

Responding to cost pressures: Can health systems slow expenditure growth and maintain performance?

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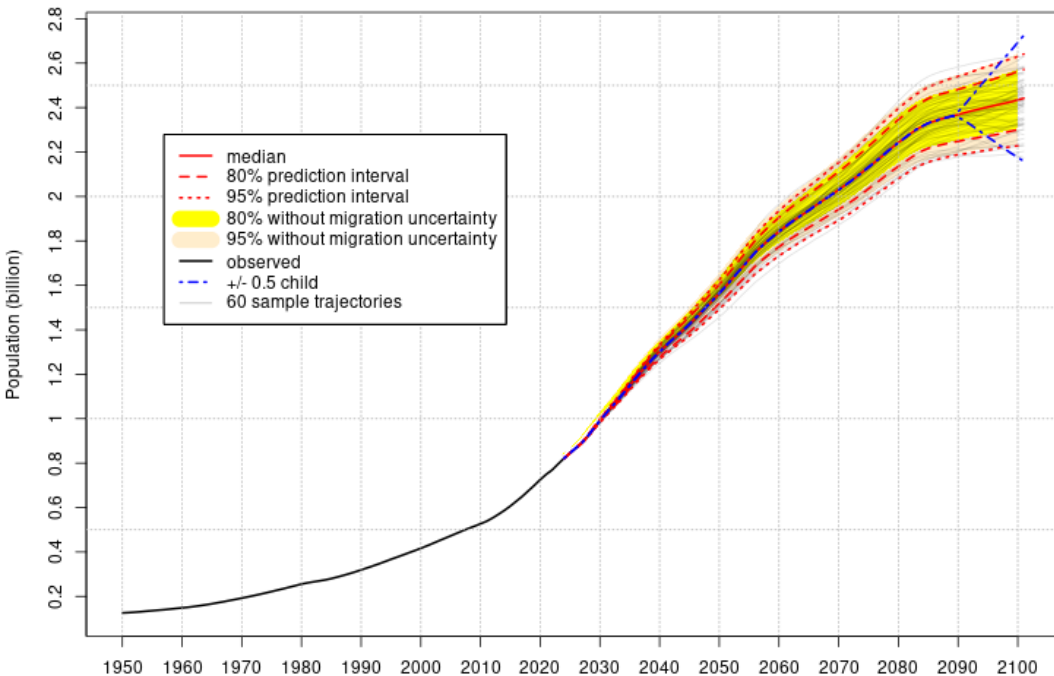
European
Observatory
on Health Systems and Policies



Countries are facing challenges raising sufficient public revenues for health



World: Population (Age 65+)



How can health care costs be better controlled *without* disrupting performance?

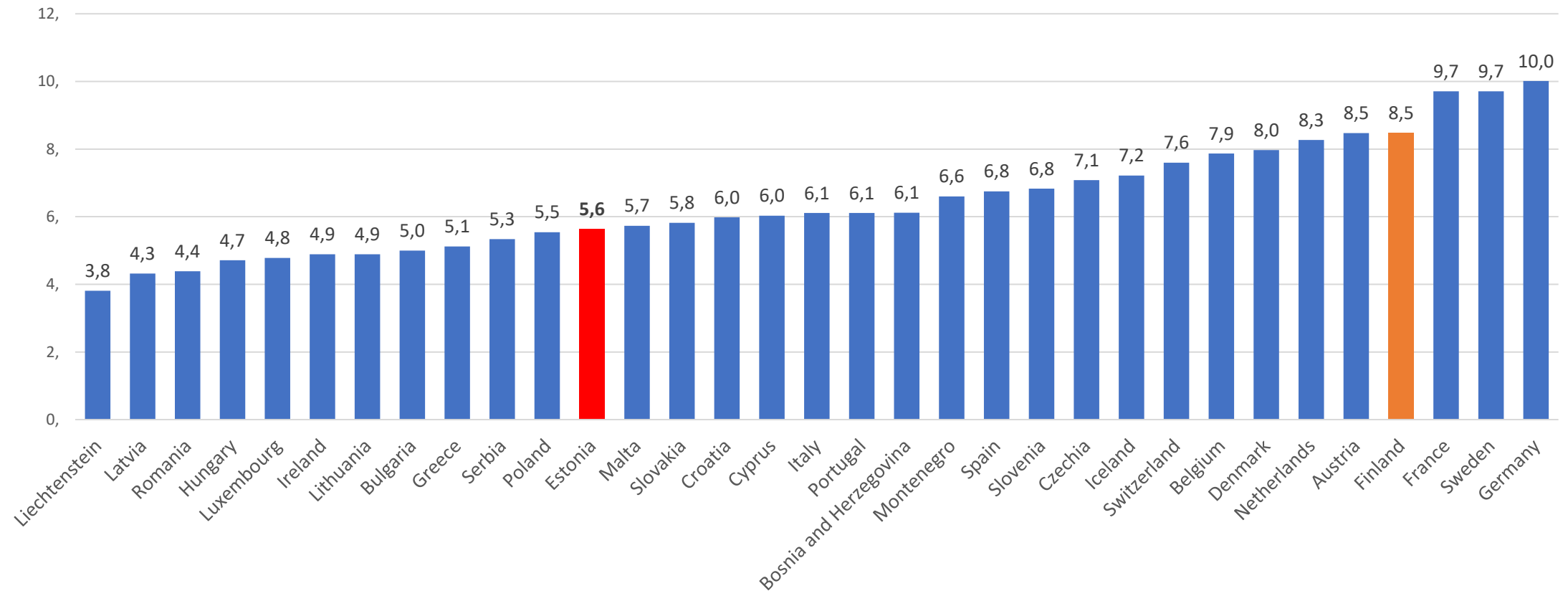
Which policy approaches work?

