Increasing the fiscal sustainability of health care systems in the European Union to ensure access to high quality health services for all

EPC
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In 1 min the story is as follows

Most EU MS face significant fiscal challenges, which are to a growing degree driven by increasing health care expenditure.

Increases in HC expenditure are a policy parameter and not really driven by unavoidable demographic trends.

Current reform efforts focus on generating short-term savings and seem to leave ample room to increase health system performance.

Therefore, the European Commission will continue to monitor this area of public spending.

European Commission

Thank you!

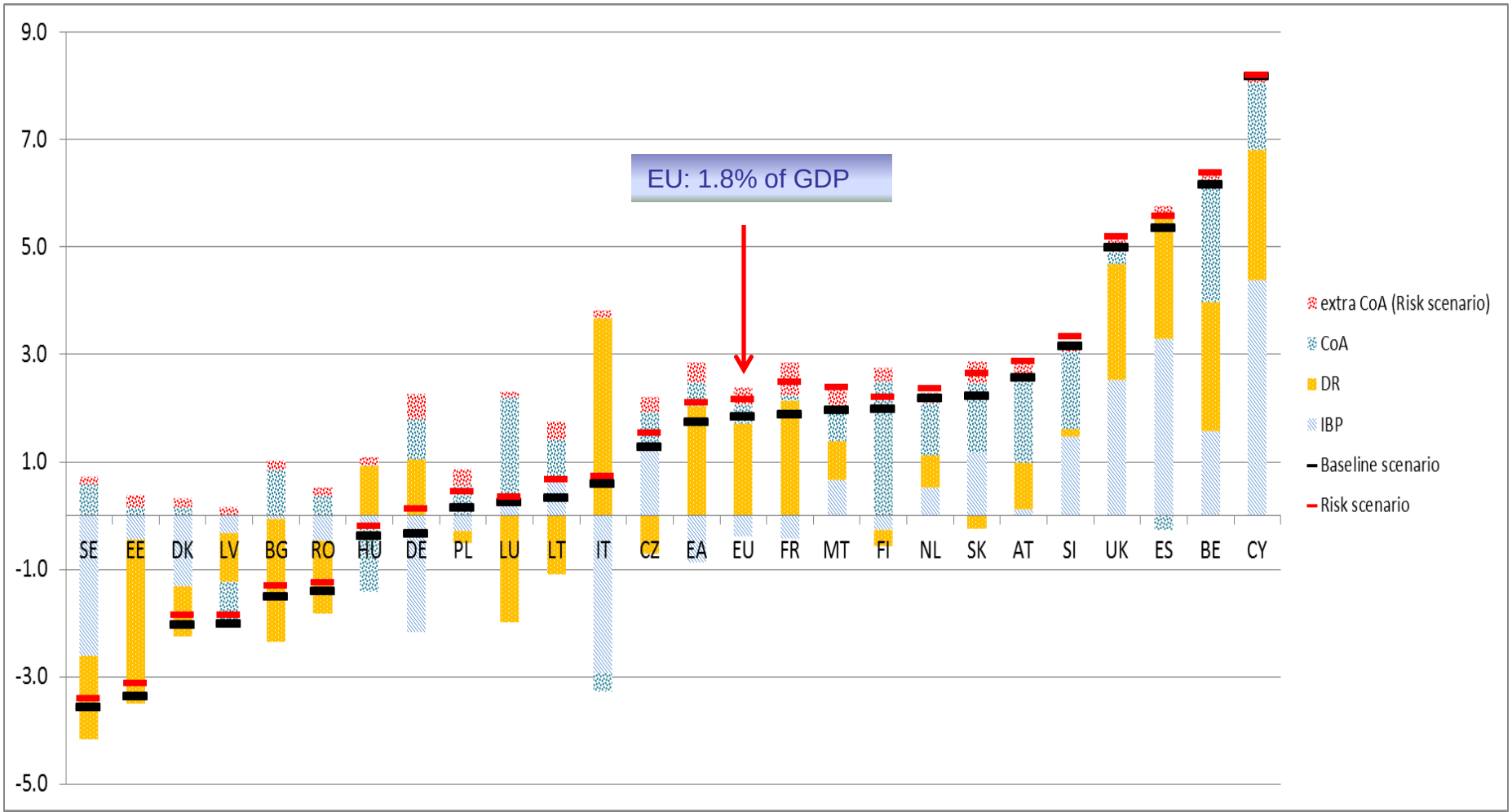
Fiscal sustainability report 2012

(tax-gap indicators)

- **S1: Required primary balance (PB) adjustment to reach 60 % debt ratio in 2030**
- **S2: Required PB adjustment to keep debt bounded over an infinite horizon (intertemporal budget constraint of general government)**

