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Health Spending Growth at Zero

WHICH COUNTRIES, WHICH SECTORS ARE MOST AFFECTED?

David Morgan, Roberto Astolfi

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RÉSUMÉ

1. Il ressort de l'édition 2012 de la *Base de données de l'OCDE sur la santé* qu'après des années de progression constante, récemment les dépenses de santé se sont nettement ralenties, voire ont reculé, dans de nombreux pays de l'OCDE. Suite à la crise économique mondiale qui a commencé en 2008, un taux de progression nul des dépenses de santé a été enregistré en moyenne en 2010, et les premières estimations pour 2011 semblent indiquer une progression faible et même négative dans nombre des pays pour lesquels on dispose de données.

2. Le présent document analyse en détail le récent ralentissement des dépenses de santé, en mettant l'accent sur les pays et les postes de dépenses les plus concernés. On s'efforce ainsi d'établir des liens entre les chiffres – en utilisant les données sur les dépenses et d'autres données tirées de la *Base de données de l'OCDE sur la santé 2012* – et certaines des diverses mesures mises en œuvre depuis le début de la crise économique. En outre, à l'aide des données préliminaires sur 2011 et d'exemples de mesures prises récemment, les perspectives d'évolution à court terme des dépenses de santé sont esquissées.

3. Étant donné que les financements publics représentent environ les trois quarts des dépenses totales de santé en moyenne dans la zone OCDE, et compte tenu des fortes pressions qui s'exercent en faveur d'une réduction des déficits publics, l'analyse se concentre sur les postes de dépenses publiques les plus concernés dans un groupe de pays membres qui connaissent une hausse négative ou nettement réduite de leurs dépenses.

4. A partir de cette analyse, on peut tirer les conclusions suivantes :

- Bien que la progression des dépenses de santé ait été en moyenne égale à zéro en 2010 dans l'OCDE, elle reste très variable d'un pays membre à l'autre ;

- Les premières estimations de dépenses pour 2011 dans un sous-ensemble de pays membres donnent à penser que la tendance au ralentissement observée en 2010 se poursuit ;

- S'agissant des pays membres affichant une progression négative ou très réduite de leurs dépenses de santé, il semble que tous les principaux postes de dépenses à l'exception des soins de longue durée enregistrent un ralentissement plus ou moins marqué ;

- En règle générale, les dépenses consacrées aux services de santé publique et de prévention sont celles qui connaissent la plus forte baisse en moyenne, même si leur rôle est moindre dans le recul global des dépenses ;

- Ce sont les baisses de dépenses sur les soins ambulatoires qui contribuent le plus à la réduction globale des dépenses dans le groupe des pays les plus concernés.

EXCEUTIVE SUMMARY

5. Health spending slowed markedly or fell in many OECD countries recently after years of continuous growth, according to *OECD Health Data 2012*. As a result of the global economic crisis which began in 2008, a zero rate of growth in health expenditure was recorded on average in 2010, and preliminary estimates for 2011 suggest that low or negative growth in health spending continued in many of the countries for which data are available.

6. This paper analyses in detail the recent slowdown in health expenditure, looking at which countries and which sectors of spending have been most affected. In doing so, the paper tries to make some linkage between the figures – using both expenditure and non-expenditure data from *OECD Health Data 2012* – and some of the various policy measures put in place since the onset of the economic crisis. In addition, using preliminary data for 2011 and examples of more recent measures taken, the paper tries to shed light on the short-term prospect for health spending trends.

7. Given that public funds account for around three-quarters of total spending on health on average across the OECD, and in the context of the strong pressure to reduce public deficits, the analysis centres on which areas of public spending on health have been most affected for a group of OECD countries that have experienced negative or significantly reduced growth.

8. On the basis of this analysis, the following conclusions can be drawn:

- Although average OECD health spending growth was zero in 2010, there remained large variations in health spending growth across OECD countries;
- Preliminary spending estimates for 2011 for a sub-set of OECD countries suggest that the slowing trend of health spending observed in 2010 has continued;
- For those OECD countries reporting negative or significantly reduced health spending growth, it appears that all main sectors of spending, apart from long-term care, have been reduced to varying degrees;
- In overall terms, spending on public health and prevention services has seen the greatest reduction on average, although the contribution to overall spending decreases is less pronounced;
- Spending cuts on out-patient care services have been the largest contributor to overall decreases in spending for the group of countries most affected.

INTRODUCTION

9. For the first time since records began in 1960, health spending growth in real terms in 2010 was on average zero in the OECD area. Since the onset of the economic crisis in 2008, health spending has stalled in many OECD countries after many years of continuous growth; and preliminary estimates for 2011 for a limited number of countries suggest that the slowdown continued.

10. The paper describes in detail the recent observed trends in health spending, identifying where the greatest falls in expenditure have taken place, both with respect to OECD countries and the main sectors of health care spending. Then, using the current evidence available, certain countries and groups of countries are identified according to the principal types of policy instruments that have been adopted during the economic crisis. In addition, using preliminary data for 2011 and more recent measures taken, the paper tries to assess the short-term prospects for health spending trends.

11. Given that public funds account for around three-quarters of total spending on health on average across the OECD, and in the context of strong pressures to cut public deficits, countries have adopted various measures to increase efficiency or adjust the resource allocations to health coming from the public budget. Governments, for the most part, wield a great deal of control over the supply and cost of health services and goods. Measures that control inputs, set caps to budgets, or freeze prices, can lead to significant cost savings or strongly contain the rate of growth in health spending. These tools have been utilised widely, albeit to varying degrees over time and across countries.

12. Reflecting the differences in health care systems across the OECD and the extent to which a country is affected by the economic downturn, a vast range of policy instruments have been implemented since the onset of the crisis. In some cases, countries were relatively unaffected or made commitments to ring-fence existing health spending - at least initially. In other cases planned reforms were accelerated or intensified in the face of a worsening fiscal situation. A broad categorisation of the different policy instruments to control public health care spending has been proposed (OECD, 2010 and Mladovsky *et al*., 2012). These can be generally described as:

- Adjusting the level of financial resources (e.g. budgetary measures, social contribution levels, etc);

- Regulating the demand for services (e.g. adjusting the scope of the benefit package or rationing services, and promoting healthy behaviour);

- Controlling the cost of care (e.g. wage controls, pharmaceutical prices, and administration costs).

13. However, it should be made clear that this paper restricts itself to identifying the trends in health expenditure between countries and across sectors and does not discuss the effectiveness of policy responses to the crisis or indeed the effect of such policies on the health status of the population.

