

Short-term Gains and Long-term Pains:

A Think Piece on Healthcare Expenditure Reforms and Obesity

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Summary

How could healthcare expenditures be reformed to better avoid big costs in the future? As governments in Europe are increasingly concerned about the level and growth of healthcare expenditures, it is critical that they take view of costs beyond those covered by an annual budget. Significant healthcare expenditures in the future could be “saved” if appropriate measures are taken now. In this paper we illustrate the inconsistency problem in healthcare expenditures by examining the nexus of obesity and type-2 diabetes. Despite the alarming prevalence of obesity in Europe as well as the fact that the population is ageing, strategic long-term investment to address the problems is lacking. Obesity being a main risk factor that causes non-communicative and chronic diseases such as type-2 diabetes, this paper underlines the importance of efficient long-term investment. In particular, it discusses the challenges and possibilities of dampening the increase in health care expenses in the future by investing in programs aimed at tackling obesity and preventing the development of chronic diseases.

1. Introduction

Budget cuts today might reduce public expenses in the short-run but lead to higher costs in the future. This policy inconsistency dilemma is perhaps more tangible in the public healthcare sector than anywhere else. While the demand for healthcare is growing at an accelerated pace – and will continue to do so as the European population grows older – the healthcare sectors around Europe are under fiscal pressure. Governments are actively trying to curb expenditure growth in healthcare, or even cutting expenditures altogether. Some governments have taken measured approaches to control expenditure growth, several others have however been ushered by the economic crisis into a new world of “slash-and-burn” methods to cut healthcare expenditures.

But as severe budget cuts are being implemented, governments and other agents of health insurance may overlook opportunities of making rational investments for the future. Investments addressing obesity is an example. It has been called a time-bomb for health-insurance systems. As one of the main factors causing chronic diseases, obesity will almost certainly increase fiscal costs for the public health insurance systems in the future.

Currently, the immediate consequences of the fiscal squeeze are pretty obvious in the healthcare sector. The budget cuts are indeed being felt across Europe as people are denied access to healthcare services that they are in need of. In fiscal terms, artificially depressing

the demand for healthcare services offers governments a chance to cut expenditures, or slow down their growth. Yet in the medium-to-long term, such an outcome is far from guaranteed. Restricting the access to healthcare services will affect the health status of individuals – and, perhaps more surprisingly, it is often likely to increase healthcare expenditures rather than moderate them.

Whereas there is no universal pattern in either direction – the medium-to-long term fiscal consequences of healthcare expenditure cuts depend on many factors – the potential inconsistency between short, medium and long-term effects require far more attention from policymakers than they currently receive. This is partly because governments are under pressure to save money in the healthcare system or, more generally, to cut public expenditures. Equally important are factors like longevity and lifestyle: the longer a person lives, the greater the healthcare costs per individual associated with lifestyle habits or non-treatments. One diagnosis that illustrates the *inconsistency problem* in healthcare is type-2 diabetes – an illness that typically develops at an advanced age but tend to reflect lifestyle habits at earlier ages.

2. Lifestyles and health

The general welfare in Western societies has increased significantly throughout the 20th century. Since the 1950s in particular, economic and technical development have revolutionised the means of transportation, communication and the flow of information as well as improved the access to food and healthcare services. Not all life-style changes have been entirely positive though. Sedentary working conditions and stressful life situations in general are beginning to take their toll. Physical inactivity together with unhealthy diets and excessive intakes of calories have contributed to the rise of obesity. In fact, obesity is considered an epidemic problem in today's society. Around 50% of all men and women in Europe were overweight in 2008. Even more alarmingly, around 23% of all women and 20% of all men were obese, according to the World Health Organisation (WHO).¹

Overweight and obesity may not cause any major physical or medical complications at a young age, although they might imply physical as well as psychological problems. At a higher age, however, obesity is one of the main risk factors causing non-communicative diseases, including chronic diseases such as type-2 diabetes, cancer and cardiovascular- and respiratory diseases. In fact, obesity and overweight are the main factors behind 44% of all diabetes cases in the world, 23% of ischaemic heart diseases and between 7-41% of all cases of cancer. Diabetes type-2 requires special attention as it is the most common form of diabetes and currently represents 90% of all cases of diabetes among patients, according to the WHO. The diabetes type-2 diagnosis applies to a condition where the body cannot assimilate insulin and/or when the pancreas is incapable of producing sufficient amounts of insulin, which serve to regulate the carbohydrate metabolism in the body. Akin to other chronic non-communicative diseases, type-2 diabetes largely results from physical inactivity and complications deriving from excessive weight.