Which do not?

What kinds of unintended or distributional effects do different cost-containment strategies produce?

Reminder: Although growth has been high, public spending remains a small share of the economy in Estonia

Government and compulsory spending as a share of GDP, data from 2023



How can we think about reductions (or slowdowns) in health spending?

Health spending= Prices X Volumes

Essentially, eliminating “waste” is the only way

Waste-> spending that does not contribute meaningfully towards goals
(e.g. financial protection, equity of access, better health outcomes)

But cutting haphazardly will have consequences for those goals!

Can health systems reduce prices and/or volumes without disrupting health system performance?

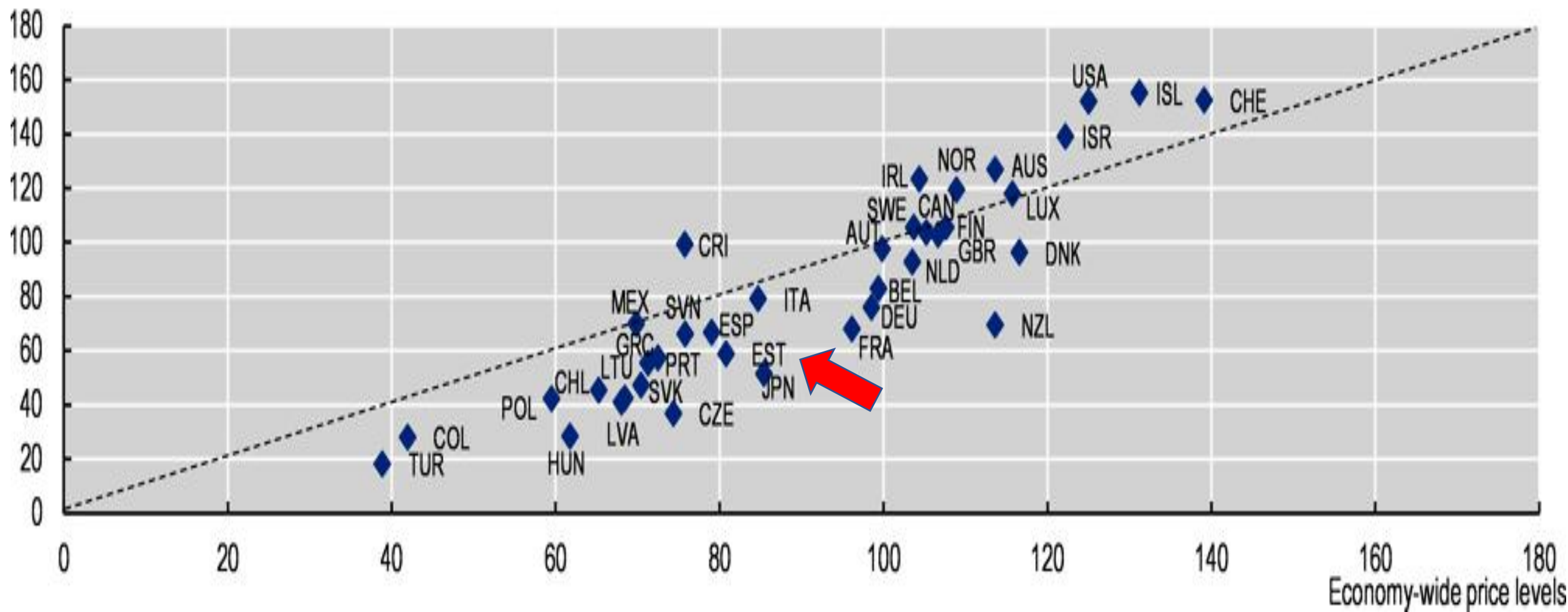
Which policy approaches work?

Health systems can reduce prices... to a point

- Many examples from the 2008-2013 financial crisis
 - Cuts in medicines prices in Portugal
 - Mandatory prescribing by active ingredient
 - Expansion of generic drugs
 - Automatic price reductions when patents expired
 - Negotiated price reductions for medicines in Greece
 - Reference pricing
 - Price-volume agreements/clawbacks
 - Reductions in payments to providers (including in Estonia, France, Greece, Ireland, Romania, Slovenia)
 - Sometimes wage reductions, sometimes tariff reduction (i.e. leaving it to the provider to adapt to lower prices)

Health prices in Estonia appear relatively low compared to the rest of the economy as of 2023, despite wage increases

