

No. 22

International responses to austerity

Evidence scan

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This scan was produced to support the Health Foundation's work examining the implications of the NHS's 'financial gap' for quality of care. For more details, see *More than money: closing the NHS quality gap*: www.health.org.uk/morethanmoney

Health Foundation evidence scans provide information to help those involved in improving the quality of healthcare understand what research is available on particular topics.

Evidence scans provide a rapid collation of empirical research about a topic relevant to the Health Foundation's work. Although all of the evidence is sourced and compiled systematically, they are not systematic reviews. They do not seek to summarise theoretical literature or to explore in any depth the concepts covered by the scan or those arising from it.

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Executive summary

Background to the project

This evidence scan was commissioned to support the Health Foundation's work examining the implications of the NHS's 'financial gap' for quality of care.* It aimed to provide evidence on austerity and health care from a wider international perspective, focusing in particular on the following four questions:

1. What policy responses have health systems internationally taken in response to the financial crisis?
2. How effective have these measures been in achieving cost savings and efficiencies?
3. What impact have these measures had – desired or unintended – on the quality of care?
4. What can the UK NHS learn from experiences and evidence from elsewhere?

The project took a case study approach, gathering and analysing evidence for the following six countries: Canada, Denmark, Ireland, the Netherlands, Portugal and Spain. In relation to Canada, our analysis principally focused on the impact of the early 1990s financial crisis. The countries were selected to provide variation on the following criteria: scale of the financial crisis and nature of the response; comparability of the health system to the NHS; availability of evidence, determined after an initial scoping search.

A summary of the major austerity responses in the six case study countries can be found in the table on pages 6–7.

Evidence was gathered from a range of sources including searches of bibliographic databases, online and grey literature sources, and a small number of interviews with leading academics and health service researchers.

Key findings

Major changes, and in some cases significant cuts, are being made to health care without any programme to monitor or evaluate their impact

None of the countries in our sample appear to have put in place mechanisms to monitor or evaluate the impact of the budget cuts and austerity measures that have been introduced. In effect, major policies are being enacted – many of which do not have a strong evidential basis – without any commitment to understand their impact on service access, delivery, quality or outcomes, or on population health more generally.

Financial crisis presents both a stimulus for and barrier to health system reform

In key respects, financial crisis provides a window of opportunity and stimulus for reform. Several countries intensified or extended existing processes of reform, while others introduced measures that might – in other conditions – have been unacceptable or considered too sensitive to pursue. But health system reform remains politically challenging, and often highly contentious, whether there is perceived to be a 'burning platform' for change or not. Indeed, the evidence gathered on the case study countries and insights from the wider literature indicates that economic crisis also creates barriers and disincentives to bringing about change on the scale that is required – especially, but not only, financial.

* See *More than money: closing the NHS quality gap*: www.health.org.uk/morethanmoney

Short-term measures to control costs have been more prevalent than efforts at structural reform, yet are unlikely to be sustainable

Policy responses to the financial crisis have typically combined short-term cost saving measures with more strategic efforts to improve productivity and/or implement (or intensify) structural reform. Nonetheless, even where a blend of strategies is being pursued, in practice short-term measures have been dominant, or have been far more likely to be implemented. Such measures include wage restraints, increasing user co-payments, changes to pharmaceutical pricing and service reductions (eg limiting opening hours) or closures (eg wards or beds). But evidence suggests that such short-term measures tend to be eased or reversed once countries start to move out of recession.

Successful reform strategies are based on strong central leadership and constructive stakeholder dialogue and engagement

A clear message emerged from the evidence reviewed that the successful implementation of structural reform is linked to the willingness of political and health system leaders to front up reform processes and engage in a genuine dialogue with professionals and the public. The findings also point to a range of factors that appear to enable longer-term structural reform:

- Whether there is a clear vision and strategic direction for system reform already in place.
- The severity of the financial situation and imperative for immediate cost savings.
- Political preferences of the ruling party and influence of external bodies.
- The extent to which proposed changes are grounded in (or are perceived to erode) the values and principles on which the health system is based.
- Willingness and ability to make investments in alternative provision to support transformational goals, such as hospital restructuring.

The case study countries provide some, limited, evidence about the impact of austerity measures on the costs and quality of care

Our original brief for this project sought an analysis of the impact of specific austerity measures on the costs and quality of care. Disentangling the effects of multi-component austerity packages is highly challenging. Attempts to do so will always run into concerns about attributing cause and effect over long period of time, particularly in systems that are highly dynamic and which operate within wider contexts that are ever-changing. Accepting this caveat, our scan did identify some evidence of the early impact of particular strategies and approaches that have been taken. This is summarised in Table 3.1 on pages 39–40.

Summary of case studies and principal responses

Country	Context	Principal features of response
Ireland	<ul style="list-style-type: none"> – GDP fell in 2008 (by 3%), 2009 (7%) and 2010 (0.4%). – Real term spending on health per capita fell by 8.7% between 2008 and 2012. 	<ul style="list-style-type: none"> – Workforce reduced including through recruitment freeze and early retirement. Biggest reductions in general and support staff and nursing (cut of 1605 WTE nurses). – Substantial salary cuts, including starting salaries for consultants cut by 30%; GP income reduced in the region of 23%. – Introduced new charges, including across range of service for those without medical cards (two-thirds of the population). – Capital spending reduced by 26%. – Sharp reduction in pharmaceutical prices, including price of off-patent medicines reduced by 20% in 2007, 15% in 2009 and a further 40% in 2010. – Expansion of primary care teams and an increase of 25% in community care packages.
Spain	<ul style="list-style-type: none"> – GDP fell in 2009 (by 3.74%), 2010 (0.32%), 2012 (1.4%) and 2013 (1.2%). – Regional health budgets fell by an average of 5% between 2010 and 2012. 	<ul style="list-style-type: none"> – 7.1% salary cut, reduction in holiday entitlement and increases in working hours; 75% cut in training budget. – Undocumented migrants and adults aged 26 and over who have not made social security contributions excluded from receiving all but basic emergency care. – Closure of continuing care centres and out-of-hours primary care services in some regions; deepest cuts made in Catalonia, where hospital departments, beds, operating theatres and outpatient centres were closed. – Introduced new charges and co-payments, mainly for medicines; older people on higher incomes now pay 10% of the cost of medicines, others pay between €8 and €60 per month depending on their pension. – Pharmaceutical prices reduced by 25% for generics and 10-16% for branded products; 500 drugs of ‘dubious therapeutic value’ de-listed.
Portugal	<ul style="list-style-type: none"> – GDP fell in 2009 (by 2.9%), 2011 (1.3%), 2012 (3.2%) and 2013 (1.4%). – Public expenditure on health care reduced in real terms by 8.2% in 2011. 	<ul style="list-style-type: none"> – Significant increases in user charges for medicines and services, although retaining financial incentive for people to access care in primary settings; exemption threshold raised, increasing the proportion of the population exempt from charges from 45-50% to 70%. – Cuts of between 3.5% and 10% to the salaries of public sector employees earning over €1500 per month; freezes on promotion and career progression; reduction in overtime; recruitment and replacement freeze. – Target to reduce hospital operational costs by 15% between 2011 and 2013 through further acute sector reconfiguration. – Extensive focus on pharmaceutical expenditure including reductions in prices, reimbursement and state subsidies. – New system to monitor prescribing patterns and feedback data to individual doctors, as well as introduction of prescribing guidelines.

Country	Context	Principal features of response
Canada	<ul style="list-style-type: none"> – 6% real term reduction in GDP per capita between 1990 and 1992. – Average 0.2% reduction in real term health budget between 1991 and 1996. 	<ul style="list-style-type: none"> – Extensive reconfiguration of the hospital sector, including closures, mergers and centralisation of services; resulting in a 27% decrease in staffed beds in short-term care units between 1986 and 1994. – In Ontario, between 1990 and 1999 the number of hospitals reduced from 225 to 150 and 28,800 beds were closed. – Moves to shift services in community settings including cuts to hospital budgets and inpatient care. – Workforce reduced and salaries cut, including 5% wage cut in Ontario and Alberta.
Netherlands	<ul style="list-style-type: none"> – GDP fell in 2009 (by 3.67%) and 2012 (0.46%). – Health spending reduced by €5bn. 	<ul style="list-style-type: none"> – Reductions in eligibility for long-term care, and exclusion of specific services (eg basic mobility aids, IVF) from mandatory coverage. – Mandatory deductibles increased from €170 to €350 between 2008 and 2013; co-payments introduced for long-term care and physiotherapy. – Extension of market mechanisms, including extension of free pricing from 10% to 70% of all defined packages of care. – Ban on for-profit hospitals lifted in an effort to attract private investment. – Public tendering for drugs introduced. – Comparative information published on website to support consumer choice.
Denmark	<ul style="list-style-type: none"> – GDP fell in 2008 (by 0.54%), 2009 (5.8%) and again in 2012 (0.28%). – Health spending has slowed since 2008, with a small (2%) real term decline in expenditure between late 2009 and mid 2011. 	<ul style="list-style-type: none"> – Rate of salary increases slowed, redundancies made in some regions. – Eligibility limited for certain procedures and surgeries (eg gastric bypass), reimbursements restricted for dental care. – 5% cut in medicine prices in 2010; promotion of generics and parallel imports. – Initiatives to improve continuity of care, including pathway coordinators and incentivising GPs to act as care coordinators for groups of patients with chronic illness. – Restructuring of acute care, with national plan to reduce number of hospitals accepting acute admissions from 42 to 20 by 2015, supported by a DKK40bn (around €5.4bn) investment fund for building, expanding and renovating hospital facilities.

1 Study aims and context

The global financial crisis

The global financial crisis, which started in 2007, has been one of the most severe economic recessions on record and its impact is still keenly felt today. The UK is one of many countries that has seen its economy shrink, alongside a rise in national debt and escalating levels of unemployment. In the UK, public debt as a percentage of GDP rose from 46.0% in 2006 to 101.5% in 2012 (Figure 1.1).

In response, governments have made – often deep – cuts to public spending. While health has been relatively protected compared to other sectors, expenditure on health has typically been cut, frozen or its growth has slowed² (see also Figure 1.2). Despite the language of ‘no cuts’ in the NHS, real terms health expenditure was 0.7% lower in 2011-12 compared to 2009-10. Since then it has grown, but by no more than 0.2% in any year.³

The financial crisis hit at a time when health systems internationally were already grappling with the issue of how to secure future financial sustainability, with growing cost pressures driven by a host of factors including demographic trends (eg population growth, an increasing older population), the rising incidence of chronic disease, the emergence of new technologies and increasing public expectations.⁴ The scale of the financial challenge facing the NHS is considerable. Analysis by the Nuffield Trust suggests that pressures on the NHS will grow by around 4% each year to 2021/22, and that there is likely to be a funding shortfall of £28–34bn by 2021.⁵ The challenge facing the NHS (and health systems more widely) is how to maintain and improve the health of the population and quality of care, while at the same time managing increasing demand in an era of austerity.

Figure 1.1 Total government debt as a percentage of GDP¹

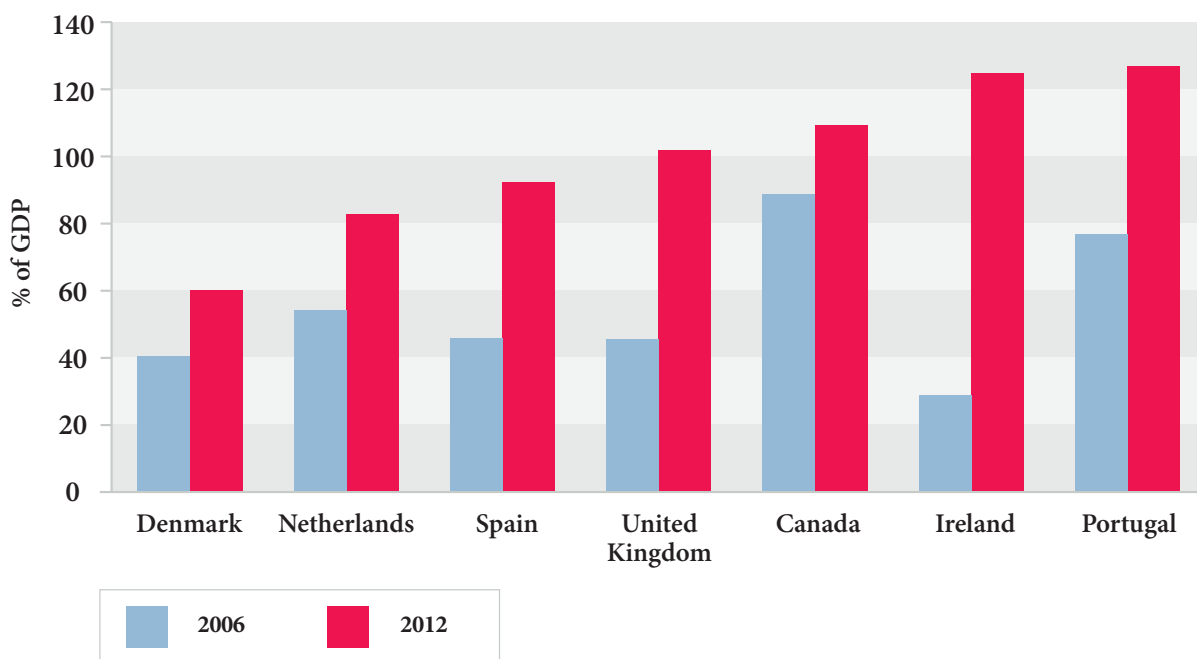
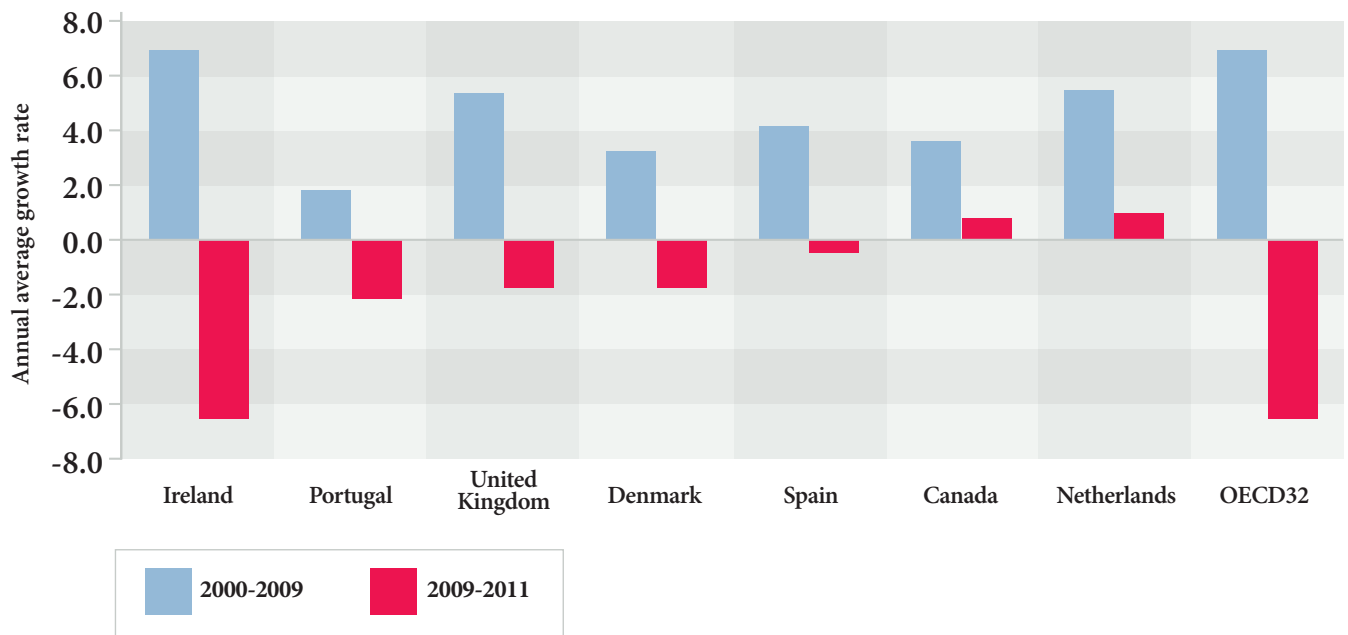


Figure 1.2 Annual average growth in expenditure on health, in real terms, 2000 to 2009 and 2009 to 2011⁶



Project aims and methodology

This research was commissioned to support the Health Foundation’s work examining the implications of the NHS’s ‘financial gap’ for quality of care.* It aimed to provide evidence on austerity and health care from a wider international perspective, focusing in particular on the following four questions:

1. What policy responses have health systems internationally taken in response to the financial crisis?
2. How effective have these measures been in achieving cost savings and efficiencies?
3. What impact have these measures had – desired or unintended – on the quality of care?
4. What can the UK NHS learn from experiences and evidence elsewhere?