DATA SOURCES AND LIMITATIONS

14. The following analysis makes extensive use of the available data – both expenditure and non-expenditure - from *OECD Health Data 2012*. However, this does impose certain limitations in so far as most recent health expenditure data for a majority of OECD countries refer to 2010 and preliminary data for 2011 are only available for a small number of countries. Thus, only the effects of early and immediate policy measures taken in 2008 and 2009 are reflected in the paper, whereas many additional measures have been taken or have come into force subsequently as economic conditions continued to be challenging in many OECD countries. Moreover, there is a limited level of detail available for the countries most affected and those imposing the more severe cuts in public spending.[1]

15. In addition, there is a lack of information on the financial resources that countries use to fund health spending. It is likely that reductions in taxes and contributions have occurred as a direct result of the economic crises. However, the current health expenditure data sources do not collect specific information on the sources used to fund health spending. Similarly, little information is available on the cost structure of the providers of health services (essentially this is limited to salaries). Finally, the lack of a specific health deflator does not allow a clear separation of the price from the volume. Available information is therefore limited to the consumption of health care goods and services in nominal terms which can only be deflated using the GDP deflator.[2]

16. The 2012 WHO report 'Health policy responses to the financial crisis in Europe'[3] has served as a rich source of information, documenting the various measures taken by European countries through a series of questionnaires sent out in March and April 2011. Additional information is available in the National Reform Programmes as presented by Member States in the framework of the EU Stability and Convergence programmes.[4]

1 Notably, Greece and Ireland currently do not produce detailed health accounts according to the System of Health Accounts (SHA).

2 That said, efforts are being made to fill some of these data gaps. For example, the implementation of *A System of Health Accounts 2011* will allow a much better tracking of the flow of revenues to the various health financing schemes, such as social insurance contributions or internal government transfers (from taxes), and progress made in the work on health-specific purchasing power parities (PPP) could support the development of internationally comparable deflators.

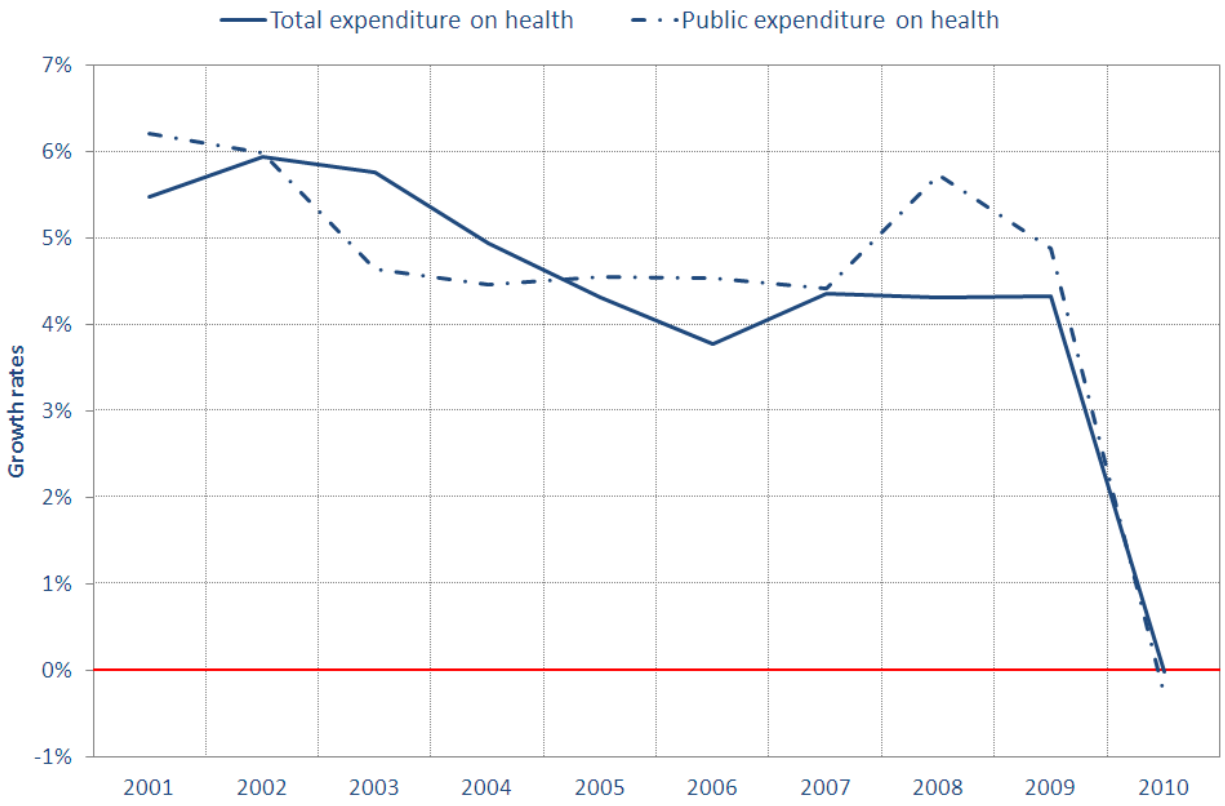
3 WHO Regional Office for Europe and European Observatory on Health Systems and Policies (Mladovsky *et al*., 2012)

4 http://ec.europa.eu/economy_finance/economic_governance/sgp/convergence/programmes/2012_en.htm

OVERVIEW OF RECENT HEALTH SPENDING TRENDS

17. The nil average growth rate, in real terms, in 2010 compares with health spending growth of 4.1% in 2009 and an annual average growth rate of 4.8% over the whole period 2000-2009 (Figure 1), when health spending continually outpaced economic growth resulting in an ever-increasing share of GDP. In 2010, health spending accounted for 9.5% of GDP on average across OECD countries, compared with 9.6% in 2009, when a sudden jump in the ratio occurred as overall economic conditions deteriorated.