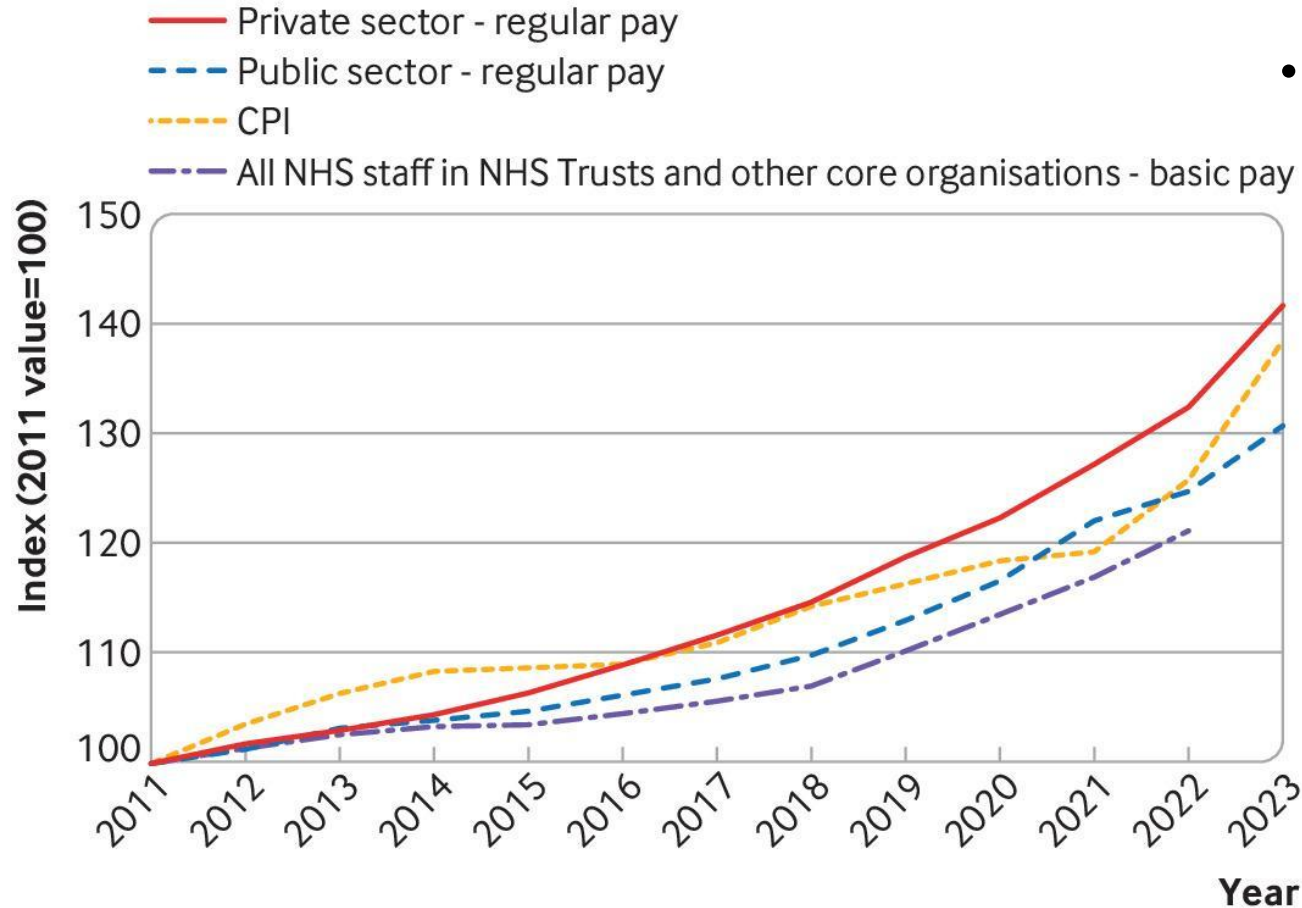
Healthcare price levels



Wages can grow more slowly than consumer prices... but not forever!

Suppressing wages indefinitely:

- Could lead to shifts to private sector (bad for equity of access)
- Could lead to recruitment/retention challenges (bad for outcomes)



Samuel Rigby et al. BMJ 2023;381:bmj-2023-075144

ANALYSIS

How inflation threatens the NHS and what policy makers can do about it

Jonathan Cylus and colleagues argue that inflationary pressures mean the NHS may have reached the limit on its ability to contain costs for goods and staff without affecting care

Samuel Rigby,¹ Hadjer Nacer,¹ Samantha Field,¹ Irene Papanicolas,^{2,3} Martin McKee,^{1,4} Jonathan Cylus^{1,2,3,4,5,6}

Inflation in the UK has soared to a rate not seen in four decades. Growth in the consumer price index (CPI), which captures price changes across a standard basket of household goods and services, reached a peak of 11.1% between October 2021 and October 2022 and remains above historical averages.¹ As a major employer and purchaser of goods and services, the NHS is inevitably exposed to macroeconomic conditions, including price changes. Internal estimates suggest inflation alone may cost the NHS £6bn-£7bn in 2023-24,² equivalent to around 4% of the £160bn NHS England budget.³ At the same time the NHS is facing record demand. In February 2023, 7.2 million people were on waiting lists for NHS consultant appointments, twice the number waiting for care in 2015.⁴

NHS operational budget, even small increases in pay will greatly affect expenditure.¹²

In addition to putting pressure on the aforementioned prices, inflation has other indirect effects. Many private finance initiative schemes used to build new hospitals or to pay for other infrastructure are structured so that trusts bear the risk of the increased interest rates used to curb inflation.¹³ Inflation may also adversely affect population health as people struggle with the costs of food and energy, thereby increasing demand for health services.¹⁴

