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CSC Roundtable: Sustainable public financing for universal access to health care in Europe

WHO Barcelona Office for Health Systems Strengthening

Division of Health Systems and Public Health

Barcelona, 22 January 2015

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WHO Regional Office for Europe
Division of Health Systems & Public Health

WHO Barcelona Office for Health Systems Strengthening

Dr Tamás Evetovits
Head of Office a.i.

The Barcelona Office within WHO

- Global Headquarters: Geneva
- European Region Head Office: Copenhagen
  - 3 specialized centers: Barcelona, Bonn, Venice
    - new centers in process: Almaty, Moscow and Istanbul
  - 29 country offices
  - 53 member states (Europe and Central Asia)

Technical focus: health systems financing & capacity building in health systems

Analytical work on health financing policies across the European Region

Country-specific policy analysis and advice to ministries of health

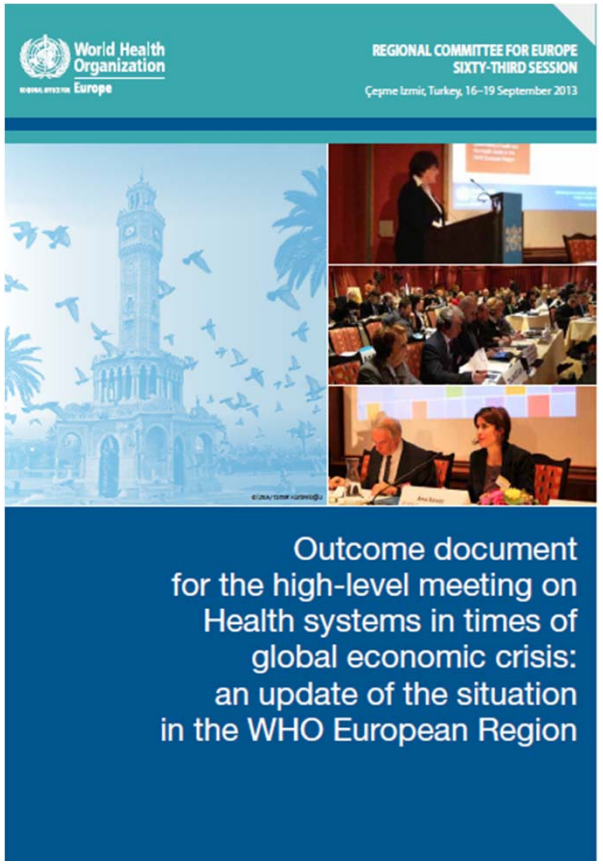
Capacity building through training courses

Health financing for universal health coverage

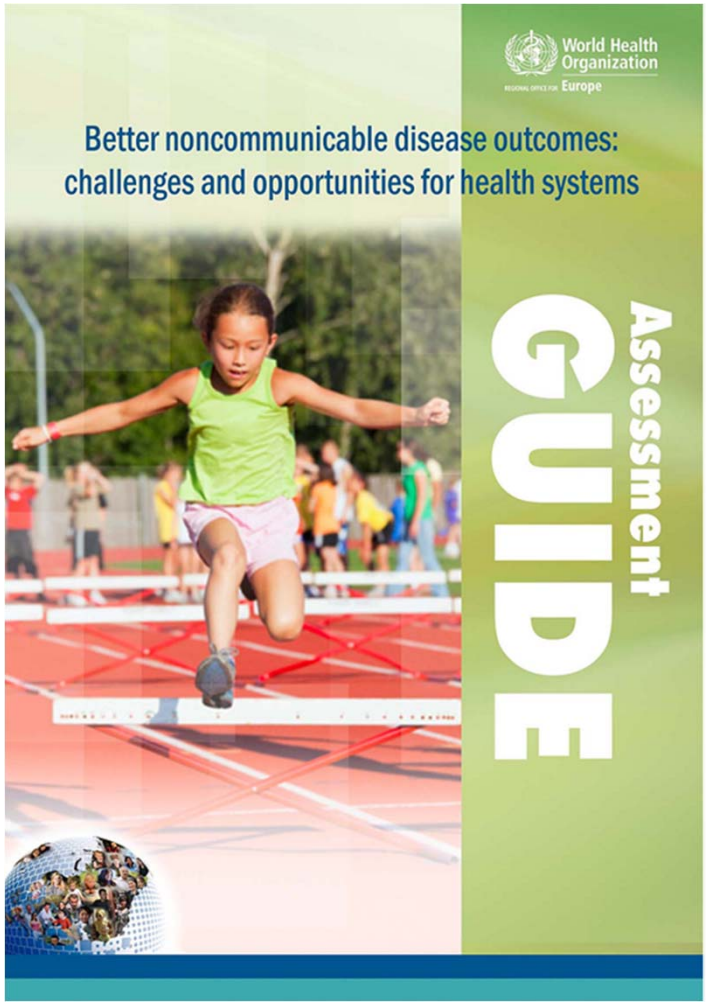
Regional experience in health financing reforms

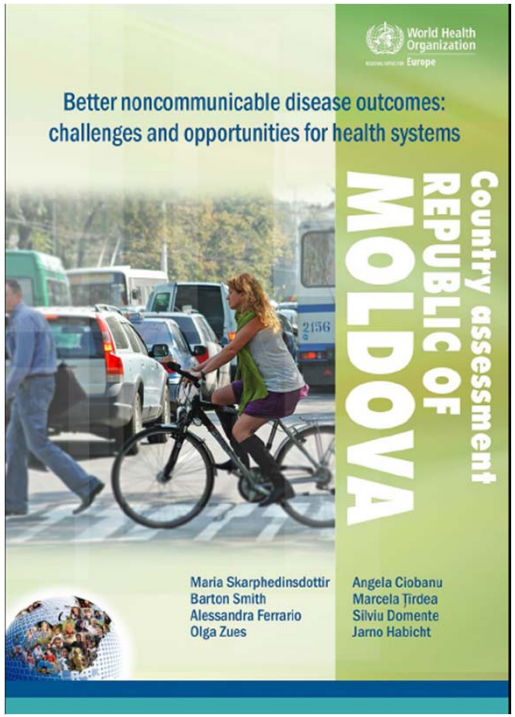
World health report on health systems financing

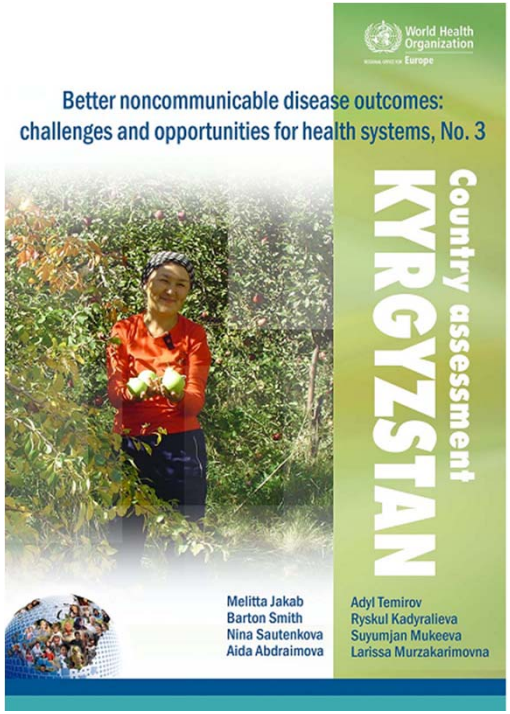
Financial crisis and policy responses

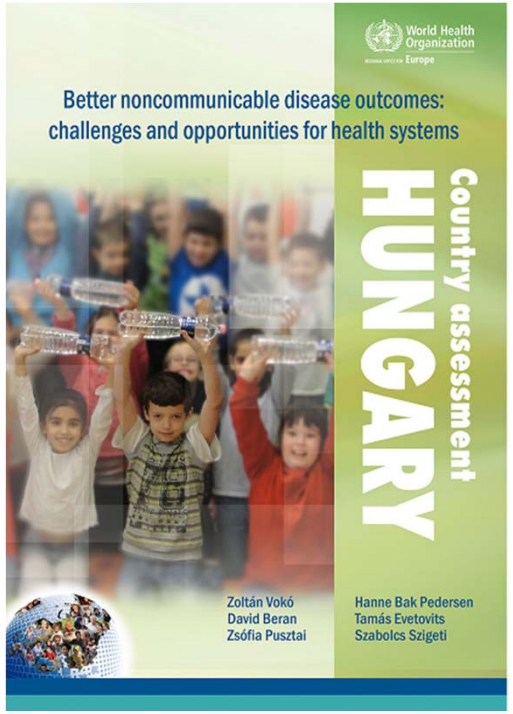


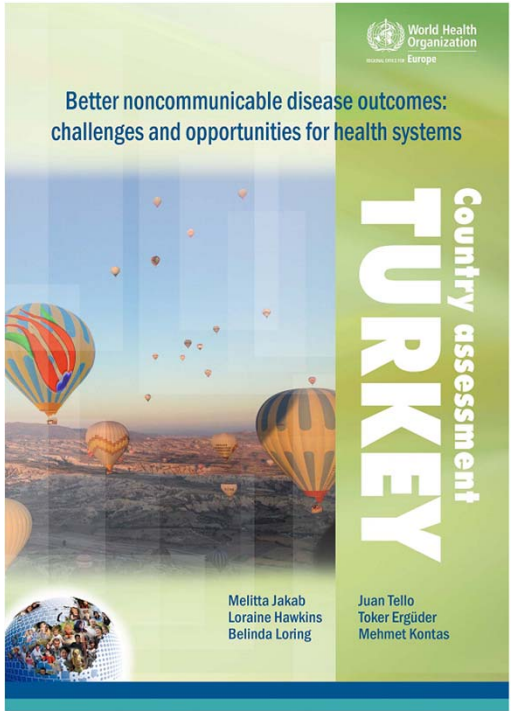
Health systems strengthening











Capacity building through training

Flagship Course on Health System Strengthening

Barcelona Course in Health Financing

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Thank you!

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Fiscal sustainability of health systems

Dr Tamás Evetovits
Senior Health Financing Specialist & Head of Office a.i.
WHO Barcelona Office

22 January 2015

Outline

- Let’s get the concept right and clarify objectives
- Reality check on health spending and its fiscal impact
- Lower public spending on health: is it a solution? For what?

Fiscal sustainability of health systems

An accounting exercise
or
a matter of choice in public policy priorities and finding the right instruments to minimize adverse effects on health, equity and financial protection?

Fiscal sustainability is meaningless if not linked to public policy objectives

- It should not be seen as a policy goal worth pursuing for its own sake
- If it were, simple cost cutting would do the job
- Equity and efficiency would suffer

- It should be treated as a constraint to be respected by all sectors
- Escalating debt may harm future generations
- Equity and efficiency would suffer

It makes more sense to think about the financial sustainability of a desired level of health system performance

Fiscal sustainability is a slippery concept

- It applies at the level of overall public spending: at a sectoral level, the concept is less clear
- How much countries spend publicly depends on the fiscal context and the priority government gives to each sector in its budget
- The impact of the health sector on 'fiscal sustainability' depends in part on choice