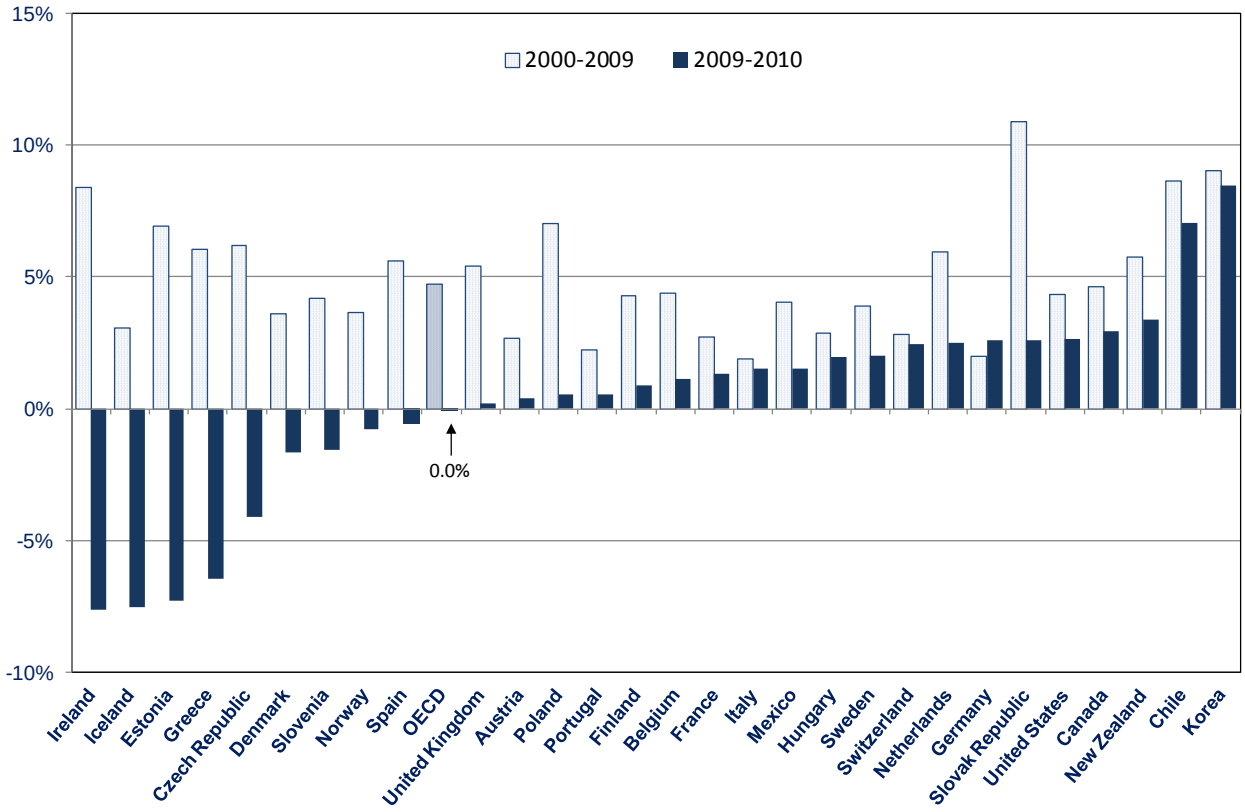
Figure 1. Average OECD health expenditure growth rates from 2000 to 2010, public and total



Source: OECD Health Data 2012

18. Apart from Germany, all OECD countries recorded a slowdown in health expenditure growth rates in 2010 compared with the period 2000 to 2009 (Figure 2). In a number of countries hardest hit by the economic downturn, some dramatic reversals in health spending occurred compared with the period before the crisis. In Ireland, total health spending in 2010 fell in real terms by 7.6%, compared with an annual average increase of 8.4% between 2000 and 2009. Similarly, in Estonia, after reaching almost 7% yearly growth from 2000 to 2009, health spending fell by 7.3% in 2010, and in Greece, preliminary estimates suggest that total health spending fell by 6.5% in 2010 after annual average growth of more than 6% since 2000. At the same time health spending still grew by around 3% in the United States, Canada and New Zealand, albeit below the average annual growth observed between 2000 and 2009. Growth in health spending remained very high, at more than 7% and 8% in Chile and Korea, respectively.

Figure 2. Average annual growth in health spending (in real terms) across OECD countries, 2000-2010



Note: Growth rates for 2009/10 are not available for Australia, Israel, Japan, Luxembourg and Turkey.

Source; OECD Health Data 2012

Preliminary figures for 2011

19. The available quantitative information suggests that a further slowdown in real health expenditure is likely to have been experienced in 2011. Preliminary estimates reported through the 2012 JHAQ data collection indicate that the unweighted average growth rate for 10 OECD countries may have fallen by approximately 0.5 percentage points in 2011 from 1.2% in 2010 to 0.7% in 2011 (Table 1).

Table 1. Preliminary estimates of 2011 health spending growth rate (in real terms) compared with 2010

Country	2010	2011
Canada	3.0%	0.7%
Finland	0.9%	1.5%
France*	1.3%	1.2%
Iceland	-7.5%	-1.8%
Italy	1.5%	-1.3%
Korea	8.5%	5.7%
Netherlands*	2.5%	1.2%
Norway	-0.8%	2.4%
Portugal*	0.6%	-5.2%
Switzerland	2.4%	2.9%
Average	**1.2%**	**0.7%**

* Refers to Total current expenditure HC.1-HC.9 (Individual and collective health care), i.e. excluding capital expenditure

Source: OECD Health Data 2012, Comptes nationaux de la santé 2011, Document de travail, Série Statistiques, n°172, Drees,

