Health policy responses to the financial crisis: Ireland in the European context

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Outline

Data collection

Policy options and responses in three areas

Any lessons?
Survey methodology

- Two waves of questionnaire sent to a network of health policy experts in 53 EURO countries

- In each country two different experts asked to describe government’s response to economic crisis with a focus on health policies

- Results received in spring 2011 and 2013

- 47 countries responded
3 policy areas

- Public funding
- Coverage
- Planning, purchasing, delivery
Public funding
3 policy options for public funding

Cut spending to match revenue

- Doing nothing as government revenues fall
- Targeting the health budget for cuts

Find additional sources of revenue

- Deficit financing
- Countercyclical mechanisms
- Reallocation across government
- New taxes

Get more from existing sources

- Enforce collection
- Lift contribution ceilings
- Abolish pro-rich tax subsidies
- Extend payroll contributions to income
- Increase taxes
Public spending on health fell in 27 countries

Annual growth rate of public expenditure on health, in real terms.

Source: WHO NHA database, 2013
Public spending on health fell disproportionately in 18 countries.
Public funding and economic crisis

• Health systems always need stable revenues

• In an economic crisis public funding levels should increase as household incomes fall because:
  – means-tested entitlement to public services increases
  – greater need for health services
Impact of financial crisis on health

• Studies (Ruhm et al) of high-income countries suggest mortality tends to fall when the economy slows down and rise when the economy speeds up.

• BUT studies of EU (e.g. McKee, Stuckler et al) also show that economic downturns pose clear risks to health due to mental health morbidity and suicide and alcohol-related mortality.
Policy options for public funding

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Reallocation across government

Differences in the % of the government budget spent on various sectors, 2007-2010, selected countries

Source: Cylus and Pearson in Thomson et al 2014
Countercyclical mechanisms are critical to address fluctuation; some are more effective than others

<table>
<thead>
<tr>
<th>Country</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estonia</td>
<td>• HIF reserves could have covered decline in payroll tax revenue but use of reserves was initially blocked</td>
</tr>
<tr>
<td>Lithuania</td>
<td>• Highly effective formula-based budget transfers to compensate for lower payroll tax revenue</td>
</tr>
<tr>
<td>Ireland</td>
<td>• Lack of mechanism to cover increase in numbers of people eligible for public services increased fiscal pressure</td>
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</tbody>
</table>
Estonia was well prepared but prudence in the health sector was used to balance the government budget.

Source: T. Habicht, EHIF, www.haigekassa.ee
Lithuania’s formula for budget transfers ensured public funding levels were stable.

Source: Jowett et al in Thomson et al 2014
Means-tested safety net in Ireland was not backed by additional public funding.

Large increase in entitlement but no increase in budget.

Source: Thomson et al 2014
### Policy options for public funding

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Raising taxes

- **General decrease tax base and SHI contributions in most countries** (due to increased unemployment, reduced wages)

Response:
- **Increase tax base for health**: eg Italy, France and Hungary
- **Increased SHI contribution rates**: eg Bulgaria, Greece, Portugal, Romania, Slovenia
- **Increase (tax funded) unemployment contributions to SHI**: e.g. Bulgaria, Czech Republic, Estonia, Hungary, Lithuania, Romania and Slovakia
- **Increase ‘sin’ taxes** (alcohol, tobacco, fat): E.g. Belarus, Bulgaria, Cyprus, Denmark, Estonia, France, Hungary, Montenegro, Portugal, Romania, Russia, Slovenia, Spain, Ukraine
Tallinn Charter 2008

Health Systems

- Demonstrate performance!!!
- Societal Well-being
- Direct contribution to the economy

Health

Wealth

Effects of ill health on economic growth

Figueras J, McKee M 2011
Coverage
Policy options for coverage

Exclude groups of people?

Increase user charges?

Streamline benefits package?

Population: who is covered?

Financial protection: what do people have to pay out-of-pocket?

Services: which services are covered?

Reduce cost sharing and fees

Include other services

Extend to non-covered

Coverage mechanisms
Policy responses across countries

- Reduced user charges (or increased protection)
- Ad hoc reduction in benefits
- Increased user charges
- Expanded population entitlement
- Restricted population entitlement
- HTA-based reduction in benefits
- Added new benefits

Introduced in Ireland

Source: Thomson et al 2014
Private spending on health increased during the crisis, mainly due to higher OOPs (2009 – 2010)

- Private expenditure on health / capita at Purchasing Power Parity (NCU per US$)
- General government expenditure on health / capita Purchasing Power Parity (NCU per US$)
Change in self-reported unmet need for cost reasons, 2008-2012

Unmet need fell

Unmet need rose but the poorest had some protection

Unmet need rose and the poorest were not sufficiently protected

Source: EU SILC data showing the % change between 2008 and 2012 in the share of the population perceiving an unmet need for medical treatment.
International evidence on user charges

