POLICY SUMMARY 5

Health policy responses to the financial crisis in Europe

Philipa Mladovsky, Divya Srivastava, Jonathan Cylus, Marina Karanikolos, Tamás Evetovits, Sarah Thomson, Martin McKee

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Executive summary

Introduction

The global financial crisis that began in 2007 can be classified as a health system shock – that is, an unexpected occurrence originating outside the health system that has a large negative effect on the availability of health system resources or a large positive effect on the demand for health services. Economic shocks present policy-makers with three main challenges:

- Health systems require predictable sources of revenue with which to plan investment, determine budgets and purchase goods and services. Sudden interruptions to public revenue streams can make it difficult to maintain necessary levels of health care.
- Cuts to public spending on health made in response to an economic shock typically come at a time when health systems may require more, not fewer, resources – for example, to address the adverse health effects of unemployment.
- Arbitrary cuts to essential services may further destabilize the health system if they erode financial protection, equitable access to care and the quality of care provided, increasing health and other costs in the longer term. In addition to introducing new inefficiencies, cuts across the board are unlikely to address existing inefficiencies, potentially exacerbating the fiscal constraint.

In 2009, WHO's Regional Committee for Europe adopted a resolution (EUR/RC59/R3) urging Member States to ensure that their health systems would continue to protect and promote universal access to effective health services during a time of economic crisis. To date, there has been no systematic cross-country analysis of health policy responses to the financial crisis in Europe, although some overviews of health system responses to the crisis have been published. This policy summary aims to address a gap in the literature by presenting a framework for analysing health policy responses to economic shocks; summarizing the results of a survey of health policy responses to the financial crisis in the European Region's 53 Member States; and discussing the potential effects of these responses on health system performance.

Understanding health policy responses to the financial crisis

When confronted by an economic shock affecting the health sector, policy-makers may decide to maintain, decrease or increase current levels of public expenditure on health. With each option they could also reallocate funds within the health system to enhance efficiency. A range of tools can be used to alter

expenditure levels, categorized under the following policy domains: the level of *contributions* for publicly financed care; the *volume* and *quality* of publicly financed care; the cost of publicly financed care.

In making decisions about which tools to use, policy-makers need to consider the impact of proposed reforms on the attainment of health system goals. Achieving fiscal balance is likely to be important in the context of a financial crisis but generally it is not regarded as a primary goal of the *health system* – on a par with or overriding health policy goals such as health gain or financial protection – since, if it were, it could be achieved by cutting public spending on health without regard for the consequences. This stands in contrast to the goal of efficiency. The purpose of trying to increase efficiency in the health sector is to maximize outcomes for a given level of public resources devoted to health care.

Governments' responses exist in a context of broader constraints and opportunities within and external to the health system. Public policy responses to economic shocks should vary according to the nature of the shock. The crisis has had devastating consequences for some countries in Europe, particularly those with high levels of pre-existing debt and deficit, which have found it difficult to borrow to sustain public spending. Inability to obtain affordable credit or to generate revenue through taxation severely constrains a highly indebted country's fiscal space, leaving it with little option but to cut public spending. Political preferences may also influence public policy responses.

Survey results

The results of the survey suggest that the response to the crisis across the European Region varied considerably across health systems and, in part, depended on the extent to which countries experienced a significant downturn in their economies. Some countries introduced no new policies, while others introduced many. Some health systems were better prepared than others due to fiscal measures they had taken before the crisis, such as accumulating financial reserves. There were many instances in which policies planned before 2008 were implemented with greater intensity or speed as they became more urgent or politically feasible in face of the crisis, particularly the restructuring of secondary care. There were also cases where planned reforms were slowed down or abandoned in response to the crisis.

Policies intended to change the level of contributions for publicly financed health care

Several countries reported cuts in the national health budget in response to the financial crisis. In some countries, cuts were partly caused by rising unemployment which reduced revenue from social insurance contributions. In a few cases,

social insurance revenues and expenditures continued to increase, in part due to the counter-cyclical contribution rate paid by the state for economically inactive people. Several countries increased or instituted user charges in response to the crisis. In contrast, others reported expanding benefits.

Policies intended to affect the volume and quality of publicly financed health care

In general the statutory benefits package and the breadth of population coverage were not radically changed following the financial crisis but some reductions were made, usually at the margin. In terms of policies to reduce demand for health services, several countries increased taxes on alcohol and cigarettes, but very few pursued health promotion policies such as healthy eating, exercise and screening in response to the crisis. Only one country increased waiting times as an explicit response to the crisis, although waiting times may also be increasing elsewhere as an indirect result of other health policy reforms.

Policies intended to affect the costs of publicly financed health care

Many countries introduced or strengthened policies to reduce the price of medical goods or improve the rational use of medicines. In most cases these policies were part of ongoing reforms. The crisis increased efforts to negotiate pharmaceutical prices in some national markets.

Some countries reduced the salaries of health professionals, froze them, reduced their rate of increase or used other approaches to lower salaries. Several countries reduced the health service prices paid to providers or linked payment to improved performance to realize efficiency gains and contain costs. Several governments are restructuring their Ministry of Health, statutory health insurance funds or other purchasing agencies in an attempt to increase efficiency and reduce overhead costs.

In many countries, the economic crisis created an impetus to speed up the existing process of restructuring the hospital sector through closures, mergers and centralization, a shift towards outpatient care and improved coordination with or investment in primary care.

Conclusions

The survey results indicate that European Region countries have employed a mix of policy tools in response to the financial crisis. Some countries seem to have used the crisis to increase efficiency, although little has been done to enhance value through policies to improve public health, which is a missed opportunity.

Policies to secure financial sustainability in the face of the financial crisis, and to improve the health sector's fiscal preparedness for financial crises, should be consistent with the fundamental goals of the health system.

To risk over-simplifying, policy tools likely to promote health system goals include: increased risk pooling; strategic purchasing, where contracts are combined with accountability mechanisms including quality indicators, patient-reported outcome measures and other forms of feedback; health technology assessment to assist in setting priorities, combined with accountability, monitoring and transparency measures; controlled investment in the health sector, particularly for health infrastructure and expensive equipment; public health measures to reduce the burden of disease; price reductions for pharmaceuticals combined with cost–effectiveness evidence and other measures to promote rational prescribing and dispensing; shifting from inpatient to day-case or ambulatory care, where appropriate; integration and coordination of primary care and secondary care, and of health and social care; reducing administrative costs while maintaining capacity to manage the health system; fiscal policies to expand the public revenue base; counter-cyclical measures, including subsidies, to protect access and financial protection, especially among poorer people and regular users of health care; and, outside the health sector, active labour market programmes and social support services to mitigate some of the adverse effects of economic downturns.

Policy tools that risk undermining health system goals include: reducing the scope of essential services covered; reducing population coverage; increases in waiting times for essential services; user charges for essential services; and attrition of health workers caused by reductions in salaries.

The discussion highlights the trade-offs involved in any policy decision. These trade-offs should be understood and made explicit so that decision-makers can openly weigh evidence against ideology in line with societal values. Policy decisions should be guided by a focus on enhancing value in the health system rather than on identifying areas in which cuts might most easily be made. Viewing fiscal balance as a constraint to be respected, rather than as an objective in its own right allows decision-makers to shift the terms of debate away from balancing the budget at any cost towards an emphasis on maximizing the health system's performance.

Key messages

- Economic shocks present policy-makers with three main challenges:
  - Health systems require predictable sources of revenue. Sudden interruptions to public revenue streams can make it difficult to maintain necessary levels of health care.
  - Cuts to public spending on health made in response to an economic shock typically come at a time when health systems may require more, not fewer, resources – for example, to address the adverse health effects of unemployment.
  - Arbitrary cuts to essential services may further destabilize the health system if they erode financial protection, equitable access to care and the quality of care provided, increasing costs in the longer term. In addition to introducing new inefficiencies, cuts across the board are unlikely to address existing inefficiencies, potentially exacerbating the fiscal constraint.
- The response to the crisis across the European Region varied across health systems. Some countries introduced no new policies, while others introduced many. Some health systems were better prepared than others due to fiscal measures they had taken before the crisis, such as accumulating financial reserves. There were many instances in which policies planned before 2008 were implemented with greater intensity or speed as they became more urgent or politically feasible in face of the crisis. There were also cases where planned reforms were slowed down or abandoned in response to the crisis.
- European Region countries employed a mix of policy tools in response to the financial crisis. Some of the policy responses were positive, suggesting that some countries have used the crisis to increase efficiency. The breadth and scope of statutory coverage was largely unaffected and in some cases benefits were expanded for low-income groups. However, some countries reduced the depth of coverage by increasing user charges for essential services, which is a cause for concern. Little was done to increase efficiency through policies to improve public health.
- Policies to secure financial sustainability in the face of the financial crisis, and to improve the health sector's fiscal preparedness for financial crises, should be consistent with the fundamental goals of the health system.
- To risk over-simplifying, policy tools likely to promote health system goals include: risk pooling; strategic purchasing; health technology assessment; controlled investment; public health measures; price reductions for

pharmaceuticals combined with rational prescribing and dispensing; shifting from inpatient to day-case or ambulatory care; integration and coordination of primary care and secondary care, and of health and social care; reducing administrative costs while maintaining capacity to manage the health system; fiscal policies to expand the public revenue base; and counter-cyclical measures, including subsidies, to protect access and financial protection, especially among poorer people and regular users of health care.

- Policy tools that risk undermining health system goals include: reducing the scope of essential services covered; reducing population coverage; increases in waiting times for essential services; user charges for essential services; and attrition of health workers caused by reductions in salaries.
- Where the short-term situation compels governments to cut public spending on health, the policy emphasis should be on cutting wisely to minimize adverse effects on health system performance, enhancing value and facilitating efficiency-enhancing reforms in the longer run.

1 Introduction

The global financial crisis that began in 2007 can be classified as a health system shock – that is, an unexpected occurrence originating outside the health system that has a large negative effect on the availability of health system resources or a large positive effect on the demand for health services. Economic shocks present three risks which health policy-makers need to contend with. First, health systems require predictable sources of revenue with which to plan investment, determine budgets and purchase goods and services. Sudden interruptions to public revenue streams can make it difficult to maintain necessary levels of health care. Second, cuts to public spending on health made in response to an economic shock typically come at a time when health systems may require more, not fewer, resources – for example, to address the adverse health effects of unemployment (see Box 1). Third, the nature of the health policy response to an economic shock may further destabilize the health system, particularly if arbitrary cuts to essential services erode financial protection, equitable access to care and the quality of care provided, increasing health and other costs and exacerbating the fiscal constraint.

In 2009, WHO's Regional Committee for Europe adopted a resolution (EUR/RC59/R3) urging Member States to ensure that their health systems would continue to protect and promote universal access to effective health services during a time of economic crisis (WHO Regional Office for Europe, 2009). The resolution built on momentum created by the 2008 Tallinn Charter, which noted that health systems promoted both health and wealth; that investment in health was an investment in future human development; and that well-functioning health systems were essential for any society to improve health and attain health equity (WHO Regional Office for Europe, 2008). More recently, WHO has addressed the challenge of sustaining equity, solidarity and health gain in the context of the financial crisis, highlighting the diversity of health policies pursued by Member States in response to budgetary pressures (WHO Regional Office for Europe, 2011b).

To date, there has been no systematic cross-country analysis of health policy responses to the financial crisis in Europe, although some overviews of health system responses to the crisis have been published (Schneider, 2009; European Commission & Economic Policy Committee (AWG), 2010; Doetter and Gotze, 2011; European Hospital and Healthcare Federation, 2011; WHO Regional Office for Europe, 2011b; European Federation of Nurses Associations, 2012).[1] This policy summary aims to address a gap in the literature by presenting a framework for analysing health policy responses to economic shocks;

[1] In addition, an article based on an earlier draft of this policy summary has been published (Mladovsky et al., 2012).

summarizing the results of a survey of health policy responses to the financial crisis in the European Region's 53 Member States; and discussing the potential effects of these responses on health system performance.

Box 1. Effects of economic downturns on health

Research on health during the Great Depression in the United States in 1929–1937 showed that while suicides rose, overall mortality fell due to a decrease in infectious diseases and road-traffic accidents (Fishback, Haines & Kantor, 2007). A recent study using city- and state-level mortalities by cause shows that, apart from rises in suicides and falls in road-traffic deaths, overall mortality changes were unrelated to the depression itself (Stuckler et al., 2011a).

The recession following the collapse of the Soviet Union in the early 1990s had devastating consequences for population health across the region, with mortality increases of up to 20% in some countries. The pace of transition, including mass privatization and the absence of a social safety net in some of the countries, extensively affected life expectancy rates (Stuckler, King & McKee, 2009). Many ex-communist countries regained their pre-transition life expectancy levels only two decades later. The adverse consequences of rapid economic reforms were found to be lower in countries in which many people were members of social organizations such as trade unions, religious groups or sports clubs (Stuckler, King & McKee, 2009).

Countries affected by the South East Asian economic crisis of the 1990s adopted different recovery strategies. Thailand and Indonesia, which reduced spending on social protection, experienced short-term increases in mortality, while Malaysia managed to sustain social protection programmes and showed no obvious change in death rates (Waters, Saadah & Pradhan, 2003; Hopkins, 2006; Chang et al., 2009).

These examples show how health outcomes following recession may differ, in part depending on the context and causes of the crisis, but also depending on a country's response.

A series of studies using aggregate-level data have suggested that health might not be affected by economic downturns in high-income countries, as mortality tends to fall when the economy slows down and rise when the economy speeds up (Ruhm, 2000, 2003, 2008; Gerdtham & Ruhm, 2006). This effect has been observed at least in the short run, with the extent of the effect varying substantially for different age groups (Joyce & Mocan, 1993), sexes (Chang et al., 2009) and diseases (Waters, Saadah & Pradhan, 2003), and the results are somewhat sensitive to the indicators used to measure economic change (Gerdtham & Johannesson, 2005; Svensson, 2007; Economou, Nikolau & Theodossiou, 2008; Stuckler, Meissner & King, 2008). Noting the counterintuitive nature of these findings (Catalano & Bellows, 2005), researchers have suggested that recessions may have a positive impact on health because increased leisure time allows people to engage in health-enhancing activities such as exercise, or to cut down on over-consumption of food and alcohol.

However, other research shows that economic downturns pose clear risks to health due to suicides and alcohol-related mortality (Stuckler et al., 2009; Stuckler, Basu & McKee, 2010; Suhrcke et al., 2011). These studies also find that adverse effects can be partly mitigated by providing job reintegration programmes and support to families during periods of economic instability, as well as maintaining regulation of the alcohol industry to avoid hazardous drinking as a coping mechanism. Where such measures have been in place, the health benefits of economic crises, such as declining road-traffic accidents as people drive less, tend to outweigh the risks, improving population health, at least in the short-term.

In summary, while additional research is needed to understand the longer-term and indirect effects of economic crises on health and health systems, some evidence from previous economic downturns suggests that recession, especially accompanied by increases in unemployment, is damaging to public health (Kaplan, 2012; McKee, Basu & Stuckler, 2012). Maintaining spending on social protection, particularly on active labour market programmes, is likely to reduce negative effects on health.

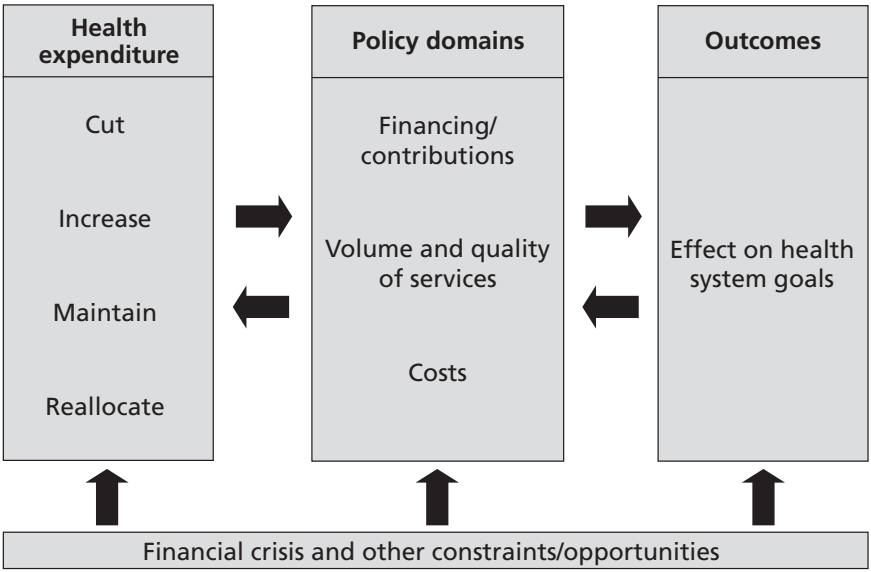
Given the long delays in publishing mortality data in many countries, only preliminary conclusions can be drawn about the effects of the current crisis in Europe. However, research to date confirms a sharp rise in suicides in the countries worst affected and a fall in deaths from road-traffic accidents, most notable in countries where initial accident levels were highest (Stuckler et al., 2011b).

More detailed evidence emerging from Greece, the European country that has been hardest hit by the financial crisis, points to a worsening of mental health status in the past two years (Economou et al., 2011; Madianos et al., 2011); self-reported general health has also deteriorated since the start of the crisis and there has been a significant increase in the number of people who felt they needed health care, but did not access it (Kentikelenis et al., 2011); the number of new HIV cases among injecting drug users (IDU) has risen dramatically, thought to be caused by reduced service provision (EMCDDA & ECDC, 2011).

2 Understanding health policy responses to the financial crisis

Fig. 1 depicts a framework for describing possible health policy responses to health system shocks. The framework has three main dimensions: health expenditure options, policy domains and outcomes. First, when confronted by an economic shock affecting the health sector, policy-makers may decide to maintain, decrease or increase current levels of *public expenditure on health*. With each option they could also reallocate funds within the health system to enhance efficiency.

Fig. 1. Health policy responses to the financial crisis and other economic shocks



Second, a range of policy tools within three main *policy domains* can be used to alter expenditure levels. These can be categorized as:

- the level of *contributions* for publicly financed care (the size of the national health budget, social insurance contributions and transfers from the health budget, aspects of fiscal policy such as earmarking taxes for health, shifting to private expenditure on health in the form of user charges or private health insurance);
- the *volume* and *quality* of publicly financed care (the statutory benefits package, population coverage, non-price rationing in the form of waiting times);
- the cost of publicly financed care (the price of medical goods, health worker salaries, payments to providers, overhead costs, service reconfiguration).

In many cases, policies will affect more than one of these factors. For example, altering the price of medical goods will not only change the unit cost of care; it may also change the volume of medical goods provided and the level of contributions, if user charges are involved.

Third, when making decisions policy-makers need to consider the impact of any proposed reforms on the attainment of **health system goals**. Health system

goals can be articulated in many ways; different policy documents put forward a range of goals (see WHO, 2000, 2010; Figueras, Lessof & Srivastava, 2006; Kutzin, 2008):

- health status: improving health outcomes and health service outcomes
- financial protection: ensuring people do not suffer financial hardship when using needed health care
- efficiency: maximizing health gain from given resources and avoiding waste, enhancing value by ensuring benefits outweigh costs
- equity: ensuring health services are distributed in relation to need and contributions are set according to capacity to pay
- quality: combines clinical effectiveness with patient experience and therefore captures safety, effectiveness, accessibility, acceptability
- responsiveness: meeting people's legitimate non-health expectations about how the health system treats them
- transparency: providing reliable information about features of the health system such as benefits, costs and quality
- accountability: monitoring and evaluation of performance which is associated with tangible consequences (penalties or rewards).

Fig. 2 makes explicit the links between health care expenditure, policy tools and goals or outcomes. Changes to expenditure should be considered in the light of their potential impact on the attainment of health system goals. Achieving fiscal balance is likely to be important in the context of a financial crisis but generally it is not regarded as a primary goal of the *health system* – on a par with or overriding health policy goals such as health gain or financial protection – since, if it were, it could be achieved by cutting public spending on health without regard for the consequences (Thomson et al., 2009). This stands in contrast to the goal of efficiency. The purpose of trying to increase efficiency[2] in the health sector is to maximize outcomes for a given level of public resources devoted to health care (Weinstein & Stason, 1977). Efficiency gains imply achieving similar outcomes at lower cost, better outcomes at similar cost or better outcomes at

[2] Technical efficiency refers to the physical relation between resources (capital and labour) and health outcomes: obtaining the maximum level of output for a given level of input or a minimum level of input for a given level of output. Productive efficiency refers to minimizing total cost for given output, or the maximization of health outcome for a given level of cost. Allocative efficiency refers to maximizing the value of the output or the appropriate combination of health programmes to maximize the health of society (Palmer & Torgerson, 1999).

greater cost, where the benefits exceed the extra cost involved (Chernew et al., 1998; Palmer & Torgerson, 1999; Docteur & Oxley, 2003; Goetghebeur, Forrest & Hay, 2003; Dormont, Grignon & Huber, 2005; OECD, 2006; Pammolli et al., 2008). As we have noted, arbitrary cuts to public spending on health in response to an economic shock may undermine health system performance by reducing financial protection, equitable access to care and the quality of care provided. This in turn might reduce efficiency by lowering health outcomes and increasing health and other costs in the longer term. In addition to introducing new inefficiencies, cuts across the board are unlikely to address existing inefficiencies, potentially exacerbating the fiscal constraint (Kutzin, 2008; Thomson, Foubister & Mossialos, 2009).

