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Mitigating the Impact of the Economic Crisis on Public Sector Health Spending

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Key messages

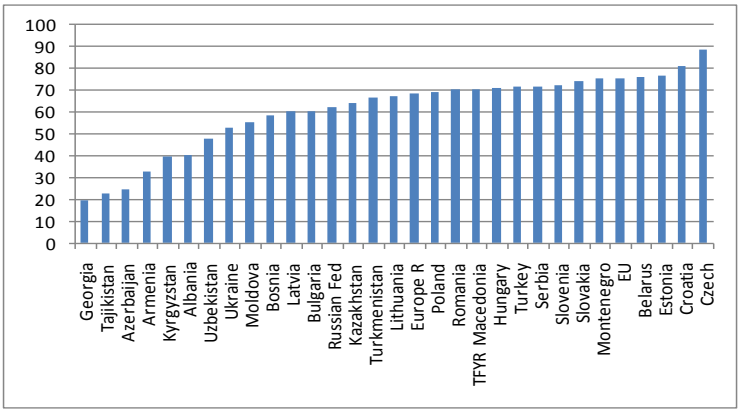
- ECA policy makers can mitigate the impact of the economic crisis on public sector health spending by: (i) increasing indirect taxes, (ii) using additional donor funding for services targeted at low-income groups, and (iii) making fiscal transfers to poorer areas.
- Increasing payroll taxes for social health insurance would negatively affect labor markets and is thus not advisable.
- Countries need to provide targeted support for the most vulnerable groups
- Financial constraints on public health spending during the current crisis will force some countries to implement short-term cost-containment measures and to identify actions that can reduce overcapacities and improve efficiency. In the longer-term, these measures can strengthen the financial sustainability of the health care systems in ECA.

Introduction

The current global financial crisis is having a substantial impact in Europe and Central Asia (ECA) where economic growth is beginning to dip, unemployment is rising and government revenues are being cut. The GDP growth rate of the region is projected to decline by 4.7 percent in 2009[1] and the flow of remittances is also expected to slow down sharply, causing particular hardship to low-income groups. While countries with fiscal capacity have adopted stimulus packages to promote economic recovery, most ECA countries are financially constrained and have revised their government budgets, including in the health sector[2]. Thus, as a result of the crisis, public spending on health may actually decrease in absolute amounts and in percentage of GDP.

The health sectors in most ECA countries are mainly financed from public sources (Figure 1 and Box 1). In countries with low levels of public spending on health[3], the majority of health services are paid for by patients. Any reductions in public health spending would thus only add to the out-of-pocket expenditures of patients, and may negatively affect access to care, particularly for the poor. There is increasing empirical evidence that public sector spending improves health indicators in low-income and transition countries, particularly in countries that have good governance systems in place[4].

Figure 1: Public Spending as a Percentage of Total Health Spending in ECA, 2005



Source: 'Health for All' database, World Health Organization. http://data.euro.who.int/hfadb

[1] *Global Development Finance: Charting a Global Recovery*, World Bank 2009. Washington, DC.

[2] Including Tajikistan, Armenia, the Czech Republic, Baltic countries, Hungary, Romania, and Slovakia.

[3] Including Albania, Armenia, Azerbaijan, Georgia, Tajikistan, and Uzbekistan (Figure 1).

[4] Gupta, S., M. Verhoeven, E.R. Tiongson: 'The Effectiveness of Government Spending on Education and Health Care in Developing and Transition Economies', in *European Journal of Political Economy*, Vol 18(4), 2002, Pages 717-737; Baldacci, E., B. Clements, S. Gupta, Q. Cui: 'Social Spending, Human Capital, and Growth in Developing Countries', in *World Development*, Vol 36(8), 2008, Pages 1317-1341.

The purpose of this Knowledge Brief is to help raise awareness of the impact of the current economic crisis on public spending in health, as well as the potential for government interventions in the health sector during the crisis. Government interventions can address the revenue side as well as the expenditure side in the health sector. They can include reforms to raise additional financing for health care and control expenditures by rationalizing overcapacities and increasing productivity.