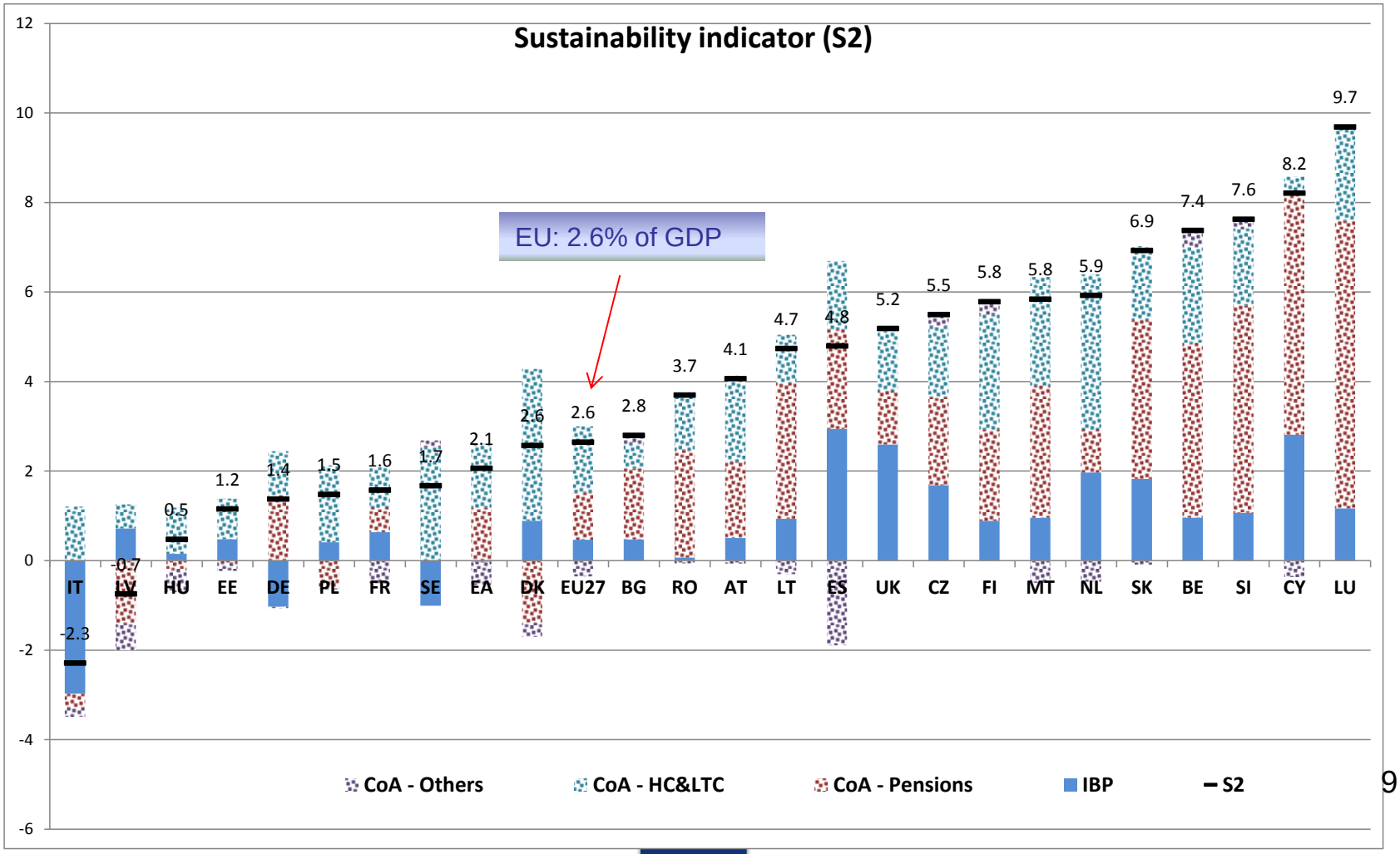
FSR2012 : Medium term challenges (S1)

- 3 Components: CoA=cost of ageing DR= Debt ratio IBP= Initial Budgetary position



FSR2012 : Long term challenges (S2)

- Differences in composition of the long-term challenges



Fiscal Sustainability Report 2012: results

European Commission

	S0	S1	S2
DE	0.04	-0.3	1.4
AT	0.09	2.6	4.1
FI	0.13	2.0	5.8
NL	0.13	2.2	5.9
SE	0.15	-3.6	1.7
FR	0.19	1.9	1.6
CZ	0.19	1.3	5.5
LU	0.20	0.3	9.7
LT	0.22	0.3	4.7
SI	0.23	3.2	7.6
BE	0.23	6.2	7.4
DK	0.24	-2.0	2.6
EE	0.25	-3.4	1.2
SK	0.26	2.2	6.9
LV	0.26	-2.0	-0.7
HU	0.28	-0.4	0.5
IT	0.28	0.6	-2.3
UK	0.29	5.0	5.2
MT	0.29	2.0	5.8
PL	0.32	0.1	1.5
RO	0.34	-1.4	3.7
BG	0.38	-1.5	2.8
ES	0.44	5.3	4.8
CY	0.57	8.2	8.2