All three sets of responses exist in a context of broader constraints and opportunities within and external to the health system. Public policy responses to economic shocks should vary according to the nature of the shock. The current economic crisis, considered by many to be the worst since the Great Depression, was triggered by a combination of easy access to credit, irresponsible lending and high-risk investment involving complex financial instruments. When investment-related loans could not be repaid, the financial instruments lost considerable value (Wade, 2009) and financial institutions and others holding or exposed to these securities suffered massive losses. Lender reluctance to take on further liabilities led to liquidity shortages and concerns about the solvency of financial institutions, deepening the crisis and causing it to extend well beyond the financial sector. Although the crisis to some extent originated in the United States (US), it quickly spread to other countries, resulting in bank failures, stock market crashes, drops in asset prices, negative gross domestic product (GDP) growth, rising unemployment and, ultimately, bailouts of entire countries.

The crisis has had devastating consequences for some countries in Europe, particularly those with high levels of pre-existing debt and deficit, which have found it difficult to borrow to sustain public spending. Inability to obtain affordable credit or to generate revenue through taxation severely constrains a highly indebted country's fiscal space, leaving it with little option but to cut public spending. Within the Eurozone, national inability to form independent monetary policy also limits policy options for combating the crisis. For Greece, Ireland and Portugal, bailout packages from the European Commission, the International Monetary Fund (IMF) and the European Central Bank (the "troika") have actually mandated public sector reforms (including reforms to the health sector) as conditionality for the receipt of funds, removing national autonomy in some areas of public policy (Fahy, 2012).

Fiscal space may be further constrained by a rapid increase in unemployment. In the European Region, unemployment rates rose from 7.4% in 2008 to 8.6% in 2009 (WHO Regional Office for Europe, 2012). Rising unemployment not only reduces household consumption and tax revenues; it also adds to pressure on the government's welfare budget, as the need for unemployment and other social security benefits, including health benefits, increases. Countries that rely on the labour market to finance health care may find that paying social insurance contributions for a growing number of unemployed people is another source of fiscal pressure. Finally, political preferences may influence public policy responses as much as the magnitude of the fiscal constraint created or exacerbated by the economic shock.

In the context of pressure for cuts in public spending, the health sector is likely to be affected. Research suggests that public spending on health in Europe has tended to fall after previous economic crises, often at a faster rate than other types of government expenditure (Cylus, Mladovsky & McKee, in press). Recent health expenditure data suggest that a similar pattern is emerging in many countries (see section 4). The health sector may be vulnerable to budget cuts for a range of reasons. Public spending on health accounts for a substantial proportion of total government expenditure: nearly 13% on average in the European Region (see Table 1). Health system inefficiencies may make it politically difficult to argue for maintaining current levels of public expenditure on health during a period of fiscal austerity. It may also be easier to cut public spending on health than to make cuts in other areas of social protection, such as pensions, either because there is more scope for efficiency gains in the health system or because health benefits are less clearly defined than other benefits (Fahy, 2012). Conversely, counter-cyclical health policies such as holding financial reserves earmarked for health or linking government contributions for economically inactive groups of people to average earnings in previous years may ease pressure to cut public spending on health (WHO Regional Office for Europe, 2011b).

Other factors that may influence the nature, scale and intensity of the health policy response to the crisis include the capacity of key stakeholders for implementation (e.g. availability of human resources and expertise); the availability and use of evidence to inform reforms (e.g. effective health technology assessment (HTA) systems in place); political feasibility (e.g. policies may be resisted or overturned by politicians, professionals or the public, or, conversely, planned "unpopular" policies may become more politically feasible in the context of the crisis); and the presence of other public sector reforms (e.g. cuts or stimulus packages affecting pensions, jobs, welfare benefits and the unemployment rate).

Table 1. Public expenditure on health as a percentage of total government expenditure, WHO European Region

Country	2008	2009	Difference 2008–2009
Kazakhstan	8.3	11.3	3.0
Monaco	15.8	18.5	2.7
Tajikistan	5.0	6.4	1.4
Azerbaijan	2.5	3.7	1.2
Bosnia and Herzegovina	14.0	15.1	1.1
Republic of Moldova	13.0	14.1	1.1
Uzbekistan	8.6	9.6	1.0
Belarus	8.2	8.8	0.6
Italy	13.6	14.2	0.6
Malta	12.4	13.0	0.6
Albania	8.2	8.4	0.2
Georgia	7.3	7.5	0.2
Kyrgyzstan	11.5	11.7	0.2
Switzerland	19.9	20.0	0.1
Andorra	21.3	21.3	0.0
Austria	15.8	15.8	0.0
Belgium	14.8	14.8	0.0
Bulgaria	9.1	9.1	0.0
Croatia	17.6	17.6	0.0
Cyprus	5.8	5.8	0.0
Czech Republic	13.3	13.3	0.0
Denmark	15.3	15.3	0.0
Finland	12.6	12.6	0.0
France	16.0	16.0	0.0
Germany	18.0	18.0	0.0
Greece	13.0	13.0	0.0
Hungary	10.2	10.2	0.0
Iceland	13.1	13.1	0.0
Ireland	16.0	16.0	0.0
Israel	10.0	10.0	0.0
Latvia	10.2	10.2	0.0

Country	2008	2009	Difference 2008–2009
Lithuania	12.8	12.8	0.0
Luxembourg	13.7	13.7	0.0
Montenegro	13.6	13.6	0.0
Netherlands	16.2	16.2	0.0
Norway	16.7	16.7	0.0
Poland	10.9	10.9	0.0
Portugal	15.4	15.4	0.0
Romania	11.8	11.8	0.0
San Marino	13.6	13.6	0.0
Slovenia	12.9	12.9	0.0
Spain	15.2	15.2	0.0
Sweden	13.8	13.8	0.0
Turkey	12.8	12.8	0.0
Turkmenistan	7.0	7.0	0.0
Ukraine	8.6	8.6	0.0
United Kingdom	15.1	15.1	0.0
Serbia	14.1	13.9	-0.2
Estonia	11.9	11.7	-0.2
Armenia	7.2	6.6	-0.6
Russian Federation	9.2	8.5	-0.7
Slovakia	15.4	14.0	-1.4
The former Yugoslav Republic of Macedonia	13.6	12.1	-1.5

Source: WHO, 2012.

3 Methods

To map health policy responses to the financial crisis, we analysed health expenditure data from the Health for All and WHOSIS databases and sent a questionnaire to a network of health policy experts in the European Region's 53 Member States. Most of the experts were based in universities, WHO country offices and other non-governmental organizations. Completed questionnaires were received in March and April 2011.

Because it was not always clear to what extent a policy was, in fact, a response to the crisis, as opposed to being part of an ongoing reform process, we asked respondents to divide policies into two groups based on whether they were (a) defined by the relevant authorities in the country as a response to the crisis or (b) either partially a response to the crisis (i.e. planned before the crisis but implemented with greater or less speed or intensity than planned) or possibly a response to the crisis (i.e. planned and implemented since the start of the crisis, but not defined by the relevant authorities as a response to the crisis). Both types of policies are reported here. We also asked respondents to provide evidence of the impact of policy responses on health system performance, but in almost every case they reported that evidence was not yet available.

Survey responses were categorized using the framework (Fig. 1). All of the data were analysed separately by two researchers (i.e. two people extracted the same data to ensure accuracy) and summarized in tables. The tables were verified by the respondents and by experts from WHO. The completed policy summary was reviewed by experts from WHO, the World Bank and the Organisation for Economic Co-operation and Development (OECD). Annex 1 contains the full results of the survey.

The study has several limitations. First, as we anticipated, it is difficult to define whether or not policies are in fact a response to the financial crisis. Second, we asked respondents to provide information distinguishing between types of health care (curative, preventative, long-term care, medical goods, etc.) where possible, but comparing types of health care across countries is challenging, particularly due to the lack of a common definition of the term "public health" (McKee & Jacobson, 2000; Kaiser & Mackenbach, 2008). Where necessary, we clarified terminology with respondents. Third, the information provided by experts may be of varying completeness and quality. Fourth, we have not been able to systematically include information on each health system's degree of fiscal preparedness. Some countries may have introduced measures to improve efficiency or cut costs just before the crisis began, so that there was not much room for further reform. It is possible to capture this in case studies, but detailed analysis covering 53 countries was beyond the scope of this exercise. Finally, evaluating policy responses to the financial crisis in a general way may be misleading because different policies need to be considered in context to establish actual impact on health system performance and health expenditure.

4 Results

Forty-five countries responded to the questionnaire. Their responses are summarized below (for more detailed results, see Annex 1), with a brief commentary on the potential impact of each policy tool on health system performance.

4.1 Overview

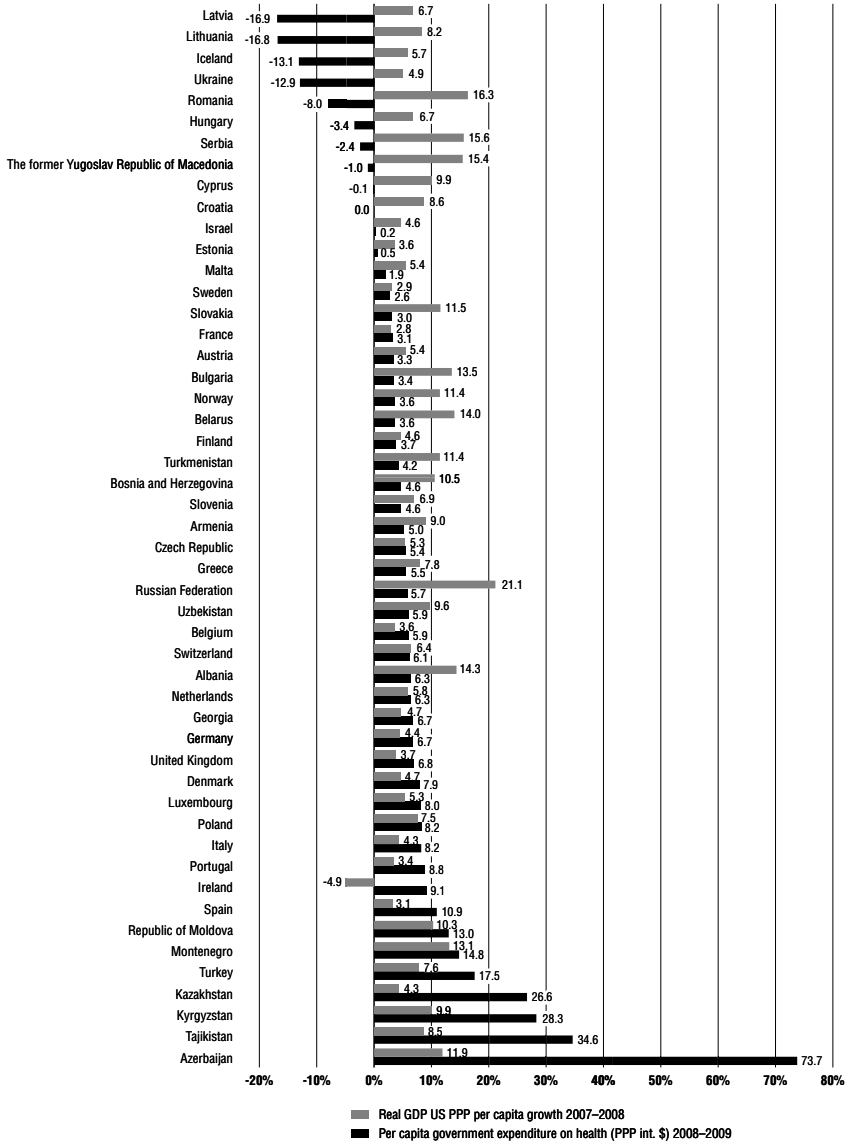
WHO data indicate that, between 1998 and 2008, government spending on health as a share of GDP increased in most European countries (35 out of 53). From 2007 to 2008 real GDP per person contracted in just one country (Ireland) but grew in all others, ranging from 2.8% in France to 21.1% in the Russian Federation (Fig. 2). From 2008 to 2009 public expenditure on health per capita grew in all but nine countries (Fig. 2).[3] This suggests there was no immediate budgetary response in the health sector to the financial crisis. However, GDP growth from 2008 to 2009 indicates a bleaker outlook: the size of the real economy contracted in 38 countries to varying degrees (from -0.1% in Portugal to -13.9% in Ukraine). Overall, real GDP per capita contracted by -3.4% in the European Region. The decline in GDP could take time to affect political decisions that influence public spending on health, so data for 2010 and 2011 should give a better picture of the trends when they become available.

Between 1998 and 2008, total government spending as a share of GDP decreased in the European Region (from 42.4% to 40.9% in aggregate); that is, the public sector's share of the economy (the size of government) became smaller. During this period, public spending on health grew to consume a greater share of total government spending (rising from 11.6% in 1998 to 12.8% in 2008), because governments maintained or increased the health share of the government budget (WHO Regional Office for Europe, 2011b). However, from 2008 to 2009 only 14 countries had an increase in public spending on health as a share of total government expenditure, ranging from 0.1% to 3% (Table 1). Most of these were Member States that have been largely unaffected by the financial crisis and where public expenditure on health is increasing from a very low base. This suggests that in affected countries, the financial crisis may already be having a negative effect on the priority governments accord to health budgets.

The effect of the financial crisis on health policy varied across health systems in Europe and in part depended on the extent to which countries experienced a significant downturn in their economies. Within the European Region, Albania, Azerbaijan, Israel and Norway were mostly insulated from the crisis and therefore reported no direct health policy responses at all. Of the countries that were affected by the crisis, some introduced several new policies in response (Czech Republic, Greece, Ireland, Portugal, Republic of Moldova); in Greece, Ireland and Portugal the reforms were part of a broader debt restructuring process which required intervention from the EU, the European Central Bank

[3] Cyprus (-0.1%), the former Yugoslav Republic of Macedonia (-1.0%), Serbia (-2.4%), Hungary (-3.4%), Romania (-8.0%), Ukraine (-12.9%), Iceland (-13.1%), Lithuania (-16.8%) and Latvia (-16.9%) all experienced a drop in real public health expenditure per capita.

Fig. 2. GDP growth and change in public spending on health per capita, WHO European Region



Source: GDP data from WHO Regional Office for Europe, 2011a; health spending data from WHO, 2011.
Note: Data purchasing power parity (PPP) adjusted.

and the IMF. In other affected countries, however, very few or no policy changes were made (Denmark, Iceland, Finland, Germany, Kyrgyzstan, Malta, Poland, Russian Federation, Slovakia, Switzerland, the former Yugoslav Republic of Macedonia, Uzbekistan). In either case, there were many instances in which policies planned before 2008 were implemented with greater intensity or speed as they became more urgent or (more often) politically feasible in face of the crisis, particularly the restructuring of secondary care. In general, a wide range of measures was used, covering all three policy domains presented in Fig. 1.

There were also cases where planned reforms were slowed down or abandoned in response to the crisis. For example, Romania abandoned a plan to build eight new hospitals and Ireland did not build one in four of proposed new health facilities. In Bulgaria the government decided to postpone full prohibition of smoking in public places. Also in Bulgaria, a policy to introduce a system of compulsory private health insurance, which was anyway unpopular with the public and doctors' unions, was rejected by a new government that wished to retain control of public resources and institutions through the National Health Insurance Fund. Bosnia and Herzegovina had difficulty implementing its recently passed health insurance laws due to a lack of reliable sources of funding, and therefore decided to wait until after the crisis. In Georgia the transfer of hospital infrastructure ownership from the state to the private sector stalled due to the withdrawal of investors as a result both of the financial crisis and war with Russian Federation in 2008; the process was resumed in 2010. Ukraine attempted to introduce programmes seeking to increase efficiency, but most were not implemented due to a lack of political will. On the other hand, some governments were able to employ the financial crisis as a lever to strengthen their position in ongoing negotiations with other health system stakeholders, in particular with the pharmaceutical sector (e.g. Austria, Latvia, Poland, Portugal, Russian Federation, Serbia, Slovenia and Turkey).

A few of the policy measures planned or implemented in response to the crisis were quickly reversed due to their unpopularity with key stakeholders, particularly efforts to reform provider payment. In Bulgaria the Ministry of Finance attempted to take control of setting health service prices but the reform was strongly resisted by the medical union and eventually reversed. For a short period Hungary introduced tighter volume controls in the payment of inpatient care providers but this was also reversed due to pressure from hospitals. In the former Yugoslav Republic of Macedonia the value of a capitation point for primary care physicians was briefly decreased by 10% before doctors' protests led to its reversal. In Romania a new system of paying general practitioners (GPs), including a cap on the number of hours worked per week, was proposed as part of a revised framework contract but rejected by GPs. In Ukraine the government attempted to stabilize rising pharmaceutical

prices by placing a cap on retail prices, which resulted in the closure of pharmacies. The approach was fiercely resisted by the pharmaceutical industry and the government responded by implementing softer price control mechanisms, which accounted for fluctuations in national currency rates.

A handful of countries were in the process of undergoing significant health sector reforms funded by loans from international organizations such as the IMF, the World Bank and the EU when the crisis struck, so cost-cutting or efficiency-increasing measures were a continuation (Romania and Serbia). Many of the Commonwealth of Independent States (CIS) countries have very low levels of health expenditure and a high proportion of spending through out-of-pocket payments, leaving very little room for cutting public spending on health (Table 1). Some of them also have ongoing obligations to external funders to increase their public health spending annually (e.g. Kyrgyzstan) and programmes aimed at increasing health system efficiency planned before the crisis are currently being implemented. One or two countries had been working to slow health expenditure growth in recent years, making it difficult to determine whether or not new policies were explicit responses to the crisis (e.g. Croatia, Switzerland).

Some countries were better prepared than others due to fiscal measures they had taken before the crisis (the Czech Republic, Estonia, Italy, Lithuania, Republic of Moldova and Slovakia). These countries were able to draw on reserves or employ other counter-cyclical mechanisms that can compensate for the reduction of payroll tax revenues. For example, at the start of the crisis, the Estonian government cut back on public expenditure, including on health (a political decision made to comply with Maastricht criteria so that Estonia could join the Eurozone; Estonia had low external debt and a low current account deficit, meaning that deficit financing was a viable alternative). The Estonian health system was better prepared for fiscal constraint than those of many of its neighbours. Better preparedness originated mainly from two sources. First, a pre-commitment to prioritize health spending in a downturn by allowing the health sector to accumulate reserves in the health insurance fund put the health insurance fund in a relatively strong position when it came to budget negotiations with the Ministry of Finance. As a result, a transparent political debate took place over the question of where to cut and how much to cut. Second, the Estonian health system invested appropriately in the health sector before the crisis; when the crisis struck, the system could cope with delays in investment without sacrificing health system goals such as quality of care in the short run. This stands in contrast to other countries, such as Hungary, where the health system had already exhausted its (non-structural) efficiency reserves by the time the financial crisis began, meaning that health system goals were likely to be eroded much faster.

Some countries prioritized paying off health sector debts at the expense of health expenditure growth. In others, health budgets were ring-fenced while other sectors experienced cuts (Belgium, Denmark and England). The Finnish government implemented an economic stimulus package to mitigate some of the negative effects of the economic downturn.

4.2 Policies intended to change the level of contributions for publicly financed health care

4.2.1 National health budget

Several countries reported cuts in the national health budget in response to the financial crisis (Bulgaria, Croatia, Estonia, Hungary, Iceland, Ireland, Italy, Greece, Latvia, Romania, Portugal, Spain). In some of these the health budget was reduced by over 20% (for example in Bulgaria and Latvia). Cuts were partly caused by rising unemployment which reduced revenue from social insurance contributions (Bulgaria, Estonia, Hungary, Romania). In other countries, social insurance revenues and expenditures continued to increase (Austria, the Czech Republic, Poland, Slovakia; in the latter due to the high and counter-cyclical contribution rate paid by the state for economically inactive people), and the national health budget also rose in France, Denmark, the former Yugoslav Republic of Macedonia and Turkey. In Denmark the education budget was used to cross-subsidize the health budget. It was maintained at previous levels in Albania, Belgium, England and Norway. Latvia received a World Bank loan in response to the crisis, to cover access to health services by poorer population groups.

