Health policy in times of crisis: challenge and opportunity
December 2009

"Strong political leadership in defence of the values of equity, solidarity, participation and efficiency in strengthening health systems, is as necessary as ever before."

Dr Nata Menabde, 2009
Deputy Director of the WHO Regional Office for Europe

Crisis at a glance: Impact and responses

- Post-crisis recovery is still slow, with high unemployment in many countries bringing falling revenues for labor-market related healthcare budgets
- Population health impact is uncertain, though adverse consequences for unemployed and vulnerable groups including migrants are likely
- Different policy responses: some governments are reducing public expenditures (Estonia, Canada's province of Alberta, Australia) – others see a window of opportunity for an enhanced public role at a time of market failure (Austria, Switzerland, U.S., Singapore)
- The crisis has brought the perennial problem of controlling healthcare costs into even sharper light. For governments assuming a stronger governance role, questions of cost-effectiveness are major issues
- Strengthening the equity and efficiency of health systems may help mitigate the adverse consequences of the crisis for those most at risk

Introduction

While national economies are slowly recovering, the global financial crisis continues to take its toll. Governments have spent trillions bailing out banks and stimulating flagging economies, yet there are predictions that unemployment will remain high, with estimates of an average of around 10 per cent in the European Union and North America in 2010. According to a recent World Bank analysis, it is the labor market that has taken the biggest hit, "young people, short-term contractors and migrant workers are worst off." (Fidler 2009)

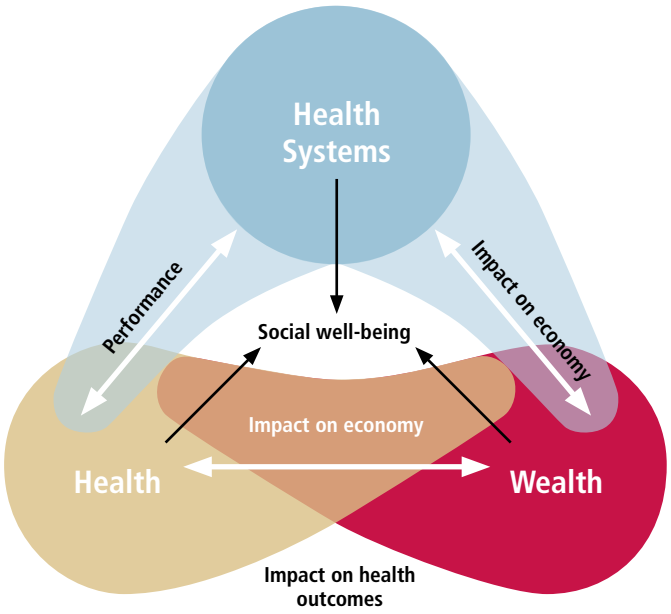
The impact of the crisis on the health of people and populations is hard to predict, likely to be mixed, and in some cases counter-intuitive. There's evidence that the jobless are at higher risk of early death, but there are ambiguous signals from studies of previous economic crises.

A review of the evidence on health impacts from three major financial downturns of the past highlights the uncertainty in predicting the health consequences of the current crisis. (Stuckler et al 2009) Surprisingly, death rates actually fell in American cities during the Great Depression in the 1930s, at a time of alcohol prohibition, yet they rose dramatically in heavy-drinking post-Soviet Russia in the early 1990s, particularly in places that implemented privatization most rapidly, or had high labor turnover. The east-Asian financial crisis of the late

1990s was associated with short-term increases in death rates in Thailand and Indonesia, but no change in Malaysia – which unlike its neighbors ignored advice from the global financial community to reduce spending on social protection. (Stuckler et al 2009)

Today, post-crisis, governments are being urged to strengthen social protection, with cost-effective investments in health infrastructure that can produce both health and wealth. (Fidler 2009, Menabde 2009) (see figure 1)

Figure 1: Health systems, health, and wealth



Source: A key concept: health systems, health and wealth [web site]. Copenhagen, WHO Regional Office for Europe, 2008

Our HealthPolicyMonitor SPOTLIGHT reveals how the crisis is having different effects on health policy in different industrialized countries. Looking at a sample of 7 countries of the International Network Health Policy & Reform that have reported and analysed the crisis' impact, it is possible to discern **two rough patterns of response.**

– **Cut public spending on health:**
Falling public revenues coupled with large stimulus spending are amplifying budget deficits in many capitals, made worse for those affected by downward currency movements. One response has been to cut public spending on health, as is happening in Estonia, a role model of a jump-start new economy in Central Europe though with few assets to fall back on, in the wealthy Canadian province of Alberta, and to some extent in Australia, where tax subsidies to private health insurance have long been critized.