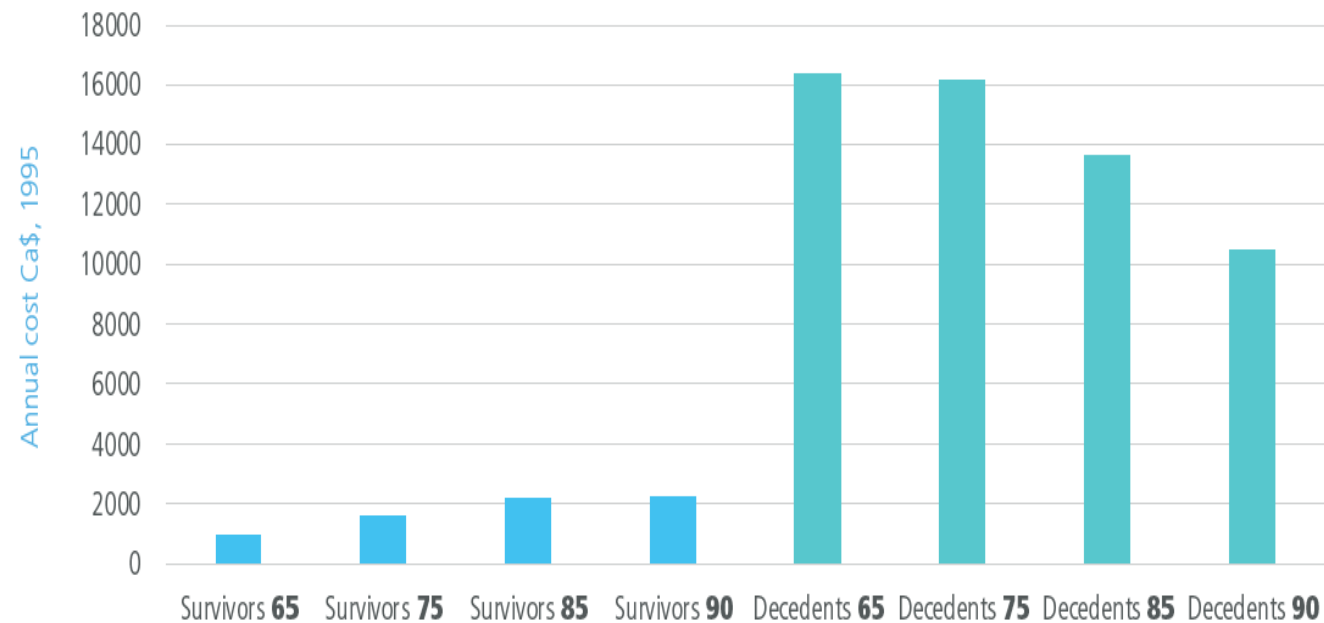
Most health prices have been kept artificially low

Although NHS providers have been unable to avoid

There may be some scope to reduce volume by disinvesting from low-value care

- Rationalize end of life care?
- Avoid duplicate diagnostics
- Incentivize care in the right place
 - 20.6% of spending is in inpatient settings in EST (EU average: 24.9%)
- HTA “re-assessments”, “Do not do” lists, and exploring variations in clinical practice

Figure 3: Costs of medical care in last 6 months of life or similar period for survivors



Supply vs. demand side interventions to reduce low value care

- Supply-side interventions tend to have fewer adverse consequences
 - Pay for performance (rewarding better than penalizing)
 - Payer restrictions (ie. some form of gatekeeping)
 - Clinical decision support tools (e.g. prompts integrated into information systems)
- Mix of interventions probably works best