As noted, decisions about whether to increase or decrease public spending on health in response to a health system shock may be driven by a mixture of political preferences and technical considerations. In the current crisis, large fiscal imbalances have left some countries with little or no choice in their response; Greece and Portugal have been were particularly affected and were required to implement public sector cuts as part of bailout conditionalities. Where the short-term situation is such that governments are compelled to cut public spending on health, the policy emphasis should be on cutting wisely to minimize adverse effects on health system performance, enhancing value as much as possible and facilitating efficiency-enhancing reforms in the longer run. The rest of this document is concerned with how this might be achieved.

4.2.2 Fiscal policy

Notwithstanding increases in taxes on alcohol and cigarettes (see below), few countries have reformed fiscal policy to increase revenue for health system financing. In Italy, regions with large health care deficits have raised local taxes to recover deficits. In France, a new tax of 2% on certain sources of income

was set up in 2009 to finance social security (including health) expenditure and was subsequently increased to 4% in 2010 and 6% in 2011. Hungary introduced a public health tax on food and drinks with a high sugar content.

Although increases in taxation may reduce the need to increase government borrowing, very few countries have used fiscal policy to raise revenue for health services in response to the current crisis. Reluctance to introduce higher taxes for health care may be underpinned by valid technical and political considerations (such as a negative effect on the labour market, productivity and competitiveness), but the perception that tax-based financing of health care is as a general rule unsustainable is unfounded (Thomson, Foubister & Mossialos, 2009).

4.2.3 Statutory health insurance revenue

Some countries increased employer/employee contribution rates either across the board or for specific population subgroups (Bulgaria, Greece, Portugal, Romania, Slovenia). Slovakia reduced the state's contribution for economically inactive people. Hungary lowered the contribution rate and the government increased its budget transfers on behalf of non-contributing but eligible population groups to compensate the statutory health insurance fund for the loss of revenue (this was its most explicit and progressive response to the financial crisis; see WHO Regional Office for Europe, 2011b). In the Republic of Moldova, the rate of discount for statutory health insurance increased from 50% to 75% for low-income populations. Turkey transferred responsibility for health care payments for government employees and their dependants from the Ministry of Finance to the Social Security Institute. Switzerland debated increasing premium subsidies for low-income families, but no measures were passed. Slovakia and Lithuania already had in place counter-cyclical measures for government subsidies for those insured by the state in order to sustain statutory health insurance revenue during a downturn. In Austria and Romania the government introduced subsidies to bail out social health insurance funds in order to help them pay off debts or prevent further indebtedness.

In countries that rely predominantly on employment-based social insurance contributions, revenue can be maintained by lifting income or earnings ceilings, broadening the contribution base to encompass non-wage income or increasing transfers from the government budget (Thomson, Foubister & Mossialos, 2009). All of these are likely to be relevant options for governments wanting to stimulate employment while maintaining or increasing public spending on health (Thomson, Foubister & Mossialos, 2009). Another strategy that may be useful for smoothing some revenue over economic cycles is to make government contributions for economically inactive groups of people counter-cyclical by linking them to average earnings in previous years, as is the case in Lithuania and Slovakia.

4.2.4 User charges (coverage depth)

Several countries increased or introduced user charges for health services in response to the crisis (Armenia, Czech Republic, Denmark, Estonia, France, Greece, Ireland, Italy, Latvia, Netherlands, Portugal, Romania, Russian Federation, Slovenia, Switzerland, Turkey). In some countries, user charges were introduced or increased in the hospital sector (Armenia, Czech Republic, Estonia (for inpatient nursing care), France, Ireland, Romania, Russia). Pharmaceuticals were subject to increased user charges in several countries (Czech Republic, France, Ireland, Latvia, Portugal, Slovenia). In England, a programme to expand the range of long-term conditions that benefit from free prescriptions was announced by the previous government but not implemented; this will now no longer be taken forward. User charges were increased for ambulatory care in Greece, Italy, Romania and Turkey. User charges for emergency departments increased in Ireland and for services not considered urgent in Italy. In Switzerland the co-insurance rate will increase from 10% to 15% for people who opt for traditional insurance plans (to encourage people to subscribe to a managed-care model of insurance).

Some countries introduced or increased charges for specific services such as *in vitro* fertilization (IVF) (Denmark and the Netherlands), ambulance transport (France and Slovenia), physiotherapy (the Netherlands), some mental health services (the Netherlands), some vaccines such as yellow fever, Japanese encephalitis, typhoid, meningitis and rabies tetravalent (Portugal), GP home visits (Romania), non-acute spa treatment, dental prostheses and some ophthalmologic appliances (Slovenia), and doctor declarations attesting to the incapacity of a patient (Portugal) (see section 4.3.1 below on reductions in the benefit package).

In contrast, other countries reported expanding benefits, targeting low-income groups in the area of pharmaceuticals (Austria, France, Ireland, Italy, Republic of Moldova), reducing user charges (Croatia for primary care and outpatient prescription drugs) or abolishing user charges for some services (Italy, Hungary – although in Hungary's case it was not a response to the crisis but it helped to promote financial protection).

Evidence from this study and a study on previous crises (Cylus, Mladovsky & McKee, in press) suggests that policy-makers may rely on user charges and other policies that shift costs to patients in an effort to slow aggregate expenditure growth. However, user charges increase the financial burden on households (Wagstaff et al., 1992) and have been shown to be equally likely to reduce the use of high-value (cost-effective) and low-value care and are particularly likely to reduce use among lower-income individuals and older people, even when the level of user charges is low (Lohr et al., 1986; Manning

et al., 1987; Newhouse & Rand Corporation Insurance Experiment Group, 1993; Gemmill, Thomson & Mossialos, 2008). Applying or increasing user charges in primary or ambulatory specialist care may worsen health outcomes and lead to increased spending in other areas (e.g. emergency care). As a result, the potential for cost savings or enhanced efficiency is limited. Targeted user charges selectively applied to low-value services or with exemptions or caps for poorer households or regular users of care are more likely to enhance efficiency. However, it may not always be possible to identify low-value care and the transaction costs involved may be significant (Braithwaite & Rosen, 2007; Bach, 2008; Thomson, Foubister & Mossialos, 2009).

4.3 Policies intended to affect the volume and quality of publicly financed health care

4.3.1. Health benefits (coverage scope)

In general the statutory benefits package was not radically changed following the financial crisis, but some reductions were made, usually at the margin. Most countries did not report how coverage decisions were made. Only the Czech Republic and Estonia reported plans to make greater use of HTA in evaluating the benefits package (although in the case of Estonia this was part of an ongoing process which was viewed more favourably by policy-makers in light of the crisis). Reported mandatory coverage reductions included lower reimbursement of: dental care for certain population groups (Estonia, Ireland); IVF, physiotherapy, mental health services and coverage of care outside the EU (the Netherlands); cosmetic surgery (Portugal); non-acute spa treatment, certain medicines, non-urgent ambulance services, dental prostheses and some ophthalmologic appliances (Slovenia); eyeglasses (Switzerland); and temporary sickness benefits paid by the statutory health insurance fund (Estonia, Hungary and Lithuania). The Russian Federation postponed adding outpatient prescription drugs to the benefits package to 2013. On the other hand, Armenia included primary care in the basic primary care package, although this was part of ongoing reforms. Other countries expanded the scope of benefits in a targeted way, and these are discussed under coverage breadth and contributions (section 4.3.2).

A fundamental objective of health policy at any time, but particularly during an economic crisis, is to maintain access to essential services for the population, especially for poorer people and regular users of health care (World Bank, 2009). Changing the range of services included in the statutory benefits package (coverage scope) can be a valuable tool for setting priorities in the health system, particularly if changes are based on evidence and aim to promote the use of high-value care and discourage the use of low-value care. It can also be used to explicitly ration the quantity of care available. Evidence on clinical practice variation and inappropriate use of services may provide

justification for limiting volume of care and enforcing clinical practice guidelines, but targeted implementation of these policies remains a challenge. Hungary introduced volume limits to inpatient services, but left it to the hospitals and doctors themselves to ration care implicitly or explicitly. In times of resource constraint countries may apply budget cuts across the whole sector, reducing funding for the majority of services available. However, cuts across the board run the risk of undermining access to needed services, adversely affecting financial protection, health and efficiency. In contrast, selective, evidence-based and transparent reductions in the scope of coverage represent an opportunity for enhancing efficiency without undermining health system performance (Thomson, Foubister & Mossialos, 2009).

To this end, many countries have adopted HTA in the last two decades to assist in setting priorities (Velasco-Garrido & Busse, 2005), mainly in the area of pharmaceuticals, and to devise clinical guidelines (Draborg et al., 2005; Lavis et al., 2007; Sorenson, Drummond & Kanavos, 2008). However, its use in determining the contents of the benefits package has been limited due to technical and political challenges and resource constraints (Ettelt S et al., 2007; Sorenson, Drummond & Kanavos, 2008). HTA is therefore more likely to be useful as part of a longer-term strategy for enhancing efficiency than as a tool for quick decision-making. Nevertheless, countries with established HTA programmes will be better placed to make informed decisions in times of economic crisis.

4.3.2. Population coverage (coverage breadth)

Ireland was the only country to remove eligibility for some aspects of statutory coverage from some residents; in 2008 the Irish government excluded wealthy individuals over the age of 70 from statutory coverage of primary care, although since the general election in February 2011 the government has announced plans to extend coverage to the whole population (universal coverage). The Czech Republic reported reducing entitlement at the margin by reducing statutory coverage for foreigners. Cyprus attributed its further postponement of implementation of universal coverage to the financial crisis, while Hungary introduced incentives for improved checks for eligibility for statutory coverage to identify and penalize those who avoid paying contributions. Several countries reported expanding statutory coverage for previously uninsured groups of people (Belarus, Bosnia and Herzegovina, Georgia, Republic of Moldova) or introducing universal coverage (the former Yugoslav Republic of Macedonia). Thus, particularly in the former Union of Soviet Socialist Republics (USSR), some countries without universal coverage are expanding eligibility for benefits to targeted population groups, but as part of ongoing reforms rather than in response to the economic crisis.

The share of the population entitled to statutory benefits is a crucial determinant of financial protection in the health system. Restricting eligibility for statutory coverage (e.g. on the basis of household income) may lead to an absolute reduction in public spending on health. However, evidence from Germany and the Netherlands demonstrates that it adds to rather than alleviates fiscal pressure in the health system (Thomson & Mossialos, 2006; Albrecht, Schiffhorst & Kitzler, 2007). This is partly due to the loss of contributions from wealthier households. It is also due to segmentation of the national risk pool, which leaves the statutory risk pool with a concentration of older, poorer and sicker people and people with non-contributing dependants (Thomson & Mossialos, 2006). The Netherlands abandoned this policy in 2006 and Germany has taken numerous measures to mitigate its adverse effects.

Lowering the breadth, scope and depth of coverage creates a role for voluntary health insurance (VHI). However, the market failures that characterize VHI, in particular information problems relating to adverse selection and risk selection, mean that those reliant on voluntary cover may be placed at risk (Barr, 2004), particularly older people and people in poor health (Mossialos & Thomson, 2004; Thomson & Mossialos, 2006, 2009). In addition, the European experience of VHI indicates that in most countries it fails to address gaps in statutory coverage: VHI market development is frequently very limited, particularly outside EU15 countries; VHI policies often do not develop to cover the most important gaps; and where they are available, they may not be accessible to those who need them most, even where the market is extensively regulated (Thomson & Mossialos, 2009).

4.3.3. Non-price rationing (waiting times, service dilution and delay)

The Estonian Health Insurance Fund supervisory board attempted to ration the volume of care provided by deciding to increase maximum waiting times for outpatient specialists' visits from four to six weeks in March 2009. No other countries reported increasing waiting as an explicit policy response to the financial crisis. Rather, in some countries health sector reforms may have inadvertently led to increases in waiting times, such as in Ireland, where changes in health policy have led to a 9% increase in the number of patients on a waiting list between 2009 and 2010.

Changing waiting times may alter demand for publicly financed care without undermining health outcomes if patients on longer waiting lists choose private alternatives (Hoel & Sæther, 2003) or choose to withdraw from treatment. A review of the literature on waiting times (Garber, 2000) suggests that resources should be allocated to different treatments according to their cost–effectiveness. However, reducing timely access to care may have an adverse impact on clinical quality, which would undermine the goal of improving health. Its use as a policy

tool may also be limited by legitimate user expectations regarding acceptable standards of health care.

There is an unexplored area of non-price based rationing mechanisms that are less tangible to both patients and policy-makers, and also difficult to research. These may take different forms of delaying, denying and diluting clinical services ("quality skimping"), with significant implications for health gain and efficiency of the use of limited resources. There is anecdotal evidence of such a response by providers to budget cuts. Delaying care in a non-transparent manner and deviating from clinical practice guidelines on the grounds of cost considerations are just two of the many implicit rationing mechanisms on the supply side. Where monitoring of provider compliance with clinical standards is weak and professional organizations are less rigorous in enforcing good clinical practice, implicit rationing mechanisms may hide some of the adverse effects of the financial crisis. While waiting lists may not be a desired alternative form of rationing, they certainly make the process explicit and more transparent. Targeted research programmes are needed to explore the magnitude of implicit rationing and provide evidence to inform policy-makers (WHO, 2011).

4.3.4 Changing individuals' behaviour (health prevention and promotion)

As previously mentioned, comparing international data on public health financing and policy is challenging due to the lack of a pan-European definition of the term "public health". The following evidence on the effect of the financial crisis on public health in Europe is therefore illustrative and cannot serve as a comprehensive overview.

Several countries increased taxes on alcohol and cigarettes (Bulgaria, Estonia and Ukraine, while the Czech Republic plans to do so in 2012) or pursued health promotion policies, such as encouragement for healthy eating, exercise and screening (Belgium, Bosnia and Herzegovina, Greece, Hungary, Republic of Moldova). These policies seek to reduce the need for health care and are generally intended to lower the volume of publicly financed care provided. Four countries reported cuts to public health budgets. In Estonia, the Ministry's health expenditure fell by 24% in 2009 compared to 2008. This was partially achieved through cutting administrative costs and cutting the public health budget from 2009. Cuts focused on non-communicable diseases (NCDs) and programmes on communicable diseases were protected. EU social funds were used to compensate for the reduction in NCD budget, but these funds will no longer be available from 2012. In Italy, there were plans to cut the fund for disease prevention and health promotion from EUR 29.6 to EUR 5.9 million in 2011. In Latvia the public health budget was cut by 88.6% from 2008 to 2010. In Ukraine, expenditure on preventative services reduced by 9%. Three countries reported the closure or merger of public health bodies. In Iceland,

there were plans to merge the Directorate of Health and the Public Health Institute in 2011. In Latvia, the Public Health Agency was closed in 2009. Many public health functions were distributed to other institutions and some were lost. In Lithuania, there was a reorganization of public health, resulting in the merger of seven public health institutions in 2009–2010.

Evidence on the economic benefits of prevention has grown in recent years, supporting broad public health promotion and preventative measures (e.g. systematic screening for hypertension, cholesterol, some cancers, health advice on diet, alcohol and smoking), although gaps remain (Schwappach, Boluarte & Suhrcke, 2007). Most published work is from the United States and Australia, however (Atun, 2004; Atun, Bennett & Duran, 2008). There is evidence to suggest that taxation can be a useful policy tool to address public health concerns and generate government revenue (Chaloupka & Warner, 2000). Along with fiscal measures, an OECD study indicates that health education and promotion, regulation and counselling on diet, smoking and alcohol by family doctors are cost–effective measures (Sassi, 2010). These policies could increase the efficiency of health service delivery in the medium to long term, but they may not address short-term fiscal constraints.

4.4 Policies intended to affect the costs of publicly financed health care

4.4.1 Prices of medical goods

Many countries introduced or strengthened policies to reduce the price of medical goods (pharmaceuticals, medical devices and equipment) or improve the rational use of drugs (Austria, Belgium, Belarus, Bosnia and Herzegovina, Croatia, the Czech Republic, France, Estonia, Greece, Iceland, Ireland, Hungary, Latvia, Lithuania, Malta, Republic of Moldova, Poland, Portugal, Romania, Russian Federation, Serbia, Slovakia, Slovenia, Spain, the former Yugoslav Republic of Macedonia, Turkey). A wide variety of measures were used, including generic substitution, INN prescribing, claw-back mechanisms, price negotiations and lengthening prescription validity. In most cases these policies were part of ongoing reforms, but the crisis often prompted, speeded up or intensified implementation. Bulgaria and the Czech Republic are also in the process of increasing government regulation of the purchasing of medical devices. At the same time, in many countries VAT increases affecting pharmaceuticals and other products have to some degree attenuated the benefits to patients gained from measures designed to reduce prices.

The crisis increased efforts to negotiate pharmaceutical prices in some national markets, highlighting the importance of the public authority as a monopsony buyer. Improved government procurement practices and positive lists contribute to lower medicine prices when balanced with regulated wholesale and retail

mark-ups (WHO, 2004). The range of approaches used by countries to control prices can include free pricing, *ex ante* pricing relative to a substitute, international reference pricing, price volume agreements, price cuts, profit controls and ex post pricing relative to a substitute (Office of Fair Trading, 2007).

However, the positive effects of price controls may be offset by increases in the quantity of drugs prescribed or a change in the product mix to include more expensive medicines. For example, the downward effect on prices attributed to reference pricing is often short-lived (Lopez-Casasnovas & Puig-Junoy, 2000; Donatini et al., 2001; Nink, Schroder & Selke, 2001). As a result, pricing policies should be combined with policies targeting health professionals to encourage rational prescribing and dispensing in primary and secondary care. Again, however, savings might be offset by increases in volume and therefore short-lived (Harris & Scrivener, 1996; Buzzelli et al., 2006; Andersson et al., 2007; Mossialos & Srivastava, 2008). Nevertheless, even if such policy measures do not lower pharmaceutical expenditure, they may enhance efficiency without any negative effect on health outcomes. Policies to promote greater use of generic medicines are likely to lower pharmaceutical expenditure and enhance efficiency (Mrazek & Frank, 2004). In contrast, policies that aim to cut public spending on prescription drugs by shifting costs to households are generally found to be of limited effectiveness and are discussed in the section on user charges above.

4.4.2 Salaries and motivation of health sector workers

Some countries reduced the salaries of health professionals (Cyprus, France, Greece, Ireland, Lithuania, Romania), froze them (England, Portugal, Slovenia) or reduced their rate of increase (Denmark). Other approaches to lowering salaries included increasing public sector pension contributions substantially and reducing the benefits, leading to a *de facto* pay cut (England), cutting overtime and night shifts, and lengthening shifts that require fewer staff and costs (Iceland), and making workers accept lower wages in order to maintain their contracts (privately contracted housekeeping and IT support staff in Serbia). In the Czech Republic physicians managed to resist cuts to their salaries through negotiation or protests. Albania, which was largely insulated from the crisis, and Belarus and Ukraine continued to increase health worker salaries. In 2011 the former Yugoslav Republic of Macedonia approved the employment of additional health workers to improve quality and access to public health institutions, as well as to prevent qualified medical staff from leaving the public sector.

Employee wages, salaries and allowances account for 42.3% of public spending on health in the 18 countries of the European Region for which data are available (WHO, 2006). This helps to explain the policy focus on cutting salaries in many countries. However, these policies may exacerbate wage imbalances

across countries (depending on the relative change in wages in net immigration countries compared to net emigration countries), possibly increasing health worker migration in Europe and other regions, and adding to problems of human resource shortages, which risks undermining quality and efficiency in the health system (Wismar et al., 2011). Wage imbalances could also be created within countries if health sector wages fall at a different rate to wages in other sectors. Policy-makers can apply a range of non-financial tools to retain workers and improve performance, including clear job descriptions, professional norms and codes of conduct, the proper matching of skills to the tasks in hand, supervision, information and communication, infrastructure including equipment and supplies, life-long learning, team management and team working, and responsibility with accountability (WHO, 2006). Improvements in these areas may provide some limited help in retaining health workers facing salary reductions and freezes.

A longer-term view of increasing efficiency in the supply of human resources for health would consider a broader range of strategies, in particular changing the skill mix and substitution of health workers' roles (typically nurses and GPs taking on some of the work of specialists or nurses taking on some of the work of GPs) to reduce the unit cost of labour or improve productivity. Reviews have found that nurse substitution typically has either no or some improved effect on the quality of care, suggesting that this policy has the potential to increase efficiency (McKee, Dubois & Sibbald, 2006). However, cost savings depend on the magnitude of the salary differential between doctors and nurses, and may be offset by the lower productivity of nurses compared to doctors (Laurant et al., 2005).

4.4.3 Payments to providers

In response to the crisis several countries have reduced the tariffs (i.e. prices) paid to providers (Estonia, Ireland, Romania, Slovenia) or linked payment to improved performance to realize efficiency gains and contain costs (new contractual measures to manage provider costs in Bosnia and Herzegovina; reported plans to introduce diagnosis-related group (DRG) payments for inpatient care in Bulgaria and the Czech Republic; pay for performance (P4P) in Italy; per capita payment in primary care in Portugal; performance assessment and result-based financing in the Republic of Moldova). The crisis speeded up reforms in this area in some countries (Austria), but in others reforms were resisted (Bulgaria, Hungary, the former Yugoslav Republic of Macedonia). In Ukraine, a system of health services quality control has been developed, but had no practical effect due to the lack of measures to deal with non-compliance. Planned changes to the legal status of health service providers in the Russian Federation affecting their payment mechanisms have been postponed until 2013.