– **Expand the state´s role in health care:**
A different response has been to expand the state's role in health care, commonly to try and contain rapidly rising expenditures, as in Austria and Switzerland, but also to expand access to care as in the United States, or to enhance the population's resilience, as is happening in Singapore.

Estonia, Canada, Australia – cutting back public resources for health care and insurance

Estonia – crisis brings heightened need to balance budget

In Estonia, years of rapid economic expansion have been followed by a sharp fall in the nation's financial position. In healthcare, the government has quickly pushed through measures to cut spending and boost revenues.

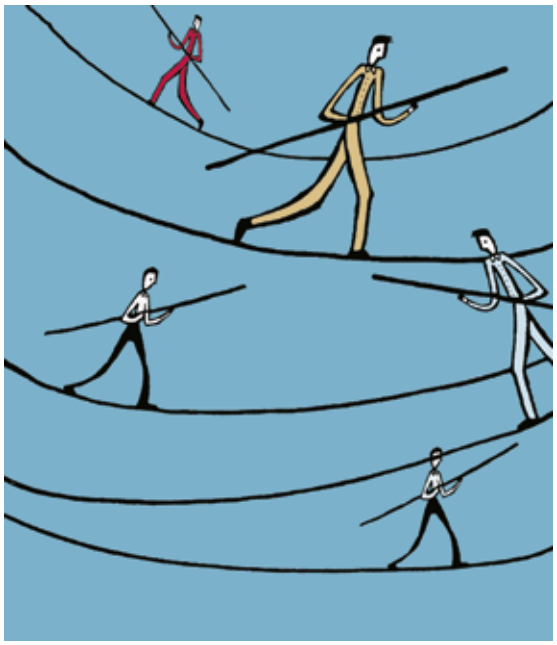
Fallout from the global financial crisis has produced a very steep decline in economic activity in the Baltic States. Following many years of expansion, Estonia has experienced a post-crisis GDP drop of more than 15 per cent. Combined with this drop in growth, currency depreciation, rising unemployment and falling public revenues has resulted in Estonia, like other previously expanding economies in this part of Europe, looking for savings in health spending. Yet while other nations' proposals have stalled or slowed due to opposition, the Estonian government swiftly implemented a range of reforms to generate revenue or reduce expenditure.

Among those reforms were

- **increases on consumption taxes for pharmaceuticals**
- **increases in the number of hours worked by some medical staff**
- **increases in the numbers of unpaid sick days for Estonians**
- **cutting public revenues for health care**

Key elements of the reform package were two major cuts to the public revenues flowing to Estonia's National Health Insurance Fund, which is used to pay for medical services for every insured person. A first wave of cuts by 8 per cent in 2009 compared to 2008 was negotiated between the Fund and service providers. However, the second wave by 6 per cent in 2010 compared to the 2009 budget has proven highly controversial. The concern is that more cuts could lead to the closure of hospitals and a reduction in services including ambulance and emergency care. Even before the crisis, Estonia's total health expenditure was among the lowest in Europe, with 5 per cent of GDP in 2006.

www.hpm.org/survey/ee/a13/1



Canada – controversy over proposed public hospitals cuts

In the wealthy Canadian province of Alberta, a new conservative-leaning government is implementing a range of measures to reduce public health spending which are meeting with considerable resistance, including from unions.

In Canada's province of Alberta, the provincial government's health expenses increased more than 13 per cent in 2008, while funding expanded by less than 7 per cent. As the global economic downturn has resulted in fewer revenues from Alberta's natural resources, the conservative government is aggressively trying to manage the health budget and reduce health expenditure.

- **Downsizing the benefit basket:** Alberta's government has appointed a committee to review the range of services currently provided to its population. Some services are already being " de-listed".
- **Reducing hospital beds and personnel:** The Alberta Health Services Board – which manages health care in the province – is planning to eliminate hundreds of mental health hospital beds, some of which would be replaced with community living support or home care. The board also plans to reduce budgets to providers, and offer voluntary retirement plans to many health employees.
- **Freezing the number of nursing home beds:** There is to be a freeze on the number of new nursing home beds. Media reports suggested the government was considering reducing nursing home beds by as many as 9.000 while increasing the supply of assisted living spaces.

