

# **FUTURE CHALLENGES TO THE PROVISION OF HEALTH CARE IN THE 21<sup>st</sup> CENTURY**

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**Consortium of Institutes of Higher Education in Health and  
Rehabilitation in Europe Annual Conference – Lisbon**

**13<sup>th</sup>-15<sup>th</sup> April, 2011**



# Presentation Outline



- The Leonard Cheshire Centre for Disability and Inclusive Development, University College London
- Bird's eye, strategic view of demographic, social, economic and technological trends in and their impact on health from a political science perspective
- The impact of an aging population
- The reconfiguration of health sector financing
- Inequalities in access to health
- Social Determinants of Health
- The challenges of implementing integrated care
- Some tentative conclusions/questions

# Leonard Cheshire Disability and Inclusive Development Centre I



- The Leonard Cheshire Centre for Disability and Inclusive Development is a partnership between Leonard Cheshire Disability and University College London
- Located in the Department of Epidemiology, Public Health and Populations Sciences
- The Centre is dedicated to generating a body of knowledge about disability issues that helps to improve the lives of people with disabilities, and the lives of their families and their communities, around the world.

# Leonard Cheshire Disability and Inclusive Development Centre II



- Senior Research Associate
  - Specialising in policy analysis in disability and international development
  - Have undertaken 3 evaluations for DFID at country offices to incorporate a disability component into their core programmes (Zimbabwe, Nigeria and Uganda)
  - Also undertook a comparative analysis of disability policy and practice in Namibia, Swaziland, Mozambique and Malawi
  - All studies employed local researchers who also had a disability
  - Teaching on master's programmes at UCL and the University of Liverpool
  - Systematic review of disability and poverty

# Challenges Facing Europe in the 21<sup>st</sup> Century

## The Heterogeneity of Europe



- The 27 Sovereign States of the EU are heterogeneous entities
  - Differing historical, economic, political and cultural trajectories
  - Important to embrace rather than deny these trends, as in order to make informed strategic future decisions, it is imperative to understand the past
  - *“History repeats itself – it has to – NOBODY LISTENS”*
  - Disparities in terms of political systems and the formulation and implementation of social and economic policy, including health
- An ageing population
- A potential decrease in the available skilled workforce in the health sector
- A reconfiguration of health care financing, that will privilege the private and voluntary sectors
- “Austerity Europe” – rapid retrenchment in public sector financing for health and social care: privatization by the back door
- The long-term impact of the 2008/2009 global economic crisis
  - Too premature to determine what implications this has for future health/social care

# Europe's Current Health Status I

(Source: *Health at a Glance: Europe 2010*, OECD)

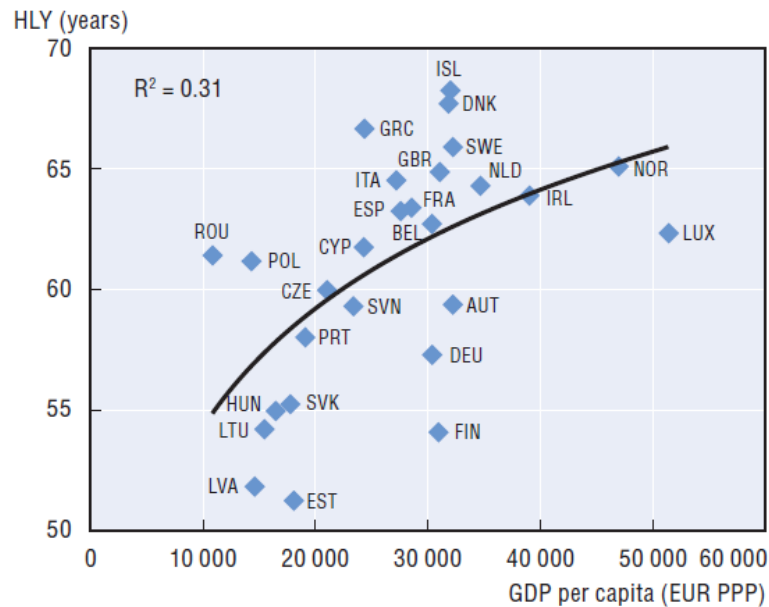


- Life expectancy
  - Average life expectancy at birth has increased by six years since 1980
    - EU life expectancy at birth is 73.4 years for men and 80.8 years for women (2007)
    - Life expectancy at 65 is 15.9 years for men and 19.5 years for women
    - There a positive correlation between income per capita and life expectancy
    - This can be attributed to a number of factors, including increased living standards, advances in medical science, better nutrition, sanitation and housing
    - The gender gap in regard to life expectancy is 6.5 years between men and women
  - Healthy life years
    - Healthy life years 2005-7 has been estimated at 61.3 years for women and 60.1 years for men
    - Defined as “the number of years in in which a person’s day-to-day activities are not limited by a condition or a health problem”