Measures that target the supply side offer considerable scope for improving health system functioning in comparison to those focused on curtailing utilization by patients. Changes in how health care is purchased and providers are reimbursed offer significant potential to enhance efficiency, quality and equity. Many EU countries have moved away from passive reimbursement of providers towards strategic purchasing, explicitly linking resource allocation to information on population health needs, cost–effectiveness and provider performance (Figueras, Robinson & Jakubowski, 2005). Measures include the use of health needs assessment, HTA, contracting, quality monitoring and performance-based payment. In addition, most countries set case-based tariffs centrally, which may promote provider competition based on quality, where quality information is available (Busse et al., 2011).

Volume and outcome contracts combined with prospective activity-based payments employing some case-mix measures, such as DRGs, have been linked to increased hospital efficiency. However, these types of contracts require sophisticated design in order to prevent gaming by providers, while the necessary information systems are in place in only a very few countries in Europe (Figueras, Robinson & Jakubowski, 2005). In physician payment, typically at the primary care level, fee-for-service and capitation have been found to be flawed methods for motivating physicians to achieve specific goals. Payment innovations that blend elements of fee-for-service, capitation and case rates can promote health system goals. These innovations include capitation with fee-for-service carve-outs, department budgets with individual fee-for-service or "contact" capitation, and case rates for defined episodes of illness (Robinson, 2001). P4P is also growing in popularity, although evidence from the United States and the United Kingdom suggests policy-makers should pay careful attention to how any P4P scheme is designed and implemented (Maynard, 2008). In any provider payment reform, various other factors are likely to influence successful implementation, including the way provision is organized and regulation.

4.4.4 Overhead costs: restructuring the Ministry of Health and purchasing agencies

Several governments are restructuring the Ministry of Health, statutory health insurance funds or other purchasing agencies in an attempt to reduce overhead costs and increase efficiency (Bulgaria, Croatia, the Czech Republic, England, Iceland, Latvia, Lithuania, Portugal, Romania).

Reducing the number of civil servants or removing their employment conditions (tenure, pay, pensions) is one way of cutting public spending on health but risks loss of skilled staff and strike action by public sector workers, as demonstrated by recent trends across Europe (Parry, 2011). Depending on the context, it also

risks losing experienced personnel at a time of rapid reform, which requires increased, not decreased, capacity for planning and oversight.

Reforming health insurance market structure (e.g. by consolidating risk pools) can also reduce overhead costs (Kutzin, 2008; Thomson, Foubister & Mossialos, 2009). In addition, addressing fragmented pooling may contribute significantly to financial sustainability because a lower number of pools means less need for complex and resource-intensive risk adjustment and, by strengthening the power of purchasers in relation to providers, may lead to better (more strategic) purchasing.

4.4.5 Provider infrastructure and capital investment

In many countries, the economic crisis created an impetus to: speed up the existing process of restructuring the hospital sector through closures, mergers and centralization (Denmark, Greece, Latvia, Portugal, Slovenia); shift towards outpatient care (Belarus, Ireland, Greece, Lithuania); improve coordination with or investment in primary care (Armenia, Lithuania, Republic of Moldova, Netherlands); merge health centres (Iceland); and reorganize emergency medical services (the former Yugoslav Republic of Macedonia). Some countries abandoned (Romania) or stalled (Georgia) investment plans to build new hospitals, slowed modernization programmes involving upgrading of hospital and ambulance services (Armenia) and purchasing of expensive equipment (Belarus), or reduced the share of capital expenditure (Ukraine). In contrast, some countries increased funding for modernization of public health providers using resources from the mandatory health insurance fund (Republic of Moldova) or developed e-health systems, with the implementation of an integrated health management information system and electronic health card (Latvia, the former Yugoslav Republic of Macedonia) and a new electronic prescription system (Croatia).

The hospital sector absorbs a large part (35–70%) of national health expenditure in the European Region (Rechel et al., 2009). Most countries are in the process of reducing hospital capacity in order to increase efficiency by closing unnecessary facilities and replacing expensive inpatient care with more cost–effective alternatives such as day surgery (McKee & Healy, 2002). These changes have generally been shown to have no negative impact on quality of care. However, while they may enhance efficiency they do not necessarily lower public spending, since savings are used elsewhere in the health system. Also, unidentified costs may be borne by patients and their carers and need to be adequately monitored (Clarke, 1996). To preserve quality of care, it is clear that reducing acute care capacity must be accompanied by investment in alternative services, such as community-based care (sometimes termed

"hospital reconfiguration"). In western Europe planning strategies have been more successful in this respect than market forces (Healy & McKee, 2002).

Some governments have sought to finance capital investment through greater use of market competition, while others are opting for a publicly led approach to capital investment. The former approach, characterized by public–private partnerships (PPPs), has been highly problematic. It may act as a barrier to collaboration between facilities offering complementary services to a defined population, leading to fragmentation and duplication. Furthermore, PPPs do not generate new financial resources for the health sector but are simply a way of raising debt finance, often transferring risk to future generations. This may benefit governments that need to meet short-term fiscal targets but does not necessarily reduce costs or increase efficiency in the longer term (Rechel et al., 2009).

Reductions in hospital capacity reflect a growing emphasis on coordinating primary, secondary and tertiary care with a view to delivering care in lower-cost settings where possible and appropriate; expanding the scope of what can be provided in lower-cost settings; and strengthening intra-system coordination to improve quality and address the inefficiency effects of fragmentation in delivery (Saltman, Rico & Boerma, 2006; Figueras et al., 2008). GP gatekeeping is an established way of coordinating care, although caution is required to ensure it does not lead to unnecessary delays in obtaining specialist care when needed. Recent developments include primary care-based networks, nurse-led strategies (France, the Netherlands, Sweden, the United Kingdom), disease management programmes, the use of multidisciplinary teams to support audit and quality monitoring, financing reforms to better integrate care involving risk-based funding or reallocation (Netherlands and Germany), bonuses for recruiting patients (France) and paying providers for performance (France, the United Kingdom) (Nolte, Knai & McKee, 2008). Evidence of the effectiveness of such reforms is inconclusive. In the key area of integration of care for people with chronic conditions, there is a lack of data on quality of care and patient outcomes across different approaches and on transferability across different systems. The evidence does suggest that reforms cannot be relied on to yield cost savings (Nolte & McKee, 2008).

5 Conclusions

The survey results indicate that European Region countries have employed a mix of policy tools in response to the financial crisis. Some countries seem to have used the crisis to try to increase efficiency, particularly in the hospital and pharmaceutical sectors, although little has been done to enhance value through policies to improve public health, which is a missed opportunity.

To date, the breadth and scope of statutory coverage have largely been unaffected. Some countries have actually expanded benefits for low-income groups, to strengthen access to health care. However, several countries have lowered coverage depth by increasing user charges for essential services, which is a cause for concern. The international evidence suggests that user charges disproportionately affect low-income groups and regular users of care, and are unlikely to reduce public or total spending on health in the longer term due to reduced use of necessary care and, in some cases, increased use of free but more resource-intensive services such as emergency care.

While research provides insight into the potential impact of many of the policies adopted, each policy needs to be carefully evaluated in the context in which it is introduced, since both a given health system's starting point and a specific policy's design will play an important role in determining outcomes. To risk simplifying, policy options can be divided into two categories: those that are likely to enhance efficiency and will not have an adverse impact on, or may even promote, other health system goals; and those that are likely to have more harmful effects.

Policy tools likely to promote health system goals:

- Increased risk pooling
- Strategic purchasing, where contracts are combined with accountability mechanisms including quality indicators, patient-reported outcome measures and other forms of feedback
- HTA to assist in setting priorities, combined with accountability, monitoring and transparency measures
- Controlled investment in the health sector, particularly for health infrastructure and expensive equipment
- Public health measures to reduce the burden of disease
- Price reductions for pharmaceuticals combined with cost–effectiveness evidence and other measures to promote rational prescribing and dispensing
- Shifting from inpatient to day-case or ambulatory care, where appropriate
- Integration and coordination of primary care and secondary care, and of health and social care
- Reducing administrative costs while maintaining capacity to manage the health system
- Fiscal policies to expand the public revenue base

- Counter-cyclical measures introduced before the onset of a health system shock
- Targeting financial protection measures towards poorer people and regular users of health care.

Policy tools that risk undermining health system goals:

- Reducing the scope of essential services covered
- Reducing population coverage
- Increases in waiting times for needed services
- User charges for essential services
- Attrition of health workers caused by imbalances in salaries relative to the rest of the economy and, where relevant, foreign labour markets.

This policy summary has highlighted the wide range of health policy responses to the financial crisis across Europe and noted some of the trade-offs involved. The crisis has left a few countries with little or no choice but to introduce cuts. Where the short-term situation compels governments to cut public spending on health, the policy emphasis should be on cutting wisely to minimize adverse effects on health system performance, enhancing value and facilitating efficiency-enhancing reforms in the longer run.

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Annex 1

Table A.1. Policies targeting financial contributions to the health system in the context of the economic crisis, WHO European Region

Notes: No information was available for Andorra, Kazakhstan, Luxembourg, Monaco, Montenegro, San Marino, Tajikistan and Turkmenistan. Text not in italics indicates a policy which was defined by the relevant authorities in the country as a response to the crisis. Text in italics indicates a policy which was either partially a response to the crisis, that is, it was planned before the crisis but implemented after with greater/less speed/intensity than planned; or possibly a response to the crisis, that is, it was planned and implemented since the start of the crisis, but not defined by the relevant authorities as a response to the crisis. A blank cell indicates no policy response to the crisis (not no response to the survey).

Country	Health budget	Fiscal policy	SHI contributions	User charges	Other
Albania	There have been some small reductions in the external financial assistance provided to Albania since the start of the crisis. However, according to the Ministry of Health there have been no major consequences in the health sector as a result and public health care expenditure as a percentage of the overall budget (i.e. 7.6% in 2008, 8.1% in 2009) and as a percentage of gross domestic product (GDP) (i.e. 2.5% in 2008 and 2.7% in 2009) have been reasonably stable since at least 2006.				

Armenia	Data from the National Health Accounts (NHA) show that although GDP and total government spending both increased in absolute terms in 2008 compared to 2007, public expenditures on health fell significantly from AMD 66 billion to AMD 53 billion. This reduction was due to the economic crisis and was contrary to the goals of the government's health policy to increase public funds allocated to the health sector and the Poverty Reduction Strategy adopted by the government for the period 2004–2015.	In 2011, the government introduced patient co-payments for a range of services nominally covered under the statutory benefits package. A major motivation is to increase government revenues, as hospitals were seen by the Ministry of Finance as a major area of the "black economy". Hence formalizing unofficial payments is the goal.
Austria	The Austrian Ministry of Health introduced the Austrian Health Fund Law in September 2009 to safeguard the revenues of sickness funds and prevent them from plunging further into debt due to the economic downturn. The Health Fund measures include an annual government cash subsidy for the sickness funds to help balance the budget and also require sickness funds to cut costs. The government contribution to the Health Fund was set at	*In a measure aiming to offer financial relief to socially vulnerable policy holders, as of 1 January 2008 a ceiling was set on prescription fees, targeted especially at people with high drug needs and low incomes. Under the new law, a cap is set at 2% of an insured person's annual net income spent on prescription drug costs, after which the*

Country	Health budget	Fiscal policy	SHI contributions	User charges	Other
Austria (cont.)	EUR 100 million in 2009 but in 2011 it was cut to EUR 40 million due to budget consolidation as a result of the crisis. The government has pledged to contribute EUR 40 million annually through to fiscal year 2014 but it remains to be seen whether the policy will continue after that. A Debt Forgiveness Law was also introduced to write off debts accumulated by the funds with yearly instalments of EUR 150 million between 2010 and 2012. As part of the Health Fund law, the Federation of Social Health Insurance Funds was required to submit a road map for cost-containment efforts in negotiation with providers, especially the doctors association.			*insured person is exempt from all prescription drug charges for the remainder of the calendar year.* *Initial calculations by the Federation of Social Health Insurance Funds predicted that the new exemption would benefit approximately 300 000 people. Given the revenue losses for statutory health insurance there is uncertainty over the sustainability of the policy in light of the economic downturn. It also remains to be seen whether the government will compensate social insurance for the revenue losses and who will ultimately pay for the cap.*	

Azerbaijan	*Delay in implementation of major health financing reform, including introduction of mandatory health insurance. In January 2008, before the crisis began, the President of Azerbaijan signed the decree approving "The Concept for Health Financing Reform and Introduction of Mandatory Health Insurance for 2008–2012". The Concept described overall approaches to health financing reform in Azerbaijan, including the establishment of an independent single-payer agency under the Cabinet of Ministers, introducing new provider payment mechanisms and per capita allocation of health care funds. In August 2008, the Cabinet of Ministers approved the Action Plan for implementation of the Concept. However, to date it has not been implemented. The crisis might have affected to some extent the willingness of the government to launch the reforms, but this is not the main stated reason for the stalemate.*

Country	Health budget	Fiscal policy	SHI contributions	User charges	Other
Belarus		A list of medical services exempt from value added tax (VAT) has been approved. In 2009 the tax system in Belarus changed from one with marginal rates to one with a flat rate of 12.0% of salary.		From 2009, the government has been investigating user charges policies as a way of raising revenue.	Increase in export of high-tech medical services to raise government revenues (in 2010 reaching USD 18.6 million, exceeding the expected amount by USD 3.1 million).
Belgium	Given the current economic situation, there was a debate on whether to respect the annual growth norm of 4.5% that was established in 2004, the final decision taken was in favour of "protecting" the health care budget.			*Enlargement of the group entitled to increased reimbursement of health care expenses: from 2007, low-income families (or individuals) are eligible. In 2011 the income ceiling was fixed at EUR 15 163.96 and increased by EUR 2807.26 for each additional family member. New reimbursements for patients with certain chronic conditions were also introduced.*	
Bosnia and Herzegovina					

Bulgaria	The Ministry of Health budget reduced from BGN 713 million in 2008 to BGN 537 million in 2009 and BGN 570 million in 2010.	Planned NHIF (National Health Insurance Fund) revenues in 2009 were BGN 2.47 million but only BGN 2.21 million was collected. Planned expenditures were BGN 2.07 million but real expenditures were BGN 1.75 million. *The government increased the social health insurance (SHI) contribution rate from 6% to 8% of income in 2009. The additional income was transferred into a reserve fund to pay for health insurance reform – the government proposed compulsory insurance provided by private funds. However this policy was unpopular with the public and doctors unions and was rejected by the new government, which wished to retain control of public resources and institutions through the NHIF. In 2011 the government agreed to use the extra funding directly on health services and accepted a balanced budget for the NHIF (i.e. to spend all the funds raised).*

Country	Health budget	Fiscal policy	SHI contributions	User charges	Other
Croatia	*Government debt for health expenditures amounted to HRK 4.8 billion in 2008; the goal thus became to reduce the deficit and ensure that spending is financed only from revenues, with new borrowing only to cover previous liabilities. By the end of 2010, the government had reduced the budget for health by HRK 1.5 billion (with unpaid debt reduced by almost 20%).* In 2011, to reduce the deficit, the government passed new legislation on fiscal responsibility (including in the health sector) in order to ensure that spending is financed only by revenues and new borrowing is only to cover previous liabilities or for development. Office-holders from state level to local level in Croatia will have to offer their resignation if it is established that they have breached the fiscal accountability legislation. According to the legislation, the total expenditure of the general budget (the government's budget plus budgets of local self-		Introduced in 2011: – health care contributions on pensions (with differentiation relative to the pension amount) – special contributions related to high-risk behaviours ("health tax on tobacco") – reimbursement of costs of medical treatment for traffic accidents from insurance companies – co-payment in primary health care; co-payment per prescription – income from supplementary health insurance.	*Co-payments have been reduced from HRK 15 in 2009 to HRK 10 for primary care visits and prescriptions.*	*Supplementary health insurance premiums increased in 2010, depending on income: an insured person (employee) with a monthly salary or income of more than HRK 5108 pays HRK 130 per month instead of HRK 80; an insured person (pensioner) with a monthly pension or income of more than HRK 5108 pays HRK 80 per month instead of HRK 50. Certain categories of insurance are exempt from payment (depends on: health status, economic status, age, etc.).*

	government units and financial plans for extra-budgetary users) is to be reduced annually by one percentage point of the projected GDP.		
Cyprus			
Czech Republic	Decrease in Ministry of Health budget by CZK 2000 million (about 30% decrease) in 2010 compared to 2008.	There was a slight increase in SHI revenues from 2008 to 2011 due to use of financial reserves. Increase of premiums for self-employed (equalization of current disparities with employees) and ceiling for premium payments slightly raised to increase contribution of high earners planned for 2012/2013.	Increase of user charges for inpatient stay from CZK 60 to CZK 100 per day in hospital planned for 2012. A law is planned for 2012 which will introduce the possibility of charging co-payments for more "luxurious" care, which will be of the same quality as the standard care provided under SHI but with better (hotel-type) amenities. The Ministry of Health cut reimbursement rate of drugs by insurance funds by 7% between 2009 and 2011. This can result in an increase of co-payments by patients if the importer/producer does not reduce the wholesale price.

Country	Health budget	Fiscal policy	SHI contributions	User charges	Other
Denmark	Continued growth in health care budgets by DKK 5 billion through 2011–2013 financed in part through cross-subsidization of the health budget from the education budget.			From 2011, introduction of user charges for *in vitro* fertilization.	
Estonia	The health insurance budget on health care (temporary sick leave benefits excluded) decreased by 1% in 2009 compared to 2008, which was achieved by using collected reserves to fill the gap between revenues and expenditures. The Ministry's health expenditure reduced by 24% in 2009 compared to 2008. This was partially achieved through cutting administrative costs and cutting the public health budget from 2009. Cuts focused on noncommunicable diseases (NCDs) and programmes on communicable diseases were protected. European Union (EU) social funds were used to compensate for the reduction in NCD budget but these funds will no longer be available from 2012.		In 2009 the decrease in SHI revenues was 11% and in 2010 5%, due to increased unemployment and decreased salaries. Estonian Health Insurance Fund (EHIF) accumulated substantial reserves before the crisis. The government did not allow these reserves to be depleted during the initial period of the crisis, but later these reserves were gradually used to compensate for the decreasing revenues of the EHIF.	*15% co-insurance rate for nursing inpatient care was introduced from 2010.*	

Finland				*User charges for public health services raised by 10% in 2010 (user charges are revised every second year based on the public pensions index).*	*An increasing number of municipalities are introducing service vouchers. The increased use of service vouchers is expected to mitigate public sector cost pressures and increase the freedom of choice of the users of services. According to a survey conducted by Sitra and the Association of Finnish Local and Regional Authorities, service vouchers are particularly used for social services. Their introduction for use in health care services was planned for 2011.*
France	Since the economic crisis, the health budget has increased sharply and the deficit has risen from EUR 4.4 billion in 2008 to EUR 10.6 billion in 2009. The health budget amounted to EUR 11.9 billion in 2010 and was planned to be reduced to EUR 11.3 billion in 2011. In 2010 the total increase in health spending was 3.2% compared to 2009. The increase in the deficit is	Following the change in the law in 2007, the allocation of revenues from tobacco tax in 2009 was increased and is now paid to the health insurance budget at a rate of 98.75%. Increase in a new contribution that is applied on some revenues (*"forfait*		*Since 2008 new co-payments for prescription drugs, doctor visits and ambulance transport are not reimbursable by private voluntary health insurance.* The social security budget of November 2010 included the following measures to increase revenues: a decrease from 35%	

Country	Health budget	Fiscal policy	SHI contributions	User charges	Other
France (cont.)	linked both with higher expenses and lower revenues from tax (e.g. General Social Contribution, the income tax earmarked for social security spending). In 2011 the planning budgetary assumption was that expenses for health would increase overall by 2.9% in comparison with 2010. The social security budget of November 2010 included a number of measures to reduce costs and increase revenues. It was anticipated that savings in 2011 in health expenses would reach EUR 2 billion.	*social sur l'épargne salariale"*), which was set up in 2009 and whose rate has increased from 2% in 2009 to 4% in 2010 and 6% in 2011. Tax and social contribution reliefs have been introduced since 2007 to promote employment.		to 30% of the rate of reimbursement of pharmaceuticals; a decrease from 65% to 60% for the rate of reimbursement of medical procedures. This comes in addition to the increase from EUR 16 to EUR 18 per day for the patient's contribution to a stay in hospital that was introduced in 2010. *In addition, French statutory health insurance has applied a new rule since 2009 that penalizes patients who do not follow the agreed medical pathway by increasing their co-payment contribution by 40%.*	
Georgia	While the state budget for the health sector grew every year since 2006, the budget for 2011 was reduced by 7.9% compared to 2010.		*Expansion of health insurance for the poor (contributions by the government); for some public sector employees (funded by government) and voluntary health insurance (state-subsidized for low-income families). Premiums for the Medical Insurance Programme (MIP)*		*Expansion of size of self-insured enrolled in prepaid risk pools through introduction of Voluntary Health Insurance (VHI) – in 2009 the share of population enrolled in these schemes reached 9.7%.*

		are fully paid by the government and purchased from private insurance companies. In 2011 the government reduced budget allocations for MIP as a result of insurance premium optimization. *In 2010, a national survey estimated health insurance coverage to be 30% of the population (20% under the subsidized, poverty-focused MIP and 10% through voluntary enrolment).*	
Germany			
Greece	In May 2010, Greece was put under the supervision of European Commission, the European Central Bank (ECB) and the International Monetary Fund (IMF) due to the public deficit and debts as well as the credit crisis. The Memorandum that Greece signed dictates a series of measures referring to the health sector, focusing especially on reduction of public expenditure. In the context of the Memorandum, public health expenditure had to be reduced by 0.5% of GDP during 2011.	From 2011, the civil servants' SHI fund employer (i.e. state) contribution rate is set at 5.1% of civil servants' salaries, while the contribution of the fund's pensioners is gradually being increased from 2.55% to 4% in 2013. Previously, the public sector did not contribute a specific percentage; depending on the needs of the social security fund, the contribution of the public sector (government) was through the state budget. With the initiation of the new social security fund for	From 2011, an increase in user charges from EUR 3 to EUR 5 in outpatient departments of public facilities; user charges in health centres removed for certain vulnerable groups.

