World Health Organization
REGIONAL OFFICE FOR Europe

SUMMARY

Health, health systems and economic crisis in Europe

Impact and policy implications

Draft for review

European Observatory on Health Systems and Policies
a partnership hosted by WHO

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Contents

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1 About the study

The global financial crisis of 2008 has turned into an economic crisis that, five years on, is far from over in Europe. Financial and economic distress has already had wide-reaching social and political consequences, but some of the most devastating consequences may be yet to come. Although the economic situation in many countries looks better now than it did a year ago, there is little reason to be optimistic when we consider the human cost of falling incomes, growing inequalities and huge increases in unemployment, particularly among young people.

Since 2008 the WHO Regional Office for Europe has engaged with Member States affected by the financial and economic crisis to support policy decisions that protect health and reduce inequalities in health. WHO's engagement is based on Health 2020 and its strong emphasis on improved health outcomes, solidarity and equity. The values, objectives and priorities of the European Health Policy adopted by the WHO Regional Committee for Europe in 2012 provide a framework for integrated and systematic action.

This document summarises preliminary findings from a new study analysing the effects of the crisis on health and health systems in Europe. The study is being carried out by the WHO Regional Office for Europe and the European Observatory on Health Systems and Policies. A full draft of the study will be available in September 2013 and published by the Open University Press in December 2013.

The study analyses:

- macro-economic and fiscal trends
- trends in health care expenditure
- health system responses to the crisis
- the impact of the crisis on health system performance
- the impact of the crisis on health
- lessons for policy.

It draws on four sources of information:

- A survey of countries in WHO's European Region carried out in two waves. The first wave involved 45 key informants in 45 countries and covered health system responses up to the end of March 2011.[1] The second wave involved 95 key informants in 47 countries and covered health system responses up to the end of January 2013. Across the two waves, no information was available for Andorra, Luxembourg, Monaco, San Marino and Turkmenistan.
- Detailed case studies of the situation in seven countries: Estonia, Greece, Ireland, Latvia, Lithuania, Portugal and Spain. Each case study discusses the nature of the crisis and the nature of the health system's response to the crisis. The countries were selected from a group of countries identified as being heavily affected by the crisis in different ways. Case studies were written by national experts and academic researchers in each of the countries based on a standard template. Initial results were discussed at an author workshop in January 2013.
- Analysis of statistical data from WHO, Eurostat and OECD.
- A review of the literature.

The findings summarised here are preliminary. Although the survey results have been validated, neither they nor the case studies have been formally reviewed.

[1] 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: World Health Organization on behalf of the European Observatory on Health Systems and Policies; 2012. http://www.euro.who.int/__data/assets/pdf_file/0009/170865/e96643.pdf

2 Macro-economic trends and public finances, 2008–2013

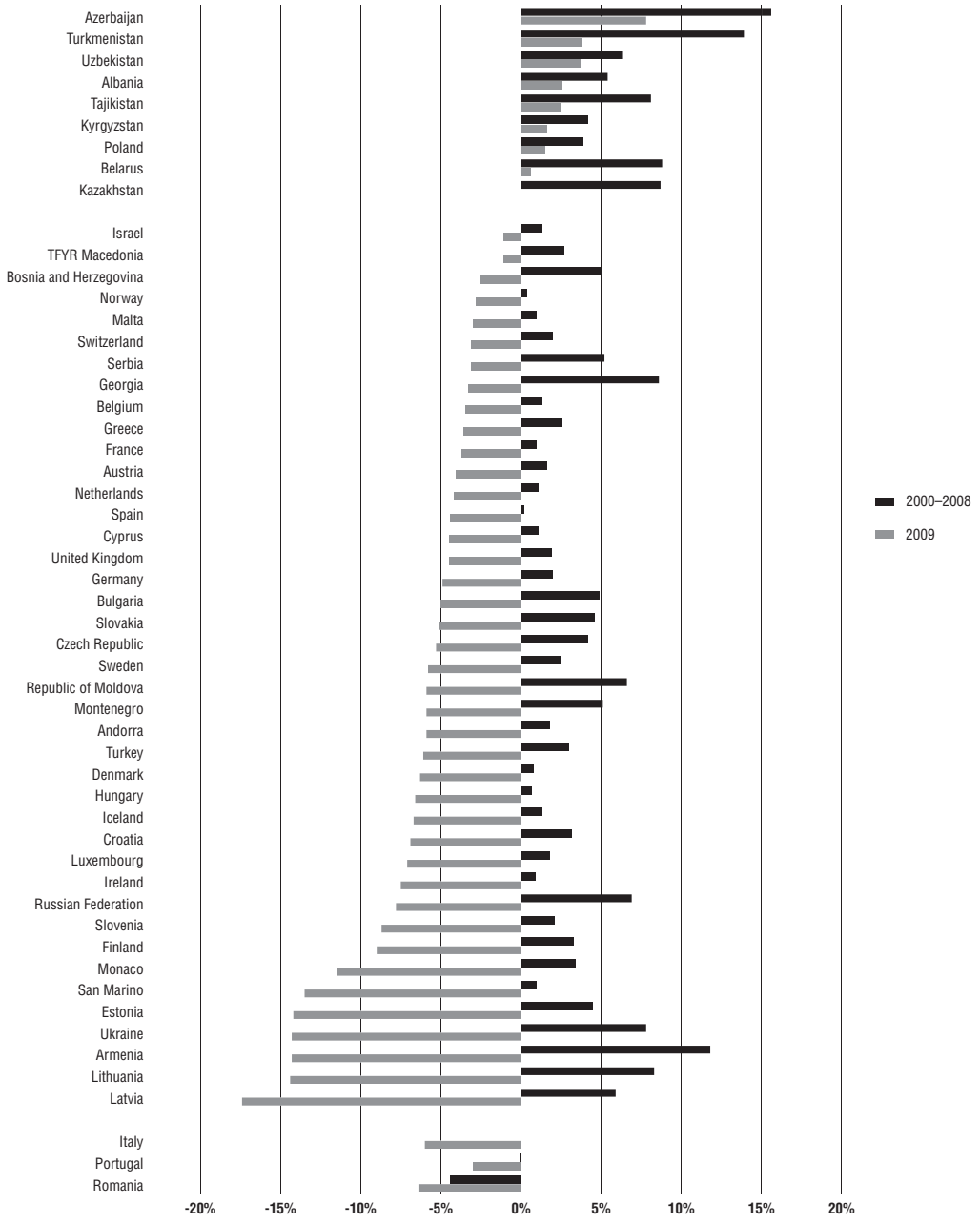
This section briefly reviews the impact of the financial and economic crisis on GDP, unemployment and public finances in Europe. It provides some context for the discussion of the health and health system implications of the crisis in the following sections.

2.1 Falling GDP

Across the European Region the shock of the global financial crisis led to a decline of 4.5% in real GDP per capita in 2009, bringing to an end a decade of economic growth (Figure 1). Poland was the only country in the European Union (EU) not to experience a fall in GDP in 2009. GDP grew in many EU countries in 2010 and 2011, but in half of them GDP fell again in 2012 and little or no growth is expected in 2013.

Some countries in the European Region have not been affected by what many now call the 'Great Recession'. GDP has continued to grow in countries such as Albania, Azerbaijan, Belarus, Kazakhstan, Kyrgyzstan, Poland, Tajikistan, Turkmenistan and Uzbekistan.