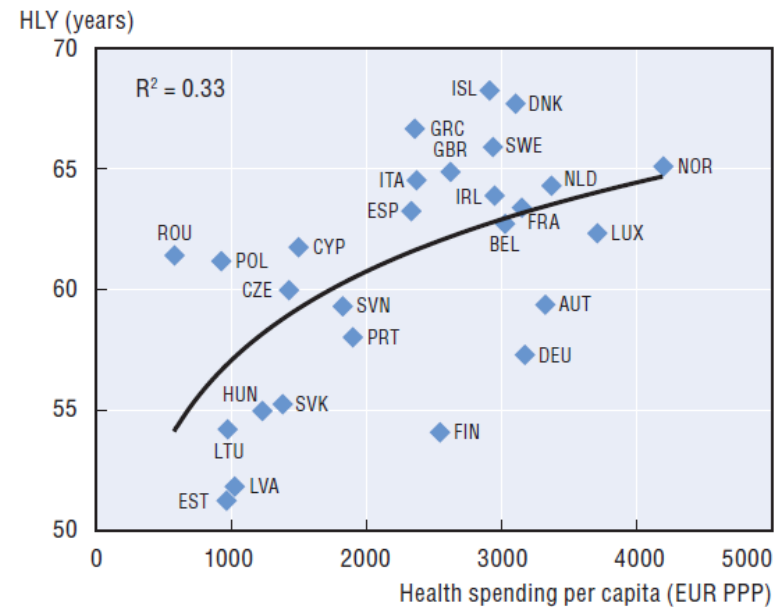
# Correlation between GDP and Health

(Source: *Health at a Glance: Europe 2010*, OECD)

1.1.2. Healthy life years (HLY) at birth, 2005-07  
and GDP per capita, 2007



1.1.3. Healthy life years (HLY) at birth, 2005-07  
and health spending per capita, 2007



# European Health Expenditure

- Health expenditure has risen in all European countries, at a faster rate than economic growth
  - In 2008, EU countries spend an average of 8.3% of GDP on health, up from 7.3% in 1998
  - However, the recent economic downturn will significantly add pressure to health service budgets, and many countries are decreasing their public expenditure
  - This is driven by political/ideological imperatives in order to reduce budget deficits
  - Also, in response to the aspiration to give patients greater choice, health providers will inevitably have to explicitly demonstrate efficiency and effectiveness within their services
  - There is a positive correlation the health expenditure and GDP, but this is stronger for countries below the average levels of European GDP per capita



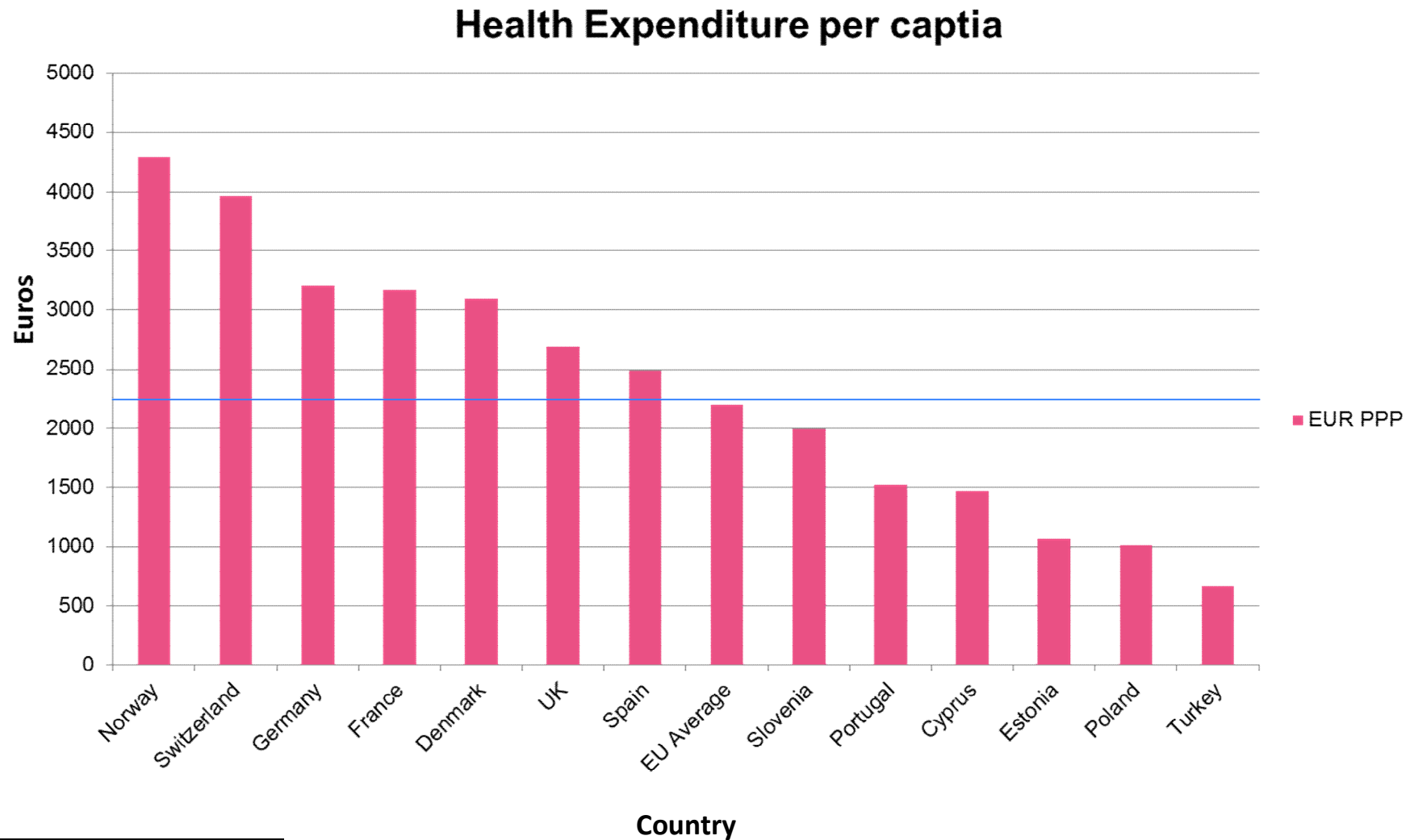
# Health Expenditure Per Capita (2007)