Country	Health budget	Fiscal policy	SHI contributions	User charges	Other
Greece (cont.)	The health budget for 2011 decreased by EUR 1.4 billion, with EUR 568 million saved through measures dictated by the Memorandum related to salaries and benefits cuts and EUR 840 million saved through cuts in operating costs of hospitals.		the Greek population (EOPYY – National Health Service Organization) the 5.1% was specified in the Memorandum.		
Hungary	The centrally set budget for the health insurance fund (HIF) did not change much nominally between 2008 and 2011, which implies that real expenditure on health decreased when adjusting for inflation. Overall, a slight reduction in government expenditure on health as a share of GDP. The total expenditure from the HIF, including also the cash benefits, was HUF 1445 million in 2008 and was expected to be HUF 1459 million in 2011.		Since 2009 the health contribution paid by the employer declined from 5% to 2% for earnings below twice the minimum wage, while it remained 5% for those above this threshold. To compensate the HIF for the loss in revenues, the central budget contribution on behalf of eligible but non-contributing persons (pensioners, youngsters, homeless, etc.) was raised from HUF 4500/person to HUF 9300/person. This entailed a major shift in the revenue mix for health: general tax revenue transfers to HIF almost doubled in order to compensate for the reduction of the SHI revenues due to reduction of the SHI contribution rates, which was meant to stimulate labour market.	*Changes in user charges NOT as a response to the crisis, but relevant in the context of the crisis response measures. In 2008 the following fees were abolished: HUF 300 per visit for services of GPs, dentists, outpatient care and outpatient rehabilitation; HUF 600 per visit in case of missing papers in outpatient care, where admittance papers are needed; HUF 1000 per visit in case of causeless use of night duty. Inpatient daily fee: HUF 300 per day.*	From 2008 pharmaceutical and medical appliance companies were obliged to pay a fee to the government exchequer for the promotional activity of their medical sales representatives. This amounts to around HUF 5 million per year (approx. EUR 20 000) for a sales representative of pharmaceuticals and HUF 1 million for one in the area of medical products.

		In 2010, the itemized health contribution (a tax of HUF 1950 per month per employee paid by employers) was abolished. *Since 2008, GPs (general practitioner) and out- and inpatient providers get HUF 50 compensation for each online eligibility check (checking the validation of insurance by social security number). This does not mean that patients without valid insurance status will not be treated, but the HIF will report to the tax agency which, in turn, collects unpaid contributions retrospectively. This measure targeted improved collection.*	
Iceland	The national budget has been cut considerably post-crisis, including approximately 5% annual cuts to the health care and social security sectors. According to national statistics, per capita total health expenditure growth was -3.1% in 2009 and -4.0% in 2010. As of March 2009, the Ministry of Health has reduced expenditures, including for equipment, drugs, operating expenses and patient transport.		

Country	Health budget	Fiscal policy	SHI contributions	User charges	Other
Iceland (cont.)	The budget of the National University Hospital has been reduced by approximately 18% from 2007 to 2010.				
Ireland	The 2009 health budget increased by 1%. Savings in the health budget of over EUR 1 billion announced in 2010 budget. In 2011, the overall budget for health was down by a further EUR 746 million (a year-on-year 6.6% cut for the Health Service Executive (HSE)). Increased funds to cover increasing numbers of people on low incomes eligible for medical cards (by September 2009, 1.4 million people were covered by medical cards, up by 4% year on year): increase in the 2009 medical card budget equivalent to a 1% real increase in funding per capita; supplementary budget announced in November 2009 and extra funds (EUR 230 million) were made available for 2010 in the December budget.	In 2009, the health levy, a surrogate income tax, was doubled to 4% on all earnings up to EUR 75 036 and raised to 5% on earnings over EUR 75 036. The threshold of payment was also reduced. Tax relief for private nursing homes and hospitals was to stop as part of a broader policy of ending property-related tax relief, however no exact end date was named. Palliative care continues to be eligible for tax relief.		From 2009, for the two-thirds of the population without medical cards (medical cards confer free access to GPs and waive hospital inpatient fees for those under certain income thresholds and some people over 70 years of age) user charges increased for public (17%) and private (20%) beds in public hospitals, use of the emergency department in public hospitals, emergency department charges, and deductibles for the drugs payment scheme (which reimburses non-medical card holders for cost of drugs over a certain amount). In the 2010 budget: introduction of a 50 cent charge for	

	The 2011 budget: minor funding increases to cancer care (EUR 10 million), homecare packages (EUR 8 million) child protection (EUR 9 million) and the Fair Deal (EUR 6 million), which provides financial support for people assessed as needing long-term nursing home care.		a prescription for all medical card holders up to a maximum of EUR 10 per family per month; increasing the drugs reimbursement threshold to EUR 120 (from EUR 100 in 2009) a month for the 70% of the population who pay for their own drugs.
Israel			
Italy	For the health care sector, in realization of the agreement between the state and the regions in December 2010, additional resources were foreseen amounting to EUR 1.1 million in 2010, as well as EUR 400 million and EUR 300 million, respectively, in the two following years, in order to increase National Health Service funding and to increase the fund for long-term care and the fund for social policy, as well as to finance investments in public sanitary infrastructures. However, in 2011 a new series of cuts in health care expenditures was foreseen by the government. The National Commission on	From 2010, regions with large health care deficits have had to raise local taxes to recover deficits.	For 2010–2011, removed fee of EUR 10 for specialist and diagnostic services. The 2011 Financial Law introduces increases in co-payment fees for visits to doctors and analysis (EUR 10+) and for interventions in emergency wards not justified by urgent situations (EUR 25+).

Country	Health budget	Fiscal policy	SHI contributions	User charges	Other
Italy (cont.)	Social Affairs in Parliament (*Commissione Affarisociali della Camera*) has discussed a series of cuts in welfare as part of the 2011 Financial Law. The cuts were very extensive. In 2011, investment in health care infrastructures was to be cut from over EUR 1 billion to EUR 236 million. Research funding for the public health care sector was to be cut from EUR 91.9 million to EUR 18.4 million. The fund for disease prevention and health promotion was to be cut from EUR 29.6 million to EUR 5.9 million. Palliative care was to be cut to only EUR 1 million. Resources for semi-automatic defibrillators and related equipment in public places was to be reduced from EUR 4 million to EUR 2 million. From 2010 a tighter budget cap was fixed for regions' pharmaceutical expenditure. The budget for drugs has been reduced in absolute value by EUR 800 million starting from 2010, being fixed at 13.3% of total public health care expenditure. Consequently the level of				

	financing by the state was reduced by EUR 800 million from the year 2010.	
Kyrgyzstan		
Latvia	The health care expenditure budget increased between 2005 and 2008 reaching LVL 576.56 million. From 2009 it decreased falling to LVL 503.73 million, and LVL 432.78 million in 2010. The following specific financial cuts in expenditure were made by the Ministry of Health in 2010 compared to 2008: treatment -40.4%; public health -88.6%; central administration -58.6%; medical and health education at university -41.7%; administration of health care financing -67.7%. Funding in the budget for work of heart health cabinets and control and epidemiological surveillance decreased by 86.9% and funding for health statistics reduced by 74% in 2010 compared to 2008. In 2009 the pharmaceutical reimbursement budget was decreased by 7.1% compared to 2008. Primary	The Cabinet of Ministers amended Regulations on the Reimbursement of Pharmaceuticals. These came into force in 2009; their effects were the reduction of the percentage of reimbursement for certain diagnoses from 75% to 50% and from 90% to 75% for other diagnoses. Thus the financial burden was partially shifted to patients. Consequently, there was an increase in patient co-payment by 59% in 2009 compared to 2008. This resulted in an average level of patient co-payments in the reimbursement system of approxi-mately 30% in 2009. At the same time, 100% reimbursement was maintained for

Country	Health budget	Fiscal policy	SHI contributions	User charges	Other
Latvia (cont.)	care was set as a priority, so cuts in the reimbursement of pharmaceuticals were proportionally smaller than cuts in the sector of inpatient health care.			the most severe diagnoses, such as oncology and endocrinology. Most of the co-payment increases were for cardiovascular system diseases. The reduction of the rate of reimbursement was a short-term measure to reduce costs; it was understood that it could seriously affect public health indicators in the longer term. The rate of reimbursement for cardiovascular diseases has been increased to the previous level of 75% from 1 November 2010. The Social Safety Net was introduced in Latvia at the end of 2009 and is financed by a loan from the World Bank. Most of the Social Safety Net spending on health care is intended to cover the co-payment of patients for health care services and to provide 100%	

			reimbursement of medicinal products for the less well-off – those who receive less than LVL 120 per month, equivalent to EUR 170. It was planned that this measure will end on 31 December 2011.
Lithuania	In 2008 government expenditure on health was LTL 1000.7 million but it declined to LTL 854.4 million in 2009. In 2009 the budget of the Compulsory Health Insurance Fund (CHIF) remained at the same level as in 2008. However, in the year 2010 its budget decreased by 8% compared to years 2009 and 2008 (LTL 4.01 billion compared to LTL 4.39 billion).	Due to increasing unemployment, the amount of money collected by the CHIF significantly declined during recent years, whereas state subsidies for people insured by the state more than doubled (from LTL 674 million in 2007 to LTL 781 million in 2008, LTL 1.1 billion in 2009 and LTL 1.5 billion in 2010). The subsidies for those insured by the state increased from LTL 353 in 2007 to LTL 428 in 2008, LTL 605 in 2009, and LTL 744 in 2010 per insured person per year. For the year 2011 it was planned that the state would pay LTL 733 per insured person. According to health insurance legislation, in any given year, this amount is calculated as approximately one-third of the average gross salary in the country two years previously.	

Country	Health budget	Fiscal policy	SHI contributions	User charges	Other
Malta					
Netherlands				Co-payments were to be increased for certain services from 2010, as a result of restrictions in the benefit package.	
Norway	The state budget has been maintained throughout the crisis due to substantial oil revenues.				
Poland	It was expected that in 2011 there would be a 2.6% increase in the National Health Fund's (NHF) revenues and expenditures compared to 2010, due to moderate increases of unemployment. By comparison, the NHF's revenues and expenditures increased by 11.5% in 2009 compared to 2008 and about 8% in 2010 compared to 2009. In 2009, the government cut its investment expenditures in health care infrastructure by half. The lower expenditures were continued in subsequent state budgets.				

Portugal	The government has initiated a comprehensive reform package to improve efficiency and to reduce significantly the costs of the health care sector. Authorities expected the package to yield savings worth EUR 700 million in 2011, of which EUR 100 million is part of an additional consolidation package. The government is committed to achieve further cost savings of EUR 200 million in 2012 by cutting operational costs by 10%. Through the Fundação para a Ciência e a Tecnologia (FCT), the state subsidizes research and development (R&D), grants higher education research scholarships and awards funding to research units. In 2011, some R&D units were informed that a large part of the predicted funding would not be available and many research scholarships are also being eliminated. It is not clear how far the cuts will go.	ADSE (health system for public sector workers) reform in 2011: the contribution of 1.5% of the salary of public workers was not planned to be increased, but the contribution of 1.3% of pensioners was planned to increase by 0.1% per year until it matches the contribution of active workers.	User charges of the NHS (National Health Service) were updated and incentives were created to promote the payment of these charges (since some people ignore demands for payment, since this is asked for after the service has been given). From 2011: (1) Increase in charges applied to some vaccines, such as yellow fever, Japanese encephalitis, typhoid, meningitis and rabies tetravalent. These charges of less than EUR 1 per vaccine increased to EUR 50–100 per vaccine. (2) Increase in charges asked for doctor declarations by a health authority or a public health professional from less than EUR 1 to EUR 20; doctor declarations attesting to the incapacity of a patient for health reasons by a medical board to EUR 50; doctor declarations of appeal

Country	Health budget	Fiscal policy	SHI contributions	User charges	Other
Portugal (cont.)				by a medical board to EUR 100. This means that a disabled person who wants to access fiscal benefits (paying less income tax, for instance, or paying less taxes when buying a car adapted for disabled people), and for whom asking for a doctor's declaration of appeal by a medical board is mandatory to access these benefits, now has to pay much more than before. State subsidy for some pharmaceutical drugs was cancelled, totally or partially: In 2010, a law which granted 100% state subsidy for some anti-depressants, anti-psychotic and other drugs associated with the treatment of a few serious mental illnesses (such as schizophrenia, dementia, autism, bipolar disorder) was revoked. Those patients now have to pay 5–10% of the cost	

			of treatment. The Order of Medical Doctors officially stated their opposition to the measure. From January 2011, 16 types of pharmaceutical drugs (for which medical prescription was not mandatory) were no longer subsidized, including paracetamol, antiacids and antivirals.
Republic of Moldova	There was a reduction of 6% in GDP in 2009. The health budget also fell in this year. However, the 2010 and 2011 budgets were not affected by the crisis as the country's economy stabilized.	There was a 7% increase in transfers from the state budget to mandatory health insurance funds in 2009 to compensate for falling revenues from payroll tax. The rate of discount increased from 50% to 75% reduction of insurance premiums for financially and economically vulnerable individuals and socially disadvantaged categories of self-employed, mostly from the countryside and the agricultural sector.	The tariffs for medical services provided on the basis of out-of-pocket payment are controlled by the state and are periodically revised depending on certain macro-economic criteria. Additionally, as a measure to improve financial risk protection, in 2010, the Ministry of Health introduced price limitation for most important and essential drugs and pharmaceuticals imported and distributed within pharmacies network.

Country	Health budget	Fiscal policy	SHI contributions	User charges	Other
Romania	Ministry of Health budget reduced from RON 4,969 million in 2008 to RON 4,417 million in 2011. The health sector was protected in comparison to other public sectors in terms of budgetary cuts.		The shrinking economy has resulted in lower levels of contributions of employers and employees to the HIF. The government intervened with subsidies from the state budget to the HIF in 2009 and 2010 to cover the insurer's debts to pharmacies and wholesalers. In 2010 the subsidy amounted to about 24% of the total health budget. Nevertheless, the HIF budget decreased from RON 16,775 million in 2008 to RON 16,497 million in 2011. *Plans to raise additional financial resources (better collection of premiums, enlargement of the premium collection basis by reducing the number of tax and contribution exceptions, better management of the system) were announced in 2010. From 1 January 2011, pensioners with an income of over RON 740 per month will contribute 5.5% of their pension to the HIF.*	New user charges to be implemented during 2011 included the following co-payments: RON 5 for a visit to a GP, RON 15 for a home visit by a GP, RON 10 for one day in hospital, RON 50 for continuous hospitalization for several days. The maximum level of co-payment will not exceed RON 600 per individual per year. The law on co-payments also stipulates exceptions, such as veterans, retired persons with less than RON 700 income per month, children, etc. In 2010 a limit on the number of reimbursed visits to a GP and specialist physician for the same condition was introduced for the first time: a maximum of five visits. In 2011 the maximum number of visits decreased to three. If a patient wants to use more than	

			the stated number of visits s/he has to pay out of pocket.	
Russian Federation	*There were expectations of slight increase in the health budget in 2011 and in upcoming years due to an increase in compulsory health insurance contributions. However, it is not clear how much regional governments will decrease health care funding once greater funds are available in insurance system.*	*New law on health insurance proposed in January 2011 and is expected to be passed in autumn 2012. The payroll Compulsory Medical Insurance (CMI) tax will increase from 3.1% to 5.1%. The revenue from the additional two percentage points will be accumulated in a special fund and used for the Presidential programme of health care modernization consisting of renovation of facilities, standardization of care and informatization.*	*A new law to become operational 2012 will legalize out-of-pocket fees in state-owned facilities.*	
Serbia				The financial crisis has reduced the volume of health sector investments since 2009, although there are large variations in the change in investment by region. The European Investment Bank and World Bank have continued to provide funding, favourable loans, and sponsored other projects.

Country	Health budget	Fiscal policy	SHI contributions	User charges	Other
Slovakia	Due to a decrease in contributions from employees and the self-employed, the rate of increase in health insurance companies' (HICs) revenues declined in 2009 (it was only +2.6%, compared to +12.5% in 2008). HIC revenues were protected to some extent by the high contribution rate by the state for the economically inactive population which in 2009 was 4.9% of the average national income of the previous two years. This resulted in an anti-cyclical character of state payments.		*While the state's contribution rate for the economically inactive population has been gradually increasing since 1993 (when it was 4%) and reached 4.9% in 2009, in 2010 the government decided to reduce it to 4.78%.*		
Slovenia	Measures adopted by the NHIF resulted in total savings of EUR 135.9 million in 2009 and EUR 239 million in 2010.		In 2009 the NHIF introduced the following measures to improve collection of revenues: more intensive cooperation with the tax administration; involvement of additional income categories in compulsory contribution schemes (e.g. self-employed entrepreneurs and investing partners in companies).	In 2009 the NHIF introduced changes treatment, certain medicines, non-urgent ambulance services, dental prosthesis, certain ophthalmological appliances). As a result, a higher percentage of costs is paid by patients (most of whom are subsequently reim-bursed by voluntary health insurance).	

Spain	The health system is decentralized to the level of autonomous regions. The regions have responsibility for budgets and applying cost-containment measures. To date the only region that has drafted an Action Plan for building sustainability of the health system is Catalonia (April 2011). Under the plan, the 2011 health budget is 10% lower compared to 2010 (and, in nominal terms, is equal to the 2007 budget). The measures are justified based on the following initial financial situation of the Catalan health system: between 2003 and 2010 the Catalan health budget increased by 76.5% and the deficit was reduced by EUR 2.61 million. Nevertheless, 2010 ended with a deficit of EUR 850 million.

Country	Health budget	Fiscal policy	SHI contributions	User charges	Other
Sweden	Increased funding (SEK 7 billion) given by the state to municipalities/county councils in 2009 to compensate for reduced local tax revenues. From 2011 onwards the annual state grants are increased by SEK 5 billion. About a third of these revenues are directed to the county councils, whose main expenses concern health care.				
Switzerland			Due to the financial crisis, HIFs suffered losses on the investments they made with the money they need to have in reserve as assets; to compensate, premiums would have had to be raised by 10–20% in 2010 rather than about 4% as in previous years. As a result, in May 2009 the government proposed measures to lower the health costs of health insurers. The government also planned to increase premium subsidies for low-income households by CHF 200 million; however after many debates between the two Chambers of the Swiss Parliament these measures were ultimately refused in	A user charges reform was agreed by the Parliament in September 2011: the co-insurance rate was planned to increase from 10% to 15% for people who opt for traditional plans (this encourages people to subscribe to a managed care model of insurance).	

