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


**Philipa Mladovsky**

**Research Fellow**
**London School of Economics, LSE Health**
**European Observatory on Health Systems and Policies**


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*Based on a presentation by Sarah Thomson at the WHO Barcelona Course on Health Financing in March 2014*

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# Outline

Data collection

Policy options and responses in three areas

Any lessons?

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# 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

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# 3 policy areas

Public funding

Coverage

Planning, purchasing, delivery

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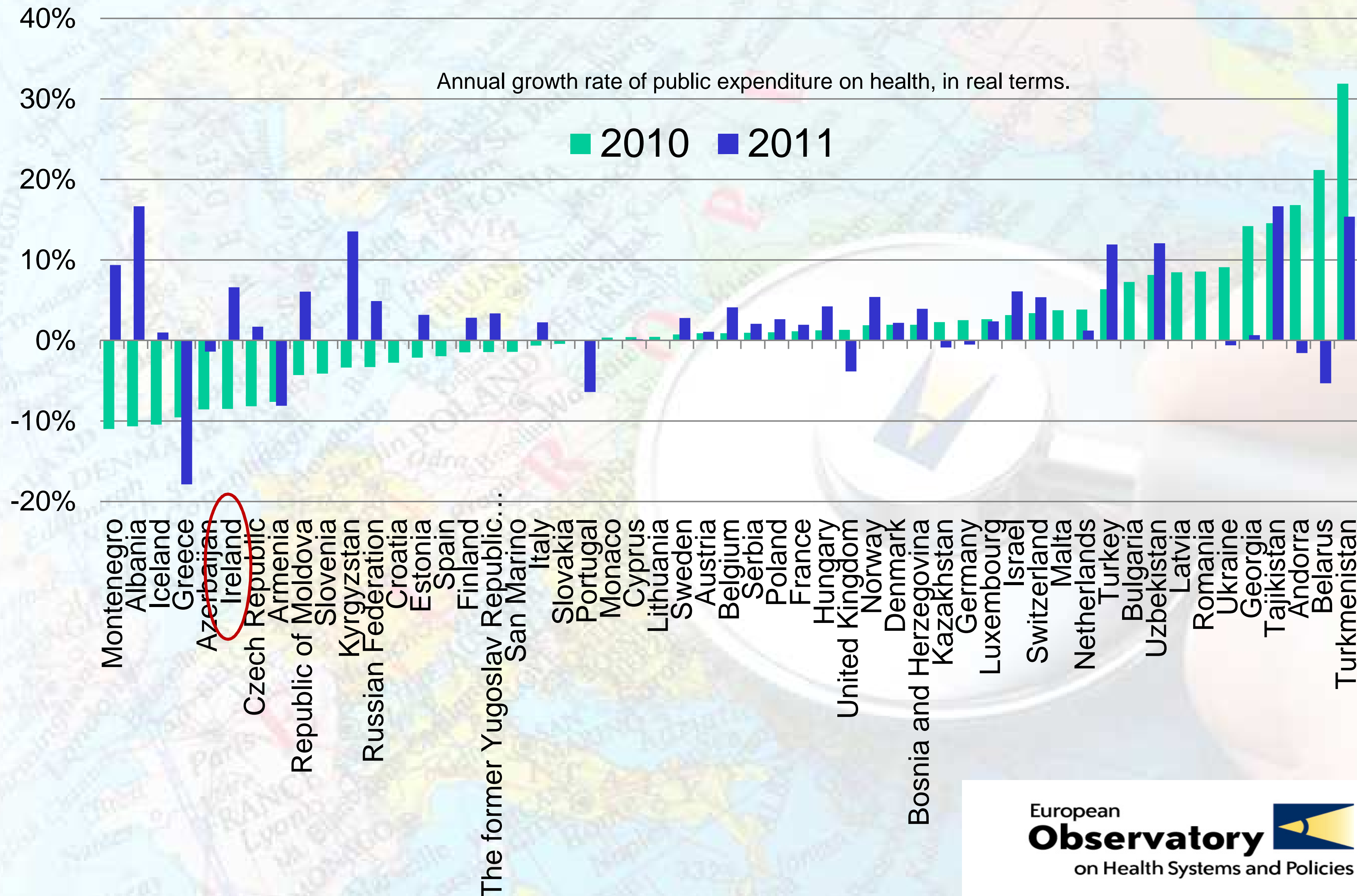
# 3 policy options for public funding

| Cut spending to match revenue | Find additional sources of revenue | Get more from existing sources |
| --- | --- | --- |
| • Doing nothing as government revenues fall<br>• Targeting the health budget for cuts | • Deficit financing<br>• Countercyclical mechanisms<br>• Reallocation across government<br>• New taxes | • Enforce collection<br>• Lift contribution ceilings<br>• Abolish pro-rich tax subsidies<br>• Extend payroll contributions to income<br>• Increase taxes |