Our brief was to focus foremost on cost containment or reduction measures which target the supply of care (see Figure 1.3 overleaf), while recognising that, in practice, health system responses to austerity have typically involved a blend of policies and approaches. Therefore, in what follows, we have reported on the main measures implemented, but have paid particular attention to ‘supply-side’ measures.

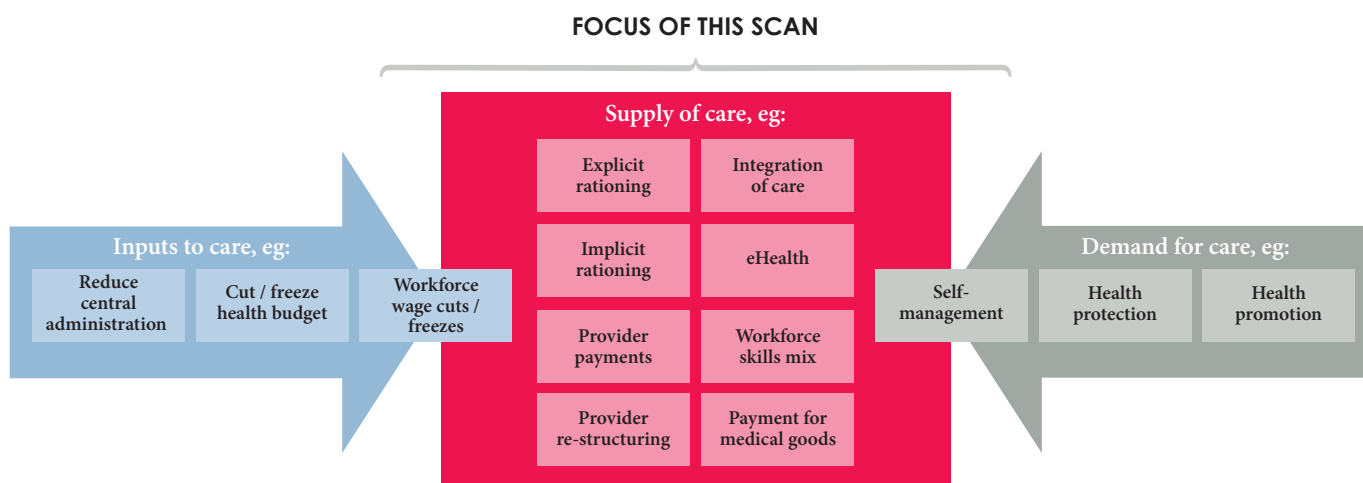
Evidence was gathered from a number of sources, including:

- structured literature searches of the following databases: MEDLINE, EMBASE, CINAHL, HMIC, Social Sciences Citation Index, ASSIA and the King’s Fund Database. The search focused on identifying empirical studies, evidence-based commentaries and review articles and news articles, published in English and since 2000 (except for Canada, where we searched from 1990 onwards). A small number of sources were translated
- analysis of major reviews^{7,8} and hand searches of their reference lists
- a small number of interviews (n=4) with academics, researchers and health system leaders in the case study countries
- web searches and grey literature from think tanks, policy and research institutes and commentators.

The evidence scan – including evidence gathering, analysis and write-up – was undertaken in an eight-week period, during July and August 2014.

* See *More than money: closing the NHS quality gap*: www.health.org.uk/morethanmoney

Figure 1.3 The main focus of the evidence scan



The case study countries

The project took a case study approach, gathering evidence on six countries selected to provide variation on the following criteria: scale of the financial crisis and nature of the response; comparability of the health system to the NHS; availability of evidence, determined after an initial scoping search (see Figure 1.4 for further details). In relation to Canada, our analysis principally focused on the impact of the early 1990s financial crisis, when substantial changes were made to the health system in an effort to reduce federal and regional public debt.

Our first sample included Germany. However, an initial review of evidence and consultation with an academic expert confirmed that the German health system had been relatively well insulated from the government’s measures to address the gap in public spending, and that there had not been an ‘austerity response’ in health care as such. Therefore, Germany was replaced with Portugal, where it was felt the degree and nature of the austerity response may contain more lessons for the UK NHS.

A comparison of the key features of the health systems included in the review, alongside the UK health system, can be found in Figures A1 and A2 in the Appendix.

Figure 1.4 Rationale for selection of the case study countries

Country	Summary rationale for selection
Canada	Mixed economy of providers; use of policies to align payments with outcomes. Opportunity to examine impact of an earlier (early 1990s) financial crisis, and more fully explore sustainability of response.
Denmark	Primary care gatekeeper role; universal coverage and care free at the point of use, predominantly publicly funded. Analogous impact of crisis/slow recovery; moves to centralise hospital services.
Ireland	Recent structural changes aiming to make the system more primary and community care driven. Significant impact of financial crisis and wide ranging response; multiple evidence sources available.
Netherlands	Use of regulated competition/plurality of providers; primary care gatekeeper role. Austerity plans introduced following financial crisis, slower recovery than some other European countries.
Portugal	National health service predominantly funded through general taxation. Significant impact of financial crisis and wide ranging response; multiple evidence sources available.
Spain	National health service predominantly funded through general taxation, GDP spend similar to UK. Significant impact of financial crisis and wide ranging response; multiple evidence sources available.

As we describe in Section 2, the case study countries have very different health systems, and also vary substantially in the extent to which they have been affected by the financial crisis. In short, we are not comparing like-for-like. Three of the countries included in our analysis – Ireland, Spain and Portugal – were amongst those whose economies were most severely affected, all going on to receive sizeable bail-out packages from the European Union and International Monetary Fund. Their responses were, more so than others in our sample, strongly shaped by external constraints, above all the conditions that each national government signed up to as a condition of receiving financial assistance. These countries took drastic measures to achieve fiscal stability, which in practice meant extensive cuts in public spending, including in health care.

By contrast, the financial challenges faced by Denmark and the Netherlands have been less immediate and extreme, and have been principally used to speed up or intensify existing processes of reform. While reductions in health budgets were seen in both countries, they nonetheless continue to have the highest share of public expenditure on health relative to GDP of all EU member states. Against these two poles, Canada represents something of a hybrid; significant cuts were made to the national and regional health budgets in the early 1990s, and some short-term cost saving measures were introduced. But the Canadian response was also strongly focused on the achievement of longer-term goals, pursued through a structural reform of hospital services.

A note about the evidence base

Before we present the outcomes of the evidence scan it is essential to draw attention to the limitations of both the evidence base and our analysis. Our aim in doing so is not to detract from the findings, but instead to frame and justify the tentative nature of our conclusions. In particular we would emphasise the following points:

- Many austerity measures have only been relatively recently implemented, and their effects are unlikely to be seen for some time. Despite a comprehensive search strategy, we were able to find very little robust evidence available on the impact of austerity responses, and it does not appear that any of the countries concerned are systematically monitoring the impact of the changes they have introduced.
- Health system responses have comprised a blend of different measures, and this prevents simple conclusions about the impact of a particular approach or intervention. Disentangling effects is difficult, if not impossible.
- It is often difficult to distinguish changes made in response to austerity from broader policies and reforms which pre-date the financial crisis, especially as austerity has been used by some governments as an opportunity to intensify or extend existing programmes of reform. This also complicates the task of describing the impact of ‘austerity responses’.
- Some of the responses to the crisis would have been implemented in its absence – there is no counterfactual against which impact can be assessed. This is a further reason why care must be taken in drawing any direct lines between crisis, responses and impacts.

A final important point is that, in analysing impacts, a distinction should be made between ‘pure’ cost savings and increasing health system efficiency.⁸ The former may be desirable (even imperative) in the midst of a financial crisis, but may also have negative impacts on other important health system goals – such as the equity, quality and outcomes of care.

2 The case studies

Introduction

The following section presents the six country case studies:

- Ireland
- Spain
- Portugal
- Canada
- The Netherlands
- Denmark

For each country, we have looked at:

- the financial crisis
- what was the main policy response?
- what has been the impact on costs and outputs?
- what has been the impact on quality of care?

Ireland

Ireland: The financial crisis

Ireland was severely hit by the financial crisis and the impact continues to be felt today. In real terms, GDP growth rates fell in 2008 (by 3%), 2009 (7%) and 2010 (0.4%). The Irish economy contracted by 10.8% between 2008 and 2010, and unemployment increased from 4.8% in 2007 to 14.2% by January 2012. Emergency legislation was introduced in February 2009, leading to substantial tax increases and cuts in social welfare support and public sector pay. The crisis resulted in Ireland entering into an international bailout agreement, worth €85bn, overseen by 'the Troika' (the European Union, the European Central Bank and the International Monetary Fund). In November 2010, the government unveiled a four year austerity plan – the National Recovery Plan – outlining deep cuts to public spending, to help it meet the terms of the international rescue deal. The plan was front-loaded with €6bn of spending cuts and tax rises being implemented in 2011 alone.

In health care, spending reduced sharply in 2010 and 2011, with most of the reductions achieved through cuts in wages and fees paid to professionals and pharmaceutical companies, and through a reduction in the size of the workforce. Real terms spending on health per capita fell by 8.7% between 2008 and 2012. Since then, health spending has started to increase, but at a very modest rate.⁹

Ireland: What was the main policy response?

The austerity response in health care has been implemented against a backdrop of wider reform. Since the early 2000s, the Irish health system has been subject to a continuous process of review and change, culminating in major structural reorganisation in the middle of the decade.¹⁰ A key aim of reform has been to make the system more primary care-driven, and better integrate primary, community and hospital care. The system has also faced longstanding challenges in relation to equity, with both public perception and published evidence pointing towards a two-tier structure. Differences in entitlements and access can be seen between publicly and privately-funded patients and around one in five of the population is covered by neither a medical card (entitling them to use most services free of charge) nor private health insurance.¹¹

In 2011, the new coalition government announced far-reaching plans for reform including free GP care for the whole population by 2015 and the creation of a Universal Health Insurance system by 2016. The Irish government

is also planning major reform of the acute sector, including the creation of hospital trusts and a shift from a historical activity-based allocation to a 'money follows the patient' funding model, intended to create stronger incentives for delivering quality and safety goals.

As with many of the countries covered in this report, it is difficult (and indeed may not be desirable) to distinguish the 'austerity response' from other reforms happening at the same time, seeking greater efficiency or cost containment in health care. What follows, therefore, covers elements of both.

Altering workforce pay, benefits and working conditions

There was a freeze on recruitment and promotion; non-replacement of staff on leave; voluntary redundancy and early retirement. By the end of 2010, the number of whole time equivalents (WTE) in the public health service was 107,972, a reduction of 3,798 since March 2009. The biggest reductions have been seen in general and support staff (-9.58%), nursing (-4.21%) and management and administrative staff (-3.71%). This amounted to an absolute cut of 1,605 WTE for nurses, the highest out of any category.¹²

A 5-15% salary cut was introduced across the public sector, expected to generate annual savings of over €1bn. In health specifically, starting salaries for consultants were cut by 30% in 2012. The recruitment freeze in nursing was lifted in 2013, but starting pay for graduate nurses was cut by 20%. There have also been cuts to pension benefits.

The number of staff at Ireland's national Health Service Executive (HSE) – responsible for the provision of health care and personal social services – has been reduced by over 12,200, or around 10%,¹³ and additional efficiency measures have been implemented within HSE, intended to achieve further savings of €90m.

There have also been cutbacks in education and training.

Cost sharing

Increases in user fees (summarised in Figure 2.1) include the following:

- For those not covered by a medical card (approximately two-thirds of the population), user charges increased across a range of services including inpatient day services, emergency care and deductibles for the drugs payment scheme (DPS). Irish residents registered with the DPS pay a maximum amount per month for approved medicines and appliances for use by themselves and their family.

- For medical card holders, a €0.50 charge for a prescription was introduced in 2010, this has subsequently increased to €2.50 (up to a maximum of €25 per month per person or family).
- Limits were introduced on dental, optical and aural entitlements. This included a cut of €30m on dental care for those on medical cards.
- The Health Levy – described as a surrogate income tax¹⁴ – was doubled to 4% on earnings up to €75,063 and 5% over this amount.

Priority setting and rationing

Income limits were introduced for medical cards for the over 70s; the effect was that the wealthiest 3.4% of over 70s lost their medical card. At the same time, medical cards were extended for low income groups because of rising unemployment and falling incomes. Since 2008, half a million additional people have been issued a medical card or a GP visit card (the latter entitling the holder to free GP care only).

Changing care providers' structure, ownership and/or payment

Fees paid to contracted professionals (eg GPs and other health professionals) were reduced. The most recent cuts under FEMPI (Financial Emergency Measures in the Public Interest) legislation have seen GP income reduced in the region of 23%.¹⁶ Pharmacy fees have been cut by between 24% and 34%.

Capital spending reduced by 26% from 2009 onwards.¹²

Reducing the cost of medical goods

An agreement was reached in 2006 between the HSE and Irish Pharmaceutical Healthcare Association to reduce the price of off-patent medicines with a generic equivalent by 20% in 2007, 15% in 2009 and a further 40% in 2010. Wholesaler margins and pharmacy mark ups have also been cut substantially.¹⁷

Changing modes or models of care

The financial crisis accelerated the trend to provide more care in primary and community settings with the expansion of primary care teams and an increase of 25% in community care packages.¹⁸

Figure 2.1 Changes to statutory entitlements in Ireland, 2008-2012¹⁵

Year	Category I	Category II
2008	None	<ul style="list-style-type: none"> – All: increase in emergency department (ED) attendance charge (without a referral) to €66 (from €60); increase in public hospital inpatient charge to €66 per day (from €60) – Drugs Payment Scheme(DPS): increase in monthly deductible to €90 (from €85)
2009	Automatic entitlement to medical cards removed from people over 70 years of age and replaced with a means test.	<ul style="list-style-type: none"> – All: increase in ED attendance charge (without a referral letter) to €100 (from €66); increase in public hospital inpatient charge to €75 per day – DPS: increase in monthly deductible to €100 – Tax relief: on unreimbursed medical expenses restricted to the standard rate of tax (20%)
2010	<p>General Medical Service scheme: introduction of €0.50 charge per prescription item (October)</p> <p>Dental Treatment Services Scheme: dental entitlements cut (April)</p>	<ul style="list-style-type: none"> – DPS: increase in monthly deductible to €120 – Treatment Benefit Scheme: dental and ophthalmic entitlements cut
2011	None	None
2012	None	<ul style="list-style-type: none"> – DPS: increase in monthly deductible to €132 – Treatment Benefit Scheme: aural entitlements cut – Long Term Illness Scheme: extended entitlement to free GP care (not yet implemented and possibly delayed)

Category I is people with medical cards, category II is people without medical cards.

Ireland: What has been the impact on costs and outputs?

The measures taken in Ireland have, in some cases, achieved significant cost savings, although whether they equip the health system for longer-term cost containment and efficiency is debatable. Since 2008, the health service budget has reduced by €3.3bn, and additional savings of €619m are required in 2014¹⁹ – this is against an overall annual budget of around €13.5bn. Per capita annual health expenditure decreased by 6.6% between 2009 and 2011, largely attributed to cuts in wages and fees, and in areas such as pharmaceutical spending.²⁰ By 2012, there were 941 fewer beds in public hospitals compared to 2008.²¹ Specific evidence includes:

- the reduction of wages by 5–15% in the December 2009 budget resulted in cost savings of €659m in health¹²
- the cost of drugs in publicly funded health schemes decreased by €434m between 2009 and 2014²²
- the cost of the Drugs Payment Scheme more than halved from €311m in 2008 to €127m in 2012²² – although see section below on Equitability for a discussion of the impact on patients.

