Editorial: From expenditure growth to productivity growth in the health sector

Almost six years since the start of the global financial and economic crisis, economic conditions vary widely across OECD countries, with the United States, Canada and Japan on a path to recovery, while the economic prospects of many European countries remain subdued. After a period in which, as part of the stimulus packages, greater resources were channelled to welfare and social protection programmes, the shift towards restoring sound fiscal conditions has often implied substantial cuts in public spending. Like other government programmes, health care has been the target of spending cuts in many OECD countries.

The crisis has had a profound impact on the lives of citizens across the world, and has tested the resilience of many families as they see their wealth and incomes decline. Millions of people have joined the ranks of the unemployed and millions more are experiencing financial stress. The combined effects of the crisis with the associated recent expenditure cuts as well as health care reforms have led to uncertainty about the impact on the health and well-being of the population. The most recent OECD health statistics, presented in this edition of *Health at a Glance*, provide a comprehensive picture of how health systems have evolved during the crisis and the challenges which lie ahead.

Most OECD countries have moved to lower health spending

Growth in health spending has slowed markedly in almost all OECD countries since 2008. After years of continuous growth of over 4% per annum, average health spending across the OECD grew at only 0.2% between 2009 and 2011. Total health spending fell in 11 out of the 34 OECD countries between 2009 and 2011, compared to pre-crisis levels. Not surprisingly, the countries hit hardest by the economic crisis have witnessed the biggest cuts in health expenditure growth. For example, Greece and Ireland experienced the sharpest declines, with per capita health care spending falling by 11.1% and 6.6%, respectively, between 2009 and 2011. Health spending growth also slowed significantly in Canada and the United States. Only in Israel and Japan has health spending growth accelerated since 2009.

In order to limit or reduce public health expenditures, countries have worked to lower the prices paid for publicly financed health care, including cutting the price of medical goods, particularly pharmaceuticals. Governments have targeted hospital spending through budgetary restrictions and cuts to wages. Several countries including Greece, Ireland, Iceland and Estonia have reduced nursing wages in response to the crisis as well as those of salaried GPs. Expenditure on prevention and public health has also been cut since 2009. Further, in several OECD countries, patients are now expected to assume a greater share of health costs.

The crisis has had a mixed impact on health indicators

What has been the effect of the crisis on health? The results are mixed. For example, while suicide rates rose slightly at the start of the crisis, they appear to have stabilised since then. There are also indications that Greece's infant mortality rate, long in decline, has been rising since the crisis started. Neither is good news. But other health indicators tell a different story: mortality from road traffic accidents, for example, has declined. Such deaths had already been steadily falling in most OECD countries, but the rate of decline accelerated after 2008 in some countries that were hard hit by the recession, likely because less economic activity means fewer cars on the roads, and so fewer accidents.

The crisis may also have led to positive changes in certain health behaviours. In particular, alcohol and tobacco consumption in a number of OECD countries fell in the immediate aftermath of the crisis. This was already a long-standing trend in most countries, but the drop in consumption has accelerated due to the combined impact of lower incomes and more stringent policies around purchasing and use. It remains a question as to whether these gains can be maintained once economic growth and household budgets improve.

As the short-term impact of the crisis on health is both bad (mental health) and good (accidents, alcohol), it is not surprising to find that there is no evidence yet of a widespread health impact in the countries hardest hit by the crisis. As with so many things in health, the pathways by which economic crisis and policies affect health outcomes are complex to evaluate. Moreover, most countries, including those most heavily affected by the crisis, continue to make progress in primary health care and the quality of acute care for life-threatening conditions. There are no signs that the crisis is raising cancer-related mortality rates, for example, and most countries have continued to raise survival rates for cardiovascular disease.