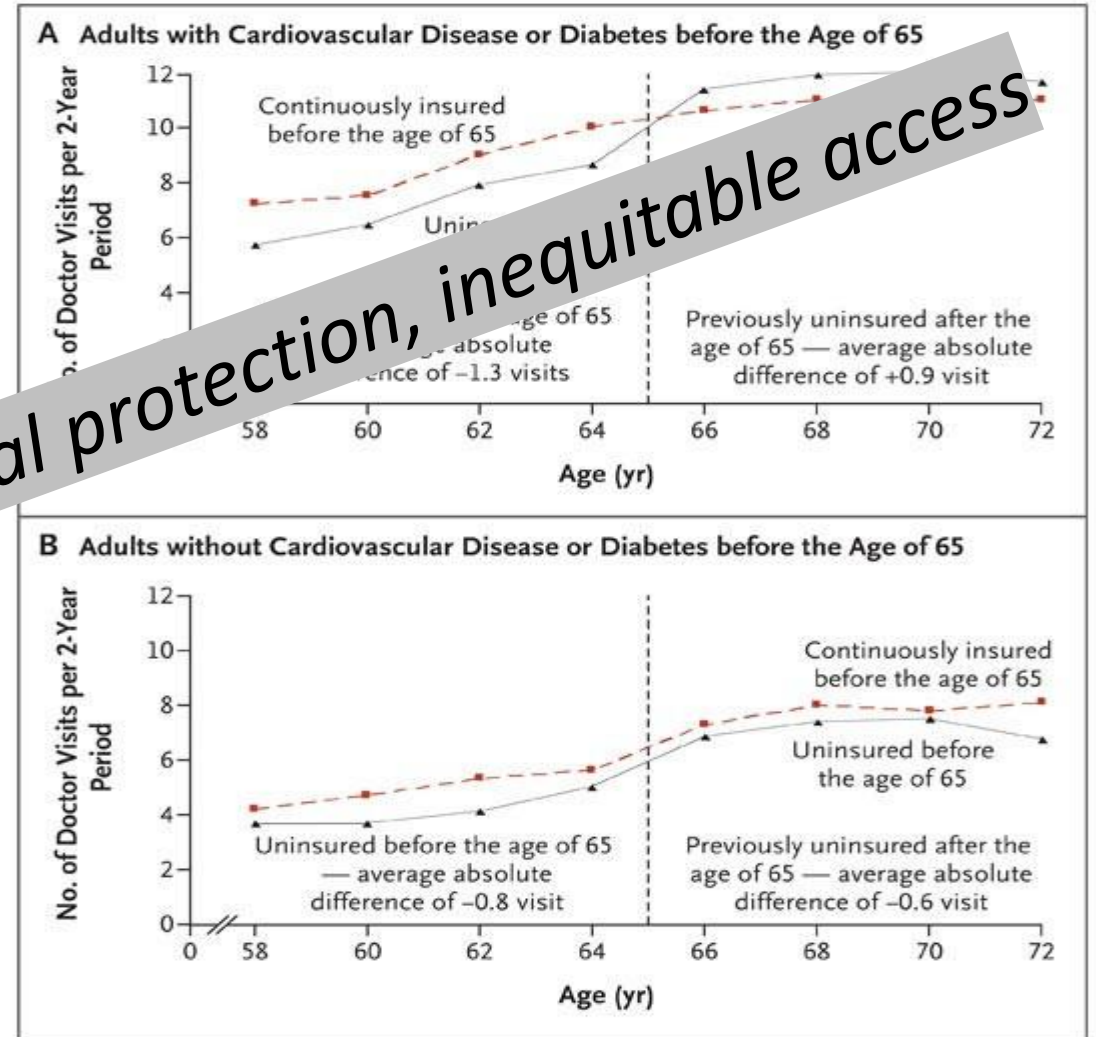
Demand-side interventions	
Nonfinancial	Financial
<ul style="list-style-type: none"> • Educational interventions (public awareness campaigns and patient information leaflets) – strong evidence • Shared decision-making between patients and clinicians – mixed evidence • Public reporting of variation in provision of low-value care between health care providers – weak evidence 	<ul style="list-style-type: none"> • Cost-sharing for low-value health technologies and treatments (co-payments, deductibles, and co-insurance) – strong evidence • Removal of low-value health technologies and treatments from a benefits package (i.e. delisting or negative lists) – strong evidence • Reference pricing to improve generic prescribing – strong evidence
Supply-side interventions	
Nonfinancial	Financial
<ul style="list-style-type: none"> • Clinical decision support tools (embedded in health information technology systems, patient pathways and policies) – strong evidence • Educational interventions (awareness campaigns, continuing professional development) – mixed evidence • Feedback to providers (cycles of audit and feedback, individual feedback to prescribers) – mixed evidence 	<ul style="list-style-type: none"> • Pay for performance (financial incentives to reduce provision of low-value health technologies and treatments) – strong evidence • Penalties or fines for overprescribing or providing unnecessary care – weak evidence • Payer restrictions (through gatekeeping, or prior approval mechanisms) – strong evidence • Risk sharing (through capitation or global budgets) – mixed evidence

What policy approaches do not work?

Reducing population coverage is unlikely to save much money

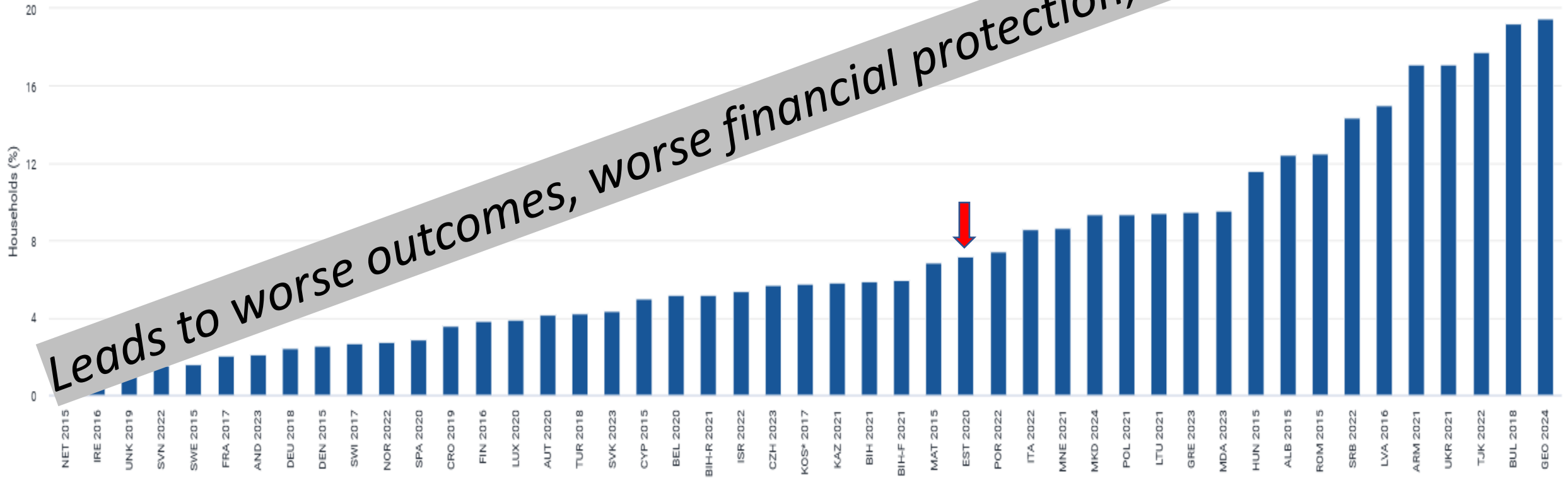
- Evidence from US Medicare program highlights beneficial effect of maintaining coverage over the lifecourse
- Coverage for Ukrainian migrant in Spain has been fairly inexpensive
 - Less than 1% of total health spending on
- Losing migrants from coverage in Spain was ultimately reversed