(Source: *Health at a Glance: Europe 2010*, OECD)

Health Expenditure Per Capita (Selected European Counties)		
Country	Health expenditure	% EU average
Norway	4,294	196
Switzerland	3,971	181
Germany	3,208	146
France	3,172	145
Denmark	3,097	141
UK	2,696	123
Spain	2,491	114
EU Average	2,192	
Slovenia	1,998	91
Portugal	1,528	70
Cyprus	1,476	67
Estonia	1,074	49
Poland	1,017	46
Turkey	671	31

# Health Expenditure Per capita (Selected Counties)

(Source: *Health at a Glance: Europe 2010*, OECD)



# Global Challenges to health care provision

## The Demographic Imperative I



- An aging population – more people will need health care for longer
- Lower fertility rates in most European countries will
  - Result in increased specialisation in geriatric provision
  - Have implications for the future training and ongoing development of health care professionals
  - These will have different trajectories throughout the European Union
- More medical and social care will be met by family members

# Global Challenges to Health Care Provision

## The Demographic Imperative II



- 2007 World Bank study on the impact of an aging population in Europe
  - The majority of countries in Europe have declining fertility rates and increasing life expectancy, resulting in an excess of deaths over births
  - In 2005, the majority of EU countries continue to have population growth, but at insufficient rates to sustain current population levels
  - This may be offset by net immigration, but it is too premature to make accurate forecast
  - Europe can be characterised as a gradual shift from a society dominated by younger cohorts to a society in which the elderly constitute a solid majority
  - Old age dependency ratio
    - 2005 – 25 people aged 65+ for ever 100 people of working age
    - 2050 – there will be 51 people (100% increase)
  - Therefore, less qualified staff to cater of potentially greater health needs