# Public spending on health fell in 27 countries




*Source: WHO NHA database, 2013*

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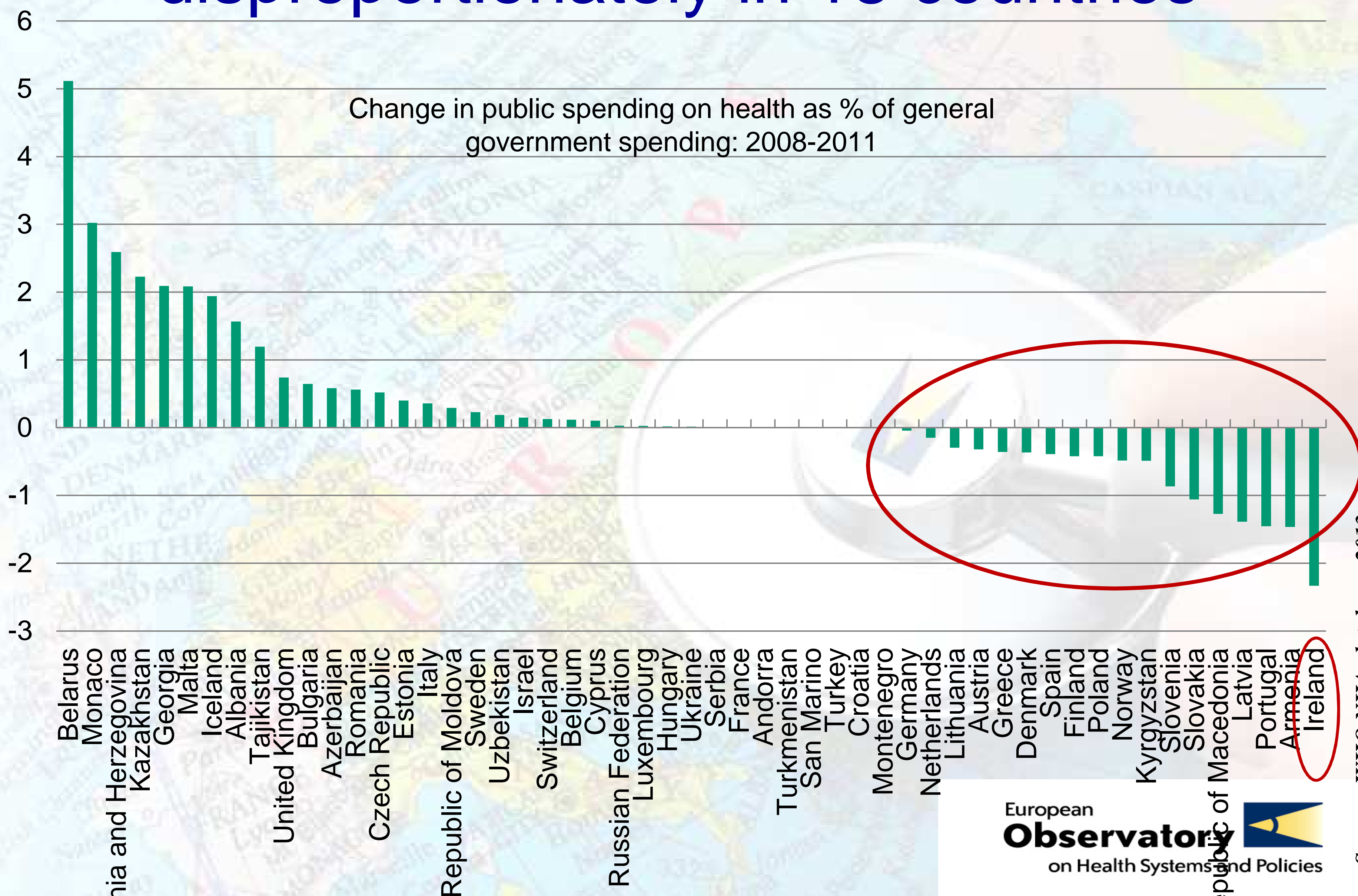
# Public spending on health fell disproportionately in 18 countries




*Source: WHO NHA database, 2013*

# 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

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# 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

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# Policy options for public funding

