Spending on health in Europe: entering a new era

May 11, 2021
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Main sources of data:

- Country level financial protection studies
- IMF World Economic Outlook (Oct 2020)

Definitions and terminology: System of Health Accounts

Inspiration: Global Health Spending Reports
Chapter 1. Health spending before the COVID-19 pandemic

Chapter 2. Spending on health is a political choice

Chapter 3. The evolution of compulsory health financing

Chapter 4. Tracking primary health care spending and its priority in government budgets

Chapter 5. COVID-19: implications for health spending
Chapter 1

Health spending before the COVID-19 pandemic
The amount high- and middle-income countries spend on health is converging but large inequalities across countries persist

Current spending on health per person in the European Region, 2018
Before the COVID-19 pandemic the health sector was growing faster than the economy.

The past 10 years has seen no or very limited change in the pattern of heavy reliance on out-of-pocket payments, making it difficult to realize significant progress towards UHC.

Real growth in current spending on health and GDP per person in the European Region by country income group, 2000-2018.

Real growth in public spending on health and out-of-pocket payments per person in the European Region by country income group, 2000-2018.
Out-of-pocket payments continue to be the dominant source of financing in almost all lower-middle-income and a third of upper middle-income countries.
The role of external funding in low- and middle-income countries has decreased, indicating a lower level of international solidarity, but remains important.
Chapter 2

Spending on health is a political choice
Public spending on health as a share of GDP tends to increase with the fiscal capacity of a country.

There is large variation among countries of similar fiscal capacity.
Although fiscal capacity is more limited in middle-income countries, governments in countries in all income groups have choices.
Chapter 2. Spending on health is a political choice

Relationship between public spending on health and out-of-pocket payments in the European Region, 2018

The out-of-pocket payment share of current health spending is generally lower in countries that spend relatively more publicly on health.
Chapter 3
The evolution of compulsory health financing
### Compulsory health financing arrangements differ across countries (I)

Characteristics of compulsory health financing arrangements in the European Region, 2018

<table>
<thead>
<tr>
<th>Type of scheme (SHA code)</th>
<th>Government schemes (HF.1.1)</th>
<th>SHI schemes (HF.1.2.1)</th>
<th>Compulsory PHI schemes (HF.1.2.2)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mode of participation</strong></td>
<td>Automatic for all residents or a specific group of people</td>
<td>Compulsory for all residents or a specific group of people</td>
<td>Compulsory for all residents or a specific group of people</td>
</tr>
<tr>
<td><strong>Basis for entitlement</strong></td>
<td>Non-contributory: typically, universal or available for a specific group of people or disease category (e.g., tuberculosis)</td>
<td>Contributory: typically based on payment by or on behalf of the insured person</td>
<td>Contributory: typically based on the purchase of a policy from a health insurance company or other agency</td>
</tr>
<tr>
<td><strong>Main method of raising revenue</strong></td>
<td>Government budget</td>
<td>Contributions, which are typically linked to earnings or income and do not reflect health risk, may be paid by the government on behalf of some non-contributing groups of people; the government may also provide general subsidies to the scheme</td>
<td>Premiums, which are not linked to earnings or income, may reflect health risk and may be subsidized by government</td>
</tr>
</tbody>
</table>
Compulsory health financing arrangements differ across countries (II) and current arrangements are a result of history (path dependency)

Compulsory health spending as a share of current spending on health in the European Region by country income group, 2018
Chapter 3. The evolution of compulsory health financing

The SHI scheme share of compulsory spending on health has fallen in high-income countries and is now highest in upper-middle-income countries

Compulsory spending on health in the European Region by type of scheme and country income group, 2000-2018
The government budget is a significant source of revenue for SHI schemes in an increasing number of countries in all income groups

Compulsory spending on health in countries in the European Region mainly financed through SHI schemes, and breakdown of SHI scheme revenue into government budget transfers and social insurance contributions, 2018
What implications for UHC?

There are no systematic differences in service coverage or financial protection between countries depending on their main health financing scheme. Gaps in population coverage are larger in countries that are mainly financed through SHI schemes.
When health systems base entitlement to publicly financed health care on payment of contributions rather than on residence, many problems occur:

- It disadvantages people in vulnerable situations
- It fosters unfairness among taxpayers
- It exacerbates inequalities in access to health services
Chapter 4

Tracking primary health care spending and its priority in government budgets
The global definition to track PHC spending is used for this chapter, it may not match the PHC definition used at country level