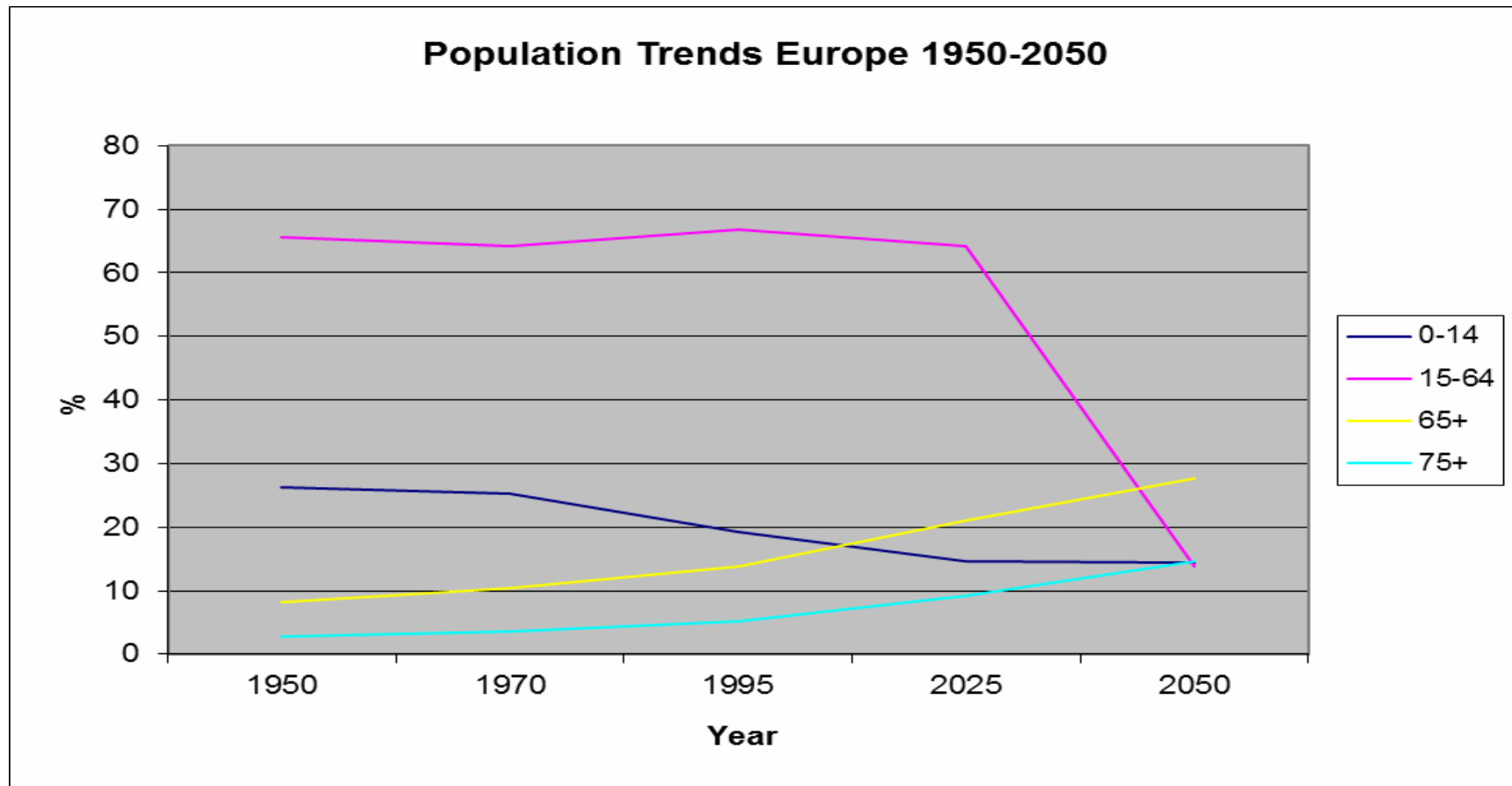
# Statistics on an Aging Population

(Source: International Institute for Applied Systems Analysis)

POPULATION TRENDS IN EUROPE: 1950-2050										
	in 1000					in % of total population				
	1950	1970	1995	2025	2050	1950	1970	1995	2025	2050
Age 0-14	143,175	166,367	139,464	103,212	90,430	26.2	25.3	19.2	14.7	14.4
Age 15-64	359,162	421,432	487,110	451,599	364,277	65.6	64.2	66.9	64.3	58
Age 65+	44,981	68,642	101,338	147,524	172,985	8.2	10.5	13.9	21	27.6
Age 75+	14,553	22,762	38,139	63,663	91,343	2.7	3.5	5.2	9.1	14.6
Total	547,318	656,441	727,912	702,335	627,691	100	100	100	100	100

# European Population Trends

(Source: International Institute for Applied Systems Analysis)



# Global Challenges to Health Care Provision

## Health Care Financing



- The next few decades will witness a reconfiguration of health care financing
  - Currently 80% of health expenditure is funded through the public sector, with an average of 4% being funded through health insurance schemes – BUT this is likely to change
  - Retrenchment of the public sector - ‘Austerity Europe’
  - Beveridge’s ideology of ‘from the cradle to the grave’ will be challenged
  - The end of the NHS in the UK?
  - Former post-Communist states will encounter significant challenges
    - De-institutionalisation

# Global Challenges to Health Care Provision

## Advances in Medical Science and Medical Research



- There will inevitably be systemic and far-reaching advancing in medical science in the coming decades
  - Stem cell research
  - Cancer
  - Heart disease
- BUT current research is not funding medical specialties pertinent to an aging population
  - For example, Dementia and conditions of increased morbidity and disabling conditions in the latter stages of life
- Research and development cost are substantial for new drugs
- What research should be prioritised when university research funding is being reduced?
- Questions of medical ethics
  - To what extent does society wish to pursue developing a “perfect human being”?