Between 2008 and 2012, evidence points to a system managing to do ‘more with less’ – with more patients seen in inpatient, day case and outpatient appointments, increasing emergency admissions and a slightly reduced length of stay, alongside reduced budgets and staff numbers. This has been taken by some commentators as evidence of a trend towards greater productivity during this period.²³ However, more recent data from HSE suggests that activity levels have fallen in all areas – apart from emergency admissions – despite increasing demand (eg because more people have become eligible for publicly funded care). Also as we note below (see section on ‘Timeliness’ on page 16), waiting times started to increase from late 2012 onwards, and several commentators have suggested that this is indicative of a system under increasing strain.¹⁶

There is also evidence that some measures are driving up costs. For example, in 2013 there was a €260m increase in spending on agency staff, despite this being explicitly targeted as an area for reducing spending in the 2010 budget (although it should be noted that reductions in agency costs were made in 2011 and 2012). There is also a risk that cuts in areas such as home care and raising user charges for prescription drugs could be a false economy, if people end up in hospital due to a lack of community support or because they have not taken essential medicines.²¹

The Irish response has, in large part, been concerned with taking money out of the system rapidly, hence the focus on areas where immediate cost savings can be achieved (eg staff numbers and salaries). In contrast to Portugal, the changes implemented have so far fallen short of structural reform of the kind that might set the health system on a course towards longer-term financial sustainability. While the opportunity to do so has not necessarily been missed, and the establishment of a system of universal health insurance is now underway, the question is whether the system will have the capacity and resources to combine the demands of short-term cost containment and longer-term reform:

‘Austerity has forced the Irish Government to scrutinise all healthcare activities and costs. This is not a bad thing. However, the depth of cuts needed means that easy cost-saving measures have now been exhausted. Structural reform is required to manage costs down further, such as moving much of the care for chronic disease out of hospitals and into primary care settings. Yet this takes time and the governance capacity to do this is absorbed with trying to hold the system together and transition to universal care. Although austerity can produce windfall gains through reducing costs and galvanising change, its benefits dissipate over time.’¹³

Moreover, cost containment measures may themselves be acting as a barrier to sought-after reforms. Despite a longstanding goal for more care to be provided outside of hospital settings, the re-allocation of resources to primary and community services has so far not been achieved. Instead, this has been an area targeted for spending cuts: since 2010, €10m has been axed from the budget for personal assistant services, with a further €1.7m of savings made by reducing funding for home care packages. The Irish Medical Organisation has been critical of a perceived gap between the rhetoric of system reform and the reality of implementation:

‘Despite the known advantages of Primary Care no new funding has been provided to support the Government’s Programme of reform for Primary Care and in fact any funding provision made has been withdrawn and diverted back to address shortfalls elsewhere in the system.’¹⁶

Ireland: What has been the impact on quality of care?

There is a broad consensus among researchers and commentators that the austerity cuts have had an impact on the quality of care in Ireland, with most attention focused on waiting time performance and out-of-pocket costs for patients. The conclusion of The Resilience Project, exploring the impact of the economic crisis and subsequent response on health care, was that core dimensions of quality have not been substantially affected, although the project did not explicitly set out to address this issue and the data cited is very limited:

*'A concern would be that given the financial and human resource reductions, an effort to maintain services could be traded off with a decline in quality. However, a number of HSE performance metrics suggest that the quality of services has improved significantly in recent years. Measures of quality that focus on cervical cytology screening, symptomatic breast cancer services and MRSA appear to indicate good outcomes.'*¹²

Timeliness

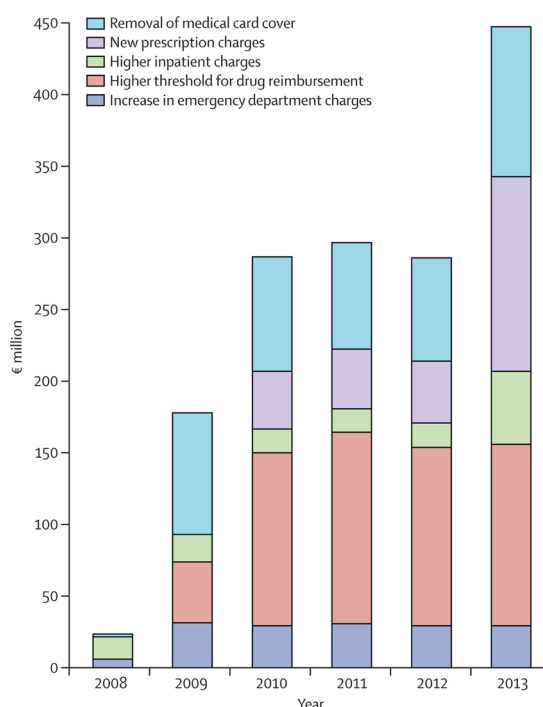
Since 2011, the government has made a commitment to address the most persistent problems in the health system, including waiting times.²³ Data from 2011 to 2013 show progress against this commitment, including a 34% reduction in trolley waits in emergency departments, and a reduction in the number of people waiting for inpatient and day case hospital treatment. Figures for November 2012 to November 2013 are less positive, showing that more people are waiting at every major measurement point (0–3 months, 3–6 months and 6–12 months). Over the same period, there has been a trebling of those waiting more than 12 months for treatment,²¹ and between December 2012 and April 2013 the total number of people waiting for six months or more for hospital inpatient or day case treatment almost doubled.¹⁶

Specific examples of how spending cuts are impacting on delivery of care have also been reported. For example, in August 2011 the *British Medical Journal* reported on the case of the Mid Western Regional Hospital in Limerick, which had closed 25 acute care hospital beds in response to a €21m in-year overspend. The hospital had already experienced a sharp rise in demand after the closure of a smaller acute hospital in the region two years previously and, even before the latest cutbacks, almost 20% of patients were waiting between 12 and 24 hours to be admitted through the unit's emergency department.²⁴

Equitability

The impact of the cuts on equitability and access to care is mixed. On the one hand, the government has extended financial protection for low income groups by increasing eligibility for medical cards, with more than half a million more people now qualifying for free care. But various changes have also resulted in increased out-of-pocket costs for patients, leading to concerns about the prohibitive effects on access to care. Critics have argued that the costs of care have not been saved, but rather have been pushed onto the public. By 2013, every person in Ireland was paying around €100 in additional costs each year for accessing care and prescription drugs (Figure 2.2).¹³

Figure 2.2 Estimates of cost shifting from the government to households, 2008-2013¹³



Burke et al report that the shrinking cost of the Drugs Payment Scheme – reduced from €311m in 2008 to €127m in 2012 – has been driven by declining numbers of people using the scheme due to hefty increases in the reimbursement threshold.²¹ In 2008, people were reimbursed for drug costs above €85 per month, but by 2013 the threshold was €144 per month. They conclude that it is, in effect, *'a direct transfer of costs from the State onto patients.'* Anecdotally, the Irish Medical Organisation reported that the combination of rising demand and a reduction in income in the region of 23% is limiting GPs' ability to carry out *pro bono* services such as phlebotomy, warfarin monitoring and blood pressure monitoring.¹⁶

Spain

Spain: The financial crisis

When the global financial crisis hit, Spain experienced one of the largest and longest declines in GDP in Europe. GDP experienced negative growth in 2009 (-3.74%), 2010 (-0.32%), 2012 (-1.4%) and 2013 (-1.2%). Unemployment increased such that – by the first quarter of 2013 – 27% of the labour force were unemployed, including over half of under 25s.^{25,26}

In April 2012, the Spanish government passed the Royal Decree Law (RDL), entitled ‘Urgent measures to guarantee the sustainability of the National Health System and improve the quality and safety of services’. The measures contained in the RDL have three main stated targets: increasing financial resources for the system, controlling expenditure, and increasing efficiency.²⁷ In July 2012, to help Spain re-capitalise its banking system a financial package of up to €100bn was agreed, overseen by the Troika.

Public funding for health care has been substantially reduced, despite Spain already having one of the lowest public expenditures on health care relative to its GDP in Europe. Total health spending fell by 10.6% between 2010 and 2013, equivalent to €150 per capita.²⁶ The central government health budget decreased by 13.7% in 2012 and 22.6% in 2013. Cuts were also made at the regional level, comprised of 17 autonomous communities – where health planning, financing and regulation is controlled – although these were less severe. Budgets fell by an average of 5% between 2010 and 2012, although the extent of cuts varied significantly from region to region.²⁶

Spain: What was the main policy response?

The Spanish response has been multi-faceted, encompassing a wide range of cost saving and containment measures. Legido-Quigley et al describe three most fundamental changes as the exclusion from cover of undocumented immigrants, increasing co-payments and privatisation of services.²⁵ While some regions have resisted centrally imposed austerity measures, others – most notably Catalonia and Madrid – have gone further.

Commentaries on the Spanish response have been the most negative and critical of all the six countries included in our analysis. Criticisms have been levelled at the perceived lack of a strategic and coordinated response; the use of a top-down approach and failure to engage key stakeholders; and the lack of an evidence base supporting many of the measures introduced. On these issues, the following views have been offered:

‘Overall, measures have been poorly coordinated, that is, isolated, incremental, and opportunistic. There was neither a strategic approach nor a common framework for action.’²⁸

‘These changes and measures have been enforced by means of parliamentary decrees and governmental regulations in what can be argued to be a strictly top down approach with no room for either professional or public participation. There is growing dissatisfaction among professionals for not being invited to participate in decision making processes concerning cuts.’²⁸

‘Although reform is necessary, some suggest that measures to date have lacked evidence-based analysis (as exemplified by the privatization controversy). With exceptions, Spain has not used the crisis as an opportunity to increase efficiency and quality, rationalize and reorganize health services, increase productivity, or regain public trust.’²⁶

There has been considerable opposition to the government’s austerity response – both in general and within the health sector more specifically.²⁶ Concerns have been voiced from many quarters that the changes fundamentally alter the principles underpinning Spanish health care, especially those of equity and social cohesion, and yet have been enacted without the support of several of the major groups who would be involved in their implementation, or consultation with regional authorities.²⁵ As we discuss in more detail below, some areas have resisted the changes or found ways around them, which may have ultimately diminished their potential impact on cost reduction.

Altering workforce pay, benefits and working conditions

One of Spain’s major policies for reducing expenditure has been to cut salaries and alter labour conditions of health sector workers, with measures taken at both regional and national levels.²⁷ There has been a 7.1% salary reduction (roughly equivalent to a month’s pay), a reduction in holiday and union representation hours, and an increase in the working week from 35 hours to 37.5 hours for GPs and primary care nurses.

Other actions include restrictions on overtime, cuts to professional training (in the region of 75%), freezing promotions, reducing on-call hours and non-replacement of posts following retirement.²⁷ Consequently there has been a drop in recruitment in all autonomous communities.²⁶ In Catalonia, where the

cuts have been deepest, the local government imposed an additional 3% cut to the salaries of 40,000 health professionals in the region's university hospitals and primary care centres, on top of the 5% wage reduction imposed by the national government.²⁹

Priority setting and rationing

The RDL contained provisions to restrict who is entitled to health care. Before it was passed, all residents were entitled to public health care, irrespective of origin and status. Now, the RDL links entitlement to the contributions an individual has made to the system.²⁷ People over the age of 26 who have not made any social security contributions and undocumented immigrants are excluded by this law from receiving all but basic emergency care, with some exceptions (eg pregnancy, under 18s and accidents). The RDL also has provisions to restrict the use of free health services by foreign visitors.²⁷ As McKee et al comment:

*'The reforms have fundamentally reworked the healthcare system from a basis of entitlement based on residence to a system where entitlement is based on employment.'*³⁰

It is estimated that around 873,000 non-residents (likely to include migrants no longer living in Spain) lost their entitlement to comprehensive care as a result of the changes.³¹

The RDL also proposes that cost-effectiveness is to be considered in determining programmes and services covered by public funds. Writing in 2013, Gallo and Gene-Badia comment that:

*'This appears to be a step forward in the use of explicit rationalisation criteria but to date little has been done in this respect.'*²⁷

More generally, budget cuts have led to reduced provision and, in some cases, service closures. Much of the evidence reported is for Catalonia and it should be borne in mind that the austerity response in this region represents the extreme end of the scale. Examples of the reduced provision include the following:

- Figures from June 2012 show that continuing care centres have been closed in at least eight regions and some have also closed out-of-hours primary care services.²⁶
- In Catalonia, cost containment measures implemented in 2011 included: closure of departments and hospital beds (nearly one in four hospital beds were closed in the summer of 2011); closure of operating theatres; summer closure of

around 40 primary care centres (around 10%); closure or reduction in opening hours at 100 outpatient centres; ending of non-urgent evening operations (a measure originally adopted to reduce waiting lists); closure of primary care out-of-hours services in rural areas, with telephone assistance and hospital emergency services substituting for this.^{25,28} From April 2010, there was also a reduction in non-urgent care including eye surgeries and hip and knee replacement.⁸

- Also in Catalonia, in 2012 there was a 2% reduction in tariffs for mental health care, 5% reduction in activity for specialised mental health care and 10% cut in the budgets for community mental health centres. Care delivery contracts were reduced by 7% and specific programmes by 8%.³² This included, for example, a support programme to provide independent living for persons with severe mental illness which was discontinued in 2012.
- Other more explicit prioritisation strategies that were announced in the Catalan Plan (although it is unclear the extent to which these have since been implemented) include: prioritisation strategies for clinical practice; improving the quality and effectiveness of pharmaceutical prescribing; interventions to promote responsible use of health services among the population; and introduction of a waiting list management system and prioritisation criteria.⁸

Cost sharing

Co-payments for some services have been increased, including the following:

- Pensioners now have to pay for drugs: those on higher incomes pay 10% of the cost of medicines, and others pay between €8 and €60 per month depending on their pension.
- People in employment now pay up to 60% more for their medicines, depending on their income, with those earning less than €18,000 annually paying 40% of the cost of medicines.
- Catalonia and Madrid have levied an additional charge of €1 per box of drugs delivered at the pharmacy, with a ceiling of €61 per year per person.
- Co-payments have been extended to prosthetics, dietary products and non-urgent ambulance trips (for example, people with disabilities now pay €5 for non-urgent ambulance trips).
- Wider measures targeting the welfare system have included reductions in dependency payments and the elimination of social security for caregivers.²⁵

Reducing the cost of medical goods

As with many of countries included in this analysis, reducing expenditure on pharmaceuticals has been a key part of Spain's austerity response. In 2010, a wave of mandatory price cuts were introduced, reducing the price for generics by 25% and for branded drugs by 10-16%.³³ There has been a reduction in the national health service listing of approved pharmaceuticals, with almost 500 drugs of 'dubious therapeutic value' removed from the national list.²⁶ The RDL also introduced a new system of prescribing by active pharmaceutical ingredient, making it easier for generics to be prescribed instead of brand name formulations.

Changing care providers' structures, ownership and/or payment

Moves to outsource management of certain services and to develop public-private partnerships pre-date the financial crisis, but have intensified in recent years – at least in some parts of the country. For example, in Madrid and Catalonia, authorities have made it easier for private companies to run hospitals. In December 2012, the government of Madrid agreed plans to privatise six recently built hospitals, outsource non-health services at the remainder of the hospitals in the region and privatise 10% of primary health services. Moves to privatise hospital and ancillary services have been proposed in other regions, all of which are governed by the conservative Popular Party.

Spain: What has been the impact on costs and outputs?

The various cuts to prices, budgets and workforce expenditure have undoubtedly reduced Spain's overall health care expenditure and made it possible to balance public budgets. There is also evidence of cost savings, especially in terms of pharmaceutical spending. Annual pharmaceutical expenditure had fallen by 17.8% by October 2012, and by more than 22% once increases in co-payments had come into force. The number of prescriptions written fell by 6.12% in 2012, and the average cost per prescription fell by 6.54%.²⁶ The total saving on pharmaceutical spending was estimated to be about €1.2bn in 2012.³² Bosch et al comment that:

*'reforms, such as encouraging generic drug prescription and ceasing public support for dozens of medicines of uncertain value, are well-founded and may improve efficiency and reduce costs.'*²⁶

Measures targeting welfare spending in the areas of dependency payments and social security for caregivers have resulted in government savings of €599m in 2012,

and estimated savings of €1.1bn in 2013 and €571m in 2014.²⁶ It is the Spanish government's expectation that cancelling the health cards of the country's 873,000 undocumented migrants will save around €500m each year, although we were unable to find any evidence to show whether these savings were being realised.