		October 2010. Measures to reduce health insurers' costs were instead introduced in 2011 (see next column).	
The former Yugoslav Republic of Macedonia	*Despite fluctuations in funding for different priority areas, the health budget was increased for 2010, 2011 and 2012, with EUR 21.8 million allocated for health in the 2010 budget, EUR 34 million in 2011 and EUR 36 million in 2012. Around 70–80% of the 2012 health budget increases are for medical equipment and technology. Overall, during the crisis, funds for social safety nets were protected while non-priority expenditures were eliminated.*	Health care contributions have been reduced from 9.2% to 7.5% in 2009 and a further reduction to 6% in 2011 was planned in order to increase foreign investments and economic activity as well as tax collection.	
Turkey	The Ministry of Health budget increased from TRY 11,994 million (2008) to TRY 14,594 million (2009), but only slightly in 2010 to TRY 14,768 million. Health expenditure as a share of the government budget rose in 2009 but fell slightly in 2010 (12.8% in 2008, 12.8% in 2009). Global budgets for hospitals have increased every year through 2011, although	*In early 2010, health care payments on the part of government employees and their dependants were transferred from the Ministry of Finance to the Social Security Institution.*	*Co-payment for outpatient visits (except primary care visits) began in the last quarter of 2008. Co-payments for outpatient medicines and prosthesis/orthotics were unchanged as a result of the crisis.*

Country	Health budget	Fiscal policy	SHI contributions	User charges	Other
Turkey (cont.)	while the 2009 (9%) and 2010 (17%) budgets increased at a high rate, the 2011 budget was slated to increase at a much slower rate (1%).				
Ukraine	Public expenditure on health as a proportion of total expenditure increased annually between 2003 and 2007. However, in 2008 it began to decrease: it was 57.2% in 2008 and 54.9% in 2009, which corresponds with the lowest index for the past seven years. The share of private resources in health financing in 2008–2009 reached 42.5% and 45.1%, most of which (~94%) is in direct payments of households (out of pocket). *Since 2010 the national budget has not been set annually, but is governed by general law "The Budget Code of Ukraine". The law determines that the amount of protected expenditures cannot be changed by reducing the approved budget allocations. The list of such expenditures was*				An SHI system is not used in Ukraine. However, since 2000, Ukraine has had a programme of voluntary medical insurance for railway workers. The premiums for voluntary health insurance increased during the crisis: in 2007–2008 the monthly contribution was UAH 16 (UAH 8 each from employee and employer); in 2009 it was UAH 24 (again split equally between employee and employer); from September 2010 it was UAH 32 (UAH 20 from the employee and UAH 12 from the employer). The premium increase is primarily due to

	significantly expanded and includes: salaries of staff dealing with the budget, drugs and bandaging material procurement, food provision, utilities and electricity of facilities, servicing the state debt, current transfers to the population, current transfers to local budgets, funding institutions of higher education of I–IV accreditation levels, providing the disabled with technical and other rehabilitation items, medical products for personal use, basic research, applied research and technological development.			a sharp rise in the price of drugs. Informal payments per capita (excluding costs of drugs purchasing) increased by 70% (from UAH 94.4 in 2008 to UAH 153.6 in 2009).
United Kingdom (England)	After years of unprecedented budget growth (6.6% per year in 1999–2007), the NHS has entered a new era of austerity. In October 2010 the Department of Health published the Spending Review settlement for the NHS which involves an average 0.1% real terms increase over the next four years and a requirement to find up to GBP 5 billion productivity improvements a year through to 2014/2015 to meet increased demand	The recession has resulted in a reduction in expected receipts and a limited increase in discretionary spending in 2009–2010 compared with previous years. Consequently, whereas planned total government receipts for 2008–2009 were GBP 575 billion, just GBP 533.8	A programme to expand the range of long-term conditions that benefit from free prescriptions was announced by the previous government but not implemented; this will now no longer be taken forward.	

Country	Health budget	Fiscal policy	SHI contributions	User charges	Other
United Kingdom (England) (cont.)	and improve the quality of its services. Overall, NHS spending will increase by 0.4% in real terms over the course of the Spending Review period; this is the lowest increase since the 1950s. However, according to many commentators, the Spending Review plans for the NHS amount to a de facto cut in NHS spending in real terms. Managers of NHS organizations now have to plan for what, in effect, amounts to a 20–30% reduction in NHS spending for the five-year period from 2011. To meet the rising costs of health care and increasing demand on its services, the NHS will have to release up to GBP 20 billion of annual efficiency savings over the next four years, all of which will be reinvested to meet rising levels of demand and to support improvements in quality and outcomes.	billion was raised. It is estimated that there was a further reduction in total receipts in 2009–2010 to GBP 514.6 billion, of which GBP 95.6 billion was generated from National Insurance Contributions, GBP 145.6 billion from income tax and the rest from a range of taxes, including corporation, excise, VAT and property rates (council tax and business rates).			
Uzbekistan					

Table A.2. Policies targeting volume and quality of care in the context of the economic crisis, WHO European Region

Notes: No information was available for Andorra, Kazakhstan, Luxembourg, Monaco, Montenegro, San Marino, Tajikistan and Turkmenistan. Text not in italics indicates a policy which was defined by the relevant authorities in the country as a response to the crisis. Text in italics indicates a policy which was either partially a response to the crisis, that is, it was planned before the crisis but implemented after with greater/less speed/intensity than planned; or possibly a response to the crisis, that is, it was planned and implemented since the start of the crisis, but not defined by the relevant authorities as a response to the crisis. A blank cell indicates no policy response to the crisis (not no response to the survey).

Country	Benefits (coverage scope)	Population coverage (coverage breadth)	Non-price rationing (waiting times)	Changing individuals' behaviour (health promotion and prevention)
Albania				
Armenia				
Austria				
Azerbaijan				
Belarus	*From 2009, citizens with radiation sickness as well as certain disabled people have the right to a 90% reduction in the price of medicines prescribed by a physician. Citizens with surgical diseases also have the right to a 90% reduction in the price of bandaging materials.*			
Belgium				*Some emphasis set on cancer screening, promotion of health food, physical activity and prevention of fatal accidents since 2007.*

Country	Benefits (coverage scope)	Population coverage (coverage breadth)	Non-price rationing (waiting times)	Changing individuals' behaviour (health promotion and prevention)
Bosnia and Herzegovina	*Since the start of the crisis, a list of essential drugs that are provided free of charge by the CHIF has been created.*	*Since the start of the crisis, amendments to the Law on Health Insurance provided coverage for children (even if their parents do not have coverage), those over 65 years of age and the uninsured. The Law on Health Insurance was revised as part of general reforms, but vulnerable groups became a focal point as a result of the crisis. However, a lack of reliable sources of funding has led to difficulties in implementing the law.*		*In 2008 and 2009, media campaigns and other health promotion and prevention activities were aimed at improving population health by advocating healthier lifestyles. These campaigns have also provided the public with information on health sector reforms.*
Bulgaria	The Ministry of Health is planning to develop a positive list of medical devices (similar to the positive list of drugs).			*With the amendment of the Health Act in 2010 tobacco smoking was prohibited in indoor public places except isolated "smoking rooms". In cafes and restaurants with area of less than 50 sq. m, the owner can choose if the whole establishment is for smokers or non-smokers. Because of the crisis (restaurants' financial problems) the government decided to postpone full prohibition. In 2009 the government increased the price of cigarettes by 25%, and in 2010 by 38%.*

Croatia	*Improvements in pharmaceutical pricing and reimbursement generated savings which made it possible to add 64 new drugs to the benefit list at the end of 2010.*	
Cyprus		In 2011 the government made the decision to again postpone the implementation of the new National Health Insurance system. Cyprus, which does not have a health care system that offers universal coverage, in 1991 voted for the law that would create a new National Health Insurance Scheme but this has not been implemented to date. According to Ministry of Health estimates, in 2007 83% of the population had comprehensive coverage free of charge at the point of service. The rest of the population has access to public health services either on reduced or full rates (2% and 15% of the population, respectively).

Country	Benefits (coverage scope)	Population coverage (coverage breadth)	Non-price rationing (waiting times)	Changing individuals' behaviour (health promotion and prevention)
Czech Republic	The basic benefit package and list of reimbursed services will be assessed from the perspective of health technology assessment (using evidence from abroad) in 2012/2013. Information to patients on which services are reimbursed will be improved in 2012. This may result in a reallocation of public and private expenditure. Mandatory use of positive lists of drugs for Ministry of Health providers (university hospitals, representing 50% of the market) introduced in 2011 (previously the list was voluntary). Further lists planned for 2012.	Entitlement to publicly financed coverage for high-risk conditions reduced for foreign citizens and responsibility for coverage transferred to private insurance in 2011 (resulting in higher premiums for foreign citizens).		Consumption taxes increase (tobacco, alcohol) planned for 2012.
Denmark				
Estonia	*EHIF reduced the benefit package in two ways. First, the system for temporary sick leave benefits was reformed. From 1 July 2009 no benefit is paid during the first three days of sickness or injury (previously first day only), the employer pays the benefit from day four to day eight (new cost-sharing mechanism, employer did not participate previously) and the EHIF starts to pay the benefit from day nine (previously from day two). The rate of sickness benefit was reduced from 80% to 70% of the insured person's income. The rate of sickness benefit in the case of caring for a child under 12 years of*		Maximum waiting times for outpatient specialists' visits increased in March 2009 by the decision of the EHIF supervisory board from four to six weeks.	*VAT on alcohol increasing since 2005 but greatest rise was in 2008 and tobacco VAT increasing since 2011.*

	age was reduced from 100% to 80%. The maximum length of maternity leave was reduced from 154 days to 140 days. Expected saving: EEK 50 million. Second, until 1 January 2009 all insured persons of at least 19 years of age could apply for the dental care benefit of EEK 300 (EUR 19.18), but from 2009, only insured persons over 63 years of age and persons eligible for a pension for incapacity for work or an old-age pension retained this right. Expected saving: EEK 4 million. *The Ministry of Social Affairs was developing a comprehensive health technology assessment system in 2011 with the help of Tartu University.*		
Finland			
France		*Le Revenu Minimum d'Insertion (RMI) or basic benefit was replaced in June 2009 by the Revenu de Solidarité Active (RSA), resulting in an increase in the number of overall recipients. With this change, beneficiaries of the new RSA automatically have the right to receive state-funded CMU (Couverture Maladie Universelle) – universal health insurance – and complementary insurance CMU-C.*	From 2011, tax on tobacco will increase by 6%.
Germany			

Country	Benefits (coverage scope)	Population coverage (coverage breadth)	Non-price rationing (waiting times)	Changing individuals' behaviour (health promotion and prevention)
Georgia		*State funding for insurance coverage for certain groups of public employees (teachers, police force and military), and a state-subsidized programme for low-income families (Medical Insurance for the Poor) were introduced (2007 and 2008 respectively). This was accompanied by interventions to increase awareness among poor people about subsidized health insurance. In 2010 MIP covered 21% of population, while in 2007 only 385 000 or 8.8% had this insurance.* *An expansion of the population covered under insurance is expected in 2012 – targeting mostly the elderly and the young.*		
Greece	Unification of benefit packages among the various SHI funds (in June 2011).	From 2011, the poor and uninsured are only allowed to be treated in designated hospitals and prescribed generics. The Memorandum imposes a limit of no more than two months for submitting an invoice for reimbursement for hospital charges to social insurance funds in Greece as		For the period 2008–2012, health promotion initiatives: cardiovascular, cancer, obesity, nutrition, oral health, maternal and child health, including a smoking law ban.

		well as other EU Member States and private HICs for non-nationals and non-permanent residents.
Hungary	In 2009 sick-pay benefits were reduced. Previously the HIF could provide sick-pay for up to one year for employees with valid insurance. Without insurance it was only 45 days. This changed to 30 days. With a minimum two-year period of insurance the amount was 70% of income. In case of a shorter insurance period or inpatient care it was 60%. After the modification these were decreased to 60% and 50%.	
Iceland	To minimize the effect of the crisis and cuts in expenditure on health services, a document was published in early 2009 focusing on public health, equity, and labour issues. A number of actions have been taken as a result, such as providing access to dental care free of charge for low-income families since 2009. *There has been increased emphasis on occupational rehabilitation by the Icelandic Rehabilitation Fund to systematically decrease the probability of employees losing their jobs due to incapacity and sickness. To this end, the Icelandic Rehabilitation Fund was established in 2008 to provide consulting services to employees who are on extended sick leave so they do not lose their jobs. Since the financial crisis, activity at the fund has increased.*	

Country	Benefits (coverage scope)	Population coverage (coverage breadth)	Non-price rationing (waiting times)	Changing individuals' behaviour (health promotion and prevention)
Ireland	From 2010, a cut of EUR 30 million to dental care for medical card holders.	From 2009, removal of medical cards for the 12 100 wealthiest (3.4%) people aged over 70. Medical cards confer free access to GPs and waive hospital inpatient fees for those under certain income thresholds. *New government elected in 2011 has proposed a universal health insurance system.*		
Israel				
Italy				
Kyrgyzstan				
Latvia				*An early cancer detection (cervical and breast cancer) programme started in 2009.*
Lithuania	In 2009 some changes were implemented reducing payment of illness benefit, which is paid for socially insured temporarily sick people from the Social Insurance Fund. For example, previously illness benefit was 85% of the salary of a socially insured person in the majority of cases. After the changes were implemented, during the first seven days illness benefit is only 40% of salary and, after the eighth day, 80% of the salary.			

Malta		
Netherlands	From 2010, limited reimbursement for IVF; physio sessions to be paid for by the patient increased to 15; coverage of care outside the EU removed and requires bilateral adjustments with certain countries; mental health services restricted and psychological care reimbursement reduced from eight to five sessions.	
Norway		
Poland		
Portugal	From 2011, the following health services under ADSE (the health system for public sector workers) will cease to be covered: services regarding working accidents and professional diseases, clinical trials, unconventional therapeutics and aesthetic surgery.	ADSE reform in 2011: benefiting from ADSE becomes optional. Belonging to this system was already optional for workers entering public administration from 2006, but until now was still mandatory for workers who had entered public administration before 2006. Specialists think that few people will leave ADSE.

Country	Benefits (coverage scope)	Population coverage (coverage breadth)	Non-price rationing (waiting times)	Changing individuals' behaviour (health promotion and prevention)
Republic of Moldova	In 2009 primary health care received priority financing from mandatory HIFs, increasing the compensated medicines spectrum and introducing generic drugs aimed at treating the most important diseases related to the disease burden and public health risks. The health care benefit package for the uninsured was extended to the provision of emergency care and full coverage of primary care, including compensated reimbursed medicines for outpatient care. (Previously all uninsured citizens had the right only to clinical examination with recommendations for assessment and treatment at the primary care level.) Since 2010, however, the level of compensated drugs has been reduced. Essentially this new legislation was not backed up with additional budget. In 2009 there was a review of National Health Programmes resulting in an extension of the list of profile diseases and of respective patient categories.	During 2009 and 2010, the Ministry of Health in cooperation with National Health Insurance Company made several amendments to the Law on MHI. The law now ensures that members of households eligible for social benefits will automatically be insured with the MHI system and receive fully subsidized health insurance. Two additional groups of persons were also granted insurance in MHI: mothers of four or more children and full-time doctoral students. These extensions in coverage are funded by increased transfers from the state budget to the mandatory HIFs. As a result, health insurance coverage, including for the most vulnerable, has increased (estimated figures suggest in 2010 it rose to 82% from 72% in 2009).		Review of the financing of preventive programmes, increasing the population immunization coverage and undertaking measures for promotion of healthy lifestyle education, according to European standards.
Romania				

Russian Federation	*Prior to the financial crisis in 2007 there were discussions of comprehensive free pharmaceutical provision for outpatients in the framework of compulsory medical insurance; however these discussions were discontinued, possibly because of the recession. In mid 2011 the discussions were re-launched and a reimbursement programme is scheduled for 2013–2015.*			*Sharp increases in alcohol and tobacco excise taxes proposed in 2009, to be implemented in 2011–2012.*
Serbia				
Slovakia				
Slovenia				
Spain		Catalonia: demanded compensation for treating patients residing in other autonomous regions from 2011.	Catalan plan: from 2011, apply a waiting list management system and make changes in waiting list prioritization criteria. From April 2010, in Catalonia: reduction in non-urgent care (eye surgeries, hip and knee replacement).	
Sweden				

Country	Benefits (coverage scope)	Population coverage (coverage breadth)	Non-price rationing (waiting times)	Changing individuals' behaviour (health promotion and prevention)
Switzerland	*Since the beginning of 2011, eyeglasses are no longer covered by mandatory health insurance. This is one of several measures intended to slow what have otherwise been consistent annual increases in health insurance premiums. Many opticians have responded by reducing eyeglass prices for children.*			
The former Yugoslav Republic of Macedonia	*In January 2011, the Ministry of Health started a campaign for people in remote regions to have better access to care. This includes free check-ups in some villages.*	Universal coverage providing essential benefits for all citizens was introduced in May 2009 and financed from the central budget. The overall number of people insured has increased as a result. Universal coverage includes preventive check-ups, immunization, coverage of part of the positive list of drugs and treatment for a range of communicable diseases.		
Turkey				
Ukraine				In March 2008 Parliament passed a law restricting the advertising of tobacco and alcohol. In order to increase revenues and reduce negative impacts on health, during 2008 and 2009 the government and Parliament regularly raised taxes on tobacco and alcohol

			products. As a result, the minimum excise duty on tobacco products has increased more than six times, the average price of a pack of cigarettes increased 2.5 times. Smoking restrictions were also introduced in public places. *Programmes and centralized measures to combat tuberculosis and on immunization received priority funding in 2009.*
United Kingdom (England)	A programme of one-to-one nursing for cancer patients and a one-week wait for cancer diagnostics was announced by the previous government but not implemented; it will now not be taken forward.	Various reports of cuts in services are emerging, probably due to less spending power resulting in some form of rationing or restriction in services in the NHS, although more evidence is needed to confirm this.	
Uzbekistan			

Table A.3. Policies intended to affect the costs of publicly financed health care in the context of the economic crisis, WHO European Region

Notes: No information was available for Andorra, Kazakhstan, Luxembourg, Monaco, Montenegro, San Marino, Tajikistan and Turkmenistan. Text not in italics indicates a policy which was defined by the relevant authorities in the country as a response to the crisis. Text in italics indicates a policy which was either partially a response to the crisis, that is, it was planned before the crisis but implemented after with greater/less speed/intensity than planned; or possibly a response to the crisis, that is, it was planned and implemented since the start of the crisis, but not defined by the relevant authorities as a response to the crisis. A blank cell indicates no policy response to the crisis (not no response to the survey).

Country	Prices of medical goods	Salaries and motivation of health sector workers	Payments to providers	Priority setting or protocols to change access to treatments, coordination of care and patterns of use	Overhead costs: restructuring the Ministry of Health and purchasing agencies	Provider infrastructure and capital investment
Albania		*Salaries of health care professionals have steadily increased in the past few years, with healthworker salaries at levels approximately twice as high as in 2005. Salaries are expected to continue to increase, according to approved budgets.*				
Armenia	During 2009 the Armenian dram was forced to float as a result of the financial crisis, leading to immediate increases in the costs of imported goods, including medicines.		*In 2008, case-based payment to health facilities (polyclinics and maternity clinics) for maternity services was introduced based on market prices under the Basic Benefit Package (BBP), which identifies*	*Ongoing national programmes prioritize primary care and improvements in maternal and child health.*		

		health services that should be provided without charge to a list of vulnerable groups or categories, such as disabled people, orphans under 18, veterans and families of war victims, families with more than three children, and children under 18 with one parent. Previously, maternity services had been financed in the same manner as all other BBP-covered services (lower than actual costs) providing incentives for informal payments.
Austria	The Federation of Social Health Insurance Funds negotiated with pharmaceutical companies to lower pricing and reimbursement and reduce the cost of drug prescribing by physicians. Cost savings of EUR 132 million in 2010 and projected EUR 222 million by 2013. Long-term contracts were established for purchasing CT and MRI scanners and for medical aids. Target to reduce spending by 0.5% annually between 2010 and 2013. No savings have yet been reported.	The Federation of Social Health Insurance Funds negotiated with the Doctor's Association over cost-control measures permitting HIFs to monitor cost-control practices and review key figures. Resulted in savings of EUR 9 million in 2010. *Current government discussions with the Länder are developing models of financing and delivering care to enhance efficiency and quality by 2012/2013. The Länder hold hospital budgets which have increasingly gone into*

Country	Prices of medical goods	Salaries and motivation of health sector workers	Payments to providers	Priority setting or protocols to change access to treatments, coordination of care and patterns of use	Overhead costs: restructuring the Ministry of Health and purchasing agencies	Provider infrastructure and capital investment
Austria (cont.)			*debt; these debt levels increased the gross general government debt by about EUR 3 billion in 2010; a fiscal equalization agreement in 2008 valid through 2014 stipulates that the government needs to develop a strategy for the next agreement due in 2014 to alter governance of health financing on the basis of an evaluation of the use of additional monies the Länder receive annually (EUR 100 million) to finance hospital care; correcting imbalances in the supply chain.*			
Azerbaijan		*Acknowledging the very low level of salaries, the government has been steadily increasing staff salaries for public sector employees. Such salary increases were made in the years preceding the financial crisis as well as in 2010. However, in 2009, no resources were*				*During 2009–2011, the government continued to allocate substantial resources to upgrade physical infrastructure and equipment in the public health sector, which suffered severely from under-investment during the 1990s and early 2000s.*

		allocated to raise salaries of the health care personnel; this might have been related to the decrease in public revenues related to a significant drop in oil prices in 2009.				*Among the major changes implemented in public health sector in recent years was the closure of the majority of small rural hospitals, which resulted in almost a 50% reduction in the number of beds in the country. Optimization of the public health care network is part of the national health sector reform and was planned before the crisis began. This is supported through a World Bank project.*
Belarus	From 2009, medicines which are not normally reimbursed can be registered and prescribed on preferential terms to individual patients deemed to be in particular need. The proportion of domestically produced medicines in the total purchased amount is steadily increasing (in 2009 – 26.5%, in 2010 – 28.2%), and there is also an increase in domestically produced medical equipment.	From 2009, reforms to increase the efficiency of roles and distribution of human resources for health: elimination of ineffective positions; introduction of standards on population-to-staff ratios at outpatient health care institutions; introduction of new positions within existing staffing levels due to filling vacant or inefficiently used positions); continued increases in basic salaries for health workers; the introduction of the position of doctor's assistant at outpatient primary health care institutions continued in	Transition to per capita budgets has ensured the economic independence and increasing responsibility of health care institutions in delivering medical care.		From 2009, reduction of overhead costs is being carried out (primarily due to reductions of administrative costs). Expenditure on fuel and energy resources, transport, business trips, communication services, etc. has been reduced.	Proportion of expensive inpatient services has decreased and resources have been redirected to the outpatient level (a total of 35.0% out of total expenditure on health were allocated to the outpatient institutions in 2009 as compared with 31.4% in 2008). Plans for investment in expensive facilities, construction and equipment, etc. have been deferred. Budgetary funds have been allocated to specific projects according to economic evaluations by experts.