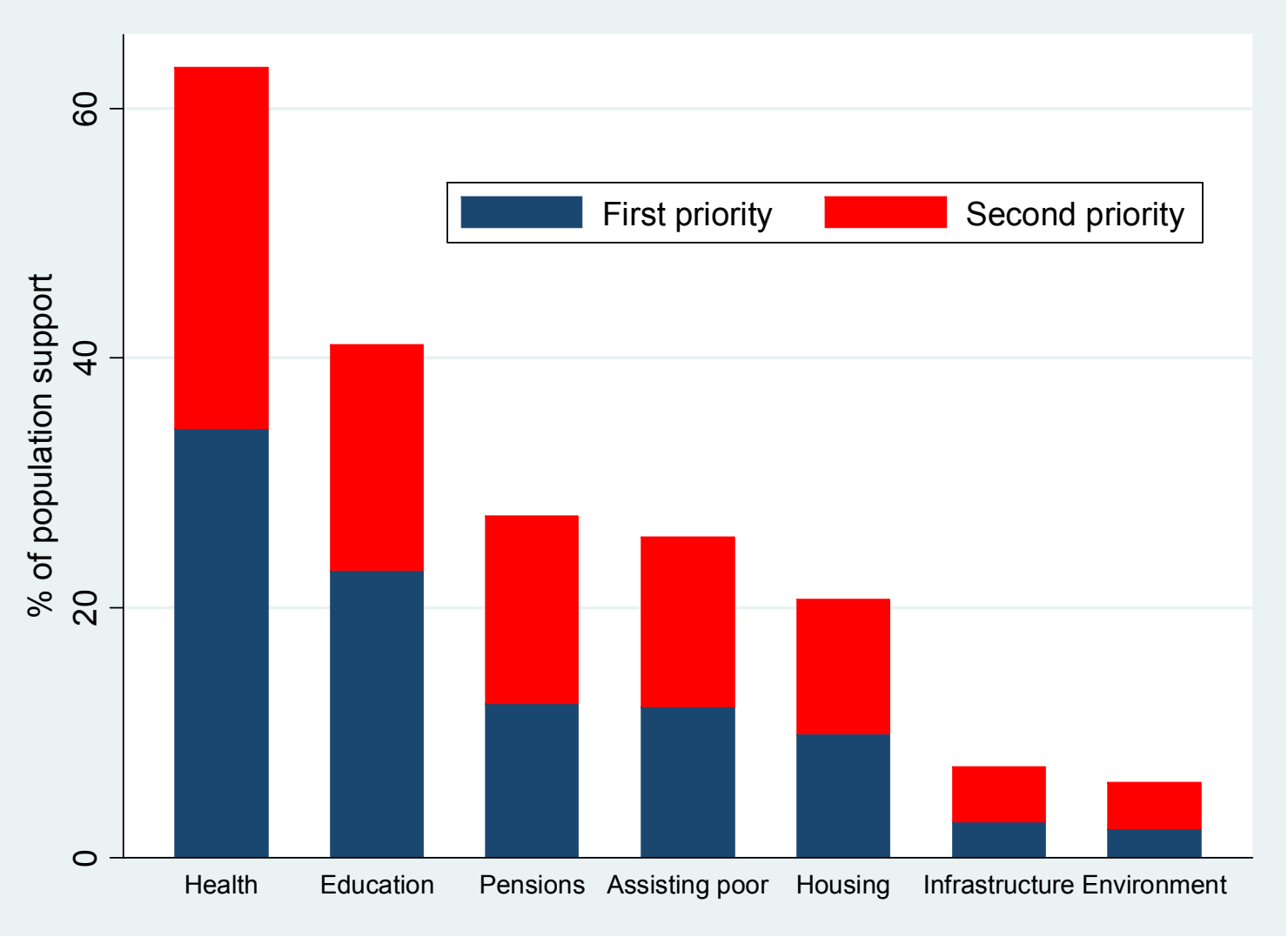
Source: Thomson et al (2009) Addressing financial sustainability in health systems, available from www.healthobservatory.eu

There is nothing wrong with health expenditure growing faster than GDP

As long as…

- other sectors are not growing that fast (no fiscal imbalance)
- spending is efficient (welfare enhancing)
- people prefer to spend the additional wealth on health (they do)

Health is the top priority for more public spending across Europe

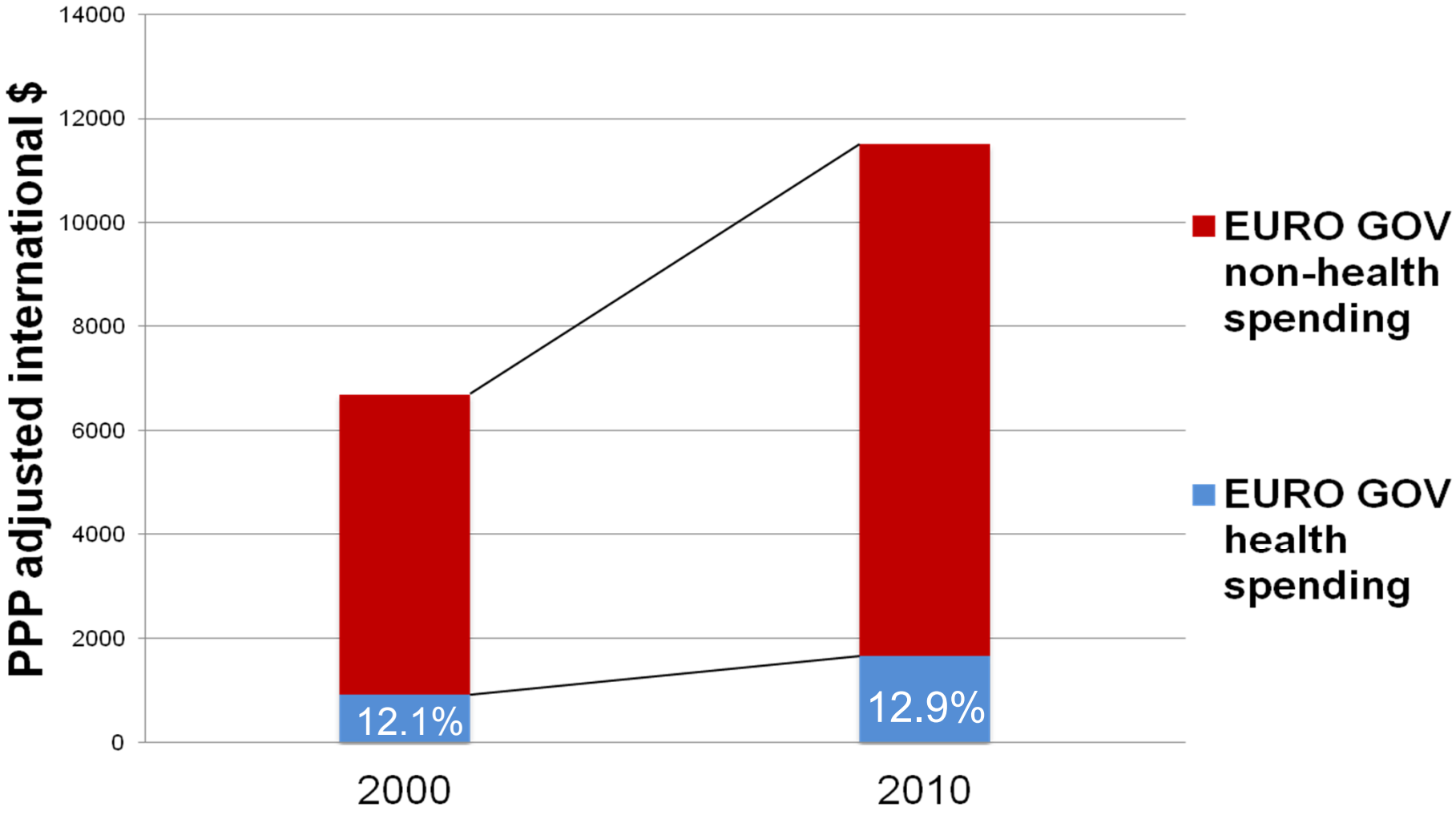


Source: EBRD Life in transition survey 2010 (see page 23) http://www.ebrd.com/downloads/research/surveys/LiTS2e_web.pdf

Outline

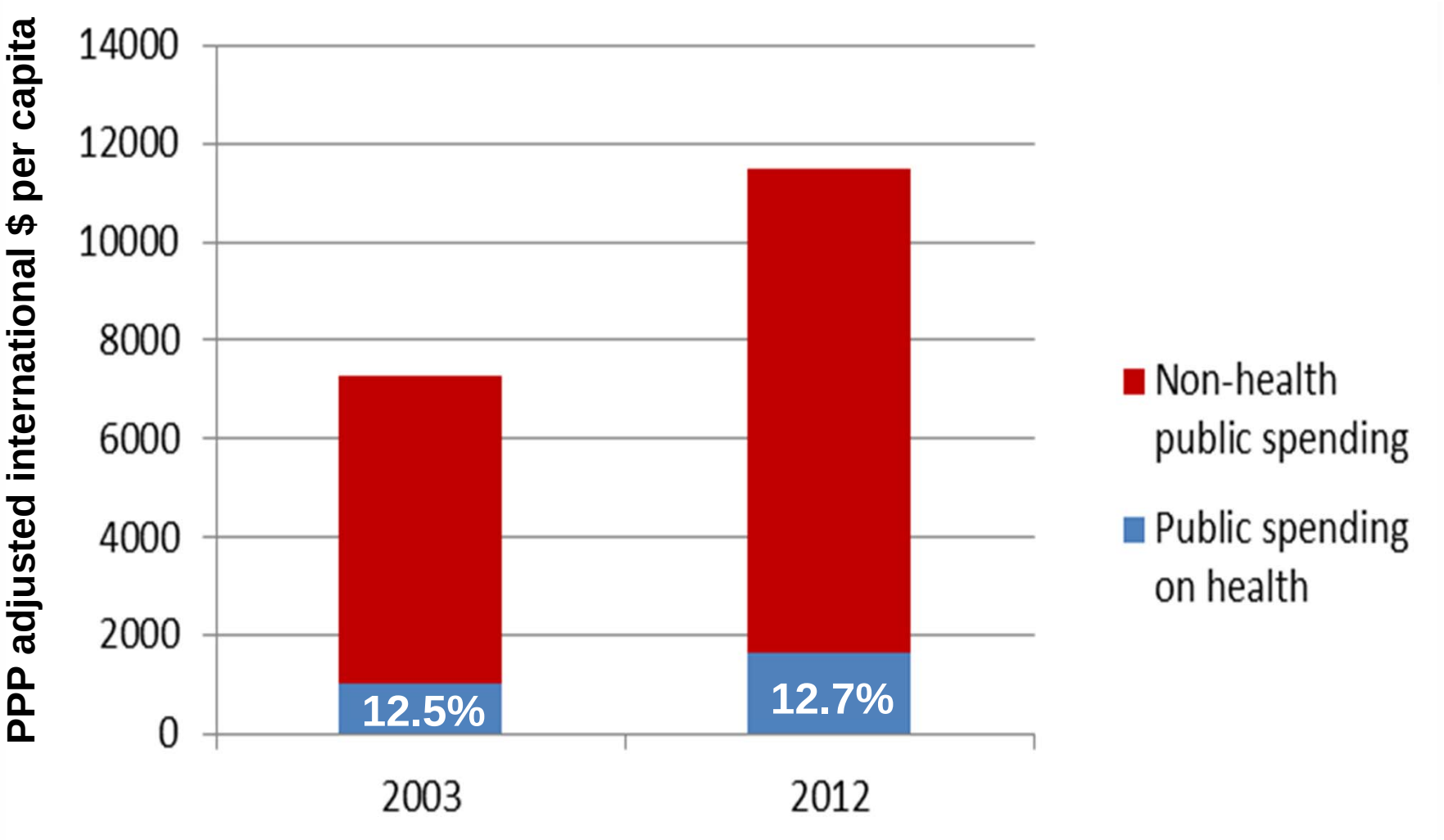
Reality check on health spending and its fiscal impact

Health spending increased, but did not carve out an unfair share of growing public spending in the previous decade



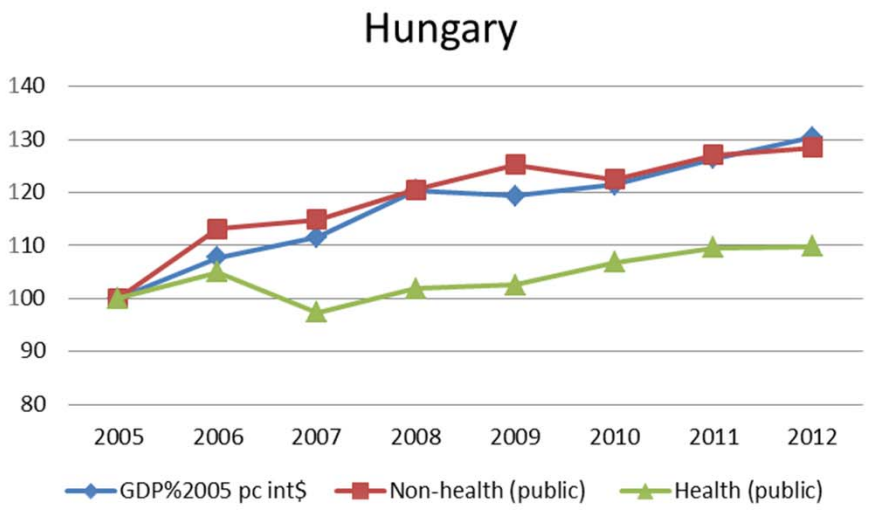
Source: WHO 2014; PPP adjusted international $ per capita averages, but the percentages reflect the averages of national-level data