Leads to worse outcomes, worse financial protection, inequitable access



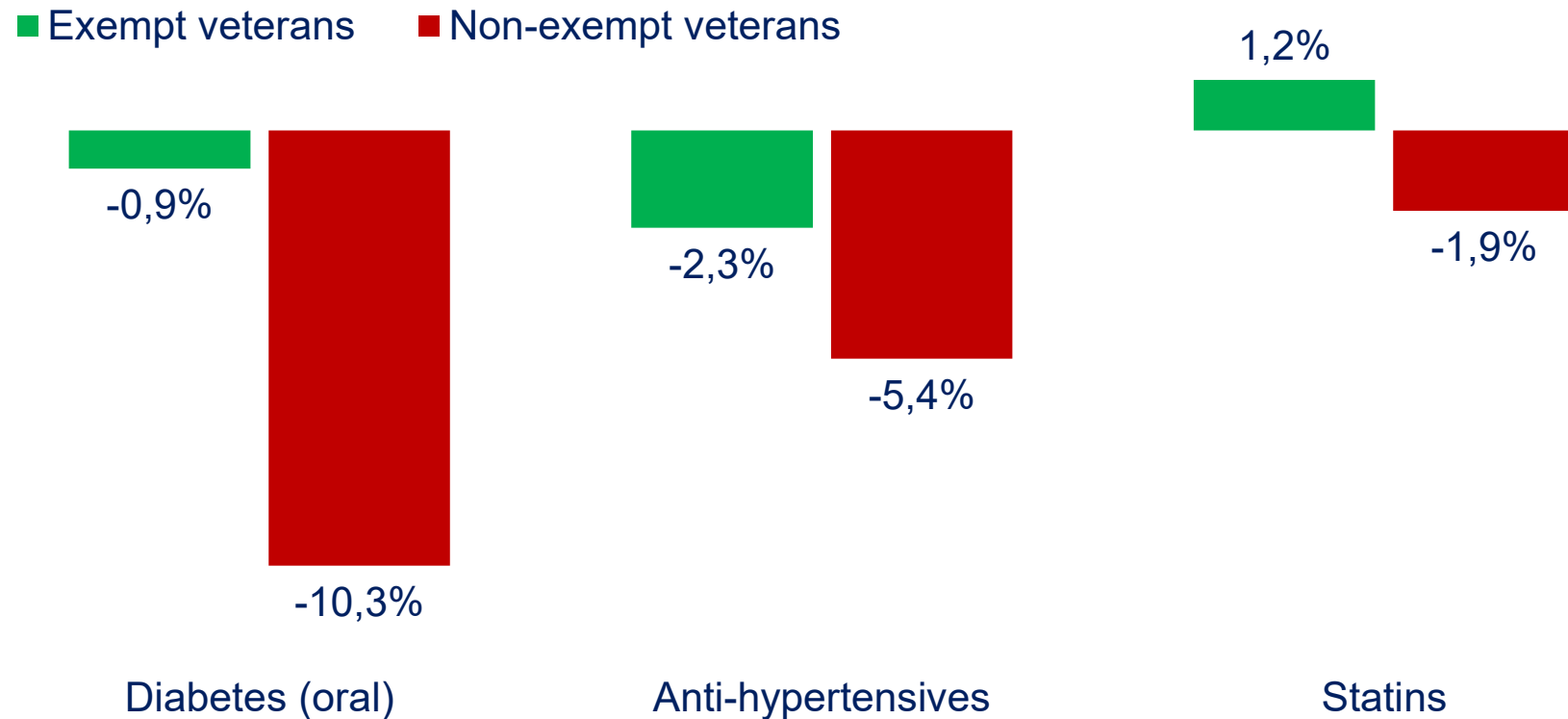
Co-payments are unlikely to be a good solution, especially with already high out-of-pocket spending

