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Impact of the Economic Crisis on Health Systems

Discussion Paper_

1. Introduction

The impact of the international financial crisis, which started in 2007, continues to be felt worldwide with many countries, including EU Member States, experiencing severe economic and financial difficulties. This manifests itself in ongoing efforts to achieve reductions in public expenditure with inevitable knock-on consequences for spending on health.
Health systems require stable and predictable flows of revenue in order to plan and manage service delivery. Sudden disruption to such flows, in circumstances such as are now being experienced to varying degrees in Member States, can make it difficult to sustain the delivery of services. The problems can be compounded by the impact of increased levels of unemployment and hence increased demand on the health system as a direct consequence of the economic downturn. Additionally, pressure to reduce health budgets in short timeframes may result in indiscriminate or blanket cuts that can undermine the overall fundamental goals of health systems such as access to, and quality and efficiency of, care.

2. Impact on Health Expenditure

Recent comparable data on health expenditure points to challenging times for most EU Member States' national health systems as growth in health expenditure per capita has slowed or even fallen in real terms._ Among the main trends emerging from the data in relation to health expenditure and financing are the following:

2.1 Health Expenditure per Capita

On average, health spending per capita across EU Member States reduced by 0.6% in real terms between 2009 and 2010_. This followed an average annual increase in health spending per capita of 4.6% in real terms between 2000 and 2009.

The data reveal the extent to which individual Member States have been affected to varying degrees. For example, austerity measures in Ireland have resulted in health spending per capita being down by nearly 8% in 2010, compared with an annual average growth rate of 6.5% between 2000 and 2009. A similar trend is evident in the case of Estonia and Greece with reductions of 7.3% and 6.7% respectively in 2010, following yearly growth rates of 7.2% (Estonia) and 5.7% (Greece) between 2000 and 2009. In other Member States (e.g. Belgium, Finland, the Netherlands, Poland, the Slovak Republic and Sweden) while there has been a noticeable slowdown in the rate of growth of health spending per capita, it has remained positive.

2.2 Financing of Healthcare

The public sector is the main source of financing health care in all EU Member States other than Cyprus. On average across the EU, 73% of healthcare was publicly financed in 2010, ranging from 86% in the case of the Netherlands to 43% in the case of Cyprus. The effects of measures taken to reduce public spending on health can be seen in the mix of public and private health financing in certain Member States which have seen both cuts in public spending on health and increases in the share of direct payments by households. In Ireland, the share of public spending has decreased by nearly 6 percentage points between 2008 and 2010 resulting in the percentage of public spending now standing at 70% which is below the EU average of 73%. The Slovak Republic and Bulgaria have also witnessed substantial reductions in public spending.

Private out-of-pocket payments comprise the second main source of funding for health services. On average 21% of healthcare was funded by out-of-pocket payments across the EU in 2010, ranging from the lowest share in the Netherlands (6%), France (7%) and the UK (9%) to the highest in Cyprus (49%), Bulgaria (43%) and Greece (38%). Just under half of EU Member States have seen an increase in the share of out-of-pocket payments in the period 2000-2010, notably the Slovak Republic (15.3%), Bulgaria (6.4%), Cyprus (5.9%) and Malta (5.6%). In Ireland, the share of out-of-pocket spending increased by 1.7 percentage points between 2008 and 2010. In 2010, it accounted for 17% of total health expenditure which is 2.1 percentage points higher than in 2000. It is notable that this trend in Ireland has occurred against a backdrop of significant additional numbers qualifying on income grounds for exemptions from healthcare fees and user charges.