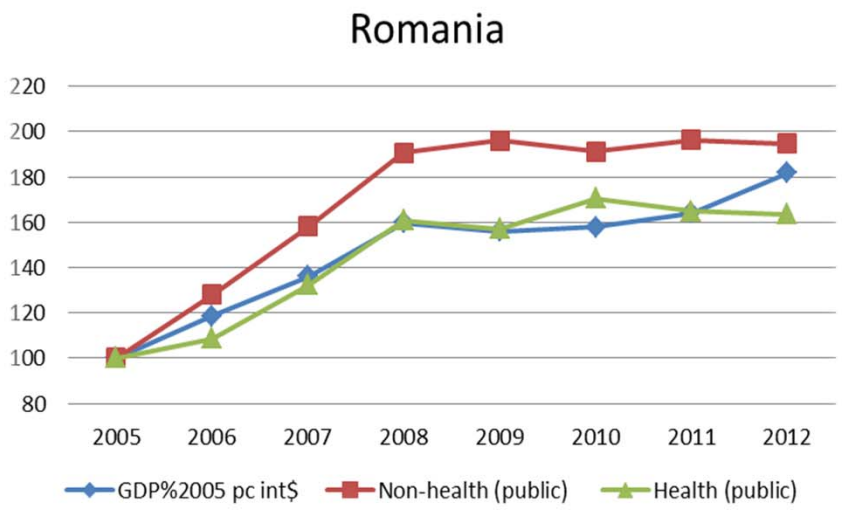
And its relative increase has almost disappeared as a result of the crisis

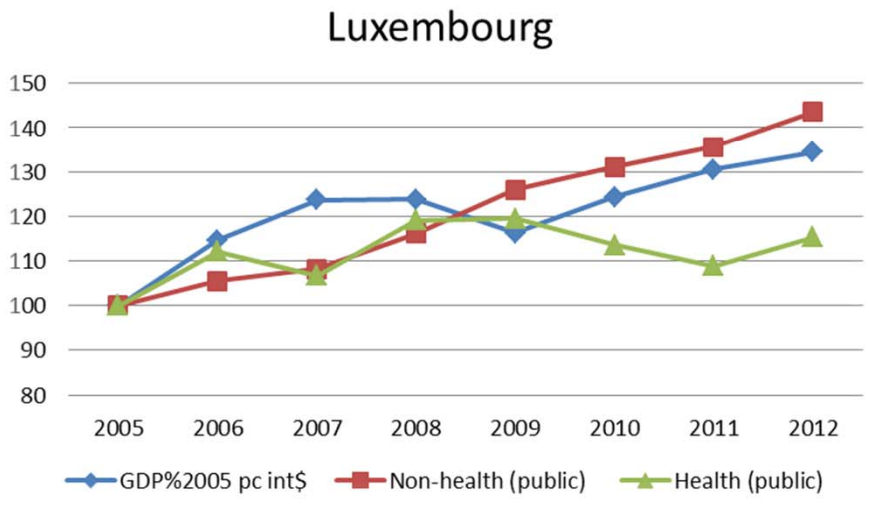


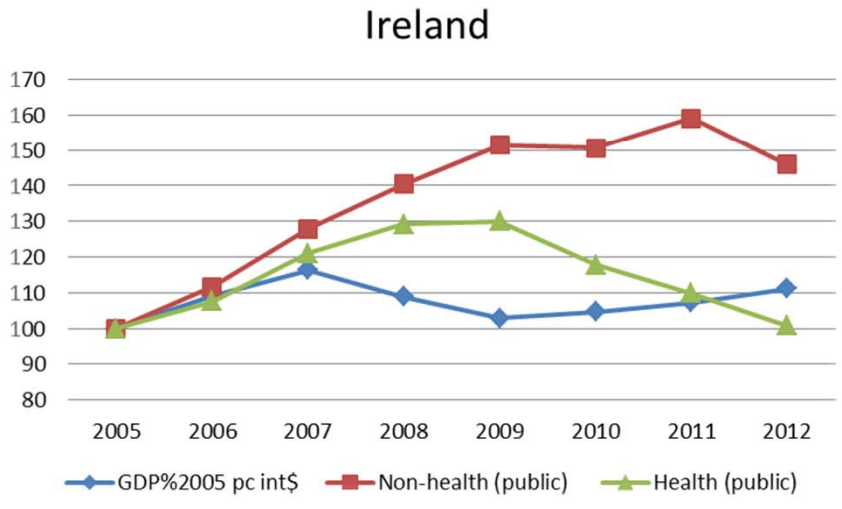
Source: WHO 2014; PPP adjusted international $ per capita averages, but the percentages reflect the averages of national-level data

Variation across countries in the relationship between GDP, non-health public spending and public spending on health

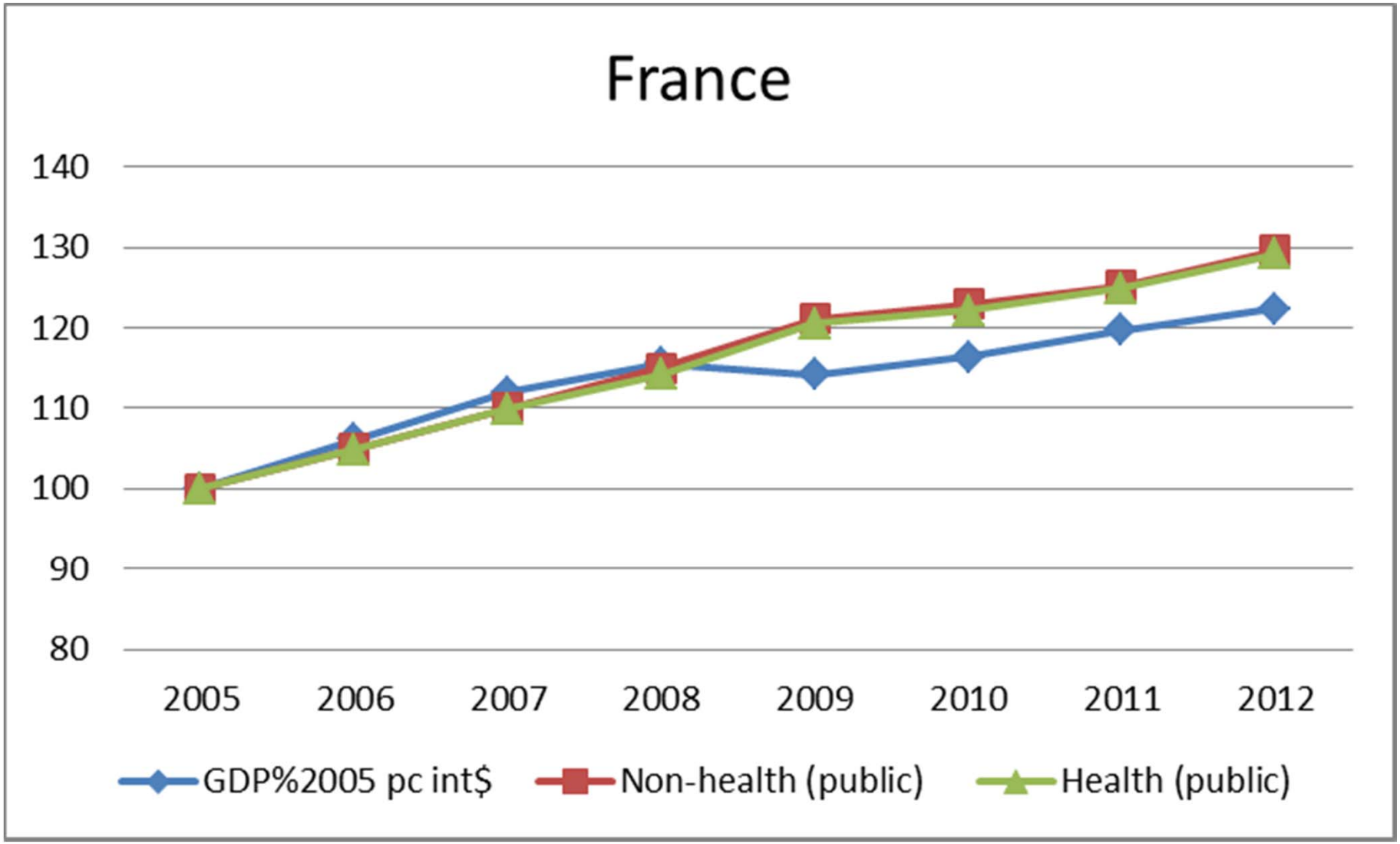








France cannot decide between health and non-health spending: clearly not sustainable