Households with catastrophic health spending



Co-payments reduce adherence to medicines for chronic conditions

Change in adherence after an increase in co-payments for war veterans

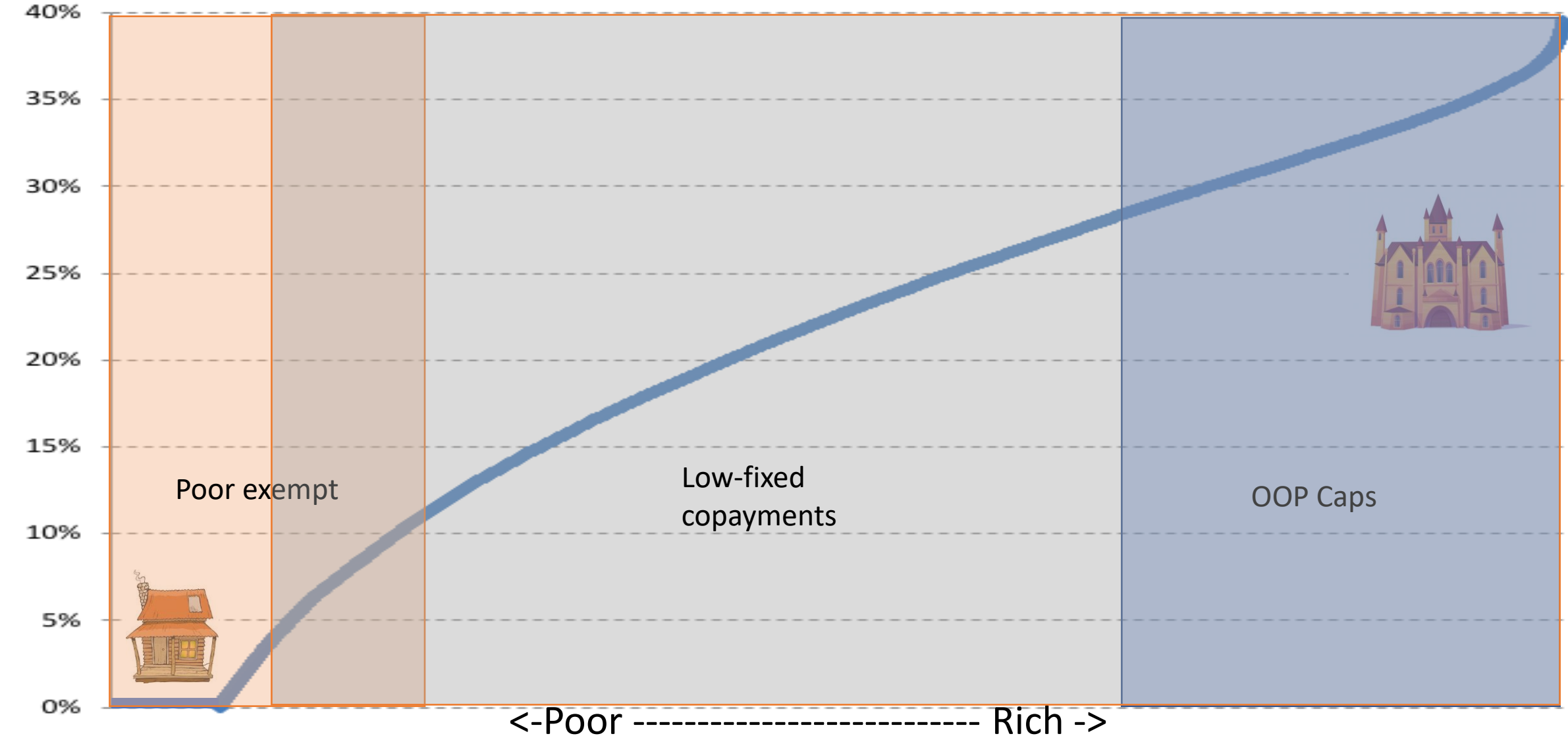


Finland recently increased co-payments, but they face access issues...

- January 2025 increase in primary and specialist user fees
- No automatic exemptions based on income (low-income people must apply for social assistance)
- There is a cap covering most services (but it is pretty high, 815 Euros as of 2026)
- Consistently among the highest rates of unmet need (on par though with Estonia...)

If you rely on more user charges you need a range of protective measures to avoid performance issues

OOP/budget



Incentivizing private insurance is unlikely to save money: insurers are risk averse and protect themselves – and it costs you tax revenues!!

PHI systematically favors



Leads to worse outcomes, worse financial protection, inequitable access

Ireland: >45% have VHI for faster access to hospitals

1957: richer people not covered for hospital care



Tax subsidies for PHI



PHI uses private beds in public hospitals; providers encouraged to prioritise PHI patients