Scale of challenge

Green: low risk

Yellow: medium risk

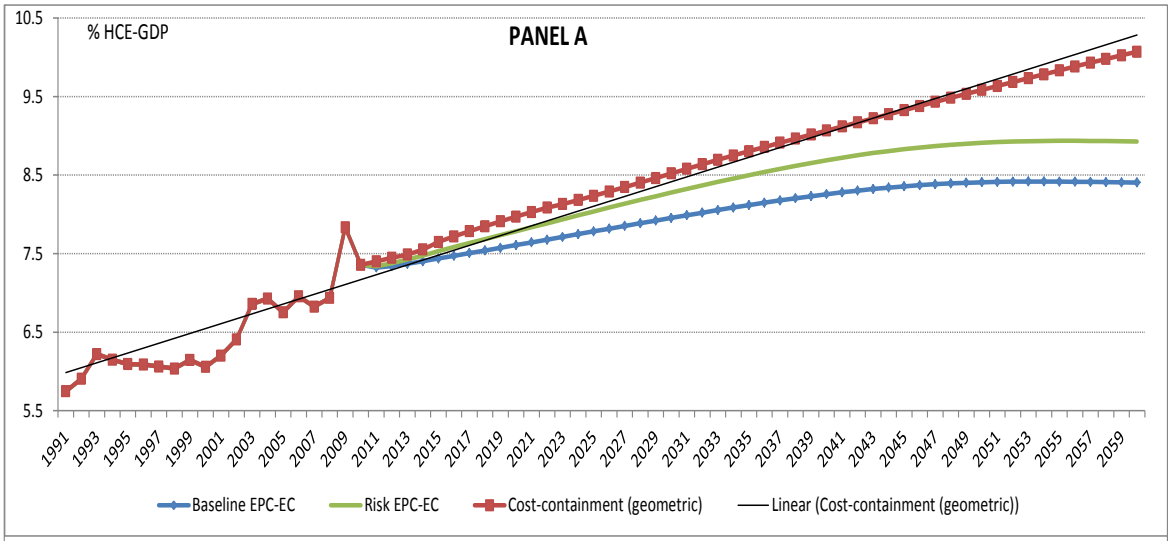
Red: high risk

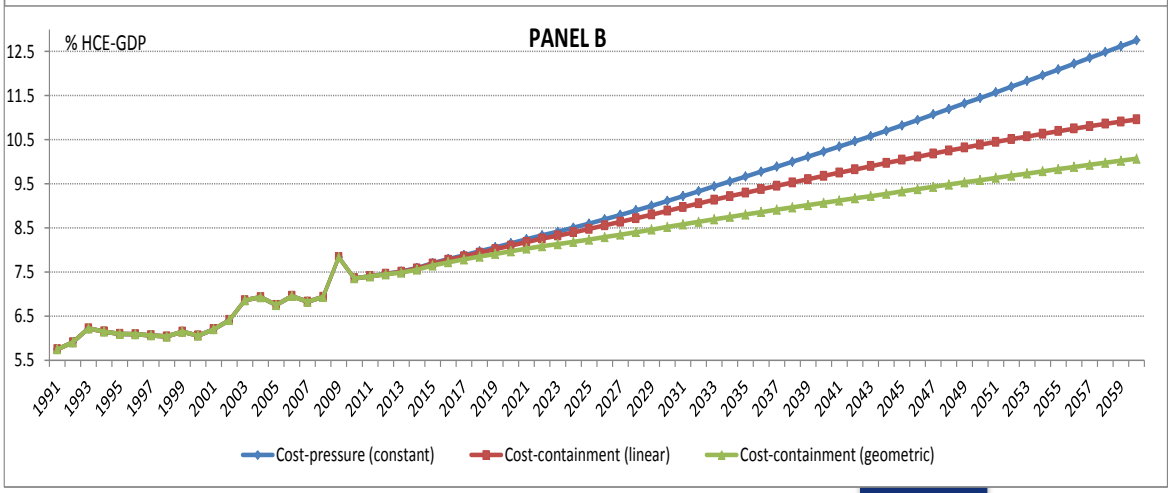
Assessing the fiscal challenges (of healthcare)

- 2012 Fiscal Sustainability Report: 22 Member States have challenges to the sustainability of public finances of medium to long-term nature
- For many of these the adjustment need due to the structural component (pensions, health/long-term care, education) is large
- 70% of the increase in age-related expenditure between 2010-2060 is due to healthcare and long-term care costs
- Question of **affordability**

Source: European Commission, own calculations.

Projections of public expenditure on health





Results:

1) Large increase also under most favourable scenario + 3pp of GDP by 2060
2) In line with existing estimates
3) EPC/EC projections below ii) and iii), reflecting the absence of a time drift