Box 1: Public Financing of Health Sectors

Public finances for health are generated from central and local government funds and payroll tax-funded social health insurance (SHI). Social health insurers receive money from payroll taxes and government funds to pay for non-contributing members and possible insurance deficits. In Slovakia, the Government contributes money on behalf of the non-working population (including pensioners, the unemployed and social assistance recipients)[5] to health insurers. Payroll-tax funded SHI usually comprises about 50-95 percent of total public spending in health in the ECA region, depending on the size of the formal economy in a given country. Countries like Kyrgyzstan, Kazakhstan, Tajikistan, and Latvia do not levy payroll taxes but use general government revenues to finance their health sectors. Public funds are transferred either directly or through the insurers to public health facilities. Instead of line-item budgets, insurers and governments increasingly pay hospitals on the basis of the number of cases treated, and make per capita payments to primary health care centers based on the populations living in their catchment areas. In addition, patients co-pay for health services and drugs received.

Ensuring Public Revenues for Health in Times of Crisis

There are a number of approaches ECA policy makers could take to mitigate the impact of the economic crisis on public sector health spending. Raising additional public revenues for health by increasing payroll taxes would negatively affect labor markets and is thus not advisable. However, other measures to ensure public funding for health include: (i) indirect taxes, (ii) additional donor funding targeted at services used by low-income groups, and (iii) fiscal transfers to poorer areas.

Increasing payroll taxes for health is not an option

Payroll contribution rates for social health insurance range from 8 percent of gross salary in Bulgaria to 15 percent of gross salary in Croatia; they are paid by employers, employees and the self-employed. With growing unemployment and a decrease in real wages, the total wage sum of countries (which is also the contribution base for social health insurance) is shrinking. As a result, insurers are facing the challenge of maintaining revenue levels to pay for members' health expenditures which are unlikely to decrease. Increasing payroll taxes to maintain insurance revenues and prevent insurance deficits is not an option, particularly not during the crisis, as it can negatively impact job growth and future economic growth.

Increase indirect taxes to finance health care

Some governments have already introduced additional indirect taxes to compensate for revenue shortfalls from payroll taxes in health insurance, and protect the levels of public spending on health. Several countries (including Estonia, Romania, Serbia and Slovenia) have increased excise taxes on alcohol, tobacco and fuel, or introduced a tax on mobile phone communication services. Poland has increased excise taxes on alcohol and car imports to finance a solidarity fund, with benefits targeted to the poor. Hungary has abolished the flat-rate health tax and raised excise taxes for fuel, tobacco and alcohol. Switzerland plans to increase its VAT rate by 0.4 percentage points to pay for the deficit in payroll-funded disability insurance.

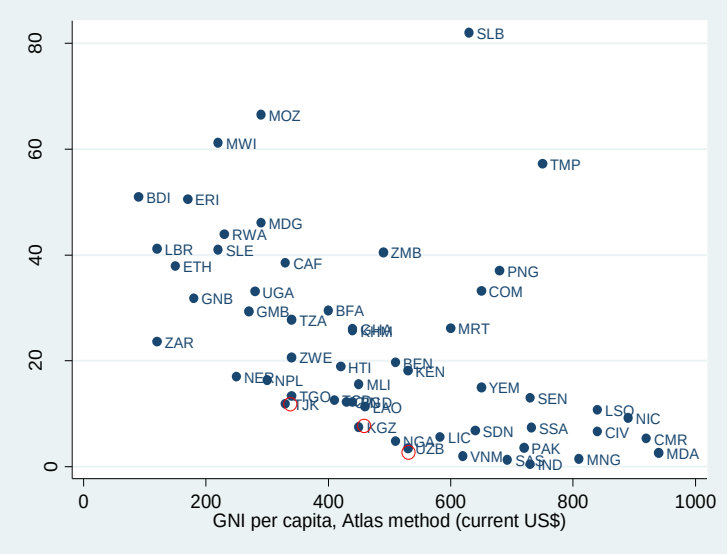
Use additional donor spending for health services targeted to the poor

Countries such as Tajikistan, Kyrgyzstan, Turkmenistan, Uzbekistan, Armenia, and Georgia have limited fiscal capacity to launch counter-cyclical fiscal programs and protect core spending during downturns. These countries are also the ones most vulnerable to increased poverty. They may need to increase spending on vulnerable groups as poorer households curb their own health spending in order to pay for food.

