Financial Crisis & Sustainability of Healthcare Systems in the European Countries

Seoul – 9th November 2012
Biography - Summary

• PhD in Economics, Master in Health Economics and Lawyer by training
• Professor in the Andalusian School of Public Health (Spain). Visiting Professor in some US universities.
• Expert for international organizations as European Commission (EC) and World Health Organization (WHO). External advisor for HTA Agency.
• Publications and research projects related to health and economics.
Agenda

• Financial Crisis in Europe. Some figures
• Relationship between financial crisis and the Healthcare Systems
• What we learned from previous crisis? Evidence
• Health policy responses to the financial crisis in Europe
• Conclusions
Some figures* about the economic crisis in Europe

*Source: www.bbc.co.uk
Gross domestic product (GDP) is the value of all the goods and services produced by a country in a single year. This chart shows the damage caused to the whole of the eurozone by the 2008 global financial crisis.
The unemployment rate has been rising significantly in the three countries that have needed bail-outs - Greece, Portugal and the Republic of Ireland. It has also risen sharply in Spain, reaching 25% this year, although Spain has a long history of unusually high unemployment.
A government's deficit is the amount by which its total spending exceeds its tax revenues. The government typically borrows the difference, adding to its debt. Some governments manage to spend less than they earn, so that they run a positive surplus. This chart shows that surplus (a number above zero) or deficit (less than zero) as a proportion of GDP (the total value of goods and services produced by the economy each year). EU rules say that countries using the euro are not allowed to have an annual deficit of more than 3% of GDP, but several countries have failed to keep to that rule in recent years.
The debt as a proportion of GDP is the total amount a country's government (including local government) owes divided by the total amount produced by its economy in the year. Greece has been near the top of the debt league for some time. Portugal and Ireland have also moved up the table for the past few years (in Ireland's case because of the enormous cost of rescuing its banks).
Economic Crisis and Health (I)

Relationship between Economic crisis and Health

Economic crisis
- \( \downarrow \) economic growth rates
- \( \uparrow \) higher unemployment & underemployment
- \( \uparrow \) higher inflation
- \( \uparrow \) bankruptcies

\( \downarrow \) household real income
leads to:
- \( \downarrow \) quantity & quality of food
- \( \downarrow \) expenditure on health & utilisation of health facilities
- \( \downarrow \) expenditure on education & school retention rates

\( \downarrow \) tax revenue
leads to:
- \( \downarrow \) government expenditure on health & education
  (including immunisation, health insurance & improvements in technology)

\( \downarrow \) Health Status
- \( \uparrow \) mortality rates
- \( \downarrow \) life expectancy

Economic Crisis and Health (II)

Health policy responses to the financial crisis

What we learned from previous crisis?
Evidence
Great Depression in the US – 1929-1937

• During the Great Depression in the United States in 1929–1937 showed that while suicides rose, overall mortality fell due to a decrease in infectious diseases and road-traffic accidents (Fishback, Haines & Kantor, 2007).
Post-communist Depression (early 1990s)

The recession following the collapse of the Soviet Union in the early 1990s had devastating consequences for population health across the region, with mortality increases of up to 20% in some countries. The pace of transition, including mass privatization and the absence of a social safety net in some of the countries, extensively affected life expectancy rates (Stuckler, King & McKee, 2009).
Relation between unemployment and adult male mortality rates in post-communist countries, 1992–94

Countries affected by the South East Asian economic crisis of the 1990s adopted different recovery strategies. **Thailand and Indonesia**, which reduced spending on social protection, experienced **short-term increases in mortality**, while **Malaysia managed to sustain social protection programmes and showed no obvious change in death rates** (Waters, Saadah & Pradhan, 2003; Hopkins, 2006; Chang et al., 2009).
Time series analyses indicated that some of the crisis’s impact on male suicides was attributable to increases in unemployment. These findings suggest an association of the Asian economic crisis with a sharp increase in suicide mortality in some, but not all, East/Southeast Asian countries, and that these increases were most closely associated with rises in unemployment (Chang S et al. 2009).
Annual per capita gross domestic product (GDP) and unemployment rates between 1980 and 2002 in South Korea