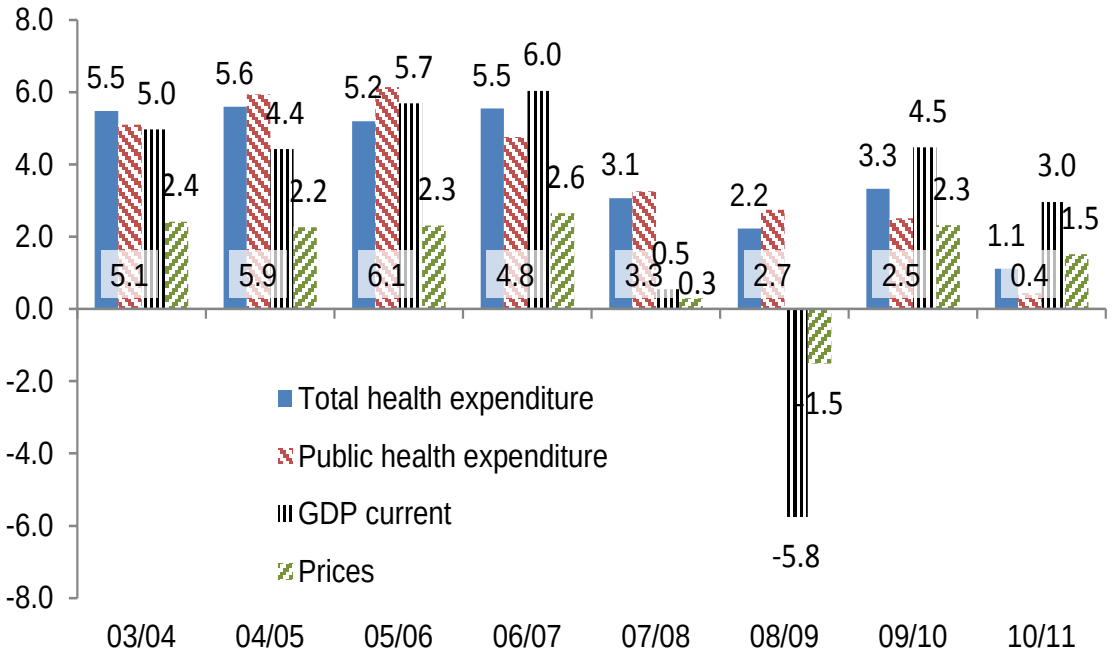
Drivers of public expenditure on health

	Period	Number of observations	alth spendi	Age effect	Income effect (c)	Price effect (d)	Residual
			(1)	(2)	(3)	(4)	(5)=(1)-(2)-(3)-(4)
BE	1996-2010	14	1.7	0.1	1.0	-0.3	0.9
BG	1992-2007	16	-0.1	0.1	2.1	-0.6	-1.7
CZ	1994-2010	14	0.4	0.1	1.8	-0.9	-0.6
DK	1985-2010	26	1.0	0.1	0.9	-0.5	0.6
DE	1993-2010	18	1.5	0.3	0.8	-0.2	0.6
EE	1996-2010	15	0.6	0.1	3.5	-1.4	-1.5
IE	1996-2010	15	3.3	-0.1	2.5	-0.9	1.8
EL	1988-2010	23	2.8	0.2	1.3	-0.3	1.7
ES	1985-2010	25	3.1	0.1	1.4	-0.3	1.9
FR	1991-2010	19	1.2	0.1	0.7	-0.3	0.7
IT	1989-2010	22	1.8	0.2	0.6	-0.1	1.0
CY	1996-2011	16	4.5	0.0	0.8	-0.4	4.1
LV	1992-2008	14	2.0	0.2	1.1	-0.8	1.5
LT	1996-2009	12	3.9	0.2	3.1	-2.0	2.5
LU	1985-2009	23	2.2	0.0	2.3	-0.8	0.7
HU	1993-2010	17	-0.5	0.1	1.6	-0.5	-1.6
MT	1996-2009	14	3.0	0.2	1.3	-0.7	2.2
NL	1985-2009	24	2.9	0.1	1.3	-0.3	1.7
NO	1985-2011	25	2.2	0.0	1.2	-0.3	1.3
AT	1985-2009	25	2.4	0.1	1.3	-0.4	1.4
PL	1993-2010	17	2.3	0.1	3.2	-0.9	0.0
PT	1996-2010	14	2.2	0.2	0.9	-0.4	1.5
RO	2000-2009	10	2.8	0.1	3.4	-1.9	1.3
SI	1993-2010	18	1.4	0.3	2.2	-0.5	-0.7
SK	1996-2010	15	1.9	0.0	2.9	-1.1	0.1
FI	1985-2011	25	1.7	0.2	1.3	-0.7	0.9
SE	1994-2010	17	1.2	0.0	1.6	-0.6	0.1
UK	1994-2010	16	3.2	0.0	1.4	-0.5	2.3
Non-weighted avg./tot		509	2.0	0.1	1.7	-0.7	0.9
% of total				5.4	83.9	-32.4	43.2
Weighted average			2.0	0.1	1.2	-0.4	1.1
% of total				7.0	59.0	-18.2	52.1

Data 1985-2010.
1/ regression to find income and age effect and price elasticities; 2/ decomposition of health expenditure growth
Results:
price effects dampened expenditure by 18%,
per capita income explains 59% of the total increase in expenditure while demographic composition 7% and residual 52%.
Residual capturing effect of omitted variables such as technologic innovations in the medical field and policy regulations.
i.e. demographic changes played a minor role in driving up public expenditure on health compared to non-demographics elements.