Country	Prices of medical goods	Salaries and motivation of health sector workers	Payments to providers	Priority setting or protocols to change access to treatments, coordination of care and patterns of use	Overhead costs: restructuring the Ministry of Health and purchasing agencies	Provider infrastructure and capital investment
Belarus (cont.)		2010 (in 2010 a total of 732 positions of doctor's assistant were introduced as compared with 62 positions in 2009).				
Belgium	*In 2010, a new cost-containment measure introduced a biannual application of a compulsory price reduction for "old" drugs: drugs reimbursed for over 12 years and less than 15 years had their ex-factory price and reimbursement basis reduced by 15%, and drugs reimbursed for over 15 years underwent a 17% reduction. New rules in place for reimbursement for implants and medical devices since 2008. Price reductions have occurred but the effect on volume is unclear.*					*Improved coordination of care with grouping of GPs and the financing of global medical records.*

Bosnia and Herzegovina	*VAT spending by health care institutions increased significantly in 2009 because, from 2009, funds to subsidize VAT for health care institutions are no longer included in federal and cantonal budgets and health care institutions no longer have the right to VAT refunds.* HIFs introduced additional contractual measures to manage, reduce and control costs of health care providers (targeting capital investments and overhead costs such as water, electricity and pharmaceuticals and devices) and quality (minimum required amount of stock) since the start of the crisis.	*As part of general reforms, education campaigns have targeted health workers (i.e. family practitioners, health institution and fund managers, etc.), placing particular emphasis on improving health institution management, strategic planning, negotiating skills, and monitoring and evaluation.*	
Bulgaria	*In 2011 the Ministry of Health was preparing to introduce diagnosis-related groups as payment methods for acute hospital care in 2012.* In 2010 the Minister of Health introduced a fee ceiling for all hospital contractors of NHIF. The maximum fee for a team of physicians is BGN 900 and BGN 700 for one physician. Previously the	In 2009 the new government announced plans to reduce administrative and overhead costs in all government institutions by 10%. In response to this in 2010 there was change of administrative and managerial structure of the NHIF which aimed	*Several reforms have been introduced in the hospital sector. In 2009, 2010 and 2011 the NHIF implemented capped hospital budgets by limiting the numbers of patients funded. In 2010 a new law and standards of competence were introduced with the aim of reducing the overall number of hospitals and NHIF-funded medical facilities. In a reform*

Country	Prices of medical goods	Salaries and motivation of health sector workers	Payments to providers	Priority setting or protocols to change access to treatments, coordination of care and patterns of use	Overhead costs: restructuring the Ministry of Health and purchasing agencies	Provider infrastructure and capital investment
Bulgaria (cont.)			fees were set by every hospital without regulation. In 2011 the government was planning to reform purchasing of medical devices by centralizing certification of medical equipment, labs and highly specialized medical activities and introducing a positive list of medical devices. The government was planning to decentralize funding for drugs for rare diseases and cancer from the Ministry of Health to the NHIF. An amendment of the Health Insurance Act in 2009 introduced determination by the Ministry of Finance of health services prices funded by the NHIF. The Ministry of Finance was initiator of this policy. Until that time prices were negotiated between the NHIF and doctors' organizations		to reduce overhead costs by several thousand BGN. Furthermore, in 2010 the Minister of Health announced plans to reduce administrative costs of the Ministry by 29.4% amounting to a saving of BGN 4 million annually.	*funded by BGN 300 million from the European Commission Operational Programme "Regional development", in 2010 the government proposed: stabilization and modernization of state oncological hospitals and treatment centres; restructuring of some municipality and state acute and long-term care hospitals; closure of some small hospitals; modernization of state and municipality hospitals; and closure of homes for social and medical care for children replaced by new day centres. In 2011 the health map was revised so that it includes not only the minimum, but also the maximum number of beds, doctors and health establishments for each region of Bulgaria. The aim of the reform was to reallocate resources according to needs.*

		and included in the National Framework Contract. The reform was met with great dissatisfaction by the medical union. As a result a new amendment was made to the Health Insurance Act in 2011 and the pricing process is once again implemented by negotiation between NHIF and doctors organizations.			In 2011 the Minister of Health postponed a stimulus policy for acute hospital care due to a lack of resources.
Croatia	*In 2010 Croatia substantially reformed its pricing and reimbursement regulation for prescription medicines. The wholesale prices of all medicines are set through international price comparisons (based on France, Italy, Slovenia, Spain and Czech Republic) and internal reference pricing. International price comparisons are used for setting maximum wholesale prices. Financing of drugs is regulated by cross-product agreements and pay back agreements (i.e. defined maximum expenditure limits, overspends paid back by pharmaceutical*	*There has been reorganization in primary care which includes capitation payments to primary care providers that are divided into "fixed" and "floating" payments. Fixed payments are based on fixed costs and floating payments are based on the number of patient referrals to specialists, prescription costs, prevention care and group practice.* *Global budgets for hospitals have increased every year up to 2010. While the 2009 budgets for hospital health care increased at rate of 3.37%, the 2010 budget was reduced by 3.28% compared to 2009.*	*As of February 2009 prescriptions for certain medicines became valid for longer (six months), which lessens the burden on family medicine doctors, reduces unnecessary visits and decreases administrative costs.*	*In January 2011 the Croatian Health Insurance Institute and Health Protection at Work merged to create the NHIF (Croatian Institute for Health Insurance).*	*An electronic records project (i.e. e-prescription and e-referrals) was piloted in 2010. E-prescription was fully implemented in January 2011. As a result, the administrative workload for pharmacists declined by over 90%.*

Country	Prices of medical goods	Salaries and motivation of health sector workers	Payments to providers	Priority setting or protocols to change access to treatments, coordination of care and patterns of use	Overhead costs: restructuring the Ministry of Health and purchasing agencies	Provider infrastructure and capital investment
Croatia (cont.)	*companies or avoided by timely donations, strict penalties for deliberate shortages). These measures decreased drug expenditure by 7%.*					
Cyprus		The salaries of all public sector health professionals were reduced. In addition, the Ministry of Health has changed doctors' overtime remuneration.				
Czech Republic	Drugs: simplified approval process for generic drugs to enter the Czech market introduced in 2010 (further measures planned for 2012). Medical equipment: auctions for purchasing new medical equipment introduced in 2011 (further measures planned for 2012).	Decrease of 10% in expenditure on salaries of public administration employees, including those working in health sector (except health professionals such as physicians, nurses etc.) in 2009. Physicians were threatened with salary cuts resulting from proposed reductions of payments to hospitals but resisted (20% of them handed in their notice). As a result insurance funds did not reduce payments and	No increase in budget for reimbursement of hospitals by insurance funds in 2010. Change of reimbursement mechanisms in hospitals from global budgets towards diagnosis-related groups planned for 2012.		Change in law to enable merging of SHI funds in order to improve efficiency planned for 2012.	Restructuring of inpatient beds is being considered (analysis being done in 2011) in order to decrease number of acute care beds and increase number of beds for follow-up care.

		salaries did not decrease. However, part of the negotiation was that physicians accepted other reforms. Implemented in 2011.			
Denmark	*As part of ongoing policies accelerated after 2008, efforts to improve rational pharmacotherapy.*	Only limited increases in salaries for health professionals as a result of negotiations in 2011.	*As part of ongoing policies accelerated after 2008, increased use of tender to strengthen competition between providers (public hospitals outside each region, private hospitals and suppliers to public hospitals in each region). Reviews of hospital budgets to identify potential savings.*		*As part of ongoing policies accelerated after 2008, centralization (hospital and department closures) to achieve economies of scale and reduce maintenance costs.* *IT improvements made as part of ongoing policies accelerated after 2008.*
Estonia	*In March 2010 the Ministry of Social Affairs (MOSA) initiated amendments to the ministerial decree on drug prescriptions to support active ingredient-based prescribing and dispensing. The amendment did not change prescribing rules, but does require pharmacies to provide patients with the drug with the lowest level of cost sharing and to note if patients refuse cheaper alternatives. In April 2010 the Health*		EHIF reduced health services prices by 6% from 2009. The objective was to balance the health insurance budget without diminishing access to care. Before the crisis, health service expenditures (also prices) increased very rapidly and therefore that 6% cut was not a big economic shock for providers. Since 2011 the price of health services has reduced by 5%, with exception of primary care where the reduction rate is lower (3%).		

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Estonia (cont.)	*Insurance Act was amended to extend the application of price agreements and reference pricing to medicines in the lowest (50%) reimbursement category (some effective drugs and many less cost-effective drugs). Price agreements previously only applied to drugs reimbursed at higher rates (100%, 90% and 75%). In September 2010 EHIF launched an annual generic drug promotion campaign on television and billboards in cooperation with MOSA, the State Medicines Agency (SAM) and the Association of Family Physicians (SFM). At the beginning of 2010 EHIF and MOSA launched a new e-prescription system, which currently operates alongside paper prescribing. The new system makes active ingredient-based prescribing easier.*					

Finland			*Service vouchers introduced for social care: caring for close relatives; domestic services; support services to housing services and housing service for disabled people. Introduction for health services was planned for 2011. Use of vouchers is intended to mitigate public sector pressures and increase freedom of choice of services users. Twenty-seven municipalities use them; 32 to expand or introduce them; 6 and 10 for specialized care; 2 and 5 for rehabilitation; 4 and 13 for dental care.*	*Significant differences exist across municipalities due to variation in financial resources and availability of health professionals. This has led to a restructuring and mergers of municipalities to pool resources. Between 2005 and 2011 the number of municipalities decreased from 432 to 336.*
France	Savings anticipated in 2011 due to decreasing cost of health products, including greater use of generic drugs.	From 2011, decrease in the fee for services of certain health professionals.		Five-year hospital sector investment plan (2008–2012) of EUR 16 billion of which only EUR 6 million is to be spent in 2010–2012.
Georgia	*In 2009 reduced market entry barriers and capital requirements for pharmacy network to increase market competitiveness, which potentially could bring prices down. Recent analysis shows that prices have come down slightly for branded medicines, but not for generics.*			In relation to capital and overhead costs, in 2007 the government aimed to increase investments in upgrading or constructing health care facilities and optimize excess provider capacity through privatization. The Hospital Development Plan called for the complete replacement of

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Georgia (cont.)						existing hospital infrastructure within a three-year period (2007–2009), by transferring full ownership rights from the state to the private sector through a tendering process. However, as a result of war in 2008 and the global financial crisis, investors and, primarily, developers have faced serious liquidity problems, which have had significant consequences with regard to fulfilling their contractual obligations under this programme. As a result, implementation of the hospital master plan stalled and many original investors, who participated in the tenders, had to withdraw and face financial penalties. The government subsequently resolved this issue by identifying new investors and currently a large number of hospitals are being constructed.

						In 2010, the way the Medical Insurance for the Poor is implemented was changed. A single contract per region was put out for competitive tender by the government, that is, private health insurers bid to be the sole insurance provider of the MIP in any given region. Part of the deal for winning the tender was that private insurers had to build new hospitals. This programme for new infrastructure should be finalized in 2012.
Germany						
Greece	The Memorandum aims at saving EUR 2 billion from pharmaceutical products – EUR 1 billion was to be saved in 2011 – reducing pharmaceutical expenditure by 1% of GDP. From 2011, positive list of medicines reintroduced (it was abolished in 2006), with a focus on generics. Reduction in VAT for medicines (11% to 6.5%); increased use of generics (50% of medicines in public hospitals should be generics); maximum generic price is 60%	From 2011, salary cuts (e.g. nurses' salary cut by 14% compared with 2009). Temporary staff employed under fixed-term contracts removed. Reduction in the replacement of staff who are retiring (for five persons who are retiring only one is to be appointed).	From 2011, reduction in pharmacists' profit by 15–20%. Liberalization of pharmacies: more than one pharmacist can work at the same pharmacy and pharmacies can be established in closer proximity to each other. Extension of hours, decrease in population threshold for setting up a pharmacy; rebates available. Development of a pricing system for hospitals on basis of medical cases, which will be used for setting hospital budgets from 2013.	A new health law introduced in 2011 provides the constitution of a main primary health care body named the National Health Service Organization (EOPYY), under the supervision of the Ministries of Health and Social Solidarity and Labour and Social Security Operation, with operations beginning in June 2011. The aims of the EOPYY are to	In June 2010, the new government that came to power enacted a law to establish a new architecture for municipalities and regions (known as the "Kallikratis" Plan). With the Kallikratis Plan, 13 regions have been created in place of 76 prefectures and the 1034 municipalities reduced to fewer than 370. Under the reorganization,	From 2011, introduction of hospital mergers and closures, including merging social health insurance and national health service hospitals. National health service hospitals' opening hours have been extended. Health and Welfare Map: from 2010, a data and index system is being developed through which (a) citizens' health status will be recorded and (b) the sufficiency, effectiveness and efficiency of health services will be assessed.

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Greece (cont.)	of branded drugs; centralized procurement of medical services and goods; private individuals are permitted to procure contracts; fines from EUR 500 to EUR 50 000 if there is deviation from the approved budget in a procurement contract.			coordinate primary care, regulate contracting of health care providers and set quality and efficiency standards, with the broader goal of alleviating pressure on ambulatory and emergency care in public hospitals. The health divisions of the main SHI funds are transferred and integrated in this organization.	regional health authorities are expected to play a much greater role in managing and organizing the human resources of the national health service.	New measures in the 2011 health law allow the expansion of private clinics in the building of infrastructure, developing new departments, units and laboratories, and hospital beds, within certain defined limits in growth rates. Expansion of the electronic prescription system from 2011: it should be used in diagnostic examinations and in inpatient care and the main insurance funds are obliged to use it.
Hungary	*From 2010, financial rewards were introduced for the rational use of drugs. Doctors are rewarded for prescription of cheaper, but therapeutically equivalent substitutes and pharmacies may promote the use of these drugs by altering doctors' prescriptions. In 2011 the government*	*The Semmelweis Plan aims at creating a career path model for health care professionals that, with changes in remuneration, education and in the conditions of employment, provides motivation for staying in the field and working in Hungary.*	In 2008 financing multipliers (weighting factors for Homogeneous Disease Groups, HBCS) for inpatient rehabilitation were raised. Since 2008 the Health Insurance Fund Administration is entitled to abrogate a financing contract if quality or other criteria are not met. In April 2009 outpatient and inpatient financing		Administrative cost of the NHIF administration is planned to be reduced from 1.5% to 1%.	

announced plans to reform the prescription drug subsidy system.

changed. There had been a pre-determined fee up to a certain volume limit. The volume limit was reduced and a floating fee for services above this limit was introduced. However the reduction in and unpredictability of the specialist providers' budgets was unmanageable and in October they were compensated with a transfer of an extra HUF 10.5 billion (i.e. not included in budget provisions), the reform was reversed and the original system restored. In 2010, inpatient providers again received extra funding in order to avoid bankruptcy (HUF 27.5 billion). It was spent mainly on the debts of institutions and shortening some waiting lists. By accepting this help, institutions agreed to make a consolidation plan, to participate in a regular debt-monitoring system and to cooperate in territorial capacity restructuring.

The 2010 government Semmelweis Plan envisaged the continuation of these reforms in 2010/2011. Extra funding will be

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Hungary (cont.)			*used primarily in three priority areas: to modernize the fleet of the National Ambulance Service, to strengthen primary care and extend its functions (in order to reduce the burden of specialized care), and to reduce the debt of hospitals and health care providers. To establish financial sustainability, effective and transparent resource allocation mechanisms are planned that are adjusted to needs. To achieve this, the plan aims to abolish the strict volume limit in inpatient and outpatient care. Treatments above the volume limit are planned to be reimbursed according to the variable cost of the case. The present fee-for-service system in ambulatory care would be replaced by a system of ambulatory Homogeneous Disease Groups (Hungarian version of diagnosis-related groups).*			

Iceland	*As of March 2009, official prescription rules must now be followed (i.e. certain generics must be prescribed before trying costlier alternatives), otherwise patients must pay 100% of drug costs. As a result, applicable drug costs were reduced by 10.7% from 2009 to 2010.*	In 2009, individual health care organizations were tasked with cutting health worker salaries. A common approach was to cut overtime and night shifts, and to lengthen shifts that require fewer staff, travel costs, continuing education, etc. This affected medical doctors and registered nurses, as well as other health care professionals and health care staff. A number of these health care employees lost their jobs. For example, over 700 people have lost their jobs at the National University hospital in the period 2007–2010 (approximately 10% of total staff). According to surveys, these cuts have created negative attitudes among staff. Currently there are physician vacancies in many health care organizations around the country. In addition, the average age of medical doctors is increasing dramatically, as medical doctors choose not to return to the country after obtaining their specialization abroad.		In October 2008, the Ministry of Health and Ministry of Social Affairs merged to reduce administrative costs and increase efficiency. There are intentions to merge the Directorate of Health and the Public Health Institute of Iceland in 2011. There have been a number of health centre mergers. For example there were around 20 rural health centres in 2007 but by 2011 there were only 12.