¹ A person is considered to be overweight (pre-obesity) when his/her Body Mass Index (BMI) is equal to or greater than 25, but under 30. Obesity, or severe overweight, refers to a condition where the BMI is equal to or above 30. The BMI is calculated by dividing the body weight (kg) by the height (meters) squared.

From a health economics perspective, the situation is likewise serious. Overweight or obesity are not merely negative externalities of our perhaps too comfortable lifestyles; they translate into significant fiscal costs and actually represent 2-8% of total healthcare costs, according to the WHO. In the coming decades, healthcare spending will increase from an average of 5.7% in OECD-countries in 2005, to 9.6% of Gross Domestic Product (GDP) in 2050, according to OECD estimates, unless no measures are taken to address the underlying factors. These figures err on the side of caution. Besides, they hide the fact that many European countries are likely to spend far beyond 10 per cent of GDP on healthcare. One study particularly focused at the effects of the demographic development on healthcare spending suggests that Spain and Germany are going to spend 25.6 and 21.4 % of GDP respectively on healthcare in 2050.² One of the main factors behind the growing healthcare costs is the increasing prevalence of chronic and non-communicative diseases amongst people, often related to obesity.³

In terms of public health policy, the imminent scenario of an ageing population suffering to a great extent from overweight and obesity suggests that healthcare investments aiming at preventing chronic diseases ought to be a priority. And there are political strategies in place to address this growing concern, both at international and national levels. At the EU-level, the European Commission adopted a White Paper in 2007 on a strategy on nutrition, overweight, and obesity-related health issues. Policymakers across Europe, and the world, have been recognising the problem and the need to prevent obesity and related chronic diseases.

However, despite the general awareness among policymakers and the public, the problem of obesity keeps rising. Obesity has doubled worldwide since 1980, according to the WHO. At the same time, there is, as pointed out in the introduction, an inherent *inconsistency problem* in healthcare expenditure reforms. The urgent need for several countries to cut spending seems to have reinforced the structural flaws in how funds are devised. Especially in crisis economies, healthcare budgets are now cut without much knowledge about how the cuts will affect the demand for healthcare – and expenditures on healthcare – in the future.

Given current economic and fiscal weather conditions, it is easy to see why the current priority imposed on the public healthcare sector is to curb cost. Ideally, cost savings today would lead to lower expenditures in the years to come. This is not necessarily the case, however. On the contrary, strategic investment that increases spending in the short-run might actually reduce costs significantly in the future. This is simple economics – and the relation between investments in the short-term and gains in the long-term is known in many different circumstances.

Now, many politicians are of course aware of the possibility that strategic investments could reduce health care costs in the future. Such investment decisions are not being taken however. At least not to a sufficient degree. Allocation of resources to improve public health in the long-term and prevention of diseases are complicated by the fact that policy-makers work with annual budgets that must balance at the end of the year. In addition to the

² Kotlikoff, Laurence & Haigst, Christian, 2005, *Who's Going Broke?* National Bureau of Economic Research, Working Paper 11833.

³ Sassi, F. et al. (2008)

reinforced need for cost savings in the wake of the economic crisis, policy-makers need to divide the already scarce resources between different sub-sectors that are competing with each other to receive more funds.

Naturally, doctors, nurses and physiotherapists would all like to see a greater share of the total budget being granted to their departments or research areas. Amid existing shortages, queues for treatment and operations as well as acute cases that require attention, it is difficult to allocate resources to address, for instance, long-term concerns like overweight or obesity. Also, in many cases, there is no diagnosis established for a patient suffering from health complications due to overweight or obesity, since it may take some years before an obese person develops an actual disease. Weight management is a long-term formula that requires support and information to effect life-style changes.

However, for hospitals and medical centres, there are, simply put, more urgent priorities than avoiding distant problems or physical conditions that may not develop into medical problems until many years from now. And to the extent that electorates reward or punish political leaders for how healthcare budgets are allocated, they are by all probability giving low priority to increase expenditures to address overweight or obesity if neither condition has induced a medical diagnosis. Consequently, few national healthcare systems in Europe put appropriate emphasis on addressing obesity.