Past trends in health expenditures /1

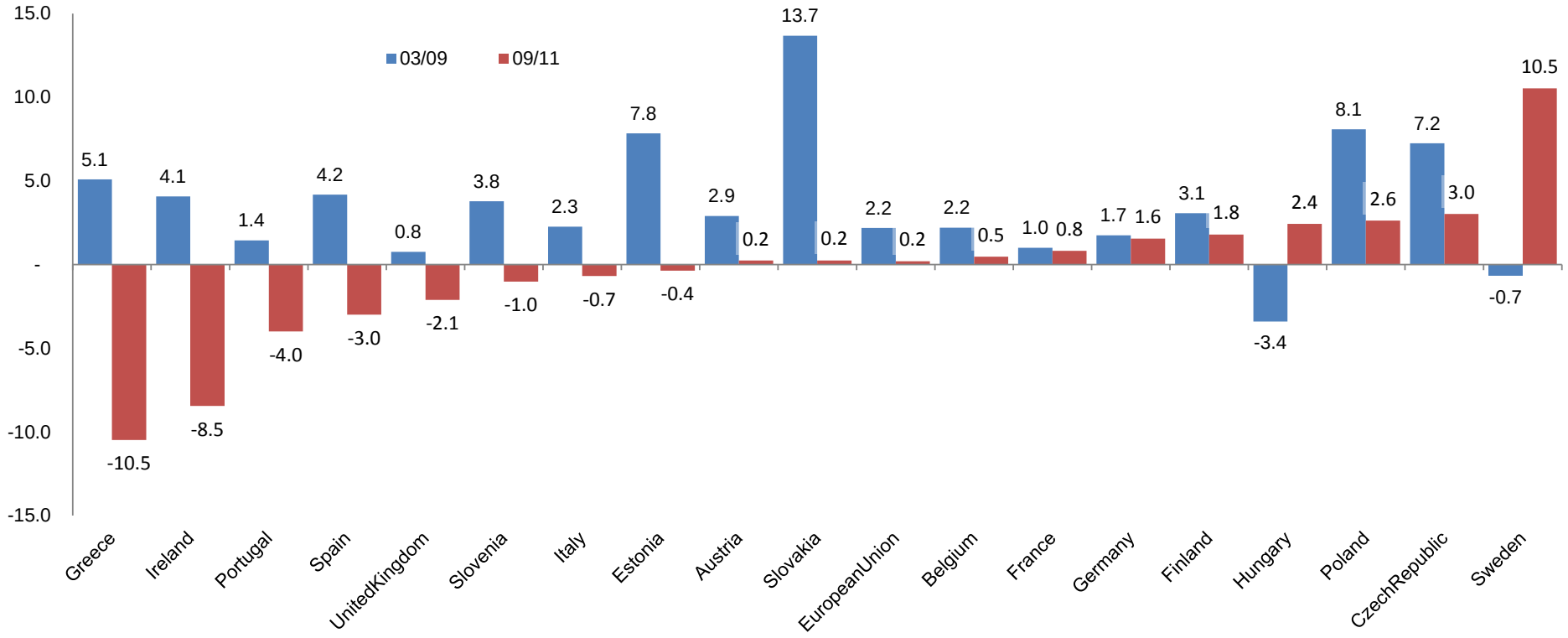
Graph: Annual average growth rates in nominal total and public health expenditure



Rapid increase in early 2000s with slow down during crisis. Since 2010, many MS undertook or planned reforms to adapt system financing and generate savings.