There is less evidence available on outputs, and the only data we identified relates to Catalonia, where cuts to services have been most severe. In this region, decreases have been reported in both primary and secondary care,²⁷ including:

- primary care visits – 5.5% reduction in 2010, 3.7% reduction in 2011
- hospital emergency visits – 4.3% reduction in 2010, 1.4% reduction in 2011.

There is no evidence that the decreasing use of primary care has had a knock-on impact on the hospital system, although the data reported are now three years old. Between 2009 and 2011, there was no significant change in either the number of people admitted with ambulatory care-sensitive conditions or non-scheduled hospital admissions.²⁷

The financial crisis has also led to unemployment among Spanish doctors, with the number of out-of-work doctors reaching 1,000 for the first time in February 2010, and rising to more than 2,000 by April 2012.³⁴

Evidence points to problems in terms of both the implementation and sustainability of the changes, with objection to the reforms playing a large part in this. Some regional authorities and numerous public hospitals have found loopholes to avoid introducing the salary cuts contained in the RDL. Some regions have also appealed to the Constitutional Court, questioning the legal bases of some parts of the RDL.²⁷

A 2012 news piece in the *British Medical Journal* reported that 1,300 Spanish doctors had promised to continue treating immigrants without official papers, calling themselves 'conscientious objectors'.³⁵ Five of the regional authorities run by the opposition party have refused to implement the policy, contending that it is inequitable, hazardous and possibly unconstitutional.²⁶ Concerns have been raised that removing cover for undocumented migrants could result in a public health crisis, with references frequently made to the experience in Greece, where there have been dramatic increases in HIV, tuberculosis and malaria rates since the government made swingeing health care cuts.²⁵

Other changes have been reversed, most notably plans by the government in Madrid to outsource management and services of six local hospitals³⁶ – a move that thousands of health professionals mobilised against, including two months of mass protest, four days of general strikes and the resignation of 322 health care managers.²⁵

Spain: What has been the impact on quality?

Despite there being a relatively large amount of literature on the austerity cuts in the Spanish health system, few studies report data on their impact on quality of care. Most of the evidence we found has focused on trends in patient experience and waiting times.

Patient experience

A key source of data on user satisfaction with health services in Spain comes from the Health Barometer survey published by the Ministry for Health, Social Services and Equality. Over the period 2000 to 2011, the overall rating given by patients of their care has increased from 5.94 to 6.59 (on a 1-10 scale). Over the same period, the proportion of service users who assessed the system as ‘good’ or ‘very good’ increased from 66.8% to 73.12%. Between 2008 and 2011 there was a slight increase – from 6.29 to 6.59, with 1 being very unhappy and 10 being very happy – in responses to the question: ‘In general, are you happy or unhappy with the way the public health care system works in Spain?’

Since the austerity cuts, the proportion of people responding to the Health Barometer survey who think health services have worsened has increased, although only marginally:

In your opinion, has each of the following health care services improved, become worse or remained the same in the last five years: primary health care, hospital care and specialist consultations?	2008	2011
% reporting that primary health care has worsened?	8.79	10.71
% reporting that hospital care has worsened?	8.6	10.52
% reporting that specialist consultations have worsened?	9.5	11.83

Data from other sources suggest that the cuts may be more substantially affecting frontline patient care. For example, complaints to the Spanish Ombudsman rose from 595 in 2011 to 1,674 in 2012. Complaints relating to access issues have increased in particular.³⁷ Research involving patients in 15 countries internationally (including UK, USA, Canada and Germany) compared views on the quality and degree of improvement of their health system gathered in an initial survey in 2008, and again five years later in 2013.³⁸ The authors conclude that, ‘it is evident that respondents in Spain have seen a stark degradation in their healthcare services as they take last place in every category.’ 53% of Spanish respondents felt that overall access to health care had worsened, while only 16% reported that it was better. Comparative results for the various questions probing aspects of patient experience are shown in Figure 2.3 overleaf.

Timeliness

One of the most extensively documented impacts has been on waiting times:

- There was a sharp increase in waiting times between mid 2012 and mid 2013, with the number of people waiting for surgery increasing by 6.4% and the average wait increasing from 76 to 100 days.³⁷
- In 10 regions, surgical waiting lists increased by 125% between December 2010 and June 2012, and patients waiting more than the established 180 days for cardiac surgery, knee and hip prostheses and cataracts increasing by 178%.²⁶
- In Catalonia, the Minister of Health announced that the maximum six-month waiting time for the 14 most common procedures would be extended to 12 months for certain operations and that a prioritisation system would be introduced to manage waiting lists on the basis of clinical criteria.

Figure 2.3 Findings from a baseline (2008) and follow up (2013) international survey of patients in 15 countries, reported changes in patient experience³⁸

Patient Experience	BETTER INFORMATION SHARED WITH ME	MORE OPTIONS GIVEN TO ME FOR TREATMENT	BETTER QUALITY	BETTER COORDINATED	BETTER LEVEL OF CARE	MORE SENSITIVE TO MY NEEDS	SPEEDIER	TOTAL
International Average	+19	+16	+13	+12	+11	+12	+8	+91
Argentina	+37	+36	+34	+33	+30	+34	+37	+241
Australia	+27	+26	+18	+19	+18	+17	+7	+132
Belgium	+27	+34	+23	+23	+23	+16	+17	+163
Canada	+19	+16	+12	+14	+12	+12	0	+85
France	+12	+16	+7	+8	+7	+6	-9	+47
Germany	+15	+18	+14	+14	-5	+9	+8	+73
Great Britain	+18	+13	+9	+11	+6	+13	+8	+78
Hungary	+12	-2	-6	-7	-9	-9	-16	-37
Italy	+2	0	-5	-4	-11	-4	-6	-27
Japan	+27	+31	+22	+25	+25	+26	+22	+178
Poland	+28	+18	+28	+15	+15	+16	+13	+133
South Korea	+45	+44	+48	+42	+58	+44	+51	+332
Spain	-14	-27	-24	-25	-27	-23	-24	-164
Sweden	+6	+4	0	-8	+1	+5	0	+8
United States	+22	+20	+15	+18	+15	+15	+14	+119

Portugal

Portugal: The financial crisis

Like Ireland and Spain, Portugal has been one of the EU countries most severely affected by the financial crisis. GDP experienced negative growth in 2009 (-2.9%), 2011 (-1.3%), 2012 (-3.2%) and 2013 (-1.4%). In 2008 the government deficit was 2.9% of GDP, reaching 9.4% the following year, alongside an unemployment rate of almost 10%. In May 2011, Portugal received a €78bn bailout, overseen by the Troika. This included substantial cuts to public expenditure being agreed as a condition of financial assistance, as outlined in a Memorandum of Understanding (MOU). The MOU contained more than 50 measures and actions pertaining to health care, with a goal to save €664m in this sector alone. A major consequence was a dramatic cut in public spending on health care, which reduced in real terms by 8.2% in 2011.³⁹

It is widely held that the measures outlined in the MOU were not only focused on short-term cost reduction and containment goals, but also sought longer-term reform of the health service to address persistent challenges. For example, one leading commentator noted that:

‘There is the wish to build mechanisms for future control of health care expenditures in the public sector. These mechanisms involve performance assessment and benchmark, the use of competition forces in public procurement, and the introduction of best practices in transparency and information in the evolution of the National Health Service. Several of the measures are important and deserve to be implemented, even outside the current crisis setting.’⁴⁰

The challenges faced by the health service prior to 2011 are, therefore, important to understand. Most notably, the Portuguese health system has been characterised by a historic over-use of emergency services. The level of attendance at emergency departments in Portugal is about twice that of the United Kingdom; whereas the number of outpatient contacts is 4.5 per person per year, compared to an EU average of 6.2.⁴¹ In an attempt to tackle this, even before austerity measures were introduced, there has been a strong policy focus on enhancing primary care, with major reforms introduced in 2005 including the creation of multi-disciplinary Family Health Units (USFs).

Other important trends include:

- ongoing reconfiguration of the hospital sector, with the number of public hospitals falling from 634 in 1970 to 77 in 2008. The early 2000s saw substantial merger activity, with the creation of ‘hospital centres’ – geographically distinct services, managed as a single unit⁴²
- longstanding emphasis on tackling waiting lists. The most recent initiative, SIGIC (The Integrated Management System for the Surgery Waiting List) was introduced in 2004 and in its first five years achieved a 28% fall in average waiting times, with the proportion of people waiting longer than the maximum guaranteed time dropping from 54% to 15%.⁴³

Portugal: What was the main policy response?

The policy response in Portugal has been extensive and virtually no part of the health system has been left untouched.

Cost sharing

While the Portuguese public already had one of the highest burdens of out-of-pocket payments, the MOU made further changes:

- There were significant increases in user charges for emergency and outpatient services, medicines and some vaccinations – but a financial incentive for people to use primary care was retained by charging lower fees for care accessed in these settings (see Figure 2.4 overleaf). The government’s main stated intention of increasing user charges was to manage demand, not generate increased revenue.⁴⁰
- At the same time the exemption threshold for low income groups was increased. Currently around 70% of the public are exempt from user charges, up from 45-50% prior to the reforms. A cap on the maximum charge per episode of care of €50 was also introduced.
- There was an end to free transportation for non-urgent treatment and a 65% reduction in the budget for publicly funded patient transportation services.⁴⁴

Altering workforce pay, benefits and working conditions

In 2014 and 2015, cuts of between 3.5% and 10% are being made to the salaries of public sector employees earning over €1,500 per month.

In health care there are also freezes on promotion and career progression, reduction in overtime and a recruitment and replacement freeze.

Priority setting and rationing

Certain services have been removed from the system of coverage for public sector workers (ADSE) including occupational injury and ill health, unconventional therapeutics and cosmetic surgery.⁴⁵

Changing care providers' structure, ownership and/or payment

The MOU created an impetus to speed up existing processes of acute sector restructuring through closures, mergers and centralisation. Targets were set to reduce hospital operational costs by 15% (€200m) between 2011 and 2013, on top of cost savings expected to be achieved through staff reductions and salary freezes.³⁹

The MOU gave less explicit attention to primary care than other services, although it did include a recommendation to give primary care and general practitioners a stronger role, including a leading role in the integrated management of illness, health promotion and management of clinical referral. There was also a clear stipulation to create more Family Health Units, move some outpatient services to these units and create a more even distribution of GPs across the country.⁴⁰

Reducing the cost of medical goods

There was an extensive focus on cost containment in relation to pharmaceutical expenditure including price reductions, promotion of generics, reduction of state subsidies for some over-the-counter medicines, reduction in pharmacy mark-ups and reduction in reimbursement of some medicines (including antidepressants and antipsychotics).⁴⁶

Regulation, monitoring and/or accountability measures

A monitoring system was introduced that feeds back information on prescribing volume and value to individual doctors, alongside the introduction of prescribing guidelines.

Introduce or increase market mechanisms

The reforms included efforts to increase competition among private providers (eg using procurement mechanisms) to reduce public expenditure, and tighter control over public-private partnership contracts.

Portugal: What has been the impact on costs and outputs?

Evidence of impact (on costs, outputs and quality) is patchy at best – it is not being gathered routinely, and there are no systematic efforts to monitor or evaluate the consequences of the reforms. In terms of cost containment, pharmaceutical policies do appear to have generated significant savings for the health service and for patients. Spending on pharmaceuticals reduced by 20% in 2011, while the market share in generics (although only in outpatient care) increased two-fold between 2008 and 2012, and average prices decreased by 55% over the same period.³⁹

While there has been a decrease in emergency consultations since peaking in 2007, it is unclear how much of this can be attributed to austerity measures and how much to prior reforms (eg of primary care). The possibility that some of this demand has been pushed elsewhere in the system has been raised. Data suggest there has been an increase in emergency attendances at private hospitals in the region of 15% between 2011 and 2012, which the Portuguese Association of Private Hospitals attributes to the increase in user payments in the public health system.⁴⁷

It is still too early to fully understand the impact of user charges. What scarce data there is indicates that service utilisation has reduced in both primary and secondary care,⁴⁸ and no shift in activity from hospitals to primary care settings is as yet evident.⁴⁹ Wider literature provides further insights here, suggesting that user charges are not

Figure 2.4 User charges for emergency and outpatient services, 2004-2012⁴⁰

	2004	2006	2007	2009	2011	2012
Emergency service						
Central hospital	€6.90	€8.50	€8.75	€9.40	€9.60	€20.00
District hospital	€6.10	€7.50	€7.75	€8.40	€8.60	€15.00
Primary care facility	€2.70	€3.30	€3.40	€3.70	€3.80	€10.00
Outpatient service						
Central hospital	€4.10	€4.20	€4.30	€4.50	€4.60	€7.50
District hospital	€2.70	€2.75	€2.85	€3.00	€3.10	€7.50
Primary care facility	€2.00	€2.05	€2.10	€2.20	€2.25	€5.00

an effective mechanism for encouraging more rational use of health services. Studies have shown that information to support decision making is often lacking, leaving people unable to distinguish high value from low value health care. Consequently, people often reduce their use of effective care by as much as their use of ineffective care.⁵⁰

Finally, evidence on the impact of an earlier wave of hospital reconfiguration – covering the period 2003 to 2009 – has been reported.⁴² It is important to note that these were foremost administrative mergers, involving the creation of single management teams with some consolidation of clinical services; the number of actual hospital units was not significantly altered. Azevedo and Mateus found that operating costs in the two years immediately following merger increased by 8%, although they acknowledge that efficiencies may only be realised over a longer time period than is covered by their analysis.⁴² They cite another study – published by Menezes et al in 2006 – which concluded that mergers had led to higher costs, since hospital centres were operating in a less efficient way.⁵¹

These conclusions echo the wider evidence base, which has shown that savings in management costs, at least in the shorter term, are typically outweighed by a combination of the direct costs of implementing mergers and the indirect costs that arise through a loss of managerial focus on service development and delivery during this time.⁵² In relation to the Portuguese experience, Azevedo and Mateus suggest that the 2003-9 mergers may have created hospital centres that were ‘too large’, which subsequently experienced diseconomies of scale. They argue that a key underlying problem is likely to be an approach to merger which was based on geography, rather than strategic (eg clinically driven) considerations:

‘One possible reason for the failing of the expected efficiency gains through mergers is probably the fact that hospitals are multiproduct firms, and product categories should be chosen carefully in order to ensure that the underlying aggregation conditions are met. Nevertheless, the main and only criteria for a merger in Portugal seems to be the geographical location, without any strategic concern before a merger is considered.’⁴²

Portugal: What has been the impact on quality of care?

Much of the debate so far concerning quality of care has focused on the impact of the reforms – and especially the increase in user charges – on patient access, with emerging evidence that increasing barriers to care may be affecting some of the most ‘in need’ groups. Therefore we report on equitability first, moving on to address other dimensions of quality where evidence has been found.

Equitability

Much of the evidence that has been recently reported is on the issue of patient access:

- In a 2011 survey, 77% of the public reported that the financial crisis had impacted on how much they were willing to spend on health care, including 28% reporting that it had had a significant or high impact.⁵³
- The decrease in primary care consultations between 2011 and 2012 was greatest amongst those exempt from user charges. It has been suggested that other financial barriers to access – such as increased out-of-pocket transportation costs – may be responsible for this.³⁹
- In a 2012 survey of 884 primary care professionals, 56% reported concerns about increasing access barriers due to transportation costs and 61% reported concerns about increasing access barriers due to user charges.⁴⁴
- In a 2012 survey of pharmacies in the Lisbon area (n=41), responses indicate that around 1 in 5 people are not acquiring all of the drugs prescribed to them, with women, the unemployed and the elderly most affected.⁴⁴
- Cost has long been the main reason people in Portugal give for not accessing health services when they need them, but the proportion of those reporting unmet health needs who cite affordability as the main cause has risen from 49.9% in 2006 to 69.8% in 2011.⁵⁴

Timeliness

Evidence suggests that the reforms may have had a temporary impact on waiting times. The number of patients on waiting lists and the proportion waiting longer than the maximum established time went up in 2011 for the first time since SIGIC was introduced in 2004. But figures dropped again in 2012, despite the continuing upward trend in demand for services (see Figure 2.7 overleaf).