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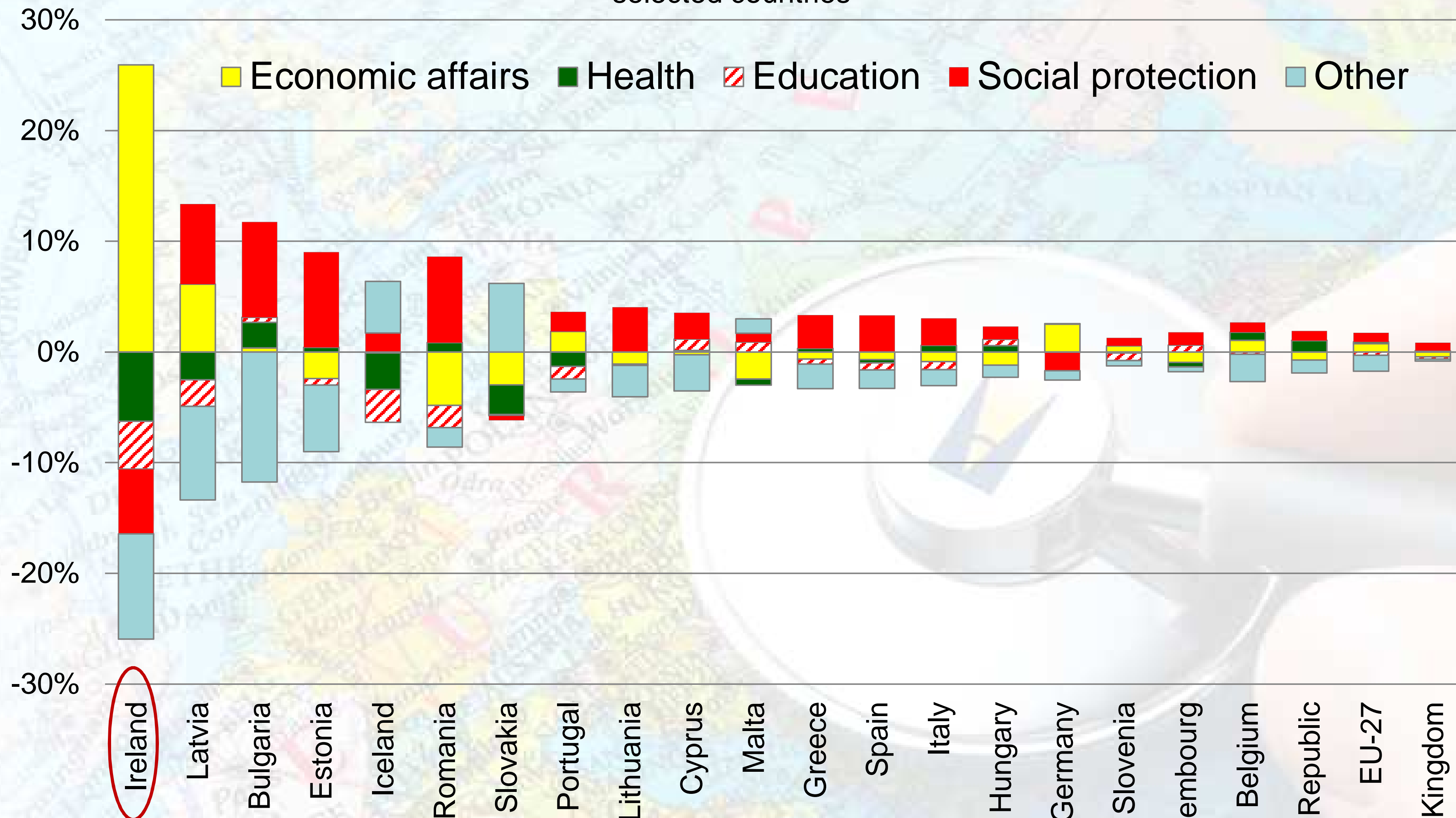
# Reallocation across government




*Source: Cylus and Pearson in Thomson et al 2014*

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# Countercyclical mechanisms are critical to address fluctuation; some are more effective than others

| Estonia | Lithuania | Ireland |
|---|---|---|
| • HIF reserves could have covered decline in payroll tax revenue but use of reserves was initially blocked | • Highly effective formula-based budget transfers to compensate for lower payroll tax revenue | • Lack of mechanism to cover increase in numbers of people eligible for public services increased fiscal pressure |

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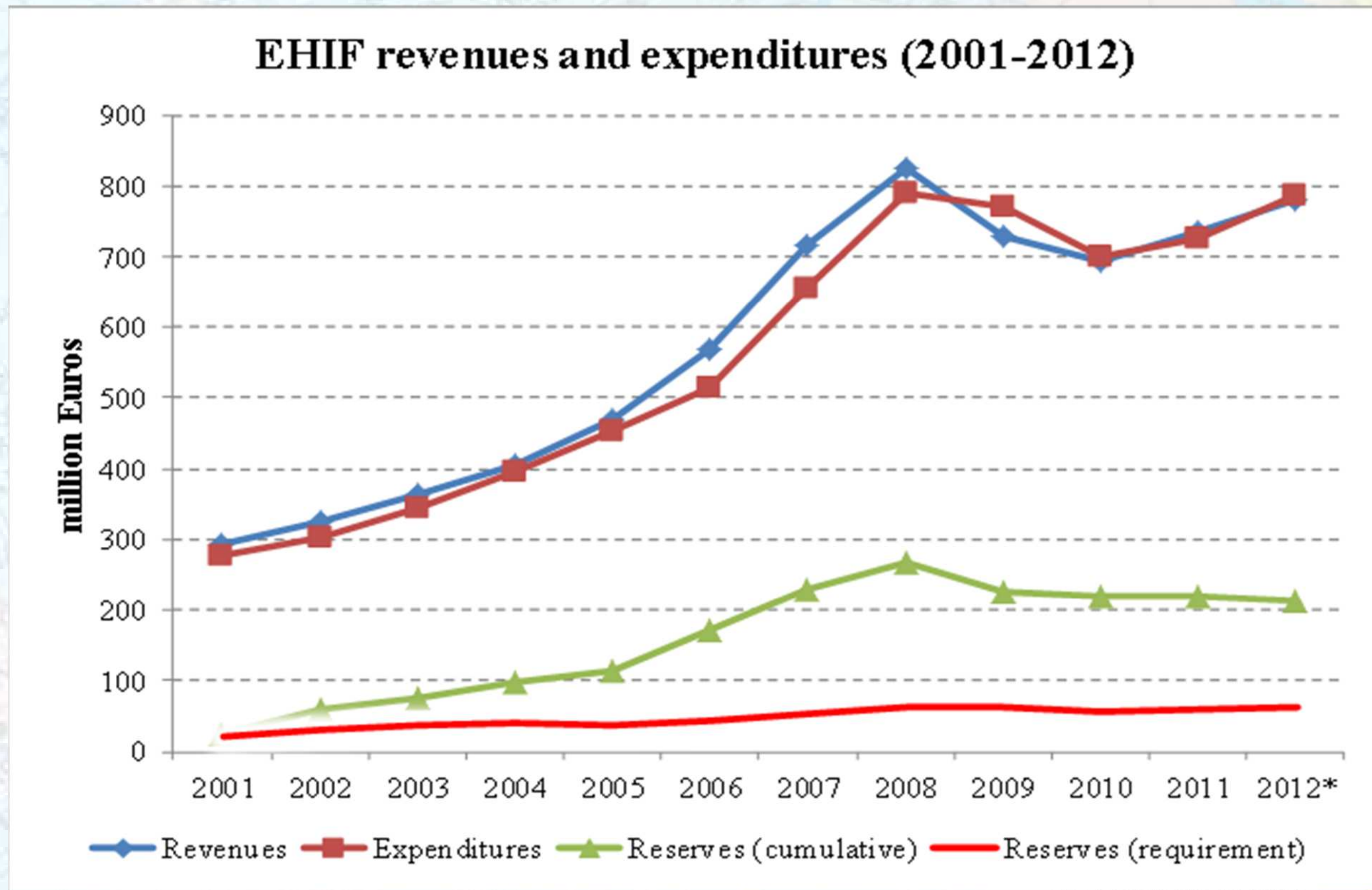
# Estonia was well prepared but prudence in the health sector was used to balance the government budget