Nevertheless, the direction that policies have taken in some countries raises some concern. For instance, prevention is often a more cost-effective way of improving health than spending money once a disease takes root. However, prevention expenditures have been reduced since 2009 (although they only account for around 3-4% of total health expenditure). One example of the consequences is the dramatic rise in the number of new HIV cases reported since 2010 in Athens, Greece, among injecting drug users. Although opioid substitution and needle exchange programmes have expanded since the start of the outbreak, the initial response fell well short of recommended levels of access, illustrating the potential long-term impact on health and spending when highly cost-effective prevention programmes are not fully implemented. Cuts in spending on preventing obesity, harmful use of alcohol, and tobacco consumption are cases of "penny-wise, pound foolish" thinking.

Likewise, cuts to the supply of health care services and changes in health care financing arrangements are also affecting access to care. After years of steady decline, average waiting times for some operations in Portugal, Spain, England, and Ireland show a small increase. There is evidence that more people in countries such as Greece and Italy are foregoing medical care due to financial constraints, reflecting reduced household incomes, but also perhaps rising out-of-pocket costs. Low-income groups are the worst affected, although they are likely to have the highest health care needs, and they may be foregoing necessary care such as medicines or routine medical check-ups for chronic conditions. This may have long-term health and economic consequences for the most vulnerable groups in society.

Towards affordable, sustainable care

Pressures to reduce public spending are likely to persist well into the recovery phase. Given the large fiscal imbalances built during the crisis, fiscal consolidation required to bring

debt-to-GDP ratios back to sustainable levels would have to be pursued for a number of years, as stressed in the 2013 *OECD Economic Outlook*. Countries' main consolidation targets vary but generally focus on inefficient public expenditures and include savings on health care.

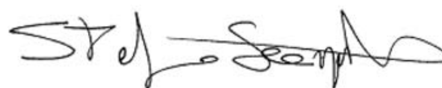
In a climate of fiscal restraint and efficiency efforts, health expenditure growth should be more aligned to a country's economic growth and its ability to raise revenue. This was not the case before the crisis, when health care funding outpaced economic growth in many countries. The crisis has pushed many countries to undertake structural reforms of their health systems, aimed at changing the incentives or the way that prices are negotiated. Examples include Greece's introduction of a new output-based hospital funding system, Italy's drive for greater competiveness in the pharmaceutical distribution market, Portugal's investment in health care performance management systems and the centralisation of pharmaceutical purchasing powers in Spain. These reforms could make important long-term contributions to the health systems' productivity and efficiency.

Governments must continue to seek clever ways by which health systems can continue to improve the well-being of patients within the new fiscal environment. Some countries are moving towards greater labour productivity by re-examining the traditional functions of general practitioners, specialists, nurses and allied health professionals. Other countries are also looking at the extent to which medical practice variation points towards ineffective or inefficient care. For example, there is a three-fold difference in the rate of caesarean sections between Iceland and the Netherlands, which have the lowest number of caesareans, and Mexico which has the highest rate. Some of this variation may be justified by clinical need, but it could also mean that women are either having unnecessary operations, or being denied care they should be getting. Evidence-based clinical pathways can improve health care productivity.

While the agenda for quality of care has now been firmly embedded in most health care systems, countries can make further gains in patient safety, thereby reducing the costs and health burdens associated with adverse events. Health care quality can also be improved by strengthening primary care systems to better manage complex conditions. The increasing prevalence of complex chronic diseases is one of the many challenges arising from ageing populations and will require constant vigilance and multidisciplinary care to prevent the onset of costly complications.

Many of the reforms implemented since the start of the crisis have had an immediate impact on public expenditure. Some have been controversial, with considerable unrest and political pressure from industry groups, and some may also have had undesirable consequences for access, outcomes and equity. For example, greater out-of-pocket costs are likely to reduce health care use among those in highest need, leading to greater inequity and inefficiency over the longer term.

In the new, more constrained, fiscal climate, the challenge for health care policy makers is to preserve quality health care coverage for the whole population while converting a system built on notions of unconstrained growth to one that is based on greater productivity and fiscal sustainability. This challenge is not new. Countries have pursued the twin objectives of efficiency and equity in health for decades. The economic crisis means that health care policy makers must swiftly and convincingly adopt a health care productivity agenda.



Stefano Scarpetta
Director for Employment, Labour and Social Affairs

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