Patient experience

Evidence on patient experience is not routinely gathered in Portugal, so understanding the impact of the reforms at this level is very difficult. We do know that patient complaints to the Health Ombudsman have increased, although the drivers of this have not been examined.³⁹

In terms of number of complaints, these have risen from:

- 2006: 115 complaints
- 2009: 146 complaints
- 2012: 407 complaints
- 2013: 638 complaints

Staff experience

Anecdotal evidence of a decline in staff experience is reported, especially among nurses. This includes high levels of unemployment for newly graduated nurses, fewer nursing staff and concerns about worsening quality of care, longer working hours and higher staff turnover.^{55,56} However, more systematic evidence (eg from workforce surveys) is not available to corroborate this.

There is some evidence from media reports that the austerity cuts may be driving health care staff to seek work elsewhere. For example, one news piece reported that the number of nurses from Portugal and Spain registering to work in the UK had increased 15-fold in the four years between 2008 and 2011.⁵⁷ Currently fewer than 1-in-5 nurses newly registering to work in the UK NHS are trained outside the UK. In recent years, the majority of the nurses who have been trained elsewhere have come from within the EU, with Portugal, Spain and Romania being the main sources.⁵⁸

Figure 2.7 Trends in waiting list performance, 2006-2012³⁹

	2006	2007	2008	2009	2010	2011	2012
No. patients on waiting list	221,208	197,150	174,179	164,751	162,211	180,356	166,798
Median time on waiting list (months)	6.9	4.4	3.7	3.4	3.1	3.3	3.0
Percentage of patients waiting longer than maximum established time	43.5	24.2	21.6	18.4	13.0	15.8	15.1
Total no. specialist consultations in hospital setting (1000)	8660.8	9176.7	9693.4	10396.2	10749.0	10997.9	11225.4
No. of first specialist consultations in hospital setting	2166.3	2383.8	2656.4	2937.6	3078.3	3169.8	3247.6

Canada

Canada: The financial crisis

Canada entered a major financial recession in the early 1990s, which lasted approximately three years. The impact on the Canadian economy was substantial: between 1990 and 1992 there was a 6% real term reduction in GDP per capita, and both the federal and provincial governments were forced to make deep cuts to address the growing deficit.⁵⁹ In health specifically, federal transfers to the provinces fell substantially – over the period 1980 to 1996, they fell from an average of 30.6% of provincial health expenditures to 21.5%.⁶⁰ In response to federal cutbacks, many provinces reduced their health budgets, reversing a long period of continuous growth in expenditure dating back to the 1970s (Figure 2.8).

The Canadian response to this fiscal crisis largely focused on restructuring the acute hospital sector, with some other cost saving measures implemented in addition, mostly in relation to the workforce. Provinces – responsible for administering health services – varied in their approach to hospital reform, but over this period a general trend can be observed away from cost containment being managed at an individual hospital level, to greater regional control.⁶² For much of the 1980s there had been a decline in inpatient beds and shift to day cases. Thus the Canadian response to the recession of the early 1990s can be seen as both a (perhaps radical) extension of an existing direction of travel, as well as a defined ‘crisis response’.

Canada: What was the main policy response?

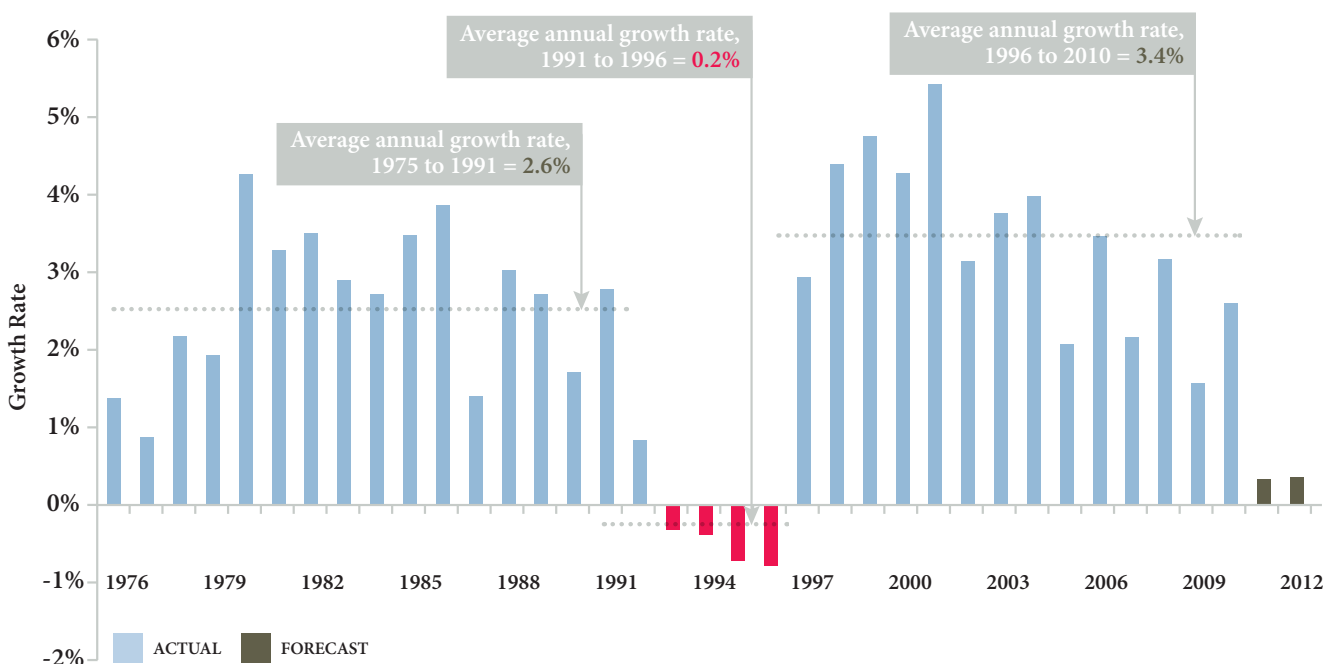
Changing care providers’ structures, ownership and/or payment

As observed by Naylor, ‘Canada used a combination of fiscal and regulatory initiatives to radically restructure the hospital sector.’⁶⁰ As a result, inpatient care was cut, community services were expanded and hospitals underwent significant consolidation. Nationally, there was a 27% decrease in staffed beds for short-term care units in the period 1986 to 1994, alongside decreases in both physician density and doctor consultations per capita.⁵⁹

Information on how each province approached reform is variable, although more detailed accounts are available for Ontario and Saskatchewan.⁵⁹ In Saskatchewan the restructuring process was implemented by local district health boards, but closely managed by the provincial government. In Ontario the task was delegated by the provincial government to an independent commission, which undertook planning, consultation and implementation. The central management of the process was critical to delivering reform on the scale required as, according to Thorlby, ‘local organisations were unlikely to undertake such fundamental reform on their own.’⁵⁹ This approach also helped reduce the risk of service disruption and fragmentation, which would have been more likely if responsibility for achieving cost savings had been devolved to an individual hospital level.

In both cases, restructuring decisions were guided by analysis of local data (eg hospital performance data, population projections) and extensive stakeholder

Figure 2.8 Total health expenditure per capita, annual growth rates in constant 1997 Dollars, 1976 to 2012⁶¹



and community consultation. Despite this, there was substantial opposition to the changes among both the public and health care professionals, even though many stakeholders had been initially supportive of the goals of reform.⁵⁹

In terms of specific changes made, at a provincial level:

- Ontario reduced the number of hospitals from 225 to 150 between 1990 and 1999,⁶³ cut hospital budgets by 18% over a similar period⁵⁹ and closed 28,800 beds⁶⁴
- Saskatchewan made significant cuts to hospital budgets: 5% in 1993, 9% in 1994 and 6% in 1995,⁵⁹ closing or converting 52 of its smaller rural hospitals in the process⁶⁵
- Newfoundland and Labrador established a process of regionalisation and hospital closure, leading to a reduction in inpatient days of 12% and admissions of 17%, although whether this was as a result of financial pressures is unclear⁶⁶
- in response to a later fiscal challenge, British Columbia had a slightly wider focus – as well as earmarking three hospitals for closure and eliminating/downgrading some emergency departments,⁶⁷ the province closed 3,000 extended care beds, replacing them with 3,500 supported living units.⁶⁸

Altering workforce pay, benefits and working conditions

The second significant component of the Canadian response to the fiscal crisis was felt by the health care workforce:

- Salaries were cut in Ontario and Alberta by 5%^{64,69} and nursing posts were reduced in Ontario⁶³ and British Columbia.⁶⁷
- It is reported that 4,568 nurses emigrated from Ontario to the USA between 1993 and 1997 – approximately 5% of the workforce. A survey of nurses who had left Ontario to practice overseas found the main reasons for doing so were lack of nursing opportunity, workplace pressures and the deteriorating economic climate.⁶³

Canada: What has been the impact on costs and outputs?

Evidence of impact on costs and outputs suffers from a lack of systematic data collection but some useful observations have been noted. For example, hospital funding in Ontario – as a proportion of health care spending in the province – fell from 50% in 1981 to 34% in 2010.⁷⁰ In Newfoundland and Labrador, standardised admissions fell by 10% and inpatient days by 5.6% in

the St John's region, and by 16% and 14% respectively elsewhere in the province.⁶⁶ There is also some evidence that hospital productivity improved during the 1990s despite growing demographic pressures over the same period. This is likely to be a combined effect of a smaller workforce (having to do 'more with less') and a shift of care from inpatient to outpatient care.⁷¹ However, it has also been noted that the focus on budgets *per se* rather than payment systems means that provinces failed to implement what are likely to have been more sustainable cost containment strategies:

*'What provinces have not done is seriously challenge the fee for service payment scheme that covers most doctors. Their associations negotiate fee schedules with provincial governments, and doctors then simply send in their bills. Strategies to bring doctors' billing under control have had limited impact. When fees are frozen, doctors bill for more, and for more expensive, services. When a cap on overall or individual billing fees is negotiated, it is not respected and costs continue to rise.'*⁶²

The issue of whether cuts in acute care were subsequently off-set by investment in other parts of the service (eg long-term care) – as was promised – has been questioned. Establishing the pattern and scale of re-investment is difficult given, as Thorlby notes, we would expect to see this process lag somewhat behind hospital restructuring.⁵⁹ The data available are limited and what could be found shows a mixed picture. According to the Ontario Health Coalition, in Ontario home care received 5.47% of total health care expenditure in 1999, declining to 4.13% by 2010.⁷⁰ Waiting times for long-term care and home care in the province are reported to now be at or above the levels of the late 1990s.⁷⁰ In the same province, however, there have also been significant investments in nurse practitioner-led primary health clinics to build a network of community health centres and aboriginal health access centres.⁶³

Two empirical studies in Winnipeg, where almost 10% of acute hospital beds were closed, found that access to hospital care had not been adversely affected as the reduction in beds had been offset by increases in day surgery, earlier discharges and a marked expansion in nursing home capacity. There was also no discernible impact on quality of care, as measured by mortality and readmission rates.⁷² More generally, there is little evidence that the hoped for shift from acute to community services was achieved in the 1990s, although progress towards this goal has been made since the early 2000s:

In the 1990s, while contending with the fiscal fallout from the recession in the early part of the decade, the federal and provincial/territorial governments cut or limited health care spending, made only paltry investments in primary health care innovation, and failed to address the conspicuous lack of primary health care infrastructure in the areas of information technology, administration, staffing, and quality improvement. During this period, innovations in the organization, funding, and delivery of primary health care were at the periphery of the system rather than at its core, although some of those initiatives laid the groundwork for later advances.⁷³

Thorlby comments that *'the financial crisis created pressure for new and innovative approaches to delivering efficient health care.'*⁵⁹ Her suggestion is that it provided an impetus for more planned reform of acute services and the removal of excess capacity which had resulted from reforms in the previous decade (eg the shift to day case surgery). But there is also some – albeit limited – evidence that the costs of the reforms outweighed the savings made. According to the Provincial Auditor in Ontario, hospital restructuring costs in the province are estimated to have been in the region of \$3.8bn, against a target of \$1bn of savings in hospital operating costs.⁷⁰ The RCN notes that around 50% of the increase in health care expenditure in the province between 1997 and 2001 can be accounted for by these costs.⁶³ However, more detailed figures on reform costs and savings could not be found with which to examine this issue more thoroughly, and it appears that no systematic evaluation of the costs or impacts of the reforms was undertaken at either a provincial or country-wide level.

Canada: What has been the impact on quality of care?

Similarly to the impact on costs and outputs discussed above, although perhaps to an even greater degree, strong evidence regarding the impact on quality is lacking. Where evidence exists, it can be characterised under the following domains of quality:

Patient safety

Ontario's Hospital Association Report Card in 1998 found that almost 50% of patients reported that staffing levels were poor or fair.⁶³

In the opinion of one commentating organisation, Ontario *'now has the fewest hospital beds per capita of any province in Canada. It also has the worst overcrowding of any jurisdiction we could find in the industrialized world.'*⁶³

After the closure and conversion of 53 small rural hospitals in Saskatchewan province there was an increase in the perinatal death rate in the affected areas, although causation could not be attributed.⁷⁴

Patient experience

There is some more systematic evidence that public confidence in the health system was shaken by the measures taken to address the fiscal crisis. For example:

- National polls showed that 60% of Canadians thought their health system was 'excellent' or 'very good' in 1991. By 1996 this had fallen to 40%, with 25% assessing it as 'fair' or 'poor'.⁶⁰
- The proportion of Canadians saying that their health service needed to be 'rebuilt completely' rose from 5% in 1988 to 23% in 2001.⁵⁹
- Evidence for Newfoundland and Labrador suggests that, while restructuring may have contributed to more efficient use of acute care beds, it did not improve integration across health care sectors, with longstanding problems at the acute care/continuing care boundary remaining.⁶⁶

Timeliness

There is evidence that access to health services deteriorated during the 1990s, with waiting lists rising and delays for diagnostic services growing, although hard data were not routinely collected at the time in many provinces and causal attribution is highly complex. Simunovic et al reported increases in surgical waiting times in Ontario for breast cancer (36%), colorectal cancer (46%), lung cancer (36%) and prostate cancer (4%) between 1993 and 2000, although there is no evidence of an adverse impact on mortality.⁷⁵ Increases in waiting times for major cancer surgery were also reported during similar time periods in Quebec⁷⁶ and Manitoba,⁷⁷ as were increased waits for cardiac and orthopaedic surgery.⁶³ There is also evidence of longer waits for hip and knee replacement surgeries, leading to increases in patients' anxiety and reduced quality of life.⁶³

Staffing and staff experience

Anecdotal evidence of a decline in staff experience is reported, especially in relation to nurses. This includes reports of poor working conditions, inadequate staffing levels and plummeting morale.^{63,69} However, more systematic evidence (eg from workforce surveys) is not available to corroborate this.

The Netherlands

The Netherlands: The financial crisis

At the time of the global financial crisis, the Netherlands had low levels of unemployment and government debt and a budget surplus. It was therefore initially assessed to be well placed to weather the downturn. As a consequence, the government absorbed the initial impact of the crisis in the form of lower tax revenues, higher expenditure and an increased deficit. GDP growth slowed in the late 2000s, and the Dutch economy declined in real terms in 2009 (by 3.67%) and again to a lesser degree in 2012 (0.46%). By 2013, however, national income had recovered to the same level as in 2007.

The Dutch health system faced a number of challenges pre-dating the global financial crisis including rising expenditure, particularly in long-term care, an inequitable two-tier system of private health insurance and state coverage, long waiting times and a perceived lack of patient-centred care.⁷⁸ The Health Insurance Act of 2006 sought to drive and frame health policy responses, including the introduction of a system of managed competition between insurers, allowing the state to re-cast its role to one of regulation and oversight, designed with the aim of harnessing patient choice and demand to drive quality and cost improvements.

In December 2009, however, the Dutch government set out a formal response to its worsening fiscal position with the stated intention to reduce the deficit to less than 3% of GDP by 2014. This response was aimed at, *inter alia*, supporting employment and achieving a balanced budget. The overall approach has been described as cautious, with a strong emphasis on tax increases. That said, budget cuts were made to health care and social security expenditure. Within the overall €15.75bn austerity programme, €5bn has been taken from health care and €7.25bn from social security. In terms of public discourse, these cuts are being framed within a wider narrative of the 'participation society', in which people must take more responsibility for their own care, with less help from the government.