Trends in age-standardized mortality rate per 100,000 for selected causes of death at age 35–79 in South Korea, 1990–2002

Age-standardised suicide rates for three age groups (15–34, 35–64 and 65+ year olds) in three East/Southeast Asian countries, 1985–2006

Cause-specific mortality rates (/100,000) and per capita income (GNI) by year for Japan, South Korea and Thailand

Relationship between unemployment and mortality

Associations of a 1% rise in unemployment with age-standardised mortality rates, by cause of death, in European Union countries, 1970–2007

Positive impact of the crisis?

Some researchers (Catalano & Bellows, 2005), have suggested that recessions may have a positive impact on health because increased leisure time allows people to engage in health-enhancing activities such as exercise, or to cut down on over-consumption of food and alcohol.
Trends in employment, smoking and obesity

Health policy responses to the financial crisis in Europe

Philipa Mladovsky, Divya Srivastava, Jonathan Cylus, Marina Karanikolos, Tamás Evetovits, Sarah Thomson, Martin McKee
Three main challenges for policy makers

• **Health systems require predictable sources** of revenue with which to plan investment, determine budgets and purchase goods and services. Sudden **interruptions to public revenue streams can make it difficult to maintain necessary levels of health care.**

• Cuts to public spending on health made in response to an economic shock typically come at a time **when health systems may require more, not fewer, resources** – for example, to address the adverse health effects of unemployment.

• **Arbitrary cuts to essential services may further destabilize the health system** if they erode financial protection, equitable access to care and the quality of care provided, increasing health and other costs in the longer term. In addition to introducing new inefficiencies, cuts across the board are unlikely to address existing inefficiencies, potentially exacerbating the fiscal constraint.

**Source:** Mladovsky et al (2012) Health Policy Responses to the Financial Crisis in Europe, Policy Summary, No.5, WHO Europe & European Observatory on Health Systems and Policies
Health policy responses to the financial crisis in Europe

– Policies intended to **change the level of contributions** for publicly financed health care
– Policies intended to **affect the volume and quality** of publicly financed health care
– Policies intended to **affect the costs** of publicly financed health care
Policies intended to change the level of contributions for publicly financed health care

<table>
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<th>National health budget</th>
<th>Fiscal policy</th>
<th>Statutory health insurance revenue</th>
<th>User charges (coverage depth)</th>
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<tr>
<td><strong>Cut in health budget:</strong> Bulgaria, Croatia, Estonia, Hungary, Iceland, Ireland, Italy, Greece, Latvia, Romania, Portugal, Spain.</td>
<td>Notwithstanding increases in <strong>taxes on alcohol</strong> and cigarettes, <strong>few countries have reformed fiscal policy</strong> to increase revenue for health system financing</td>
<td>Some countries <strong>increased employer/employee contribution</strong> rates either across the board or for specific population subgroups (Bulgaria, Greece, Portugal, Romania, Slovenia).</td>
<td>Several countries increased or introduced <strong>user charges for health services</strong> in response to the crisis (Armenia, Czech Republic, Denmark, Estonia, France, Greece, Ireland, Italy, Latvia, Netherlands, Portugal, Romania, Russian Federation, Slovenia, Switzerland, Turkey). In some countries, user charges were introduced or increased in the <strong>hospital</strong> sector (Armenia, Czech Republic, Estonia (for inpatient nursing care), France, Ireland, Romania, Russia). <strong>Pharmaceuticals</strong> were subject to increased user charges in several countries (Czech Republic, France, Ireland, Latvia, Portugal, Slovenia).</td>
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**Source:** Author’s elaboration based on Mladovsky et al (2012)
### Policies intended to affect the volume and quality of publicly financed health care

