



# Mitigating the Impact of the Global Economic Crisis on Household Health Spending

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## Key Messages

- The economic crisis is impacting the ability of households in ECA countries to pay for health care. Declining government revenues and spending on health are likely to exacerbate health-related financial hardships for households.
- There are a number of approaches ECA policy makers can take to mitigate the impact of reduced public sector budgets on household health spending.
- Most common instruments to protect lower-income groups against higher out-of-pocket health spending include transparent cost-sharing mechanisms with explicit exemption criteria; and targeting of public funds to pay for services predominantly used by lower-income groups.

## Introduction

The ongoing financial and economic crisis has hit hard the lives of citizens in Eastern Europe and Central Asian (ECA) countries. Economic growth has started to dip, unemployment is rising and government revenues are expected to fall. The crisis is having a direct impact on the ability of households to pay for health care, a situation that will likely be exacerbated as real government spending on health care declines in many countries due to reduced revenues from the general government budget and payroll-funded health insurance. Patients may have to pay higher prices for health care, make do with reduced access to

necessary health services and medicines, and face other health-related financial hardships as well.

This Brief draws on the experience of countries (outside ECA) in coping with public financing shortfalls, to provide suggestions for mitigating the impact on ECA households of reduced public health spending. First, however, it is important to examine private health spending patterns in the ECA region.

## Private Health Spending in ECA Countries

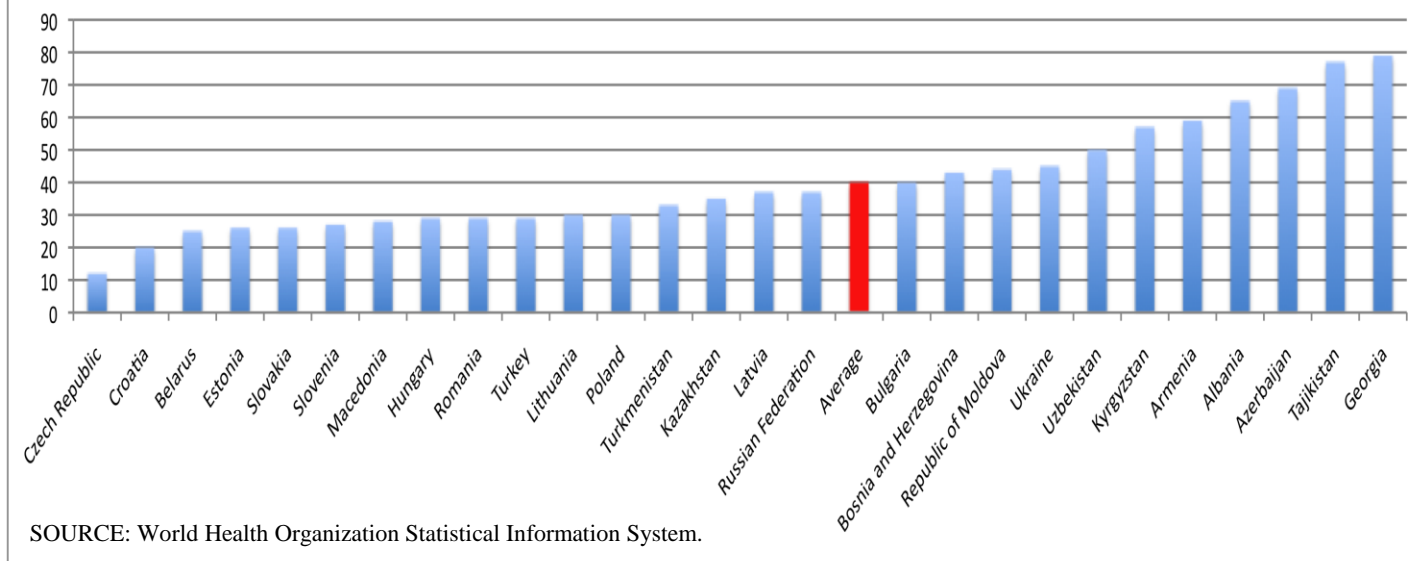
Private health expenditure accounted for 40 percent of total health spending in the ECA region in 2006 (Figure 1), compared to just 27 percent in countries that are members of the Organization for Economic Cooperation and Development (OECD). In six ECA countries, the private share exceeded 50 percent.

In the ECA region, most private health expenditures comprise out-of-pocket payments for health care, including user fees or co-payments for insurance-covered services, payments for health services not covered by insurance and informal (or under-the-table) payments to providers. Private health expenditure is underestimated in many ECA countries due to difficulties in obtaining information on informal payments for services (a common practice in the region).