# Global Challenges to Health Care Provision

## From “patients” to “customers”



- Power relations between patient and health care professionals are changing
  - From “patients” to “customers”
  - Increasingly there is a global marketplace for healthcare where “consumers” have increased and ostensive informed choices
- BUT do consumers of health care and sufficient knowledge to make informed choices?
- Rising expectations of health consumers
  - Are these affordable and realistic?
- A further challenge is the trend towards more integrated portfolio of medical and social care
- This will result in the imperative for the medical and “social service” professions to work more closely

# Global Challenges to Health Care Provision

## Challenges of effective patient/user involvement



- User involvement in health policy is becoming increasingly important globally – not least across Europe
  - Changes the power relations between patients and health professionals
  - Trajectory from hierarchical to a participatory approach to policy, planning and implementation
  - Human rights and choice
- However, “patient involvement” is a highly contested concept
  - Do patients really want to participate?
  - Study in the United States concluded that 52% of the general population would prefer to leave decisions to clinicians (Levinson, Kao, Kuby and Thisted, 2005)
  - Tension between professional clinical knowledge and the political imperative of democratic, accountable and transparent policy and practice

# Global Challenges to Health Care Provision

## Challenges of effective patient/user involvement



- Factors affecting patient involvement
  - Acceptance of patients role
  - Level of health literacy
  - Confidence in own capacities
  - Types of decision required
  - Stakes of proposed outcome
  - Types of illness and comorbidity
  - Age
  - Gender
  - Social-economic status
  - Health-care worker professional specialty

(Source: Lontin et al 2010)

