Looking Backward to See Forward I:

The Central Quandary:

How sustainable is “health security” within EU if subsidiarity to national governments gives way to open coordination within the Single Market Project?

Looking Backward to See Forward II:

Multiple Incremental Questions:

- Should supplies and equipment be a Single Market issue (Pharma)?
- Should health funding be a Single Market issue (commercial insurance companies)?
- Should public hospitals’ contracts be a Single Market issue (UK, Sweden)?
- Should home care be a Single Market issue?
- Etc. etc. etc.

Looking Backward to See Forward III:

Beyond Incremential Policymaking:

- “Health security” is the forest
- Forests need careful management to thrive
- Clear-cutting every tree in the name of productivity (as in USA) is not a successful forest management strategy

Looking Backward to See Forward IV:

The Health Policy Challenge:

To develop an EU approach that reinforces and strengthens existing levels of “health security”