Figure 1. Falling GDP in 2009 contrasts with GDP growth since 2000: average annual change in real GDP per capita, WHO European Region, 2000–2008 and 2009



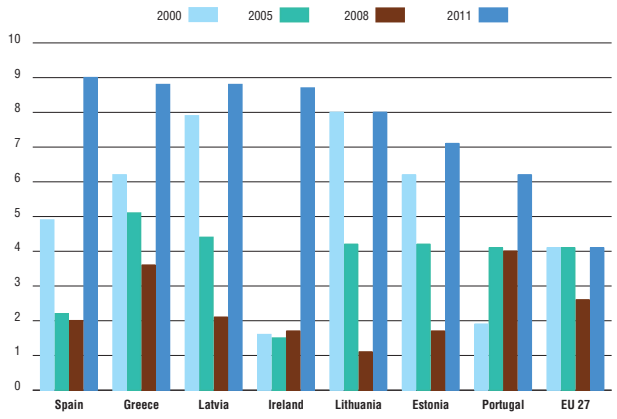
Source: National Health Accounts data[2]

[2] http://www.who.int/nha/en/

2.2 Rising unemployment

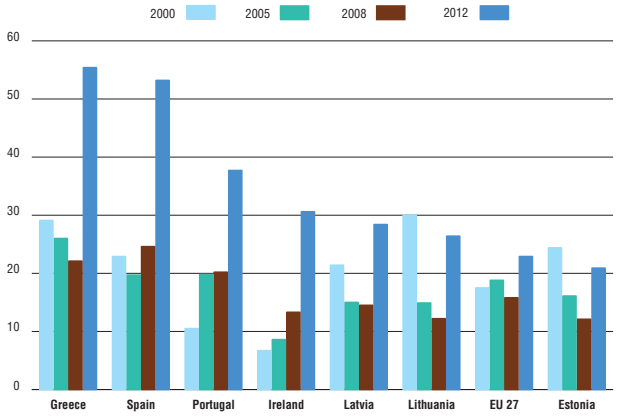
The crisis has led to sharp increases in unemployment. Unemployment in the EU rose from an average of 7.1% of the population in 2008 to 9.7% in 2010 and 10.5% in 2012. Estonia, Ireland, Latvia and Lithuania experienced the largest increases in unemployment between 2007 and 2010 but from relatively low levels (around 5% in 2007 tripling to around or over 15% in 2010) and unemployment is now falling in the Baltic states.[3] In countries such as Portugal, Greece and Spain unemployment has also risen to very high levels as a result of the crisis and continues to grow, reaching 16%, 24% and 25% respectively in 2012. Long-term unemployment levels have quadrupled in many of these countries (Figure 2), while youth unemployment has reached rates of over 50% in Greece and Spain (Figure 3). Countries such as Bosnia and Herzegovina and the former Yugoslav Republic of Macedonia did not experience a dramatic rise in unemployment but already had very high levels at the onset of the crisis (over 20% and 30% respectively in 2008).[4]

Figure 2. Long-term unemployed as a share (%) of the active population, EU 27 and selected countries, 2000–2011



Source: Eurostat[5]
Note: Not seasonally adjusted data

Figure 3. Unemployment among people aged less than 25 years (%), EU 27 and selected countries, 2000–2012



Source: Eurostat[6]
Note: Not seasonally adjusted data

2.3 Growing indebtedness and higher borrowing costs

As a result of falling GDP and growing unemployment government finances have deteriorated – a situation compounded by increases in the cost of borrowing. Higher borrowing costs reflect a range of economic and political factors. Government debt as a share of GDP was already high in some countries in 2008 and pressure caused by the crisis – in particular a collapse of tax revenues – rapidly raised new doubts about these countries' ability to meet their financial obligations. Other countries had maintained low levels of debt but failures in the financial services sector led to high levels of private debt requiring public funding to avoid a banking collapse. In a handful of countries the cost of borrowing reached the point at which international financial assistance was needed and economic adjustment programmes were imposed by the European Commission, the European Central Bank and the International Monetary Fund.

Government debt as a share of GDP has risen sharply, particularly in the European Union, and some governments have faced large increases in the cost of borrowing. At the same time the availability of credit for private sector investment has declined; household purchasing power has fallen as unemployment has increased and wages are frozen or falling. These factors have compounded the constrained fiscal position of governments.

[3] EU unemployment data in this section are from Eurostat http://appsso.eurostat.ec.europa.eu/nui/show.do?dataset=une_rt_a&lang=en

[4] World Bank data http://data.worldbank.org/indicator/SL.UEM.TOTL.ZS

[5] http://appsso.eurostat.ec.europa.eu/nui/show.do?dataset=une_ltu_a&lang=en

[6] http://appsso.eurostat.ec.europa.eu/nui/submitViewTableAction.do

3 Changes in public spending on health, 2008–2011

This section briefly reviews changes in public spending on health based on analysis of statistical data. There is more discussion of the ways in which national health budgets were affected by the crisis in section 5.1.

3.1 Levels of public spending on health

In many countries public spending on health has declined since 2008. Table 1 lists the countries in which per capita spending on health by government fell, relative to the previous year, between 2008 and 2011. Countries shown in bold experienced reductions in spending in more than one year.

Table 1. Countries with a reduction in per capita public spending on health (national currency units), 2008–2011

2008	2009	2010	2011
Andorra	**Andorra**	Albania	**Andorra**
France	Bulgaria	**Armenia**	**Armenia**
Luxembourg	**Croatia**	**Croatia**	**Czech Republic**
Malta	**Estonia**	**Czech Republic**	Germany
	Hungary	**Estonia**	**Greece**
	Ireland	Finland	**Ireland**
	Latvia	**Greece**	Netherlands
	Lithuania	Iceland	Portugal
	FYR Macedonia	**Ireland**	Slovakia
	Romania	**Latvia**	**Spain**
	San Marino	**Lithuania**	United Kingdom
		Montenegro	
		Slovenia	
		Spain	

Source: Authors' calculations based on WHO National Health Accounts[7]
Note: Countries shown in bold experienced reduced spending in more than one year

Figure 4 provides a more detailed breakdown of reductions in public spending on health in selected countries between 2008 and 2012. It shows significant variation across countries in the magnitude, duration and timing of reductions in the health budget. Estonia, Latvia and Lithuania only experienced two years of lower spending, in contrast to three or more years in Greece, Ireland and Portugal.

3.2 The public share of total spending on health

Between 2008 and 2010 the public share of total spending on health remained stable in over half of the countries in the European Region. It fell in 22 countries, although in most countries the reduction was small – above 5 percentage points in the former Yugoslav Republic of Macedonia, Ireland and the Russian Federation only.