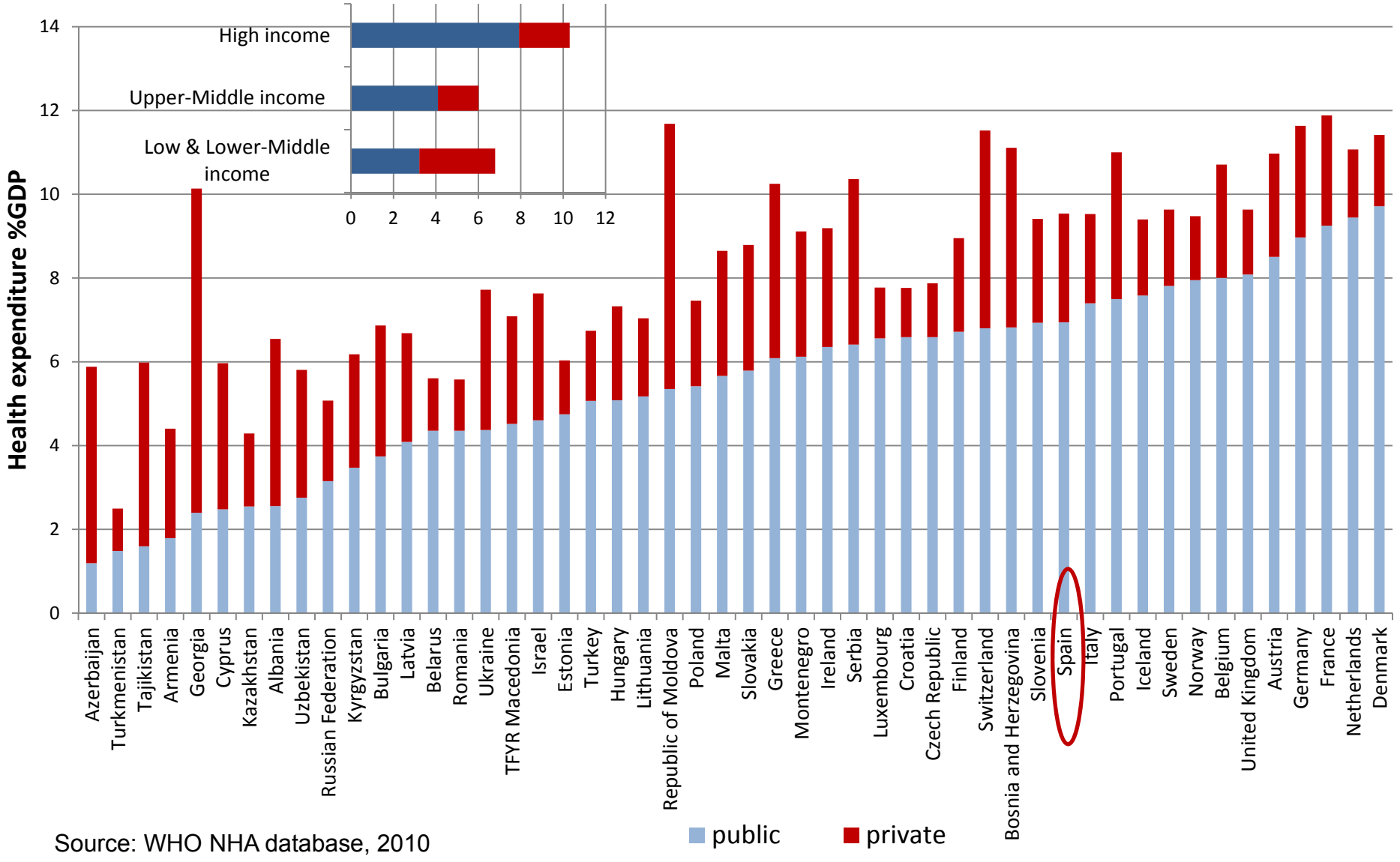
Outline

Lower public spending on health is a poor solution to fiscal sustainability

Insurance function and public financing

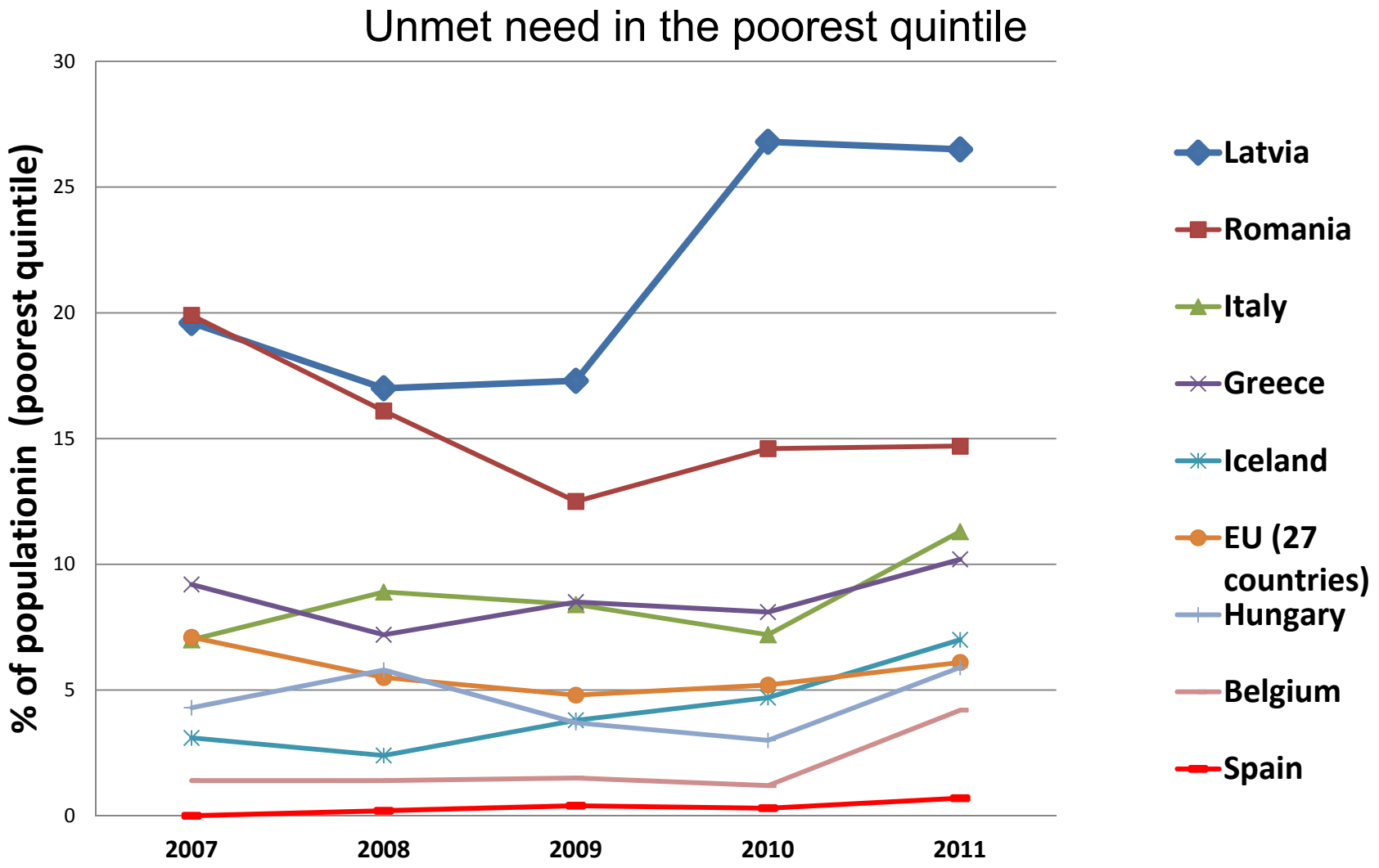
- Let's not forget the primary reason why health is a big ticket item on the public budget
- Public financing achieves better financial protection and equity in access to care i.e. health insurance according to need and not according to ability to pay
- These objectives should influence fiscal policy as well as cuts in spending when they are unavoidable

Private (mostly out-of-pocket) spending is high and growing: bad for health, inefficient and inequitable



Source: WHO NHA database, 2010

How much inequity is “sustainable” in Latvia?



Source: EU SILC

Efficiency gains are part of the solution…

„Improving efficiency is a far better option than cutting back on services or imposing fees that punish the poor”

Dr. Margaret Chan, Director-General
World Health Organization

…but spending cuts ≠ efficiency

Health systems need stable, predictable sources of revenue

The insurance function of public financing calls for counter-cyclical spending on health

Shifting the burden to patients is a poor alternative to many other options

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Economic crisis, budget cuts and health system performance

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Senior Health Financing Specialist

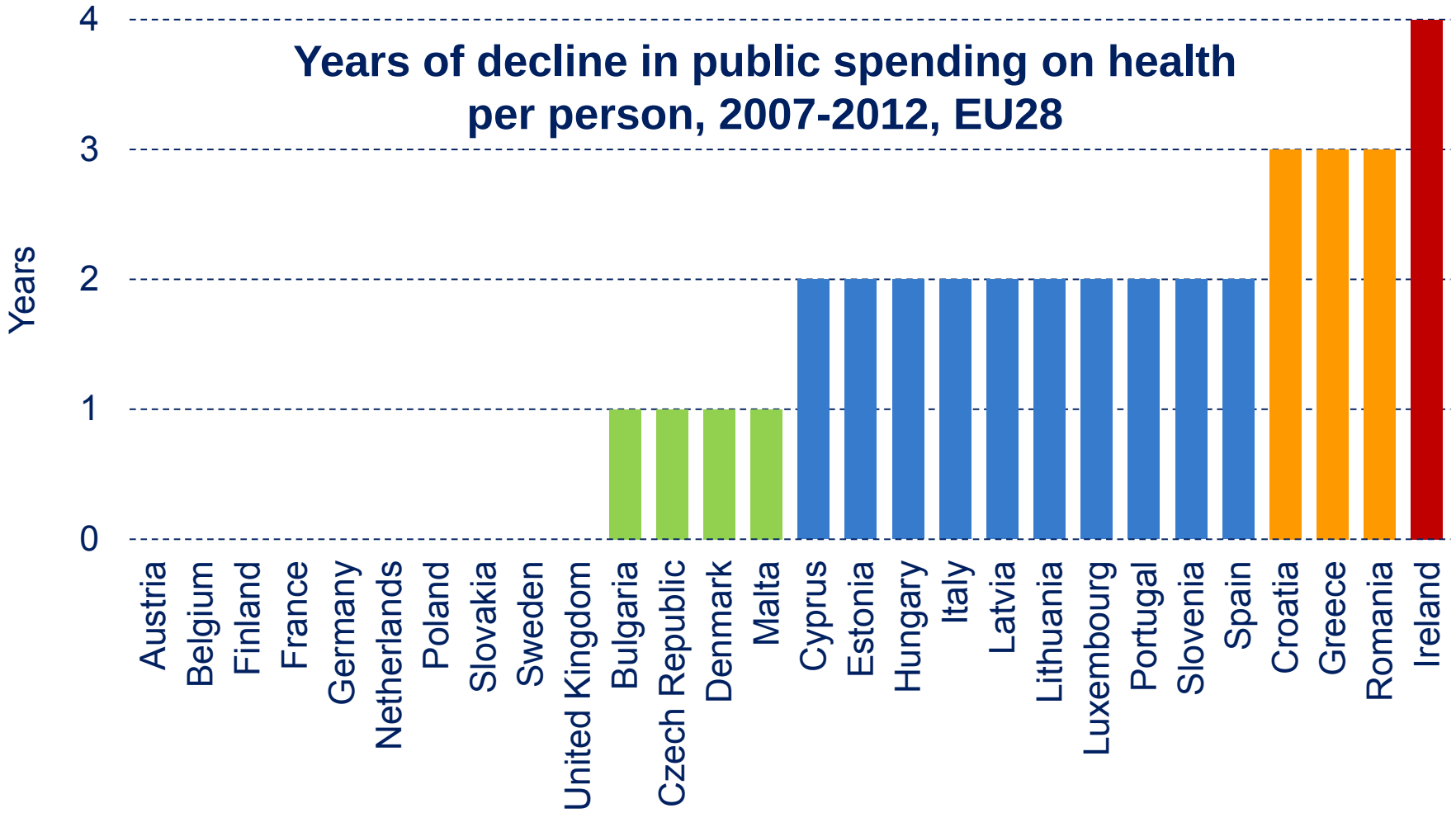
WHO Barcelona Office
Division of Health Systems and Public Health

Barcelona, 22 January 2015

Evidence from earlier economic shocks

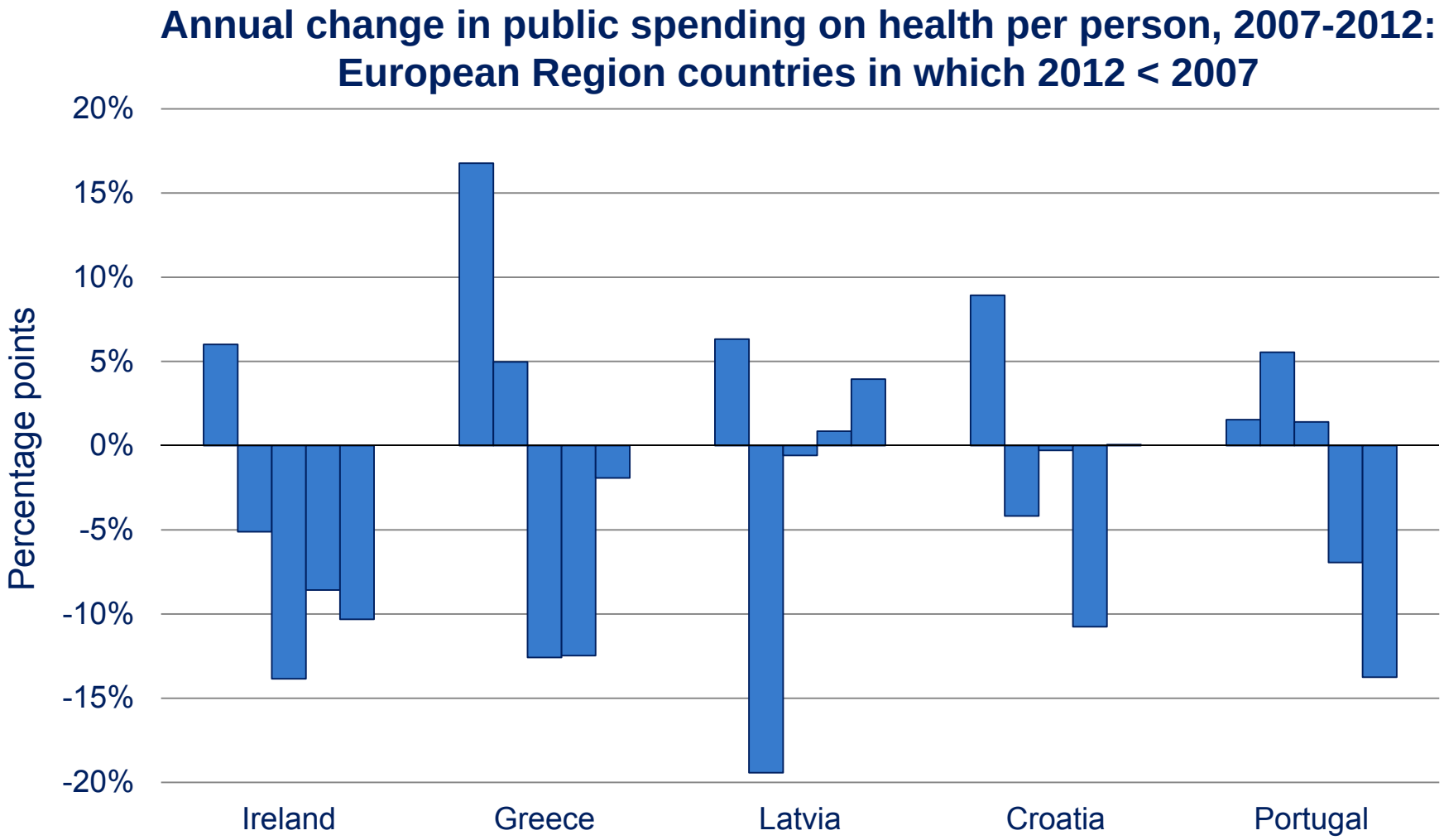
- Affect health but don't affect everyone equally: health worsens in people who lose their jobs
- Negative effects can be mitigated
- **Countercyclical public social spending is critical**: greater need, greater reliance on publicly financed services
- **Protecting access to health care is critical**, especially for those at risk of job loss, poverty

