



EPHA 4th ANNUAL CONFERENCE 2013:

The future of public health: policy decisions today for tomorrow's populations

Our health, our economy, our society, our future: a Brave New World

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Commissioner; Minister; Regional Director; Esteemed colleagues from other international organisations and from the public health community throughout Europe;

I am greatly honoured that the European Public Health Alliance asked me here today to speak at this conference. Before I get into the body of my speech, I would like to make some remarks directly to those of you involved in the Alliance.

There are – literally – hundreds of Think-Tanks seeking to guide European policy, but few, surely, that deserve our support more than the European Public Health Alliance. Health accounts for nearly 10 per cent of European GDP, and so it is not surprising that there are many important and powerful lobbies in the health sector. Not all of them are ‘forces for good’, but rather seek to ensure that their interests – in particular, their profits – are supported, often at the expense of the health of European citizens, and at a high cost to European taxpayers. The European Public Health Alliance has proven itself to be an important counterweight to such pressures. You have sought to promote policies that put the health of people first, not profits; and you have drawn attention to the missed opportunities for improving health by investing in public health.

We in the OECD follow your work closely, and I am sure that this is true for all the other international organisations here today. Your work is very much appreciated, and we strongly encourage you to continue to shed light on waste and inefficiency in health systems, and to make the case for health as a top priority for policymakers across the continent.

We need you to do this, as only now, after five years of seemingly endless crises, are we starting to see a few small signs that the worst of the economic recession is past. Even so,

unemployment remains at horrifying levels in many countries, and inequality is much higher than it was. Our economies are weak; there is little money available for 'grands projects'. Those of us who believe that there is a good economic case to ensure that we have strong health systems that deliver good health to our populations, will have to fight hard to be heard above all the other competing claims for more resources.

By 2009, many European countries had the best health systems the world had ever seen. What was driving improvements in health systems prior to the crisis? One word sums it up: 'more'. We were hiring *more* doctors, more nurses, to do *more* expensive diagnostics using MRI and CT scans, to dispense *more* pharmaceuticals, to deliver *more* spectacular new surgical interventions, and paying higher prices in the process. And this all required *more* money. A lot more – health spending per person in Europe went up around three times more quickly than income per person in the decade prior to the crisis.

There is nothing wrong in principle with spending more on health - people may well be happy to prioritise health over other ways of spending money. However, as the resource-tap was left wide open for health, there was less of a move towards ensuring that money was spent efficiently and affordable. Then circumstances changed and public spending on health collapsed from around 4.5 percent real growth per year up to 2009 to 1 percent declines each year since then. When the tap was switched off, and health systems could no longer rely on 'more' and in some cases had to do with 'less', health systems too often cut the obvious rather than make the important structural changes to make health care efficient and affordable over the longer term.

I expect that nearly everyone here today will agree with me when I say that, like it or not, it will be a long time before we see regular increases in health spending of the size that we did before the crisis. We have to adjust our health systems to deliver maximum health gains within this new fiscal reality.

My main message to you today is that this has not happened. Despite all the pain of cuts in health spending in many countries, the increases in copayments that hit households so hard, and the reductions in salaries of health workers, we still have health systems that are often strikingly inefficient and often ineffective.

This failure to transform our health systems has often been because there has been far too much focus on what we spend on health today and not enough on how much we will spend on health tomorrow, and the day after.

The worst example of this has been in spending on prevention. Work by the OECD and many others has provided evidence that overwhelmingly shows that careful investment in tackling obesity, harmful use of alcohol and a range of preventive activities is a hugely better way of spending money than dealing with the consequences once they appear. Yet when we look at spending on different areas of health, which one has seen the biggest cuts in spending in Europe? Prevention. In both 2010 and 2011, spending on prevention fell.

We know why. People who are sick know who they are and want treatment; people who will become sick do not always recognise the risks they are running. Most politicians know that there are more votes in being today's saviour than the next quarter century's prophet. But understanding why prevention does not get the attention it deserves does not excuse its neglect. We spend less than 3 per cent of all health expenditure on prevention. My second

message to you today is that an efficient, effective health system needs to give prevention a much higher profile than it is getting. I know that you at the European Public Health Alliance agree with me on this: we must continue to work together to get this message heard.