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<th>Health benefits (coverage scope)</th>
<th>Population coverage (coverage breadth)</th>
<th>Non-price rationing (waiting times, service dilution and delay)</th>
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<td>In general the statutory benefits package was not radically changed following the financial crisis, but some reductions were made, usually at the margin. For example, lower reimbursement of: dental care for certain population groups (Estonia, Ireland); IVF, physiotherapy, mental health services and coverage of care outside the EU (the Netherlands); cosmetic surgery (Portugal); non-acute spa treatment, certain medicines, non-urgent ambulance services, dental prostheses and some ophthalmologic appliances (Slovenia); eyeglasses (Switzerland); and temporary sickness benefits paid by the statutory health insurance fund (Estonia, Hungary and Lithuania)</td>
<td>The Czech Republic reported reducing entitlement at the margin by reducing statutory coverage for foreigners. Cyprus attributed its further postponement of implementation of universal coverage to the financial crisis. Several countries reported expanding statutory coverage for previously uninsured groups of people (Belarus, Bosnia and Herzegovina, Georgia, Republic of Moldova) or introducing universal coverage (the former Yugoslav Republic of Macedonia).</td>
<td>The Estonian Health Insurance Fund supervisory board attempted to ration the volume of care provided by deciding to increase maximum waiting times for outpatient specialists’ visits from four to six weeks in March 2009. No other countries reported increasing waiting as an explicit policy response to the financial crisis. Rather, in some countries health sector reforms may have inadvertently led to increases in waiting times, such as in Ireland, where changes in health policy have led to a 9% increase in the number of patients on a waiting list between 2009 and 2010.</td>
<td>Several countries increased taxes on alcohol and cigarettes (Bulgaria, Estonia and Ukraine, while the Czech Republic plans to do so in 2012) or pursued health promotion policies, such as encouragement for healthy eating, exercise and screening (Belgium, Bosnia and Herzegovina, Greece, Hungary, Republic of Moldova).</td>
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Source: Author’s elaboration based on Mladovsky et al (2012)
### Policies intended to affect the costs of publicly financed health care

<table>
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<th>Prices of medical goods</th>
<th>Salaries and motivation of health sector workers</th>
<th>Payments to providers</th>
<th>Overhead costs: restructuring the MoH and purchasing agencies</th>
<th>Provider infrastructure and capital investment</th>
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<tr>
<td>Many countries introduced or strengthened policies to <strong>reduce the price of medical goods</strong> (pharmaceuticals, medical devices and equipment) or <strong>improve the rational use of drugs</strong> (Austria, Belgium, Belarus, Bosnia and Herzegovina, Croatia, the Czech Republic, France, Estonia, Greece, Iceland, Ireland, Hungary, Latvia, Lithuania, Malta, Republic of Moldova, Poland, Portugal, Romania, Russian Federation, Serbia, Slovakia, Slovenia, Spain, the former Yugoslav Republic of Macedonia, Turkey). A <strong>wide variety of measures were used</strong>, including generic substitution, INN prescribing, claw-back mechanisms, price negotiations and lengthening prescription validity. In most cases these policies were part of <strong>ongoing reforms</strong>, but the crisis often prompted, speeded up or intensified implementation.</td>
<td>Some countries <strong>reduced the salaries of health professionals</strong> (Cyprus, France, Greece, Ireland, Lithuania, Romania), <strong>froze</strong> them (England, Portugal, Slovenia) or reduced their rate of increase (Denmark)</td>
<td>Several countries have reduced the <strong>tariffs</strong> (i.e. prices) paid to providers (Estonia, Ireland, Romania, Slovenia) or <strong>linked payment to improved performance</strong> to realize efficiency gains and contain costs (new contractual measures to manage provider costs in Bosnia and Herzegovina; reported plans to introduce diagnosis-related group (DRG) payments for inpatient care in Bulgaria and the Czech Republic; pay for performance (P4P) in Italy; per capita payment in primary care in Portugal; performance assessment and result-based financing in the Republic of Moldova).</td>
<td>Several governments are <strong>restructuring the Ministry of Health</strong>, statutory health insurance funds or other purchasing agencies in an attempt to reduce overhead costs and increase efficiency (Bulgaria, Croatia, the Czech Republic, England, Iceland, Latvia, Lithuania, Portugal, Romania).</td>
<td>In many countries, the economic crisis created an impetus to: <strong>speed up the existing process of restructuring the hospital sector through closures, mergers and centralization</strong> (Denmark, Greece, Latvia, Portugal, Slovenia); shift towards outpatient care (Belarus, Ireland, Greece, Lithuania); <strong>improve coordination with or investment in primary care</strong> (Armenia, Lithuania, Republic of Moldova, Netherlands); merge health centres (Iceland); and <strong>reorganize emergency medical services</strong> (the former Yugoslav Republic of Macedonia). Some countries abandoned (Romania) or stalled (Georgia) investment plans to build new hospitals, slowed modernization programmes involving upgrading of hospital and ambulance services (Armenia) and purchasing of expensive equipment (Belarus), or reduced the share of capital expenditure (Ukraine). In <strong>contrast</strong>, some countries increased funding for modernization of public health providers using resources from the mandatory health insurance fund (Republic of Moldova) or <strong>developed e-health systems</strong>, with the implementation of an integrated health management information system and electronic health card (Latvia, the former Yugoslav Republic of Macedonia) and a new electronic prescription system (Croatia).</td>
</tr>
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**Source:** Author’s elaboration based on Mladovsky et al (2012)
Policies targeting financial contributions to the health system