Decline in public spending on health: often small, sometimes sustained



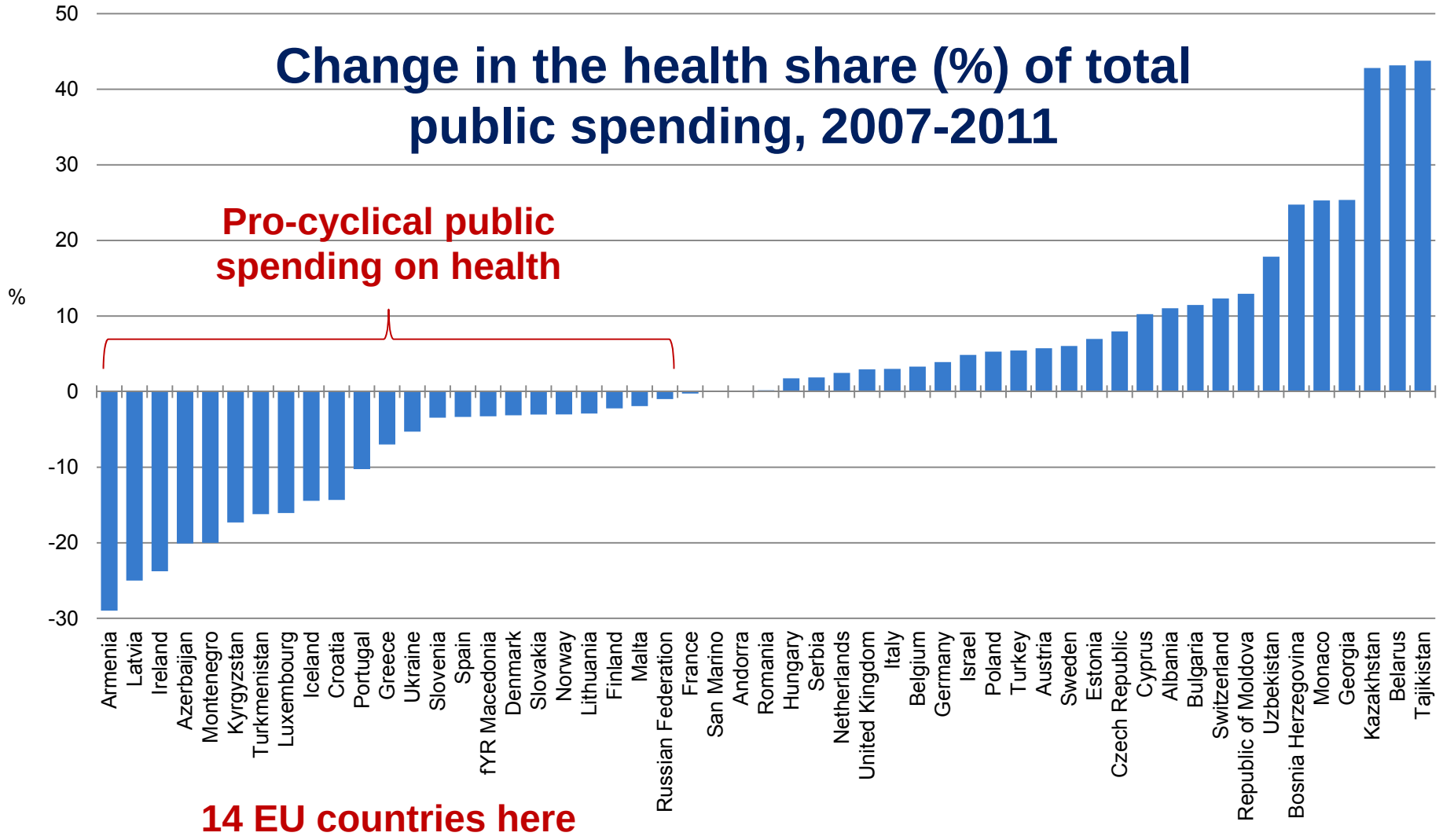
Source: Thomson et al 2014 using data from the WHO Global Health Expenditure Database

Decline in public spending on health: often small, sometimes severe

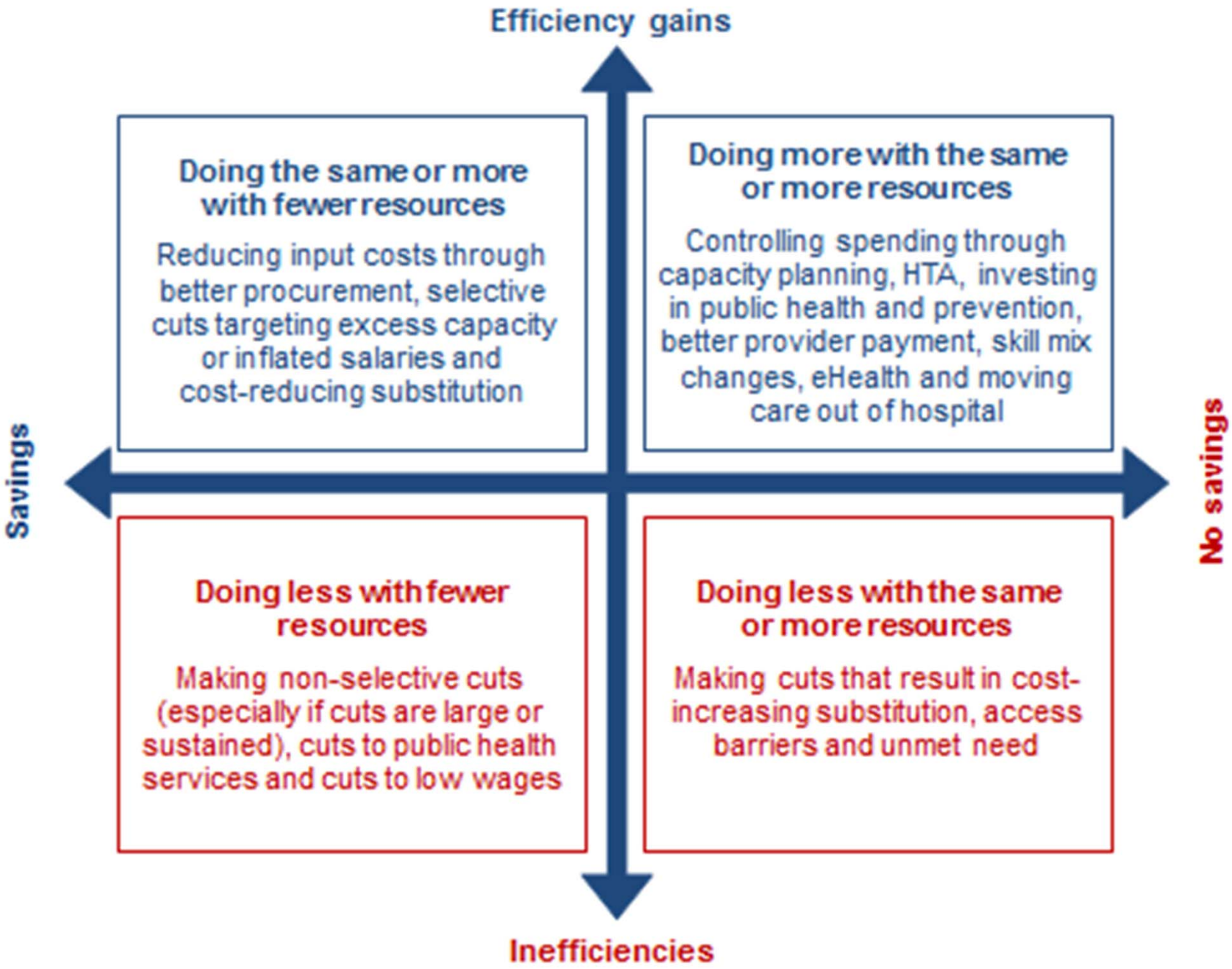


Source: Thomson et al 2014 using data from the WHO Global Health Expenditure Database

Evidence of pro-cyclical public spending on health



Source: Thomson et al 2014 using data from the WHO Global Health Expenditure Database



Source: Thomson et al 2014

The holy grail: savings and efficiency gains?

Policy response	Countries
Hospitals: lower prices and investment	28
Cuts to overhead costs	22
Drugs: efforts to lower prices	22
Health workers: lower pay and numbers	22
Hospitals: closures or mergers	11
Drugs: generic prescribing, substitution	9
Abolishing tax subsidies for richer people	2

The knee-jerk response: short-term savings and inefficiencies?

Policy response	Countries
Cuts to public health budgets	6
Cuts to primary care funding	5
Hospitals: lower prices and investment	28
Health workers: lower pay and numbers	22
Cuts to overhead costs	22

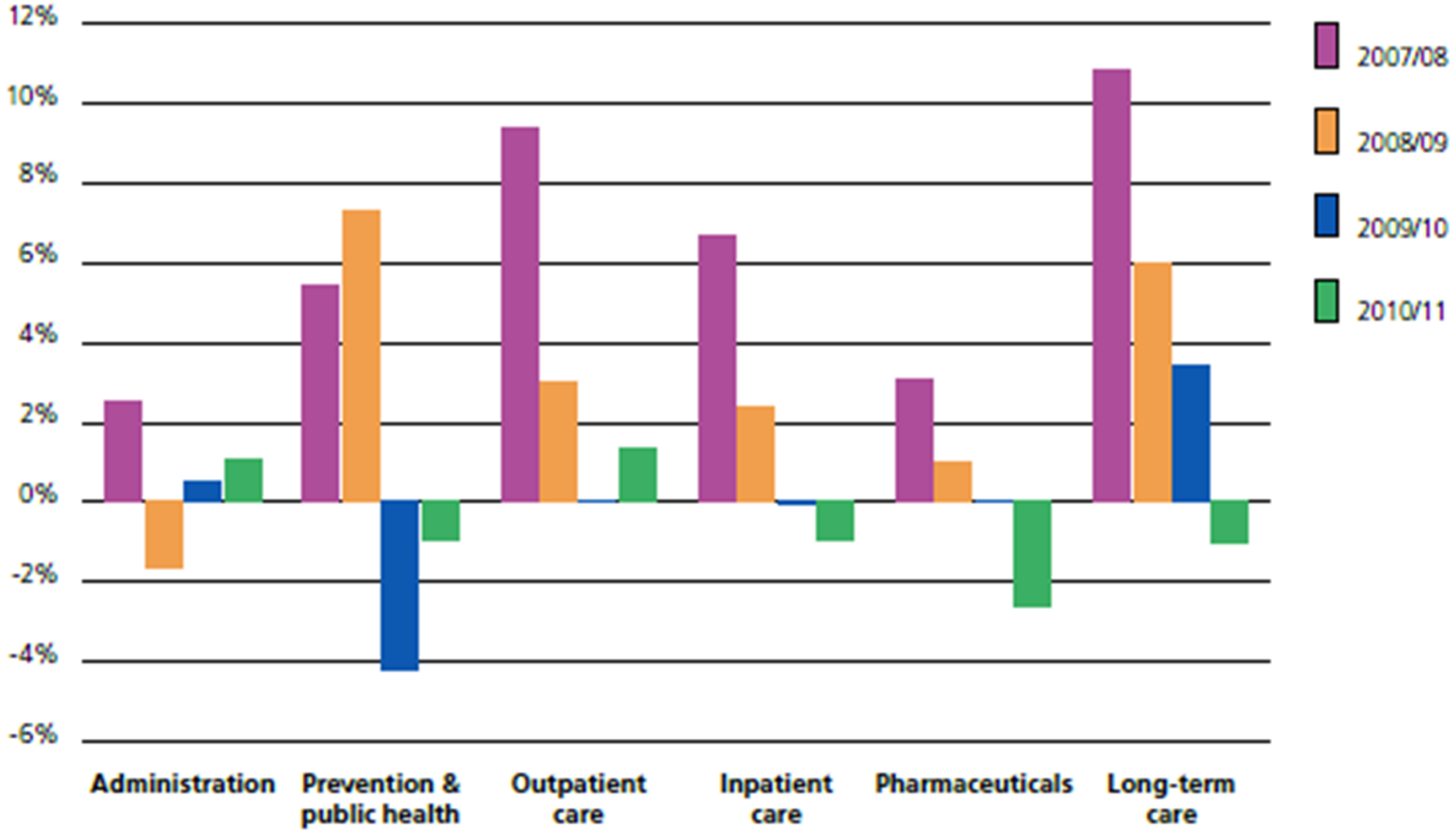
Longer-term thinking: efficiency gains without savings?