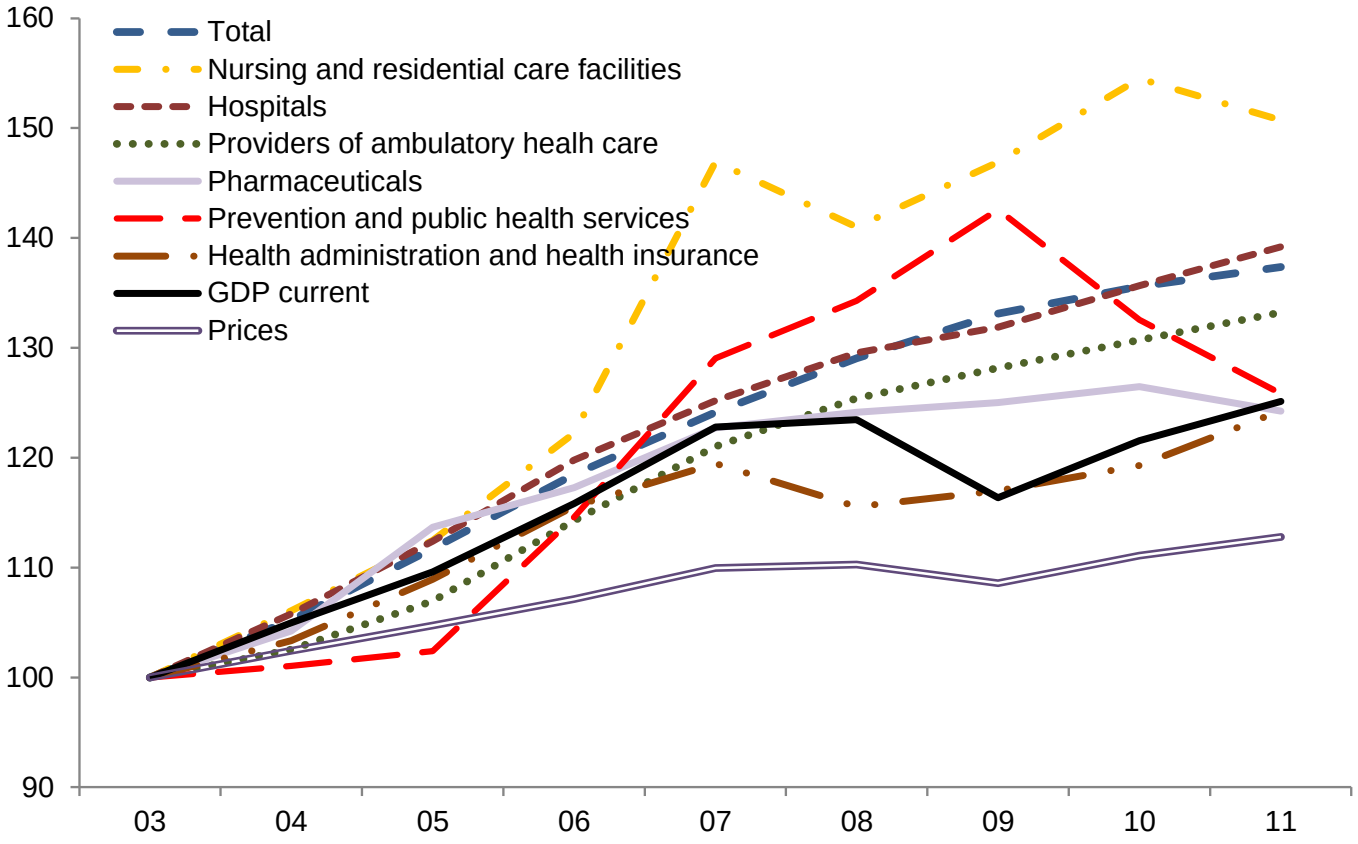
Past trends in health expenditures /2

Graph: Annual average growth rates in real public health expenditure per capita, 2003-2009 and 2009-2011



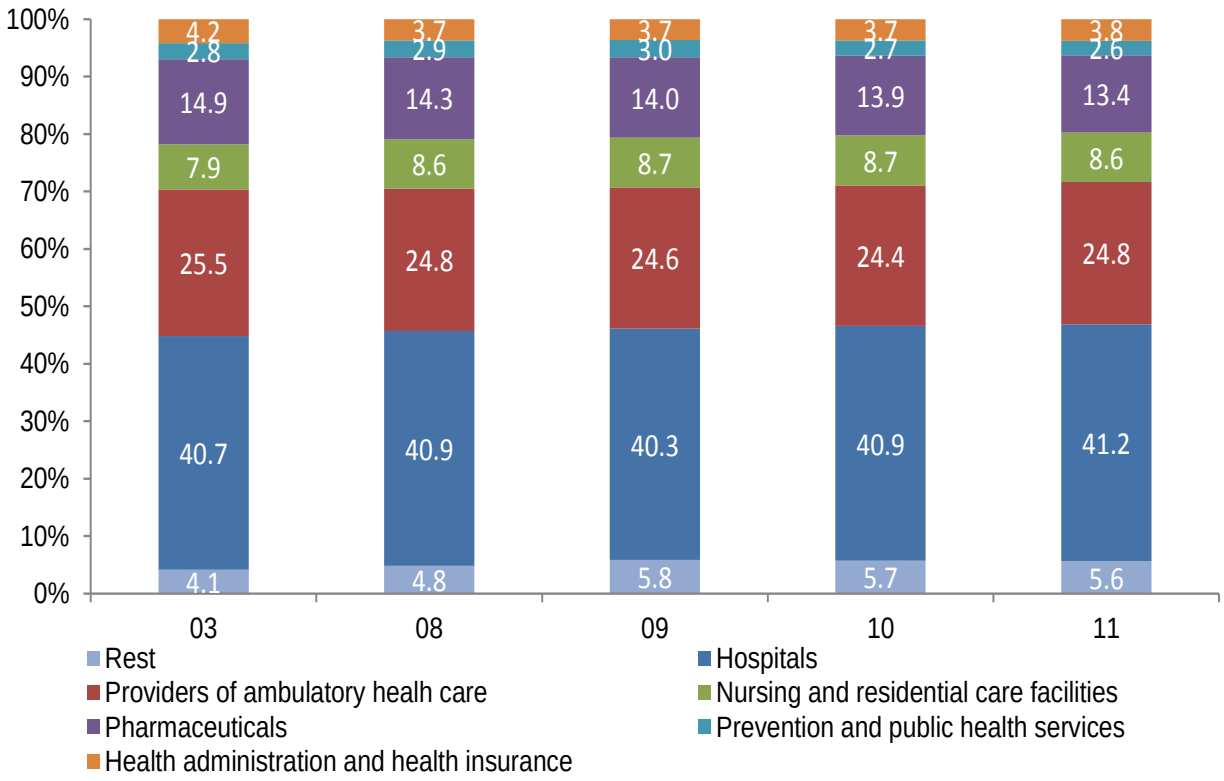
Past trends in health expenditures /3

Graph: Evolution of nominal public health expenditure by areas (2003 = 100), 2003 -2011