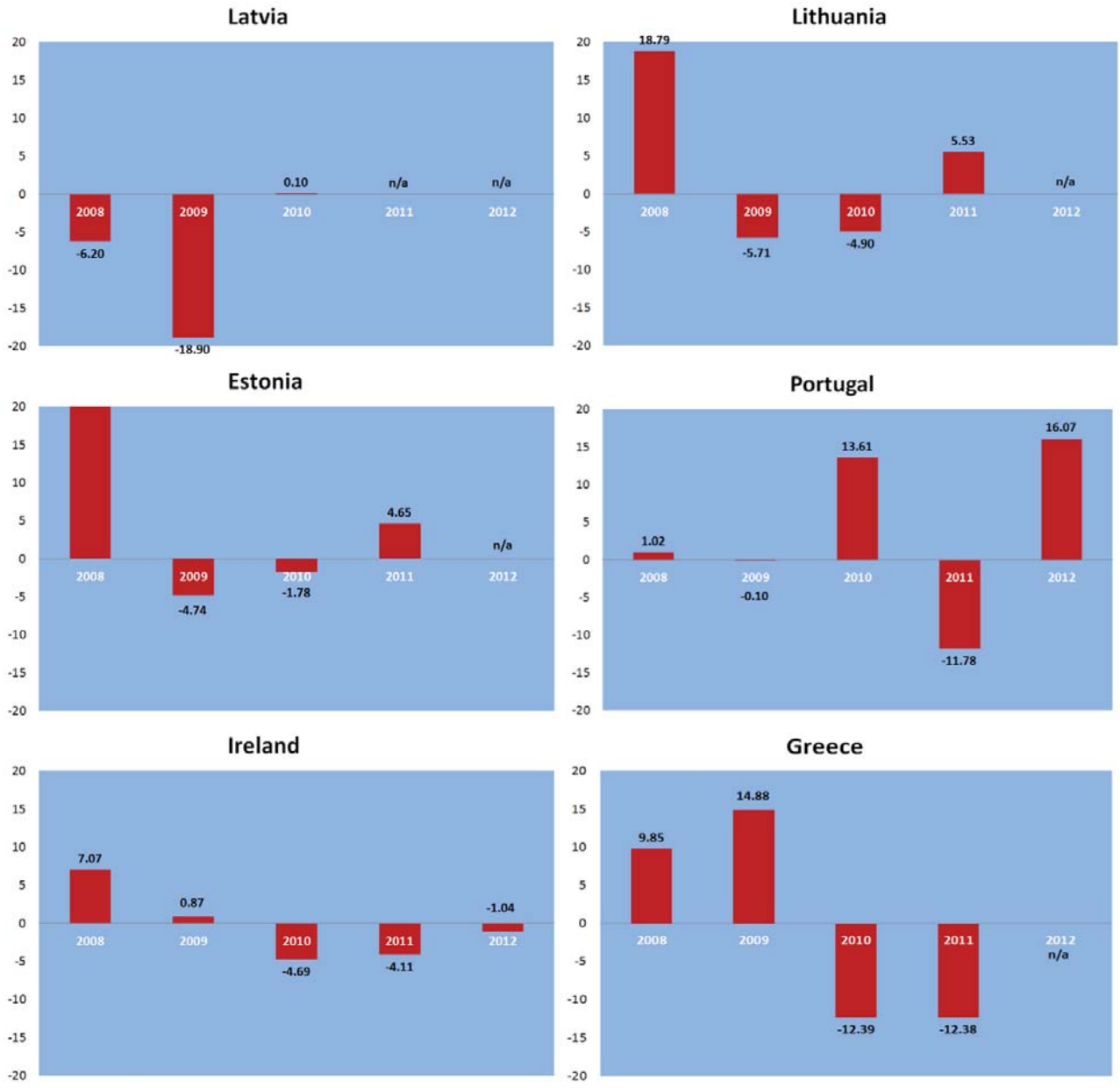
Among countries that already had high levels of private spending in 2008 – defined here as over 30% of total spending on health – the public share fell by more than 2 percentage points in Albania, Armenia, Bulgaria, Hungary, Latvia, the former Yugoslav Republic of Macedonia, Russian Federation and Slovakia but grew in Andorra, Azerbaijan, Belarus, Bosnia and Herzegovina, Cyprus, Georgia, Greece, Kazakhstan, Kyrgyzstan, Malta, Switzerland, Tajikistan, Turkmenistan and Uzbekistan.

3.3 The health share of the government budget

On average, the health sector accounts for about 13% of government spending in the European Region. The health share of the government budget rose or remained stable in many countries in 2010, but fell in around 20 countries. The largest falls, of around 1 percentage point, were in Iceland and Ireland. About half of all EU countries experienced a decline in the health share of government spending between 2007 and 2010, including in some of the countries most affected by the crisis (Ireland, Latvia, Lithuania, Portugal, Spain).

[7] http://www.who.int/nha/en/

Figure 4. Annual change in public spending on health (national currency units), selected countries, 2008–2013



Source: Authors' calculations based on national data
Note: n/a = data not available

4 Implications for population health

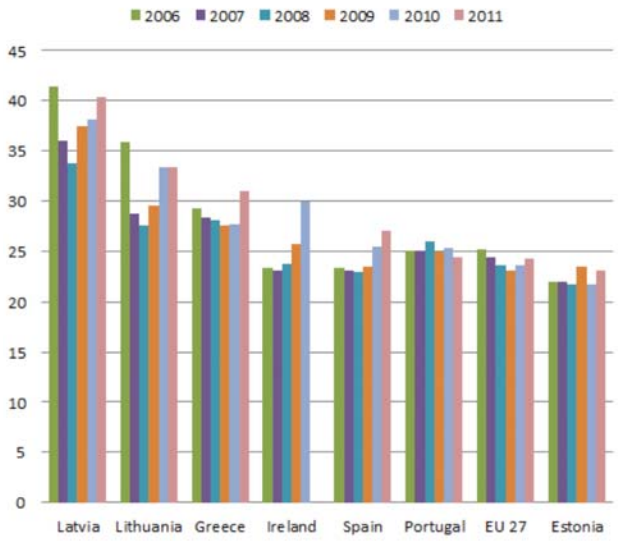
This section briefly summarises evidence on the impact of earlier recessions on health and evidence on the health effects of the current crisis.

4.1 The health impact of economic recession: evidence from earlier recessions

The health impact of economic recession varies across countries and across population sub-groups within countries. There is now an extensive volume of research from earlier recessions showing that the fiscal response of a country to recession – the extent to which it chooses to follow a path of austerity rather than one of countercyclical spending – and the presence of effective social safety nets affect the magnitude of the risk of ill health.[8]

As health needs are likely to increase as household incomes fall (Figure 5), the policies introduced in response to fiscal tightening may have an added effect on population health.[9] Thus, if some services have insufficient capacity to respond to increased need for treatment or experience cutbacks, there may be additional costs (financial and human) as a consequence of patients failing to obtain timely and effective care.

Figure 5. Change in the share of the population at risk of poverty or social exclusion, EU27 average and selected countries, 2006–2011 (or latest available year)



Source: Eurostat[10]

[8] Report on social determinants of health and the health divide in the WHO European Region. Copenhagen, WHO Regional Office for Europe (forthcoming 2013).

[9] European Health Report 2012 http://www.euro.who.int/en/what-we-do/data-and-evidence/european-health-report-2012/chapter-1.-where-we-are-health-status-in-europe-and-the-case-for-health-2020

[10] http://appsso.eurostat.ec.europa.eu/nui/show.do

4.2 The health impact of the current crisis

Quantifying the health effects of the crisis has been difficult and delayed due to lack of timely and relevant data on health status. In some countries, even the most basic mortality data are several years old, making it nearly impossible to draw up to date conclusions on the effect of the crisis on health. Moreover, there are few data on morbidity and health care utilisation and the available data are rarely internationally comparable. Repeated delays in establishing the European Health Interview and Examination Surveys have placed Europe at a significant disadvantage in assessing the human cost of the crisis and the impact of government policies introduced in response to the crisis.

There have been few targeted studies to quantify the health effects of government policies introduced in response to the crisis. Uptake of research findings to develop more effective policies to protect health and address social inequalities has also been limited. The following paragraphs highlight the already considerable consequences of the crisis and of austerity measures for the health of Europe's citizens.

Mental health has been the area most sensitive to economic changes so far. A long-term decline in suicides in the European Union has been reversed,[11] with increases concentrated among men of working age.[12] In the newest EU Member States suicides peaked in 2009 and remained high in 2010.[13] In other Member States further increases were observed in 2010 Research in England has confirmed the close association with job losses.[14] with other research identifying an association with unemployment and the fear of unemployment.[15]

Beyond the bare statistics, there have been many media accounts of suicides associated with the consequences of austerity policies, which in some countries have led to widespread public protests and a rolling back of more draconian measures.[16] However, suicides are only the tip of the mental health iceberg and research in a number of countries has shown marked increases in depression

[11] STUCKLER D, BASU S, SUHRCKE M, COUTTS A & MCKEE M (2011). Effects of the 2008 recession on health: a first look at European data. *Lancet*, 378, 124–5.