Policy response	Countries
Investing in promotion and prevention	12
Moving care out of hospital	11
More HTA to inform delivery	9
More HTA for coverage decisions	7
More eHealth	4
Increased funding for primary care	3
Primary care skill mix changes	3

(Unintended) consequences? No real savings, potential for inefficiencies

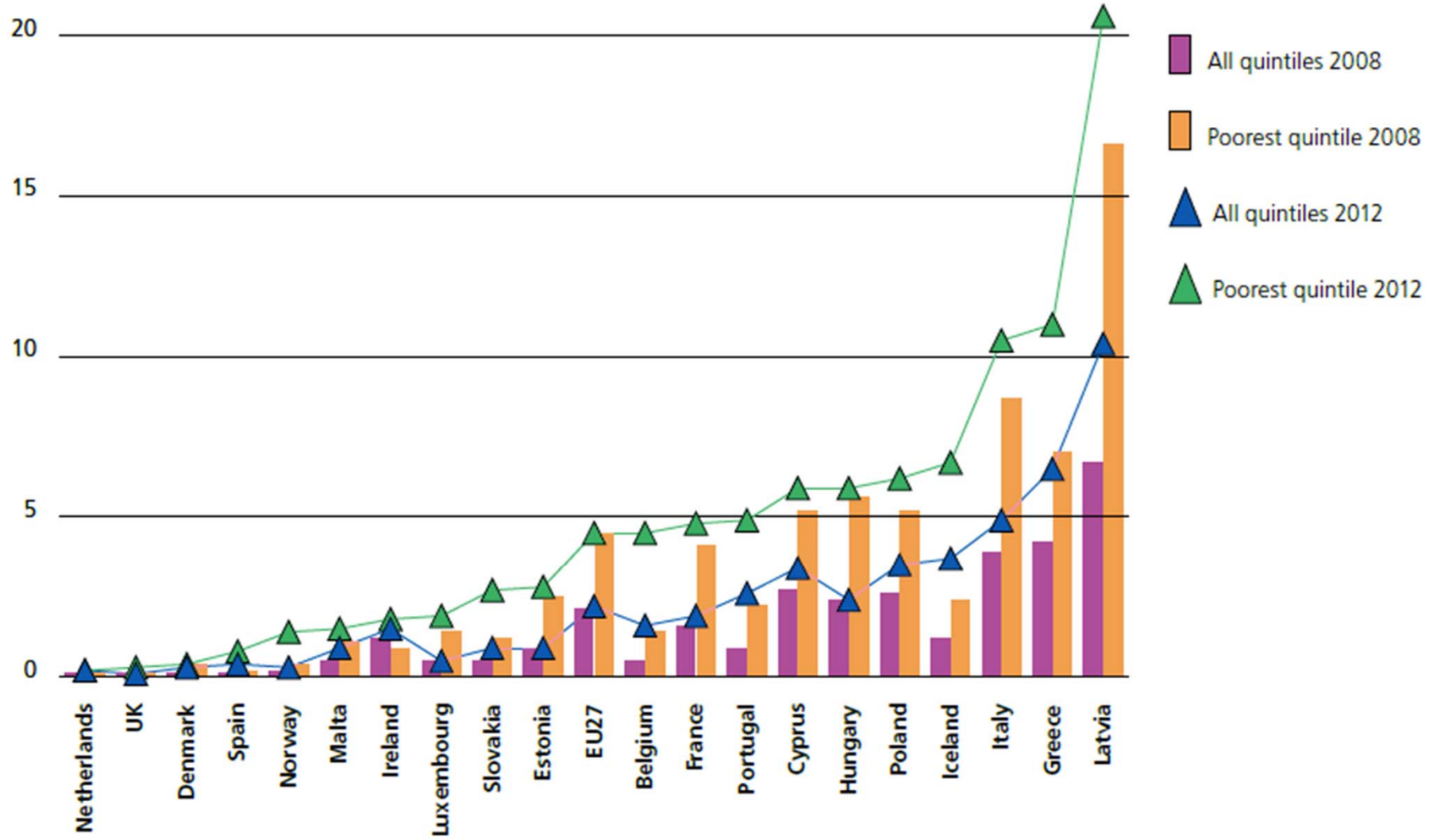
Policy response	Countries
New or higher user charges without protection for poorer, sicker people	13
Cuts to population entitlement for vulnerable groups of people	6

Annual change in spending on different parts of the health system



Source: Thomson et al 2014, OECD-WHO-Eurostat data for EU and Iceland, Norway, Switzerland

Evidence of higher unmet need due to cost, 2008-2012



Source: Thomson et al 2014 using data from EU-SILC and showing only countries in which unmet need due to cost rose

Policy makers have choices, even in austerity

Before cutting spending on health:

- consider the trade-offs
- balance short-term needs (economic fluctuation) and long-term needs (health, health system performance)

Where cuts are chosen make sure they are selective, informed by value and don't cost more in the long run

Next time: no horizontal cuts across the board

The importance (and limits) of improving efficiency

- Should be a permanent effort
- Avoid rushed implementation of complex reforms
- Reforms should be underpinned by capacity, investment, realistic timeframes
- Efficiency gains will not bridge a large/sustained gap between revenue and expenditure
- Many countries successfully mobilised additional public revenue

Looking ahead…

- Mitigating the negative effects of a crisis requires strong governance and leadership
- In spite of awareness, promoting access and financial protection was not a priority in economic adjustment programmes
- Limited evidence of negative effects: we have the tools to monitor but are not using them systematically

WHO-Observatory joint study: survey methodology

- Two waves of a questionnaire sent to health policy experts in 53 countries in 2011 and 2013
- In 2013, 92 experts in 47 countries responded
- Study summary: http://www.hfcm.eu/
- Full study available in 2015

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Monitoring Universal Health Coverage In Europe

Melitta Jakab
Senior Health Economist
WHO Barcelona Office

22 January 2015

Introduction

”Universal coverage is the hallmark of a government’s commitment, its duty, to take care of its citizens, all of its citizens. Universal coverage is the ultimate expression of fairness”

Dr. Margaret Chan, Director General, WHO at the 55th World Health Assembly

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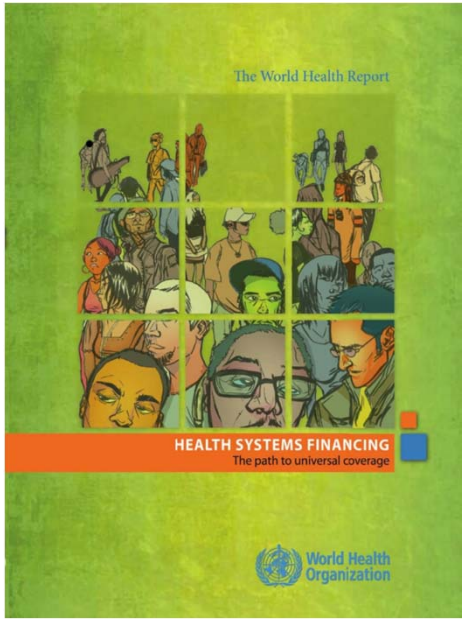
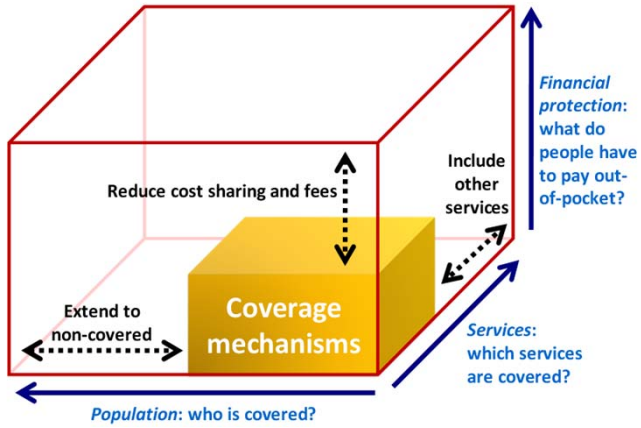
Definition of UHC

All people have access to needed health services (incl. prevention, promotion, treatment & rehabilitation) of sufficient quality to be effective

The use of these services does not expose any user (or his/her family members) to financial hardship





Derived from World Health Report 2010, p.6
Also World Health Assembly Resolution 58.33,

Measurement streams

All people have access to needed health services (incl. prevention, promotion, treatment & rehabilitation) of sufficient quality to be effective

MEASUREMENT STREAM 1

The use of these services does not expose any user (or his/her family members) to financial hardship

MEASUREMENT STREAM 2

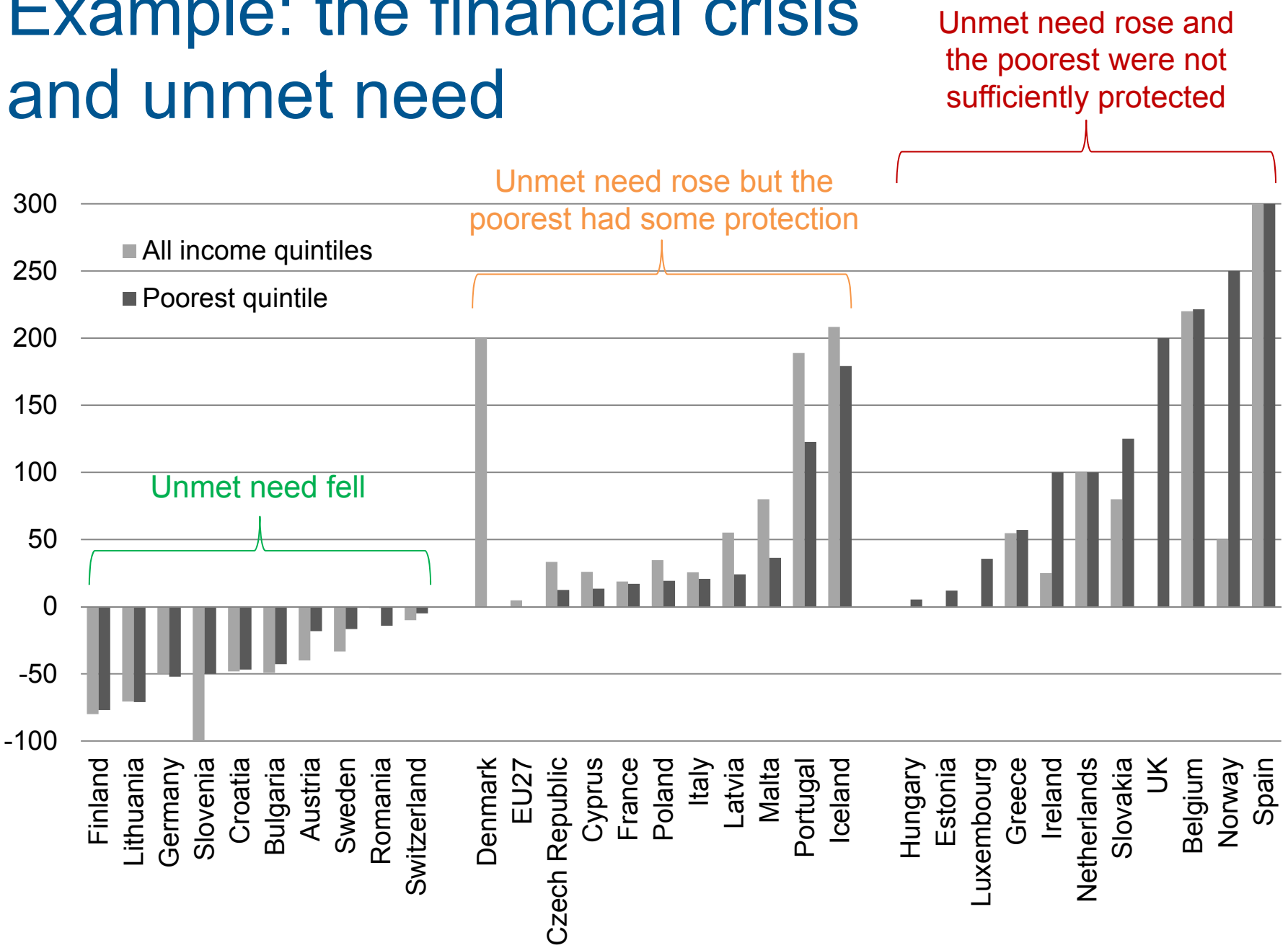
Derived from World Health Report 2010, p.6