<table>
<thead>
<tr>
<th>Includes</th>
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<tbody>
<tr>
<td>• general outpatient curative care (HC.1.3.1)</td>
<td>• inpatient curative care (HC.1.1)</td>
</tr>
<tr>
<td>• dental outpatient curative care (HC.1.3.2)</td>
<td>• day curative care (HC.1.2)</td>
</tr>
<tr>
<td>• curative outpatient care, not elsewhere classified (HC.1.3.nec)</td>
<td>• specialized outpatient curative care (HC.1.3.3)</td>
</tr>
<tr>
<td>• home-based curative care (HC.1.4)</td>
<td>• unspecified curative care (HC.1.nec)</td>
</tr>
<tr>
<td>• outpatient long-term health care (HC.3.3)</td>
<td>• rehabilitative care (HC.2)</td>
</tr>
<tr>
<td>• home-based long-term health care (HC.3.4)</td>
<td>• inpatient long-term care (HC.3.1)</td>
</tr>
<tr>
<td>• preventive care (HC.6)</td>
<td>• day long-term care (HC.3.2)</td>
</tr>
<tr>
<td>• a share (80%) of medical goods provided outside health care services (HC.5)</td>
<td>• unspecified long-term care (HC.3.nec)</td>
</tr>
<tr>
<td>• outpatient OTC and prescribed medicines</td>
<td>• ancillary services (HC.4)</td>
</tr>
<tr>
<td>• a share (80%) of health system administration and governance costs (HC.7)</td>
<td>• other health care services not elsewhere classified (HC.9)</td>
</tr>
</tbody>
</table>

- In 2019 WHO proposed a global definition of PHC based on SHA 2011 methodology
- SHA 2011 offers at least three options for constructing PHC spending (HC, HP, HCxHP)
- 37 countries in the Region report data on PHC spending using SHA 2011 framework, but there is room for improvement
PHC accounts for less than half of current spending on health, but there is considerable variation across countries.

General outpatient care and outpatient medicines account for the largest share of PHC spending.
The priority given to PHC in allocating public spending varies substantially.
WHO calls on all countries to invest an additional 1% of GDP in PHC

• Investing an additional 1% of GDP in PHC would result in an extra spent publicly per person on PHC in:
  • Republic of Moldova - US$ 32
  • Georgia - US$ 44
  • Russian Federation - US$ 115

• Careful tracking PHC spending and increasing public spending on PHC by an additional 1% of GDP are needed to enter a new era in health financing
Chapter 5
COVID-19: implications for health spending
COVID-19 has led to the deepest economic shock in decades

Countries were quick to mobilize additional revenue for health
Many countries will need significantly increased public investment in health but pressure on health budgets will increase as government revenue falls.

Potential sources of pressure on health budgets in the context of COVID-19:

**Higher spending on health**
- COVID-19 health response, including vaccine rollout
- Maintaining non-COVID-19 health services
- Backlog of delayed or cancelled health services
- Foregone care: lower health status, higher health service unit costs
- Unemployment & poverty: higher demand for publicly financed health services
- Preparedness for future shocks

**Lower revenue for health**
- Economic contraction
- Rising unemployment
- Falling wages
- Declining remittances
- Increasing poverty
- Cuts to external aid
Learning from the 2008 global financial crisis: austerity slowed public spending on health

Average annual change (%)

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<tr>
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<tbody>
<tr>
<td>GDP</td>
<td>2.8</td>
<td>0.5</td>
<td>2.3</td>
</tr>
<tr>
<td>Health (public)</td>
<td>3.6</td>
<td>0.7</td>
<td>1.8</td>
</tr>
<tr>
<td>OOPs</td>
<td>2.6</td>
<td>-1.2</td>
<td>2.1</td>
</tr>
</tbody>
</table>

Average annual growth in OOPs (%)

Average annual growth in public spending on health (%)
Learning from the 2008 global financial crisis: austerity undermined progress towards UHC

Shifting health care costs onto households increased unmet need and financial hardship in Greece and other countries in Europe

Health financing policy is less resilient to economic shocks in some countries

- Public spending on health (% government spending)
- Out-of-pocket payments (% current health spending)
Well-designed public policy can mitigate the negative effects of COVID-19 and build health system resilience

<table>
<thead>
<tr>
<th>Broaden the public revenue base for the health system</th>
<th>Introduce and strengthen automatic stabilizers</th>
<th>De-link access to health services from health insurance status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Re-design co-payment policy to protect people at risk of poverty or social exclusion and people with chronic conditions</td>
<td>Reprioritize the government budget to ensure sustained increases in public spending on health</td>
<td>Use priority-setting processes and other instruments to ensure additional public investment in the health system meets equity and efficiency goals</td>
</tr>
</tbody>
</table>
Austerity is not an option

There is no economic recovery without health security

HICs: don’t be complacent

LMICs: learn from the mistakes of HICs after 2008

Health security requires political will, better tax systems and international solidarity