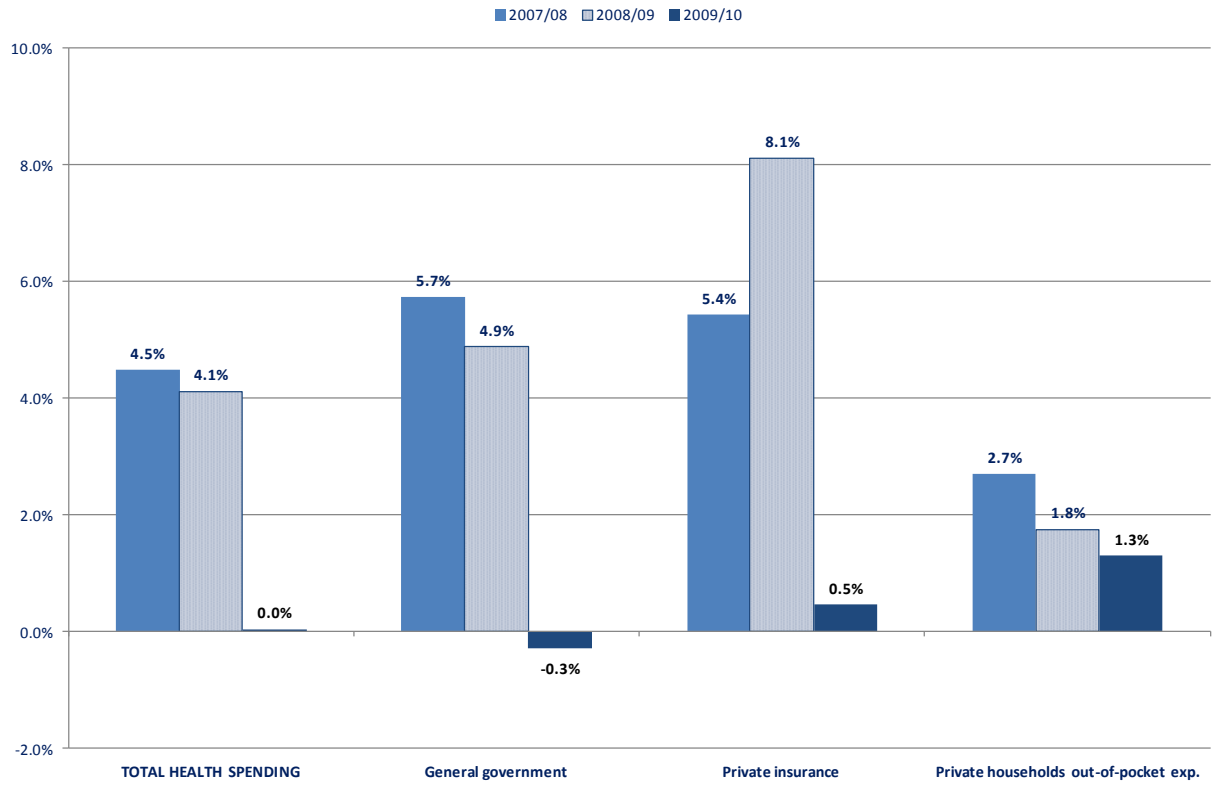
Cuts in public spending on health

20. Since public financing accounts for around three-quarters of overall health spending on average across OECD countries, much of the overall drop in total spending can be attributed to the decrease in public expenditure on health. While the overall level of government health spending tended to be maintained in the immediate wake of the economic slowdown - even in some of the hardest-hit countries - cuts in public spending really began to take more widespread effect in 2010. Growth in public spending on health averaged -0.3% in 2010 compared with 4.9% in 2009 (Figure 3). By contrast, spending on health care by households continued to grow over the period. This may be in part due to additional cost-sharing measures in a number of countries shifting the financing burden away from public to private sources. That said, there was still a decrease in the growth rate from 2.7% in 2008 to 1.3% in 2010.

21. In a number of European countries, drastic measures to cut public spending were put in place. Iceland, Ireland and Greece saw public expenditure on health fall, in real terms, by 9.3%, 9.9% and 10.8% respectively between 2009 and 2010. Some other countries, particularly European countries hit hard by the crisis such as Estonia, Czech Republic, Spain and Slovenia, saw more modest falls in public health spending of between 1% and 4%. By contrast, both France and Italy saw public health spending continuing to show a small increase of around 1.5% in 2010.

22. Outside of Europe, government health spending continued to grow in 2010 – albeit slower than previous years, but still at 3.1% in Canada, 3.6% in New Zealand ,4.5%, in the United States, and 8.6% in Korea.

Figure 3. Average annual growth in health spending by type of financing, 2008-2010



Source: OECD Health Data 2012

Reductions in spending across most sectors

23. To assess which sectors of the health care system have seen the greatest decreases in expenditure, it would appear more insightful to restrict the analysis to public expenditure, and to those countries that experienced negative growth in public spending on health in either 2009 or 2010 and/or a significant reduction in growth in 2010 compared with 2009. This yields a sample of 17 countries.[5]

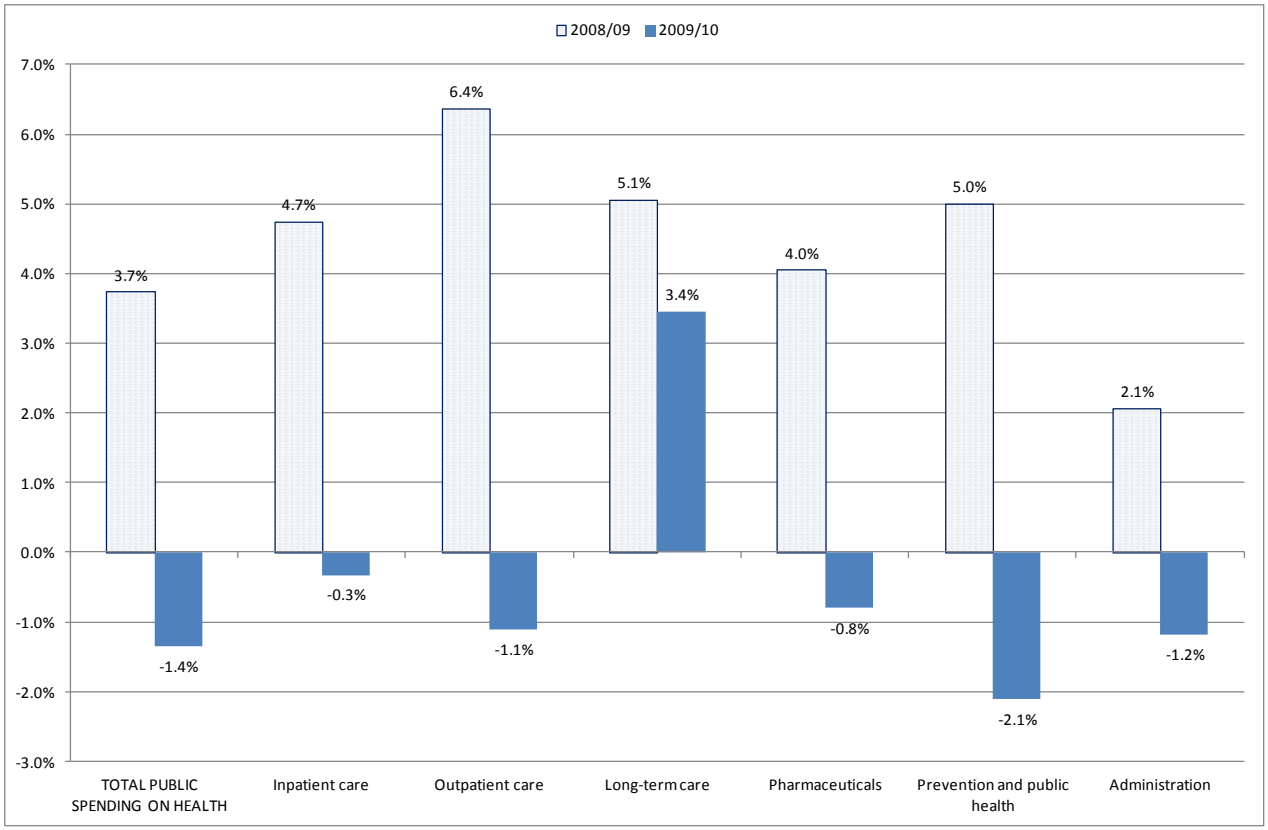
24. For this subset of countries, the growth in total public health spending in 2009 was 3.7% (compared with an overall OECD average of 4.8%), but with a more pronounced drop of 1.4% in 2010 (Figure 4). The three main areas of spending - inpatient, outpatient and pharmaceuticals - all suffered major reversals in growth, reflecting the various policy instruments put in place and detailed in the following section. The most significant drop was in out-patient or ambulatory care (and on closer inspection would suggest in the area of specialist care, although the data split between general and specialist care is less robust), where strong growth of 6.4% in 2009 turned into a decrease of 1.1% on average in 2010. It is notable that this has been a major contributor to the overall decrease in public health spending.