Fiscal pressures may cause low-income countries to seek additional external assistance to protect their core spending. In these countries, continuous donor aid can prevent an increase in out-of-pocket payments by patients and ensure spending on key health services targeted at vulnerable groups so that progress can continue to be made towards the Millennium Development Goals (MDGs). Generally, poorer countries with higher disease burden receive greater external aid. Therefore, accessing additional donor aid may be difficult for some lower-income ECA countries that receive less donor support for health compared to other countries at similar levels of GDP (Figure 2). In the ECA region, these countries include Tajikistan, Kyrgyzstan and Uzbekistan. To mitigate the impact of the crisis on poorest households, donor aid will thus need to be kept flexible to allow additional funding to countries that are hardest hit.

[5] In 2008, the contribution amount was 4.5 percent of the national average salary.

Figure 2: Health Spending Support from Donors as a Percentage of Total Health Spending, 2005/06



Source: World Bank, HNP Stats 2005. Countries ranked based on their GNI per capita.

Make fiscal transfers to support health care in poorer regions

In decentralized health sectors, local governments (for example, districts and municipalities) are the owners of hospitals--they pay for infrastructure and maintenance costs, as well as for recurrent costs in the absence of insurance. Since the 1990s, socio-economic inequalities have increased in ECA, including within countries and across local governments. This means that poorer districts will raise less own revenues per capita to finance public services than wealthier districts; hospitals in poorer areas may end up underfunded as a result. In response to the crisis, Lithuania and Serbia have already announced cuts in budget transfers from the central to local governments. Reducing fiscal transfers, particularly to poorer areas, may negatively affect hospital budgets and capitation rates for primary health care and further contribute to unequal public funding in health across districts or municipalities. To prevent insufficient public funding for health in regions with declining local revenues, central governments would have to transfer additional funds to poorer regions to ensure the availability of health care services.

Cost-Containment Strategies to Manage Health Spending

Several short-term measures are available to ECA policy makers to manage health spending. In some countries, policy makers are using this crisis to implement reforms and manage expenditures with the objective of improving the longer-term performance of the health sector. At the same time, countries are protecting selected expenditure items targeted at lower-income groups.

Short-term measures: postpone investments, reduce overhead costs, corporatize hospitals, and reduce payments to providers

Fiscal constraints force governments to prioritize public spending and postpone investments in expensive medical technology and infrastructure. Kazakhstan has put its Presidential Program for hospital and school investments on hold in response to the crisis. In addition, countries like Estonia and Kazakhstan are planning to reduce overhead expenditures by consolidating ministerial administration. The Polish Government plans to corporatize hospitals under commercial law to address the financial risk caused by accumulated hospital debts. Similar measures have been introduced in Hungary and Slovakia as well.

Latvia has reduced prices paid to physicians and hospitals and tightened co-payment exemption mechanisms. However, if reductions in public payments are not accompanied by cost-containment strategies, providers who receive less public funding may increase prices to patients to maintain their revenue levels. This could exclude the poor from care.

While these short-term actions may lower current health spending, none of them is expected to have any meaningful impact on containing the growth of future health spending and strengthening the systems' financial sustainability.

Rationalize overcapacity in hospitals

In ECA, the main cause of wasteful health expenditure is overcapacities in hospitals and hospital beds. Hospitals consume the major part of health spending. Since hospital rationalization is politically difficult to implement, the current crisis may provide an opportunity for governments to restructure hospitals, based on a health sector rationalization plan or a master-plan. Such reforms are generally accompanied by measures to improve the productivity of the health workforce. Hospital rationalization tends to be accompanied by provider payment reforms to set financial incentives to hospitals. As a result, hospitals will be encouraged to shorten the average length of stay, treat patients in less-costly outpatient settings where possible, and close unnecessary hospital beds, or transfer acute care beds into less-costly chronic care beds.