Stream 1: Common approaches

- Approach 1: Perceived unmet need through surveys
  - Works in a large variety of contexts
  - Sensitive enough to policies that expand access
  - Good tool to monitor progress
  - Too general to prompt concrete policy action
- Approach 2: Indicators for tracer-conditions
  - Conditions with high epidemiological relevance
  - Evidence base that intervention is cost-effective
  - Quality adjusted
  - Measured regularly, reliably, and comparably

Equity: distribution across population

Example: the financial crisis and unmet need



Source: Thomson et al 2014 using data from EU-SILC and showing only countries in which unmet need due to cost rose

Example: Coverage of tracer conditions in the global monitoring framework

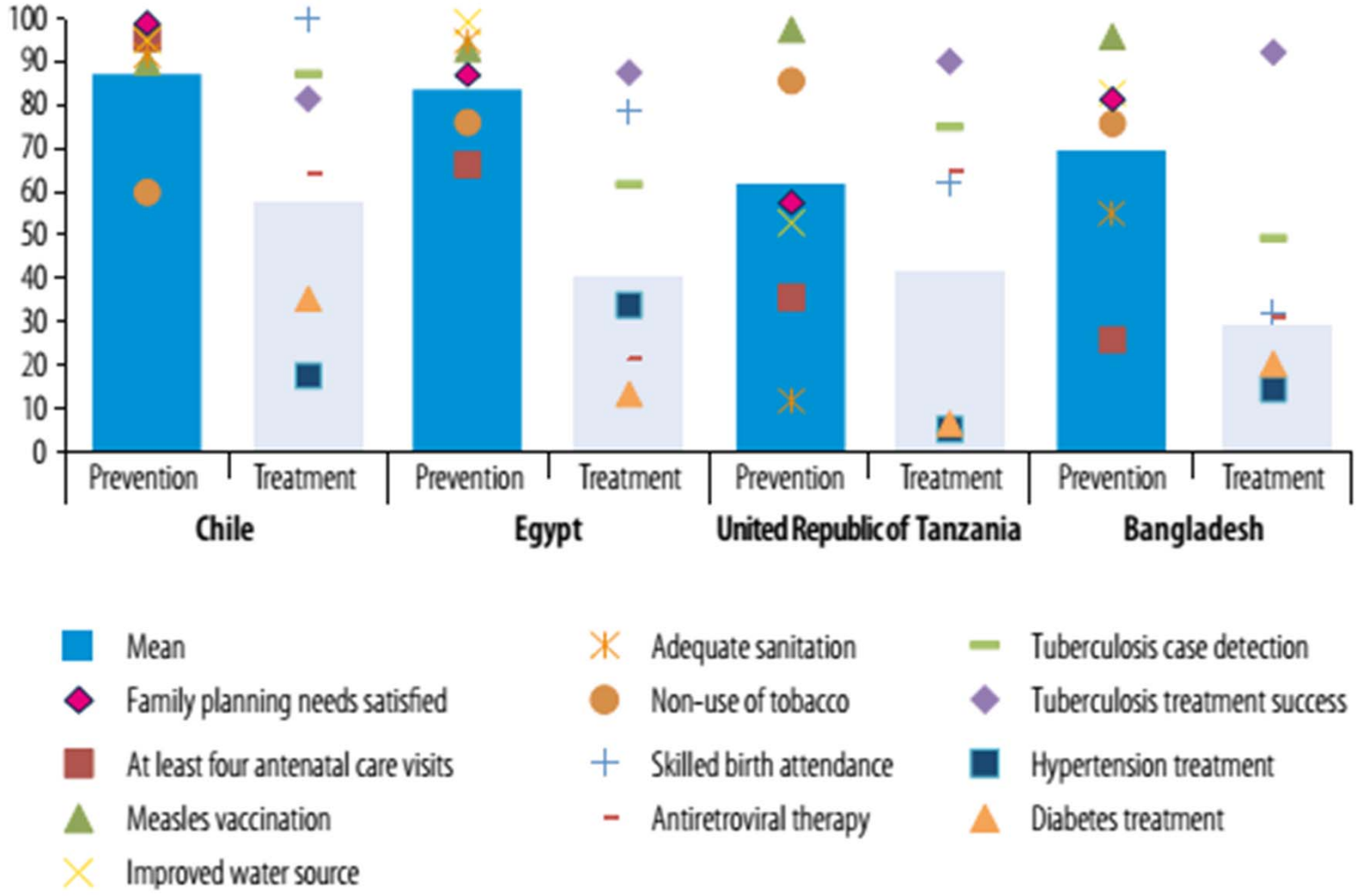
Prevention

- satisfaction of family planning needs
- at least four antenatal care visits
- measles vaccination in children
- improved water source
- adequate sanitation
- non-use of tobacco.

Treatment

- skilled birth attendance
- antiretroviral therapy
- tuberculosis case detection and treatment success (combined into a single indicator)
- hypertension treatment
- diabetes treatment

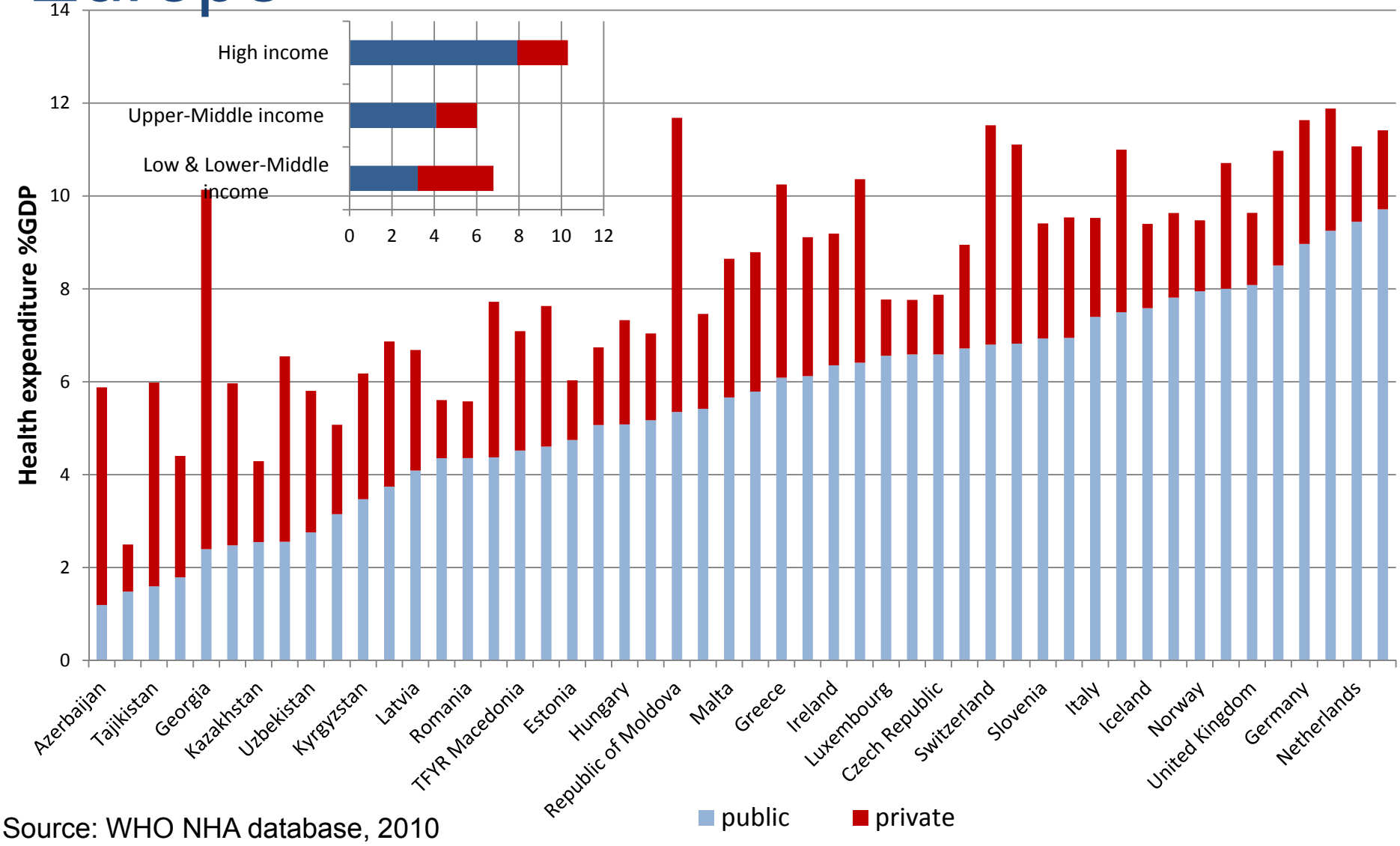
Coverage in four countries



Stream 2: Basic considerations

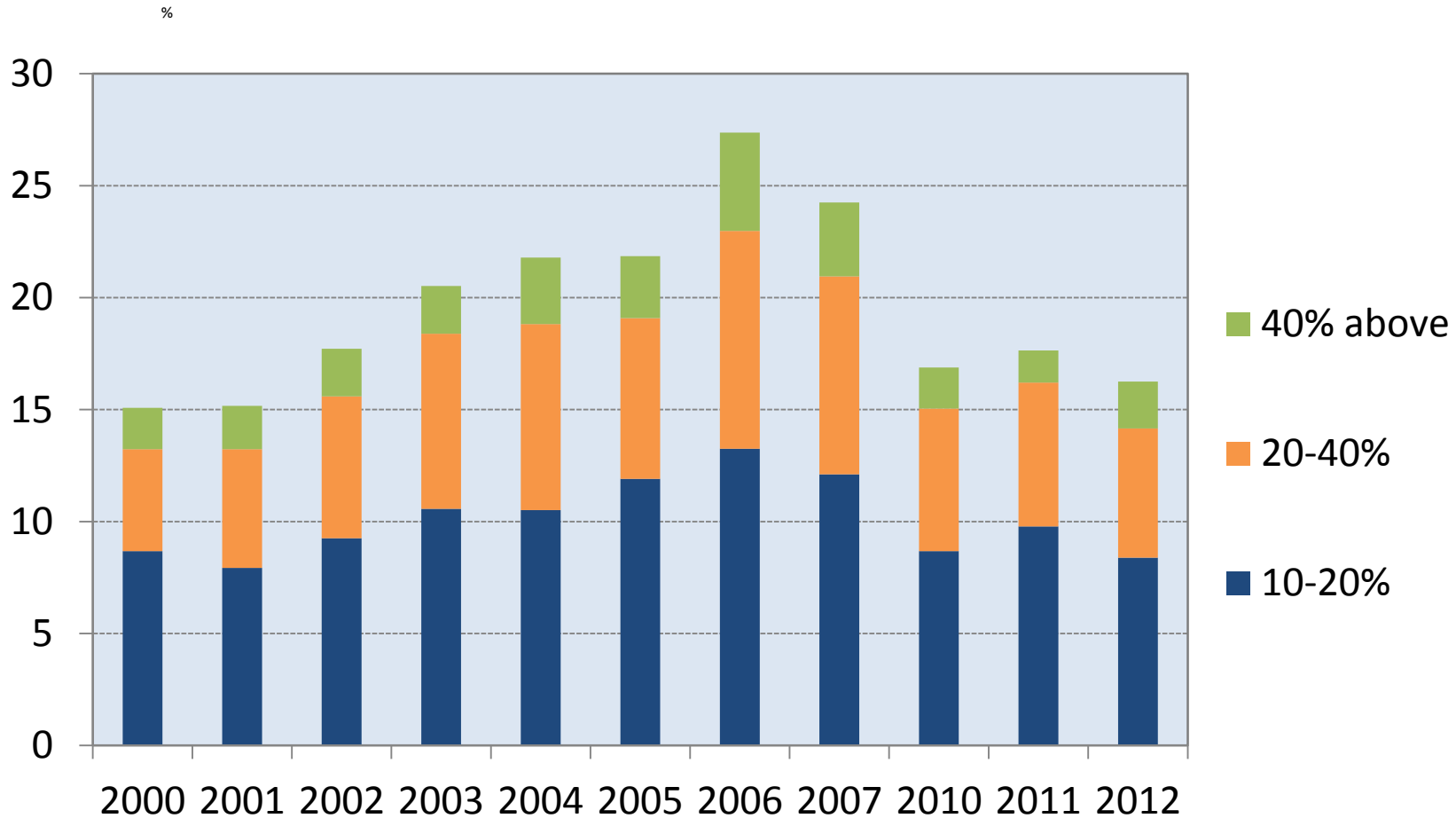
- Measurement of financial protection advanced much in past decade
- Financial protection is the degree to which households are protected from financial risk when ill
- Frequently used measures include **catastrophic** and **impoverishing expenditures**
- Requires household survey
- Quality of survey can greatly influence the result and hence seemingly goal attainment