25. On the other hand, the provision of long-term care services has continued to be a cost pressure, even in those countries affected by the crisis, with average growth at 3.4% between 2008 and 2010. Regarding collective services, for which government plays the primary financing role in most countries but

5 Belgium, Canada, Czech Republic, Denmark, Estonia, Hungary, Greece, Iceland, Ireland, Italy, Mexico, New Zealand, Poland, Portugal, Slovenia, Spain and United Kingdom.

which contribute less to the overall total government spending, both spending on prevention services and on health administration suffered strong reversals in 2010. Prevention and public health spending in particular recorded an annual average decrease in real terms of 2.1% between 2008 and 2010 as programmes were either shelved or postponed.

Figure 4. Average growth by main function of health care for selected OECD countries, public expenditure, 2008-2010



Source: OECD Health Data 2012

26. A range of policy measures, including spending cuts, targeting resources more efficiently or shifting costs from the public to the private sector have been adopted to control the rise in health spending since the onset of the economic crisis. The following section reviews the various measures taken according to these three main policy domains.

MEASURES TO ADJUST THE LEVEL OF FINANCIAL RESOURCES

27. In the immediate wake of the economic crisis a number of countries made commitments to safeguard health care budgets in the short term but undertook reductions in subsequent years. Estonia, for example, was able to draw on some of the financial reserves built up in previous years to fill the immediate

gaps left by decreasing social contributions in 2009. In Ireland, the health budget actually increased by 1% in 2009, but cost-containment measures were implemented in 2011 with the overall budget for health cut by 6.6%.

28. In Portugal, the government made commitments to achieve significant savings in 2011 and 2012. Savings were made by reducing tax allowances and health benefit schemes for civil servants as well as cutting the number of management staff, as a result of concentration and rationalisation in state hospitals and health centres. In September 2011, the country announced an 11% reduction in the NHS budget for 2012, twice the budget cut under the EU/IMF bailout agreement.[6]

29. Others countries made more immediate cuts from the outset – for example, the budget of the Czech Ministry of Health was cut by around 30% between 2008 and 2010. A similar scenario occurred in Slovenia and Iceland (5% annual cut to the budget).

30. While Belgium maintained budgets at previous levels, France and Denmark saw rising health budgets in the short-term – in the latter case, the health budget was cross-subsidised by cuts in the education budget. As part of the Spending Review in the United Kingdom in October 2010[7], the spending plans for the English National Health Service (NHS) for the period 2011/12 to 2014/15 were laid out, amounting to a total real increase over the period of only 0.4%. The NHS also committed to making £20 billion annual efficiency savings over the same period through the Quality, Innovation, Productivity and Prevention (QIPP) programme.

31. In a number of countries with statutory health insurance schemes, dwindling revenues due to rising unemployment and higher health demands resulted in some planned increases in the employee or employer contribution rates e.g. in the cases of Greece and Portugal, or a tightening of the collection measures, as in the case of Slovenia.

32. In Hungary, in order to compensate for the loss of revenues in the National Health Insurance Fund, the funding mechanism was shifted significantly in 2009 with a reduction in the employers' contribution rate (meant to stimulate the labour market) with the shortfall being compensated by government transfers from general tax revenues (Figure 5).

33. A widespread measure has been the increase (or introduction) of user charges for health services, or in some cases, the removal of eligibility for a proportion of the population for some health services. This has resulted in a shift of the financing burden from public to private sources. As a result, while government spending contracted in many affected countries, there were increases in household expenditure and health care services covered by private insurance, particularly in 2009. Many of the co-payment measures were planned to come into force in 2011 and 2012 and are yet to show in the expenditure figures.

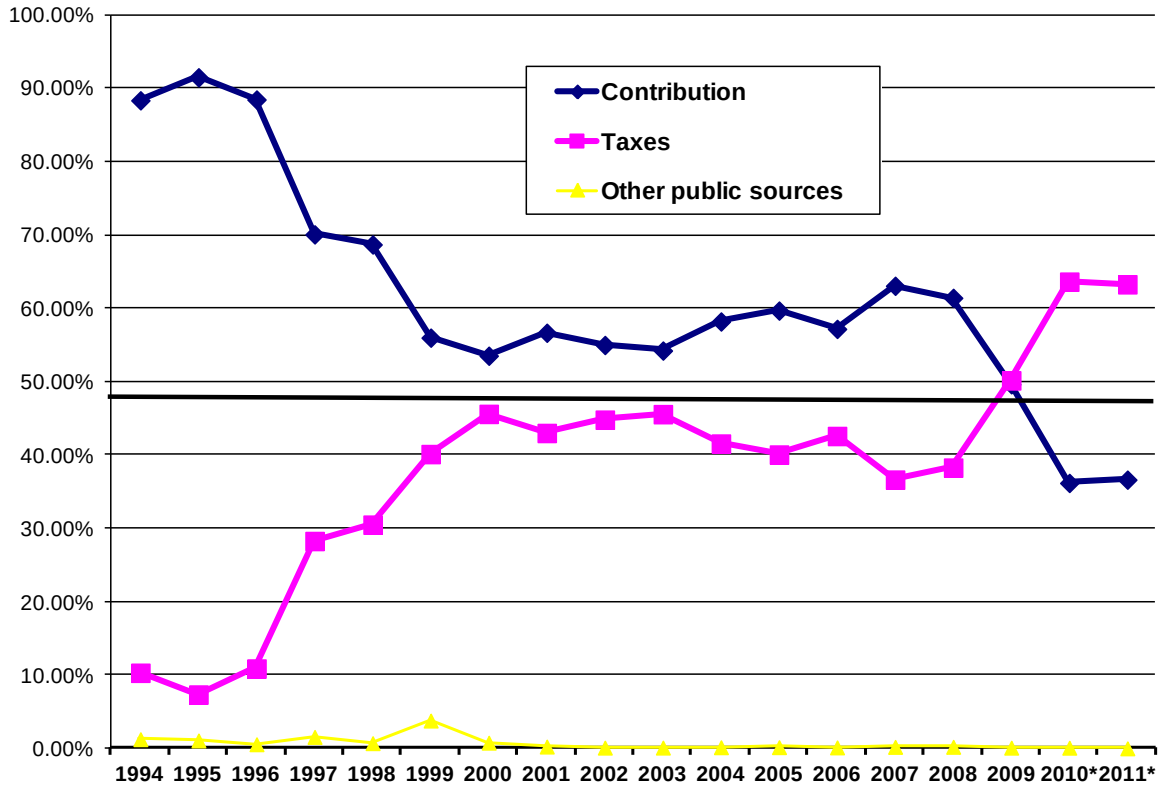
34. For example, the Czech Republic saw a more than 50% increase in out-of pocket payments for in-patient services in 2009. Further measures from 2012 will adjust the thresholds for standard costs of treatments defined so that patients willing to opt for more expensive treatments will be obliged to pay the difference between the actual cost and the standard amount paid by the health insurance company. Non-prescribed drugs will be funded exclusively out of pocket, while hospitalisation fees have been increased by more than 60 % (from CZK 60 to CZK 100 per day from 1 December 2011). In France, the Statutory Health Insurance Fund (CNAMTS) applied new rules in 2009 (extending similar rules brought in during 2007) increasing the charges covered by patients who do not follow the agreed medical pathway: co-

6 Economist Intelligence Unit (2011), "Portugal healthcare: Hospitals for sale", Economist Intelligence Unit, London.

7 http://cdn.hm-treasury.gov.uk/sr2010_completereport.pdf

payments previously fixed at 30% of the social security tariff before 2007 increased to 50% and then up to 70% in 2009.