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Ireland	Renegotiation of deals with pharmaceutical companies from 2010.	In 2009: moratorium on recruitment and promotion, non-replacement of staff on leave, ending of temporary contracts, staff transfer, voluntary redundancy, cutbacks in education and training. In the 2010 budget: lower fees paid to contracted professionals (GPs and other health professionals) producing estimated savings of EUR 659 million. In the 2011 budget: reduced agency and locum staffing, reduced professional fees, early retirement and voluntary redundancy proposed.	From 2008, reduced annual fee to GPs who treat medical card holders. From 2009, reduction of 8% on all professional fees and cut to pharmacy fees of 24–34%. Further cuts in fees of 5% for health professionals were introduced in 2010 and 2011.		HSE commitment in 2009 to reduce administrative, management and advertising costs by at least 3%. Cuts in administrative spending introduced in 2010 budget, including reducing HSE staff by 6000 (EUR 300 million) plus additional efficiencies in the HSE (EUR 90 million). Cuts in administration (EUR 43 million) were proposed in the 2011 budget.	Measures to provide more services with fewer resources: hospital day care increased by 5% in the first six months of 2009 relative to 2008 and above the 2009 target. Outpatient (OPD) appointments increased by 3% between the first six months of 2008 and 2009, and the number of new OPD attendances have increased by 6% in the same period. Hospital capacity reduced by 519 beds between January and July 2009.
Israel						
Italy			*From 2010, performance measurement introduced and linked to payment of providers as a cost-containment measure.*			
Kyrgyzstan						

Latvia	*In 2009 pharmaco-therapeutic reference groups were extended and more attention was given to the international comparison of pharmaceutical prices. The Centre of Health Economics re-evaluated the cost–effectiveness and prices for the treatment of HIV/AIDS in 2009 and specified recommendations for the prescribing of pharmaceuticals. Previously, the pharmaceuticals for HIV/AIDS were purchased centrally but have been included in the reimbursement system since 2010. On the basis of an evaluation of cost–effectiveness and negotiations with companies on price reductions based on international comparisons, the Centre of Health Economics made significant price reductions – from 3% to 49% – compared to prices in 2009. This enabled treatment for an increasing number of patients for the same amount of money.*			*In 2009 a programme to increase responsibilities and duties for family doctors, including increased support for the provision of health care at home was introduced.*	*The Public Health Agency was closed in 2009. Many public health functions were distributed among other institutions and some were lost. As part of a reorganization of the institution which develops state policy on availability of health care services and manages the state financing of health care aimed at diminishing state administrative expenses, the Health Payment Centre (HPC) was established in 2009. This change was associated with a cut in the programmes budget of LVL 127.8 million or 24.8% in 2009 compared to 2008 and staff redundancies. Furthermore, the total number of employees decreased from 313 (2008) to 139 (2009). There was also reorganization of emergency services. In February 2009 instead of*	*The number of publicly funded hospitals with inpatient care provision in Latvia decreased from 88 in 2008 to 72 in 2009 and 39 in 2010. The number of hospitals per 100 000 inhabitants in 2009 was 3.18, compared to 1.73 in 2010. The number of hospital beds decreased from 746/100 000 inhabitants in 2008 to 625 in 2009 and 493 in 2010. In 2009 compared with 2008 the number of hospital admissions and bed days in inpatient hospitals decreased by 27.1%. Average costs per single hospital stay decreased by 1.2% but the cost of one inpatient day increased by 6.8%. The average length of stay in hospitals in 2008 was 9.5 days, compared to 8.7 in 2009 and 8.5 days in 2010. In 2009, due to the closure of several regional hospitals, the activity of and services provided by day clinics increased significantly. In 2009 the number of patients treated at day hospitals was 39 507, but in the first eight months of 2010 it was 50 938. In 2009 there was a total of 373 313 hospitalizations.*

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Latvia (cont.)					*39 institutions one Emergency Medicare Service was established in order to gradually take over emergency medicine functions from Medicare institutions, to centralize the emergency system and to save administrative costs. This reduced the number of emergency medical calls by 10% in 2009.*	
Lithuania	The Plan for the Improvement of Pharmaceutical Accessibility and Price Reduction was approved in July 2009. From 2010 there were new requirements for generic pricing, e.g. the first generic has to be priced 30% below the originator, while the second and third generics must be priced at least 10% less than the first	Decrease of 10% in salaries of medical staff in 2009 and 6% decrease in 2010.	*Moving from the current national case-based payment for hospitals to an internationally recognized standard diagnosis-related groups system was in preparation in 2011.*		*In 2009 a programme of reorganization of the network of medical institutions into district, regional and national levels was introduced. Uniting hospitals into larger legal entities reduced the number of institutions providing health*	*Health care system reforms of 2009 have a primary goal to reduce the volume of inpatient services, while directing available funds to primary health care, outpatient aid (increase by at least 5%), as well as day inpatient (increase the volume by at least 8%) and nursing services, and to redirect health care specialists to outpatient and day*

	generic to be reimbursed. A newly priced catalogue of medicines which are reimbursed from the CHIF was enacted. Medicines started to be reimbursed according to active substance (INN) of the product and patient has the right to choose medicine for which co-payment is smallest. The base price of more than 1000 medicines was reduced. Before this reform, personal expenses for the co-payments for these products comprised LTL 130 million per year; it is estimated that if patients choose cheaper medicines from the new price catalogue, LTL 80 million per year of personal expenses will be saved. Compulsory HIF expenditure on drugs and medical devices in the ambulatory care sector decreased from EUR 197.88 million in 2008 to EUR 201.64 million in 2009 and EUR 189.22 million in 2010, while the number of prescriptions rose.		*care services by 24. The economic effect is anticipated to be LTL 137 million.* Restructuring of the Ministry of Health and institutions accountable to it was started in 2009–2010. Reorganization of public health – seven public health institutions were merged in 2009–2010.	*surgery services, as well as long-term care.*

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Malta	*A legal framework to set a maximum reference price at the point of decision regarding entry into the formulary was established in 2009. This is yielding the desired results. During 2010, certain prices of medicines decreased, resulting in more favourable prices for public procurement.*					
Netherlands	From 2010, policies allowing HIFs to have a greater role in purchasing care accelerated, playing an important role in the reduction of prices of, for example, medicines and executing a "preferential policy" to keep drug prices under control.		From 2010, as part of the changes to purchasing by SHI funds, pharmacists receive a pre-defined fee for each service and bonuses are removed.			*From 2010, greater integration of primary care at the community level to reduce use of hospital care and promotion of e-mental health to increase self-management.* *In line with the reform of the Dutch health care system in 2006, from 2010, the private market was further stimulated to invest in the health care sector. Therefore a system of regulated profit creation in health care was introduced. This should lead to external*

			(private) capital for care innovations, quality improvements, patient logistics and better service. No profits for care providers will be allocated during the first three years after the date of investing. Instruments and regulations are designed to ensure critical care when financial problems appear in hospitals, stressing the responsibility of hospitals through an "early warning system". Exit bonuses for managers in the health care sector are restricted to a maximum of EUR 75 000.
Norway			
Poland	*A new law was presented by the government in 2011, to regulate the reimbursed drugs market. The key elements of the regulations are as follows: maximum limit of NHF expenditures for drugs reimbursement was established at the level of 17% of total expenditures – when the limit is exceeded, producers of pharmaceuticals included in the reimbursement system will be obliged to*		*New law introduced in 2011 to allow hospitals to be corporatized. They will continue to be publicly owned but will be subject to bankruptcy laws. This is intended to improve financial management.*

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Poland (cont.)	*pay back certain amounts; maximum margin on drugs sold by wholesalers and pharmacies; prices of reimbursed drugs in pharmacies will be fixed; no discounts are allowed between wholesalers and pharmacies. The law is very much criticized by the pharmaceutical industry, pharmacies and other interested parties, but has a strong support from the government and the Parliament.*					
Portugal	From 2011, centralized procurement of medicines and diagnostic tests; reductions in pricing and reimbursement; faster availability of generics, prescribing by active ingredient, prescribing guidelines, e-prescribing. Measures included in the 2011 national budget: (1) Price reduction on generic drugs that have high prices compared with international ones,	From 2010, measures regarding public workers including health workers: (1) Freezing salaries. (2) Freezing promotions and career progression in public administration. (3) Freezing admissions and reducing the number of hired people (especially workers with more precarious contracts). (4) Reducing some expenses such as some	Move to per capita payment in 2011.	From December 2010: eliminating the practice of "indiscriminate" check-ups and routine exams without technical/scientific foundation; introducing measures in information systems to prevent the prescription of exams with no	Target to save 5% on current expenditure costs in every department/ medical service, excluding personnel costs, in 2011. The Office of the High Commissioner for Health is scheduled for closure after publishing the National Health Plan 2011–2016.	*Following past trends in recent years, there has been a reduction in hospital beds and more recently closure of primary care centres. Data regarding beds per 100 000 inhabitants show a decrease from 336.7 beds in hospitals in 2008 to 334.8 in 2009 and from 5.5 beds in primary health centres in 2008 to 4.6 in 2009. Regarding the number of primary*

	starting with the most sold generics omeprazol and simvastatin: prices should be at least 35% lower than the brand pharmaceutical drug. (2) Price reduction of 7.5% on biological pharmaceutical drugs. (3) Price reduction on supplementary diagnostic and therapeutic procedures: 5% on clinical diagnostic tests and 3% on medical imaging. (4) Price reduction of 10% on glycaemic control consumable test strips for diabetics. (5) Price reduction on haemodialysis. (6) Decrease the price of pharma goods subsidized by state by 6%.	travel and eating expenses, overtime costs, eliminating the possibility of receiving public salaries while also receiving pensions. This led to an unexpected increase in retirement of doctors; nearly 600 doctors had asked for retirement by November 2010.		advantage to the patient; disciplining consumption in ambulatory hospital; charging a financial penalty in case of inappropriate use of pharmaceutical drugs.	*health centres, more recently there has been a slight decrease of primary health centres (for example 377 in 2008 to 375 in 2009), but a very strong decrease in primary health centre outposts or peripheral units (1778 in 2008 to 1318 in 2009).*
Republic of Moldova			In 2009, development of performance assessment and results-based financing, aiming at medical personnel motivation, quality improvement and resource efficiency. The health providers contracted within mandatory health insurance are paid and reimbursed in line with tariffs and cost	The Ministry of Health has drawn up a plan of action to combat and mitigate the effects of the crisis on public health, in accordance with the provisions of the programme to stabilize and revive the economy of the country for 2009–2011. It	Despite the restrictions introduced by the Ministry of Finance on capital investments, and limitations on staffing and training expenditures, the Ministry of Health succeeded in maintaining and even increasing the financing of such domains by passing a new amendment in the Law on Mandatory Health Insurance. Thus a law

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Republic of Moldova (cont.)			of medical services, approved commonly by Ministry of Health and the National Health Insurance Company based on a special formula that includes caps on overheads and some running costs, and adjusted each year in the context of the rate of inflation and trends in HIFs' accumulation of revenue and spending.	envisages redistributing the financing of different types and levels of health assistance, including inpatient advanced technology and expensive medical services. Priority funding of emergency and primary health care (more than 31% of the funds of CMI) permitted the maintenance of access to appropriate medical services and extension of the list of compensated medications.		adopted by the Parliament in July 2010 legitimated the new "fund for development and modernization of the public health providers" within the mandatory health insurance framework. The financial resources collected are used predominantly for capacity development of health providers, including capital investments, procurement of modern and expensive equipment, sanitary transport, information technologies, etc. Investment plans for costly equipment were reviewed and put on hold in 2009.
Romania	Under pressure from pharmaceutical companies and wholesalers, the Ministry of Health updated prices of pharmaceuticals to reflect the new exchange rate	In 2010 the government cut the salaries of all staff employed in the public sector, including hospital physicians and other hospital personnel by 25%. This led to	From 2009 onwards the point value base on which GPs are reimbursed decreased as per the framework contract which stipulates that any fluctuation in		*At the beginning of 2011 Ministry of Health announced the merger of 111 hospitals; 71 hospitals will be converted into*	Before the crisis the Ministry of Health announced a plan to build about eight new hospitals for which a preliminary feasibility study was done. As a

	(it had worsened due to inflation) causing an increase in prices in 2009. In 2011 the NHIF changed the reference price system for reimbursed drugs in order to contain costs by stimulating the prescription of medicines with prices below the reference price. *A claw-back mechanism for pharmaceutical companies was introduced in 2010 (after VAT deduction a percentage from the total sales of reimbursed drugs has to be paid back to Ministry of Health; the claw-back rate is on a sliding scale depending on value of total sales).*	a decrease in the contribution for health (to understand the scale of this it is worth mentioning that in 2010 were about 1.4 million public employees out of about 4 million contributors to the HIF).	the income of the NHIF can be reflected in the payment level of the primary care. *A new system of GP payment (reducing the per capita component of GP revenue in favour of fee-for-service linked with some performance evaluation) and a limitation of number of hours worked per week was proposed as part of a revised GP framework contract in 2010; it was rejected by GPs and was being revised in 2011.*	*nursing homes for the elderly.* *Increased accountability in the management of hospitals was transferred to local government as part of an ongoing process of decentralization.* *Plan to introduce a new health information system and an "insurer card" in order to increase efficiency in the system and reduce bureaucracy announced in 2010.*	result of the financial crisis this plan was abandoned. Purchase of equipment was also reduced.
Russian Federation	*An essential drugs list pricing regulation, registering producers' prices and limiting maximum wholesale and retail mark-ups was implemented in 2010.*		*Liberalization of the legal status of state and municipal facilities: they will become either "autonomous non-profit-making" "budgetary" or "government" facilities. The former two types will have the right to charge citizens for public services and will be permitted to go bankrupt. They are to be paid according to fixed block grants for a certain volume of services, with*		*Overall RUB 460 billion (USD 15 billion) is expected to be used for a modernization project over two years (2011–2013). The split of the additional taxes collected is skewed towards capital investment (building and renovation, medical equipment – RUB 300 billion), with the information systems development component receiving RUB 34 billion and the Medical*

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Russian Federation (cont.)			*care provided above the threshold at the expense of the citizens. The categorization of facilities into the three groups was expected in 2011, but is still ongoing, with effect as of 2013.*			*Standardization project (the least clear in terms of content) getting RUB 136 billion.*
Serbia	The public HIF asked pharmaceutical companies to reduce their prices, and in response pharmaceutical companies waived 10% of total sales for March 2011 through March 2012 with the possibility of an extension of this arrangement. In similar fashion, the HIF is trying to reduce expenditures for medical devices but it is unclear yet whether this will be successful.	Since 2010, housekeeping and IT support workers in health care institutions (who are privately contracted) have accepted lower wages so that they have been able to keep their contracts. Often this has meant that their contracts stayed the same in dinars (RSD) but decreased in real terms due to inflation and the dinar to euro exchange rate.				

Slovakia	*Reference based drug pricing was introduced in 2009 and 2010. It has been the key policy change mitigating the impact of the 2009 crisis.*				*Acute lack of funding in the General Health Insurance Company led to delayed payments to pharmacies and providers. The government stepped in to rescue it. This step was disguised by the merger with the Common Health Insurance Company (CHIC) on 1 January 2010. The merger secured EUR 65 million from the state budget and another approximately EUR 33 million from the financial reserves of the CHIC.*	
Slovenia	In 2009 the NHIF revised lists of medicines; reduced prices of medicines through negotiation with suppliers; provided information to the public regarding proper use of medicines; provided training in rational prescribing for physicians; and reduced the price of dialysis due to lower prices of erythropoietin.	Measures adopted by the government in the field of public sector salaries (total savings EUR 23 million each year): in 2009 there has been no adjustment of basic salary to inflation; in 2010 this adjustment was lower than inflation rate; delaying further elimination of wage disparities (until economic growth improves substantially);	In 2009 the NHIF reduced the price of health services (generally) by 2.5% and implemented penalties for health care providers related to the breach of the contract between the fund and the provider.		In 2009: selective reduction in material costs by the NHIF, reduction of direct costs of NHIF.	In 2009 the NHIF reduced expenditure on tertiary services by 5%.

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Slovenia (cont.)		abolition of the allowance for over-performance from April 2009 onwards. NHIF introduced measures to reduce absenteeism: strengthening the lay control of absence from work; training in assessment methods regarding absence from work for GPs.				
Spain	National level: attempts to reduce pharmaceutical expenditures (through more favourable negotiation with the pharmaceutical providers, but not through more efficient use of medicines). Catalan plan: from 2011, develop efficient prescribing strategies based on cost effectiveness, co-responsibility among providers and patients, use of generics or lower-cost alternative.	National level: short-term reduction of salaries to all civil servants (health personnel included) initiated by the Treasury from 2010.	Catalonia: negotiation of contracts with providers and reduction in price paid per medical act reduced by 2% from 2011.	Catalonia: from 2011, develop prioritization strategies in clinical practice; guarantee better process organization; improve the quality and effectiveness of clinical management of pharmaceutical prescribing; monitoring quality and knowledge of health professionals; interventions to promote responsible use of health services among the population.	Catalonia: from 2011, introduction of administrative simplification rules (expected impact is to increase savings by 25%), including austerity measures, to the management of health centres and greater use of electronic management.	From 2011, in Catalonia: more use of IT system and e-health. Prioritize investment in replacement of existing infrastructure (rather than new infrastructure).

Sweden		*Many county councils are planning reductions in human resources through an employment freeze, e.g. by not replacing retired staff or not using stand-ins when personnel are on sick leave.*			
Switzerland					
The former Yugoslav Republic of Macedonia	*In 2010, for the first time the HIF used reference prices for drugs on a positive list that is adjusted based on drug prices in Slovenia, Croatia, Serbia, Bulgaria. This allowed the HIF to purchase more new drugs within the same budget and more drugs for the insured without co-payment (increase of 76%).*	*In January 2011, to try to compensate for the emigration of health workers, the Ministry of Health approved the employment of an additional 200 doctors, 60 nurses, 20 X-ray and lab technicians in public health organizations, which will cost EUR 2–2.5 million annually. This is intended to improve quality and access in public health institutions, as well as to prevent qualified medical staff from leaving the public sector.*	The HIF paid off all debts of health institutions in 2008, costing approximately EUR 80 million. As a result, transfers to public health institutions were reduced in 2009 by 6.1%. In April 2010, the value of a capitation point was decreased by 10% (MKD 5) for primary health care doctors for six months, although this was reversed after doctors protested.		*To increase the quality of health services since the crisis, there have been miscellaneous health sector changes, including a reorganization of emergency medical services, the establishment of a committee dedicated to the improvement of the health sector, and implementation of an integrated health management information system and electronic health card.*
Turkey	As of 2009, the reimbursement cap in the reference price system for pharmaceuticals has been reduced (from 22%) to 15% of the price of the most inexpensive medicine that could be prescribed for the same indication. As a result,				

Country	Prices of medical goods	Salaries and motivation of health sector workers	Payments to providers	Priority setting or protocols to change access to treatments, coordination of care and patterns of use	Overhead costs: restructuring the Ministry of Health and purchasing agencies	Provider infrastructure and capital investment
Turkey (cont.)	some pharmaceutical companies whose drugs were not previously covered have voluntarily cut their prices in order to be covered again; this has led to substantial savings, around approximately TRY 1 billion.					
Ukraine	In October 2008 prices for drugs and medical products increased dramatically due to currency fluctuations. The government set limits of supply and sales allowances for the drugs on the essential drugs and medical products list (not higher than 12% of wholesale prices and not more than 25% of the procurement price; for drugs and medical products, purchased from budgetary funds – not exceeding 10% for both the wholesale and procurement price). The attempt of price retention was not successful and resulted in	*As salary falls under protected expenditure, in 2009 salary expenditure rose at almost 3% (then it slightly decreased in 2010). At the same time, the government's decisions related to public sector employees adopted in 2009 (increase of minimal and basic salary) allowed it to maintain and even slightly raise salaries (by 4–7%) for all categories of medical personnel. The government introduced an increase for seniority (number of working years) for doctors and nurses at a rate of 10% to 30%*		In 2009, despite the crisis, the Ministry of Health developed a vertically organized system (ranging from the Ministry to health care providers) of management and control of medical care quality, which included monitoring and compliance with clinical protocols and medical standards. However, no sanctions for non-compliance with medical standards or motivations to		In 2008 the government adopted a programme "Overcoming the impact of the global financial crisis and ongoing development". A special section was devoted to ensuring the provision of high-quality and available medical services, where, in particular, certain measures to optimize the network of health care facilities were stipulated. In fact, the programme was not implemented. In 2009, the number of medical facilities had not changed, the number of beds decreased by 7% due to restructuring, initiated by local

a reduction of the range of drugs available. It also increased the proportion of high-cost drugs, brought about a reduction in the network of pharmacies, caused a rise of unemployment in this sector and contributed to the growth of social tension. The government, having responded to criticism, implemented a softer and more market-oriented mechanism of price control by introducing a formula that takes into account currency fluctuations. In 2008 drug prices rose by 15% compared to the previous year, in 2009 by 42%, but in 2010 by 6.4%. The slower growth rate of prices was due to the replacement of drugs purchased in countries with high costs (Germany and Switzerland) with drugs from countries with lower costs, in particular from India, as well as drugs produced locally.

of salary, significantly raising the salary of medical staff in 2010 (by 24–53%). While in 2008 in USD equivalent the salaries of medical personnel have been reduced by almost 30%, in 2010 they almost returned to the pre-2008 level.

follow them had been stipulated. Therefore this policy had no practical effect on the activities of medical personnel.

authorities, which did not have sufficient funds for the maintenance of health facilities. As a result, the number of small rural hospitals decreased by 50% as they changed their profile to ambulatory clinics. Judging by the dynamics of the total expenditures, the most affected functions are inpatient care (reduction of real expenditures by 13%, in USD equivalent by 33.6%), provision of drugs (by 2.5% and 25.5% respectively), prevention services (9% and 30.3%), but most of all, fixed capital expenditures (by 22.4% and 40.7%).

During the crisis there have been changes in the structure of budgetary expenditures for utilities of facilities (growth in 2009 at 2% with some decline in 2010). Share of drug and food expenditure has stayed relatively stable, while the share of fixed capital expenditures that do not relate to protected expenditure declined sharply in 2008 (by more than three times) and in 2010 continue to remain low (3.7% of total).

Country	Prices of medical goods	Salaries and motivation of health sector workers	Payments to providers	Priority setting or protocols to change access to treatments, coordination of care and patterns of use	Overhead costs: restructuring the Ministry of Health and purchasing agencies	Provider infrastructure and capital investment
United Kingdom (England)		From April 2011, at least two-year pay freezes for health professionals at a time of rising inflation. Planned measures to increase efficiency include continuously improving workforce productivity.		Planned measures to increase efficiency include: applying best practice throughout the NHS in the management of long-term conditions; driving down inconsistencies in admissions and outpatient appointments.	The administration budget has been reduced by 33% in the Spending Review for the period April 2011 – March 2014. One planned measure is a reduction in the number of arm's-length bodies (e.g. Health Protection Agency, the Food Standards Agency and the National Treatment Agency for Substance Misuse) from 18 to a maximum of 10 by 2014.	The capital spending budget has been reduced by 17% in the Spending Review for the period April 2011 – March 2014.
Uzbekistan						

Joint policy summaries

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   Gilles Dussault, James Buchan, Walter Sermeus, Zilvinas Padaiga
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