Reductions in health expenditure are compounded by increasing pressures on the health system arising from a range of factors. Notable amongst these are the demographic and epidemiological changes in the make-up of our society, as well as developments in healthcare technology. Data show that the share of the population aged 65 and over across the EU was 16.4% in 2010 compared with 14.7% in 2000. Within individual Member States the data show the share of those aged 65 and over ranges from in excess of 20% in the case of Germany and Italy to 11.5% in the case of Ireland. The increasing burden of chronic disease is also placing additional pressures on health systems. Estimates point to 30 million people, or more than 6% of the population aged 20-79 years of the EU, having diabetes in 2011, with 42% of adults with diabetes aged less than 60 years. Unless addressed, it is estimated that the number of people with diabetes in EU Member States could rise to more than 35 million in less than 20 years.

3. Policy Responses

Evidence suggests that national health systems' responses to the financial crisis are, to a certain extent, determined by the degree to which the economies of individual Member States have been affected by the financial crisis. The results of a recent survey in the broader European region_ showed varied responses (up to April 2011) which can be summarised as follows: -

while some countries introduced very few or no new measures (e.g. Denmark, Finland, Germany, Malta, Poland and the Slovak Republic), others introduced many changes to their health systems (e.g. Czech Republic, Greece, Ireland and Portugal);
some health systems were better prepared than others to cope with the downturn because of fiscal measures taken prior to the crisis (e.g. Czech Republic, Estonia, Italy, Lithuania and the Slovak Republic). Examples include accumulation of financial reserves and reducing healthcare prices very rapidly in response to the crisis;

in certain cases, the crisis facilitated more timely implementation of policies planned before the downturn by rendering them more urgent or politically feasible, particularly the restructuring of secondary care, and
in certain other cases, planned reforms were slowed down or abandoned in response to the crisis.

A complete picture of evidence in relation to the actual impact of policy responses to the financial crisis on health system performance is still emerging. However, some of the trends in policy responses to the financial crisis are outlined in sections 3.1 to 3.3 below.

3.1 Financing of healthcare

As identified in section 2 of this paper, there was an overall slowdown or reduction in health spending in almost all EU Member States in 2010.

Few countries appear to have reformed fiscal policy in order to raise revenue for financing health systems. Among the exceptions is France which introduced a new tax of 2% on certain sources of income to finance social security, including health care expenditure. This was introduced in 2009 and has since been increased to 4% in 2010 and then to 6% in 2011. Hungary introduced a public health tax on food and drinks with a high sugar content. Certain countries increased contribution rates for statutory health insurance (e.g. Bulgaria, Greece, Portugal, Romania and Slovenia).

As already noted, user charges for health services were increased or introduced in a number of countries (e.g. Czech Republic, Denmark, Estonia, France, Greece, Ireland, Italy, Latvia, Netherlands, Portugal, Romania and Slovenia). The sectors affected by such changes to the user charging regime (e.g. the hospital sector, pharmaceuticals, ambulatory care) varied across Member States although the majority of changes related to pharmaceuticals.

3.2 Healthcare Coverage

In general, apart from changes at the margins, no major alterations were made to the statutory benefit packages or the population covered for statutory benefits in Member States. Examples of reductions in overall coverage include lower reimbursement of the following: dental care for certain population groups (e.g. Estonia and Ireland); IVF, physiotherapy and mental health (e.g. the Netherlands) and cosmetic surgery (e.g. Portugal). Some countries have also established negative lists for pharmaceuticals (e.g. Spain).

With a view to improving health outcomes and reducing the need for avoidable healthcare costs, some countries initiated programmes to support changes to individuals' behaviour through public health promotion and preventative measures. These included the introduction of initiatives to promote healthy eating, exercise and screening e.g. (Belgium, Greece and Hungary) and increasing the taxes on alcohol and cigarettes e.g. (Bulgaria and Estonia).

Finally, it is acknowledged that Health Technology Assessment (HTA) is a useful tool for priority-setting as it relates to healthcare coverage and that those countries that have HTA programmes may benefit from more informed decision-making during periods of financial crisis._

3.3 Strategies for Enhancing Efficiency

Many countries engaged in initiatives to drive efficiency and lower the cost of healthcare.