*Source: T. Habicht, EHIF, www.haigekassa.ee*

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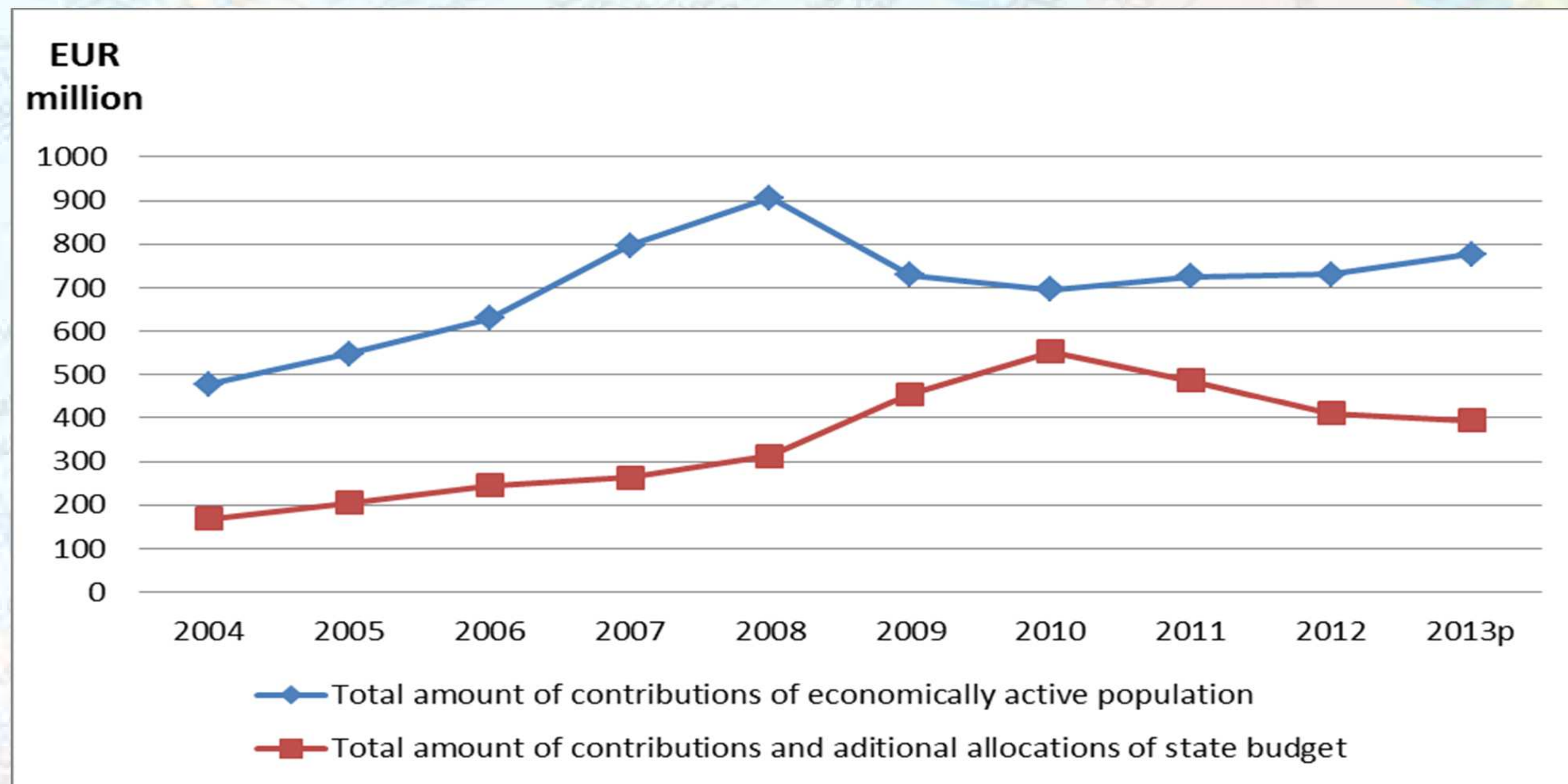
# Lithuania's formula for budget transfers ensured public funding levels were stable