- Applying UC across the board reduces the use of low- and high-value (necessary and unnecessary) health services in almost equal measure (Newhouse et al 1993, Swartz 2010)

- Applying UC to relatively cost-effective patterns of use, e.g., obtaining outpatient prescription drugs in primary care, shown to increase the use of more expensive inpatient and emergency care (Tamblyn et al 2001)

- Little evidence that UC lead to more appropriate use or long-term cost control or successfully contain public spending on health care

- UC may contribute to enhancing efficiency in use of health services if applied selectively based on value

- But need clear evidence of value and potentially high transaction costs involved

- Supply side reforms have more scope for cutting costs and increasing efficiency than demand side policies
Planning, purchasing, & delivery
### Policy responses across countries

<table>
<thead>
<tr>
<th>Policy changes</th>
<th>Number of countries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical products - procurement and provider payment</td>
<td>38</td>
</tr>
<tr>
<td>Restructuring health ministries, public health bodies or purchasing organizations, reducing overheads, cutting salaries</td>
<td>34</td>
</tr>
<tr>
<td>Strengthen public health (including increasing taxes)</td>
<td>28</td>
</tr>
<tr>
<td>Reforming primary care</td>
<td>19</td>
</tr>
<tr>
<td>Restructuring hospital sector</td>
<td>19</td>
</tr>
<tr>
<td>Reducing hospital fees, tariffs or budgets</td>
<td>18</td>
</tr>
<tr>
<td>Hospital payment methods</td>
<td>18</td>
</tr>
<tr>
<td>Reducing health sector worker pay</td>
<td>16</td>
</tr>
<tr>
<td>Abandoning or stalling hospital sector investment</td>
<td>13</td>
</tr>
<tr>
<td>Developing eHealth</td>
<td>11</td>
</tr>
<tr>
<td>Public health – decreased funding or closing / merging bodies</td>
<td>6</td>
</tr>
<tr>
<td>Decreased funding for primary care</td>
<td>5</td>
</tr>
<tr>
<td>Increased funding for primary care</td>
<td>5</td>
</tr>
<tr>
<td>Primary care payment method</td>
<td>5</td>
</tr>
<tr>
<td>Skill mix</td>
<td>3</td>
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</table>

*Introduced in Ireland*
### Policy responses

<table>
<thead>
<tr>
<th>Positive changes</th>
<th>Challenges</th>
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<tbody>
<tr>
<td>• Agreement and action on previously infeasible reforms</td>
<td>• Resistance from powerful actors</td>
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<tr>
<td>• Targeted price reductions</td>
<td>• Time needed</td>
</tr>
<tr>
<td>• Better procurement, prescribing and dispensing of drugs</td>
<td>• Difficulty of making upfront investments to produce long-term savings</td>
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<td></td>
<td>• Policy reversals or incomplete implementation</td>
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Convince the public and decision-makers of ability to enhance value in public spending

- Cut selectively: inappropriate or ineffective services, inflated prices
- Address waste: excess capacity or overhead costs, use of expensive alternatives, fragmented procurement, fragmented pooling
- Invest carefully: HTA, prevention, medical equipment, infrastructure, skill mix, primary care, care coordination, aligned incentives
Conclusions
Some key lessons (1)

- Scope for efficiency gains is constrained by starting point, degree of pressure, timeframe
- Pressure for short-term savings is often stronger than desire for efficiency: cost cutting ≠ efficiency
- Complex reforms are difficult, especially in a crisis: they require investment and time
- Countries often went for the low-hanging fruit
Policy responses to the crisis

- Guidelines
- E health
- P4P
- Skill mix
- Co-ordinated care
- HTA
- Rationalise hospitals
- Public health
- Delayed investment
- Cutting benefits
- Price controls
- User charges
- Population exclusions
- Training, research cuts
- Staff cuts
- Salary cuts
- Cutting benefits
- Salary cuts
- Training, research cuts
- Staff cuts
- Price controls
- User charges
- Population exclusions
- Delayed investment
- Cutting benefits

Adapted from Repullo 2013
Some key lessons (2)

Blanket cuts do not promote policy goals

There are limits to efficiency gains, especially when pressure is sustained

Countries were resourceful in maintaining public funding levels: a good lesson for the future
Quick fixes may keep the system running, but eventually longer-term solutions will be needed
Crisis as opportunity

• Fiscal sustainability: constraint, not policy objective
• (Extra) spending should demonstrate value
• Be transparent & explicit about trade offs
• Don’t forget the other sectors (social)!
• Learn to communicate the case for health and wealth
• Increases in performance: reducing costs through efficiency, e.g.
  – Hospital reconfiguration
  – Improved purchasing
  – Drugs: rational use and pricing
  – Evidence base medicine
Further details


  http://www.euro.who.int/__data/assets/pdf_file/0009/170865/e96643.pdf


www.healthobservatory.eu
Health & Financial Crisis Monitor

www.hfcm.eu

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