- The health levy (a surrogate income tax) was doubled to 4% in 2009 on all earnings up to €75,036 and raised to 5% on earnings above this amount.

- In 2011, the overall budget for health was down by €746 million (a year-on-year 6.6% cut for the Health Service Executive (HSE). Most of the budget reductions in 2010 and 2011 were achieved through cuts in public sector wages, reductions in the numbers working in

- In 2012, another €750 million is forecast to be taken out of the health system, this time coming from a reduction to frontline services with on average a 4% to 5% cut in provision despite a growing and ageing population

- User charges have also increased. For example, the 2010 budget introduced a 50 cent charge per prescription for all Medical Card holders, up to a maximum of €10 per family per month

Policies targeting volume and quality of care

- In 2009, the entitlement to Medical Cards was removed from the 12,100 wealthiest people aged over 70 (equivalent to 3.4% of people in this group).

- By December 2011, over 1.7 million people were covered by Medical Cards, up from 1.2 million in December 2007 – a 42% increase over 4 years. This reflects the policy objective to ensure that access to health care for the poor continued to be protected.

Policies affecting the costs of publicly financed health care

- Measures mainly in recruitment and salaries of health sector workers. In 2009, a moratorium was put in place on recruitment and promotion of health care personnel. The 2010 health budget introduced lower fees for contracted professionals (GPs and other health professionals), producing an estimated saving of €659 million; while in 2011, agency and locum staffing levels were lowered and early retirement and voluntary redundancies were proposed. In February 2012, a further 3,800 health service employees left the health system under an incentivized scheme.

- In 2009, an 8% reduction on all professional fees was imposed, as was a cut to pharmacy fees by 24% to 34%; and further cuts in fees of 5% for health professionals were introduced in 2010 and 2011

- Administrative costs were also targeted. In 2009, there was a commitment to reduce the HSE's administrative, management and advertising costs by at least 3%. Further cuts in administrative spending were introduced in the 2010 health budget, including reducing HSE staff by 6,000 (with savings of €300 million), as well as additional efficiencies within the HSE of €90 million. The 2011 budget proposed cuts in administration of €43 million.
In the context of the MOUs, public health expenditure must be reduced by 0.5% of Gross Domestic Product (GDP). Consequently, the health budget for 2011 decreased by €1.4 billion, with €568 million saved through salary and benefit-related cuts and €840 million saved through cuts in hospital operating costs.

User charges have increased. From 2011, the examination fee in out-patient departments of National Health Service (NHS) hospitals and primary care health centres increased from €3 to €5, with exemptions for certain vulnerable groups.