In assessing the Dutch response it should therefore be recognised that cost containment was already a key priority before the financial crisis occurred. Despite the reduced impact felt by the country due to the ameliorating effects of its starting position, in choosing to reduce health and social care expenditure, the Dutch government has been able to strengthen this as a priority and perhaps go further and faster than would otherwise have been the case.

The Netherlands: What was the main policy response?

Priority setting and rationing

Although not a substantial part of the Dutch response, there have been efforts to control costs through rationing, particularly in areas such as long-term care where there has been a move to reduce eligibility through stricter criteria in an attempt to focus on those who 'really need it'.⁷⁸ This is as a result of the transfer of responsibility for supporting people with long-term conditions in their homes from the government to local authorities in 2007, coupled with cuts to funding of both day care and residential care.

There have also been gradual reductions in the scope of coverage of the mandatory health insurance package between 2009 and 2012, for example in the areas of:

- sleep medicine
- medication for erectile dysfunction
- basic mobility aids (all excluded)
- IVF (restricted to three cycles)
- weight management advice (limited to three hours per year).

Additionally, primary care growth has been limited to 1% in 2014 and 1.5% in 2015-17 and only where this is shown to be a substitute for hospital care.

Cost sharing

The introduction and extension of user charges has been a key feature of the Dutch response to the crisis. Between 2008 and 2013, mandatory deductibles were increased from €170 to €350. Co-payments were introduced for long-term care in 2009 and, from 2010, users had to pay for their first 15 physiotherapy sessions (rising to the first 20 in 2012).

Introduction or increase in market mechanisms

A range of new and extended market mechanisms were established by the Dutch government in an effort to bear down on costs. In 2010 the number of Diagnostic Treatment Combinations (DTCs, or defined packages of care) used to reimburse hospital activity was reduced to allow for easier negotiation of their price between insurers and hospitals. Additionally, the number of DTCs subject to free pricing (where the price is freely determined by the market rather than by government) rose from 10% of all combinations in 2005 to 70% in 2012. The ban on for-profit hospital care was also lifted in 2010 in an effort to attract private investment.

The government also introduced public tendering for drugs with the aim of increasing transparency in prices and reducing costs. The bidding company with the lowest price wins exclusive contracts for a period of 3-6 months with the insurer who issued the tender.

Regulation, monitoring and/or accountability measures

The government introduced a website comparing provider quality to support consumer decision making in 2006. In 2012 they outlined measures to carry out more rigorous checks on the cost-effectiveness of new treatments.

The Netherlands: What has been the impact on costs and outputs?

The literature has generally focused on the cost impact of the 2006 Health Insurance Act and the resulting introduction of managed competition between insurers. There is little evidence of the impact on costs or outputs specifically related to the crisis. This will reflect the pre-existing nature of the issues which were then heightened by the fiscal tightening. In terms of those impacts, commentators have observed that cost containment does not appear to have been achieved by the Act. Indeed, expenditure increased at an average annual rate of 5% between 2006 and 2011.⁷⁹

Maarse argued that the Act may have exerted a downward pressure on hospital costs but that there was no clear evidence of this yet.⁸⁰ This may be due to a lack of health care quality data to aid insurers, quasi-monopolistic hospitals in some regions, and the fear that insurance providers have of losing customers if they restrict choice of provider.⁸¹ It does appear, however, that public tendering of pharmaceuticals has generated significant savings – €355m in 2008 alone.⁸²

Care integration has been a longer term ambition of the Dutch health and social care system and, whilst there has been a drive for integration of care as a cost control measure, Mladovsky et al have argued that it cannot be relied upon to deliver cost savings, at least in the short to medium term.⁸ There will, of course, be other reasons to continue to push for better integrated services.

The Netherlands: What has been the impact on quality of care?

There is a general lack of information about quality of care and, perhaps because of this, quality has not been a strong feature of newly invigorated consumer choice arising from the Health Insurance Act. Insurers have been mainly competing on the prices of their policies and the costs of services. Suitable information about quality of care, and patient outcomes in particular, is lacking.⁸³

Despite this, as of 2010, some quality indicators had improved but perhaps not in line with rising expenditure. A recent analysis of the Dutch health system concluded that:

*‘It is still too early to assess the true effectiveness of the Dutch health reforms, if success “would imply that the competitive changes enhance value and efficiency in purchasing healthcare”’.*⁸⁴

Nonetheless early indications are positive. In the 2010 Dutch Healthcare Performance Report it was shown that Dutch residents were living longer, the cost effectiveness of health promotion tactics had improved and accessibility was mostly excellent. Of those surveyed, 85% said that they had no problem with access and 90% were pleased with the service they received. Leading health care analyst, Professor Alain Enthoven, recently congratulated the Dutch for being ‘in the lead’ in health care reform and the Netherlands came top of the Euro Health Consumer Index, scoring particularly highly in relation to patient rights and information, and range and reach of services. Indeed, the Dutch health system has been among the top three rated every year since the Index was started in 2005, with the comparatively high level of patient participation in decisions about how health services are delivered proposed as a key factor in this.⁸⁵

There are also problems with provision, as with any health system. For example, accessibility is not good across the board: there are persistent waiting lists in certain sectors and reaching GP practices by telephone during office hours is often difficult. There are also wide variations amongst health care providers in terms of both price and quality, with insufficient data to effectively compare them and therefore make an informed choice.⁸⁴

It should also be noted that the Dutch were meticulous in their openness, ensuring that they kept the public informed throughout the reform process. Furthermore, the 2006 reforms were not the result of rushed ideas but rather the culmination of decades’ worth of deliberation and discussion which helped to avoid later costly U-turns. One recent commentary concluded that:

*‘If the UK is to follow NHS reform through successfully, the Government would be wise to learn from the “particularly effective public information campaign” that was deemed to be “a model of robustness and clarity” in the Netherlands and to bring reforms in gradually.’*⁸⁴

Denmark

Denmark: The financial crisis

The Danish economy was hit hard by the financial crisis, with GDP declining in 2008 (by 0.54%), 2009 (0.8%) and again in 2012 (0.28%). Nonetheless, Denmark was able to maintain relatively low levels of public debt and unemployment,⁸⁶ and therefore has been able to pursue pre-existing commitments to address key long-term challenges within its health services. As a result, the Danish government has ring-fenced health spending and allowed budgets to continue to grow, albeit at a slower rate, for much of the period. The exception to this is late 2009 to mid 2011, when there was a small real terms decline in health expenditure (Figure 2.9). Taken together, these issues suggest that longer-term trends in the Danish health system have not been strongly affected by the recession.⁸⁷ This makes the Danish story markedly different from most of the other case study countries.

The two key challenges have been ones of rising costs, driven by an ageing population, and concerns about the decentralised nature of health care decision making, leading to inequalities in both access and quality of care across the Danish municipalities.

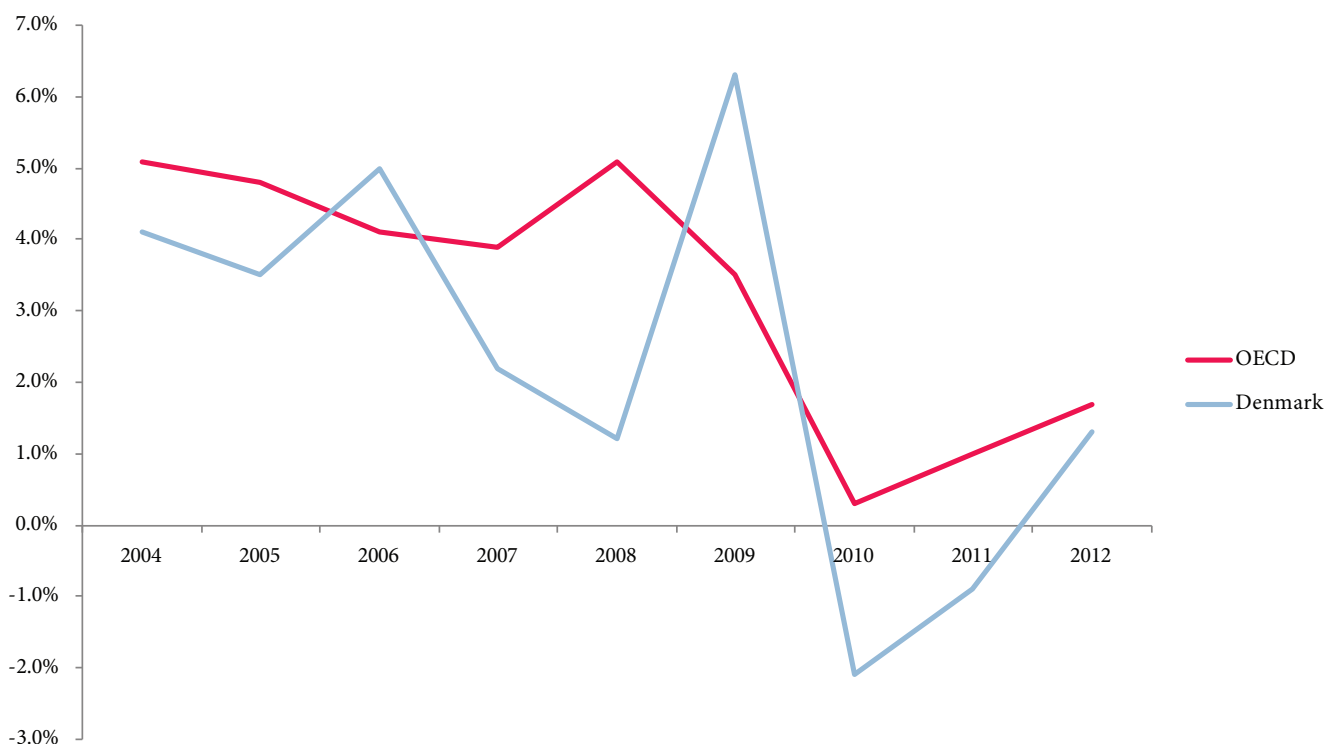
It should be noted, however, that as the crisis has abated there remains some doubt about whether better consistency of delivery had been achieved. For example, the OECD reported:

*'A lack of consistency in assignment of responsibilities across levels of governments, which generates waste through duplication, weak control over spending and a lack of incentives to provide cost effective services.'*⁸⁹

In 2012 a new 'budget law' was introduced, setting budget levels for the entire public sector (at state, regional and municipality level) and specifying sanctions for municipalities and regions if the specified budget levels are exceeded. The new budget law emphasizes a strong political focus on budget restrictions and expense control following the economic crisis, but the specific strategies and approaches for cost containment are still decided upon and managed at a regional level.

Thus, the collection of measures enacted in response to the crisis was relatively minor in comparison to steps taken in other parts of Europe, with questionable impact. They are, however, likely to have subtly shifted discourse in Denmark on certain key issues such as prioritisation.

Figure 2.9 Health expenditure growth rates (in real terms) since 2004, Denmark and OECD average⁸⁸



Denmark: What was the main policy response?

Altering workforce pay, benefits and working conditions

A traditional Danish response to recession has been to reduce the number of employees in the central ministry and agencies and, while a decision to repeat this was taken in 2011,⁸⁶ health care staff were left relatively unaffected. The main impact for this group of public sector employees has been a reduction in the rate at which wages were growing – significantly different to that seen in other European countries where wages were frozen or reduced in response to the crisis.⁸

The European Hospital and Healthcare Federation suggests that some redundancies were adopted as one of the methods for making savings at the regional level although their report argues that this is also a result of a longer-term move to balance budgets as well as the financial crisis⁵⁶ – an example of the difficulty commentators experience in attempting to isolate the impact of a relatively benign fiscal crisis from pre-existing trends.

Priority setting and rationing

Prioritisation has traditionally been, *‘somewhat taboo in the Danish debate about health care, but recently, probably because of issues such as the economic crisis, prioritisation has emerged as a topic for political discussion.’*⁹⁰ The discussion has included a debate on whether a Danish version of England’s National Institute for Health and Care Excellence (NICE) should be introduced.

Some have observed that the crisis has undermined earlier efforts to prioritise some forms of care over others. Reforms introduced in 2007 included provisions to incentivise the municipalities to place greater emphasis on prevention and rehabilitation outside of hospitals. However, *‘Incentives have not yet shown significant effects in the municipalities and the recent financial crisis has contributed to very tight municipal budgets and difficulties in finding means for new preventive initiatives.’*⁹⁰

Some changes to coverage have been made, but these have not so far affected core services. For example, guidelines have been introduced for some procedures and surgeries, such as gastric bypass surgery, placing limits on eligibility. The Danish government has also restricted reimbursements for dental care, providing new guidelines stating that patients may only receive reimbursement for a limited number of services each year. More attention has been focused on improving access than managing demand. In 2013, new patient rights came into force requiring hospitals to complete diagnostic processes within 30 days of referral; this will be extended to mental health services later in 2014 or 2015.

Cost sharing

There has been no explicit policy relating to user charges and it has remained a peripheral issue in the Danish response. Charges have been limited to a few services such as IVF treatment and sterilisations and even then a number of these charges were abolished when a new government came to power in 2011.⁹⁰

Reducing the cost of medical goods

Similar to other countries’ responses, much of the Danish focus on cost reduction has been in pharmaceutical prices. A price freeze on medicines has been enforced in Denmark since 2009, ensuring that the pharmacy purchasing price cannot exceed May 2009 levels. On top of this, in January 2010, a 5% price cut on medicines came into force. Generics have also been promoted, with further reductions in expenditure expected to be achieved through the use of parallel imports.

These controls have brought Danish drug prices in line with the average price recorded in a reference price basket of countries including Austria, Belgium, Finland, Ireland, Norway, Sweden, the Netherlands, Turkey and the UK. In the past it has been shown that the Danish pharmaceutical market was somewhat liberal, resulting in Danish hospitals paying as much as 22% more than their Norwegian counterparts for medicines, making this an obvious area for action.

Changing modes or models of care

Danish health care policy has had a longer-term goal of ensuring that patients receive continuity of care given the fragmented nature of the system. Several initiatives to improve patient experience have been implemented as part of this, including the introduction of pathway coordinators and incentivising GPs to act as care coordinators for groups of patients with chronic diseases. There is also an emphasis on targeting chronic diseases through prevention and follow-up interventions.⁹¹

Notwithstanding these developments, health reforms and quality initiatives have largely focused on secondary care (see next section for example), with far less attention given to the modernisation of primary care. One recent review concluded that:

*‘Danish general practice is not currently stepping up to the task demanded of it. In many ways, primary care remains a passive recipient of knock-on effects of administrative and hospital reforms, with few ambitions for a modern national primary care service.’*⁹²

Changing care providers' structure, ownership and/or payment

In connection with the Danish regional reform of 2007, plans for major restructuring of acute care were announced. The National Board of Health proposed that the number of hospitals accepting acute admissions be reduced from 42 to around 20 by no later than 2015, and issued binding guidelines for this process to be followed by the regions. This signalled a move away from devolved decision making to a more centrally managed and standardised planning process for acute sector reform.⁹³ Other initiatives include national planning of the distribution of specialties across hospitals and the centralisation of units into 'joint acute wards' (essentially a single ward for emergency and acute patient admissions). It was recognised that implementation would require substantial capital investment, and the Danish government created a fund of DKK25bn to build, expand or renovate hospital facilities, to which regions added DKK15bn of co-funding (around €5.4bn in total).

An expert group was established to assess regional hospital projects and make recommendations about the allocation of the investment fund, with final decisions made by the Ministry of Health and Ministry of Finance. These plans were strictly assessed against evaluation criteria including the extent of adherence to the centrally issued guidelines and plans for out-of-hospital acute services.⁹³ There was considerable uncertainty in terms of projected demands (eg population growth, disease patterns), so the expert group worked on the assumption of an approximately 20% reduction in inpatient activity and 40% increase in outpatient activity over the period 2007 to 2020.