# Global Challenges to Health Care Provision

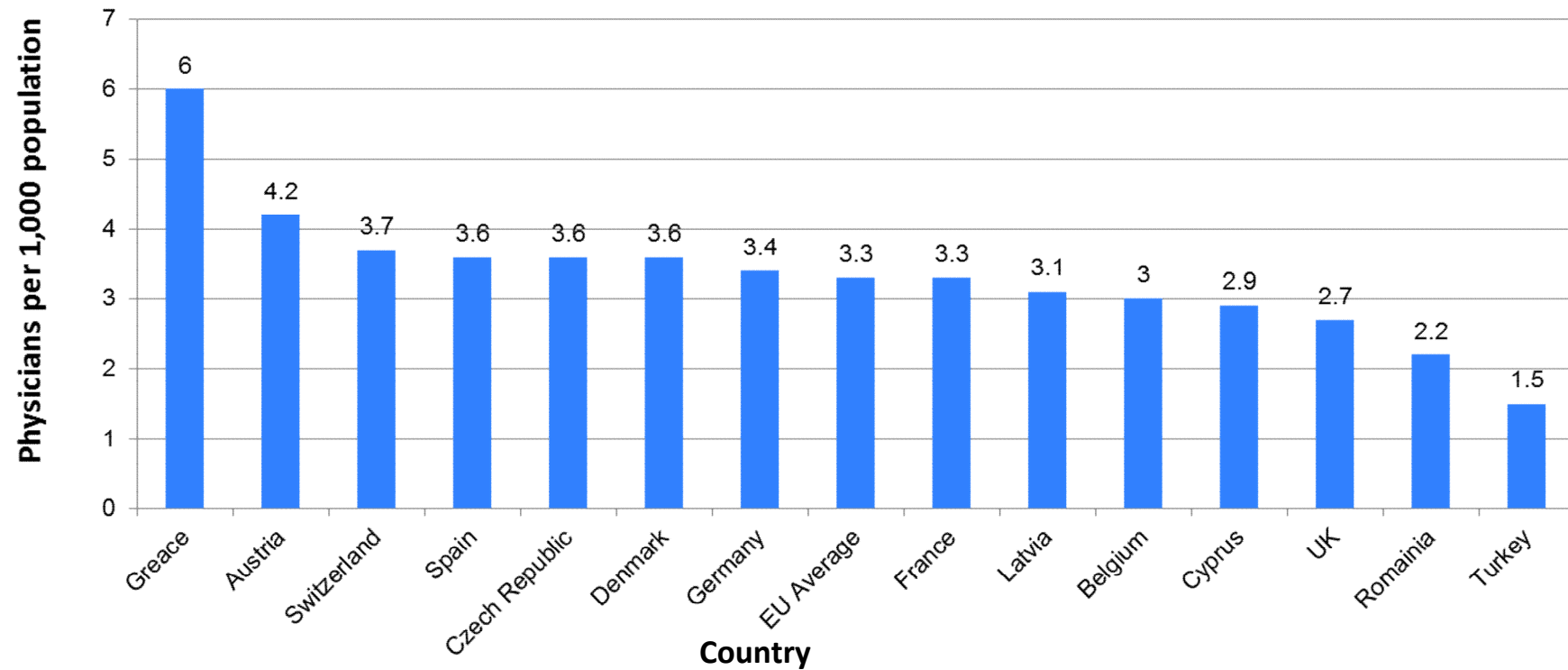
## Skills Shortage in the Health Sector



- Increasing concern regarding shortage of doctors
  - Significant variation between countries, with the lowest being in Turkey
  - Although the number of doctors per capita in most European countries is increasing, this is insufficient to accommodate the needs of an aging population
  - The balance between general practitioners and specialist has significantly increased in recent years
    - More specialist than generalists
- Also there is a projected shortage of nurses, physiotherapists, occupational therapists, etc. in many EU countries

# Physicians per 1,000 population (2008)

(Source: *Health at a Glance: Europe 2010*, OECD)



# Global Challenges to Health Care Provision

## Central and Eastern Europe



- Central and Eastern Europe are encountering significant challenges
  - Movement away from a centrally-planned economy to those which embrace market forces
  - Transition from institutional to community service provision
  - Introduction of private medical insurance
- Policy-makers are struggling to develop appropriate policy tools and frameworks
  - Principles of efficiency, cost effectiveness and benchmarks for minimum standards

# Global Challenges to Health Care Provision

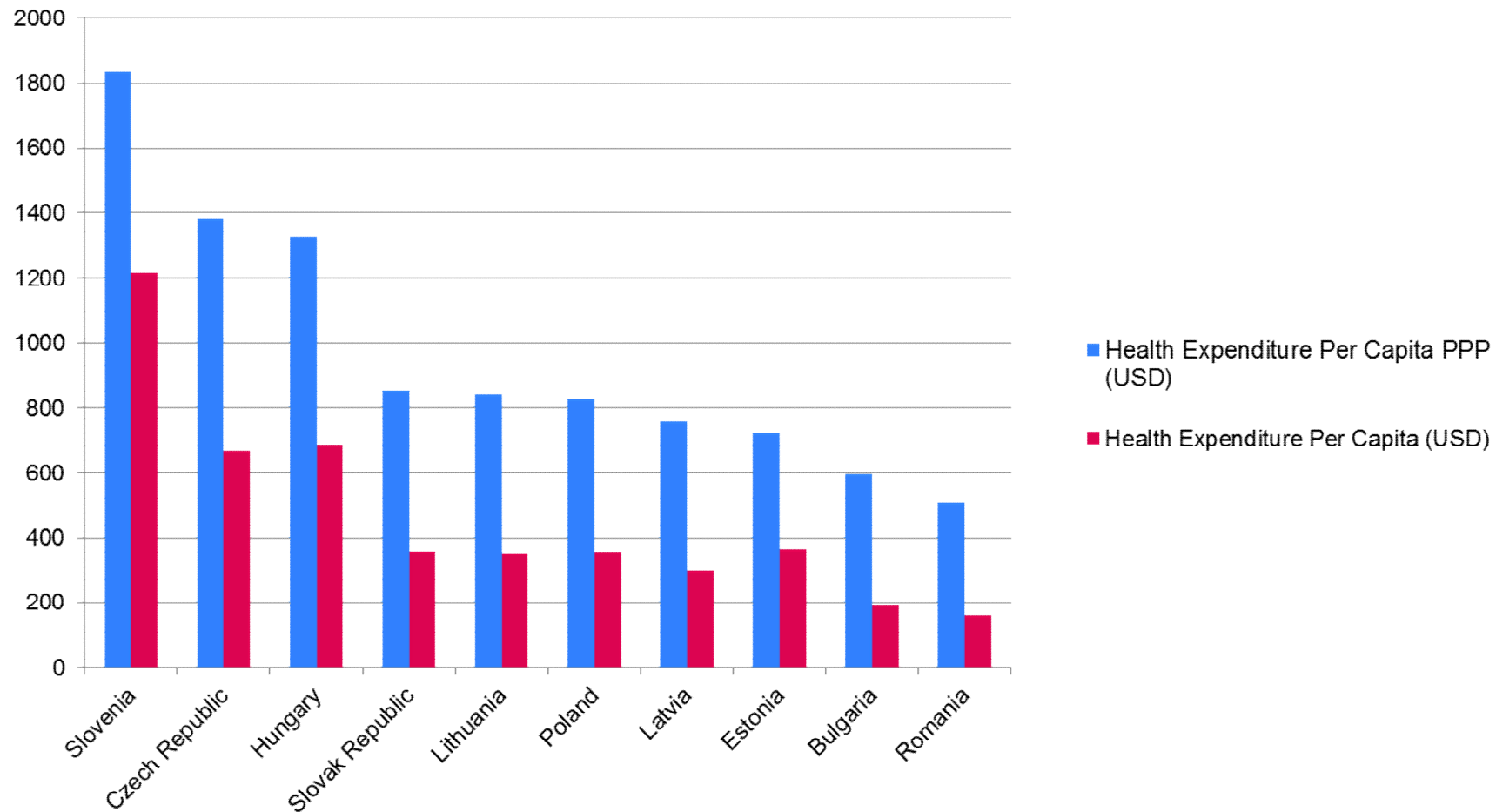
Levels of Health Spending in 10 Central and East European Countries  
(Source: Walters et al 2008)