Figure 5. The share of various revenue sources of the Hungarian Health Insurance Fund, 1993-2011.



Source: Szigeti, Sz., Evetovits, T., Gaál, P. (2012)

35. In 2009, the effect of changes to coverage in Ireland contributed to an increase of around 40% in private insurance pay-outs for health services, and the share of out-of-pocket spending increased by 1.7 percentage points between 2008 and 2010. In Iceland, the share of out-of-pocket spending increased by 2.2 percentage points over the same period. In both cases this reversed a trend of a decreasing burden on households since 2000.

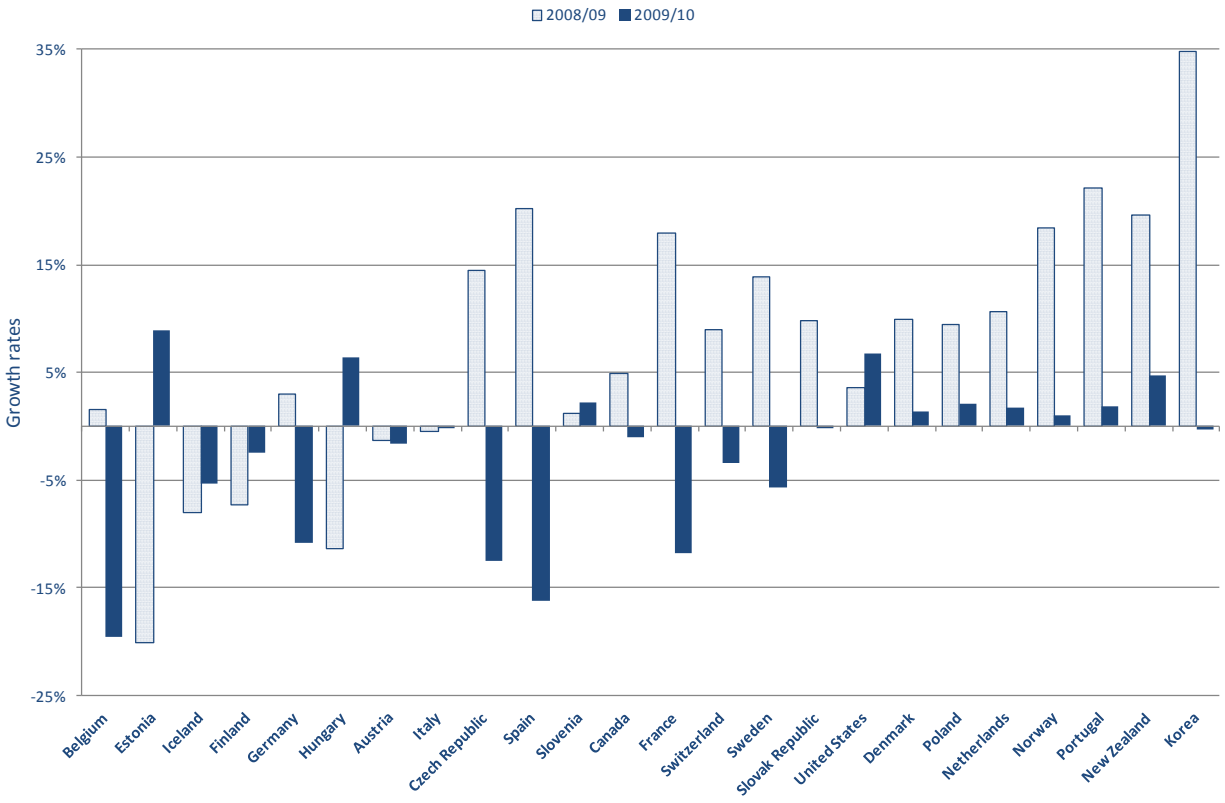
CONTROLLING THE DEMAND FOR SERVICES

36. Policies to control the demand for services, such as through health promotion campaigns to reduce alcohol and tobacco consumption or to improve healthier living may be seen as more longer-term strategies rather than policies to immediately tackle public sector deficits. In fact, as can be seen in Figure

4, there were significant reductions in government spending in the area of prevention and public health in 2010. When examined on a country-by-country basis, it can also be seen that most of the countries who reduced overall public spending on health, such as Estonia, Iceland and Hungary, made large reductions in the amount allocated to prevention and public health between 2008 and 2010 – only Portugal stands out as the country from this group that increased spending in this area in 2010 (Figure 6).

37. However, the outbreak of the Influenza A (H1N1) virus in 2009 and the resulting bulk purchase of vaccines helps to explain some of the large increases in prevention expenditure in 2009 and subsequent decreases in 2010. Nevertheless, detailed national sources for France and Germany suggest that removing expenditure related to H1N1 vaccines altogether still resulted in a decrease of around 2% in real terms in prevention expenditure in 2010.[8]

Figure 6. Annual growth in government spending on prevention and public health services, 2008-2010



Note: Countries ranked on annual average growth rates between 2008 and 2010

Source: OECD Health Data 2012

38. In terms of amending the benefit package, it would appear, at least in the early stages, that few changes took place in terms of coverage in line with the fundamental objective of maintaining access to care for the population, or the most vulnerable sections of the population. Subsequent measures may have been taken in the light of the ongoing pressures on government finances. However, only Ireland removed

8 KJ1 Statistics - Summarised financial records of the Statutory Health Insurance Funds: http://www.bmg.bund.de/krankenversicherung/zahlen-und-fakten-zur-krankenversicherung.html
Comptes nationaux de la santé 2011, Document de travail, Série statistiques, n°172, septembre 2012 http://www.drees.sante.gouv.fr/IMG/pdf/seriestat172.pdf