One of the most controversial aspects of the cost-saving plan is to close more than half the beds at a large mental health facility in the city of Edmonton, and replace them with community services. The plan has produced a strong public reaction, including television advertisements opposing the bed closures, funded by a union of public employees. Nurse associations and civil society groups are also campaigning against the changes, though the government is in a strong position to weather the storm of protest.

www.hpm.org/survey/ca/a14/2

Australia – plans to wind back public subsidies to private insurance

In Australia the government is seeking savings in health care expenditures, to help meet post-crisis budget challenges. One area targeted for savings is the large and controversial public subsidy to private health insurance premiums.

While less affected than many other countries by the financial crisis, Australia's centre-left government's response has been dramatic. It has committed **billions of taxpayer dollars to "stimulus" spending,** including direct payments to most Australians and increased infrastructure funds for education and transport.

The stimulus spending is credited with enhancing Australia's early economic recovery, but has contributed to an **expanded budget deficit.** This in turn **sparked a range of new measures to wind back public expenditures, including proposed savings in the area of health.** The biggest and most controversial proposal is the plan to cut public subsidies for private health insurance premiums, estimated to produce savings of almost A$2 billion over four years.

Under an existing scheme introduced by the previous conservative government, the taxpayer contributes about one-third of the cost of annual private health insurance premiums, a subsidy available to anyone independent of their wealth. The scheme has been sharply criticized by some observers as being both inefficient and inequitable, but it is strongly supported by the private health sector and medical organizations. Driven in the aftermath of the crisis to look for ways to pay for the post-crisis stimulus spending, the current Labor government turned against the subsidy it was never fond of. In early 2009, it proposed reducing the size of the subsidy for middle-income earners, and removing it altogether for those on high incomes. The reform also included slight increases in the existing tax penalties for middle and high-income earners who do not have private health insurance.

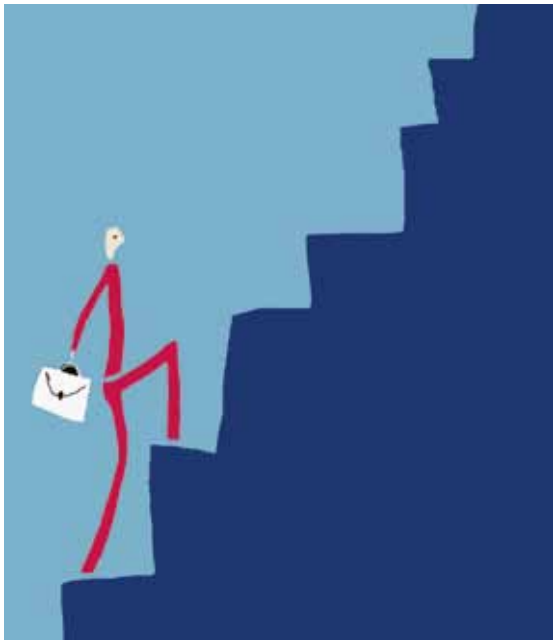
The plan has met with strong opposition from the conservative parties, and some independent politicians, who have combined to reject the legislative reforms in the nation's Senate. Despite the rejection, the government has not yet abandoned its plan.

www.hpm.org/survey/au/a14/3

The opposite trend: Rising expenditures in Austria, Switzerland, the U.S., and Singapore