**Leonard  
Cheshire  
Disability**

Country	Health spending per capita (USD)	Health spending per Capita PPP (USD)	% Health spending GDP (USD)
Bulgaria	191	595	4.4-7.5
Czech Republic	667	1,383	7.5
Estonia	366	722	5.3
Hungary	684	1,327	8.4
Latvia	301	756	8.4
Lithuania	351	838	6.6
Poland	354	827	6.5
Romania	159	508	6.1
Slovak Republic	380	854	5.9
Slovenia	1,218	1,883	8.8

# Central and Eastern Europe

Levels of Health Spending in 10 Central and East European Countries  
(Source: Walters et al 2008)





# Global Challenges to Health Care Provision

## Social Determinants of Health (SDH)



- Increasingly influential in global debates regarding the future design and development of health policy
- Driven by the World Health Organization
  - SDH can be broadly defined as “the conditions in which people live and work that affect their opportunities to lead healthy lives”
  - Socio-economic status, level of education, geographical location, occupational status, etc
  - Primarily concerned with health equity and the “social gradient” to health
- Globally, the SDH results in an adverse asymmetrical impact on those from the poorest and socially excluded groups in any society – including Europe

# Global Challenges to Health Care Provision

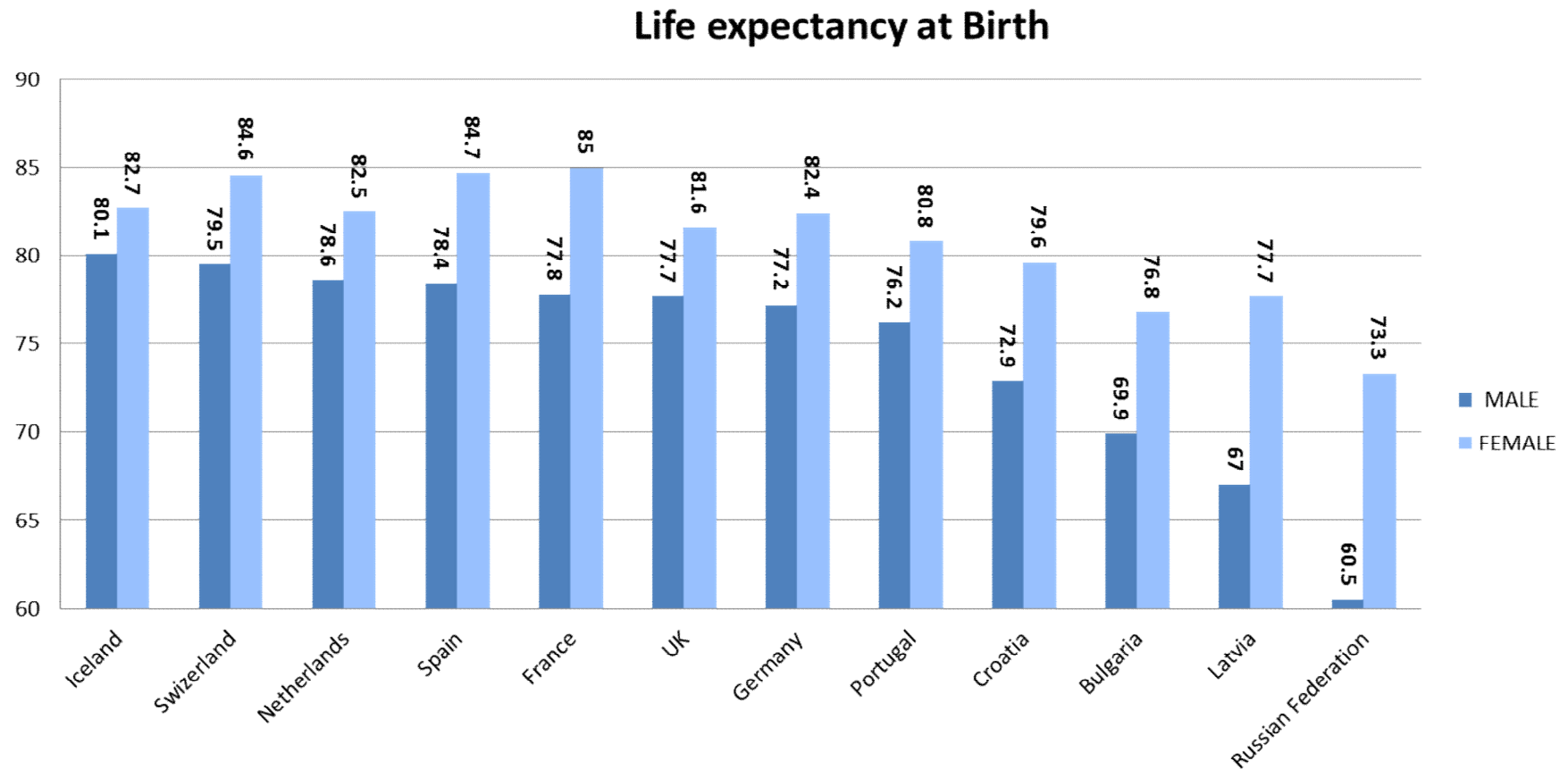
## Social Determinants of Health (SDH)