1991: richer people covered for inpatient care



Demand for public hospital treatment grows



Waits increase; non-rich start to buy PHI



Waits increase even more



2002: public buys care from private hospitals



2013: tax subsidies for PHI reduced



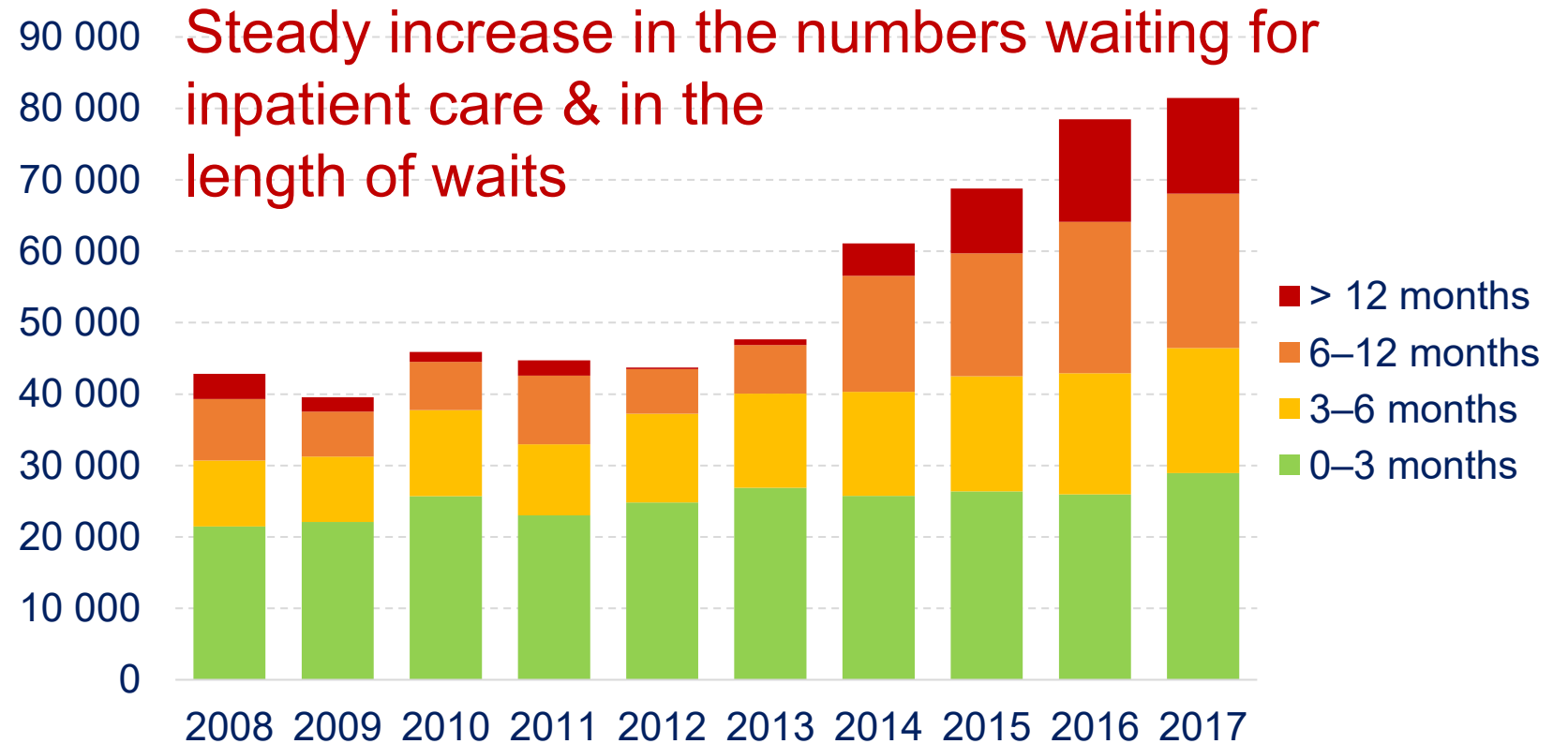
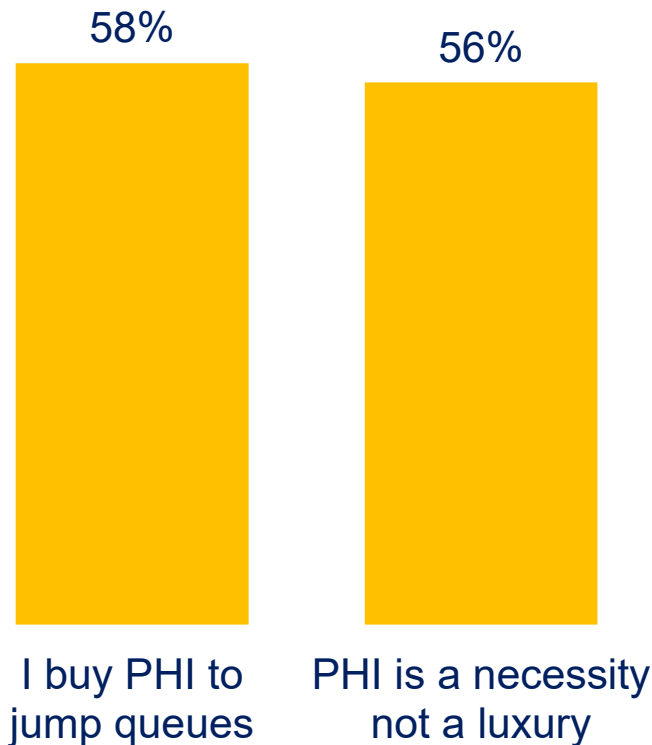
2015: penalties for not buying PHI when young



Ireland: indiscriminate tax subsidies, perverse incentives & blurred boundaries skew resources away from need

Poor people subsidise faster access for richer people

40% of PHI-financed care takes place in public hospitals



Other countries have used the cost-of-living crisis to reduce households' financial burden

- Hospital user charges in Ireland
- Voluntary health insurance in Slovenia



It is difficult to make cuts and not have adverse effects on performance

- You **can** get rid of low value care
- You **can** cut some prices or make them grow more slowly
- You **can** raise some user charges **but** with lots of protections (so it isn't necessarily going to achieve much)

- You **should not** cut population coverage
- You **should not** incentivize private insurance – tax credits reduce public revenues!
- You **should not** create barriers to services that you want people to use (and that they need)

- Question should not be about how to spend less but about how to spend better!
 - No increases in prices or volume should be allowed without demonstrably better outcomes
 - Final thought: be wary of AI as a solution to sustainability challenges because it is likely to increase volume