*Source: Jowett et al in Thomson et al 2014*

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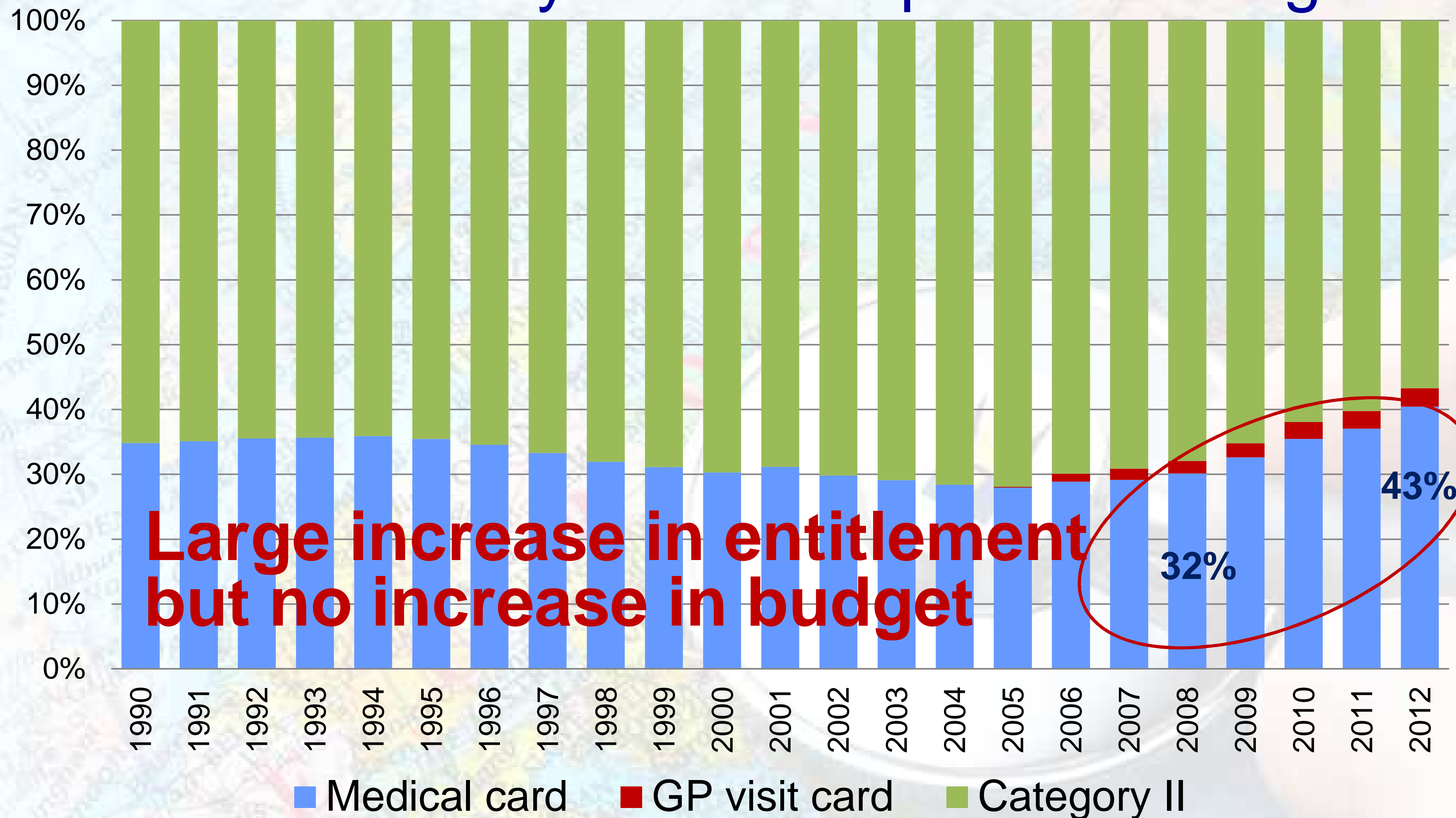
# Means-tested safety net in Ireland was not backed by additional public funding

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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*