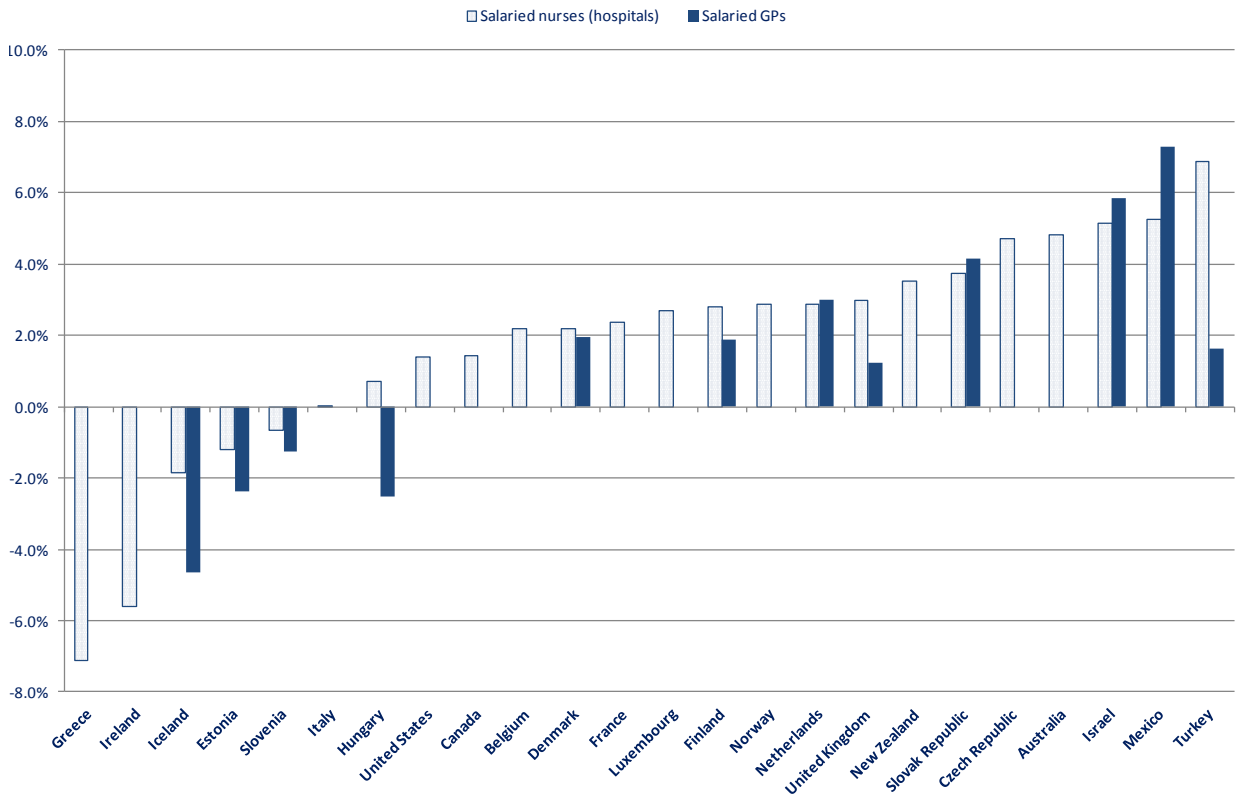
the eligibility of wealthy individuals for statutory coverage of primary care, while the Czech Republic tightened the entitlement for coverage for foreigners.

AMENDING THE COST OF CARE

39. Given the high proportion of health care spending accounted for by wages and salaries – more than 42% of public spending in the 18 countries of the WHO European Region for which data are available (WHO, 2006) - an immediate measure taken in some of the hardest hit countries has been to cut wages and salaries, or reduce the size of the health care workforce. In Ireland, for example, a series of measures from 2009 resulted in a freeze on recruitment and promotion as well as actual cuts in wages or reductions in the number of healthcare workers, lower fees paid to GPs and other health professionals and pharmaceutical companies and an accelerated programme of early retirement and voluntary redundancy. Similarly in Iceland, cuts in overtime, night shifts and training were imposed as well as actual salary cuts and reductions in the workforce.

40. Figure 7 shows that the decrease in average remunerations for nurses (in hospitals) and salaried GPs across a large sample of OECD countries. Greece, Ireland and Iceland all show significant reductions in salaries between 2009 and 2010.

Figure 7. Nominal change in average nurse and GP remunerations, 2009-2010



Source: OECD Health Data 2012

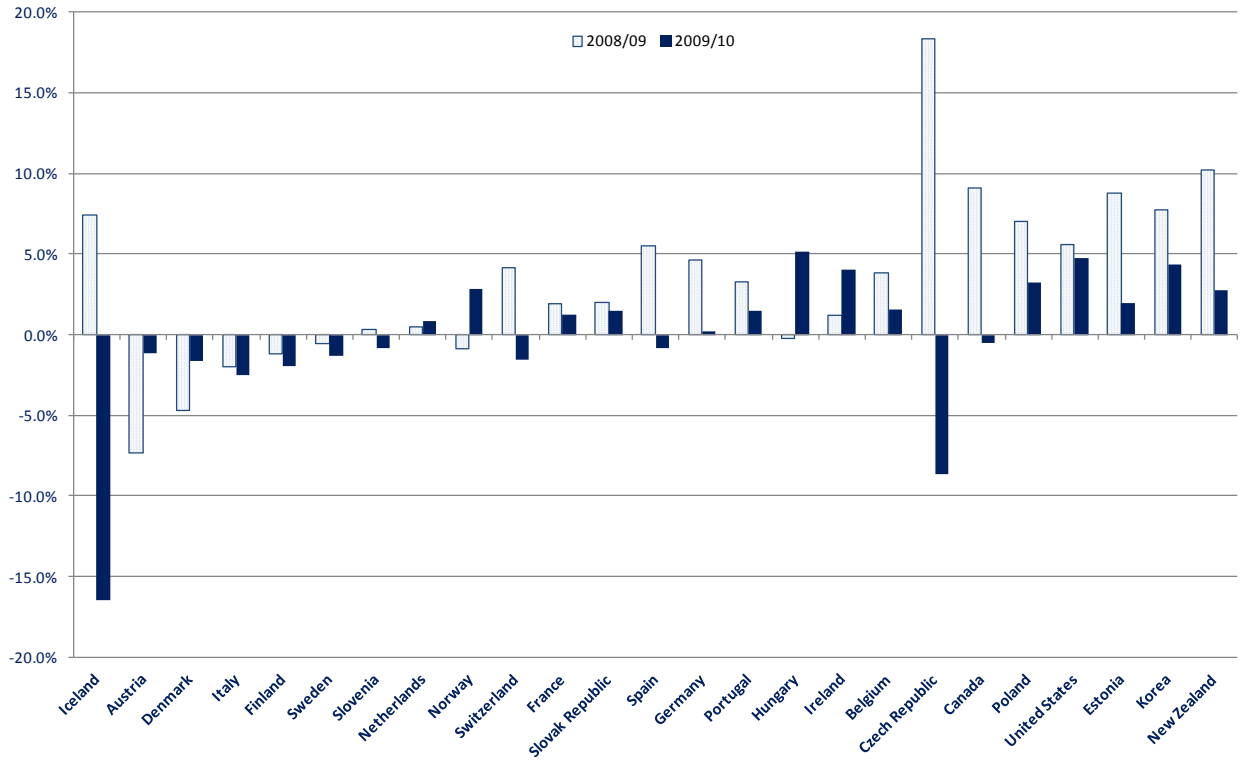
41. Concerning payments to providers, a number of measures have been put in place by countries. In the Czech Republic, there was no increase in the reimbursement of hospitals from the insurance funds in 2010. There is also a change towards DRG-based payments to be introduced in 2012. Estonia targeted the payments to the health care providers by reducing the prices of health care services by 6% from 2009, following rapidly increasing prices before the crisis. Prices in primary care saw a lower reduction of around 3%.