Among the measures taken were reductions in the cost of pharmaceuticals or efforts to improve the more rational use of medicines (e.g. Austria, Belgium, Czech Republic, France, Estonia, Greece, Ireland, Hungary, Latvia, Lithuania, Malta, Poland, Portugal, Romania, the Slovak Republic, Slovenia and Spain). Measures taken include the following: generic substitution; international non-proprietary name (INN) prescribing; claw-back mechanisms; price negotiations and lengthening prescription validity. National negotiations and better procurement practices contributed to efforts to reduce the price of pharmaceuticals. The importance of combining pricing policies with initiatives aimed at encouraging more rational prescribing and dispensing of drugs in order to enhance efficiency is recognised.

Based on available data, pay costs account for approximately 42.3% of public spending on health. As a consequence, certain Member States reduced the salaries of health professionals (e.g. Cyprus, France, Greece, Ireland, Lithuania and Romania). In other Member States, salaries were frozen (e.g. UK, Portugal and Slovenia) or their rate of increase was reduced (e.g. Denmark). Ensuring that such measures do not result in shortages of skilled personnel is a challenge and calls for effective human resource policies aimed at retaining skills and expertise, e.g. life-long learning, clear job descriptions, team working, etc.

Several countries reduced the prices paid to providers of healthcare (e.g. Estonia, Ireland, Romania and Slovenia). Other changes implemented include pay for performance (e.g. Italy) and per capita payments in primary care (e.g. Portugal). It is acknowledged that targeting the supply side and moving away from passive reimbursement payment systems appear to offer more scope for achieving greater efficiencies and better quality care compared with initiatives aimed at limiting utilisation of services by patients._

Other initiatives have focused on reducing overhead costs and increasing efficiency through restructuring of the Ministry of Health, statutory health insurance funds and other purchasing bodies (e.g. Bulgaria, Czech Republic, England, Latvia, Lithuania, Portugal and Romania). Restructuring within the hospital sector has also taken place involving closures, mergers and centralisation (e.g. Denmark, Greece, Latvia, Portugal, Ireland and Slovenia), a shift towards outpatient/daycase care (e.g. Ireland, Greece and Lithuania) and greater investment in and coordination with primary care (e.g. Greece, Lithuania, the Netherlands, Portugal and Spain).

There is increasing recognition of the importance of integrated health care involving greater coordination across healthcare settings, more focus on prevention and, where appropriate, the provision of care in lower-cost settings. Among initiatives undertaken in this general area are the development of primary care-based networks, nurse-led strategies, disease management programmes, financing reforms to facilitate integrated care, bonuses for recruiting patients and paying providers for performance.

4. Conclusion

In summary, comparable data show that health spending per capita slowed or reduced in real terms in most EU Member States in 2010. The responses of individual Member

States' health systems to the financial crisis are to a certain degree determined by the extent to which national economies have been affected by the financial crisis. While some of the initiatives undertaken by individual Member States formed part of a process of ongoing reform, in certain instances, the financial crisis provided the necessary impetus to implement policy reforms with a greater degree of urgency. However, in many cases, countries were left with no option but to cut spending on healthcare.

The challenge for Member States is to focus on initiatives that mitigate the impact of the financial crisis on the health system and that target achievement of greater efficiency and effectiveness in health sector spending. Examples of such initiatives include strategic purchasing, reduced prices for pharmaceuticals combined with policies to promote more rational prescribing and dispensing, greater integration and coordination of health care across care settings and shifting from in-patient to day-case or primary care. Initiatives that have the potential to place achievement of health policy goals at risk include the application of user charges for essential services, indiscriminate reductions in essential service coverage and attrition of health professionals as a result of cuts in pay.

It is critical to keep an eye on the longer-term challenges of health systems. Some short-term measures to achieve savings may be inconsistent with the challenges facing European societies, e.g. the need for strong Primary Health Care systems, health-in-all policies, and interventions which tackle risk factors related to non-communicable diseases. Pressure to take rapid action often limits the policy options available, and can result in policy responses which do not align with long term health policy goals.