[12] BARR B, TAYLOR-ROBINSON D, SCOTT-SAMUEL A, MCKEE M & STUCKLER D (2012). Suicides associated with the 2008–10 economic recession in England: time trend analysis. *BMJ*, 345, e5142.

[13] STUCKLER D, BASU S, SUHRCKE M, COUTTS A & MCKEE M (2011). Effects of the 2008 recession on health: a first look at European data. *Lancet*, 378, 124–5.

[14] BARR B, TAYLOR-ROBINSON D, SCOTT-SAMUEL A, MCKEE M & STUCKLER D (2012). Suicides associated with the 2008–10 economic recession in England: time trend analysis. *BMJ*, 345, e5142.

[15] LEWIS G & SLOGGETT A 1998. Suicide, deprivation, and unemployment: record linkage study. *BMJ*, 317, 1283–6.

[16] BBC NEWS (2013). *European court rules against Spanish eviction laws (14/03/2013)* [Online]. Available: http://www.bbc.co.uk/news/world-europe-21789650 [Accessed 25/03/2013.]

and anxiety,[17] with one study demonstrating a strong association with job loss and mortgage foreclosure.[18] A small Greek study of people experiencing job loss suggests job loss may be associated with an increase in deaths from myocardial infarctions.[19]

It is difficult to predict how infectious diseases will respond to an economic crisis. The response depends on the presence of foci of infection and the means of transmission (such as insect vectors) in a population, as well as the extent to which investment in public health surveillance and control is maintained. Well-documented outbreaks in some of the countries that have experienced the deepest austerity measures include the re-emergence of malaria and transmission of dengue fever.[20] Greece has seen a major upsurge in HIV infections among intravenous drug users, coinciding with substantial reductions in funding for needle exchange programmes.[21]

A long-term decline in infant mortality has been reversed in Greece since 2008, with two consecutive years of increases.[22] At the same time there has been a 32% increase in the number of stillbirths.[23]

Changes in household incomes as a result of growing unemployment have an effect on risky behaviours such as levels of smoking and alcohol consumption. Recessions also have an effect on deaths from road traffic accidents, which tend to decline, reflecting lower car use. A reduction in road traffic deaths has been observed in several European countries, especially where rates were initially high.[24] The situation in relation to alcohol is more complicated. Research in the United States indicates that overall consumption may fall during a recession, reflecting affordability, but hazardous consumption by those already at risk may increase.[25] Unfortunately, evidence from Europe is so far limited.

Research so far has concentrated on health outcomes where the lag between economic downturns and death or disease is short, such as mental health outcomes, infections and injuries. However, it is very likely that there will be effects on health that may not manifest themselves for some time. These may arise from changes in population access to needed services, such as proper management of chronic disease with patient participation and adherence to treatment. There are increasing accounts, especially from Greece and Spain, of growing difficulties in accessing necessary care. Some countries have made considerable efforts to absorb health budget reductions by reducing the cost of publicly financed services (e.g. the price of pharmaceuticals and public sector salary levels), thereby protecting access to needed services. However, other policy changes such as the closure of facilities, reductions in staffing and reduced opening times, as well as higher user charges, can be expected to restrict access. By deterring access to timely and effective care, these changes are likely to incur greater financial and human costs, for example by increasing the risk of amputations, blindness or renal failure among people with diabetes or suicides among those with mental health problems.[26] So far, however, there has been no detailed research on this issue.

[17] ECONOMOU M, MADIANOS M, PEPPOU L E, PATELAKIS A & STEFANIS C N (2013). Major depression in the Era of economic crisis: A replication of a cross-sectional study across Greece. *J Affect Disord*, 145, 308–14.
COSTA G, MARRA M, SALMASO S & GRUPPO A (2012). [Health indicators in the time of crisis in Italy]. *Epidemiol Prev*, 36, 337–66.
KATIKIREDDI S V, NIEDZWIEDZ C L & POPHAM F (2012). Trends in population mental health before and after the 2008 recession: a repeat cross-sectional analysis of the 1991–2010 Health Surveys of England. *BMJ Open*, 2.

[18] GILI M, ROCA M, BASU S, MCKEE M & STUCKLER D (2012). The mental health risks of economic crisis in Spain: evidence from primary care centres, 2006 and 2010. *European Journal of Public Health*, doi: 10.1093/eurpub/cks035.

[19] DRIVAS S, RACHIOTIS G, STAMATOPOULOS G, HADJICHRISTODOULOU C & CHATZIS C (2013). Company closure and mortality in a Greek bus company. *Occup Med (Lond)*.

[20] BONOVAS S & NIKOLOPOULOS G (2012). High-burden epidemics in Greece in the era of economic crisis. Early signs of a public health tragedy. *J Prev Med Hyg*, 53, 169–71.
SOUSA C A, CLAIROUIN M, SEIXAS G, VIVEIROS B, NOVO M T, SILVA A C, ESCOVAL M T et al. (2012). Ongoing outbreak of dengue type 1 in the Autonomous Region of Madeira, Portugal: preliminary report. *Euro Surveill*, 17.

[21] ECDC 2012. Risk assessment on HIV in Greece. Technical report. Stockholm: European Centre for Disease Prevention and Control.

[22] EUROSTAT 2013. *Statistics database* [Online]. European Commission. Available: http://epp.eurostat.ec.europa.eu/portal/page/portal/statistics/search_database [Accessed 25/03/2013.]

[23] VLACHADIS N & KORNAROU E (2013). Increase in stillbirths in Greece is linked to the economic crisis. *BMJ*, 346, f1061.

[24] STUCKLER D, BASU S, SUHRCKE M, COUTTS A & MCKEE M (2011). Effects of the 2008 recession on health: a first look at European data. *Lancet*, 378, 124–5.

[25] BOR J, BASU S, COUTTS A, MCKEE M & STUCKLER D (2013). Alcohol use during the Great Recession of 2008–2009. *Alcohol Alcohol*.

[26] MCDAID D, SASSI F, MERKUR S, eds. Promoting health, preventing disease: the economic case. Maidenhead, Open University Press (forthcoming 2013).

5 Implications for health system performance

This section draws on the survey and case studies to summarise health system responses to the crisis and to discuss the implications of these responses for health system performance. We acknowledge the difficulty of saying with certainty how responses to the crisis have affected health systems. Policy changes cannot be fully evaluated outside the context in which they are introduced and many have not been evaluated at all. Some changes have been reversed due to opposition or an improvement in public finances. Longer-term effects may not yet be evident. Comparative analysis presents further challenges and monitoring trends is sometimes complicated by changes in important survey questions. As a result the discussion in this section is general and tentative.

When faced with financial pressure, policy makers can try to:

- meet spending commitments by maintaining or increasing public funding for health care; this may involve depleting reserves, increasing deficit financing or changing the mix of public funding sources by introducing new taxes or new earmarking for health
- reduce public spending on health care by changing the breadth, scope and depth of coverage
- obtain more from available resources by improving efficiency.

We discuss policy changes in each of these three areas.

5.1 Maintaining public funding for the health system

Ensuring that levels of public funding for health care are adequate, public revenue flows are predictable and revenue is raised in a way that does not unfairly burden households is essential to safeguarding equitable access to needed health services.

About twenty countries reported that the national health budget was smaller as a result of the crisis due to deliberate adjustments, rises in unemployment or a combination of the two. The extent to which having a smaller budget for health care is problematic depends on a range of factors in addition to the magnitude, timing and duration of budgetary reductions illustrated in Figure 2. Countries are likely to find it difficult to cope with budget shortfalls if demand for publicly financed health care is rising; entitlement to publicly financed health care is means tested and incomes are falling; automatic stabilisers are absent; and public spending as a share of total spending on health care is low.