42. As mentioned above, Ireland introduced a significant reduction in fees to health professionals, imposing an 8% cut in 2009 with further cuts of 5% in 2010 and 2011. Similarly, Slovenia introduced price reductions of 2.5% on health services with related penalties for those health care providers breaching the contracts.

43. Many countries have also introduced measures to contain government spending on pharmaceuticals (Figure 8) which is one of the main components of overall public health spending (around 17.5% of current health expenditure on average across OECD countries). At the onset of the crisis, reforms were already planned in a number of countries and were accelerated or intensified in the aftermath of the crises. Countries such as Greece and Ireland had historically reported high per capita spending on pharmaceuticals, and sought to reduce the bill. In Greece, pharmaceutical savings through negotiated prices and other cost-cutting measures helped to reduce health spending overall by around 3bn Euros by 2011, contributing to a reduction in the overall public deficit equivalent to 1% of GDP.[9]

[9] Based on presentation made to the 14th OECD Meeting of Health Accounts, October 10-11, 2012. http://www.oecd.org/els/healthpoliciesanddata/Item13aGreecepresentationtoOECD(3).pdf

Figure 8. Annual growth in government spending (in real terms) on pharmaceutical and other medical non-durables, 2008-2010

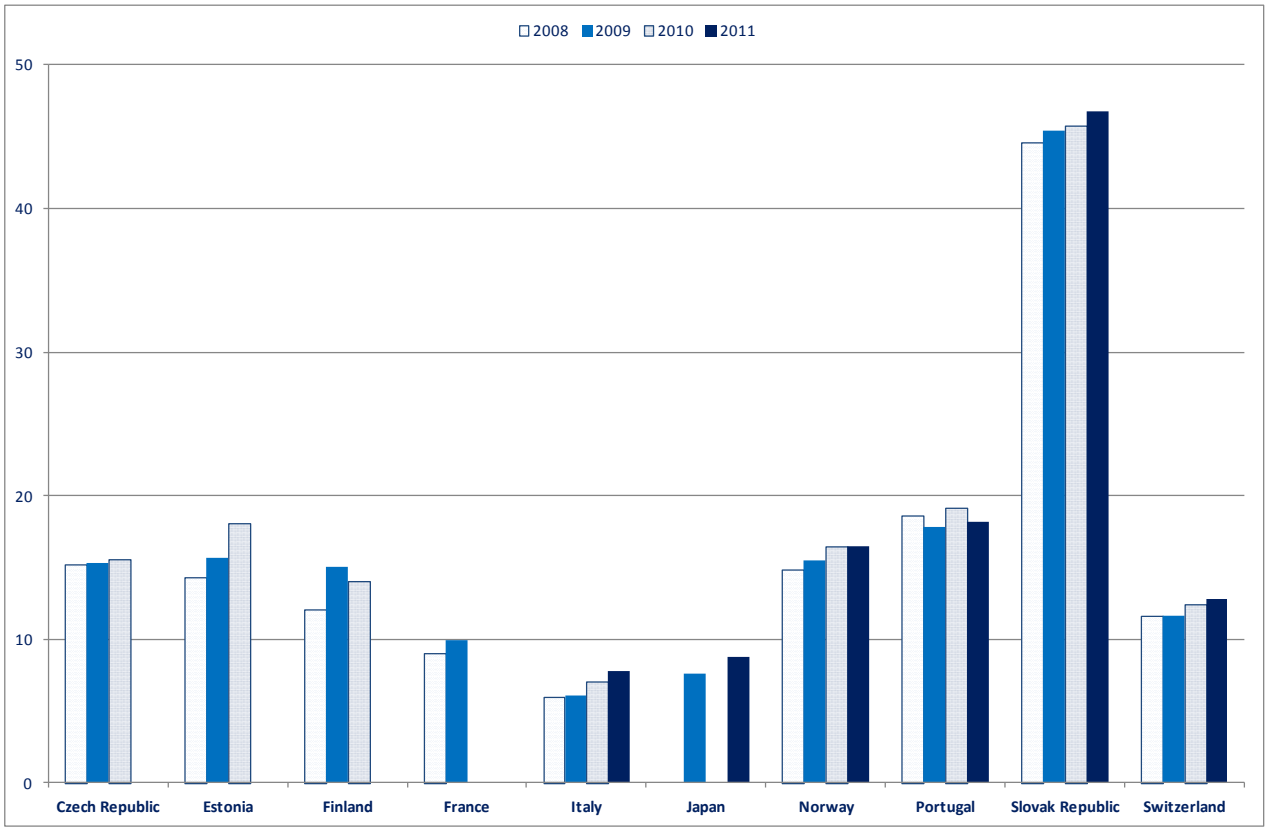


Note: Countries ranked on annual average growth rates between 2008 and 2010 from lowest to highest.

Source: OECD Health Data 2012

44. Other savings have been made in medical goods spending by introducing incentives to doctors for rational prescribing (e.g. Hungary). Portugal introduced a number of measures from 2011 aimed at price reductions on a series of pharmaceutical products, as well as centralised procurement of medicines and guidelines in order to reduce administration costs. There was also a general move in many countries towards increasing the share of generic drugs although there remain large variations in the market share of generics across countries (Figure 9). However, it may be concluded that based on an overall analysis, the reduction in pharmaceutical spending had less of an effect on reducing overall health spending compared with outpatient spending.

Figure 9. Share of generics (value) in the total pharmaceutical market, 2008-2011



Source: OECD Health Data 2012

45. A number of countries have also targeted the overhead costs of administering the health care system. Although only accounting for around 3% of total health spending, there is wide variation in the costs associated and scope for improved efficiency measures. Figures from health accounts suggest that that there were significant reductions in administrative costs in 2010 of between 6-10% in real terms in Austria, Czech Republic and Spain.

46. Finally, investment plans have also shelved in a number of countries, including Estonia, Ireland, Iceland and Czech Republic. Figures for a group of 20 OECD countries for which data are available suggest that capital spending by government is likely to have fallen on average by around 5% in 2009 and 2010.

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