Since June 2011, the benefit packages of the various SHI funds have been rationalised and unified to provide the same reimbursable services across all health insurance funds. Such diagnostic tests used to be covered on an out-patient basis, even partially, but now they must be paid for out-of-pocket.

Regarding quality of care, significant increases in the number of admissions to public hospitals have been reported (at least 24% in 2010 compared with 2009) and 8% in the first half of 2011 compared with the same period in 2010. According to the General Secretariat of the Ministry of Health (MoH), out-patient visits to public health centres also increased by 22% in 2011 compared to the previous year.

However, considerable efforts also have focused on preventive action. For the period 2008 – 2012, quite a large number of health promotion initiatives have been established in the areas of cardiovascular disease, cancer, obesity, nutrition, oral health, and maternal and child health. A smoking ban in public places also has been implemented.

From 2011, cuts in the salaries of health care personnel have been implemented. For example, nurses’ salaries have been reduced by 14% compared with 2009. In addition, temporary staff employed under fixed-term contracts have not had their contracts renewed and there has been a significant reduction in the replacement levels of retiring staff (for every five people retiring only one will be appointed).

Secondly, policies are focusing on the cost of medical products, particularly pharmaceuticals. The MOU aims to save €2 billion from pharmaceutical products (with a target of €1 billion in 2011), thus reducing pharmaceutical expenditure by 1% of GDP.
Germany's Merck halts supply of cancer drug to Greek hospitals

Sat, Nov 3 2012

FRANKFURT (Reuters) - German pharmaceuticals firm Merck KGaA is no longer delivering cancer drug Erbitux to Greek hospitals, a spokesman said on Saturday, the latest sign of how an economic and budget crisis is hurting frontline public services.

Drugmakers raised concerns with EU leaders earlier this year over supplies to the euro zone's crisis-hit southern half and Germany's Biotest in June was the first to stop shipments to Greece because of unpaid bills.

Publicly-owned hospitals in some countries worst hit by the euro zone debt crisis had been struggling to pay their bills, Merck's chief financial officer, Matthias Zachert, was quoted as saying by German paper Boersen-Zeitung in an interview on Saturday.

He said however that the only country where Merck had stopped deliveries was Greece.

"It only affects Greece, where we have been faced with many problems. It's just the one product," he told the paper.

A spokesman for the company told Reuters that the drug concerned was Erbitux and that ordinary Greeks can still purchase it from pharmacies.

Some countries have taken action to pay bills, such as in Spain, where the government has said it will help hospitals to pay off debts.

"That has improved things, even though the situation should still be regarded as critical for the coming years," Zachert said.

Erbitux is Merck's second best-selling prescription drug, bringing in sales of 855 million euros ($1.1 billion) in 2011 from treating bowel cancer and head and neck cancer. ($1 = 0.7785 euros)

(Reporting by Frank Siebelt and Victoria Bryan; editing by Patrick Graham)
The assault on universalism: how to destroy the welfare state

Sociology

Reforming drug co-payments in Spain: One step forward, two steps back

The economic crisis is being accompanied by a series of profound reforms in the health sector that are having a significant impact on the population’s well-being. One of the most substantial issues, and in recent weeks one of the most hotly debated in Spain, revolves around the issue of co-payments for prescription drugs.

Pharmaceutical expenditure in Spain is characterized by several paradoxes: while the average price of drugs tends to be lower in comparison to other European countries (1), Spain’s per capita expenditure is one of Europe’s highest (2), due largely to the elevated number of prescriptions per patient and year (3). As it is said from the health economics’ perspective, we have a demand-side problem not a supply-side problem.
Conclusions

European Region countries have employed a mix of policy tools in response to the financial crisis. Some countries seem to have used the crisis to increase efficiency, although little has been done to enhance value through policies to improve public health, which is a missed opportunity.
Recommendations – by Stuckler

• Active Labour Market Programmes

• Health Stimulus Funding

• Evidence-Based Crisis Response Plan

*Source: EUPHA 2011
Thank you very much for your attention

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