Austria – new government "health fund" enhances public role

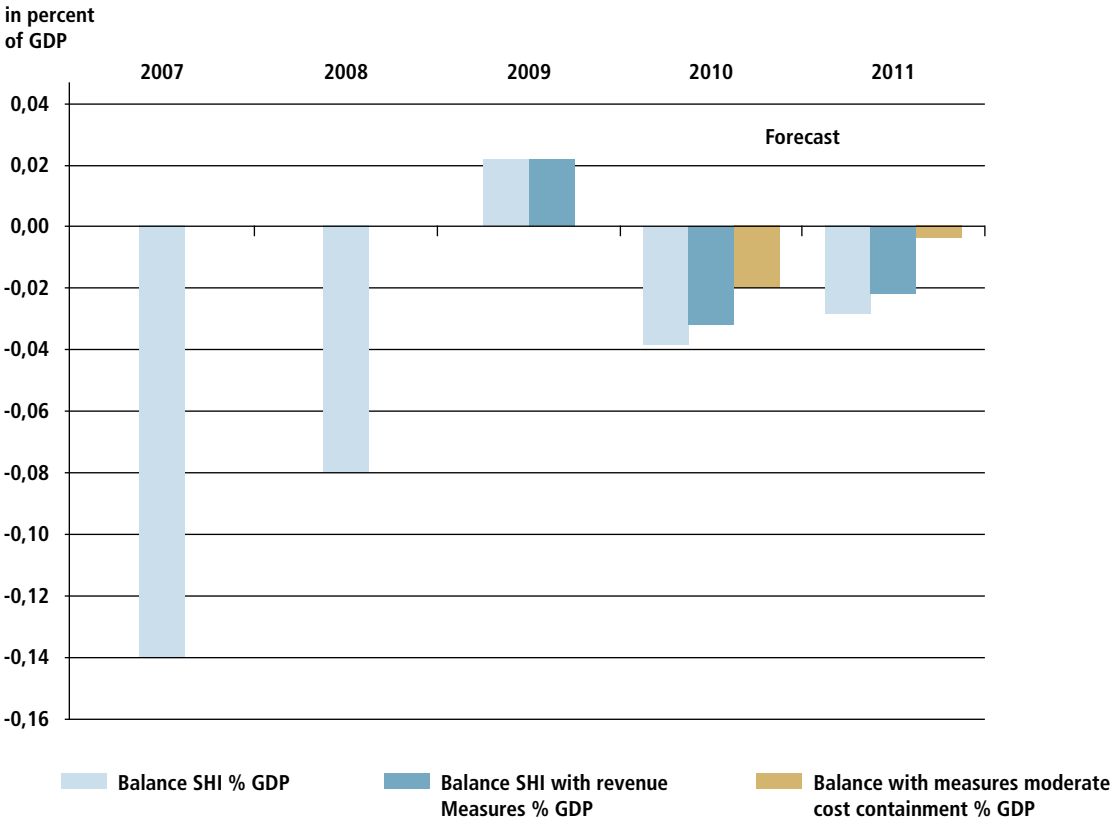
In Austria the financial crisis has exacerbated long-term budgetary shortfalls within the sickness funds. These are now being tackled by a reform that could fundamentally change the governance of the nation's healthcare system.



Foreshadowed early in 2009 by the incoming centre-left government, a **new publicly controlled health fund** will officially start in 2010. It will make an initial injection of 100 million Euros of taxpayers' revenues into Austria's main sickness funds, which collectively cover around 80 per cent of the population.

For many years sickness fund revenues have been falling further and further behind their expenditures, with an accumulated gap now of more than 1 billion Euros. These debts will be forgiven in installments adding up to 450 million Euros. Overall the government will invest about 600 million Euros between 2009 and 2013, in addition to reducing VAT taxes for drugs. Figure 2 shows estimates of the sickness fund balance for 2010 and 2011 in different scenarios.

Figure 2: Estimated balance of social health insurance (SHI) in percent of GDP, in scenarios 2007 to 2011



Sources: Hofmarcher, May 2009 and updated in December 2009

Rising unemployment is putting further pressure on sickness fund revenues, with the crisis a catalyst for this latest reform. **A key element of the reform will be to link the on-going flow of taxpayers' money to the implementation of cost-containment measures by the formerly very autonomous sickness funds. In line with developments in other nations, the reform is designed to enhance the state's role in monitoring and stewardship of the social health insurance sector.**

A "road map" developed by Austria's Federation of Social Health Insurance Associations outlines the proposed cost-containment measures. They include new contractual arrangements with doctors and laboratories, and incentives targeting doctors to achieve more rational, cost-effective prescribing of pharmaceuticals. Twice-yearly evaluations of cost-containment measures are planned, but at this stage it is uncertain they will be achieved, as the "road map" is short on detailed agreements of contracted and quantified targets.

Experts see the combination of better liquidity for social health insurance with cost containment in the health sector as appropriate. However, they see further need for health reform in Austria, in particular regarding questions of cost efficiency in the hospital sector.