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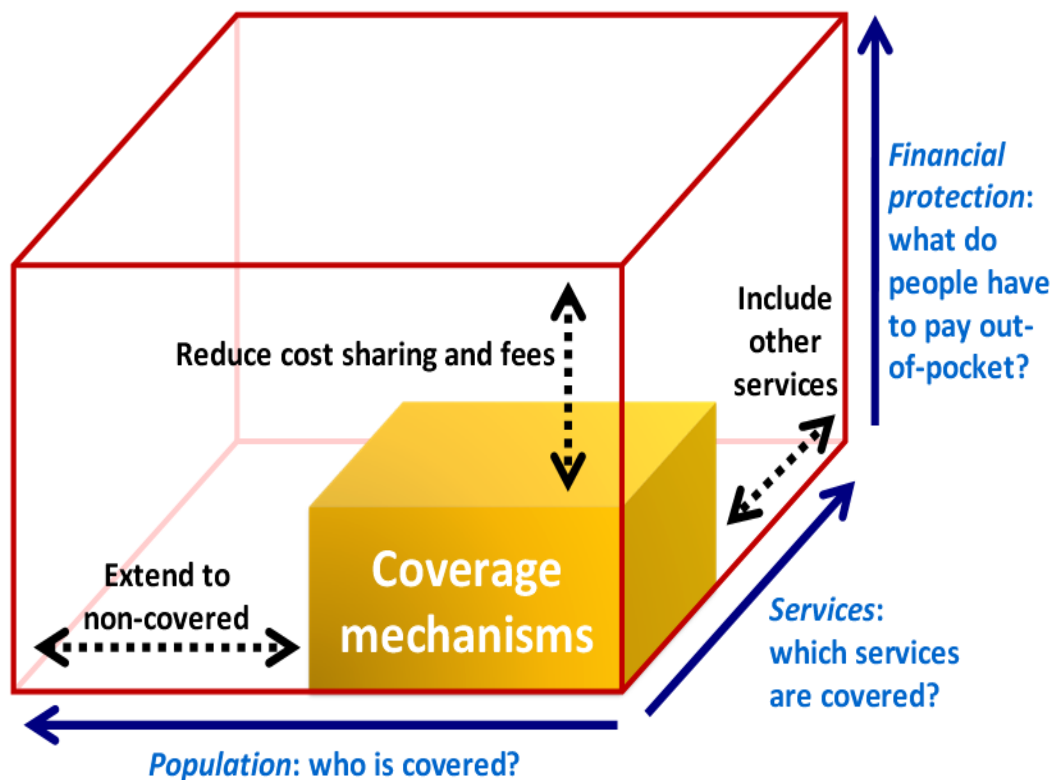
# Policy options for coverage




Increase user charges?

Streamline benefits package?

Exclude groups of people?

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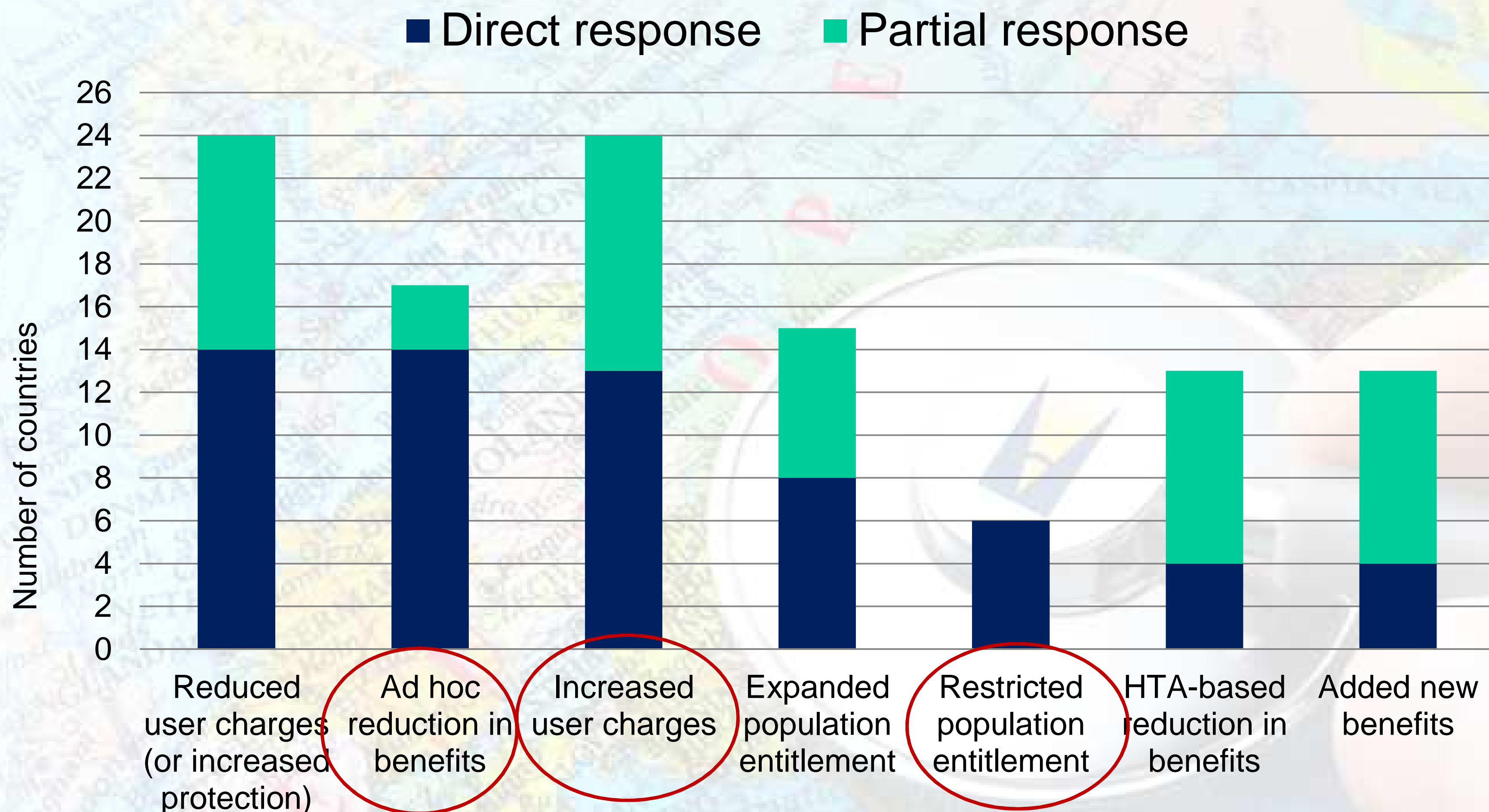
# Policy responses across countries