Ireland is a case in point. The previous section has shown how growing unemployment and poverty are likely to increase demand for health care in many European countries in the medium to longer term. In Ireland, however, they had an immediate effect on the health system. As the share of the Irish population at risk of poverty has grown (Figure 3), so has the share eligible for access to publicly financed health care, which is subject to a means test. Between 2008 and 2012 the share of the population entitled to free primary care rose by more than 10 percentage points, from 32% to 43%. The Irish Department of Health has had to cover the cost of this extra demand for publicly financed health care with a budget that is now in its fourth year of cuts and may be cut again in 2014. Cyprus, another country that relies on means-tested access to health care, may soon find itself in a similar situation.

Health systems that rely heavily on the labour market to finance health care can also be badly affected during an economic crisis if there are no automatic stabilisers in place to smooth the flow of funds to the health sector. The government budget may be shrinking just as earmarked revenues from wage-based contributions are falling, jeopardising the ministry of health's ability to transfer funds to the health insurance system. In such cases countries that do not have robust mechanisms for government budget transfers or health insurance reserves – automatic stabilisers with a countercyclical effect – may face particular challenges.

The countries we surveyed reported adopting a range of strategies to compensate for reduced revenue for the health sector. These efforts were concentrated in countries that mainly finance health care through employment.

5.1.1 Raising contributions and broadening the revenue base

Several countries tried to generate additional revenue for the health insurance system by:

- increasing contribution rates across the board (Bulgaria, Montenegro, Netherlands)
- raising the ceiling on contributions (Bulgaria, Czech Republic for self-employed people, Netherlands)
- broadening the revenue base by extending contributions to non-wage income such as dividends (Slovakia) and pensions (Croatia, Greece for civil servants, Portugal for civil servants, Romania for wealthier pensioners) or to self-employed people (Slovenia) and redundancy payment (France)
- enforcing revenue collection (Hungary).

However, to avoid further pressure on the labour market some countries:

- reduced employee contributions (Croatia, Germany, Moldova, Montenegro)
- reduced employer contributions (Hungary).

To limit the government's exposure to health insurance costs some countries have reduced or fixed employer contributions for public sector workers (Greece, Portugal).

5.1.2 Increasing transfers from government budgets

Some countries tried to maintain or increase the level of government budget transfers to the health insurance scheme (Germany, Hungary, Lithuania, FYR Macedonia, Montenegro, Romania, Switzerland). In contrast, others reduced them (Finland, mainly targeting drug reimbursement; Slovakia).

5.1.3 Automatic stabilisers: reserves and countercyclical formulas

In some countries the health budget was protected by measures introduced in anticipation of an economic shock, including:

- health insurance fund reserves (Czech Republic, Estonia, Slovenia)
- countercyclical formulas for government budget transfers (Lithuania, Slovakia).

5.1.4 Introducing new taxes

A few countries adapted fiscal policy to offset the effects of the crisis on the health budget by:

- increasing the share of non-wage taxes allocated to health care (France, capital gains tax; Italy, in regions with substantial deficits in the health sector)
- introducing new taxes earmarked for social security including health (France, Hungary) and for public health programmes (Hungary).

5.1.5 Targeting to protect people with low incomes

Several countries took steps to protect people with low incomes when attempting to secure revenue for the health sector:

- selectively reducing contributions for people with low incomes (pensioners in Montenegro)
- selectively increasing contributions for wealthier people (self-employed people with very high incomes in France, wealthier pensioners in Romania)
- reducing employer contributions for public sector workers (Portugal, for schemes that disproportionately benefit wealthier workers and pensioners)
- abolishing tax subsidies for wealthier households (Portugal).

5.1.6 Implications for adequacy, stability and fairness in health financing

Falls in the health share of the government budget may have a negative effect on the adequacy of public resources for health care, particularly when unemployment and poverty are placing greater demands on the health system. EU countries have been particularly affected in this respect; about half experienced a decline in the health share of government spending between 2007 and 2010, including in some of the countries hit hardest by the crisis (Ireland, Latvia, Lithuania, Portugal, Spain). During an economic crisis, countries with means-tested entitlement to publicly financed health care are especially likely to struggle as a result of budget cuts (Cyprus, Ireland).

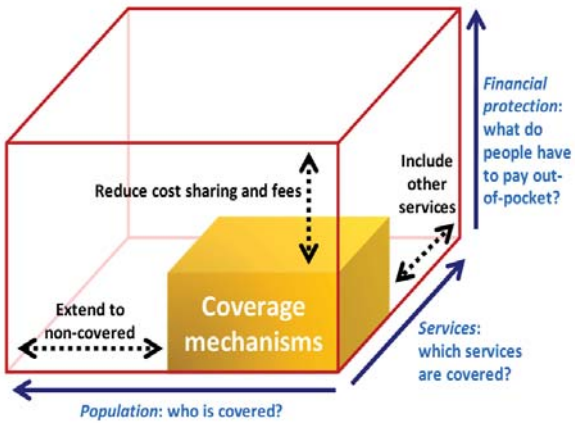
Health systems require stability in revenue flows. Those that rely heavily on the labour market to finance health care are particularly vulnerable to economic fluctuation. During the crisis automatic stabilisers such as reserves and countercyclical formulas were critical to ensuring stability in countries such as Estonia and Lithuania. However, political constraints prevented the Estonian Health Insurance Fund from making full use of its reserves. Had the Fund been able to rely fully on its reserves, it would not have had to have cut coverage to the same extent (see below). Some countries without automatic stabilisers were able to act quickly to protect government budget transfers to the health insurance system or secure additional funding by introducing new taxes, new earmarking of existing taxes or better enforcement of revenue collection. A handful of countries increased taxes on unhealthy goods such as tobacco and alcohol, which were already earmarked for health, but we do not know whether these increases provided additional revenue for the health sector. In general, the primary aim of taxing unhealthy goods is to change behaviour rather than to raise revenue.

Reductions in the public share of total spending on health care may lower fairness in financing the health system because public sources of finance are generally much less regressive than private sources. The public share did not fall by much in many countries but even a relatively small decline might be a cause for concern where levels of private spending on health care are already high. Changes likely to have had a positive effect on fairness in financing include higher contribution ceilings, broadening the public revenue base to include non-wage income, targeted reductions in contributions for lower-income households and targeted reductions in tax subsidies for wealthier households. For example, Portugal has abolished one tax subsidy for wealthier people and is attempting to reduce another that disproportionately benefits wealthier people.

5.2 Reducing health coverage

Levels of health coverage determine the extent to which people are protected from the financial consequences of ill health (financial protection) and have access to needed services. When public resources for health care are limited, policy makers may try to relieve financial pressure by reducing coverage. Coverage has three dimensions (Figure 6):

Figure 6. Dimensions of health coverage



Source: WHO[27]

[27] World Health Report (2010). Health systems financing – the path to universal coverage. http://www.who.int/whr/2010/en/index.html

- the population covered: 'breadth' or universality
- the range of services covered: the 'scope' of the benefits package
- the share of service cost covered: 'depth', whether or not people have to pay user charges for covered services.

By reducing any aspect of publicly financed coverage policy makers are effectively shifting costs to individuals. This creates opportunities for private finance in the form of out-of-pocket payments (including user charges) and voluntary (private) health insurance. As a result we would expect to see an increase in private spending on health care.

Key issues include the extent to which increased reliance on private finance (as a result of reductions in coverage) relieves rather than exacerbates financial pressure; strengthens rather than undermines health system performance; and, in particular, enhances or at least does not lower efficiency in the allocation and use of public resources.