Out-of-pocket health expenditures represent a significant burden on households in some ECA countries. For instance, in Latvia, where the private share of total health expenditure is almost 40 percent (Figure 1), out-of-pocket (OOP) expenditure for health care represented 4.7 percent of household expenditure in 2006.<sup>1</sup> An analysis on the

<sup>1</sup> Xu, K et al. (2009), Access to Health Care and the Financial Burden of Out-of-Pocket Health Payments in Latvia, WHO.

**Figure 1. Private expenditure on health as a percentage of total expenditure on health, 2006**



equity impact of OOP payments charged from 2003-2006 in Slovakia found that co-payments caused the share of household income spent on health to increase on average from about 1.4 percent in 2000 to 3 percent in 2005. The lowest income groups were paying almost 5 percent compared to the richest groups who spent only 2 percent of household income on health<sup>2</sup>.

### Why is Spending on Private Health Care so High?

The underlying reasons for high private spending on health care in the ECA region vary by country, but there are some common explanatory factors.

OECD experience shows a strong link between national income and health expenditure, with relatively richer countries spending a higher share of income on health. In many ECA countries, total health spending has outstripped economic growth over the past years. Rapid advances in medical technologies, population ageing and rising public expectations were largely responsible for the growth in health spending, which was particularly notable in the area of pharmaceuticals. However, in less wealthy ECA countries in particular, public expenditure on health has not increased at a rate commensurate with total health expenditure and economic development. This has increased the pressure on private sources of financing to make up the shortfall between total expenditures and available public resources.

<sup>2</sup> Kiss, Stefan et al. (2007), *Equity in Health Care Finance in Slovakia - the Impact of the Reform*, Erasmus University, Rotterdam.

Pharmaceuticals represent the largest component of out-of-pocket spending for most people in the region. In Hungary, for instance, two-thirds of out-of-pocket health expenditures are on medicines. Although pharmaceutical prices vary across countries, there is evidence that they vary less than income differentials, particularly in countries where parallel trade<sup>3</sup> is possible.<sup>4</sup> In countries with formal cost-sharing requirements, rates are often highest for pharmaceuticals. For example, in Bulgaria, about 52 percent of total household health spending is on pharmaceuticals.

In order to finance the increasing cost of health, many ECA countries have established cost-sharing requirements where patients pay user fees and co-payments when receiving care. This practice is, however, politically unpopular in a region that has a tradition of publicly-financed health care which is nominally free to the users (although under-the-table payments are expected as gratuities for special treatment, like faster service).

### How Will the Economic Crisis Impact Household Spending on Health Care?

The economic crisis will have both a direct and indirect impact on private health spending and population health.

<sup>3</sup> Price differences between countries invite traders to arbitrage, that is, buying pharmaceuticals in low price countries and selling them in high price countries. The effect of this “parallel trade” on prices depends on the nature of price regulation. Parallel trade may cause prices to rise in low price countries and may lower prices in high price countries

<sup>4</sup> See OECD (2008), *Pharmaceutical Pricing Policies in a Global Market*.

Experience with past crises in middle-income countries suggests that reduced employment and household incomes will have a negative impact on nutrition and utilization of health services. The vulnerable groups--such as women, children, the poor, and informal sector workers—are at greatest risk.<sup>5</sup>

The indirect impact of the crisis depends on government actions taken in response to reduced revenues. Possible actions include cutting budgets for health care providers, increasing cost-sharing, cutting benefits (or foregoing expansion of benefits to coverage of new medicines and devices), and/or reducing the supply of services (effectively increasing waiting times). An unintended effect of many such actions will be reduced access to services due to increased financial barriers and increased risk of health-related financial hardship. Specific concerns include:

- Decisions to cut health professionals' salaries or to delay salary payments to staff may exacerbate the pressure on patients to make informal payments for services. Unpaid staff members are also more likely to moonlight and have private practices, which will negatively affect the availability of service delivery in public facilities. This may also force patients to seek care in the more expensive private sector.
- Patients may respond to increased costs by reducing compliance with prescribed treatments, which could ultimately lead to complications or flare-ups of chronic conditions and increased prevalence of conditions, especially among the poor. Evidence from experience in Europe, in the United States and in developing countries shows that reduced service utilization (associated with increases in cost-sharing) affects poor people disproportionately.<sup>6</sup>
- Cuts in public health spending and services will also disproportionately affect the poor, unless steps are taken to counter this move. During a previous financial downturn, for example, preventive health care for children in Argentina dropped 38 percent in the general population but much more (57 percent) in the poorest households.
- Out-of-pocket spending may raise the financial burden on families already suffering from

economic setbacks due to the downturn, even if, on average, private health expenditure does not increase.