**Introduced in Ireland**

**Source:** *Thomson et al 2014*

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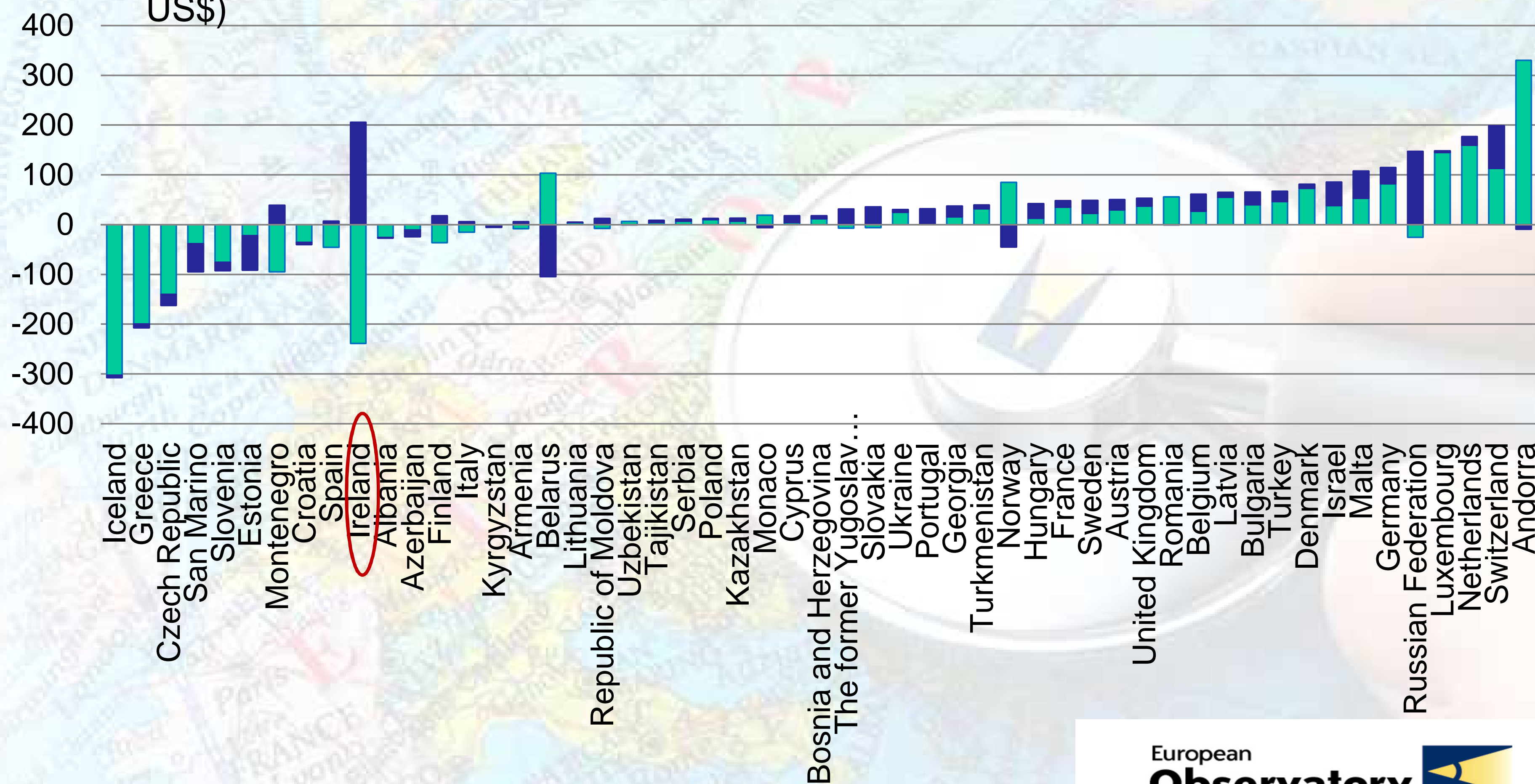
# Private spending on health increased during the crisis, mainly due to higher OOPs (2009 – 2010)