Reductions in coverage may not undermine performance if they are selective, systematically informed by evidence of cost-effectiveness (value) and do not damage equitable access to effective and needed health services. In contrast, reductions that are made across the board, without any attempt to prioritise or protect access to cost-effective care, are highly likely to result in worse outcomes and greater inefficiency.

Many of the countries we surveyed reported reductions in coverage. Reductions were generally at the margin, mainly affected coverage scope (benefits) and depth (user charges) and were often accompanied by efforts to protect poorer people from higher user charges. Countries that restricted coverage may have done so from a relatively generous starting point and may still offer better coverage than countries that did not introduce changes in response to the crisis.

5.2.1 Reducing population coverage

Removing entitlement from parts of the population can present an important financial risk to the government, in addition to obvious political and health risks. The magnitude of the financial risk depends on policy design. Excluding people from publicly financed coverage may exacerbate rather than relieve financial pressure if it is richer people who are excluded or if their exclusion is financially compensated by the government – for example, if they no longer have to pay contributions or if the government gives them tax subsidies for private spending on health care.

Countries did not report attempting to exclude richer people from coverage. Some countries with universal entitlement:

- removed entitlement for people without permanent resident status (Czech Republic, Spain)
- changed the basis for entitlement from residence to insurance status (Spain, for people aged over 18).

Some countries without universal entitlement:

- delayed implementation of proposed coverage expansions (Cyprus, Ireland)
- removed entitlement for specific groups of people (Cyprus is instructed to abolish beneficiary class 'B'; Ireland abolished entitlement to free primary care for wealthier people aged over 70)
- expanded coverage for people who are unemployed for longer periods – a particularly vulnerable group of the population (Estonia now provides access to free emergency care for people who are registered unemployed for more than nine months; Greece only covers unemployed people aged between 29 and 55 for two years but from 2014 the government will grant free access to treatment in public hospitals to long-term unemployed people and families living below the poverty line).

As a result of many of these changes some people are likely to be worse off in terms of access to health care, particularly as user charges have also increased in the countries concerned (albeit from a relatively low level in the Czech Republic and Spain).

5.2.2 Streamlining the benefits package

The crisis presented countries with an opportunity to tackle the often politically challenging task of streamlining the benefits package. Reducing coverage of services known to be of low value (non-cost-effective) may not generate substantial net savings but it is likely to enhance efficiency in public spending on health care.

In spite of severe financial pressure, countries did not report making changes to the benefits package based on evidence of cost-effectiveness. A few reported efforts to distinguish more clearly between what is and is not (fully) covered (Czech Republic, Spain) and plans to make greater use of health technology assessment (Czech Republic, Estonia, Spain). Several reported efforts to promote more cost-effective use of prescription drugs (see below).

The publicly financed benefits package was not radically changed as a result of the crisis. A few countries reported adding new benefits, usually at the margin (Belgium, Bulgaria, Italy, Latvia, Netherlands). Notable reductions in coverage included:

- temporary sick leave (Estonia, Hungary, Lithuania)
- a cap on the number of publicly covered doctor visits for the same condition in a year (Romania, five visits per year in 2010, reduced to three in 2011)
- some mental health services (Netherlands)
- dental benefits for adults (Estonia, Ireland, Slovenia).

5.2.3 Increasing user charges

User charges are generally imposed to raise revenue for the health system or to limit third-party payer costs by encouraging people to think twice before using health care. In general user charges are of limited usefulness because they do not have a selective effect. Strong evidence indicates they reduce the use of low- and high-value health services in almost equal measure. Applying user charges across the board is therefore likely to deter

people from using necessary treatment (even where charges are quite low), which might have a negative impact on health. In addition, there is little evidence to suggest that user charges lead to long-term cost control or contain public spending on health care.

User charges may improve health system performance if they are applied selectively based on value. A value-based approach would remove financial barriers to cost-effective health care, clearly signal value to patients and providers and ensure that patient and provider incentives are aligned. Such an approach is not a panacea, however, and is most likely to be useful when user charges are already widely used, there is clear evidence of value and it is politically less feasible to target providers.

Sixteen countries reported introducing or increasing user charges for the following services:

- ambulatory care (Cyprus, Estonia, Greece, Iceland, Italy, Latvia, Portugal, Turkey)
- prescription drugs (Cyprus, Czech Republic, France, Greece, Ireland, Latvia, Portugal, Slovenia, Spain)
- hospital care (Armenia, Czech Republic, France, Greece, Ireland, Portugal, Russian Federation)
- use of emergency departments (Cyprus, Ireland, Portugal, non-urgent use in Italy)
- ambulance transport (France, Slovenia)
- long-term care (Estonia)
- specific items (IVF in Denmark, non-routine vaccines in Czech Republic and Portugal, some medical devices in Czech Republic, medical certificates in Portugal, dental prostheses in Slovenia)
- Latvia substantially raised the annual cap on user charges, lowering protection for those not exempt from user charges, although some of the increases in user charges were also reversed.

Several countries, including many of those listed above, took the following steps to protect people from financial hardship when accessing health care:

- reducing user charges (Croatia for primary care and outpatient prescription drugs)
- abolishing user charges (Greece for diagnostic tests in public hospitals for everyone, for all user charges in public facilities for people with diabetes and organ transplants and, from 2014, for treatment in public hospitals for long-term unemployed people and families living below the poverty line)
- expanding exemption from user charges for low-income people for prescription drugs (Ireland, Moldova, Portugal, Slovakia, Spain) or dental care (Iceland) or any type of care (Latvia, later reversed)
- expanding entitlement to reduced user charges (Belgium, France, Latvia).

5.2.4 A greater role for voluntary (private) health insurance

In theory voluntary health insurance could protect people from having to pay out-of-pocket. In practice it does not effectively fill gaps in public coverage in most European health systems – particularly in countries with high levels of private spending on health care – and its ability to relieve pressure on public budgets is extremely limited. We would not therefore expect voluntary health insurance to be a useful policy tool in an economic crisis.

France was the only country to report promoting voluntary health insurance (by expanding entitlement to free voluntary cover for poorer people), although spending through voluntary cover increased in a few countries (notably in Ireland). No country reported removing tax incentives for voluntary health insurance, even though there is little evidence of such incentives being a cost-effective use of public funds.

5.2.5 Implications for access to needed and effective health care

The crisis has increased financial pressure for many households, especially those affected by unemployment. Falling incomes may adversely affect access to health care, particularly in countries where levels of out-of-pocket payments are already high, making it more difficult for households to absorb increases in user charges.

Data on changes in service use are difficult to interpret and need to be assessed on a case by case basis. Countries report higher use of some health services since 2008 and reduced use of others. However, survey data from several countries indicate reduced use due to financial barriers (Armenia, France, Greece, Latvia, Switzerland, Ukraine), higher use of cheaper forms of care (Belgium) and substantially higher out-of-pocket payments for diagnostic tests and other treatment (Lithuania).

Reductions in coverage were generally made at the margin and many countries have tried to protect poorer people from higher user charges. Nevertheless, changes in the basis for entitlement to health care (for example, from residence to insured status), delayed implementation of coverage expansions planned before the onset of the crisis and some significant reductions in protection are likely to have negative consequences for equity of access to health care.

To understand the full effects of changes to health coverage will require careful monitoring of patterns of service use and indicators of financial and other barriers to access, although in many countries the necessary data are unavailable. Some changes may not directly affect access to health care – for example, reduced temporary sick leave benefits – but nevertheless shift the costs of ill health onto employees and should also be carefully monitored.

5.3 Generating savings and enhancing efficiency

Countries reported using a wide range of strategies to adjust to having fewer financial resources. The challenge has been to maintain universal access to high quality health care by introducing policies that generate savings and efficiency gains. Under normal circumstances such policies are often a priority, but the crisis has provided additional impetus in many countries.