- WHO has commissioned a review of the SDH in Europe 2010-2012
  - Important to note that the WHO European Region is much larger than the EU
- Main findings of the 2010 interim report
  - The health of the European population has improved in recent years, but systemic inequalities remain
  - Life expectancy at birth varies significantly between countries
    - 20 years for males and 12 years for females
  - Findings show that the key determinants of health include early years experiences, education, employment, quality of work, social protection schemes, and residential location

# Social Determinants of Health Europe: Selected Countries

(Source: European Health For All Database, 2010)



# The Challenge of Integrated Care I

## Definitions



*“Integrated care is a concept bringing together inputs, delivery, management and organisation of services related to diagnosis, treatment, care, rehabilitation and health promotion”*

(Grone and Garcia-Barbero, 2001)

*“Integrated care is a coherent set of methods and models on the funding, administrative, organisational service delivery and clinical level designed to create connectivity, alignment and collaboration within and between the cure and care sectors”*

(Kodner and Spreeuwenberg, 2002)

*“Integrated care refers to a coherent and co-ordinated set of services which are planned, managed and delivered to individual service users across a range of organisations of co-operating professionals and informal carers. It covers the full spectrum of health and healthcare-related social care”*

(van Raak et al, 2003)

# The Challenge of Integrated Care II

## Basic Concepts



- Integrated care has become an integral component of health policy throughout Europe
- Encompasses an holistic conceptualisation of health and well-being
- Very contested concept, with no universally agreed definition
- There has been a long-standing disconnect between health and social care policy and practice
- Historically, there has been a universal right to the provision of health care, but no such entitlement applies to social care exists
- With the “privatisation” of health care, increasing emphasis given to familial support

# The Challenge of Integrated Care III

## Potential Advantages



- Addresses the complexity of the complex health and social care needs of an aging population
- Explicitly recognises the holistic and inter-connected spheres of health and social care needs
- Potential to act as a catalyst for the effective and sustained social inclusion of vulnerable and socially excluded groups in contemporary society
- May lead to greater system efficiencies
- May result in increased quality of care provided

# The Challenge of Integrated Care IV

## Potential Policy Challenges



- May result in vulnerable populations falling through the net
  - Lack of clarity of roles and responsibilities
- Disjuncture/dis-connect between healthcare/social purchasers and providers
- Distinct professions have to work in a collaborative manner which has hitherto not been the case
- Unhealthy competition between providers
- Predicated on the notion of “informed patient choice”
- Privatisation of health/social care
  - Potential to place undue pressures on family members
- The goals and expectations of policy-makers, providers and “customers” may be totally different
  - Disjuncture between policy and implementation

## Conclusion: Key Challenges to the Future Provision of Health Care in Europe



- Answer – I do not know, but here are some key questions to consider
  - What is the portfolio of skills needed by the medical, para-medical and social care professions to address the heterogeneous and complex health and social care needs of Europe's population?
  - What are the most appropriate strategies for addressing the needs of an aging population?
  - What role should be played by the voluntary sector, in the light of Austerity Europe?
  - What are the most important priorities for medical research?
  - How should health and social care be funded in the 21<sup>st</sup> century?
  - Is integrated care in Europe a useful and financially viable model?