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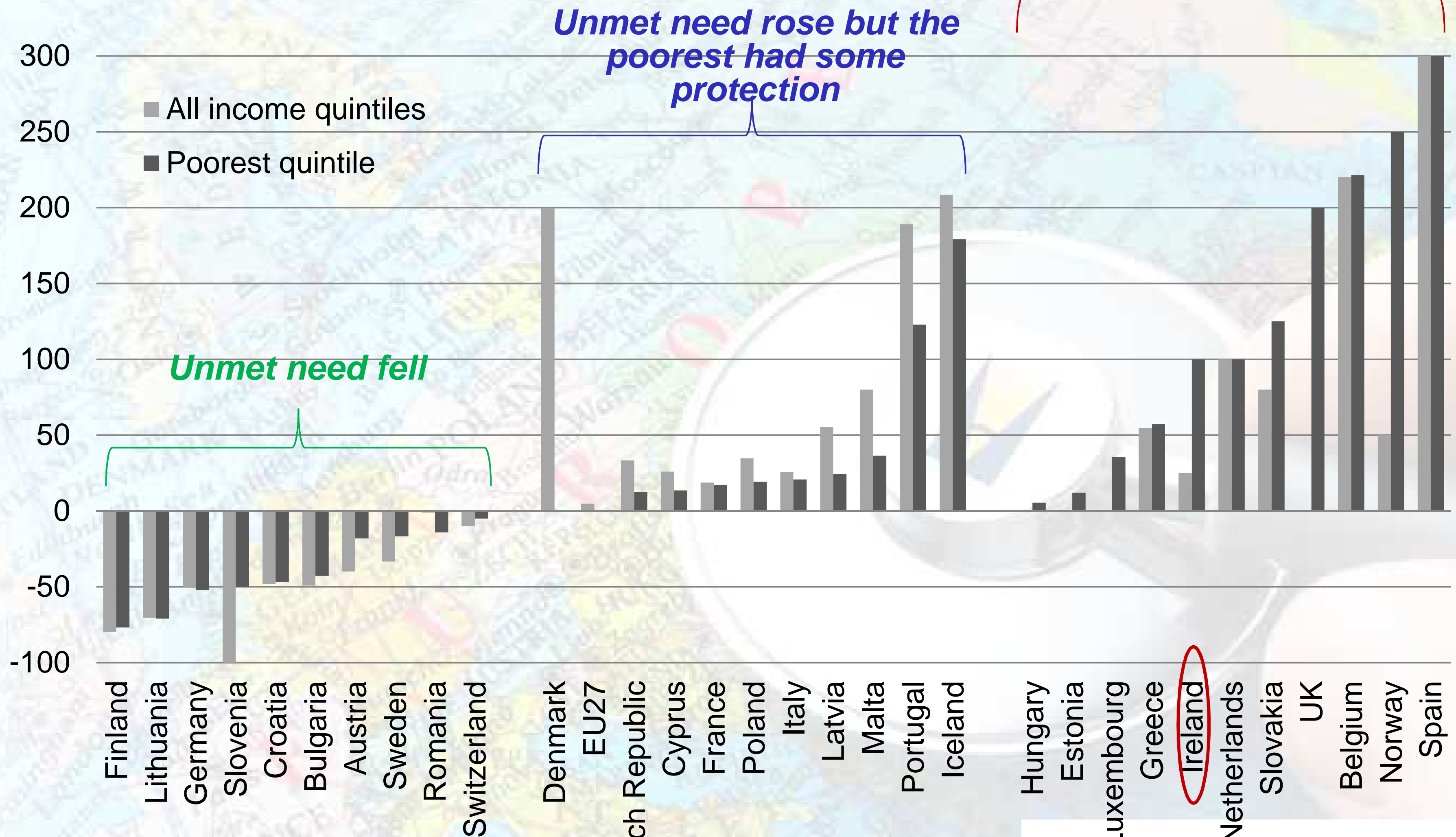


Source: EU SILC data showing the % change between 2008 and 2012 in the share of the population perceiving an unmet need for medical treatment

# 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, eg 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

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# Policy responses across countries

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

**Introduced in Ireland**

# Policy responses

## Positive changes

- Agreement and action on previously infeasible reforms
- Targeted price reductions
- Better procurement, prescribing and dispensing of drugs

## Challenges

- Resistance from powerful actors
- Time needed
- Difficulty of making upfront investments to produce long-term savings
- Policy reversals or incomplete implementation

# 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

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# Conclusions

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# 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

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# Policy responses to the crisis

Guidelines

E health

P4P

Co-ordinated care

Skill mix

HTA

Rationalise hospitals

Public health

Delayed investment

Cutting benefits

Price controls

Population exclusions

User charges

Training, research cuts

Staff cuts

Salary cuts

Adapted from Repullo 2013

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# 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

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Quick fixes may keep the system running, but eventually longer-term solutions will be needed

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# 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

- Thomson et al (2013) Health, health systems and economic crisis in Europe Impact and policy implications. DRAFT FOR REVIEW. World Health Organization on behalf of the European Observatory on Health Systems and Policies: Copenhagen http://www.euro.who.int/__data/assets/pdf_file/0011/186932/Health-and-economic-crisis-in-Europe4.pdf
- Mladovsky, P., Srivastava, D., Cylus, J., Karanikolos, M., Evetovits, T., Thomson, S. and McKee, M. (2012) *Health policy responses to the financial crisis in Europe.* Policy summary 5. World Health Organization on behalf of the European Observatory on Health Systems and Policies: Copenhagen http://www.euro.who.int/__data/assets/pdf_file/0009/170865/e96643.pdf
- Mladovsky P et al. (2012). Health policy in the financial crisis. *Eurohealth*, 18:1. http://www.euro.who.int/__data/assets/pdf_file/0005/162959/Eurohealth_Vol-18_No-1_web.pdf

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