The strategies countries adopted include efforts to:

- adapt provider payment
- strengthen pharmaceutical policy
- prioritise and strengthen primary care access and quality
- reduce costs by restructuring organisations and facilities
- prioritise cost-effective investment
- improve population health.

5.3.1 Adapting provider payment

Health worker costs account for the largest share of health expenditure and have been a common target for savings, sometimes in countries where health remuneration has grown sharply, even excessively, in recent years. Countries also tried to lower health service prices, introduce new payment methods and link payment to evidence of performance (quality and cost-effectiveness). Changes included:

- reducing the level of salaries and fees paid to health workers (Belgium, Cyprus, France, Greece, Ireland, Latvia, Lithuania, Portugal, Romania, Slovenia, Spain)
- freezing salaries and fees (Germany, United Kingdom) or limiting the rate of increase (Austria, Denmark, Italy, Slovenia)
- reducing health worker benefits in other ways such as changing pension entitlements, increasing working hours, cutting overtime (Croatia, Cyprus, Estonia, Iceland, Montenegro, Portugal, Slovenia, Sweden, United Kingdom)
- non-replacement of retiring staff (Austria, Belgium, Greece)
- negotiating lower tariffs for health services, most often hospital care (Bulgaria, Czech Republic, Denmark, Estonia, France, Ireland, Lithuania, Romania, Slovenia)
- introducing or tightening hospital budget constraints (Bulgaria, Croatia, Latvia)
- imposing caps on overhead costs (Belgium reduced the cap on sickness funds' overhead costs)
- increasing government control over procurement of pharmaceuticals and medical devices (Bulgaria, Czech Republic, Greece, Slovakia, United Kingdom)
- linking provider payment to evidence of improved performance (Bosnia and Herzegovina, Italy, Moldova).

Some countries tried to avoid or mitigate undue effects on timely access that might have been caused by changes to provider payment by:

- introducing, extending or enhancing the transparency of waiting time targets or guarantees (Czech Republic, Estonia, Hungary, Slovakia, Slovenia, Spain, United Kingdom)
- making greater use of private sector capacity to reduce waiting times (France, Malta, Montenegro).

5.3.2 Strengthening pharmaceutical policy

Containing spending on pharmaceuticals has long been an important policy direction in the European Region. The crisis enhanced the bargaining power of governments and other purchasers and many countries were able to negotiate lower prices for publicly purchased or reimbursed pharmaceuticals and medical devices. Some countries also ramped up policies to achieve greater use of generic drugs (now available for most chronic conditions).

Around 30 countries reported policy changes in one or both of these areas, often as part of ongoing reforms (Austria, Belarus, Belgium, Bosnia and Herzegovina, Bulgaria, Croatia, Cyprus, the Czech Republic, Estonia, France, Greece, Hungary, Iceland, Ireland, Latvia, Lithuania, FYR Macedonia, Malta, Moldova, Montenegro, Poland, Portugal, Romania, Russia, Serbia, Slovakia, Slovenia, Spain, Turkey, Ukraine).

5.3.3 Strengthening primary care access and quality, particularly for people with chronic conditions

Primary care provides a wide range of vital services including prevention, timely detection of disease and disease management. Ensuring people have easy access to primary care of good quality may generate savings and is likely to enhance efficiency by preventing ill health and avoiding use of more expensive services. This is particularly important for people with chronic conditions. Evidence shows how better disease management and patient empowerment can improve outcomes and reduce costs by preventing or delaying complications and use of acute care.

Improving care for people with chronic conditions requires expansion of task profile and investment in primary care, including information technologies. While the crisis has provided impetus for some of these changes, real improvement may be difficult to achieve without leadership and additional investment. Nevertheless, some countries have tried to expand primary care by:

- removing existing user charges for primary care based on evidence that even low charges can deter patients from using essential services (Croatia)
- inducing a shift away from inpatient care, often through financial incentives, mostly towards primary care (Belarus, France, Greece, Ireland, Italy, Latvia, Lithuania, Moldova, Russian Federation, Ukraine, United Kingdom)
- improving coordination across levels of care or investment in primary care (Armenia, Hungary, Moldova, United Kingdom).

5.3.4 Restructuring or reorganising the health system

The corollary to strengthening primary care is to reduce reliance on hospital care and remove excess infrastructure to save on fixed costs. A long-standing policy in the European Region, tackling excess infrastructure has moved forward as a result of the crisis. Many countries reported closing, merging or centralising

provider facilities, most often hospitals (Bulgaria, Cyprus, Czech Republic, Denmark, Greece, Hungary, Iceland, Italy, Latvia, FYR Macedonia, Portugal, Romania, Slovakia, Slovenia, Spain).

To achieve short-term savings by lowering overhead costs, some countries also reported closing, merging, centralising or cutting staff in non-provider organisations such as the health ministry, public health agencies and, less frequently, health insurance funds (Bulgaria, Croatia, Czech Republic, Denmark, Greece, Iceland, Kyrgyzstan, Latvia, Lithuania, Moldova, Portugal, Romania, Scotland, Serbia, Slovakia, Spain, Tajikistan, Ukraine, United Kingdom). In a few countries quite radical changes took place.

Capital investments were a common target. Cancelling or delaying capital investment projects may make sense when short-term savings are needed. In the longer term delaying needed investment can be counterproductive for health system efficiency, particularly if investment is needed to enable primary care to cope with shifts away from hospital care. Countries reported:

- reducing capital investment: Armenia, Belarus (expensive equipment), Bosnia and Herzegovina, Romania, Ukraine, United Kingdom
- delaying capital investment projects: Azerbaijan, Bulgaria, Georgia, Switzerland
- using public-private partnerships: Romania, Spain (Madrid), United Kingdom (Scotland).

5.3.5 Cost-effective investment in health goods, services, skills, technologies, infrastructure and quality improvement

In addition to attempts to make greater use of cost-effective drugs, encourage cost-effective patterns of use and shift care out of hospitals, a few countries took other steps to enhance efficiency, including:

- developing a strategy to address financial pressures through improved quality (United Kingdom)
- introducing or expanding the use of practice guidelines or care protocols (Belgium, Cyprus, FYR Macedonia, Portugal)
- introducing or expanding the use of HTA (Belarus, Montenegro, Spain (planned), Turkey)
- increasing investment in e-health (Croatia, Czech Republic, FYR Macedonia, Moldova, Romania, Serbia).

5.3.6 Improving population health

Some countries took steps to improve population health by:

- introducing health promotion policies (Belgium, Bosnia and Herzegovina, Croatia, Greece, Hungary, Lithuania, Malta, Moldova, United Kingdom, Northern Ireland)
- introducing smoking bans (Bulgaria, Hungary)
- introducing or increasing taxes on unhealthy goods such as alcohol, tobacco, sugary drinks and fatty food (Belarus, Bulgaria, Croatia, Cyprus, Denmark, Estonia, France, Hungary, Montenegro, Portugal, Russian Federation, Slovenia, Spain, Ukraine).

At the same time, some countries reduced spending on public health services (Czech Republic, Denmark, Estonia, Italy, Latvia, FYR Macedonia, Netherlands, Ukraine).

5.3.7 Implications for efficiency and user experience

Due to the almost complete absence of evaluation and analysis it is difficult to estimate the effects of measures taken to generate savings on efficiency and quality in health care organisation and delivery. Many countries reported reductions in the cost of inputs (pharmaceutical prices, health worker salaries and fees, health service prices) leading to savings. However, savings are not the same as efficiency gains.