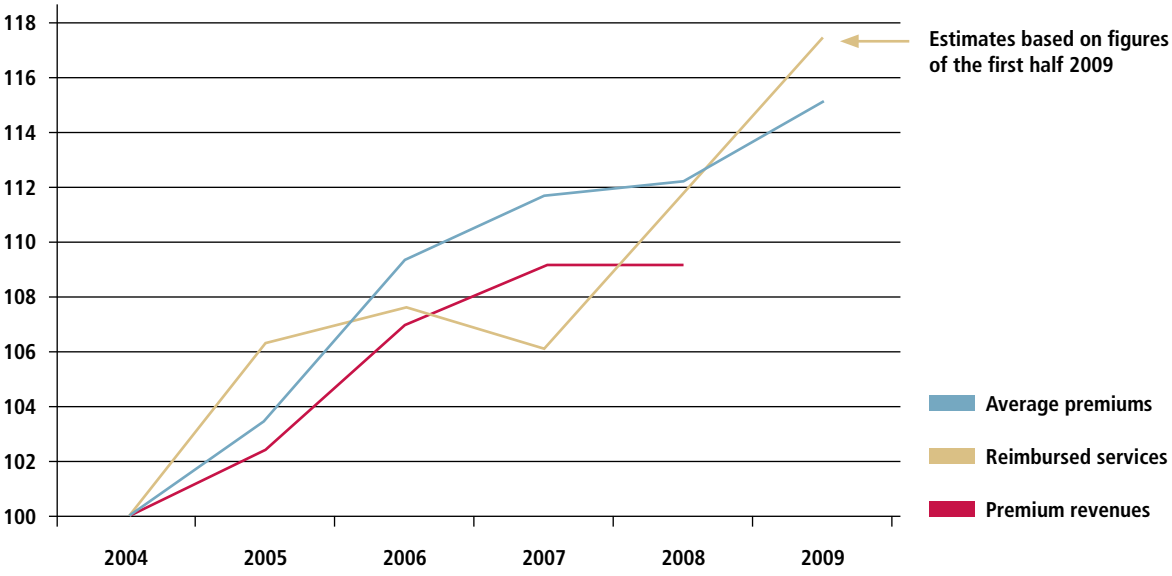
www.hpm.org/survey/at/a14/2

Switzerland – emergency government intervention to curb cost increase

In Switzerland, as in many nations, unsustainable increases in health care costs are high on the policy agenda, and pushed higher by the crisis. The federal government is moving to play a bigger role in controlling costs, but has met strong opposition in it's attempt.

The poor financial health of Switzerland's health insurance companies has deteriorated further because of the global crisis. (see figure 3) The large number of Swiss who've been switching health insurers in search of lower premiums – with higher deductibles – had already caused a drop in revenues for the insurers. This situation has only been made worse by the current economic situation and developments in the financial markets' that brought about the need to rectify accounting values of the reserves. As a result, health insurance premiums are set to rise by almost 9 per cent in 2010, causing the state to introduce urgent measures to curb accelerating health care costs.

Figure 3: Index of total reimbursed cost, total premium revenues and average premiums



Source: Crivelli 2009

Four main measures have been proposed:

- **Controlling provider remuneration:** The government aims to exert greater control over the fees paid to providers. The decision of a fee reduction for laboratory tests carried-out in doctors' offices sparked protests and street demonstrations.
- **Subsidies for low-income households:** The government has attempted to intervene in the insurance market, offering even more money to subsidize the premiums of the many Swiss households who've been overwhelmed by regular double-digit premium increases. Interestingly, the Swiss government is also seeking to discourage people who are "good risks" from chasing lower premiums by selecting higher deductibles, because of the deleterious affects on the system's solidarity.
- **Controlling costs of outpatient care:** There are plans to extend local government control over the costs of outpatient hospital services, an area of great expenditure growth.
- **New co-payments:** In an attempt to reduce demand for unnecessary services, the government proposed the introduction of new co-payments, which would result in higher out-of-pocket costs.

The current crisis of rising costs is occurring against a backdrop of long-term inability to get consensus on how to fix the problem, in part because of many conflicts-of-interest involving the political sector and lobbyists. The current plans were developed quickly, are highly controversial, and have subsequently been watered down and slowed down by the Parliament.

www.hpm.org/survey/ch/a14/1

United States – crisis as a push for overdue reforms

In the United States the crisis has coincided with a new president's desire to see universal health insurance coverage, alongside other policy reforms designed to strengthen and modernize the nation's fragmented and inefficient health system.