Public – private expenditure mix in Europe

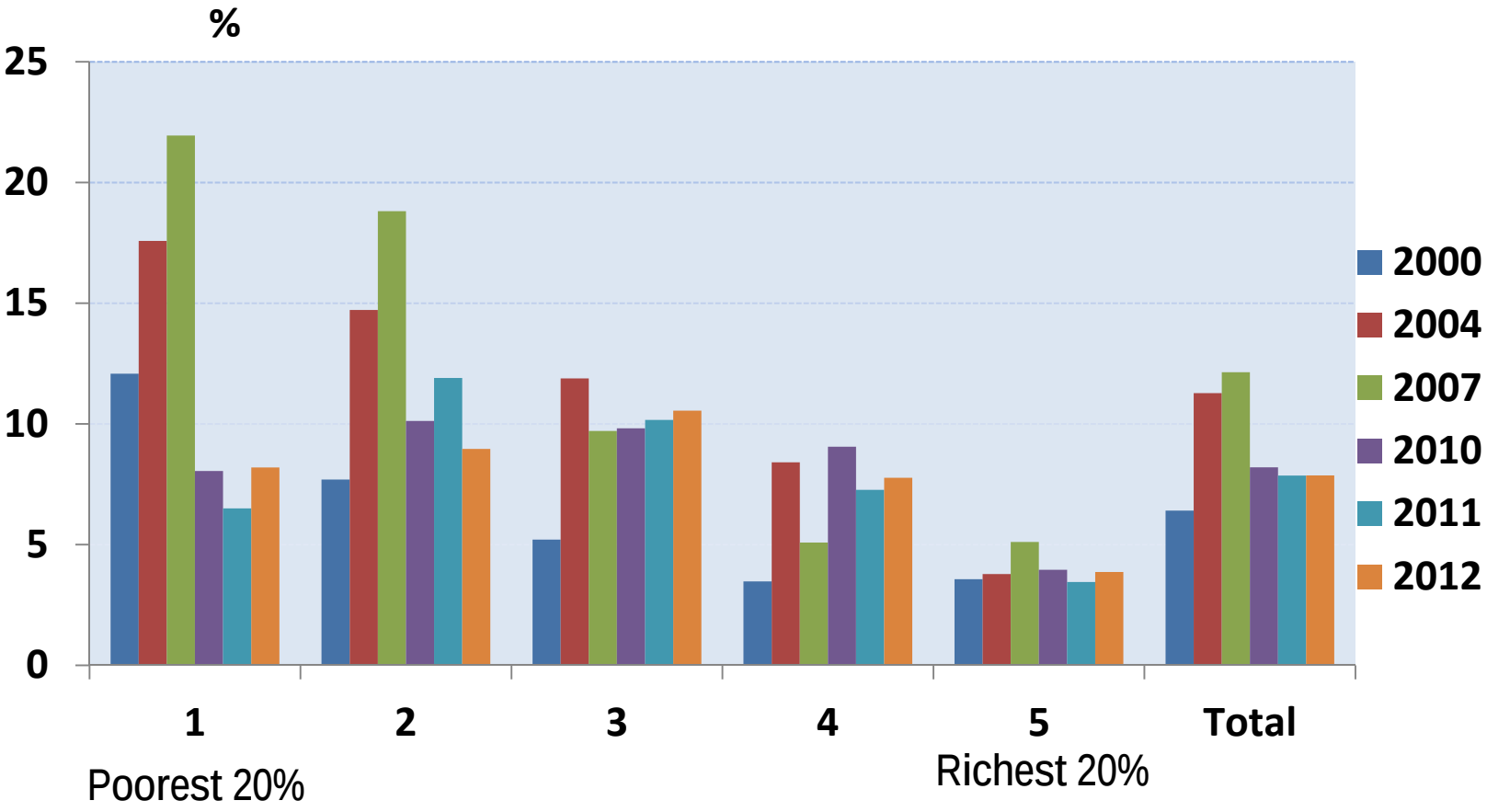


Source: WHO NHA database, 2010

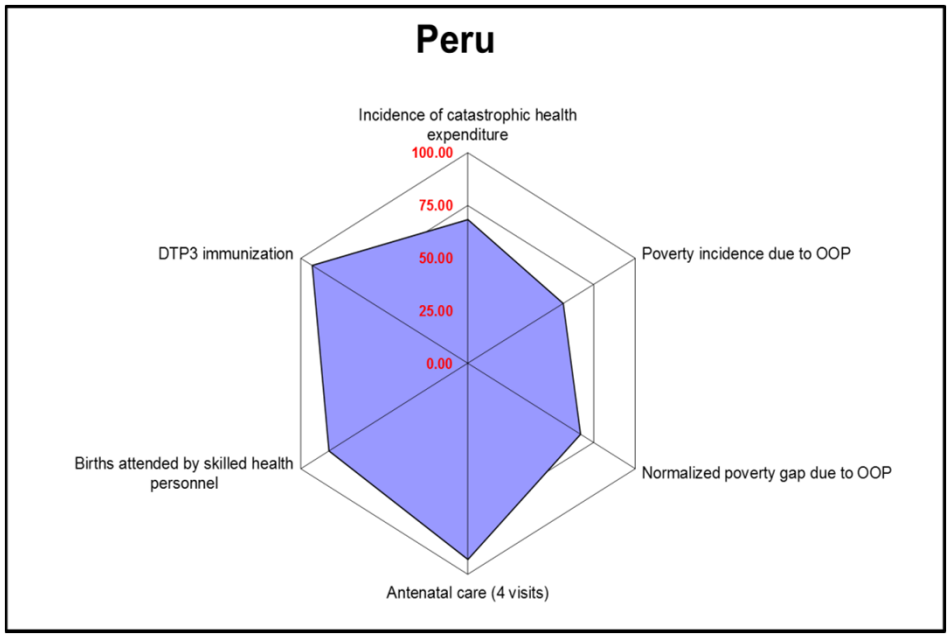
Incidence of catastrophic expenditures in Estonia

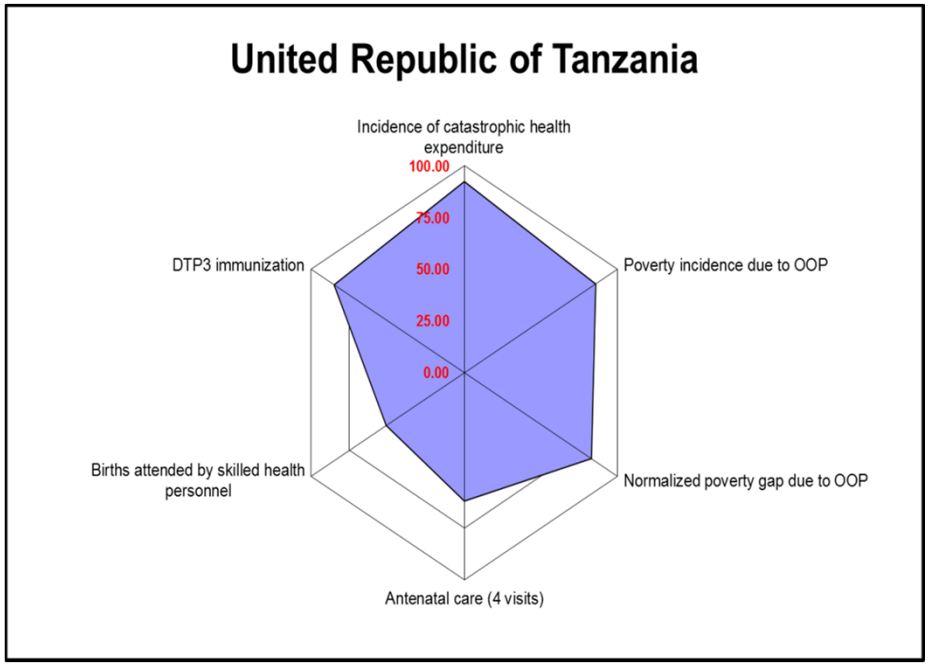


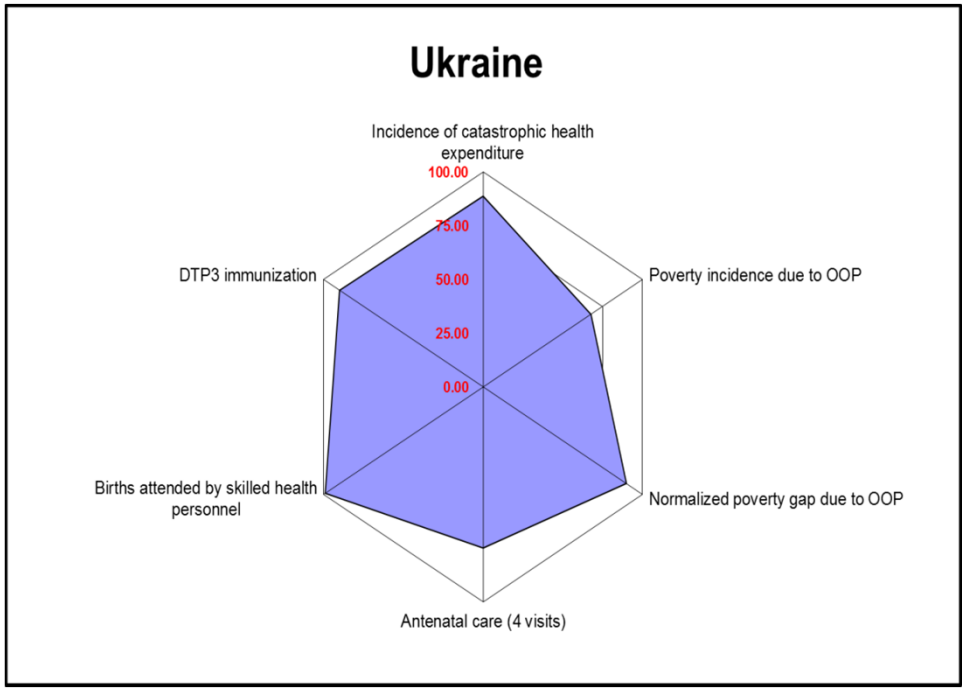
Incidence of catastrophic expenditures in Estonia by income quintile



Bringing stream 1 and 2 together: Benchmarking health system performance







Policy instruments (1)

- **Predominance of stable and predictable public financing** with as broadly based revenue collection mechanisms as possible
- **Single pool** of all public funding (general tax and payroll tax) preferably at national or oblast levels
- **New purchasing mechanisms** linked to population and/or outputs rolled out boldly

Policy instruments (2)

- **Realistic, equitable, and evidence based benefit design**
  - Respecting the size of the funding envelope and fiscal space while ensuring predictable public funding
  - Protecting equity through a transparent and simple mechanisms of co-payments with exemptions
  - Ensuring that the benefit package reflects evidence based, high-impact and low-cost interventions

Policy instruments (3)

- Attention to **transparency**, **governance** and **accountability** arrangements is key
  - Opportunity to reinforce important public financing management reforms

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WHO Barcelona Office for Health Systems Strengthening

- Established in 1999
- Supported by the Government of the Autonomous Community of Catalonia, Spain
- Focuses on health systems financing: analytical work and capacity building
- Staff work directly with Member States across the European Region
- Part of the Division of Health Systems & Public Health of the WHO Regional Office for Europe www.euro.who.int

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