Past trends in health expenditures /4

Graph: Distribution of public health expenditure by area, 2003 to 2011



Composition: hospital care (41%), ambulatory care (25%), pharmaceuticals(14%), nursing and residential care (9%), health administration and insurance (4%) and prevention and public health services (3%)

Shares changed only slightly in a decade at EU level:
increasing (nursing and residential care),
constant (hospitals and prevention)
decreasing (health administration, ambulatory care and pharmaceuticals)

Assessing recent expenditure (trends)

- …In 2010, in the EU(27) €2,550 were spent per capita on healthcare
- …out of which €75 was spent on prevention, i.e. €0.20 per day
- …compared to the cost of a e.g. coffee?
- What is prevention worth (to us)?
- OECD (on obesity): Cost of a package of health education and promotion, regulation, fiscal measures, counseling in primary care around on average less than 20€ per capita

Source: European Commission, own calculations.

2010 Joint EPC – EC (DG ECFIN) Report on Health Care Systems

- How to contain spending pressures through **efficiency gains**, in order to ensure fiscally sustainable access for all to high-quality health services …

Policy challenges/reform options

- The joint report points to **10 main policy challenges** to contain spending in an efficient and equitable manner
- **Country fiches**, with detailed analysis of:
  - recent trends in HC spending and coverage
  - collection, pooling and allocation of financial resources
  - Providers status, referral system and patient choice
  - Purchasing, contracting and remuneration systems
  - Information and monitoring systems
- Country specific challenges/recommendations have been **endorsed by Member States**

10 policy challenges to be addressed

- Macro-type controls on resources and budget (aggregate cost-containment measures- e.g. cap on total HC expenditure), to be associated to micro-type incentives-based reforms;
- Limit demand by increasing cost-sharing and reducing tax deductions, while addressing equity and access concerns;
- Improve the general governance (decision-making, management, contracting systems) of the system;
- Improve data collection and information channels and use available information to support performance improvement;
- Reduce the unnecessary use of specialist and hospital care while improving primary health care services (and referral system);

10 policy challenges to be addressed

- Increase the value for money of pharmaceutical spending;
- Enhance hospitals' efficiency through an increasing use of day-case surgery and concentration of some hospital services;
- Ensuring a balanced mix of staff skills;
- More systematic use of health-technology assessment (HTA) to determine cost-effective treatment to be financed publicly;
- Promoting more effective health promotion and disease prevention to improve health status and reduce the demand for health services.

What has been done recently?: Assessing recent reforms

Adjusting financing		Country
	Increased contributions to public health insurance system	Netherlands, Bulgaria, Czech Republic, Greece, Portugal, Romania, Slovenia, France, Hungary
	Decreased contributions to public health insurance system	Germany, Hungary
	Increased transfers from state budget	Germany, Hungary, Lithuania, Romania, Slovakia
	Decreased transfers from state budget	Finland, Slovakia
	Reallocated or introduced new taxes	France, Italy, Hungary
	Improved automatic stabilisers	Czech Republic, Estonia, Slovenia, Lithuania, Slovakia

Source: WHO (2013), " Health, health systems and economic crisis in Europe: impact and policy implications"; European Commission services.

Assessing recent reforms

Changing health coverage		Country
	Reduced population coverage	Czech Republic, Spain, Cyprus, Ireland
	Increased population coverage	Estonia, Greece
	Changed benefits package	Expanding: Belgium, Bulgaria, Italy, Latvia, Netherlands Reducing: Estonia, Hungary, Lithuania, Romania, Netherlands, Ireland, Slovenia
	Changed user charges	Increased: Cyprus, Estonia, Greece, Italy, Latvia, Portugal, Czech Republic, France, Ireland, Slovenia, Spain, Denmark Decreased for vulnerable groups: Greece, Ireland, Portugal, Slovakia, Spain, Latvia, Belgium, France

Source: WHO (2013), " Health, health systems and economic crisis in Europe: impact and policy implications"; European Commission services.

Assessing recent reforms

Generating savings		
	Limit the increase of, freeze or reduce salaries and fees	Belgium, Cyprus, France, Greece, Ireland, Latvia, Lithuania, Portugal, Romania, Slovenia, Spain, Germany, United Kingdom, Denmark, Italy, Slovenia
	Reduced health worker benefits	Cyprus, Estonia, Portugal, Slovenia, Sweden, United Kingdom
	Increased cost containment in hospital spending	Bulgaria, Czech Republic, Denmark, Estonia, France, Ireland, Lithuania, Romania, Slovenia, Latvia
	Increased control of procurement of pharmaceuticals and medical goods	Bulgaria, Czech Republic, Greece, Slovakia, United Kingdom, Romania
	Strengthened pharmaceutical policy	23 EU Member States
	Reduced capital investments	Romania, United Kingdom, Bulgaria

Source: WHO (2013), " Health, health systems and economic crisis in Europe: impact and policy implications"; European Commission services.