Manage pharmaceutical expenditures

Some countries have introduced cost-saving measures to reduce pharmaceutical expenditures. These measures include continuous expenditure control in public tendering of pharmaceuticals; reducing the number of tenders to purchase larger quantities at lower prices; procurement of generic drugs instead of brand-name drugs; putting least costly drugs on the essential drugs list; reference price setting; and having physicians adhere to standard

prescription protocols. These measures are particularly important for nations where pharmaceuticals have to be imported and paid for in foreign currency, in countries facing the risk of currency devaluation during economic downturns, and in countries that have health sector debts and arrears in foreign currency.

Improve targeting efficiency in health

Many health safety net programs do not efficiently target the poorest segments of society. While some countries have clearly defined exemption rules from co-payments, most ECA countries do not use means-testing to identify exempt groups. In OECD countries, lower-income individuals tend to be exempt from co-payments in health service use. They are identified based on their income tax assessment.

Social health insurers usually pay for sick-leave and maternity leave which are often generously defined, independent of the patients' socio-economic backgrounds. For example, Lithuania just extended the untargeted maternity leave benefit to two years, although the World Bank recommended a reduction to one year. Other countries—among them, Hungary, Serbia and Latvia--are trying to improve the targeting efficiency of their health systems as a consequence of the crisis. Hungary introduced a 10 percent cut in sick-leave payments. Serbia halved sick-leave expenditures for the health insurers by obliging employers to pay for the first 30 days of illness of employees. In Latvia, the maximum period for sickness benefits has been reduced from 52 to 26 weeks.

Protect spending on pro-poor health programs

When governments do not spend enough on ensuring the availability of services and drugs in public health facilities, better-off citizens can seek more expensive care in the private sector but the poor lose out. To protect the poor against the negative impacts of the economic crisis, health spending can be used as a potential crisis response mechanism. This can be achieved by protecting government-funded health programs used by low-income groups--including immunization and maternal and child health care in public health centers, as was done in Argentina during the 2001/02 crisis. During the Asian crisis, Thailand doubled subsidies to the Voluntary Health Card (VHC) insurance scheme, providing access to care for unemployed and low-income groups. As a result, there was a marked increase in service use by Card holders, allowing poor people to afford care during the crisis[6]. In response to the current crisis, Armenia (with the support of the World Bank) has committed to restoring health spending of about US$ 3.8m for priority programs for the poor, and for maternal and child health services.

Governments can also invest in targeted subsidies for lower-income groups to offset the possibility of higher out-of-pocket health spending by patients. For example in Switzerland and in the Netherlands, the Governments pay means-tested subsidies to individuals with incomes below defined thresholds, based on their taxable income. As a result, about 70 percent of Dutch and 40 percent of Swiss households receive means-tested subsidies and health coverage at reduced prices.

The World Bank's Role: Working with Countries in Addressing Longer-Term Policy Challenges

The World Bank has already provided technical assistance and fiscal support to countries hit by the crisis. At the same time, the Bank is working with countries in addressing longer-term policy challenges in health to better mitigate the impact of the current downturn. In ECA, these longer-term measures include:

- Efforts to decrease payroll taxes and increase the share of general budget funds for health.
- Reforms in provider payments to pay capitation payments to outpatient health care providers and case-based payment to hospitals.
- Specific measures to improve equity in health financing and the financial viability of health systems.
- Modernizing management and the provision of care to increase productivity and reduce wasteful spending, and improving equity in access to quality health care.
- Improving governance and institutional capacity to prevent leakage in public spending.

Investing in these measures will help governments to be better prepared to respond more adeptly to future crises.

About the Author
Pia Schneider is a senior economist working on health system reform in the ECA region.

[6] 'Protecting Pro-Poor Health Services during Financial Crisis, Lessons from Experience,' in Gottret P. et al, HNP, World Bank, March 2009.