The policies countries reported introducing can be discussed in terms of four different scenarios:

- Savings were made in areas also likely to enhance health system efficiency through higher productivity or better quality. Examples include switching to generic drugs and switching from inpatient to day case surgery.
- Savings were achieved but efficiency was lowered. This could happen when reductions in input costs lead to disproportionate reductions in productivity or quality. Examples include large cuts to hospital budgets that create long waiting times for effective services or deteriorations in quality, cuts to health worker salaries where these are already low, and delaying capital investment that would improve quality and productivity. In countries such as Greece and Romania, where health worker salaries were low, further reductions may be damaging for the workers concerned and for patients, who may end up paying informally to supplement low wages. Financial pressures are reported to have increased waiting times in several countries (Estonia, Greece, Iceland, Ireland, Latvia, Romania, United Kingdom).
- Savings were not made or spending increased but efficiency improved. Examples include investing in prevention and health promotion, investing in e-health or restructuring to improve care coordination, investing in health technology assessment and developing best practice guidelines, refining provider payment methods.
- Savings were not made and efficiency did not improve. Examples include failing to put in place value-based approaches to investing in goods, services, skills, technologies and infrastructure.

In some cases policies were introduced but not fully implemented; introduced but overturned; or introduced and had unintended consequences. For example, reductions in the prices paid for pharmaceuticals in Greece combined with delays in reimbursing pharmacies limited the availability of medicines and increased the need for out-of-pocket payments by patients. The reasons for partial implementation vary across countries but resistance from interested parties – most often providers and pharmaceutical companies – is a common thread.

6 Summary

This section summarises the study's main findings and policy implications.

The magnitude of the shock associated with the financial and economic crisis – its depth and duration, the pace of recovery – has varied substantially across countries in Europe. Macroeconomic responses to the shock have also varied. Some countries recovered rapidly. Others have not put in place policies that have achieved economic recovery and are now entering a fourth or fifth year without significant economic growth.

Although the crisis has had significant consequences for health and health systems in some countries, these consequences are not always easy to quantify. Research on health has focused on areas with a short time lag between recession and death or disease, such as mental health outcomes, infections and injuries. There is some evidence of increased suicides – the tip of the mental health iceberg – and increases in depression and anxiety. **It is likely, however, that there will be negative effects on health that may not be seen for some time**, particularly if the number of long-term unemployed people continues to grow, social safety nets experience further cutbacks and there are changes in population access to needed health services.

Public spending on health fell in absolute terms and as a share of total government spending in many countries, in spite of efforts to protect the health budget. Countries with means-tested entitlement to publicly financed health care and those that rely heavily on the labour market to fund the health system are particularly vulnerable to economic fluctuation. Regardless of the nature of the health financing system in place, however, **policy responses have been important in determining countries' ability to maintain an adequate and stable flow of funds to the health sector**. Automatic stabilisers (reserves and countercyclical formulas for government transfers to the health insurance system) played a critical role in some countries. In others, governments acted quickly to protect transfers and secure additional funding.

Health systems adopted a wide range of strategies to cope with having fewer resources. Reductions in coverage were mainly marginal and sometimes accompanied by efforts to protect poorer people, but a few countries delayed needed expansions in coverage of essential services. Many countries tried to strengthen pharmaceutical policy by lowering drug prices and encouraging greater use of generics. Many also adapted provider payment by reducing salaries or (less commonly) service prices. Several countries reported closing, merging or centralising provider facilities and other organisations to cut overhead costs.

Due to the lack of evaluation and analysis it is difficult to assess the effects of these strategies on health system performance. Substitution policies such as switching to generics are likely to have saved money and enhanced efficiency, while downward pressure on health worker salaries where these were already low may have achieved short-term savings at the expense of efficiency gains. Some changes, combined with falling household incomes, are likely to have increased financial and other barriers to access.

Some health systems were better prepared than others to deal with downward pressure on budgets as a result of the crisis. Health system factors that may have helped health policy makers in responding to financial pressure include: countercyclical fiscal policies; relatively low levels of out-of-pocket payments; understanding of the weaknesses in the health system and areas in need of reform; good information about the cost-effectiveness of different services and strategies; and clear priorities. These factors may have enabled some countries to protect health revenues, given them leeway in terms of reducing coverage through higher user charges if needed and allowed them to act swiftly to introduce changes in priority areas.

Poor health system performance undermines resilience, making it harder to cope with financial pressure. Underlying weaknesses in the health system can make it harder for countries to respond effectively to financial pressure. For example, countries with fragmented purchasing and delivery systems or underdeveloped primary care may struggle to encourage greater care coordination or achieve a shift away from inpatient care. Similarly, countries with major gaps in coverage and high levels of out-of-pocket payments are likely to find it difficult to avoid increasing financial barriers to access.

Sustained pressure and pressure to achieve substantial savings in a short period of time may jeopardise health system financial sustainability. Some countries are approaching a third, fourth or even fifth year of health budget reductions. As a result they may not be able to generate savings through further reductions in health worker salaries and service prices and may have to consider more fundamental changes. Countries may also face pressure to achieve substantial savings very quickly. Both scenarios pose challenges. First, developing and implementing more complex reforms generally requires political support, technical capacity, upfront investment and time, all of which are likely to be in short supply in a deep or prolonged crisis. Second, the sorts of changes that are needed may not deliver immediate savings. Third, some changes risk damaging access to needed services or eroding health worker motivation. Fourth, poorly designed and implemented reforms may fail to address inefficiencies or create new ones, threatening financial sustainability in the longer term.

Some countries have seen the crisis as an opportunity to introduce needed health system reforms. Several have tried to improve health system performance by introducing overdue reforms. However, the extent to which they have been able to do so varies across countries and reforms. Not surprisingly, reforms involving major structural change have been more difficult to implement than – for example – reductions in pharmaceutical prices. Major structural change also requires capital investment, which has been a common target for cuts.

Very few countries have taken steps to promote cost-effective investment in the health system. At a time of financial pressure we might expect a focus on ensuring that all spending is 'good' spending. Yet there are numerous instances of countries failing to protect or introduce cost-effective policies to prevent ill health, strengthen primary care access and quality and improve care co-ordination, particularly for people with chronic conditions. And with the exception of pharmaceutical policy, there has been almost no emphasis on promoting value-based investment in and payment for goods, services, skills, technologies and infrastructure. These failures may reflect undue pressure to make short-term savings at the expense of longer term financial sustainability; lack of information, analysis and capacity for effective decision making; and resistance from stakeholders. The latter is likely to be exacerbated by prolonged cuts, limited opportunity for consultation, poor communication and lack of transparency.

If cuts in government spending cannot be avoided, it is important that they are made carefully, with a view to avoiding negative effects on health and welfare. Public spending on health is an investment in social and economic development. It therefore makes economic sense to protect funding for cost-effective health services, including public health services. Public health services are proven to improve health outcomes at relatively low cost and can contribute to economic recovery.

Social policies can mitigate negative health effects. Unemployment has grown rapidly as a result of the crisis and continues to grow in some countries. Social policies can limit periods of unemployment, provide safety nets for people without work and mitigate the negative health effects of being unemployed. The health sector plays a critical part in social protection. By providing timely and equitable access to effective health services, health systems can ensure that people do not suffer additional financial hardship as a result of being ill.

Strong governance and leadership are needed now more than ever to protect health. The crisis has posed intense challenges for health systems in many countries and continues to do so in some, particularly in the European Union. Although countries have generally tried to protect access to needed health services, there is a risk that barriers to access will increase as unemployment and poverty push up demand for treatment while health budgets are further constrained. The human and financial costs of the crisis are likely to become more evident as time passes.

Monitoring and evaluation are essential but limited by the absence of timely and relevant data. Policy makers in Europe need much better access to health and health systems information and analysis. Assessing the effects of the crisis on health and health systems has been difficult, reflecting the relatively low priority governments have placed on collecting timely and relevant data on health status, use of health services and health service outcomes.