Another example of where short-term thinking has got in the way of good policymaking has been in the disturbing increase in co-payment rates for health services in many countries. This has been the most widespread change in health policy in Europe over the past few years. Virtually every country that has cut health spending has also increased co-payments.

But it is a false saving: there is very little evidence that increased co-payments reduce public spending on health, particularly over the longer term. On the other hand, there is considerable evidence that co-payments discourage people from seeking the help they need and increase health inequalities.

I acknowledge that many countries that have increased co-payments have also extended safety nets to protect the most vulnerable. This is to be welcomed. But how much more enthusiastically we would welcome a more radical change in how we pay health providers! We still generally reward providers who deliver more services, whether the population needs them or not, rather than rewarding providers who deliver more health. If that is too much to ask, then at least we should be paying providers according to the quality of care they provide not just its quantity.

This, then, is my third message to you: let us please ask policymakers considering an increase in copayments to think again. We need to change the incentives facing providers of health services, not patients.

My fourth message also touches on inequalities. Everyone involved in health knows that there are huge variations in medical practice, both across countries but perhaps more worryingly, also within countries. In work we are currently completing at the OECD, we have found that it is quite common to find a region in a country which performs four times as many bypass surgeries than another region, even after adjusting for age profiles. The same is true for many other services. Either some people are not being offered the health care they need, or else others are having unnecessary procedures pushed on them. Either way, this situation is unfair and inefficient. If we want to argue that health systems deserve more money, we have to show that we can deliver value for money and tackle inequalities: these variations in medical practice are proof that we are failing to do either. It is a great shame that the crisis has not stimulated more reforms to address this issue.

My fourth message is that we must seek more uniformity in the services that patients receive, to prove that we can spend money wisely.

Ladies and gentlemen, I have up to now been quite critical of the response of health systems to the crisis. I do not believe that I have been unreasonable in this. Much of what has happened in Europe since 2008 has consisted of tinkering with the existing system of financing and delivering health care, rather than changing the system to reflect the fact that we have fewer resources, and are likely to see demands for health care exceed new funds for health for many years to come. But some countries have made changes that are worth applauding.

For example, many countries have taken a more cost-conscious approach to their pharmaceutical policies. Big savings have been made, in Greece, Ireland, Portugal, Spain.

Efforts to increase use of generic alternatives have paid off in many of these countries, and others across Europe. Some of the reforms address one of the big differences between health care systems; namely the prices we pay for treatments. The crisis has spurred much needed action in some countries but there is scope to expand these reforms to other countries as well as beyond pharmaceuticals, including devices and hospital treatments.

Another area where there have been some changes is in consolidating services. A few countries have closed under-performing hospitals; merged accident and emergency services; or centralised purchasing of services.

These are examples of policies that have reduced costs while either maintaining or even increasing quality of services.

My final message is that we should praise the countries that have introduced these changes loudly in order to encourage more such changes. Saving money while maintaining or improving services is an admirable achievement, and our criticisms of bad policies such as cutting spending on prevention and increasing co-payments will be all the more effective if we show that there are alternatives.

In conclusion, many of you will be familiar with the remark by Don Berwick, who is now CEO of the Commonwealth Fund in the United States:

‘Every system is perfectly designed to achieve exactly the result it gets’.

He is right. Our health systems in Europe are perfectly designed to meet new challenges by channelling new resources to address them. Now there are no new resources. We need a different system, one which takes resource constraints into account, and stops providing services which are not cost-effective. Such a system will make prevention a priority; will reject easy 'solutions' such as increasing copayments; and will reduce waste and inefficiency by providing more uniform services at affordable prices.

Civil Society in general and the European Public Health Alliance in particular play a vital role in drawing attention to policy failings and helping countries to learn from one another. I hope the OECD can help you in your continuing efforts to play this role in the future.