The United States administration is moving towards a number of major health sector reforms. The biggest one is the push for near universal health insurance coverage being driven by President Obama and the Democrats in Congress. Among other reform elements is a commitment to spend almost **US$20 billion for a new nationwide system of health information technology,** which passed through congress as part of the post-crisis recovery act in early 2009.

The aim of the information technology reform is to offer providers and patients real-time access to standardized, compatible electronic health records, potentially reducing unnecessary services and medical errors. Advocacy group concerns about privacy and confidentially have been assuaged this time around, and doctors' groups have accepted generous incentives to take up the technology: up to US$18 000 per provider.

A second development is the expansion of comparative effectiveness research. The recovery act allocated US$ 1.1 billion to strengthening the evidence base in health care, comparing the benefits and harms of tests and treatments.

The push for universal health insurance coverage for the more than 40 million uninsured has so far been less successful, though Congress is on track to pass legislation in 2009 and have it signed by the President in early 2010. Specific options are still being debated such as a public option that would compete with private insurers. Other issues being debated include abortion coverage, coverage for immigrants and taxes to pay for the various options.

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www.hpm.org/survey/us/b13/5

Singapore – health spending boosted as part of "resilience" package

In Singapore the nation's reserves are being used to fund an expansion of public health expenditure, with extra money to subsidize patient out-of-pocket costs, healthcare infrastructure and thousands of new healthcare related jobs.

In stark contrast to the nations winding back their health expenditure, Singapore has reacted to the financial crisis with hefty increases in government spending, which are part of a large S$20 billion economic stimulus known as the "Resilience Package."

The nature of Singapore's export-oriented economy makes it extremely vulnerable to global changes. It was the first East Asian country to fall into recession following the crisis, which has subsequently produced the most serious downturn since independence four decades ago. **Drawing on reserves of national savings, the government's stimulus package includes a boost of S$1 billion to the health budget, part of which is designed to help patients through tough times.**

Importantly some of the "resilience" resources will be used to subsidize patients' medical bills and reduce out-of-pocket expenses, but the extra money will be spent on a range of other activities as well. The government will immediately create over two hundred new jobs in health care, and provide re-training to people who have lost jobs in other industries. On top of that **more than 4000 new healthcare jobs are to be created over the next two years – including nurses, pharmacists, counter-staff and telephone operators.**

The post-crisis stimulus package will also include **more funding for long-term care, including community hospitals, rehabilitation facilities, home care and palliative care.** Meanwhile, other plans to develop hospitals and medical centers have been brought forward to capitalize on cheaper construction costs.

www.hpm.org/survey/sg/a14/1

Mitigating the impact of the crisis on health

A series of recent international meetings on health care, coordinated by the World Health Organization, have stressed the importance of strengthening health systems at times of crisis, re-affirming commitments to the values of equity, solidarity, responsiveness, efficiency, transparency and accountability. **Strengthening health systems is seen as a fair and efficient way to mitigate the deleterious effects of the crisis for the most vulnerable, and to build the health and wealth of societies into the future.** (Menabde, 2009)

Yet the reality of domestic health policy-making is in general far less august than these honorable aspirations. As we've read, in several countries policy-makers are cutting back on some areas of public expenditure in health, as in Canada and Estonia, though they are trying to do so while avoiding harm to access and equity.

Perhaps fortuitously, the financial crisis has brought the perennial problem of controlling healthcare costs into even sharper light. In the nations with mandatory health insurance schemes featured in this update – Austria and Switzerland – the crisis has presented an opportunity for the state to try and play a bigger role in cost-containment. In the United States, where health now accounts for almost one-fifth of the entire economy, that desire to control costs is coupled with a costly plan to massively expand access.

In most of the examples presented here the proposed reforms have generated heated controversy, as vested interests jostle to defend or expand their piece of the health pie. In Australia, for example, the private insurance sector and its political supporters have stymied the planned reductions in public subsidies to private premiums, temporarily at least. In Switzerland much-needed solutions to exploding premiums also appear to be in trouble politically.

Recent market failure – which in fact produced much of the current crisis – is not expected to lead to any "new economic order" with equity at its heart (Moynihan et al 2009, p. 14). **However, it does appear possible that the crisis has strengthened the hands of those keen to construct high quality, efficient and fair healthcare systems characterized first and foremost by universal access. Such systems may not only help build resilience during this crisis, but will be better equipped to mitigate the impact of the next downturn.**

This report was written by Ray Moynihan, based on the following sources:

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