Although the Danish government expects cost efficiencies from hospital reconfiguration it has not specified in detail how these gains are expected to arise. Some regions announced expected operational savings of up to 8% per year though – as Kristensen et al note – 'with great uncertainty.'⁹⁴

Regulation, monitoring and/or accountability measures

A further trend in the Danish health system has been a commitment to developing a set of information systems on health services which support users' ability to choose providers by allowing them to access information on a range of quality indicators, such as waiting times for specific interventions and incidence of adverse medical events. This builds on the longstanding development of mechanisms for quality monitoring and assurance in the Danish health system, including the establishment in the mid 2000s of a national Healthcare Quality

Programme. On this issue, a recent OCED review noted that, 'Denmark has established an array of mechanisms for monitoring and improving health care quality that few other OECD countries have.' But it went on to add that, 'Across the health care system, however, there is little evidence of quality indicators being used to guide and drive system-wide service improvements.'⁹²

Denmark: What has been the impact on costs and outputs?

There is very little evidence on the impact of the changes – certainly the set of policies enacted which were explicit responses to the financial crisis – on either costs or outputs. This is likely a function of the relatively minor response, and the fact that some of the longer-term developments are unlikely to have had a measurable impact so far.

What we do know is that all five Danish regions have managed to stay within their agreed targets for health care expenditure since 2009, with a real term reduction in expenditure reported in 2010 and 2011. Overall expenditure in 2012 was at the same level as in 2009. While hospital activity has consistently increased – rising 13% between 2009 and 2012 – so too has productivity.⁹⁰ According to the Danish Regions,⁹⁵ productivity rose by more than 5% in both 2010 and 2011.

With regard to hospital reconfiguration, our search was unable to identify any evidence on the impact of the process so far. An *ex ante* evaluation by Kristensen et al estimated the potential gains for a sample of proposed mergers.⁹⁴ Their analysis concluded that, while some mergers would lead to considerable cost reductions, in several cases merged hospitals were likely to become too large and result in diseconomies of scale. The authors highlighted a lack of focus on the precise mechanisms by which cost savings will be achieved, noting that:

*'The National Board of Health concluded that different services must be concentrated across fewer sites to maximize the benefits from links between specialties and other important drivers such as medical training and accreditation requirements. These arguments are primarily related to economies of scope with respect to quality rather than costs. That is sparse attention seems to have been paid to cost economies.'*⁹⁴

There are also questions about the sustainability of some of the policy responses, which have proven to be short-lived in nature. For example, charges introduced for services such as IVF were abolished when a new government came to power in 2011.⁹⁰ More significant structural changes (such as improving continuity of care) are likely to be far more sustainable, however the financial crisis may be affecting pursuit of these longer-term goals. For example, the 2007 reforms included incentives for municipal authorities to develop initiatives to promote prevention, but a recent commentary suggests that tightened municipal budgets have stalled efforts in this area.⁹⁰

Denmark: What has been the impact on quality of care?

Similarly, there is very little evidence reported of the impact that recent reforms have had on quality of care. As with any health system, the Danish system has both strengths and weaknesses. While service utilization patterns vary by region, the system performs relatively well in terms of equity and access. However, Denmark still lags behind other Nordic countries in terms of general and some types of cause-specific mortality (most notably cancer), and poor continuity of care continues to be a major issue.⁹⁰

Patient safety

Our search found no evidence to show that efforts to contain costs have caused a decline in the quality of care. However, according to some unions, staff are reporting making more clinical errors because of the constant demand for efficiency and a continued pressure to treat more patients.⁹⁵

Patient experience

The main survey tool for measuring patient satisfaction with services shows high degrees of satisfaction over the years in question for both inpatient and outpatient services.⁹⁰

3 Key themes and discussion

Despite the diversity of countries and health systems included in this scan, and the variation in how they have been affected by the financial crisis, several common themes emerged from our analysis, which are reported below. An overall observation is that countries have pursued a relatively narrow range of responses, with efforts at cost saving and containment largely focused on a handful of strategies targeting areas such as user co-payments, workforce salaries and/or working conditions and pharmaceutical pricing. Most countries have sought to blend measures to achieve immediate or short-term cost savings with some elements of structural reform, most notably restructuring hospital services. However, as we discuss below, experience suggests that these different types of policy response – while not incompatible in principle – can be difficult to align in practice.

Major changes, and in some cases significant cuts, are being made to health care without any programme to monitor or evaluate their impact

As we have already noted, many of the austerity measures in the countries reviewed have only been relatively recently implemented, and their effects are unlikely to be seen for some time yet. That said, one of the most striking findings of this scan was that none of the countries appear to have put in place mechanisms to monitor or evaluate the impact of the budget cuts and austerity measures that have been introduced. In effect, major policies are being enacted – many of which do not have a strong evidential basis – without any commitment to understanding their impact: on service access, delivery, quality or outcomes, or on population health more generally. Some high-level indicators of system performance (eg waiting time data, activity data) are available, although these are of limited value in tracing the specific impact of austerity measures, and problems of attribution are rife. We were able to find some independent evaluations and assessments – and have had to rely heavily on their findings – but these are

often time limited, focus on specific measures and/or trace the impact of changes made in only certain parts of the health system.

Financial crisis presents both a stimulus for and barrier to health system reform

In many respects, financial crisis provides a window of opportunity and stimulus for reform. Several countries intensified or extended existing processes of reform, while others introduced measures that might – in other conditions – have been unacceptable or considered too sensitive to pursue. This is not to say that austerity policies were in all cases uncritically accepted – there has been resistance and opposition in some countries, most notably in Spain. What the findings suggest is that financial crisis appears to bring the issue of reform to the fore, strengthening the case about for the need for change and providing an opportunity to open up debate to a wider audience (including the public).

But it does not necessarily make the process of agreeing and implementing reform easier. This remains politically challenging, and often highly contentious, whether there is perceived to be a ‘burning platform’ for change or not. As Clemens et al observe, in times of crisis, *politically it is more important to have short-term successes than to prepare for long-term gains.*⁷ Indeed, the evidence gathered on the case study countries, and insights from the wider literature, indicates that economic crisis also creates barriers and disincentives to bringing about change on the scale that is required – especially, but not only, financial.

A key issue here is that the task of balancing budgets places increasing demands on staff and managers at a time when the workforce may be contracting. This has been most marked in the three countries receiving financial assistance packages and in Canada in the early 1990s, where health spending decreased substantially in real terms. Significant amounts of money were taken out of these systems, often in very short time periods. These increasing demands reduce capacity for, and may

intensify resistance or apathy towards, longer-term system redesign and reform. The difficulty of meeting the twin demands of cost containment and system reform is highlighted in a recently published study, exploring the impact of the NHS reforms and efficiency savings programme on cancer services in England. Reflecting on the insights gleaned from in-depth interviews with cancer professionals and stakeholders, the authors conclude that:

‘The set of contextual circumstances arising from the [NHS] reforms, combined with the lack of resources to provide any ‘headspace’ were seen as hampering efforts to develop services and improve performance. Many interviewees spoke of a hiatus, with cancer services “standing still” for the last two to three years.’⁹⁶

Short-term measures to control costs have been more prevalent than efforts at structural reform, yet are unlikely to be sustainable

Policy responses to the financial crisis have typically combined short-term cost saving measures with more strategic efforts to improve productivity and/or implement (or intensify) structural reform. In short, immediate financial stability and longer-term financial sustainability are being pursued simultaneously. Looking at those countries which have had more defined ‘austerity’ responses (ie excluding the Netherlands and Denmark), this is particularly true for Portugal, where it is clear that key aspects of the austerity programme are seeking to address longstanding problems within the health system. The main exception, however, is Spain, about which Gene-Badia et al comment:

‘The economic crisis situation has not been seen as an opportunity for a major reorganisation in the provision of services, that is, as a positive shift in our traditional delivery patterns and inertias. We are witnessing a so-called path-dependency of previous decisions made in this area and we are incapable of any degree of divergent thinking. In brief, it appears as though we are missing yet another opportunity to improve our health care system.’²⁸

Nonetheless, even where a blend of strategies is being pursued, in practice short-term measures have been dominant, or have been far more likely to be implemented. Such measures include wage restraints, increasing user co-payments, changes to pharmaceutical pricing and service reductions (eg restricting eligibility) or closures (eg wards or beds). This situation may reflect the longer timescales involved in planning, designing

and implementing structural reform. Equally it might suggest that actions to cut costs have taken priority over longer-term goals. Whichever of these is correct, and it is probably a combination of both, there is a risk that short-term cost saving measures have to be traded against service quality and provision.⁸ Although this does not always have to be the case – pharmaceutical pricing reforms appear to be a notable exception.

As the wider literature shows, the emphasis on quick fixes is evident in policy responses to austerity generally⁸ as well as in relation to strategies for hospital reform⁷ and pharmaceutical policy.⁹⁷ For example, an analysis of strategies for European hospital reform in times of economic crisis led Clemens et al to conclude that:

‘So far there has been a tendency towards short-term and quick-fix solutions to contain cost. This involves the reduction in payment for medical goods and staff salaries, lowering the operational costs of hospital activity and cuts in hospital infrastructure maintenance and capital investments. Though they have some impact short-term, these measures are not likely to control future growth in spending. Moreover, evidence from previous crises suggests that reductions in expenditure growth have always been only a temporary fix and that health spending growth resumes as soon as economies begin to grow again’.⁷

The final point that Clements and colleagues make – that short-term measures tend to be eased or reversed once countries start to move out of recession – is echoed in several of the commentaries we reviewed. Some evidence of this is also provided by the Canadian case study. For example, the workforce reductions made during the 1990s were subsequently reversed from 1999 onwards – once the country was out of recession – and the size of the clinical workforce has grown steadily since then.⁹⁸

It is still too early to assess whether the strategies implemented in response to the 2007/08 financial crisis are sustainable. For most of the countries reviewed, the major austerity policies were announced between 2010 and 2012, but implementation is ongoing and further measures are still being announced in some cases.

As time progresses, it will be interesting to see what happens as the economic outlook improves – especially in light of the evidence above. Will health systems find it easier to build mechanisms to control health expenditure once immediate financial pressures have eased, or will there be less motivation to do so? The huge financial challenges that health systems – including the NHS – face have been exacerbated by recession, but

are not the outcome of it. They will persist, and in all likelihood increase over time, even once the need for austerity has passed.

Successful reform strategies are based on strong central leadership and constructive stakeholder dialogue and engagement

So what can be learned from the case study countries about how opportunities for reform can be harnessed and maximised? A clear message emerges from both Canada and the Netherlands about the importance of openness and honest debate, as well as broad and ongoing stakeholder engagement. In no small part, the successful implementation of structural reform in these countries seems to be linked to the willingness of political and health system leaders to front up reform processes and engage in a genuine dialogue with professionals and the public. Much can be learned in particular from the Canadian experience, where the passing of time allows for richer reflection. The main points of learning from the restructuring of hospital services in the early/mid 1990s are summarised in the following box:

- Be clear at the earliest stage about the size and nature of the problem.
- Develop and share a clear vision and narrative to support the change – be clear about what is really being sought (eg better integration rather than simply reductions in hospital services).
- Engage the public early and unite them around the vision – secure strong community leadership.
- Identify and use research and evidence in formulating the plan.
- Offer hope that the aim is to improve quality, at least in some areas, to make difficult changes more palatable.
- Investment in community services should occur alongside any restructuring of hospital services.

Sources: Royal College of Nursing 2012,⁶³ Thorlby 2011⁵⁹

The need for engagement is also evident in what has happened in Spain. Austerity measures have been resisted in some cases and subverted in others (eg with professionals refusing to exclude undocumented migrants from publicly funded treatment). Opposition is driven not only by the content of the changes themselves but also by what has been perceived, by some at least, as politicians' use of the financial crisis to pursue ideological goals. It also reflects anger at the way in which the changes have been enacted – through a top down, unilateral approach, with little or no grounding in an evidence base.

The evidence assessed in this scan does offer some insight into the factors that appear to enable longer-term structural reform:

- Whether there is a clear vision and strategic direction for system reform already in place.
- The severity of the financial situation and imperative for immediate cost savings.
- The political preferences of the ruling party and influence of external bodies (eg the Troika).
- The extent to which proposed changes are grounded in (or are perceived to erode) the values and principles on which the health system is based.
- A willingness and ability to make investments in alternative provision to support transformational goals, such as hospital restructuring. This suggests the need for dedicated funds to stimulate and support the development of new models of care and to enable the transition to these (as has been recognised in Denmark, for example).

What also comes through from the Canadian experience is the need for reform to be centrally driven and managed. Summing up the learning from the major restructuring of the hospital sector achieved in Ontario and Saskatchewan, Thorlby asserts that, *‘Although each province adopted very different approaches, central drive and strong leadership were key features in both cases. This was underpinned by an awareness that local organisations, left to themselves, were unlikely to reform services, however strong the plans or the financial imperative.’*⁵⁹

The case study countries provide some, limited, evidence about the impact of austerity measures on costs and quality of care

Our original brief for this project sought an analysis of the impact of specific austerity measures on the costs and quality of care. Disentangling the effects of multi-component austerity packages is highly challenging. Attempts to do so will always run into concerns about attributing cause and effect over a long period of time, particularly in systems that are highly dynamic and which operate within wider contexts that are ever-changing. Accepting this caveat, our scan did identify some evidence on the early impact of particular strategies and approaches that have been taken. This evidence should be treated as tentative, because for many of the studies concerned the period of analysis was relatively short, and therefore longer-term outcomes are still unknown. A summary of this evidence is provided in Table 3.1 on the following pages.

Table 3.1 Summary of evidence on how the major policy responses to austerity have impacted on quality and costs and their sustainability

Measure	Impact on costs	Impact on quality	Sustainability
<p>Altering workforce pay, benefits and working conditions</p>	<p>Given staff salaries account for 42.3% of public expenditure on health,⁸ wage restraints could be an effective short-term measure to constrain or reduce health spending. Evidence on the cost savings achieved through wage restraints is, however, limited. In Ireland, a reduction in staff salaries of between 5% and 15% produced cost savings of €659m in health.</p> <p>Staff may need to be recruited and/or trained post-recession, with associated costs. If this happens, cost savings may be short lived.</p>	<p>There was anecdotal evidence (eg from Portugal, Canada and Spain) of a decline in staff morale and concerns about impact of staff reductions/shortages on quality and safety of care. In several countries there have been temporary increases or upward trends in waiting times, with a possible (unconfirmed) link to staffing shortages.</p>	<p>Evidence from previous economic recessions (eg Canada) suggests short-term wage restraints are lifted once economic recovery is underway thus costs are saved only temporarily. Little evidence that countries have pursued longer-term workforce strategies, such as role substitution or changing skill mix.</p>
<p>Priority setting and rationing</p>	<p>Evidence not yet available. Changes to coverage have generally been marginal and not affected core services so cost savings are likely to be limited.</p> <p>The Spanish government estimates that €500m will be saved each year from excluding undocumented migrants from health coverage (although the possibility of there being knock-on costs cannot be discounted).</p>	<p>No evidence found. Impact on quality will be highly dependent on the measure concerned and whether the aim is balancing budgets (eg relaxing waiting lists targets) or improving efficiency (eg health technology assessment to support prioritisation).</p>	<p>This is likely to depend on the particular measure concerned. Evidence not yet available for the case study countries.</p>
<p>Cost sharing</p>	<p>The Portuguese experience suggests that user fees generate very little additional revenue for health systems, even where they are substantially increased, and are not effective as a means of encouraging more rational health-seeking behaviour (although they may lead a reduction in service use <i>per se</i>).</p> <p>Evidence from both Portugal and Ireland shows they can substantially increase out-of-pocket costs for patients.</p>	<p>Evidence from Portugal, Ireland and the wider literature,^{99,100} shows that user fees can present a major financial barrier to accessing care and vital medication, with poorly served groups (eg low income, the elderly) most affected. For example, the proportion of Portuguese people reporting unmet health needs who cite affordability as the main cause has risen from 49.9% in 2006 to 69.8% in 2011. Likely to be increasing inequity in access to care.</p>	<p>Unclear whether, in those countries that have introduced or increased of user fees, this is a temporary cost saving measure or permanent policy. This may ultimately depend on emerging evidence of their impact, eg on equity and access to care.</p>
<p>Changing modes or models of care</p>	<p>Evidence not yet available – outcomes are only likely to be seen over a longer-term period. Wider evidence on the economic impact of care closer to home and service integration is mixed, and varies according to the particular approach taken and local contextual factors. Some evidence of reductions in inappropriate admissions and length of stay, especially when payment systems are redesigned.¹⁰¹</p>	<p>Evidence is not yet available. Wider evidence base points to benefits, especially for certain groups (eg frail older people, people with multiple long-term conditions). Highly integrated primary care systems that support continuity of care are associated with better patient experience.¹⁰²</p>	<p>Changing models and modes of care is a long-term strategy for health system reform, not a short-term measure.</p>