As regards the factors behind obesity, a vast body of research shows that these are multiple and that the conditions are prevalent across all social strata and age groups. However, obesity tends to be more frequent amongst disadvantaged social groups. The share of obese people also increases among higher age groups.⁴ Moreover, overweight and obesity is a problem among both men and women in all European member states, although there are of course variations between countries. For example, according to Eurostat, the highest shares among women over 18 years in 2008/2009 were in the UK (23.9%), Malta (21.1%) and Latvia (20.9%). Among men, the highest shares were in Malta (24.7%, the UK (22.1%) and Hungary (21.4%). The lowest proportions of obesity were observed in Romania (8% for women and 7.6% for men), Italy (9.3%; 11.3%), Bulgaria (11.3%; 11.6%) and France (12.7%; 11.7%).

Encouragingly, overweight and obesity problems are often related to factors that can be influenced by public policy. Research also shows that most preventive interventions have positive cost-effectiveness ratios when compared to a scenario where no policy intervention takes place. Measures such as fiscal policies and taxes; education in early school-years or at the work place; and physician or dietician counselling in primary care and health clinics are approaches that have proven to be effective in addressing obesity.

The complication lies in the fact that obesity is a wide-spread phenomenon. It is difficult to reach out to the whole population in an efficient way. Certain interventions have intrinsic short-comings as they only target a limited group of people. In order to maximise the impact of public health policy, a holistic approach consisting of working at several fronts and involving a wide array of stakeholders is advocated by the OECD. Several types of policy interventions obviously lie outside of the health care sector, but health care policies such as weight management programs can play an important role in tackling obesity by providing

⁴ Sassi, F et al. (2009) OECD Health Working Papers, No. 48

treatment for individuals at high-risk. Counselling and weight management programs are evidently more expensive than for instance mass-media campaigns or intervention at school-level. But the important advantage of this type of health care policies is that the people who are most in need of assistance in order to avoid chronic diseases from developing are also the ones who will benefit most from weight management programs.⁵

3. Can the structure of healthcare expenditures be reformed?

This short think piece has discussed what we call the *inconsistency problem* in the structure of healthcare expenditures: in order to curb current expenditure growth, or cut expenditures, investments that would reduce healthcare expenditures in future are not done. This piece has illustrated this problem by examining the nexus of obesity and type-2 diabetes.

The increasing problem of overweight and obesity is clearly reflected in the growing prevalence of non-communicative and chronic diseases in Europe, of which the high frequency of type-2 diabetes is one of the most striking examples. This is not to say that obesity is the only explanatory factor causing type-2 diabetes, nor is it suggested that healthcare policies could eliminate type-2 diabetes by addressing obesity. Nevertheless, in sum, the challenge facing policymakers can be presented like this:

- i)* If the prevalence of overweight and obesity continues to grow, the share of the population that will develop type-2 diabetes will almost certainly expand.
- ii)* If the prevalence of type-2 diabetes continues to increase, the cost pressure on the healthcare budgets will accelerate given that the treatment is expensive (the costs, of course, varies between healthcare systems).
- iii)* Investments to address obesity would most probably reduce the prevalence of type-2 diabetes, but it requires an expansion of resources now. Similarly, reductions in current spending to address obesity would most probably increase the prevalence of type-2 diabetes in the future, although it would save money now.

If these propositions hold true, the question is: is it not preferable to invest in weight management programs now in order to avoid much larger healthcare costs in future? The answer is fairly obvious: Yes. It is preferable from all sorts of perspectives – medical and economic – to invest now as to avoid larger costs in future. Yet the fact remains that current healthcare budgets do not reflect such a preference. Nor do other policies – e.g. tax incentives – encourage people to make such investments themselves by paying for it themselves, out of pocket, without subsidies.

The nexus of obesity and type-2 diabetes is an example of an inconsistency problem regarding the way in which priorities and decisions are made in relation to healthcare expenditures. As governments are now moving to slow down increases in expenditures, or even slash expenditures, it is becoming more important that existent resources are utilised in a rational way that makes sense from an economic point of view.

⁵ Sassi, F et al. (2009) OECD Health Working Papers, No. 48

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