- Increased out-of-pocket health spending may push more individuals into poverty. According to a paper prepared by the Norwegian Ministry of Health Care for a recent European region Ministerial meeting, out-of-pocket payments for medicines for persons with chronic conditions were among the most significant causes of health-related financial catastrophe in middle-income countries.

These risks may be increased by crisis-related developments. Prices of imported medicines will increase due to currency depreciation in some countries, making them less affordable for public and private purchasers. The pharmaceutical cost problem is likely to be further exacerbated in some countries that are implementing or increasing a value-added tax on pharmaceuticals as a revenue generation tool, and by cost-sharing increases that have been planned and implemented in countries such as Croatia.

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### What can be done to mitigate the Impact of Reduced Public Sector Health Spending?

There are a number of approaches ECA policy makers can take to mitigate the impact of reduced public sector budgets on household health spending.

A first approach is to ensure and maintain adequate financing for those services that are used by the poorest and most vulnerable (for example, primary care services rather than specialist care). Careful targeting of public resources to vulnerable groups is needed to minimize the overall impact of real reductions in public spending and to counteract the tendency of health spending to become less progressive during times of economic contraction. Consequently, public funds could be targeted to services that are predominantly used by lower-income groups or in low-income areas. For example, governments may want to protect funding for maternal and child health care services provided in public primary health care facilities, and for the treatment of communicable diseases like tuberculosis that mainly affect lower-income groups.

A second approach is to introduce formal cost-sharing (or co-payment) requirements where these do not already exist, and take steps to reduce the practice of informal payments through public information campaigns and staff training. In formal cost sharing, access barriers and financial hardship risks can be minimized with the use of caps and exemptions from payments. Most European countries have explicit exemption criteria for co-

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<sup>5</sup> See Gottret et al. (2009), 'Protecting Pro-Poor Health Services during Financial Crises: Lessons from Experience,' The World Bank, March 2009.

<sup>6</sup> See Ray (2002), 'User Charges for Health Care,' in *Funding Health Care: Options for Europe*, European Observatory.

payments. Population groups and services that tend to be exempt from fee payments include: (i) children under a specific age; (ii) homeless people; (iii) emergency and preventive services; (iv) public health services, and (v) pregnancy, obstetric and neonatal care services. Sweden provides an example of a co-payment scheme in which patients receive a 'green card' exempting them from co-payments if they are members of vulnerable groups or if they reach established caps on cost-sharing as defined by a maximum amount payable in a year.

A third approach is to make targeted cuts in public resource allocation and seek increased efficiency in health care delivery. For instance, where excessive, inpatient capacity can be pruned, and outpatient care can be substituted for inpatient care where appropriate. Many OECD countries used such methods to achieve savings during the 1990s.<sup>7</sup> Although politically challenging given the status of hospitals and important local employers, the crisis can provide an opportunity to make much needed spending cuts. Thailand provides an example of a country that used a previous financial crisis as an incentive to make major efficiency-enhancing reforms.

In the same vein, policy makers can target cost-sharing increases, to the extent possible, so as to increase efficiency. The use of 'reference-pricing' schemes, in which patients pay more out of their own pockets for brand name medicines that have low-cost alternatives, is an example. Variable reimbursement rates, common in many western European countries, can also be used to ensure access to medicines that are considered essential. For example, in Switzerland, patients have to make higher co-payments for non-generic drugs than for equivalent generics. As a result, patients purchased lower-priced generic drugs instead of brand-name drugs, leading to a market share increase for generics from 20 percent in 2005 to 33 percent in 2006. At the same time, prices for non-generic drugs declined, narrowing the price difference between generic and non-generic drugs.

Policy-makers have been tempted to promote voluntary health insurance so as to shift costs to privately insured individuals while ensuring affordable access to care. However, in most countries, private health insurance (which provides coverage for services that are not publicly financed) is mostly purchased by higher income groups that anyway seek care in the private sector. Private insurance is not necessarily an instrument that will improve access to health care for lower-income groups.

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## The Longer-Term Agenda

While policy solutions need to be tailored to national circumstances, it is important to keep the focus on the long- and medium-term goals that have been established for health systems. Some of these crucial goals are aimed at addressing inequalities in health financing, health service use, financial sustainability of health systems, and general population health. Keeping these goals in mind will ensure that actions taken in response to the economic crisis do not run counter to the progress already made in strengthening the health systems. At the same time, health sector policy-makers will need to recognize that the economic crisis is having an impact on the health systems and the populations they serve, and take the necessary steps to address the immediate and related issues.

## About the Author

Elizabeth Docteur is an independent research analyst with more than 15 years' experience informing public policy decision making through positions in the legislative and executive branches of US government, the international arena and civil society.

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<sup>7</sup> See Docteur and Oxley (2003), 'Health-Care Systems: Lessons from the Reform Experience,' OECD Health Working Paper No. 9.