Measure	Impact on costs	Impact on quality	Sustainability
Changing care providers' structure, ownership and/or payment	Evidence from Canada, Portugal and Denmark suggests that anticipated cost savings from hospital restructuring are not achieved, and in the short-term restructuring may increase costs and create diseconomies of scale. In Ontario it was estimated that restructuring costs were \$3.8bn, against a target of \$1bn of savings in hospital operating costs. A similar picture emerges from the wider evidence base about hospital mergers failing to achieve anticipated cost savings, at least in the short term. ⁵²	Likely to depend on the form that restructuring takes, but concrete evidence is limited. Wider evidence base supports centralisation of some clinical services for improving patient outcomes (eg stroke ¹⁰³ , cancer ¹⁰⁴); purely administrative mergers are less likely to improve quality. Evidence from several countries of temporary increases or upward trends in waiting times, with possible (unconfirmed) link to hospital and bed closures.	Mixed – likely to depend on the original rationale for restructuring, and the extent to which a strategic (rather than purely geographical) approach is taken. In Canada, some evidence of hospitals de-merging post-recession.
Reducing the cost of medical goods	Evidence from across several countries (eg Ireland, Portugal, Spain, the Netherlands) suggests that significant cost reductions have been made from pharmaceutical pricing reforms. Pricing controls led to reductions in overall pharmaceutical expenditure of €434m in Ireland (between 2009 and 2014), of 17.8% in Spain, and of 20% in Portugal. In the Netherlands, public tendering for pharmaceuticals generated €355m of savings in 2008 alone.	No evidence to suggest that the reforms have had a negative impact on quality. Access to medicines appears to have been affected by increased user fees in some cases (see cost sharing above).	Responses so far have tended to be quick pricing measures, with no fundamental changes to reimbursement systems; this reflects a wider pattern in pharmaceutical policies implemented in response to the financial crisis. ⁹⁵ Uncertain whether the pharmaceutical industry will seek to negotiate more favourable terms once economic recovery is underway.
Regulation, monitoring and/or accountability measures	Evidence not yet available for the case study countries. Main function of performance assessment is to benchmark and improve quality, not directly save costs.	No impact as yet reported from case study countries. Wider evidence suggests that performance assessment can drive quality improvement, but only when certain factors are in place (eg information must be able to inflict reputational damage by being reliable, published, widely disseminated and understood by the public ¹⁰⁵).	Systems for performance assessment of hospitals (and other providers) are a long-term strategy for quality improvement, not a short-term measure.
Introduce or increase market mechanisms	Limited evidence from the Netherlands suggests that market mechanisms may have exerted a downward pressure on hospital costs; although the Dutch reforms also introduced a cap on secondary care expenditure, which is likely to be a contributory factor.	No evidence as yet reported from the case study countries. Will be highly dependent on the model of competition implemented and broader contextual factors. Wider evidence is mixed, with some studies reporting that market competition has had a negative impact on quality, ¹⁰⁶ while others report improved quality. ¹⁰⁷	Unclear and likely to depend on a complex range of factors. A key question is whether market mechanisms can co-exist alongside current efforts to foster collaboration and integration of care for certain specialities (eg cancer) and groups (eg frail older people).

4 What are the lessons for the NHS?

What does all this mean for the NHS? Four years into austerity, the NHS has implemented or is considering implementing many of the responses seen in other countries. Given the depth and scale of the financial crisis, it is also likely that UK public sector spending on health services will remain below long-term growth rates for many years to come, implying the need for further changes ahead. At a more general level, the current period of austerity will eventually come to an end but the certainty of similar events occurring in the future remains. Learning the lessons from the experience of other countries is therefore vital, both to allow the NHS to rise to the challenge of ongoing budgetary restraint and as a way of preparing for the next, inevitable fiscal squeeze.

Long-term reform requires a clear and coherent strategic vision and targeted investment

The most general reflection is that financial crisis presents both threats and opportunities and the portfolio of responses can, if carefully thought through, mitigate the former whilst securing the latter. With clear pre-existing policy drives, the Netherlands and Canada were able to go further and faster with changes that had benefited from a degree of forethought. Much of the criticism of the Spanish response has related to the lack of a clear overall strategic vision. The key lesson from this is that, while all countries introduced short-term cost containment actions, those with a pre-existing vision for health system reform were able to more effectively blend this with the pursuit of longer-term strategic goals.

The experience of other countries also shows that maintaining a strategic overview as the response is developing enables planners to better align action across the system in a self-reinforcing way. The efforts in

Canada to refocus care into lower cost settings outside of hospital point to the need to match investment in community and primary care services to safeguard access and quality of care. This demonstrates the importance of carefully sequencing (dis)investments and reforms, which has not happened as fully as it should in any of the systems analysed. With the NHS looking to refocus care from acute to community based services as part of its effort to improve the quality and efficiency of care, this should give pause for thought.

Political and system leaders must engage all stakeholders in an honest and open dialogue about the need for change

Large-scale changes to health services will be noticed by the public and professional groups and countries which did not find ways to communicate effectively were often less successful than they would have otherwise have been. Spain was strongly criticised for its inadequate engagement with professional groups and the resulting strong opposition led to a dilution of the desired impact from the changes enacted. The Netherlands, however, was meticulous in its openness which, taken together with their carefully developed strategy, has enabled the Dutch health system to more successfully assimilate sustainable change (including the introduction of a system of managed competition among health insurers). For the NHS, the current broad narrative is of a service which has been protected from austerity with still growing budgets (albeit at a much slower rate than in the recent past). With many researchers and commentators forecasting a significant budgetary gap in the near future there is a risk that the public is not sufficiently 'warmed up' to the need for perhaps imminent and wide-scale structural reform. This is likely to make the task of arguing for and implementing such changes more difficult.

Measures to achieve short-term financial balance will not secure longer-term financial sustainability

This highlights another important lesson for the NHS – how to achieve sustainable change while being preoccupied with short-term financial exigencies. Financial crisis can create a ‘burning platform’ to justify changes that would, ordinarily, be difficult or impossible to achieve. Staff and the public will be more likely to support (or at least not actively oppose) changes if they understand the causes and scale of the problem, and are involved in and understand the narrative supporting the change. As a result, changes that are in the long-term interest of the health system stand a greater chance of being successfully implemented in a sustainable way.

However, in times of crisis, some short-term measures may be unavoidable. Actions to contain costs – such as workforce reductions, wage restraints and bed closures – were enacted in almost every country, although there is evidence that they may prove to be unsustainable in the longer term. There is also evidence that, while they may increase productivity in the sense that services are doing ‘more with less’, there have been negative impacts on quality of care. The evidence base is limited, but does suggest that structural reforms are the most likely route to improving efficiency for the long term.

While evidence is patchy, the NHS can learn from experience elsewhere about what works (and what doesn’t) in achieving cost savings

A common feature across the reviewed countries was a focus on pharmaceutical prices. Every country found ways to significantly reduce the costs of pharmaceuticals, some against a backdrop of poor spending controls in the past. In the UK NHS, price and profit controls have been a longstanding feature of the pharmaceutical pricing system, and rational use of medicines is promoted through the National Institute for Health and Care Excellence (NICE). Nonetheless, medicines account for more than 10% of NHS spending, and ways of getting better value from the drugs budget are currently being explored. In 2013 the government and pharmaceutical companies entered into a five-year agreement that introduced a fixed limit on NHS spending on branded medicines for the first time. Spending will remain flat for two years, followed by increases of less than 2% in the following three years.

The evidence we have gathered suggests that this is an area where further cost containment could be achieved without a negative impact on quality of care. This should go beyond the quick pricing measures that the countries in our review have tended to employ to more radical changes in reimbursement systems, which are likely to yield longer-term and more sustainable benefits.

As a further reflection for the NHS, hospital mergers were a feature of the response in several countries, but with very mixed results. The experience in the countries which attempted this suggests that costs are equally likely to rise as fall (as demonstrated by Portugal in particular) if there is insufficient attention given to the way in which savings are going to be achieved. It is also unlikely that geography and proximity will be the best guides to securing cost savings. The general lesson arising from this is that, unless well designed, hospital mergers are unlikely to release cashable savings and may detract from service quality. If poorly designed, they may lead to an increase in overall costs as diseconomies outweigh savings. ‘Unnatural’ mergers may even end up being reversed in future.

Change and reform should safeguard NHS values, not erode them

As a final reflection, there is a need to think carefully about responses which impact on the principles underpinning the health care system. The issue often causing the most concern amongst commentators has been the degree to which equitable access has been maintained. For some, this principle has been carefully guarded throughout the response to the crisis, although in a number of countries there has been a significant erosion in equity. Out-of-pocket costs have increased substantially in some countries, mainly but not solely as a result of new or increased user fees. As commentators have noted in these countries, even small payments can have a large impact on people with low incomes and frequent users of health care service (for example those with long-term conditions).

The long-term consequence of this reduction in equity is yet to be felt in those countries which have moved in this direction. If Portugal is an example of what could happen, user charges may grow in scale and extent in the coming years particularly if, as seems likely, fiscal restraint remains in place for the medium term.

Final reflections from Steve Moore – member of the research team, and former NHS PCT Chief Executive and Area Team Director

‘As someone who has been directly involved in the development of local responses to tightening health care allocations in the NHS, this project has provided a fascinating insight into how systems in other countries have responded to similar and, in many cases, even bigger challenges. The NHS is famously bad at looking outward for lessons on how to respond to new challenges, preferring to find its own way – often characterised as “muddling through elegantly”. What I find intriguing and perhaps reassuring is the sense of familiarity I get from understanding the range of the responses used in countries with often quite different systems, contexts, underlying principles and histories. The NHS should feel greater confidence about using international evidence – the attitude of “not invented here” does not, I believe, hold water in the light of the above analysis.

The lessons we have identified for the NHS, facing – as it does – an ongoing and unprecedented funding squeeze will resonate with the many people grappling with how to make change happen on the ground. I would only add to these with the reflection that truly transformational change takes time, investment and above all the attention of the smart people who work in the service every day. If these people are entirely absorbed with simply trying to hold the system together, it is unlikely those changes will take place.’

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Appendix: Comparison of the key features of the health systems

Tables A1 and A2 on the following pages provide a brief summary of the the key features of the health systems reviewed in this scan.

Figure A1 Health system comparisons: design of benefit, governance and primary care role

	Design of benefit		Governance		Primary care role	
	User payments/ cost sharing	Exemptions	System structure	Who governs?	Role of primary care	Gatekeeping?
UK	Varies by nation – direct payments required in some nations for ophthalmic services, social care and private treatment, and cost sharing for dental work and prescriptions	Exemptions may apply based on age, medical grounds or receipt of benefits	England: 211 CCGs and NHS England responsible for commissioning health care for population; Scotland: 14 regional NHS Boards, seven Special NHS Boards; Wales: seven local health boards; Northern Ireland: care commissioned by the Health and Social Care Board, advised by five local commissioning groups	Responsibility for health rests with the respective national government	Required to register with a GP to access free care	Yes
Canada	Some benefits not covered so citizens often buy private health insurance to cover these. No caps on cost sharing, some benefits are not covered. Varies among provinces.	No cost sharing for Medicare but some exemptions for non-Medicare services. Relief for those with a disability and those with significant medical expenses.	Regionally administered universal public health insurance (Medicare)	3 territories and 10 provinces are responsible for administering Medicare and planning health services.	Generally no requirement or incentive to register with a GP, but is a requirement for some capitation models.	Yes

	Design of benefit		Governance		Primary care role	
	User payments/ cost sharing	Exemptions	System structure	Who governs?	Role of primary care	Gatekeeping?
Denmark	Often covered by PVHI (private voluntary health insurance). OOP (out of pocket payments) low compared to other countries – needed for pharmaceuticals, dental care etc. No caps on cost sharing but decreasing co-payments with higher drug OOP spending. No cost sharing for hospital and primary care.	Cap on OOP for drugs for chronically ill. Financial assistance for low income and terminally ill.	98 municipalities responsible for health prevention, dentists etc.	5 regions manage and finance hospitals. They also fund GPs. National government sets regulatory framework and is in charge of general planning and supervision.	Required to register with a GP (98% of population).	Yes
Ireland	Self payments for those without a medical card for GP services and hospitals treatment when not referred. Annual maximum charge on co-payments. There is a co-payment for inpatient care.	Those who qualify for a medical card are exempt from charges.	Much of health care provision is from state through the HSE (Health Service Executive).	Heavily regulated public system managed by centralised government authorities.	Required to register with a GP for those with medical card. Not for rest of population.	Yes
Netherlands	Every insured person aged 18+ pays a deductible of €350 for any health care costs in a given year. No caps on cost sharing, annual deductible (€350) covers most cost sharing.	Children are exempt from cost sharing. Those on low income get premium subsidies. GP care exempt.	40 health care insurers – insurance based market.	Regulated publicly but private delivery. Government monitors quality.	Required to register with a GP.	Yes

	Design of benefit		Governance		Primary care role	
	User payments/ cost sharing	Exemptions	System structure	Who governs?	Role of primary care	Gatekeeping?
Portugal	Co-payments exist for most private healthcare services but are generally small compared to cost of service. No cap on OOP payments. User charges exist for consultations, visits, tests and procedures.	Exemptions from co-payments include pregnant women, children under 12 years of age, pensioners on low income, and those on social security.	Management of service takes place at regional level; 5 regions.	Responsibility for planning and resource allocation remains highly centralised. Hospital budgets defined centrally.	Required to register with a GP.	Yes
Spain	Co-payments for services including drugs, ambulance trips and prosthetics. Undocumented immigrants cannot access free health care services. Some use of PVHI.	Pensioners and people who are severely disabled, have certain chronic diseases or have suffered occupational accidents are exempt from some co-payments	17 regions have responsibility for management and services	Limited federal government role	Required to register with a GP	Yes

Figure A2 Health system comparisons: finance and funding, and provision and payment

	Financing and funding			Provision and payment			
	Health expenditure, % GDP (2012)	Financing of system	Public/private balance (2011)	Service provision for primary care	Primary care payment	Service provision for hospital care	Hospital payment
UK	9.3%	Tax based system	82.8%/17.2%	Private group (various health professionals)	<ul style="list-style-type: none"> - Capitation - FFS (fee for service) - P4P (pay for performance) 	Public/Private for profit/Private not for profit	<ul style="list-style-type: none"> - DRG (diagnosis related groups) - Procedure service payment
Canada	10.9%	Tax based system	70.4%/29.6%	Private group (physicians only)	<ul style="list-style-type: none"> - FFS - Capitation 	Public/Private for profit/Private not for profit	<ul style="list-style-type: none"> - Prospective global budget
Denmark	11%	Tax based system	85.3%/14.7%	Private group (various health professionals)	<ul style="list-style-type: none"> - FFS - Capitation 	Public/Private for profit	<ul style="list-style-type: none"> - Prospective global budget - DRG
Ireland	8.9%	Tax based system	67.0%/33.0%	Private group (various health professionals)	<ul style="list-style-type: none"> - FFS - Capitation 	Public/Private for profit/Private not for profit	<ul style="list-style-type: none"> - Prospective global budget
Netherlands	11.8% (excluding investments)	Social Health Insurance – multiple insurers with choice	85.6%/14.4%	Private group (various health professionals)	<ul style="list-style-type: none"> - Capitation - FFS - P4P - GB (global budget) 	Public/Private not for profit	<ul style="list-style-type: none"> - DRG
Portugal	9.5% (excluding investments)	Tax based system	65.0%/35.0%	Public clinics (various health professionals)	<ul style="list-style-type: none"> - Capitation - P4P - GB 	Public/Private for profit/Private not for profit	<ul style="list-style-type: none"> - Prospective global budget - Procedure service payment
Spain	9.4% (2011)	Tax based system	73.0%/27.0%	Public clinics (various health professionals)	<ul style="list-style-type: none"> - Capitation P4P 	Public/Private for profit/Private not for profit	<ul style="list-style-type: none"> - Line-item remuneration - Prospective global budget

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