Assessing recent reforms

Improving efficiency		
	Strengthened access to primary care	France, Greece, Hungary, Ireland, Italy, Latvia, Lithuania, United Kingdom
	Developed strategy for quality	United Kingdom
	Expanded use of clinical guidelines	Belgium, Cyprus, Portugal
	Expanded use of HTA	Spain, Cyprus
	Invested in e-health	Czech Republic, Romania
	Took steps to improve population health via health promotion	Belgium, Greece, Hungary, Lithuania, Malta, United Kingdom
	Increased "sin taxes"	Bulgaria, Cyprus, Denmark, Estonia, France, Hungary, Portugal, Slovenia, Spain

Source: WHO (2013), " Health, health systems and economic crisis in Europe: impact and policy implications"; European Commission services.

Assessing recent reforms

- Recent reforms focused on generating savings and improving the financing side;
- A limited number of EU Member States have been active in structural reforms directed at generating efficiency gains;
- There seems to be ample scope for further reforms improving the performance of health care systems and their fiscal sustainability.

Source: WHO (2013), " Health, health systems and economic crisis in Europe: impact and policy implications"; European Commission services.

European Semester

- **In 2012**, **6 EU countries** got country-specific recommendations in healthcare or long-term care
  - Austria, Belgium, Bulgaria, Cyprus, Germany and the Netherlands.
- **In 2013**, **15 EU countries**:
  - Austria, Belgium, Bulgaria, Czech Republic, Finland, France, Germany, Luxembourg, Malta, the Netherlands, Poland, Romania, Slovakia, Slovenia and Spain.

European Semester 2013

BE	CSR2: "In view of fiscal sustainability, improve the cost-efficiency of public spending on long-term institutional care."
BG	**CSR4: "Ensure effective access to healthcare and improve the pricing of healthcare services by linking hospitals' financing to outcomes and developing out-patient care".**
CZ	CSR3: "Take measures to significantly improve cost-effectiveness of healthcare expenditure, in particular for hospital care".
DK	-
DE	**CSR1: "Pursue a growth-friendly fiscal policy through additional efforts to enhance the cost-effectiveness of public spending on healthcare and long-term through better integration of care delivery and a stronger focus on prevention and rehabilitation and independent living. "**
EE	-
IE	Programme country
EL	Programme country
ES	**Increase the cost-effectiveness of the health-care sector, while maintaining accessibility for vulnerable groups, for example by reducing hospital pharmaceutical spending, strengthening coordination across types of care and improving incentives for an efficient use of resources.**

European Semester 2013

FR	**CSR1: "[…]. and increase the cost-effectiveness of healthcare expenditure, including in the area of pharmaceutical spending."**
IT	-
CY	Programme country
LV	-
LT	-
LU	CSR 3: "Curb age-related expenditure by making long-term care more cost effective, in particular through a stronger focus on prevention, rehabilitation and independent living […] "
HU	-
MT	CSR2: "To ensure the long-term sustainability of public finances, […] and pursue health-care reforms to increase the cost-effectiveness of the sector, in particular by strengthening public primary care provision."
NL	CSR3: "Implement the planned reform of the long-term care system to ensure its cost-effectiveness and complement it with further measures to contain the increase in costs, with a view to ensure sustainability."
AT	CSR 4: "Effectively implement the recent reforms of the health care system to make sure that the expected cost efficiency gains materialise. Develop a financially sustainable model for the provision of long-term care and put a stronger focus on prevention, rehabilitation and independent living."

European Semester 2013

PL	**CSR1: "With a view to improving the quality of public finances minimise cuts in growth-enhancing investment, reassess expenditure policies improving the targeting of social policies and increasing the cost effectiveness and efficiency of spending in the healthcare sector."**
PT	Programme country
RO	CSR3: "Pursue health sector reforms to increase its efficiency, quality and accessibility, in particular for disadvantaged people and remote and isolated communities. Reduce the excessive use of hospital care including by strengthening outpatient care. "
SI	CSR2: "Contain age-related expenditure on long-term care and improve access to services by refocusing care provision from institutional to home care, sharpening targeting and means-testing of benefits, and reinforcing prevention to reduce disability/dependency."
SK	CSR1: "[…] further improve the long term sustainability of public finance by […] increasing the cost-effectiveness of the health-care sector".
FI	CSR1: "… Ensure the cost-effectiveness and sustainability of long-term care and put a stronger focus on prevention, rehabilitation and independent living."
SE	-
UK	-

Main conclusions

- Health systems require attentive and regular monitor and policy attention in order to continuously adjust settings, governance and the incentive structures present in the system.
- Measures introduced in the last two decades aimed at

  - improving value for money and
  - slowing down the growth of health spending

  will have to be intensified in the immediate future to achieve the needed consolidation of public finances in Europe
- Increasing cost-effectiveness of health systems can ensure that health care reforms do not conflict with the overarching goal of ensuring equitable access to health care

European Commission

Thank you!